

THE LEARNING CURVE

Volume XIII, 2024
ISSN : 2321-7057



Department of Psychology
Lady Shri Ram College for Women

The Learning Curve

Department of Psychology

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ISSN: 2321-7057

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Building Cultures & Plugging Gaps: Paving the Long Road to Women's Inclusion at Work

Kanika K. Ahuja¹ & Megha Dhillon²

Abstract: Diversity and inclusion are currently extremely popular subject matters of discussion at work places. While the global female labor force participation has remained fairly flat over the last three decades, in India it has declined. Many companies speak of their earnest commitment to gender equity. However, to what extent have these discussions and claims of commitment, translated into meaningful progress? Women still remain under-represented at every level. Processes of hiring and promotion continue to favour men. Income disparities remain significantly noticeable. We must develop cultures of work wherein all employees feel respected and have equal opportunities to grow and advance. This article explores the inequalities that continue to persist, the factors that contribute to gender gaps and our recommendations to address these gaps in the work sector. We place emphasis on the need for companies to take more decisive action by treating gender diversity as a business priority and embedding it into policies that make work places more welcoming for women.

Keywords: Women at workplace; Glass Ceiling; Diversity and Inclusion; Female labor force participation; Gender gap

Nearly half of the world's population is women. Yet, women face poorer income opportunities compared to men across the world. The global labor force participation rate for women is barely over 50% compared to 80% for men (The World Bank, 2022). Women have fewer options for business expansion and career advancement, as well as a lower likelihood of working in formal employment. And even when women work, they earn less - 77 cents for every \$1 paid to men (The World Bank, 2024). With respect to India, the World Economic Forum ranked our country 135 out of 146 in its Global Gender Gap Index for 2022 (Global Gender Gap Report, 2023). While men earn 82% of the labour income in India, women earn 18% (World Inequality Report, 2022). Recent evidence suggests that these gender gaps have exacerbated due to the COVID-19 pandemic (e.g., Collins, Landivar, Ruppanner, & Scarborough, 2021; Villarreal & Yu, 2022).

Are women less likely to actively seek work? In 2016, ILO and Gallup surveyed women around the world and found that this was not true. An overwhelming 70% of women wanted to be in paid employment (ILO, 2022). However, a persistent set of socio-economic barriers keep them out of the

workforce. Globally, while female labor force participation has remained fairly flat over the last three decades, in India it has *declined* from 34.1 per cent in 1999-00 to 27.2 per cent in 2011-12. The current gender gap in India stands at 50.9, with only 19.2% women participating in labour workforce as opposed to 70.1% men (ILO, 2022). Researches undertaken to analyze this baffling trend of low and declining female labor force participation in India have focused on explanations like rising education and income effect, measurement issues leading to underestimation, lack of employment opportunities, the structural transformation of the economy, and the socio-cultural set up (e.g., Mehrotra & Parida, 2017; Rangarajan, Kaul, & Seema, 2011; Sanghi, Srija, & Vijay, 2015). The lack of basic facilities is another critical factor keeping women from entering the workforce. For instance, many employers in India have failed to provide sufficient and separate toilet facilities for female workers, leaving them struggling to find safe sanitation. In March 2022, the Union Finance Ministry asked all public sector banks and financial institutions to take the necessary steps to provide separate toilets for female bank workers, in response to such grievances received from the Bank Employees Federation of India (BEFI) (Bandyopadhyay, 2023).

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Women representation in corporate India is around 17%. GCCs (global capability centres) in India, however, have made good progress in promoting gender diversity, with nearly five lakh women currently employed, representing 28% of the total employees according to a recent Pure Storage and Zinnov report titled 'Towards a Gender Equitable World' (Nearly 5 lakh women employed in Indian GCCs, 2024). Despite these encouraging numbers, it is sobering to note that at the senior level (9-12 years of experience), the representation of women falls to 15.7%, further declining to 6.7% in executive roles. The percentage of women holding board seats in corporate India stands at 18.3% (lower than the global average of 23.3 per cent), those chairing boards drops to a dismal 4.1%, and women CEOs still only at 5.1%. A similar glass ceiling can be seen the world over. For instance, women account for only 8% of Fortune 500 company CEOs (Hinchliffe, 2021) and 30% of S&P 500 directors (Spencer Stuart Board Index, 2021) in the U.S.

Maximum attrition is seen at mid-senior levels due to factors such as family and caregiving responsibilities, limited access to career advancement and opportunities, and poor work-life balance. Researchers suggest that women in comparison to men face higher role overload, a sense of having too many responsibilities to handle in a reasonable amount of time, specifically across the work-family interface. The paths between family-role overload and total-role overload and between family-role overload and perceived stress are significantly stronger for women in comparison to men (Duxbury, Stevenson, & Higgins, 2018). After all women are mothers, caregivers, daughters, wives, sisters, friends in addition to employees. We are not suggesting that men do not occupy multiple roles, but that women must juggle them with greater difficulty and accountability.

A study published by the Society for Human Resource Management (2022) showed that as women move up the ladder, they also become increasingly disillusioned about equal access. Women are less likely than men to feel included in key networks at their organization and to feel taken seriously as a leader. Additionally, women are less likely to say that their manager encourages them to take on leadership roles. Organizational practices of sharing internal job

openings further unfairly advantage men - more men are promoted internally than women. Female managers of color are even more disadvantaged: they are over five times more likely (21%) than their white female counterparts (4%) to say they have quit a job after being overlooked for a leadership opportunity at work.

Research suggests that although engaging in networking is crucial for career success (e.g. Wolff & Moser, 2009), women's professional networks are often less powerful and effective than men's (Hanson, 2000; Renzulli, Aldrich, & Moody, 2000; Rothstein, Burke, & Bristor, 2001). Not only do women face extrinsic barriers of structural exclusion resulting from work-family conflict and homophily, but also the intrinsic barrier of their own hesitations to instrumentalize social ties. As recipients, women are careful not to over-benefit and emphasize the moral aspects of reciprocity; as donors, they run the risk of underestimating and poorly marketing their own contributions in a professional context due to gendered modesty (Greguletz, Diehl, & Kreutzer, 2019). Earlier research on the 'feminine modesty' effect (Cialdini & De Nicholas, 1989) has shown that women underrepresent their achievements in public to avoid being perceived as unfeminine and to appear noncompetitive, perpetuating persistent gender inequalities at the workplace. Lack of self-promotion by women places them at a disadvantage relative to men in communicating their true qualities and achievements to employers, leading to suboptimal hiring and promotional opportunities, and ultimately, gender gap in labour force participation.

Another issue that continues to remain significant and under-addressed is the safety of women at the workplace. The Sexual Harassment of Women at Workplace (Prevention, Prohibition, and Redressal) Act, 2013 (POSH Act) was introduced over a decade ago to safeguard women from workplace harassment. The law requires an employer with more than 10 employees to form an Internal Complaints Committee (ICC) with whom women employees can file a formal sexual harassment complaint. ICCs have to be headed by a woman, have two or more employees, and an external member such as an NGO worker. The ICC should have a minimum of four members, at least half of whom should be female. The law also mandates the

creation of local committees (LC) at the district level to register complaints from women working in companies with less than 10 employees and from the informal sector. However recent events have revealed significant shortcomings in the implementation of the law. In 2023, the Supreme Court of India called out the problems in the constitution of ICCs, citing a report that 16 out of 30 national sports federations in the country had not constituted an ICC. It also pointed out the improper constitution of ICCs where established, suggesting that they either had an inadequate number of members or lacked a mandatory external member (Munjali, 2023). One concern is that the Act does not satisfactorily address accountability. It does not specify who is in charge of ensuring that offices and other workplaces comply with the Act. Neither is it specific about who can be held accountable if it is not followed. Moreover, although the informal sector employs over 80% of India's working women, the law is still largely inaccessible to them. Despite the law having been in existence for more than 10 years, workplace sexual harassment cases remain highly under-reported in India. Power dynamics of organizations, fear of professional repercussions, stigma, lack of trust in the system, a tendency to normalize sexual harassment, tend to deter women from filing complaints (Ahuja, Padhy, & Srivastava, 2019). Sexual harassment has serious mental health consequences. Using longitudinal survey data from the Youth Development Study, combined with in-depth interviews, Houle et al (2011) found that sexual harassment is a stressor that is associated with increased depressive symptoms. Their quantitative results showed that women and men who experience more frequent sexual harassment at work have much higher depressed mood than non-harassed workers, even after controlling for prior harassment and depressive symptoms. Moreover, sexual harassment early in the career, has long-term effects on depressive symptoms in adulthood. Negative experiences at work may be especially detrimental to mental health if they occur repeatedly through the career, as the accumulation of workplace stressors may exert larger effects than a single isolated incident (Avison & Turner, 1988).

The Road Ahead

Boosting gender diversity is not just a moral or ethical issue, it makes business sense too. When women thrive

in leadership roles, organizations benefit too. Organizations with a higher proportion of women in leadership are more likely to report improved business outcomes, such as greater creativity and innovation and increased productivity. One meta-analysis suggested that having more women on firms' boards of directors impacted its overall financial performance. Further, women's leadership was associated with sales performance (Hoobler, Masterson, Nkomo, & Michel, 2018). And when affective or social outcomes for employees, the organization, and other stakeholders are taken into consideration, the impact of women's leadership becomes even more meaningful (Huffman, Cohen, & Pearlman, 2010). From an economic standpoint, reducing gender gaps in labor force participation could enhance global GDP considerably.

What needs to be done?

First, we need to reexamine various policies and programs implemented to boost gender diversity, such as maternity leave, child care leave, etc. According to the Maternity Benefit Act, 2017, employers allow expectant mothers to avail up to 26 weeks of paid leave, among other benefits. However, a 2018 study by HR services company TeamLease showed that maternity benefits discouraged many companies in key sectors such as aviation, education, real estate, IT, and e-commerce from hiring women (Banerjee, 2022). It is high time India Inc. introduces a mandatory paternity leave act. This will redefine the responsibilities of childcare and both the parents, not just the mother, will play an equal role. We need more role models like Ranveer Singh and Virat Kohli.

Second, women need to be encouraged to network and self-promote. Decades of research (e.g., Rudman, Phelan, Moss-Racusin, & Nauts, 2012) has highlighted a double-bind, whereby if women do not self-promote, it is seen as lack of ambition or 'leadership' acumen; if they do, it is interpreted as lack of femininity. Engendered cultural norms expect women to be selfless, humble, and empathetic. In the workplace, such norms and the unwillingness to promote our achievements make women invisible to employers doling out promotions. The double standard for self-promotion is a significant barrier to women's equitable treatment, as while self-promotion is necessary for career advancement, only women are subject to

negative consequences for it. We need to thus change the negative connotations attached to female self-promotion. Interestingly, there is evidence that while women feel uncomfortable when engaging in self-promotion, when promoting others, they do not (Smith & Huntoon, 2014). In this sisterhood perhaps lies the key to reducing the gender gap. Policies aimed at changing the social environment where females self-promote or at least promote other women could be effective in closing the gender gap.

Further, special attention must be given by organisations to create ecosystems conducive to sustaining growth for women returning to work, whether after a maternity break or an even longer one till children grow older and begin school. Returnship programs may also be implemented to engage women who may have left the workforce during the pandemic. Returnships provide valuable opportunities for organizations to access untapped female talent that could not find a way in the workforce due to resume gaps. Programs like these can assist women in reentering roles that are more in line with their experience and knowledge and engage them in meaningful ways that are consistent with their career aspirations, as opposed to settling for roles that are not appropriate to their expertise. For instance, Wipro's Wow Mom program aims to support, enable and engage with women employees proceeding for and returning from maternity leave. The company's 'Begin Again program' is an inclusion and diversity initiative for women, who are looking to re-launch their career after a break – be it for a sabbatical, motherhood, elderly care, travel, or other personal reasons. Dr. Reddy's Laboratories is another gender-inclusive company that has led several initiatives to employ and empower women at the workplace. The company has attempted the deliberate hiring of women in their sales force and manufacturing, which makes up 60% of their workforce across all levels. The SHE (Special Hospital Executives) program is an initiative involving an all-women sales team of medical representatives. The company provides extended support to women transitioning back into the workforce after a career break by assembling a team of SHEs. There is also 'Career Comeback for Women', a platform that enables the hiring of women who are on career breaks. Women's careers are supported by part-time working

hours, limited workload, and single-client management for SHEs, compared to regular medical representatives who work long hours and deal with multiple clients and products. To promote safety as well as enhance employability, 'pick and drop cabs' for women are driven by women.

From a more long-term perspective, allowing women to better balance work and motherhood is essential for all modern societies. Women are needed in the force work and yet the survival of the human species demands that women devote time to child-bearing. Countries that do not allow for women to transition back to work after marriage or motherhood entail the risk of either losing out on women as employees or witnessing negative birth rates. The second demographic transition (Lesthaeghe, 2010) that entails decline in the total fertility rate to below replacement level (2.1 children per woman) is due as much to modern contraception as to personal aspirations of women for more opportunities regarding self-career development (Gu, Andreev, & Dupre, 2021). The case studies of the companies mentioned above demonstrate that change is possible. The starting point seems to be sensitive leadership that recognizes the benefits of gender equity at the workplace and formulates policies that strategically promote diversity. Leaders must then call for appropriate training of all employees, sensitization programs, flexible work schedules and the creation of safe spaces at work that are imperative to creating gender-equity.

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Decolonizing psychology and surmounting the colonialism legacy: Reparation and restitution in the humanizing process

Rashmi Singla¹ & Berta Vishnivetz²

Abstract: Decolonization, colonialism, and persisting coloniality are issues that have received increasing attention in mass media, political discussion, academic networks, art, literature, and digital spaces in the last decades and simultaneously encounter resistance. To explore decolonization in psychology, it is imperative to review the origins of colonization, the emergence of Eurocentrism, and its consequences in geopolitics, mental health, laws, rules of organizations and in societies in Global North and South. We raised a question to understand such complex processes: “how to surmount the dehumanization inflicted by colonialism through restitution, restoration, and forgiveness towards decolonization” and reviewed global strategic research on colonial and decolonial issues. This provided a broad theoretical valuable step towards legitimizing native, indigenous epistemological and cosmological forms of understanding. We found similarities in the experiences of most colonized people who have suffered the dehumanization and the genocidal effects of colonization, some of them could be generalizable despite the different colonial histories. We focused on the consequences of the colonial period in India and point out the need of decolonizing, primarily based on the Indian political psychologist Nandy's (1983) studies, who explored colonialism through colonizing societies, the colonized, and resistance to it. Moving on poses multiple challenges and entails an open mind beyond the Global North and South. Including contemporary studies, this open-minded position emphasizes how we as psychologists, may contribute to the global decolonial turn in psychology to move on and forward, overcoming the pains of the past, to making progress now and in the future.

Keywords: Colonization; Decolonization in Psychology; Indigenous; Eurocentrism

Decolonization, colonialism, and pervading coloniality are issues that have received increasing attention in mass media, political discussion, academic networks, art, literature, and digital spaces in the last decades. However, there is also strong opposition in universities, museums, and mass media to open to decolonization; it is just ignored (Mignolo, 2021, p. ix). To grasp these paradoxes, we approach decolonization by breaking it down into its morphemic elements and analyzing its constituents; the word “colonize” serves as the core, while the prefix “de” signifies removal. Essentially, “decolonization” implies the elimination of colonialism and its enduring influences (Falola, 2024, p.1).

We consider a background of multiple levels of geopolitical locations to foreground decolonization in psychology, keeping in mind that territorial independence did not abolish the severe problems generated during the European colonization in the

“appropriated” regions. It accentuated how colonial influence was more profound and challenging to surmount. The history of colonization globally is partly unveiled in the UK, the USA, Canada, Australia, New Zealand, South American countries, and some African and Asian countries in the Global South. The studies published are often ignored and banalized to avoid controversy and maintain the Western European hegemony, Eurocentrism, as the source of scientific knowledge and civilization. Falola (2024) directs attention to the level of knowledge production and distribution. His example: “Western schools” during colonialism were abattoirs /slaughterhouses where many aspects of indigenous original beliefs and identity were gruesomely removed. The Colonizers had no interest in educating the colonized, risking they would develop enough consciousness to challenge the harsh conditions in which the native communities were kept.

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To explore decolonization, we take a point of departure in colonization, including a short review of its history and the consequences of Eurocentrism, geopolitics, and mental health. Next, we focus on decolonizing psychology through selective perspectives, focusing on the Indian political psychologist Nandy's (1983) ground-breaking study exploring colonialism concerning colonizing societies, the colonized, and resistance. Lastly, we discuss decolonizing psychology globally to move on.

Questioning Euro-American knowledge through decolonization

We question the hegemony of Euro-American "Scientific" knowledge in the backdrop of credited scholars from different continents and periods, such as Fanon (1925-1961), Mbembe (1957-), Segato (1951-), and Nandy (1937-). They unveiled the dehumanizing mechanisms of colonialism and its consequences in the construction of subjectivity and relations, and they also presented possibilities and actions for becoming dignified human beings. Based on their studies, we answer the question: How can we surmount the dehumanization inflicted by colonialism through decolonization-reparation and restitution?

Colonization: A Short History and Geopolitical consequences

The emergence of European capitalism, from the sixteenth century until the present, has depended upon the systematic exploitation of human beings and environmental resources of other countries (not the countries of the colonizers). The "conquistadores" and colonizers conducted a systematic usurpation, extraction, and exploitation of resources following the politics of conquest. The illegal/ forced appropriation expanded to control the government of local communities, their language, law, education, health, family structure, and spirituality. By the nineteenth century, two-thirds of the world had been colonized/dominated by Europeans. Mignolo (2021) highlights a connection between colonization amid geopolitical locations, as there

are commonalities in the colonization processes and local differences.

In almost all colonized territories, colonial powers defined national borders according to exploitation in favor of their profits and interests, as illustrated by Barlowe and Thompson (2009). An example is Rwanda, where colonial powers (German, Belgian, and later French) defined ethnic groups, 'renamed' their belonging, and created new countries. The original populations were manipulated into a new arbitrary "reorganization." The very tense situation generated by this abuse of power among the different groups increased and exploded in 1994 with a brutal genocide that Hutus committed against Tutsi ethnic groups.

In South Asia, the colonial project of "divide et impera" (divide and rule) led to India winning independence in 1947 after more than two centuries of British Colonization. However, freedom came with the horrors of the partition, when East and West Pakistan were hacked off the stooped shoulders of India by the departing British, leaving behind a million dead, 17 million displaced, and billions of rupees of property destroyed (Tharoor, 2017a, 2017b).

Zooming into Denmark, the Nordic country (where the authors reside) has a colonial history comprising a few Caribbean islands sold to the USA in the 20th century. India's Nordic secret, Tarangambadi /Tranquebar, was sold to the British in 1845 for 1.25 million Indian rupees (BBC, 2021). At present, in Kalaallit Nunaat/ Greenland, one can observe the after-effects of the atrocities committed in the name of White Christian civilization. There is not much talk in the public and academic spaces about the consequences of the Danish colonization of Greenland.

Dominant narratives and Nordic exceptionalism, a tendency to view itself as outside the colonial heritage of race and imperialism (Sandset, 2019), assume that colonization, along with racialization, belongs to the past in Europe. However, they still exist in Europe and the Nordic countries with universalistic welfare state practices of contested 'benevolence' and 'solidarity,' assimilationist politics, and upholding the white heteronormative nuclear family (Keskinen et al., 2019). The systematic power abuse resulted in racialization,

brutalization, and dehumanization, which are some of the devastating consequences observed and remaining from the colonial period. Critical research has pointed out that racialized welfare logics are at play in welfare state practices, where one encounters silenced and forgotten logic and practices of racism and racialization. These geopolitical consequences are vital for comprehending decolonization psychology in the Nordic context.

Consequences of colonization on mental and spiritual health

The devastation suffered among the indigenous populations across the centuries has been and still is poor health, social disruption, trans- and intergenerational trauma, low or non-education, suppression, and prohibition of original culture, language, rituals, and spiritual practices.

The cosmologies of the indigenous communities had no separation between spiritual, religious, health practices, world view, law/rules. What distinguishes their traditional health systems (cosmologies) from medical Western health treatments is the strong emphasis on spiritual healing as an inseparable component of all healing and health recovery (Wintrob, 2009). Healing rituals bring relief from intra-familial, interpersonal, and communal stressors simultaneously and are equally crucial to relieving symptoms of physical illness. Colonizers forced, in all the communities of the usurped territories, the suppression of spiritual indigenous rituals and traditions, which were labeled as blasphemy, heresy, superstitious, and criminalized (Barlowe & Thompson, 2009). Almost all indigenous communities were forced to be baptized into Christianity on both continents, Africa, and America. Otherwise, they risked persecution and prison, among other cruel punishments.

We bear witness that the origin of many of the present organizations, behaviors, habits, relations, and social structures, such as family, racialization, and the construction of subjectivity, is the persisting legacy of colonial domination as the result of coercion imposed during the colonial period (Duran & Duran, 1995). Moreover, they describe their clinical experience working with Native American communities: they

explain the fundamentally different world views between the white Anglo-Saxon/White European descendants and native communities. For example, in Western thinking, matter and psyche are separate. In Native American thinking, matter and psyche are inseparable; restoration of balance demands harmony. Duran and Duran (1995) sum up the complexity of reactions among native Americans as "soul wounds" instead of the ones used in DSM-5 and ICD-11, such as PTSD. "Soul wound" is at the core of much of the suffering that indigenous peoples have undergone as a result of the systematic oppression experienced over five centuries.

Soul-wound was integral to indigenous knowledge before Columbus arrived in America. This notion needs to be understood in a historical context to be helpful to the modern therapist providing therapeutic services and consultation to the Native American community. "Soul wound" encompasses concepts such as soul, psyche, myth, dream, and culture as part of the continuum that makes people's dignified experience of being in the world. Then, one can understand the "soul wound" (Duran & Duran, 1995). It may bring restitution of the feelings of a community that has not had the world acknowledge the systematic genocide perpetrated on them.

Some examples of the consequences of soul wounds engendered by the violence perpetrated by colonizers are described by Duran and Duran (1995) as follows: "The original warrior" was neglected, comprehending identity loss - split ego, uncontrolled aggression, estrangement of their original values, leading to self-hatred, alcoholism, and, in many cases, suicide. Children were removed from family to attend school, boarding military school, where they were baptized, their names changed, and their ancestral language was banned. When coming back to their original community, they felt utterly alienated. The depersonalizing process was suffered not only by the individual but also by the community and the descendants, resulting in massive intergenerational and transgenerational psychological trauma. These facts illustrate the harassment undergone by American natives, being stripped of their existential meaning, e.g., the oppressor became an integral part of the personality as one's personality was constructed under repressive circumstances, suppressing the original

rituals to mourn their losses, coerced to learn and talk a new language, being christianised.

This Machiavellian oppression and exploitation resulted in 1/3rd of Native American males being imprisoned during their lifetime because of violence. These narratives illustrate well that the native systems of understanding suffering were more comprehensive than the current DSM and ICD diagnostic systems of diseases. The rigid colonial practice of forbidding humanitarian assistance as financial farsightedness, implying that mercy could be misunderstood as softness, led to much mental suffering.

Western practitioners do not recognize these circumstances as inter-transgenerational trauma, which means that these 'symptoms' are still prevalent among descendants of indigenous people, many of them living in reservations and precarious living conditions. Although they were already described as the result of forced acculturation of Native Americans, these were not and are still not recognized in the International Diagnostic systems. The loss of spirituality meant irreparable damage to the indigenous communities. While all were obliged to be Christianized, most managed to maintain the original rituals in secrecy and, when discovered, were brutally punished. These descriptions also help us understand the devastation the indigenous population Kalaallit Nunaat/ Greenland went through as their spiritual beliefs were ridiculed and they were considered 'primitives.' Here, one observes the atrocities committed in the name of White Christian civilization and still suffers the consequences of the colonial period, such as high suicide rate and alcoholism, family violence, and unemployment (Singla & Høgh-Thøgersen, 2020). The removal of Greenlandic children in the 1930s - 1950s to 'civilize them' still has serious consequences, such as intergenerational trauma for the Greenland community.

There are many similarities in the experiences of most colonized people who have suffered the genocidal effects of colonization. Therefore, some of the discussion is generalizable despite the different colonial histories. The theoretical development is a valuable step towards legitimizing native epistemological and cosmological forms of understanding.

Western institutions still conduct irrelevant research and clinical practice that implies that people who do not prescribe to their worldview are 'genetically inferior.' Foucault (1973) calls these "technologies of power" authorized by the sciences of medicine. He illustrated that, far from objective statements of truth, the science of medicine emerged fully implicated in practices of domination. Decolonization in health implies a quest for equity and social justice, which entails the restitution of cosmological, epistemic, and ontological violence in diverse geographies (Singla et al., 2022).

Colonialism and Construction of Eurocentrism

We now focus on the consequences of colonialism in the constitution of Eurocentrism, white supremacy, Christian hegemony, racialization, brutalization, and dehumanization pervading at present in most European countries. Eurocentrism has affected the laws, the institution's worldview, public organizations, and private life, especially when considering immigrants. We base this review on Segato (2022) and Mbembe (2013, 2023), who raise the question: How does Eurocentrism affect European people's imagination and intelligence?

From a decolonial point of view, Eurocentrism perceives Europe as consequences of the emergence of the entity America in the scheme of a "new world – organization," and a new subjectivity emerged after the conquests and colonization. The 'appearance' of America from the end of the fifteenth century gave birth to Europe with a new subjectivity, modernity, and capitalism and to the people's racial classification and geopolitics, leading to racialization: the indigenous, the negro, and the white. Quijano in Segato (2022) calls these categories the "re- originalization" of the world after the advent of America (p. 85). Within that new epistemic scheme, Europe needed to stand up as superior to others, and more than that, it must turn its origin unique and exclusive. Thus, all humanity became the "Other" of Europe in a context where being "the Other" is an anomaly. A deviation of the universal subject, a residue /the scum of the true political Agora and moral order, is defined by Europeans (Segato, 2022, p. 84). It resulted in a very polarized division of topics between universal and minority themes derived from the consecration of Europe as representative of

the human community.

The establishment of modernity in Eurocentric Western Europe engendered an excellent machine for producing minoritized anomalies of all kinds. Anyone who does not conform to these norms becomes a misplaced anomaly and is subject to expulsion, banishment, and exclusion from society. Segato (2022) states that Eurocentrism, as an ideology, naturalized, defeated, and exterminated all those who do not fit the values of the majority. When it is not fully achieved, it expels the difference under the label "uncivilized," consisting of a threat to civilization, demonizing it. At the same time, we can learn from natives' politics that does not generate this distance between ruling summits and their peoples and a politics that can imagine a plural world without reifying nature and bodies. Eurocentrism generated ethnocentrism, which assumes that one's societal worldview is the only proper or civilized one (Berger & Luckman in Rogoff, 2003).

It is pertinent to make clear that the dehumanizing, brutalizing procedure is not an individual action. Dehumanization is immersed in the pervading worldview and performances of the governmental system, its organizations, and its procedures. Some European governmental organizations often claim to be "benevolent" and "compassionate" but do not practice it with families in a vulnerable position, denying their human rights.

The above points show how Eurocentrism influenced Europeans in the past five centuries. It is relevant to consider Mbembe's (2023) views about two forms of Eurocentrism, an early one, "primitive Eurocentrism," and "late Eurocentrism." The "primitive Eurocentrism" focused on and created racialization, conquering the 'uncivilized' non-Christians, dehumanizing them, exploiting, and devastating complete communities, and appropriation of territories and resources. The emergence of "late Eurocentrism" in the 21st century has turned even more radical, more virulent, and vindictive than the aforementioned "primitive Eurocentrism" related to racialization and dehumanization. It seeks to justify Europe's shrinking, inward-looking approach, its withdrawal from the world, and its eclipse by calling for extirpative violence against the current ideas and facts that contest the European hegemony of norms and

values (Mbembe, 2023, p.175).

Though territorial colonization is almost over, coloniality prevails. Coloniality refers to the set of values, ideas, and attitudes imposed by Europeans on other groups and societies as part of the attempt to create a universal system (Falola, 2024). We now move on to decoloniality.

The concept of decoloniality proposes a process to surmount the established Eurocentric knowledge hierarchies "decoloniality" and models. At the same time, decoloniality does not seek to reject the approaches and alternatives offered by Western institutions but to comprehend their validity and limitations while also agreeing that they can be flanked by other sources of knowledge as recognized by different peoples of the world" (Falola, 2024, p.2). This inclusion and restitution of diverse sources of knowledge is taken further by Mignolo's (2021) investigation of decoloniality with the stance that pluriversality is displacing the Western universality of knowing, which began at the end of fifteenth century.

Continuing with decolonization, we draw upon a recent illustration of a call towards decolonizing psychology and its global response in the American Psychological Association context, also a coedited book about decolonial-anticolonial journey and psychology's paradigmatic transformation Comas-Díaz et al. (2024), which is somewhat recent development, as Henrich et al. (2010) had pointed out that 97% of American psychological research comes from WEIRD societies—an acronym for Western, Educated, Industrialized, Rich, and Democratic

Decolonizing psychology– recent and historical perspectives

In a call for a special issue, "Towards a decolonial psychology: Recentring and reclaiming global marginalized knowledges" by American Psychology Journal (APA, 2023), decolonizing is defined as an ethical commitment that involves dismantling the colonial structure of Euro-American psychology by asking questions about what counts as knowledge, whose knowledge is valid, who controls the production of knowledge, who is deemed an expert, and who are we accountable to in our psychological research and for

what purposes. Decolonial psychological knowledge disrupts and, at times, displaces Eurocentric psychological knowledge with ideas, theories, and concepts that are more relevant to the experiences and lifeways of communities worldwide and are sought globally. It may be interpreted as a sign of interest in decolonial psychology with increasing strength, leading to multiple knowledge ecologies. At the same time, we are critical about the North American appropriation of decolonizing psychology, as usually American psychological research findings are based on 5% of the population but are often posited as having universal applicability and relevance for 95% of the world (Arnett, 2002). We consider APA journal's definition reductionistic, simplifying the complexities of decolonizing, which is a much more comprehensive phenomenon.

However, we move beyond the above APA journal illustration from 2023, concentrating on other geographical contexts and earlier periods, among others, the decolonial turn highlighted by Kessi (2016). Kessi et al. (2022) in South Africa challenged the hegemonic Western knowledge and adhered to the decolonial movements in the rest of the world. In this new wave of decolonial thinking, psychologists have drawn upon community psychology practices to expand the theorizing of power, identity, and knowledge, invoking restitution and social justice. At the same time, Kessi (2024) has pinpointed psychologists' complicity in colonization and coloniality in legitimizing forms of interiorization and control, primarily through androcentrism, paternalism, and biological determinism, especially biological differences, which serve as an organizing principle for societies.

Nandy: An Unconventional Study of Colonialism and Decolonization

Nandy (1983), in *The Intimate Enemy: Loss and Recovery of Self Under Colonialism*, focuses on the complexity of subjectivity, external and internal processes, and the borderlands between culture and psyche to address social and political concerns. He argues that colonialism damaged both colonized and colonizing societies. He also emphasizes that coloniality patterns are not only about economic gain, political power, or technological domination but also include

colonization of the mind. Additionally, discussing how the Indians broke traditional norms of Western culture to protect their vision of an alternative future, he emphasizes the importance of visions in fighting oppression, and the cultural resources that keep such visions open and plural, thus valuable for decolonizing psychology. Nandy asserts that the colonized Indians do not remain simple-hearted victims of colonialism; they become participants in a moral and cognitive venture against oppression (Nandy, 1983, xiv). Through psychoanalysis as a tool for disruption, critical concepts, and Indian cosmology, Nandy demonstrates that with nearly four hundred years of exposure to the West, Indians have "self-confidence" vis-a-vis the West. A Westener, Indianized -British [Rudyard Kipling] could not be both Western and Indian, whereas the everyday Indian, even when he remains Indian, is both Indian and Western" (Nandy, 1983, p.76).

Through the conceptual frame of "identification with the aggressor," Nandy discusses that the Western view of hypermasculinity in colonial culture's ordering of sexual identification began to permeate into the socio-religious-literature-art movements of India, with 'Kshatriyahood' (the martial portion of Indian caste system) becoming the indicator of authentic Indianhood. Indian concepts of purusatva (masculinity) and naritva (femininity) were polarized against one another, and the existence of any form of androgyny was then perceived as a negation of man's identity. This transition also depicted Gods as getting increasingly martial/ masculine or feminine, against earlier androgynous 'ardhanarishwaran' (half man half woman God). The Indian freedom fighter Gandhi found a new language of dissent and resistance built on Indian cosmology, giving place to androgyny: man's access to feminine, protective maternity values and the psychology of everyday life in India. Moreover, the resistance is also reflected through the compromises along with not being psychologically overwhelmed: "he [Indian] is archetypical survivor ... seemingly he makes all-round compromises, but he refuses to be psychologically swamped, co-opted or penetrated." (Nandy, 1983, p. 111).

Nandy (1983) emphasizes that colonialism did as much damage to the colonized societies as it did to the colonizing societies. In India, tremendous

psychological uprooting and cultural disruption were caused, though partly confined to the vast country's urban centers and semi-westernized upper/ middle classes. Nandy acknowledges colonial scholars like Fanon and Memmi for shedding light on the colonial situation's interpersonal patterns. The cultural and psychological pathologies produced by the colonizers in their societies have yet to be well known. Regarding it as a less popular interpretation of colonialism because there is interest in denying that the colonizers were at least as much affected by the ideology of colonialism and their degradation, too, can be terrifying, "decivilization of the colonizer". He explains that British colonizers from small islands were overwhelmed, and colonialism led to long-term cultural damage. Firstly, colonialism brought to prominence in British society the least humane and tender aspects of British culture. Colonialism was a hyper-masculine project, and anything that was not masculine and virile was de-emphasized... an 'underdeveloped heart,' which separated them not from the Indians but from each other (Nandy, 1983, p. 34). Secondly, colonialism produced in Britain a false cultural homogeneity by consigning to the colonies all dissenters and rebels. Finally, colonialism encouraged the colonizers to attribute themselves "magical feelings of omnipotence and permanence", leading to British's natural right to rule India. Decolonization is thus beneficial not only for the colonized but also for the colonizers.

Deftereos's (2013) reading of Nandy highlights his distinct interventions and alternatives to address social and political concerns, which are further taken up in the final section. An illustration of such alternatives is openness, which implies moving beyond the polarities-universal versus parochial; material versus spiritual; self-conscious; well defined versus a fluid, open self-definition. The two ends of these polarities meet in coping with or resisting to oppression, "when psychological and cultural survival is at stake, polarities... do break down and become partly irrelevant, and the directness of the experiences of suffering and spontaneous resistance to it comes through at all planes" (Nandy, 1983, p. 11).

Psychology decolonizing: Diverse ways

Directing attention to the psychology discipline, we

consider, in resonance with Bhatia (2018), the movement to decolonize as embedded in several distinct but related critical and cultural theories, perspectives, and methods, which may not use the term "decolonize" but, in essence, provide alternative ways to reimagine the discipline of psychology. Some of these are liberation psychology (Martin-Buro, 1994), indigenous psychology (Bulhan, 1985; Enrique, 1992; Sinha, 1986, Tripathi, 2011), narrative psychology (Brockmeier, 2014, White, 2007), dialogical psychology (Hermans & Kempen, 1993), and cultural psychology (Bruner, 1986, Chaudhary et al., 2022; Paranjape, 1984, Rogoff, 2003, Shweder, 1991).

Hodgetts et al. (2020), in New Zealand, advocate for a globally responsive psychology discipline concerned with social issues conducted from various perspectives, committed to making the world a better place for everyone. In India, Sinha, a visionary psychologist, already four decades back, drew attention to *Psychology in a Third World Country: The Indian Experience* (1986) and played a significant role in shaping contemporary psychological research. He underlined indigenization, both within involving the indigenous understanding and without, adaptation of knowledge from outside, through integrative processes (Sinha, 1998). He traced four phases in the scientific psychology development in India since its beginning in Calcutta University in 1915—the pre-independence phase, the postindependence phase of expansion, the phase of problem-oriented research and the phase of indigenization, first two phases were dominated by "foreign" theories and applications, while the third phase was still characterized by the dominance of the Western framework with signs of some orientation to Indian cultural reality implying decolonization.

Globally, decolonization has been entailed since the 1960s through several projects in the Andes regions covering seven South American countries: Venezuela, Colombia, Ecuador, Peru, Bolivia, Chile, and Argentina, where professionals and community leaders actively work to increase the recognition of traditional medicines encouraging the improvement of community health facilities. "It has everything to do with the indigenous population achieving legal, medical, and social equality, and the recognition of their inherent dignity as the first human settlers of those

countries, whose heritage goes back centuries and millennia" (Wintrob, 2009, p.8).

A current example is research by Ahuja and Khurana (2021), exploring how passion and intimacy in relationships changed after the COVID-19 lockdown in the Indian context. How couples spent time with each other during the lockdown holds important implications for relationship satisfaction and the relevant practitioners. Norms that define a relationship, particularly about participation in domestic work by men in the Indian context, must be revisited to adapt to the new normal. By including Indian practices and lifestyles and moving beyond the Global North, the study illustrates syntheses of knowledge from both the Global South and Euro-American context, contributing to the decolonization of psychology.

Another recent example of decolonizing psychological research is the inclusion of spirituality in exploring intimate couples living apart transnationally (LATT), primarily in Denmark, though with a global reach (Singla, 2024, in press). Moving beyond the simplistic dichotomy of technology as 'rational' and spirituality as 'irrational,' spirituality is perceived as a sense of wholeness and interconnections, deemed salient by most research participants in both the Global North and the Global South. Spirituality is hardly addressed within psychosocial services providing ethnic minority mental health and couple counseling in Denmark. Mainstream psychological explanatory models for health and illness that view human beings as biological machines exclude spirituality. These findings make us question the fundamental differences in the spiritual orientations of the Global North versus the Global South (Fernando, 2010).

Decolonizing psychological knowledge needs comprehending frameworks and concepts, which is important for both the Global South and the Global North. The beneficiaries of a decolonial process are not only people in postcolonial spaces, the majority of the world in the Global South, but also the participants of European modernity. Decolonizing proposes reinventing actions and interactions that do not seek to join only explanatory models established by Eurocentric hegemony. It is necessary to reconstitute ancestral rules, rituals, and practices that the colonizers

suppressed and even forbade. We recall examples of many communities from the Andes reestablishing spirituality and ancestral rituals to preserve nature and counter deforestation and climate change.

The colonial structure still existing in many parts of the world is a planetary problem, and we need to consider it a hyper-complex issue of which decolonizing psychology is a part. These examples show that decolonizing psychology attempts to transform colonial structures, mindsets, and practices and reconfigure power in not only countries where colonial oppression has been perpetrated but also globally in the colonizing societies based on their pathologies (Nandy, 1983). Following Oyêwùmí in Gordon (2018), expanding people's agency, the communities, and the contextual history, along with other multiple responses are vital to move decolonial psychology forward. This resonates with Chaudhary (2021) in Indian context that it through the inclusion of diverse understanding rather than suppression, psychology can move forward.

Moving forward

Moving forward from a long-term perspective poses multiple challenges and entails an open mind beyond the Global North and South. This open-minded emphasis is in line with Quijano in Segato (2022), who said that, despite being from the South, he did not think about the Global South or for the Global South but for the world. Decades back, Freire (2011) questioned: Does the relief of colonialism signify a genuine end of oppression? He demonstrated how the oppressor dwells in the oppressed and is imprisoned in the relationship with the oppressed. Both need to get free.

At the same time, decolonization was initially intended as a revolutionary concept, but contemporary debates, including in the Global North, have arguably mainstreamed the concept of decolonization. We can ask if decolonizing academia itself has been colonized. This does not make decolonizing academia irrelevant; instead, it emphasizes the importance of continuous attention to how structural inequality is reproduced and resisted.

We, thus, return to the question we raised in the first part: how to surmount the dehumanization inflicted by colonialism through restitution, restoration, and

forgiveness towards decolonization. In agreement with Mbembe (2015), who claimed, "There is only one world. We are all part of it and have the right to it. To build a world that we share, to restore the humanity stolen from those who have historically been subjected to a process of reification". Thus, reparation is a project of reassembling amputated parts, repairing broken links, and relaunching the forms of reciprocity, without which humanity cannot progress. Restitution implies recognizing what might be called the other's share and restoring what has been lost.

Decolonization, as the *elimination of colonialism and its enduring influences*, requires reparation and restitution to achieve shared goals of transformation and social justice for the planetary community. It provides frameworks and concepts to build, renew, and enhance psychology as a discipline, ensuring pluriversity through diverse geographic coverage.

We revisit some distinct interventions and alternatives delineated by Nandi to address social and political concerns and provide answers to what decolonizing psychology implies, specifically in India. For restitution, recovery of what was lost or under the threat of being lost, a plurality of ideologies can be accommodated as complementary of *this-worldly materialism* and the *other-worldly spiritualism*. Moreover, decolonizing implies openness; the culture is protected against hegemonistic, proselytizing cosmologies through compromises, having a *fluid self-definition*, and learning from others, provided such learning is profitable. Following the bird's eye view of the development of psychology in modern India by Mohanty (2021), we discern four varieties of approaches- colonized "*Yankee Doodle*", *indigenized*, *indigenous*, and *Indian psychology*. The approaches of Indian psychology and indigenous psychology share a common concern for cultural rootedness of research, though the former is marked by understanding the Indian psyche through the framework drawn almost exclusively from the cultural and traditional wisdom, while the former is more open to contextualization and non-traditional cultural framing. The last three approaches imply decolonization in diverse forms, to comprehend coloniality, generate ideas and actions to center *decoloniality* in psychological teaching, research and practice, and thus moving forward.

Inclusion of the familiar values, ways of life, syntheses of the familiar with what is from the outside, and other sources of knowledge as recognized by different people of the world. Decolonizing knowledge would lead to improved psychology, not only in India but globally. Pluriversity, instead of just universality, flanking Western knowledge with knowledge from other parts of the world is vital to move on. Despite opposition to decolonization in academia and media, we as psychologists, hopefully, contribute to *the global decolonial turn in psychology* to move on and forward, dealing with the pains of the past and making progress now and in the future.

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Traumatic Injury and Resilience Over Time

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Abstract: This article explores traumatic brain injury and resilience. Just like trauma, resilience is different from person to person. Yet there are a common set of factors established as contributing to human resilience. The work presented here explores my personal journey of overcoming adversity and finding a footing in life in the aftermath of an adverse life-transforming accident, through the lens of psychological literature.

Keywords: Traumatic brain injury; Resilience; Mind; Memory and positivity

I am a professor of Economics at a reputed college affiliated with the University of Delhi. I am also a nature enthusiast and an avid cyclist who enjoys covering long distances at high speeds. Along with possessing these attributes, I am the survivor of a traumatic brain injury acquired through an early morning cycling accident I had in May 2023. The injury I sustained on that occasion significantly impacted almost all the capacities I am supposed to have mastered as a professor and athlete. The accident emerged to be a life-transforming experience in more ways than I can count. This article is a space where I explore my attempts to make sense of one of the most unexpected events I have ever experienced. I also connect my lived experiences with psychological literature on trauma and the human capacity for resilience.

Trauma

By its very nature, trauma (defined as an emotional response to a terrible event like an accident or natural disaster) is complex and affects everyone differently. Some individuals may display criteria associated with Post-Traumatic Stress Disorder (PTSD) while others demonstrate brief sub-clinical symptoms that do not meet diagnostic criteria. People can have strong emotional reactions in the aftermath of a trauma exhibiting depression, anxiety, hostility and high levels of stress (Wiseman et al., 2015). Further, the impact of trauma may range from subtle to highly destructive. The specific effect on an individual depends on many factors including their personality characteristics, age, gender, the nature of the adversity they endure and

sociocultural factors (Hildebrand et al., 2016). Interestingly trauma has a close relationship with resilience, a theme that I will elaborate upon later in the article. My own experiences of recovering from brain injury have taught me that it is of utmost importance for us to navigate the trauma, by calling forth our capacity for resilience. According to the American Psychological Association (2020), resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands. I came to understand that a person must make a conscious decision somewhere during their recovery to manage their emotions, thoughts and behaviors in a healthy way so that they can get back to their lives.

Trauma Due to Injury

Traumatic brain injury is defined as damage to the brain resulting from an external mechanical force, such as rapid acceleration or deceleration, impact, blast waves, or penetration by a projectile (Cohen Veterans Bioscience, 2023). The degree of the injury can range from mild to severe, however according to the Lancet Neurology Commission, several people experience health loss and disability as an outcome. These result in major socio-economic burdens for individuals, families, communities and nations. Globally, the annual incidence of TBI is variably estimated to be 27 million to 69 million. Also called the 'silent epidemic', TBI remains a growing public health concern especially in low and middle income countries (Dewan et al., 2018). Hyder (2007) suggests that countries of the

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global south face a double-hazard with respect to TBI; they have a high prevalence of risk factors for TBI, while being the least prepared to address it when it happens. Therefore, both, the incidence of TBI and the case-fatality from TBI can be very high. In terms of long term outcomes and recovery, disturbances of cognition (often in the form of executive dysfunction), emotions (mood), and behavior constitute the most disabling aspects of TBI. The term neuro-behavioral disability has been used to encompass the diverse range of disabilities that may result in noticeable alterations in a person's character or personality. These changes can be a great source of stress to the patient and their family members (Humphreys et al., 2013).

Accidents and events that cause TBI involve damage to the nerve cells and tissues in the brain, due to which they can no longer efficiently communicate with the rest of the body. Brain injuries are not necessarily visible on the outside. When we have external injuries, everyone can see them and validate the fact that we are injured. However with a brain injury, we may not necessarily receive that validation. On the surface the person affected may come across as 'fine' but it is only the survivor who knows how the injury is impacting them. Research has indicated that TBI patients, whether recovered or non-recovered, tend to describe feeling that "something is not right after their injury" and talk about their efforts to seek clarification, explanations, a diagnosis, and a treatment plan. Many describe the process of seeking diagnosis and validation as a long and slow battle that can be stressful. Patients can have difficulty articulating what is different about their health to their health providers. When patients feel their symptoms and experiences are validated by others and acknowledged as known consequences of their injury, they describe feeling reassured, with peace of mind coming from the expectation that they will recover in time. Thus validation and reassurance appear to facilitate recovery and a coherent understanding of their experience. However, when participants feel their experiences and symptoms are disbelieved, they feel invalidated, stressed and confused (Snell et al., 2017).

Recovering from TBI means that the damage to brain cells and tissues must heal so that we can regain our ability to think, imagine and recall. However these healing processes can take a great deal of time and

harbour much uncertainty, because no one really knows how one's brain will operate after healing. Author Kelly Bernharn (2023), herself a TBI survivor writes that "the toll of traumatic brain injuries and the mystery of how the brain repairs itself, or doesn't, is still perplexing and under-researched". Healing is a step-by-step process and the time duration involved may easily range from 6 months to over a year (Sullivan, 2021).

My Injury and Experience

On that fateful summer morning of 2023, I was rushed to the hospital by a co-cyclist. I had had an accident and the doctors found that a massive brain injury, a cerebral edema along with multiple injuries in my head, hands and legs as well as a nasal blockage. I was completely unconscious for two days. My family brought me home after 11 days from the hospital. The following months were very difficult. I felt lost as I had no memory of what my life had been about, till the point of the accident. I did not know who I was, what I did or who the people around me were. I wanted to speak, but for some reason was unable to. Neither was I able to recollect any aspects of the accident that had brought me to the hospital. Even now, although several months have passed, I am unable to remember anything related to the accident. The trauma to my brain had impacted my vision and other senses- I suffered from double vision and had no sense of taste or smell. When I was being discharged, I had been forewarned that I was likely to endure headaches, shortness of breathing, chest pain, nausea, sleepless nights and irritability. During that time of sitting at home, I felt great regret over my decision to go cycling on that particular day. It filled me with anger and gave me sleepless nights. The anxiety I felt was often transferred to my partner.

It took me a month to remember that I was a teacher who taught Economics although I could remember nothing from the course material. Things that were central to my identity at one point of time had become inaccessible to me. This created an internal vacuum which was extremely emotionally draining. I would cry all the time and lament to my partner that I no longer knew what to

do with myself. My life had changed and the path ahead seemed unclear. I felt that I was no longer fit to teach, remember or read anything. I knew my visible injuries would disappear with time. I was far less confident about the injuries I had from within. Most modern trauma systems are structured around five essential phases of care: injury prevention, prehospital emergency stabilization and transport, acute hospitalization, rehabilitation, and reintegration with society. Although the medical system accessible to me adequately dealt with the first 3 phases, rehabilitation, and reintegration with society do not necessarily fall under the purview of hospitals. Yet as Rosenberg et al., (2020) suggest these are vital periods of recovery that patients must navigate, often on their own and with little guidance from their doctors. Very little research has been conducted on these final phases of recovery once contact with healthcare providers becomes less frequent.

What next after trauma: Resilience

Where does one go after enduring extreme hardship? What are we supposed to tell ourselves when we are overwhelmed with flashbacks of the past or the fear that the trauma will return in the future? These are very challenging questions to answer, but for me the answer to these lay in the human capacity for resilience. Among people with spinal cord injury, resilience has been associated with psychological strength, adaptive coping and spirituality (Monden et al., 2014). Further optimism, hope and perseverance have also been identified as important contributors to individuals' ability to adapt after injury (Monden et al., 2014). In the case of brain injury, resilience has been found to play a role in positive rehabilitation outcomes (Bertisch et al., 2014).

The impacts of TBI differ from person to person. Hence it is no surprise that resilience and its manifestations also differ for each one of us. The value of resilience lies in the fact that it helps us to rise above the loss of meaning in life, so that we protect ourselves. To be resilient means to re-construct meaning, when a prior sense of meaning has been lost. Psychiatrist and holocaust survivor Victor Frankl (1984) said "For the meaning of life differs from man to man, day to day and from hour to hour. What matters, therefore, is not the meaning of life in general but rather a specific meaning

of a person's life in general". Human resilience is an outcome of things that we often take for granted when our lives are on track. Although some psychologists regard resilience more as a trait rather than state (Rainey et al., 2014), to me, the social support of loved ones was crucial. Every time I wondered whether I would be able to lead life like I used to, my partner would reassure me continuously. They said that our minds and bodies become stronger everyday, when we think positively. The importance of positive thinking has been recognized by Zimmerman (2020) who suggests that the most resilient among us are people who generally don't dwell on the negative, who look for opportunities that might exist even in the darkest times. My partner's support during that time was critical for my recovery in many ways. Their faith that I would get better enabled me to believe in my own ability to overcome my hardships. A great deal of psychological research has shown the protective effect of perceived social support on mental health in stressful situations (Li et al., 2021; Bloom et al., 2001). Social support is critical because it helps us feel like we are a part of something larger than us (Schwarzer & Knoll, 2007). The commonly distinguished types of social support include emotional, instrumental, and informational support. Emotional support is the opportunity to be able to trust and share most often with a close confidant. Instrumental support refers to help with concrete needs for example through the supply of money or aid. Finally, informational support is the availability of advice or information regarding important issues at hand. My partner and my family provided me with all these forms of support, when I needed them the most. I also realized that recovery was about taking one step at a time. There is no magical wand that can be waved by anyone to hurry the process. One has to put in the time and effort to recover. We have to keep our minds active and stimulated. As someone keen to regain my health, I made sure I did just that. Initially when I had come home after the accident, I would struggle with my daily activities. After about 3 weeks, I was given a register and was asked to write my name and the basic activities I did every day. This was rather difficult to start with and I had to ask the others around me what I should jot down. But it got easier with time. I was also asked to sit with the laptop every day and read books or novels loudly. Once again I struggled - the letters were not straight, and I could not pronounce anything correctly.

I almost felt like a child in kindergarten. However, I persisted, every day for hours, sometimes reading loudly at midnight on my laptop or on kindle. And that is how change began to happen, for the better. I stopped having medicines once I could, as they tended to put me to sleep and did not let me think or read anything. For a while I was unable to walk on my own and neither did my family allow me to venture out of the house alone. It was after a month of returning home that my family allowed me to walk on my own. I initially started with short walks, marked by trepidation that I would not be able to walk the way I did earlier. But my fears were unfounded and after some time I began to walk and run regularly, even for long distances at good speed. Walking and running were helpful in abating the negative thoughts that had been troubling me. Finally after 3 months, I started driving again which had been unthinkable at one point of time.

I re-joined my workplace and started teaching again. Some struggles continued, for instance, I went to the washroom one day and wanted to zip my trousers, yet I was unable to identify where it was. In the face of these struggles, I persisted thanks to the support of my students and my own commitment to recovery. I would wake up at 4.30 AM each morning and fill page after page with all that I wanted to teach in class, so that I would remember it well. After my lectures, my students would reassure me that they could follow my teaching and this went a long way in re-building my confidence. I soon concluded that no doctor can tell us about how best to deal with trauma. There is no medicine that can heal TBI completely. Ultimately it is one's decision to get better along with the support of those around us, that counts for a lot. In fact this idea is supported by emerging empirical evidence. Rosenberg et al., (2020) conducted an exploratory qualitative study to better understand how patients view recovery after traumatic injury. Fifteen participants who were 1 to 3 years post-injury were purposefully sampled to include a range of ages, socioeconomic backgrounds and injury severity. The researchers found that the process of regaining a sound sense of self was essential to achieving favorable subjective outcomes. Participants expressed varying levels of engagement in their recovery process, with those on the high end of the engagement spectrum tending to speak more positively about their outcomes. They also reflected on key transitions in the recovery process, such as the transition from more structured

care environments (i.e., an inpatient facility) to less structured environments (i.e., home). No longer able to rely on institutional support systems to guide their recovery process, many patients found that the responsibility for recovery had passed to them and their own support systems, just as they had in my case.

Conclusion

Just as trauma is experienced differently by everyone, so is resilience. Although resilience comes from ordinary things in life, we must remember to build it brick-by-brick. I would say that if we want to cry after trauma, let us cry and express our emotions. Being emotionally expressive, whether it is through laughter or tears is not bad and certainly not a sign of weakness. In the initial months of my recovery, I met a young man who, like me, was walking very slowly. When we spoke to each other I came to know that he had suffered a spinal injury during swimming. He had stepped out of his home for the first time in 9 months. We were both struggling mentally and physically, yet he told me "Ma'am it happens but we will deal with it over time." His optimism helped to boost my sense of positivity. If I am asked how resilience is built, I would say that there are three things of great importance. The first is to have a sense of positivity, even when times are tough. The second is a sense of optimism that our struggles can turn us into better versions of ourselves. And the third aspect is to have a sense of meaning and purpose in life to which we are committed. Recently, I finished teaching one full semester and this involved correcting student assignments. These tasks might sound mundane to many, but for me were important accomplishments. The tool box I developed - reading for long hours day and night, walking for long hours, positive thinking, spending time with loved ones - helped me get here. Finally, I was able to write this article, a feat that was beyond my imagination for many months.

Acknowledgement. Thanks to LSR, Principal Prof. Suman Sharma and all faculty members who prayed for me every day, my cycling co-riders, my ex-colleagues at Lal Bahadur Shastri National Academy of Administration, my family and finally my partner who was always there for me and brought me back to who I was. Gratitude to Megha for her contribution and feedback towards valuable input for the paper.

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Touch Unveiled: Navigating the Power, Potential and Prohibitions of Touch Across Therapies

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Abstract: This comprehensive review of 60 research papers spanning from 1940 to 2020 delves into the multifaceted role of touch across developmental stages and in therapeutic contexts. It examines diverse therapies, including massage therapy (Catalonia, Subtle Touch, Fractional Decompression), Psychobiological Approach to Couples Therapy, havening (Amygdala Repotentialisation Therapy), Somatic experiencing therapy, canine-assisted therapy, body-oriented therapy, Emotional Freedom Technique, touch in CBT, and touch in mindfulness. The study also investigates touch's effectiveness in addressing disorders such as Dementia, Alzheimer's, PTSD, Depression, and Anxiety. It scrutinises gender and expertise in touch therapy, particularly in the Indian context, while considering appropriateness for regressed patients and survivors of sexual abuse. The research explores the complexities surrounding touch in therapy, focussing upon factors like fear of misconduct, the impact of past experiences, cultural variations, and ethical principles as outlined by the American Psychological Association. Despite ongoing debates, the paper concludes that touch holds potential for improving interpersonal relations and therapeutic success, emphasising the need for further applied exploration.

Keywords: Touch; Touch in Therapy; Therapeutic Touch; Embodied Psychotherapy

Forget about 'Netflix and chill', it's all about 'Hugs and Healing' for real relaxation. Or is it? Touch, often termed the fifth sense, is intricately linked to our skin, our body's largest and oldest sense organ (Montagu, 1971), experienced from prenatal stages, through various forms of tactile stimulation, such as cuddling, breastfeeding, and interpersonal contact, throughout life (Dieter et al., 2003; Lagercrantz et al., 2009). The significance of touch spans various domains. Developmentally, it serves as a vital form of communication from infancy, nurturing a secure attachment between a child and parent. Research by Bowlby in 1952 highlighted that infants deprived of touch faced mortality rates 30-100% higher. Furthermore, touch plays a crucial role in early development, fostering feelings of safety, security and love in children, with its absence linked to significant cognitive and neurodevelopmental delays (Bowlby, 1988; Clulow, 2001; Gillath et al., 2008; MacLean, 2003). Kaler and Freeman's study in 1994, focusing on orphan children, revealed that none of them functioned cognitively at their expected age levels, underscoring the profound impact of touch on psychological development.

Touch in psychotherapy has been cautiously labelled a "slippery slope," with ethical concerns prioritizing avoidance of potential harm over recognizing its therapeutic potential (Fosshage, 2000; Kertay & Reviere, 1998). While literature highlights touch's capacity for healing and fostering deeper connections between therapists and clients, academic attention to its benefits remains relatively scant, despite its role in communication and rapport-building within therapeutic interactions (Ogden, 2006; Rothschild, 2000). Ethical touch is generally viewed as non-erotic and based on clinical judgment, serving to enhance therapeutic engagement rather than constituting therapy itself.

Therapeutic touch, known for its positive impact on bio-behavioural markers, offers significant benefits in reducing postoperative symptoms and stress levels. Research by Coakley and Duffy (2010) showcases its efficacy in lowering cortisol levels, the "stress hormone," thereby promoting better health outcomes. Additionally, neurotransmitters like dopamine, serotonin, and oxytocin, released through nurturing touch, further

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contribute to psychological well-being, exemplified by decreased amygdala reactivity and increased feelings of love and relaxation (Anderson et al., 2014; Ellingsen et al., 2016). Furthermore, empirical evidence from a 2008 study highlights the biological benefits of therapeutic touch in reducing pain and anxiety levels, as demonstrated through lymphocyte subset analysis (McGill Pain Questionnaire; Visual Analogue Scale for Anxiety). In the Humanistic and Gestalt perspective, touch is advocated as a means of fostering genuine therapeutic relationships, facilitating personal development and enhancing communication. Gestalt therapy, pioneered by Fritz Perls, integrates touch to connect individuals with their bodily sensations, emphasizing natural and spontaneous interaction (Imes, 1998; Perls, 1973). Similarly, the Humanistic tradition promotes person-to-person contact as a crucial aspect of therapy, as evidenced by touch-oriented techniques in encounter groups during the 1960s and 1970s (Rogers, 1970; Stenzel & Rupert, 2004). Contrastingly, within the psychodynamic perspective, touch is historically intertwined with debates concerning its therapeutic efficacy and potential risks. Freud initially utilized touch to induce catharsis and access repressed memories but later abandoned its use due to concerns over erotic transference (Breuer & Freud, 1957). While Anna Freud emphasized the developmental importance of touch for infants' sense of security and attachment, contemporary psychoanalysts often avoid touch, influenced by Freud's cautionary stance (Freud, 1965). However, neo-Freudians and object-relation theorists acknowledge touch's role in forming secure attachment styles, suggesting its consideration in therapeutic practices to address attachment-related issues (Ainsworth, 1978; Anisfeld et al., 1990).

Rationale

The rationale behind this paper is to tackle the enduring debate surrounding the incorporation of touch within therapeutic environments. Given the lack of definitive guidelines and agreement on whether touch should be endorsed or restricted in professional therapeutic settings, there is a pressing need for a thorough examination. The paper seeks to offer clarity and direction for therapists and policymakers alike, aiming to improve the overall well-being of individuals undergoing therapy.

Objectives

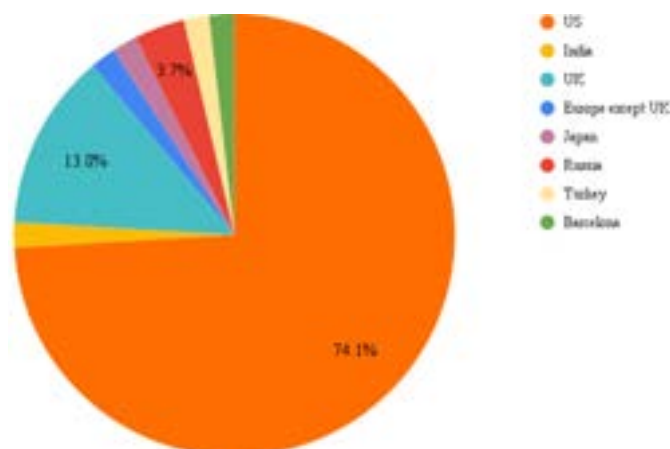
This paper aims to examine the efficacy of a range of touch-based therapies in enhancing mental and emotional wellness. Additionally, it seeks to explore the varied applications of touch in therapy, encompassing body-oriented interventions, to assess its therapeutic effectiveness in promoting mental well-being across different disorders, fostering a comprehensive understanding of the role of touch in counselling and therapeutic practices. Furthermore, it investigates the diverse factors influencing restrictions on physical contact in therapy with the goal of enhancing understanding for ethical and culturally competent psychotherapeutic practices

Method

60 research papers were reviewed from the period 1940 to 2021 with most research papers published in the two decades- 2000-2020. Databases referred to were PubMed, JSTOR, ScienceDirect, PsycINFO, APA PsycNet, National Institute of Mental Health, among others. Indices and search terms used were touch in therapy, touch therapy in India, role of gender in touch, role of culture in therapy, massage therapy, perspectives of touch in therapy, effectiveness of touch in therapy, touch and disorders, ethics for using touch in therapy, significance of touch, touch deprivation, types of touch therapy, touch and COVID, touch and AI, among others.

Figure 1

Country-wise distribution of reviewed papers



Results

Based on the papers reviewed, the authors were able to understand touch and its utility in clinical settings under the following headings presented:

Modalities of Touch in Therapeutic Approaches

Massage Therapy

Hippocrates, around 400 BC, introduced the concept of "medicine as the art of rubbing," now recognized as massage therapy. Unlike relaxation techniques, massage therapies do not require cognitive engagement. Since effective massage therapy only necessitates moderate pressure (Diego et al., 2004; Field et al., 2004), they tend to be suitable for individuals with attention deficits, including children (Field et al., 2007).

Catalonia, a structured touch therapy, induces the orienting reflex (OR), positively impacting affective and cognitive states. Developed by Petho Sandór during World War II, Catalonia involves a sequence of 10 light touches on distinct tactile points, regulating sympathetic and parasympathetic responses (Farah, 2017; Sandór, 2019). Another technique, Fractional Decompression, gradually releases pressure through touch, benefiting patients unresponsive to verbal psychotherapy (Delmanto, 2008).

Research shows massage therapy's effectiveness in reducing prematurity in pregnancy, improving visual attention task performance and intelligence test scores, alleviating anxiety and stress hormones in children, mitigating chemotherapy-related fatigue and anxiety and reducing uncontrolled movements in Parkinson's disease (Field et al., 1999; Cigales et al., 1997; Hart et al., 1998; Diego et al., 2002; Karagozoglu & Kahve, 2013; Hernandez-Reif et al., 2002). In various medical contexts, massage therapy emerges as a valuable element for patient well-being and stress relief.

Psychobiological Approach (PACT)

To treat couples in couple therapy, Solomon and Tatkin (2011) created the psychobiological approach (PACT). Inter-partner contact is used in this method during a couples counselling session. Eye contact, holding hands, moving towards and away from each other and

direct embracing are all PACT therapeutic techniques. These exercises are meant to encourage contact and connection between the couple while also helping them feel at ease being close to one another.

Havening/ Amygdala Repotentialisation Therapy

Nurturing touch, as exemplified in Dr. Ronald Ruden's Havening technique, positively influences subjective well-being by promoting the healthy processing of traumatic events and distressing memories (Ruden, 2010). Havening, also known as Amygdala Repotentialisation Therapy, addresses the role of biological structures in emotional and behavioural responses rooted in encoded traumatic memories.

During Havening, gentle touch on the face, palms, and arms, coupled with bringing the distressing event to awareness, induces biological changes leading to adaptive processing by the amygdala (Gordon et al., 2013). This touch-induced response involves the release of dopamine and oxytocin and promotes a shift in attention and perception through change in alpha activity (Ellingsen et al., 2016; Portnova et al., 2020).

Ruden suggests that touch induces delta activity, activating basic homeostatic and primal motivational processes, inhibiting amygdala activity when confronting traumatic events (Knyazev, 2012). However, recent research by Sumich and colleagues (2022) yielded mixed findings, with site-specific decreases in gamma waves post-Havening but inconclusive support for increased delta activity. Increased beta activity was noted, potentially linked to implicit cognitive processing of traumatic events. These nuances highlight the complexity of understanding the impact of Havening on brain activity and psychological states.

Touch in Cognitive Behavioural Therapy

The brain can still learn, develop, and adapt to new experiences and information of touch since the human brain keeps its plasticity for a lot longer than was originally thought. Cognitive behavioural therapy shows us that altering habits and attitudes through repetitive cognitive restructuring is achievable. Basic cognitive behavioural principles support the idea that, like any behaviour, the more we touch, the more we will

grow accustomed to touch. The client might be instructed, for instance, to touch others more frequently in daily life. Cognitively, the client's fears of touch can be reality-tested to see if they are really based on real risk or merely the residue of childhood attachment wounds. Talk therapy targets the cognitive functions of the brain, but for long-lasting improvement, the brain must undergo several changes (Lucas, 2012).

Somatic Experiencing Therapy

For those with anxiety or depression, self-touch serves as a comforting coping technique rooted in Somatic Experiencing therapy. In a somatic exercise, clients close their eyes, assume a comfortable position, and embrace themselves. They identify a soothing position, often reminiscent of a caregiver's touch and are encouraged to recreate it during moments of distress. This somatic position exercise aids in coping with stress and provides a psychobiological relaxation strategy for use beyond therapy sessions.

Touch, skilfully applied by a trained counsellor, emerges as a significant intervention for trauma treatment within the framework of Somatic Experiencing therapy (Berendsen, 2014). The counsellor's sensitive use of touch helps traumatised clients regain self-regulation by adhering to safety guidelines and understanding nervous system regulation and the threat response cycle.

Touch in Mindfulness

In focusing therapy, a mindfulness-based approach, patients enter a meditative state to identify the physiological manifestations of their problems (Berendsen, 2014). They close their eyes, relax, and place their hand on a troubling body part (such as the throat for anxious clients who fear confrontation). In this case by asking the client to describe the sensation, the therapist guides clients to process the source of anguish related to self-worth and facilitates a portion of their own wound healing by exploring the needs of that distressed part through a psycho-biological mindfulness-based touch approach.

Touch in association with Canine-Assisted Therapy

When clients interacted with and touched puppies in canine-assisted therapy, it was found that their moods

improved. The ability to interact with animals can be a valuable tool for stress management. Clients who have previously had pleasant interactions with animals will find this resource to be especially valuable. Giving clients access to animal-assisted activities and counselling could be a low-cost resource to support them and encourage a stronger sense of well-being (Davis et al., 2017).

Body-Oriented Therapy

Childhood trauma affects a significant proportion of individuals, with therapy playing a crucial role in mitigating its impact. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that by age 16, over two-thirds of children experience at least one traumatic event. Therapy, addressing issues early on, can reduce the risk of chronic illnesses and mental health problems. Cynthia Price's case study on "Body-oriented therapy as an adjunct to psychotherapy in childhood abuse recovery" emphasises the value of body-focused therapy in aiding survivors of childhood abuse, particularly in conjunction with psychological care (Price, 2005).

Emotional Freedom Therapy (EFT)

Emotional Freedom Technique (EFT) combines exposure and cognitive therapies with acupressure to treat psychological distress. Developed by Craig and Fowlie (1995), the protocol involves acknowledging a distressing event and pairing it with self-affirming statements while tapping on acupressure points. This down regulates limbic system activity, relevant to memory and stress response. EFT is effective for anxiety-related disorders and post-traumatic stress disorder (PTSD), as demonstrated in a study by Church and colleagues (2012) on psychologically or physically abused adolescents. A single session significantly improved post-test scores, reducing intrusive and avoidant symptoms.

Touch in Therapy: Correlates of Gender and Expertise

Therapeutic touch practices among psychologists vary considerably. Stenzel and Rupert (2004) surveyed 470 psychologists practicing adult individual psychotherapy, revealing a predominant reluctance

toward physical contact with clients. Approximately 90% of respondents reported seldom or never engaging in touch during sessions, except for the customary handshake. The frequency of touch correlated with therapist and client gender, theoretical orientation, and prior touch experience.

In the Indian context, Joshi et al. (2010) surveyed 61 counsellors and therapists regarding attitudes toward and frequency of touch use in therapy. Gender played a significant role, with female counsellors exhibiting a more positive attitude toward touch and employing it more frequently than their male counterparts, despite experience levels. These gender differences stem from socialization and cultural norms, with men often perceiving touch as less helpful compared to women. Research indicates that same-sex touch avoidance is more prevalent among men due to historical homophobic norms, while women tend to engage in more frequent physical contact.

Female therapists tend to utilize touch more frequently than males, a trend supported by previous studies (Cowen et al., 1983; Holroyd & Brodsky, 1977; Pope et al., 1986). Touch is often associated with femininity, empathy and care, aligning with societal gender roles. Conversely, men may suppress emotions, particularly in the presence of other men, to uphold masculine ideals, leading to discomfort with male-to-male touch.

Older male counsellors may exhibit more favorable views toward touch, as touch from older males may be perceived as less threatening. Regardless of gender, clients may feel vulnerable in the face of touch, particularly in male-to-male interactions, where power dynamics are more pronounced.

Effectiveness of Touch-Based Interventions in Treating Disorders

Counselling aims to foster relationship healing, particularly addressing attachment wounds stemming from touch deprivation or inconsistency in childhood experiences. Drawing from psychoanalytic and developmental psychology, counsellors educate clients on techniques to address attachment wounds and cultivate a secure attachment stance with oneself and significant others. These interventions range from

learned techniques, such as those in cognitive-behavioural therapy, to experiential methods reintroducing touch and attachment as safe experiences.

Pinson (2002) conducted an exploratory study interviewing four psychoanalytically oriented therapists who incorporated touch in therapy sessions. The study revealed that therapists primarily based their decision to touch on the specific needs of their patients and their individual circumstances, rather than on their therapeutic orientation or general attitude towards touch. Touch was observed to provide patients with a sense of safety, presence, and encouraged growth and integration, thereby reducing their suffering.

Touch deprivation has been linked to neurological dysfunction and developmental disorders such as autism and ADHD. Research indicates that early touch deprivation, particularly in institutional care settings with minimal physical contact between children and caregivers, leads to deficits in sensory stimulation and sensitive caregiving. Casler (1965) demonstrated that infants receiving additional tactile stimulation exhibited higher developmental scores.

Goldfarb (1943) compared foster children who experienced institutionalisation in their early years to those who did not, finding a higher prevalence of aggressive behaviour disorders among the former, attributed to a lack of parental touch during infancy.

Lowrey (1940) observed negative behavioural effects, including excessive crying, stubbornness, difficulty eating, aggression and shyness, in children raised in hospital settings, where touch was lacking, suggesting adverse consequences of touch deprivation.

Dementia & Alzheimer's Disease

Detrimental cortisol levels are prevalent among individuals with Alzheimer's disease (AD). Woods and Dimond (2002) explored non-invasive techniques for regulating cortisol levels in AD patients, highlighting the positive impact of therapeutic touch. Woods et al. (2009) investigated the effects of therapeutic touch on patients with dementia exhibiting behavioural symptoms and elevated cortisol levels. Their study involved delivering therapeutic touch to the

experimental group on the neck and shoulders twice daily for three days, while the control group received a placebo treatment. Findings indicated that therapeutic touch effectively mitigated behavioural symptoms and reduced cortisol levels in dementia patients.

PTSD

Experiences of trauma often result in a dissociation of the mind-body connection. Krystal (1988) highlighted the impact of severe trauma, such as that experienced by concentration camp survivors, which can lead to blunted affect (a diminished ability to comprehend and interpret emotional cues from bodily sensations). Neurobiological studies indicate deactivation of the Broca's area, the brain's expressive speech centre, in individuals with PTSD. Considering this, body-oriented techniques offer a promising avenue for integrating somatic and psychological experiences, enhancing bodily sensations among trauma survivors.

Finneran (2009) conducted a mixed survey study involving 45 individuals with PTSD or traumatic experiences, exploring the efficacy of self-selected body-centred techniques involving therapeutic touch. The findings revealed that these touch-based interventions effectively reduced distress and promoted integration of mind-body relations, particularly among those who experienced trauma within interpersonal relationships.

Depression

Field et al. (1996) found that children exhibiting symptoms of PTSD and depression post-Hurricane Andrew showed reduced anxiety, depression, and symptom frequency after receiving massage therapy twice a week for a month, compared to a control group exposed to a relaxation video only. This intervention bolstered the children's self-image, as reflected through their self-drawings. For instance, a girl on the first day drew a small drawing with no facial features, and the same girl on the last day drew a birthday party with friends. This study underscores the therapeutic benefits of touch beyond interpersonal trauma, extending to traumatic experiences like natural disasters.

Prohibitions and Contraindications to the Use of Touch in Therapy

The major reasons for imposing restrictions on physical contact in therapy include fear, concerns about risk management such as potential misinterpretations and legal consequences, ignorance, adherence to traditional psychoanalysis' emphasis on therapist neutrality and rigid boundaries, the influence of gender roles, where some feminists argue that male therapists may disempower female clients due to inherent power dynamics in patriarchy and biases held by therapists or clients against touch (Phelan, 2009). The apprehension centres on the fear that touch could lead to inappropriate sexual contact or allegations. Lazarus and Zur (2002) argued that the sexualisation of touch is ingrained in Western culture and reflects faulty beliefs in psychotherapy. Carere-Comes (2007) suggested that touch would be widely accepted if not for the taboo surrounding the management of erotic transference and countertransference. The fear of sexual misconduct is justified, as demonstrated in a survey where 44% of psychologists reported clients disclosing sexual contact with previous therapists (Stake & Oliver, 1991). Ethical complaints also frequently cite sexual contact with clients as a top reason (Report to the Ethics Committee, 2006).

The impact of patients' past experiences significantly influences their responses to touch. For instance, a woman who has suffered sexual abuse from her father might harbour apprehensions about appropriate touch from a male therapist or anyone perceived as having authority, regardless of gender. Touch is also emotionally disorienting for individuals with PTSD driven by interpersonal trauma, as was demonstrated by Strauss and colleagues in 2019. Two separate studies examined how different forms of interpersonal and impersonal touch were perceived and processed in PTSD patients versus healthy controls. Patients suffering from PTSD demonstrated a strong dislike for touch as well as interpersonal stroking (skin-to-skin) whereas touch was appreciated by the control group.

Another factor influencing the appropriateness of touch, as identified in literature, is the client's expectations and the contextual setting. In an exploratory study by Suiter and Goodyear (1985)

involving 120 counselors and 120 clients in a military mental health clinic, negative perceptions arose when semi-embraces were employed. The authors suggested that this negativity could be attributed to touch introducing more intimacy than desired by the recipients, compounded by the stigma associated with touch in military environments. Contraindications to touch also stemmed from clients' attitude toward touch and their cultural and religious beliefs. In certain cultures, the utilization of touch in psychotherapy is more freely embraced. In Europe, for instance, the incorporation of body therapies with a focus on touch is more positively acknowledged (Rowan, 2000). Asian and Mediterranean cultures diverge significantly on their perspectives and manifestations of touch. Asian cultures generally lean towards a non-touch-oriented society, avoiding overt displays of affection, touching, or prolonged body contact. However, certain Asians, particularly Koreans and Filipinos of the same sex, may be seen walking hand-in-hand, a gesture symbolizing friendship. In contrast, Mediterranean and Middle Eastern cultures engage in close talking and regular physical contact. European countries exhibit a mix of cultural views on touch; Germany tends to be non-touching, while Italy embraces touch as commonplace and even expected. Regardless of broader cultural perceptions of touch, its application in psychotherapy varies. For instance, although Asian cultures typically avoid public displays of touch, exceptions exist, as seen in certain Japanese groups open to therapies incorporating rhythmic touching, especially in dance, facilitating healthier and more supportive interactions for patients (Sakiyama & Koch, 2003). Psychotherapists must be cognizant of cultural and cross-cultural understandings of traditions, particularly regarding touch. This entails recognizing not only what is acceptable in a culture overall but also what aligns with an individual's preferences within that culture, considering the variations therein. Merely identifying with a particular culture doesn't imply adherence to all assumed customs associated with that culture.

Ethical Considerations

Fuller (2006) has examined the concept of touch in alignment with the fundamental principles outlined in the American Psychological Association (APA) 2003 Code of Ethics. The APA code underscores

beneficence and non-maleficence as primary ethical considerations in professional conduct. Other pertinent principles in the APA code are informed consent, justice, integrity, fidelity, responsibility and respect for the rights and dignity of the client, including their autonomy to refuse any intervention. Fuller contends that for any use of touch to be deemed ethical, it must adhere to these principles. Benjamin and Sohnen-Moe (2003) propose that employing touch responsibly necessitates a comprehensive understanding of core psychological concepts, including the meaning of the therapeutic relationship, transference, countertransference, power differentials, projection, repression, and denial.

Limitations and Future Implications

While the paper holds strengths, it is not a meta-analysis and lacks primary data collection. Originality and a fully balanced perspective may be limited. Ethical concerns in cultural contexts are acknowledged and the overall scarcity of research in the field, especially in experimental quantitative studies, poses challenges. The role of extraneous and mediating variables remains understudied, suggesting opportunities for future research refinement.

Looking ahead, this paper prompts considerations for future research and practice. Exploring touch in therapy within diverse cultural contexts is crucial, acknowledging the potential variations in its interpretation. There is a need for the development of a more comprehensive code of conduct by prominent professional organisations, such as the American Psychological Association, the American Counselling Association and others, to ensure ethical and culturally sensitive practices. Moreover, the organisational sector could benefit from further exploration of touch's potential role in building motivation and enhancing efficiency, opening avenues for practical applications in diverse settings.

Conclusion

The COVID-19 lockdown revealed the profound impact of touch deprivation on mental health, particularly emphasising the significance of intimate touch (Mohr et al., 2021). Goodman and Teicher's (1988) nuanced perspective on touch in therapy

highlights its effectiveness. The emergence of Huggable, a therapeutic robotic companion (Stiehl, 2005), exemplifies innovative solutions using touch in comparative psychology. Despite its importance, touch in therapy remains insufficiently explored. This conclusion calls for future research to leverage technology and psychology advancements, aiming to deepen our understanding of the varied benefits and limitations of touch in diverse therapeutic contexts.

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Understanding Attitudes of Indian Youth towards Homosexuality: A mixed method study

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Abstract: In a landmark ruling in 2018, homosexuality was decriminalised in India. This was the first step not just towards equality of homosexual individuals and their rights, but also towards reducing stigma and restoring dignity. In another turn of events, India also denied rights of same-sex marriage to these individuals in the latest Supreme Court judgement of 2023. While these events happened at the apex level, the ground reality remains unexplored. Through this study, we aimed at measuring attitudes of Indian Youth towards Homosexuality based on their gender and education, and to develop a deeper understanding of the same, using Attitudes towards Homosexuality Scale for Indians (AHSI) developed by Ahuja (2017). The scale was administered on 211 individuals out of which 6 individuals, 3 high scorers and 3 low scorers, were contacted for telephonic semi-structured interviews to gain more insight on their attitudes. Quantitative data was analysed using descriptive and inferential statistics while the qualitative data was analysed using thematic analysis. Results indicate a significant difference between males and females, and those studying liberal arts and science on attitudes towards homosexuality. The study also taps into the basis of the formation of such attitudes and suggests that cultural influences, social environment, educational environment and personal factors play an important role.

Keywords: Beliefs; Homosexuality; Youth; India

Homosexuality as a term was coined by Karoly Maria Benkert in the late 19th century (Pickett, 2002). It may be simply defined as sexual, emotional or romantic relationships between people of the same sex (e.g., Cardoso & Werner, 2013). The first traces of the existence of individuals from the LGBT community in India takes one back to ancient India where different religious texts have mentioned the existence of individuals from the third gender [that] includes people who have conventionally been called homosexuals, bisexuals, transgender people and intersex people. Ancient books like Baudhayana Dharmasutra, Kamasutra, Arthashastra, Mahabharat, Ramayana, Puranas etc. have all directly or indirectly acknowledged the presence of people from the community, whether it is in a positive light or a negative one. Mediaeval ages epics also present tales of homosexuality in prominent figures like Sultan Mahaud of Ghaznaha and Ayaz, Mubarak Shah Khalji and Khusri, Alauddin Khalji with Malik Kafur etc. (Kumar & Gupta, 2023). The scriptures and carvings of several temples like Khajuraho, Ambernath Shiva, Bhuvaneshwar Rajarani, Bagali Shiva and

Konark tell a story of their own (Ahuja, 2017). Despite this, a common societal narrative that we've seen over years is how homosexuality is a foreign concept. Little is known about how banning homosexuality was a foreign concept as it was "morally unethical" in the eyes of the British, leading to a legal censorship of such acts in 1861, with the introduction of Section 377 in IPC. With this also began attacks, elimination and execution of individuals from the LGBT community. Human Rights Watch reported harassment against HIV/AIDS prevention activists, sex workers and men who have sex with men and other LGBT groups (Dagras, 2021).

Srivastava and Singh (2015) examined the psychosocial factors that contribute towards the stigma of homosexuality and found that the idea of homosexuality was a direct threat to how society views the world. This becomes even more pronounced in a country like India which is a collectivistic society. Indian society also expects the child to be responsible towards their parents in some sort of way and lead a life in accordance with not just theirs but also their family's

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wishes. Deviation from this expectation especially in homosexual individuals makes them more vulnerable to stigma and mental health consequences due to lack of family support (Srivastava and Singh, 2015).

A recent survey found that 52% of gay men without peer support suffer violence in India. More than half of men who faced violence (52.4%), sexual abuse (55%) and emotional torture (46.5%) lived with their parents and were in the closet (Chaturvedi, 2018). Multiple such studies make it evident that while law making is done at the apex level of the society, the time taken for these changes to trickle down to the masses and cause actual societal changes in much more. A study by Sahni et al. (2016) tapped on the implicit attitudes of college students using the Implicit Association Test and found that about 60% of the participants had an automatic preference towards heterosexual individuals over homosexual individuals. This was explained by how mainstream attitudes influence personal beliefs. Allport's Contact Hypothesis (1954) was also used here to explain how individuals in contact with homosexuals had a more positive attitude towards homosexuality as compared to those who do not.

As noted by Ahuja (2017), key factors like gender, contact with homosexuals, and education can influence attitudes towards homosexuality. A key factor that can be noted here, especially when taking youth into account is the role of pop culture. Ayoub & Garretson (2017) noted how younger people have been trailblazers when it comes to making space for homosexual individuals. They add how representation of gay characters in mass media added to societal change. Some research has highlighted the role of religion too. For instance, a multilevel analysis of 79 countries done by Jäckle and Wenzelburger (2014) showed how religiosity explains an individual's homonegativity.

Therefore, the rationale of the present study is to understand the sources of biases, stereotypes, prejudice and thereafter discriminatory attitudes towards homosexual. Such discriminatory practices not only impact the mental health of queer individuals but also increase the burden of mental health in the system. It further deepens the gaps between minorities versus majority and might disturb the society as whole. Hence exploring the attitudes among college going youth in the Indian context becomes important.

The objectives of the current study are as follows: (1) To find difference between the attitude of male and female participants on attitudes towards homosexuality; (2) To find difference between Liberal Arts and Science pursuing participants on attitudes towards homosexuality; (3) To explore factors that play a role behind the attitudes of participants towards homosexuality.

Null hypothesis of the study is as follows: there will be no significant difference between male and female participants, and those students pursuing liberal arts and sciences on attitudes towards homosexuality. The alternative hypothesis of the study is as; there will be a significant difference between male and female participants, and students pursuing liberal arts and sciences on attitudes towards homosexuality.

Method

Design

The study follows a mixed-method approach and collects data using a standardised questionnaire and a semi-structured interview. Quantitative data is analysed using SPSS version 21.0, while qualitative data is analysed using Thematic Analysis (Braun, Clarke, & Gray, 2017).

Measures

The study collected basic demographic details of the participants including their email ID, age, sex, field of education, contact with homosexual individuals and taking informed consent. A standardised questionnaire called Attitudes towards Homosexuality Scale for Indians (AHSI) developed by Ahuja (2017) was used. It is a 5-point Likert type questionnaire with 20 questions, with a strong split-half reliability of 0.91.

The study also uses semi-structured interviews to get an in-depth understanding of how the participant's attitude towards homosexuality was formed. The open-ended questions were formed in line with the literature procured, for example, "How was your first encounter with information regarding homosexual individuals?", "How do you think your society/culture around you have impacted your attitudes towards homosexuality?". To analyse this, we used Thematic Analysis ((Braun, Clarke, & Gray, 2017) in order to get clear themes with

rich quantitative codes.

Participants

The questionnaire was administered to 211 participants using Google Forms. Inclusion criteria included individuals who are Indian residents, are above the age of 18, are cisgender and heterosexuals. A semi-structured interview was also carried out with six participants, three of whom were high scorers on the scale and the other three were low scorers to get an in-depth idea about how their respective attitudes got shaped. About 76% females and 24% males participated in the study. The mean age was 25 years and 73% pursued liberal arts and about 27% pursued science courses.

Procedure

The Attitudes towards Homosexuality Scale for Indians (Ahuja, 2017) questionnaire was administered and participants with high and low attitudes on AHSI were identified and contacted for their interview to understand their attitudes in-depth. A semi-structured interview schedule was created and validated by four clinical psychologists and administered on these six

individuals after which the verbatim was analysed using Thematic Analysis (Braun & Clarke, 2006) to generate broader themes on how these attitudes were formed. Based on focused group discussions various themes were put under one broad theme and subsequent sub-themes and later coding was done.

Results

The data obtained was analysed statistically using percentages, t-test for independent means using SPSS version 21.0. The results are presented here as per the hypothesis of the study. About 76% females and 24% males participated in the study. The mean age was 25 years and 73% pursuing liberal arts and about 27% pursuing science courses. Amongst the participants, 57% reported being in contact with homosexual individuals while 43% reported having no contact. A significant difference was found on attitude towards homosexuality between male ($M=79.62$, $SD=19.1$) and female ($M=90.44$, $SD=11.8$) participants $t(212)=3.78$, $p<.001$, Cohen's $d=0.68$ as evident in Table 1. Female participants had a more positive attitude towards homosexuality as compared to male participants.

Table 1

Difference between male and female participants on attitude towards homosexuality

Measures	Males (n=50)		Females (n=162)		t(212)	Cohen's d
	M	SD	M	SD		
Attitude	79.62	19	90.44	11.86	3.78*	0.68
High (%)	72		74			
Medium (%)	2		7			
Low (%)	26		22			

*Note: * $p<.05$, Attitude towards homosexuality*

A significant difference was found on attitude towards homosexuality between students of liberal studies ($M=90.39$, $SD=12.32$) and science courses ($M=81$, $SD=17.92$), participants $t(212)=3.62$, $p<.001$, Cohen's $d=0.61$ as evident in Table 2. Students pursuing liberal studies showed more positive attitudes towards homosexuals than students pursuing science studies, as evident in Table 2.

Table 2

Difference between Liberal Arts and Science pursuing participants on attitudes towards homosexuality

Measures	Liberals (n=155)		Science (n=57)		t(212)	Cohen's d
	M	SD	M	SD		
Attitude	90.39	12.32	81	17.92	3.62*	0.61

*Note: *p<.05, Attitude towards homosexuality*

As per demographic details taken, about 57% of participants were in contact with homosexuals, that is, they either knew someone who is homosexual on a one-on-one basis. More females (61%) are in contact with homosexuals than males (42%), as evident in Table 3.

Table 3

Males and females who had contact with homosexuals on attitudes towards homosexuality

Measures	Yes (%)	No (%)
Contact (n=212)	57	43
Males (n=50)	42	58
Females (n=162)	61	39

Table 4 shows the qualitative analysis conducted on data derived from interviews. A qualitative means of analysis was used to gain an in-depth understanding of the attitudes of youth and their sources. The analysis was done using Braun & Clark's (2006) six-phase process of thematic analysis. For phase one, interviews were transcribed, read and re-read to develop a familiarity with the data and broad observations were made. For phase two, initial codes were generated keeping in mind the fourth objective of our study which was to explore factors that play a role behind the attitudes of participants towards homosexuality. For phase three, generated codes were analysed, interpreted and themes were generated. During this process, similar codes were put together into one sub-theme and similar sub-themes were put together into one theme. For phase four, all of these generated themes were reviewed to see if they were relevant to the objective of the study or not and how well they explained the

phenomenon at hand. For phase five, themes were given appropriate names to make the data set more coherent to understand under simple headings. Finally with phase six, generated results were reported in the results section of this study.

The first theme that was generated was 'Cultural Influences' which includes the sub-themes of religion and societal norms. The theme taps into how cultural values, expectations and traditions impact one's attitude towards homosexual individuals. The prominent sub-themes noticed within this theme were one's religion and the values that one learns from the society that they live in, and how these shape their attitudes.

The second theme that was generated was 'Social environment' which focuses on one's immediate social surroundings and environment which is generally

included in their day to day interactions. Here three prominent sub-themes explored the role of familial attitudes, peer influence and media influence on one's attitude towards homosexuality.

The third theme explored how one's educational background affects their attitudes towards homosexuality. Sub-themes here explored institutional atmosphere, that is, campus environment and collectivistic attitude of an educational institute and how that affects attitudes towards homosexuality. It also explored how one's curriculum, as noticed by the quantitative analysis also between liberal arts and

science students, impacts their attitude towards homosexuality.

The fourth theme finally explored 'Personal Factors' keeping into mind how despite being surrounded by a society, there's some influence that an individual and their thoughts and experiences can have on shaping up their attitudes. This included sub-themes of Personal experiences, which is a person's first-hand experience with a homosexual individual and Perceived Stigma towards individuals from the LGBT community.

Table 4

Themes and sub-themes from Thematic Analysis

Themes	Codes
Cultural influences	Religious expectations and implications Adherence to standardised norms of heterosexual society Personal autonomy despite cultural influences Emphasis on fixed gender role
Social Environment	Nature of one's work being liberal Nature of one's education being liberal Exposure to queer friendly media Access and understanding of feminist theories Access to social media Being in touch with someone with lived experiences Adherence to parental expectations
Educational environment	Exposure to education that emphasises importance of biology over other aspects Lack of access to spaces providing accurate information Inculcating empathy through experiences
Personal factors	Having one on one interaction with people from the community Having friends who are homosexuals Sensitivity towards perceived stigma Personal willingness to learn more about the community

Discussion

The goal of the study was to measure and attitudes of Indian youth towards homosexuality based on gender and education. Through this paper we aimed to explore the attitudes of youth and also gain an in-depth understanding of these attitudes and how these attitudes have been formed.

Gender differences in Attitude

As observed by Ahuja (2017), our study also found a significant difference between attitudes towards homosexuality in males and females with females having a more positive attitude towards homosexuality than male participants. Similar findings have been observed in several studies like those conducted by Ilango et al. (2020) and Miller et al. (2021). Based on our qualitative analysis, we found that women tend to explain homosexual experiences by stepping into their shoes and exhibiting empathy. For example, a participant was noted saying *“they are also human and they also deserve basic human dignity”*. This can be attributed to how women are interpersonally oriented, especially in a collectivistic society like India.

Differences based on education

As observed by Ahuja (2017), our study also found a significant difference between attitudes towards homosexuality in participants from liberal studies and science courses, with participants from liberal studies showing more positive attitudes towards homosexuality than those pursuing sciences. Similar findings are shown in studies conducted by Yr, Suttrave, and Hegde (2022) and Banwari et al. (2015).

Qualitative data from the interviews made this aspect even clearer. Following are some relevant verbatims from the interviews. For instance, one female with a positive attitude towards Homosexuality, from liberal studies said, *“I think it adds a lot because umm... My education never took me to an orthodox thinking. I have my masters in mass communication and there we are always dealing with new challenges of society and it's our work to normalize. I normalize myself though my professors. By watching films like ritu perna gosh they have made films on these aspects only and reading books written by them on them and by watching films like moonlight which won Oscar also... I think these kinds of films, magazines, research papers*

and feminist theories have helped me a lot.”

One male with a negative attitude towards homosexuality, from engineering, in sharp contrast said, *“My education has always taught me that the root of everything is 2 chromosomes which is x and y. I don't think it matters much, even if I was from medical I would say this, even if I was from non-med I would say this, even if I was from accounting I would say this because it's a fact.”*

Formation of Positive or Negative Attitudes

Based on the qualitative data analysis, it was noted that culture can influence one's attitude towards homosexuality through the medium of religion and norms that are widely followed in the Indian subcontinent. Following verbatims are an example to help understand these themes further, *“My religion doesn't allow it and I can't go against it. It's very simple”; “They just don't fit in. How will a family function without a mother and a father? I don't mean to demean anyone but I personally am not able to see it happen”; “My religion doesn't really support homosexuality. I am religious but I can separate myself from it when needed. I think the world has also moved on.”*

It was also noted that social environment can influence one's attitudes towards homosexuality. The subtheme of media influence was heavily filled with codes about pop-culture. Following are some examples to explain these sub-themes further: *“I had a bad circle in school and college. I think Insta gave me a sense of what's right and what's not otherwise I would've still been in my bubble”; “On social media I am reading lot of success stories about them and in web series I have seen such characters in positive light so I feel comfortable around them and I feel that's why I have a positive attitude for them”; “I will feel awkward taking a homosexual to my home because I know my parents won't be comfortable.”*

Participants were also seen expressing how their attitudes were shaped by the atmosphere around which they had grown up and expressed concerns about the need to update the curriculum. *“I think no one is talking about these things. There is no knowledge and we don't know what they are facing. If we knew then we would want to change our view point”; “Streams of education don't matter. Medical students know about XY chromosomes, non-medical also know, accountancy also know. It's a fact that no one can*

change or be unaware of”; “In our school we used to make fun of their way of saying and how they clap and if any boy has a girlish voice we used to make fun and all people laughed but as I entered college there I had lot of discussion with my friends, teachers and in societies I realised that they also have problems in this society and I started feeling bad for them then I read lot of articles about them”.

Lastly, while environment and society definitely shape our attitudes, one’s personal experiences and individual’s personal encounters with people from the community, in person or otherwise, and how that adds to their perception about them. The following examples may illustrate: “Yes I have my friend they are equally competent good in studies very loyal to us and understanding. I feel that they still don’t share much feelings with us but as friends we are connected and helpful to each other”; “Yeah of course I have friend they are homosexuals I have been with them I never felt any difference with them”; “I don’t think I will feel comfortable if my close friend opens up about such things. I don’t know how I will react. I’ve never even had an encounter so I can’t even imagine.”

All in all, formation of these attitudes can be attributed to unique experiences of an individual ranging from their cultural influences, social environment, educational environment and personal factors. This can be well understood in the Indian context where we exist in a collectivistic society because of which aspects like religion, family, friends and norms act like adhesive to our identities, binding them together in a larger social context.

Limitations and Future Directions

The sample size was small and students from various courses and streams were not included in the study. Comparisons of t-independent tests also have disproportionate sample sizes. The future studies could include attitudes of professionals or stakeholders in the society.

Conclusion

The results of the present study showed a significant difference in attitudes towards homosexuality between not only male and female participants but also participants who had different areas of education, that is, liberal arts and science. Qualitative analysis of the interviews showed how factors like cultural influences,

social environment, educational environment and personal factors can play a role behind an individual’s attitudes towards homosexuality. Youth being an asset of our country should be encouraged to have discussions about gender at home, school and community level. Parents should also include gender neutral practices in their daily lives.

Acknowledgements: We would like to extend a special thanks to Dr. Kanika Ahuja for granting us the permission to use her scale for this study. We would also like to thank Praggapti Gosh, Consultant Psychologist at Mental Health Foundation India for her guidance in bringing this paper together.

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Exploring self-concept among gifted children through analysis of the movie Gifted

Shubha Chechi¹ & Gargi Bansal²

Abstract: This present paper aims to explore the theory of “self-concept” through the analysis of the movie Gifted (Webb, 2017). The paper discusses the impact of movies on shaping perceptions of the general masses. It describes the alliance between psychology and media and how the relationship between the two is interwoven and highlights the role of media in forming the stereotypes and its generalisation around various psychological concepts. It aims to bring forward the hardships faced by gifted children and their caretakers. The paper revolves around various themes emerging from the movie including the suitability of gifted programs in schools for such children with this rare behaviour. It also highlights how the expectations from family and society can result in damaging their self-esteem in many ways.

Keywords: Gifted; Media; Rare-behaviour; Self-concept; Caretakers.

Rare behaviour is behaviour that significantly deviates from statistical or societal norms. The definition of such behaviour is culturally sensitive and what is considered rare behaviour in one culture may not be rare in another, because different cultures around the world have different practices and norms. Some statistically unusual behaviours can be maladaptive in nature and be considered undesirable such as having a lower IQ or holding uncommon beliefs. In contrast, other rare behaviours might be desirable and considered an asset such as a higher-than-average IQ, in 'gifted' children. It is a universal human desire to be born *gifted*, as being *gifted* is synonymous with superior performance and achievements than one's peers. But most of us do not realise the kind of adversities that are accompanied by this rare human trait.

The National Association of Gifted Children (NAGC) defines “giftedness” as “an ability to demonstrate outstanding levels of aptitude (defined as an exceptional ability to reason and learn) or competence (documented performance or achievement in top 10% or rarer) in one or more domains. The earlier definitions of giftedness have centered around intelligence and creativity, but now the concept has evolved with time because of several researches (e.g., Carman, 2013; Cross & Cross, 2019; Kaufman & Stenberg, 2008; Stoecker, 2009). At times

giftedness is equated with high IQ, creativity, talent, and multiple skills but due to the varying cultural norms and lack of a unified theoretical view, there is no standard way to define it. Mostly giftedness is displayed during early childhood and it might take numerous forms. Some individuals are globally gifted whereas others are gifted in specific domains, such as in academics, sports, music, or specific academic fields, hence gifted children are associated with a wide range of talents, aptitudes, abilities, and skills (Daniels & McCollin, 2010)

The concept of giftedness is often brought forth through several Hollywood movies featuring both gifted kids and adults in diverse ways, yet commonly highlighting the eulogizing light they stand in, often alienated from their peers. While *Shine* (Hicks, 2006) and *The Greatest Showman* (Gracey, 2017) feature musical prodigies, intellectual paragons with exceptional mathematical abilities are the focus of films like Gifted (Webb, 2017). Bollywood does not stand too far away in terms of the portrayal of the concept of giftedness, and a movie called *Three Idiots* (Hirani, 2009) has been enjoyed by the audience, reflected by its success.

Media and psychology have a long-standing partnership, with audio-visual resources like movies

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playing a crucial role in portraying psychological concepts and spreading awareness about mental health issues. The effective use of these resources is associated with enhanced imagination, increased attention span, active learning and enhanced emotional and cognitive responses (Rasul, Bukhsh, & Batool, 2011; Perciful & Meyer, 2016) making them valuable in various fields such as healthcare training, counseling, therapy, classroom education, marketing, and advertising. However, media can also perpetuate prevalent stereotypes (Mastro, Behm-Morawitz, & Kopacz, 2008), leading to misinterpretations of marginalized groups (Yuen, 2016; Rider, 1994). Accurate portrayal of characters can encourage a positive attitude towards those belonging to the same minority groups as media-based strategies have been effective in reducing racial and gender stereotypes and reducing homophobia (Ramasubramaniam, 2007; Madžarević & Soto-Sanfiel, 2018). Additionally, media has a significant role in shaping audiences' perceptions of gifted children, setting standards for behavioural and cognitive traits. Stereotypic representations in newspapers contribute to stigmatization, while evidence-based representations can help destigmatize them (Bergold, Hastall, & Steinmayr, 2021). Inaccurate portrayals in films can lead to negative attitudes and decreased self-esteem, affecting gifted young people's social functioning and self-esteem which leads to behavioural problems (Eren, Çete, Avcıl, & Baykara, 2018). Vialle (2007) found that gifted young people are often stereotypically portrayed in films as non-sporting, female, and unpopular, in undesirable settings populated with obnoxious characters. Studies (Gerbner, Gross, Morgan, & Signorelli, 2002; Nabi & Riddle, 2008) also confirm media's effectiveness in changing attitudes towards gifted children, attributed to cultivation and identification, shaping perceptions, beliefs, attitudes, and values.

Why *Gifted*?

While the movie *Gifted* primarily explores Mary's family dynamics, it also unveils stereotypical perceptions of gifted kids by their families, teachers and societies which puts them under pressure to meet those expectations and live up to the standards set by others while neglecting their own emotional needs. It depicts well the lack of understanding on caregiver's

part regarding emotional development who see them just as an achievement and an extension of themselves to make them proud rather than a separate human being with their own needs and thoughts. As a result, many gifted children end up suffering the consequences of the lack of proper emotional and academic support, such as burnout and depression. If psychological assistance is not provided on time, it may lead them to suicide, as in the case of "*Diane Adler*", Mary's mother. The movie is informational in that aspect and stresses the need for balance between providing a 'normal' childhood and nurturing gifted abilities. While many movies featuring gifted characters tend to be stereotypical in portraying gifted children as one-dimensional oddities, typically closed off, socially awkward and introverted with undesirable physical qualities with glasses on at all times, *Gifted* diverges from this pool of movies and presents the gifted child prodigy with slightly more accurate characteristics.

Objective

Through the use of audio/visual material, the objective of the study is to analyze the movie *Gifted* and explore the following themes:

1. Shaping of self-concept through parental, societal, and family influence.
2. The overall impact of specialized programs.
3. Depression in gifted children and their caregivers.

Method

Gifted is a 2017 movie directed by Marc Webb which revolves around a seven-year-old child prodigy with extraordinary mathematical abilities and her uncle Frank, a boat mechanic in Florida. The movie explores the challenges that come with raising a gifted child through themes of family dynamics and academics and presents the dilemma of harnessing gifted abilities at the cost of conventional childhood for the benefit of society or letting children have childhood, like peers their age. It begins with Mary Adler, gifted in mathematics, starting her first day of school with much disinterest as she is opposed to the idea of attending a regular school. She would rather be homeschooled, reasoning that she has no interest in being friends with her classmates as she is content being friends with her next-door neighbour Roberta and her one-eyed cat, Fred. Mary's personality is a blend of confidence,

intelligence, and empathy, showcased throughout the movie as she navigates complex ideas and brings unique perspectives to situations. Her innate curiosity is responsible for her being an engaging conversationalist and on many accounts, Frank can be seen talking to her like an adult rather than a child. Their dynamic is best reflected when the two converse about the existence of God, in which rather than taking the easy route and affirming belief in God, Frank explains the difference between faith based on emotions and feelings as opposed to facts, and hence no one knows if God exists. On multiple occasions, Mary's unwavering confidence and ability to stand up for herself and others has also been witnessed.

However, with *Evelyn's* (Mary's grandmother) introduction, a custody battle between the son and mother sets off, letting Mary's future be divided into two different paths, one by her Uncle Frank who wishes she attends school with her non-gifted peers. Evelyn sees this as a hindrance in her progress to achieving full potential like her mother Diane and sets the second path to enrol her into a gifted program instead. Evelyn's background is of importance here as it also sheds light onto the reason for her persistence to uproot Mary from the life she has been living so far to raise her like Diane, Mary's mother. In the film, she is seen reminiscing about the time she spent as a math researcher which gets exchanged in turn for a husband and two children, one of whom turns out to be a gifted math prodigy and eventually serves as an instrument for her to live her dreams through. Unfortunately, for Diane, the pressure put by her mother to focus on her studies leaves her isolated from the rest of the world and questions her existence and worth which quickly escalates into her attempting suicide. Afraid that Mary might go down the same path, he quits his job and comes to Florida, away from his controlling mother.

Analysis

The qualitative study was based on thematic analysis of

the movie *Gifted* following the six-step process given by Clarke and Braun (2016): familiarization, coding, generating themes, reviewing themes, defining and naming themes, and writing up. After watching the movie multiple times to get familiarized, characters were closely analyzed individually and with relation to their environment to identify recurring psychological themes: Giftedness in children as well as adults, the self-concept in gifted children, depression in gifted children and their caregivers and the impact of gifted programs on children which were then used to formulate research questions. Based on the discovered themes, a coding system was created to analyse the film using theoretical framework from various theories such as Cooley's looking-glass self-theory (1902) and self-concept as given by Rogers (1959) and characters are examined to formulate subject matter. Related studies were found and used to support the current findings of the study.

Mary Adler and Frank Adler were the main characters analyzed in relation to each other, as well as other characters such as Mary's grandmother and her mother, Diane Adler. The emergent themes were noted in detail, following a latent level analysis and supporting evidence from specific scenes, dialogues and character interactions based on actors' performances, facial expressions, and body language was also added, followed by categorizing and organizing the data through coding. Audience responses of the movie's themes and messages were also taken into consideration. A thorough analysis of the coded data was done to explore the interconnections between the emergent themes and draw insights from their patterns and variations. This analysis is conducted without the constraints of predetermined theoretical frameworks, allowing for a more exploratory and flexible interpretation of the movie's psychological dimensions.

Figure 1

Themes uncovered from the movie Gifted

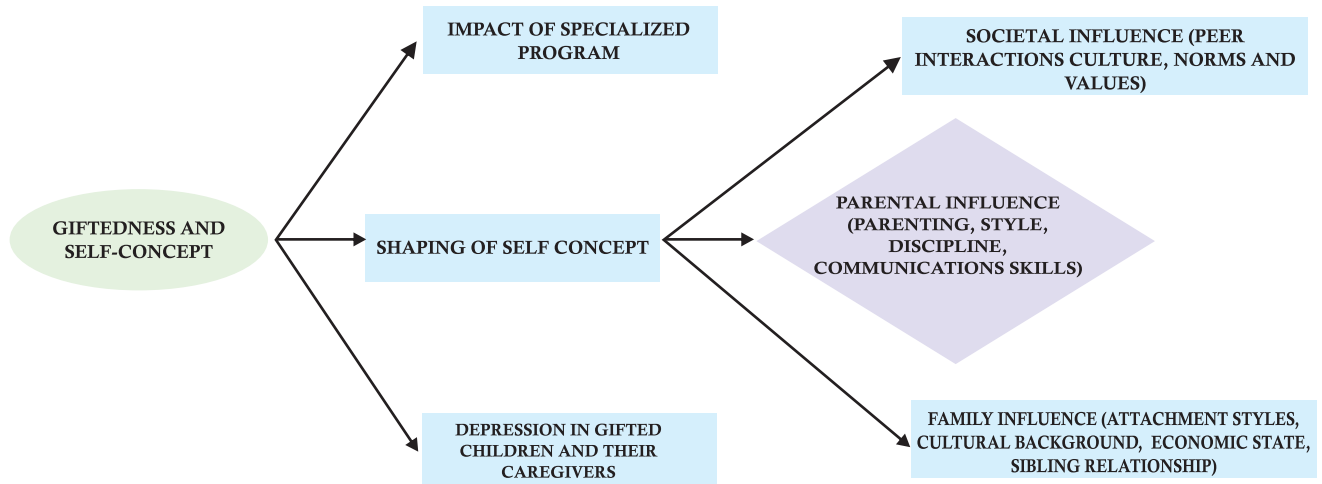


Table 1:

Thematic analysis of movie Gifted

Theme	Sub-themes	Codes
Self-Concept in gifted children	Shaping of self-concept through parental, societal, and family influence	Contrast between self-esteem in two different situations with two different caregivers.
	Depression in gifted children and their caregivers	Exhibition of depressive symptoms (withdrawal, feelings of sadness and inadequacy, crying)
	The overall impact of specialized gifted programs	
		Benefits and Drawbacks of gifted programs

Result and Discussion

An examination of the movie's plot, characters, and their portrayal uncovered the following themes below:

Shaping of self-concept by parental, societal, and family influence

Central to humanistic psychology, self-concept refers to an individual's perception, evaluation, and

understanding of themselves based on several factors such as personal experience, social interaction, and cultural influences and plays a role in governing behaviour and emotions while often tied to self-image and self-esteem. Baumeister (1999) defines self-concept as "The individual's belief about himself or herself, including the person's attributes and who and what the self is". Lewis (1990) presents two aspects of self, i.e. existential and categorical. Relationships and early experiences with caregivers primarily shape the development of children's self-concept. Between six

and nine months of age, children begin to recognize themselves as separate people and not a part of their caregivers, marking the first form of self-concept. This reportedly evolves and develops such that children demonstrate self-recognition, awareness of their characteristics, and identification of feelings and preferences whilst seeking out social interactions.

Mary Adler's self-concept evolves throughout the story as she navigates the intricate circumstances surrounding her family and academics. Initially, Mary is homeschooled by her uncle Frank, rather unconventionally because of her exceptional communication skills and extraordinary mathematical abilities by encouraging her to make decisions for herself and setting a stage to explore interests enthusiastically without judgments. Furthermore, he communicates well with her as shown by him expressing his disappointment when she yells at the Principal on her first day, which shapes a positive self-concept.

Fostering a positive self-concept in children is essential for establishing healthy relationships with parents and peers (Myers-Walls, Hinkley, & Reid, 2017). It also encourages a positive outlook regarding the future and results in high self-esteem and confidence which is reflected in the movie through relationships between her and Frank as well as Roberta. Mary's confidence is unwavering when she stands up for her classmate against twelve-year-old bullies responsible for tripping the classmate down to ruin his art project. Several studies show that gifted children have a higher self-concept (general and academic self-concept) as compared to their non-gifted peers (Infantes-Paniagua et al, 2022; Hoge & Renzulli, 1993), often reflected in adulatory confidence, ever-increasing curiosity and the ability to explore new situations assertively.

Apart from parental influence, interactions with friends and society are eminent in shaping the self-concept (Janos, Fung, & Robinson, 1985). Cooley's looking glass theory emphasizes the role of social interaction in shaping an individual's identity, stating that "the concept of self or one's sense of identity comes not only from direct contemplation of themselves, or the personal qualities but also from the examination of the way one is perceived by others in

the society" (Cooley, 1902). In a social situation, an individual visualizes how others perceive and make judgments based on those perceptions which either upholds their self-image or and then responds to those judgements positively or negatively. Negative feedback impacts self-concepts negatively whereas positive leads to a pleasing impact on self-concept accompanied by increase in self-confidence and an assured self-identity. Mary's interactions in the movie are limited to Frank and Roberta as she does not have interest in making friends her age as she finds them boring. However, both the interactions in the movie nurture a positive attitude towards self and encourage her to explore her own capabilities. Later, when she finds out that her biological father did not try to reach out to her despite living in the same state, she states feeling undesirable and questions if it is because she is not "good enough" for him. At the end of the movie, Mary once again encounters a new social situation in the form of girl scouts but adjusts quite well and is seen playing with her friends which shows that she has a high self-concept. It is noteworthy that in the classroom, Mary does not falter when her teacher challenges her by asking complex mathematical questions when she appears bored and uninterested in the class activities. This gives the impression that she is self-assured in her abilities which derives from the fact, again, that gifted children have higher self-esteem than their non-gifted peers apart from being more emotionally intelligent.

Depression in gifted children and their caregivers

Children who are gifted are usually characterized as more intense, sensitive, and idealistic; they can see the contradictions and absurdities in the values and behaviors of others (Beljan et al., 2006). They are more likely to question the nature and purpose of their lives and the lives of those around them because of sensitive awareness and idealism. They become keenly aware of their smallness in the larger picture of existence and they feel helpless to fix the many problems that trouble them. Gifted children are hence more likely than those who are less gifted to experience spontaneous existential depression as a result of their mental and emotional abilities and interactions with others. A similar emotional state could be observed in *Diane* as well, who committed suicide after finding a solution to a popular one of the seven millennium problems, the Navier-Stokes equation which can be attributed to her

centering the purpose of her life to the solution of the popular maths problem. Meanwhile, Mary does not suffer from existential depression in the movie but does not fail to question the existence of those around her, including God.

In general, gifted kids exhibit more depressive symptoms than their peers (Eren, Çete, Avcıl, & Baykara, 2018). They are more likely to be excluded from social groups they belong to and consequently experience isolation and loneliness due to intellectual differences. Researchers (Gross & Feldhusen, 1990; Roberts & Lovett, 1994; Roedell, 1984; Silverman, 1993) have suggested that because gifted children deviate from the norm and have heightened responses, they are more likely to experience unusual social and emotional challenges. Super-sensitivity, perfectionism, and differences in intellectual, emotional, and social domains are among the factors that contribute to these unusual challenges (Winsor & Mueller, 2020). Historical evidence also amounts to the fact that gifted children have experienced clinical depression in the past, though they might disguise symptoms for various reasons. (Jackson & Peterson, 2003). In the movie, Mary is isolated from her peers twice, once when she is being homeschooled by Frank and the second time when her grandmother hires a tutor for her but the conditions both times were extremely different. As opposed to the encouragement and love provided by Frank which does not affect her negatively, the isolated environment provided to her (putting her pet cat for adoption) by her grandmother is rather overwhelming and distressing, as exhibited by her bursting into tears as soon as she sees Frank and wishes to go home. The short time she spends at the primary school can be highlighted by outbursts and unwillingness to make friends. While this is not indicative of depressive behaviour in the clinical sense, Mary seems to struggle with feelings of loneliness (her only friend being next-door neighbours Roberta) and is often vulnerable at times. It also highlights behavioural problems experienced by gifted children. Diane's struggles with mental health, implied through flashbacks and her strained relationship with her mother and boyfriend also reveals depression in gifted children, if left untreated, can worsen over time which contributed to her tragic end.

Research on caregivers of gifted children experiencing clinical depression is limited, though they may be prone to developing depression due to various stressors, such as the need to meet high expectations that come with raising a gifted child and navigating educational systems that do not properly manage the gifted education system, failing to accommodate their needs (Mascher, 2021). They may also experience social isolation as other parents do not share common problems with them that may come with raising a gifted child. A similar situation was faced by Mary's uncle Frank, who was seen struggling to give a fulfilling upbringing to Mary as her peers. Throughout the film, Frank's depression can be seen through his body language, inability to make genuine connections, romantic and otherwise with other people and feelings of sadness. The choice of whether to let Mary be with her peers or enroll into a gifted program is a burdening responsibility. At times, signs of burnout can be noticed where he feels powerless.

The overall impact of specialized gifted programs

Frank, concerned about Mary's social and emotional need which are generally not fulfilled due to poor management of Gifted and Talented programs and other factors which contribute to predisposition of mental disorders in gifted children, enrolls her into a community school where she attends lessons with her non-gifted peers, which can be characterized by boredom, frustration as she talks rudely to teachers as well as principle and withdraws from classroom activities purposely, and it's only after the custody battle, Mary is seen attending the Oaks college with other older students. Gifted children enrolled in regular school programs withdraw into themselves and have only a few friends. They may be bored with their schoolwork, become frustrated and discouraged, and may deliberately underachieve to make themselves acceptable to their classmates (Aziz et al., 2021). Diane's attendance in gifted program proves to be disadvantageous to her mental health due to mismanagement and authoritarian parenting style (Baumrind, 1999) of Evelyn who makes it clear that sole purpose of her daughter's life is to work on the Navier-Stokes equation, and in progress sets clear expectations regarding how her life should unfold and restrictions on things that are "distracting." Participation in the gifted program has mixed effects on

students' self-concept. On the one hand, research reveals that while a lot also depends on other factors, being a part of the gifted programs influences students' self-concept, their self-esteem and self-image (Hertzog, 2003). Studies aimed at exploring influence of gifted and talented programs on student's self-concept reveal that post enrolment, gifted children develop an elevated sense of self perception and an increase in self-concept because of their awareness that the program is highly competitive and admired (Kalaji & Alborn, 2022). On the other hand, other researchers have shown the *Big-Fish-Little-Pond (BFLP)* effect which predicts that academic self-concept is lower in gifted children enrolled in higher achieving programs as compared to lower achieving programs. Hence, the more competitive a gifted program is, the worse students tend to feel about their academic achievements which reflects poorly on their self-concept. A review of the effects of gifted and talented programs on academic self-concept showed a decline in three components of academic self-concept over time but did not affect non-academic self-concept (Marsh, Chessor, Craven, & Roche, 1995; Tokmak, Sak, & Akbulut, 2021).

Limitations and Implications for further research

The study utilizes a secondary source of data for analysis. It also presents analysis of only one movie for studying giftedness which limits generalization to other children. Moreover, the focus of the movie is not psychological so it does not cover theories or topics in depth. More case studies in different age, socio-economic background and ethnicity may be analyzed for a more nuanced understanding. Further, utilizing primary sources such as surveys and observation ensures original insights and hence, increases the depth.

Conclusion

Giftedness is the ability to demonstrate outstanding levels of aptitude or competence in one or more domains. The objective of the study was to analyze the movie *Gifted* and explore different psychological themes emerging from the parental, societal, and family influence on socio-emotional development in gifted children and their caregivers using audio/visual aids which highlighted important themes. Interplay between the environment, societal expectation and

giftedness shapes the self-concept of Mary, a gifted seven-year-old prodigy and throws light on the profound impact of the relationship between self-concept, self-esteem and depression which influences other domains of life such as relationship with peers, caregivers and familial relationships and vice versa. The movie steers away from the stereotypical representation of gifted children in media to more accurately portray the struggles of gifted children such as isolation, loneliness, academic expectation through Mary. The portrayal of depression highlights the vulnerability of gifted children and the need for early intervention and mental health resources within educational settings.

The movie also emphasizes the importance of the role of caregivers and educational systems in supporting the socio-emotional needs of gifted children. Frank's struggle to balance Mary's intellectual needs with her emotional well-being as well as his own highlights the importance of having support systems for gifted individuals, such as gifted programs and for their caregivers as well.

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Exploring Attachment Styles, Psychological Distress, and Loneliness among Indian Young Adults: A Moderation-Based Survey Approach

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Abstract: The present study investigated the moderating effects of attachment styles on the relationship between psychological distress and loneliness in young adults from Delhi, India. Participants (N=151) aged 18-24 years, completed the UCLA 3-Item Loneliness Scale, the Kessler Psychological Distress Scale (K10), and the Relationships Questionnaire (RQ). Moderation analysis was carried out using SPSS PROCESS macro. The overall regression model was found to be significant, and a significant negative association was observed between psychological distress and loneliness. Significant differences in loneliness were observed between preoccupied and secure attachment styles, and fearful and secure attachment styles, with securely attached individuals reporting the highest levels of loneliness. Conversely, differences in loneliness between dismissing and secure attachment styles were nonsignificant. Moreover, the impact of psychological distress on loneliness did not significantly vary among those with different attachment styles. Thus, attachment styles were not found to significantly moderate the relationship between psychological distress and loneliness. The present study highlights the experiences of loneliness among securely attached individuals as well as a negative correlation between psychological distress and loneliness. It prompts important questions for future investigation, including the role of age, personality traits, coping mechanisms, and resilience in relation to attachment styles, psychological distress, and loneliness.

Keywords: Attachment Styles; Loneliness; Psychological Distress; Moderation

Loneliness can be defined as a distressing feeling accompanied by the perception that one's social needs are not being fulfilled in terms of the quantity and quality of social relationships (Hawkey et al., 2008; Peplau & Perlman, 1982). It is influenced by major life events such as the loss of loved ones, relationship and friendship break-ups, psychological disorders, and social restrictions like isolation and quarantine, particularly during a pandemic, which can lead to feelings of loneliness in individuals. Even before the COVID-19 pandemic, loneliness was already a significant public health concern (Cacioppo & Cacioppo, 2018; Holt-Lunstad, 2017; National Academies of Sciences, Engineering, & Medicine, 2020).

Psychological distress refers to a state of emotional suffering, discomfort, and overwhelm often accompanied by symptoms of depression and anxiety

(Mirowsky & Ross, 2002). It can manifest in physiological symptoms like lethargy, headaches, and insomnia, and can disrupt daily activities and social functioning (Kirmayer, 1989; Kleinman & Kleinman, 1991; Wheaton, 2007).

Attachment theory elucidates the human propensity to develop strong affectional bonds with others (Bowlby, 1977) and serves as an indicator of the degree of security experienced in interpersonal relationships (Baron & Branscombe, 2011). Hazan and Shaver (1987) describe secure, avoidant, and ambivalent attachment styles, while Bartholomew and Horowitz (1991) proposed four attachment styles: secure, fearful, preoccupied, and dismissing. These attachment styles shape the quality of relationships, thoughts about others, behaviours, support-seeking tendencies, and the extent of self-disclosure (Baron & Branscombe, 2011).

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Recently, considerable evidence from longitudinal studies (Dinero et al., 2008; Jones et al., 2017) has accumulated to show that in addition to early caregiving experiences, ongoing and relatively recent interpersonal and attachment experiences play a pivotal role in influencing adult attachment patterns, with attachment stability increasing significantly from adolescence (a period characterized by large and rapidly changing social networks, evolving social roles, and biological changes) to adulthood. Together, these studies reiterate the importance of studying attachment styles in adolescence and young adulthood.

Studying loneliness, psychological distress, and attachment theory in young adults in India is important for several reasons. Firstly, understanding the prevalence and impact of loneliness and psychological distress in this population can help identify the specific needs and challenges faced by young adults in India. Research has shown that young adults are particularly vulnerable to loneliness, and the COVID-19 pandemic has exacerbated feelings of isolation and distress (Bu et al., 2020; Hysing et al., 2020). Examining these issues within the Indian context provides valuable insights into the unique cultural, social, and economic factors that may contribute to loneliness and psychological distress in this specific population. Secondly, investigating attachment theory in young adults can shed light on the influence of early attachment experiences on their current relationships and well-being. Attachment styles play a crucial role in shaping the way individuals perceive and navigate their social connections (Bartholomew & Horowitz, 1991). Understanding attachment patterns in Indian young adults can provide valuable information about the interplay between cultural norms, family dynamics, and attachment-related experiences in shaping their interpersonal relationships and mental health outcomes.

The Interplay between Attachment Styles, Loneliness, and Psychological Distress

Findings indicating a significant positive relationship between loneliness and psychological distress have appeared in several studies in recent years (Cacioppo et al., 2006; Konno et al., 2021; Mushtaq & Sirajudeen, 2021) across multiple age groups and geographical locations. Interestingly, Yung et al. (2021) found this

positive relationship to be significant at the moment-to-moment and day-to-day levels. However, studies exploring the relationship between loneliness and psychological distress among young adults in the Indian context are limited. Moreover, Heu et al. (2021) direct our attention towards a paucity of research regarding the experiences of loneliness within socially embedded cultures such as the one prevalent in India. Thus, in light of the existing findings we hypothesize a significant positive relationship between loneliness and psychological distress among Indian young adults (Hypothesis one).

Furthermore, empirical evidence consistently demonstrates that attachment styles, specifically secure, fearful, preoccupied, and dismissive, exert a noteworthy influence on individuals' subjective experiences of loneliness and psychological distress. Extensive research supports the notion that individuals with a secure attachment style tend to exhibit lower levels of loneliness and psychological distress, indicating a greater sense of emotional well-being (Erozkan, 2011; Goossens et al., 1998; Kıralp & Serin, 2017). Conversely, individuals with a fearful attachment style often confront heightened levels of loneliness and psychological distress, owing to internal conflicts and difficulties in interpersonal relationships. Similarly, those with a preoccupied attachment style frequently report elevated levels of loneliness and psychological distress, driven by apprehensions about rejection and an excessive preoccupation with maintaining close connections (Ciocca et al., 2020; Erozkan, 2011). Additionally, individuals with a dismissive attachment style, characterized by an inclination to avoid emotional intimacy, may experience heightened levels of loneliness and psychological distress (Erozkan, 2011; Spence, Jacobs, & Bifulco, 2018). These collective research findings underscore the substantial impact of attachment styles on individuals' subjective experiences of loneliness and psychological distress. Although limited research has specifically examined the impact of attachment styles on loneliness and psychological distress in the Indian context, several studies have explored the association between attachment styles and these outcomes separately. For example, Suri et al. (2019) found that individuals with a secure attachment style reported lower levels of loneliness and psychological distress. Dhal et al. (2007) observed that Indian adolescents with

a secure attachment style experienced lower levels of loneliness compared to those with insecure attachment styles. These findings indicate that attachment styles shape the experiences of loneliness and psychological distress among individuals in the Indian context.

Attachment Styles as Moderators

Despite the substantial body of research linking attachment styles, loneliness, and psychological distress, certain gaps persist. Numerous studies have reported the moderating effect of attachment styles on

the relationship between brand attachment and brand personality (Tuan et al., 2012), maternal lifetime betrayal trauma and parent and child well-being (Choi & Kangas, 2020), reasons for studying and academic outcomes and GPA (Gore & Rogers, 2010), and marital adjustment and depressive symptoms (Scott & Cordova, 2002). However, the role of attachment styles as moderators in the relationship between loneliness and psychological distress remains an underexplored area. Hence, in light of the existing literature, we hypothesize the following:

H1: There is a significant positive relationship between loneliness and psychological distress among Indian young adults.

H2: Attachment styles significantly moderate the relationship between loneliness and psychological distress.

Conceptual and statistical diagrams representing this are illustrated in Figures 1 and 2 respectively.

Figure 1

A Conceptual Diagram of the Moderation Model with Attachment Styles as the Moderator

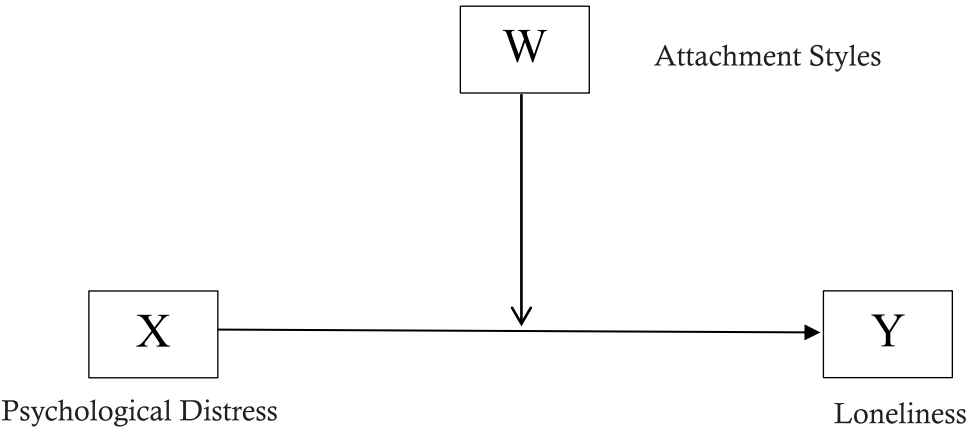
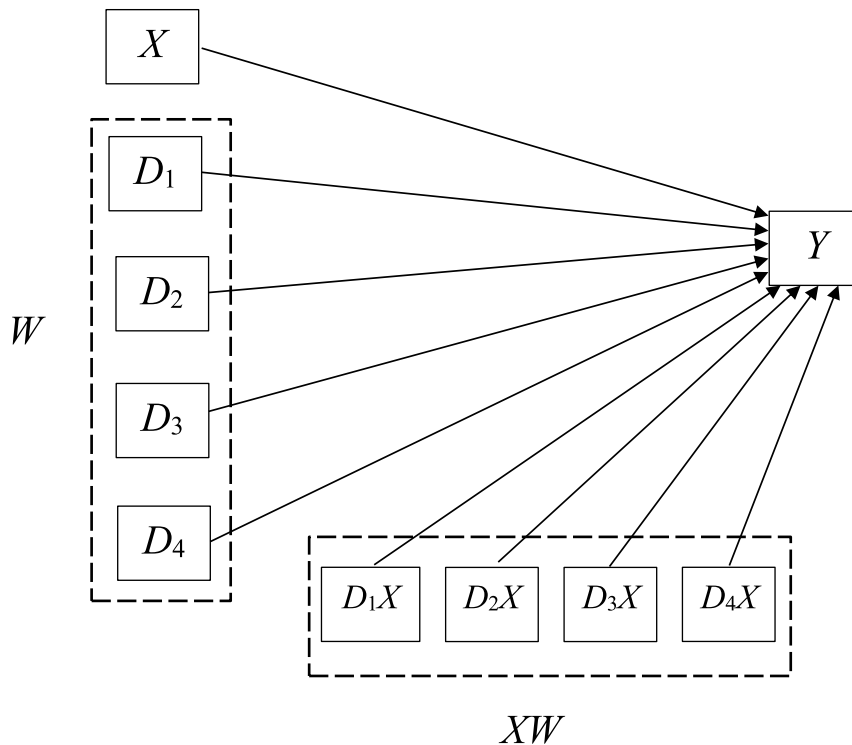


Figure 2

A Statistical Diagram of the Moderation Model with Attachment Styles as the Moderator



Note. D_1 , D_2 , D_3 , and D_4 represent different levels of the multicategorical variable, namely, secure, preoccupied, dismissing, and fearful attachment styles.

Method

Participants

The present study utilized a convenience sampling method to gather data from 151 Indian young adults aged 18-24 years residing in Delhi. Of these, 86 (57%) were women. To ensure methodological rigour and establish robust inclusion criteria, factors such as age and place of residence were carefully considered and controlled for. The exclusion criteria included individuals below 18 years of age and those who resided outside Delhi.

Design

The present study utilizes a descriptive survey research design to study the relationship between loneliness and psychological distress and the impact of attachment styles on this relationship. Data from participants were collected online using the survey method with the help

of Google Forms. Using an online mode of data collection enabled the gathering of data for each variable at multiple time points, helping to mitigate (to a certain extent) the inherent common method bias associated with relying solely on a single data collection approach (survey). A moderation analysis was employed to determine the strength and direction of the relationship between psychological distress and loneliness as well as the moderating effect of attachment styles on this relationship.

Measures

The UCLA 3-Item Loneliness Scale. The UCLA 3-Item Loneliness Scale (Hughes et al., 2004; Russell, Peplau, & Ferguson, 1978; Russell, 1996) was used to assess loneliness, measuring relational connectedness, social connectedness, and self-perceived isolation. The scale had a range of 3-9, with higher scores indicating greater loneliness. This version of the scale has been found to demonstrate high reliability, with coefficient alpha

values ranging from .89 to .94 across various samples such as college students, nurses, teachers, and elderly (Russell, 1996). These results indicate strong internal consistency and suggest that the scale consistently measures loneliness across different populations. Scores on this scale have been found to be strongly related to those on other established measures of loneliness such as the NYU Loneliness Scale and the Differential Loneliness Scale indicating the scale's strong convergent validity. Construct validity of the scale is underscored by significant positive correlations of scores to personality traits of Neuroticism and Introversion-Extraversion, as well as depression. The scale's discriminant validity has been supported by negative correlations between loneliness and measures of self-esteem and social desirability. The discriminant validity of the scale is further supported by confirmatory factor analysis which revealed that the measure of loneliness defined distinct factors and related differently to other mood and personality measures (Russell, Kao, & Cutrona, 1987).

Kessler Psychological Distress Scale. Psychological distress was measured using the Kessler Psychological Distress Scale (K10) (Kessler et al., 2003), consisting of 10 items assessing emotional states. Scores ranged from 10 to 50, with higher scores indicating higher levels of psychological distress. The scale has demonstrated consistent psychometric properties across a number of major sociodemographic subsamples, including good test-retest reliability and good internal consistency ($\alpha=.92$) (Kessler et al., 2002). Additionally, factor analyses conducted in general population samples indicated that the questions within the K10 scale possess high loadings on a first principal factor of nonspecific distress, consistent with other widely used scales in this domain. Moreover, the scale has been found to exhibit good precision within the 90th–99th percentile range of the population distribution, with standard errors of standardized scores ranging from 0.20 to 0.25. The K10 scale also exhibited good discriminant validity with areas under the Receiver Operating Characteristic (ROC) curve of 0.87–0.88 for disorders having Global Assessment of Functioning (GAF) scores of 0–70 and 0.95–0.96 for disorders having GAF scores of 0–50. This indicates the scale's ability to strongly discriminate between community cases and non-cases of DSM-IV/SCID disorders.

Relationships Questionnaire. Attachment styles were assessed using the Relationships Questionnaire (RQ) (Bartholomew & Horowitz, 1991), an adaptation of Hazan and Shaver's (1987) three-category attachment measure. The questionnaire consists of four statements resembling four attachment styles, namely, secure, fearful, dismissing, and preoccupied, of which respondents must select one that best describes them. In addition, respondents are also asked to rate how well or poorly each of those statements corresponds to their general relationship style on a 7-point Likert scale ranging from 1 (Disagree Strongly) through 4 (Neutral/Mixed) to 7 (Agree Strongly). The attachment prototype with the highest rating was used to categorize participants into specific attachment styles. In case two or more attachment prototypes were equally rated, then the statement resembling one of the four attachment styles selected by the respondent was considered to categorize them. The scale has been shown to have a test-retest reliability of 0.74–0.88 (Ligiéro & Gelso, 2002) and a good construct, convergent and discriminant validity across cultures (Schmitt et al., 2004).

Procedure

The three scales were administered to the participants who met the inclusion criteria. Informed consent was taken from all the respondents prior to their participation. All queries that surfaced during the administration of the scales were addressed. The results were analyzed using moderation analysis.

Results

Prior to conducting the data analysis, a normality test was performed to assess the distribution of the data, and the results indicated a violation of the assumption of normality. Consequently, moderation analysis was utilized to examine the data using SPSS software (Version 29.1.00), given its applicability to non-normal data (Hayes & Montoya, 2017). The data was screened for outliers using the Mahalanobis, Cook's, and Leverage tests and was also found to be in adherence with the assumption checks for linearity, homogeneity, and homoscedasticity. Hence, the hypotheses were evaluated for statistical significance by employing a moderation analysis using SPSS PROCESS Macro. The demographic characteristics of the participants are

given in Table 1. The mean age of the participants was 19.477 (SD = 1.934). The participants reported a mean score of 6.15 (SD = 1.632) on the measure of loneliness and 25.15 (SD = 8.115) on the measure of psychological distress. Individuals with a secure attachment style reported the highest scores on loneliness (M = 7.17, SD = 1.689) followed by those with a dismissing attachment style (M = 6.71, SD = 1.537). While individuals with a preoccupied attachment style reported the lowest scores on

loneliness (M = 5.27, SD = 1.194), those with a fearful attachment style reported similar scores (M = 5.47, SD = 1.289). On the measure of psychological distress, individuals with a fearful attachment style reported the highest scores (M = 29.05, SD = 7.469) followed by those with a preoccupied attachment style (M = 27.00, SD = 7.502). Securely attached individuals reported the lowest scores on psychological distress (M = 21.29, SD = 7.887) while those with a dismissing attachment style also obtained a low score (M = 23.15, SD = 7.548).

Table 1

Demographic characteristics of participants

Sample Characteristics	N	%	M	SD
Gender				
Male	65	43		
Female	86	57		
Age			19.477	1.394
Attachment Style				
Secure Attachment	35	23.18		
Preoccupied Attachment	37	24.50		
Dismissing Attachment	41	27.15		
Fearful Attachment	38	25.17		
Loneliness			6.15	1.632
Psychological Distress			25.15	8.115
Loneliness				
Secure Attachment			7.17	1.689
Preoccupied Attachment			5.27	1.194
Dismissing Attachment			6.71	1.537
Fearful Attachment			5.47	1.289
Psychological Distress				
Secure Attachment			21.29	7.887
Preoccupied Attachment			27.00	7.502
Dismissing Attachment			23.15	7.548
Fearful Attachment			29.05	7.469

Note: N= 151

The overall regression model was found to be significant ($F(7,143) = 13.86, p < .05$) and the variables (attachment styles and psychological distress) explained 40% of the variance in loneliness ($R^2 = .40$). As depicted in Table 2, a significant and negative association ($b = -.1114, t(151) = -3.97, p < .05$) was observed between psychological distress (PD) and loneliness. Thus, the first hypothesis proposing a significant positive relationship between loneliness and psychological distress is not supported and psychological distress was found to be a negative predictor. Noteworthy differences in loneliness among different attachment styles surfaced. Secure attachment style was used as the reference category in line with the indicator coding employed by PROCESS macro. Differences in loneliness were found to be significant between preoccupied and secure attachment styles ($b = -1.3300, t(151) = -4.06, p < .05$), with individuals characterized by preoccupied

attachment style exhibiting a lower level of loneliness. Similarly, significant differences in loneliness were observed between fearful and secure attachment styles ($b = -.9894, t(151) = -2.91, p < .05$) with lower levels of loneliness observed in individuals with fearful attachment style. Conversely, differences in loneliness between dismissing and secure attachment were found to be nonsignificant ($b = -.2105, t(151) = -0.67, p > .05$). Furthermore, the analysis of interaction 1 (Int 1) revealed that the impact of psychological distress on loneliness in individuals with a preoccupied attachment style does not significantly differ from those with a secure attachment style ($b = .0354, t(151) = .883, p > .05$). Similar results were obtained with regard to interactions 2 and 3 (Int 2 and Int 3), with no significant differences observed between dismissing and secure attachment styles ($b = .0231, t(151) = .594, p > .05$), as well as, between fearful and secure attachment styles ($b = .0402, t(151) = 1.008, p > .05$). Consequently, none of the interactions exhibited statistical significance

Table 2

Moderating effects of attachment styles on the relationship between loneliness and psychological distress

Variable	b	SE	t	p	95% CI	
					LLCI	ULCI
Constant	6.7413	0.2435	27.6872	0.000	6.26	7.2226
PD (X)	-0.1114	0.0281	-3.9726	0.0001*	0.1669	-0.056
W1	-1.33	0.3273	-4.0643	0.0001*	-1.9769	-0.6832
W2	-0.2105	0.3206	-0.6565	0.5126	-0.8443	0.4233
W3	-0.9894	0.3397	-2.9126	0.0042*	-1.6609	-0.3179
Int 1	0.0354	0.0401	0.8834	0.3785	-0.0438	0.1147
Int 2	0.0231	0.039	0.5941	0.5534	-0.0539	0.1001
Int 3	0.0402	0.0399	1.0081	0.3151	-0.0387	0.1191

Note: * $p < 0.05$ indicating a significant result; PD= Psychological Distress; W1= preoccupied vs secure; W2= dismissing vs secure; W3= fearful vs secure; Int 1 (interaction 1) = W1 X PD; Int 2 (interaction 2)= W2 X PD; Int 3 (interaction 3)= W3 X PD; LLCI= lower limit; UL= upper limit

The test of unconditional interaction showed that the inclusion of the interaction term ($X*W$) did not produce a significant change in R^2 ($F(3,143) = .4060, p > .05, \Delta R^2 = .0051$). This is shown in Table 3. Thus, our second hypothesis, positing the role of attachment styles as a significant moderator in the relationship between loneliness and psychological distress is not supported.

Table 3

Test of highest-order interaction

	ΔR^2	F	df 1	df 2	p
X*W	0.0051	0.4060	3.0000	143.0000	.7489

Note: X = Psychological Distress; W = Attachment Styles

Discussion

The present study attempted to deepen our understanding of the nuanced relationships between attachment styles, loneliness, and psychological distress in Indian young adults, falling in the 18-24 years age group. Furthermore, the role of attachment styles as moderators of the relationship between psychological distress and loneliness was explored.

Firstly, our regression analysis showed that attachment styles and psychological distress collectively and significantly accounted for 40 per cent of the variance in loneliness. This pattern of results is consistent with previous research that reports the influence of both psychological distress (Cacioppo et al., 2006; Konno et al., 2021; Mushtaq & Sirajudeen, 2021) and attachment styles (Ciocca et al., 2020; Deniz et al., 2005; DiTommaso et al., 2003; Erozkhan, 2011; Goossens et al., 1998; Kıralp & Serin, 2017; Spence, Jacobs, & Bifulco, 2018) on loneliness.

Contrary to our initial hypothesized association, the study revealed a significant and negative relationship between psychological distress and loneliness. However, past researchers report a positive relationship between these variables (Cacioppo et al., 2006; Konno et al., 2021; Latikka et al., 2022; Mushtaq & Sirajudeen, 2021). While previous research studies report contrasting findings, a cogent line of reasoning to substantiate the present findings could be that individuals experiencing high levels of distress may actively seek help to alleviate their distress by nurturing

and sustaining meaningful relationships with important others, potentially lowering their loneliness (Chen, 2012; Walters et al., 2008). This may be furthered by an increased sense of social connectedness that has accompanied the open conversation and awareness around mental health issues which has been witnessed in the last few years (Kishore et al., 2011; Rangaswamy & Patel, 2010). Collectively, these factors may reduce feelings of loneliness while facing distress. Interestingly, Jackson and Cochran (1991) found that only specific types of psychological distress, namely depression and low self-esteem were found to be significantly and positively associated with self-reported loneliness, after controlling for intercorrelations between the subscales in the measure employed. Consequently, they argue that the substantial chunk of literature reporting a significant positive association between psychological distress and loneliness could be attributed to the measurement problem of high intercorrelations between psychological symptomatology as assessed by widely used inventories (Mischel, 1968).

Furthermore, we obtained evidence for significant differences in the amount of loneliness experienced by individuals with different attachment styles. The findings of the present study parallel those of other studies that report a significant difference in loneliness between individuals with preoccupied and secure attachment styles, as well as fearful and secure attachment styles (Ciocca et al., 2020; Deniz et al., 2005; DiTommaso et al., 2003; Erozkhan, 2011; Goossens et al., 1998; Kıralp & Serin, 2017; Spence,

Jacobs, & Bifulco, 2018). Interestingly, no significant differences were observed in individuals with dismissing and secure attachment styles, and comparisons of mean loneliness scores showed the highest scores among individuals exhibiting these attachment styles. While higher levels of loneliness in persons with a dismissing attachment style have been reported in the past (Erozkan, 2011), these results present one of the first pieces of evidence of individuals with a secure attachment style reporting higher levels of loneliness. The present study's finding of individuals with secure attachment styles reporting a higher level of loneliness contrasts with previous research (Bernardon, Babb, Hakim-Larson, & Gragg, 2011; Erozkan, 2011). Although secure attachment is generally associated with lower levels of loneliness, these studies suggest that secure attachment does not entirely eliminate feelings of loneliness. Kiralp and Serin (2017) found a low negative correlation between loneliness and secure attachment, indicating that securely attached individuals may still experience some degree of loneliness. Additionally, Ross and Inagaki (2022) discovered that securely attached individuals engaged in intense recollection of past positive social interactions during periods of social isolation, which heightened their feelings of loneliness. These findings imply that factors such as individual differences in recollection and the context of social isolation can influence the relationship between secure attachment and loneliness. Further research is warranted to comprehensively investigate the underlying mechanisms and contextual influences in the association between attachment styles and loneliness.

Another major finding in this study is that attachment styles were not found to moderate the relationship between psychological distress and loneliness significantly. Although the influence of attachment styles on loneliness and psychological distress has been well documented (Bartholomew & Horowitz, 1991; Ciocca et al., 2020; Erozkan, 2011; Surcinelli et al., 2010), the present study showed that the impact of psychological distress on loneliness did not vary significantly across different attachment styles. We believe that the moderating influence of attachment styles on the relationship between psychological distress and loneliness may exhibit a greater degree of complexity than the initially hypothesized simple moderation. In fact, attachment

styles have been found to interact with perceived social support, coping strategies, and resilience (Karreman & Vingerhoets, 2012; Khodarahimi et al., 2016; Ognibene & Collins, 1998). Hence, additional investigation involving the aforementioned variables is merited to uncover the nuanced relationship between attachment styles, loneliness, and psychological distress.

Although the present results clearly support certain aspects of attachment style theories and the interactive effects of attachment styles on the experience of loneliness and psychological distress, it is appropriate to recognize some potential limitations of the study, one being the generalizability of results and the need for a larger sample size. Additionally, common method bias (CMB), which occurs as a result of using a single method for measuring all variables in a study, poses a limitation in the present study. However, efforts were made to tackle this bias. Despite using a survey (common method) to measure all the variables, data collection for each variable was done at different points in time, ensuring sufficient time intervals in between and reducing the likelihood of participants responding consistently across variables. To reduce social desirability bias, participants were encouraged to provide honest responses by assuring them of the anonymity and confidentiality of their responses. Nevertheless, given the reliance on self-report measures, some degree of social desirability bias may still be present in the data. Furthermore, different statistical analyses incorporating variables such as resilience, coping strategies, personality traits and social support may yield valuable insights.

Conclusion

Despite these limitations, this study sheds light on the profound experiences of loneliness among securely attached individuals during a period of limited social interactions. It raises important questions for future investigation, including the role of age, personality traits, coping mechanisms, and resilience in relation to psychological distress and loneliness. The present study also builds on a handful of studies that elucidate the advantages of insecure attachment styles with regard to individual and group survival in threatening conditions and reproductive fitness in certain ecological conditions that securely attached individuals do not exhibit, particularly in dangerous and threatening

situations (Belsky et al., 1991; Belsky et al., 2010; Ein-Dor et al., 2010). Together, these findings have theoretical and practical implications, serving as a foundation for understanding insecure attachment styles and their potential for fostering healthy relationships and healthy functioning, and can inform interventions aimed at promoting healthy relationships.

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DIY vs. PRO: Unveiling self-labeling, stigma, and attitudes towards help seeking in young adults

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Abstract: With information on mental disorders readily available to young adults, this study delved into the dynamics of self-labeling and help-seeking attitudes. Using a mixed methods approach it examined why some individuals prefer to self-diagnose while others approach mental health professionals to deal with their concerns. The sample comprised 58 self-diagnosed and 45 clinically-diagnosed individuals between the ages of 18 and 30 years. The participants were administered the Self-identification of Mental Illness Scale and the Stigma Scale. Subsequently, interviews were conducted with 20 participants (10 from each group) to assess attitudes towards seeking professional help. Statistical analysis revealed no significant difference in self-labeling tendencies and stigma towards mental illness for the two groups. Thematic analysis of the interviews uncovered an overall positive attitude toward seeking help. The other facets that emerged focused on barriers in accessing help and the impact of self-diagnosis or seeking professional help. Implications are discussed.

Keywords: Self-diagnosis; Professional help; Self-labeling; Stigma; Attitude

In recent years, there has been a notable transformation in the landscape of mental health awareness, characterized by a growing inclination towards self-diagnosis (Oswalt et al., 2018). This is particularly prevalent among young adults who navigate a complex array of emotions and experiences (Mojtabai et al., 2002). Noticeably, there has been an increasing prevalence of serious psychiatric diagnoses among the youth (Moreno et al., 2007), though we know little about how they interpret their concerns or deal with the stigma they encounter (Hinshaw, 2005; Wahl, 2002). Understanding these phenomena is crucial due to the established link between stigma and negative outcomes such as treatment avoidance, under-utilization, and poor adherence (Sirey et al., 2001; Vogel et al., 2007). Self-diagnosis or self-labeling represents a deliberate choice made by an individual (Pillay, 2010). Here the person, without seeking medical consultation, identifies and attributes specific symptoms they have to a particular disease or disorder (Ahmed & Samuel, 2017). The practice of self-diagnosis, although not a recent development, has gained prominence over the years, due to the enhanced accessibility of information on the internet (Avery et al., 2012; Yan & Sengupta, 2013). Engaging in self-diagnosis has the potential to act as a catalyst for de-stigmatizing discussions

surrounding mental health. Although it can empower individuals to actively engage in their mental health journey, it concurrently presents the risk of misinterpretation and unwarranted anxiety, emphasizing the need for enhanced mental health literacy. The phenomenon of confirmation bias is relevant in the context of self-diagnosis, as individuals may unconsciously seek information that aligns with their preconceived notions (Schweiger et al., 2014). This bias can impede effective communication with mental health professionals (MHPs) and increase the chances of misdiagnosis and inappropriate treatment choices. Given these risks, most mental health professionals maintain that a clinical diagnosis conducted by a licensed mental health professional such as a psychiatrist or clinical psychologist is imperative. This process incorporates the application of standardized diagnostic criteria and involves an act of categorization, resulting in the assignment of a precise 'diagnostic label' as the ultimate outcome.

Factors underlying self-diagnosis

Recognizing one's symptoms as potential indicators of mental illness represents a crucial initial step towards seeking professional help. Thoits' model (1985) rooted

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in labeling theory suggests that individuals may engage in self-labeling by observing their own behaviors, thoughts, and feelings, which can motivate help-seeking behavior. Help seeking behavior includes an individual's disposition, beliefs, and perceptions regarding the acceptability, desirability, and efficacy of reaching out for professional assistance to address mental health concerns. It encompasses one's willingness, openness, and comfort level in seeking help (Picco et al., 2016). The attitude towards help seeking among young adults is shaped by evolving societal perceptions and increased awareness (Lipson et al., 2019). Today the youth in urban areas, exhibits a growing recognition of mental health issues, reflecting a positive shift in attitudes towards seeking help (Rickwood et al., 2007). An increasing number of young individuals are acknowledging the importance of addressing psychological well-being. This evolving mindset is fostering a more proactive approach, creating the foundation for improved mental health outcomes and resilience (Milin et al., 2016).

However, some young adults may still be hesitant to approach professionals due to fears of being labeled and subsequently stigmatized (Yeh et al., 2003). The process of being assigned a label can have various kinds of impacts on a person. How a label is perceived is dependent on numerous internal (medical history, age, sex, culture) and external (service availability, country) factors, and differs by perspective (Coggon et al., 2003). Nevertheless, labels tend to have the ability to activate stereotypes and negative behaviors towards those perceived to be part of a uniform, undesirable group, a phenomenon termed 'public-stigma' (Corrigan & Watson, 2002; Link & Phelan, 2001). Young people are particularly susceptible to stigmatizing labels due to youth being a time of identity consolidation characterized by a compelling need for competence, social acceptance, and autonomy (Wisdom et al., 2006). Stigma is a symbolic indication signifying to others that an individual possesses a quality diminishing them from a state of being perceived as "whole and normal" to one of being considered "tainted and devalued" (Goffman, 1963). Stigma is an established barrier to help-seeking for mental illness (Clement et al., 2014; Eisenberg et al., 2009). It impacts the willingness to seek help (Mojtabai et al., 2002) and even seeking information about mental health and counseling (Lannin et al., 2016). Additionally, a

psychiatric label can give rise to self-stigma, indicating the shame and self-directed prejudice experienced by the 'marked' individual, who internalizes negative stereotypes (Corrigan, 2007). Self-stigma is prevalent among those with mental illness, where individuals internalize societal stereotypes and integrate them into their self-perception. This process, known as self-concurrence, results in a decline in self-esteem as negative beliefs about oneself become entrenched (Werner, Aviv & Barak, 2008). A correlation between self-stigma and reduced self-esteem, social isolation, and reluctance to seek help is highly evident. (Corrigan, Watson, & Barr, 2006; Link & Phelan; 2001). Here it must be mentioned that there are some individuals who do not endorse or accept for themselves the negative stereotypes associated with mental illness (Camp et al., 2002; Moses, 2009). Labels can also yield positive effects, partially counteracting the stigmatizing and demoralizing impact. Certain psychiatric patients express relief in having a label that can capture their psychological symptoms, validate their experiences, and provide guidance on what to expect and how to cope (Hayne, 2003; Karp, 1996). Recognizing and accepting a mental health problem for many is a dynamic and protracted process that may not neatly align with the formal diagnosis process (Aneshensel et al., 2012).

The dynamics of self-labeling and attitudes toward seeking help exhibit variability across cultures, influenced by distinct societal norms and beliefs. There remains a noticeable gap in literature concerning these variables within the Indian context, particularly among the young adult population. This study endeavors to address this gap by exploring self-labeling tendencies, conceptions around stigmatization and attitudes towards professional help seeking among self-diagnosed and clinically diagnosed young adults in India. The research delves into the stigma surrounding labels acquired through formal or informal diagnostic processes and examines how attitudes toward seeking professional help are framed.

Method

The following hypotheses were developed for the present study:

H1: Individuals who are self-diagnosed will

demonstrate significantly higher self-labeling tendencies than those who have sought clinical diagnosis.

H2: Individuals who are self-diagnosed will demonstrate significantly higher stigma towards mental illness than those who have sought clinical diagnosis.

Sample

The sample comprised 103 individuals, between the ages of 18 and 25 years, divided into two groups based on their approach to diagnosing their mental health conditions. Within the sample, 58 (56.31%) participants had self-diagnosed, while 45 (43.68%) had sought and received a clinical diagnosis. Further, utilizing convenience sampling, 10 participants from each group were selected for in-depth interviews. In the self-diagnosed group, the highest number of participants (43.10%) reported anxiety-related issues. In the clinically diagnosed group, the highest number of participants (55.56%) experienced a comorbidity of anxiety and depression. Approximately 49.01% of the participants resided in Tier 1 cities and the remaining participants were from Tier 2 and Tier 3 cities.

Tools

The study utilized the Self-Identification as Having a Mental Illness Scale (SELF-I), the Stigma Scale, and an interview as its tools. The scales and interview were both administered online.

Self-Identification as having a mental illness scale (SELF-I). The 5-item scale developed by Schomerus et al. (2012) was used to assess subjective perceptions of one's own identity in relation to mental illness (Stolzenburg et al., 2017). Items are answered on a 5-point Likert scale and reverse coded when necessary. SELF-I has acceptable levels of test-retest reliability and internal consistency (Cronbach's $\alpha = .85$ to $.87$) in untreated individuals with mental health problems (Schomerus et al., 2019). Construct, criterion and discriminant validity for the tool have also been established (Schomerus et al., 2019).

The Stigma Scale. This is a 28-item measure with 5-point Likert-type response format developed by King et al.

(2007) used to measure the construct of stigma. It is composed of 3 sub-scales (viz. discrimination, disclosure, and positive aspects), of which nine items are reverse coded. Cronbach's α for the stigma scale is 0.87 (King et al., 2007).

The interview

For the clinically diagnosed group, the interview schedule explored several key domains: the onset and personal understanding of their mental health concern, the journey and experiences in seeking professional help, insights into the treatment process and its implications, and the impact of treatment on their personal lives as well as attitudes towards receiving help. For the self-diagnosed participants, the schedule focused on the onset and personal understanding of their mental health issues, the process and experiences related to self-diagnosis, and the overall impact of self-diagnosis. These domains were identified and refined through an exhaustive review of relevant literature. English and Hindi versions of the schedule were devised and pilot-tested before use.

Data Analysis

To ascertain the differences in stigma levels, as well as self-labeling tendencies between the self-diagnosed and clinically diagnosed groups, an independent t-test was conducted employing the IBM Statistical Package for the Social Sciences (SPSS), Version 20 for Windows. The interview data was transcribed and analyzed using the six-phase thematic analysis framework as outlined by Braun and Clarke (2006). This comprehensive methodological approach encompasses the following phases: (a) Familiarization with the data (b) Generation of initial codes (c) Searching for themes (d) Reviewing themes (e) Defining and naming themes (f) Producing the report. The analytic process was grounded in the data itself, rather than conforming to predetermined categories or theoretical frameworks.

Results

The results indicated that there were no significant differences between both groups with respect to self-labeling. Thus, the first hypothesis for the study was rejected (Table 1).

Table 1

Comparison of groups on Self-Labeling

Diagnosis	N	Mean (SD)	t-value (df)	p-value
Self	58	14.67 (2.19)	0.877 (101)	0.191
Clinical	45	14.31 (1.90)		

There were no differences found for stigma across both the groups, leading to the rejection of the second hypothesis (Table 2).

Table 2

Comparison of groups on level of Stigma

Diagnosis	N	Mean (SD)	t-value (df)	p-value
Self	58	49.26 (15.18)	-1.57 (101)	0.059
Clinical	45	53.96 (14.96)		

Thematic Analysis Results

There were five broad themes that came to light after the thematic analysis of the interviews.

Theme 1. Process of Self-Labeling

The Self-Diagnosed group. All the individuals who self-diagnosed made use of information on websites or employed online assessments. One participant expressed her route of diagnosing herself as follows- *"Psychological tests that there are on the internet, I took like a million of those tests to just confirm that maybe I- I may be going through something bad."* Additional routes to diagnosis were relating one's symptoms to others who received a diagnosis and learning about symptoms in psychology classes attended in college. The interviews highlighted some risks of engaging in soliciting information through the internet. A participant reported that she had body image issues and thus, was fascinated to see a woman suffering from anorexia losing weight so quickly. Therefore, she hoped to have the same disorder. *"It's a girl talking about an eating disorder and how they've lost so much weight drastically day after day suffering from an eating disorder. So, I thought it would be good if I had that disorder...I wanted to have an*

eating disorder because I wanted to lose weight."

Clinically Diagnosed group. In this group it was found that people chose to deal with some problems on their own and for others, they added the element of professional help. One person said *"Although have received a clinical diagnosis for depression and anxiety; eating disorder has been self-diagnosed since I felt the prior two were more serious. And thought I could manage eating disorder by myself."* Lack of proper psycho-education from the professional led participants to resort to online websites to address their queries. A participant explained with regard to the medicine prescribed to her *"she did not tell me but I was very curious about it. I was going to take something that would change certain stuff in my brain. So I googled up everything, every side effect possible."* In addition, participants had used their prior exposure to psychology and read websites to understand their condition better.

Theme 2. Impact of the approach chosen for diagnosis

The Self-Diagnosed group. The positive impacts of self-labeling were found to revolve around increased self-awareness and accurate labeling of symptoms and

experiences. The accuracy in identification contributed to a better understanding of one's conditions and reduced self-blame. A participant said *"stuff which made me blame myself earlier...like why I'm so weak or like, I can't even do this thing... has obviously reduced quite a bit because I know that it's not like weakness but rather anxiety."* The process of self-diagnosis fostered a balanced perception of personal strengths and weaknesses. A participant who self-diagnosed with anxiety described this shift, stating, *"surprisingly this diagnosis has made me think of myself from a pretty weak to somewhat strong person."* This reevaluation led to a kinder self-view, enabling individuals to *"cut some slack"* for themselves. This gentler self-assessment was coupled with the acquisition of effective coping strategies, as one participant explained: *"it has the pros because I learnt something new about my body and myself. I understand that you know, some things are to be dealt with more delicately."* Additionally, self-diagnosis appeared to alter participants' perceptions of others. One participant observed a newfound empathy and patience in their interactions: *"if somebody out of the blue is being a little rude to me... I would take a moment and think that ...okay, something must have happened with them so I should deal with it more delicately"*

However, some participants experienced negative repercussions, such as increased self-pity and overreaction, attributed to the knowledge of their conditions, as one explained: *"I started self-pitying and started overreacting to things, because of the knowledge of being, anxious, or being depressed."* For some participants, self-diagnosis of anxiety led to diminished efforts in facing challenges *"earlier I was very anxious but, I didn't know I had anxiety. So I would still try to like force myself a lot to do these things. But ever since I've like diagnosed myself, I like play it off as because I have anxiety so I can't really do anything about it."*

Clinically Diagnosed group. One significant positive impact of approaching mental health professionals was the role of diagnosis in facilitating acceptance and understanding of one's mental health challenges. Many participants expressed gratitude for the assistance provided by MHPs. For instance, one participant's interaction with her college counselor marked the beginning of her journey toward acceptance and seeking therapy ahead. *"I reached out to my college counselor and then I discussed things with her as to*

how to navigate through this" Participants also emphasized the progress and personal growth following their diagnosis and engagement with MHPs. Through therapy and psychiatric visits, individuals reported gaining insights into their thoughts and behaviors, fostering a deeper understanding of themselves. One participant said, *"I'm taking therapy and I'm consulting a psychiatrist from my hometown. And both are extremely good. They diagnosed me further with rapid cycling bipolar disorder. And based on that they changed my medication and I have been doing really well since then"*. Furthermore, participants described significant changes in their self-perception and coping strategies post-diagnosis. Changes in self-management and increased awareness about the mental health severity around themselves were also evident. *"Now I think I have answers to a lot of my questions and I understand people's situations better"* Engagement with MHPs contributed to enhancing confidence and improving emotional regulation. Therapy sessions helped them gain confidence and manage their emotions more effectively in various situations. On the other hand, the lack of a personalized treatment approach and prescription of heavy medications without considering lifestyle or potential side effects led to uncertainty and fear about continuing seeking help. One participant explained *"I knew that if I go back to a psychiatrist or at least the same psychiatrist, I know I will mess up my entire career because of the medications."* Additionally, participants shared instances of receiving incorrect diagnoses or inadequate assessment processes and reliance on parental input without thorough questioning which were cited as contributing factors to misdiagnosis. *"My first psychiatrist didn't diagnose me properly. He just said that I might have panic disorder; whereas later it turned out to be BPD. I wasn't questioned properly. All the questions were asked to my parents. And my parents didn't know me."* Participants expressed dissatisfaction with treatment approaches that were imposed without regard for their preferences and needs which resulted in feelings of discontent.

Theme 3. Outlook towards the approach opted

Self-diagnosed group. Participants who self-diagnosed acknowledged both the advantages and shortcomings of it. Self-diagnosis was also deemed essential for those lacking resources, aiding in clarity and identifying root issues: *"self-diagnosis is really essential for people who don't*

have the means. I feel like it takes away a lot of like confusion and, doubt about yourself. And it can actually make you aware of things that's causing your problems. It's not you, it's your illness." Yet the process of self-diagnosis seemed to stand in a "grey area" as acknowledged by many. *"Google kuch bhi dikha deta hai, ek choti si cheez ko cancer bata deta hai."* Participants also highlighted that self-diagnosis might not work for everyone. The shortcomings of self-diagnosis included risks (of not getting proper treatment) or having self-doubt that *"Sometimes you do end up doubting yourself like am I just making it up in my head because I read about it"*. Additionally, one participant highlighted how social media has made the process of self-diagnosing worse by taking away the seriousness of it as everyone on the internet is 'suffering' from a mental disorder: *"You see people online being like, 'oh, I have autism. And like I have ADHD but...Do I have an ADHD quiz?' does not really equate as diagnosis."*

Clinically Diagnosed group. Despite recognizing the necessity of seeking professional help, the participants said they often encountered resistance and disbelief from family members, as evidenced by accounts of familial dismissal of their mental health struggles as mere phases. *"I pushed them to visit a psychiatrist. But still, there was a restriction from my father and my father still believes that bipolar disorder is nothing and it is just a phase"*. Moreover, they grappled with the fear of judgment and sometimes had to hide the fact that they were seeing a professional. A participant mentioned, *"But some part of me could not really get to tell her(mother) that I am, you know, seeking out therapy."* Another issue was the difficulty in finding the right therapist. As one person said, *"you know you'd gonna meet to a bunch of shitty therapists before you find the one for you."* However, amid these challenges, almost all participants also exhibited resilience and determination in seeking professional help and pursuing treatment. Despite facing societal and familial resistance, many participants acknowledge the necessity of therapy and medication in managing their mental health conditions. Additionally, some highlighted the importance of early intervention by MHPs, recognizing the potential benefits of timely and expert intervention in mitigating the adverse effects of mental health disorders.

Theme 4. Barriers to seeking help

Self-Diagnosed Group. The fear of others finding out, along with factors like unaffordability, uncertainty about reaching out, and lack of support acted as major barriers to seeking professional help for self-diagnosed participants. Another significant barrier identified was the invalidating of issues, where participants perceived their mental health concerns as insufficiently severe to warrant professional intervention. *"Its not that much that help would be needed"*. Parental attitude also emerged as a critical factor, with mental health-related stigma within families inhibiting help-seeking. *"My father doesn't really believe, thinks that therapy is for the weak minded."* Negative experiences with MHPs also deterred individuals from seeking further help. A participant shared, *"I would have considered college counsellor but then one of my friends with depression told me that her experience with the counsellor was really horrible."* Finally, some individuals found it difficult to foster a positive change for themselves and thus remained stuck in old patterns. A participant said, *"it feels like sometimes you just don't want to be better. Like you feel like hiding behind your illness and you feel like, oh, I'm anxious, so I have free time, like not doing stuff that others do."*

Clinically Diagnosed Group. Finances came as a barrier to seeking help in both groups. For those who had sought treatment in the past, the costs involved made it difficult for them to continue the treatment. Lack of adequate resources further exacerbated this issue, as individuals faced limited options for accessing affordable or subsidized mental health services. Additionally, at times the absence of support from friends, emerged as a barrier, leaving individuals feeling isolated and unsupported in their efforts to seek or continue treatment.

Theme 5. Attitude towards Professional Help

Self-diagnosed group. Individuals predominantly exhibited positive attitudes towards MHPs, emphasizing a sophisticated understanding of therapy's benefits. Trust in MHPs was clearly evident amongst self-diagnosed participants, as they believe experts can efficiently address their issues. Some participants expressed regret about not seeking professional help sooner, highlighting the importance of early intervention by MHPs. *"I would have been better*

off with professional help from the start." Many acknowledged the limitations inherent in self-diagnosis. However, various barriers hindered their access to help, including financial constraints, unsupportive familial contexts, and a lack of awareness regarding available resources. Reluctance and hesitation towards medication were highlighted by concerns about potential side effects and changes induced by medication. *"I've heard things about medication, bringing people down in different ways. And it feels very overwhelming."* Misconceptions and skepticism also surfaced in a participants' statement *"I feel that sometimes I can also read minds and what is the work of psychiatry...that is reading your mind."* Some expressed doubts about finding someone who understands the gravity of their issues. The notion that there is no one *"good enough"* to comprehend or help (9.72% of the total participants) *"they are not intelligent enough to actually be able to understand what I'm trying to push through."*

Clinically Diagnosed group. Participants presented a multifaceted perspective on MHPs. On the positive side, there was a strong endorsement of therapy as an effective tool, with participants willing to recommend it to others. This reflected a belief in the potential benefits of therapy and a compassionate approach towards helping others access mental health support. A cautious approach to therapy selection was acknowledged, emphasizing the trial-and-error process in finding the right therapist. *"it's always hit and trial until you find someone who gets you... that would work out best for you"*. Moreover, the act of sponsoring therapy for others, as mentioned by one participant, illustrated a sense of social responsibility and a desire to contribute positively to mental health enhancement.

Discussion

The findings of the study reveal important aspects of self-diagnosing practices as well as the choice of approaching MHPs. Although to start with the study focused on the differences that could emerge between both groups, several similarities were encountered. Both groups were inclined towards a tendency of self-diagnosis to a similar extent as well as have shown similar levels of stigma. Some of the similarities discovered in the interviews were that all the participants used some information on the internet to understand their conditions better and they all

recognized the benefits of consulting mental health professionals. Financial constraints and a lack of mental health resources, also emerged as common barriers to seeking help, along with the prevalent stigma surrounding mental health among family and friends. Another similarity between the groups was the negative experiences they had with MHPs. Despite these shared challenges, a positive attitude towards seeking help was exhibited by both the groups.

The results carry the implication of there being the need to create higher levels of mental health literacy and improving some of the practices followed by professionals in the country when they are approached by young people for assistance. The term 'mental health literacy' was first introduced in 1997, and it was defined as 'knowledge and beliefs about mental disorders which aid their recognition, management or prevention' (Jorm et al., 1997). It is composed of several components, including (a) the ability to recognize specific disorders of types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information. Not only is this literacy important at the individual level, it is also important at the family and community level. This is because participants in both groups spoke of how familial attitudes and the fear of how they would be perceived by others were barriers to seeking therapy. Fear of labels or anticipation of stigma is a common barrier to adolescents' help-seeking and mental health (MH) service utilization (Moses, 2009; Boldero & Fallon, 1995; Yeh et al., 2003). These diverse barriers collectively highlight the complex interplay of personal, familial, societal, and systemic factors that influence young adult's decisions regarding professional help-seeking. Diagnostic labels given by clinicians provide a convenient means for describing patients that includes the presentation of symptoms and may imply the expected course and prognosis. Despite the benefits of diagnostic labels, they often serve as cues to signal stereotypes (Garand, 2010) and these need to be checked. Regarding the improvement in services, it is important for therapists to clarify the effects of medication to their patients and explain their condition to them. Research by Olfson et al. (2016)

emphasizes the importance of considering individual factors and potential side effects when prescribing psychiatric medications as one prominent issue highlighted by clinically diagnosed individuals is the challenges associated with medication. There is also the need for more affordable therapy and treatment options. Financial aspects as indicated by Kaur et al. (2023), are a formidable obstacle in accessing mental health care, particularly in contexts like India where resources may be limited. According to the Indian Council for Market Research (2009), the lack of resources and resistance to online therapy is another barrier as many districts in India do not have a minimum number of trained MHPs in primary and secondary care settings and discomfort with online therapy options acts as a significant barrier for both groups in less urbanized areas.

The pitfalls of self-diagnosis have to be communicated to young people who may be engaging in this practice and thus may be facing some risks. Research has shown that credibility of websites is less important for users in practice as they largely ignore the source of their medical information (Eysenbach & Köhler, 2002) with treatment avoidance being a real risk associated with online help-seeking (Pretorius et al., 2019). Content exists online that can be stigmatizing, triggering, or that may reinforce harmful behaviors and thoughts (Bell et al., 2018; Frost et al., 2016). This risk is exacerbated as young people may incorrectly attribute certain sources as helpful when in fact, they are dangerous (Best et al., 2016; Horgan & Sweeney, 2010). Research indicates that while online help-seeking seems to act as a gateway behavior to further help-seeking (Pretorius et al., 2019; Best et al., 2016; Collin et al., 2011), it also harbors risks like misinformation, delayed treatment, low-efficacy, or dangerous self-treatment through recreational drugs (Charlton, 2005).

Limitations & Future Implications

The study findings must be considered within the confines of certain limitations. Potential response bias may have impacted the sample representativeness, given the inherent differences in attitudes towards mental health between participants who volunteered to participate in this study compared to those who declined. Social desirability bias in self-report

measures could have influenced outcomes. Sampling bias from convenience-based methods might restrict generalizability. Moreover, the study lacked a comprehensive examination of a disorder's impact on self-labeling tendencies, neglecting symptom severity and duration. Moving forward, the study underscores critical implications. While participants exhibited positive attitudes towards MHPs, structural barriers such as affordability and accessibility, alongside negative encounters with professionals, impeded help-seeking behaviors. Hence, interventions are warranted to enhance accessibility and affordability of mental health services, coupled with ensuring comprehensive training and licensing for professionals. Additionally, addressing mental health stigma and stereotypes among family and friends is imperative, as their negative attitudes and lack of support deter individuals from seeking or continuing treatment.

Conclusion

The present study explored the self-labeling tendencies, stigma and attitude towards help seeking in self-diagnosed and clinically diagnosed young adults. The quantitative results revealed that both groups engage in self-labeling and have no significant differences with respect to stigma. The thematic analysis of the interviews revealed critical insights into the processes and implications of self-diagnosis versus clinical diagnosis in the context of mental health challenges among young adults. The identified themes shed light on the multifaceted nature of individuals' experiences, ranging from the pathways to diagnosis, the impact of the chosen approach, barriers to seeking help, and attitudes toward professional assistance. In light of these findings, it is evident that a comprehensive approach to mental health care is imperative, one that integrates both mental health literacy and improved professional guidance. By addressing the identified barriers and promoting a collaborative model of care, stakeholders can better support young adults in navigating their mental health journeys and fostering resilience and well-being.

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- Abstract with keywords
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- Limitations and Directions for Future Research
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