A STUDY TO ACCESS THE LEVELS OF SELF-EFFICACY AMONG HEALTH CARE PROFESSIONALS WORKING IN COIMBATORE CITY

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ABSTRACT

Background: Self-Efficacy has become a significant topic of investigation in both the psychological and in organizational literatures. Self-Efficacy is the faith in one's effectiveness in performing a specific task. People with high Self-Efficacy are presumed to set higher goals and outperform those with low Self-Efficacy. Self-Efficacy theory is an important factor of Bandura's social cognitive theory, which suggests high inter-relation between an individual's behavior, environment and cognitive factors. Bandura showed that difference in Self-Efficacy correlates to fundamentally different world views. People with high Self-Efficacy generally believe that they are in control of their own lives, that their own actions and decisions shape their lives, while people with low Self-Efficacy may see their lives as outside their control.

Objective: To assess the level of Self-Efficacy among doctors working in Coimbatore City.

Materials and Methods: The study is descriptive in nature and adopted survey strategy. The study used the Self-Efficacy tool comprising of 22 questions, developed by Bruno A. Cayoun. Data was collected through a questionnaire from 448 doctors from various hospitals. The data was analyzed using appropriate statistical methods.

Results: The result of the present study may contribute to the better understanding of self-efficacy parameters that affect the work process in either means with the view to increasing the quality of service in the health care sector.

Key words: Self-Efficacy, Doctors, Health care sector, Levels, Emotions

SELF-EFFICACY

Self-Efficacy refers to an individual’s perception of his or her capacity to perform a specific task. Self-efficacy is a person's judgment about being able to perform a particular activity. High self-efficacy in one area may not coincide with high self-efficacy in another area. Self-efficacy is specific to the task being attempted. Albert Bandura in the year 1986 clarified that Self-Efficacy is the belief in one’s capabilities to mobilize personal resources, such as motivation, cognitive, and behavioral skills, in order to orchestrate task-specific performance. Theoretically and empirically, Self-Efficacy has been shown to have wide-ranging implications for organizational behavior.

Self-Efficacy also has been validated as making an impact on learning and performance applications, such as training, leadership, decision making, and creativity. Importantly, Self-Efficacy measures must be adapted to the specific task under investigation. Self-report tools are used to address perceptions of

capability across a range of performance outcomes. Guided by Bandura's work, some scholars differentiate Self-Efficacy "magnitude" from Self-Efficacy "strength" and Self-Efficacy "generality." Magnitude refers to a comparative level of performance (e.g., whether one believes she can produce one, two, or three publications next year), while strength refers to one's confidence (e.g., probability) in achieving at that level. Four factors influence Self-Efficacy. They are such as: past performance, vicarious experiences, verbal persuasion and physiological cues (Source: http://www.oxfordbibliographies.com/). Efficacy helps people to either adopt a precaution measure or change risk behaviors in favor of other behaviors. People with high level of Self-Efficacy shows open-mindedness, have high communication skills, cooperative working desire, willingness to learn, plan and harmony, patient, tolerant, gentle and wise manners. Teachers who have high level of Self-Efficacy have tendency to perform in organizational planning and more willing to use new methods to satisfy student's learning needs.

Profession and Self-Efficacy

The shortage of healthcare professionals in most countries is well documented; it has reached such an extent that some hospitals are offering bonuses to lure healthcare workers from other employers. Every healthcare professional is an important part of the healthcare system, and shortage in any area creates problems for other cadres of workers. Industry-wide shortages create the possibility that patients will receive sub-standard care or even be placed in danger. These shortages also create an environment that is not conducive to retaining the most qualified and experienced healthcare professionals.

The healthcare industry requires a more skilled workforce today as a result of advancement in medical technology and the demand for more sophisticated patient care. Job Satisfaction among healthcare professionals is increasingly being recognized as a measure that should be included in quality improvement programmers. Low Job Satisfaction can result in increased staff turnover and absenteeism, which affects the efficiency of health services.

On behalf of the great aim which done by the health care provider especially on mental health scheme , and Belief in the role of health care provider in this direction , Mental health has become the medicine of the future in the world , which is care of more sensitive group in our society .World health organization & improved countries on variety of its philosophy and its goals give mental health a huge care & importance , became of having efficient crew improving the level of mental health employment , that & will increase the efficiency of our reaching for good results we have to believe that the employer in mental health field in the main aim of maintenance efforts in health ministry .

REVIEW OF LITERATURE

Masoome Alidosti, **Masoumeh Delaram**, **Lila Dehgani and Mojgan Maleki Moghadam (2016)** in their study the aim was to determine the relationship between Self-Efficacy and burnout among nurses working in Behbahan city, Iran. In this cross-sectional study, 151 nurses were randomly selected from 3 hospitals in Behbahan city proportionate to their staff number. Data were collected using the Maslach burnout and the Scherer Self-Efficacy questionnaires. The findings of the present study showed that increasing Self-Efficacy among nurses can lead to a decrease in burnout in the subscales of depersonalization, emotional exhaustion, and lack of personal accomplishment. Adopting strategies for increasing the Self-Efficacy would help reduce the burnout and increase motivation and satisfaction among the nurses.

Zerat M, Hassani M, Rashidi A, Alidosti M, Sharifirad GR, et al., (2014) study shows that Self-Efficacy is an assurance one feels about certain activities which affects his level of personal efforts and performance. In other words, Self-Efficacy influences motivation and the stronger the belief, the more motivated and active the person will be. People with higher Self-Efficacy are more successful when faced with challenges. This is especially true in the profession of nursing where they always have to deal with unforeseen situations, which could be factors leading to burnout. Given that the main motivation for the progress and development of human society is the promotion and protection of human health

and since health care professions have the highest rates of burnout, investigating the effect of Self-Efficacy on burnout can be a beneficial way of empowering nurses with the aim of reducing the incidence of burnout.

Consiglio C, Borgogni L, Ebrahimi Moghadam H, Rathi N, Rastogi R, et al., (2014) study illustrates and reported that increasing Self-Efficacy among municipal employees would lead to a decrease in emotional exhaustion and consequently reduces the amount of burnout. The Spearman correlation test showed that all subscales of burnout are significantly and inversely related with Self-Efficacy, so that by increasing Self-Efficacy the rate of burnout would decrease in all aspects. Moreover, the results of the Rathi's study showed a significant relationship between Self-Efficacy and personal accomplishments. Consiglio C also proved that the amount of an individual's success in his job is a strong predictor for burnout. According to the results, it can be argued that Self-Efficacy is an important variable in the formation of a sense of competence and success in human beings. For an effective performance, one needs to have both skills and the ability to perform those skills. Thus, Self-Efficacy with the increase of a feeling of success helps individuals use their skills at their best in order to solve the problems. In other words, Self-Efficacy creates the belief that one has the ability to perform his duties under different conditions.

Zerat M, Adeyemo, Ghanji, Ackfeldt, et al., (2014) in their study contends the investigation on job stress among faculty members of Nigeria University and found out that Self-Efficacy alone or in combination with emotional intelligence is a powerful predictor of job stress; in other words, Self-Efficacy and job stress have a reverse relationship. However, it is clear that job stress leads to burnout and reduces job satisfaction and have reported a significant relationship between Self-Efficacy, job stress and job satisfaction, showing the inverse relationship between Self-Efficacy and depression.

Kokkonen, Shikai, et al (2014) study examined on Japanese nurses which showed that nurses with higher Self-Efficacy would less frequently face depression. In a study by results showed that high levels of burnout were associated with lower levels of Self-Efficacy. This study was conducted to evaluate the effects of caring for the elderly with dementia and showed that nurses who take care of these patients are more prone to exhaustion and burnout, which consequently affects their quality of care.

Tizdast T, Oyzer K, Akbari R, Philbin MK., et al., (2013) states in their study that hospital is one of the most important health care institutions where nurses play an important role in restoring the physical and mental health of the patients. However, they are under severe stress because of their workforce stress and the services they provide. Pressures such as work conditions, lack of personal accomplishment, few opportunities for promotion and strict rules may lead to burnout. A burnout syndrome is recognized with symptoms of fatigue, forgetfulness of one's own needs, commitment to an external factor, long-term hard work, a sense of self-pressure, being influenced by the managerial staff and excessive attention to the clients' needs. Burnout includes three categories of emotional exhaustion, depersonalization and lack of personal accomplishment.

Jette Ammentorp, Janus Laust Thomsen, Dorte Ejg Jarbol, René Holst, Anne Lindebo Holm ovrehus and Poul-Erik Kofoed (2013) study states that the aim was to investigate how medical students' perceived Self-Efficacy of specific communication skills corresponds to the evaluation of simulated patients and observers. All of the medical students who signed up for an Objective Structured Clinical Examination (OSCE) were included. As a part of the OSCE, the student performance in the "parent-physician interaction" was evaluated by a simulated patient and an observer at one of the stations. After the examination the students were asked to assess their Self-Efficacy according to the same specific communication skills. This study showed that students scored their communication skills lower compared to observers or simulated patients. The differences were driven by only 2 of 12 items. The results in this study indicate that Self-Efficacy based on the Calgary Cambridge Observation guide seems to be a reliable tool.

Ebrahimi Moghadam H, Badri Gargari R, Khodabakhsh MR., et al., (2013) their study discusses that various studies have shown that the amount of burnout is not similar for people working under the same conditions. In other words, burnout is caused by the interaction of numerous factors, including those related to individual, interpersonal and career characteristics. This means that the universal phenomenon of burnout is generally dependent on the unique personality of a person and the individual's capacity to cope with difficulties may reduce the problem of burnout. Self-Efficacy is one of the factors that affect the way an individual deals with pressures.

A study by **Noman Aftab, Dr. Asghar Ali Shah and Roqia Mehmood (2012)** examined the investigation regarding the relationship between Burn out and Self-Efficacy among physicians. Data was collected from physicians N=80 (n=40 males and n=40 females) working in the different hospitals of Wah Cantt, Taxila and Rawalpindi. Significant negative relationship was found between Burnout and Self-Efficacy. Another significant negative relationship between Self-Efficacy and Emotional exhaustion was found. Significant negative relationship was found between Self-Efficacy and Depersonalization. Another significant positive relationship was found between Self-Efficacy and Personal accomplishment. Results revealed that female physicians experienced more Burnout than male physicians. On Self-Efficacy no significant gender difference was found among physicians.

The study by **Liaw SY Scherpbier A, et al., (2012)** used independent ratings of clinical performance to show that this was independent of self-reported confidence, saying that this highlights 'the potential danger of simulation experiences in leading toward overestimation of confidence over actual performance' and recommending that 'future studies should focus on the observation of clinical performance as a valid assessment strategy'.

In recent work, **Artino et al (2012)** showed that medical students' reported Self-Efficacy increased over time in relation to students' skills, experience and capabilities. Proxy measures such as Self-Efficacy are one way of means trying to understand the potential impact of an educational intervention on later clinical practice; they are necessary because it is nearly impossible to follow clinical trainees into practice in order to observe their performance, in an attempt to attribute it to the intervention.

Like **Artino et al (2012)** that reported Self-Efficacy can be a useful measure in estimating learners' abilities in a variety of clinical education situations. In this case, drawing from the concept of a relation between Self-Efficacy and ability, they designed a scale to measure reported confidence in approaching clinical scenarios and hypothesized that exposure to simulation training would increase self-reported efficacy in this domain.

RESEARCH METHODOLOGY

The study is a descriptive type in which the unit of analysis is the health care professionals and then the approach adopted is the quantitative one. The measures used are like: demographic profile and Self-Efficacy items. The demographic profile includes age, gender, marital status, etc. of the professionals. The study has used the Self-Efficacy construct tool by Bruno A. Cayoun's Mindfulness-Based Self-Efficacy- Revised scale which was developed and upgraded during the year 2004. The scale has 6 factors namely: Emotion Regulation, Equanimity, Social Skills, Distress Tolerance, Taking Responsibility and Interpersonal Effectiveness. Emotion Regulation is comprised of questions 1, 4, 6, 7, 12 and 18. Equanimity is comprised of questions 5, 10, 13 and 19. Social Skills is comprised of questions 2, 3 and 20. Distress Tolerance is comprised of questions 8, 16 and 17. Taking Responsibility is comprised of questions 11, 21 and 22. Interpersonal Effectiveness is comprised of questions 9, 14 and 15. There are also reverse coded questions in this scale and they are 16 in number. The reverse questions are such as: 1, 2, 3, 4, 6, 7, 8, 11, 12, 14, 15, 16, 17, 18, 21 and 22. The scale contains 22 questions in the 5-point Likert scale containing five choices like: 5- Completely Agree; 4- Agree; 3- Neither Agree nor Disagree; 2- Disagree; 1- Completely Disagree. The reliability value of this tool for the study is .8 and has adopted Cronbach's Alpha value as the reliability analysis.

Objectives of the study

- To study the demographic profile of the respondents.
- To measure the level of Self-Efficacy among the respondents of varied demographic profile.
- To determine the association between Self-Efficacy among the respondents of varied demographic profile.

ANALYSIS AND INTERPRITATION

CROSS TABULATION

The Cross tabulation procedure forms two-way and three-way analysis. It provides measures of association for two-way and three-way tables. Cross tabulation was carried out for the demographic data of the respondent.

Cross tabulation of Gender and Age

Age (in years)	Gender		Total
	Male	Female	
Less than 30	106	189	295
30-40	50	61	111
40-50	15	7	22
Above 50	12	8	20
Total	**183**	**265**	**448**

Among the 448 respondents 183 respondents are male of which 106 respondents are on the age group of less than 30 years, 50 respondents fall between the age group 30-40 years, 15 respondents fall between the age group 40-50 years and 12 respondents fall under the age group of more than 50 years of age. Among 265 female respondents 189 are falling under the age of less than 30 years, 61 respondents fall between the age group 30-40 years, 7 respondents fall between the age group 40-50 years and 8 respondents fall under the age group of more than 50 years of age.

Cross tabulation of Gender and Designation

Designation	Gender		Total
	Male	Female	
Professor	15	10	25
Associate professor	13	6	19
Assistant professor	18	15	33
Senior resident	18	54	72
Junior resident	119	180	299
Total	**183**	**265**	**448**

Among the 448 respondents 183 respondents are male in which 15 respondents are professors, 13 respondents are associate professors, 18 respondents are assistant professors, 18 respondents are senior residents and 119 respondents are junior residents. Among the remaining 265 female respondents 10 respondents are professors, 6 respondents are associate professors, 15 respondents are assistant professors, 54 respondents are senior residents and 180 respondents are junior residents on their designation.

Cross tabulation of Age and Designation

Designation	Age (in years)				Total
	Less than 30	30-40	40-50	Above 50	
Professor	0	0	5	20	25
Associate professor	0	3	16	0	19
Assistant professor	2	30	1	0	33
Senior resident	38	34	0	0	72
Junior resident	255	44	0	0	299
Total	**295**	**111**	**22**	**20**	**448**

Among the 448 respondents 295 respondents fall under the age less than 30 years in which no respondents are professors and associate professors but 2 respondents are assistant professors, 38 respondents are senior residents and remaining 255 respondents are junior respondents. In 111 total respondents of age between 30-40 years of age no respondent is a professor, 3 respondents are associate professors, 30 respondents are assistant professors, 34 respondents are senior residents and 44 respondents are junior residents. In 22 total respondents of age between 40-50 years of age 5 respondents are professors, 16 respondents are associate professors, 1 respondent is assistant professors and no respondents are senior and junior residents. Out of 20 respondents in the age above 50 years no respondents are junior residents, senior residents, assistant professors and associate professors, finally 20 respondents are professors.

Cross tabulation of Gender and Discipline

Discipline	Gender		Total
	Male	Female	
General physician	66	64	130
Dental	39	130	169
ENT	20	4	24
Cardiology	10	2	12
Pediatric	14	10	24
Anastasia	11	24	35
Gynecology	0	9	9
General medicine	13	13	26
Orthopedics	9	0	9
Dermatology	1	9	10
Total	**183**	**265**	**448**

Among 448 respondents 183 respondents are male in gender and in which 66 respondents are General physician, 39 respondents are in Dental discipline, 20 respondents are in ENT discipline, 10 respondents are in Cardiology discipline, 14 respondents are in Pediatric discipline, 11 respondents are in Anastasia discipline, no respondent is under Gynecology, 13 respondents are in General medicine, 9 respondents are in Orthopedics and 1 respondent is in Dermatology discipline. In remaining 265 female respondents 64 respondents are General physician, 130 respondents are in Dental discipline, 4 respondents are in ENT discipline, 2 respondents are in Cardiology discipline, 10 respondents are in Pediatric discipline, 24 respondents are in Anastasia discipline, 9 respondents are under Gynecology, 13 respondents are in General medicine, no respondents are in Orthopedics and 9 respondent are in Dermatology discipline.

Cross tabulation of Annual income and Discipline

Discipline	Annual income (in lakhs)				Total
	2-5	5-8	8-10	More than 10	
General physician	104	14	3	9	130
Dental	111	50	8	0	169
ENT	14	4	2	4	24
Cardiology	1	4	6	1	12
Pediatric	14	6	0	4	24
Anastasia	23	6	3	3	35
Gynecology	7	1	0	1	9
General medicine	21	4	0	1	26
Orthopedics	6	2	0	1	9
Dermatology	7	1	1	1	10
Total	**308**	**92**	**23**	**25**	**448**

Among 448 respondents in total 308 respondents are between 2-5 lakhs of annual income in which 104 respondents are in General physician discipline, 111 respondents are in Dental discipline, 14 respondents are in ENT discipline, 1 respondent is in Cardiology discipline, 14 respondents are in Pediatric discipline, 23 respondents are in Anastasia discipline, 7 respondents are in Gynecology discipline, 21 respondents are in General medicine, 6 respondents are in Orthopedics and 7 respondents are in Dermatology. 92 respondents are between 5-8 lakhs of annual income in which 14 respondents are in General physician discipline, 50 respondents are in Dental discipline, 4 respondents each are in ENT and Cardiology discipline, 6 respondents are in Pediatric discipline, 6 respondents are in Anastasia discipline, 1 respondent each is in Gynecology and Dermatology discipline, 4 respondents are in General medicine, 2 respondents are in Orthopedics discipline. 23 respondents are between 8-10 lakhs of annual income in which 3 respondents each are in General physician and Anastasia discipline, 8 respondents are in Dental discipline, 2 respondents are in ENT discipline, 6 respondents are in Cardiology discipline, 1 respondent is in Dermatology discipline and no respondents are in Pediatric, Gynecology, General medicine and orthopedics . 25 respondents are more than 10 lakhs of annual income in which 9 respondents are in General physician discipline, no respondent is in Dental discipline, 4 respondents each are in ENT and Pediatric discipline, 1 respondent each is in Cardiology, Gynecology, General medicine, orthopedics, Dermatology and 3 respondents are in Anastasia discipline.

DESCRIPTIVE STATISTICS

The Descriptive procedure displays univariate summary statistics for several variables in a single table and calculates standardized values (z scores).

Descriptive Statistics

Variables/ construct	Factor	Minimum	Maximum	Mean	Standard deviation
Self-Efficacy	Emotion regulation	1	5	3.07	.857
	Equanimity	1	5	3.66	.720
	Social skills	2	5	3.10	.627
	Distress tolerance	1	5	3.01	.790
	Taking responsibility	1	5	3.00	.823
	Interpersonal effectiveness	1	5	2.75	.633

Inference

Descriptive statistics reveals that for all the factors other than Emotion regulation, Social skills, Distress tolerance, Taking responsibility and Interpersonal effectiveness has the mean value high above 3.5 which indicates high level of Self-Efficacy among the Doctors. The standard deviation is also low for all the factors, which indicates low variability in the responses given by the respondents which is positive.

LEVELS OF SELF-EFFICACY

Age and Self-efficacy level cross tabulation

AGE In years	LEVELS OF SELF-EFFICACY						TOTAL
	LOW		MEDIUM		HIGH		
< 30	Count	10	Count	253	Count	32	295
	Expected count	9.2	Expected count	259.4	Expected count	26.3	259.0
30-40	Count	2	Count	109	Count	0	111
	Expected count	3.5	Expected count	97.6	Expected count	9.9	111.0
40-50	Count	2	Count	18	Count	2	22
	Expected count	0.7	Expected count	19.3	Expected count	2.0	22.0
> 50	Count	0	Count	14	Count	6	20
	Expected count	0.6	Expected count	17.6	Expected count	1.8	20.0
Total	Count	14	Count	394	Count	40	448
	Expected count	14.0	Expected count	394.0	Expected count	40.0	448.0
Pearson Chi-Square Value = 27.205[a]				**Sig**. = .000			

It is interpreted that out of 448 respondents 295 respondents fall below 30 years of age in which 10 respondents have low level of Self-Efficacy, 253 respondents have medium level of Self-Efficacy and 32 respondents have the high level of Self-Efficacy. 111 respondents fall between the age group 30-40 years in which 2 respondents have low level of Self-Efficacy and 109 respondents have medium level of Self-Efficacy. 22 respondents fall between the age group 40-50 years in which2 respondents have low level of Self-Efficacy, 18 respondents have the medium level of Self-Efficacy and 2 respondents have the high level of Self-Efficacy. 20 respondents come under the age more than 50 years of which 14 respondents have the medium level of Self-Efficacy and 6 respondents have the high level of Self-Efficacy.

To test whether there is significant association between the levels of Self-Efficacy and age of the respondents, chi-square analysis was carried out. The significance value is 0.000 which indicate the significant level to be lesser than 0.05 and it is inferred that there is association between the age of respondents and the levels of Self-Efficacy.

Gender and Self-efficacy level cross tabulation

GENDER	LEVELS OF SELF-EFFICACY						TOTAL
	LOW		MEDIUM		HIGH		
Male	Count	4	Count	168	Count	11	183
	Expected count	5.7	Expected count	160.9	Expected count	16.3	183.0
Female	Count	10	Count	226	Count	29	265
	Expected count	8.3	Expected count	233.1	Expected count	23.7	265.0
Total	Count	14	Count	394	Count	40	448
	Expected count	14.0	Expected count	394.0	Expected count	40.0	448.0
Pearson Chi-Square Value = 4.346[a]				**Sig**. = .114			

It is interpreted that out of 448 respondents 183 respondents are male in which 4 respondents have low level of Self-Efficacy, 168 respondents have medium level of Self-Efficacy and 11 respondents have high level of Self-Efficacy. 265 respondents are female and in which 10 respondents have low level of Self-Efficacy, 226 respondents have medium level of Self-Efficacy and 29 respondents have high level of Self-Efficacy.

To test whether there is significant association between the levels of Self-Efficacy and gender of the respondents, chi-square analysis was carried out. The significance value is 0.114 which indicate the significant level to be greater than 0.05 and it is inferred that there is no association between the gender of respondents and the levels of Self-Efficacy.

Marital status and Self-efficacy level cross tabulation

MARITAL STATUS	LEVELS OF SELF-EFFICACY						TOTAL
	LOW		MEDIUM		HIGH		
Single	Count	10	Count	226	Count	26	262
	Expected count	8.2	Expected count	230.4	Expected count	23.4	262.0
Married	Count	4	Count	168	Count	14	186
	Expected count	5.8	Expected count	163.6	Expected count	16.6	186.0
Total	Count	14	Count	394	Count	40	448
	Expected count	14.0	Expected count	394.0	Expected count	40.0	448.0
Pearson Chi-Square Value = 1.870[a]				**Sig.** = .392			

It is interpreted that out of 448 respondents 262 respondents are single in which 10 respondents have low level of Self-Efficacy, 226 respondents have medium level of Self-Efficacy and 26 respondents have high level of Self-Efficacy. 186 respondents are married and in which 4 respondents are having low level of Self-Efficacy, 168 respondents have medium level of Self-Efficacy and 14 respondents have high level of Self-Efficacy.

To test whether there is significant association between the levels of Self-Efficacy and marital status of the respondents, chi-square analysis was carried out. The significance value is 0.392 which indicate the significant level to be greater than 0.05 and it is inferred that there is no association between the marital status of respondents and the levels of Self-Efficacy.

Educational qualification and Self-efficacy level cross tabulation

EDUCATION QUALIFICATION	LEVELS OF SELF-EFFICACY						TOTAL
	LOW		MEDIUM		HIGH		
BDS	Count	6	Count	124	Count	24	154
	Expected count	4.8	Expected count	135.4	Expected count	13.8	154.0
MBBS	Count	2	Count	111	Count	9	122
	Expected count	3.8	Expected count	107.3	Expected count	10.9	122.0
MD	Count	6	Count	79	Count	3	88
	Expected count	2.8	Expected count	77.4	Expected count	7.9	88.0
MS	Count	0	Count	31	Count	2	33
	Expected count	1.0	Expected count	29.0	Expected count	2.9	33.0
MDS	Count	0	Count	14	Count	1	15
	Expected count	0.5	Expected count	13.2	Expected count	1.3	15.0
DM	Count	0	Count	12	Count	0	12
	Expected count	0.4	Expected count	10.6	Expected count	1.1	12.0
MCH	Count	0	Count	23	Count	1	24

	Expected count	0.8	Expected count	21.1	Expected count	2.1	24.0
Total	Count	14	Count	394	Count	40	448
	Expected count	14.0	Expected count	394.0	Expected count	40.0	448.0
Pearson Chi-Square Value = 22.343[a]				**Sig**. = .034			

It is interpreted that out of 448 respondents 154 respondents have BDS as qualification and in which 6 respondents have low level of Self-Efficacy, 124 respondents have medium level of Self-Efficacy and 24 respondents have high level of Self-Efficacy. 122 respondents have MBBS as qualification and in which 2 respondents have low level of Self-Efficacy, 111 respondents have medium level of Self-Efficacy and 9 respondents have high level of Self-Efficacy. 88 respondents have MD as qualification and in which6 respondents have low level of Self-Efficacy, 79 respondents have medium level of Self-Efficacy and 3 respondents have high level of Self-Efficacy. 33 respondents have MS as qualification and in which 31 respondents have medium level of Self-Efficacy and 2 respondents have high level of Self-Efficacy. 15 respondents have MDS as qualification and in which 14 respondents have medium level of Self-Efficacy and 1 respondent have high level of Self-Efficacy. 12 respondents have DM as qualification and in which 12 respondents have medium level of Self-Efficacy. 24 respondents have MCH as qualification and in which 23 respondents have medium level of Self-Efficacy and 1 respondent have high level of Self-Efficacy.

To test whether there is significant association between the levels of Self-Efficacy and educational qualification of the respondents, chi-square analysis was carried out. The significance value is 0.034 which indicate the significant level to be lesser than 0.05 and it is inferred that there is association between the educational qualification of respondents and the levels of Self-Efficacy.

Annual income and Self-efficacy level cross tabulation

ANNUAL INCOME (In lakhs)	**LEVELS OF SELF-EFFICACY**						**TOTAL**
	LOW		**MEDIUM**		**HIGH**		
2-5	Count	7	Count	278	Count	23	308
	Expected count	9.6	Expected count	270.9	Expected count	27.5	308.0
5-8	Count	6	Count	77	Count	9	92
	Expected count	2.9	Expected count	80.9	Expected count	8.2	92.0
8-10	Count	1	Count	20	Count	2	23
	Expected count	0.7	Expected count	20.2	Expected count	2.1	23.0
>10	Count	0	Count	19	Count	6	25
	Expected count	0.8	Expected count	22.0	Expected count	2.2	25.0
Total	Count	14	Count	394	Count	40	448
	Expected count	14.0	Expected count	394.0	Expected count	40.0	448.0
Pearson Chi-Square Value = 12.962[a]				**Sig**. = .044			

It is inferred that out of 448 respondents 308 respondents have their annual income between 2-5 lakhs and in which 7 respondents have low level of Self-Efficacy, 278 respondents have medium level of Self-Efficacy and 23 respondents have high level of Self-Efficacy. 92 respondents have their annual income between 5-8 lakhs and in which 6 respondents have low level of Self-Efficacy, 77 respondents have medium level of Self-Efficacy and 9 respondents have high level of Self-Efficacy. 23 respondents have their annual income between 8-10 lakhs and in which 1 respondent have the low level of Self-Efficacy, 20 respondents have medium level of Self-Efficacy and 2 respondents have high level of Self-Efficacy. 25

respondents have their annual income more than 10 lakhs and in which 19 respondents have medium level of Self-Efficacy and 6 respondents have high level of Self-Efficacy.

To test whether there is significant association between the levels of Self-Efficacy and annual income of the respondents, chi-square analysis was carried out. The significance value is 0.044 which indicate the significant level to be lesser than 0.05 and it is inferred that there is association between the annual income of respondents and the levels of Self-Efficacy.

ANOVA

Analysis of Variance of the respondents of varied age group

DIMENSION	MEAN				SD				F value	Significance (2-tailed)
	< 30 Years	30-40 years	40-50 years	>50 years	< 30 Years	30-40 years	40-50 years	>50 years		
Emotion regulation	3.25	2.78	2.27	2.92	.788	.842	.854	.971	17.15	**.000**
Equanimity	3.52	3.87	3.92	4.28	.742	.590	.542	.567	13.43	**.000**
Social Skills	3.12	2.99	2.98	3.47	.633	.528	.793	.704	3.715	**.012**
Distress Tolerance	3.05	2.84	2.58	3.83	.758	.709	.960	.855	12.31	**.000**
Taking Responsibility	3.06	2.83	2.59	3.37	.816	.747	.755	1.097	5.553	**.001**
Interpersonal Effectiveness	2.83	2.62	2.35	2.60	.657	.545	.559	.525	6.693	**.000**

Significance @ 0.05 levels

Interpretation

There is significant difference in emotion regulation factor (F=17.154, P<.05), equanimity factor (F=13.432, P<.05), social skills factor (F=3.715, P<.05), distress tolerance factor (F=12.311, P<.05), taking responsibility factor (F=5.553, P<.05) and interpersonal effectiveness factor (F=6.693, P<.05) among the respondents of different age.

Analysis of Variance of the respondents of varied marital status

DIMENSION	Mean		SD		F value	Significance (2-tailed)
	Single	Married	Single	Married		
Emotion regulation	3.26	2.18	.761	.914	32.692	**.000**
Equanimity	3.47	3.93	.742	.593	49.941	**.000**
Social Skills	3.11	3.08	.640	.609	.217	.641
Distress Tolerance	2.98	3.05	.726	.873	.892	.345
Taking Responsibility	3.05	2.91	.832	.805	3.137	.077
Interpersonal Effectiveness	2.81	2.66	.633	.626	6.143	**.014**

Significance @ 0.05 levels

Interpretation

There is significant difference in emotion regulation factor (F=32.692, P<.05), equanimity factor (F=49.941, P<.05) and interpersonal effectiveness factor (F=6.143, P<.05) among the respondents of varied marital status.

There is no significant difference in social skills factor (F=.217, P>.05), distress tolerance factor (F=.892, P>.05) and taking responsibility factor (F=3.137, P>.05), among the respondents of different marital status.

Analysis of Variance of the respondents of varied annual income

DIMENSION	MEAN				SD				F value	Significance (2-tailed)
	2-5 lakhs	5-8 lakhs	8-10 lakhs	>10 lakhs	2-5 lakhs	5-8 lakhs	8-10 lakhs	>10 lakhs		
Emotion regulation	3.11	3.18	2.48	2.75	.794	.947	.858	1.01	5.733	**.001**
Equanimity	3.66	3.45	4.03	4.09	.702	.769	.454	.645	8.109	**.000**
Social Skills	3.11	3.00	3.01	3.31	.623	.582	.582	.816	1.810	.144
Distress Tolerance	3.01	2.96	2.52	3.72	.740	.769	1.02	.809	10.37	**.000**
Taking Responsibility	2.98	3.11	2.25	3.25	.812	.765	.751	1.05	4.031	**.008**
Interpersonal Effectiveness	2.78	2.78	2.43	2.53	.599	.748	.382	.687	3.184	**.024**

Significance @ 0.05 levels

Interpretation

There is significant difference in emotion regulation factor (F=5.733, P<.05), equanimity factor (F=8.109, P<.05), distress tolerance factor (F=10.379, P<.05), taking responsibility factor (F=4.031, P<.05) and interpersonal effectiveness factor (F=3.184, P<.05) among the respondents of different annual income.

There is no significant difference in social skills factor (F=1.810, P>.05) among the respondents of different annual income.

Analysis of Variance of the respondents of varied locality

DIMENSION	Mean			SD			F value	Significance (2-tailed)
	Rural	Urban	Semi-urban	Rural	Urban	Semi-urban		
Emotion regulation	3.25	3.06	2.90	.852	.870	.733	2.309	.101
Equanimity	3.44	3.70	3.71	.729	.729	.595	3.539	**.030**
Social Skills	3.05	3.11	3.07	.572	.643	.579	.285	.752
Distress Tolerance	2.92	3.01	3.19	.715	.807	.749	1.627	.198
Taking Responsibility	3.04	2.97	3.10	.878	.814	.816	.614	.542
Interpersonal Effectiveness	2.82	2.75	2.59	.531	.672	.421	1.822	.163

Significance @ 0.05 levels

Interpretation

There is significant difference in equanimity factor (F=3.539, P<.05) among the respondents of different locality.

There is no significant difference in emotion regulation factor (F=2.309, P>.05), social skills factor (F=.285, P>.05), distress tolerance factor (F=1.627, P<.05), taking responsibility factor (F=.614, P<.05) and interpersonal effectiveness factor (F=1.822, P<.05) among the respondents of different locality.

FINDING OF THE STUDY

- Self-Efficacy level on Age reveals that on 448 total respondents 295 are below 30 years of which 10 have low level of SE, 253 have medium level of SE and 32 have high level of SE. 111 respondents are between 30-40 years of which 2 have low level of SE, 109 have medium level of SE and none have high level of SE. 22 respondents are between 40-50 years of which 2 have low level of SE, 18 have medium level of SE and 2 have high level of SE. 20 respondents are more than 50 years of age in which none have low level of SE, 14 have medium level of SE and 6 has high level of SE.
  The chi-square test significant value is 0.000 and it is inferred that there is association between the age of respondents and the levels of Self-Efficacy.

- Self-Efficacy level on Gender reveals that on 448 total respondents 183 are male of which 4 have low level of SE, 168 have medium level of SE and 11 have high level of SE. 265 respondents are female of which 10 have low level of SE, 226 have medium level of SE and 29 have high level of SE.
  The chi-square test significant value is 0.114 and it is inferred that there is no association between the gender of respondents and the levels of Self-Efficacy.

- Self-Efficacy level on marital status reveals that on 448 total respondents 262 are single of which 10 have low level of SE, 226 respondents have medium level of SE and 26 respondents have high level of SE. 186 respondents are married of which 4 respondents have low level of SE, 168 respondents have medium level of SE and 14 respondents have high level of SE.
  The chi-square test significant value is 0.392 and it reveals that there is no association between the marital status of respondents and the levels of Self-Efficacy.

- Self-Efficacy level on educational qualification reveals that out of 448 respondents 154 respondents have BDS as educational qualification and in which 6 have low level of SE, 124 have medium level of SE and 24 respondents have high level of SE.122 respondents have MBBS as educational qualification in which 2 respondents have low level of SE, 111 have medium level of SE and 9 respondents have the high level of SE. 88 respondents have MD educational qualification and in which 6 respondents have low level of SE, 79 respondents have medium level of SE and 3 respondents have high level of SE. 33 respondents have MS as educational qualification and in which no respondent have low level of SE, 31 respondents have medium level of SE and 2 respondents have high level of SE. 15 respondents have MDS as educational qualification and in which no respondent have low level of SE, 14 respondents have medium level of SE and 1 respondent have high level of SE. 12 respondents have DM as educational qualification and in which no respondent have low level of SE, 12 respondents have medium level of SE and no respondents have high level of SE. 24 respondents have MCH as educational qualification and in which no respondent have low level of SE, 23 respondents have medium level of SE and 1 respondent have high level of SE.
  The chi-square test significant value is 0.034 and it is inferred that there is association between the educational qualification of respondents and the levels of Self-Efficacy.

- Self-Efficacy level of annual income reveals that out of 448 respondents 308 respondents are having annual income between 2-5 lakhs and in which 7 respondents have low level of SE, 278 respondents have medium level of SE and 23 respondents have high level of SE. Among 92 respondents are having annual income between 5-8 lakhs and in which 6 respondents have low level of SE, 77 respondents have medium level of SE and 9 respondents have high level of SE. Among 23 respondents are having annual income between 8-10 lakhs and in which 1 respondent have low level of SE, 20 respondents have medium level of SE and 2 respondents have high level of SE. Among 25 respondents are having annual income between more than 10 lakhs and in which no respondents have low level of SE, 19 respondents have medium level of SE and 6 respondents have high level of SE.

  The chi-square test reveals that the significant value is 0.044 and hence there is an association between the annual income of respondents and the levels of Self-Efficacy.

ANOVA

- There is significant difference in emotion regulation factor, equanimity factor, social skills factor, distress tolerance factor, taking responsibility factor and interpersonal effectiveness factor among the respondents of different age.
- There is significant difference in emotion regulation factor, equanimity factor and interpersonal effectiveness factor among the respondents of varied marital status.

  There is no significant difference in social skills factor, distress tolerance factor and taking responsibility factor, among the respondents of different marital status.
- There is significant difference in emotion regulation factor, equanimity factor, distress tolerance factor, taking responsibility factor and interpersonal effectiveness factor among the respondents of different annual income.

  There is no significant difference in social skills factor among the respondents of different annual income.
- There is significant difference in equanimity factor among the respondents of different locality.

  There is no significant difference in emotion regulation factor, social skills factor, distress tolerance factor, taking responsibility factor and interpersonal effectiveness factor among the respondents of different locality.

CONCLUSION

Self-efficacy has proven to be an important construct for health care sector's achievement since the traditional environments. Its importance has been consistent over a period of several decades, through all levels of the developmental process or with the innovative process, with various case populations, and in varied fields of health care sector. It is vital for health care professionals to aid patents in succeeding their maximum potential and prepare them for a better life of continuous well-being. Doctors have to make the necessary adjustments so that all patients will have many opportunities to meet or exceed their health goals in all arenas.

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