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PAKISTANI CONSUMERS ATTITUDE TOWARD FOREIGN AND DOMESTIC PRODUCTS

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ABSTRACT

The Pakistani consumers' positive attitude towards foreign made items has had a negative effect on the domestic manufacturing industry. This research investigated the importance of a Pakistani manufactured *product* upon consumers purchase attitude.The sample comprised of 135 respondents belonging to middle and upper middle class Pakistani society. They were required to fill in questionnaire related to the attitude towards Pakistani and foreign manufactured car. The Pearson Correlation indicated perfect positive correlation between Brand Name and country of manufacture. Further analysis revealed difference of consumers' attitude regarding Pakistani and foreign manufactured products. They had a more positive attitude towards foreign made item as compared to Pakistani manufactured. Various other related variables have also been discussed.

INTRODUCTION

Social psychologists agree that attitudes and actions have a reciprocal relationship, each feeding the other.According to Saks and Krupat (1988), it is a widespread assumption that attitudes are critically important to the conduct of

human affairs. Not only do political campaigners worry about people's attitudes, but so do government in power, educators, propagandists, lobbyists, lawyers, sellers and all the rest of us.

The measurement of attitudes is equally important to the private sector. Indeed, the founders of political opinion polling got their start doing consumer research. The decision to launch a new product or to modify an old one (large cars to small, for example) and the timing of such decisions involve vast sums of money *to be* made or lost. Business people increasingly include the findings of "market research" among the considerations that guide those decisions (Jacoby, 1975; Woodside, Sheth, & Bennett, 1977).

The step from measuring attitudes to predicting behavior is a short but precarious one. How stable are measured opinions? And even if attitudes are measured well, how closely related are they to the behavior they are intended to predict? It is after all, the implications attitudes have for behavior that make them so important in the applied world.

Petty and Cacioppo (1981), defines attitude as "A general and enduring feeling, positive or negative, about social objects. The social objects include people, physical entities, events, and abstract ideas. The positive or negative feelings are evaluative reactions to those objects, and they vary in degree. You may like someone or something a lot or just a little."

Positive attitudes toward initially neutral things may be acquired merely by exposure to those things (Zajonc,1968). It is not necessary that a person recognize the stimulus (Moreland & Zajonc, 1979) or even have meaningful beliefs about it (Zajonc, 1980). The more exposure, up to a point, the more positive one's attitude toward the object. No theory of attitude acquisition could be simpler.

Empirical research has demonstrated this effect with regularity. In various experiments it has been shown that novel stimuli presented frequently are better liked than other, virtually identical, stimuli presented less frequently. This has been done with Chinese characters (Zajonc, 1968), photographs of strangers (Zajonc, 1968), people (Saegert, Swap, & Zajonc, 1973), and music (Wilson, 1979), among other things. In one study, researchers showed people photographs of themselves were either normal photographs or mirror images, and asked which they liked better, close friends of photographed person were given the same

choice. As the mere exposure hypothesis would predict, people tended to like their mirror-image photographs, the version of their face they most frequently saw. Their friends tended to choose the normal images, the version they had seen most often (Mita, Dermer, & Knight, 1977).

The mere exposure effect implies that we not only become accustomed to objects - people, ideas, music products - that we encounter frequently in our environment, but that we develop positive attitudes toward them as well. In studies of elections, it has been found that the candidate who is given the most mass media exposure usually wins (Grush, 1980). In a study of primary elections, the candidate receiving the most media exposure was the winner in 83 percent of the cases (Grush, McKenough & Ahlefng,1978).

Advertisers of products apply this principle in campaigns hoping to gain customers simply by presenting the product with a high frequency on television in magazines, and in store displays (Cacioppo & Petty, 1980; Simon & Arndt, 1980). However, mere exposure works only up to a point. Moreover, jokes seem not to get better at all with repeated hearings. Antagonistic processes- liking the familiar while seeking the novel - are undoubtedly at work (Jakobovitz, 1968; Maddi, 1968). But with the right spacing and variety, the mere exposure effect can be harnessed to produce quite positive attitudes.

The idea that observers infer people's attitudes from their behavior seems obvious. But Bern's self perception approach holds that the same process also occurs for each individual (Bern, 1967, 1972). He believes that we do not have direct introspective access to our own attitudes. Rather, we learn about our own attitudes the same way another person does - by observing our reactions attitude objects.

Now we will divert out attention towards literature of Consumers Attitudes Towards Foreign and Domestic Products. The majority of Country of Origin studies have been conducted with consumers in developed countries. These studies show that consumers in those countries tend to prefer products from developed countries to those from less developed countries (Jaffe and Martinez 1995; Wang and Lamb 1983). In particular, they tend to prefer products from their own countries first and foremost, then products from other developed countries and lastly, products from less developed countries (Okechuku 1994; Wag and Lamb 1983). Surveys show that Americans prefer American-made products to foreign products (Bruskin Report 1985; Gallup 1985). Wang and

Lamb (1983) have proposed a hierarchy of countries based on their level of economic development. Products from countries low on this hierarchy are perceived to be of lower quality than products from countries higher in the hierarchy. Okechuku (1994) found that American, Canadian, German and Dutch respondents preferred TV sets or car radio made in their own country first and foremost, followed by brands made in other developed countries, and lastly those made in the developing countries of South Korea and Maxico. Ettenson (1993) found that price ,was relatively less important than coo in Russian. Klenosky, Benet, and Chadraba (1966) found that Czech consumers preferred German cars and TV sets, but not polish ones, to those made in the Czech Republic. Chung and Pysarchik (2000) in study on Korean students studying temporarily at a large mid Western University in the USA found that there is a positive relationship between their attitudes and their intention to buy either domestic or imported products. The components of cultural pressure face saving and group conformity have a weaker influence on attitudes than product evaluation, and they are significant predictors for domestic products but not for imported products.

Knight (1999) found that compared to imported goods, consumers appear to prefer domestically manufactured Goods and are often willing to pay a higher price for them. It is usually only when imported goods are of significantly superior quality that consumers will pay more to obtain them.

In view of the foreign literature review the purpose of the present research is to find out Pakistani consumers Attitude toward foreign and Domestic Product.

The following hypotheses were framed:

1. Pakistani Consumers will like to purchase products manufactured in developed countries than products manufactured in their own country.

2. Pakistani consumers will like to purchase high priced products of developed countries as compared to low priced Pakistani products.

3. Pakistani consumers will consider foreign products more safer and reliable as compared to Pakistani products.

METHOD

Sample

Sample comprised of 135 upper middle and middle class members of Pakistani society. Whose educational qualification was at least graduation and their average family income was from Rupees 25000 to Rupees 100000 per month. They were the residents of Karachi and involved in Government jobs e.g. teaching, financial, health department and those who have their own small business or work in a variety of managerial and professional positions. Their age range was from 25 years up to 45 years and they all were married.

Procedure

To study Pakistani consumers attitudes towards foreign and domestic products, 200 subjects were approached during their duty hours at their respective work place. They were requested to fill in the questionnaire and the researcher waited till it was filled. After detailed scrutiny only those forms were considered for research purpose whose subject fulfilled the criteria of the sample for present research.

RESULTS

Table 1

Correlations of Brand Name

Order of Preference

Brand Name	A	B	C	D
Toyota	1.000	-.028	-.591	-.473
Nissan	-.028	1.000	-.404	-.281
Suzuki	-.591	-.404	1.000	-.165
Kia	-.473	-.281	-.165	1.000

Table 11

Percentages of Brand Name

Order of Preference

Brand Name	A	B	C	D
Toyota	70.37	11.11	5,92	12.29
Nissan	09.62	44.44	41.48	4.44
Suzuki	17.03	29.62	31.11	22.22
Kia	02.96	14.81	21.48	60.74

Table 111

Correlation of Country of Manufacture

Order of Preference

Country of Manufacture	A	B	C	D
Made in Pakistan	1.000	-.510	-.110	-.493
Made in Japan	-.510	1.000	-.521	-.184
Made in China	-.110	-.521	1.000	-.125
Made in Korea	-.493	-.184	-.125	1.000

Table 1V

Percentages of Country of Manufacture

Order of Preference

Country of Manufacture	A	B	C	D
Made in Pakistan	19.25	31.11	19.25	30.37
Made in Japan	71.85	10.37	02.22	15.55
Made in China	0.74	22.96	41.48	34.81
Made in Korea	8.14	35.55	37.03	19.25

Table V

Correlations of Retail Price

Order of Preference

Retail Price	A	B	C	D
Low Price Pakistani Car	1.000	-.102	-.101	-.737
High Price Pakistani Car	-.102	1.000	-.483	-.218
Low Price Foreign Car	-.101	-.483	1.000	-.303
High Price Foreign Car	-.737	-.218	-.301	1.000

Table VI

Percentage of Retail Price

Order of Preference

Retail Price	A	B	C	D
Low Price Pakistani Car	20.74	12.59	26.66	40
High Price Pakistani Car	14.81	40.74	35.55	8.88
Low Price Foreign Car	31.85	34.81	25..92	7.40
High Price Foreign Car	32.59	11.85	11.85	43.70

Table VII

Percentages of Safety and Reliability

Country	Safety	Reliability
Pakistan	38.51	37.77
Foreign	61.48	62,22

DISCUSSION

It is clear from table I, II, III and IV that there is a positive correlation between Brand Name and Country of Manufacture ($r = 1.00$, $N=135$, $p<.01$). Toyota car was given first preference by 70.37 % consumers and Japan was given first preference by 71.85 % people for country of manufacture. Similarly those who gave first preference to Suzuki car (17.03 %) also gave first preference to Pakistan (19.25 %) as country of manufacture, indicating that brand name and country of manufacture go side by side. Those who preferred Toyota car also preferred Japan assembled cars and those preferred Suzuki, also preferred Pakistani assembled car. Giving first preference by majority to Japanese car as compared to Pakistani cars, rightly confirms our first hypothesis that "Pakistani consumer will like to purchase products manufactured in developed countries than products manufactured in their own country". It is also clear from answers of our fourth and fifth question where the consumers were asked about the country which produces safer and reliable products. Table VII indicates that 61.48 % and 62.22 % considered Foreign made cars as more safe and reliable, respectively, 38.51 % and 37.77 % considered Pakistani car as safe and reliable respectively. Thus proving our third hypothesis also that "Pakistani consumers will consider foreign products more safe and reliable as compared to Pakistani products". Our confirmation of two hypothesis goes well along with the findings of Kaynak, Kucukemiroglu and Hyder (2000) which indicate that Bangladeshi consumers overwhelmingly preferred western made products.

Consumers tend to prefer domestic products in countries where there is strong patriotism, national pride or consumer ethnocentrism (Heslop and

Papadopoulos 1993). On other hand, preference for domestic products to be weaker in economically underdeveloped countries (Cardell 1992). Levin (1993) and Bos (1994) report that Mexicans have a poor perception of domestic goods, rating American and Japanese household electronic products above Mexican made brands. Jordan (1996) reports that there is a great demand for western consumer goods among Indian consumers. In China, manufacturers pass off local products as western in a practice referred to as 'maoyang' (Gilley 1996). Consumers in the former socialist countries of eastern and central Europe prefer western to domestic product (Ettenson 1993; Papadopoulos, Heslop, and Beracs 1990).

In comparing the retail price it is clear from table V and VI that those who gave first preference to foreign brand name, also gave importance to high price foreign car ($r = 1.00$, $N=135$, $p<.05$).In a question related to country of manufacture 32.59 % gave first preference to high price foreign car and 14.81 % gave first preference to high price Pakistani car. It clearly shows the attitude of Pakistani consumers towards Pakistani products. Even if the foreign car is of high price they will prefer to by it as compared to Low (20.75 %) or high priced Pakistani car. The result clearly proves the second hypothesis " that Pakistani consumers will like to purchased high priced products of developed countries as compared to low priced Pakistani products". Confirmation of third hypothesis shows that the level of patriotism of Pakistanis, appears to be too low. Besides there is a general attitude among Pakistanis to consider the Pakistani manufactured items as of low quality even though it has foreign Market value because of its superior quality. Knight (1999) found that compared to imported goods, consumers appear to prefer domestically manufactured goods and are often willing to pay a high price for them, it is usually only when imported goods are of significantly superior quality that consumers will pay more to obtain them.

Americans are concerned about COM because they want to make sure it is a domestic brand (Bruskin Report, 1985), while Pakistanis are concerned about COM because they want to make sure it is not a domestic brand. Middle and upper middle class Pakistanis do not resist to pay high price for the foreign made item. Detailed analysis of five answers clearly shows that for Pakistani consumers country of manufacture is most important followed by brand name, reliability, safety and retail price.

In conclusion we can say that together with previous work by consumer researchers, these results provide insight into the preference given by the

consumers when they plan to purchase any product. For Pakistani consumers country of manufacture is more important than price and other product attributes. Brand name is given similar importance. The Pakistani consumers give less importance to made in Pakistan label and more importance to the label of foreign developed country. Safety and reliability of the foreign products are two important reasons for the Pakistani consumer preference for foreign products.

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APPENDIX

Questionnaire

Name: _____Age: _____Sex:_____
Married/Unmarried: _____Academic Qualification:_____
Occupation:_____Religion:_____
Earning Members: _____ Monthly Income:_____
Residential Address: House No./Apartment No._____Street:_____
City _____Socioeconomic Status _____
Transportation used for daily traveling: Personal/Private, If Personal: Name and Model: _____. If Private: type _____
Would you like to purchase a new car: Yes/No.
If yes give answers to the following questions:
Your duly filled-in questionnaire will give us information regarding your attitude towards different types of cars which will be measured through your ideas regarding different brand of cars, country of its manufacture, retail price, reliability and safety. There are multiple answers to a given statement. In question No.1, 2 and 3, you are required to give your preference by giving proper order to multiple answers e.g. a, b, c and d. Where a = first preference, b= second preference, c=third preference and d= fourth preference.

In question No. 4 and 5 you just have to circle the preferred answer only.

1. Brand Name:

I would like to purchase: Order of Preference

- **Toyota Car**
- **Nissan Sunny Car**
- **Suzuki Car**
- **Kia Car**

2. Country of Manufacture: Order of Preference

I would like to purchase a car which has a label of:

- **Made in Pakistan**
- **Made in Japan**
- **Made in China**
- **Made in Korea**

3. Retail Price: **Order of Preference**

I would like to purchase:

* **Low Price Pakistani Car**
* **High Price Pakistani Car**
* **Low Price Foreign Car**
* **High Price Foreign Car**

4. Safety: **Order of Preference**

I would like to purchase:

* **Pakistani 1000 cc Car/1200 cc Car/1600 cc Car**
* **Foreign 1000 cc Car/1200 cc Car/1600 cc Car**

5. Reliability: **Order of Preference**

- **Pakistani manufactured car which provide me high satisfaction due to good running condition and other internal functions.**

- **Foreign manufactured car which provide me high satisfaction due to good running condition and other internal functions.**

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PRE-POST EVALUATION OF DEPRESSION AND ANXIETY IN PATIENTS UNDERGOING MASTECTOMY AND HYSTERECTOMY

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ABSTRACT

The present research evaluated depression and anxiety in patients undergoing mastectomy and hysterectomy during their pre-surgical and post surgical phases. A Pre-Post Research Design was used. Sample consisted of 50 mastectomy patients and 50 hysterectomy patients, selected from the Surgery/Gynecology Department of Mayo Hospital, Hameed Latif Hospital, Jinnah Hospital and Lady Wellingdon Hospital of Lahore, Pakistan. Each subject was individually administered Depression Scale and Anxiety Check-List twice: 1-7 days before and 1-7 days after surgery. The hysterectomy patients seemed to experience more depression and anxiety ($t=-2.55;df=48;*p<0.05$ $t=-5.74,df=48;p<0.05$ respectively) during their post surgical phase as compared to their pre-surgical phase. Interestingly enough the mastectomy patients showed greater depression ($t= 0.96;df=48;p>0.05$ and anxiety ($t=1.68$; $df=48;*p<0.05$) in the pre-surgical phase as compared to their post surgical phase. Therefore both the groups showed significant difference in their depression and anxiety scores during their pre-surgical and post surgical phases. Nevertheless mastectomy patients manifested greater depression and anxiety as compared to the hysterectomy patients

probably due to the greater psycho-social and sexual value associated with the loss of this organ.

INTRODUCTION

Breast cancer is the most common form of cancer in women. It has been widely studied with respect to its psychological impact because it is a disease which threatens an organ that is intimately associated with self-image, self-esteem, sexuality, femininity, and reproductive and nurturing capacity (Massie & Holland, 1991). Not all breast lumps are cancerous. There are three kinds of breast lumps: cysts (fluid filled sacs, also called fibrocystic disease or cystic mastitis), fibroadenomas, and malignant tumors. If a malignancy is confirmed the treatment is some form of mastectomy, that is, surgical removal of the breast (Hyde, 1991).

Most cancer treatments, including surgery can be extremely unpleasant. Surgery often requires a great amount of recuperation, sometimes new physical problems, and may cause substantial disfigurement (Kaplan & Kerner, 1998). Altered body image is a change in the perception of one's appearance, bodily functions or state of health with the potential for a change in self-esteem. This may be triggered by an actual physical change such as injury, surgery, illness (Adams & Bromley, 1998).

Mastectomy is a frequently performed, emotionally stressful surgical procedure (Euster, 1979). According to Ashurst and Hall (1989) a woman's identity, her perception of herself as a woman, her femininity and her self confidence are closely bound up with her body-image. The effects of mutilating surgical techniques, such as mastectomy, are well known and disturbances in body-image and psychosexual functioning has been commonly reported (Dean, Hughes, Hughson et al, Maguire, Moris, as cited in Watson, 1991). Physical disability or disfigurement may have profound impact on body-image (Heatherton & Hebl, 1998).

Breast cancer victims who must undergo mastectomies often feel a loss of femininity (Leake & Friend, 1998). The majority of women find the loss of a breast extremely distressing. Many women speak of feeling 'mutilated' or 'incomplete' and their self image as a woman may be challenged (Roberts & Adam, 1987). A woman about to undergo mastectomy has to deal with the loss of

body part, which may be important among other things to her femininity and sexuality (McPherson & Anderson, 1987).

The diagnosis of breast cancer is threatening on many levels. Most obvious is the fact that the patient's life is placed in jeopardy by the disease and that surgical intervention for the disease is disfiguring. The patient not only has to cope with the blow on her femininity, but also with the constant reminder of her potentially life-threatening disease (Ashurst & Hall, 1989). Woods (as cited in Joiner & Fisher, 1981) discusses the cultural emphasis on the female breast as a symbol of femininity and as a reinforcement for the desire for a whole and perfect body. Breast shape and size are presented by the media as a criterion for sexual desirability. Bard and Sutherland (as cited in Joiner & Fisher 1981) relate a woman's reaction to her mastectomy to her individual perception of the breast and her personal psychosexual development. They indicate a cultural, physiological, and psychological interaction which determines the individual meaning of the breast to each woman. In a developing country like Pakistan where media is playing an important role in emphasizing the importance of physical attractiveness and 'sex appeal' the acceptance of the alteration in body image may be very difficult for women undergoing mastectomy.

Woods (as cited in Joiner & Fisher, 1981) argues that the value assigned to the lost breast will probably be influenced by the extent to which the woman bases her self worth and acceptability on her appearance. In women who relate to others through physical attractiveness, feelings of self-rejection may develop when they perceive their bodies as having been disfigured by mastectomy. In Third World countries like Pakistan, where the level of education is low and illiteracy prevails women are observed to be perceived as sex objects and great importance is attached to their body image. Mutilation or loss of an organ especially related with their femininity is perceived as an assault on their womanhood.

Peck (as cited in Joiner & Fisher, 1981) indicates that anxiety is the most common patient response followed by depression characterized by appearing sad or having lost interest in usual pursuits. Defence mechanisms such as denial and displaced anxiety are common. Bard and Sutherland (as cited in Joiner & Fisher, 1981) see expression of anxiety and tension as emotional reactions during the postoperative period.

The mastectomy patient's role in social and interpersonal situations may be altered in various ways after surgery. Harrell (as cited in Joiner & Fisher, 1981) wrote that a woman must learn how to cope not only with herself but also with the reactions of others to her surgery. The absence of a breast and the importance attached with body image may elicit various reactions from others which have to be dealt with. The mastectomy and its physical and psychological aftermath can profoundly affect a woman's professional outlook as well. It has been generally observed that mastectomy is a traumatic experience for professional women as well as housewives in Pakistan. The altered body image as a result of mastectomy may be very difficult for women to accept. Lack of professional help and emotional support at home are also factors that may contribute to the development of depression and anxiety in the patient.

The other variable of interest in the present research is hysterectomy. Hysterectomy is the surgical removal of the uterus. The uterus is a muscular, hollow pear shaped organ and is firmly anchored in the body by a number of ligaments. The organ itself consists of a thick muscular wall inside which is a thin lining, the endometrium (Atlas of the Body, 1980). A woman's capacity to create, bear, and nurture a child is the very essence of her womanhood (Ashurst & Hall, 1989). As this surgical procedure results in the loss of reproductive capacity it is avoided in younger women. The psychological importance of the uterus and the consequences of its removal have meaning because the uterus is central to a woman's sense of wholeness and well being (Ashurst & Hall, 1989). Even for women who do not wish to have more children the uterus is not an organ to be discarded lightly. The very knowledge that she is 'normal' and the recurrent evidence of this by way of menstruation, are psychologically if not physically important (Tindall, 1993).

The psychological importance of the uterus and the results of its malfunctions are significant because the uterus is an organ associated with fundamental aspects of well being, of 'being well' as a woman (Ashurst & Hall, 1989). The side effects of this surgical treatment invariably cause some loss of function such as cessation of menstruation, infertility and hormonal imbalance. These changes may in turn influence sexual functioning patients may also experience a general feeling of malaise. Jachimsen (as cited in Branolte-Bos, 1991) found that 82% of hysterectomy patients reported a poor body-image. At a social-cultural level, gynecological cancer may threaten the female image. Wren (1978) suggests that the possible cause for regret in women for the loss of their

uterus is related to the concept that the uterus is the source of a woman's femininity and the loss of this organ makes her less of a woman.

Many women are surprised to find that after they have undergone hysterectomy they feel 'spoiled' and less valuable (Lewis & Chamberlin, 1991). Hysterectomy has traditionally been regarded as having an adverse effect on women's sexuality because it is thought to reduce their sense of femininity (Gath et al., as cited in Lloyd, 1991). Women are referred to psychiatrists much more commonly after hysterectomy than after any other operation (Tindall, 1993). According to Roeske (1978) the most frequent psychopathological reaction is depression, as a mourning process occurs as a woman reintegrates her gender identity after the operation.

Pakistan is a country with a birth rate of 3.1%, the highest in the world. Mainly parents desire a large family and, in particular a large number of sons in Pakistan (Mubasher & Sathar, 1997). As great importance is attached having sons in Pakistan, the hysterectomy if performed in younger women is like a death-knell as it signals an end to their capacity to produce children particularly sons.

A woman who is unable to produce children is viewed as being incomplete and is assigned a low status within the family as well as society. Her inability to produce children isolates her and raises doubt about her self-worth. This may cause the woman to reassess the meaning and purpose of her marriage (Khalid, 1996). Loss of the ability to bear children may also result in increasing family pressures and at times divorce or remarriage of the husband.

Depression is one of the most common adult psychological problems. Depression may occur in combination with medical illnesses for both physiological and psychological reasons. Depression is a common reaction to a serious medical event, such as major surgery and can be an early symptom of a medical disease (Miller, Norman & Dow, 1988). Nearly all people who become physically ill have to make some degree of psychological adjustment. Minor disturbances of mood may be common, however for some patients the psychological consequences are maladaptive in various ways (Lloyd, 1991). Lipowski (as cited in Lloyd, 1991) describes threat and loss as two of the five major categories of the meaning of illness. When an illness is perceived as a threat the patient focuses on the anticipation of physical or psychological damage. This perception is highlighted when there is considerable doubt

concerning the nature of the illness and its outcome. Thus the perception is greatest during the period immediately following the onset of acute illness or when an established i9llness takes an unusual course with the development of new and unexpected symptoms. Anxiety is then the commonest emotional accompaniment. According to Lipowski (as cited in Lloyd, 1991) loss refers to either an anatomical or symbolic loss associated with illness. Anatomical loss of body parts, for example, amputation, mastectomy or colostomy requires major psychological adjustment but a symbolic loss is not less important if illness involves irreparable damage to self-esteem, status or pursuit of cherished goals. Lipowski (as cited in Lloyd, 1991) states that "the subjective significance of the part of the body affected is a crucial factor in determining the emotional response and coping behavior. The more highly valued the body part or function the more intense the psychological reaction." Thus it has been argued that loss of symbolically significant organs like the uterus or breast will carry major emotional repercussions.

The reactions experienced by women undergoing mastectomy are similar to those of bereavement i.e. an initial phase of disbelief that it has been removed, followed by sadness and depression (McPherson & Anderson, 1987). Freud (as cited in Farooqi, 1996) in his major work on depression, "Mourning and Melancholia" described both normal mourning and melancholia (depression) as responses to the loss of someone or something that was loved. Psychodynamic theories emphasize the concept of loss as a precipitant of depression, with particular emphasis on the experience of a lost love object. Ego psychologist Beck, Rush, Shaw, and Emery (as cited in Miller, Norman & Dow, 1988) have also argued that the experience of significant loss can predispose someone to depression by activating depressogenic cognitive schema. The effect of other "loss states" such as child birth where the foetus breaks its special link with the mother, and hysterectomy where the capacity to bear children is lost have also been studied (Barker, 1992). Depression has long been associated with the concept of loss (Freud & Bowlby as cited in Barker, 1992) and a relationship between certain losses and the onset of depression has been observed by a number of researchers (Barker, 1992). Changes in health status are often referred to in the context of the experience of "loss". People experience loss when there has been: the loss of a relationship through death or separation, failure, removal or alteration of body parts, whether external or internal; or an alteration in physical, psychological or social functioning. Such experiences may be acute or gradual, temporary or permanent, obvious to others or possible to conceal (Adams & Bromley, 1998). Freud (as cited in Ahmad and Munaf, 1991) states

that the fundamental determinant of automatic anxiety is the occurrence of a traumatic situation; and the essence of this is an experience of helplessness on the part of the ego in the face of an accumulation of excitation, whether of external or of internal origin, which cannot be dealt with. Anxiety is the response of the ego to the threat of the occurrence of a traumatic situation, and the essence of this is an experience of helplessness on the part of the ego in the face of an accumulation of excitation, whether of external or of internal origin, which cannot be dealt with. Anxiety is the response of the ego to the threat of the occurrence of a traumatic situation. Such a threat constitutes a situation of danger. Internal dangers involve separation from, or loss of, a loved object, or a loss of its love, a loss or separation which might in various ways lead to an accumulation of unsatisfied desires and so to a situation of helplessness.

Baum (1995) suggests that surgical procedures like mastectomy and hysterectomy are emotionally stressful and may lead to depression and anxiety in females undergoing these procedures. The removal or alteration of body parts, which are symbolically significant, may cause major emotional repercussions to the females whose femininity and role-identity seems to be threatened by such procedures. The uterus and breasts contribute to a woman's sexual identity. They are related to the concepts of femininity, sexuality, procreation and motherhood and are necessary parts of a woman's body-image (Ashurst & Hall, 1989). The main purpose underlying the research project is to investigate the emotional repercussions these surgical procedures might cause. The present research is an attempt to investigate depression and anxiety as experienced by patients undergoing mastectomy and hysterectomy during their pre-surgical and post surgical phases.

Umegaki, Minami, Katou, Kawasaki, Fukunaga and Shimizu (1993) conducted a research in Japan that focused on the pre-operative psychological status of patients undergoing radical mastectomy and total hysterectomy. Using four different psychological tests, the pre-operative psychological status of patients undergoing radical mastectomy for breast cancer was compared with those of patients undergoing total hysterectomy for uterine myoma. Research findings suggest that patients undergoing hysterectomy disclosed lower postoperative anxiety and slight nervousness and persistent depression pre-operatively. In contrast, patients with breast disease, those with nervousness had persistent anxiety and depression, while those without nervousness showed the same persistent depression as in hysterectomy patients, as well as a high anxiety level postoperatively. The researchers speculate that the persistence of depressive

mood during the pre-operative period is a factor in the psychological disturbance of mastectomy patients.

Kissane, Clarke, Ikin, Bloch, Smith, Vitetta and McKenzie (1998) conducted a cross-cultural survey in Melbourne, Australia to determine psychological morbidity and quality of life of women with early breast cancer. The subjects (N=303) were interviewed and administered Quality of Life (QOL) questionnaires three months after undergoing conservative breast surgery or radical mastectomy. Results indicate high rates of psychological and psychiatric disturbances. 45% of the sample had a psychiatric disorder, 42% of the sample had depression and anxiety, or both 27.1% had minor depression, 8.6% an anxiety disorder, 9.6% major depression and 6.9% a phobic disorder. 20% of the women had more than one disorder.

Ohkawa, Tanaka, Morkawa, Takeda and Katoh (1992) studied psychosomatic reaction to hysterectomy in Japan. Subjects (N=120) who had undergone simple hysterectomy were examined before and as long as one year after the operation. Anxiety scores of the subjects were high before surgery and rapidly declined postoperatively. High scores on depression were observed before and two weeks after the operation. A close correlation was observed between the results of psychological tests and the number of psychological symptoms. Psychosomatic disorders associated with hysterectomy are characterized by various symptoms but mainly by a depressive state. Less psychological and physiological symptoms were observed 6 months after the hysterectomy.

Maguire, Lee, Bevington, Kuchemann, Crabtree and Cornell (1978) investigated psychiatric problems experienced in the first year after mastectomy by 75 women in Britain. The control group consisted of 50 women with benign breast disease. Throughout the follow-up period, incidence of psychiatric problems was higher among the women who had undergone mastectomy. 25% of the experimental group needed treatment for anxiety or depression or both, as compared to the 10% of the control group 33% of the subjects in the mastectomy group reported moderate or severe sexual difficulties as compared to 8% of the control group. Altogether 39% of the subjects in the mastectomy group had serious anxiety, depression or sexual difficulties.

Umegaki, Minami, Katou, Kawasaki, Fukunaga and Shimizu (1992) studied the changes in the psychological status of 63 patients who had undergone

a simple hysterectomy procedure in Japan. They administered the Spielberger's rating scale "The State – Trait Anxiety Inventory" (STAI), Self-Rating Depression Scale (SDS), Maudsley Personality Inventory (MPI) and the Baum Test Ratings obtained show a significant decrease in anxiety post operatively but no significant change in depressive mood during the pre-operative period. 75% of the patients manifested psychological fragility or lability in the Baum test. Research findings suggest that depressive mood affects strictly the psychological status in post-operative period more than anxiety. It is also suggested that depressive mood during the pre-operative period is responsible for the post-operative psychological disturbance.

Khalid (1999) investigated the relationship of family's emotional closeness and breast-cancer patients' adjustment to illness in Pakistan. The results indicate that patients who reported the best adjustment to breast cancer also reported higher levels of family cohesion. Significant relationship between adjustment to illness and family cohesion was also found.

Cancer is viewed as a lethal and menacing disease. Breast cancer is a cancer that threatens a woman's body image and her self worth and may cut short her hope of fulfilling her role as a wife and mother. The response of a care-giver after such a diagnosis may either provide her or deprive her of the security of being loved and esteemed despite the presence of their illness. Research conducted by Farooqi and Akbar (1995) determined the degree of depression expressed by caregiver spouses. Findings suggest that females differ significantly from males on degree of hopelessness/helplessness and are more inclined to seek spiritual help.

Surgical procedures like mastectomy and hysterectomy are emotionally stressful and may lead to depression and anxiety in females undergoing these procedures. The removal or alteration of body parts, which are symbolically significant, may cause major emotional repercussions to the females whose femininity and role-identity seems to be threatened by such procedures. In the light of the Pakistani society it can be observed that emphasis on body-image by media, coupled with the importance associated with childbearing are such circumstances in which mutilation or removal of such vital organs may cause serious threat to their womanhood. Removal of these organs and lack of emotional support at home may result in emotional problems and women may manifest anxiety and various depressive symptoms. The main purpose underlying the research project is to investigate the emotional repercussions these surgical

procedures might cause. The research focuses on evaluating differences in depression and anxiety as manifested by patients undergoing mastectomy and hysterectomy before and after surgery.

METHOD

Sample

The sample consisted of 100 adult Pakistani patients: 50 mastectomy cases and 50 hysterectomy cases. The mastectomy cases (n=50) and hysterectomy cases (n=50) were selected from the Surgery and Gynecology Departments of Mayo Hospital, Hameed Latif Hospital, Jinnah Hospital and Lady Wellingdon Hospital of Lahore, Pakistan.

The mean age of mastectomy patients was 44.7 years and the mean age of hysterectomy patients was 42.4 years. The level of Education ranged from 1-16 grades in both the categories. Among the patients undergoing mastectomy 48% were uneducated, 38% were between grade 1 to 10, 12% between grade 11 to 14 and 2% were between grade 14 to 16. Among patients going through hysterectomy (n=50) 64% were uneducated, 16% were between grade 1 to 10 and 20% between grade 11 to 14. Among patients undergoing mastectomy 5% were working and 95% were non-working. Among patients undergoing hysterectomy 36% were working and 64% were non working (Refer to Table I).

Table I

Descriptive Characteristics of the Sample (n=100)

Variables	Mastectomy Cases		Hysterectomy Cases	
	Frequency	Percentage	Frequency	Percentage
Subject's Age				
30-39 (years)	15	30%	14	28%
40-49	14	28%	30	60%
50-59	16	32%	5	10%
60	5	10%	1	2%
Level of Education				
Illiterate	24	48%	32	64%
Grade 1-10	19	38%	8	16%
Grade 11-14	6	12%	10	20%

Grade 15-16	1	2%	0	
Occupation				
Working	5	5%	18	36%
Non-working	45	95%	32	64%
Marital Status				
Married	50	100%	50	100%
Duration of Marriage				
10-15 (years)	12	24%	7	14%
16-20	8	16%	12	24%
21-25	4	8%	14	28%
26-30-31-35	9	18%	15	30%
36-40	11	22%	1	2%
41-45	3	6%	1	2%
	3	6%		
Total Monthly Income				
1,000 – 1,499	1	2%	-	
1,500 – 6,499	36	72%	10	20%
6,500 – 11,499	5	10%	22	44%
11,500 – 16,499	2	4%	5	10%
16,500 – 21,499	4	8%	13	26%
21,500 – 26,499	1	2%	-	
26,500 – 31,49	1	2%	-	
No Of Children				
1 -2	10	20%	4	8%
3-4	15	30%	23	45%
5-6	18	36%	19	27%
6-7	6	12%	1	2%
9-10	1	2%	3	6%

Note: Percentage of each sub-classification is based upon the total number of subjects in each group:
mastectomy cases n = (50)
and hysterectomy cases (n=50)

Material

Depression Scale, Anxiety Check-List and Personal History Questionnaire were constructed. The Depression Scale whose rationale was derived from DSM IV (1994) & Beck Depression Inventory (1993), measured the severity of depression and consisted of 19 items. The Anxiety Check-List whose rationale was derived from DSM IV (1994) and Taylor Manifest Anxiety Scale (1951) consisted of 55 items.

Procedure

Official permission was sought to draw sample from the Surgery and Gynecology Departments of Jinnah Hospital, Lady Wellingdon Hospital, Hameed Latif Hospital and Mayo Hospital of Lahore, Pakistan. The mastectomy cases (n=50) were selected from the Surgery Department of Mayo Hospital, Jinnah Hospital and Hameed Latif Hospital, Lahore. The hysterectomy cases (n=50) were selected from the Gynecology Department of Lady Wellingdon Hospital, Lahore. The researcher selected only those patients whose age was between 30 to 60 years as incidence of this type of surgery is highest in this age range (Baum, 1995). Moreover the researcher selected only those patients who had been married for 10 or more years, with at least one child and were undergoing either procedure, mastectomy or hysterectomy for the first time.

After obtaining informed consent from the patients and assuring them of confidentiality, the researcher first administered the Personal History Questionnaire to collect demographic information from the patients. The Anxiety Check-List and Depression Scale were individually administered by the researcher to both the mastectomy and hysterectomy patients. Each patient was evaluated on the Depression Scale and Anxiety Check-List twice: during the pre-surgical phase (1-7 days prior to surgery) and post surgical phase (1-7 days after surgery).

RESULTS

Table II

Pre and post Anxiety Scores (mastectomy and hysterectomy) on the Anxiety Check List

Anxiety Scores	N	M	SD	SE	t
Pre-Surgical Scores	100	22.47	15.65	2.06	-2.17*
Post-Surgical Scores	100	26.95	13.39		

t=-2.17;df=98; *p<0.05

Note. M= Arithmetic Mean; SD= Standard Deviation, SE= Standard Error, Pre-Surgical Scores refer to subjects' scores on Depression Scale and Anxiety Check-List 1-7 days prior to surgery, Post-Surgical Scores refer to subjects' scores on Depression Scale and Anxiety Check-List 1-7 days after surgery.

Table III

Pre and post Depression Scores of hysterectomy patients on the Depression Scale

Depression Scores	N	M	SD	SE	t
Pre-Surgical Scores	50	10.44	4.31	0.80	-2.55*
Post Surgical Scores	50	12.48	3.71		

t= -2.55; df=48; *p<0.05

Table IV

Pre and post Anxiety Scores of hysterectomy patients on Anxiety Check List

Anxiety Scores	N	M	SD	SE	t
Pre-Surgical Scores	50	13.38	10.86	2.39	-5.74*
Post-Surgical Scores	50	27.10	13.00		

t= -5.7455; df=48; *p<0.05

Table V

Pre and post Anxiety Scores of mastectomy patients on Anxiety Check List

Anxiety Scores	N	M	SD	SE	t
Pre-Surgical Scores	50	31.56	14.43	2.83	1.68*
Post-Surgical Scores	50	26.8	13.90		

t = 1.68; df=48; *p<0.05

Table VI

Difference between Means of pre-post Depression Scores of patients (mastectomy and hysterectomy) on Depression Scale

Groups	N	M	SD	SE	t
Mastectomy Patients	50	1.36	6.03	1.10	3.10*
Hysterectomy Patients	50	-2.06	4.94		

t = 3.10; df=48; *p<0.05

Table VII

Difference of Means between pre-post Anxiety Scores of patients (mastectomy and hysterectomy) on Anxiety Check-List

Groups	N	M	SD	SE	t
Mastectomy Patients	50	3.60	15.72	2.63	6.58*
Hysterectomy Patients	50	-13.72	9.93		

t = 6.58; df=48; *p<0.05

Table VIII

Pre and Post Depression Scores of patients (mastectomy and hysterectomy) according to Age

Age Groups	Means of Pre-Surgical Depression Scores	Means of Post-Surgical Depression Scores
30-39	12.17	13.24
40-49	8.06	13.02
50-59	10.7	12.47
60-69	12	12.6

N=100

Table IX

Pre and Post Anxiety Scores of patients (mastectomy and hysterectomy) according to Age

Age Groups	Means of Pre-Surgical Depression Scores	Means of Post-Surgical Depression Scores
30-39	19.27	27.13
40-49	20.70	27.47
50-59	28.52	25.6
60-69	26.83	26.83

N=100

Table X

Pre and Post Depression Scores of patients (mastectomy and hysterectomy) according to Total Monthly Income

Total Monthly Income	Means of Pre-Surgical Depression Scores	Means of Post-Surgical Depression Scores
1,000-6,499	14.17	13.65
6,500-11,499	11.66	13.14
11,500-16,499	8.00	10.42
16,500 & above	10.68	11.00

N=100

Table XI

Pre and Post Anxiety Scores of patients (mastectomy and hysterectomy) according to Total Monthly Income

Total Monthly Income	Means of Pre-Surgical Anxiety Scores	Means of Post-Surgical Anxiety Scores
1,000-6,499	29.36	29.68
6,500-11,499	17.20	7.18
11,500-16,499	14.85	21.42
16,500 & above	15.10	21.89

N=100

Table XII

Correlation between Pre and Post Depression Scores of patients (mastectomy and hysterectomy) and emotional support (husband and family)

	Husband's Emotional Support	Family's Emotional Support
Pre-Surgical Depression	-0.261	-0.248**
Post-Surgical Depression	-0.051	0.051

** p<0.01

N=100

Table XIII

Correlation between Pre and Post Anxiety Scores of patients (mastectomy and hysterectomy) and emotional support (husband and family)

	Husband's Emotional Support	Family's Emotional Support
Pre-Surgical Anxiety	-0.436**	0.443**
Post-Surgical Anxiety	-0.020	-0.023

** p<0.01

N=100

DISCUSSION

The results (t=-2.17;df=98;*p<.05) as given in Table 2 indicate that there is a significant difference in anxiety of the subjects during the pre and post surgical phases. The post-surgical evaluation of anxiety of both groups (M=26.95) is higher as compared to the pre-surgical evaluation (M=22.47). According to Bard and Sutherland (as cited in Joiner and Fisher, 1981) expression of anxiety and tension are emotional reactions to surgery during the postoperative period. Baum (1995) states that over 30% of women develop

significant anxiety and depression following radical surgery. Peck (as cited in Joiner & Fisher, 1981) indicates anxiety as the most common patient response to surgery followed by depression. In case of breast cancer, as patients are unaware of the outcomes of the surgery and the threat or danger of recurrence is present, marked anxiety is a common psychological reaction.

Research findings also suggest significant difference in depression ($t=2.55$; $df=48$;$^*p<0.05$) of hysterectomy patients during the pre surgical and post surgical phases. Greater depression is manifested in the post surgical phase by patients undergoing hysterectomy ($M=12.48$) as compared to their pre-surgical phase ($M=10.44$) (See Table III). According to Lipowski (as cited in Lloyd, 1991) anatomical loss of body parts which have a symbolic significance are a crucial factor in determining emotional response. As the uterus is a highly valued body part, its loss carries physical and emotional repercussions and may result in intense psychological reactions. It can be observed that in Third World countries like Pakistan, great importance is attached to the capacity to bear children. Patients who have undergone hysterectomy have to come to terms with their incapacity to bear children, which can threaten their self-worth. Research conducted by Ohkawa et al (1992) and Roeske (1978) suggests that high levels of depression are observed before and after surgery.

Further analysis of the current research findings reveal no significant difference in pre and post surgical depression ($t=0.96$; $d=48$; $p>0.05$) in mastectomy patients. Greater depression is manifested in the pre-surgical phase by patients undergoing mastectomy ($M=14.56$) Research conducted by Umegaki et al (1993) also indicates that depression level in patients undergoing mastectomy is high pre-operatively. According to Baum (1995) the diagnosis of breast cancer is threatening on many levels, the most obvious of which is the fact that the patient's life is placed in jeopardy by the disease and that surgical intervention of the disease is disfiguring. The impending threat of loss of a major organ inherently essential to womanhood may lead to helplessness on the part of the patient which may lead to manifestation of depression. It can be argued that as individuals are victims of a serious disease it may promote feelings of helplessness and hopelessness. After surgery patients may feel that some measures have been taken to combat the debilitating disease due to which they may feel a certain degree of control. The belief that the surgeon or physician has now controlled the cancer may result in temporary alleviation of depression. Depression may decrease initially but as awareness of alteration in body-image is realized depression may increase.

Current research findings (t= -5.74; df=48;*p<0.05) also indicate significant difference in anxiety in hysterectomy patients during the pre surgical and post surgical phases. The current results indicate that pre-surgical anxiety (M=13.38) is low as compared to post surgical anxiety (M=27.10) (See Table IV). According to Wilson-Barnett (1992) medical procedures evoke anxiety and discomfort and many patients remain inadequately prepared to face this experience. This significant difference indicates that anxiety does not decrease post operatively and is a common reaction to the fear of the unknown. It may be argued that in a society like Pakistan women are viewed as "breeding machines" due to which loss of an organ vital to femininity, inability to fulfill the "role identity" demanded by the prevailing culture, incapacity to bear children and physiological changes accompanying the surgery might cause post-operative anxiety to increase.

Difference in pre and post surgical anxiety in mastectomy patients (t=1.68; df=48; p>0.05) was also found. Decrease in post surgical anxiety (M=26.80) is consistent with Lipowski's (as cited in Lloyd, 1991) view that when an illness is perceived as a threat the patient focuses on the anticipation of physical or psychological damage. Decrease in post surgical anxiety indicates decrease in anticipation and lessening of doubts and fear of the unknown. As surgery is perceived as a major, emotionally stressful experience, relief at having passed through the ordeal successfully might result in decrease in anxiety post-operatively.

Results (t=3.10;df=48;*p<0.05) indicate that a significant difference exists between mastectomy and hysterectomy patients on their evaluation of depression before and after surgery. Patients undergoing mastectomy (M=1.36) differ significantly in their pre and post surgical depression as compared to hysterectomy patients (M=-2.06) (See Table VI). The effect of mastectomy on the physical appearance is a major concern for patients. As compared to patients undergoing hysterectomy, the physical effects of mastectomy are clearly visible. The removal of the breast not only alters physical appearances but also deprives a woman of a basic way of relating to others and she must learn how to cope with not only herself but with reactions of others to her surgery (Harrel as cited in Joiner & Fisher, 1981). It is observed that in Pakistan the woman's role as a sexual partner is emphasized. Doubts about one's appearance and desirability as a sexual partner are factors that play an important role in development of depression. Physical disfigurement may have a profound impact on body-image, which can threaten self-esteem (Heatherton & Hebl, 1998). Women suffering

from breast cancer need strong emotional support, acceptance and understanding for they are dependent on others to boost their self-worth (Kapoor, Ahmad & Ahmad, 1987).

It is clear from the research findings (t=6.58; df=48;*p<.05) that a significant difference exists between mastectomy and hysterectomy patients on their pre and post surgical evaluation of anxiety. Current research findings indicates that the mean of anxiety in mastectomy patients (M=3.60) is higher than the mean of anxiety in patients undergoing hysterectomy (M= -13.72) (See Table VII). The diagnosis of breast cancer causes severe psychological repercussions. This is because of the sudden need for a mutilating breast operation and because of the threatening confrontation with a potentially lethal disease. Fear of recurrence of cancer and doubts about the success of the surgery may cause high anxiety in patients undergoing mastectomy.

Both pre (M=12.17) and post (M=13.24) depression scores are highest for the age bracket 30-39 and are observed to decrease with increasing age. According to Corney, Cowther, Everett, Howells and Shepherd (1993) there is a strong psychogenic element brought about by loss of fertility, disfigurement, depression and anxiety about one's desirability as a sexual partner and younger women are a very vulnerable group. The debilitating experience of surgery, which results in disturbances in body-image and the loss of the ability to bear children is more significant in earlier age. However, results show that anxiety is highest for the age bracket 50-59 (M=28.52) (Table VIII & IX).

It was noted that both pre and post depression and anxiety is highest for patients in the lowest income bracket. It may be argued that unavailability of financial support is an important factor which plays a part in increased symptomology (Table X & XI).

There was presence of a significant negative relationship between pre surgical depression and emotional support given by the husband (r=-.261) and the family (r=-.248) to the patient. Results also indicate the existence of a significant negative relationship between pre surgical anxiety and emotional support given to the patient by the husband (r=-.436) and family (r=.443) See Table XII & XIII). According to Jamison, Wellisch and Pasnau (1978) the effect of surgery on the female self-concept and role of social support in recovery are related. Low levels of support from family and spouse indicate poorer outcome.

The period before surgery appears to be of maximum stress for most women and counseling particularly before surgery may help to lessen apprehensions (Jamison, Wellisch & Pasnau, 1978). Due to lack of emphasis on psychotherapeutic interventions and rehabilitation programs many patients may overlook the psychological aspect associated with their surgery. Intolerance for psychological diseases may also inhibit females from expressing their true feelings. Counselling, rehabilitation and psychotherapy may help in relieving psychological stress felt by the family and depression and anxiety in the patient.

As compared to patients undergoing hysterectomy, the physical effects of mastectomy are clearly visible. The removal of the breast not only alters physical appearances but also deprives a woman of a basic way of relating to others and she must learn how to cope with not only herself but with reactions of others to her surgery (Harrell as cited in Joiner & Fisher, 1981).

According to Jamison, Wellisch and Pasnau (1978) the effect of surgery on the female self-concept and role of social support in recovery are related. Low levels of support from family and spouse indicate poorer outcome. Counselling of family members may help in effective coping with stress they may be undergoing due to the illness of the patient. Attention must be paid to the needs of the patients in terms of psychological and emotional support after surgery, which may result in decrease in depression and anxiety.

An equal comparison between mastectomy patients and patients with gynecological cancer over the same time span in recommended so that added complexity as a result of cancer diagnosis is controlled and does not become a confounding variable.

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DEVELOPMENT OF SOCIAL ANXIETY SCALE AND SOCIAL CONFIDENCE SCALE: A PRELIMINARY REPORT

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ABSTRACT

The present article is concerned about the development of Social Anxiety Scale (SAS) and Social Confidence Scale (SCS) in one attempt. Students' consensus and item-total correlations were the two criteria of selection of items. Upper 10 items of each scale were selected. Both the scales are internally consistent and temporally stable. They are convergently and discriminatingly valid also. Since psychometric ingredients are consistently high ($p<<.001$), the scales are recommended for confident use in personality research.

INTRODUCTION

Goffman's (1959) self-presentation theory suggests that people have instinctual tendency to present themselves to others but they all are not dispositionally alike in doing so. There are people who feel discomfort in presence of others, while others feel comfort. Those who get nervous in real or imagined social situation like wedding anniversary, birthday party, musical concert, celebration of one's promotion, departmental meetings, etc., are classified as socially anxious people. Such people feel themselves lonely in social gatherings, they find hard to meet people at parties, to talk to them, to argue their viewpoints with people who disagree, etc. As such, social anxiety may be defined as a feeling of discomfort in social interactions (Feningstein, Scheiver & Buss, 1975, Schiever & Carver 1985). It is concerned about how one is appearing to

others or how others are looking at him (Buss, 1980, Leary, 1980, Leary & Schelker, 1981). Socially confident people are opposite to socially anxious people. As such, social confidence, by definition, is a feeling of comfort in the midst of people. A socially confident person is one who enjoys social gatherings and is carefree of others' impressions.

The concept of social anxiety, as a personality trait, captured the attention of a good many researchers to the extent that they developed their own measures of social anxiety under different labels. For examples: Cheek & Buss's (1980) "Shyness Scale", Feningstein, Scheiver & Buss's (1975) "Self-Consciousness Scale", Hart Leary & Rajeski's (1989) "Social Physique Anxiety Scale", Jones & Briggs's (1986) "Social Reticence Scale", Leary's (1983a) "Social Anxiousness Scale", Leary's (1983b) "Brief Version of Fear of Negative Evaluation Scale", Leary & Meadow's (1991) "Blushing Propensity Scale" McCroskey's (1978) "Personal Report of Communication and Apprehension", Modiglian's (1968) "Embarrassability Scale", Watson & Friend's (1969) "Social Avoidance and Distress Scale", and many more.

Correlational researches have shown that socially anxious people lack assertiveness (Lawrence, 1970). They have problems in assertively behaving in various domains. (Arrindell, Sanderman, Hagerman, Pickersgill, Kwee Vander Molen & Lingsma (1990). Although they know to be assertive, they behave more submissively than their counterparts (Alden & Cappe, 1981; Alden & Safran, 1978; Arkowitz, Lichtenstein, McGovern, & Hines, 1975; Glassgow & Arkowitz 1975; Goldfried & Sobocinski, 1975: Schwartz & Gottman 1976; Sutton-Simon & Goldfried, 1979; Vitkus & Horowitz, 1987). Their submissive behavior is not due to their social skill deficit but, to them it is an easy way, to avoid disapproval of others. "Arkin (1981) coined the term protective self-presentation to describe a "safe" style where the individual is motivated to avoid social disapproval but remain engaged in (rather than avoid) social interaction, in contrast to acquisitive self-presentation where the individual is motivated to achieve social approval (and, we would add, improved status)" (Trower & Gilbert 1989, page 31). Socially anxious people are reported to become fearful, overly self-conscious and they have thinking difficulty (Beck, Emery, & Greenberg, 1985, Buss, 1986); they are shame sensitives (Harder, 1995); and they are self-monitoring (Buss, 1986); they are

Authors are thankful to Professor Mark R. Leary for his ready help with his scales and reprints

more prone to depression (Beck 1967); and they are more jealous (Bringle, Roach, Andler & Evenbeck, 1979). They attribute their failure to themselves (Arkin, Appleman & Burger, 1980); and they perceive themselves more lonely than their counterparts (Russell, Papalu & Curton, 1980). They also "avoid mutual gaze, have poor speech flow and in extreme cases, avoid social encounters altogether. For these and other reasons it has been argued elsewhere (Trower and Gilbert, 1989) that social anxiety represents both an acute awareness of potentially inferior status in comparison to others (and hence vulnerability to status losses and rejections) plus the involuntary activation of submissive strategies" (Trower, Sherling, Beech, Harrop and Gilbert, 1998, Page 157).

Social confidence concept has not been explored. It has simply been considered opposite to social anxiety.

DEVELOPMENT OF SCALES

The objective of the paper is to develop two scales: Social Anxiety Scale and Social Confidence Scale in one attempt.

Concept-generation

Some university students were personally contacted to cooperate with the researcher to conduct a piece of research in psychology. They were given the following instructions to this effect.

"You know/you should know that some of your class/university mates are shy, lonely and socially anxious students while others are bold, extravert and socially confident students. Please prepare a list of characteristics typical of them. Use two sheets of paper, one for socially anxious students, the other for socially confident students".

Fifty one students complied with the request. The characteristics supplied by them were improved and shortened, In this way, 18 characteristics were considered typical of socially anxious students, and 24 of socially confident students. (For clarity, characteristics are the manifestations of the concept and statements phrased on the characteristics are technically called items).

Item-selection

A list of 42 items (18 items for social anxiety scale and 24 items for social confidence scale) was received from the students. On classification items were found to be based on affective and behavioral components of social anxiety and social confidence. Two hundred fourteen university students (100 men and 114 women) were given the scales with instructions to separately tick the strong items which are most truly an index of the concept of social anxiety and those strong items that are most truly an index of the concept of social confidence. Items getting 50% and above 50% endorsements were considered to be the first criterion of the selection of items suitable for making a scale of social anxiety. In the same way, items getting 50% and above 50% of endorsements were considered to be the first criterion of the selection of the items for social confidence. In this way, 15 items and 17 items were initially selected for making up the scales of social anxiety and social confidence respectively.

An important point to be mentioned, here, is that the uniformity of the personality attributes of the data collector could not be maintained for the simple reason that the data were collected on several occasions for one phase or the other over a period of about five years.

Item scoring

Traditionally positively phrased items of a concept are scored on 5 to 1 point scale (i.e. Always (5) to Never (1)). The scoring of negatively phrased items is reversed (i.e. 1 to 5 point scale (Always (1) to Never (5)). The sum of scores on both the positively and negatively phrased items is taken to be an index of the concept under measurment.

Since we are interested in measuring social anxiety and social confidence in one attempt, responses to each and every item of social anxiety scale (item # 3,5,7,8,10,11,12,14,16,19) and social confidence scale (item # 1,2,4,6,9,13,15,17,18,20) were scored on 5 to 1 point (Always (5) to Never (1)). The scores were summed scalewise.

Item-analysis

The sum of scores both on individual item of a concept and total scale (of the same concept) was subjected to item-total correlations. Item-total correlations of social anxiety scale and social confidence scale ranged from .52 to .84 and .61 to .82 respectively. Upper 10 items of social anxiety and upper 10 items of social confidence were finally selected for making up social anxiety scale and social confidence scale. Randomly mixed 20 items appear in appendix.

RELIABILITY

The social anxiety and social confidence scales were found to be internally consistent .87 and .81 respectively in a mixed sample of 360 university students, and temporal stabilities of social anxiety scale and social confidence scale were found to be .79 and .83 respectively-in a mixed sample of 388 university students over a period of almost three-month gap. Average score made by a mixed sample of 1079 university men and women on Social Anxiety Scale was 35.3 and average score made by a mixed sample of 1345 university men and women was found to be 31 on Social Confidence Scale. These values may be regarded as normative data of Social Anxiety Scale and Social Confidence Scale respectively.

VALIDITY

In order to determine the validity of Social Anxiety Scale (SAS) and Social Confidence Scale (SCS) correlational studies were made between the scales under-evaluation and Blushing Propensity Scale (Leary & Meadows, 1991), Brief Version of Fear of Negative Evaluation Scale (Leary, 1983b), Extraversion (Eysenck 1958), Interaction Anxiousness Scale (IAS) (Leary, 1983a), Loneliness Scale (Russell, Pepalu & Cutrona, 1980), Opener Scale (Miller, Berg & Arthur 1983), Revised Public-Self-Consciousness Scale (Scheier & Carver, 1985), Revised Social Anxiety Scale (Scheier & Carver, 1985), Self-Monitoring Scale (Synder1987), Sociability Scale (Gordon, 1556) and Submissiveness Scale (Allen & Gilbert, 1997). t test was also used to test the significance of the product moment correlation coefficients.

In addition, four negatively phrased items of Leary's (1983a) IAS and four negatively phrased items of Leary's (1983b) Brief Version of Fear of

Negative Evaluation are assumed to have convergent relationship with SCS. The four items of Leary's (1983a) IAS are: (1) I am usually at ease when speaking to a member of the opposite sex, (2) I am probably less shy in social interactions than most people, (3) I seldom feel anxious in social situations, (4) I usually feel relaxed around other people, even people who are quite different from. The four items of Leary's (1983b) Brief Version of Fear of Negative Evaluation Scale are: (1) I am unconcerned even if I know people are forming an unfavorable impression of me, (2) I rarely worry about what kind of impression I am making on some one, (3) Other people's opinions of me do not bother me, (4) If I know someone is judging me, it has little effect on me. The 4 items of Leary's (1983a) IAS and 4 items of Leary's (1983b) Brief Version of Fear of Negative Evaluation Scale were separately given to university students alongwith the SCS with the instructions to respond each item on a 5 point scale (Aways (5) to Never (1)). The scores were totalled scale-wise and subjected to correlational analysis with a view to knowing the nature of relationship between the pairs of interest.

Table I

Correlations between Social Anxiety Scale (SAS) and other Measures of Social Anxiety

		df	r	t
SAS -	Interaction Anxiousness	127	.51	6.68
SAS -	Brief Versionn of Fear of Negative Evaluation	93	.57	6.69
SAS -	Blushing Propensity	98	.44	4.85
SAS -	Revised Social Anxiety	104	.55	6.71
SAS -	Revised Public Self Consciousness	104	.52	6.28
	Average	105.2	.51	6.20

All t values show that correlation coefficients are significant at $p << .001$. Average t value is also significant at $p << .001$.

Table I shows that product-moment correlations between SAS and other social anxiety scales namely Interaction Anxiousness Scale, Brief Version of Fear of Negative Evaluation Scale, Blushing Scale, Revised Social Anxiety Scale, and

Revised Public Self Consciousness Scale are positively significant (p≤.001). The average correlation (.51) at an average df (105.2) is also significant (p<.001).

Table II

Correlations between Social Anxiety Scale (SAS) and other Personality Scales

		df	r	t
SAS-	Loneliness	111	.47	5.60
SAS-	Submissiveness	114	.51	6.33
SAS-	Self Monitoring	97	.34	3.56
	Average	107.3	.44	5.08
SAS-	Extraversion	80	-.42	-4.14
SAS-	Opener	108	-.50	-6.00
SAS-	Sociability	110	-.43	-5.00
SAS-	SCS	110	-.52	-6.38
	Average	102	-.47	-5.38

All t values are significant at <<.001, except 3.56 which is significant at .001 and –4.14 which is significant at <.001. Both average t values are also significant at <<.001.

Table II shows that personality variables like loneliness, submissiveness, self monitoring are found to be positively associated (<.001). The average correlation coefficient (.44) at an average df (107.3) is also significant. All these correlation coefficients show that these social discomfort scales (table 1) and personality variables (table 2) are convergently associated with SAS. Table 2 also shows that other personality variables like extraversion, opener sociability and SCS are negatively related to SAS at .001 level of significance. The average correlation coefficient (-.47) at an average df (102) is also significant (p.001). Meaning-thereby that these negative correlation coefficients are an index of the discriminant validity of SAS. Like SAS, convergent validity of SCS was first assessed (Table 3).

Table III

Correlations Between Social Confidence Scale (SCS) and 1) four Negatively Worded Items of Leary's (1983a) IAS 2) four negatively worded items of Brief Version of Fear of Negative Evaluation (FNE), (Leary 1983b)

		df	r	t
SCS-	Four Negatively Worded Items of IAS	71	.57	5.85
SCS-	Four Negatively Worded Items of Brief FNE	97	.52	6.00
	Average	84	.54	5.90

All t values are significant at <<.001. Average t value is also significant at <<.001.

Table III shows that product moment correlations between SCS and four negatively phrased items of IAS and between SCS and four negatively' phrased item of Brief Version of FNE are positively significant (P<.001). The average correlation coefficient (.54) at an average df (84) is also positively significant. The reasonable positive relationships show the convergent validity of SCS.

Table IV

Correlations between Social Confidence Scale (SCS) and Personality Scales

		df	r	t
SCS-	Interaction Anxiousness	127	-.53	-7.04
SCS-	Brief FNE	93	-.48	-5.28
SCS-	Blushing Propensity	98	-.42	-4.58
SCS-	Revised Social Anxiety	104	-.47	-5.28
SCS-	Revised Public Self Consciousness	104	-.44	-4.99
SCS-	Loneliness	111	-.51	-7.26
SCS-	Submissiveness	114	-.34	-3.86
SCS-	Self Monitoring	97	-.42	-4.56
	Average	106	-.45	-5.18
SCS-	Extraversion	80	.41	4.02

SCS-	Opener	108	.47	5.53
SCS-	Sociability	110	.44	5.14
	Average	99.3	.44	4.88

All t values are significant at <<.001, except –3.86 which is significant at .001. Average t values are also significant at <<.001.

Table IV shows that personality scales like Interaction Anxiousness Scale, Brief Scale of Fear of Negative Evaluation, Blushing Scale, Revised Social Anxiety Scale, Revised Public Self-Consciousness Scale, Loneliness Scale, Submissiveness Scale, Self-monitoring Scale are negatively associated with SCS at and less than .001 level of significance. The average significant negative correlation coefficient (-.45)) at an average df (106) also shows the discriminant validity of SCS. The relationship of SCS with Extraversion Scale, Opener Scale and Sociability Scale is positively significant at and less than .001. The average significant positive correlation coefficient (.44) at an average df (99.3) is an added convergent validity of SCS.

"Validity is a process. Much is needed to be done in order to establish the validity of the scale (Razi and Khalique, 2001). As such, the present work is simply a preliminary report on the development of "Social Anxiety Scale" and "Social Confidence scale".

SAS and SCS have emerged up with 10 items in each. The responses to items are made on 5 to 1 point scale (Always 5 to Never 1). The sum of the scores is made scale-wise. Internal consistency, temporal stability, convergent validity and discriminant validity are high. Although the validity samples are not very large, consistently significant reasonable relationships (p<<.001) make us feel to recommend the scales for confident use in personality research. It depends upon the researcher either to use both the scales on a sample or to use one scale of interest.

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APPENDIX

Given below is a list of twenty statements. Read them and indicate whether you always, ften, sometimes, rarely or never feel and behave so. Mark a tick (✓) to show the frequency of your feeling and behaviour.

DO NOT LEAVE ANY STATEMENT UNTICKED

1.	I confidently talk to people at parties.	Always	Often	Sometimes	Rarely	Never
2.	I argue my point of view even with those who hold a different view.	Always	Often	Sometimes	Rarely	Never
3.	I am sensitive to others' impressions of me.	Always	Often	Sometimes	Rarely	Never
4.	I enjoy when I feel I have become the focus of attention of all others.	Always	Often	Sometimes	Rarely	Never
5.	I become upset when I feel guests are looking at me.	Always	Often	Sometimes	Rarely	Never
6.	I initiate people to talk and laugh in social evenings.	Always	Often	Sometimes	Rarely	Never
7.	I avoid to attend social gatherings.	Always	Often	Sometimes	Rarely	Never

8.	I get nervous while talking to people.	Always	Often	Sometimes	Rarely	Never
9.	I find myself lively in social functions.	Always	Often	Sometimes	Rarely	Never
10	I prefer to sit in a corner while others interact with each other.	Always	Often	Sometimes	Rarely	Never
11	I feel uneasy in social evenings.	Always	Often	Sometimes	Rarely	Never
12	I feel myself looking lost and lonely at parties.	Always	Often	Sometimes	Rarely	Never
13	I feel relaxed in social interactions.	Always	Often	Sometimes	Rarely	Never
14	I avoid to continue conversation with people not known to me.	Always	Often	Sometimes	Rarely	Never
15	I feel comfortable when I interact with people.	Always	Often	Sometimes	Rarely	Never
16	I find difficult to mix with people.	Always	Often	Sometimes	Rarely	Never
17	I do not bother about others' impressions of me.	Always	Often	Sometimes	Rarely	Never
18	I feel comfortable in social gatherings.	Always	Often	Sometimes	Rarely	Never
19	I am afraid of being evaluated by others.	Always	Often	Sometimes	Rarely	Never
20	I do not care of being evaluated by others.	Always	Often	Sometimes	Rarely	Never

Name:_____

Sex: _____ Class/Organization _____

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MACHAVELLIAN PERSONALITY TRAITS: A CROSS GROUP COMPARISON

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ABSTRACT

The present study was an exploratory attempt to measure Machavellian personality trait amongst various student groups. For the purpose of comparison scores of undergraduate students, studying Engineering, Business, Information Technology and Humanities subjects were taken into consideration. Results showed all students scoring in the middle of the scale, with Information Technology students scoring relatively higher. Findings are discussed in the light of cultural factors and current professional interests of the youth.

INTRODUCTION

Personality can be thought of the sum total of ways in which an individual reacts to and interacts with others. It is most often described in terms of measurable traits that a person exhibits. Among the factors that exert pressures on our personality formation are the culture in which we are raised, our early conditioning, the norms among our family, friends and social groups, and other influences that we experience. The environment we are exposed to plays a substantial role in shaping our personalities. For example, culture establishes the

norms, attitudes and values that are passed along from one generation to the next and create consistencies over time.

The early work in the structure of personality revolved around attempts to identify and label enduring characteristics that describe an individuals' behavior. Popular characteristics include shy, aggressive, submissive, lazy, ambitious, loyal and timid. These characteristics when are exhibited in large number of situations, are called personality traits (Buss, 1989).

The more consistent the characteristic and the more frequently it occurs in diverse situations, the more important that trait is in describing the individual. Efforts to isolate traits have been hindered because there are so many of them. Allport and Odbert (1936) identified 17,953 traits. It is virtually impossible to predicts behavior when such a large number of traits must be taken into account.

In recent years, an impressive body of research supports the notion that five basic personality dimensions underlie all others. – These are more typically called the Big Five. The five factor model of personality include traits such as Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experience. Research on the Big Five has found important relationships between these personality dimensions and job performance (Barrick and Mount, 1991, 1993). Hence, specific personality attributes could be powerful predictors of behaviors in organizations. Specific attributes that have been the focus of research include, locus of control, self-esteem, self-monitoring, propensity for risk taking, and type A personality. The personality characteristics of Machiavellian is named after Niccolo Machiavelli, who wrote in the sixteenth century on how to gain and use power (Robbins, 1998). An individual high in Machiavellian Pragmatic, maintains emotional distance and believes that ends can justify means.

Psychologists have developed a series of instruments called Mach Scales to measure a persons Machiavellian orientation (Christie and Geis, 1970). Research studies indicate that Machiavellianism is a personality trait that varies from person to person. (Geis and Moon,1981). An individual with a high Machiavellianism score tends to:

* Be rational.
* Be capable of lying to achieve personal goals.
* Be skilled at influencing others.
* Put little weight on loyalty and friendships.

* Not be easily swayed by opinions of others.

On the low end of the scale, individuals tend to be overly naïve and trusting. Some conditions allow people with high Mach scores to flourish. Particularly uncertainty that results from a restructuring, change in leadership, or any organizational crises provides settings that are ideal for those with Machiavellian personality traits because of their ability to manipulate others for their own advantage (Nahavandi and Malekadeh, 1997). The results of research using the Mach test have found: (1) men are generally more Machiavellian than women; (2) older adults tend to have lower Mach scores than younger adults (3) there is no significant difference between high Machs and low Machs on measures of intelligence or ability (4) Machiavellianism is not significantly related to demographic characteristics such as educational level or marital status and 5) high Machs tend to be in professions that emphasize the control and manipulation of people e.g. managers, lawyers, psychiatrists and behavioral scientists (Christie and Geis, 1970).

The present study is an attempt to explore Machiavellian trait amongst different student groups. Previous research conducted by Mclean and Jones (1992) on 206 undergraduates has shown that business students were significantly more Machiavellian than were science students but not more than arts students. Marketing students were the most Machiavellian of the business students studied.

METHOD

Sample

200 undergraduates studying in various educational institutions of Karachi comprised the sample for the present study. Their age ranged between 19-24 years.

Instrument

To assess Machiavellians traits, a simple 10 item self report measure was utilized (Geiss and Christie, 1970). An average score on this scale is about 25. A

person scoring much higher than this, say 38 would be classified as a HIGH MACH. Person scoring lower than 25, would be classified as a LOW MACH.

Procedure

Sample for the present study was drawn from N.E.D. University, Karachi University (Arts Faculty), Aptech Institute of Information Technology and Institute of Business Administration. For the purpose of data collection faculty members were contacted and depending on the availability of spare time, students were approached in class rooms. While students were assembled in class rooms, 50 students were randomly selected from each group. Within the Arts faculty of Karachi University more than one department was contacted till a sample of 50 students was reached.

Before filling in the Mach Scale, participants were informed that they would be participating in a research project which aims to study different personality patterns amongst students belonging to various professions. After giving informed consent, students were tested in a group setting. Upon completion of the questionnaire participants were thanked, for their cooperation. Mean scores of the four groups were utilized for making comparison with each other.

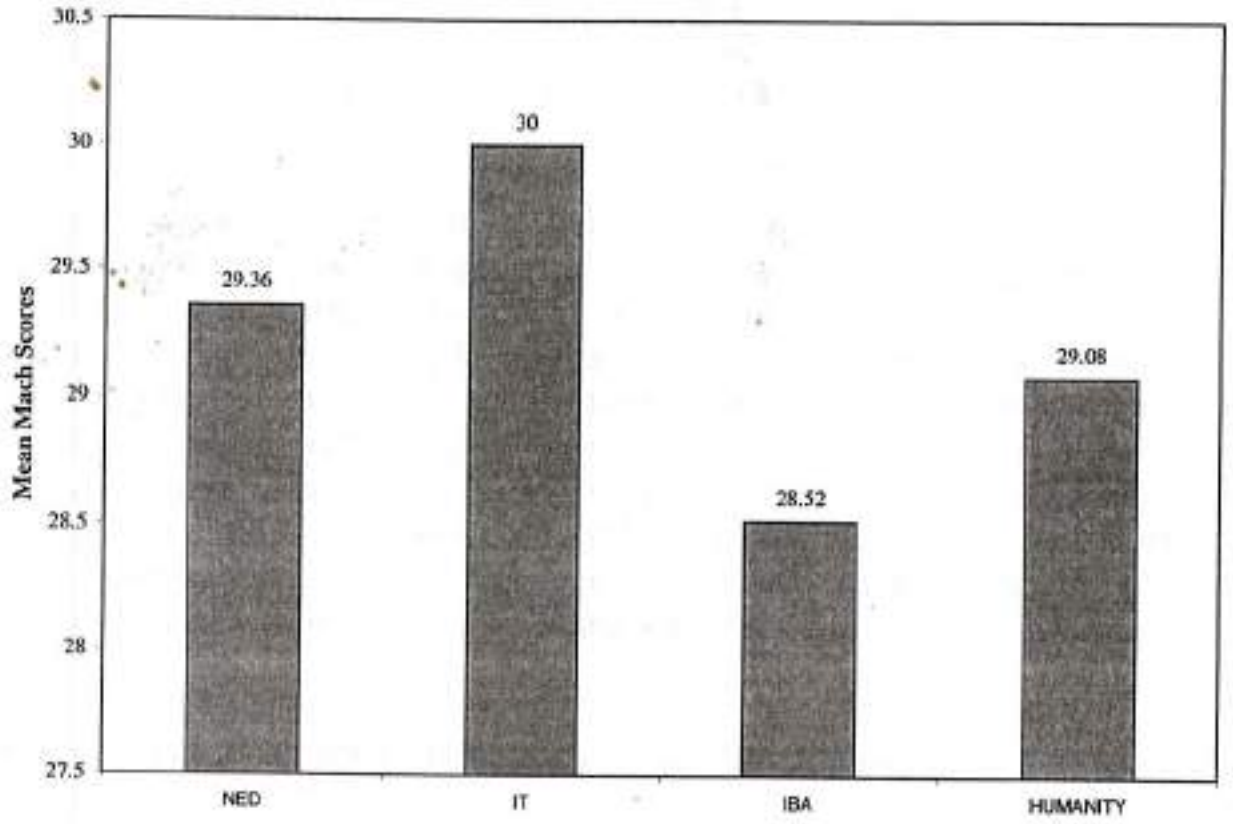
RESULTS

Table Showing Mean Mach Scores for Engineering, Information Technology, Business and Humanities Students

	N	Mean	SD	Std.Error of Mean
NED	50	29.3600	5.1300	.7255
IT	50	30.000	4.4147	.6243
IBA	50	28.5200	5.0355	.7121
HUMANITIES	50	29.0800	4.6723	.6608

Graph

Graph Showing Mean Mach Scores for N.E.D, Information Technology, Institute of Business Administration and Humanities Students



Group of Students

DISCUSSION

Personality characteristics are permanent and fundamental characteristics that show up in many situations. However, in personality psychology, the approach assumes more and more an interaction of personality and situation (Mischel, 1968) as cited in Antonides, and Van Raaiji, Fred 1998) Personality characteristics mainly show themselves in situations that fit the characteristic.

Organizational behavior research has focused on specific personality styles or traits that are considered to be important in understanding the complexities of individual differences. Six of these styles are relevant to managers i.e. locus of control, authoritarianism, Machiavellianism, self-esteem, Type-A, Type-B personality and problem solving styles (Carrell and Heavrin, 1997).

A considerable amount of research has been directed towards relating high and low-Mach personalities to certain behavioral outcomes. (Christie and Geis 1970, Romanaih, 1994). High Machs manipulate more, win more, are persuaded less, and persuade others more than do low Machs (Christie and Geis 1970).

Table shows that across various student groups, score mostly fall in the middle range of the Mach Scale, with information technology students scoring relatively higher than the other student groups (X = 30.00) These findings assume importance when viewed from the cultural perspective. Our culture and religion engenders humbleness and respect for the right of others, thereby letting go of one's welfare in the favour of other people. With such cultural and religious orientations, it may be difficult for a person not to give a socially acceptable response to items such as "There is no excuse for lying to someone else", "Most people forget more easily the death of their father than the loss of their property", and "It is hard to get ahead without cutting corners here and there".

However, in keeping with the modern trends some professions demand certain skills or personality traits like using social power to influence people and being able to persuade others. Probably, since Information Technology is a rapidly developing field in Pakistan and large number of students are opting for it, as a profession. To ensure success, people involved have to work sharply and competitively. They also require strong persuading powers to convince people about their product e.g. different soft wares developed by them, so students who possess such traits even in moderation are more likely to choose such professions as compared to a naïve, trusting and submissive individuals.

Several cultural differences affect Mach scores. For example, managers from the people's Republic of China score higher on the Mach Scale than their U.S. counterparts. It appears that the Chinese are more willing to use social power to accomplish their goals (Terpstra, et al. 1993). This finding is consistent

with China's high-power distance culture where authority is broad and respected (Nahavandi and Malekzadeh, 1999).

Some leaders with High Mach scores are tolerated and successful because they obtain results in the highly competitive, complex business environment (Dumaine,1993 as cited in Nahavandi and Malekzadeh, 1999).

An important question that the research on Machavellian Personality traits poses is do high Machs make good employees? That answer depends on the type of job and whether ethical implications are considered in evaluating performance. In jobs that require bargaining skills (such as labor negotiations) or that offer substantial rewards for winning (as in commissioned sales), high Machs will be successful (Robbins, 1998).

From the organizational behavior perspective assessing individual differences can help managers understand not only themselves but also others and can spur self-improvements which lead to greater productivity, special care has to be taken, however, not to label or to over generalize about their personalities, which are complex combinations of traits, values and attitudes.

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RELATIONSHIP OF MASCULINITY TO SELF ESTEEM SELF ACCEPTANCE AND DEPRESSION IN PAKISTANI FEMALES

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ABSTRACT

The purpose of present study was to determine the relationship of masculinity to self esteem, self acceptance and depression in females. After detailed literature review, it was assumed that females scoring high on masculinity would have high self esteem, self acceptance, and would have low depression score. In order to test various hypotheses, The PRF ANDRO Scale (Berzins, Welling and Wetter, 1977), Mehrabian Self Esteem Scale (Mehrabian, 1998), Self Acceptance Scale (Berger cited in Rathus&Nevid, 1992) and Mehrabian Depression Scale (Mehrabian, 1994), were administered to a sample of 40 professional and 40 non-professional females. Demographic information was explored through detailed interview and Personal data form. Pearson Product Móment Correlation indicates a significant positive relation between masculinity and self esteem, while insignificant relation of masculinity with depression and self acceptance. Regression analyses also indicate masculinity to be a significant predictor of self esteem and insignificant predictor of depression and self acceptance.

INTRODUCTION

Historically the acquisition of appropriate sex-typed behaviors and characteristics, resulting in a masculine identity in males and feminine identity in females, has been considered a prerequisite to mental health by theorists of Socialization processes (Bandura, 1969; Mischel, 1966). Differential behaviors and characteristics have been endorsed in the sex-typing processes, with the more instrumental competency- oriented masculine traits consistently viewed as more positive and more valued than the expressive relationship oriented feminine traits (Basoff & Glass, 1979; Taynor & Deaux, 1975). Masculinity and femininity are no longer viewed as mutually exclusive dimensions of a bipolar continuum, and the concept of psychological androgyny-the endorsing of the both traditionally masculine and feminine attributes- has recognized traditional perspectives on sex roles (Bem, 1974; Singer; 1976).

There was the growing significance of Bem's Androgyny model which suggests that Androgynous people are better adjusted (Bem, 1974, 1976, 1977), and reflect greater general adjustment and, mental health than their sex typed counterparts (Bem, 1974a, Gilbert, 1981, Spence, Helmreich and Stapp, 1975). Bem had challenged the previously existing congruency models, which reflect the importance of sex appropriate role as the pre requisite of mental health. Despite these changes in the traditional sex role ideology, sex roles remain a part of Western culture and although different in many ways probably is a part of every culture (William and Best, 1982). Some studies suggest that higher self esteem and more flexibility are more to masculinity than to femininity or a combination of two (Taylor and Hall, 1982). Researches have indicated that competency related masculine attributes correlated with the high self esteem and mental health in both men and women. It is their predictive significance which associates androgyny to mental health (Antill and Cunningham, 1980; Basoff & Glass, 1979; Thomas & Rezinkoff, 1984). Similarly Rosenkartz et al (1968), Broverman et al (1972), reported that compared with men, women have lower self esteem. The stereotype description of males is culturally more highly favored and valued. However in a study, a sex Rep suggested that women could see themselves as feminine and still be high on self esteem and health (Baldwin et al, 1986), but at the stereotype level the personality characteristics associated with the concept of masculinity may be more favorable or desirable for both men and women. Lamke, (1982) found masculinity and androgyny associated with popularity and high self esteem in both gender adolescence. Whitley (1983) found that the higher the people's masculinity score regardless of gender, the

higher their level of self esteem tended to be. Silvern and Ryan (1979) also reported that only female sex type consistently appears deficient in terms of self esteem. According to Shaw (1982), androgynous women rate stressful life events as less desirable than do feminine women. Pedhazar and Tetenbaum, (1979) found that masculine items on sex role inventories are more socially desirable than feminine items. Females with high abilities found male oriented tasks more attractive and performed better in such situations, both sexes preferred masculine tasks and viewed performance on them as better (Deaux & Emswiller 1974, Sorrentino & Short 1974).Bem (1974b, 1979, 1981, 1985), suggested that depending on a host of developmental factors, both men and women can incorporate various degrees of masculinity and femininity in their self definitions. These Self definitions, or social identity, include how we conceptualize ourselves including how we evaluate ourselves (Higgins 1996). This identity includes a unique aspect Self Concept, which possesses some specific content but overall structure of the self content is same for all individuals (Reutsch & Heffner, 1994).

The most pervasive social identity is related to gender. Once people acquire a specific pattern of gender relevant characteristics, they tend to behave in ways that are consistent with their assumptions about appropriateness (Chatterjee & McCarrey, 1991).

Researches stressed the importance of self esteem (the value of one's strength), as well as an important self concept counterpart of self esteem, i.e. the self acceptance (the valuing of one's self despite short comings) (Shostrom, 1974), as the correlates of masculinity (Long, 1986). According to Lau (1989), both men and women who endorse purely feminine role are lower in self esteem than either masculine or androgynous individuals. In an interpersonal situation, high femininity is associated with feeling depressed after failing at an interpersonal task (Sayers, Baucom & Tierney, 1993).

Allport (1961) used the term self acceptance as in the meanings of emotional security i.e., A person should feel enough confidence in himself to tolerate frustrating events and his own shortcomings without becoming inwardly bitter or outwardly hostile. Threatening emotional impulses must be accepted but should be held in check by a sense of moderation lest they produce serious depression or impulsive attack on others.

Gough (1956) describe high scorers on self acceptance as intelligent, outspoken, cool, versatile, witty, aggressive, self centered and have more confidence. While low are methodical, conservative, dependable, conventional, easy going, quiet, self abasing, passive in action and narrow in interest.

Long (1986), found masculinity as best predictor of self esteem in professionals, college students, clients and victims of domestic violence, and of self acceptance in all groups except professionals. Bem (1975) also characterized masculine role by assertiveness, ambitious and so on and feminine role as warm, tender, gentle etc. Many studies have revealed that gender related personality traits (Instrumentality and expressiveness) have a strong relation to Psychological health (Nezu & Peterson 1986; Roos & Cohen, 1987; Sharpe & Heppner, 1991; Spence, 1991; Whitley, 1984). Instrumentality according to Spence (1991) has been associated with masculinity and constitutes autonomy, dominance and assertiveness, while expressiveness as a label for femininity, reflecting empathy, nurturance and Interpersonal sensitivity. Brems and Johnson (1989); Brooks, Morgan and Scherer (1990), Burnett, Anderson and Heppner (1995); Nezu and Nezu (1987); Nezu et al (1986) found instrumentality having consistent relationship with Psychological adjustment. Brooks et al (1990);Burnett et al (1995); Ross and Cohen (1987), found high instrumental people as less depressive, anxious, lonely or worried and have higher self esteem and better adjustment. Present study was conducted in order to investigate relationship of masculinity with self esteem, self acceptance and depression in Pakistani females.

The following hypotheses were framed:

1. Women having high masculinity scores will have high self esteem scores.

2. Women having high masculinity scores will have high self acceptance scores.

3. Women having high masculinity scores will have low depression scores.

METHOD

Sample

Sample for the study was 80 females, including professional females (n=40) and non professional females (n=40), married and single equal in number from different localities of Karachi. Their age range was 20 years up to 35 years. Their minimum level of education was graduation.

Material

A Personal data form was filled by the sample, which included the information regarding marital status, educational level, occupational status ,birth order ,family structure and age.

Masculinity and femininity level was measured through PRF ANDRO Scale (Berzins, Whitley and Wetter,1977).Self esteem and Self acceptance were measured by using the Mehrabian Self Esteem Scale (Mehrabian,1998) and Self Acceptance Scale (Berger). Mehrabian Depression Scale (Mehrabian, 1994) was administered for measurement of Depression.

Procedure

Sample was initially screened out by a detailed interview. After interview procedure, respondents were required to fill in the Personal data form and to respond on PRF ANDRO Scale. After break of 05 minutes, scales for measuring self esteem, self acceptance and depression were administered. Pearson Product Correlation and Regression was applied to interpret the data in statistical terminology.

RESULTS

Table I

Means and Standard deviations of various variables
N= 80

Variables	Mean	Standard deviations
Age	26.9125	5.1168
Masculinity	15.6125	4.0079
Femininity	19.1125	2.5999
Self esteem	15.2000	9.9408
Self acceptance	123.7750	18.1812
Depression	-36.0750	22.1461

Table II

Pearson correlation of masculinity and femininity with self esteem, self acceptance and depression

N= 80	Self esteem	Self acceptance	Depression
Masculinity			
Pearson correlation	.324**	.205	-0.168
Sig. (2 tailed)	.003	.068	.137
Femininity			
Pearson correlation	-.050	-.264*	-.013
Sig. (2 tailed)	.657	.018	.906

Table III

Partial Correlation controlling the effects of age, employment status, marital status, family structure, monthly income and birth order

N= 80, df=72	Self Esteem	Self Acceptance	Depression
Masculinity	0.3030	0.2011	-0.1585
Sig.(2 tailed)	0.009	0.086	0.177
Femininity	-0.0906	-0.2839	-0.0090
Sig.(2 tailed)	0.443	0.014	0.940

Table IV

Model summary of Regression analysis of self esteem, self acceptance and depression

	R	R^2	Adjusted R
Predictor: Masculinity			
***self esteem**	0.324	0.105	0.094
***self acceptance**	0.205	0.042	0.030
***depression**	0.168	0.028	0.016
Predictor: Femininity			
***self esteem**	0.050	0.003	-0.010
***self acceptance**	0.264	0.070	0.058
***depression**	0.013	0.000	-0.013

Table V

Analysis of variance with masculinity, (constant) as a predictor

variables		Ss	df	ms	F	Level of Significance
Self esteem	**Regression** **Residual** **Regression**	821.796 6985.004 7806.800	1 78 79	821.796 89.551	9.177	.003
Self acceptance	**Residual** **Total** **Total**	1095.440 25018.510 26113.950	1 78 79	1095.440 320.750	3.415	.068
Depression	**Residual** **Total** **Total**	1092.284 37653.266 38745.550	1 78 79	1092.284 482.734	2.263	.137

Table VI

Analysis of variance with femininity ,(constant) as a predictor

Variables		Ss	df	ms	F	Level of Significance
Self esteem	**Regression** **Residual** **Regression**	19.790 7787.010 7806.800	1 78 79	19.790 99.833	.198	.657
Self acceptance	**Residual** **Total** **Total**	7.043 38738.507 38745.550	1 78 79	7.043 496.648	.014	.906
Depression	**Residual** **Total** **Total**	1816.851 24297.099 26113.950	1 78 79	1816.857 311.501	5.833	.018

DISCUSSION

It is clear from table II that significant positive correlations was found between masculinity and self esteem (r= 0.324**, df = 78, P<0.05), whereas presence of negative correlation between masculinity and depression(r= -0.168, df = 78, P>0.05), is indicated. No significant correlation was found between Masculinity and self acceptance(r= 0.205, df = 78, P>0.05), Femininity and self esteem(r= -0.050, df = 78, P>0.05), femininity and Depression (-0.013, df = 78, P>0.05), and negative correlation between femininity and self acceptance(r-0.264*, df = 78, P<0.05) was also found. Same trend emerge while controlling Age, Marital status, Family structure, Birth order, Employment status, and Monthly income of the family when regression analysis was applied.

Table IV,V,and VI presents the summary of regression analysis which shows masculinity to be a significant predictor of self esteem(F=9.177,df=1,78, P< 0.05) ,while insignificant predictor of self acceptance(F=3.415,df=1,78, P> 0.05) and depression (F =2.263, df = 1,78, P>.05). Further femininity appears to be insignificant in predicting self esteem (F=0.198,df=1,78, P> 0.05) and self acceptance(F=0.014,df=1,78, P> 0.05), but significant predictor of depression(F=5.833, df=1,78 , P<0.05).

Findings seem consistent with the assumption regarding relationship of masculinity to one of the aspect of mental health i.e. self esteem. Masculinity appears to be a significant predictor of self esteem, how ever insignificant as a predictor of self acceptance and depression. These findings only partially confirm findings of Long (1986), which suggest masculinity as a strong predictor for both self esteem and self acceptance. As cited earlier self esteem is the "value of one's strength "and self acceptance is the "valuing one's self despite short comings." For people, sex role identity is an essentially important for their self concept, on which they often evaluate themselves.According to Kagan (as cited in London and Rosenhan, 1968), sex role identity is not completely conscious, however meeting the culture's sex role standard does not guarantee the integrity of one's sex role identity. A woman who acts masculine in terms of these standards does not necessarily feel that she is highly masculine. Possession of some sex typed traits in other words is necessary but not sufficient for a firm sex role identity, there fore having their perceived "short comings" in mind a woman might have schemas related to their feminine characteristics and therefore lacks harmony to their sex typed behavior, thus unable to develop any significant relation of their masculine attributes to self acceptance.

Entire of our sample of professional women and non professional women was highly educated. Long's findings for professionals were also similar to present findings. It appears that highly educated Pakistani women tend to adapt a masculine role, not harmonious to their ideal self, only for the purpose to meet the sex role standards of the culture, related to work and high education. Babladelis et al (1983) found that those with more education tend to be more androgynous where as those with lower education tend more to give stereotyped responses. It might be their requirement to cope with standards of society and culture that they adapt both sort of sex type responses and thus appeared as an androgynous person.

Previous researches do indicate that gender role stereotypes of women may bear closer similarity to depression than stereotypes of men. People typically give description of healthy adults in terms of such traits as assertiveness, competence and rationality (Rothbaum, 1983) conversely, healthy women are described as warm, emotionally expressive, dependant and demure. These expectations render the woman who conforms to these traditional gender role stereotypes closer in behavioral terms to a depressive pattern. But our analyses suggest that relationship of depression to gender related attribute (correlation with masculinity=-0.168, df=78 p>.05) though consistent to the anticipated direction, how ever, is not significant. Neither masculinity nor femininity was found significant as a predictor of depression, maybe because scores of depression deviated largely. Another possible reason is some stress or social support which may have played its part as an extraneous variable, for example due to cultural limitations, all of Pakistani educated females are unable to express their masculine role overtly or even covertly. If they enter labor force, they are not allowed to cross the boundaries laid by Muslim society. In Pakistani culture, society laid the stress on females to confirm stereotype sex role behaviors. When a female, adopt masculine gender role, she starts to face negative feedbacks from her environment, she at least might feel isolated from others who possess harmonious gender role identity.

Another area might be social-support which can play important role in determining the insignificant relation of gender role identity in depression. In Pakistan "time is not considered as money". Majority of women are housewives who have enough time to give support and be supported by others. Females usually get their catharsis through close by neighbors; member of joint family or reliable work colleagues, which help them to relieve their tension. Traditional feminine role in our society might be more vulnerable to get support from

significant others in the environment. While a masculine personality might perceive by others as "self sufficient" 'resulting in deprivation from necessary sympathy and support from their family members, yet work environment to some extent do the need full but they have to face the negative consequence of adapting masculine role particularly, their independence.

Hence one can say that masculinity in females is not the only variable contributing in lowering their depression. Other variables also play important role in determining positive, negative or no relation between masculinity and depression as Bernard (1972) found marital status as a contributing factor to mental health and White (1979) noted that growing age minimizes the differentiation of sex roles. Several factors in our study as age, marital status, family income, employment status, family structure, and birth order had been controlled while computing the relationship between the variables. All of these variables do not seem to play any significant role in resulting relationships. Future research may search for other significant factors influencing the mental state in females.

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A STUDY OF PERCEIVED PARENTAL ACCEPTANCE REJECTION IN MALE AND FEMALE ADOLESCENTS

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ABSTRACT

The study was designed to examine the differences of perceived Parental Acceptance-Rejection between Male and Female Adolescents. Abbreviated Maternal and Paternal Acceptance-Rejection Questionnaire (PARQ, Ahmed & Gielen, 1987) was administered to 100 Male and 100 Female adolescents. t test was applied to find out the differences between the two groups. The mean differences indicates that Male Adolescents perceived both their Parents especially Fathers to be significantly more Aggressive, more Neglecting, more Rejecting as compared to the female adolescents. The findings of this research are consistent with universalistic postulates of Parental Acceptance and Rejection theory developed by Rohner (1975).

INTRODUCTION

Parental Acceptance-Rejection theory (PART) introduced by Rohner (1975), predicts that rejected children world over tend more than accepted children to be hostile and aggressive; to be emotionally unstable; to be emotionally unresponsive; and to have negative world view. The theory explains major consequences of parental acceptance-rejection for behavioral, cognitive and emotional development of children and for personality functioning of adults. The theory assumes that all human beings have a generalized need for positive response, i.e. love, approval, warmth, and affection, from people significant to

them. Studies of parent-child relationship demonstrate that the specific methods of discipline are not as important as is the need for the total configuration of family environment and interpersonal interaction. Sullivan (1953) claimed that psychological problems stem from interpersonal relationships, in particular, the parent-child relationship. Children of rejecting parents develop severe anxiety. As they grow up, they feel threatened in almost any close relationship. Consequently, they respond to other people either by rigid, self-protecting behavior (neurosis) or by withdrawing completely from the social situations (psychosis). Sullivan pointed out that as children each of us develops a "self system" which is a dynamism we learn through appraisal of others, to avoid threats to our security.

Horney (1945) believed that "neuroses" are an expression of disturbance in human relationship resulted from bad parenting, whether punitive or overindulgent, negligent or overprotected. The parent-child relationship is determined by several factors including the marital relationship of parents. Harmonious relations between parents are essential for the stable and well-integrated personality of the child! Any disturbance, damage or break in this relationship will have detrimental effects on the growing child. There may be different factors contributing to family disorganization, e.g. death, divorce, desertion, or remarriage of parents. A child's experience in the family is greatly influenced by family structure, i.e. whether the child lives in a nuclear or extended family, with two parents or just one; both natural parents or one is a stepparent. Children growing up in one-parent homes, whether due to divorce or death of parent, have to cope up with numerous stresses. The bulk of research evidence to demonstrate that children grow up better adjusted when they grow up in two parent home characterized by love and free of discontent and that an inaccessible, rejecting, or hostile parent is more damaging than an absent one (Hetherington & Parke, 1986).

The Acceptance Rejection project is the cross cultural survey component which utilized a sample of 101 societies from around the world to explore the implications of parental acceptance and rejection for (1) aspects of personality development (2) adult personality characteristic, and (3) institutionalized expressive system including religious beliefs, certain medical beliefs, art forms, folklore and mythology mainly non-utilitarian features of a social system that can be viewed as being expressive of personality.

It is important to recognize that parental acceptance and rejection deal only with warmth and affection, and the various ways warmth and affection can be shown to or withdrawn from children such as in the form of aggression, hostility or neglect or indifference. Other dimension of parental behavior such as permissiveness (autonomy) and restrictiveness (control) must not be confused with acceptance rejection. The rejected child is the one who is anxious, hostile, insecure and emotionally unstable and who devalues his feelings of self worth and self adequacy, is likely to generalize these feelings onto the nature of the world as being an unfriendly, hostile person! Any child who has experienced so much psychological hurt at the hands of people who are most important to him comes to expect very little more from life itself. The very nature of life for him is threatening, dangerous, and an unhappy experience. That is, the child is likely to develop a negative world view.

Adults who were rejected as children tend to have strong needs for affection, but they are unable to return it because they have become more or less emotionally insulated or unresponsive to potentially close interpersonal relation. Adults who were unloved as children are also inclined to have less tolerance for stress and for this reason they are less emotionally stable than adults who were accepted children. These adults when become parents are likely to reject their own children. In this way the rejection cycle is perpetuated and also the personality syndrome just described.

Do parents prefer the boy or the girl? This is not an easy question to answer because of the different value concept about the off-spring of each sex in diverse cultures. However, there have been some attempts to study children's perception of sex-preferences by the parents.

One view which seems to have had wide controversy in explaining sex-preferences of both terms of Oedipus complex and cross-sex preference, however, the cross-sex preference diminishes after age of four or five. The little boy makes pace with his father and adjusts by identifying himself with him. This identification is sort of assimilation.

Parental preferences are culturally determined through the process of socialization in which specific individual experiences, socio-cultural influence, attitude-value configuration and many idiosyncratic factors play significant roles. The perception of parental preference may also develop on their own life experiences or their interpretation of them. Experiences of only children or the

treatment of oneself or one's sibling by either parent or indirect verbal or non-verbal expressions of parental preferences may determine the child's perception of the value of his own sex in the eyes of either parent.

Sex-role identification and cultural prescription of sex-roles and behaviors are initially defined by each culture. Every culture prescribes sex-roles in terms of the premium placed on the sex of the off-spring in which its turn is determined by the nature of its social structure, laws of inheritance and property distribution and the pattern of family constellation. These variables presumably affect parental preferences for the sex of the off-spring. These variables point out to the inevitable assumption that there may be cross-cultural variations in parental preference for sex of the off-spring. Cultures are known to differ in their preference for the male child so much so that entire cultures are sometimes designated as male-dominated.

Rohner's theory thus underscores an assumption that all human beings, at all ages, appear to possess a generalized need for a positive response from people who are "significant" or closest to them. A denial of any or all such need or any uncalled for description of the channels of expressions of these gestures would lead to negative consequences on the overall and healthy personality development. This, in turn, would result in a variety of mild to severe maladaptive behaviors. Furthermore, if their parents reject children they are likely to express themselves unworthy of love and affection of others. Such rejection leads to, among other things, emotional instability and negative self-esteem which inhibit warm and intimate relationships with others, such emotional handicaps aggravate the rejected individual's negative perspective of life, and he/she becomes hostile and insecure and devalues his/her image of self worth.

Research and clinical experience in technologically advanced societies, especially U.S.A. and Western Europe, add support to the afore-mentioned deleterious effects of parental rejection. Rejection has therefore, been implicated in a variety of behavioral and psychiatric disorders including neuroses, some forms of psychoses, academic problem, personality and conduct disorders. The list of disorders is long and it is strongly suspected that parental rejection can be attributed in one way or other, to almost any psychogenic disorder. To be more specific parental acceptance – rejection theory (PART) predicts that rejected children are more likely to be hostile, aggressive, passive-aggressive or to have problems with the management of hostility and aggressive, and to a negative

world view. All or part of these expectations have been confirmed repeatedly in a world-wide hollow cultural study of 101 societies (Rohner, 1975), in the U.S.A. (Rohner and Nielson, 1978; Rohner, 1986) among Korean-American (Hahn, 1978), and also among Pakistani children (Haque, 1987).

In a country like Pakistan with its male-dominated social life, and with majority of women, confined to the chores of the household and separate from male company(except that the husband or brother and father) there is likely to be an emphasis on parental preferences for the male child. Even mother may prefer a male child to a female one since parents particularly mothers consider boys as their insurance for old age. In industrial societies like U.S. the basis of parental preference may be different, since children after adolescence do not remain with them. But in Pakistani society the adolescents mostly remain with their parents and the parental preferences about their children affect the perception of adolescents about the parents. The aim of resent study was to find out the gender difference in perception of parental acceptance-rejection among adolescents.

Before conducting the present research, the following hypotheses were formulated:

1. Male adolescents will perceive their mothers as more affectionate than female adolescents.
2. Male adolescents will perceive their mothers as more hostile than female adolescents.
3. Female adolescents will perceive their mothers as more neglecting than male adolescents.
4. Female adolescents will perceive their mothers as more rejecting than male adolescents.
5. Female adolescents will perceive their fathers as more affectionate than male adolescents.
6. Male adolescents will perceive their fathers as more hostile than female adolescents.
7. Male adolescents will perceive their fathers as more neglecting than female adolescents.
8. Male adolescents will perceive their fathers as more rejecting than female adolescents.

METHOD

Sample

The sample comprised of 100 male and 100 female adolescents. Their age range was from 14 to 17 years, and they belonged to different schools of Karachi.

Instruments

The instruments used in this study was Urdu version using back translation techinque, (Haque, 1981) of the abbreviated Maternal and Paternal Acceptance-Rejection questionnaire (PARQ) (Ahmed & Gielen, 1987). (The split-half reliability of Maternal and Paternal PARQ were found. Mother PARQ=0.85, Father PARQ=0.82). Mother and Father PARQ measures the way adolescents from 14-17 years of age perceived their mothers' and fathers' treatment to themselves during childhood years. All the four scales of adolescent PARQ (mother and father), totaling 60 items each were used in this study (Appendix A& B). The PARQ consist of four subscales which measure parental warmth/affection (20 items); parental hostility/aggression (15 items); parental neglect/indifference (15 items); and parental rejection (10 items). The self-report questionnaire items were scored on a 4 point Likert-like scale i.e. "Almost Always True" was assigned a score of 4, and "Almost Never True" was assigned a score of 1. In order to avoid response set bias, some of the items are keyed in the opposite direction and they were scored reversely.

Procedure

Before carrying out the study in the schools, a written permission for data collection was taken from the Principals of the schools. The rapport was established with the students and the confidentiality of their responses was ensured. A verbal explanation was given pertaining to the test and cooperation was sought from them.

Statistics

To compare the results of Male and Female Adolescents in terms of their perceptions of their fathers' and mothers' Acceptance-Rejection behavior, t test was applied.

Operational Definitions of Various Variables

Parental Acceptance which refers to "the warmth, and love parents can give to their children". It has two principal expressions, physical and verbal. Warmth and affection include praising, complimenting, saying nice thing to or about a child.

Rejection is defined as "the absence or significant withdrawal of warmth, affection or love by parents toward children". It takes three major forms (Rohner, 1975): (1) hostility and aggression, (2) indifference and neglect, (3) undifferentiated rejection.

Hostility may be defined as "feelings of anger, resentment, enmity, and ill will or malice towards the child". Aggression refers to behaviors that have as their intention the physical or psychological hurt of another person, of oneself, or (symbolically) of an object. Aggression may be physical and verbal. Physical aggression includes hitting, biting, pushing, shaking, pinching, scratching, scalding and the like. Verbal aggression, on the other hand, includes sarcasm, belittling, cursing etc.

Indifference and neglect may be defined as "physical and psychological unavailability of parents and paying no attention to needs of child".

Undifferentiated rejection is the feeling of being unloved, unwanted or rejected without necessarily having of the above positive indicators of rejection present e.g. when the child says "I can't show you that my parents were mad at me. I can't say they neglected me" said on articulate child in a recent research project. "They tried, I guess, but they just didn't like me".

RESULTS

Table I

Perceived warmth in mothers by male and female adolescents

Variable	Sex	M	SD	df	t	Level of significance
Warmth	Male	26.12	6.71	198	3.76	p<.001
	Female	22.12	6.16			

Table II

Perceived hostility in mothers by male and female adolescents

Variable	Sex	M	SD	df	T	Level of significance
Hostility	Male	32.08	10.66	198	3.28	p<.05
	Female	24.32	6.16			

Table III

Perceived neglect in mothers by male and female adolescents

Variable	Sex	M	SD	df	t	Level of significance
Neglect	Male	13.12	10.97	198	1.90	p>.05
	Female	20.24	6.57			

Table IV

Perceived rejection in mothers by male and female adolescents

Variable	Sex	M	SD	df	T	Level of significance
Rejection	Male	11.12	10.88	198	1.79	p>.05
	Female	21.00	6.98			

Table V

Perceived warmth in fathers by male and female adolescents

Variable	Sex	M	SD	df	t	Level of significance
Warmth	Female	28.36	10.09	198	2.84	p<.05
	Male	24.18	8.39			

Table VI

Perceived hostility in fathers by male and female adolescents

Variable	Sex	M	SD	df	t	Level of significance
Hostility	Male	36.12	12.36	198	6.01	p<.001
	Female	26.40	10.10			

Table VII

Perceived neglect in fathers by male and female adolescents

Variable	Sex	M	SD	df	t	Level of significance
Neglect	Male	27.10	12,15	198	2.38	p<.05
	Female	22.54	8.62			

Table VIII

Perceived rejection in fathers by male and female adolescents

Variable	Sex	M	SD	df	T	Level of significance
Rejection	Male	29.16	12.20	198	2.55	p<.05
	Female	24.26	8.74			

DISCUSSION

The statistical analysis in the Table I reveals that male adolescents perceive significantly more warmth/affection in their mothers as compared to female adolescents, (t=3.76, df=198, p<.001). These results, confirmed the hypothesis No. 1. These results may be due to the fact that in a country like Pakistan with its male dominated social life, there is likely to be an emphasis on parental preference especially the mothers, for the male child. In most of the Pakistani families, it has been observed that in daily routines of life more warmth and affection is given to boys as compared to girls, not only by parents but also by grand-parents as the male child is considered to be the future bread earner and a supporter in their old age. Hence male adolescents receive more warmth and affection from parents than female adolescents.

The statistical analysis in the Table II reveals that male adolescents perceived significantly more hostility/aggression in their mothers as compared to female adolescents. ($t=3.28$, $df=198$, $p<.05$). When one talks of Pakistani culture, generally it has been observed that during the formative years of children parents start socializing and disciplining their children. They try to shape their children's behavior into mature, responsible, productive and functioning members of the society (Khan, 1999). In this connection greater emphasis usually is given to disciplining the boys as compared to girls thinking that the boys will have to share their father's responsibilities and on the other hand girls will have to go to their husbands' homes so the parents are a little bit lenient to them. (though the trend is changing, but the pace is quite slow). When the female child does something wrong, the parents try to convince her logically, giving reasons to which they mostly comply and submit even after having hot argument with the parents, whereas in case of boys very rarely this is the case, mostly if they have any argument with the parents, they express their resentment, it is not easy for them to bow before the parent's will.

In Pakistan, child rearing practices and discipline involve little positive reinforcement and lay greater emphasis on the child not being bad or naughty rather than being good (Zaman, 1988). May be due to these reasons the male children/boys perceive significantly more hostility in their mothers.

The hypothesis 3rd that female adolescents will perceived their mothers as more neglecting than male adolescents was not proved, as indicated in Table III ($t=1.90$ $df=198$ $P>.05$) that there is insignificant difference between female and male perception of mother's neglect and indifference. The reason for this may by that due to increase in literacy rate the trend in child raring practices is also changing. Now the mothers are gradually becoming more aware of psychological impact upon girls due to discrimination between boys and girls. The change in mother's attitude towards their daughters might be an attributional for insignificant results.

The hypothesis 4th states that "female adolescents will perceive their mothers as more rejecting than male adolescents". In this case too the results are insignificant table IV ($t=1.79$ df 198 $P>.05$).

Although various studies of child rearing practices in the past revealed that most of the parents rear female children differently than that of male children (Ahmad 1988). They curb the open expression of hostility and aggression in case

of female child and encourage her to be submissive, thinking that she will have to go to a different environment when she gets married. So she should be more tolerant but as mentioned earlier with the changing trend in society there is also a change in ways parents up-bring and train their children. That can be one of the reasons why both male and female perceive their mothers as neglecting in alike manner.

The statistical results in Table V show that female adolescents perceived significantly more warmth and affection in their fathers than male adolescents($t=2.84$, $df=198$, $p<.05$).This is in congruence with psychoanalytic theory, which states that the girls are more attached/closer to their fathers than mothers. In Pakistani society it has generally been observed that fathers have more warm and loving attitude towards their daughters as compared to boys. The daughters are also attached and caring towards their fathers. Love begets love, hostility, breeds hostility. The fathers' caring behavior towards their daughters is perceived as warm and affectionate towards them.

The results in Table VI show that male adolescents perceived more hostility and aggression in their fathers as compared to female adolescents ($t=6.01$, $df= 198$, $p<.001$). Males perceived their fathers to be more hostile and aggressive towards them as compared to females. These results may be due to the fact that parents especially fathers consider them immature and they want to protect them from wrong trends of society. On the other hand girls mostly stay at home as compared to boys. So the male adolescents perceived their fathers as more hostile and aggressive as compared to female adolescents. In a study Maccoby and Jackline (1980) found that children as young as age one, fathers punish or prohibit behavior of their sons more than their daughters. This indicates that the manners in which parents respond to child's aggression also help to shape it (i.e. aggression). Cross-sectional and longitudinal data indicate that the frequency and severity of parental physical aggression is related to a variety of child adjustment problems and predict many negative developmental outcomes (Cicchetti & Lynch, 1995, Malinosky-Rummell & Hansen, 1993; Patterson et al., 1992; Strauss, 1994). As mentioned earlier in Pakistani society more emphasis is given to negative reinforcement than to positive ones. Fathers are usually strict and not closer to their children. Mothers exploit the image of the father to control the behavior of their children. Consequently the child grows up into an adult who is afraid of his father, afraid of God, afraid of his boss or any other authority (Zaidi, 1975).Perception of male child about father as hostile is more

strengthened when they realizes that he also neglects or ignores his positive behavior. This is clear from table VII ($t=2.38$, $df=198$, $p<.05$).

Results in Table VIII show that male adolescents perceived their fathers more rejecting and undifferentiated as compared to female adolescents ($t=2.55$, $df=198$, $p<.05$). As in most of the Pakistani families father's role is just that of a bread-earner, he plays a passive role in up-bringing of the children, is generally being neglecting and rejecting the children without realizing what impact such type of behavior will have on the growing child's personality. Longitudinal studies indicates that if the parents are perceived as unloving towards their children, then the children tended to be more aggressive. Similarly if the parents punished their children for aggression but ignored their good and cooperative behavior then the children tended to be more aggressive (Eron, Walder & Lefkowitz, 1971; Huesemann & Eron, 1984). Also it has been observed that in child rearing practices parents follow strict rules for male children's training as compared to females and females are more submissive as compared to males by the process of socialization in our society. With growing literacy rate and influx of western culture, the trend in child rearing practices as well as family structure are changing (though the pace is slow). It is hoped that with the increase in parental education, equal treatment and status will be given to children without gender discrimination by both parents. Fathers will also play an equally active role as that of the mothers because due to influx of "imported" culture, women have also started sharing the financial burden with their husbands. So it seems the moral and ethical obligation of their counterparts to help their wives in up-bringing their children properly so that they grow up as healthy and functioning members of society.

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APPENDIX "A"

بچوں کی پرورش کے متعلق سوالنامہ

سوالات

	میرے لئے درست ہے		میرے لئے درست نہیں ہے	
	اکثر	کبھی کبھی	بہت کم	کبھی نہیں
☆ماں میرے بارے میں اچھی باتیں کہتی ہے	.....	.....	.....	.....
☆جب میں بدتمیزی کرتا/کرتی ہوں تو ماں مجھے برا بھلا کہتی ہے	.....	.....	.....	.....
☆ماں مجھ پر بالکل توجہ نہیں دیتی ہے	.....	.....	.....	.....
☆ماں حقیقت میں مجھ سے محبت نہیں کرتی ہے	.....	.....	.....	.....
☆میری ماں گھریلو معاملات میں مجھ سے بات چیت کرتی ہے اور میری رائے پر توجہ دیتی ہے	.....	.....	.....	.....
☆جب میں ماں کی بات نہیں سنتا/سنتی تو میری شکایت دوسروں سے کرتی ہے	.....	.....	.....	.....
☆ماں مجھ پر بھرپور توجہ دیتی ہے	.....	.....	.....	.....
☆ماں میرے دوستوں کو گھر پر لانے پر میری ہمت افزائی کرتی ہے اور ان کو خوش کرنے کی کوشش کرتی ہے	.....	.....	.....	.....
☆ماں میرا مذاق اڑاتی ہے	.....	.....	.....	.....
☆ماں مجھ پر اس وقت تک توجہ نہیں دیتی جب تک کہ میں ان کے لئے پریشانی کا باعث نہ بنوں	.....	.....	.....	.....
☆جب ناراض ہوتی ہے تو مجھ پر چیختی چلاتی ہے	.....	.....	.....	.....
میں ماں پر آسانی سے بھروسہ کرکے اپنی اہم باتیں بتا سکتا/سکتی ہوں	.....	.....	.....	.....

	میرے لئے درست ہے		میرے لئے درست نہیں ہے	
	اکثر	کبھی کبھی	بہت کم	کبھی نہیں
☆ماں مجھ سے سختی سے پیش آتی ہے	.....	.....	.....	.....
☆ماں مجھے اپنے پاس رکھنا پسند کرتی ہے	.....	.....	.....	.....
☆جب میں اچھا کام کرتا/کرتی ہوں تو ماں میری ہمت افزائی کرتی ہے	.....	.....	.....	.....
☆ماں مجھے بلاوجہ مارتی ہے	.....	.....	.....	.....
☆ماں وہ کام کرنا بھول جاتی ہے جو اسے میرے لئے کرنا ہوتا ہے	.....	.....	.....	.....
☆ماں مجھے ایک بوجھ خیال کرتی ہے	.....	.....	.....	.....
☆ماں دوسروں کے سامنے میری تعریف کرتی ہے	.....	.....	.....	.....
☆جب ماں غصہ میں ہوتی ہے تو مجھے سخت سزا دیتی ہے	.....	.....	.....	.....
☆ماں اس بات کا اطمینان کر لیتی ہے کہ مجھے مناسب کھانا کھانے کو ملتا ہے	.....	.....	.....	.....
☆ماں مجھ سے گرمجوشی اور محبت بھرے انداز میں بات کرتی ہے	.....	.....	.....	.....
☆ماں مجھ پر جلد غصہ کرنے لگتی ہے	.....	.....	.....	.....
☆میرے سوالوں کے جوابات دینے کے لئے ماں کے پاس وقت نہیں ہوتا	.....	.....	.....	.....
☆میں ایسا محسوس کرتا/کرتی ہوں کہ ماں مجھ سے بیزار ہے	.....	.....	.....	.....
☆ماں میری تعریف کرتی ہے جب میں اس کا مستحق ہوتا/ہوتی ہوں	.....	.....	.....	.....
☆ماں مجھ پر غصہ کرنے کے بعد مخالفانہ رویہ اختیار کرتی ہے	.....	.....	.....	.....
☆ماں کو اس بات کی فکر رہتی ہے کہ میرا دوست کون ہے	.....	.....	.....	.....
☆ماں حقیقی معنوں میں میرے کاموں میں دلچسپی لیتی ہے	.....	.....	.....	.....
☆ماں مجھے سخت باتیں کہتی ہے	.....	.....	.....	.....

	میرے لئے درست ہے		میرے لئے درست نہیں ہے	
	اکثر	کبھی کبھی	بہت کم	کبھی نہیں
☆جب میں ماں سے مدد طلب کرتا/کرتی ہوں تو وہ مجھے نظر انداز کر دیتی ہے	.....	.....	.....	.....
☆ماں سمجھتی ہے کہ میری مصیبت کا ذمہ دار میں خود ہوں	.....	.....	.....	.....
☆ماں مجھے اس بات کا احساس دلاتی ہے کہ وہ مجھے چاہتی ہے	.....	.....	.....	.....
☆ماں مجھے کہتی ہے کہ میں ان کے اعصاب پر سوار رہتا/رہتی ہوں	.....	.....	.....	.....
☆ماں مجھ پر خاص توجہ دیتی ہے	.....	.....	.....	.....
☆ماں مجھے کہتی ہے کہ جب میں اچھا کام کرتا/کرتی ہوں تو وہ فخر محسوس کرتی ہے	.....	.....	.....	.....
☆ماں میرے جذبات کو بار بار ٹھیس پہنچاتی ہے	.....	.....	.....	.....
☆ماں ان اہم واقعات کو بھول جاتی ہے جس کو میں چاہتا/چاہتی ہوں کہ وہ یاد رکھے	.....	.....	.....	.....
☆ماں مجھے اس بات کا احساس دلاتی ہے کہ اگر میں نے شرارت کی تو مجھے پیار نہیں کیا جائیگا	.....	.....	.....	.....
☆ماں مجھے اس بات کا احساس دلاتی ہے کہ میں نے جو کچھ کیا ہے وہ اہم ہے	.....	.....	.....	.....
☆جب میں کوئی غلط کام کرتا/کرتی ہوں تو ماں مجھے ڈراتی اور دھمکاتی ہے	.....	.....	.....	.....
☆ماں میرے ساتھ وقت گذارنا پسند کرتی ہے	.....	.....	.....	.....
☆جب میں پریشانی میں مبتلا ہوتا/ہوتی ہوں تو ماں میری مدد کرتی ہے	.....	.....	.....	.....
☆جب میں ناشائستہ حرکتیں کرتا/کرتی ہوں تو ماں میرے دوستوں کے سامنے مجھے شرمندہ کرتی ہے	.....	.....	.....	.....

	میرے لئے درست ہے		میرے لئے درست نہیں ہے	
	اکثر	کبھی کبھی	بہت کم	کبھی نہیں
☆ماں مجھ سے دور رہنا چاہتی ہے	.....	.....	.....	.....
☆ماں میری شکایات کرتی ہے	.....	.....	.....	.....
☆ماں میری رائے کا احترام کرتی ہے اور اس کے اظہار میں میرے ہمت افزائی کرتی ہے	.....	.....	.....	.....
☆ماں دوسرے بچوں کے مقابلے میں مجھے کم سمجھتی ہے خواہ میں نے کتنا ہی اچھا کام کیوں نہ کیا ہو	.....	.....	.....	.....
☆ماں گھریلو معاملات میں میری پسند کا خیال رکھتی ہے	.....	.....	.....	.....
☆ماں وہ کام مجھے کرنے دیتی ہے جس کو میں اہم سمجھتا/سمجھتی ہوں چاہے وہ ان کے لئے کتنا ہی پریشانی کا سبب کیوں نہ بنے	.....	.....	.....	.....
☆ماں مجھے دوسرے بچوں کے مقابلے میں کم تر سمجھتی ہے	.....	.....	.....	.....
☆ماں مجھے رشتہ دار یا پڑوسی کے سپرد کر دیتی ہے	.....	.....	.....	.....
☆ماں مجھے اس بات کا احساس دلاتی ہے کہ وہ مجھے پسند نہیں کرتی ہے	.....	.....	.....	.....
☆میں جو کچھ کرتا/کرتی ہوں ماں اس میں دلچسپی لیتی ہے	.....	.....	.....	.....
☆جب میں تکلیف یا بیماری میں مبتلا ہوتا/ ہوتی ہوں تو ماں مجھے دلاسہ دیتی ہے اور کہتی ہے کہ تم ٹھیک ہو	.....	.....	.....	.....
☆ماں مجھے کہتی ہے کہ جب تم غلط کام کرتے/کرتی ہو تو مجھے بہت شرمندگی ہوتی ہے	.....	.....	.....	.....
☆ماں مجھ پر جتلاتی ہے کہ وہ مجھے سے بہت پیار کرتی ہے	.....	.....	.....	.....
☆ماں مجھ سے نرمی اور رحم دلی کا برتاؤ کرتی ہے	.....	.....	.....	.....
☆جب میں غلط کام کرتا/کرتی ہوں تو ماں مجھے شرمندہ کرتی ہے یا جرم کا احساس دلاتی ہے	.....	.....	.....	.....
☆ماں مجھے خوش رکھنے کی کوشش کرتی ہے	.....	.....	.....	.....

APPENDIX "B"

بچوں کی پرورش کے متعلق سوالنامہ

سوالات

	میرے لئے درست ہے		میرے لئے درست نہیں ہے	
	اکثر	کبھی کبھی	بہت کم	کبھی نہیں
☆باپ میرے بارے میں اچھی باتیں کہتا ہے	.....	.....	.....	.....
☆جب میں بدتمیزی کرتا/کرتی ہوں تو باپ مجھے برا بھلا کہتا ہے	.....	.....	.....	.....
☆باپ مجھ پر بالکل توجہ نہیں دیتا ہے	.....	.....	.....	.....
☆باپ حقیقت میں مجھ سے محبت نہیں کرتا ہے	.....	.....	.....	.....
☆میرا باپ گھریلو معاملات میں مجھ سے بات چیت کرتا ہے اور میری رائے پر توجہ دیتا ہے	.....	.....	.....	.....
☆جب میں باپ کی بات نہیں سنتا/سنتی تو میری شکایت دوسروں سے کرتا ہے	.....	.....	.....	.....
☆باپ مجھ پر بھرپور توجہ دیتا ہے	.....	.....	.....	.....
☆باپ میرے دوستوں کو گھر پر لانے پر میرے ہمت افزائی کرتا ہے اور ان کو خوش کرنے کی کوشش کرتا ہے	.....	.....	.....	.....
☆باپ میرا مذاق اڑاتا ہے	.....	.....	.....	.....
☆باپ مجھ پر اس وقت تک توجہ نہیں دیتا جب تک کہ میں ان کے لئے پریشانی کا باعث نہ بنوں	.....	.....	.....	.....
☆باپ جب ناراض ہوتا ہے تو مجھ پر چیختا چلاتا ہے	.....	.....	.....	.....
☆میں باپ پر آسانی سے بھروسہ کرکے اپنی اہم باتیں بتا سکتا/سکتی ہوں	.....	.....	.....	.....
☆باپ مجھ سے سختی سے پیش آتا ہے	.....	.....	.....	.....
☆باپ مجھے اپنے پاس رکھنا پسند کرتا ہے	.....	.....	.....	.....

	میرے لئے درست ہے		میرے لئے درست نہیں ہے	
	اکثر	کبھی کبھی	بہت کم	کبھی نہیں
☆جب میں اچھا کام کرتا/کرتی ہوں تو باپ میری ہمت افزائی کرتا ہے	.....	.....	.....	.....
☆باپ مجھے بلاوجہ مارتا ہے	.....	.....	.....	.....
☆باپ وہ کام کرنا بھول جاتا ہے جو اسے میرے لئے کرنا ہوتا ہے	.....	.....	.....	.....
☆باپ مجھے ایک بوجھ خیال کرتا ہے	.....	.....	.....	.....
☆باپ دوسروں کے سامنے میری تعریف کرتا ہے	.....	.....	.....	.....
☆جب باپ غصے میں ہوتا ہے تو مجھے سخت سزا دیتا ہے	.....	.....	.....	.....
☆باپ اس بات کا اطمینان کر لیتا ہے کہ مجھے مناسب کھانا کھانے کو ملتا ہے	.....	.....	.....	.....
☆باپ مجھ سے گرمجوشی اور محبت بھرے انداز میں بات کرتا ہے	.....	.....	.....	.....
☆باپ مجھ پر جلد غصہ کرنے لگتا ہے	.....	.....	.....	.....
☆میرے سوالوں کے جوابات دینے کے لئے باپ کے پاس وقت نہیں ہوتا	.....	.....	.....	.....
☆میں ایسا محسوس کرتا/کرتی ہوں کہ باپ مجھ سے بیزار ہے	.....	.....	.....	.....
☆باپ میری تعریف کرتا ہے جب میں اس کا مستحق ہوتا/ہوتی ہوں	.....	.....	.....	.....
☆باپ مجھ پر غصہ کرنے کے بعد مخالفانہ رویہ اختیار کرتا ہے	.....	.....	.....	.....
☆باپ کو اس بات کی فکر رہتی ہے کہ میرا دوست کون ہے	.....	.....	.....	.....
☆باپ حقیقی معنوں میں میرے کاموں میں دلچسپی لیتا ہے	.....	.....	.....	.....
☆باپ مجھے سخت باتیں کہتا ہے	.....	.....	.....	.....
☆جب میں باپ سے مدد طلب کرتا/کرتی ہوں تو وہ مجھے نظر انداز کر دیتا ہے	.....	.....	.....	.....

	میرے لئے درست ہے		میرے لئے درست نہیں ہے	
	اکثر	کبھی کبھی	بہت کم	کبھی نہیں
☆باپ سمجھتا ہے کہ میری مصیبت کا ذمہ دار میں خود ہوں	.....	.....	.....	.....
☆باپ مجھے اس بات کا احساس دلاتا ہے کہ وہ مجھے چاہتا ہے	.....	.....	.....	.....
☆باپ مجھے کہتا ہے کہ میں ان کے اعصاب پر سوار رہتا/رہتی ہوں	.....	.....	.....	.....
☆باپ مجھ پر خاص توجہ دیتا ہے	.....	.....	.....	.....
☆باپ مجھے کہتا ہے کہ جب میں اچھا کام کرتا/کرتی ہوں تو وہ فخر محسوس کرتا ہے	.....	.....	.....	.....
☆باپ میرے جذبات کو بار بار ٹھیس پہنچاتا ہے	.....	.....	.....	.....
☆باپ ان اہم واقعات کو بھول جاتا ہے جس کو میں چاہتا/چاہتی ہوں کہ وہ یاد رکھے	.....	.....	.....	.....
☆باپ مجھے اس بات کا احساس دلاتا ہے کہ اگر میں نے شرارت کی تو مجھے پیار نہیں کیا جائیگا	.....	.....	.....	.....
☆باپ مجھے اس بات کا احساس دلاتا ہے کہ میں نے جو کچھ کیا ہے وہ اہم ہے	.....	.....	.....	.....
☆جب میں کوئی غلط کام کرتا/کرتی ہوں تو باپ مجھے ڈراتا اور دھمکاتا ہے	.....	.....	.....	.....
☆باپ میرے ساتھ وقت گذارنا پسند کرتا ہے	.....	.....	.....	.....
☆جب میں پریشانی میں مبتلا ہوتا/ ہوتی ہوں تو باپ میری مدد کرتا ہے	.....	.....	.....	.....
☆جب میں ناشائستہ حرکتیں کرتا /کرتی ہوں تو باپ میرے دوستوں کے سامنے مجھے شرمندہ کرتا ہے	.....	.....	.....	.....
☆باپ مجھ سے دور رہنا چاہتا ہے	.....	.....	.....	.....
☆باپ میری شکایات کرتا ہے	.....	.....	.....	.....

	میرے لئے درست ہے		میرے لئے درست نہیں ہے	
	اکثر	کبھی کبھی	بہت کم	کبھی نہیں
☆باپ میری رائے کا احترام کرتا ہے اور اس کے اظہار میں میری ہمت افزائی کرتا ہے	.....	.....	.....	.....
☆باپ دوسرے بچوں کے مقابلے میں مجھے کم سمجھتا ہے خواہ میں نے کتنا ہی اچھا کام کیوں نہ کیا ہو	.....	.....	.....	.....
☆باپ گھریلو معاملات میں میری پسند کا خیال رکھتا ہے	.....	.....	.....	.....
☆باپ وہ کام مجھے کرنے دیتا ہے جس کو میں اہم سمجھتا/سمجھتی ہوں چاہے وہ ان کے لئے کتنا ہی پریشانی کا سبب کیوں نہ بنے	.....	.....	.....	.....
☆باپ مجھے دوسرے بچوں کے مقابلے میں کم تر سمجھتا ہے	.....	.....	.....	.....
☆باپ مجھے رشتہ دار یا پڑوسی کے سپرد کر دیتا ہے	.....	.....	.....	.....
☆باپ مجھے اس بات کا احساس دلاتا ہے کہ وہ مجھے پسند نہیں کرتا ہے	.....	.....	.....	.....
☆میں جو کچھ کرتا/کرتی ہوں باپ اس میں دلچسپی لیتا ہے	.....	.....	.....	.....
☆جب میں تکلیف یا بیماری میں مبتلا ہوتا/ہوتی ہوں تو باپ مجھے دلاسہ دیتا ہے اور کہتا ہے کہ تم ٹھیک ہو	.....	.....	.....	.....
☆باپ مجھے کہتا ہے کہ جب تم غلط کام کرتے/کرتی ہوں تو مجھے بہت شرمندگی ہوتی ہے	.....	.....	.....	.....
☆باپ مجھ پر جتلاتا ہے کہ وہ مجھ سے بہت پیار کرتا ہے	.....	.....	.....	.....
☆باپ مجھ سے نرمی اور رحمدلی کا برتاؤ کرتا ہے	.....	.....	.....	.....
☆جب میں غلط کام کرتا/کرتی ہوں تو باپ مجھے شرمندہ کرتا ہے یا ☆جرم کا احساس دلاتا ہے	.....	.....	.....	.....
☆باپ مجھے خوش رکھنے کی کوشش کرتا ہے	.....	.....	.....	.....