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HOSTILITY ANXIETY BIDS OF THE PATIENTS AND THE PSYCHOTHERAPISTS' INTERVENTIONS

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ABSTRACT

This research was conducted to see the impact of the psychotherapists' approach-avoidance interventions on the hostility with hostility anxiety bids of the patients. Seven psychotherapists of Institute of Clinical Psychology, University of Karachi participated in this study. First two recorded audio-cassettes of four patients of each therapist were subjected to content analysis. It was hypothesized that (a) approach interventions of the psychotherapist would elicit further expressions of hostility anxiety of the patients and (b) with avoidance interventions of the psychotherapists, such expressions would tend to decrease. In order to test the hypotheses, Sign test was applied and the result were found in the expected direction.

INTRODUCTION

Psychotherapy is a process of verbal interaction between the two persons, i.e. the patient and the therapist. Through this interactions or verbal exchanges the therapist attempts to establish a trusting relationship with the patient and communicates to the patient the message that he/she understands him/her and wants to help him/her in overcoming his/her difficulties, to make him learn to withstand certain amount of stresses and emotional tension without having the feeling of being dejected or deprived. This enables the patient to lead a better life.

It has generally been observed that nearly every patient (depending on his/her past experiences) expresses a marked degree of hostility in the course of

his/her inter personal dealing with the psychotherapist. Outside the therapeutic situation he/she has to control his/her hostile impulses, as an open expression of hostility is not liked by the people. In therapy session, due to tolerant and permissive attitude of the therapist he/she finds an outlet for his/her forbidden hostile impulses. Not only this, but he/she also expresses his/her hostility with whom he/she has conflictual relationship. It has been observed that some people have hostility anxiety along with hostility itself. Therefore, in therapy session sometimes the patient who is highly hostile, becomes anxious at the expression of his/her own hostility, i.e. on the one hand the patient wants to express his/her hostility towards the therapist with whom he/she has conflict and on the other hand he/she feels inhibited and guilty at such expression. This may be due to fear of retaliation by the therapist or anticipation of the disapproval of the therapist. This is a manifestation of hostility anxiety which is an expression of guilt, fear or anxiety about hostility.

The therapeutic interventions used by the psychotherapists are approach and avoidance reactions of the therapists to the patients' bids/verbal behavior.

The assumption that approach serves as positive reinforcement and avoidance as negative reinforcement was postulated by Bandura et al., (1960) and Winder et al., (1962). Patient psychotherapist verbal interaction was coded from the tape recordings. The findings confirmed the hypothesis that approach responses would be more effective than avoidance responses in getting the patient express his/her hostility. Not only this, there were instances in which the patients were likely to change the object of their hostility with the avoidance reactions of the therapist.

Murray (1954, 1956) conducted two studies in this connection. In the first study, it was found that when the therapist approached the patients' expressions of hostility, then there was an increase in such expressions. On the other hand when such expressions were avoided by the therapist, there was a decrease in the frequency of such expressions. In another study, Murray (1956) developed a number of topic categories into which the content of the patient's verbalizations could reliably be classified. Then he plotted the response frequencies of these categories over a series of eight interviews. He found that the frequency of 'approved' categories increased, while the frequency of 'disapproved' categories decreased significantly over time. He interpreted these findings within learning theory framework, i.e., mild approval on the part of the therapist equals positive reinforcement while mild disapproval has the effect of negative reinforcement on the patient. The importance of Murray's findings is that the course of therapy

followed learning theory expectations without the therapist or patient conceptualizing the therapy process in learning theory terms.

Rogers (1960) conditioned positive and negative self-references in a group of college students in six 10-minute quasi therapy sessions in which Subjects were asked to talk freely about themselves. It was found that reinforcing negative self-references led to an increment in the frequency of their omission. Positive self-references extinguished when they were not reinforced. Kopplin (1963) in his study found that the clients continued expressing hostility significantly more after approach than after avoidance of such expressions by the therapist early in psychotherapy.

In a study Caracena (1965) found that there was no significant difference in the percentage of verbalization of dependent statements after approach and avoidance. So the hypothesis that verbalization of dependent statement would be greater after approach than avoidance could not be supported.

The findings of Varble's study (1964) were that there were great variations between individual therapist in the proportion of approach and avoidance reactions to the patient's bids of hostility. It was quite possible that hostility did increase in those clients/patients whose therapists mainly approached and decreased for those whose therapists mainly avoided such expressions.

Schuldt (1966) conducted a study to see the effects of psychotherapists' approach and avoidance responses on the clients' expression of dependency. The result suggested that the clients in all stages of therapy tended to continue expressions of dependency when such responses were approached by the therapists and discontinued such expressions when avoided by the therapists. It was also found that the therapist tended to maintain a relatively consistent rate of approach throughout the therapeutic process. In another study Varble (1968) found that therapists' approach reactions to patients' hostility bids elicited further such expressions, while avoidance elicited non-hostile material at all stages of therapy. Contrary to expectation the frequency of such elicitation did not increase and the proportion of hostility expressed in an interview decreased overtime in therapy. Ahmad (1988) formulated and tested two hypotheses related to the expression of dependency needs of the patients. The findings were that the patients were more likely to continue the discussion of dependency following therapists approach reactions than they were following the therapist's avoidance reactions. Therapeutic interactions are situations in which there is a large difference between the clients and the therapists in their relative power of

expertise. As therapists are clearly in a 'one-up' position, clients are highly motivated to earn their therapists' approval (Schwartz, Friedlander & Tedeschi, 1986). Horvath and Luborsky (1993) suggested that the patient's freedom in the relationship with the therapist to express both positive and negative affects and the therapists' ability to facilitate and welcome these feeling play important role in therapeutic process. Hill, Thompson and Corbett (1992) and Rennie (1994) demonstrated how difficult and how important negative expression is for patients in therapy and the freedom to voice these feelings is an indication of good therapeutic relationship.Stiles and Shapiro (1994) argued that active ingredients in psychotherapy are the techniques and interventions and the amount (dosage) of the active ingredients should correlate with outcome.

In a study on "The Interaction of the Alliance and Therapy"... Sexton et al., (1996) concluded that high alliance first sessions are characterized by relatively, more negative patient verbal content and therapist listening their low alliance first sessions. It may be that this negative content is a reflection of a developing alliance. Perhaps high alliance patients feel almost immediately safe enough to say what they have in their minds, whereas low-alliances patients' neutral contents may reflect a more guarded stance.

In the light of the literature review, the following hypothesis were formulated:

Hypothesis 1:

If the hostility bids of the patients with hostility anxiety are approached by the psychotherapist, then the frequency of hostility anxiety bids will increase.

Hypothesis 2:

If the hostility bids of the patients with hostility anxiety are avoided by the psychotherapist, then the frequency of hostility anxiety bids will decrease.

METHOD

Sample

The data for this study was obtained from 56 tape-recorded interview sessions. (1st two psychotherapy interview sessions) of 28 neurotic hostile patients who had undergone psychotherapy at the Institute of Clinical Psychology, University of Karachi, Pakistan. These patients were treated at the

Institute of Clinical Psychology, over a period of 10 years. In this study four PhD. interns and three faculty members participated. They had an average of minimum of two years of supervised experience in psychotherapy. The sample consisted of 28 patients, 10 males and 18 females, ranging between the ages of 20 to 45 years with a mean age of 32. 11 years.

Procedure

In coding the patients-psychotherapist interactions, the method of Content Analysis (developed by Bandura et al, 1960) was used. This method basically codes all the patients' bids as hostility and hostility with hostility anxiety, dependency, dependency anxiety, sex, sex anxiety or others and codes all psychotherapists' reactions as approach or avoidance.

The first two tape-recorded psychotherapy sessions were subject to content analysis. In coding the interviews, if a statement was judged as indicative of hostility with hostility anxiety of the patient, then both the therapist's responses and the immediately following patient's bids were noted down.

Two trained scorers i.e. scorer A and the researcher herself independently scored 12 tapes (randomly selected) from a pool of 56 tapes to secure inter-scorer reliability. Agreement was satisfactory for the frequency of all the categories (Table 1).

In order to determine the frequency of increase and decrease in the patient's bids of hostility with hostility anxiety as a function of approach and avoidance of the therapists, Sign Test was applied.

Operational Definitions of Various Variables:

a. Patients Bids:

These are defined as the statements or expressions of the patients about various variables, such as hostility, hostility with anxiety, dependency, dependency anxiety etc. the bids of the patients, which are relevant in this study which is defined as any expression of fear, anxiety or guilt about hostility along with hostility or statements inflicting difficulty in expressing hostility (Ahmad 1988).

b. Psychotherapist Response Categories:

Psychotherapist Response Categories are defined as the reactions of the therapists to the patients' statements or expressions about various variables.

The psychotherapist response categories are divided into two general classes, which are:

(i) Approach Reactions:
These are defined as the reactions of the psychotherapist which are designed to elicit from the patient further verbalization of the topic under discussion.

(ii) Avoidance Reactions:
These are the reactions of the psychotherapist, which are designed to inhibit, discourage or divert the patient from further verbalization of the topic under discussion.

RESULTS

Table I

Overall Ratio of Inter-Scorer Agreement

	Response Categories	Overall Ratio of Agreement
a	Therapists' Approach interventions	.92
b	Therapists' Avoidance interventions	.93
c	Patients' Response Categories	.87
d	Others	.92
e	Object Category	.91

Table II

Ratio of hostility bids with hostility anxiety after approach interventions to ratio of hostility bids with hostility anxiety after avoidance interventions of the Therapists in the Patients

No.	Hostility Bids with Hostility Anxiety after Approach	Hostility Bids with Hostility Anxiety after Avoidance	Sign
1	.64	.57	+
2	.77	.43	+
3	.77	.50	+
4	.58	.50	+
5	.80	.75	-
6	.78	1.13	+
7	.93	.54	+
8	.52	.36	-
9	.58	.69	+
10	.50	.39	+
11	.57	.54	+
12	.56	.55	+
13	.58	.57	+
14	.82	.53	+
15	.64	.57	+
16	.92	.77	+
17	1.1	.77	+
18	.93	.85	+
19	.85	.75	+
20	.88	.83	+
21	.93	.83	+
22	.86	1.14	-
23	.78	.77	+
24	.91	.77	+
25	.88	.87	+
26	1.15	.66	+
27	.87	1.2	-
28	.66	.60	+

Significant at .01 level.

DISCUSSION

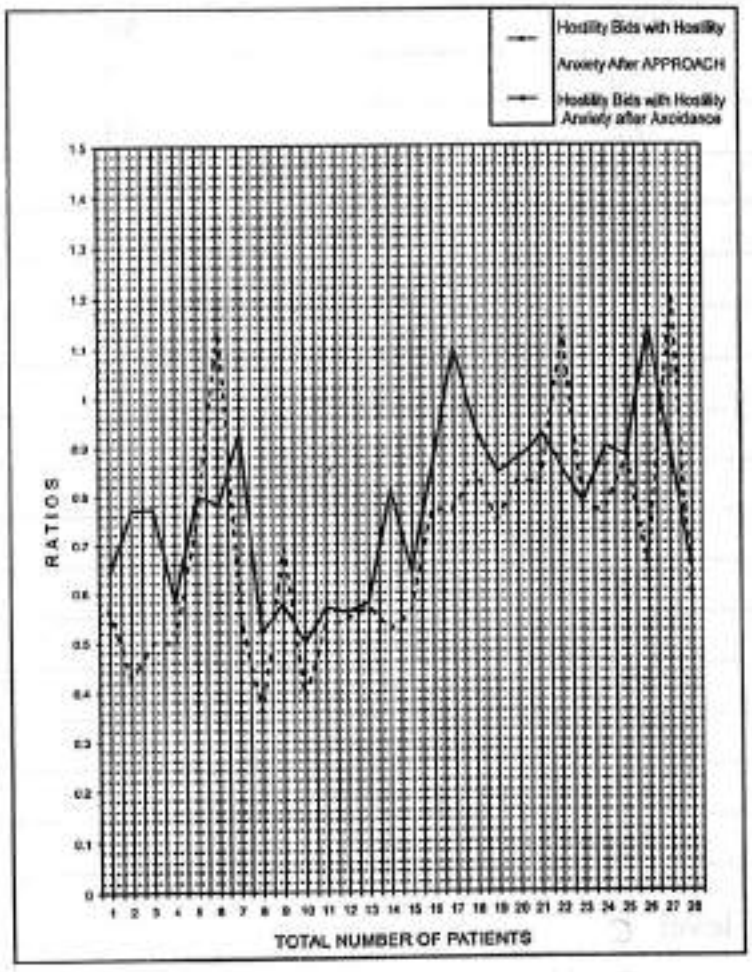
The purpose of this study was to find out which types of therapeutic interventions are most workable with the patients who come to seek psychotherapeutic help. This study is primarily based on Skinner's operant conditioning concept of reinforcement. It tries to explain the patient therapist verbal interaction in psychotherapy.

The hypothesis No.1 states that:

> "If the hostility bids of the patients with hostility anxiety are approached by the psychotherapist, then the frequency of hostility bids with hostility anxiety bids will increase".

GRAPH A

Ratio of hostility bids with hostility anxiety after approach interventions to ratio of hostility bids with hostility anxiety after avoidance interventions of the therapists in the patients



This hypothesis is supported by the data and is significant at $p < .01$ level.

Table no. II and a Graph A show out of 28 patients, 24 patients were the ones whose hostility with hostility anxiety expressions increased after approach intervention of the therapists.

As there is a dearth of research on the topic of hostility bids with hostility anxiety in Pakistan as well as in developed countries, generally it has been observed that Pakistan being an under developed country where the literacy rate appears to be approximately 26%, parent due to lack of formal education, are unaware of proper child-rearing techniques. They unknowingly seem to inculcate anxiety, guilt and shame in their children during the socialization period. When the child does something wrong, mostly so much guilt and shame is inflicted on him/her by the elders around him/her (including his parents) that he/she becomes more and more anxious. The statements "I have done something wrong, what will other people say..." all such type of statements add up to his/her anxiety, guilt and shame with the result that he/she becomes inhibited and defensive.

It appears as if anxiety, guilt and shame are culture-bound concept. Peoples in Pakistani culture, mostly, are brought up to be more other-directed and less inner-directed. The community, the family and grand parents are considered to be the "significant others" in Pakistani culture (Khan, 1979).

Children and adults who are brought up by the parents who inhibit the open expressions of hostility, they develop the same kind of attitudes. If ever they openly express hostility towards other then they feel guilty after such expressions. In therapy, with the supportive and encouraging attitude of the therapist such patients get a climate in which they can openly express their hostility, not only hostility but all their apprehensions, fears and guilt which are associated with their hostility expressions. That is why with approach interventions of the therapists the frequency of hostility with hostility anxiety expressions of the patient increase. The therapist encourages such expressions with the idea that when the inhibited and pent up feelings of the patients take the form of verbal expression, then his anxiety which is connected with hostility will be lessened and he will be relieved of the tension and distress he/she is having which in turn will lead to his improvement. It is interesting to mention that in Pakistani culture sex role differentiation is quite apparent (Ahmad, 1998). In child -rearing practices most of the parents rear female child differently from that of a male child. In case of female child they mostly curb free expression of aggression and hostility, encourage her to be submissive, thinking that she has to

go a different and new environment when she gets married. So she should be more tolerant as compared to a male child. This attitude of the parents persists throughout the socialization process, so much so that being submissive becomes a part of Pakistani female's personality.

When a female client with such a past history enters psychotherapy, the permissive and encouraging attitude of the therapist acts as reinforcer with the result that she feels free to talk more and more about the hostility and the anxiety associated with it.

It is worth mentioning that the sample for the study consisted of more female patients than male patients. It can be assumed that besides other factors the gender differences in child rearing process could also be a contributing factor in generating more of hostility anxiety expressions after the approach interventions of the therapist. But it is also worth keeping in mind that these were the immediate effects of approach interventions of the therapist, it could have been possible in the long run that constant approach on the part of the therapist might have caused the patient to perceive him as a controlling authority which could have made the patient stop the expression of the topic altogether.

The hypothesis No. 2 states that:

"If the hostility bids of the patients with hostility anxiety are avoided by the psychotherapist, then the frequency of hostility bids with hostility anxiety bids will decrease".

This hypothesis is supported by the data and is significant at $p < .01$ level.

Table no. II and a Graph A show that out of 28 cases the results of 24 patients were in the predicted direction i.e. with the avoidance interventions of the psychotherapist there was a decrease in the hostility with hostility anxiety bids of the patients. In case of only 4 patients there was an increase in the hostility with hostility anxiety responses of the patients after avoidance interventions of the therapists.

Pakistani society is predominantly a tradition-oriented society. The traditions and norms of the society show a great reverence for ancestral ways and conformity to old traditions e.g. conformity to elders and a reverence to authority is an important feature of Pakistani society. Dependency on authority figures has its roots in family structure in Pakistan, which mostly follow the extended family

system. Thus what is viewed as intrusiveness in the West, is seen as an expression of care and concern in Pakistani culture (Khan, 1979, Zaman, 1988). On the basis of the available studies on child rearing practices in Pakistan it can be said that usually few positive techniques are employed by Pakistani parents to inculcate discipline. Basic training patterns and behavior control devices are mostly based on the use of negative reinforcement / incentives. Fathers are usually strict and not closer to their children. Mothers exploit the image of the father to control the behavior of their children. This practice starts at a very early age and continues at different stages with change in the types of threat, but the nature of incentives remains negative. Consequently the child grows up into an adult who is afraid of his/her father, afraid of God, afraid of his/her boss, or any other authority (Zaidi, 1975). Children try to be good not because they are inherently good but to be please the authority. An over concern with other people's opinion about themselves also develops.

Being members of such culture, if hostile people express their hostility openly, then the authority figures feel threatened so much so that in order to curb such expressions they inflict guilt and shame on them, with the result they develop guilt, thinking why were they hostile, what others will think about them, they should not be hostile any more, so on and so forth. These negative feelings about themselves urge them not to express their hostile feelings any more, because of the fact that not only they are apprehensive of the disapproval of other people/significant others but also due to anxiety and guilt feelings which are associated with their hostility expressions.

In psychotherapy sessions patients whose major complaint being hostility with hostility anxiety, when face the avoidant behavior of the psychotherapist, then they tend to be discouraged and become more and more self-critical. It appears as if their punitive super ego inflict guilt on them, due to which they tend to be more restrictive in further expressions of their hostility bids with hostility anxiety. As people in Pakistan are mostly other-directed rather than inner-directed, in order to please the therapist or to get their approval, patients either discontinue the topic of discussion which they find is not liked or approved by the therapist or if they continue talking on the same topic, then the frequency of such expressions decreases.

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LIFE-STRESS AND DIABETES: A CONGRUENCY HYPOTHESIS

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ABSTRACT

The purpose of this study was to sample representative stressful events experienced by diabetics and to find out a concomitant relationship between life stresses and blood-sugar levels of diabetic sample. To test this assumption, the Social Readjustment rating scale (SRRS) of Holmes and Rahe (1967) was administered on 160 diabetics from two general diabetic centers of Karachi city. The entire sample (N=160) was asked to rate, on a 10-point rating scale, the stress level experienced by them during the past one year. The results indicate that significant findings were obtained only when negative changes were considered. No significant correlates of positive changes were found. Further research should focus on exploring the life stresses that are particularly relevant to the Pakistani culture and prospective methodology be used for identifying the stresses. Moreover, there has been an increasing interest in intervention programs to teach patients to cope with stress.

INTRODUCTION

Diabetes Mellitus is a world health problem. It is more common amongst developed countries W.H.O. (1985) estimate that diabetes mellitus affected 100 million people throughout the world. According to Hoet (1991), It was estimated that 120 million people throughout the world have diabetes, the majority of whom living in developing countries. In Pakistan, it is estimated that 3 million people suffer from diabetes (Shera, Rehman and Rafique, 1991).

The main purpose of the present research is to study empirically the impact of life stresses and on the metabolic control of diabetics and to find out a concomitant link among the psychological variable and the course of illness. Psychosocial studies of Diabetes have consistently indicated a significant association between Stressful life Events and Diabetes. In the present research, Diabetes Mellitus is here used as a typical chronic disease in which somatic,

psychological, and social aspects are involved. Numerous past researches suggest the approach for studying Diabetes Mellitus, through studying the relationship between Life Events and Diabetes is to elucidate whether or more unspecific stress situations could provoke diabetes in genetically vulnerable individuals (Grant, Kyle, Teichman and Mendels, 1974: Rahe, Arajarvi, Punsar and Karvonen, 1976).

There is a longstanding demonstration of an association between life-stress and illness (Lief, 1984; Hinkel, Evans and Wolf, 1951a; 1951b; Hinkle et al., 1958; Rahe, Myer Smith, Kjaer, and Holmes, 1964; Rahe and Holmes, 1965; Rahe and Arthur, 1967; Rahe, Rubin, Arthur, and Clark 1968; Jacobs, Spilken, Norman, and Arthur, 1973 : Grant, Kyle, Teichman, and Mendels, 1974; Rahe, Arajarvi, Punsar, and Karvonen, 1976).

Traumatic experiences can create anxiety, stress and tension that can produce impact severely on ones physical and psychological well being. Numerous researches report that negative life events are an important causative factor in the Psychological stress. The relationship between stressful life events and well being both physical and psychological, is the focus of great deal of research. High level of stress are found related to depression (Akiskal and McKinney, 1975; Payke, 1969; Brown, and Harris, 1987) and other forms of psychopathology (Dohrenwend, 1979). In addition, a bulk of researches report that the onset and severity of many physical discorders are related to life stress (Dohrenwend and Dohrenwend, 1974).

Diabetes Mellitus is a world health problem and affects all societies at various stages of development. Diabetes Mellitus is characterized by a defect in insulin secretion or action. Insulin acts to make cell membrane permeable to glucose a process that is essential for normal metabolism. In diabetes, because of an absolute or relative lack of insulin, (insulin an endocrine hormone is secreted by the beta cells of the pancreatic Islets of the Langerhans, probably because of auto immune destruction of beta cells loss of production and secretion results) glucose cannot readily be used by the cells of the body and accumulates in the bloodstream. Some is excreted in the urine, causing an osmotic disuresis. Because the cells of the body can not metabolize glucose, the cells instead metabolize glycogen, fat and protein, depleting the body's energy reserves. This process if unchecked, and continues, further accompanied by fatigue, weight loss and dehydration leading to either hyperosmolar coma or Ketoacidosis and ultimately, death.

Much of the information on the etiology of diabetes has been derived from genetic and immunological studies in families. The myth of the "diabetic personality" failed to provide evidence for a specific personality. But some writers have suggested that emotional stress or psychological problems also precipitate the disease. As there is no evidence that a stressful life style can cause any disease, including diabetes. But it is possible that stress could bring on symptoms in someone already headed for diabetes. Stress affects diabetes control by way of "stress hormones" and results in blood sugar fluctuation.

Researches have been carried out on three lines, suggesting the direct effect of stress on the course of diabetes.

1. Many hormones have been shown to affect carbohydrate metabolism and blood glucose level as well as insulin. All of these hormones are under neural cortisol, epinephrine, nor-epinephrine, growth hormones, glucogen, control and have been shown to be significantly affected by psychological stress (Surwit, Williams and Shapiro, 1982).
2. Positive relationships between stress and the occurrence diabetic "crises" have been referred in the literature (Nabaroo 1965; Grant Kyle, Teichman, and Mendels, 1974).
3. Stress management techniques such as family therapy and relaxation techniques (Deniels, 1953).

Psychological stress may disrupt dietary compliance, activity level or insulin usage, indirectly affecting blood glucose level. Cohen, Vance, Runyan, and Hurwitz (1960) reviewed 73 cases of diabetic acidosis, the most common precipitating factor (27%) was the omission of insulin. In half of these cases insulin omission was attributed to psychological stress. They also reported higher glycosylated hemoglobin (GHb) levels in diabetics with high anxiety as determined by interview than in diabetics with medium or low anxiety, the latter groups did not differ. Holmes and Rahe (1974) suggested that an accumulation of "LIFE CRISIS UNITS" alters the course of diabetes, not just acute stress. Others have reported positive correlation between undesirable life events and diabetes course (Grant, Kyle, Teichmen, and Mendels 1974). Lustman, Arney and Amodo (1981) concluded, that evidence does support a relationship between stress and diabetes. However, in recent years, there has been an increasing interest in the relationship between emotional and psychological factors and diabetes mellitus (Hauser, and Pollets, 1979; Surwit, Socovern, and Feinglos, 1982).

Unfortunately, in Pakistan there is a dearth of information about the psychological aspects of diabetes mellitus. To the best of researchers' knowledge, this is the first attempt to study the role of life stresses on the glucose metabolism of diabetics. The purpose of the study was to determine the effect of life stress on the blood sugar metabolism of diabetics and to identify the nature of life stresses of diabetics, Insulin-Dependent Diabetes Mellitus (IDDM) and Non-Insulin Dependent Diabetes Mellitus (NIDDM).

A clearly raised fasting glucose concentration in excess of 140 mg/100 ml or a post absorptive blood glucose (2 hrs after meals) in excess of 200 mg/100 ml unequivocally establishes the diagnosis of diabetes mellitus. No evidence of stroke, cancer, end-stage renal disease, blindness, hypertension, pregnancy and lactation was present. Known behavior pathology was also ruled out.

METHOD

Sample

160 diabetics patients were taken randomly from the two diabetic centers of Karachi city. The diabetic sample comprised of NIDDM (N=80) and IDDM (N=80) married and unmarried sample including both genders whose age was taken from 25 to 65 years.

Procedure

A list of 43 events (Holmes & Rahe Social Readjustment Rating scale 1967) was selected for this study; except for one item which was changed slightly i.e. item no. 42 (Christmas) was changed to Eid in the introduced scale because all patients were Muslim and is more appropriate according to their religion. Before administering the SRRS on the subjects the scale was initially translated in Urdu language by a panel of judges, afterwards it was back translated in original English language, therefore no significant difference was found in terms of translation. The new Urdu version items did not have any effect in terms of meaning and interpretation.This list of 43 events was presented to the diabetics for the rating of stress level on a 10 point scale (1 to 10). The rating scale was printed next to each event and were asked to circle one of numbers to indicate the level of stress associated with the event during the past one year.

The following instructions were given to subjects:

The following is a list of events that may be experienced by you during the past one year, if you have experienced stress on any of the following events, you can rate them according to their intensity. Please rate how much stressful these events could be by using the following stress rating scale.

1--------2--------3---------4----------5----------6----------7--------8-------9------10
Not at all stressful Moderately stressful Extremely Stressful

RESULTS

Demographic variables of diabetic patients (N=160) presented in table from I to V.

Table I

	Age	Aca-demic Quali-fication	Monthly Income	Family Mem-bers	Blood Sugar Random	Present Weight	Dura-tion of Illness
Mean	39.838	13.750	6359.375	06.050	300.769	69.214	07.488
S. Dev.	04.131	01.930	2759.872	01.722	48.398	10.604	03.653
Range	15.000	08.000	17000.000	10.000	296.000	51.000	19.000
Min	30.000	08.000	3000.000	00.000	120.000	39.000	01.000
Max	40.000	16.000	20000.000	10.000	416.000	90.000	20.000

Table II

Age	Past Weight Kg	Insulin Depen-dency	Inj.	Here-ditory Factors N=82	Mother N=49	Father N=39	Brother N=64
Mean	72.476	00.500	01.206	00.513	00.306	00.244	00.400
St.Dev.	10.961	00.502	01.369	00.501	00.462	00.431	00.626
Range	56.000	01.000	04.000	01.000	01.000	01.000	03.000
Min.	39.000	00.000	00.000	00.000	00.000	00.000	00.000
Max.	95.000	01.000	04.000	82.000	49.000	39.000	03.000

Table III

Age	Sister Death N=46	Father Death N=104	Mother Death N=89
Mean	00.288	00.650	00.556
St.Dev.	00.587	00.478	00.498
Range	03.000	01.000	01.000
Min.	00.000	00.000	00.000
Max.	00.300	01.000	01.000

Table IV

Age	Water Intake / day	Irrit-ability (Rat-ing) 5pt	Nervous Tension (Rating) 5pt	Physical Weak-ness (Rating) 5pt	Feeling of Fatique (Rating) 5pt	Palpitat ion (Rating) 5pt	Dizzi-ness (Rating) 5pt
Mean	08.125	03.081	03.462	02.344	02.944	01.281	01.138
St.Dev	04.167	01.475	01.228	01.341	01.411	01.476	01.320
Range	20.000	05.000	05.000	05.000	05.000	05.000	05.000
Min.	00.000	00.000	00.000	00.000	00.000	00.000	00.000
Max.	20.000	05.000	01.000	05.000	05.000	05.000	05.000

Table-V

	Reduced Work Efficiency Before Past one year rating 5pt scale	Redced Work Efficiency at Present Rating 5pt scale	Frequency of Urine/day Rating 5pt scale	Disturbed Sleep Rating 5pt scale	Food Intake Rating 5pt Scale
Mean	02.609	03.675	05.376	03.313	03.225
St. Dev.	01.219	01.281	01.714	01.437	00.897
Range	05.000	05.000	09.000	05.000	06.000
Min.	00.000	00.000	00.000	00.000	00.000
Max.	05.000	05.000	09.000	05.000	06.000

Table-VI
Descriptive analysis of the social readjustment rating scale (SRRS)

	Mean	ST. DEV.
Blood Sugar Random	300.769	48.398
01. Death of Spouse	.256	01.204
02. Divorce	.006	00.079
03. Marital Separation	.113	00.952
04. Jail Team	.000	00.000
05. Death of Closed Faimily Member	7.456	02.527
06. Personal Injury or Illness	7.744	02.016
07. Marriage	0.556	01.620
08. Being Fired from Job	0.100	00.919
09. Marital Reconciliation	0.538	01.737
10. Retirement	0.056	00.712
11. Change in Health of Family Member	6.650	02.860
12. Pregnancy	2.038	03.561
13. Sexual Difficulties	3.150	03.700
14. Gain of New Family Member	2.088	03.292
15. Business Readjustment	0.319	01.510
16. Change in Financial Status	4.250	03.790
17. Death of Closed Friend	3.050	03.793
18. Change to Different Line of work	1.244	02.689
19. Change in Number in Arguments with Spouse	5.694	03.291
20. Mortgage over Rs. 10,000/-	2.613	03.699
21. Foreclosure of Mortgaged or Loan	1.844	03.315
22. Change in Responsibilities at Work	5.575	03.284
23. Son or Daughter Leaving Home	0.000	00.000
24. Trouble with In-Laws	5.063	03.462
25. Outstanding Personal Achievement	0.825	02.451
26. While Beginning or Stopping work	0.100	00.899
27. Beginning or Finishing School	0.869	02.232
28. Change in Living Conditions	4.213	03.650
29. Revision of Personal Habits	1.256	02.626
30. Trouble with Boss	2.344	03.570
31. Change in Work Hours or Conditions	2.969	03.855
32. Change in Residence	2.056	03.167
33. Change in Schools	0.006	00.079

Table continued

	Mean	ST. DEV.
34. Change in recreation.	5.719	03.004
35. Change in Religious Activities	3.869	03.531
36. Change in Social Activities	6.363	02.803
37. Mortgaged or Loan Less Than Rs. 10,000/-	3.156	03.902
38. Change in Sleeping Habits	6.938	02.376
39. Change in Number of Family Get-Together	6.481	02.870
40. Change in Eating Habits	6.219	02.295
41. Vacations	3.788	02.811
42. Eid	6.075	03.403
43. Minor Violation of the Law	0.825	01.948

Table-VII

Factors Analysis of the SRRS Holmes and Rahe Life-Stresses/Factors

Factor	Eigen Value	Percentage of Variance	Cumulative Percentage
1.	06.28782	16.10	16.10
2.	04.72914	12.10	28.20
3.	02.97252	07.60	35.90
4.	01.95752	05.00	40.90
5.	01.79636	04.60	45.50
6.	01.49459	03.80	49.30
7.	01.41694	03.60	53.00
8.	01.30987	03.40	56.30
9.	01.28984	03.30	59.60
10.	01.16160	03.00	62.60
11.	01.07464	02.80	65.40
12.	01.02559	02.60	68.00
13.	00.93700	02.40	70.40
14.	00.89637	02.30	72.70
15.	00.86781	02.20	74.90
16.	00.83991	02.20	77.10
17.	00.80295	02.10	79.10
18.	00.74974	01.90	81.10
19.	00.67188	01.70	82.20
20.	00.63832	01.60	84.40
21.	00.5.8324	01.50	85.90

Table continue

Factor	Eigen Value	Percentage of Variance	Cumulative Percentage
22.	00.54987	01.40	87.30
23.	00.49415	01.30	88.60
24.	00.47594	01.20	89.80
25.	00.43636	01.10	90.90
26.	00.39929	01.00	91.90
27.	00.38840	01.00	92.90
28.	00.34501	00.90	93.80
29.	00.33640	00.90	94.70
30.	00.32390	00.80	95.50
31.	00.29761	00.80	96.30
32.	00.26679	00.70	97.00
33.	00.25988	00.70	97.60
34.	00.22549	00.60	98.20
35.	00.21155	0.50	98.80
36.	00.15576	00.40	99.20
37.	00.13569	00.30	99.50
38.	00.12751	00.30	99.80
39.	00.06675	00.20	100.00

Items No.04, 07, 10 and 23 have been deleted from the SSRS by the varimax rotation.

Table-VIII
Multiple Regression of SRRS Scores and Blood Sugar Random of Diabetics (N=160)

SRRS	Variables	Blood Sugar	Blood Sugar	Beta T	Significant "T"
34	Change in Recreation	03.669480	2.216450	.227722	1.656 .1005
11	Change in Health of Family Member	02.383460	1.988284	.140838	1.199 .2330
41	Vacations	01.709735	2.050255	099319	0.834 .4060
13	Sexual Difficulties	01.534583	1.723344	.117310	0.890 .3750
26	While Beginning or Stopping Work	01.456904	5.475910	.027051	0.266 .7907
01	Death of Spouse	01.198591	5.556708	.029818	0.216 .8296
31	Change in Work Hours or Condition	01.143595	2.378015	.091073	0.481 .6315

A demographic questionnaires was used to obtained information for the variable like academic qualifications, monthly income, family members, blood sugar random, duration of illness, present weight (Table 1): past weight no. of insulin injections used/ day hereditary factors involved, diabetic mother's father / brother (Table II); diabetic's sister, father/mother & death, (Table III): Water intake / day, mood irritability, nervous tension, physical weakness, feelings of fatigue, palpitation and dizziness (rate on a given 5-point rating scale), shown in Table IV. Similar variables were identified to identify the severity of illness. For the purpose of the data analysis, the mean and the standard deviations were computed (Table VI), the mean blood sugar random of the sample irrespective of the type of diabetes appeared 300.769 mg% which seems on the quite higher side of the illness, In relation to the hyperglycemic picture of the sample item No. 5, 6, 13, 17, 19, 22, 28 and 35 contributed to it. The life-stresses has an adverse effect on the glycemia control of the diabetics especially item 40 (change in eating habits $\overline{X}$ = 6.219, SD = 2.295), also correlates with Item 41 (EID, $\overline{X}$ = 6.075, SD = 3.403).

By closely examining the Table III, on factor analysis of the SRRS, the item 04, 07, 10 and 23 were automatically detected through varimax rotation, probably because of the low factor loadings on the these items.

DISCUSSION

The general purpose of the present investigation was to determine the degree of relationship between desirable and undesirable life change and diabetic control. The results indicated that significant findings were obtained only when negative changes were considered. No significant correlates of positive changes were found (item 14, 25, 26). It may be noted that it is not entirely surprising that no significant overall relationships between negative life change and poor diabetic control were found, as it has frequently been suggested that measures of life-events are not likely to be useful for purposes of prediction unless variables that medicate the impact of life changes on health and adjustment are considered.The incidence and severity of various diseases have been linked to psychosocial factors such as life events and difficulties. Although earlier studies suggested links between psychosocial factors and the etiology of diabetes mellitus. Very little is known about the psychiatric consequences of diabetes especially in patients over the age of 16 years. Yet mental health is an important factor in the ability to cope up with diabetes. Diabetics experiences a variety of symptoms as part of their disease such as fatigue ($\overline{X}$=02.944, SD=1.411); reduced work efficiency ($\overline{X}$=03.313, SD=1.437) etc. In the present study, the reported symptoms (Table IV and V) indicate the severity of 'diabetes.

The multiple regression analysis shows that the on the SRRS, item 34 (Change in recreation) has been highly correlated with the raised blood sugar level. The next increase appeared on the item No.11 (Change in the health of a family member).

Previous research has suggested that social support may affect chronic illness in two ways, as a buffer against disease, or as a stressor through lack of support. Indeed personal networks are not static structures, and often change their properties as a result of major life-event such as on item 36 (Change in social activities $\overline{X}$ = 06.363, SD = 2.803) and item 39 (Change in number of family get together, $\overline{X}$=06.481, SD = 2.870). Most studies concord that events generating anxiety, specific intrapsychic conflicts emotional deprivations, conscious and unconscious threat to security and unpleasant psychological experiences may upset diabetic control.

Since the present study was retrospective in nature, and such studies can never adequately address the fact of recall bias as inevitably there are interpretations the patient and their families about the onset of their disease. In future, prospective studies may help t entangle the role of stress in genetically susceptible individuals. Despite the fact that stress / metabolic relationships in diabetes are not completely understood, there has been an increasing interest in intervention programs to teach patients to cope with stress. There is a tendency to treat diabetics as a homogeneous group. While individual differences are recognized, for example different IDDM patients are on different doses of insuline. Similarly, stress may influence diabetic control in different ways for different patients.

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ROLE OF EMPATHY IN COUNSELING AND PSYCHOTHERAPY

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ABSTRACT

This paper presents an overview of the literature on the development of the construct of empathy and its role in counseling and psychotherapy. The historical development of the construct describes the changing definition and meaning of empathy. Difference between empathy and some other related constructs (sympathy, projection, and identification) is described. There are many empathy terms used in the literature, however, all disciplines of counseling and psychotherapy identify two major types of empathy: (a) affective empathy, or feeling the same way as another person, and (b) cognitive or role-taking empathy. Different modes of communication used by counselors to convey empathic conditions to client has been discussed. Research in the area of counseling and psychotherapy indicates that empathy is being practiced in counseling for the last 45 years. Although each school of thought provides a different perspective of the nature and operation of empathy , a convergence is clearly evident. Counselors practicing empathy believe that it functions to ensure an ongoing understanding and sensitivity to all therapeutically relevant aspects of the client's world. These aspects include those that the counselor has brought to the client's development in the counseling relationship. In the light of this empathic understanding and sensitivity , the client makes increasingly more choices for his or her personal development. Importance of counselor training in empathy is emphasized. In the end implications for research and practice are suggested.

INTRODUCTION

Empathy is to express understanding of others, to identify with problems, share feelings and accept emotions at face value. It has been said that to

empathize is to see with the eyes of another, to hear with the ears of another, and to feel with the heart of another (anonymous English author as quoted by Alfred Adler, 1927). One can examine the connotation of empathy in biology as a form of instinctive reverberation, its definition in psychoanalytic theory as a form of identification, its equation in social psychology with experimental role-taking and in sociology as mutual understanding among members of the same in-group. A major focus of attention in this paper is the development of the construct of empathy and its role in counseling and psychotherapy. Therapists have to be eclectic in their approach because insights concerning the meaning and function of empathy are boundless in the sciences and humanities. No single source can be expected to account fully for the phenomena of empathy in human relations.

Historical Development of the construct:

The term "empathy" derives from the Greek word empatheia, which implies an active appreciation of another person's feeling. Titchener (1909) is credited with the first use of empathy in English as a translation of the German word "einfuhlung". He outlined the theories of German psychologist Theodore Lipps, envisioned a state of aesthetic awareness in which the perceiver loses self-awareness as his identity becomes used with the object he is observing (Boring, 1957). McDougall (1908), used empathy to describe something quite different – a primitive process of emotional contagion. Until the 1960's the concept of empathy was theoretical rather than empirically defined. In succeeding years, definitions of empathy have continued to vary widely.

Research on empathy began in 1960's and contemporary theorists and researches continue to investigate the role of empathy in counseling and psychotherapy. May (1989), in "The Arts of Counseling", directly considers counseling as an art primarily by way of empathy, which he regards as "the key to the counseling process" and the cathartic quality that results from empathy.

Working within the broad framework of humanistic psychology, Rogers (1957) conducted extensive research into the process of counseling and psychotherapy. Rogers (1957) first identified the construct and produced a landmark paper, "The Necessary and Sufficient Conditions of Therapeutic Personality Change," which made a strong case that empathy and related constructs are all that is needed to produce change in a client. Rogers (1951,1980) introduced empathic understanding as a core condition of therapy, describing it as the therapist's effort to "enter the client's phenomenal world – to experience the client's world as if it were his/her own without ever losing the 'as

if' quality. It has been constantly reiterated by Rogers during the past 45 years. Subsequent researchers worked on the concept in different ways but its practice has been cultivated in depth by counselors in general and by client-centered counseling in particular. Sullivan (1953) believed that empathy is a form of communication on a non-verbal level which can be traced back to the relationship of the infant to its mother. It is a direct and immediate apprehension of feelings in other person. The importance of empathy to psychotherapy outcomes was well established by Traux and Carkhuff (1967). After that, others (Bergin and Suinn, 1975) have challenged their conclusion and finished their review of literature by suggesting that empathy and other facilitative conditions are probably not sufficient "except in highly specific, client centered type conditions". In other reviews, Lambert , Dejulio, and Wolfe (1978) also questioned empathy's role in psychotherapy. Despite the reviews that question empathy's importance in counseling/psychotherapy, it continues to be viewed as an important construct. Theorists and researchers continue to investigate whether empathy is crucial to counseling and psychotherapy success. For example, Barrett-Lennard (1981) described the theoretical empathy cycle in human interactions, including psychotherapy. He supported his concept by referring to research studies in which the clients perceptions of empathy were positively related to counseling outcomes.

Capuzzi and Gross (1995) in the "Counseling and Psychotherapy", write that empathic understanding is the ability to feel with the clients as opposed to feeling for the clients. In short, empathy is the tendency of a perceiver to assume that another persons feelings, thoughts and behavior are similar to his/her own. The counselor or the therapist must be able to enter the client's world, understanding the myriad aspects, such that the client perceives that he/she has been heard accurately.

Cognitive and Affective Empathy:

The construct of empathy is highly subtle and is regarded as both an affective and cognitive phenomena. The affective component of empathy is recognized when a person is said to feel as another and cognition is reflected when a person is said to understand as another. Simply stated, cognitive empathy refers to intellectually taking the role or perspective of another person. That is, seeing the world as the other person does. Affective empathy refers to responding with the same emotion to another person's emotion i.e. feeling the same way as another person does. This construct allows practitioners to respond effectively and assures clients that their confidence in the counselor or therapist is justified. All

psychological, social and developmental theories state that empathy is important for initiating and building a counseling relationship.

Mode of Communication for Empathy in Counseling/Psychotherapy:

The mode of communication used by counselors to convey empathic conditions to clients has been researched and discussed in literature. These modalities are the verbal and nonverbal communication systems. Counselors who demonstrate high levels of empathy tend to use the attending and listening skills frequently. Listening involves more than just hearing, it also requires seeing, expressing and feeling. Moreover non-verbal components of attending behavior, such as eye contact, body posture, trunk lean, and physical distance have been shown to relate to empathy (Haass and Tepper, 1972).

Bozarth (1984) proposed that the concept of empathy is idiosyncratic that emphasizes: "(1) the transparency of the therapist in relation to the other person; (2) the person-to-person encounter in the relationship; and (3) the intuition of the therapist.The basic premise is that the role of therapist is that of being transparent enough to perceive the world non-judgmentally, as if the therapist were the other person, in order to accelerate the formative tendency of the other person towards becoming all that he or she can become" (p.69).

A counselor using idiosyncratic empathy might respond with metaphor, other imagery, personal reaction, and non-verbal messages.

Primary and Advance Accurate Empathy:

At the primary level, empathy is the ability to understand, identify and communicate feelings and meanings that are at the surface level of client's disclosure. At the advance level, it is the ability to understand, identify and communicate feelings and meanings that are buried, hidden or beyond the immediate reach of clients. Such feelings and meanings are more than covert, rather than overt client expression (Egan, 1982). It requires the same attending skills plus something else from the counselor's world, such as, self disclosure, directives, and interpretation. At this level, a counselor uses focused summaries of what clients have said, helps them to see the larger picture by putting their experiences into perspective, helps them find patterns in their behavior and gives meanings to these themes, and suggests alternate frames of reference by which they can consider their behavior in a different light. Carkhuff (1987) maintains that when accurately add to client's expressions, we are helping them understand

where they are and in relation to where they want or need to be. Personalized empathic responses can acknowledge the meaning or significance described experiences have for the client, the feelings related to the problem, and the goal itself. The greater the degree of therapist's empathy, the greater the chance that the client will move forward in the therapy.

Empathy and Counseling Theories:

Empathy and the accompanying empathic condition, such as respect, warmth, genuineness, and acceptance are foundational to most helping theories. However different counseling theories demonstrate empathy in different forms. Psychoanalytic theory stresses the affective quality of the empathic process, which is reviewed as a consequence of the mechanism of identification as delineated by Freud (1955). For him empathy was the "mechanism" by means of which we are enable to take up any attitude at all towards another mental life. Freud regarded it as essential for establishing the rapport between patient and therapist that makes interpretation possible (Pigman, 1995; Warren,1994). Kohut (1995) argues that introspection and empathy are essential ingredients of psychoanalytic observation and limits of psychoanalysis are defined by the potential limits of introspection and empathy. The aim of empathic understanding in person-centered therapy is to encourage the client to get closer to themselves, to experience feelings more deeply and intensely, and to recognize and resolve the incongruity that exists within them. Rogers (1980) interpreted that counseling does not involve interpreting the condition of another or attempting to overcome unconscious material. Empathy is offered to clients so that they may listen to themselves more clearly. The influence of Carl Rogers has been so profound and pervasive that it has changed the face of the helping professions from objective reality. According to Mearns and Thorn (1988), in person-centered approach, empathy is a process, a process of being with the client. Empathy is not a "technique" of responding to the client, but a "way-in-relation" to the client. It often feels like being on the same train, as the client! It is the client's journey which the counselor is joining and staying with, no matter how bumpy it is. He sees the terms empathy unconditional positive regard and congruence as related, in so far as the existence of one facilitates the establishment of the other. For the person-centered counselor empathy is more than a mere reflection of feeling. It is not simply objective knowledge ("I understand what your problem is"). Instead empathy is grasping the subjective world of the client and communicating this deep understanding to the client.

It is generally viewed that cognitive-behavioral therapy underscores the need for empathy in accurately understanding the clients problems but Sloane and Staples (1984) found that behavioral therapist exhibited higher or equal levels of empathic condition than did other psychotherapists. Successful patients in both therapies rated their personal interaction with the therapist as the single most important part of treatment. Garfield (1995) discussed that a positive therapeutic relationship and outcome is facilitated by rational-emotive therapist authority and confidence in their approach, and empathy is an important part of that approach. In a behavior modification program, successful clients rated their therapists higher on the dimension of empathy (Schlinder et al, 1983). Empathic responses are frequently used in child-centered play therapy. In this technique empathic responses are statements which therapists makes, that reflects either the content of the child's behavior, or of the child's feelings or thoughts.

A summary of the literature (Cheng, 1990) about family therapy has shown that the affective processes of identification and resonance, the cognitive process or role-taking have been identified as contributing to empathy. She suggested that empathic role taking is an important tool for teaching family therapy interventions. Gureney (1983) also identified empathy as effective for the enhancement of marital and family therapy. The concept of empathy is recognized as the key to quality counseling and an absolutely essential element in therapeutic relationships.

Although each school of thought provides a different perspective on the nature and process of empathy, a harmony and similarity is evident. Kahn (1991), for examples, in his study of Freud, Rogers, Gill and Kohut, cites "a new harmony, a new consensus". In this convergence the humanistic tradition, as represented by Rogers, and the Psychodynamic tradition, as represented particularly by object relations theory, jointly highlight empathy as "probably most important of all [the therapeutic conditions] ... [and the therapist's] major contribution to the client" (p.151). The ideal therapist is first of all empathic. When psychotherapists of many different orientation describe their concept of the ideal therapist, they are in high agreement in giving empathy the highest ranking out of twelve variables. This finding is based on a study by Raskin (1974) of 83 practicing therapists of at least eight different therapeutic techniques.

Counselor Training in Empathy:

The therapist moments of greater effectiveness, both as diagnostician and as healer, has a positive relationship with his/her empathic capacities. To perform

the professional responsibilities skillfully, the role of counselor training in empathy is very important. Aspy and Roebuck (1972) well said in this regard, that an "empathic way of being can be learned from empathic persons." The most important implication of this finding is that the ability to be accurately empathic is something which can be developed by training. Counselors and therapists can be helped to become empathic. This is specially likely to occur if their teachers and supervisors are themselves individuals of sensitive understanding (Aspy and Roebuck,1972). It is most encouraging to know that this elusive quality, of utmost important in therapy, is not something one is "born with", but it can be learned most rapidly in an empathic climate.

Methods of teaching empathy have been developed and tried out as a part of research studies. Extended package programs such as Carkhuff's (1980) "Human Relations Training", Ivey and Autheir's (1978) "Microcounseling", and Kagan's (1975) "Interpersonal Process Recall" usually involve multiple methods, including modeling, didactic instructions, feedback and experimental exercises. These programs are shorter than 8 hours and run as 100 hours. Furthermore, training involves other dimensions (such as genuineness and positive regard) as well as empathy. Artificial client stimuli may be used, but real counseling sessions are equally included.

Recent studies investigated the effects of training on counselor's empathic understanding. Barak (1990) demonstrated the use and effectiveness of the empathy game, which is intended to promote counseling students empathic skills through a stimulating and competitive procedure. He found that the empathy game could be easily implemented in counselor training programs. This study can be considered a demonstration to a new procedure, and further research should examine more closely its contribution to counselor training. Egan (1975), in a training manual, presented eight rules for communicating more accurate empathy.

Counselor's communication skill proficiency has the strongest relationship with perception of the counselor's quality of empathic understanding and with the participants willingness to see the counselors (Goldin & Doyle, 1991). It suggests that communication of empathic needs continue to be a primary focus in the training of programs of counselors. Gold (1992) investigated the relationship between resolutions of Erikson's psychological state of intimacy/isolation and counselor trainee empathy. Results showed no significant effects for any variable age, gender, status on empathy, suggesting that empathic skills is not a function of gender, age or status. No doubt it is difficult for the therapist to maintain

empathic and caring attitude when they are threatened with violence and physical discomfort. But the real challenge of empathic approach is to accept those who seem unacceptable and work with them to change their behavior, attitude and feelings.

For empathy to be effective, there must be a balance of affective and cognitive, subjective and objective, active and passive. In order for the counselors to be empathic, their self-boundaries must be flexible. Counselor and client both require the same capacity for being in touch with one's own inner experience and for being in touch with the inner experience of others. What distinguishes the therapist from the client in matters of empathic communication is the degree of sensitivity, the ability to control one's own responses, and their sourcefulness and energy necessary for communicating when unusual stress and distortions intrude. When he/she accepts the responsibilities of counseling or therapy, he draws on his/her specialized training in empathic skills.

CONCLUSION

The literature presented in this paper supports the contention that empathy is a significant component in human relationships, especially in psychotherapy and counseling. In light of this review of literature , the following conclusions can be drawn regarding our current state of knowledge of empathy and implications of this knowledge for research and practice.

- Although there is a considerable theoretical literature concerning empathy, its development and practice in counseling, there is a dearth of research on the role of empathy in postmodern approaches.
- While empathy has been defined as the single most important dimension in establishing a counseling relationship, no studies have clearly defined what counselor responses are perceived as empathy by African-American, Asian and Mid-Eastern clients.
- A lot of work has been done during the last 40 years in the developmental, social and counseling/psychotherapy fields. However , up to now, these fields have carried out their studies fairly independently from each other.

IMPLICATIONS

In view of the above conclusions, following implications can be derived for future research and practice.

- Knowledge from the fields of developmental, social psychology, and counseling/psychotherapy must be used to plan and carry out basic and applied studies. In this way each, field can benefit from the others designs and measures, and with this integration, the scope of research and practice will be broader.
- Research should focus on the measurement of empathy and the ways of increasing empathy in helping professions.
- Research with multicultural perspective can be helpful in facilitating the role of empathy in multicultural counseling.
- There should be training programs and workshops for graduate students in the area of counseling and for the working counselors as well to enhance the understanding and intentional use of empathy.
- To study the effectiveness of empathic understanding in counseling practice, longitudinal and cross-sectional studies should be planned. In this way we can move in new directions that will expand our understanding.
- For the precision of the gain in research and practice, studies should be done in natural situation (in vivo) rather than in laboratory situation.
- Follow-up studies should be done to see the long term effects of empathic counseling.
- Counselors should use various kinds of empathy (affective and cognitive) differentially. They should identify which empathy seems appropriate with which goals, at what stage, and with which client. The important thing here is to realize the need for flexibility in empathic counseling.

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SOCIO-ECONOMIC STATUS: A FACTOR IN MARITAL ADJUSTMENT

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ABSTRACT

The current research was conducted to investigate the socioeconomic status as a factor in marital adjustment. A sample of 90 females, coming from different socio-economic groups: (i) lower class; (ii) middle class; (iii) upper class (30 in each subgroup) was selected. The age range of married females was 20-40 years. The sample was drawn from the different areas of Lahore City. A comprehensive Marital Adjustment Questionnaire was administered which assessed the respondents' relationship with inlaws, financial adjustment, leisure time being spent with the spouses, mutual understanding, and marital satisfaction. The results ($t=2.67$; $df=58$; $*p<.05$) also indicate that the females from the upper class ($X=124$) are well adjusted in their marital lives as compared to the females who belong to middle class ($X=112$). The results ($t=2.43$; $df=58$; $*p<.05$) indicate that the females from the middle class ($X=112$) are better than the females who belong to lower class ($X=102$) in terms of their marital adjustment. In addition to this, high positive relationships between the scores of financial adjustment and marital adjustment for the groups of lower, middle and upper classes ($r=.68$; $r=.74$; & $r=.76$ respectively) were found. In the light of current research findings, it may be inferred that socio-economic status is a significant factor in promoting the marital adjustment of the Pakistani married females.

INTRODUCTION

The present scientific, technological, and electronic advancement of the developed countries catches attention of the world. It is the main objective of all countries of the 'thirdworld' to become developed nations of the world. Pakistan is a poor country of the 'third world' with per capita income of 400US$. This income is very unevenly shared (Alam, 1994). In view of the fact that the basic

needs and attainment of better living conditions, is a human right, and also that the linkages between income, education, decreased fertility and improved health have made money/income resources a necessity of the success of national development programmes. Money becomes increasingly important as a nation moves from agricultural through industrialized to post industrial economies (Rice and Tucker; 1986). Social scientist/economist argue that the process of spending, saving, investing, borrowing, transferring, or exchanging money, can change the society, as well as,its marriage institutions. It is observed that money is an instrumental resource in the psychosocial and economic development of nations.

It has been observed that the Pakistani society is highly stratified with wide disparities in the distribution of money. According to Jalil's (1981) report, "In 1980, approximately 64% of the inhabitants of Lahore City lived in slums, an area defined as having high population and housing density, low rents and inadequate living conditions, 10% lived in Katchi Abadies" (Jalil, 1981; P.2).

In Pakistan, where patriarchal family unit is structured on males authoritarianism and the females are assigned primarily reproductive, domestic and dependent roles, who are economically dependent on their husbands. This complete dependency forces the wife to comply with the demands of her husband. Females have very limited decision making power in their family matters. It is quite clear that the impact of traditional gender roles on the marital life is not in the favour of women. It has been observed that the rates of marital dissolution, divorce, and mental illness are increasing day by day (Tariq, 1987). Hollingshead (1968) suggests that frequency of marital dissolution is higher in the working or lower class than in the upper and middle class. There are probably many reasons; the main one appears to be the greater economic stress in lower socio-economic strata. Thus, it may be argued that better living conditions and financial resources would facilitate marital adjustment.

By observing these two phenomena, i.e. economic problems and marital maladjustment in Pakistan, the question arises: whether there is any relationship between one's socio-economic status and marital adjustment? The present research investigated that whether the females who belong to upper class would show better marital adjustment as compared to the females coming from the middle and lower classes.

Galbraith (1958) states that "people are poverty stricken when their income, even if adequate for survival, falls markedly behind that of the community".

Poverty characterizes as a sense of deprivation that some people feel because they have less income or fewer material possessions than most other people have (Dye, 1987). As it has been observed that money or high socio-economic status promotes better ways of living by providing sufficient necessities of life and poverty produces a feeling of deprivation because of low income. Therefore, it may be inferred that high socio-economic status would promote one's marital adjustment, as well.

Traditionally, in Pakistan, a family starts its' function when a man marries a woman. Rice and Tucker (1968) explained that "a family is a system of claims, obligations and mutual responsibilities. Members live together and share resources, adults are responsible for themselves and for their children". The institutions of marriage and family are inevitably intertwined. With the advent of marriage two persons add a new member to their already existing families and create an entirely new family. It has been observed that marriage is the oldest universal institution. The institutions of marriage and family have a significant role to play in a society. With reference to Pakistani society, it has been observed that in most of the families husband is the only 'provider' of the family and the role of 'caretaker' is assigned to the wife. Hence, it can be said that any conflict between spouses may lead to the disruption and disintegration of the family system. It may also affect the socialization of children and husband-wife relationship. Smart and Smart (1979) suggest that "income sometimes becomes a cause of disharmony. The depressing effect of low income on marital satisfaction is stronger for blacks than it is for whites". Hence, it may be suggested that high income or having more financial resources leads towards better adjustment between spouses.

Marital adjustment is a broad term. There are a number of issues involved in it. Burgess; Locke and Thomas (1963) indicate that "a successful marriage is a union in which the attitudes and acts of husband and wife are in an agreement of the chief issues such as handling family finances". Marlow and Sproles (1984) describe that for many families, failure to achieve a certain standard of living or some individualized goals can have serious psychological consequences for the affected members. It cannot be said that money can buy happiness; however, a significant lack of financial resources may undermine happiness. Komarovsky (1977) writes about the impact that poverty can have on a marriage. She argues that a life can become "a constant struggle to meet the bills for rent, groceries, a pair of shoes, a winter coat the T.V. set and the washing machine". It has been observed that without money, families live in constant dread of financial drains, such as illness, layoffs or broken appliances. It has been observed that the

husbands who view themselves as poor providers, see their self-esteem crumble. This problem is sometimes aggravated by the disappointed wives who criticize their husbands. Thus, it is clear that low income produces significant stress for a marital unit. It may be argued that this stress is an obstacle to the adjustment between spouses.

Money and financial resources play an important role in achieving basic needs of the life. Finances do provide a sense of security, and generally, in improving the quality of life. In a broad perspective, financial resources are seen prerequisite for the progress in the developed countries. Since, it has been observed that family is the primary unit of the society; it may be argued that financial resources are crucially important in marital adjustment, as they are important in the advancement and development of the society, country and the world.

METHOD

The present research follows an ex-post facto design. The different social classes among married females already exist in the society and the researcher studied whether this affected their marital relationship with their husbands? A sample consisted of 90 house-wives with different social classes was selected from different areas of Lahore City. The age range of married females was 20-40 years. Their marital period ranged from 1 to 15 years. A comparative group sampling strategy was used. Three groups consisting of the upper class (with monthly income 12,000 or above); middle class (with monthly income 5,000-10,000) and lower class (with monthly income 1500-4000) were compared with each other on their marital adjustment.

In the current research, the marital adjustment of the subjects was measured by Dawood and Farooqi's Marital Adjustment Questionarrie (MAQ, 1996a) which has been devised by the researchers using the basic rationale of Burgees Adjustment Schedule (1960). MAQ consisted of 52 items with three fixed alternative choices for each item. Each subject had to mark only one choice which represented her feelings in the best way. Total score of a subject was obtained by adding all the scores on all the 52 items of the questionnaire. The Questionnaire measured (i) relationship with in-laws (ii) leisure time being spent with the spouse, (iii) financial adjustment, (iv) mutual understanding between spouses, and (v) marital satisfaction. Moreover, a Personal History Questionnaire (Dawood & Farooqi, 1996b) was also devised by the researchers which determined the socio-economic class of the subjects and other demographic characteristics. Each subject was administered MAQ and PHQ, individually.

RESULTS

Table I

$\overline{X}$ SD, SEDX of the Scores of the females of Upper socio economic class and the females of Lower socio economic Class on Marital Adjustment Questionnaire

Groups	$\overline{X}$	SD	S.ED $\overline{X}$	t
UpperClass	124	14.10		
			3.71	5.92
Lower Class	102	18.10		

T = 5.92; df = 58; * p < .05

Table II

$\overline{X}$, SD, SED$\overline{X}$ of the Scores of the females of Upper socioeconomic class and the females of Middle socio economic class on Marital Adjustment Questionnaire

Marital Adjustment	$\overline{X}$	SD	S.ED $\overline{X}$	t
UpperClass	124	14.10		
			4.20	2.8
Middle Class	112	14.56		

T = 2.8; df = 58; * p < .05

Table-III

$\overline{X}$, SD, SED$\overline{X}$ of the Scores of the females of Middle socio economic class and the females of Lower socio economic Class on Marital Adjustment Questionnaire

Groups	$\overline{X}$	SD	S.ED $\overline{X}$	t
Middle Class	112	18.10		
			4.25	2.35
Lower Class	102	18.10		

T = 2.3, df = 58; * p < .05

Table IV
Correlation between the scores of Marital Adjustment and Financial Adjustment of the females of Upper, Middle and Lower Classes

	Variables	Sum of scores	Sum of squares	Interaction (XY)	r
Upper Class	Marital Adjustment (X)	3692	460124	50149	76
	Financial Adjustment (X)	401	5551		
Middle Class	Marital Adjustment (X)	36373	388747	41450	.74
	Financial Adjustment (Y)	359	4521		
Lower Class	Marital Adjustment (X)	3063	318887	30673	.68
	Financial Adjustment (Y)	291	3141		

DISCUSSION

The research findings ($\overline{X}$=124; $\overline{X}$=112; $\overline{X}$=102, respectively) indicate a systematic increase in the marital adjustment of the groups of females of upper socio- economic class (monthly income 12,000 or more), middle socio-economic class (monthly income 1,000-5000) and lower socio-economic class (monthly income 1500-4000).

The results given in Table-I (t=5.92; df=58; *p<.05) indicate that the upper socio-economic group showed greater marital adjustment as compared to the lower socio-economic group (with monthly income 1500-4000) (X=124 & X=102, respectively) Although it has been observed that money cant buy happiness, but a significant lack of financial resources may undermine happiness. It may be argued that limited financial resources of the females of lower socio-economic group may stand as an obstacle in the way of their marital adjustment, whereas, ample financial resources often promote marital adjustment of the upper socio-economic group.

The results given in Table-II (t=2.8, df=58, p< .05) show that the females who belong to upper socio-economic class are better adjusted in their marital

lives (X=124) as compared to the females (X=112) who belong to middle socio-economic class. Dye (1987) also found that poverty produces a feeling of deprivation, and finances do provide a sense of security and improvise the quality of life. It has been observed that in most Pakistani families, the wife has to manage the household affairs when they have less money; thus the stress of coping falls disproportionately on women. It may be argued that high socio-economic status would assist the females to establish smooth relationships with their husbands.

The results given in Table-III ($t=2.3$; $df=58$; $p<.05$) indicate that the females who belong to middle socio-economic class are better as compared to the females who belong to lower socio-economic class in terms of their marital adjustment (X=112 & X=102, respectively). Hollingshead (1968) suggests that among the many reasons of marital dissolution, the main one appears to be the greater economic stress in lower socio-economic strata. Without money, families live in a constant dread of financial drains, such as illness, layoffs, or broken appliances. It may be inferred that the females of socio-economic group would score high (X=112) on MAQ as compared to the females of lower socio-economic group (X=102) probably due to their relatively high socio-economic status.

Thus, it can be concluded that significant differences in the mean scores of the marital adjustment are due to belongingness to different social classes (upper, middle and lower classes). These results are quite consistent with the previous research findings (Hollingshead, 1968; Smart & Smart, 1976; and Marlow and Sproles, 1984). Thus, it can be argued that socio-economic status is a significant factor in promoting marital adjustment of Pakistani females.

The results given in Table-IV indicate high positive relationship ($r= .76$; $r=.74$; $r=.68$ respectively) between the scores of financial adjustment and marital adjustment for the groups of upper socio-economic and lower socio-economic classes. Therefore, it may be concluded that increase in one's socio-economic status would increase one's marital adjustment, as well. Consequently, the findings of the present research indicate that socio-economic status certainly promotes the marital adjustment of Pakistani females. For the development of a prosperous society, as well as healthy atmosphere at home, it is necessary to have such financial resources which can easily fulfill the basic needs and demands of the life. With reference to Pakistani society, it can be argued that by increasing financial resources and promoting better living conditions, it would become an easy task to achieve the target of a developed nation of the world.

The present research was conducted by taking a sample of only 90 married females (30 in each cluster). Therefore, the results of this research cannot be generalized to the entire Pakistani population of married females. The subjects were not matched on the variables of husband's age, number of family members, type of family, etc. So, in order to get more comprehensive results subjects should have been matched on above mentioned variables in order to rule out the possibility of interaction. Thus, the present research has been an attempt to probe into the personal lives of females of different socio-economic groups, in order to determine their level of marital adjustment. Therefore, it was obvious that the respondents would be reluctant to reveal such information. Hence, with reference to present research, it may be argued that the researcher did not have much time to establish rapport with some of the respondents so that they could have revealed the personal information required. Despite having certain limitations, the present research points towards the need to raise the socio-economic status of the females, especially those living in the slums, or katchi abadies, where the basic necessities of life cannot be properly fulfilled. Therefore, the government and private organizations should take the responsibility of establishing training institute for the females to equip them with education and better skills for earning a living for a better life.

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OCCUPATIONAL STRESS SCALE DEVELOPMENT

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ABSTRACT

The study aimed at occupational stress scale development. A Likert type occupational stress scale was developed in Urdu. There are ninety items in the scale. The item analysis, intercorrelation matrix and cronbach alpha coefficients were computed to determine the psychomertric properties of the occupational stress scale. The ninety item scale has alpha reliability value of .92 and criterion validity of .89. The high reliability and validity values recommend the use of occupational stress scale as an authentic research instrument.

INTRODUCTION

Occupational stress is the study of all those aspects of work that either have or threaten to have a bad effect on individual. They include physical properties of job environment, pollution, extremes of heat, cold, humidity, pressure, noise, bad man machine design, time pressures, deadlines, non-standard working hours, organizational or administrative irrationality, demotion, transfer, non-availability of extrinsic rewards (increase in pay), conflict with boss or subordinate, ambiguity about job security etc. there have been considerable studies on occupational stress. Phillips (1982) discusses the nature of occupational stress and its relationship to health and psychological problems in a number of major profession. Cohen (1980) suggested the sources of occupational stress ranging from bureaucratic pressure to fatigue and mental load Cooper and Marshall (1979) made an extensive review of studies on occupational stress and concluded that constant occupational stress cause poor mental health, psychosomatic disease

and coronary heart disease. It is suggested that unattractive salary, job insecurity (in form of forced premature retirement) and little authority are the major sources of stress among executives. French and Kaplan (1970) found in their study of 2000 executives attending a medical checkup. There was strong evidence that older and the more responsible the executive, the greater the probability of the presence of an illness. Alfredson, Spetz, and Theorell (1985) analyzed data from Swedish national registers representing over 958,000 people and found that hospitalization for myocardic infarctions were higher among both men and women in jobs categorized as stressful, hectic and monotonous. So far no systematic research work has been done to understand and measure occupational stress prevalent in Pakistani organizations. Studies have been carried out on occupational stress by Indian researchers Sen (1982), Surti (1982), Bhatnaghar and Bose (1985). In Pakistan Kaur, Shah and Haq (1993) carried out a research on occupational stress and found that occupational stress experienced by private sector managers was higher than public sector managers. The Indian occupational stress scale (OSS) was developed by Pareek (1982). The scale has 50 items on ten subscales, there are five items on each sub-scale. The subscales are Inter Role Distance (IRD), Role Stagnation (RS), Role Expectation Conflicts (REC), Role Erosion (RE), Role Overload (RO), Role Isolation (RI), Personal Inadequacy (PI), Self Role Distance (SRD), Role Ambiguity (RA), and Resources Inadequacy (RI). The above sub-scales provide useful insight into major and minor stressors experienced by individuals working in different types of organizations.

METHOD

The purpose of current study was to develop an indigenous Occupational Stress Scale in Urdu on the pattern and style of Indian Occupational Stress Scale developed by Pareek (1982).

Sample

The total sample in the study consisted of 116 subjects (72 bankers and 44 lecturers). There were 66 males and 50 females. They were between 22-58 years of age. Their educational level ranged from intermediate to masters. Their monthly income ranged from Rs.3000/- to Rs.25000/-. The sample included married and unmarried bankers and lecturers. The range of service was 1-20 years.

Instrument

The study employed the following instruments.

1. Occupational Stress Scale
2. Self-Rating Scale
3. External Measure of Stress
4. Demographic Questionnaire

Occupational Stress Scale (OSS):

The Indian version of Occupational Stress Scale by Pareek (1982) was translated into Urdu. Three university professors who are considered authority on Urdu language and who are on the teaching faculty of Oriental College Punjab University were consulted on the various stages of the translation of the questionnaire. The three university professors agreed on the final translated version of the questionnaire. The OSS Urdu version consisted of 50 self-descriptive statements. It had ten subscales with five items on each subscale. Some additional statements relevant to the occupational stress construct were generated from the literature available on occupational stress. The forty new generated self-descriptive statements were translated into Urdu and they were compared for their relevance and redundancies with the main construct and two statements were deleted due to duplication.

The translated statements obtained at the five steps were merged with 30 additional statements to form an eighty-item scale. Ten items of the scale were repeated in such a manner that one item from each subscale of the OSS was repeated to check the response consistency of the subjects. The final translated version consisted of ninety items on ten subscales. There were 9 items on each subscale. Each item of the scale was to be rated on a Likert type 5-points rating scale ranging from 0-4 indicating the extent of stress experienced by the individual.

The "0" on the scale indicated "Never", 1 "Occasionally", 2 "Sometimes", 3 "Frequently", & 4 "Always".

Self-Rating Scale

A group of 50 bank employees were selected. These were 25 males and 25 females. They were interviewed to find out about the intensity of the job stress experienced by them. In the light of the bank employees interviews a self rating

scale was developed. The self-rating scale with 5 rating categories was constructed to get the subjective estimate of the stress experienced by the persons. The scale range from 0-4. The subjects were required to indicate the amount of job stress experienced by them, with the help of these response categories. The 0 on the scale indicated "never", 1 "Occasionally", 2 "Sometimes", 3 "frequently", 4 "Always" for the individuals during their execution of daily duties and responsibilities at work place.

External Measure of Stress

A group of 40 heads of institutions as selected. There were twenty branch managers and twenty principals of the colleges. They were interviewed to find out about the intensity of job stress as experienced by their subordinate officer. In the light of these interviews the external measure of stress was developed. The external measures of stress was also developed to cross validate the subjective estimate of stress. This scale was completed by the head of the institutions who gave their evaluations of the stress on the given scale as perceived by them about their respective officers. The scale also had 5 rating categories ranging from 0-4.

Demographic Questionnaire

A demographic questionnaire was constructed to collect some basic information about the age, sex, profession, marital status, duration of service and income of the subject.

Procedure

The subjects were individually approached at their work place. The subject's consent was taken for the participation in the study. The subjects were informed about the purpose of the study. The subjects were given instruction prior to the administration of the demographic questionnaire, the OSS and self-rating scale. All three measures were administered to each subject one after the other in the mentioned above order. The external measure of stress was taken for each person from their respective head of the institution.

The following analyses for the data were performed:

1. Item Analyses
2. Inter Correlation's Matrix
3. Cronbach Alpha
4. Concurrent and Criterion Validity.

The item analyses revealed the item total correlation ranging between .10 to .74 at .01 significance level except for item 17 and 58, which were excluded, the remaining 88 items of the scale were retained.

The Inter-Correlation Matrix of subscale scores with total was computed to test the relevance of the each subscale to the total scale. All the correlations of subscales with the total scale are significantly high at .01 level and their range is .61 to .87. These high positive correlations show that the subscales are correlated with each other and that also pertain to the same general construct. The diagonal represents the perfect positive correlation 1.0 of each subscale with its own respective subscale.

RESULTS

Table-I
Intercorrelation Matrix of subscales with total scale

Sub Scale	IRD	RS	REC	RIN	RO	RI	PI	SRD	RA	RE	Total
IRD	1.0	.66	.63	.69	.80	.51	.37	.59	.57	.49	.79
RS		1.0	.68	.75	.68	.68	.38	.71	.74	.71	.85
REC			1.0	.74	.61	.71	.52	.73	.66	.71	.85
RIN				1.0	.72	.66	.51	.66	.67	.72	.87
RO					1.0	.65	.46	.67	.70	.59	.86
RI						1.0	.54	.76	.73	.68	.83
PI							1.0	.38	.52	.45	.61
SRD								1.0	.71	.62	.84
RA									1.0	.65	.85
RE										1.0	.80
Total											1.0

P** .01

Table-II
Cornbach Alpha of the Occupational Stress Scale and subscales

Scale	Alpha Coefficient
OSS	96
IRD	.84
RS	.74
REC	.72
RIN	.75
RO	.86
RI	.66
PI	.70
SRD	.73
RA	.78
RE	.74

P** .01

The Cronbach Alpha of the total scale and the subscales were computed to test the reliability. The Cronbach Alpha coefficient for the total scale was .96 and the range of Cronbach Alpha coefficients for the subscales were .66 to .86 at .01 significance level.

Table-III
Concurrent and criterion validity of OSS

S.No.	Tests	Correlation	Validity
1	Correlation between OSS Scores of Self Rating	.66	Concurrent validity
2	Correlation between OSS and Scores of External Measure of Rating	.62	Criterion validity
3	Correlation between Self Rating and External Measure of Rating	.89	High Positive

P** .01

The Concurrent and Criterion validity were computed. The correlation between the scores of OSS and self-rating was .66 which is significantly high. The two measuring devices have Concurrent Validity. The correlation of External Measure Rating with OSS was .62. There is significantly high positive correlation between External Measure Rating and OSS. The high positive correlation between the Self-rating and External Measure of rating is .89 which supports the fact that both ratings are consistent with each other.

DISCUSSION

As the items of the new constructed OSS were empirically generated, it satisfied the Validity Criterion of the Scale, set by Nunnally (1978) which requires the representative sampling of the items from a specified content domain. The homogeneity of the scale items was tested with the help of Item Analysis. The correlation for each item with the total score was computed. All the items of the scale that qualified on both item-total correlation and item subscale correlation were retained. The reliability of the scales was estimated by Cronbach Alpha Coefficient which is an indicator of the internal consistency of the scale (Cronbach, 1970). The high values of the Alpha Coefficients support our appropriate sampling of the contents and right phrasing of the items of the scale (Kline1986, Kaplan and Souccuzzo, 1982).

The Concurrent and Criterion validity was also estimated. The obtained high Concurrent and Criterion validity pinpoints to the fact that the new developed scale is an authentic measure of Occupational Stress.

It can be concluded that the present research aimed at the construction and development of an Occupational Stress Scale in Urdu for the Pakistani population. While developing the scale difficulties were encountered due to non availability of such scale. An effort was made to construct a scale with sound psychometric characteristics. This scale can be used to study and measure the occupational stressors which are operating in Pakistani organizations. This information can be of tremendous organizational relevance for development of suitable occupational stress management strategies which can ensure physical and mental well being of the employees as against occupational stress.

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OCCUPATIONAL STRESS SCALE TRANSLATED AND ADAPTED IN URDU

پیشہ ورانہ دباؤ

ہدایات:

برائے مہربانی ان صفحات پر کچھ نہ لکھیں۔ اپنے جوابات (ردِ اعمال) اس علیحدہ جوابی ورق پر تحریر کریں، جو آپ کو فراہم کی گئی ہے۔

لوگ اپنے منصب کے متعلق مختلف احساسات رکھتے ہیں۔ ایسے ہی احساسات کو بیان کرنے کے لئے کچھ بیانات ذیل میں درج ہیں۔

اپنے جوابات کو تحریر کرنے کے لئے جوابی ورق استعمال کریں۔ ہر بیان کو پڑھیں اور جوابی ورق پر بالمقابل نمبر کے سامنے جگہ پر اس بات کی نشاندہی کریں کہ آپ اپنے ادارے میں اپنے منصب کے حوالے سے کتنی مرتبہ اس انداز میں محسوس کرتے ہیں؟

* اگر آپ کبھی بھی یا شاذ و نادر ہی اس انداز میں محسوس کرتے ہوں تو (صفر) لکھئے۔
* اگر آپ کبھی کبھار (چند ایک مرتبہ) اس انداز میں محسوس کرتے ہوں تو (ایک) لکھیئے۔
* اگر آپ بعض اوقات اس طرح محسوس کرتے ہوں تو (دو) لکھیئے۔
* اگر آپ اکثر اوقات اس انداز میں محسوس کرتے ہوں تو (تین) لکھیئے۔
* اگر آپ بہت زیادہ یا ہمیشہ اس انداز سے محسوس کرتے ہوں تو (چار) لکھیئے۔

۱۔ میرا منصب میری گھریلو زندگی میں مداخلت کا باعث ہے۔

۲۔ مجھے خدشہ ہے کہ میں اعلیٰ تر ذمہ داریاں اٹھانے کے لئے اپنے موجودہ منصب سے کافی کچھ نہیں سیکھ رہا۔

۳۔ میں مختلف لوگوں کے ساتھ کئے جانے والے متصادم تقاضوں کو پورا کرنے کے قابل نہیں ہوں۔

۴۔ مجھے سونپی گئی ذمہ داریوں سے عہدہ برآہ ہونے کے لئے مطلوبہ معلومات حاصل نہیں۔

۵۔ مجھ پر کام کا بوجھ زیادہ ہے۔

۶۔ دوسرے منصب کے حامل افراد میرے منصب کو مناسب توجہ اور وقت نہیں دیتے۔

۷۔ اپنے منصب کی ذمہ داریوں سے نبرد آزماء ہونے کے لئے میرے پاس مناسب علم اور معلومات نہیں ہیں۔

۸۔ مجھے اپنے منصب میں ایسے کام کرنا پڑتے ہیں جو میرے اندازے اور سوچ کے برعکس ہیں۔

۹۔ میں اپنے منصب کی وسعت اور ذمہ داریوں کے بارے میں واضح تصور نہیں رکھتا۔

۱۰۔ حال ہی میں میرے منصب کی اہمیت میں کمی کی گئی ہے۔

۱۱۔ میری دوسری کئی ایک دلچسپیاں (سماجی، مذہبی وغیرہ) ہیں جو نظر انداز ہوتی ہیں، کیونکہ ان کی طرف متوجہ ہونے کے لئے مجھے وقت نہیں ملتا۔

۱۲۔ میں اپنے موجودہ فرائض منصبی میں اس قدر مصروف ہوں کہ اعلیٰ تر ذمہ داریاں سنبھالنے کے لئے خود کو تیار کرنے کے قابل نہیں ہوں۔

۱۳۔ میں اپنے ہم سطح لوگوں اور ماتحتوں کے متصادم تقاضوں کو پورا کرنے کا اہل نہیں ہوں۔

۱۴۔ اپنے منصب میں موثر ہونے کے لئے مجھے کافی وسائل حاصل نہیں۔

۱۵۔ کام کی مقدار میرے کام کی عمدگی میں مداخلت کرتی ہے۔

۱۶۔ میرے منصب اور دوسرے افراد کے منصب کے مابین کوئی مناسبت نہیں ہے۔

۱۷۔ میری خواہش ہے کہ اپنے منصب کی ذمہ داریوں سے عہدہ برآہ ہونے کے لئے میرے پاس زیادہ مہارتیں ہوں۔

۱۸۔ میں اپنے منصب میں اپنی تربیت و مہارت کو استعمال کرنے کے قابل نہیں ہوں۔

۱۹۔ میں نہیں جانتا کہ جن لوگوں کے ساتھ میں کام کرتا ہوں وہ مجھ سے کیا توقع کرتے ہیں۔

۲۰۔ بہت سے افعال جو میرے منصب کا حصہ ہونے چاہئیں تھے وہ کسی دوسرے منصب کو دیئے گئے ہیں۔

۲۱۔ میرا منصب مجھے اپنے اہلِ خانہ کے ساتھ کافی وقت گزارنے کی اجازت نہیں دیتا۔

۲۲۔ میرے پاس وقت اور مواقع نہیں کہ میں اپنے منصب کے آئندہ چیلنج کے لئے خود کو تیار کروں۔

۲۳۔ میں اپنے اراکین اور دوسرے کے تقاضوں کو پورا کرنے کا اہل نہیں ہوں کیونکہ یہ ایک دوسرے کے ساتھ متصادم ہیں۔

۲۴۔ اپنے منصب میں کام کرنے کے لئے میرے پاس لوگ کافی نہیں۔

۲۵۔ مجھے بہت زیادہ زمہ داری سونپی گئی ہے۔

۲۶۔ میرے منصب اور دوسروں کے منصب کے مابین زیادہ مشاورت کی ضرورت ہے۔

۲۷۔ مجھے اپنے منصب کے لئے معقول تربیت حاصل نہیں۔

۲۸۔ میں ادارے میں جو کام کرتا ہوں وہ میری دلچسپیوں سے متعلق نہیں۔

۲۹۔ میرے منصب کے بہت سے پہلو مجھ پر غیر واضح ہیں۔

۳۰۔ میں آج کل جو ذمہ داریاں سنبھالے ہوئے ہوں اس سے زیادہ سنبھالنا پسند کروں گا۔

۳۱۔ میری ملازمتی ذمہ داریاں میری غیر ملازمتی ذمہ داریوں سے مداخلت رکھتی ہیں۔

۳۲۔ میرے منصب میں ذاتی ترقی کی بہت کم گنجائش ہے۔

۳۳۔ میرے افسران کی توقعات میرے ماتحتوں کی توقعات سے متصادم ہیں۔
۳۴۔ میں قدرے فکرمند ہوں کہ میرے منصب میں ضروری سہولیات کا فقدان ہے۔
۳۵۔ میرے منصب کے کچھ غیر اہم حصوں میں کمی کی ضرورت ہے۔
۳۶۔ اراکین کے مختلف امور کی منصوبہ بندی اور انکے مشترکہ مسائل کے حل میں میرے منصب کے ساتھ ساتھ کئی دوسرے منصوبوں کی شمولیت کا کوئی ثبوت نہیں۔
۳۷۔ کاش میں نے خود کو اپنے منصب کے لئے اچھی طرح تیار کیا ہوتا!
۳۸۔ اگر مجھے اپنے منصب کی حدود کو متعین کرنے کی مکمل آزادی ہوتی تو میں اس سے کچھ مختلف کام کرتا جو میں اب کر رہا ہوں۔
۳۹۔ میرے منصب کو واضح طور پر مزید تفصیل سے متعین نہیں کیا گیا۔
۴۰۔ جو کام مجھے سونپا گیا ہے میں اس سے کہیں زیادہ کر سکتا ہوں۔
۴۱۔ میرے اہلِ خانہ اور دوست شکایت کرتے ہیں کہ اپنے منصبی کام کے بھاری تقاضوں کے باعث ان کے ساتھ وقت نہیں گزارتا۔
۴۲۔ میں اپنے منصب میں جمود محسوس کرتا ہوں۔
۴۳۔ مختلف لوگ میرے منصب سے جو متضاد توقعات رکھتے ہیں میں اس سے پریشان ہوتا ہوں۔
۴۴۔ میری خواہش ہے کہ مجھے سونپے ہوئے کام کے لئے زیادہ مالی ذرائع حاصل ہوتے۔
۴۵۔ میں اپنے منصب میں کام کے بوجھ تلے دبا ہوا محسوس کرتا ہوں۔
۴۶۔ جب میں تبادلہ خیالات یا اراکین کی مدد کے لئے خود سے بھی کوئی قدم اٹھاتا ہوں تو دوسرے منصب کے افراد کی طرف سے مجھے کوئی مثبت جواب نہیں ملتا۔
۴۷۔ اپنے ملازمتی منصب میں موثر ہونے کے لئے مجھے زیادہ تربیت اور تیاری کی ضرورت ہے۔
۴۸۔ میں اپنے منصب میں جو کام کرتا ہوں وہ میری ذاتی اقدار سے متصادم ہے۔
۴۹۔ میں اپنے منصب کی ترجیحات کے بارے میں واضح تصور نہیں رکھتا۔
۵۰۔ میری خواہش ہے کہ مجھے زیادہ چیلنج دینے والے مشکل کام کرنے کے لئے دئے جاتے۔
۵۱۔ کام کو زائد وقت دینا میری گھریلو زندگی میں مداخلت کرتا ہے۔
۵۲۔ اپنی موجودہ منصبی کارگردگی سے متعلق مجھے نتائج کا علم نہیں ہے۔
۵۳۔ میں اپنے عملے کے اراکین مابین کشمکشوں کو حل کرنے کوشش کرتا ہوں۔
۵۴۔ مجھے اپنے کام کو پورا کرنے کے لئے وافر وسائل اور مواد مہیا نہیں کیا جاتا۔

۵۵۔ مجھ پر ایسے کام کی بھرمار ہے کہ میں اس کو عام دفتری اوقات میں ختم نہیں کر سکتا۔

۵۶۔ میرے دفتری عملے کے ساتھ دیر سے آنے اور جلدی گھر جانے سے متعلق بہت جھگڑے/ بحث ومباحثے ہوتے ہیں۔

۵۷۔ میں جانتا ہوں کہ میں نے کام میں اپنے وقت کی تقسیم مناسب نہیں کی۔

۵۸۔ میں اپنے ادارے کی مالی تحفظ کے لئے نئی پالیسیوں اور پروگراموں کو مکمل کرتا ہوں۔

۵۹۔ مجھے اپنے کام کو جاری رکھنے کے لئے ادارے کے اصول یا پالیسی کو تبدیل کرنا ہے۔

۶۰۔ مجھے جو ملازمتی ذمہ داریاں سونپی گئی ہیں، ان کو پورا کرنے کے لئے میں ناکافی اختیار رکھتا ہوں۔

۶۱۔ دفتر کا کام گھر لانا گھریلو زندگی پر اثر انداز ہوتا ہے۔

۶۲۔ میں نہیں جانتا کہ اس ادارے میں میری ترقی اور آگے بڑھنے کے کیا مواقع موجود ہیں۔

۶۳۔ میں اپنی پوری کوشش کرتا ہوں کہ عملے کے اراکین میں سے متاثرہ فریقین کو مصالحت پر راضی کر سکوں۔

۶۴۔ میرے کام سے متوقع امید کے لئے مجھے زیادہ وقت نہیں دیا جاتا۔

۶۵۔ میرے کام کرنے کی مقدار اس چیز پر حائل ہوتی ہے کہ میں اس کو کس قدر بہتر کرتا ہوں۔

۶۶۔ میرا دفتری عملہ کام کرنے کے بجائے فضول گوئی اور وقت ضائع کرنے میں خوش رہتا ہے۔

۶۷۔ میں اپنی نوکری کے کردار کو نبھانے کے لئے مکمل تعلیم یافتہ نہیں۔

۶۸۔ مجھے اپنی نوکری میں ایسے کام کرنے پڑتے ہیں جو میرے ذاتی قدروں سے تصادم پذیر ہیں۔

۶۹۔ مجھے اپنے سے متعلق تمام تر باتوں سے، بہت زیادہ دباؤ کا تجربہ ہے۔

۷۰۔ میرا کرداری عمل میرے کرداری تجربے کا پوری طرح احاطہ نہیں کرتا۔

۷۱۔ میری تنخواہ مجھے اس بات کی اجازت نہیں دیتی کہ میں اپنے خاندان کے بنیادی ضروری تقاضے پورے کر سکوں۔

۷۲۔ میرا کردار مجھے فکر وعمل کی سچی آزادی کی اجازت نہیں دیتا۔

۷۳۔ اگر ایک شخص میرے کام سے متعلقہ فیصلوں کو تسلیم کرتا ہے تو دوسرا نہیں کرتا۔

۷۴۔ مجھے مختلف امور میں درکار مواد وقت پر مہیا نہیں کئے جاتے۔

۷۵۔ میرے کام کی بھرمار سے مجھے جسمانی وذہنی طور پر تھکاوٹ کا احساس ہوتا ہے۔

۷۶۔ میرا دفتری عملی ایک دوسرے کی ٹانگ کھینچنے میں ملوث ہے۔

۷۷۔ میری خواہش ہے کہ میں اپنے کام کو بروقت ختم کرنے کے لئے کوئی اچھا طریقہ تلاش کر سکتا۔

۷۸۔ لوگ مجھے میری ایمانداری کی وجہ سے ناپسند کرتے ہیں۔

۷۹۔ میرے کام کے کردار سے متعلق ادارے کے اصول یا پالیسیاں میرے ذہن میں واضح نہیں ہیں۔

۸۰۔ میرا کرداری عمل میرے لئے مقابلے کے کاموں کی ادائیگی کے لئے مواقع مہیا نہیں کرتا۔

۸۱۔ میرا منصب میری گھریلو زندگی میں مداخلت کا باعث ہے۔

۸۲۔ میں اپنے موجودہ فرائض منصبی میں اس قدر مصروف ہوں کہ اعلیٰ تر ذمہ داریاں سنبھالنے کے لئے خود کو تیار کرنے کے قابل نہیں ہوں۔

۸۳۔ میں اپنے اراکین اور دوسروں کے تقاضوں کو پورا کرنے کا اہل نہیں ہوں کیونکہ یہ ایک دوسرے کے ساتھ متصادم ہیں۔

۸۴۔ میری خواہش ہے کہ مجھے سونپے ہوئے کام کے لئے زیادہ مالی ذرائع حاصل ہوتے ہیں۔

۸۵۔ مجھ پر ایسے کام کی بھرمار ہے کہ میں اس کو عام دفتری اوقات میں ختم نہیں کر سکتا۔

۸۶۔ میرے دفتری عملے کے ساتھ دیر سے آنے اور جلدی گھر جانے سے متعلق بہت جھگڑے/ بحث ومباحثے ہوتے ہیں۔

۸۷۔ میں اپنی نوکری کے کردار کو نبھانے کے لئے مکمل تعلیم یافتہ نہیں۔

۸۸۔ لوگ مجھے میری ایمانداری کی وجہ سے ناپسند کرتے ہیں۔

۸۹۔ مجھے اپنے کام سے متعلق تمام تر باتوں سے بہت زیادہ دباؤ کا تجربہ ہے۔

۹۰۔ میری خواہش ہے کہ مجھے زیادہ چیلنج دینے والے مشکل کام کرنے کے لئے دیئے جاتے۔

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EFFECT OF COGNITIVE BEHAVIOUR THERAPY ON GENERALIZED ANXIETY DISORDER: A SINGLE CASE STUDY

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ABSTRACT

Cognitive Behavior Therapy was found to be effective in the treatment of Generalized Anxiety Disorder by number of researches conducted in the West. The aim of the present study was to see the effectiveness of Cognitive Behavior Therapy with a Generalized Anxiety Disorder patient in Pakistan. The subject was a 22 years old, single female, presenting a wide range of physical, psychological, and behavioral complaints; such as low mood, stiffness and tension in the body muscles, difficulty in concentration, lack of confidence, shy behavior, uncontrollable repeated images during study, hopelessness regarding her success in obtaining aspired academic achievements, interpersonal problems with family and friends and a low self worth and esteem. In dealing with case AB research design was employed. A pre-assessment (Phase-A) was done through informal and formal assessment tools which included history taking, mental state examination, administration of Minnesota Multiphasic Personality Inventory (MMPI), Beck Depression Inventory (BDI), Padua Inventory (PI), State Trait Anxiety Inventory (STAI) and Standard Progressive Matrices (SPM). Following hypotheses were formulated:

(a) Cognitive Behavior Therapy will reduce the anxiety, muscular stiffness and will change the feeling of worthlessness.
(b) Cognitive Behavior Therapy will help the client in adjustment with family members and friends.
(c) Cognitive Behavior Therapy will enable the client to cope and eliminate her intrusive images.

(d) Cognitive Behavior Therapy will enable the clients to cope effectively with noxious stressful situations.

Phase-B comprised of utilization of Cognitive Behavior Therapy techniques. A total number of 20 sessions spreaded over a period of 5 months were conducted. At the end of the B-Phase post assessment was done with the use of same measures. Percentages were calculated to compare the pre and post assessment. Results revealed supportive evidence for all the hypotheses. Discussion and recommendation were given.

INTRODUCTION

Cognitive Theory of Emotions asserts that the quality and the intensity of any emotion is generated by its own particular appraisal (Synder and Forsyth, 1991). Anxiety state patients are likely to interpret ambiguous events in negative fashion (Last and Herson, 1988). Himble, Thyer and Papsdrof (1982) found a negative relationship between rationality and levels of anxiety (Rehman, 1991).

Rational Emotive Theory is most attractive to and works best with an educated and articulate client (Garfield, 1995). Butler et al in 1991 found Cognitive Behavior Therapy more effective than Behavior therapy alone after 4-12 sessions and at 11-24 months follow up with anxious patients (Chambless and Gills, 1993). Rational Emotive Therapy reduces self report of general anxiety, speech anxiety and test anxiety. As for social anxiety RET effects improvement in both self-report and behaviour (Davison & Neale, 1994). Activity scheduling, increasing tolerance, balanced diet, postponement of maladaptive behaviour, self instructions, owing emotions, keeping diaries and relaxation exercises proved highly beneficial for the modification of the effective component of anxious patients (Beck and Emery, 1985).

Many researches have found the efficacy of Cognitive Behavioural therapies (CBT) for Generalized Anxiety Disorder (GAD) especially. Hollon in 1980 reported that Cognitive therapy was successful in treating two patients suffering from GAD with panic attacks (Last & Herson, 1988). Glark in 1986 treated six patients who were mainly suffering from non-phobic, free-floating anxiety using Cognitive Behavioural Therapy (Last and Herson, 1988). Borkovec et al, in 1992, used Cognitive Behaviour Therapy with relaxation treatment and found significant positive changes in anxious patients (Chambless & Gillis, 1993).

The above mentioned survey of literature reveals the effectiveness of CBT with anxiety disorder but most of the studies were conducted in the west. The aim of the present day study was to see the effectiveness of the CBT with anxiety patients. The client was a 22 yrs old unmarried female awaiting her BA examination results. She belonged to a middle socio-economic class. She came with the presenting complaints of constant tension and anxiety, low mood stiffness, difficulty in concentration, uncontrollable repeated images during study. She reported lack of confidence, shyness, helplessness, regarding her success in obtaining aspired academic achievements, interpersonal problems with family and friends and a low self worth and esteem. The client was diagnosed as suffering from Generalized Anxiety Disorder. Her psychosocial stressors were problems with primary support group, parental discord, disagreement with relatives, educational problems and no peer group support system. Her current GAF was 50 and highest GAF for last 1 year was 51.

In view of her case particulars following Hypotheses were formulated:

a. Cognitive Behavior therapy will reduce the client's anxiety and muscular stiffness, and will change her feelings of worthlessness.
b. Cognitive Behavior therapy will help the clients in adjustment with family members and friends.
c. Cognitive Behavior therapy will enable the client to cope and eliminate the intrusive images.
d. Cognitive Behavior therapy will enable the client to cope effectively with noxious stressful situations.

METHOD

Case History

The client's father was 49 years old educated upto B.A. She reported to be having restrained relationships with her father. She feels angry with him for belittling and threatening her mother for a divorce every time the parents argue. Her mother was a 50 yrs old housewife educated upto F.A. The client reported not being close to her mother but used to have some sharing of problems with her. The client had four siblings who are all younger to her. The first sibling was a 21 years old brother educated upto B.A. and the client felt a little close to him. The second sibling was a 19 years old brother who left studying when in F.A. The third sibling was a 13 years old sister studying in grade 7. The client reported to be loving towards the youngest sibling who was a 9 years old brother in grade-4.

The client had normal birth and milestones. There was no history of any neurotic trait. She started schooling at the age of 5 years and usually ranked first in her class. Her family shifted to Saudia when she was in class 3. At the age of 8 years a significant event occurred in the client's life. She reported that she along with her siblings was left with a male cousin. Though not very clear what happened, the client reports that he raped her. At that time it didn't affect her much and she did not report to anybody because she considered the experience too odd. The client's menstrual cycle started at the age of 13 years and her reaction to it was normal. Her academic performance deteriorated in class 8. The family shifted back to Pakistan in 1990 due to the Gulf war. She passed her matriculation with first division but was deeply disappointed as parents criticized her for not getting higher marks. She got admission in F.Sc but failed in exams very badly. Then she got admission in F.A. and passed with second division. She took her B.A. exams with lots of concentration problems. The client was considered to be a quiet sort of person who was not close to anyone in the family and had no close friends. She had high academic aims as the only means of attention by parents was having an above average performance.

It was the sudden recall of the event of possible rape that triggered the present illness in the client. It happened when the client was13 year old and it was the same year that she reached puberty. From then onwards her concentration started deteriorate and her academic performance fell low. This was criticized by her parents and later on he developed the mentioned symptoms. She was referred to the Centre for Psychology for psychological treatment by one of her teachers.

Material

Following measuring instruments were used for the pre and post assessment:

1. Beck Depression Inventory (BDI): According to Shaw, Valts and Mc.Cable in 1985 BDI Scores in the range of 0-9 show no depression, 10-15 mild level of depression, 16-23 moderate and 24-63 severe depression (Kendall & Watson, 1989). The scale's split half reliability is 0.93 and validity is 0.73 reported by Beck, et al, in 1960 and 1967 (Kendall & Watson, 1989).

2. Minnesota Multiphasic Personality Inventory (MMPI): The MMPI is designed to provide an objective assessment of some of the major personality characteristics that effect personal and social adjustment. The ten clinical scales are not expected to measure pure traits but to represent discrete

etiological or prognostic entities. There are 3 additional validity scales. The present MMPI is a revised version with 366 items though the actual number of items is 399. The inventory has high reliability. The test is known to be a valid one. The mean of the test is a T score of 50 with 10 T.Scores as on standard deviation from the mean A T. Score of 70 or higher therefore indicates severe psychopathology. (Hathaway & McKinley, 1966).

3. Padua (Inventory (PI)): The PI consists of 60 items describing common obsession and compulsive behaviors and allows investigation of the topography of such problems in normal and clinical subjects. The reliability ranges from .90 in males to .94 in females. The correlation of PI with other questionnaires which investigate obsessional and compulsive complaints ranged from .61-.71 (Sanvio, 1988).

4. Standard Progressive Matrices (SPM): The SPM is a test of a persons capacity at the time of the test to apprehend meaningless figures presented for his observations, see the relationship between them, conceive the nature of the figure completing each system of relations presented divided into 5 sets of 12. SPM was designed in 1938 to cover the widest possible ranges of mental ability to be equally useful with person of all ages whatever their education or physical condition. SPM has a split half reliability of 90 and test retest reliability of 80-90, the validity of the test ranges from 54-86 (Raven, et al, 1984).

5. State Trait Anxiety Inventory (STAI): Trait anxiety refers to relatively enduring characteristics of the individual regardless of place and time, whereas state anxiety is limited to a particular time or situation. STAI was used to measure both (Speilberger, 1970), trait and state anxiety levels in the client. The A-state scale is a sensitive indicator of transitory anxiety, experienced by the client in psychotherapy and can be used to ensure change in A-state intensity that occurs in different situations. STAI form gives a T-Score with the mean of 50 with both trait and state scales. The test retest reliability coefficient is relatively high ranging from .73-.86 and stability coefficient for STAI state scale tends to be low i-e, 0.16-0.54. Both traits and state scales have a high degree of internal consistency (Spielberger et al, 1970).

Procedure

In the present single case study AB research design was employed. A total number of 20 sessions were conducted in a time period of approx 5 months, comprising of two phases, i-e, assessment (Phase-A) and treatment (Phase-B). In Phase-A, assessment was conducted at both informal and formal levels for which six sessions were used. Informal measures comprised of history taking, mental state examination, observation by the therapist and the client's self ratings. Formal assessment was conducted through psychological tests mentioned. In the phase B which was the treatment phase, therapeutic techniques of Cognitive Behavior Therapy, Deep breathing exercise, positive imagery techniques, 16 muscle progressive relaxation daily activity schedule, positive self statement, ABC Technique, Bibliotherapy, Rational emotive imagery (REI), role playing, modeling, coping statements, Hedonic Calculus, thought stopping, and homework assignments were used. At the end of the phase B all the tests used in the pre-testing were administered as a post assessment to find the effect of the treatment phase. Percentages were calculated to compare the pre and post assessment scores on MMPI, BDI, PI, STAI, and SPM and self rating.

RESULTS

Table-I
Comparison between the Pre and Post assessment and percentages of change in scores on MMPI

Scale	Pretest scores	Category	Post-Test score	Category	Difference of %age	% of change
L	40	Low	43	Low	3	7.5
F	80	Marked	64	Moderate	16	20.0
K	40	Low	52	Normal	12	30.0
Hs	52	Normal	42	Low	10	19.2
D	80	Marked	59	Normal	21	26.2
Hs	51	Normal	42	Low	9	17.6
Pd	69	Moderate	71	Marked	2	2.8

Mf	43	Low	51	Normal	8	18.6
Pa	77	Marked	56	Normal	21	27.2
Pt	81	Marked	60	Moderate	21	25.9
Sc	92	Marked	67	Moderate	25	27.1
Ma	73	Marked	53	Normal	20	27.3
Si	76	Marked	60	Moderate	16	21.6

Table-II
Results of Pre and Post test scores on BDI, STAI, PI and SPM

Name of the Pretest	Pretest score %	Post test Score %	% age Difference	% age change
BDI	18 (28.5)	5 (7.93)	20.64	72.24
STAI				
State Anxiety	37 (46.25)	30 (37.50)	8.75	18.97
Trait Anxiety	68 (85)	38 (47.50)	37.5	44.11
PI	102 (42.50)	26 (10.83)	31.67	74.51
SPM	Rank 56	Rank 55		S

Table-III
Comparison between Pre and Post test Scores on various variables by self rating on a 0-10 scale

Variables	Pre-Rank	Post- Rank	%age Difference	%age Change
Hopelessness	9.5	3.5	40	42.10
Anger	8.5	2.0	65	76.47
Depression	9.5	1.5	80	84.21
Anxiety	9.0	1.5	75	83.37
Fearfulness	8.5	3.5	50	58.82
Lack of Self Esteem	9.0	2.5	65	72.22
Lack of Confidence	8.0	3.5	35	43.75
Lack of Concentration	5.5	3.5	20	36.36

DISCUSSION

The comparison of pre and post assessment test scores has revealed that all the hypotheses are supported. Hence Cognitive Behavior Therapy proved to be an effective in treating Generalized Anxiety Disorder. Improvement in the present client's symptomatology is attributed to the therapy strategies used in phase-B. Supportive techniques were used from the very beginning of therapy, which helped to develop rapport between the client and the therapist.

The use of progressive relaxation exercise comprising of 16 muscle groups, deep breathing exercise and positive imagery helped in reducing client's anxiety levels and body tension. Various studies by Davison and Neale (1994), Foreman (1993) and Chambless & Gills (1993) have supported the effectiveness of relaxation exercise, alone or in combination with other techniques for clients suffering from anxiety.

The role of Bibliotherapy in developing insight and reduction in anxiety has been supported by many researches as quoted by Davison and Neale (1994), Scogin, et al (1989) and Ellis and Grieger (1977). The client reported positive changes in her cognition by the information provided by the reading materials. Activity schedule helps in bringing organization in the life of a client and enhances self esteem (Seligman, 1990) the client developed positive attitude towards life and positive self esteem by doing her daily chores in a systematic fashion as compared to wasting her time worrying about her exams, interpersonal relation and low mood. Her post assessment score on BDI has been 05 which indicates no depression, whereas her pre-assessment score was 18 indicating moderate depression (Table-II) Self rating by the client on the variable of lack of self esteem showed 72.22% improvement (Table-III).

The use of assertiveness training including modeling, observation, behavioral rehearsal and feedback helped in bringing an improvement in the social skills of the client self-rating on the variable of lack of self confidence showed 43-75 improvement (Table-III). The effectiveness of assertiveness training for the anxious people who have deficit in social skills has been reported by Davison and Neale (1994), Last & Hersen (1988), L'Abate & Milan (1985). Herson et al (1983), Harre & Lamb (1983) and Ellis & Grieger (1977).

The use of RET techniques especially disputing and rational emotive imagery (RI) helped the client to develop effective rational thinking and experience appropriate emotion. This is supported by the improvement in her

STAI results (Table-II). This also increased her confidence and self-esteem and lowered the sense of helplessness, supported by the pre and post self rating of the client (Table-III). The effectiveness of RET techniques has also been found by Davison and Neale (1994), Last and Herson (1988), L'A bate & Milan (1985), Beck and Emery (1983), Ellis & Grieger (1977).

Coping skills training including Hedonic Calculus, Diversion, and anger dealing techniques helped in the development of a repertoire of skills to make decisions by herself. This also helped her to manage stressful situations effectively. For e.g. she was able to interact with her cousins without fear of ridicule. The efficacy of coping skills has been quoted by Davison & Neale (1994), Eayrs (1987), Gelder et al (1983), and Ellis & Grieger (1977).

Thought stopping techniques proved successful in reducing the frequency of repeated images, supported by her PI results (Table II). Thought stopping which is mostly used with obsession has been reported to be effective by Turner, et al, (1981).

Homework assignments helped in generalizing the learning process in the session to the outside world. On the MMPI Pre-test, the client obtained elevated scores on the sub scales of F, O.Pd, Pa, Pt, Sc, Ma and Si, which indicates severe psychopathology. At the post assessment most of the subscales scores became normalized shifting from marked to moderate range, (Table I) indicating the effectiveness of cognitive behavior therapy in the treatment of GAD. The improvement in the various aspects of client brought about positive changes in her social and occupational functioning. She is now able to interact with people appropriately and has started working as a teacher at a private school.

The AB design used in the present study is the simplest form of the ABAB research design. Although the improvement in the client is attributed to phase B, it is possible that changes may have been due to some other variables (Kazdin, 1982), like maturity or some environmental factors. To ascertain that the change in the client was due to the treatment (Phase B), an ABAB design ought to be completed. Family therapy was also lacking in the present treatment. Family therapy should be introduced so that the environment becomes conducive to positive change and there is less stress for the client. Therapy should be continued until the client feels that she can take responsibility for herself. Further studies should be done to investigate the effects of Cognitive Behavior Therapy with Generalized Anxiety Disorder.

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