118, Block-20,
Abul Asar Hafeez Jalindhri Road,
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DEPRESSION MANIFESTED BY MALE AND FEMALE CHILDREN OF THE SINGLE PARENTS (BY DEATH)

Shazia Hameed
and
Yasmin Farooqi
Department of Applied Psychology
University of the Punjab

ABSTRACT

The present research was conducted to investigate the manifestation of depression in male and female children of the single parents (by death). A sample of 120 (60 males and 60 females) was selected from six different educational institutions of Lahore City within the age range of 16-25 years. A Personal History Questionnaire (PHQ) and Farooqui's Urdu version of Beck Depression Inventory (BDI) were administered on each subject, individually. The research findings ($Z=3.74$; $N=120$; $^*p<.05$) clearly indicate that both male and female children who have experienced their mother's death manifest more depression ($\bar{X}=17.56$ and $\bar{X}=10.30$ respectively) as compared to the children who have experienced their father's death. Furthermore, females with father as single parent manifested more depression than females with mothers as single parent, ($\bar{X}=22.70$ and $\bar{X}=12.13$ respectively) Male manifest more depression then females in case of their father's death ($\bar{X}=11.73$ and $\bar{X}=8.87$ respectively). Thus, it may be argued that gender differences and parental death would have a combined effect on depression as manifested by the children of single parents.

INTRODUCTION

Children in each and every culture are brought up within a social framework, because, human beings are social and they cannot live in isolation. The first contact of the child with his/her social world, starts with his/her mother and then, with family members. Thus, family may be considered as a fundamental social institution of socialization process and a basic unit of the social organization all around the world. Family plays a vital role in the socialization of a child as it shapes his/her behavior according to the norms and values of the society in which he/she lives.

Chilman, Nunnally & Cox (1988) denied family as, "Two or more people in a committed relationship from which they derive a sense of identity as a family". (Chilman, Nunnally & Cox, 1988, P.11) Thus, a family can be seen as the most important group in which intimate relationship exists among its members and everything that happens to one member would have an effect on all the other family members, specially the children. Hence, it may be argued that the death of a closer family member, especially, the parental figure, would have it's devastating impact on children and the family as a whole. Because death of a loved one is one of the universal stressful life experiences, therefore, it can lead to the temporary breakdown or symptoms of emotional disturbance amongst the grieved. Scarpitti & Anderson (1989) describe death as a reality as birth, growth, maturity and old age. They, further, argued that although death is a universal physiological process, the experience of the death of a loved one is distinctly social in nature. Consequently, the death of a parental figure may be experienced as severe, painful and often a devastating experience by the family members; particularly, for the bereaved children.

Whenever, one losses some one close to him/her through death; he/she experiences both grief and mourning. Cavanaugh (1990) defined grief as "Sorrow, hurt, anger, guilt and other feelings arise after suffering a loss" (Cavanaugh, 1990, P.483). Mourning concerns the ways in which one expresses his/her grief. Typically, the bereaved person experiences as mixture of strong emotions, including depression, anxiety, guilt, anger, despair and apathy. Stevens - Long (1984) argues that the intensity of grieving is affected by a host of factors, including how close one was to the deceased, age of the deceased, and suddenness of death. Above all, it depends upon the relationship of the deceased and the bereaved person.

Hetherington & Parke (1986) explain the significance of early parent - child relationships. They argue that in the course of socialization, parents serve important roles as teachers and models for their children. They presence of both mother and father strengthens the child's initiative and confidence. Therefore, loss of a parent can disrupt normal functioning of the children as it involves critical changes in individuals' social environment... children lose not only a key relationship, but, also an important psychological buffer between them and death, they are now next in line. Malinak, Hoyt & Patterson (1979) emphasized that when one's parent dies, it often leads the surviving children to redefine the meanings of parenthood and the importance of time spent together. Thus, it may be hypothesized that the absence of a parent (either by death, divorce or separation) would lead to depression in his/her children.

It has been observed that the death of a parental figure has detrimental effects upon the psychological as well as physical health of their children in Pakistan, probably, because Pakistani families are traditionally characterized by a strong emotional bonding and dependency among the family members. Thus, when a parent dies, it hurts the child more because of loosening the strength of the bond and nurturance among the family members. Although family members may have a number of sincere friends to share their grief, yet, they cannot rebuild their lives easily. Adler (1991) has pointed out that having a wealth of friends, money or self-esteem does not protect people from feeling depressed when a loved one dies. Hence, it may be argued that the death of a parent would lead to depression in his/her children.

Pakistani children are emotionally and economically dependent on their parents, therefore, death of a parent deprives them of a primary source of protection, guidance, love, advice and a role model for their own parenting style. Thus, it may be hypothesized that they would experience the trauma of the death of their parent/parents more intensely as compared to the children in the Western society which promotes the process of separation, individuation and self-actualization at a much earlier stage of development. Papalia (1990) describes that children growing up with one parent do not have two adults who can share child-rearing responsibilities, take them to out-of-school activities, serve as gender role models and demonstrate the interplay of personalities. Chodorow (1978) links the formation of gender identity to the social organization of families. She argues in her "Object Relations Theory" that children learn values and attitudes appropriate to their sex, through the activities their parents expect of them. Usually, the girls develop their identities through identification with their mothers while boys identify with their fathers for the healthy development of their personalities, as adults across the world. Consequently, serious problems may arise in the identification process due to the absence of one parent by death, especially, the same-sex parent. There are numerous research findings which suggest that father's absence has a grace impact on the gender role identification of his sons (Clausen, 1966; Newson & Newson, 1976). On the other hand, the daughters appear to have more psychological problems when the mother is gone by death (Santrock, Warshak & Elliot, 1982). Thus, it can be argued that the loss of a father would adversely influence the boys more and maternal deprivation could provoke an intense stress in girls.

The loss of a parent has a long-lasting influence on his/her children, however, it's intensity depends upon a number of factors, such as, sex of children; gender of the deceased parent; age of the deceased and his/her children at the time of

death; number of siblings; family structure, birth order etc. Although all these factors are important in increasing or decreasing the intensity of problems faced by the children of single parents, yet, parental death, in itself, is certainly a universal stress that can disrupt the normal functioning of the bereaved children. In reality, mother and father play very significant and different roles for their children through out their life span. The father usually acts as breadwinner and protector and mother acts as a homemaker and primary caretaker of the several dependent children.

It has been observed that a traditional Pakistani mother and father have different responsibilities to manage their household problems and to run their homes smoothly. Mother plays a key role in the development of a child's personality as she comforts her children, feeds them and makes them feel safe and calm emotionally. Father, usually, shoulders a major part of discipline as the child grows up. So, it can be hypothesized that depression experienced by children who lost their mothers by death would be different from depression manifested by the children who have lost their fathers.

Nice (1992) states that the children's reactions to loss of a parental figure include anger with the departing or dying parent. Often, they have an overwhelming desire for the missing parent to remain or return and powerful fantasies about the re-establishment of their previous family life.

Death is referred as a cause of permanent loss, because the children cannot rebuild their family and have no chance to meet the lost parent again in their lives. So they feel helpless and hopeless which then can lead them to depression (Beck, 1967). They may start thinking that future is hopeless and they cannot do anything to make it better. Sometimes, sense of guilt is produced in depressed children by the defense mechanism of denial and self-blaming, consequently, they evaluate themselves in a negative way which may further increase their depression. Kovacs and Beck (1978) described hopelessness and negative self-evaluation as an underlying cause in reducing motivation to engage in actions that might reduce depressive symptoms. It has been observed that depression is the main problem faced by most of the members of the single parent families. So the question arise: what is depression? What are its main symptoms and how does one develop it as a reaction to major loss of significant others?

Dorothy (1985) defines depression as the most widespread and unpleasant condition involving an experience of lack of control. People can become suddenly and seriously depressed when a loved one dies. Shaw, Kellam & Mottram (1982), suggest common signs and symptoms of depression that a

person complains or exhibits. These symptoms are: (1) Sadness; (ii) Weight loss and poor appetite or weight gain and increased appetite; (iii) Sleep disturbances; (iv) Change in a person's activity level, becoming either lethargic or agitated; (v) Loss of energy and fatigue; (vi) Negative self-concept, feeling of worthlessness and guilt; (vii) Difficulties in thinking and decision making and (viii) Recurrent thoughts of death or suicide.

Empirical evidence suggests that teens living in single-parent families are more likely to commit suicide than their peers living in the both-parent families. As death of a parent influences all the areas of personality development of their children, including gender role development, cognitive, intellectual and emotional development, therefore, these children usually manifest a lot of emotional development, therefore these children usually manifest a lot of emotional and psychosocial problems. According to Beck (1976) they may have all these problems due to their "depressogenic schemata". Beck (1976) has suggested in his cognitive theory of depression that negative thinking is one of the major symptoms of depression. Negative thinking about himself/herself, future and significant others is the main contributing factor in persistence and severity of a person's depression. He further argues that it results from the activation of negative cognitive structures or schemata.

In fact, mother and father have to play different roles in the upbringing of a child. In addition to playing an important role in the socialization process by verbalizing and practicing the values of the culture, the parent socializes the child by serving as a model for the child to imitate. According to the observational Learning Theory (Mischel, 1970) most of learning occurs through the observation of a model, especially, the same sex model. As a result, presence of the same sex parent is very important for the normal upbringing of his/her children. It may be hypothesized that the death of the same-sex parent would have more adverse effects on his/her children than the death of the parent of opposite gender. Probably, because the young girls develop a tendency to imitate mommy's behavior and boys try to imitate dead's behavior to derive a sense of their own identity. Thus, the parental death may have detrimental effects on their social and emotional lives and can cause serious disruptions in their normal functioning. These psychosocial and emotional problems can precipitate the most unpleasant state known as depression.

Freud (1950) suggested that depression is related to early parental loss and unresolved mourning. Psychoanalysts tend to view the loss of a mother more significantly than the loss of a father. Depression can be produced by loss of a positive reinforcer, such as, a parent (Lewinson, Younger & Grosscup, 1979).

Pakistani children appear to have intense family attachment patterns. They have strong emotional ties of dependency with their parents. Thus, it may be argued that the parental death would emotionally disturb the Pakistani child more intensely. In short, death of a parent can provoke an intense emotions of grief, loneliness and helplessness in children which are salient features of depression.

METHOD

The present research was carried out by following an ex-post facto research design. A true experimental research design could not be used, because the researchers did not have direct control on variables such as age of the subject; number of siblings; socioeconomic status of subjects duration of parental loss etc. Myers (1986) described the ex-post facto design as a plan for conducting a research in which the researcher looks at the effects of selected traits, events or behaviors, systematically but without actually manipulating them. Since death of a parent (either father or mother) is a pre-existing condition, the researchers tried to look at the relationship between the death of a parent and manifestation of depression in his/her children. The researchers, further, studied the effects of gender differences among such children.

Sample:

The sample consisted of 120 subjects (60 males and 60 females) within the age range of 16-25 years. They were selected from six different educational institutions of Lahore City: (1) Forman Christian College for Men; (2) Government College for Men; (3) Hailey College of Commerce, Punjab University; (4) Lahore College for Women; (5) Madarsa-Tul-Binat, Lahore and (6) University of the Punjab, Lahore. A comparative group sampling strategy was used. Four groups consisting of the (i) 30 males with father as the single parent; (ii) 30 females with father as the single parent; (iii) 30 males with mother as the single parent and (iv) 30 females with mother as the single parent were compared with each on their manifestation of depression.

Procedure:

In this research Farooqi's Urdu Version of Beck Depression Inventory (BDI-1996) measured the depression manifested by the subjects. Moreover, a Personal History Questionnaire (PHQ was devised by the researchers to gather information about subjects' age; education; monthly income; type of family system; birth order; number of siblings; age at the time of parent's death; cause of parent's death and name of provider. Each subject was administered PHQ (Farooqi & Hameed, 1996) and Farooqi's Urdu Version of BDI (1996), individually.

RESULTS

Table I

$\bar{X}$ SD and SED$\bar{X}$ of the Children (age 16-25 years) of the Single Parents (either Mother or Father Alive) on BDI.

Groups	BDI X	BDI SD	SED$\bar{X}$	Z
Children having father as the single parent	17.56	12.39	1.94	3.74
Children having mother as the single parent	10.30	8.50		

Z= 3.74; N=120; *p<.05

The results (Z=3.74; N=120; *p<.05) given in Table 1 indicate that children with father as the single parent manifest more depression ($\bar{X}$ =17.56) as compared to the children with mother as the single parent ($\bar{X}$=10.30). Thus, it may be stated that the maternal loss by death has more adverse effects on the children than that of paternal loss by death.

Table II

$\bar{X}$, SD and SED$\bar{X}$ of the Male and Female Children (age 16-25 years) of the Single Parents on BDI

Group	BDI	SD	SED$\bar{X}$	Z
Female Children of the single parent	17.78 15.78	12.22	2.02	1.83
Male Children of the single parent	12.8	9.79		

Z = 1.83; 120;p> .05

The results (Z = 1.83; N = 120; p>.05) in Table 2 does not reveal a significant difference between depression experienced by the female and male children of the single parents. However, further analysis of their mean scores reveals that female children manifest more depression ($\bar{X}$=15.78) than male children ($\bar{X}$=12.08) of the single parents. Therefore, it may be argued that the females manifest more depression than males when they encounter death of their parent (either mother or father).

Table III

$\bar{X}$,SD and SED$\bar{X}$ of the Female Children (age 16-25 years) of the Single Parents (either Mother or Father Alive) on BDI

Groups	BDI $\bar{X}$	SD	SED$\bar{X}$	t
Female Children having father as single Parent.	22.70	12.63	2.64	5.24
Female Children having mother as single parent	8.87	7.12		

t=5.24, df=58; *p>.05

The results (t=5.24; df=58;p>.05) given in Table 3 reveal significant difference in depression manifested by the females living with father as the single-parent and the females living with mother as the single-parent. The females having father as the single-parent appeared more depressed ($\bar{X}$=22.70) than the females with mother as the single-parent ($\bar{X}$=8.87). Hence, it may be argued that the female children are more depressed when they lose the parent of same gender by death (i.e. mothers).

Table IV

$\bar{X}$,SD and SED$\bar{X}$ of the Female and Male Children (age 16-25 years) of the Single Parents (Father Alive) on BDI

Groups	BDI $\bar{X}$	SD	SED$\bar{X}$	t
Female Children having father as single Parent.	22.70	12.63	2.96	3.46
Male Children having mother as single Parent	12.43	10.17		

t=3.46; df=58; *p<.05

The results (t=3.46; df=58; *p<.05) mentioned in Table 4 indicate that females showed more depression ($\bar{X}$=22.70) than males ($\bar{X}$=12.43) when their mothers were dead. Thus, it may be stated that female children tend to become more depressed than the males in case of their mother's death.

Table V

$\bar{X}$,SD and SED$\bar{X}$ of the Female and Male Children (age 16-25 years) of the Single Parents (Mother Alive) on BDI

Groups	BDI $\bar{X}$	SD	SED$\bar{X}$	t
Female Children having mother as single Parent.	8.87	7.12	2.19	1.30
Male Children having mother as single Parent	11.73	9.72		

t=1.30; df=58; *p>.05

The results (t=1.30; df=58; p>.05) shown in Table 5 reveal that male children experience relatively more depression ($\bar{X}$=11.73) than the female children

($\overline{X}$=8.87) when their fathers were dead. Thus, it may be argued that a father's death may produce depression in sons more frequently than in daughters.

DISCUSSION

The present research findings indicate that both the female and male children (age 16-25 years) manifest above average depression ($\overline{X}$=15.78 and $\overline{X}$=12.08, respectively) even if sufficient time (after the parent's death) has been elapsed. These results are very much consistent with the previous research work done by Arthur, Bettie & Kemme (1964). Cortees & Fleming (1968) also found that boys suffer more than girls in case of their father's death. The current research findings ($\overline{X}$=11.73 and $\overline{X}$=8.87), respectively) further suggest that the male children would manifest more depression than the female children in case of their father's death. There is sufficient empirical evidence (Kastenbaum, 1972) which supports that maternal loss tends to be more detrimental for their daughters than their sons as girls identify with their mothers for their healthy personality development. Consequently, the untimely loss of identification figure (role model) would make them more depressed as compared to boys in case of their mother's death. The present research findings (t=3.46; df=58; *p<.05) clearly support the above mentioned notion that the daughters would feel more depressed than sons when they experience death of their mothers.

Interestingly enough, the children with father as the single parent manifested more depression ($\overline{X}$=17.56 and $\overline{X}$=10.30, respectively) than the children with mother as the single parent. These results are consistent with the theoretical framework given by the psychoanalysts (Freud 1950, and Bowlby 1960a, 1960b) in which they tended to view the loss of mother more significant than the loss of a father. It may be argued that the mother acts as the home-maker and caretaker, especially, in Pakistan and mother's first priority is her children, so they have more attachment strings with maternal figure than with the paternal figure present at home. As a result, the death of mother often breaks down the intense love relationship and dependency needs between the mother and child. Hence, the children, especially the daughters, would experience their mother's death more intensely than their father's death. Briefly speaking; death of a parent is a permanent loss and a universal stress, therefore, it can cause depression and many other psycho-social and emotional problems in both the female and the male children of the single parents. Thus, brief counseling must be introduced for such bereaved children to enable them to grapple with their parental loss.

The future research work must focus on cross-cultural study of similarities and differences in the psychosocial and emotional problems manifested by the children of single parents by death, divorce and separation. Furthermore, comparative groups can be drawn and studied from different age groups and socio-economic classes to explore the diversity of their reactions to parental loss. Such research projects would enable us to introduce better management and preventive programs at community level.

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PERSONALITY CHARACTERISTICS OF REFUGEES AND NON-REFUGEES

Shabana Kausar
and
Shabila Kausar
Department of Educational Psychology
University of Alberta
Canada

ABSTRACT

The study aimed to compare the personality characteristics, general adjustment pattern, and attitude of adolescent boys (age ranging between 12-18 years) from refugee and non-refugee families living in Muzaffarabad, Azad Kashmir, Pakistan. Rotter Incomplete Sentence Blank (RISB, Urdu version) was administered to 60 adolescent boys belonging to refugee (N=30) and non-refugee (N=30) families. A multidimensional personality inventory, "Tashkhis Nama" (Alavi, 1994) was also administered to obtain the score of neuroticism and confidence. t-test and chi-square were applied to find out the difference between two groups. The findings supported the hypothesis that refugees have more neurotic tendencies and low level of confidence as compared to non-refugees. It was also revealed that the boys from refugee families scored significantly higher than their peers on maladjustement and conflicting attitude towards their future, self, and other people.

INTRODUCTION

The work "refugee" came from the French verb "refugier" which means "to take refuge or to seek shelter". Refugees are among the world's most disadvantaged people (Loescher & Loescher, 1982). The plight of refugees is universal, long-term problem that is as old as human history. From Biblical times till today they have been among the world's most enduring tragedies. The twentieth century is, as the German novelist Heinrish Bollouce remarked, "the century of refugees and prisoners". In this century, people who fear persecution or death continue to leave their countries. The hope of a better life and a

determination to escape political oppression are the powerful motives that have always brought refugees to other countries.

During the past several years in Southeast and South Asia, people have swept across borders, in search of refuge. The war, worsening economic conditions and conflicts between ethnic have caused several million people to leave their homes. Caught between danger at home and loss of identity in a strange land, refugees seek safety in societies where they are isolated, different, and often impoverished. In addition to the loss of loved ones, the trauma of escape and separation, they also experience culture shock because of unfamiliar housing, food, language, and climate. As a result they develop the feelings of anger, fear, loneliness, and insecurity and (Ashabranner & Ashabranner, 1987). Fear, not only for themselves but for what they may be happening to their friends and families.

Besides the suffering, trauma, persecution, and loss l of loved ones and their homeland, a refugee must also deal with the loss of identity. This identity crisis becomes a hurdle in the process of assimilation and integration in the new country (Fitzpatrick, 1966). With a new life in a strange land refugee begins to feel both incompetent and vulnerable. Anxiety, fear, frustration, and emotional disturbances appear often the refugee becomes apathetic, helpless, hopeless, or aggressive (American Friends Service Committee, 1975). Stress, anxiety, and confusion are a part of the daily life in refugee camps. The ubiquitous presence of insecurity, fear, stress and inadequate diet increase the susceptibility to physical and mental illness.

The upheaval of the refugee's lives is especially traumatic for the young victims. Ashabranner & Ashbaranner (1987) state that nine out of every ten unaccompanied young refugees are caught in emotional crisis. This emotional crisis may show itself in a number of ways, i.e., having trouble getting to sleep, sleeping too much, uncontrollable anger, appetite loss, and feelings of sadness so deep that the person cannot help crying. Depression is a problem for young refugees not when they first arrive at a new place but after they have been making an effort to adjust in their new homes for several weeks or even months. Sometimes this emotional crisis and depression is so severe that the child must be placed in a psychiatrist's care (American Friends's Service Committee, 1975).

It is generally being maintained in the literature and by the public that the immigrant population tends to show higher admission rates to mental hospitals (Suh, 1980). When it comes to the refugees, however, there is a very little disagreement that the rates of psychiatric illness among refugees is rather high

(Tepper, 1980). Studies on social interaction of refugees from the Soviet controlled area of the Central Europe frequently mention reports of repetitive nightmares (Pinter, 1969; Zimmerman, 1958). In such nightmares, the refugee finds himself back in his native country but is unable to escape again or attempts to escape usually under risky or dramatic condition. Such nightmares are viewed as symptomatic of the transition in personal identity experienced by the refugees.

We know from the above mentioned studies and recent historical changes that massive refugee movement can unbalance peace and stability in the world as well as unbalance stability in individual's lives. For psychological, humanitarian, and political reasons we need to know more about the current world refugees' problems. Despite increasing number of refugees in the world, this area is neglected by the researchers and scholars. Dearth of research in this area became important reasons for this study.

This study has been planned to compare the personality characteristics, general adjustment pattern and attitude of refugees from Held Kashmir, India and non-refugees from Azad Kashmir, Pakistan. The purpose is to provide an understanding of the personality problems of adolescent refugees. As far as the personality and psychological problems of refugees are concerned, no local or empirical study has been conducted in this regard. A local doctor told that people of such areas are so frightened that they have become the victim of insomnia and many other psychological problems (Shahbaz, 1990). On the basis of above mentioned studies and reports as well as a study by Tanveer and Fahmida (1989) on the problems of Afghan refugees, it has been hypothesized that:

1. Refugees (R) show more neurotic tendencies as compared to non-refugees (NR).
2. R show low level of confidence as compared to (NR).
3. R are maladjusted as compared to NR.
4. R show conflicting attitude towards themselves, their future, and other people as compared to NR.

METHOD

Sample:

The participants of the study comprised 60 adolescent boys (30 refugees and 30 non-refugees). Refugee group has been selected from the Held Kashmir refugees residing in Ambore Camp of Refugees, Muzaffarabad, Azad Kashmir and non-refugee group has been selected from the two local public high schools

for boys in Azad Kashmir. The age range for both groups was between 12-18 years. The education level of the participnts was between 6th to 10th grade. Minimum duration of the stay for the refugees in Azad Kashmir refugee camp is one year at the time of the study.

Instruments:

Following psychological tests and questionnaires have been used for the personality assessment of the participants.

1. A Multidimensional Personality Inventory, "Tashkhis Nama" (Alavi, 1994) has been used to assess the personality characteristics (neuroticism and confidence) of the participants. Persons scoring high in this scale tend to have maladjusted personalities. They are burdened by anxiety, sadness, and have inferiority feelings. Those scoring low in this inventory tend to be more self-confident and well-adjusted to their problems.

2. Urdu version of the Rotter Incomplete Sentence Blank (RISB, High School form) has also been administered to R and NR to see their general adjustment pattern and attitude towards life. It is a semi-structured projective technique in which the subject is asked to complete a statement for which the first word or words are supplied.

3. Demographic Information Questionnaire: It has been used to get demographic information from the participants, i.e., age, education, duration of stay in refugee camp, and number of siblings etc.

Procedure:

Tashkhis Nama, RISB and the demographic information questionnaire were administered to the subjects one by one to see their adjustment and attitude. Tashkhis Nama was scored according to the instructions given in the scoring manual. Qualitative analysis of three items of RISB has been done to understand the attitude of the subjects towards self, future and other people.

RESULTS

To find out the results, the chi-square and t-test (two-tailed) were applied to the data. The results of the study have been presented in the following tables.

Table I
Neurotic Tendencies in R and NR as measured by Tashkhis Nama

Groups	Mean	Variance	t-value
R	16	26.31	4.54
NR	11	14.45	-

df = 58, P<.01

The findings of the table I supported the hypothesis that R have more neurotic tendencies as compared to the NR group.

Table II
Confidence in R and NR as measured by Tashkhis Nama

Groups	Mean	Variance	t-value
R	17.26	30.47	6.07
NR	10.63	10.61	-

df = 58, P<.01

It is observed from the table value (t=6.07, P<.01) that confidence level of the R is significantly lower than that of NR.

Table III
Adjustment pattern of R and NR as measured by RISB

Groups	Mean	Variance	t-value
R	131.93	58.26	5.61
NR	114.37	121.75	-

df= 58, P<.01

As indicated by the t-value (5.61) in the table III, a significant difference has been found in the general adjustment pattern of R and NR.

Table IV
Summary of the chi-square tests on the Attitude of R and NR

Attitude towards	Groups	C* f	N* f	P* f	X2	Level of Significance
Self	R NR	18 5	5 16	7 9	13.3	P<.01
Future	R NR	8 7	15 3	7 20	14.32	P<.01
Other People	R NR	18 15	6 4	6 11	2.14	N.S

df= 2 C* = Conflicting attitude
N* Neutral P* = Positive attitude

The summary of the above table reveals that experiences before, during and after the process of taking refuge hardened the feelings of refugees towards their inner and outer world. They are disappointed from their future. Their attitude towards self and future is highly conflicting as compared to the NR group. On the other hand no difference has been found between the two groups in the attitude towards other people.

DISCUSSION

It is crystal truth that those who are compelled to leave their motherly homeland, have to encounter countless problems. These refugees are people learning to live with uncertainty. They are the displaced people of this century who have fled their homes because of war, poverty, or starvation. Presence of fear, continuous state of shock, uncertainty, and insecurity creates mental barrier in them. The inner and outer struggle to bear the loss of loved ones and to adapt with the environmental changes creates many psychological and emotional problems. Research is desperately needed to understand these psychological and emotional problems and to evaluate the process of adaptation and assimilation in refugees.

The results of this study support the hypothesis (1 & 2) that refugees show neurotic tendencies and lack of confidence as compared to non-refugees. The life in the refugee camps is not just a matter of material deprivation, but also a matter

of not being able to plan or hope for the future the way teenagers and young people are meant to do. The future is not bright to them - the continuing war offers little hope for the eventual return to their homelands. They are in state of shock, always worried and substituted day dreaming (Riffat, 1992). The turmoil of every day life develops neurotic tendencies, decrease their self-confidence, and emotional stability.

Although refugees and immigrants have played a central role in the history of civilization and in the development of nations and continents, the social-psychological dimension of the process of refuge and resettlement has received little attention. The process of refuge represents an interruption and frustration of natural life expectancies, with all the related anxieties and potential damage to the self-concept. It induces intellectual and emotional stress in the lives of refugees and leads them towards maladjustment. The low score in adjustment in this study indicates the presence of stress, anxiety and frustration in the lives of adolescent refugees. Leon Davico, an official of the office of the United Nations High Commissioner for Refugees had such impressions after a visit to refugee camps in the Horn of Africa in 1981:

"I cannot shake from my mind images of a brief walk ..... I see eyes of 20,000 people ..... Men, women, and children .... Gazing apathetically from skeletal figures; gazing without passon, without any apparent feeling of any kind" (UNHCR, 1981).

To see the attitude of adolescent refugees toward life, self and others, qualitative analysis of some items in RISB is done, which reveals their ambitions to become "Mujahid" or to die "in the way of Allah". They all had strong desire to go back to their homes. Their attitude towards their future and self is conflicting as compared to their peer group. Individual descriptions reveal the feelings of sadness, hopelessness and helplessness. Cernovsky's study (1988) confirmed the findings of this study in which he interviewed with 100 refugees and 56% reported dreams in which they were again in their home country, wishing to or attempting to escape.

It seems that the experiences of migration and refugee affect the adolescents the most. More than half of the world's refugees are under the age of sixteen. The needs of these refugee children, on any content, in any circumstance, remain similar to the needs of children everywhere: security, family life, food, clothing, shelter, health care, education, and a chance to compete for a viable future. What refugee children lack most of all is security and stability. Their parents are unable to comfort them with the assurance that life will be better in the future. The parents themselves view survival as paramount, and the special needs of their children may go unnoticed.

Increasing number of refugees are being settled thounsands of miles from home, in societies and cultures vastly different from their own. The situation of each group of refugees is different from other group so we cannot generalize the results of the present study to all refugee groups. Cross-cultural and longitudinal studies are needed to completely understand their problems. The degree of personal involvement of host countrymen can give emotional boost and relief to the homesick refugees. Talking about their feelings rather than repressing them can be helpful to alleviate the trauma and shock of homelessness and to win the battle of hopelessness. Helping unaccompanied refugees fight depression is a task for everyone who is a part of their lives. It is a battle they must finally win for themselves.

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PERSONALITY VARIABLES OF PSYCHOTHERAPIST AND THEIR EFFECT ON THERAPEUTIC OUTCOME

Farrukh Z. Ahmad
and
Samira Maniar
Institute of Clinical Psychology
University of Karachi

ABSTRACT

In the present study it was hypothesized that therapist's personality variables have their effect on number of their patients being Remainers or Terminators in therapy. In order to test this hypothesis the Personality Research Form-E alongwith a questionnaire prepared was given to 33 student psychotherapists comprising of six male therapist's and 27 female therapists of the Institute of Clinical Psychology, University of Karachi. The therapist's were divided into 2 groups, depending on their high or low scores. Mann Whitney U. Test was applied in order to get statistical significance of the results. It was found that those therapist's who scored high on abasement, aggression, autonomy, change, exhibition, impulsivity and succorance they had more terminators as patients as compared to those therapists's who were low on these variables.

INTRODUCTION

The personality of the clinician plays a considerable role in the effectiveness of his art of moulding the individual towards a better adjustment. His personality makeup colors the information gathered as well as the outcome of his attempts to help the individual. (Ahmad and Khalique, 1983).

The therapist brings to the relationship a variety of relatively stable characteristics that are independent of and exist incidentally to the treatment relationship. Among the inferred traits considered to be most relevant to therapeutic effectiveness are therapist personality styles, emotional adjustment and beliefs or value systems.

Luborsky (1953) viewed the psychotherapist personality as a major factor in success. He selected psychotherapists of high and low competence groups. The high competence group was found to be superior on a) work capacities b)

relationship with people and c) regulation of affect and impulse. Low competence group were described as hostile aggressive, insecure, showing anxiety, over sympathetic, over identifying and over or under controlled. The general mental health of the high's was judged to be better than that of the low's. Luborsky concluded that aptitude at an early stage of psychiatric training is related to later skill. And given equal training, personality is a major factor in success as a psychotherapist.

Another study conducted in this area is by Traux, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash and Stone (1966), who examined the treatment of 40 outpatients seen by therapists judged as offering high level of accurate empathy, nonpossessive warmth, and genuineness showed significantly more improvement on overall indexes of change than patients whose therapists were judged as low in the combined conditions.

An illustration of the impact of therapist characteristics on outcome was reported in a study that evaluated treatment for families of juvenile delinquents (Alexander, et al., 1976). Treatment focused on modelling, prompting, and reinforcement of clear communication and clearly presenting demands, generating alternating solutions to problems. Therapists characteristics were rated prior to treatment and included several dimensions such as confidence, self disclosure, balming, and clarity of communications. Given the inter-correlation patterns, two larger dimensions were generated to describe the therapists and were referred to as relationship (affective behavior, warmth and humor) and structuring (directiveness and self confidence) dimensions. The results indicated that treatment outcome, defined by recidivism among the adolescents, changes in family communication, and continuing in treatment were predicted by relationship and structuring dimension of the therapist. Indeed approximately 60 percent of the outcome variance was accounted for by these therapist dimensions.

Whitehorn and Betz (1954), contributed a valuable piece of research in their study of therapist characteristics in relation to treatment outcomes. They analyzed the case records of one hundred schizophrenic patients treated at the Henry Phipps psychiatric clinic. Using ratings and similar measures of outcome as a criterion, they isolated one group of therapists whose patients had a high improvement rate and another group whose patients improved relatively little. The more successful (Group A) therapists showed better understanding of the meaning and motivations of the patients behavior; their diagnostic formulations went beyond mere clinical description and appeared to place greater emphasis on the patient as a person rather than as an individual displaying a certain psychopathology; they appeared to focus on constructive aspects of the patients

behavior aimed at working out a better solution to his life problems, rather than on the mere decrease of symptoms or "better socialization".

Interestingly, too, Group A therapists made greater use of "active personal participation" in their contacts with patients than did the less successful) (Group B) ones, who were characterized by patterns of passive permissiveness, interpretation and instruction, and practical care. The authors interpretation of their findings was that in the treatment of schizophrenic patients, those therapists are more successful who succeed in establishing a personal relationship characterized by trust and confidence, and who are more "active" in helping the patient to reorient himself in his relationship.

Hiler (1958) studied characteristics of the therapist which might influence the patient to remain in therapy or to discontinue. Using an indirect measure of the patients motivation for therapy (total number of responses on the Rorschach), he showed that therapists who were rated by colleagues as most warm and friendly tended to keep in therapy a larger percentage of unproductive patients. This finding seemed to apply particularly to female therapists. Furthermore, therapists who were rated as more competent tended to lose a fewer productive patients.

Gardner (1964) described, concepts of warmth, permissiveness and understanding, as aspects of the ideal therapeutic relationship.

McNair and Lorr (1964) and Mintz, Luborsky and Auerbach (1971), identified three essential dimensions of psychotherapeutic intervention involved. (1) Warm, personal relationship; (2) directive active method; and (3) Psychoanalytically oriented treatment approach.

Traux, Fine & Millis (1968) suggested that there is greater patient improvement during psychotherapy with therapists high in persuasive potency than with therapists relatively lower in persuasive potency. Further, those results suggested that the therapist's persuasive potency operates independently of his level of accurate empathy, non-possessive warmth and genuineness.

Another study of the effect of individual therapists on the wellbeing of clients has been reported by Yalom and Lieberman (1971). These researchers tried to compare the outcome of persons who participated in encounter groups directed by leaders with different theoretical orientations. Although they were unable to show the superiority of any one theoretical orientation over another, the authors found some startling effects attributable to the leadership style of particular group leaders. Each group leader in their study was rated both by participant questionnaires and observer schedules. The participant and observer

rating were reduced to four basic dimensions of leader behaviour: emotion stimulation, caring, meaning attribution and executive functions. The leader were then grouped into seven types: "Aggressive stimulators", Love leaders", "Social Engineers", "Laissez Fair", "Cool, Aggressive Stimulators", "High Structures" and "The Tape Leaders". Although the data showed that characteristics of some participants made them more vulnerable to negative changes than others, the main finding was that the style of the group leader was the major cause of casualties. The most damaging style, "Aggressive Stimulators", was characterized by an intrusive, aggressive approach that involved considerable challenging and confronting of the group members.

These leaders were impatient and authoritarian in approach, and they insisted on immediate self-disclosure, emotional expression, and attitude change. There were five leaders of this type and all produced casualties except one.

Probably the most dramatic example of the individual therapists effect on patients was published by Ricks (1974). He studied the adult status of a group of adolescent boys, many of whom were experiencing nearly intolerable degrees of anxiety, vulnerability, feelings of unreality and isolation. The boys were seen by either of two therapists in a major child guidance clinic. The more successful therapist A was labeled "Super Shrink" by one of the boys, and Ricks retain this label in describing his techniques versus those of therapist B whom Bergin and Suinn (1975) have called "pseudoshrink" most of whose cases become schizophrenic. It was found that therapist A devoted far more time to those who were most disturbed while the less successful therapist did the opposite. Therapist A also made use of resources outside of the immediate therapy situation, was firm and direct with parents, supported movement toward autonomy, and facilitated problem solving in everyday life, all in the context of a strong therapeutic relationship. It is also noted that therapist B was frightened by the boys pathology and withdrew from them.

Careful studies like this give strong support to traditional clinical beliefs regarding the effects of therapist personality, adjustment and counter transference phenomena on outcome.

Morris & Suckerman (1974 a), found that a warm friendly therapist using systematic desensitization treatment was more effective in reducing fear of snakes than a cold, impersonal therapist.

Bent & Putnam, Kiesler, & Nowicki (1979) found that those patients who were satisfied with therapy, described their therapist as, warmer, more likable, more active, and more involved.

Hartlage & Sperr (1980) found that patient saw the ideal therapist as making good impression, being frank and honest, and appreciative. They felt that ideal therapist should be self respecting and able to take care of himself, he should be firm cooperative, friendly, confident and have respect for others.

Hoyt (1980) explored the content of good and poor therapy session among a group of homogeneous patients presenting stress disorders. Hoyt demonstrated that poor sessions, based upon rating of experts, were characterized by therapist efforts to extract factual information or to give advice.

In a study Luborsky, Mclellan, Woody, O'Brien, Auerbach (1985), they found that the therapists personal adjustment and interest in helping the patient appear to be positively related to post treatment outcome.

In a study Lafferty, Beutler and Cargo (1989), examined differences between more and less effective trainee psychotherapists. Therapists were assigned to one of two groups depending on whether the preponderance of their patients changes in symptomatology indicated more or less improvement over the course of therapy. Therapist variables included emotional adjustment, relationship skills, eliciting patient involvement, credibility, directiveness and theoretical orientation. Less effective therapist were revealed to have lower levels of empathic understanding, to rate their patients as more involved in treatment, and to rate themselves as more supportive than the more effective therapists. Less effective therapists also valued comfort and stimulation significantly more and valued intellectual goals significantly less than did more effective therapists.

In a most recent research conducted by Elliott and Wexler (1994), therapeutic impacts were found to fall into two broad groups: helpful and hindering. In addition, two kinds of helpful impacts were found: (a) task impacts, in which clients experienced progress on theirpresenting problems (e.g., insight into self or problem solution) and (b) relationship impacts, in which clients reported some form of positive interpersonal contact with the therapist or counselor (e.g., feeling supported or closer to the therapist). In contrast to these two varieties of helpful impacts. Hindering impacts involve the client's negative experiences; such as feeling misunderstood or impatience with lack of progress. The highest ratings were obtained for the Relationship Impacts Scale, particularly on the items understood, supported, and closer to therapist, which corresponded to the central treatment principle of fostering a genuine, prizing, empathic relationship (Greenberg et. al. 1993). An informal review of the therapists who received the highest and lowest SIS Helpful Impacts scale rating in this study suggested the possibility that the high-rated therapists acted in a more friendly, personal and active manner then did the low-rated therapists.

In the light of theoretical and literature review the following hypotheses was postulated by the author:

Hypothesis No. 1:

If the psychotherapist is high on abasement then he will have more patients as terminators as compared to those psychotherapists who are low on abasement.

Hypothesis No. 2:

If the psychotherapist is high on aggression then he will have more patients as terminators as compared to those psychotherapists who are low on aggression.

Hypothesis No. 3:

If the psychotherapist is high on autonomy then he will have more patients as terminators as compared to those psychotherapists who are low on autonomy.

Hypothesis No. 4:

If the psychotherapist is high on change then he will have more patients as terminators as compared to those psychotherapists who are low on change.

Hypothesis No. 5:

If the psychotherapist is high on exhibition then he will have more patients as terminators as compared to those psychotherapists who are low on exhibition.

Hypothesis No. 6:

If the psychotherapist is high on impulsivity then he will have more patients as terminators as compared to those psychotherapists who are low on impulsivity.

Hypothesis No. 7:

If the psychotherapist is high on play then he will have more patients as terminators as compared to those psychotherapists who are low on play.

Hypothesis No. 8:

If the psychotherapist is high on succorance then he will have more patients as terminators as compared to those psychotherapists who are low on succorance.

METHOD

Sample:

33 student psychotherapists of the Post Magistral Diploma in Clinical Psychology at the Institute of Clinical Psychology, University of Karachi served as subjects. There were 6 male psychotherapists and 27 female psychotherapists.

Procedure:

In order to assess the personality variables of the psychotherapists, Personality Research Form-E (PRF-E) Jackson, (1984) was administered individually.

Out of the 20 personality scales only following 8 scales were used in the present research. Abasement, Aggression. Autonomy, Change, Exhibition, Impulsively, Play and Succorance.

For each PRF-E scale two groups were formed, one consisting of high standard scores obtained on that scale and the other of low standard scores. For the purpose of the study, "high scores" were defined as those falling higher than one standard deviation above the mean standard score and "low scores" as those falling lower than one standard deviation below the mean standard score for that scale.

Each student psychotherapist was given a questionnaire to fill, the information required was as followed: number of patients seen by them for the purpose of psychotherapy during their training period; number of sessions with each patient, and whether the patients were terminated with the consent of the psychotherapist or without the consent.

The term Remainer and Terminator as defined by Ismail (1988); the Remainer cases are defined as those cases who continue to remain in psychotherapy for atleast 30 sessions and/or are successfully terminated on the recommendations of the Director of the Institute. The Terminator cases are those cases who leave psychotherapy without the adivce of the therapist and those who terminate before 10 sessions of psychotherapy.

Mann-Whitney U-test was computed to investigate whether or not there were significant difference between the remainers or terminators of both the high score group and low score groups.

RESULTS

Table I

The Effect of the Therapist's Level of Abasement on the Number of Terminators in Therapy

Level of Abasement	Number of Therapist	Number of Terminators	Average Number of Terminators
High	9	272	80.77
Low	17	679	39.94

n1 = 9
n2 = 17
u = 25
Significant at .02 level.

Graph "A"

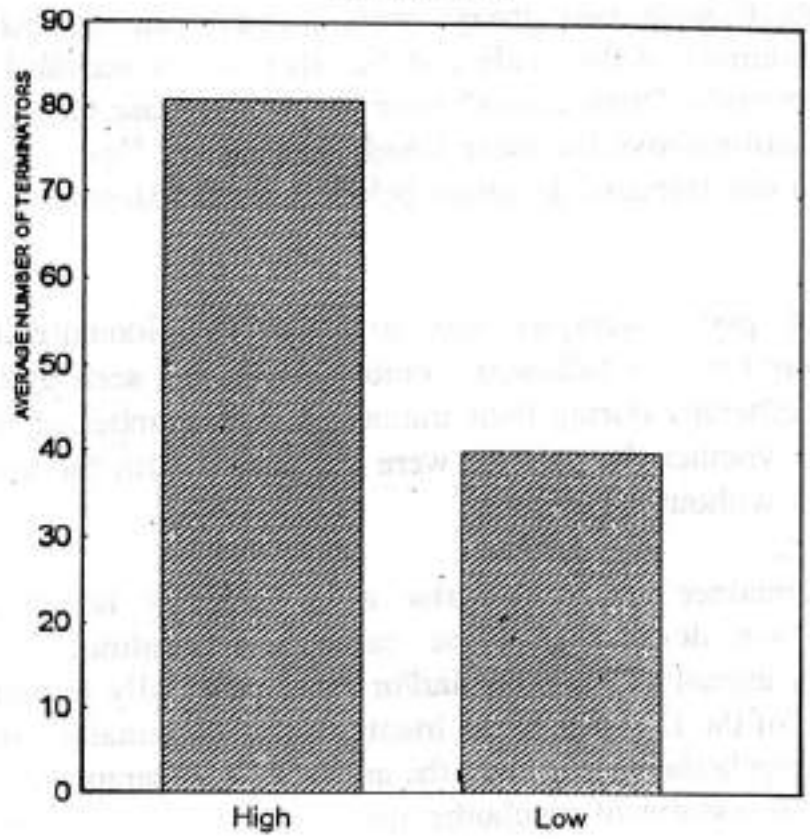


Table II

The Effect of the Therapist's Level of Aggression on the Number of Terminators in Therapy

Level of Aggression	Number of Therapist	Number of Terminators	Average Number of Terminators
High	9	639	71
Low	20	704	35.2

n1 = 9
n2 = 20
u = 21.5
Significant at .002 level.

Graph B

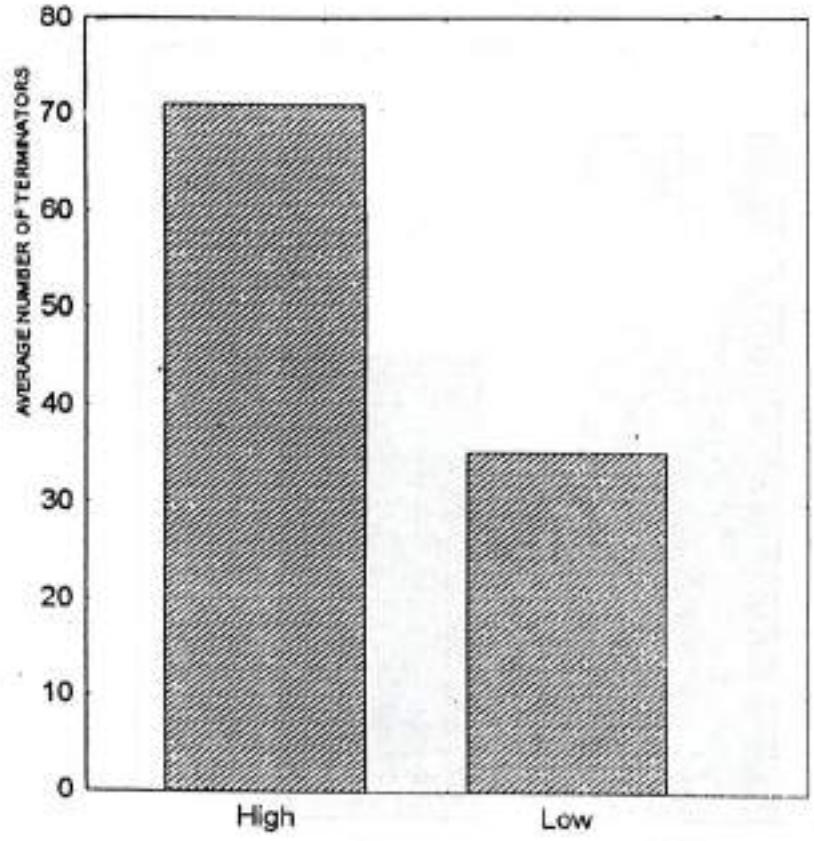


Table III

The Effect of the Therapist's Level of Autonomy on the Number of Terminators in Therapy

Level of Autonomy	Number of Therapist	Number of Terminators	Average Number of Terminators
High	8	570	71.25
Low	22	1058	48.09

n1 = 8
n2 = 22
u = 50
Z = 1.78
Significant at .0375 level.

Graph C

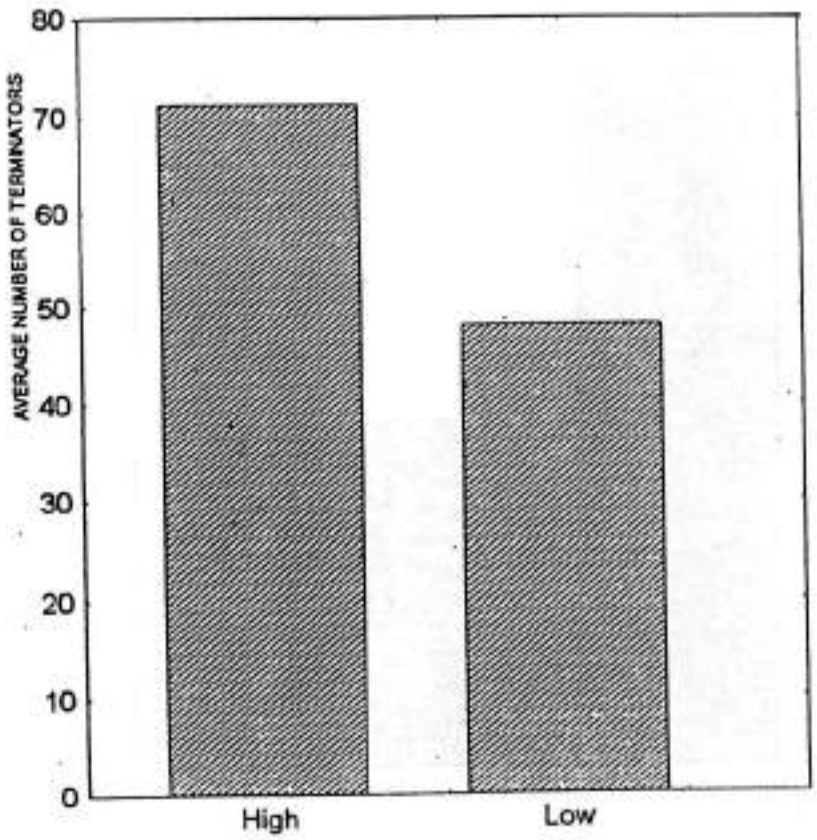


Table IV

The Effect of the Therapist's Level of Change on the Number of Terminators in Therapy

Level of Change	Number of Therapist	Number of Terminators	Average Number of Terminators
High	10	700	70
Low	15	580	38.66

n1 = 10
n2 = 15
u = 35
Significant at .05 level.

Graph D

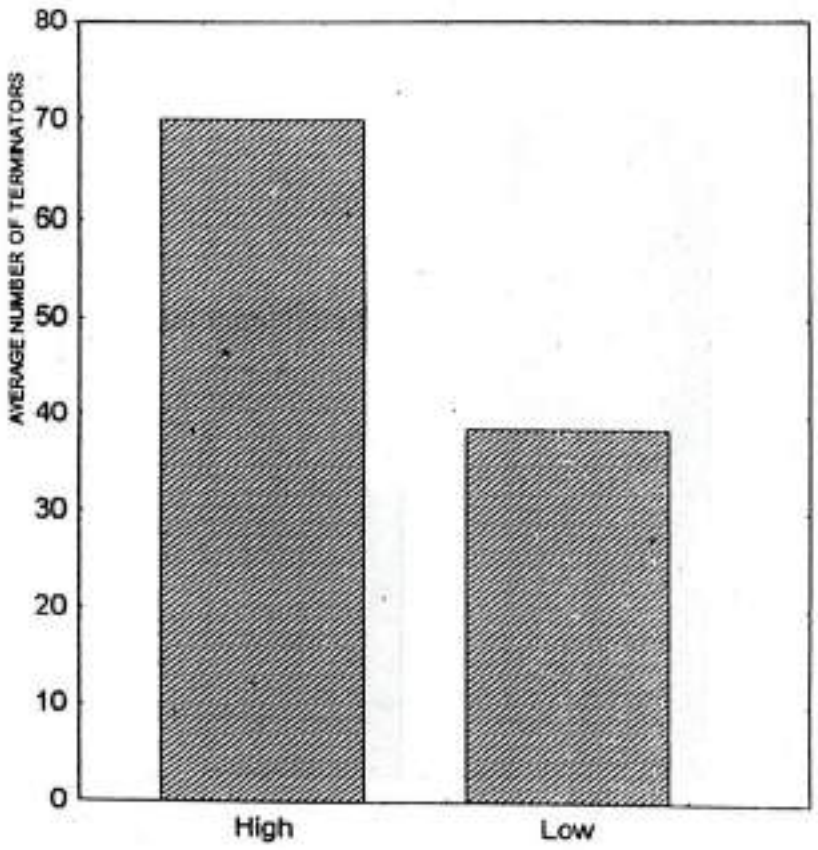


Table V

The Effect of the Therapist's Level of Exhibition on the Number of Terminators in Therapy

Level of Exhibition	Number of Therapist	Number of Terminators	Average Number of Terminators
High	12	812	67.66
Low	11	325	29.54

n1 = 11
n2 = 12
u = 25
Significant at .02 level.

GraphE

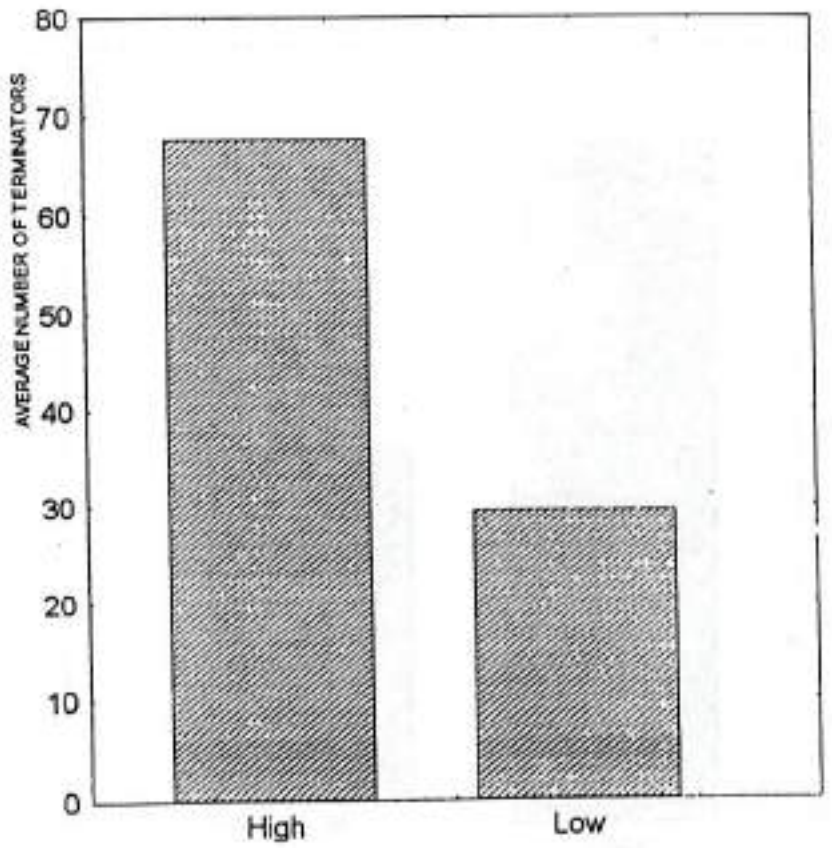


Table VI

The Effect of the Therapist's Level of Impulsivity on the Number of Terminators in Therapy

Level of Impulsivity	Number of Therapist	Number of Terminators	Average Number of Terminators
High	8	375	62.5
Low	17	641	37.70

n1 = 8
n2 = 17
u = 20
Significant at .05 level.

Graph F

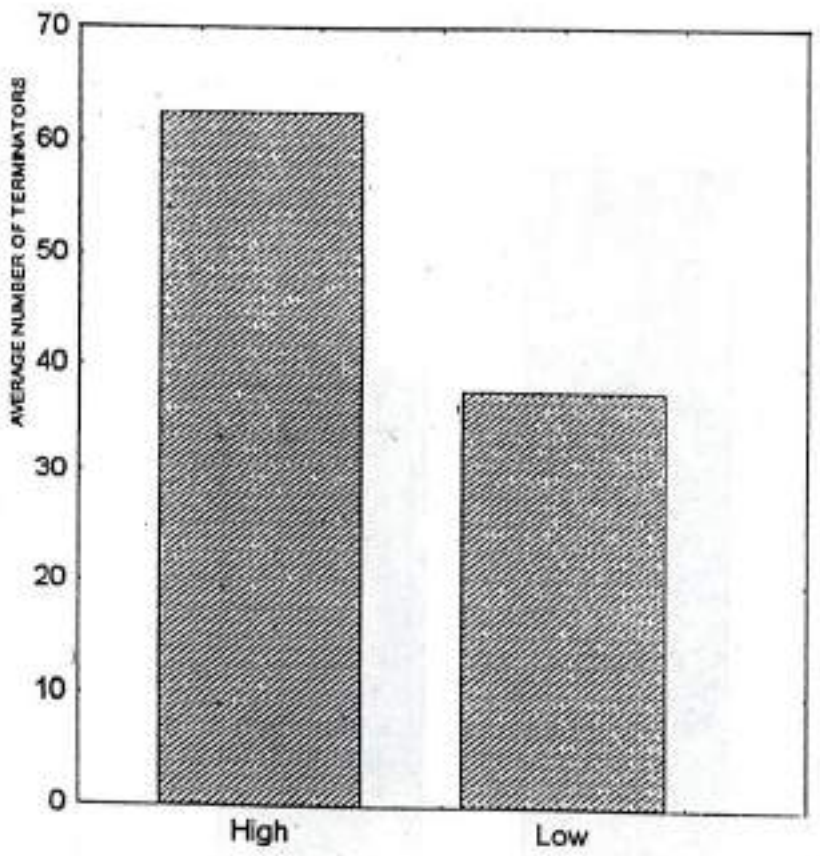


Table VII

The Effect of the Therapist's Level of Play on the Number of Terminators in Therapy

Level of Play	Number of Therapist	Number of Terminators	Average Number of Terminators
High	5	356	71.2
Low	12	1232	51.33

n1 = 5
n2 = 12
u = 40
z = 1.15
Insignificant

Graph G

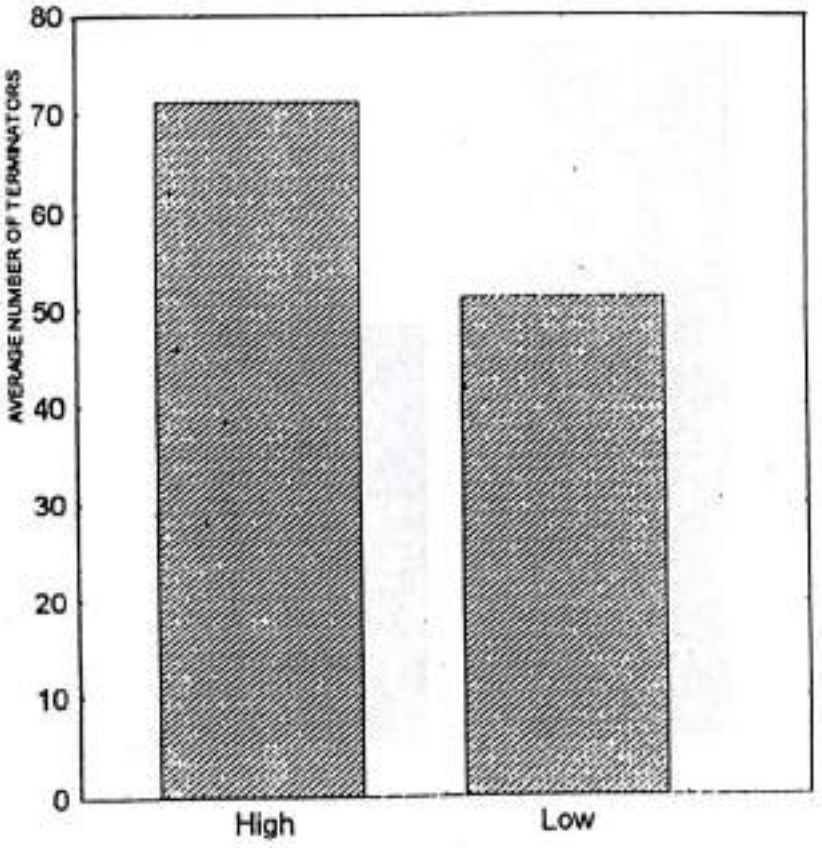


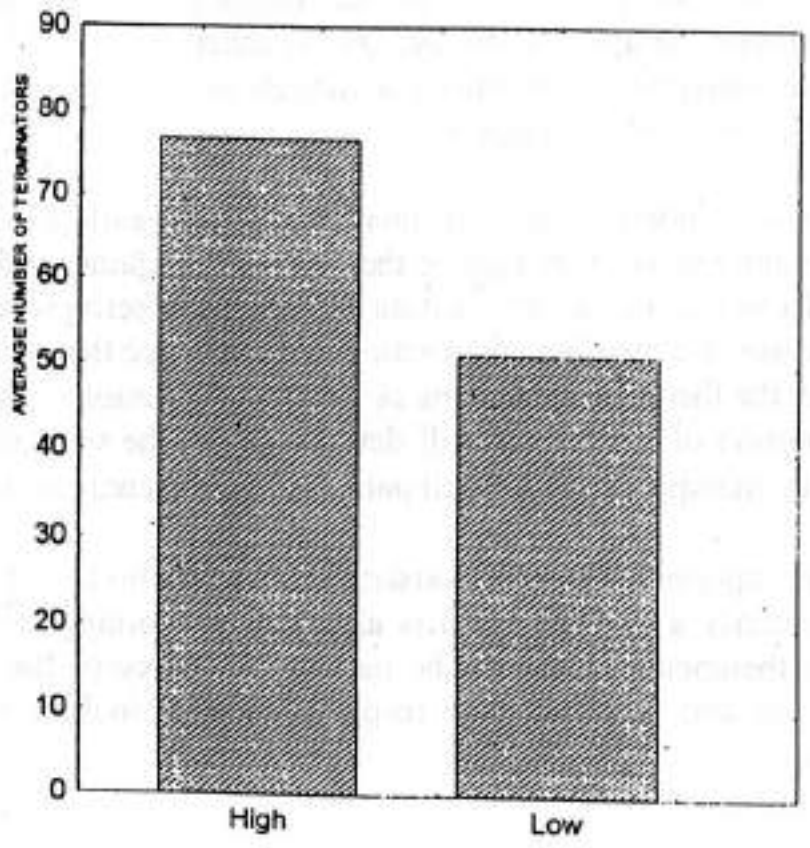
Table VIII

The Effect of the Therapist's Level of Succorance on the Number of Terminators in Therapy

Level of Succorance	Number of Therapist	Number of Terminators	Average Number of Terminators
High	7	536	76.57
Low	21	1073	51.09

n1 = 7
n2 = 21
u = 40.5
z = 1.75
Significant at .0401 level.

Graph H



DISCUSSION

This study was undertaken to find out which personality characteristics of the therapist will produce negative effect on the treatment of the patients.

The hypothesis No. 1 states that: "If the psychotherapist is high on abasement then he will have more patients as terminators as compared to those psychotherapists who are low on abasement".

This hypothesis is supported by the data and is significant at $P<.05$ level.

A person who accepts blame and criticism even when he is not at fault, is self critical; he will not be able to relate to people in an appropriate manner, and other people will not respect him and listen to him.

If the therapist has the tendency to blame himself for his failures, even when not deserved he will act in a similar manner in the therapeutic situation. He would blame himself for all the failures he faces even though he is not at fault. And this belief in turn will make him lose confidence in himself and he would not be able to continue therapy effectively. On the other hand, if the patient gets the feeling that his therapist is not confident enough he will not feel like talking about his problems with such a therapist.

The therapist who underestimates his own importance easily gives way when persuaded and is submissive. This type of therapist will respond to the patient in similar manner. He will not be able to handle the patient effectively he will easily give up when pressured by the patient. There is much chance that the patient will start manipulating the therapeutic sessions as well as the therapist. In this type of situation the condition of the patient will deteriorate and he will not be able to gain anything from therapy and as a result patient might discontinue treatment.

Prestige is an important factor in Pakistan. A person who is self-critical will lose prestige. Similarly a therapist who is all the time blaming will act in the same way in the therapeutic session. The patient will perceive the therapist as unable to help him and thus will lose respect and trust in him and will not continue treatment.

The hypothesis No. 2 states that: "If the therapist is high on aggression then he will have more patients as terminators as compared to those psychotherapists who are low on aggression".

This hypothesis is supported by the data and the difference between the two groups is significant at P<.002 level.

It is quite clear that when a therapist who is irritable, argumentative, is easily annoyed, hot tempered, he will have difficulty in keeping a patient for longer duration in therapy.

When a patient comes across such a therapist, he will feel ill at ease. He will become defensive and rapport with the therapist will not be established. The patient might not find any reduction in symptoms and thus he will discontinue treatment.

Yalom and Lieberman (1971) reported that the most damaging effect on the well being of the client was produced by the "Aggressive Stimulator", characterized as an intrusive aggressive approach. Such therapists are impatient and authoritarian in approach.

Pakistani society is an aggressive society where people are hot-tempered and easily lose control. When a patient who enters the therapeutic situation is confronted with a therapist who is hostile, argumentative, and pushy, the patient will feel uneasy and uncomfortable while discussing his problems. And when a patient is ill at ease he will not be able to discuss his problems openly with the therapist and thus will discontinue.

The hypothesis No. 3 states that: "If the psychotherapist is high on autonomy then he will have more patients as terminators as compared to those psychotherapists who are low on autonomy".

This hypothesis is supported by the data and the difference between two groups is significant at P<.0375 level.

A therapist who enjoys being unattached and may become rebellious when confronted with restraints might face difficulty in therapeutic situations. There are set limitations and certain rules and regulations which should be followed in a therapy session. The therapist who does not like restraints, confinement or restriction of any kind will have difficulty in obeying the rules; he will do whatever pleases him without taking into consideration the patient and his needs. He might be able to devote much time and might show lack of interest in the

patient. When a patient gets the impression that the therapist is uninterested in him and does not show any warmth, he will find it difficult to disclose his problem and personal life to such a therapist. It is well-known that patients often come into therapy with a history of experiences of rejection by others. When such patients face similar situations in therapy sessions it is less likely that they would continue treatment and thus will probably terminate early.

The hypothesis No. 4 states that: "If a psychotherapist is high on change then he will have more patients as terminators as compared to those psychotherapists who are low on change".

This hypothesis is supported by the data and the difference between the two groups is significant at $P<.05$ level.

Psychotherapy is lengthy treatment process which requires persistence on the part of therapist as well as patient. If a therapist does not like routine work is inconsistent, he might not like the therapy process and will not take interest in it. This lack of interest will hinder in the way of producing a conducive therapeutic session. Therapy requires involvement on the part of the therapist as well and if the therapist is unpredictable, keep on changing topics in sessions, flightly, irregular and cancels appointments with the patients, this situation transits the feelings of being unwanted and rejected in the patient, this, in turn, produces in the patient resistance and rapport, which is an essential ingredient in the therapeutic process, is not built up. Ahmad (1988) found that when the therapist keeps on changing topics in therapy sessions, his patients terminate early.

The whole therapeutic process demands persistence and regularity on the part of both patient and therapist. If the therapist behaves in an unpredictable manner and shows irregularity, he will fail in generating a conducive therapy environment.

Thus an attitude characterized by a very high level of change contributes to instability within the person, the therapist who finds it difficult to stick to one task may be easily bored with the patient and will lose interest in the patient. His boredom with routine and lack of interest in the therapeutic sessions will be transmitted to the patient and as a result the later will discontinue treatment.

In our culture also a person who hates routine work, is inconsistent in his approach while dealing with people is perceived as untrustworthy. A therapist who behaves in an unpredictable manner and is not consistent in his approach while handling patients is likely to be perceived as untrustworthy. The patient

who is already quite disturbed because of his problems will become more disturbed in an uncertain therapeutic session and thus will discontinue treatment.

The hypothesis No. 5 states that: "If the psychotherapist is high on exhibition then he will have more patients as terminators as compared to those psychotherapist who are low on exhibition".

This hypothesis is supported by the data and the difference between the two groups is significant at $P<.02$ level.

Psychotherapy is a process of treatment in which the patient talks about his problems and the therapist discusses with the patient about the ways and means to overcome these problems. If the therapist is boasting about himself and wants to win attention by showing off he will be more involved in himself rather than the patient. The therapist may not be able to convey empathy and warmth which is a necessary ingredient for effective psychotherapy. This might be harmful for the betterment of the patient and he might discontinue early.

Saretsky (1980) discusses those narcissistic tendencies in the analyst that make difficult an optimal degree of objectivity and relatedness and thus lead to treatment error. Thus a therapist engrossed in himself will not be able to give the patient the attention which he needs and as a result of this he will terminate early.

Specially in Pakistan more importance is given to the way in which people behave. A person who acts in an immodest way is perceived as a person of low prestige. A therapist is seen as a person who is sophisticated, reserved and mature. If a therapist acts in an immature manner he will lose prestige and respect in the eyes of the patient and will be unable to keep patients in therapy.

The hypothesis No. 6 states that: "If the psychotherapist is high on impulsivity then he will have more patients as terminators as compared to those psychotherapists who are low on impassivity".

The hypothesis is supported by the data and the difference between the two groups is significant at $P<.05$ level.

On the basis of a series of studies carried out at Pennsylvania State University, Snyder (1953) lists a number of therapist variables which seem to affect the patient doctor relationship, emotional control is one of them.

Therapy teaches a patient to control his emotions and express it in a socially acceptable way. The therapist is supposed to be mature enough to confront the patient's infantile attempts to escape responsibility. But if the therapist himself is rash and is unable to control his own emotions he will be unable to inculcate

control in the patient, which he himself lacks. Therapy with such type of a therapist will produce harmful effect on the patient.

Therapy also inculcates in the patient the feeling of being cared for and being wanted. But the therapist who is reckless, irrepressible, and easily loses control will be unable to create a supportive environment in the therapeutic sessions. The patient will have a feeling of being in an unpredictable situation in which the therapist behaves in unpredictable manner. This feeling will produce anxiety and tension in the patient and he will not look forward to having a therapeutic session.

The hypothesis No. 7 states that: "If the psychotherapist is high on play then he will have more patients as terminators as compared to those psychotherapists who are low on play".

This hypothesis is not supported by the data and the difference between the two groups is insignificant.

The reason for this might be that therapists are trained to behave in a certain way. They are trained to behave in a professional way. The therapist usually maintains some distance with the patient. The patient is permitted to discuss anything with the therapist but the therapist has to respond on certain set lines.

Hence, whether a therapist is high on play or low on play this will not have any effect on the professional relationship they have with the patient. As a result there will be no difference in the number of patients they have as terminators.

The hypothesis No. 8 states that: "If a psychotherapist is high on succorance then he will have more patients as terminators as compared to those psychotherapists who are low on succorance".

This hypothesis is supported by the data; the difference between the two groups is significant at $P<.0495$ level.

A therapist who gives a picture of a person who needs protection, is helpless, wants reassurance from other people, will feel insecure and uncared in the absence of support.

This type of therapist, who himself is in need for attention and sympathy, will be unable to give comfort and warmth to the needy person. Luborsky (1953), reported that insecurity in the therapist is one of many factors responsible for unsuccessful treatment of patients.

It is quite clear that when a person comes to a therapist, it is because he has problems and because these problems are experienced by him as some kind of suffering. The patient enters into treatment with a belief that he will be helped by the therapist to overcome these problems. But when he comes across a therapist who himself is suffering from feelings of insecurity, helplessness, who himself is in need of being loved and given attention then it is unlikely that this type of therapist will be able to help the patient and instead might aggravate his problems. Thus, as a result of this the patient will discontinue treatment.

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A COMPARATIVE STUDY OF THE GENDER DIFFERENCE IN THE LEVEL OF DEPRESSION

Musarrat Alam Khan
and
Syeda Tahira Quaid
Institute of Clinical Psychology
University of Karachi

ABSTRACT

The level of depression among men and women was compared. It was hypothesized that the women tend to be more depressed than men. IPAT-Depression Scale was administered to a sample of 100 men and 100 women. In order to find out the statistically significant difference `t' test was applied. The results were found in the expected direction.

INTRODUCTION

Depression is so prevalent these days that it has been called the `common cold' of mental disorders. With reference to the present stressful life events, no one can claim that he/she has never experienced depression in his/her life time. Every one at times experiences enough sadness, despair, loss of pleasure or interest in usual activities, loss of energy, disturbance in appetite and sleep etc. These things interfere with the individual's family life, work or social adjustment. In majority of the cases this will be a transient or a passing state and they don't need any professional help for their problems. A small segment of society experiences it in an acute form so much so that it can be diagnosed as having maladaptive levels of depression. Such depression can be a miserable state which compels the sufferer to seek professional help. Due to non-availability of statistical data it is difficult to quote the exact number regarding the prevalence of depressive patients in Pakistan. Also it is difficult to draw any conclusion about

the incidence of sex ratio in Pakistan. This study is an attempt to investigate whether depression is more common in males or females.

Studies carried out in advanced countries indicate that more women than men fall prey to depression and seek treatment for that. It has also been found that women are less likely to make complete recovery from depression than men. (McMahan & McMahan 1983). Also it was found that depression, especially in severe forms occurs much more frequently in women than in men. Statistics collected in several parts of the world confirm this marked difference. Winokur & his associates (1971) in U.S. found a greater incidence of depression in women in relatives of 129 subjects. In Iceland, Helgason (1964) found that females are at much greater risk of affective psychoses. In Denmark, McCabe (1975) found that women admitted to hospitals for affective psychoses were much more as compared to males. (male-female ratio was 0:64). In United States.

Weissman and Klerman (1977) consistently found a 2:1 female-to-male ratio for depression. In all other industrialized Western countries they found the ratio almost the same. Among highly industrialized countries, only in Finland and Norway was the preponderance of female depression although still present, not as marked. However they found that in a small number of developing countries (India, Iraq, New Guinea & Rhodesia) there seems to be a preponderance of male depressives.

Weissman & Klerman (1977) asked an important question of whether the reported preponderance of female depressives was an artifact? According to this hypothesis women perceive, acknowledge, report and seek help for depressive stress and symptoms more than men. This attitude and habit would account for the sex ratio findings. Reviewing data from the pertinent literature the authors were able to exclude the importance of these attitudes and they reached the conclusion that the female preponderance is real and not due to an artifact. Weissman and Klerman reaffirmed the possibility of a genetic factor in the etiology of depression but concluded that the evidence from genetic studies was insufficient to draw conclusions about sex differences. Instead, according to them, social status discrimination and inequities would lead women to legal and economic helplessness and dependency on others, which in turn would give rise to low self-esteem and low aspirations. These would eventually lead to clinical depression. Also, according to them, "learned helplessness" would produce in women a cognitive set against assertion which is reinforced by societal expectations. This learned helplessness is a characteristic of depression.

While discussing marriage in relation to depression, Gove (1972, 1973) concluded that whereas being married has a protective effect for men, it has a detrimental effect for women. They found that married women had a higher incidence of mental illnesses. The reason for that may be that due to the experience of having sustained a loss or been threatened by loss with the consequent adoption of a pattern of submissiveness to a dominant other or for obtaining approval and gratification from the dominant other, so on and so forth.

Anxious depressive reactions associated with every day life experience are most frequently encountered and are associated with a number of causes linked with situational stressors. Rates of disorders for more serious forms, like unipolar and bipolar depressions, vary according to many factors. Unipolar depression rates are higher in women aged 35-45 years, and are higher among individuals with histories of family disruption and recent negative life events. In contrast, the incidence of bipolar depressive reactions seem to increase with age and membership in higher socio-economic classes (Boyd & Weissman, 1982).

Beck (1960) studied 966 clinical cases with respect to sex and severity of depression. Among males 31% showed no depressive symptoms, 33% showed mild depressive symptoms, 31% showed moderate depressive symptoms. Among women, the corresponding percentage were none: 18%, mild: 29%, moderate 42% and severe 11%.

Cohen (1967) found that among individuals hospitalized with a diagnosis of manic depressive reactions, women outnumbered men in a ratio of 1-1/2 or 2 to1.

Krug, (1976) compared the raw score distributions of men and women on the items of IPAT-Depression scale. The results were quite positive. There is a slight tendency for women to score higher than men on the test.

Tennov (1975) found that all forms of depression are more frequently found in women than in men. Many attempts have been made to explain this phenomenon. Several studies indicate that women are more likely to become depressed because they have a more negative image of themselves (Silverman, 1968).

Depression is not the only kind of mental illness to which women seem to be more subject than men. Gove & Tudor (1973) who defined mental illness as consisting of neurotic disorders and functions psychoses examined results of research conducted since the 2nd World War and concluded that all data indicate that more women than men are mentally ill (P.827). They attribute this statistics

to the fact that women today "find their position in society to be more frustrating and less rewarding than do men.....".

According to American Psychiatric Association (1988) about 15% of American adults have at some time had major depression and about one in twenty have been depressed seriously enough to require hospitalization. Serious depression is about twice as common in women as among men.

According to another study (Boyd & Weissman, 1981) 3% of women diagnosed as having major depression. The percentage of Americans who will have at least one major depressive episode sometime during their lives is 8-12% for men and 20-26% for women.

Studies in the United States and Europe suggest that at some time during their lives 5 to 10 percent of men and twice that many women will suffer a major depressive episode (Seligman, 1988).

Women, especially women who have previously been depressed are at greatest risk for depression. Curiously the gender difference in depression rates does not exist in college students or among bereaved persons (Nolen-Hoeksema, 1987).

A study of women in 35 different cultures indicate that many women in American society particularly those who have been over-committed to their maternal roles, suffer from depression when their children leave home for colleges, jobs or marriage (Bart, 1972). In females depression appears to be linked in some way both to the menstrual cycle and childbirth. Many women report feeling depressed, uncomfortable and irritable around the start of their menstrual periods. For majority of women who reported these feelings, depression is too mild to be considered maladaptive. But some women experience rather serious menstruation-linked depression. Similarly a small but significant minority of women experience depression following childbirth, the so-called postpartum depression. This depression is mild, transient but it can be quite serious. One possibility for this type of depression is the changes in hormonal levels associated with these events. On the other hand it seems quite possible that psychological factors (negative view of menstruation, restricted activities etc.) and childbirth (new responsibilities, exhaustion, changes in routine are the causes of depression. New fathers who do not experience hormonal changes often report "postpartum" depression too, among these two causative factors, weight of evidence currently supports the psychological position (Weissman & Klerman, 1977).

Gender is a risk factor for depression which is diagnosed at higher rates among women. (Cleary, 1987). For low socio-economic status (SES) the consequences of depression are potentially more severe than for affluent women.

The discriminant functional analysis revealed that men and women differed significantly on all depressions. It was also revealed that women reported significantly more depressions than men. (Schutte, Moos & Brennan., 1995).

As a review of the literature on gender difference in depression indicates that more females are likely to be depressed as compared to males, the present study is an attempt to investigate if there is any difference in the level of depression between males and females in Pakistan. It was hypothesized that females would be more depressed as compared to males.

METHOD

Sample:

It consisted of 200 subjects (100 males and 100 females). Their ages ranged from 25-45 years. They were all married, holding Masters' degree (in various subjects) and working in different colleges as Lecturer and Assistant Professors.

Procedure:

To find out the level of depression, IPAT-Depression scale (self-analysis form) was used. Standard procedure was followed in administration and scoring of the mentioned scale.

To find out the statistically significant difference in the level of depression of both the categories (i.e. males and females) `t' test was applied.

RESULTS

The results of the statistical analysis are shown in Table No. I where `t' obs=2.64, df = 198 and P=<.01 which indicates that a statistically significant difference exists between the level of depression of men and women. The percentages of scores on IPAT-Depression scale are indicated by Table No. II and Graph No. I, i.e. women scored 74% and men scored 23%.

Table I

Difference in the level of Depression of Males and Females

Females	Males
Nx =100	Ny =100
X =8.26	Y =5.61
S =50.11	Sxy =1.001
tobs =2.64	df =198

Significant at P<.01 level

Table II

Percentages of Scores of Males and Females High on Depression Scale

Females	Males
74%	23%

DISCUSSION

As indicated by the above mentioned Tables, there is a statistically significant difference between the rate of depression of both the sexes. From the results, it can be inferred that females tend to be significantly more depressed than males. Now the question arises as to why is this so? According to Nolen-Hocksema (1987), society has often rendered women than men helpless to control their lives which help to explain why women have been twice as vulnerable to depression as men.

In Pakistan it has been observed that in females childhood experiences of loss of parental love or threat of such loss may be an attributional factor in the

development of depression especially in families which have gender prejudices and in which a girl has already been born. The birth of a boy is welcomed warmly and the presence of the older girl is neglected. A great deal of attention is given to the newborn boy and the girl experiences a trauma of loss of love. Also in majority of the families consecutive births of female children brings sadness and a wave of shock in the entire family. In families consisting of both male and female children, the male child is mostly given preference whereas the female child is neglected. This attitude of the parents toward female children persists throughout their lives, which, in turn, gives rise to feelings of insecurity, inferiority and inadequacy in females. These psycho-social factors predispose females to depression.

It has also been noticed that a female child is not encouraged to experience as active a childhood as a male child. From the very beginning, dependency, and approval seeking behaviour is inculcated in a female child with the result that this behaviour becomes her life style which affects a wide range of her interactions. Furthermore, it has also been observed that no matter how much capable and talented she is, she cannot make decisions for her career as well as for marriage. (though the trend is changing but the pace is very slow).

Literature review reveals that even in Western society women are encouraged from their childhood to feel better to have a man's approval than a woman's approval. Also they are taught to be reactive rather than proactive. They learn to live for and through others and define themselves in terms of others. They are expected to be selfless helpers and not to have needs for a lot of space, both territorial as well as psychological. They often learn to gear their thoughts to what will make a man feel comfortable (Pierce, Sanfacon, 1977). It is quite surprising to see such trends in developed countries.

Muslim women in Pakistan are lucky as their religion gives them equal rights to muslim men, but it is sad to mention that due to lack of proper education (literacy rate being 26%) at times they are deprived of their lawful rights.

Pakistan is a patriarchal society, here female submissiveness is encouraged. She is expected to look after other people's needs, no matter how difficult it is for her. Often in her effort to meet the societal demands and expectations she becomes sad. But she has to repress her sadness, anger and frustration that is due to her subordinate way of living. This repression, in turn gives rise to depression.

Feministy, in majority of the Pakistani families is confused with being dependent. In such families, man becomes the direction maker, to the point of fostering a state of helplessness in women. This very state of helplessness which has previously been fostered by men is later been bitterly criticised by them. Only in the areas of motherhood and home making, she is allowed to assert herself. Even sometimes in those areas too, she has to face male interference. Hence women have very little to do, which they can consider stimulating. In such a situation they feel dissatisfied. The acquired state of dependency and submission makes them depressed.

In Pakistan, married working women, on the one hand have an elated self-image that they are sharing their husbands financial responsibilities and on the other hand sometimes they develop not fulfilling their household duties properly. Majority of Pakistani husbands think that household chores are purely feminine responsibilities. They take it as an insult to help their wives. So in such an atmosphere the already over burdened wives are likely to feel depressed.

Last but not the least, is the speculation which has already been mentioned is the hormonal changes which take place after child birth as well as during menstruation period are also responsible for the development of depression in females.

In the light of the afore-mentioned discussion it can be concluded that the low literacy rate differences in child rearing practices including gender prejudices, inculcation of dependency and submissiveness in female child, male dominance in Pakistan in general, and hormonal changes in females are some of the attributional factors of depression in Pakistani females.

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MATERNAL ANXIETY AND PSYCHOPATHOLOGY

Seema Munaf
and
Sajida Agha
Institute of Clinical Psychology
University of Karachi

ABSTRACT

The present study was designed to study the significance of maternal anxiety in the development of psychopathology. The sample was taken from the Institute of Clinical Psychology, Asghar Hospital and also from Karachi Psychiatric Hospital. The clinical interview was taken from the mothers of the psychotic and the neurotic patients and then their anxiety level was measured through TAT cards. The 't' test was applied in order to determine the significant difference between the level of anxiety of mothers of the psychotic patients and mothers of the neurotic patients. Although the mean anxiety of the mothers of the psychotic patients was more than the mothers of the neurotic patients, yet the result was not statistically significant.

INTRODUCTION

The results indicate that the mean anxiety level of the mothers of the psychotic patients is not more than the mean anxiety level of the mothers of the neurotic patients. In every day organized activities human beings are bound together by their connection with a definite portion of environment by their association with a common shelter and by the fact that they carry out certain tasks in common. The concerned character of their behavior is the result of social rules, customs, either sanctioned by explicit measures or working in an apparently automatic way (Malinowski, 1953). Individual require certain amount of "primary contact" which is interpreted as contact in which emotions might be expressed either through a great deal of interaction within a single relationship. If the interpersonal relationship is not based on positive consequences, it gives rise to anxiety in a person and severe anxiety gives way to pathological symptoms. This is true in

parent child interaction; since children tend to observe and imitate the behavior of their parents. Parental behavior can have a highly beneficial or detrimental effect on the way a youngster learns to perceive think, feel and act. Undesirable parental models are important reasons why certain mental disorder and other forms of maladaptive behavior tend to run into families. Psychopathology may stems out of disturbance in interpersonal relationship.

In the beginning of life, man's first educative experience comes from his feelings of anxiety transmitted by his mother, from her behavior, looks and general attitude which center-around anxious moments in child's care and welfare. Through empathy, the child observe the feeling of anxiety concerning his health and safety, which he first noticed in his parents. Some anxiety makes him learn what is good and what is harmful but too much anxiety makes him withdraw into a shell of security (Sullivan, 1953). If the mother of infant is anxious and angry or other wise upset, the unpleasant emotion can be induced in the infant. This induction of anxiety is not the result of feared objects outside the body or of forces within the infants body but instead from the interpersonal influence of the mother or mothering person.

A classical study found that mothers who are subjected to severe emotional stress during pregnancy appear to have a much higher incidence of premature deliveries. Even in the case of full-term babies, severe maternal stress appears to be associated with hyperactivity in the fetus during later pregnancy and after brith to be reflected in feeding difficulties, sleep problems, irritability and other difficulties in adjustment (Blau et al., 1963; Sontag, Steeler and Lewis, 1969).

According to Sameroff and Zax (1973b), "the potential schizophrenic influences his environment as well as being influenced by it. For example, a hyperactive, cranky infant may seriously strain an already disturbed mother who is not secure in her care taking ability. Such a mother might be at her worse with a difficult child but be altogether adequate with an easy child". The transaction between mother and child in which each affects the behavior of the other, helps to produce the stressful environment. Children born to schizophrenic women also suffered more birth complication than normal control. The same was true for the children of depressive mother. When their schizophrenic and depressive mothers were differentiated with respect to chronicity of their psychological disorder. Sammeroff and Zax (1973a) found that high chronicity related to number of delivery complications irrespective of diagnosis.

One of the study on infants was conducted by Ottinger and Simmons (1964). They found that babies of highly anxious mother cries more than babies whose mothers were low anxious. Simmon, Ottinger and Haugh (1967), found that

women who are anxious during pregnancy, are more likely than less anxious mothers to have infants who go into distress during delivery, who cry more before feeding and who are more active in hospital nursery.

The risk of mother losing control and abusing her child may increase as a consequence of maternal depression. The flattened or negative effect of the depressed mother, combined with general lack of empathy, conceitedness and enjoyment of the child constitutes a syndrome of psychological neglect that may be more lethal to the child's developing sense of self competence than actual abuse (Musick, Clark and Householder, 1979).

Studies of children with a mentally disturbed parents particularly the anxious mother, indicate that such children belong to high-risk group and differ from low-risk children in a number of respects. Rate of development and other psychological variables show deviation and irregularities in these children (Anthony and Koupernik, 1974). Two distinct lines of investigation link maternal depression and maladaptive children's behavior. One has focused on perception of children's maladjustment, suggesting that depression in mothers may be associated with children's problem or exaggerated concern with children's conduct which sometimes lead to inappropriate clinical referral. Researches suggest that the child's actual behaviors as well as maternal depression contributes to perception of externalizing maladaptive behavior (Brody and Forehand, 1986).

Cohler, Greenbaum, Weiss, and Hartman (1975) found that young children of depressed mother showed both greater intellectual impairment and disturbance in the ability to deploy attention than the children of either Schizophrenic or well mother. Infants may respond to maternal anxiety by withdrawal and failure to thrive where as the preschool and school age children display a wide range of behavior and learning problems.

In studies of schizophrenics, it appeared often that in mother-child relationships in which mother seemed not want to be understood and she can justify it by emphasizing that she looked tired and is in need of rest. This type of communication often lead to neurotic tendencies in a person (Bowlby, 1965).

A tense and anxious mother can transmit her anxiety to even a very young adult. If interactions with such a faulty parental model continue the child may learn anxiety reactions similar to those of mothers. In the studies of behavior disorders of children Jenkins (1966, 1968, 1969), found that over anxious children tend to have neurotic mothers who are themselves anxious. As one neurotic young adult group expressed the problem in the cause of psychopathology, "I guess there is more of my over anxious neurotic mother in me than I had realized."

Studies of 17 schizophrenic and their mothers, 14 non-schizophrenics and their mothers and 15 normal families investigated the degree and type symbiosis in the mother. Rating was made on six characteristics of symbiosis. Generally result indicate the schizophrenic and their mothers showed more evidence of being enmeshed in a symbiotic relationship than did the mothers in the other group (Summers, Frank and Walsh, From, 1977).

The purpose of the present study is to find out the significance of mothers anxiety in the development of psychopathology. It is expected that more anxious mothers will contribute in the development of psychotic disorder in their children and relatively less anxious mother will contribute in the development of neurotic disorder. Hence the hypothesis thus framed is, "mothers of the psychotic patients will be more anxious as compared to the mothers of the neurotic patients".

METHOD

Sample:

The sample consisted of 15 mothers of the neurotic patients and 15 mothers of the psychotic patients. The age range of the patient's mothers was between 40-60 years. The sample was collected from the Institute of Clinical Psychology, University of Karachi, Asghar Hospital, Karachi and Karachi Psychiatric Hospital, Karachi.

Procedure:

The diagnosis of the neurotic and the psychotic patients was taken from the records of the patients available in the concerned hospitals. The patient's mothers were then contacted at the outdoor patient department which was held twice a week in Asghar Hospital and daily in Karachi Psychiatric Hospital and at the Institute of Clinical Psychology.

The mothers were then taken into confidence and they were requested to give an interview. On the basis of the interview, salient features of the patients atheir mothers were filled in a form. The mothers of the patients were also tested with three TAT cards (Card No.11, 12BG and 19).

Scoring of the level of anxiety was made on five point scale, where score five was considered as highly anxious and score of one indicated least anxious. Rating of each TAT story was done by three clinical psychologist in order to rule out any error in scoring.

The scoring of the anxiety for the mothers of the psychotic patients and the neurotic patients was then statistically treated with t test.

Patient's mothers were also rated on various other symptoms, through the interview but the mean score was not statistically treated. These symptoms were (1) palpitation (2) guilt feeling (3) suspiciousness (4) aggression and (5) body pains.

RESULTS

Table I

Table-I Indicating Difference Between the Level of Anxiety of the Mothers of the Psychotic Patients and Mothers of the Neurotic Patients

Group	Mean	t	df	P
Mothers of the Psychotic patients	4.33	0.79	28	P>.05
Mothers of the Neurotic Patients	3.40			

Table II

Table-II Indicating Mean Difference Between Mothers of the Psychotic Patients and the Mothers of the Neurotic Patients on Five Symptoms

S. No.	Symptoms	N	Mean of the Mothers of the Psychotic Patients	N	Mean of the Mothers of theNeurotic Patients
01	Palpitations	11	0.73	10	0.67
02	Guilt Feelings	4	0.27	3	0.20
03	Suspiciousness	7	0.47	4	0.27
04	Aggression	12	0.80	11	0.73
05	Body Pains	8	0.53	9	0.60

DISCUSSION

It is clear from the table that the mean anxiety of the mothers of the psychotic patients is more ($\bar{X}$=4.33) as compared to the mean anxiety of the mothers of the neurotic patients ($\bar{X}$=3.40) but the result is not statistically significant (t=0.79 df=28, P>.05).

The non-significant result may be due to the sample size which was too small. If taken a larger sample, it might have contributed in bringing about the significant result.

This non-significant difference also indicates that the mothers of the psychotic patients and the mothers of the neurotic patients behave in the similar manner. It is the child who is born with certain specific patterns, which make him sensitive to respond to the anxiety of the mother in a different way. Here we cannot discard the influence of the father and various other factors responsible for the development of psychopathology.

When we go through table-II it is clear that the palpitation which is one of the component of anxiety is less present in both the groups i.e. mean =0.73 for the mothers of the psychotic patients and mean =0.67 for the mothers of the neurotic patients as compared to the aggression which is more in both the groups i.e. mean =0.80 for the mothers of the psychotic patients and mean =0.73 for the mothers of the neurotic patients.

Hence from the above discussion it is clear that the anxiety of the mother is not the only factor in the development of psychopathology in children but other factors are as important or are more important in the development of psychiatric disorders.

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CASE HISTORY AND TREATMENT OF A CASE OF PANIC ATTACKS WITH HALLUCINATIONS

Farrukh Z. Ahmad
Institute of Clinical Psychology
University of Karachi

INTRODUCTION

A forty five year old married man suffering from acute anxiety due to visual and auditory hallucinations and fear of *jins* and other supernatural species was referred to the author by a medical doctor as no psychotropic drugs worked on his hallucinations.

CASE HISTORY

Mr. Tahir (not his real name) was an educated businessman. He came from a well to do and educated family. His wife, who was a housewife, highly educated and had three children. She married a man before him and had a son, but that man happened to be involved in bad company and hence divorced her and remarried a foreign lady. The first son of the wife was look after by her own parents. The patient was absolutely alright till 1992. His parents were both involved in looking after their family business as well. He was the only son and had four sisters who were all married to educated and influential people. They were settled in a city and were very sophisticated in their outlook.

The patient reported that one day he was coming back to home from his factory at about 11.00p.m as he saw that a lady (whom the family knew very well and who was married to one of their best friends) standing there and looking for conveyance. He was quite surprised as the lady herself had many cars and drivers to take her around. He stopped the car and she told him that she wanted to go back to her house as her driver had disappeared with the car. He gladly gave her a lift and began to drive towards her house. As he reached the inter section which was about two houses away from her house, she suddenly opened the door of the car and disappeared in thin air. Mr. Tahir was flabbergasted and tried to look for her but could not succeed. He then went to her house and pressed the bell of the door. When he asked about the lady, the chowkidar gatekeeper

told him that she was fast asleep and never went out that night. Mr. Tahir was so upset that he could hardly reach his car and drive it back to his house. When he reached his house he was absolutely pale and drenched in perspiration and almost fainted at the doorstep. His wife called for an ambulance and took him to the best hospital in the city. He was given a medical aid immediately in the emergency department and the doctors told the wife that he was under a grate shock. For almost five days Tahir remained admitted in the hospital but did not tell the story to any one.

After coming from the hospital he started his routine work but did not drive the car himself and complained that he was now losing money in all the business deals which were established by the family over a period of years.

According to Mr. Tahir he had to touch a business and would lose the money in it. One day his wife told the story to a mutual friend and said that something has happened to her family as an evil eye had befallen and that they were losing their emoluments rapidly. An acquitance with whom she was talking apprised her that the lady who was seen in the car by Mr. Tahir was doing black magic on her friends who were better than her financially. The wife told the entire story to Mr. Tahir and he had to take his wife into confidence and told her about the episode of that night. He revealed that after that episode that lady was seen by him almost everyday when he would pass near the Shrien and in case at the intersection where she disappeared. He also remarked that she was always dressed in one of her finest apparels and would laugh like a mad woman.

After this the wife narrated the story to her parents-In- law and they took him to various spiritual healers. One of the spiritual healers came to live in the house and recited the holy Verses and as he was reciting the verses, Mr. Tahir again went into fit and became pale and drenched in perspiration. This was witnessed by the entire family and Holy man asked Mr. Tahir to go and look into the store and see if he could identify any odd stuff over there. Mr. Tahir went into the store and saw that there were many wires in the room, spread all over the floor and each wire had about 9 knots in it and the Holy man opened all the knots and handed over the wires to the family and asked them t destroy them in the ocean. After this episode, Mr. Tahir began to feel that he was financially becoming better day by day and all his losses were recovered but he would not get over the hallucinations and still was afraid to travel alone in a car.

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TREATMENT

Mr. Tahir was given a battery of tests including projective tests by the author. He was very cooperative and his projective tests results depicted on psychotic symptoms in him. He thus given the diagnosis of having "panic attacks with Hallucinations".After the investigations the author decided to conduct psychoanalytically oriented therapy along with hypnotherapy in order to remove his panic attacks and hallucination. The patient began to come of therapy on the basis of six day a week and indulged in free association very effectively.

During his free association he narrated an episode in his childhood when he was sexually assaulted by one of his aunts and was morally afraid of his own parents and other family members because he felt guilty and as a result developed hatred for his aunt. She appeared to him as witch (churail). After the emergence of this episode partially in the hypnotic state and partially during free association the author tried to connect the two incidences and explained him that his childhood experience has now taken a turn and he was going through the same guilt and panic attacks. The therapy lasted for about two years and his sessions were tapered gradually after months of working through. The insight was inculcated and both the panic attacks and hallucinations disappeared.

At the moment he is working very successfully and has even cordial relations with the female family friend who was the subject of his hallucinations.