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ALTRUISTIC BEHAVIOR ADAPTATION
AND VALIDATION OF SCALE

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ABSTRACT

In order to develop an instrument for assessing altruistic behavior, a scale was adapted on the model of "Personal Norms Questionnaire" by Schawrtz (1977). This scale was tested on a sample of 292 university students. Its test re-test reliability was established, (r = .68, significant at .01 level) and external criterion validity (Chi square = .68, significant at .05 level) was found for the male population. Cut off scores were established to discriminate between High, Low and Moderate scorers.

INTRODUCTION

Proverbs like "Kindness is its own reward" and "He who helps others helps himself" represent one of the noblest behaviors of mankind and reflect the society's general view about the· importance and desirability of this virtue. Helping behavior also termed as prosocial and Altruistic behavior, has received a lot of attention from social psychologists. To distinguish between the two, Altruistic behavior is a voluntary, self sacrificing act performed with the intent of providing benefit to another person without conscious regard for one's self-interest e.g. running into a burning house to rescue a stranger's child. Prosocial behavior is a much broader category. It includes any act that helps or is designed to help others. Prosocial behavior may range from the most selfless acts of altruism to helpful acts motivated entirely by self-interest. Research involving helping behavior began in the late 60's and early 70's.

Latane & Darley (1970) proposed the following model for helping behavior:

> Noticing a person, event or situation requiring help
> Making an interpretation that help is required
> Assuming responsibility for taking action
> Deciding on the form of assistance
> Implementing the assistance

Early research sought to identify the differences between helpers and non-helpers (London, 1970), but few consistent differences were found between traits or personality of individuals. However, recent work has shown the importance of differences in empathy and moral judgement of sophistication (Eisenberg & Mussen, 1978; Hoffman 1981; Toi & Batson, 1982), while the answer to the question, "Is there an altruistic personality?" remained controversial, more attention began to be paid to situational factors. Thus a lot of work was carried out on various aspects of helping.

People in the supermarket were more likely to give money to buy milk rather than cookie dough (Bickman et al., 1973). Students were willing to lend notes to another classmate because their teacher was poor at lecturing (Weiner 1980), to lend rent money to an acquaintance in need due to illness (Meyer & Mulherin, 1980), and give donation money to a handicapped woman in a wheel chair (Pilivin, Piliavin & Rodin, 1969).

Seventies were also marked by a lot of research centering around what was known as the "bystander effect." This referred to the passivity of bystanders during emergencies. The indifference, apathy and dehumanization of present others who did not help in emergencies lamented the alientation of the existing culture.

Other factors found to be influencing helping behavior included physical attractiveness of the person in need. (Benson, Karabenick & Lerner, 1976). Slowhower et al (1980), studied the degree of similarity between the helper and the person in need. Emswiler, Deaux & Willits (1971) studied students helping behavior towards confederates dressed as hippies/straights. Greater helpfulness was found towards someone with a similar attitude, Tucker et al. (1977).

Results of a good number of studies suggest that people who are in a good mood are more likely to help than those in a neutral or bad mood (Rosenthal, Moore & Underwood, 1976; Isen & Levin, 1972; Cunnigham, 1979). Since effects of mood may be transitory or fleeting, therefore the temporal effects of moods were also studied. Isen, Clark and Schwartz (1976) proved the transitory nature of mood effects. Less consistent evidence is available for relationship between negative mood and reduction in helping (Cialdini, Darby & Vincent, 1973) than for it, (Underwood, Berenson, Berenson, Cheng, Wilson, Kulik, More & Wenzel, 1977). One reconciliation of these conflicting findings has been suggested by Thonpson, Covan & Rosenham (1980), by experimentally proving that the nature of this relationship depends upon whether people's attention is focussed on themselves or on other individuals. When negative mood is focused on themselves, it is likely to produce less helping. Other research has also shown that those in a bad mood will be apt to help if helping is easy to carry out (Weyant, 1978), if they themselves are responsible for being in a bad mood (Rogers, Miller, Mayent & Duvall, 1982) or if they think helping will relieve their bad mood (Maniucia, Banmann & Cialdini, 1984).

Theoretical Perspectives on Helping:

The understanding of Prosocial behavior has benefited from 3 broad theoretical perspectives.

1) Sociobiological Perspective:

We are predisposed to help. It is part of our genetic, evolutionary heritage (Darwin, 1871). This point of view is quite controversial. Affirmative views have been provided by Wilson (1975) and Rushton (1980). This view explains few basic prosocial behaviors like parent's caring for their young. It holds that human societies have gradually and selectively evolved skills, beliefs and technologies that promote the welfare of the group.

2) The Learning Perspective:

In growing up, children learn their society norms about helping. At, home, school and in the community, adults teach children that they should help people. Helping is promoted through reinforcement and through the effects of rewards and punishment for helping and observing model others who help.

3) The social exchange perspective:

In any situation, the decision to help involves a complex process of social cognition and decision-making, based upon the benefit and costs of helping. Human interactions are guided by "social economics" and a "minimax" strategy is used – i.e. minimizes the costs and maximize rewards. The goods exchanged may be material like money, or social like love, services, information, and status. Rewards, also, may be external like appreciation from friends, or internal like calming down ones anxiety, acquiring a sense of satisfaction and a rise in self-esteem.

Although it cannot be denied that altruistic behavior is in the best interest of mankind, the years of the 20th century have been the most intolerant and violent years of history. It is unfortunate that with the advancement of knowledge, communication and information, we have lagged behind in terms of personal enlightment and moral values. This great need for the revival of altruistic behavior has been subject of concern for many a social scientist and even animal psychologists (Hamilton, 1972). It should therefore be of utmost concern to human psychology as well. The vehicle by which "helping behavior" is inculcated in humans is through the development of norms. The extent to which a norm has been internalized is reflected in an individuals "personal normative structure", a structure which has been studied by social psychologists. Although, methodologically difficult to define precisely, the general structure of people's personal norms regarding helping can be determined. To measure this construct Schwartz (1977), constructed a series of questions designed to measure feelings of obligation in a variety of situations. He found, that certain norms were widely held, with relatively little variability among people, e.g., most people felt a fairly strong obligation to donate a heart (after their death) to a close relative who needed a heart transplant. On the other hand, there was a great variability in response to a question asking about the willingness to donate bone marrow to a stranger.

One implication of a normative view of helping is that there ought to be a clear relationship between norms related to helping behavior and subsequent helping. Also, the stronger and stabler the norms, the stronger the relation should be. This hypothesis was confirmed in a study on college students by Schwartz (1977). He concluded that stable, consistent norms are predictive of the actual occurrence of helping behavior. With the help of the Scale provided by Schwartz, an attempt was made to measure the personal normative structure and thereby the

level of helping behavior in a selected set of students in Karachi University. Schwartz's scale was adapted to suit relevant, specific, cultural situations requiring help in Pakistan. Hence was evolved a new measure, which was to be tested for test-retest reliability, external, criterion validity and cut off scores.

METHOD

Sample:

292 students from Karachi University, Arts and Science Faculty were randomly selected. The sample consisted of 147 females and 145 males, students of B.A./B.Sc (Hon.) and M.A./M.Sc., ranging in age between 17-24 yrs, belonging to a predominantly middle income bracket.

Materials:

Based upon a questionnaire to measure Personal Norms of Helping Behavior (Schwartz 1977) – an adaptation of 21, culturally specific situations requiring help was prepared by the researcher in collaboration with 15 senior students of the Psychology Department.

Procedure:

Prior to the study proper, during a brain storming session, situational specific items were generated by students themselves. This was done to develop a culturally appropriate instrument measuring altruistic norms among students. The final questionnaire consisted of 21 items of which 3 were selected from the Schwartz Scale and 18 were new. These items were expected to tap helping responses to typical cultural situations for example, sending a meal to your newly shifted neighbors, to vacate a seat for elderly in a crowded bus, to support your household servants in times of need, to arrange for an ambulance for the injured if you have witnessed an accident, to aid a stranger being beaten up on the road, to notify police about a robbery in the neighborhood etc. The new scale was examined and scrutinised by 2 senior teachers who served as judges to test the quality of items. They determined the ease and difficulty of situations in rank order. This prepared scale was administered to the student population. Instruction was given to them to rate each item on a 5 point scale ranging from 1-5, where 1 = no obligation to help, and 5 = very strong obligation to help.

On the basis of the first administration of the scale, cut off scores were determined at Q1 = Lower quartile and Q3 = upper quartile. The obtained scores were thus placed into three categories. The range of the scale scores was between 21—105.

After a one-month interval, the scale was readministered to the same students in order to check the stability of their responses over time. Ten days later, the students were recontacted and asked if they would like to be a part of a programme designed to help a group of blind students. Their responses were noted in the form Yes/No. Reasons for not being able to help were also noted.

A Correlation was calculated between the first and second administrations of the Scale. Cut off scores discriminating between low, moderate and high scorers are as follows:

Low scorers on helping = 21-67
Moderate scorers on helping = 68-84
High scorers on helping = 85-105

RESULTS

Table I

Test Re-test Correlations for Administrations I & II of the Helping Behavior Scale

Groups	N	R	Significance level
M+F	292	0.68	0.01
M	145	0.69	0.01
F	147	0.68	0.01

M = Male
F = Female

Table II

Chi Square Analysis of Males

Frequencies of the 3 Categories of Helping Opting to Help

Categories	Yes	No	Raw totals
High Helpers	23	05	28
Moderate Helpers	38	32	70
Low Helpers	27	20	47
Column Totals	88	57	145

$X^2 = 6.8$ Significant at 0.05 Level

Table III

Chi Square Analysis of Females
Frequencies of the 3 Categories of Helpers Opting to Help

Categories	Yes	No	Raw Totals
High Helpers	25	17	42
Moderate Helpers	35	36	71
Low Helpers	18	16	34
Column Total	78	69	147

$X^2 = 1.108$ Not Significant

Table IV

Percentages of Male and Female Helpers on the basis of Self Reported Scores on Helping Behavior Scale

Categories	Male%	Females%
High Helpers	19.30	28.57
Moderate Helpers	48.27	48.29
Low Helpers	32.41	23.21

Table V

Percentage Scores of 3 Categories, Who Actually Volunteered to Help

Categories	Females %	Males %
High Scorers	52%	82%
Moderate Scorers	49%	54%
Low Scorers	52%	57%

Graph 1

**Scatter Diagram of Scores of Test-Retest Reliability of
Helping Behavior Scale (rtt = 0.68)**

First Administration
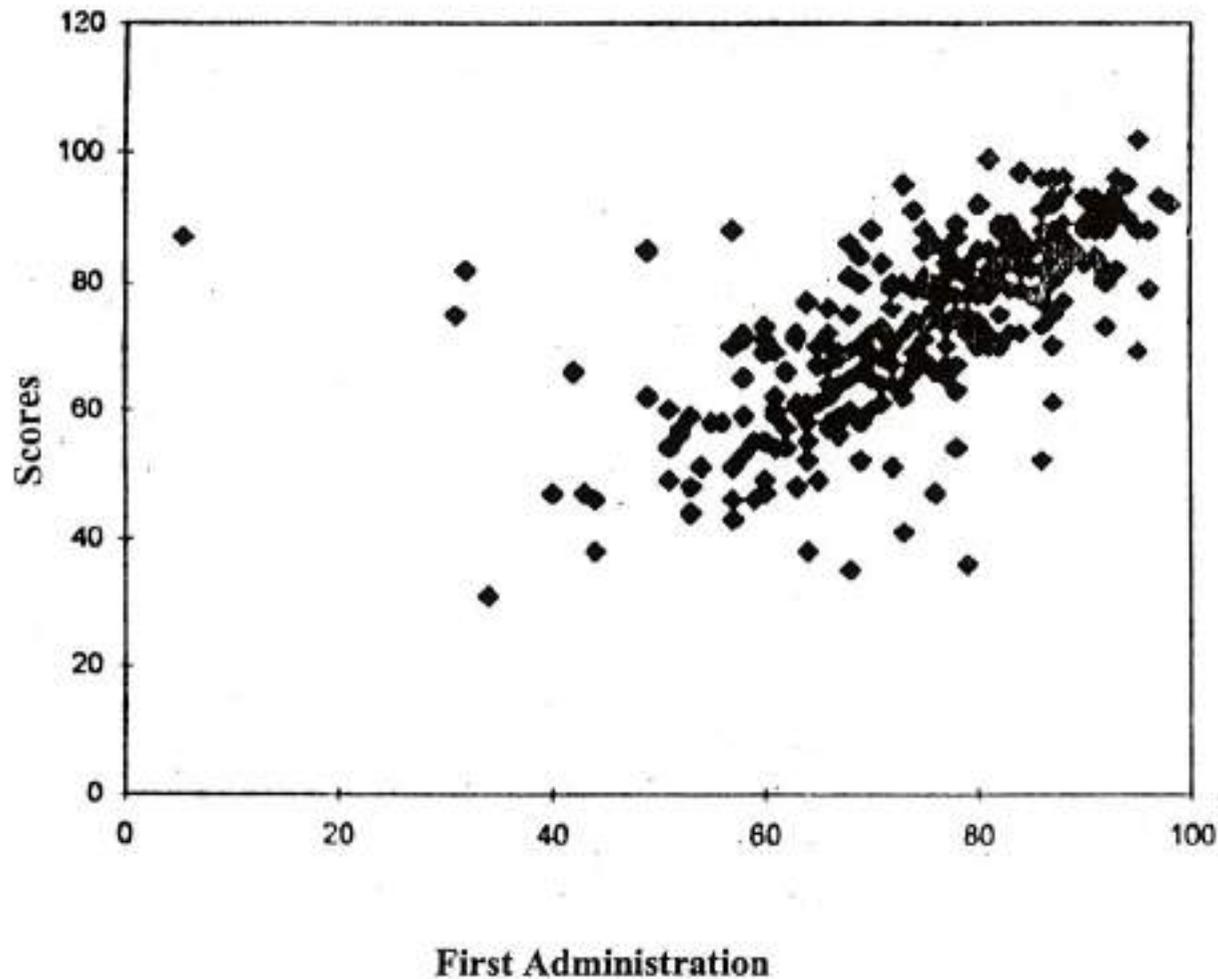
The data was further analyzed by subjecting it to chi-squares analysis. The purpose of this was to check if there was a significant difference between the 3 categories of high, moderate and low scorers, in opting to help in a real situation. Helping the blind was, thus, taken as an external, criterion measure to validate the newly developed scale.

Tables 2 and 3 provide frequencies of those opting to help the blind and Tables 4 and 5 and graphs 2 and 3 provide percentages of the same.

Graph 2

Comparison of Percentages of Yes Responses for Males Who actually volunteered to Help

Yes Responses
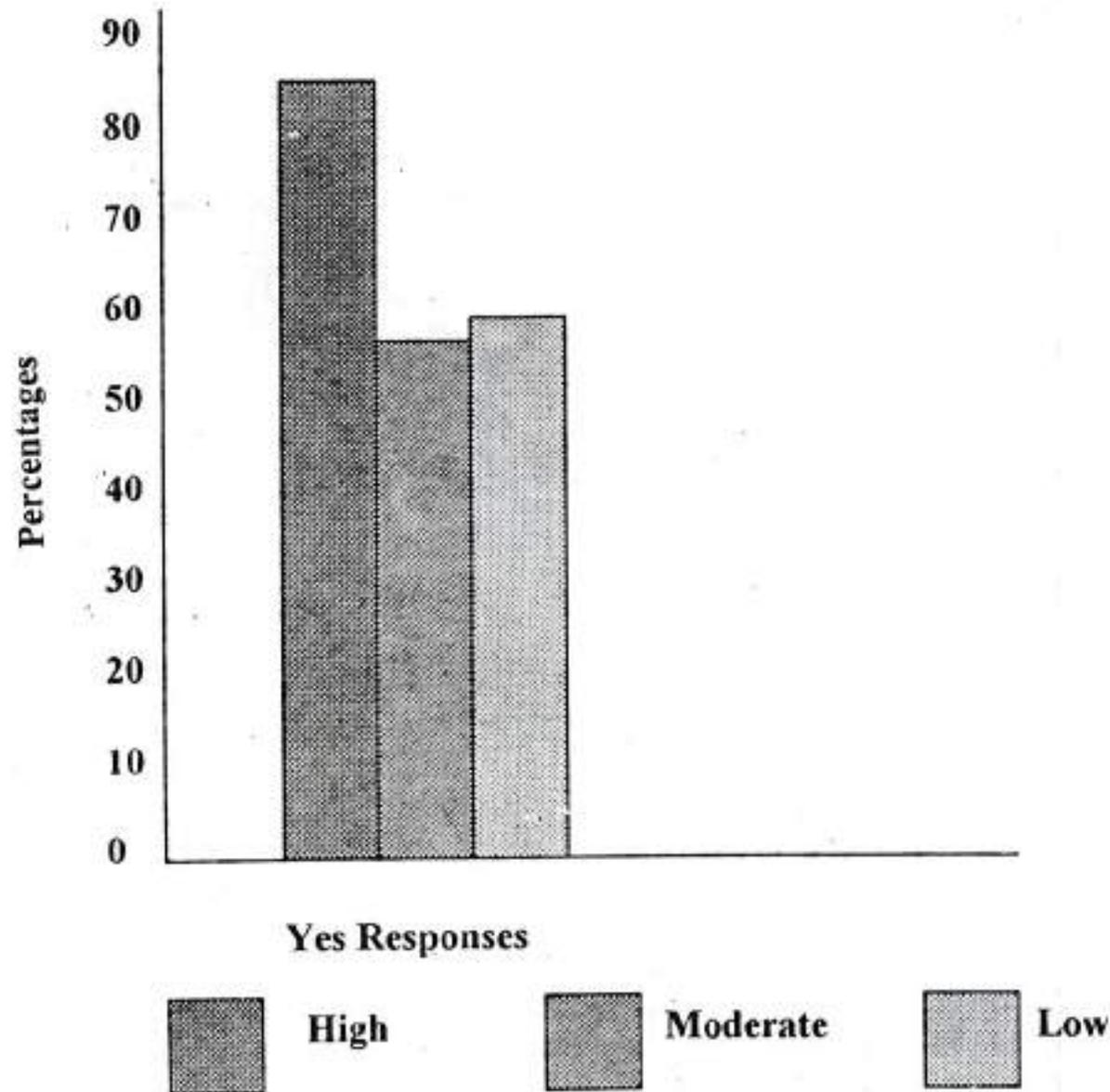
High   Moderate   Low

Results for Males (Table 2) indicates a significant degree of difference between high, moderate and low helpers in agreeing to help. The chi-square value obtained was 6.8 and was significant at the .05 level. The scale is, therefore, a good predictor of helping behaviour for the males under study.

Graph 3

**Comparison of Percentages of Yes responses for Females who
actually volunteered to help**
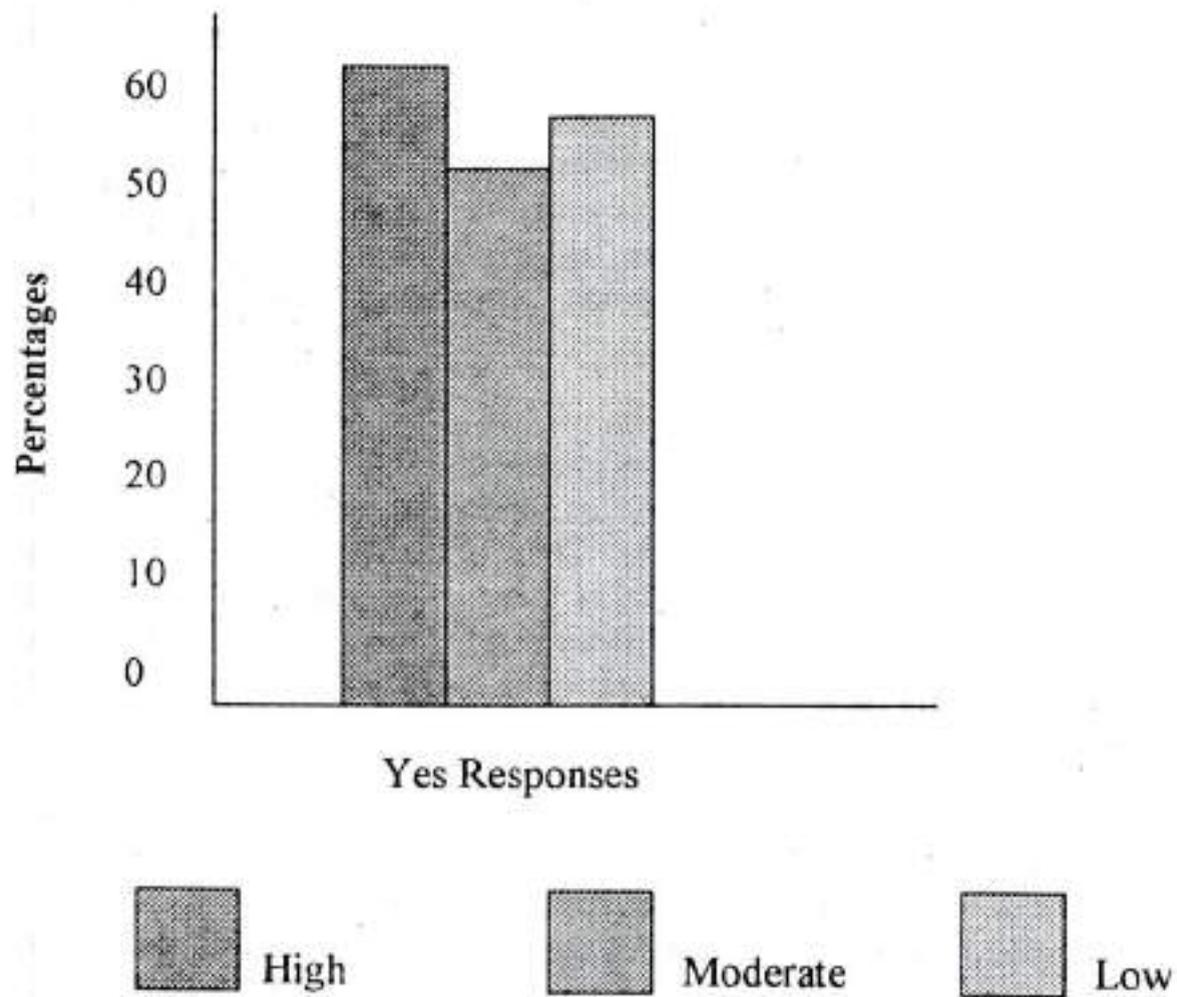
Results for Females, Table 3, however, do not show a significant difference
between the High, Moderate and Low Scorers and the subsequent behavior.

DISCUSSION

The results obtained provided us with a measure of presence of helping as part of the normative structure of male and female Karachi University students. Results in Table 4 show that among the females, 28.57% reported themselves as high helpers, 48.29% as moderate helpers and 23.21% as low helpers. Among the males, the percentage of High helpers, (19.3%) was comparatively lower and Low Helpers (32.4%) was higher as compared to females. This goes well with the universal image of a female being better equipped as a caretaker and help provider. The percentage of moderate helpers being 48.29% for females and 48.27% for males was approximately the same. These results give an indication that helping as a trait appears to be somewhat normally distributed among the students population. It is also of some degree of satisfaction that the virtue of Helpfulness and Kindness though apparently seeming to be losing its significance in today's world is not as non existent among the new generation as we might have assumed.

The validity and reliability are two important criteria a scale has to fulfill. The scale was therefore tested for stability and consistency over time. If helping was part of the personal normative structure of these students the scores would be expected to remain stable over time. The correlation obtained by applying Pearson Product Moment Correlation was found to be significant for both males and females at the .01 level of significance. There was thus a high degree of correlation between the scores obtained in the two administrations of the same scale.

The reliability of a scale, though important in itself is meaningless in the absence of its validity. Scores on socially desirable traits like helping would definitely need to be validated against an external, objective, realistic criterion. Helping the blind students was, thus taken as an external criterion measure to validate the helping behavior scale. Frequencies of High, Moderate and Low male and females helpers who opted to help the blind were obtained and subjected to a Chi Square Analysis. The results for Males (Table 2) showed a significant degree of difference between the various categories of helpers. (High, Moderate and Low) and volunteering to help. The scale may therefore be considered a good predictor of discriminating between High, Moderate and Low scorers both internally and externally (only for the situation under study).

The results for females (Table 3) however seemed to give different picture. The difference between the High, Moderate and Low helpers here did not seem to indicate an equivalent desire to help the needy blind student. This was indirect contradiction to the previous finding of higher percentage of females being also high scorers on the scale. The validity of the Scale for the female population therefore appeared to be questionable (Table 5). In order to understand this, an analysis of the responses of female students who said "No" to helping the blind was made. This revealed that these students were under great pressure to reach home in time. Apparently, they had to abide the rules and regulations set by the family to a greater extent as compared to the males. They, also perceived the transportation problems as more severe. Most females also reported a greater pressure of exams and assignments. (The exams were actually close by. But research has also reported female students as being more conscientious and more involved in academic as compared to their male counter parts). Who was to be helped, male or female was found to be another important query. Such concern is understandable in a cultural set up like Pakistan and the conservative background of the female students.

In the light of the above discussion, it can be concluded that the developed "Helping Behavior Scale" proved suitable for discriminating between High, Moderate and Low Scorers. It provided consistent and reliable results when tried on the same individuals over a one-month interval. It also proved valid for the male group, when a validity check was carried out in a simulated situation. This criterion however did not prove valid for the female students. Perhaps, another more suitable criterion is necessary to validate it. It may be of interest to know that work in this connection is already in progress.

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APPENDIX

This Questionnaire has been developed to give us an insight into people's attitudes. Different people respond differently to various situations like the ones given below. Imagine yourself in these situations and give us a response, which you think would be most true about you. You are required to give your true judgement in accordance to the rating scale given below:-

Please put in the appropriate box as shown below:

V. Strong obligation to help	Strong obligation to help	Little obligation to help	V. Little obligation to help	No obligation to help

Do not give more than one answer.

Give the first response that comes to your mind.

Do not hesitate in asking any question to avoid misunderstanding.

QUESTIONNAIRE

How obliged to help would you feel in the following situations?

		V. Strong obligation to help	Strong obligation to help	Little obligation to help	V. Little obligation to help	No obligation to help
1.	Volunteering to hold books/bags of others in a Bus/Shuttle.					
2.	If a classmate is weak in a certain subject and asks for your assistance.					
3.	If you have seat for an elderly person standing in a crowded bus.					
4.	If you have to give a financial donation for a charitable cause.					
5.	If you discover a dropped wallet containing the owner's I.D. Card.					
6.	If you see a person with a flat tyre.					
7.	To send a meal to your new neighbours who are settling down.					
8.	If you see a lady who has dropped her shopping bags.					
9.	If you see an injuring animal lying on the road.					
10.	If you see a blind person trying to cross the road.					

11.	If you see a stranded stranger asking for help.					
12.	To notify the police about a robbery in the neighborhood.					
13.	To support your household servants in times of need.					
14.	To arrange for an ambulance for the injured if you have witnessed an accident.					
15.	If a stranger is being beaten up on the injured if you have witnessed an accident.					
16.	To donate blood to a needly stranger while you are a visitor at a hospital.					
17.	To save victims if a fire breaks out in the neighborhood.					
18.	To donate your kidney to a needly patient if you are contacted by the authorities.					
19.	To opt for an donation after your death.					
20.	To opt for a bone-marrow transplant for a close relative.					
21.	To testify as an eye-witness for a murder case.					

OCCURRENCE OF SPOUSAL AGGRESSION AS REPORTED BY FEMALES IN EARLY AND LATER PHASES OF THEIR MARRIAGE

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ABSTRACT

The present research investigated the occurrence of spousal aggression (physical and psychological) as reported by females in early and later phases of their marriage. Ex-post facto research design was used. A sample of 30 educated married females was taken. All of them were working women with an average total monthly income of Rs. 20,530 and mean age of 35 years. The sample was reached by the researchers through Legal Aid Center, Lahore; Aurat Foundation, Lahore; Doctors of U.C.H., Lahore; Beacon House School System, Lahore; and Social Welfare Department of the Punjab, Lahore. Each subject was administered Personal History Questionnaire and Scale for Spousal Aggression (Farooqi and Rehman, 1996).

The research findings indicate that the females exposure to spousal Aggression (physical and psychological) decreases with an increase in the marital period.

INTRODUCTION

In third world countries such as Pakistan, India, Bangladesh etc. the females are mostly caught in a web of cultural practices and prejudices that divests them of their individually and moulds them into submissive, self-sacrificing daughters, sisters and wives (O'Connell, 1994). Pakistani society is primarily male-dominant where most of the families are headed by males, who act as "providers". On the other hand, the females are usually seen in the role of "passive recipients" being dependent upon the male family members for the fulfilment of their basic needs of life. This factor leaves them all the more vulnerable to be exploited both physically and emotionally by their male counterparts when they enter their marital lives. Therefore, even if the females are working and earning a living, their efforts would not be duly valued. Banerjee (1990), argues that the under-evaluation of women's labour and other roles is both an instrument and manifestation of the "unholy alliance between social literary, patriarchy, and diversity of group identities".As a result, often women are denied a sense of identity distinct from the family or the community in developing and highly conservative societies (Banerjee, 1990).

In Pakistan where most of the marriages are arranged through "Cast" and "Baradari" system, it has been observed that usually there is greater pressure on the females to sustain the marital life by pleasing her husband in the way he wishes. Therefore, in trying to save this bond, usually a wife has to suffer from a lot of stress and emotional strain, which may lead to a perpetual bearance of spousal aggression on her part.

The present research focuses on the issue of spousal aggression with special reference to the husband's violent and aggressive behavior toward their wives.

Aggression has been defined as, an action performed with the deliberate intention of harming or inuring another person (Berkowitz, 1981; Stang & Wrightsman, 1981). It has been further suggested that aggression may have three components, action, intention and actual harm or injury. Aggression as action may include expression of aggression in cognitive form, as well as, in verbal form. An angry husband actually resorting to beating his wife may represent an example of aggression in action whereas the use of abusive language by the male spouse in order to abash, degrade or threaten the female spouse would be an example of aggression in verbal form.

The current research has been an effort to investigate the occurrence of both physical and psychological spousal aggression as experienced and reported by the females in the early and later phases of their marital lives.

Tedeschi, Smith, and Browne (1974) argue that aggression happens not by accident but because an individual intends to harm another. A furious husband who has angrily injured his wife, cannot call this incident an accident. It is referable that in extremely conservative and male dominant societies like that of Pakistan, people seem to rely more on violence or force to solve or escape problems, particularly of matrimonial nature. Men, who are thought to be born with an inherent right to rule their wives, often express their aggression on trivial matters. This can be due to fear, ignorance, guilt and shame induced by religious and socio-cultural beliefs and deter, the abused females from exposing themselves as victims of spousal abuse.

Clinical studies reveal that a large number of battered wives come from families in which their mothers were also abused (Haider, 1996). In his studies, he, tried to classify these women into three types. The first type of women may identify with their abused mothers and consequently become dependent upon men who abuse them. The second type of women would identify with their sadistic fathers, feeling angry toward their mother. They may provoke their husbands into punishing them. Still another type of females who would enter into the abusive relationship are unaware but later find themselves unable to terminate it.

Farooqi (1996) argues that battered women throughout the world do not keep in touch with their friends and family out of overwhelming feelings of shame and embarrassment. As a result, they keep on bearing all types of physical violence and psychological degradation probably in their desperate attempts to maintain the façade of home peace. Consequently, the underreporting of domestic violence fails to give us a true picture of the grave situation across diverse cultures (Cascardi, O'Leary, Lawrence & Schlee, 1995). This situation is all the more grim in Pakistani society where the females are an under privileged, under educated and most traumatized group.

Mednick and Wiessman (1975) have emphasized that women are discouraged from self assertion, achievement orientation and independence, probably, due to their traditional feminine roles assigned to them through the socialization process from cradle to grave. Myers (1987) has discussed that the power of socially prescribed roles to shape our attitudes, our behavior and even

our sense of self is no where more evident than in society's implanting ideas about masculinity and femininity and how men and women should behave. In a highly conservative society like that of Pakistan, the social norms prescribing the male-female behaviors are even more strict and impose greater obligation on the females especially in the role of wives. Moreover, many investigators report that females are less competitive and more cooperative than men (Gilligan, 1982; Knight & Dubro, 1984). Therefore, females do not usually compete men in their struggle to gain power and dominance in the society. As a result a male feels free to use all types of opprobrious behavior in order to maintain the image of a controlling father, brother and particularly a husband. In most of the situations such an attitude of the male oppressor would lead to acts of violence. The consequences would be more for the victim and the family, if the oppressor would be the husband of the degraded, humiliated and abused women.

Keeping in view Bandura's (1977) Social Learning Theory, it may be argued that the male perpetrator's behavior can be an imitation of the fathers' role as a husband or he may simply be modeling the behavior of a male aggressor in the family, society or mass media. Aldarondo and Sugarman (1996) argue that the persistence of husband's violence can be predicted by such 'risk markers' as witnessing parental violence especially that of a father toward the mother. Seppa (1996) concludes that in general, the domestic (spousal) abuse would remain under reported because the family members might want to preserve the family unit, may depend upon the abuser for financial support, might not view emotional abuse as violence and might not trust the authorities. Here, it can be argued that females being considered as the weaker sex would be subjected to the experience of helplessness, fear, shame, embarrassment and guilt in case of quitting the abusive marital relationship. Therefore, in their attempts to sustain the family they may become victims of both the physical and psychological spousal aggression. The victimized women seem to have learned their passive role through the process of socialization. This learning process may be explained through Bandura's (1982) Social Learning approach, which suggests that faulty learning or inadequate socialization process promotes dependency and timidness in females. There is sufficient clinical and empirical evidence which suggests that victimized females complain about the occurrence of spousal abuse often early in marriage and its frequency increases across time (Walker, 1979; Leonard & Senchak, 1996). This situation appears even more depressing in Pakistani social set-up which encourages male dominance in all phases of life and in turn promotes female timidness; as well as, their dependency. Hence, the present research has focused females in early and later phases of their marriage.

In highly rigid and oppressive societies like that of Pakistan, where the females are chained in the conventional feminine roles of obedience and sub-surveillance; it seems, to say "Yes" to all the decisions taken by the male members of their familes is ingrained in them. Their suppressed, timid and fearful behavior can be easily observed in their marital lives. They may be subjected to psychological, as well as, physical abuse in case they try to give their own opinion or to express their personal feelings in daily life matters. Moreover, the females' apprehension, that their husbands may become even more aggressive if they would try to protest against the abuse afflicted upon them, compel them to keep their voices shut in their mouths. Thus, they end up bearing the spousal aggression for years or throughout their marital lives with a flickering hope in their heart that the situation might change for the better.

It is fretful, that very little research work has been done in this much needed but sensitive area of domestic violence. The current research can be considered just one step toward understanding the complex issue of domestic violence as reported by Pakistani women. The findings of this research may contribute towards introducing more effective, preventive and management programmes for the victims of spousal abuse.

METHOD

Sample:

The sample consisted of 30 educated married women with the mean age of 35 years. They were all working (Doctors, Architects and Teachers etc) and their average total monthly income was Rs.20530. Moreover, they were reached by contacting Legal Aid Centre, Lahore; Aurat Foundation, Lahore; U.C.H., Lahore; Beacon House School, Lahore; and Social Welfare Department of the Punjab, Lahore.

Procedure:

The present research follows an ex post facto research design, as the condition of interest (occurrence of spousal aggression both psychological and physical) was pre-existing in the population and could not be randomly assigned. Myers (1980) states that an ex post research design refers to a study in which in

researcher looks at the effects of selected traits, events or behaviors systematically but without actually manipulating them.

The researchers devised two scales to measure the occurrence of spousal aggression. The scale for psychological spousal aggression consisted of eight (8) items and measured the frequency of occurrence of aggressive behaviors in an average week. The scale for physical aggression consisted of fourteen(14) items and measured the frequency of occurrence of aggressive acts in an average month. The responses of the subjects on both the scales were scored as follows:

A score of zero (O) was given if there were no psychological/physical, aggressive acts.

A score of one (1) was given if psychological/physical aggressive acts occurred once or twice in an average week/month.

A score of two (2) was given if psychological/physical aggressive acts occurred three or four times in an average week/month.

A score of three (3) was given if psychological/physical aggressive acts occurred five or more times in an average week/month.

Moreover, a personal history questionnaire was also devised an administered by the researchers in order to obtain the demographic details about the subjects.

RESULTS

Table - I

Scores of the Working Women on the Scales for Spousal Aggression with reference to their Duration of Marriage

Duration of Marriage (In Years)	Psychological and Physical Aggression
1-4	11
5-8	10
9-12	4
13-16	3
17-20	3
21-24	3
24-28	4

Table – II

Frequencies and Percentages of Episodes of Spousal Aggression

Types of Psychological Aggression	Frequency	Percentage
Frowning & Staring unnecessarily	15	50.00%
Shouting	24	80.00%
Criticism	11	36.67%
Taunting	08	26.67%
Snubbing unnecessarily	14	46.67%
Abusive Language	05	16.67%
Humiliating in the presence of relative	06	20.00%
Derogatory attitude	10	33.33%

Table – III

Frequencies and Percentages of Episodes of Spousal Aggression

Types of Psychological Aggression	Frequency	Percentage
Throwing things around	11	36.67%
A Little slap	07	23.33%
Pushing	04	13.33%
Wrestling	02	06.67%
Pulling the hair	02	06.67%
Punching	03	10.00%
Biting	02	06.67%
Choking	00	00
Burning	00	00
Injuring with a household object	01	03.33%
Injury with a weapon	00	00
Throwing acid on face/body	00	00
Forcing a partner to engage in sexual activities	05	16.67%
Forcing a partner to engage in repulsive sexual acts	01	03.33%

DISCUSSION

The results given in Table-I indicate that the female's exposure to spousal aggression (both physical and psychological) decreases with an increase (9-12 years) in the marital period.

It can be argued that working women's economic independence would let the abusive husbands feel all the more necessary to use aggressive behaviors, in order to induce control over their wives lives. Such an oppressive and abusive behavior of the husbands would be evident in the early phases of their marriage. But with the passage of time, their wives responsibilities would increase both inside and outside the home. As a result, the working women would probably not be that easily available at home for their husband's aggressive outbursts.

Table-II and Table-III give an overall picture of the occurrence of different types of spousal aggression (psychological and physical, respectively) among the working women.

Table-II indicates that 50% of the females reported being stared at by their husbands quite often in an average week, whereas, 80% reported being shouted at, quite frequently by their husbands in an average week. Moreover, about 47% of the women reported being snubbed unnecessarily and 33% reported the use of derogatory attitude by their husbands in an average week.

Results given in Table-III indicate that 37% of the women reported that their husbands manifested the aggressive acts of throwing things whereas 23% of the women reported the occurrence of the aggressive acts of a little slap by their husbands in an average month. The aggressive acts of pushing and punching were also reported by the females, as occurring quite often in an average month (13.33% and 10.00%, respectively). Moreover, about 17% of the abused women also reported forced sex by the male spouses.

The present research findings clearly indicate that the females living in Pakistan are subjected to greater social pressures, which, often, compel them to bear all types of aggressive and abusive behaviors from their husbands. The situation in Pakistani society is so grim that even the working females, seem to be carrying in their hearts, the belief that their efforts to improve the economic condition of their family would not be duly valued by the male dominant society and its institutions. Therefore, they continue to bear all types of the physical and psychological outburst of spousal aggression for almost indefinite time span. Nevertheless, the findings indicate that frequency of violent acts decreases with the passage of time but it does not end.

In future, better results can be yielded by increasing the sample size, conducting intra-profession analysis after taking a large group of females from the same profession, and by extending the time span of the research. Moreover, the researchers may plan a cross provincial/cultural study by drawing the sample from all over the country. The researchers can also take females from different professions and conduct a comparative study. There is also a need for careful and detailed assessment of traumatic incidents for research and clinical purposes. Such data would suggest that in population seeking professional help, at least it is not uncommon to have experienced multiple traumatic stressors during their lives.

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INFLUENCE OF LEARNING TRIALS ON MEMORY RETENTION OF PLANARIA: DUGESIA TIGRINA

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ABSTRACT

The following research was conducted to determine: (1) the influence of learning trials on memory retention of planaria: Dugesia tigrina, and (2) the extent of retention after a 2 day time period. Results indicated that learning trials do influence memory retention in planaria, and that the extent of retention is associated with the amount of prior training before the retesting.

INTRODUCTION

The most familiar free-living flatworms are the planarians. These invertebrates belong to the phylum platyhelminthes (Flatworms). Their body features bilateral symmetry; a permanent, internal reproductive system; various layers and bundles of muscles; a branching, bling gut that reaches throughout the body; an excretory system composed of specialized cells, and a simple nervous system with an enlarged brain in the anterior end (Whitten and Pendergrass , 1980).

In worms, and in planaria , we find the first appearance of a central nervous system. Planaria have a concentration of nerve cells forming a cerebral ganglia, or brain in the head end of their body. From this brain, there are two strandlike concentrations of nerve cells commonly called lateral nerve cord which run tailward near the ventral surface. These two nerve trunks, one on each side of the body have numerous cross connectives known as transverse nerves as well as lateral branches. The whole system has the appearance of a ladder (Burnes, 1974; Mc Farland, 1981).

Research indicates that planarians tend to have the ability to learn simple tasks, that their responses to stimuli can be conditioned, and that memory of training can be artificially transferred from one planarian to another. They are considered by many animal behaviorists to be the simplest animals on the phylogenetic scale that exhibit an ability to learn in response to simple conditioning (Davis, 1984; Ford, 1972).

Studies of learning and memory of planaria have made use of both the regenerative and cannibalistic capacities of the animals. During regeneration, memory was apparently unhampered and was demonstrated by the regenerated offspring . This suggested a cellular basis for memory (Corning, 1967). In cannibalistic studies, it was found that planaria could pass on their learning of a maze by merely being cut into fine pieces, fed to untrained, naïve planaria. The latter subjects seemed to gain molecules of memory as this form of research questioned whether memory might be transferred via ingested cells. Cannibal planaria learned to run the same maze correctly with far fewer trials when their diet included only cut up planaria having previously learned the task (Jacobson, 1971; Jacobson, & Horowitz, 1966; Loomis Napoli, 1975).

Planarians are negatively phototaxic, in that they avoid or refrain from light. McConnell (1967), reported on conditioning planarians using light and shock in the conditioning process. In some research with planaria using light and shock in a learning task , it has been questionned if true conditioning had resulted in the subjects' performance, or was the performnce due to mere sensitization of the organisms (Ford, 1972; Milne & Milne, 1982).

If a planarian is exposed repeatedly to a bright light, then it will react by contracting and/or moving away from the light source. When exposed repeatedly to mild electric shocks, it will continue to respond by contracting. If these two conditions are combined (repeated bursts of bright light, then after a few seconds

a shock), the planarian will later act as if ''anticipating'' the shock after the light presentation. This acquired reactivity is not centered in the brain, because when a worm trained under the two combined conditions is cut in half and each half is allowed to regenerate, both the anterior and posterior regenerated sections will react to the stimuli. Memory seems to be somehow stored throughout the central nervous system of the planarian, and it can be transmitted through the animal's cells and it can be transmitted through the animal's cells and tissues (Storer et al., 1987).

The following research was conducted to determine:
(1) The influence of learning trials on memory retention of planaria: Dugesia tigrina, and
(2) the extent of retention after a 2 day time period.

METHOD

Sample:

Sample consisted of eighty-eight planaria (Dugesia tigrina). They were obtained from a biological supply house.

Materials:

6 – Train-A-Trays; 2-1.5 volt dry cells; pipette; Fluke Model 23 Series II Multimeter; Fluke 8oT-150U, Temperature Probe; magnifying glasses (3x & 5x); 2- Rubbermaid bowls (285 ml capacity); 1- 75 watt light bulb; Greenlee 93-1065F Digital Light Meter; 2 –15cm 12 guage wired; 18.925 liters bottled spring water, and 453. 6 grams beef liver.

Procedure:

The 88 planaria were randomly divided into 4 groups of 22 Ss each. All subjects were fed approximately one gram of beef liver once a week until the research process was conducted. They had their water changed daily and their bowls were cleaned.

The conditions under which the planaria were tested included the light source 20cm above the Train- A-Tray. The measured illumination level was 41. 9 foot

condles. Room temperature was held constant between 70°F and 72°F. Water temperature was maintained at 70°F. The total resistance of the wire , water and worms was 0.7 ohms. All trials were run beginning at 8:00 p.m. until completion. Learning trials consisted of light / shock conditioning in which the Ss were placed into a train-A-Tray apparatus connected to a power source of 2-1.5 volt dry cells connected in series. Light was shown directly on the planaria for 3 sec., and on the 3rd sec., a mild shock was delivered. Contracting responses of the Ss were measured based on their "anticipating" the shock after the light presentation on 2 consecutive trials.

The 4 groups of Ss were randomly labeled Groups A,B, C, and D. Training procedures included the following: Group A was trained using the light/shock conditioning of 25 trials for 10 days. Two days after Group A's training was complete, the Ss' memory retention was tested with further light/shock presentation. Group B was trained with light/shock conditioning of 25 trials for 7 days, and, as above, after 2 days the planaria were tested again with the light /shock conditioning. Group C was trained (25 trials per day for 5 days), as well as Group D (25 trials for 3 days) with light/shock conditioning followed by retesting after 2 days.

RESULTS

Figure 1, indicates the performance data for all of the four S Groups - A,B, C, and D. Each illustration graphically displays the mean score for each S group, for the trial after which shock was " anticipated" after 2 consecutive trials, on each day of training. It also shows the retest performance, for each s group, with the retesting data gathered after 2 days following the completion of the light/shock conditioning period. It can be seen that, regardless of the days of training, ten, seven, five or three, the Ss' trials of " anticipation" decreased with each successive day of light/shock conditioning. Furthermore, when noting the performance of S groups A and B. It was found that the Ss reached the criteria level "anticipation" after 2 consecutive trials) on the very first 2 trials, on days 8,9 and 10 for group A, and on day 7 for group B.
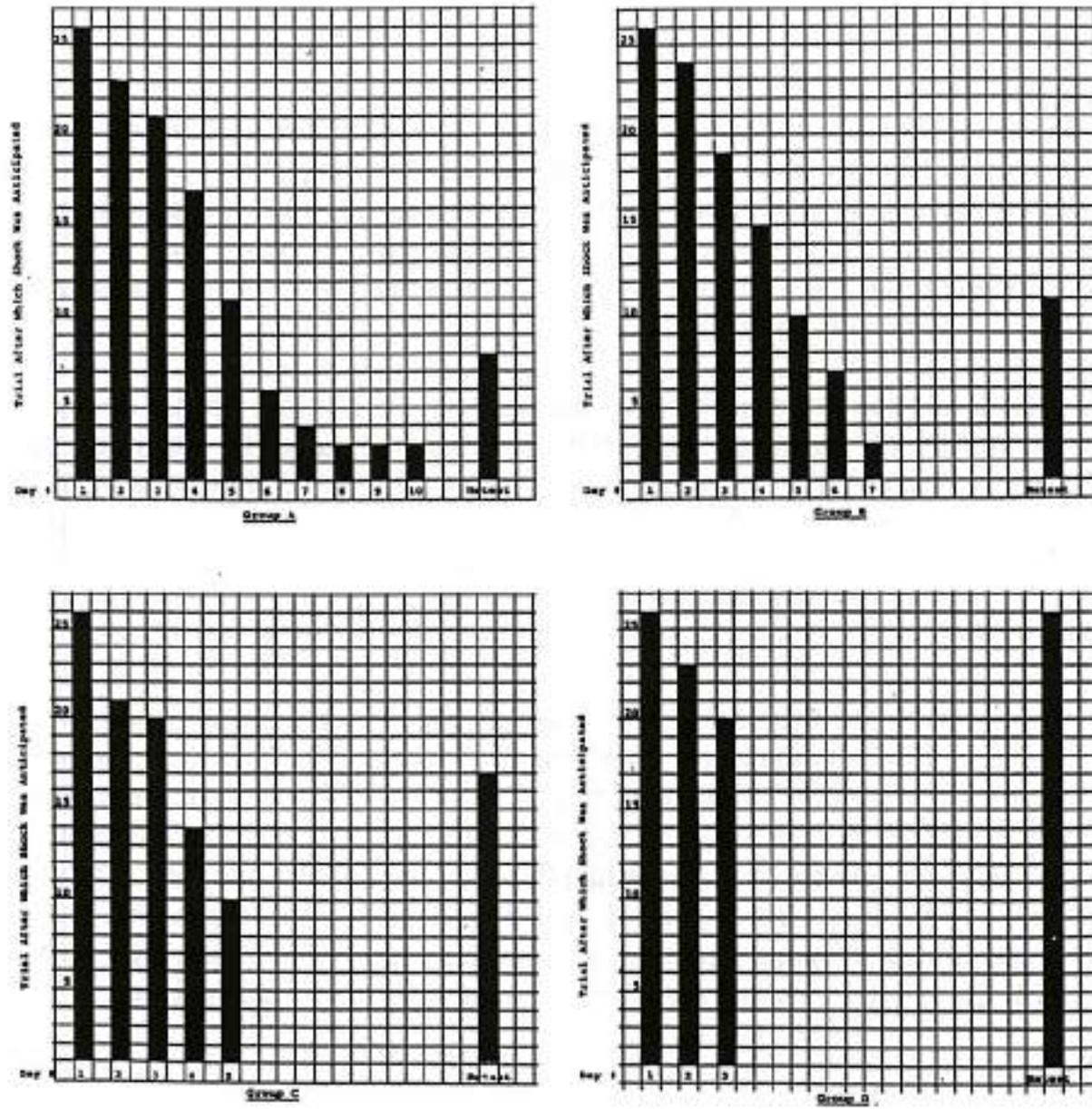
Figure 1: Performance data for all of the four groups – A,B,C and D. Each illustration graphically displays the mean score for each S group, for the trial

after which shock was " anticipated" after 2 consecutive trials, on each day of training . It also shows the retest performance.

DISCUSSION

Learning trials do influence memory retention in planaria. With all four S groups, during the course of a light/ shock conditioning period, the planaria decreased their mean trial after which the shock was anticipated suggesting that they had memory retention of the training from the pervious day (s). This "memory retention" tended to stabilize or level off at about the 7th day (Group B) or 8th day (Group A) of trials.

Considering the relative extent of learning or retention for each S group by day, the amount of " memory" was relatively about the same, for example, note the Ss performances, for all four groups on days 1, 2, and 3. Performances on days 4 and 5, for Groups A,B, and C, and those on days 6 and 7 , for Groups A and B are about the same. These similarities might suggest that planaria have a "limited" amount of memory retention each day and/ or on successive days during a light/ shock training period.

The extent of retention after a day time period, for all s groups, tends to be associated with the amount of prior training before the retesting. The date indicate that more days of training are related to an increase in memory retention. Planaria having 10 days of light/shock conditioning had the greatest retention; Ss having 3 days of light/shock training had the least retention of the four s groups. They seem to have to have at least 4 or 5 consecutive days of conditioning in order to have any memory retention, since the Ss receiving 3 days of training (Group 3) did not demonstrate memory retention during the retest period.

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THE EFFECT OF COGNITIVE BEHAVIOUR THERAPY AND PHOTOTHERAPY ON BIPOLAR 1 DISORDER: A CASE STUDY

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ABSTRACT

The present single case study was designed to see the effect of cognitive behaviour therapy (CBT) and phototherapy on 17 years old male client with the complaints of depressed feelings, sad mood, hopelessness, obsessional ideas, feeling of anxiety and guilt related to obsessional ideas preoccupation with the past, anger and hatered for self, father and home, weeping episodes, poor memory, suicidal ideation, palpitations, visual hallucinations, delusion of persecution, increased appetite and sleep and tremors in hands. The client was diagnosed on DSMIV as having bipolar I disorder with recent episode depressed. AB research design was used. Pre assessment was done with the use of rating scale, baseline chart, state trait anxiety inventory (STAI), state trait anger expression scale (STAXI), Beck depression inventory (BDI), standard progressive matrices (SMP), Padua inventory (PI), Wechsler memory scale (WMS) and Minesota multiphasis personality inventory (MMPI). It was hypothesized that (a) cognitive behaviour therapy would help in reducing the intensity, frequency and duration of the symptoms of anger, obsessional rumination, and depressed feeling (b) cognitive behavior therapy will help the client in better adjustment with the family (c) phototherapy would help in reducing the feelings of depression (d)

thought stopping alongwith cognitive therapy would help the client in reducing obsessional ideas, associated anxiety and guilt feelings. In the B phase therapeutic techniques of cognitive behavior therapy and phototherapy were employed. A total number of 19 sessions of 1hour duration spread over a period of three months were conducted. At the end of the B phase post-assessment with the use of same instruments was conducted. Comparison between pre and post assessment supported all the hypotheses. Results were discussed and recommendations were given.

INTRODUCTION

Cognitive behavior therapy has been found effective in the management of Bipolar disorder. Ellis and Grieger (977), Barlow (1985). Dryden (1988) have illustrated a case of 50 years old man who was depressed after loosing his job and as a result of his sex problems. He was feeling quite worthless. By using Disputing irrational beliefs (DIBS) techniques, a six months follow up revealed that the client started enjoying his university courses and was free of depression. His initial score on BDI was 42. After 10 sessions his score came down to 3 and after six months follow up his score was 1. Ellis used ABC cognitive model with one of his clients having anger and taught him the relationship between AB and C with which the client was able to control his anger (Ellis 1994). Similarly Woods (1987) in his study with a staff of a large corporation showed positive result by changing irrational beliefs resulting in decreased emotional distress (Joyce, 1995). Fisher (1978) noted that there were several controlled studies which showed positive results of using cognitive restructuring and enhancing problem solving skills in dealing with anxiety, depression, compulsions, confusion about goals, lack of confidence and inability to make decisions (Warner, 1982). The effectiveness of CBT in treating clients has been revealed by number of studies (Ellis & Becker, 1982, Ellis 1986, Velton, 1968).

The major indication for phototherapy is depressive disorder with seasonal pattern. More than 50% of studies have shown that light therapy is effective with elevating depressive mood. Exposure to bright light in the morning and evening causes a phase advance of biological rhythms that

effectively treats the delayed circadian rhythm associated with depressive disorder with seasonal pattern (Blehar & Rosenthal, 1989).

A number of single case studies have been conducted on the Bipolar 1 disorder regarding it's etiology, related complications, theoretical explanations, treatment strategies and prognosis in the western countries, but there was no research work with reference to Pakistan. The aim of present single case study was to see the role of cognitive behavior theapy and phototherapy in the treatment of a Pakistani client with Bipolar 1 disorder with recent episode, depressed. The client came with the complains of depressed feelings, and mood, hopelessness, obsessional ideas, preoccupation with the past, anger and hatred for self, father and home, weeping episodes, poor memory, suicidal ideation, palpitations, visual hallucinations, delusion of persecution, increased appetite and sleep and tremors in hands.

CASE HISTORY

The subject was a 17 years old, student of F.Sc. unmarried male. His father was 40 years old, educated upto F.Sc. He was a very aggressive and authoritative person who usually beats, snubs, scolds and abuses his children and wife. The client reported to have a strained and full of hatred relationship with his father. Client's mother was a 48 years old, graduate housewife.

The client was somewhat close to his mother but did not have any sharing with her. The mutual relationship between parents was full of conflicts and quarrels. The client was second among four siblings and reported to have satisfactory relations with all of them. His elder sister was also diagnosed as having depression and was under the treatment of a psychiatrist.

He had a normal birth history and achieved his developmental milestones without any complication. There was no history of any neurotic traits in the childhood. His schooling started at the age of 5 years and he was an above average student. He never participated in extracurricular activities. He wanted to become an engineer but he lost interest in studies in the second year of F.Sc. due to depressed mood. He has changed his goal, as now he wants to do MBA. He is passive and anxious regarding his social relationships. The client did not have any sexual experience. There is no

reported history of masturbation and homosexuality. He has timid and shy attitude towards the opposite sex. He wants to get married to a simple girl after being established financially.

History of present illness can be traced back to 7 years of his age when he started withdrawing from the family and social relationship and became aloof. Then he gradually developed the previously mentioned symptoms and with the passage of time these symptoms started aggravating both in intensity and frequency. He remained under the treatment of a psychiatrist but found no improvement. Then he was referred for psychological treatment.

Tentative Diagnosis based on DSM IV:

AXIS 1 292.53	Bipolar 1 disorder: Most recent episode Depressed with a typical features.
AXIS II V71.09	No diagnosis
AXIS III	None
AXIS IV	Psychosocial stressors: Parental rejection, Skewed family pattern, difficulty and failure in achieving goals.
AXIS V	Current GAF 45 Highest GAF past year 60.

Hypotheses:

1. Cognitive Behavior Therapy would help in reducing the intensity, frequency and duration of the symptoms of anger, obsessional rumination and depressed feelings.
2. Cognitive Behavior Therapy will help the client in better adjustment with the family.
3. Phototherapy would help in reducing the feelings of depression.
4. Thought Stopping along with cognitive therapy would help the client in reducing obsessional ideas, associated anxiety and guilt feelings.

METHOD

The present research project began by using the AB phase of the ABAB design with a male client. In the phase A of this research project baseline chart, rating scale, STAI, STAXI, MMPI, SPM, BDI, PI, were used for the purpose of pre-assessment. In the B phase, management programme spreaded over 3 months duration was designed. Total treatment programme included 19 sessions of 1 hour each. Relaxation exercises, Activity Schedule, Pleasure and Mastery. Thought Stopping, Disputing Irrational Belief (DIBS), Double column technique, Hedonic Calculus, Rational Emotive Imagery (REI), Coping Statement, Positive Self Statements, Problem Solving Operant Conditioning, Stay In there Activities, Rational Proselytizing, Rational Role Reversal, Homework assignments, Empty Chair Technique, Vivid Visual cues, Family Counselling and Phototherapy were the techniques used in the treatment phase B. At the end of the phase B, post assessment was done with the use of same instruments to find the effect of treatment.

Description of Measuring Instruments:

1. Baseline Chart: The client was given a baseline chart to maintain record of intensity, frequency and duration of his intrusive thoughts, aggressive behavior and depressive feelings for a week. Intensity was rated on 0-10 scale.

2. Padua Inventory (PI): The Padua Inventory consists of 60 items to be rated on a 0-4 scale describing common obsessional and compulsive behavior and allows investigation of the topography of such problems in normal and clinical subjects (Sanavio, 1988).

3. Standard progressive matrices (SPM): This test is developed by Raven (1983) to see the person's capacity to think clearly and can be used as a test of intellectual efficiency. It covers the widest possible range of mental ability and is considered a culturally fair test.

4. State trait anxiety inventory (STAI): This test is comprised of separate self report scales for measuring two distinct anxiety concepts state anxiety and trait anxiety. STAI gives T Scores, with a mean of 50 and S.D of 10 and percentile ranks for both trait and state scales. The test retest reliability of the A-trait Scale of STAI is relatively high ranging

from 0.73 to 0.86. Both the trait and state scale have a high degree of internal consistency (Speilberger, Gorsuch, Lushene, 1970).

5. Beck Depression Inventory (BDI): It consists of 12 items designed to measure depressed mood over the previous 7 days, each with four response alternatives ranging from 0 to 3.0 indicating lowest/absence of depression, whereas 3 indicating severity of depression. Split half reliability of 0.93 has been reported by Beck et al (1961). In the present study, Urdu version of BDI was used which was translated and standardized by Sitwat and Bashir (1990).

6. State Trait Anger Expression Inventory (STAXI): The STAXI provides concise measure of the expression of anger. It consists of 44 items which forms 6 scales and 2 sub-scale: State anger, measuring the intensity of anger feelings at a particular time and Trait anger measuring the individual differences in the disposition to experience anger (Spielberger 1979).

7. Weschsler memory scale (WMS): It is used as a rapid, simple and practical examination scale. It has two parallel forms: Form 1 and Form 2, for pre and post test consists of seven subtest. In the present study Urdu version adapted in Pakistan by Hamid and Mehmood (1989) was used. This adapted measure was standardized on a sample of 25 males and 25 females, falling within the range of 16-25 years.

8. Minnesota Multiphasic Personality Inventory (MMPI): This test was developed by Hathaway and McKinley (1966) is designed to provide an objective assessment of some of the major personality characteristics that effect personal and social adjustment as well as it helps in the diagnosis of psychological illness. It includes nine clinical, one social and four validity scales. It is translated into Urdu and standardized for Pakistani population by Mirza (1974).

9. Behavioral Rating Scale: was used for the presenting problems and the client was asked to rate his feelings of anxiety, anger, hopelessness, level of confidence, level of disturbance due to obsessive compulsive behavior. The 0 rating shows no problem at all and 10 shows maximum level, whereas 5 present average disposition.

RESULTS

Table – I

Beseline of Anger, Depressed Feeling and Obsessional Ideas
Pre and Post Assessment

	Depressed Feelings			Anger			Obsessional Ideas		
	Fre	Int	Dur	Fre	Int	Dur	Fre	Int	Dur
	Per	(0-0)	Hrs.	per	(0-0)	Hrs	Per	(0-10)	hrs
	Day		min.	Day		Min	day		min
Ave.Pre	1	9	5.57	5	6.8	1.20	3.9	3.85	05.07
Ave.Post	0.42	4.67	2.34	2.1	3.8	0.37	1.1	3.1	04.25
Change	0.58	4.33	3.22	2.9	3	0.35	2.8	.75	0.-18
% age of Change	58%	48%	53%	58%	44%	48%	71.8%	19.48%	9.35%

In all the three areas there is an improvement in all the three categories ie., frequency, duration and intensity.

Table -II

Rating Scale's Percentage of Change

Problem	Percentage of Change
01. Low confidence	60%
02. Hands shivering	10%
03. Indecisiveness	60%
04. Sad feeling In darkness	60%
05. Suicidal ideation	40%
06. Low interest in studies	60%
07. Sadness in the evening	70%
08. Restlessness	50%
09. Anger	70%
10. Weeping episodes	60%
11. Low interest in routine	60%
12. Fatigoability	60%
13. Obsessional ideas	40%
14. Poor memory	30%
15. Hate for self	70%
16. Preoccupation with the past	40%
17. Muscle Tension	50%
18. Fear in exams	60%
19. Poor comprehension	30%

The maximum improvement is in the area of anger, hatred for self, depressed feeling in the winter evening, which is 70% in each whereas all other areas are improved more than 50% .

Table - III

State Trait Anxiety Scores and Percentile Ranks for Pre and Post Assessment

	State		Trait	
	Raw Score	P. R.	Raw Score	P. R.
Pre	70	99th	61	99th
Post	27	3rd	30	17th
Difference (Pre-Post)	57	96	3i	82

The difference in the percentile ranks on state and trait score show marked improvement. The improvement reveals that the client found better, about self-regarding perceived feelings of tension and apprehension and heightened autonomic nervous system activity. He found improvement in his coping skill to deal with anxiety provoking Situations (Spielberger, 1970).

Table - IV

State Trait Anger Expression (STAXI) Scores and Percentile Ranks

	Pre-Assessment		Post-Assessment	
Anger Scale	Raw Score Rank	Percentile Rank	Raw Score Rank	Percentile Rank
S.Ang	2993rd	14	58th	35
T.Ang	82nd	5	<2nd	0
T.Ang-T	16>99th	8	82nd	17
T-Ang-R	1699th	9	50th	49
Ax-In	2187th	18	60th	27
Ax-out	2699th	18	79th	20
Ax-Con	7 < 1	23	51st	-50
Ax-ex	56 >99	15	14th	85

The result on STAXI show that the AX/EX scale's Percentile Rank have decreased to 14th from 99th percentile rank. Although there are scales, such as S. Ang, T.Ang-R, Ax-in, Ax-cons, which are nearer to the average range of percentile rank i.e., 50. T-Anger and Ax-Ex are both below 50th percentile ranks revealing the client's denial in experiencing angry feelings, (Spielberger, 1970). Ax-out and T-Ang-T's percentile ranks are greater than the 50th percentile ranks, showing the client's aggressive expression and quick tempered behavior at the post assessment level (Spielberger, 1970).

Table – V

The Pre and Post Results on PI

	Pre	Post	Difference (Pre-Post)
Raw Score	116	59	57
Category	Moderate	Mild	Normal

There is an improvement of Obsessive Compulsive Behavior as the difference is of 57 points between pre and post assessment Scores on (PI).

Table –VI

Pre and Post Assessment Scores on BD

	Pre	Post	Difference
Raw Score	26	11	15
Category of Depression	Moderate	Mild mood Disposition	

There is a difference of 15 points between the pre and post assessment on BDI with 26 points at Pre Assessment and 11 points at Post Assessments, which shows marked decrease in the Depression Level.

Table – VII

Pre and Post Assessment Scores on SPM

	Pre	Pre
Raw Score	50	53
P.R.	78th	87th
Category	Above Average	Above Average

In both the Pre and Post Assessment the client's intellectual capacity is definitely above average. The percentile ranks increased from 78th to 87th.

Table – VIII

Wechsler Memory Scale (WMS)

Sub-test Pre-Post	Pre	Post	Mean	SD	Pre-Test Analysis	Post-Test Analysis	Difference
Information	5	6	5.86	0.35	Below mean	Within mean	01
Orientation	5	5	4.86	0.35	Within mean	Within mean	00
Mental Control	5	5	6.98	1.00	Below mean	Below mean	00
Logical memory A	13	20	17.04	3.17	Within mean	Within mean	07
B	8	12	16	15.44	3.18	Within mean	04
Average	7	12.5	18	16.20	3.03	Within mean	5.5
Digit Span							
i) Forward	6	6	5.98	1.09	Within mean	Within mean	00
ii) Backward	3	4	4.80	0.89	Within mean	Within mean	01
Visual Reproduction	13	13	11.04	2.24	Within mean	Within mean	00
Associate learning							
i) Easy	8.5	8.5	8.76	0.55	Within mean	Within mean	00
ii) Hard	6	6	8.22	2.72	Within mean	Within mean	00
Total	14.5	14.5	16.98	3.00	Within mean	Within mean	00

The improvement of 5.5 points and I point in the sub-test i.e. logical memory and digit Backward respectively which are clearly related to the level of

concentra-tion so that greater concentration results in the improvement in these areas (Wechsler 1956, and Bootzin, 1992).

Table – IX
Pre and Post Assessment Scores on MMPI

Sub-Scale	Pre- T-Corrected	Post- T-Corrected	Pre-qualitative Analysis	Post-qualitative Analysis
Validity Scales	Score	Score	This client is Admitting his	L=problems are Being admitted,
L	31	31	Problem and	F=psychotic patient,
F	70	66	Wants assistance,	K=limited personal
K	29	42	Revealed through LFK	Resources available to deal with problems
Clinical Scales				
I-HS	54	54	Normal body	Normal body concern
2-D	80	60	Concern general	Dissatisfaction with
			Sadness	Some-thing
3-HY	61	63		Superficial xtroverted
4-Pd	62	56	General concern about social problems	Having typical number of complaints about
5-MF	53	60	Interested in traditional Masculine concerns.	Authority, & Tendency Toward asthetic sense.
6-Pa	65	72	Interperpersonal sensitivity and rathional thinking	Suspicious, hostile overal sensitive and verbalize these qualities.
7-Pt	69	47	General punctual in meeting otherwise become worried.	Worried, tensed and Indecisive.Overt Anxiety is usually
8-Sc	64	53	Thinking in different way from others.	Normal thinking Pattern.
9-Ma	46	46	Normal activity level	Normal activity level
I0-Si	74	59	Introverted, timid shy, Significant others.	Balance between socially introverted behaviors.

There was an improvement in the subscales; D and Si whereas there is deterioration in the scores on Pa which reflects the presence of psychotic feature; essential component of Bipolar I Disorder (Kaplan and Sadock 1993).

DISCUSSION

A comparison of pre and post assessment has indicated that intervention strategy implemented was successful and all the hypotheses were supported.

The client showed improvement in the main complaints of depressed feelings, low interest in studies and routine activities as is revealed through D scale of MMPI, rating scale, baseline chart for depressed feelings and BDI. Cognitive restructuring practiced with the client changed the irrational thinking and helped him reduce his anxiety, hopelessness, depression and anger. ABC model, disputing irrational beliefs (DIBS) and reational emotive imagery (REI) proved very effective as is shown by reduction in scores on BDI, STAI and STAXI. It also confirms the findings of earlier studies reported by Ellis (1994), Haaga and Davison (1993), Holmes (1991) and Synder and Forsyth (1991).

Hedonic Calculus used during the treatment phase helped the client to learn how to make decisions on his own. The behavioral ratings of his problem related to inability to make decision showed marked improvement. Coping statement and positive self suggestions helped the client in rearranging his daily life and consequently reduced his level of depressed feelings, hopelessness, anxiety related to obsessional ideas, anger and multiple physical complaints. Ellis and Bernard (1985) also reported the effectiveness of these techniques.

At the post assessment level there is marked improvement in the area of low interest in studies. This purpose was achieved with the help of activity schedule, self reinforcement procedures and pleasure and mastery technique. As reported by Kandel, Ayllon & Roberts (1976), Kanfor & Karoly (1972), Goldiamond (1965) and Ferster, Nuranberger & Levile (1962) and Turner (1981) that the self reinforcing procedure and mastery rating help in dealing with the problem of low interest in routine activities or at work.

With the use of thought stopping technique the client showed improvement in the area of obsessional ideas. Psychological tests results, baseline chart and rating scale showed marked improvement. The effectiveness of this technique was also reported by Jenike, Baer and Minchiello (1990). Deep breathing and relaxation exercise of Jacobson (1938) was very effective in reduction of anxiety and anger. According to the researches reported by Davison and Neale (1994), Holmes (1991), Wolpe (1990), Beck, Emary and Greenberg (1985) and Turner (1981), relaxation exercises helped in reducing anxiety level, tension and restlessness.

Assertivensess and social skills training helped in increasing his level of self confidence. The empty chair technique helped reduce his anger towards his father. He was able to express his angry feelings and to develop insight in a safe non-judgemental environment of therapeutic session. Family counselling helped in the improvement of relations with the family. The Skewel family pattern along with High Expressed Emotions (EE) and cognitive deviance (CD) were taken into account. Family therapy sessions although has little pace in mood disorders but it is necessary component when there is family history of mood disorder, (Kavanigh, 1993). The client's problem of feeling depressed in the winter evening was dealt with phototherapy. Earlier studies concucted by Blechar and Rosenthal (1989) suggested that the major indication for phototherapy is major depressive disorder with seasonal pattern. More than 50% studies have been shown that light therapy is effective in improving mood states, although the actual mechanism of action is unknown (Kaplan & Sadock, 1993).

To sum up, the above mentioned findings reveals that the cognitive behavior therapy and phototherapy are very effective in helping subject with Bipolar 1 disorder. It is recommended to conduct single case studies with other research designs, so that the effect of the present treatment can be thoroughly studied. More sessions are needed for family therapy. There is also a great need of minimizing the role of phototherapy along with maximizing the role of cognitive behavior therapy. Further studies should also be conducted to investigate the effect of cognitive behavior therapy and especially the phototherapy.

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PSYCHOLOGICAL EFFECTS OF PAID WORK ON MARRIED WOMEN

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ABSTRACT

The purpose of the present research was to determine the effects of paid work on married women. It was hypothesized that married working women will experience less anxiety, aggression, conflict with authority and will have good Interpersonal relationships and stress management than housewives. In order to test various hypotheses, sample consisted of ninety married women which included 30 doctors, 30 lecturers & 30 housewives. The age range of working & non-working women was from 30-45 years. Manifest Anxiety Scale and Questionnaires measuring, aggression, conflict with authority, interpersonal relationships and stress management were administered on the sample. Analysis of variance was applied to find the statistical significance of the results. Significant difference was found only on the variable of stress management.

INTRODUCTION

In almost every society women has had a lower status than men. Women have faced more social restriction and have consistently received less recognition for their work than men. Women have been regarded differently than men, not only biologically but also emotionally, intellectually and psychologically. Double standards have often existed for marriage, divorce, jobs and for various social conducts. More societies in their traditional doctrines have ascribed an inferior status to women. Many societies have concluded that woman shall play secondary and supportive role to men. Women spend most of their adult life being pregnant, nursing infants and raising the older children. Women since they were forced to remain around the home were also assigned the less prestigious, domestic tasks of cooking, serving and working. These sex roles became part of tradition. These distinctions were not only recognized as practical of necessary work but also seen as natural ways for men and women to be. Before the industrial revolution practically all societies had come to assign distinct role to men and to women. Women were sincerely involved in domestic and child rearing activities, while men were involved in functions such as economic support and protection of family.

Women in preindustrial societies were also often involved in food producing and economic support such as making clothes, growing and harvesting garden crops and helping on the farms but their specific responsibilities were often viewed as inferior and requiring fewer skills because they were unpaid and they were not considered as working women.

Work tends to be seen as paid, full time, continuous and outside the home. However, this model of work is male dominated and does not reflect the reality of most women's experiences. Much of women's work is invisible and unrecorded in the national income. More over, because women's work does not 'fit' this model, it is marginalised (Challender, 1985).

Toril; Angela; et al. (1985), reports the work of ILO, Bureau of statistics that in modern industrial society jobs have always tended to be created on the assumption that workers have no domestic responsibilities. They are expected to be available at places and times to suit the employer. This is the main reason why women, though half of the worlds population are only a third of the world's official income – earning labor force. A radical change in life – styles and life patterns has resulted from the increased number of women in paid work. Women

are now spending an increasing proportion of their lives in paid work, although few adopt the typical male pattern of continuous employment. Most women work full time until the birth of their first child. In the past these women would have returned to employment once their children had grown up. Women are now returning to employment more quickly after child-birth and on increasing number are returning to employment between births, mostly to part – time job. It was added that most of the women prefers part time jobs, because full time job require both a confidence and a freedom to work long hours that few women possess. In Indonesia and Bangladesh less than 1 percent of managers are women. In Egypt, Peru, Japan, Australia and Norway between 3 to 10% are at administrative post. In US 15% of managers are women and in Barbados, El Salvador and Hungary it is 25%.

Women account for 89% of all time workers (Labour Force Survey 1985), and 70% of employed women with dependent children work part time (Equal Opportunities Commission, 1985) The presence of children and domestic responsibilities have a strong influence on the number of hours women can do paid work. It has been suggested that part time jobs are being constructed specifically as jobs for married women (Bgeechey and Perkins, 1987).

There also may be some problems in the husband – wife relationship associated with working women. It may be due to the husband holding the traditional view being the only family wage – earner and as a result his sense of masculinity is threatened. On the other hand as a result of social changes and moves towards equal employment opportunities there is an increased emergence of women in the workforce, which indicate the desire of many women to establish career in life. Most women have started evaluating their worth and success in terms of employment. It may also indicate willingness to enhance a family standard of living by having two income while many couple see this as a worth while sacrifice, many women value work because of the reward it brings.

Freedom of choice is of course a key element but if a wife works because she want to, she is better satisfied with her marriage than either house wife or employed wife who wish they were not working (Safilios - Rothschild, 1970). It has been found that wage earning enhances a wife's self – esteem, power and influence on the couples decision. They feel that they can put their talents and abilities to more profitable use (Bart, 1972). May be due to this they feel less anxious, depressed than housewives. For many women work becomes a necessity because they need the feeling of creating something new (Terkel, 1972). This

feeling of creating something new in turn increases her self esteem and diminishes her depression, which she might have when she feels herself over burdened due to dual type of responsibility.

Gove and Tudor (1973) found that among married women, full time housewives seem to have more Psychological Problems than the working wives. They gave many reasons why the housewives role in modern societies may be stressful. One of the reasons they gave is that for many women full time housework is restricted to one single social role. Secondly, much of the housewife's work is repetitive and undemanding and does not call for a high degree of expertise. It is out of keeping with the educational attainment of many women. Thirdly, the housewife's role is relatively unstructured. Her isolation and lack of structured job demands make it possible for her to brood over her troubles. As contrast to this the working women usually does not have opportunity to be obsessed with, that is why she tends to have less psychological problems.

In one study conducted by Ferree (1976), housewives said, "they were going crazy staying home and not seeing anybody but four walls all day," because house work is considered to be a low status and isolating, full time house wives tend to be unhappier with their lives and inturn are more depressed than working woman.

Burke & Weir (1976) in a study on 189 couples, housewives reported more worries, sickness and feelings of "being in a rut" than did working wives. In another study of 135 working class women in Boston, it was found that even when compared with unglamorous wage – earning jobs (such as waitress, nurses, store clerk etc.) paid work provide more personal satisfaction than homework. A survey of 842 women and 691 men by the National Opinion Research Center found that wives who were educated and capable of holding high status occupation were more frustrated and unhappy with their lives in marriage, when they were not employed than were those who were working (Richardson, 1979).

Several studies conclude that working wives are more satisfied with their lives than housewives. There is some evidence that the category of women are those with husband, children and a job to which they are only moderately committed (Shaver and Friedman, 1976). It has been found that if an employed mother is happy with her job or able to provide for her child's daily needs so that she need not worry about her child's security she may perform as a parent as well

or better than an unemployed mother. In many cases, unemployed mothers find their home-making job overly stressful because money problems are more likely to occur in families having one employed spouse. Finally, and perhaps more importantly, employed mothers tend to encourage their children to be more independent and self-sufficient from an early age (Hock, 1980).

In a sample of working women studied in 1976, 76% said that they would continue to work even if they did not have to (Dubnoff, Veroff & Kaulk 1978). This suggests that many women find the world of work particularly satisfying. Martin and Roberts (1984a, 1984b) found that employed wives report more satisfaction with marriage than homemakers if they are working by choice and / or have the approval & support of their husband (Vaydanoff, 1987). The husband of such women also report more marital satisfaction than husbands of homemakers. The increasing number of married women with children who are in employment. More than 50% of women with dependent children are economically active. Paid employment is now the norm for women.

Scarpiti (1989), found that house wives were more often depressed than the employed women and also when the house wives were depressed, they showed more impairment in physical and mental functioning than did working women.

In Pakistan, Khan (1994) found that working women are more satisfied and less depressed as compared to housewives.

Although above mentioned studies shows that work tends to have good impact on mental health of women, yet some studies do indicate that there are some problems of working women related to full time work, dual responsibilities and harassment at work places which contribute in the development of various psychological problems, for example Brown, and Bifulco (1990), assessed the effect of employment on risk of clinical depression in 354 working – class women with children. Full time working mothers were at high risk for depression. This was explained by either prior work strain or a severe event involving deviant behavior on the part of the husband, boy friend or child. Neither factor was relevant for part time workers. For full time workers, the severe event may have represented either failure in the motherhood role or a sense of entrapment in an unrewarding work or domestic situation. Subjects in part time work had a low rate of onset compared with non-workers. This difference may be related to non working subjects feeling less secure about their marriages.

According to Chaudhari (1999) women who are getting into newer modern role have multiple responsibilities of career, home and children, impairing their coping mechanisms. Countries like India are confronted with some very common problems like poverty and unemployment, which have a direct and indirect impact on the social and mental wellbeing of the population. Urban crowding and poor working condition lead to **Anxiety, Depression** or chronic stress related mental health problems.

Ebrahim (2001) reports a survey, on work place harassment conducted by the Working Women Support Centre, in which a random cross of 200 working women from executive secretaries to PAs, Semi / Un–skilled labor and even domestic workers were interviewed. Not surprisingly, 93% responded affirmatively to the fact that they had faced some form of harassment of which 80% said they have not or would not contemplate reporting the incidents or even share it with others. In extreme cases, 60% of women suffer post traumatic stress disorder; where as depression and guilt affects almost all who have experienced harassment. Fifty eight percent of respondents in a series of interviews said harassment led to insecurity, which deterred them from seeking work out side the home. The forms of harassment included mental harassment which 50% women felt, 40% complained of physical and 10% sexual harassment of the 20% who were diagnosed clinically depressed, 5% had contemplated suicide and 15% diagnosed phobic.

There are some more studies which have found little difference in over all satisfaction between the working and non working women (Blood and Wolf, 1960) .In a study of 132 middle class women Baruch and Barnett (1980) found no difference between working women and women at home in their role satisfaction or self esteem.

The purpose of the present research is to investigate the difference between Pakistani working and Non working women on different psychological aspects, such as anxiety, aggression, conflict with authority, Inter personal relationship and stress management because we believe that due to dependent family structure in Pakistan, our Pakistani working women will experience less anxiety, aggression, conflict with authority and have good Inter personal relationship and stress management as compared to non working wives in similar family setup.

METHOD

Sample:

Sample consisted of ninety married women which included 30 doctors (M.B.B.S), 30 lecturers and 30 housewives. Entire sample was drawn from middle socioeconomic class and their age ranged from 30 to 45 years. The educational level of the Lecturers and housewives was Masters in the respective fields.

Procedure:

All the subjects were individually interviewed and tested. First of all they were required to give their responses on case history and Interview form used in the Institute of Clinical Psychology. Then after they were requested to fill in the form of Manifest Anxiety Scale, and questionnaires of Aggression, Conflict with authority, Inter personal Relationship and Stress management. The Scoring was made through hand scoring key. The scores were then treated with ANOVA in order to interpret the results in the statistical terminology.

RESULT

Table I

Table Showing Mean of the Doctors, Lecturers and Housewives on Five Variables

Variables	Doctors	Lecturers	Houswives
Anxiety	40.70	38.93	39.73
Aggression	8.233	7.133	7.200
Conflict with authority	6.800	7.800	7.400
Interpersonal relationships	8.967	8.500	8.233
Stress management	8.267	8.167	9.733

Table II

Difference In the Level of Anxiety of Doctors, Lecturers and Housewives

Source	df	Ss	Ms	F	P
Factor	2	47	23	0.20	P>.05
Error	87	10162	117		
Total	89	10209			

Table III

Difference In the Level of Aggression of Doctors, Lecturers and Housewives

Source	df	Ss	Ms	F	P
Factor	2	22.82	11.41	2.07	P>.05
Error	87	479.63	5.51		
Total	89	502.46			

Table IV

Difference In the Level of Conflict with Authority of
Doctors, Lecturers and Housewives

Source	df	Ss	Ms	F	P
Factor	2	15.20	7.60	2.26	P>.05
Error	87	292.80	3.37		
Total	89	308.00			

Table V

Difference In the Level of Interpersonal Relationships of Doctors, Lecturers and Housewives

Source	df	Ss	Ms	F	P
Factor	2	8.27	4.13	2.47	P>.05
Error	87	145.83	1.68		
Total	89	154.10			

Table VI

Difference In the Level of Stress Management of Doctors, Lecturers and Housewives

Source	df	Ss	Ms	F	P
Factor	2	46.16	23.08	3.36	P<.05
Error	87	597.90	6.87		
Total	89	644.06			

DISCUSSION

It is clear from table No. I, II, III, IV, and V, that for Doctors, Lecturers and Housewives the mean anxiety is 40.70, 38.93 and 39.73 respectively and F = .20, P>.05. The mean Aggression is 8.233, 7.133 and 7.200 respectively and F = 2.07, P>.05. The mean conflict with Authority is 6.80, 7.800 and 7.400 respectively and F = 2.26, P>.05. The mean Interpersonal relationship is 8.80, 8.40 and 8.27 respectively and F = 2.47, P>.05. The analysis of results indicate that there is no significant difference in the level of anxiety, aggression, conflict with authority, and Interpersonal relationship among female doctors, female Lecturers and housewives. The insignificant difference among groups on four variables gives us a clear picture of Pakistani educated married working women. It appears that Pakistani working women does not consider work outside their house as a burden and anxiety producing and it does not interfere with their daily functioning as a

result they psychologically behave and respond to the environment in a way similar to how it is responded by the housewives.

No significant difference on four variables further make it clear that whether females are handling their house work or office work outside their residence, they follow the stereotype role of being female and follows the Norms of Pakistani women. Both the groups of women behave in the way which is expected to be the typical way of female of the age group studied in the present research.

All of them become anxious, aggressive, has conflict with authority and has good or bad Inter personal relations in alike manner. This non significant difference between working and non working Pakistani women, go well along with the work of Blood and Wolf (1960).

The insignificant differences do not mean that working women of Pakistan do not have to face any other social problem. The significant mean difference on the variable of stress management for doctors, Lecturers and housewives i.e. $X=8.267$, 8.167 and 9.733 respectively, and $F=3.36$ $P<.05$ indicate that although they do fulfill their dual responsibilities but have some difficulty in managing stress. Housewives are able to manage stress more efficiently as compared to doctors or Lecturers. Experience also shows that with children married Fulltime working women has difficulty in reaching at work place on time and they try to leave their office more early as compared to their male colleagues. Unlike housewives they easily become fatigue because they not only have to look after their immediate family but also has the responsibility to look after their In-laws.

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APPENDIX –A

Instructions:

Below are the items that would give you an idea whether your anger interferes in coping with problems. Mark the following statements either true or false:

1	At times I feel like smashing things.	T / F
2	I sometimes tease animals.	T / F
3	I am easily downed an argument.	T / F
4	At times I have a strong urge to do something harmful or shocking.	T / F
5	In school I was sometimes sent to the Principal for cutting up.	T / F
6	Sometimes I feel as if I must injure either myself or someone else.	T / F
7	At times I feel like picking a fistfight with someone.	T / F
8	I get mad easily and then get over it soon.	T / F
9	I don't blame anyone for trying to grab everything he can get in this world.	T / F
10	I can easily make other people afraid of me, and sometimes do for the fun of it.	T / F
11	I easily become impatient with people.	T / F
12	Sometimes I enjoy hurting persons I love.	T / F
13	I get angry sometimes.	T / F

APPENDIX – B

Instructions:

Do you have problem in dealing with people in position of authority? Mark the following statements as true or false:

1	I have often had to take orders from someone who did not know as much as I did.	T / F
2	I think a great many people exaggerate their misfortunes in order to gain the sympathy and help of others.	T / F
3	I think most people would like to get ahead.	T / F
4	I enjoy a raise or game better when I bet on it.	T / F
5	Most people are honest chiefly through fear of being caught.	T / F
6	In school I was sometimes sent to the Principal for cutting up.	T / F
7	Most people will use somewhat unfair means to gain profit or an advantage rather than to lose it.	T / F
8	I don't blame anyone for trying to grab everything he can get in this world.	T / F
9	It is safer to trust nobody.	T / F
10	At times, I have been so entertained by the cleverness of a crook that I have hoped he would get by with it.	T / F
11	Most people make friends because friends are likely to be useful to them.	T / F
12	If several people find themselves in trouble, the best thing for them to do is to agree upon a story and stick to it.	T / F
13	The man who provides temptation by leaving valuable property unprotected is about as much to blame for its theft as the one who steals it.	T / F
14	Most people inwardly dislike putting themselves out to help other people.	T / F
15	I have often met people who were supposed to be experts who were not better than I.	T / F
16	People generally demand more respect for their own rights than they are willing to allow for others.	T / F
17	It is all right to get around the law if you don't actually break it.	T / F
18	I enjoy gambling for small stakes.	T / F
19	I have never been in trouble with the law.	T / F
20	I think nearly anyone tell a lie to keep out of trouble	T / F

APPENDIX – C

INTERPERSONAL SCALE

Instructions:

How are your relations with other people?
Mark the following statements as Yes or No

Item	Question	Yes	No
1	Are you sensitive to the feeling of other people?		
2	Do you know how to " tune in" to what, how, why people feel as they do?		
3	Can you "emotionally read" other people?		
4	Are you a cooperative, constructive team player?		
5	Would others say you are responsible and dependable?		
6	Do you do things for and with people because it is right to do so?		
7	Do you honour and act according to your conscience?		
8	Are you capable of having mutually satisfying relationships?		
9	Are you comfortable around people?		
10	Would you say you have excellent human relation's skills?		
	TOTAL:		

APPENDIX – D

STRESS MANAGEMENT SCALE

Instructions:

Below are the statements which describe how your are able to manage stress.
Mark the following as Yes or No

Item	Question	Yes	No
1	Do you handle adverse events well?		
2	Do you manage frustration effectively?		
3	Do you live life so as not create a feeling of "overload"?		
4	Do you cope well in new situations with significant unknown factors?		
5	Do you usually minimize anxiety to avoid feeling stuck?		
6	Do you generally get a good night's sleep?		
7	Are you able to hold back comments in a disagreement even though you would like to "blast" the person?		
8	Can you say that "road rage" for you personally is under control?		
9	Do you cope well with daily events that can sometimes be frustrating?		
10	Do you avoid losing control so as not hurt people physically, verbally or emotionally?		
11	Would your associates say you manage your anger well?		
12	Do you deal well with disappointment?		

CASE HISTORY AND TREATMENT OF CHILD ABUSE

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INTRODUCTION

A 40 years old married man was brought to the clinic by his wife as he was indulged in child abuse for the past six years.

CASE HISTORY

Zafar (not his real name) was the son of a landlord (Zamindar) from the interior of Sindh. He was the only son and inherited a large estate at the age of 20 years. He got married to one of his cousins at the age of 27 years, and had four children, two sons and two daughters. His wife noticed that he was beating his two sons ruthlessly at small offenses and at times without any reasons. She got panicky when she found out that Zafar was also assaulting his daughters sexually. The wife got very upset. She has a confided in one of her friends, who advised her to go and see a psychologist. She then came to the psychologist and reported the entire matter. Zafar was brought to the clinic under the pretext that it was his wife who needed the treatment and he had to cooperate by coming to the psychologist.

TREATMENT

During the discussion, he became interested in getting himself treated and agreed to undergo psychotherapy for his symptoms. He was given intensive psychotherapy. He used to come six times a week. During the sessions he reported that after he lost his father who died in violent scuffle with one of his

opponents. He narrated that he could not stand the sight of young children, both male and female because the fight between the opponents and his father took over the problem of children. He reported that he used to beat up boys in the village but no body dared to report the matter to his mother or uncle. He became so ruthless that he could not control his anger against his own children. He used to beat up the boys. When the girls came to the rescue of their brothers, he became violent and attempted to assault them sexually which he could not succeed. These impulsive episodes used to occur after he had faced tension between himself and his farmers.

During the psychotherapy sessions he confessed that he was so ashamed of his behavior that he could not possibly narrate to anyone. He also admitted during free association that the man who killed his father had been assaulting him sexually as a young kid. He relived the episode of his own assault and began to realize after a prolonged working through that his impulsive out bursts of child abuse were actually a revenge toward the man who killed his father.

After catharsis, generalizations and interpretations he gained insight into his problems and became normal and understanding toward the problems of young children.

He reports after a period of six months to the psychologist, at times phones to say that he is better. About six years have now passed and he has not had any relapse of the symptoms.