Chapter One

INTRODUCTION

1.0.0 INTRODUCTION

1.1.0 Adolescence

Adolescence is a period of great change and strong emotion. The term 'adolescence' is derived from the latin verb 'adolescere' which means "to grow into maturity" as it is marked by a very rapid physical and psychological changes in a person. It can also be defined as that time of life when an immature individual in his teens approaches the culmination of his physical and mental growth. Physiologically an individual becomes an adolescent with the advent of puberty and the ability to reproduce his kind. Chronologically girls generally reach puberty between twelve and fifteen years of age. Boys reach puberty one or two years later than girls do. Psychologically and chronologically adolescence ends when an individual attains a consistent and comparatively widespread level of maturity. But the development of this maturity is a very slow process and there is no available means of measuring it. Therefore, it is normally assumed that as the individual reaches early twenties he has attained atleast a moderate level of psychological maturity and he is an adult rather than an adolescent.

Adolescent therefore is an adult in the making. Hence this is a period when he needs guidance in order to understand himself and his environment. This is the age when the person does not know whether he is a child or an adult. Children consider him a grown up and adults consider him a juvenile. He has

to adjust himself with varying and sometimes conflicting demands from his parents, teachers, playmates and the community. He is told to take the responsibilities, to show some judgement and to take decisions and then he is treated as a child and is expected to be submissive and obedient to his parents and teachers. It is rightly said that adolescence is a period of 'stresses and strains'.

If the personality development at various stages has progressed fairly well, adjustments are not difficult. Otherwise, many persons enter this period as shy, nervous and timid individuals.

1.1.1 History of the study of adolescence

Adolescence as a field of study got its due attention in the latter half of the 19th century when Darwinian evolutionists were trying to assemble support for their own theories and found childhood as a great source of proof for their hypotheses. But G.Stanley Hall (1844-1924) was one of the first psychologists to give extensive time and effort to the study of adolescence.He defined adolescence in terms of physiological changes occuring in adolescents. He begins this period from 12 to 13 years of age and ends when full adult status is attained by 22 to 25 years of age. According to Hall, "adolescence is a period of storm and stress". This view was published in his book 'Adolescence' in 1904 which was in two volumes. The publication of this

book paved the way for further research and made adolescence the subject of scientific study. Before publishing this book in 1882 Hall had written on the moral and religious training of children in which he discussed the psychological nature of the adolescents and stressed the importance of a careful study of that period.

In 1891 Burnham, following on the lines of Hall, wrote that "a study of the psychology of adolescence should form part of the education of every teacher in the higher institutions. The subject should be studied scientifically from the standpoint of physiology and in its ethical, social and pedagogical foundations". He himself made use of the questionnaires, diaries and autobiographical accounts to write about the kind and nature of problems encountered by adolescents. In 1893 Daniels discussed the psychological aspects of adolescents and also gave a description of the puberty ceremonies in primitive culture. In the late 1890's again Lancaster studied adolescent behavior by means of questionnaires and published biographies.

The works of these early psychologists were non-experimental in nature as they had made extensive use of biographies, anecdotes, questionnaires, diaries, etc. The surveys were based on small and biased samples. Therefore, these studies were important but had many errors of both fact and judgement. Thus, the work following Hall stressed on the refinement of research

techniques and adoption of a more objective approach. This gradually led to the replacement of the storm and stress hypothesis with the position such as supported by the anthropologist Mead (1928) that adolescence is not of necessity a time of storm and stress unless the adolescents environment is such that storm and stress is created. A facilitative environment can accelerate if not eliminate the problems commonly believed to characterise the second decade of life. This point of view also suggests that an adolescent undergoes new changes and experiences and that these changes and experiences do lead to new feelings and ways of life and that they do pose problems to which the individual must adjust.

Today psychologists study either social and emotional growth of adolescents or physiological growth of adolescents. Some are interested in studying adolescent's learning and intellectual problems in school and elsewhere. Whatever may be the objective of the study the important aspect in dealing with an adolescent is to take him as he is, to realize that he is the product of his time, his culture, his past and present psychological and physical environment. It is also important to realize that there will be individual variations and that these must be known and understood in order to do an adequate job in working with an adolescent.

1.1.2 Major aspects of adolescence

For understanding the adolescents it is important to know about certain major aspects of adolescence concerning growth and development. This would help in better understanding of the problems of behaviour and adjustment of adolescents and would result in more effective treatments. J.E. Horrocks (1954) has given some of the major aspects of adolescence in his book on adolescents. They are:

a) Adolescence tends to be a time of seeking status as an individual.

During adolescence the adolescents try to become more independent by trying to free themselves from childish submission to parents and other authority figures. They start taking certain decisions about their vocations, interest and even economic independence to an extent.

b) Adolescence tends to be a time when peer group relations become of major importance.

The adolescent becomes anxious to gain status and recognition among his peers. Therefore, he tries very intensely to conform to the peer group standards. Heterosexual interests also develop and can sometimes cause complexities and conflicts in emotions.

c) Adolescence is a time of physical development and growth that forms a continuous pattern common to race, but idiomatic to the individual. It is during adolescence when physical maturity is attained. Therefore,

there is rapid altering of the body and a change in the body image. Also, the motor functions become more skillful.

d) Adolescence tends to be a time of intellectual expansion and development of academic experience.

At this age the adolescents have to adjust to the increasing demands of academic and intellectual requirements. They are supposed to learn new skills and concepts by gaining knowledge and experience in different areas and also to interpret their environment in the light of these experiences.

e) Adolescence tends to be a time of development and of evaluation of values. Adolescence is also a time of breaking old values and forming new ones which is accompanied by an increasing awareness of "self", a development of self-ideas and an acceptance of self in harmony with those ideals. It is also a time of conflict between youthful idealism and reality.

The above points give a clear picture of the pattern of development and growth of adolescence but there is one most important point to be understood and that is even though the growth and development follow a similar pattern for all individuals there are always some individual variations and these variations should always be considered before making a judgement about an adolescent, his life or his problems.

It is also important to know that adolescence is the last chance of achieving a good adjustment towards self and the environment because as the adolescent becomes an adult his problems of maladjustment get well set and become difficult to reverse by readjustments. Therefore, it becomes very important to know why there is a need to study adolescence.

1.1.3 Need to study adolescents & the changes occuring in adolescence

Adolescence is a crucial period of life span which has not been fully understood by the parents, teachers & the society as a whole. Therefore, it becomes necessary to study & understand it not only in terms of a boy or a girl but in terms of all adolsecents & in what respect they are alike or different. Since adolsecence is a period of change i.e. end of chilhood & beginning of adulthood, it becomes important to know what kind of changes occur in this period physiologically, psychologically & socially.

At physiological level adolescents show increased levels of physical & intellectual growth and development as there is increased level of growth & sex hormones released by various glands in the body. Adolescents also show new urges & desires & become more aware of their bodies & powers. They even start showing interest in the opposite sex.

Psychologically the adolescents reach new peaks of efficiency & skills. Their thought process & reasoning ability too reach new heights & they become

more efficient in dealing with theoretical, abstract, philosophical & complex concepts & issues. They even become more independent of home i.e. psychological weaning is achieved. There is also a heightened preoccupation with the self.

Socially the importance of peer group is maximum in adolescence. Adolescents like spending more time with their peers instead of their families. They get more involved in group activites & conforming to group norms becomes an important issue.

All these changes occuring in adolescence have an impact on the adolescents. These impacts can become positive or negative by the kind of response they get from their environment about these changes. If they get a positive support from the environment they are able to accept these changes healthly but if there is no support or negative response then they can develop problems in accepting these changes which in turn can become a hurdle to their healthy growth & development into adults.

Therefore, in order to fully understand the impact of these changes, the problems created by these changes & finding effective ways of dealing with the problems there is a need to study adolescence .

It is also important to note that all adolescents require their need of attention, need to feel that they are wanted & have an established place in the

community. Whenever these needs are denied the adolescents are bound to develop some kind of problem which can cause stress & anxiety or emotional conflicts.

1.1.4 Problems of Adolescence

Rutter & his colleagues (1979) demonstrated in a study that while adolescent turmoil was by no means universal, approximately 46% of the 14-15 year old population surveyed had experienced significant emotional distress involving anxiety, unhappiness & ideas of reference. Such feelings often passed unnoticed by adults & if transient, generally did not interfere with school or socialization. However, in some cases where such experience was persistent or prolonged, progress to psychiatric disorder occured and serious evaluation of the features presented as 'adolescent turmoil' was warranted. It can be further said that adolescents' emotional problems usually develop within the context of multiple stress factors operating concurrently. Such factors can include:

a) conflicts over independence where the youngster feels oppressed by the limitation placed on him.

b) the upsurge of sexual & aggressive drives related to hormonal stimulus.

c) a lessening of trust in and a questioning of authority figures, including parents.

d) pressures to conform & to achieve academically, socially, economically & sexually.

e) peer group pressures which may exert a positive or a negative influence.

f) stresses of identity formation. This factor is the most important & can be most difficult to resovle in the absence of adequate & acceptable identificatory role models. Also with continuing conflict in integrating diverse cultural or ethnic streams this critical task can become more difficult for the adolescent.

These conflicts in adolescence can lead to minor transient emotional problems on one end and to severe psychotic disorders at the other end.

From several surveys it has been estimated that about 20% adolescents suffer from psychotic disorders out of which about two fifth have conduct disorders, further two fifths suffer from emotional disorders like anxiety states, depression or some affective disorder & one fifth suffer from mixed emotional conduct disorders.

1.1.5 Behaviour disturbances of adolescence

During adolescence behavioural disturbances are common & can often become serious in nature. Therefore, it becomes important to evaluate these disturbances. But they cannot be evaluated on the same scales used in other

phases of life. As Blos (1941); Ausubel (1950,1952) and Ausubel and Kirk (1977) point out, even relatively severe deviations from acceptable behavioural standards in adolescence are not necessarily ominous in their prognostic implications. Adolescent behavioural disturbances can be meaningfully appraised only in terms of adolescent norms.

Behaviour disturbances in adolescence are not disease entities but symptoms or reactions caused by emotional disturbance or environmental maladjustment.

Emotional instability in adolescents reflects a lowered threshold of behavioural reactivity i.e. a tendency to respond intensely, diffusely & in an undirected & unadaptive fashion to stimuli that would otherwise be too weak or too general to provide any response. Whenever emotional instability is induced in part or in whole by frustration of goal directed behaviour, deprivation of need or status or threat to physical integrity, the lowered threshold of behavioural reactivity is invariably accompanied by such subjective responses as insecurity, rage, inadequacy & anxiety. These emotionally charged feelings occur in response to the threat to self esteem, security & ability to cope with the environment that is inherent in such situations. Thus, it can be said that the period of adolescence is one of flux, filled with anxieties, frustrations, indecisiveness, identity crisis, looking out for support and a struggle between dependency needs & independence. The emotional instability occures along with physiological changes that occur in the body. The cause of emotional

instability in most of the cases can be due to inadequate interpersonal relationships between the adolescent & his immediate environmental fears & anxieties of his childhood.

From the above descriptions it can be seen that anxiety is a very common & a very frequent cause of distress in adolescence. DSM - III-R also shows anxiety disorders of childhood & adolescence as a separate category again indicating its importance during adolescence. Therefore, it becomes necessary to understand anxiety in greater detail also as the two disorders taken in the present study are the sub-categories of the anxiety disorder of childhood & adolescence.

1.2.0 Anxiety

To understand adolescents it is necessary to understand the concept of anxiety. Anxiety is a normal reaction to some life situations. However, anxiety that is excessively strong & debilitating or that appears to be chronic may be a sign of a clinicaly significant disturbance. Anxiety reactions are more common in adolescence & their frequency appears to increase particularly in the period between the onset of puberty & early adulthood (Senn & Solvit, 1968). Therefore anxiety in general terms can be defined as "a persisting distressful psychological state arising from an inner conflict". The distress may be experienced as a feeling of vague uneasiness or foreboding, a feeling of being

on edge or as any of a variety of other feelings such as fear, anger, restlessness, irritability, depression or other diffuse & nameless feelings. The inner conflicts arise due to incompatible impulses, desires or values, e.g. when a person is angry but is afraid of giving offense. Fear of failure, poor social adjustment & disturbed parent/child relations are all examples of distress and conflicts that can trigger anxiety reactions. The psychological symptoms of acute anxiety are a sense of impending doom, restlessness, agitation & fearfulness. Physical symptoms are nausea, vomiting, dizziness, headache, sweatiness, trembling & respiratory disturbances. Such symptoms can be caused by various factors.

Crow & Crow (1956) on the basis of their investigation, on 658, 15-16 year old high school students have given a list of factors which can be the causes for anxiety in adolescents. These factors have been given in the form of a chart.

1.2.1

Life Area	Boys cause/s of Anxiety	Girls Cause/s ofAnxiety
School Life	Home work Getting along with teachers Tests Marks Failure Reciting in class Grade for parent's sake College entrance Being accepted	Home work Getting along with teachers Tests Marks Failure Reciting in class Parent's attitude towards grade Being accepted College entrance
Home Life	Arguments with siblings Arguments with parents Arguments between parents Strict parents Arguments about dating Treating unjustly	Younger brothers get what they want Parental domination Parents object to going steady Conflicts with parents Conflicts on values Arguments in home
Boy -Girl Relationship	How to get a date Girls I like don't like me Girls cost too much How to be invited to parties Mother objects to my going steady How to have a girl go steady Inability to dance Does girl love me ? Girls of another religion How to forget the girl who jilted me	How to meet new friends Boys I like don't like me How to be popular Boys are too demanding I would like to go steady Loss of boyfriend Behaviour of boyfriend Sexual relations to maintain Girls who try to steal boyfriends How to get over love for boy How to refuse a date tactfully
Friends	Are they true friends? Friends may not like me To be worthy of good friends How to make friends To be popular	Are friends true friends? Not to let friends down To be popular How to be a leader in a group Feelings of inferiority

Vocational Choice	State of indecision How to get a job	State of indecision How to get into show business
Religion	Should I marry out of my religion? Indecision Not attending religious services	Should I marry out of my religion? Doubt about religious values Fear parents will discover that I wish to change my religion
Health	How to grow more How to loose weight Pimples Disease	Thinness & smallness Fear of loosing good health Disease Illness tendencies

The given chart shows a number of causal factors of adolescent anxiety but an important aspect to note is that the causes, experiences & the impact of the anxiety can vary from person to person.

After understanding the causal factors the next step is to understand the symptoms of anxiety in detail.

1.2.2 Symptoms of Anxiety in Adolescents

For many adolescents temporary periods of anxiety may occur which are followed by the development of more effective patterns of behaviour. Some adolescents however, may experience some disorganisation of personality that may interfere with their further development. While trying to make an assessment of the symptoms of anxiety in adolescents it is important to know that the symptoms can be varied & numerous. In a psychiatric interview for a study of normal adolescent boys, Offer (1969) asked the boys to describe their feelings & experience with anxiety. Then they were asked how common,

long & uncomfortable their feelings with anxiety were and also to indicate how frequently these occured in a variety of situations. From such evidence as is available it can be assumed that anxiety may be widespread among adolescents. Jersild (1963) in his book "Psychology of Adolescence" has talked about some of the prominent symptoms of anxiety in adolescents. They are :

1. an adolescent is anxious if he responds in a way that is out of proportion to the occasion or "overreacts" by being greatly upset by little things; if he is bitterly angry at something that seems trivial; if he is plagued with guilt beyond the limits of genuine remorse; if he has worries or fears that are "irrational" in the sense that his worries are quite out of proportion to any overhanging threat or he is afraid of dangers that actually do not exist & continues to be afraid in spite of reminders from his own experience that there is nothing to fear.

2. an adolescent is also anxious if he "underreacts"; if he shrinks from any show of anger when anger is justified or is apathetic & unmoved in situations where normally a person would feel joy or apprehension or grief.

3. an adolescent is suffering from anxiety if he has unaccountable moods like being depressed or having sudden outbursts of crying for no

apparent reason or feeling "out of sorts" & edgy without knowing why.

4. an adolescent is also said to be anxious if he is driven by compulsions like an unrelenting compulsion to compete; an unaccountable urge to repeat acts that previously have brought him into trouble & which, from a rational point of view, he knows will get him into trouble again. An adolescent has compulsions which probably signify anxiety when he is in " a fever of activity", has an urge to rush hither & yon, is unable to sit still or to relax as though he cannot bear the thoughts that spring up in an unoccupied moment.

5. an adolescent is suffering from anxiety also if he acts distinctly "out of character", if he has mild & friendly ways but now & then does things that are unnecessarily cruel.

6. an adolescent can also be anxious if he is exceedingly rigid in his attitudes, is self-righteous, markedly smug, prudish or dogmatic.

7. an adolescent is also said to be in the grip of anxiety if he imposes impossible standards on himself, if he expects more of himself than anyone could possibly demand of him & then deplores himself for not living up to these standards.

8. an adolescent who is backward in his studies will also show anxiety. It is likely that he has been made to feel that it is his own fault if he does not do well. So he may feel guilty as though one part of him were blaming another part of him about not living upto expectations placed upon him by others. Or he may feel guilty & also feel a strong resentment toward those who fail him, and yet be in conflict about this resentment.

9. an adolescent also shows anxiety when he complains bitterly about his parents & finds serious faults with them. It is not easy to feel anger at a parent without also having a guilty notion that one should be a dutiful & loyal child.

10. an adolescent is prevailed by anxiety when he turns against his background, his upbringing, the social group in which he was reared, the religious or racial group into which he was born. When a person turns against his home & the environment & the traditions in which he was reared he is turning against something that is part of himself. Unless he resolves this conflict in some way he will probably be anxious to some degree.

From these points it is evident that anxiety has an important part in adolescence & is clearly anxious experience accompanied by diffuse, highly

unpleasant & often vague feelings of apprehension with one or more bodily sensations. It is unplesant even in its mildest forms & can become increasingly unpleasant as it intensifies. It is an alerting signal; it warns of impending danger & enables the person to take measures to deal with a threat.

1.2.3 Behavioural Theory of Anxiety

Mowrer (1950) argued that William James (1884) supported the then current supposition that anxiety was an instinctive reaction to certain objects or situations which might not represent real danger. Some years later J.B. Watson (1913) demonstrated experimentally, which was contrary to Jamesian view, that most human fears are specifically relateble to & dependent upon individual experience.

According to general behavioural theory when the pattern of internal expressive responses appropriate to a painful situation, occurs in the absence of the pain stimuli, it is called anxiety in ordinary language. Anxiety has some of the characteristics of punishment itself & the relief of anxiety can serve to reinforce behaviour just as does the relief from pain. In the study of instrumental conditioning in which the animal learns to stay away from a charged grid, the effective mechanism in the learning is assumed to be the relief from anxiety. The stimuli that are consistently associated with shock evoke anxiety. The withdrawal response removes those stimuli & thus relieves

the animal of anxiety. This relief reinforces withdrawal when the child is put in a situation that has been associated with punishment. When he becomes anxious, he shows some of the behaviour expressive of anxiety & then learns to perform the patterns of behaviour that relieve him of the anxiety. Thus, according to behavioural theory anxiety is a learned process which can be changed by unlearning the old and relearning a new behavioural pattern which does not cause anxiety.

DSM - III - R gives the description of the anxiety disorders of childhood & adolescence with its three sub-disorders, namely

a) Separation Anxiety Disorder

b) Avoidant or Withdrawal Disorder of Childhood & Adolescence

c) Overanxious Disorder

Since, the later two disorders form a part of the present study they will be disccussed in detail.

1.3.0 General Clinical Description of Anxiety Disorders of Childhood & Adolescence

The general description of anxiety disorder can be given by three main components:

a) Psychological: like worry, apprehension or dread often expressed as specific fears, eg. of the dark, of being left alone. etc.

b) Psychomotor: like tension, restlessness & hyperactivity.

c) Psychophysiologic: like headaches & stomachaches, dizziness, palpitation & flushing & shortness of breath.

Along with these primary problems some secondary problems can also occur during anxiety. Anxiety can interfere with school performance & peer relationships & produce reluctance in playing with others, especially competitive games. Due to anxiety adolescents become highly sensitive, shy & show signs of immaturity. They are highly dependent on parents & home & are often irritable, demanding, clinging & argumentative. But this dependency is also resented & again becomes a cause for anxiety.

1.3.1 Separation Anxiety Disorder

Separation anxiety disorder is characterized by exessive anxiety on separation from the major attachment figures or from home or other familiar surroundings. When so separated such children experience anxiety to the point of panic, beyond that expected at their developmental level. This disorder can occur as early as preschool years but usually it appears around 11 to 12 years of age. It is found in both the sexes equally. Adolescents may not directly express any anxious concern about separation from a mothering figure. Yet their behaviour patterns often reflect a separation anxiety in which they may express discomfort about leaving home; engage themselves in

solitary activities and continue to use the mothering figure as a helper in buying clothes & entering social & recreational activities. Behaviour modification techniques have shown positive results with this disorder by involving the child, his parents, peers & the school in the treatment plan.

The next two disorders to be discussed form a part of the present study because it is seen that today many adolescents are suffering from avoidant disorder or overanxious disorder. This can be attributed to the present society which is a fast growing and highly competitive. This fast growth and high competition is on the rise in every field, be it academic or social and the adolescent is expected to excel in all the fields and be called an "all round achiever". But since only a handful are actually able to achieve the title, the rest are forced to suffer the pangs of anxiety of being called "loser" in all or some fields.

The investigator believes that this anxiety is most of the time caused by the non-assertiveness of the adolescents. The adolescents under the parental and environmental pressures are not able to speak up their desires and wishes or even limits. This further increases their sufferings. To keep onself away from such sufferings many of the adolescents develop some kinds of undesirable behavioural patterns or disorders. Overanxious disorder and withdrawn or avoidant disorder are two such disorders.

1.3.2 Overanxious Disorder

Overanxious adolescents are worriers. Their anxiety is not focussed on a specific situation or reactive to a particular stress. They simply worry about life, especially the future, which is unknown and thus is filled with danger. They soon become indecisive as they fear the consequences of any move on their part. Worry about grades in school, how adults and peer view them and about harm coming to themselves and others, especially family members, is common. Their worries have a persistent, obsessive quality that often make them seem much older than they really are. They feel shy and inadequate, have difficulty enjoyng. There is some evidence that childhood social incompetence is related to adult mental health problems (Cowen, Pederson, Babigian, Izzo & Trost, 1973). If they are not treated, they may continue to constrict their lives and become introverted, chronically worried adults.

Definition

According to DSM-III-R, the essential feature of overanxious disorder is excessive and unrealistic anxiety or worry for a period of six months or longer. Adolescents with this disorder tend to be extremely self-conscious, to worry about future events (e.g. examinations, the possibility of injury or inclusion in peer group activities) or about meeting expectations (e.g. deadlines, keeping appointments or performing chores) and to be concerned about the discomforts or dangers of a variety of situations. Such adolescents

may also be overly anxious about competence in a number of areas and especially about what others think of them. In general, the disorder presents a picture of excessive worrying and fearful behaviour.

The overanxious adolescents have usually high levels of verbal and intellectual abilities. The disorder is more common in small middle and upper socio-economic families where there is unusual concern about performance and achievement even when the child is functioning at an adequate or superior level.

The disorder is equally common in boys and girls and the familiar pattern shows that mothers who are themselves anxiety ridden are more prone to have children with overanxious disorder.

This disorder is typically the result of the gradual development of a character pattern, although it is occassionally of sudden onset due to a great deal of inner stress which develops due to over concern about competence and external performance. Overanxious adolescents especially feel concerned about what others think of them.

1.3.3 Withdrawn or Avoidant Disorder

Adolescents with avoidant or withdrawn disorder are shy. Dealing with others is stressful and they fear rejection. Overanxiety may be focussed on strangers.

These children avoid others in order to avoid the anxiety of dealing with them. They are inhibited and isolated from peers and remain excessively dependent on family members. Although they are comfortable in the family setting, relationships with family members sooner or later deteriorate because the family cannot fulfill what should be new and gratifying relationships with others in the outside world. They are often teased by peers because of their immaturity and social awkwardness, playing with younger children if at all. Adolescents lack self-confidence which interferes with peer group attachments and dating. They often remain overly serious and studious. Extremely sensitive to criticism, they withdraw and experience both anxiety and depression in their isolation. If left untreated, the condition may develop into a way of life, an avoidant personality disorder, with unwillingness to enter into social relationships outside the home.

Definition

According to DSM-III-R, avoidant or withdrawal disorder is characterized by a persistent and excessive shrinking from contact with unfamiliar people that is of sufficient severity to interfere with social functioning in peer relationships, is of at least six months duration and is coupled with a clear desire for social involvement with familiar people such as family members and peers the person knows well. Relationships with family members and other familiar figures are warm and satisfying

Withdrawn adolescents tend to hold back from establishing interpersonal contacts or satisfactory relationships with strangers to an extent where it becomes noticeable as interfering with their peer functioning. But if given considerable support they can relate warmly and naturally in home situation and can even participate in social groups.

The disorder is more commonly seen in girls than in boys, may be because of socially sanctioned roles of passivity and withdrawal in girls. It is also common in adolescents whose mothers have also shown the symptoms. Parents who support suppresive and avoidant behaviour also have children having this disorder. Most studies have emphasized the etiological importance of temperament and parental management in the development of a fixed pattern of withdrawal. Temperamentally, the "slow to warm up child" and the "easy child" seem especially vulnerable to this behavioural disturbance (Thomas et al, 1968).

The "slow to warm up child" is slow to adopt, has a low activity level, shows initially withdrawal responses to new stimuli, has low intensity of reactions and has negative mood responses. Also has an inherent tendency to withdraw, especially in unfamiliar surroundings.

The "easy child" on the other hand, develops problems because his adapatibility allows parents to impose idiosyncratic styles of behaviour during

early childhood that later conflict with extra familiar expectations and lead to rejection in school or on the playground. Withdrawn behaviour thus appears as a defensive tactic to avoid criticism, teasing and other painful encounters with the larger world.

1.4.0 Nonassertiveness

Nonassertiveness is the violation of your own rights by failing to express your thoughts and needs openly and thereby allowing others to disregard them. For a nonassertive individual whatever the 'other person' thinks is okay but whatever he thinks doesn't matter. He is not able to communicate his real feelings just to avoid unpleasantness. For the goal of nonassertiveness is "to appease others and avoid conflict at any cost" (Lange and Jakubowski, 1976). By behaving in such a fashion the nonasserter lets himself be taken advantage of and in turn doing serious harm towards himself and his esteem.

Nonassertiveness can be harmful emotionally, physiologically, socially and practically. Emotionally the nonasserter doesn't feel good about himself for behaving nonassertively. He hates himself for not knowing how to make an assertive response. This often makes him depressed and results in poor self-concept and poor self-esteem. With this unexpressed anger, anxiety gets built up inside and can further cause physiological problems like headaches, ulcers, high blood pressure and sometimes even skin diseases which can result due

to stress of the emotional problems. Socially too the nonasserter faces difficulty in asking for help from others, saying 'no' to unreasonable requests or speaking up his opinions or even replying back to unwanted criticism. They behave nonassertively to avoid the disapproval of others yet they fail to gain the approval in the end. People do not like them, much less respect them, for being spineless. They may pity them, but often this pity eventually turns to annoyance and finally contempt (Jakubowski-Spector, 1973). Nonassertiveness is harmful in intimate relationships also as the unexpressed needs can hamper the relationship.

Finally the practical problems of nonassertive behaviour are that the nonasserter may end up buying useless items from sales people or keeping items which they were afraid to change even when they were faulty. They lend things which they never wanted to lend. They attend parties where they are uncomfortable or indulge in conversation with people they don't like, etc. The list of practical problems of a nonasserter is endless and gives him nothing but pain and anxiety. Thus, it can be said that nonassertiveness is one of the major causes of anxiety and its reactions in adolescence. Therefore, in the present study only those adolescents were chosen for sample who were nonassertive in addition to being overanxious or withdrawn.

After discussing disruptive behaviour disorders now the different intervention techniques used in order to reduce the disruptive disorders will be discussed. As the intervention techniques used form a part of Behaviour Therapy, they will be discussed under its heading.

1.5.0 Behaviour Therapy

Behaviour therapy according to Wolpe (1969), is the use of experimentally established principles of learning for the purpose of changing unadaptive behaviour. Unadapted habits are weakened and eliminated; adaptive habits are initiated and strengthened. In other words it can be said that disturbed behaviour is conceived as the resultant of learning and therefore, its modification requires relearning. In the behavioural therapy paradigm, observable behaviour itself is the focus of interest and there is little concern about subjective feelings, internal states or unconscious determinants. Thus, if the environmental conditions, which shape and maintain behaviour are manipulated, then the behaviour in men as well as animals can be altered through the same general principles.

1.5.1 History of Behaviour Therapy

The earliest reports on behavioural approach can be dated back to 1920's when there came some scattered reports on 'Behaviourism' by Watson, Jones

and Others (Watson and Rayner, 1920; Jones, 1924). But the full practical use of behavioural therapies began in the mid to late fifties.

In 1953 Skinner published a work entitled "Science and Human Behaviour" in which he attempted to analyze complex human behaviour using the basic learning principles. This publication was an important step in establishing behaviour therapy as a separate entity. Around this time many behaviourists (for eg. Fuller 1949; Greenspoon, 1955; Azrin & Lindsley, 1956) reported about the usefulness of principles of learning in altering human behaviour. Behaviour therapy got further impetus after the publication of two important books : Case Studies in Behaviour Modification and Research in Behaviour Modification, both edited by Ullmann & Krasner (1965). But the most important book for the development of behaviour therapy was Psychotherapy by Reciprocal Inhibition written by J. Wolpe (1958). Wolpe's book was based on classical or respondent conditioning principles. In this book only, Wolpe presented the specific therapy techniques of systematic desensitization and assertiveness training. The term behaviour therapy as such was introduced by Eysenck in 1959. These publications made behaviour therapy a very important and effective technique for the treatment to various behaviour disorders. First journal on behaviour therapy named "Behaviour Research and Therapy" appeared in 1963. In 1969 A. Bandura published a book named "Principles of Behaviour Modification" which was very influential in

expanding the field of behaviour therapy. As the research continued, behavioural treatment techniques became more effective and produced more verifiable results in a wide variety of areas (Franks, 1969). A. Bandura in 1969 further added the techniques of immitation learning or modeling to the field of behaviour therapy. 1970's saw the important development of cognitive- behavioural theory and methods. Here the emphasis was on what people say to themselves or think and how this affects feelings and behaviour.

In 1980's there was a resurgence of interest in "neobehaviorism" (Eysenck, 1982; Wilson, 1982). This stressed the role of classical conditioning in the occurance and treatment of behaviour disorders especially neurosis. In 1980's only there was an increased interest in "behavioural medicine" approaches. Behavioural medicine refers to psychological approaches to a large number of medical disorders like obesity, cigarette smoking, hypertension and headaches, etc.

1.5.2 Current Status of Behaviour Therapy

The diverse views and different types of treatment techniques presented above make it difficult to define behaviour therapy. Early definitions regarded behaviour therapy as a conceptulization of behaviour and treatment on the basis of the laws and principles of learning (Eysenck, 1964; Wolpe and Lazarus, 1966). Now since the field is very developed and there is extensive

use of learning theory principles, the term behaviour therapy and behaviour modification are used interchangeably. Hence, behaviour modification is defined as treatment based on experimental findings from the psychology and social sciences (Krasner & Ullmann, 1973; Yates, 1970). Inspite of the diverse views and different approaches within the field there are certain characteristics which distinguishes behaviour therapy from other fields. In general they are :

a) it focusses on current rather than historical determinants of behaviour.

b) emphasizes overt behaviour change as the major criterion in evaluating treatment,

c) relies on basic research from psychology to generate hypotheses about treatment and specific techniques,

d) specifies treatment in objective and operational terms so that the procedures can be replicated.

e) specifies very carefully the target behaviour and the techniques for measuring outcome.

In addition to these five characteristics the major positive characteristic that distinguishes behaviour therapy reflects more of a general scientific approach towards treatment and clinical practice rather than a particular conceptual stance or set of theoretical propositions.

1.5.3 Important Theories of Behaviour Therapy

Watsonian Behaviourism :

John B. Watson was "responsible for crystallizing the existing trend toward objectivism" in psychology (Kazdin, 1978). Watson viewed psychology more objectively and in 1913 published a paper called "Psychology As the Behaviourist Views It". In it he described two essential qualities of behaviourism:

a) introspection as a method was to be replaced with observation, the method used by the animal psychologists, and

b) psychologists must abandon the study of consciousness and focus instead on overt behaviour and its relation to environmental stimuli.

This system came to be known as S-R psychology or Stimulus-Response bonds through which all behaviours could be explained.

Watson popularized behaviourism and claimed that it would be used to solve human problems.

Skinner & Operant Conditioning :

B.F. Skinner (1953) wrote a book "Science and Human Behaviour" which is one of the foundations of modern behaviour therapy. The book explains the basic principles of operant conditioning in a very simple form. It states that behaviour is learnt and strengthened as a result of its consequences. The term "operant" suggests a person whose behaviour operates or acts upon the environment to produce consequences. In turn, these consequences influence the probability that the behaviours that preceded them will recur. The main effect of operant conditioning is that randomly emitted, trial-and-error behaviour are progressively shaped into meaningful patterns of activity as a result of their outcomes. Positive consequences strengthen the likelihood of previous operants, while aversive consequences weaken the probability of similar future responses.

Skinner asserts that observation of learnt relationships between environmental stimuli and overt behaviour will ultimately allow for a complete picture of the development, maintenance and alteration of human behaviour.

Wolpe and Eysenck and Classical Conditioning:

J. Wolpe (1958, 1982) and H. Eysenck (1982) focus upon the classical or respondent conditioning principles (Pavlov, 1927; Hull, 1943) to understand and eliminate human distress, particularly anxiety. According to them classical conditioning broadens the concepts available to the behavioural model and is useful to a large group of anxiety based clinical problems which includes clients's subjectively experienced distress.

Wolpe and Eysenck explained the importance of both operant and classical conditionig for understanding and changing any behaviour disorder and that there are functioning during its formation also. This could be explained with an example : a man fearfully avoids social events, may be partly because of past negative experiences (i.e., operant conditioning : he enters a room and everyone laughs at his cloths), and partly because of the discomfort of such experiences which have got associated with parties (i.e, classical conditioning : he gets a stomachache upon receiving a party invitation). Thus, it is clear that both operant and classical conditioning are involved in the appearance of specific behaviour patterns (Mowrer, 1939).

1.5.4 Basic Principles of Behaviour Therapy

1) There is a continuity between normal and abnormal behaviour which implies that the basic laws of learning apply to all

behaviours. Maladjustive behaviours are acquired through the same psychological processes as any other behaviour.

2) Therapeutic techniques are based on the empirical findings and theoretical foundations of experimental psychology.

3) Therapy is aimed at the modification of overt, maladaptive behaviours. The cognitions and emotions that accompany overt behaviour are also dealt with, but in a more direct manner than in many other therapeutic approaches. Treatment is tailored to the unique needs of each client.

4) There is a focus on the clients present problems. This here-and-now emphasis results in less attention to early childhood experiences or historical material than is the case in psychoanalysis.

5) There is a commitment to the experimental evaluation of treatment. The behaviour therapist attempts to employ techniques that have been scientifically investigated through experimental group designs or single-subject methodology.

6) Emphasis on problem-focused techniques and empirical validation of treatment does not reduce the need for behaviour

therapists to be sensitive clinicians who are concerned about the welfare of their clients and who exercise good clinical practices when providing their services.

The above principles are based on the reviews of the field of behaviour therapy (Farkas, 1980; Kazdin, 1978; Ross, 1985; Wilson, 1978).

1.5.5 Misconceptions about Behaviour Therapy

1) The most common misconception is that behaviour therapists do not believe in the value of interpersonal relationships. They are often cold and aloof with their clients. But in reality behaviour therapists do acknowledge the importance of meaningful interpersonal relationships. Therefore, a great deal of therapy time is spent in developing rapport and understanding the client's needs and problems and fixing a therapy according to his needs.

2) Another misconception is that behaviour therapy is too simplistic in its approach and cannot encompass the more complex behaviours of human beings. This problem can be very efficiently solved by reducing the complex behaviours to basic principles and work with these principles in a very precise manner. When this is done, situations that seemed

extremely complex and difficult to manage often become relatively easy to manage. Thus, behaviour therapy can be used in a wide variety of situations with exceedingly complex problems.

3) Another misconception is about nature of symptoms and their role in the planning of treatment. It is believed that behaviour therapists are interested only in symptoms and that they overlook more basic issues and aspects of life. But the fact is that behaviour therapists are not concerned only with symptoms, rather they are concerned with the behavioural change that leads to efficient functioning and happy living following treatment. Symptoms reported by clients are taken seriously and often are regarded as target behaviours to focus on in treatment. The crucial point in behaviour therapy is to clearly specify the behaviour to be changed and thus give direction to the therapy.

4) Yet another misconception is that behaviour therapists are overly technique-oriented. It is said that behaviour therapists seem to believe that all problems can be handled by some particular manipulative technique or device. But in reality,

specific techniques used are based on scientific principles and are used in very precise ways for specific purposes.

5) One more misconception is that behaviour therapist are not interested in insight. The answer is that behaviour therapists equate therapy with behaviour change leading to more effective functioning and thus, the emphasis is on making the person more capable of dealing with the problems. Often, when the problems are no longer a threat, the insights come spontaneously.

6) Another misconception is that behaviour therapy negates every other approach to therapy and that it is all one needs. Infact it is not so. It is one of the most effective ways of treating emotional disturbance but by no means the only way. Other forms of therapy are also effective and do help many people. However, behaviour therapy provides a useful rationale and framework for conducting therapy.

7) The final misconception is that behaviour therapy is very simple to do. But actually it is a very complex and demanding approach to treatment. It requires proper application of

techniques with a considerable understanding of emotional disturbance as well as the principles of learning.

1.5.6 Behaviour Therapy Techniques

Behaviour therapy is a wide field which offers number of treatment techniques for behaviour disorders. These techniques have proved to be successful and are independent of each other. Different techniques can be used for differnet problems in different situations. Some of the frequently used techniques are:

1) **Systematic Desensitization** - It was developed by J. Wolpe and states that a person can overcome maladaptive anxiety elicited by a situation or object by approaching the feared situations gradually and in a psychophysiological state that inhibits anxiety.

2) **Flooding** - It is based on the principle that escaping from an anxiety provoking experience reinforces the anxiety, through conditioning. Thus by not allowing the person to escape, anxiety can be extinguished and the conditioned avoidance behaviour can be prevented.

3) **Implosion or Implosive Therapy** - It is similar to flooding but implosive stimuli are more intense than those actually found in

life and sometimes include material that would be important in causing a certain fear.

4) **Graded Exposure** - It is also similar to flooding except that the phobic object or situation is approached through a series of small steps. The treatment is carried out in a real life context.

5) **Aversion therapy** - In this a noxious stimulus (punishment) is presented, immediately after a specific behavioural response, to be eliminated, which is eventually extinguished.

6) **Shaping** - It is a procedure for developing new behaviours by initially reinforcing any act that remotely resembles the ultimately desired behaviours.

7) **Time-out** - It is a special example of extinction which reduces the frequency of an unwanted behaviour by temporarily removing the person from a setting where reinforcers exist for that behaviour.

8) **Token economies** - It is a procedure for implementing the principles of contingency management to alter a variety of behaviours in a group of people. It operates on the principle of being compensated for one's labors which works as a positive reinforcement for the client.

9) **Extinction** - It takes place when the reinforcement for a particular response is withdrawn. Unreinforced, the behaviour usually stops.

10) **Contingency contracting** - It is a form of contingency management in which a formal agreement is made between the therapist and the client as to how much work will be done and what will be the consequences of certain behaviours.

11) **Fading** - It is the gradual removal of a formerly predominant means of reinforcement by allowing a new or different reinforcing circumstance (or stimulus) to take over. One fades out one method of control (reinforcer) in favour of another one.

12) **In-vivo Therapy** - As the term implies, this is the practice of conducting therapy, in the actual life situation in which the problem occurs.

13) **Negative reinforcement** - It refers to the removal of an aversive stimulus by negative reinforcement. Thus, fastening one's belt in order to turn off a buzzer (which is annoying), is an example of negative reinforcement.

14) **Reciprocal Inhibition** - This term was advanced by J. Wolpe. It refers to inhibiting a given behavioural tendency by its reciprocal or opposite. Thus if one is relaxed, he cannot be anxious; the way to combat anxiety is to learn and practice relaxation.

15) **Modeling** - It is a very important technique of behaviour therapy. It was developed by A. Bandura (1969). In modeling the hazards of unguided trial-and-error behaviour can be eliminated by simply observing competent models. Observing models perform the required behaviour often shortens the process of learning. Observation of the consequences of a model's behaviour may either inhibit or disinhibit imitative behaviour in an observer. Observing the behaviour of others can also facilitate the performance of similar responses already present in the repertoire of the observer. Modeling has been used to treat many clinical problems like social withdrawal, obsessive-compulsive behaviour, unassertiveness, antisocial conduct, aggressiveness, etc. There are several variations to the basic modeling procedures like participant or live modeling, symbolic modeling and covert modeling which has been used in the present study and will be discussed later.

The therapies discussed above are some of the common ones used in behaviour therapy sessions. These therapies can be used independently or in combination depending upon the clients needs and the competence of the therapist. But the technique/s to be used should never be imposed on the client rather the treatment strategy to be used should be fully conceptualized and well planned.

There is one more behavioural technique called Assertive Training which is commonly used and has proved to be successful with different behaviour disorders. In the present study, this very therapy was used in the form of Role-playing and Covert-Modeling for treating the two behaviour disorders of adolescents discussed earlier in the chapter. The therapeutic techniques are discussed below.

1.6.0 Assertive Behaviour

Before talking about the techniques of assertive training it is important to understand the meaning of Assertiveness or Assertive Behaviour.

Assertiveness can be defined as "the appropriate expression of feeling in ways that do not infringe upon the rights of others" (Alberti & Emmons, 1974; Wolpe & Lazarus, 1966) or it can also be defined as "standing up for personal rights and expressing thoughts, feelings and beliefs in direct, honest and

appropriate ways" (Lange & Jakubowski, 1976). From the above definitions Assertive Behaviour can be characterized by three points:

a) it is interpersonal behaviour involving the honest and straightforward expression of thoughts and feelings;

b) it is socially appropriate;

c) when a person is behaving assertively, the feelings and welfare of others are taken into account (Rimm and Masters, 1979).

Thus, by behaving assertively the client will benefit in two ways: first, he will feel better by lowering anxiety levels, and second, he will be able to achieve his goals in life, thereby increasing the access to social and material reinforcements.

1.6.1 Background

The first systematic description of assertion training, was given by A. Salter's Conditioned Reflex Therapy (1949). In his publication he suggested that most people are too well socialized. Their primary motivation is to be pleasant and accommodating to the needs of others. Their feelings and emotions are concealed. According to Salter this emotional inhibition produces conflict within the individual and makes it impossible to achieve real emotional satisfaction with others. Therefore, Salter's goal was to teach the inhibited individuals how to express their feelings directly. His treatment strategy was

to propose behavioural and specific behaviours for reducing inhibitions. The excitatory techniques proposed for "inhibited" individuals were feeling talk, facial talk, contradict and attack, deliberate use of "I", expressed agreement when praised and improvisation. For Salter (1961), "Therapy consists of getting the individual to re-educate himself back to the healthy spontaneity of which his life experiences have deprived him. Inhibitory history stops repeating itself and excitation (i.e., spontaneity) regains its birthright".

Assertive training got its real due because of the work of J. Wolpe (1958). He suggested that as young children, inhibited individuals were probably punished for expressing their feelings and were taught acceptable ways of responding. Regardless of their feelings, they were asked to behave in certain correct manners. That is why inhibited individuals are typically anxious in interpersonal relationships. According to Wolpe there is a lack of integrity of expression of basic feelings and emotions" (Wolpe and Lazarus, 1966). Wolpe advocated that assertive responses were particularly effective in inhibiting interpersonal anxiety and trained his clients in specific assertive skills. Thus Wolpe (1973) defined assertive behaviour as "the proper expression of any emotion other than anxiety toward another person".

Lazarus (1973) on the similar basis of Wolpe, suggested four response categories of assertive behaviour: (a) the ability to initiate, continue and successfully terminate conversation, (b) the ability to say no, (c) the ability to make requests or ask for favors, and (d) the ability to express positive and negative feelings.

Many authors like Alberti and Emmons (1974) stress that assertion is based on the expression of ones "rights". Some authors emphasize the social and interpersonal problem-solving aspects of assertion (Goldfried and Goldfried, 1975; Heimberg and others, 1977). Some authors see assertion as selecting the most socially effective response from all the possible alternatives. Socially effective responses are the ones which result in maximizing the reinforcement for all persons involved in a situation. Rich and Schroeder (1976) gave a functional definition of assertive behaviour "as the skill to seek, maintain or enhance reinforcement in an interpersonal situation through an expression of feelings or wants when such behaviour risks loss of reinforcement or even punishment".

Thus, it is clear that the central theme of the various definitions of assertive behaviour revolve around being able to present and express oneself comfortably in social situations and to engage, without undue anxiety, in positive coping behaviours in problem situations. Proper assertion enables people to exert more control over their lives, develop more self-respect and

self-confidence, effectively see that their needs are met and receive respect from those around them.

1.6.2 Assertive Training

From the above discussion it can be said that assertive training is primarily concerned with two major interpersonal goals: anxiety reduction and social skill training.

Assertive training can be defined as a therapeutic process which attempts to increase the patient's ability to engage in interpersonal behaviour involving the expression of feelings or wants, when such behaviour risks the loss of approval and even punishment (Rimm and Masters, 1974; Rich and Schroeder, 1976; Heimberg et al, 1977).

Assertive training consists of a broad array of such behavioural strategies designed to increase social-interpersonal assertiveness, while simultaneously decreasing passivity, deference and withdrawal.

1.6.3 Who needs Assertive Training?

Assertive training is a behavioural approach which can be used with majority of cases who ask for help. It is particularly worthwhile for individuals who have difficulty asserting themselves in particular interpersonal situations. Corey (1977) pointed out certain cases where assertive training can be particularly helpful. They are:

a) Those who cannot express anger or irritation.

b) Those who are overly polite and who allow others to take advantage of them.

c) Those who have difficulty saying "no".

d) Those who find it difficult to express affection and other positive responses.

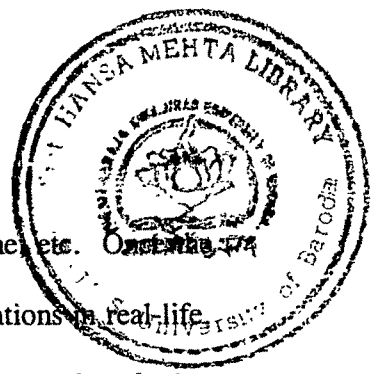
e) Those who feel they don't have a right to have their own feelings or thoughts. Along with the above cases assertive training can be helpful even for people who are overaggressive, overbearing, hostile and garrulous. It is also used for cases of psychosomatic disorders. Heimberg and others (1977), after reviewing literature, noted that assertive training has been used in number of cases like aggressive and explosive behaviour (Foy, Eisler and Pinkston, 1975; Frederiksen and others, 1976); alcoholism (Eisler, Hersen and Miller, 1974); sexual deviatious (Edwards, 1972); family problems (Eisler and Hersen, 1973; Fensterheim, 1972); Chronic psychiatric patients (Edelstein and Eisler, 1976; Hersen and others, 1975). It has also been used for enhancing the adjustment of handicapped persons (Mischel, 1978); for training selected groups such as women (Jakubowski-Spector, 1973);

Phelps and Austin, 1975; Osborn and Harris, 1978); job interviewees (McGovern and others, 1975); the elderly (Corby, 1975); high school and college students (Rathus and Ruppert, 1973); and school administrators (Smith, 1975). Thus, it is seen that assertive training can be used on a wide scale and in present times is a very successful technique.

1.6.4 General Procedure of Assertive Training

There are certain basic procedures to be followed in assertive training. The first step is to identify the need and specific areas where assertive training is required. This can be done by pencil-and-paper tests, interviews, diaries, direct observation, etc.

The second step is to make the client to understand the benefits of assertive behaviour and how nonassertive behaviour can be defeating in nature. The next step is to choose a situation to start with. First of all, generally, a situation is chosen which is easy to deal with and success is assured. Difficult situations should be taken up at later stages. The way to deal with a problem can be more than one. Thus, all possibilities are discussed with the client and the one most appropriate for him is chosen. Again it is important to choose an alternative which has high probability of success and which will work as reinforcer for the client. The client should also be taught to correct his eye



contact, body posture, gesture, facial expression, voice, tone, etc. Once the client learns these techniques he is asked to try out the situations in real-life. But after every trial he should be asked to report back so that further corrections and improvements can be made.

The clients with a reasonable amount of coaxing and encouragement, can begin to assert themselves within few days or weeks. But one most important point to be noted is that any assertive act which is likely to have a punishing or a negative consequence should not be instigated initially as it would discourage the client from further attempts of assertion. In some cases parental or family counselling may be important as the environmental pressures may nullify the clinical advantages of assertive training. Another important point to be noted is that it should be pointed out to the client that getting overly assertive might also have negative consequences. He should be discreet in choosing the situation where assertion is important.

1.6.5 Problems in Assertive Training

During the process of assertive training some problems might occur which might hamper the process of training. These should be taken into account and properly handled for the success of the therapy. Some problems may be:

a) The client may have difficulty in learning to analyze a situation and the ways to assert himself. This usually happens when in one situation the

client may understand how to deal with the problem but might feel at a loss in the next situation. This can be solved by initially picking up similar problems where the client might find it easy to transfer his training till he learns to cope with different problems.

b) Another problem can be that the client does not want to change and become more assertive and takes therapy only as a means of depending on the therapist for solutions. This should be discussed out with the client and clearly pointed out that he has to make the effort to find solutions for his problems and the therapist will only guide and help.

c) Another problem may be that the client is not able to assert without being aggressive. Then he has to be carefully taught to differentiate between assertion and aggression and also to respond appropriately to different situations.

d) Another problem may be that the client's assertive behaviour may result in some sort of negative reaction from others. For this therapist has to reassure and explain that such setbacks can occur but the client should again try with more confidence.

e) One more problem may be that clients usually feel that they do not have the right to assert. Such problems should be explored and the

therapist should be supportive and help the client change his feelings towards assertion itself.

1.6.6 Assertive Training in Group

Assertive training can be conducted on one-to-one basis or in group settings. Conducting assertive training in groups has been found to be more effective since in group settings the client can get the much needed support and encouragement whenevever he tries a new behaviour. Another advantage is that in group setting the client can profit by watching others acquiring assertive skills. Still another advantage is that the group can provide the feedback, and also the opportunity to practise assertive behaviours. Thus, it is clear that group training is better than individual training for teaching assertive skills.

Assertive training can be given by using the techniques like Role-playing or Modeling. These techniques can be given in different forms like modeling can be live, symbolic or covert in form. The techniques of Role-playing and Covert Modeling will be discussed here as they were used in the present study because they have been found to be successful in reducing nonassertiveness.

1.6.7 Role-playing

Role-playing is a technique in which the therapist and the client act out the relevant interpersonal interaction and in the process, the client takes up the

role of himself as he is and the therapist takes up the role of "significant others" from the client's life. The technique was used by Wolpe (1958) as an assertive therapeutic technique. According to Raths and others (1966), role-playing is a technique which assists an individual in the clarification of feelings and emotions as they relate to existing reality in three ways:

a) It can focus on real occurances. An incident may be reenacted and the client told to attend to the feelings aroused or an incident may be re-enacted with the client changing roles and attending to the feelings aroused by these new roles. An individual may be directed to deliver a soliloqucy to re-create an emotionally loaded event (Moreno,1946). Emphasis here is on expressing feelings that were hidden or held back when the event first occured.

b) It can focus on significant others. The client may portray a significant person in his/her life about whom a great amount of conflict is felt.

c) It can focus on processes and feelings occuring in new situations. Directions for this type of role-playing may be very specific, with the clients being provided with special characters and actions; or directions may be vague, allowing the client to form his/her own characters.

A role is a pattern of behaviour that a person develops from his life experience in order to cope up with the situation he faces. He develops or perceives his role in terms of the anticipatory roles of other persons. The number and kind of roles a person takes, vary, as do the intensity and completeness with which the roles are executed. Hence, role-playing is the process of assuming the role or characteristic of another person or oneself at another time and of acting accordingly. Thus role-playing in a therapeutic situation is a reliable way to test and train spontaneity to learn by recognizing the meaning of behaviour. In a therapeutic situation the assertive training is conducted under the guidance of therapist and then it is transfered to real-life situation.

Role-rehersal

In the process of role playing, role-rehersal is very important. Here, the therapist while playing the role of the "significant other" tries to bring about the changes in vocal and postural expressions of the client from less assertive to more assertive modes. The client is made to repeat every statement until it is totaly satisfactory. The aim of role-rehersal is to make the client to express himself with his real 'adversary" (or the significant other) so that the anxiety the latter evokes may be reciprocally inhibited and assertive behaviour established. During rehersal, it is presumed, that each act of assertion inhibits the anxiety associated with given interpersonal situation and weakens the

maladaptive anxiety response pattern and tends to foster more adaptive interpersonal behaviour.

Role -reversal

Here the client takes up the role of "significant other" and the therapist takes up the role of the client. This helps the client to better predict the behaviour and reactions of others and hence adjust his behaviour accordingly. Each person has a particular position in relationship to the other and with the role-reversal technique the possibility of understanding the other person's thinking, feeling and behaviour increases because of the identification with the other. As a result of this the attitudes of both can be changed. Role reversal can define and clarify an issue. It also makes it possible for the role player to move into the other role and show how he wants to be treated. Thus, role reversal not only establishes the area of conflict but also leads to the way out of conflict.

Thus, role playing as a technique is very successful and is frequently used as an assertive therapeutic technique.

1.6.8 Covert Modeling

Cautela (1971) has suggested that modeling stimuli can also be presented in imagination by means of instructions. The client imagines a model performing a particular behaviour rather than viewing a live or filmed model's

performance. This procedure, therefore, is called covert modeling. Here it is assumed that the representational processes operative in live modeling are altered through imagination of a model's performance. Covert modeling thus, involves three components: imagination of situations where problem is expected or occurs; imagination of one or more persons dealing comfortably with these problem situations; and imagination of favourable consequences for the model. During the training the client 'in imagination' should be able to express positive feelings like approval, love and affection as well as the negative feelings like anger, dismay, disgust and irritation.

While using the covert modeling technique following basic components should be present: a) an acceptable or desirable model engaged in the desired target behaviour; b) specified approach behaviour to be developed or modified; c) a natural terminal reinforcement for the behavioural sequence.

Before starting the technique the client should be given the rationale of the treatment. In general, the rationale should be given to overcome the preconceptions about non-assertiveness to which the client often refers. The client should also be explained that since it is a novel procedure it is very importnat to reherse. Rehersal can also be done in the imagination and should be continued till the client perfects himself. Also, since it is a novel technique

some practice sessions should be given where the client imagines mundane scenes which are unrelated to non-assertiveness.

These practice scenes serve to familiarize the client with the general procedures and to sensitize him to focus on imagening. After this only the real therapy should be given by first finding a model and then imagining him dealing assertively with the problem situations.

The model chosen should be similar to the client as greater the similarity between the model and the observer, greater will be the effect of covert modeling on behaviour (Bandura, 1971). It is also important to note that the consequences following the model's behaviour directly influence the performance of the client. If the model is rewarded for assertive behaviour, the client is more likely to repeat the behaviour and if the model is not rewared, the client is less likely to repeat the behaviour (Kazdin, 1974 and 1976). Thus there are two basic requirements one is description of the situation or the context in which the assertive response is appropriate and the other, an assertive response by the covert model in the scene. Thus, it is clear that one purpose of covert modeling is to increase the frequency of the occurance of some specific adaptive behaviour patterns.

Covert modeling can also be used to initiate particular behaviour pattern which is not in the clients current behavioural repertoire. It is also employed to

shape or improve a behavioural pattern which the client currently performs. In the process, a client's behaviour is guided towards greater effectiveness and efficiency.