Chapter-1

Introduction
An important concern of psychology is to address itself to issues and problems which distress individuals and impact negatively on their optimal functioning and sense of well being. Those manifesting full-fledged pathology receive appropriate intervention and treatment, but many of us who do not fall into the category of any well defined psychological disorder may be in the grips of anxiety and tension, which are disturbing and painful.

There are different problems in each individual's life, and each of us deals with them in different ways. Some people tackle their problems effectively, although they may experience some degree of anger, worry or anxiety, which are unavoidable parts of human life. However some people get disproportionately worried even when problems are very small because they probably exaggerate the possible negative consequences of their problems. Most often, the reason behind this behaviour is a trait called neuroticism. This trait is a mental structure inferred from observed behaviour where a consistence occurrence of behaviours identified as neurotic is found across situations and over time. Even more important for the psychologist is to be alert for behaviours and signals which point towards occurrence of pathology in the future, and if possible to pre-empt them. It may justifiably be presumed
that individual who are high on the trait of neuroticism are likely to become pathologically neurotic in the future, as compared to those who possess the neuroticism trait within normal range. Therefore, if individuals having higher than normal level of neuroticism are identified and with the help of some interventions, their negative outlook and inappropriate behaviours are modified, the likelihood of their developing pathology would be vastly reduced.

Learning techniques like cognitive restructuring or meditation could be prove helpful in controlling such behaviour. Therefore it would be meaningful to study the impact of cognitive restructuring and meditation on alleviation of problems of individuals high on neuroticism.

NEUROTICISM:

The term neurosis was coined by the Scottish doctor, William Culleirn in 1769 to refer to a “disorder of sense and motion” caused by a general affliction of the nervous system. The term (also psychoneurosis or neurotic disorder) in modern psychology refers to any mental disorder which though causing distress does not interfere with rational thoughts or the person’s ability to function. This is in contrast to psychosis and to more severe disorders.
A neurosis, in psychoanalytic theory, is an ineffectual coping strategy that Sigmund Freud (1887-1902) suggested was caused by emotions from past experiences overwhelming or interfering with present experiences. For example, someone attacked by a dog as a toddler may have a phobia or overwhelming fear of dogs. Although Freud recognize that some phobia’s are symbolic and expressed as repressed fear. In Carl Jung’s (1953) theory of analytical psychology a neurosis results from the conflicts of two psychic contents, one of which must be unconscious.

Despite its long history, the term, "neurosis" is no longer in common use. Current classification system of APA has abandoned the category of neurosis. Disorders formerly termed as neurosis are now described under the heading of anxiety disorders and dissociative disorders and somatoform disorders.

Neuroticism is considered to be a predisposition for traditional neurosis, such as phobias and other anxiety disorders. Neuroticism is a personality trait defined by the tendency to react to events with greater than average negative affect. In a sample of 7,076 adults, neuroticism predicted the onset of both anxiety disorders and depression (de Graaf et al. 2002). People with high level of neuroticism were more than twice as likely to develop an
anxiety disorder as those without high neuroticism. A major study of twins suggests that neuroticism explains at least part of the genetic vulnerability to depression (Fanous, Prescott and Kendler, 2004). Thus, there is good evidence that people who tend to experience negative affect are at elevated risk for developing depression.

Neuroticism refers to individual differences in emotional stability. Persons high on neuroticism are prone to experience anxiety as well as other negative emotions, such as, anger, disgust, and sadness, and also prone to hold unrealistic ideas (Costa and McCrae, 1992). As measured by such inventories as the Revised NEO Personality Inventory (NEO PI-R; Costa and McCrae, 1992), individuals scoring high on neuroticism are often tense, worried, or angry, feel inferior; are unable to resist craving; and are more likely to interpret ordinary situations as threatening, and minor frustration as hopelessly difficult. They are often self conscious and shy, and they may have trouble in controlling urges and delaying gratification. Neuroticism is related to emotional intelligence which involves emotional regulation, motivation, and interpersonal skills (Goleman, 1997).
On the opposite end of the spectrum, individuals who score low on neuroticism are more emotionally stable and reactive to stress. They tend to be calm, even tempered, and less likely to feel tense or rattled. Although they are low in negative emotions they may not necessarily be high on positive emotions.

Most researchers agree that neuroticism is temporally and situationally stable (Costa and McCrae, 1992; Eysenck, 1967; Watson and Clark, 1984). Neuroticism is typically viewed as a continuous trait, rather than a distinct type of person. People vary in their level of neuroticism, with a small minority of individuals scoring extremely high or extremely low on this dimension. Because most people cluster around the average, neuroticism test scores approximate a normal distribution given a relatively large sample of people. Neuroticism is one of the most studied personality traits in psychology, and this has resulted in a wealth of data and statistical analysis. It is measured on The EPQ, The NEO PI-R, and other personality inventories.

Neuroticism refers to the tendency to experience negative feelings. A negative feeling is a combination of different emotions like fear, anxiety, panic and sadness. While most of us do get negative at times, more and more people are regularly lapsing into
negative emotions. No one is born negative, but often traits are
genetic or develop due to certain situations like repeated failure,
trauma or an accident.

The transition from a neurotic personality to overt
symptomatology may be precipitated by factors that differ
somewhat from one neurotic reaction to another. In general, three
types of precipitants may be distinguished. First a breakdown may
occur when the individual's life situation changes, usually in the
direction of added responsibilities. Until he is promoted to a new
position, or marries, or becomes a parent, he functions well enough
and may use his neurotic traits for adaptive purpose- eg. a certain
degree of neurotic aggressiveness may stand the individual in good
stead occupationally. But he may perceive change in his situation as
threatening and dangerous. He may be reminded of childhood
dangers eg. parenthood may revive long conflicts with his own
father or marriage may revive unacceptable childhood sexual
impulses or fear of inadequacy. To quote Fenichel (1945) "Most
precipitating factors are experiences that are (objectively or
subjectively) somehow similar to childhood events that gave to
decisive conflicts". In case precipitation due to occupational
success, a frequent additional factor is that the individual
achievement may be less satisfying than those he pictured in fantasy. Paradoxically his success leads him to feel that he has failed.

A second type of precipitant consists of a progressive undermining of previously adequate defenses by physical illness, biological deprivation, actual failure, the death of a loved person or some other severely stressful condition. The precipitating trauma of combat neurosis is a special case of this type. Defenses are normally intensified under stress but if it is sufficiently prolonged and intense, the energy needed to maintain the defenses may be depleted.

The third and quite different pattern is the individual who from year to year expends more and more energy on the maintenance of defenses. As the burden of maintaining them increases, he becomes more tense and fatigued, and unable to behave spontaneously or enjoy himself. Eventually, he breaks down and develops overt symptoms. A long series of difficulties rather than a single event is responsible for his neurosis.

Eysenck and his associates (1947, 1952, 1953) have developed an objective dimensional framework in which
personality can be described in terms of several mutually orthogonal dimensions; introversion - extroversion and neuroticism in particular.

Eysenck states that the most frequent neurotic disorder of the extraverted type is hysteria. On the one hand speaking of introversion, he maintains that "This typical neurotic disorder is psychasthenia; a disorder which is characterized on the one hand by marked sensitivity, on the other hand by great exhaustion and constant tiredness". Nowadays we would probably refer to it as "anxiety state" or "reactive depression" rather than to the obsolescent term psychasthenia, which also held overtones of obsessional compulsive tendencies. On the basis of factorial study of 700 neurotics, Eysenck (1944) suggested the term "dysthmic" as a more modern equivalent to cover this syndrome of correlated affective disorder. In literal translation, this term means mood disorder and appear to single out the hypothetical underlying emotional dysfunction or hyperfunction posited by Gross (1992), Jordan (1890), and Jung (1921).

Although Jung (1921) never formally elaborated this part of the hypothesis, it can be seen quite clearly that implicit in his scheme is a second factor additional to, and independent of that of
extraversion- introversion. This factor we may call neuroticism; it is identified as that particular quality which hysterics and psychasthenics have in common as compared with normal persons. The independence of introversion and neuroticism is specially stressed by Jung. It is a mistake to believe that introversion is more or less the same as neurosis. As a concept, the two have not the slightest connection with each other. If we wish to represent a complete scheme, then, we must have recourse to two orthogonal factors or axes, one which represents the extravert-introvert continuum, the other normal-neurotic continuum.

The Psychophysiological basis of Neuroticism

Eysenck (1967) takes the view that neuroticism is characterized by individual differences in emotional responsiveness, excitability and agitation. The autonomic activation concomitant with the emotional expressions of fear, anger and distress, which characterize neurotic states, contrasts with the relatively low level of autonomic activity which may be implicated in differences in sensitivity, attention and specific cases of conditioning between introverts and extroverts.
Eysenck (1967) has suggested that behavioural differences between high and low neuroticism subjects may be interpreted in terms of differential thresholds for hypothalamic activity and in particular to differences in responsivity of the sympathetic nervous system 'with high neuroticism scores associated with greater responsivity'. This suggestion can be considered by exposing subjects from normal population to stressful stimuli or stressful conditions of varying intensity. A second suggestion with different implications is derived from the discussion of differences between corticoreticular arousal and autonomic activation (Eysenck 1967) where it is stated that for individuals who have frequently experienced strong emotions for long periods of time, the distinction between activation and corticoreticular arousal may not apply; for these individuals quite mild stimuli are emotionally activating.

The emotional stability-instability described by the neuroticism dimension has been linked solely to autonomic activity. The behaviours encompassed within the extraversion and neuroticism classification, such as dysthymia and psychopathy, may be explicated by consideration of specific emotional response
patterns or systems rather than emotional behaviour in general (cf. Izard 1972).

This direction has been advanced by Gray (1973), who proposed a modification of Eysenck (1967) position. The strength of Gray's proposal rests on the development of a model of emotions which was derived from an analysis of learning theory and physiological psychology. An attempt was made to explain differences in extraversion and neuroticism from the model. Gray identifies introversion with behavioural inhibition or fear in response to signals of either punishment or frustrative non-reward which were mediated by a system linking the orbital frontal cortex, the hippocampus, the medial septal area and the ascending reticular activating system. Extraversion is identified with approach behaviour in response to signals of rewards which are mediated by a system linking the septal area, medial forebrain bundle and medial hypothalamus. Neuroticism is depicted as a dimension of increasing sensitivity to both reward and punishment. In this view, introversion and extroversion are served by functionally distinct emotional systems, while neuroticism is determined by both.
Cognitive intervention

Cognition is a term that groups together the mental processes of perceiving, recognizing, conceiving, judging and reasoning. Cognitive science focuses on how people structure their experience, how they make sense of them, and how they relate their current experiences to past ones that have been stored in memory. These cognitions are believed to be linked to feeling, behaviour and physiology. Thus if a situation is perceived (cognition) as a threat by someone, adrenalin will be released into the body increasing the heart and breathing rates (physiology), the person will feel fear (affect or emotion) and will react (flight or fight behaviour).

Cognitions are available to our conscious minds- we can think about our thoughts and therefore we can change them. Beck described three types of cognitions which strongly influence an individuals feelings and behavior.

**Information processing:** Individuals are constantly receiving information from the internal (for example their own bodily reactions) and external environments which their brains process and make sense of.
**Automatic thoughts:** Many thoughts of an individual occur as if ‘out of the blue’. Beck called these spontaneous cognitions “automatic thoughts”. They are part of the person’s internal dialogue, described as unplanned moment to moment thought that flow through our minds. Often on the edge of awareness, they can be difficult to recognize.

**Schema:** This is a term given to hypothetical cognitive structures which act as templates to filter incoming information. They are the unspoken rules or underlying core beliefs learned through early experiences, which every individual holds about self, others and world.

Schemas can be adaptive and healthy or maladaptive and unhealthy. Maladaptive schemas tend to be negative, rigid and absolute. It is not people’s experiences or situations that make them angry, depressed or anxious but the way they process the information and think about those experiences.

Cognitions are the primary targets for change in therapy. The process of change begins with the cognitive therapist educating the clients about the cognitive models and the role of thoughts, emotions, and behaviour. Behaviour therapy is now almost entirely
replaced by the concept of cognitive behaviour therapy. Early
behaviour theory, with its emphasis on learning, seems somewhat
antithetical to developmentalism. The view of early behaviourists
on the development of human nature was limited to the learning
concepts of operant and classical conditioning. Watson (1930)
claimed that behaviour should be the sole subject matter of
psychology and that it should be studied through observation. It this
paradigm, conscious processes (eg thinking) were determined to be
outside the realm of scientific inquiry.

The cognitive revolution was brought forth by Beck, Ellis and
others due to the fact that as clinicians found the available system
of therapy unsatisfactory. All cognitive interventions attempt to
produce change by influencing thinking, which is assumed to play a
causal role in the development and maintenance of psychological
problems (Dobson and Dozois, 2001).

In 1970 there were only three "cognitive therapies", the
Personal Construct Approach developed by George Kelley (1955),
Aron T. Beck’s (1963-1970) nascent Cognitive Therapy, and Albert
Ellis's (1962) Rational Emotive Therapy. These three systems are
probably still most often associated with the generic term cognitive
therapy. But the popularity and usage of cognitive approach in
different context to deal with psychological and behaviour problems can be seen from the emergence of large number of specific therapies that have emerged and fall under the cognitive umbrella. The current cognitive therapies include

1) Personal Construct Therapy (Kelley 1955),
2) Logotherapy (Frankl, 1959)
3) Rational -Emotive Therapy (Ellis, 1962)
5) Multimodal Therapy (Lazarus, 1971, 1976)
6) Problem Solving Therapies (D. Zurilla, and Goldfried, 1971)
7) Rational Behaviour Training (Goodman and Maultsby, 1974)
8) Rational Stage Directed Therapy (Tosi and Eshbaugh, 1980)
9) Cognitive Behaviour Modification (Meichenbaum 1977)
10) Integrated Cognitive Behaviour Therapy (Wessler, 1983)
12) Cognitive Developmental Therapy (Mahoney, 1980, 1985)
13) Epistemic Therapy (Krulanski and Jaffe, 1983)
14) New Cognitive Psychotherapy (Surez, 1985)
The roots of cognitive therapy can be found in the early writings of the stoic philosophers Empictetus and Marcus Aurelius and the later works by Benjamin Rush and Henry Maudsley, among others. It was Epictetus who, in the first century A.D. wrote that “People are not disturbed by things but the view which they take of them” Benjamin Rush the father of American Psychiatry wrote in 1986 that by exercising the rational mind through practice, one gained control over otherwise unmanageable passions that he believed led to some forms of madness. A century later Henry Maudsley reiterated the notion that it was the loss of power over the coordination of ideas and feelings that led to madness and that the wise development of control over thoughts and feelings could have a powerful effect. In more modern times, Alfred Adler’s approach to dynamic psychotherapy was cognitive in nature, stressing the role of perception of the self and the world in determining how people went about the process of pursuing their goals in life. George Kelley is often accorded a central role in laying out the basic tenets of the approach, and Albert Bandura’s influential treatise on learning theory provided a theoretical basis for incorporating observation in the learning process.
Cognitive and cognitive-behavioral intervention approaches posit that organisms are not just the passive recipients of stimuli that impinge on them but instead interpret and try to make sense out of their worlds. These approaches do not reject more traditional classical and social learning; but they also suggest that cognitive mediation plays a role in coloring the way those processes work in humans.

Theorists such as Albert Ellis, the founder of Rational Emotive Therapy, and Aron Beck, the founder of Cognitive Therapy began their careers adhering to dynamic principles in theory and therapy but soon became disillusioned with that approach and over the time, began to focus on their patients conscious beliefs. Both ascribed to an ABC model, which states that it is not just what happens at point A (A antecedent event) that determines how the person feels and what he or she does at point C (the affective and behavioral consequences) but that it also matters how the person interprets those events at point B (the person’s belief). For example, someone who loses a relationship and is convinced that he or she was left because he or she is unlovable is more likely to feel depressed and fail to pursue further relationships than someone who considers his or her loss a
consequence of bad luck or product of mistakes that he or she will not repeat the next time. Both theorists worked with patients to actively examine their beliefs to be sure that they are not making situations worse than what they necessarily are. Ellis typically adopts a more philosophical approach based on reason and persuasion, whereas Beck operates more like a scientist, treating his patients' beliefs as hypotheses that can be tested by encouraging his patients to use their own behaviour to test the accuracy of their beliefs.

These approaches focus on the role of information processing in determining subsequent affect and behaviour. Beck, for example has argued that distinctive errors in thinking can be found in each of the major types of psychopathology. For example, depression typically involves negative views of the self and the future whereas involves anxiety an over determined sense of responsibility for ensuring safety of oneself and others. Efforts to produce change involve having the patient first monitor fluctuations of mood and relate those changes to ongoing flow of automatic thoughts, subsequently using one's own behaviour to test accuracy of these beliefs. For example a depressed patient who believes that he or she
is incompetent will be asked to provide an example of something he or she should be able to do but cannot.

The patient is then invited to list the steps that anyone else would have to do to carry out the task. The patient is then encouraged to carry out those steps just to determine whether he or she is as incompetent as he or she believes (typically, the patient is not).

The process of changing subconscious thoughts through bringing a person to a conscious awareness of incorrect programming is called cognitive restructuring. It is a useful tool for understanding and turning around negative thinking. It helps us put unhappy negative thoughts “under the microscope”, challenging them and in many cases re-scripting the negative thinking that is behind them. In doing this, it can help us approach situations in a positive frame of mind. This is obviously important because not only negative moods are unpleasant for us, they also reduce the quality of our performance and undermine our working and social relationship with other people.

The “cognitive restructuring” tool is based on the approach to cognitive therapy. The rationale used in cognitive restructuring
attempts to strengthen the client's belief that 'self talk' can influence performance and particularly that self defeating thoughts or negative self-statement can cause emotional distress and interfere with performance.

Greeg d. (2001) states that cognitive restructuring is based on the idea that we often respond to daily stressful events with a negative, distorted mental monologue. Our internal mental monologue is continuous, automatic and occurs partially outside of awareness in some people. The monologue is more likely to consist of negative, distorted thoughts, called negative automatic thoughts. When negative monologues occur to frequently or intensely in stress, unhealthy negative emotions like anxiety or anger can result.

Negative automatic thoughts are those cognitions which are closest to the surface of consciousness. Beck (1976) recognized, however, that there were also deeper cognitions which incline the person to interpret events in relatively fixed patterns. Working in parallel with personal construct theorist (Kelly 1955), he began to conceptualize the idea of cognitive structures. Beck initially used, and then abandoned, Kelly's term 'construct' preferring the description of earlier psychologists. Such as Bartelett (1932) by using the term 'schema' or the plural; schemata' to describe
cognitive structures. Schemata are of course not always problematic.

Beck (1976) describes a range of cognitive distortions leading to disturbance. They are as follows:

**All or nothing thinking:** This refers to polarization into two extreme categories of a phenomenon which really exists on a continuum. For example “safe” is when there is no risk at all “danger” when there is a slight risk; being ok is when I do not make a mistake at all; being bad is when I make even a small mistake.

**Mental Filter:** Positive information is excluded, leaving the field dominated by negative information. For example, concluding ‘I never get things right’ after making one small mistake, despite numerous life achievements.

**Over generalization:** Taking one negative event and using it to conclude that everything is going to be wrong. For example, spilling a cup of coffee at breakfast and concluding ‘Everything is going to be wrong today.’

**Jumping to conclusions:** Going straight to a negative interpretation when there is little or no evidence to support this for example: you end up by yourself at break-time and conclude ‘My colleagues are avoiding me.’
Discounting the positive: Positive experiences are dismissed on ground such as “Anyone could have done this”

Magnification: Difficulties and shortcomings are exaggerated. For example, forgetting a name and concluding ‘I am useless at relationships”

Should Statements: Tyrannical demand that oneself, others or the world in general must be some other way than they actually are.

Emotional reasoning: The assumption that negative emotions are a completely accurate guide to reality – Just feel they all hate me therefore they do all hate me.

Labelling: The attachment of a personality ‘tag’ to a piece of behavior. For example, failing a job interview means I’m a failure.

Personalisation: Holding oneself responsible for an event outside one’ control. For example, My husband would not drink if I was a better wife.

Mind reading: Guessing the content of someone else’s thought without checking it out with them: You’re just saying that to be nice, she thought I was terrible.

Crystal ball gazing: Predicting the future; “It’s bad now so it will always be awful”, “I am going to make a complete fool of myself”.
The first step of cognitive restructuring is to identify negative automatic thoughts. It is the most difficult part because these thoughts are so automatic, continual and occur partially outside of awareness. Consequently, we do not pay much attention to them or realize that, when we are faced with stressful situation our negative thought may be responsible for this stress. The most effective way to recognized negative automatic thoughts is to track, in writing, the feelings and negative automatic thoughts that accompany stressful situations because often individuals are unaware of there own interpretation of events. When an individual thinks about a situation in which he or she felt upset and tries to recollect what he or she was thinking about, and the emotion developed and what did the event mean to the person he is able to track the negative thoughts. By observing their own thoughts some weeks, individual generally find that certain types of negative thoughts occur again and again, in slightly modified forms. After recognizing them, the individual realizes that we can not change the situation that causes it but we can change our emotional responses towards it. By learning how to challenge and change negative automatic thoughts, the individual can be more realistic and accurate in thinking about stressful situations.
Once negative thoughts are identified, client and counselor can work together to test out the validity of their way of thinking, treating the thoughts or negative predictions as hypotheses to be tested rather than as facts. The overall message in challenging the client’s way of thinking is to enable the client to take his /her thoughts to court, enabling information and evidence to be collected for the defense and prosecution, rather than automatic jumping to conclusions based on one way of seeing things.

There are three main approaches to challenging thoughts: the process of guided discovery using Socratic questions thought diaries and behavioral experiments. Guided discovery involves asking questions in order to understand individuals point of view and help the person to discover alternatives (Beck and Young 1985). The key method of guided discovery is the Socratic method which uses systematic questioning and inductive reasoning (Overholser, 1993).

The aim of the Socratic method is to guide discovery (Padesky 1993a). In the best cognitive therapy, there is no answer. There are only good questions that guide discovery of a million different individuals answers. The Socratic method is not a case of the counselor trying to persuade the client to see things from his
point of view. One common mistake is to ask too many leading questions, too soon, without taking time to explore why the client thinks the way he does. Questions such as ‘Do not you think it would be more helpful if you did x? or do you think this way because-------- (counselor guesses)? may well close down the process of discovery, imposing the counsellor’s way of seeing before discovering the client’s manner or enabling client’s viewpoint. Open questions, in a gentle and friendly manner, enable client and counselor to explore issues collaboratively. A useful question when wanting to clarify meanings is to ask ‘what do you mean when you say x? This helps to define more clearly the meaning of thought, which may be very idiosyncratic. Other useful questions are as follows:

- What is the evidence that x is true? What is the evidence against x being true?
- What might be the worst that could happen?
- And if that happened, what then?
- What leads you to think that might happen?
- How does thinking that make you feel?

Padesky (1993a) defines a number of characteristics of good Socratic questions. Firstly, they are those to which the client has
the answers. e.g. 'what might be the consequences of thinking x to yourself' is more likely to elicit from client a useful answer, such as. 'It makes me feel bad, it stops me getting on with my work.' Secondly, Socratic questioning draws the client's attention to relevant information which may be outside the client's focus. Thirdly Socratic questioning moves from the concrete to the more abstract from enabling the client to generalize from the discussion and therefore applying new information elsewhere. If the client reports being 'bad' what does this mean? Initial questions focus on specific concrete examples or areas where the client believes himself to be bad such as bad at job, bad to be so angry. Guided discovery will initially aim to explore the meaning and relevance of badness to these examples. For example, the client may discover that he is not particularly good at some aspect of his job, but generally does a good job. Whilst being angry all the time is not particularly helpful but being angry all the time does not make him a bad person. The aim of guided discovery is for the client to learn how to question thoughts and beliefs on his own. Rather than just asking questions in sessions, the therapist can teach client that if he has the automatic thought 'I am bad' he must learn to ask himself 'what does bad mean? What is the evidence I am bad? Is there anything in myself that is not all bad? Why am I ignoring this at the
moment? And other questions to reduce the potency of the negative thoughts.

Once the client has begun to question her thought and see that there might be alternatives, it is useful to record these using a full diary, sometimes known as a “Dysfunctional Thought Records” or more friendly ‘Thought diary’. When the client is able to think and record alternative thoughts, it leads to improvement in emotions.

The client should be told that it requires practice for the new kind of thinking to feel true just as it takes time for any new skill (such as driving a car) to feel comfortable and natural. With time, it begins to become natural to think about one’s life situation in a fair and realistic manner.

A behavioural experiment aims to help the client to test out thoughts and beliefs in order to discover their relative validity or truth (Beck et al 1979). According to Beck there is no such thing as cognitive technique, only a cognitive framework. He clarifies this principle of cognitive therapy and stresses that the cognitive therapist can choose from a variety of therapeutic techniques so long as the basic principle of cognitive therapy are kept. The techniques should fit with the model of therapeutic change.
Behavioural experiments involves creativity on the part of both therapists and clients. It has one important pre-condition, that is they must be ‘no-lose’ experiments aimed at both gathering information and testing out alternatives. Whatever the outcome, something has been learned. It is preferable that the outcome will not be as the client fears although if it is this can also be used as an opportunity to assess whether the fears were exaggerated or how one can learn to deal with difficult situation.

Cognitive therapy uses a range of what might be described as behavioural approaches. Weekly Activity Schedule, Distraction and Problem Solving are some commonly used techniques. The Weekly Activity Schedule is frequently used in cognitive therapy for depression, helping the clients to become more active and increase the level of enjoyable activities in life. Distraction is a means of taking the mind off problems or symptoms and paying attention to something else. It can involve physical activity, focusing on a mental image and mental chewing gum such as arithmetic or remembering means of capital cities. It is useful for clients who find it difficult to tolerate strong emotion, giving them a first aid measure for use within sessions in daily life to reduce emotion when it threatens to overwhelmed them. Problem solving
encourages the client to work out practical and psychological ways of dealing with problems using her own skill and resources as well as help from others. It can be particularly helpful for individual where life stress are contributing to their problems and where the individual is either finding difficulty in addressing or solving these problems or avoiding the problems.

Cognitive Counselling

Cognitive counselling begins with the initial interview. The initial interview has many purposes: initiating a relationship, providing a rationale for cognitive therapy, producing symptom relief, and eliciting important information. Right from the start, the therapist imparts to the client the expectation that cognitive therapy will be time limited. During the initial interview, therapist starts to define problems. Definition of problems entails both functional and cognitive analyses.

The functional analysis seeks to answer questions such as: what are the component parts of the problem? "How is it manifested? In what situations does it occur?" What is its frequency, intensity and duration? And what are the consequences.
The cognitive analysis identifies the client's thoughts and images when emotion is triggered, the extent to which the client feels in control of thoughts and images can predict about the likelihood of the problems occurring and what will happen. From the beginning, therapists train clients to monitor their feelings, thoughts and behaviour and to recognize the connections between them. Homework is a main feature throughout cognitive therapy. An example of an early homework assignment might be asking to record their automatic thoughts when in distress.

During initial sessions, therapists and clients draw up problem lists which can consist of specific symptoms, behaviors or pervasive problems. Their function is to assign treatment priorities. Considerations in prioritizing treatment include magnitude of distress symptoms severity, and pervasiveness of theme. Therapists approach each problem by choosing the appropriate cognitive and behavioral technique to apply. Therapists always offer a rationale for each technique. In addition, both when suggesting and implementing techniques, therapists elicit feedback from clients.

While the early stages of counseling may focus on symptom removal, middle and later stages are more likely to emphasize changing clients pattern of thinking. Clients are helped to
understand the interrelationship between their thoughts, feelings and behavior. Once they can challenge automatic thoughts that interfere with effective functioning, then they can identify and examine the underlying assumptions or beliefs generating such thoughts. Assumptions may be revealed as themes in automatic thoughts across time and across situations. Once assumptions and core beliefs have been identified and their disruptive power understood, then cognitive therapy aims to assist clients to examine their validity and current usefulness and then discard or amend them as appropriate.

As cognitive therapy progresses, clients develop their skills of being their own therapist. Client assumes more responsibility for identifying problems, analyzing his thinking and creating suitable homework assignments. The therapist shifts from being fairly didactic to facilitating clients as they develop their cognitive self help skills. The frequency of sessions decreases as client become more proficient.

Being mainly a short-term structured approach, cognitive therapy tends to have its ending built into its beginning. Therapy ends when goals are reached and clients feel confident about implementing their new skills. From the outset therapists discuss
with client the criteria and expectation for termination. There are number of ways of assessing progress, including relief from symptoms, changes in reported and observed behavior, and change in thinking both inside and outside therapy.

**MEDITATION**

Meditation is a mental discipline by which one attempts to get beyond the conditioned, "thinking" mind into a deeper state of relaxation or awareness. Meditation often involves turning attention to a single point of reference. It is recognized as a component of almost all religions. Meditation originated from Vedic Hinduism, which is the oldest religion that professes meditation as a spiritual and religious practice. The Bhagavad Gita stresses the importance of meditation. In the Sixth Chapter of Bhagavad Gita- "The Yoga of Meditation" describes the technique of meditation and the characteristics of the Yogi who is well established in meditation. The Bhagavad Gita stresses the importance of meditation as follows. "Make a habit of practicing meditation and do not let your mind be distracted. In this way you will come finally to the lord who is the light-giver, the highest of the high".
Meditation has always been central to Buddhism and considered a key tool in spiritual development. The historical Buddha himself, Buddha Shakyamuni, was said to have achieved enlightenment while meditating under a Bodhi tree. Most forms of Buddhism distinguish between two classes of meditation practices, shamatha and vipassana, both of which are necessary for attaining enlightenment. The former consists of practices aimed at developing the ability to focus the attention single-pointedly, The latter includes practices aimed at developing insight and wisdom through seeing the true nature of reality.

Meditation in Islam is the core of its creed. A Muslim is obligated to pray five times a day. During those times of prayer, the Muslim is expected to focus and meditate on Allah through the recitation of Quran and dhikr in order to establish and strengthen the connection between Creator and creation. This, in turn, is meant to guide the soul to truth. This meditation is intended to help Muslims maintain spiritual peace in spite of challenges they may experience in their work, social and family life. In this manner, the five time daily peaceful prayer are meant to serve as a model for the Muslims conduct during the whole day, transforming it into a
There are two more concepts or schools of meditation in Islam Tafakkur and Tadabbur, literally meaning reflection upon the universe. Muslims feel this is a form of intellectual development which emanates from a higher level, i.e., from God. This awakens and liberates the human mind, permitting man's inner personality to develop and grow so that he may lead his life on a spiritual plane far above the mundane level. This is consistent with the global teaching of Islam, which views life as a test of our practice of submission to Allah, The one God.

Another form of mediation is Sufi mediation, similar to Buddhist meditation, known as Muraqaba (means "concentration" referring to the "concentration of abilities"). It is largely based on mystical exercise. However, this method is controversial among Muslim scholars. One group of Ulama, Al-Ghazzali, for instance, have accepted it, another group of Ulama, Ibn Taymiya, for instance, have rejected it as a bid'ah (religious innovation).

The Jains use the word Samayika, a word in the Prakrit language derived from the word samay (time) to denote the practice
of meditation. The aim of Samayika is to transcend the daily experiences of being a "constantly changing" human being, Jiva, and allow for the identification with the "changeless" reality in the practitioner, the Atma. The practice of Samayika begins by achieving a balance in time. If the present moment of time is taken to be a point between the past and the future, Samayika means being fully aware, alert and conscious in that very moment, experiencing one's true nature, 'Atma' which is considered common to all living beings.

In Sikhism, the practices of Simran and Nam Japo encourages quiet meditation. This is focusing one's attention on the attributes of God. Sikhs believe that there are 10 "gates" to the body (gates are energy centres). The top most energy level is called Damas Dwar. When one reaches this stage through continuous practice, meditation becomes a habit that continues whilst walking, talking, eating, awake or even sleeping.

In contemporary psychological literature, meditation is a broad and generic term to include all those spiritual practices prevalent in traditions like Buddhism, Christianity, Jewish Kabalah, Taoism, etc. It is also used to refer to many other mental devices or techniques developed by researchers for example, Clinically
Standardised Meditation (Carrington, 1987). Thus the term is used as a "conglomerate word" and under this conceptual umbrella a number of different techniques and intents are grouped (Carrington, 1987). They include sitting quietly, relaxing, closing the eyes, breathing deliberately, focusing attention on an object or image non analytically, observing the thought process without judging, repeating sound mentally, rhythmic moving of the body as in Sufi dervish dance and so on.

Meditation categorisation is also based on goals. Carrington (1987) speaks of "Practical" and "Spiritual" meditation. Spiritual meditation is historically embedded in centuries-old religious traditions. Practical form of meditation is contemporary and frequently practiced in the west. The objective of spiritual meditation is to attain spiritual development, through the process of deepening the range of human spirit and changing the entire life of human being. Practical meditation affects the practitioner's life in certain practical ways, without changing their lives in an essential fashion. The objective of practical meditation is to enrich the experience of the average practitioner who continues to function within the framework of ordinary society. Other researchers have
also referred to such distinctions (Johnson, 1982; Rao, 1984; West, 1986).

Compulsion to make such distinctions arise from the need to be theoretically and methodologically specific in examining meditation as a subject of scientific scrutiny. Meditative practices which involve sitting and chanting mantras, focusing on breathing, being passively aware of thought process are also considered as self-regulation strategies which act at the mental level. Many studies have been conducted on them and the relative efficacy of these techniques has been discussed and debated (Holmes, 1984; Shapiro, 1982). In terms of practical utility, meditation as a technique can be beneficial in and of itself for psychosomatic and psychological problems (Murphy and Donovan, 1997; Shapiro and Walsh, 1984; Walsh, 1999; West, 1987)

Another important focus of research on meditation is to examine its psychotherapeutic and growth benefits (Ali et al. 1988; Bogart, 1990). Investigations have found that meditative practices enhance psychological growth and well being. They also serve as therapeutic adjuncts both in reductive and reconstructive therapies, besides serving as a supportive therapy technique.
Form the view point of modern psychology, investigations on Yoga and other meditative practices are of significance in enhancing the understanding of the body-mind relationship. They have also helped in redefining the boundaries of discipline to include hitherto neglected human phenomenon viz. consciousness, as a valid subject matter (Naranjo and Ornstien, 1971; Ornstien, 1972, 1973; Osis, Bokert and Carlson, 1973; Tart, 1969, 1975; Walsh, 1980)

In their review of scientific studies of meditation, published in the International Journal of Psychotherapy, Perez-De-Albeniz and Holmes (2000) identified the following behavioural components of meditation:

1) Relaxation
2) Concentration
3) Altered state of awareness
4) Suspension of logical thought processes, and
5) Maintenance of self observing attitude.

In the words of Morse and Furst (1979) "Meditation is an altered state of awareness that is induced by the repetitive of some content stimulation". The stimulation may be external, internal or
physical. As a result of repeated constant stimulation, an individual, without trying, achieves varying degrees of relaxation, subjective change in body image, certain distortions of reality and ability to decrease the ability of the autonomic nervous system functions.

Benson (2000) of the Mind-Body Medical Institute, which is affiliated with Harvard and several Boston hospitals, reports that meditation induces a host of biochemical and physical changes in the body collectively referred to as the "relaxation response". The relaxation response includes changes in metabolism, heart rate, respiration, blood pressure and brain chemistry.

Richards and Begin (1997) gave the empirical evidences in support of meditative states producing significant healing of body and mind. Physiologically, meditation evokes a relaxed response, trains and strengthens awareness, centres the body-mind. It calms the central nervous system, relieves stress, bolsters self esteem, reduces anxiety and alleviates depression.

There have been some Indian investigations of psychological and physiological benefits of meditation. Dhar (1996) quoted the major results.
Studies on normal individuals have indicated that a regular practice of Yogic postures (physical) leads to psychological improvement in the intelligence and memory quotient and a decrease in the pulse rate, blood pressure, and respiration and body weight. The biochemical examination of the blood has shown decrease in blood sugar and serum cholesterol, and rise in the serum protein level. However, practice of breathing exercise Paranayam etc. alone produces similar results except that fall in serum lipid were more marked than was noted in the practice of physical postures. Kundalini meditation has been used with great benefit not only for improving the level of consciousness, but also in the treatment of certain mental illness. Powerful psychophysiological changes referred to as "raising the Kundalini" (Gopi-Krishna, 1976) etc. are unlikely to be fictitious.

Bhaskaran (1991) observed that meditation would appear to have preventive potentials through its relaxing effect in stress-induced psychological disorders.

"Relaxation is not something that you do. It is a natural response that you allow to happen. Relaxation is what is left when you stop creating tension." When the tension melts away, we
discover that we are at peace, at the centre and naturally in sympathy with all creation.

Whatever technique of meditation one is practising, it is necessary to have the ability to place your attention on the object of meditation and hold it there without distraction. The power of a concentrated mind can be focused effectively to enhance and deepen insight into other meditative themes or goals. Concentration meditation is the foundation for all other kinds of meditation. Through the power of concentration we build our capacity to overcome distraction and to sustain mental focus. The power of scattered mind is very limited.

In concentration meditation, whether one sit crossed legged, in a chair, or kneel with a meditation bench is largely a matter of style and preference. It is advised to experiment and see what works best. It is especially important to sit comfortably, with the spine straight and the body upright and relaxed. Sitting in this way, it will be much easier to remain alert. It is important to sit naturally and at ease and avoid forcing the body into uncomfortable postures.

Next thing in concentration meditation is to select a focus for concentration. There are thousands of object of attention that are
classically prescribed for developing concentration. An ideal concentration focus would be one that is sufficiently easy for one’s attention to find and hold with clarity and one that brings peace or joy to the mind but doesn't create too much excitement or boredom as one focuses on it. If we select a focus that has meaning for us, we need to be watchful that it doesn’t create too many associations or distractions.

For most people, the simplest and most direct method for developing mental stability and concentration is to focus upon the flow of breath, the steady balancing rhythm of in breath and out-breath. The breath is often used because it is easy to find and continually present. Meditating on the flow of breath is considered the most effective method for helping people with busy minds to quiet the internal dialogue.

Sri Swami Ram's lecture entitled "Science of Breath" quoted that “Science of breath is a complete Science of philosophy". Breath plays a great role for cleansing pores and lungs. The movement of lungs control various systems. If one learns to regulate the movements of lungs, one can even have control over all autonomic nervous system, involuntary system and that part of mind which is being used by involuntary system can be brought
under conscious control very easily. Science of breath is a practical Science. One cannot read or study this Science through books. If individual is sad or worried, then his breath starts behaving in a funny way. If individual is happy, then breath will behave in a different way.

To understand Science of Breath, one should practice a few days how to sit still and observed breath. There are many breathing exercises. After learning deep diaphragmatic breathing and forming a habit, one should learn alternate breathing. That helps in channel purification- Nadi Shodhana. There are various exercises of Nadi Shodhana. Later on, one can use his mind and change the breath.

Next thing in concentration meditation is to develop balance. Once the meditator has settled his/her mind on the object and is focusing his attention, he is advised to relax the mind a little. If he grasps too tightly at the object, the mind will become agitated the your body tense. If there is too much relaxation, the attention will wander or fade.

With practice and patience, the person learns to distinguish between these two states and finds the balance necessary to deepen attention.
In meditation, as one begins to relax, it is quite common to experience what are called "release phenomena". These may include jerking or quivering of the body as one is falling asleep, gurgling of the stomach, tingling feelings or numbness, memories, mental images, inner sound, or other perceptual changes. Release phenomena are common indicators that the practice of relaxation or meditation is becoming effective in dissolving deeply embedded mental, emotional and physical holding patterns. The best way to deal with these experiences is to simply allow them to arise, unfold and dissolve without distracting the attention.

Regardless of the work we do or the position we hold, our mind body is our primary instrument that is why it is no surprise that skills in meditation and relaxation are becoming recognized as vital to our peace of mind and the quality of our health, work and relationships.

From the above exposition in which the major concepts relating to neuroticism, cognitive restructuring and meditation have been clarified, it appears logical to expect that symptoms of neuroticism and problems faced by people high on neuroticism are likely to be alleviated through cognitive restructuring and meditation.
In the next chapter, empirical evidence is being cited to bring out clearly findings that have been obtained in this regard, so that by evaluating researches which support or which may contradict our research questions, hypotheses may be formulated in the proper manner.