DISCUSSION OF RESULTS
CHAPTER VI

DISCUSSION OF RESULTS

FAMILY PATHOLOGY:

It was hypothesized that, “the patients of anxiety disorders and asthmatics will be higher on normal cohesive type (higher score indicates lesser cohesiveness), Egoistic family type, Altruistic family type, and anomic family type, indicating greater family pathology as compared to their normal counterparts”.

The anxiety disorders group and asthmatics revealed greater family pathology on the whole as compared to normals. These results support the hypothesis. On the sub types, these patients revealed pathology on egoistic family type and anomic family type. According to the “Family Typology Manual”, Altruistic family type and normal cohesive family type are not good predictors of pathology, while egoistic and anomic family types predict pathology more correctly because of their pathogenic structures. The obtained results are in line with the above statement. The previous literature has revealed that pathogenic family structure is regarded as an overarching risk factor that increases an individual’s vulnerability to particular stressors. Wolberg (1944), Bateson (1960), and Roff & Knight (1981) reported that pathogenic family patterns may lead to adjustment difficulties.
Without a secure and adequate “home base”, the individual’s personality may suffer serious and lasting distortions. The individuals who grow up in pathogenic family environments find it difficult to establish and maintain marital and other intimate relationships. Bloom, et al. (1978) in their comprehensive review of the effects of marital disruption found that disruption is a major source of psychopathology, physical illness and death, suicide, and homicide.

Since the individual lives within a family context, family factors have proved to be important predictors of psychosocial adjustment in ill and healthy population. Many researchers suggest that the family environment contributes a great deal to the onset of physical and psychiatric illness. The researchers working in the field of environment and health agree that there exists a health illness continuum and human functions rise and fall accordingly. Moos & Moos (1971, 1976) using family environment scale have reported significant differences between family environment of normal families and of distressed families, the latter being less cohesive, expressive, organized, independent, less achievement oriented, religious, and with more conflicts. These families were also less concerned with intellectual, cultural, and recreational activities. Schizophrenia and neurotic depression have also been reported to be related to environment of the individual’s family.
(Paskiewiz, 1977, Wetzel, 1978). The most significant aspect of the family environment is warmth relationship between parents and child. Studies by Jacob, et al. (1971) and Rohner (1980) showed that warmth is the most crucial and pervasive factor affecting child’s development. Parental rejection leads to the development of neuroticism in the formative years of life.

Keitner, et al. (1985) found that dysfunctioning in the families gives rise to anxiety disorders in the individual. They also found that unsupportive parents’ attitude made the individual more vulnerable towards psychopathology.

Some recent studies are also in agreement with the present results. Nehra (1993) studied family typology and perceived social support in neurotics and found that neurotics on the whole showed greater family pathology, and perceived less social support as compared to normals. In another study, Verma, et al. (1995) found that psychotics showed greater family pathology than normals. The results further indicated that psychotics were higher on altruistic, egoistic and anomic family types than normals. However, no significant differences were found on normal cohesive family type between psychotics and normals.

Egoistic family adheres to the standards of the family. The members of the egoistic family tend to have more sacrificing nature to maintenance of the family image. Due to this, they find
that their self is ignored because of the family image. Nobody bothers about each other’s feelings. Their internal motive is to just maintain the social prestige of the family. The patients of anxiety disorders and asthmatics need adequate support and warmth from the family members, which they are not able to receive and perceive. Hence, they feel too much ignored and lonely which deteriorates their mental and physical conditions.

In anomic family, the individual self is given the highest importance by the family as such. In these families the individual members have their own way of life, style of interaction, and personal conviction. The members of these families are highly individualistic and do not bother about the other members and are rarely influenced by them. In this type of family there is hardly any discussion and no common way adopted to achieve the family goals. In extreme examples, except living under one common roof, the family members have nothing else much in common. Therefore, they feel too much neglected, because everybody is busy in his/her own mean ends. There is lack of perceived adequate support, warmth, and trust from the family, which makes them more vulnerable towards psychopathology (Bhatti, et al., 1986).

The results further revealed that disease × gender interaction was significant on altruistic family, anomic family and on total family pathology. After an inspection of the results, it was found
that asthmatic males were significantly higher than anxiety disorder group and normal males on these family types, whereas in females, the anxiety disorders group was significantly higher than asthmatic and normal females. It shows that in the pathogenic family types, (altruistic and anomic) males are more prone to develop asthma whereas females are more prone to anxiety disorders. It is generally observed that the males suppress the feelings of distress and anxiety while the females reveal the symptoms of anxiety. The suppressed feelings may give rise to the asthmatic problems in the males. Asthma has been conceived as “suppressed crying” caused by an impulse to cry joined with a need to inhibit both propensities relating in turn to a fear of abandonment (Carsen, Butcher & Mineka, 1998). Females tend to exhibit the direct symptoms of anxiety more often than males.

Faulty parent-child relationships in the childhood do contribute to the maladjustments of the individual throughout life. Knapp, et al. (1966) found that asthmatic subjects demonstrated an excessive mother-child bond and core anxiety around the threat of separation. This often acts as a powerful emotional arousal and a breakdown of psychological defenses and thus percpitating asthma. Sharma & Nandkumar (1980) and Meijer (1981) observed that asthmatic subjects manifested marked affectional and dependency need in relation to mother and they were anxious,
insecure, aggressive, and experienced irrational fears and guilt feelings.

The results further revealed that on normal cohesive type the females perceived lower family cohesiveness than the males. However, the 3 factor interaction revealed that this was mainly true about the middle aged asthmatic females and not the young females who did not differ from their male counterparts. It could be possible that by middle age, females value family cohesiveness more than the males and they expect it from the other family members. It may be because of their higher expectations that they perceive the existing cohesiveness to be lesser than it ideally should be. Lesser family cohesiveness seems to affect middle aged women who in turn become prone to asthmatic problems.

The main effect of age was found to be significant on altruistic family type. Middle aged group revealed more pathology in comparison to younger group. Middle aged group revealed more pathology due to particular characteristics of the family. In altruistic families too much 'we' feeling gives rise to pathological dependency. The members are always ready to sacrifice anything for the welfare of each other. Conversely, the members are also prone to immaturity and dependency, with the result that self-reliance, self-help and self sufficiency are poorly developed. Solidarity and mutual help dominate the transactions in these
families to such an extent that they lead to pathological dependency in some members (Bhatti, et al., 1986). Middle aged individuals perhaps due to their age feel more dependent upon other members of the family.

The above discussion reveals that pathogenic family structure plays an important role in the onset of mental and physical disorders. The patients of anxiety disorders and asthmatics do not get healthy family environment. When a family exhibits some kinds of pathology, it definitely affects all the members. Stable and healthier families, no doubt, are able to give support to all the members and act as a buffer against all the adversities. Such a system makes base for individual to be in healthy and stable environment which is good for his physical and mental health. On the other hand, pathogenic families are deprived of such healthy environment and are often stressed by unhealthy interactions in the family. Such a family atmosphere makes the individual more vulnerable to develop physical/psychological problems.

FAMILY INTERACTION PATTERNS:

It was hypothesized that the patients of anxiety disorders and asthmatics will show dysfunction in all the six areas of family interaction patterns, viz reinforcement, social support, role, communication, cohesiveness, and leadership.

The results revealed that asthmatics manifested more
dysfunction on reinforcement and social support, while anxiety disorders group manifested dysfunction in the area of leadership. Normals revealed dysfunction in the area of communication. However, on role cohesiveness and on total family interaction patterns none of the differences between groups were found to be significant.

Asthmatics revealing more dysfunction in the areas of reinforcement and social support could be because asthmatics find it difficult to imbibe the socially approved behaviours of the family. When they feel restrictions they may start feeling choked and breathless. They do not perceive adequate social support. Also they withdraw themselves from meeting new people. People may stay at a distance from asthmatics because of the fear of getting infection. In the absence of adequate reinforcement and social support, they may find themselves at a loss and asthma may be an indirect way of demanding help and support from others.

Anxiety disorders group manifested dysfunction in the area of leadership. Lack of clear-cut leadership in the family would mean lack of direction. This may lead to the feelings of insecurity and apprehensions about many things resulting into the anxiety disorders. It is also possible that anxiety disorder patients lack self-confidence and feel overstressed and hence become unable to take a lead or command.
Surprisingly, communication dysfunction was lower in the asthmatics and anxiety disorder group than in the normal group. It could be that in Indian families, the sick persons are paid a lot of attention and family members try to interact with them and ask them about their problems. Since everyone in the family shows concern about the sick person, communication would also be more because family members do not want the sick person to feel lonely.

Gender differences showed that males perceived lower dysfunction in family patterns of reinforcement, social support, and communication. It could be due to the higher sensitivity of females compared to the males as discussed earlier.

The younger age group reported more dysfunction in the areas of communication, cohesiveness and leadership. The problems of communication and family cohesiveness are typical when there are young members in the family. The clashes between generations are quite common and leadership is not very effective and stable. Even parental harmony is also sometimes at stake. The family members lack proper direction and there is hardly cohesiveness in the family.

The interaction of disease and age showed that all this was mainly true about the younger disease group than the normal group. So it is clear that the young asthmatics and anxiety disorder patients perceive more family dysfunction than the normals.
From the above discussion one can infer that family interactions play an important role in the development of an individual. These interactions and interpersonal relationships are between parent and parent, between parent and child, between siblings and any other relative or person living in the household. The healthy functioning of interaction patterns enhances mental health of the individual. On the other hand, dysfunction or poor interaction patterns such as lack of social support in the family, undefined roles and inadequate reinforcement, lack of communication skills and presence of weak leader and poor leadership qualities may predispose the individual towards poor mental health or psychological and physical problems. Thus, healthy interpersonal relationships amongst the family members are important factors for maintaining the equilibrium of the family. Strong family ties encourage self-reliance, confidence, and healthy attitudes towards life which would make an individual less vulnerable to psychological problems.

DAILY HASSLES

As compared to normals, asthmatics and anxiety disorders group revealed significantly higher mean on daily hassles in terms of disturbed psychological functioning, independent of person’s psychological functioning and also on total score of daily hassles (Table III-B). The hypothesis (Ho.-3) that anxiety disorder patients
and asthmatics will experience more daily hassles as compared to their normal counterparts finds support in the present results. One plausible reason why anxiety disorder patients experienced more hassles could be due to their heightened sensitivity to negative stimuli that may influence their behaviour, cognitions, and mood, especially negative moods such as anxiety and depression, (Tellegen, 1985; Clark, et al., 1994). It has been opined by some researchers that anxiety disorder patients also make negative evaluations of self, others and their experience, and hence experience more stress. Such patients usually show a chronic negative affect and a tendency to report physical symptoms in the absence of actual illness (Smith, et al., 1989; Gallaghar, 1990; Clark, et al., 1994). Anxiety disorder patients also manifest psychological symptoms which have direct effect on mental and physical health (Sutherland & Cooper, 1990). Researchers have also revealed that high negative affectivity individuals are more likely to hold negative views of themselves, others, and events and to experience feelings such as tension, anger, guilt, sadness and sense of rejection than low negative affectivity individuals. Watson & Clark (1984), characterized high negative affectivity individuals as experiencing negative affect even when provoking events are absent, suggesting that negative affectivity is a prevailing state.
Individuals with high negative affectivity report more stress in their daily lives than low negative affectivity’s (Watson, 1988). Various researchers (Watson & Pennebaker, 1989; Bolger & Schilling, 1991; Marco & Suls, 1993) are also of the view that individuals scoring high on negative affectivity report more frequent daily stressors and also rate events as more severe, even in the absence of events. Negative affectivity is associated with more negative mood states, hence more daily hassles perceived by the individuals.

Gunthert, et al. (1999), also tried to explain the negative affectivity with the help of his own model in terms of the negative interpretation bias. According to this bias, anxiety disorder patients misinterpret neutral encounter as negative encounters. This bias also results in an accurate labelling of an encounter, or it might actually create a negative encounter at that time. These individuals have negative recall bias with respect to interpersonal stressors (Marco & Suls, 1993). It has further been reported that memories of negative interpersonal events are more accessible to anxiety disorder patients. Negative self evaluation bias could be the reason for experiencing more stress in the daily life.

Diary studies have also differentiated between positive and negative affective states and the results have indicated that stressful or undesirable daily events lead to increase in negative
affect (N.A.), but these events have negligible or only modest effect on positive affect of the individual. These studies have also shown that mood states are more negative on days with many or severe stressful events (Stone & Neal, 1984; Delongis, et al., 1988; Repetti, 1993; Affleck, et al., 1994; Smith & Chirstensen, 1996; David, et al., 1997). Diary studies have also found that the impact of events depends on the context in which they occur. Certain types of stressful or undesirable events which appear to be more likely than others to provoke negative mood states include interpersonal conflicts, events occurring in the domains of work or family and friends, and health problems (Bolger, et al., 1989; Repelti, 1993; David, et al., 1997).

From the above discussion, it is evident that anxiety disorder patients experience more daily hassles because of their heightened sensitivity to negative stimuli, and their negative evaluations of self, others, and their experiences. The anxiety patients are generally caught in a web of negative behaviour, cognitions, and moods. They are found to experience more interpersonal stressors, and their perceptions of daily events are more negative. Due to their negative affectivity they react emotionally. The emotional reactivity is also a part of the negative affectivity. Bolger & Schilling (1991) tried to explain the emotional reactivity in relation to neuroticism. They investigated the mechanism through
which anxiousness leads to distress in daily life. It may lead to distress through exposing people to greater number of stressful events, through increasing their reactivity to those events or through a mechanism unrelated to environmental events.

Bolger & Zuckerman (1995), found that individuals who were high on neuroticism reacted to interpersonal stress with more anger and depression than did those who were low on neuroticism. Suls, et al. (1998) also found that neuroticism is related to emotional reactivity in response to both interpersonal and non-interpersonal problems and undesirable family and friend stressors, undesirable leisure and financial stressors (David, et al., 1997).

In their differential choice effectiveness model, Bolger & Zuckerman (1995), proposed that emotional reactivity can be explained by differences in both coping choice and coping effectiveness. Coping choice refers to the coping mechanisms that individuals use in response to stress. Coping effectiveness concerns the degree to which the coping strategies are effective in reducing stress. Anxiety disorder patients are more emotionally reactive and they choose less adaptive coping strategies. As they tend to cope poorly and they base their appraisal on previous, unsuccessful coping experiences, they make lower evaluations of the ability to cope with current stressors (Gallagher, 1990; Gunthert, 1999). Such individuals use more hostile reactions, self
blame, distancing, withdrawal and less planful problem solving to cope with daily hassles (Bolger, 1990; O'Brien, et al., 1996). Ineffective coping strategies could be the reason as to why anxiety disorder patients experience more daily hassles.

Lu (1994) is of the view that anxiety as a personality trait actually aggravates the impact of daily life stress. Findings of his study prove that anxious individuals are unable to cope with precipitating daily life events. Further, personal factors such as coping repertoire and coping effectiveness determine whether life events will transform into or create further minor daily hassles.

The results further revealed that apart from anxiety disorder patients, the asthmatics are also higher on experiencing daily hassles than normals. Some previous researchers too have indicated some relationship between daily hassles and strains with a number of physical complaints and psychological as well as psychosomatic problems.

Delongis, et al. (1988), examined the somatic and psychological effects of common everyday hassles on 75 married couples across 20 assessments. Overall, there was a significant relationship between daily stress and the occurrence of both concurrent and subsequent health problems. Lepore, et al. (1991) found that chronic strains were associated with greater level of psychosomatic symptomatology as well as low perceived social
support. David, et al. (1996) examined the lagged relationship between daily events and somatic complaints. Forty eight students completed the assessment of daily experience questionnaire and the somatic symptoms subscale of the General Health Questionnaire for five days. They found that undesirable events were correlated with somatic symptoms three to four days later.

On the contrary, research on daily events and upper respiratory infection has tended to find the absence of desirable events to be more consistently predictive of reported symptomatology than the presence of undesirable ones (Stone, et al., 1987). Asthma patients also report that intense emotional states accompany acute attacks of labored breathing. Due to their intense emotional state it was recognized that psychological variables contribute to asthma.

Previous researches have also shown that asthma symptoms are aggravated by psychological problem (Dohrenwend, et al., 1984; Swearinger & Cohen, 1985). The psychological mechanism involved is not very clear. One possibility is that the breathing obstruction that is characteristic of asthma may be produced by stress induced activity of the autonomic nervous system, which stimulates mucus secretion, increased blood flow and constriction of the bronchial tubes. Situation variables and personal vulnerability appear to combine in producing symptoms.
of asthma. In some people who have inherited a tendency for hyperactive airways, stress and emotional factors may precipitate asthma attacks or make them more severe (Teiramaa, 1981; Levitan, 1985). One’s anxieties and preoccupations, as well as one’s rewarding social ties, probably interact with biological variables (e.g., heredity) and environmental occurrences influencing how we cope while healthy and how one recovers from illness. Daily hassles influence our mood, our personality and experiencing of stress level. Like asthmatics, anxiety disorder patient also experienced more hassles because they use ineffective coping skills and they perceive events in a negative way. Such patients are more reactive to negative stimuli and experience more stress (O’Brien & Delongis, 1996).

COPING STRATEGIES

It was hypothesized that, “the patients of anxiety disorder and asthmatics will be higher on negative and avoidance approach and normals will adopt more active cognitive and positive approach as their coping strategies”.

When faced with a stressful situation, normals reported the higher use of a problem-solving approach (active cognitive approach) than the asthmatic group and the anxiety group. Out of the two disease groups, asthmatics used the active-cognitive approach lesser than the anxiety disorder group. The two disease
groups used more of avoidance-negative approach. There were no differences in the religious and social support, and avoidance positive approaches in the three groups. The anxiety group also used more of positive and negative approach. The more frequent use of problem-solving strategies by normals is in agreement with the findings of Folkman & Lazarus (1980) who reported that problem-focussed and emotion focussed coping were used in virtually every stressful encounter. Active cognitive and behavioural coping methods were more often reported by normals, while anxiety patients reported more avoidance coping behaviour. Similar results have been reported by Billing & Moos (1981) and Lazarus (1966). A large number of normals reported the use of help-seeking behaviours, while anxiety patients reported keeping feelings to themselves. Normals thus make greater use of their social networks for coping assistance (Rao, et al., 1989).

Normals indicated the use of a positive approach to stress, while neurotics reported making negative comparisons. An ability to retain an optimistic outlook even when faced with stress may serve as a resistance (Lazarus, 1966; Menaghan, 1982).

In stressful situations, an individual attempts to evaluate the problem, to appraise and implement possible course of action, and to regulate his or her emotional response. The individuals who are high in neuroticism use less problem-focussed strategies and rely
more on emotional and wishful thinking. They tend to rely on emotion-focused forms of coping particularly the ones that involve escape-avoidance and self-blame (Avoidance negative and positive approach). They are also prone to endorse coping responses that indicate hostile reactions, passivity, and indecisiveness (Parkes, 1986; Endler & Parkes, 1990; Bolger, 1990; Hooker, et al., 1994; Terry, 1994).

According to Magnus, et al. (1993) anxiety patients adopt more of confrontive coping strategies in response to conflicts. These ineffective coping strategies, i.e., confrontive (less planful coping, less of active cognitive component) coping with conflicts spawn or continue the conflicts, as they continuously feel more distressed than normals. They make poor coping choices in dealing with stress. Due to their heightened negative affectivity, they react in a hostile way. Finally, it could be that they engage in less anticipatory and preventive coping than other people, which results in greater exposure to stressors, including conflicts.

Bolger & Zuckerman (1995) reported that individuals who are high on neuroticism reacted to interpersonal stress with more anger and depression than did low neuroticism individuals. They found that a high level of neuroticism was associated with the use of more planful problem solving, self-controlling coping, social support seeking and escape avoidance. In contrast, with a
community sample of adult men, David & Suls (1999), found that neuroticism was associated with use of catharsis and relaxation to cope with daily stressors.

Behavioural avoidance is a prominent feature of the anxiety disorder, with avoidance generally being viewed as part of the disorder itself, rather than as coping strategy. However, for many anxiety sufferers, behavioural avoidance may initially be used as a strategy for coping with anxiety. Davey, et al. (1995) reported that phobia sufferers are more likely to use avoidance as a general coping strategy than are non-clinical samples. Cognitive avoidance (e.g., an agoraphobia sufferer imagining that he/she is in a safe place while undertaking an anxiety provoking task) has, in fact, been shown to be a common feature of many phobics (Watts, Trezise & Sharrock, 1986), and it has been implicated in the maintenance of phobic symptoms.

O'Brien, et al. (1996) and Gunthert, et al. (1999) found that anxiety disorder patients make poor choices regarding how to handle stress. These individuals use more hostile reactions, self blame, distancing, withdrawal and less planful problem solving to cope with stress. Basically these patients adopt less adaptive coping strategies to combat the stress and hence feel more distressed.

Anxiety disorder patients also had larger coping repertoire in
comparison to normals and asthmatics. However, their coping repertoire included strategies of positive approach, negative approach, and avoidance negative approach. A larger coping repertoire indicates a broader range and variety of coping behaviour at the individual’s disposal (Pearlin & Schooler, 1978). Previous researches show that a larger coping repertoire of the individual indicates that such a person may be more flexible in his use of coping responses. Coping behaviours in themselves may not be ‘good’ or ‘bad’, but the situation in which they are used may make them ineffective (Wheaton, 1983). The patients of anxiety disorders adopt more of these strategies when they face stressful situations. On the other hand, normals though have smaller coping repertoire yet they may feel less hassled because they use more of adaptive and problem-focussed strategies (Rao, et al., 1989).

The present findings further indicate that asthmatics are less flexible in their coping methods as compared to anxiety disorders group. Small size of coping repertoire indicates that coping strategies/behaviours are less flexible at the individual’s stake. Such individuals adopt very selective coping behaviours. Asthmatics are also less flexible in adopting their coping behaviours. It was found that asthmatics adopt more of negative and avoidance negative approach and less of active cognitive approach. The above results are in line with those of
Vingerhoets (1985) who found that males who adopt emotion focussed coping report high level of psychosomatic complaints than those who adopt problem focussed coping. Such studies imply that it is very important to directly solve the problem than to avoid it.

Sokhey, et al. (1994) also found that the asthmatics differ from normals on the way they cope with stress, i.e., they use less of problem-solving approach and have less ability to retain an optimistic outlook towards life, when faced with stress, which serves as a resistance. They also differ from normals, on the way they avoid stress, i.e., they get away less from things for a while or take a vacation to avoid stress.

Farr (1999) found that patients with asthma cope with their disease in ways that are deleterious to them. The coping styles used by these patients often were used by them before the onset of the asthma, but the asthma amplifies those styles, and the coping styles can amplify the asthma. They reflect denial, anger, bargaining and depression as their coping styles (avoidance coping strategies). Some studies in literature are based on psychological defenses used by asthmatics as their coping strategies. Dirks, et al. (1980) have defined three types of coping styles in asthmatics. They are an appropriate adaptive response to asthma management, the use of hopeless dependency on physician and
hospital services, and inappropriate excessive independence. The third defensive style, which is related to patient's high use of denial of his/her illness, and of the need for compliance with medication, has been noted to lead to excessive hospitalization rates.

Denial is a normal coping mechanism in response to adversity and is usually adaptive. Increased levels of denial are likely to be helpful in allowing patients to cope with chronic illnesses, yet retain a normal social facade; and in our culture where abnormal physical appearance or function is heavily stigmatized, an increased amount of denial is probably essential to allow patients with asthma to cope and feel relatively normal. Denial is also increased in situations of constant loss, and clearly asthma is associated with loss particularly in health and self-esteem and is also commonly used as a defense against fear, anxiety and depression.

The results further revealed that males have smaller size of coping repertoire in comparison to females. Males adopt less of positive approach, negative approach, avoidance positive approach, and avoidance negative approach in comparison to females. On religious and social support, males and females did not differ from each other. Gender differences play a vital role in coping strategies. Both men and women rated problem-focussed coping
responses as more generally effective than seeking social support, and the latter as more effective than emotion-focussed coping responses. Previous researches have also compared the coping responses of men and women. Pearlin & Schooler (1978), in a study of effectiveness of various coping responses for reducing stress coming from strains in parental, marital and occupational roles by sex, found that the single coping devices men used were often externally directed and were the most effective for reducing stress. Tanck & Robbins (1979) examined the coping responses of college students to academic pressure and found that men were more likely than women to seek sexual gratification and use marijuana, whereas females ruminated, ate constantly, and became dysfunctional or irritable. Overall, however, the most common coping responses for both sexes was similar: analyzing the source of stress, taking direct action and seeking company. Carver, et al. (1989) also lend support to the Tanck & Robbin's (1979) results.

On the contrary, Folkman & Lazarus (1980) showed that males and females did not significantly differ in their use of emotion-focussed and problem-focussed coping behaviour. On the whole, these findings, albeit mixed, suggest that men and women may use coping strategies consistent with instrumentality and
expressiveness respectively.

There is also evidence that women tend to react to problematic situations via emotional expressiveness and that men more often act on their environment instrumentally through constructive or destructive means (Gutman, 1965; Erikson, 1968; Witkin, 1974). Billing & Moos (1981) also found that men reportedly used avoidance and emotion-focussed coping less frequently than did women. Several other studies have also revealed that men use more problem-focussed coping strategies than women (Folkman & Lazarus, 1980; Viney & Westbrook, 1982; Stone & Neale, 1984; Brem & Johnson, 1989).

Vingerhoets, et al. (1990) also found that males preferred problem-focussed coping, planned and rational actions, positive thinking, personal growth and humour, day dreaming and fantasies, women preferred emotion-focussed coping, self blame, expression of emotions/seeking social support, and wishful thinking/emotionality.

Ptacek, et al. (1992) studied gender differences in seven coping strategies in terms of frequency of use, extent of use, relative use, and the frequency with which each method was used first in the coping sequence. The results revealed that men preferred more problem-focussed coping and women preferred more use of emotion-focussed coping and seeking support from
others. Both men and women rated problem-focussed coping responses as more generally effective than seeking social support, and the latter as more generally effective than emotion-focussed strategies.

The current results are in line with these studies. Men used less of avoidance strategies as compared to women. The two hypotheses, the socialization hypothesis and structural hypothesis, have guided most of the gender related research. The socialization hypothesis holds that men and women are socialized to deal with stressful events in different ways. According to this hypothesis, specifically, it is suggested that because of widely held sex role stereotypes and gender role expectations, men socialized to a greater extent to deal instrumentally with stress, whereas women tend to be socialized to express emotion, to employ emotion-focussed coping methods, and to seek the support of others (Pearlin & Schooler, 1978; Mainiero, 1986; Rosario, Shinn, Morch & Huckbel, 1988). Stokes & Wilson (1984) also suggested that men and women are socialized in ways that encourage problem focussed coping in men.

The second hypothesis about gender differences focuses on the structural aspects of the situation. Both Folkman & Lazarus (1980) and Billing & Moos (1981) stressed that gender differences in coping may be attributed to differences in the kinds
of stressful situations that men and women typically encounter. According to this view specific classes of situations demand particular methods of coping. Therefore, if men and women experience dissimilar types of events, then men and women should appear to cope differently. Several studies have indicated that women experience more stresses associated with health and family, whereas men report more stresses related to work and finances.

The present results further revealed that the normal males used lesser of religious and social support than the anxiety disorder group and the asthmatic group. Differences in anxiety disorder and asthmatic males were not significant. There were no differences in the females. From these results it is evident that normal males adopt less of religious and social support and more of active cognitive approach. One plausible reason may be that normals indicated the use of positive approach to stress, while anxiety disorders group reported making negative comparisons. An ability to retain an optimistic outlook even when faced with stress serves as a resistance (Lazarus, 1966; Menaghan, 1982). Moreover, anxiety disorder and asthmatic males try to get rid of their problems, so they are inclined more on religious and social support. Due to their weak mental and physical conditions they adopt less of direct and planful strategies. As Pinneaus (1976) in his cross-sectional studies found that social support reduces
psychological strain (e.g., anxiety, high blood pressure) as well as psychological stress, e.g., role ambiguity and provides a buffer against strain caused by psychological stress. On the other hand, female groups did not differ from each other. It may be because normal women also use the emotion focused strategies as much as those suffering from some disorder.

The findings further indicated that young females adopt less of negative avoidance approach compared with young males. Whereas, in case of middle aged group, middle aged males adopt less of this strategy than middle aged females. Previous studies are in agreement with present results on the younger sample. Males adopt negative avoidance approach to combat the stress. Tanck & Robbins (1979) found that men are more likely than women to seek sexual gratification and use of marijuana, on the other hand females ruminated, ate constantly and become dysfunctional or irritable. Carver, et al. (1989) found that men more often turned to drugs or alcohol as a means of coping method.

However in case of middle aged group, middle aged males adopt less negative avoidance approach than middle aged females. McCrae (1982) found that coping repertoire among older persons becomes more restricted and is characterized by passive and less flexible responses. Therefore, this could be the reason that middle aged males adopt less of avoidance negative approach than
females. Moreover, middle aged males adopt those strategies which provide them fruitful results. Wingard (1984), Rice, et al. (1984), & Strickland (1988), reported that women suffer more from psychological distress and minor somatic disorders, whereas, men seem to be especially vulnerable to life threatening disease such as myocardial infarction and cancer. These studies show that males generally adopt less avoidance strategies but they focus more on direct action in comparison to females.

The results further revealed that middle aged males use less coping strategies in comparison to middle aged females. There were no differences in the younger group. The plausible reason may be that with age, the individual understands the practicalities of life and he/she adopts more direct and planful actions. Previous studies in the literature have also shown that males generally adopt less coping strategies in comparison to females. Data reported by Astor Dubin & Hamman (1984) suggest that females employ both cognitive and interpersonal strategies in dealing with stressful conditions, whereas men mainly restrict themselves to cognitive strategies.

McCrae (1982) found that coping repertoire among older persons becomes more restricted and is characterized by less flexible responses. Therefore this could be the reason that middle aged males have smaller size of coping repertoire.
The results also indicated that middle aged group adopts more of active cognitive approach and religious and social support as compared to younger age group. The plausible reason could be that with age, the individuals become more experienced and wise. Instead of avoiding the situation, they try to solve the problem. Higher use of religious and social support coping by the middle aged could be because by that age, the individual’s social support network increases and one realizes the importance of sharing one’s sorrows, griefs and stresses with others. They don’t feel shy from showing their dependence on others. People also become more religious with age and start using religion as a way of coping to various stresses.

The findings further indicated that young normals adopt less of negative approach than anxiety disorders group as well as asthmatic group. On the other hand, the middle aged, asthmatics adopted less of negative approach as compared with anxiety disorders group and normals. As mentioned earlier the normals generally adopt more of active cognitive approach and positive approach to combat the stress (Menaghan, 1982). Normals appraise their difficult situations with more wide spectrum. They believe in seeking the help from others and make greater use of their social networks while confronting with stress whereas anxiety disorders group and asthmatic group keep feelings to themselves. Therefore,
they rely more on negative approach. This seems to be especially true about the younger group.

The middle aged anxiety disorders group as well as normals rely more on negative approach. The plausible reason may be due to age, patients try to avoid the things, because denial is a normal coping mechanism in response to adversity. Moreover, middle aged anxiety disorders group adopts more of religious and social support. Rao, et al. (1989) found that anxiety disorder patients report more of emotion-focussed and avoidance strategies. It is rather difficult to explain why asthmatics (middle aged) used this approach lesser.

The A × B × C interaction on active cognitive approach showed that in the young group, the differences in the disease groups were of the same nature as for the main effect of disease in both males and females, i.e., the normals were the highest, followed by the anxiety disorder group and then the asthmatics. In the middle aged group, comparisons between the disease groups in the males and females separately revealed that in case of the males asthmatics were significantly lower than the anxiety disorder group and the normals. On the other hand, in case of the females, none of the differences between the disease groups yielded significant results. It is clear from these findings that normal males (both young and middle aged) used more of active cognitive approach.
The point that males use more of problem solving approach and the females use more of emotion focussed approach has already been discussed earlier. This seems to be especially true in the middle age group.