THEORETICAL ORIENTATION
CHAPTER II
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FAMILIAL FACTORS (FAMILY TYPOLOGY, AND FAMILY INTERACTION PATTERNS), DAILY HASSLES, COPING STRATEGIES, ANXIETY DISORDERS AND ASTHMA

A)  FAMILY TYPOLOGY

In most of the societies about a century ago, the family was the most valued system in almost all spheres of life and human living. The members of a family, therefore, used to live in closely knit environment. Basham (1967) is of the view that the basic unit of Aryan society was the family, and this family was the joint one. In these types of families, there existed a deep sense of family solidarity which led to nepotism and various other abuses. It also provided a social security to its members particularly in times of distress. In addition, incompetent and non-contributory members of the family were also well accepted, protected and cared for.

Family plays an important role in the development of the personality of a person. It is the first institution which gives direction to the individual and moulds the basic pattern of his thinking, with regard to conduct, norms, and values of the society that exercise a durable and persisting influence upon him throughout his life. The sum total of all the family roles being
played within a given family represents its structure (Duvall, 1977).

It is the family which first provides an emotional setting, a climate of affection, an interpersonal network in which growing child can work towards self enhancement through the feeling of warmth, comfort, love and acceptance. Family teaches the child how to behave in certain situations which enables the child to grow out from home and meet the world face to face.

Family is culturally determined biological entity for social living. Family is a social reality conceived by culture for its biological growth. Biology is tamed through norms and values derived from culture, and for maturity of the biology of the family, family selects a frame of reference through its introduction to the social reality.

In the Indian context, the goal of life is the realization of self. For this purpose, family enables the man to perceive himself. Perceiving oneself is directly dependent upon the rituals inherited by his/her family from the culture. Depending upon the socio-economic position of the family, certain minor adjustments are made in these socially and culturally approved rituals. The degrees variation with regard to the performance of the rituals is reflected through the family’s self which is ascribed to and achieved by the family based on its social status in the ladder of social hierarchy.
This makes the Indian family a unique family system in the world. Indian family is a means for the ultimate truth, the realization of the self. Therefore, the Indian families in general have their own self (Bhatti, et al., 1986).

There are certain families which do not portray a very healthy family self. The members may be dependent upon each other, aloof from each other or too egoistic in their interactions with each other. Such families may represent a pathological family structure.

In order to understand the family pathology, the understanding of family self is very essential. Durkheim, (1956) classified families into four types.

I. Normal Cohesive Type

These families adhere to the institutional means to achieve the culturally prescribed goals. Such families would always follow the set patterns of behaviour based on the normative standards of the contemporary social system. In such families the members are held together by mutual attraction, belongingness and work for the common objectives of the family.

II. Egoistic Family Type

These families adhere to the standards of the family. They do not mind sacrificing anything to maintain the ‘family image’ and ‘social prestige’ of the family. They are so bound by the tradition
of the family, that they are oversensitive to any sort of threat to the ‘family image’ and attach prime importance to the ‘social prestige’ of the family. In these families, the family as a social system becomes excessively independent of and impervious to influences from the society.

### III. Altruistic Family Type

These families are characterized by extreme cohesiveness and too much of ‘we feeling’. The members have high mutual trust and firm interpersonal commitment. The atmosphere is saturated with regard and emotional warmth. The members of such families would not mind sacrificing anything and everything 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 transaction in these families to such an extent that they lead to pathological dependency in some members.

### IV. Anomic Family Type

In these families the individual members have their own way of life, style of interaction and personal convictions which are often idiosyncratic. They are highly individualistic and do not bother about the other members and are rarely influenced by them.

Apart from these, Fisher (1977), described families in
various stages of clustered existence. These family types are described below:

a) Constricted Family Type

These families are characterized by an excessive restriction of major aspects of emotional life such as expression of anger.

b) Internalized Family Type

Such families tend to view the world with fear, hostility and threat.

c) Object Focussed Families

These families are characterized by over emphasis on the children, the outside community or the self.

d) Impulsive Family Type

It is characterized by a troublesome adolescent who displaces his/her parental based anger on to the community.

e) Child like Family Type

These are often young families where the adults can never be thoroughly separated from their families of origin.

f) Chaotic Family Type

This is a somewhat rare group composed of poorly structured and decompensating families, where chronic psychotics and delinquency are often rampant.

On the basis of his clinical experience, Mahal (1975) has
described the following patterns seen in Indian families:-

**i) Leaderless Families**

Mostly poor families with no long term goals and motives concerned mainly with day to day living, elders providing poor leadership. Such families, because of lack of loyalty to each other, are liable to and are often exploited by others.

**ii) Split Families**

Where there are factions within the family because two or more persons are competing for leadership. Common goals are poorly pursued in such families.

**iii) Authoritarian Families**

Male authoritarian leadership is a very common pattern in India except in Kerala, where the matriarchal system is more prevalent. Family functions smoothly provide the leader, inspite of his authoritarian approach, he remains supportive and sensitive to the needs of the dependents but resentment and rebellion may result if the leader becomes selfish and insensitive.

**iv) Families with Democratic Leaders**

Leaders in such families remain sensitive, responsive and helpful towards the dependents and through the means of better communication, encourage group interaction and group participation and thus enhance group belongingness. Such families
are productive and enthusiastic, working cooperatively for common long term goals.

v) **Families in Transition**

Such families go through phases of confusion of values and dual orientation while changing from one pattern to another, e.g., from shared group family life to individualism.

vi) **Family in Crisis**

When a particular pattern is disrupted by different crisis like the sudden death of the leader particularly an authoritarian leader or entry of a new incompatible member into the family by marriage.

These types of families may also exhibit some pathologies which are given below:-

Pathogenic family is an overarching risk factor that increases an individual’s vulnerability to particular stressors. The pathogenic parent child patterns such as parental rejection, are rarely found in severe form, unless the total familial context is abnormal.

Roff & Knight (1981) in his longitudinal study of persons who became schizophrenic in early adulthood, found two types of mothering — neglectful and over protectiveness to be common among those individuals who had poor long term outcomes.

i) **Discordant Families**

In this type of families, one or both the parents are not
gaining satisfaction from the relationship. One spouse may express feelings of frustration and disillusionment in hostile way such as nagging, belittling, and doing things purposely to annoy the other person. Children who grow up in discordant families are likely to find it difficult to establish and maintain marital and other intimate relationships.

ii) Disturbed Families:-

In this type of families the one or both of the parents behave in grossly eccentric or abnormal ways and due to their behaviour, they keep the constant emotional turmoil in the family. The children who grow up in such families are caught up in an unwholesome and irrational psychological environment.

Lidz, et al. (1965) described two similar patterns in the family background of many schizophrenic patients and they called these patterns; (a) marital schism, in which both parents are constantly embroiled in deep seated conflicts; (b) marital skew, in which the healthier marital partner, in the interest of minimizing open disharmony, essentially accepts and supports the frequently bizarre beliefs and behaviour of his or her spouse.

i) Disrupted Families

A disrupted family is incomplete as a result of death, divorce, separation, or some other circumstances. Bloom, Asher & White, (1978) concluded that disruption in marriage is a major
source of psychopathology. Feelings of insecurity and rejection also aggravated by conflicting loyalties in children while staying with one of the parent.

**ii) Inadequate Families**

An inadequate family is characterized by inability to cope with the ordinary problems of family living. It also lacks the resources, physical, or psychological, for meeting demands with which most families can satisfactorily cope. The incompetencies of such a family stem from immaturity, lack of education, mental retardation or other shortcomings of the parents. These types of families which are floundering against odds for its resources, cannot give its children the feeling of safety and security, they need or adequately guide them in the development of essential competencies.

**iii) Antisocial Families**

Antisocial families espouse values not accepted by the wider community. In some families the parents are overtly or covertly engaged in behaviour that violates the standards and interests of society, and they may be chronically in difficulty with law. Children in such families may be encouraged in dishonesty, deceit, and other undesirable behaviour patterns.

Above mentioned family types described by different researchers depict one fact that family is a primary social unit.
When a family exhibits some kind of pathology, it definitely affects all the members. Stable 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 often stressed by unhealthy relationships, and interactions in the family. Such a family atmosphere makes the individual more vulnerable to develop physical/psychological problems.

The present investigator has chosen to study the family typology as given by Bhatti & Channabasavana (1985) on the basis of Durkheim (1956) in relation to psychopathology. This scale has 4 family types i.e., Normal Cohesive Type, Egoistic Type, Altruistic Family Type, and Anomic Family Type. According to this scale higher the total score, more the pathology, and lower the score less the pathology.

**FAMILY INTERACTION PATTERNS**

Family interaction patterns are defined as, “those various socio-psychological transactions occurring in the family as a system, to evolve processes for decision making, emotional expressions and personal views, assigning tasks and social status, enabling the family by generating morphogenesis at emotional,
intellectual and social levels through the manipulation of internal and external social milieu of the family as a whole” (Bhatti, Subakrishna, & Ageira, 1981). These interpersonal relationships are between parent and parent, between parent and child and any other relatives or person living in the household. These are mainly based upon emotions and feelings, many of them buried deeply beneath the surface of overt action and operating at the subconscious level. Most important is the spirit or atmosphere of family life where all members interact with each other on the basis of common expectation about appropriate behaviour both for themselves and for the other persons.

Interaction is the generic name for a whole set of processes taking place between individuals. The behaviour of one is the cause and effect of the behaviour of others. Interaction denotes the social behaviour involved when two or more persons interstimulate each other by any means of communication, and hence modify each other’s behaviour (Nye & Berardo, 1966). The family is conceived as a unit of interacting personalities (Schvaneveldt, 1966). As the family is a system of interdependent and reciprocal relationships, the behaviour of any family member affects all the other family members and consequently affects family equilibrium. Interpersonal relationships between family members are important factors for family dynamics. An interpersonal relationship is a
relationship based on personal interaction rather than on any legal or structural basis. The term refers to the system of the interaction between two or more persons. It refers to the persons acting and reacting to one another in a social situation and involves appearance, verbal communication, and overt gestures. The term family interaction refers to the peculiar or distinctive character of relationships which occur between members of the family. The peculiarity consists in the fact that family members interpret and define each other's actions instead of merely reacting to them. This is done through the use of the symbol system of communication. Non-symbolic interaction takes place when one responds directly to the action of another without interpreting that action.

Generally speaking, in daily life, members of the family engage in non-symbolic interaction as they respond spontaneously and without reflection, to each other's bodily movements, expressions and tone of voice. Symbolic interaction takes place when a response is made to a communication as well as to the meaning, the gestures have to the communicator and the receiver. If the gesture has the same meaning to the person to whom it is directed, the two parties understand each other. The meaning is not inherent in the phrase but arises in the process of interaction between the two persons. As a result, the same gesture will have different meanings according to the context, situation, and
circumstances surrounding the interaction (Eshleman, 1974).

According to evolutionary point of view (Channabasavanna, et al., 1982), every family has patterns of leadership, communication, role, reinforcement, cohesiveness, and social support system, which are defined as follows:-

**Leadership** — A family member engaged in decision making through consensus for the growth of the family as a system is the leader of the family.

**Communication** — A process through which the family members convey their feelings, emotions and personal view.

**Role** — Socio-culturally prescribed and ascribed tasks to be performed by different family members according to their age and sex.

**Reinforcement** — Processes adopted by the family to enable the members to imbibe socially approved behaviour.

**Cohesiveness** — Processes adopted by the family for a firm degree of mutual trust and interpersonal commitment.

**Social Support System** — Family support is defined as feeling that person is cared for and valued by other family members and that he or she can fall back on the family network in difficult times. In behavioural terms, family support refers to emotional, instrumental and financial assistance obtained from one’s family.
According to Bhatti, et al. (1985) interactional patterns are of following types:-

_Cordial Interaction Patterns_ — These patterns stand for mutual love and respect, cooperation among family members and general consensus on common objectives, leadership, role playing and methods of social control in family.

_Indifferent Interaction Patterns_ — These patterns depict a lack of cohesiveness, unconcerned, apathetic disinterest among family members and lack of general closeness on common objectives, leadership, role playing and methods of social control in family.

_Antagonistic Interactional Patterns_ — These patterns mean mutual resistance, active explicit opposition, hostility and conflict among family members on common objectives, leadership, role playing and methods of social control in family.

Within the family context, interpersonal relationships between family members are important factors making for development, equilibrium or frustration in family life. These are influenced by internal processes such as status relations, role playing, stress reactions, decision making, communication patterns and socialization.

On the other hand, sometimes faulty perception of interactions can lead to misunderstanding and conflicts, in the
family. When such misperceptions are not solved from time to time they can lead to deep rooted conflicts, hostility, feeling of revenge, aggression, and along with these feelings every gesture may be misinterpreted. So such families can at one time show pathological self which can effect both the physical and mental health of the family. This can lead to lots of stress. Due to this, pathological family self may emerge. Further, this pathogenic family structure leads the individuals to adopt the pathological ways of behaving.

The present investigator has chosen to study the family interaction patterns as given by Bhatti & Channabasavanna (1986) in relation to dysfunction in different areas of interaction patterns. This scale constitutes 6 areas of family interaction patterns, i.e., role, social support system, communication, cohesiveness, reinforcement, and leadership.

**Family Support and Therapeutic Role of Family**

Family support is defined as a feeling that a person is cared for and valued by other family members and that he or she can fall back on the family network in difficult times. In behavioural terms, family support refers to emotional, instrumental and financial assistance obtained from one’s own family. House & Khan (1985) distinguished emotional support from appraisal support (such as affirmation and feedback), informational support and instrumental support (such as money and effort). The factors which relate to
these types of family support are — family size, living arrangement, frequency of contact, closeness of relationship, sharing responsibilities, communication pattern and so on. It is only the family which provides a major source of support during stressful situations to the person. Family members provide physical and emotional support to facilitate the patient’s recovery. Family treatment and care are important predictors of successful coping with many diseases. Kleinman (1974), observed that more than 80% of all sickness are managed within the family and its extended network without resorting to professional help from outside.

The family plays more significant role in the cases, diseases such as rheumatic arthritis, asthma and diabetes. Interpersonal boundaries are often redefined in the face of chronic problems, strong interpersonal relations among the family members provide strong emotional support to the person and help them in managing their own lives, and strong emotional support helps them in adjusting to new realities of the life. Family relationships are essentially the most important source of support that a ill person can have.

Joint families provide a larger support base which acts as a buffer against the stress of disease or disability (Kakar, 1982; Sethi & Sharma, 1982). Nuclear type families have more health problems (Bharat, 1991). Social support (of which family is the
most important component), can directly improve health, as well as act as a buffer against the effects of stress (Caplan, 1974; Cassel, 1976). Support influences health by enhancing coping effectiveness; by changing the ways people under stress appraise their situation and respond in an effort to master or to adapt to the demands of the chronic illness (Gore, 1985). Emotional and social support thus protects people from the deleterious effects of prolonged distress. The family support provides an opportunity to the patient to ventilate his/her anxieties freely, to arrive at a shared understanding of the disease and to explore various alternative coping strategies. Lack of social support makes one susceptible to psychopathology. The characteristics of the recipient, provider, and the setting may determine whether social support provided is effective or not. For example, available family support will be beneficial only if people have social skills to mobilize help from those in their support network (Hirsh, 1981).

In general, it is the family which first provides an emotional setting, a climate of affection, an interpersonal network in which growing child can work towards self enhancement through the feeling of warmth, comfort, love and acceptance at home. Family teaches the child how to behave in certain situations which enables the child to grow out from home and meet the world face to face. The most significant aspect of the family environment is the
warmth relationship between parent and child. Warmth is most crucial and pervasive factor affecting child’s development. Parental rejection leads to the development of neuroticism in formative years of life. Development of anxiety has also been found closely associated with parental rejection. In the end we can say that social support from the family plays, a very important role and kind of family one has would determine, to a large extent, how much social support one gets.

DAILY HASSLES

Life without stressors and strains especially in the current century cannot be imagined. Main reasons being change in basic life styles, working conditions/patterns, etc. Everybody seems to be moving so fast in life, and working hard and thus barely having time for one’s own self. Today, it holds true for both men and women, the result is feeling much hassled and stressed because of daily routines of the life. Daily hassles are environmental stressors of stable, repetitive and chronic in nature. They include trouble of ordinary day to day life, which might be related to the domains of work, family and social environment. Conflicts among spouses (Pearlin, 1975) and dealing with children or parents (Levine & Scotch, 1970), etc. have been identified as some of the important sources of daily hassles. The nature of daily hassles varies from one group to the other, depending upon the individual’s resources

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and nature and composition of the proximal social environment. These hassles are found to be specially important in determining individual’s social functioning, health status, and morale (Lazarus & Cohen, 1977). Hassles are irritant things that annoy or bother us, they can make us upset or angry. These are smaller events that occur more frequently than do major events (Lewinsohn & Talkington, 1979; Stone & Neale, 1982; Lazarus & Delongis, 1983).

All daily hassles are not equally significant for all the individuals. The hassles which reflect ongoing themes or issues of particular concern in the person’s life should have more important impact on the psychological and physiological economy of the person, than other incidents like traffic jams or accidents of weather, result from vicissitudes of the moment. The former is named as “central hassles” and the latter “non central” or “peripheral hassles”.

Hassles which are high in centrality should be more important in predicting health outcomes for several reasons. First, because of the psychological salience of central hassles, they are likely to result in preoccupation that continues long after an encounter seems to be over, as in (Horowitz, 1976, 1982) concept of cyclical denial and intrusive thought following a traumatic event. Secondly, central hassles are more closely related to
important patterns of goals, beliefs and commitments. As a consequence, they will generate more distress. Thirdly, central hassles should recur more frequently than peripheral ones because individual’s stable beliefs system, coping ineptitudes or other personal agendas should propel them into similar kind of interpersonal and intrapsychic difficulties again and again. Brown & Harris (1978), found that the degree of depression experienced by women following a loss depends on meaning of that loss for the individual; life did not necessarily seem to result in greater stress reactions. Therefore, central hassles are the ones in which a person feels more concerned. This kind of hassles could reflect a troubling problem, perhaps a problem that is an ongoing theme in one’s life, such as an unresolved conflict, an unfulfilled need, or a personal inadequacy.

Peripheral hassles are those hassles which are not very central ones. They may happen as often and be just as aggravating, but they do not have to do with anything deeply important. That is why they don’t reflect issues that are central to us but have to do with matters, that are superficial.

Daily hassles may be related to various psychosocial variables. They can be viewed in relation to social support, locus of control, variation in mood and psychological well being. Social support is that which is perceived by a person from his family,
friends, and neighbours, etc., during his/her stressful time, which insists him to believe that he is cared for and loved by a network of mutual obligations. Social resources may be positively associated with physical and mental health (Moos & Mitchell, 1982), because they provide emotional support, tangible assistance and informational guidance.

Most people who experience psychological problems do not seek professional help. They tend, rather to use alternative resources, such as family members, friends, neighbours, employers, or community helpers (Veroff, Kulka & Douvan, 1981). The experience of stress, coupled with low level of social support has been found to be associated with psychological distress (Billing & Moos, 1981). Individuals who integrated into social system are likely to experience a more supportive milieu during life crises and consequently, are better able to cope with stressful events (Myers, Lindenthal & Pepper, 1975). Indeed, people with low levels of social support may be the ones who are most adversely affected by life change (Dean & Lin, 1977; Eaton, 1978).

Although, it may not be possible to avoid the ongoing stressors and strains of everyday life, it is possible for individuals to mobilize support from their social network in times of perceived need. Social support protects against the development of mental disorder only when the individual is exposed to stressors, like
negative life events. Dalgard (1986), conducted a study on the interaction between neighbourhood characteristics and social support with respect to mental health. In low quality neighbourhood, there were widespread economic problems, lack of social arenas and weak social support increased the rate of anxiety and depression. In high quality neighbourhood, weak social support has little effect upon mental health.

Thus, this might indicate that social support has no direct effect upon mental health but rather acts as a buffer, reducing the risk of mental disorder, when the individual is exposed to a stressful social environment.

Mood has also been found to be related to daily hassles. Common observation suggests that mood worsens as problems occur over the course of a day and people differ in their disposition for negative mood states depending upon their psychological well being (Watson & Clark, 1984). Several empirical reports indicate that the occurrence of minor daily problems is associated with lower psychological well being and (mild) physical symptoms (Rehm, 1978; Stone, 1981; Clark & Watson, 1988; Delongis, et al., 1988). Minor stressors produce physical or emotional threats because they create discrepancies between the demands of the situation and the resources of the
person, and thereby increase acute distress (Lazarus & Folkman, 1984).

Besides mood, individual differences also play a significant role in bearing the severe effects of daily hassles. The evidence suggests that people differ in their disposition to experience negative affect. Negative affectivity (NA), more commonly known as neuroticism, is a “mood dispositional dimension” characterized by low self concept and distressing feelings (Watson & Clark, 1984). High negative affectivity individuals are more likely than low negative affectivity to hold negative views of themselves, others, and events, and to experience feelings such as tension, anger, guilt, sadness, and sense of rejection. Watson & Clark characterized high NA individuals as experiencing negative affect even when provoking events are absent, suggesting that NA is a prevailing state. Individuals with high NA report more stress in their daily lives than low NA’s (Watson & Clark, 1988).

It has been reported that high NA’s were exposed to more daily stress, especially of an interpersonal nature, and that high NA’s were more distressed by these events than were low NA’s (Bolger & Schilling, 1991). They concluded that both exposure and reactivity to stressful situations by NA individuals may account for their chronic levels of distress.

It has also been found that besides the negative affectivity
(NA), there is also individual vulnerability, and it’s related with daily hassles, mood, and health status. For example, at the physiological level, there may be specificity in the immune system response to different kinds of stress or emotional experience occurring in different individuals. At the psychological level, variations in the way people cope with the problems that create hassles, or in their emotional response to those hassles, could influence the relationships. For example, some people may be more effective at problem solving than others, and some people may be more effective at regulating their distress than others, leading in such cases to low or negative relationships. Those ineffective in coping, in contrast, should show strongly positive relationships between stress levels and disturbed mood.

Some life events, hassles, networks and types of social support are consequences of personal disposition in general and psychopathology in particular, whereas others are independent of such characteristics. The central hassles play a unique role in the prediction of psychological symptoms. This involves physical and material resources, society’s rules and values and the subject’s habits and set ways of doing things. Problems related with needs, expectations, interpersonal skills and emotional control played a significant role in hassles.

There are several issues in relation to hassles. Firstly, the
thing or situation or individual which is central for one person is not necessarily central for another person. For example, those having to do with intimate social relations or those related to life goals such as achievement or social esteem would generally be seen by everyone as most central because of the importance of these issues in most people's lives. Secondly, central hassles play an important role because they seem to reflect, to a significant degree, problem with personal needs and expectations and/or deficits in coping skills. This fits the psychodynamics view that personal agendas, that people bring with them to a stressful encounter may help to contribute to the problem. Thirdly, to a considerable degree, central hassles produce more emotional distress and at the same time more positive feelings, when things worked out well than did non central hassles. This suggests that the stakes in central hassles (i.e., the possibility for harm, loss, mastery or gain) are greater than those in non-central hassles. Fourthly, the dimension of centrality played an important role in the prediction of psychological symptoms. For example, the individual who has vulnerable self esteem with respect to competence on the job, the hassles are likely to touch on central psychological theme and thus be extremely threatening and psychologically disruptive. For the individual whose self esteem is not so clearly interwoven with job performance, the same hassles
may be much less disturbing at the time or less likely to (distress) disturb afterwards.

Stress events play a significant role in psychological and social adaptation of the individual. The occurrence of events of a highly stressful nature has a negative effect on both social functioning and personality dynamics. Highly stressful situations result in more schizophrenic forms of response. Some psychologists are of the view that psychological vulnerability is also related to hassles and psychological symptoms. Vulnerability refers to factors that result in a greater risk of experiencing psychological stress itself (i.e., sense of harm, threat or challenge and their associated emotions), regardless of how it is coped with and whether or not it is associated with maladaptive outcomes.

Thus, in short one can emphasize that daily hassles are irritant things that annoy or bother us, they can make us upset or angry. All daily hassles are not significant for all the individuals. The hassles which are independent of our psychological functioning disturb us at the low level but on the other hand, the hassles which are dependent upon our psychological functioning disturb us more. When the stress of daily hassles becomes too severe, it makes the individual more vulnerable and can predispose him towards the psychological and physical symptoms. This concept has been used in the present study to assess if any
significant differences are there between anxiety disorders and asthma patients as compared to their normal counterparts. It would be worth while to probe and see how much patients of anxiety disorders and asthmatics experience hassles from their daily activities as compared to their normal controls.

COPING STRATEGIES

“Set in motion at one time or other the material of life has been constantly bent on reaching a plus from minus situation” (Adler, 1964).

From birth to death the individual is faced with a succession of problems or challenges, ranging from major crises such as serious injury or bereavement (Parkes, 1972; Shontz, 1975) to the routine hassles of everyday living (Glass & Singer, 1972; Kanner, et al., 1981). These experiences not only can result in emotional distress and other signs of disturbances, but may have long term cumulative effects on both physical and psychological health (Holmes & Masuda, 1974; House, 1974; Paykel, 1974; Brown & Harris, 1978).

However, each one of us has, over time, developed skills of mastery and adaptation in our dealing with the physical and social world (Murphy, 1962). With the appropriate attitude and adequate resources, one can maintain a degree of equilibrium in the face of adversity. The forms of behaviour which reflect this kind of
resistance to problematic situations are termed, “Coping”, they are the things that people do to avoid being harmed by life strains (Pearlin & Schoo, 1978).

Coping refers to any response to external life strains that serves to prevent, avoid or control emotional distress and is separable both from the life strains experienced by people and from the state of their inner emotional life. Hamburg & Adams (1967) defined coping as, “the seeking and utilizing of information”.

Lazarus, Averill, & Opton (1974) defined it as, “problem solving efforts made by an individual, when the demands he faces are highly relevant to his welfare and when these demands tax his adaptive resources”.

Freedman, Kaplan, & Sadock (1975) described coping as, “conscious and unconscious ways of dealing with stress without changing one’s goal”.

All these definitions imply that stressors are not passively received by the individual but that he actively engages in certain thoughts and behaviour to mitigate and avoid their impact.

According to Lazarus & Folkman (1984) coping is the person’s constantly changing cognitive and behavioural efforts to manage specific external/internal demands that are appraised as taxing or exceeding the person’s resources. This definition has
three key features — First, it is, “process oriented meaning that it focuses on what the person actually thinks and does in a specific stressful encounter; Second, coping as, “contextual”, that is, influenced by the person’s appraisal of the actual demands in the encounter and resources for managing them; Third, what constitutes good or bad coping. Hence, coping is simply defined as a person’s efforts to manage demands whether or not the efforts are successful.

Theoretical antecedents of coping can be traced back to psychoanalytical and ego psychology. Freud (1937), postulated the ego mechanisms of defence described as the habitual unconscious and sometimes pathological processes that are employed to resolve conflicts between an individual’s impulses and constraints of external reality. Most of the approaches to study and measure coping behaviour are based on three broad prospectives — (a) ego processes; (b) trait processes; (c) the special demands of specific situations.

The work of Menninger (1954), Haan (1969), & Valliant (1977) drew on a hierarchical approach to coping, derived from the developmental psychoanalytic formulation. Some defenses were said to be more healthy or less regressed than others presumably as a result of stress or trauma. Haan (1969), proposed a tripartite hierarchy with coping as the most healthy and
developmentally advanced process of adaptation, defense as a neurotic process, and ego failure as the most severely regressed and perhaps psychotic adaptive process. In terms of ego processes, Haan (1969) formulated tripartite model of ego functioning comprising ten generic ego processes, expressed in three modes — coping, defense, and fragmentation. Trait measures of coping have been comprehensively reviewed by Lazarus, Averill, & Opton (1974), and Moos (1974). They are dispositional or personality attributes that lead to specific responses (e.g., Repression-sensitization, Byrne, 1964). Trait measures taken alone, however, are poor predictors of coping behaviour as they assume that people are behaviourally consistent across situations.

Historically, coping has been viewed primarily as a response to emotion. Much of the research on the relationship between emotions and coping in humans has focussed on the ways in which emotion in the form of anxiety can interfere with cognitive functioning and hence coping (Spielberger, 1966, 1972; Krohne & Haux, 1982; Schwarger, 1984; Vander, Ploeg, Schwarger & Spielberger, 1984). Two mechanisms of interference have been emphasized, a motivational one in which attention is redirected from a task at hand to a more pressing emergency (Schonpflug, 1983), and a cognitive one in which anxiety related thoughts that are irrelevant to performance made functioning
difficult (Alpert & Haber, 1960). Coping mediates emotions in stressful encounters. For example, positive reappraisal is associated with a decrease in distress (disgust/anger) and an increase in positive feeling (pleasure/happiness and confidence) in the younger group and with a worsened emotional state (more worry, fear) in the older group. The subjects in younger group reported more encounters having to do with their jobs while, the subjects in older group reported more encounters having to do with health (Folkman, et al., 1987).

Four types of coping were strongly associated with change in emotion — planful-problem solving, positive reappraisal, confrontive coping and distancing. Planful-problem solving is an inherently adaptive form of coping and confrontive coping and distancing are inherently maladaptive. Thus, planful-problem solving can be maladaptive if people persist in it in circumstances where nothing can be done to alter the outcome (Collins, Baum & Singer, 1983), and confrontive coping can be adaptive when the situation calls for getting another person to act.

Therefore, efficacious coping is important as it reduces stressor’s effect. It is very important to use appropriate coping strategies to solve a particular problem and one cannot make generalizations of coping behaviour. Theoretically, a large coping repertoire means a broader range and variety of coping behaviour.
at the individual's disposal (Pearlin & Schooler, 1978) and suggests that such a person may be more flexible in his use of coping responses (Wheaton, 1983). Coping behaviours in themselves, may not be 'good' or 'bad' but the situation in which they are used may make them effective or ineffective. Keeping in mind, this view Horowitz (1979) developed coping themes.

i) **Rejection** — In this theme, the individual may take the form of relatively passive attitude. He displaced his aggression in the form of suspicion or hostility to people involved in the situation, even if they are not responsible for the course of events.

ii) **Control** — This theme is also known as cognitive or informational control. In this theme the individual imposes self control and thinks carefully to solve the problem. This theme merely comprises a desire for information to enable the accurate prediction of events.

iii) **Resignation** — In this theme the individual withdraws himself from previously valued goals and ambitions because he finds himself as relatively powerless in achieving goals.

iv) **Dependency** — The individual may lean completely on external resources, or may simply look to them with trust to bolster.

v) **Avoidance** — The individual sees himself as under threat, but
postpones, confrontation by avoiding situations or thoughts that would cause anxiety.

vi) Minimization — The individual sees himself as secure and the situation as non-threatening. As far as he is concerned, there is little or nothing to worry about and nothing that needs to be done.

To recapitulate, coping is behaviour directed towards the resolution or mitigation of a problem, with the aim of changing the situation or its perceived implications, or combating the negative emotion generated. This may be attempted by overt or covert means and with effective coping, stress can be avoided or eliminated.

Coping has two main functions — (a) the regulation of emotion, i.e., emotion-focused coping; (b) management of the problem that is causing the distress, i.e., problem-focused coping. Both these above mentioned functions are used in most stressful encounter and their relative proportion varies according to the severity of the encounter (Folkman & Lazarus, 1980).

Thus, the description of behaviour as coping implies both the existence of a real or imagined problem and a movement toward its solution or mitigation. It is a behaviour which has not only a stimulus but also a project which gives its direction. This type of behaviour is called coping strategies. Coping strategies may be
either consciously or unconsciously directed. A person may choose and plan the behaviour which seems to him appropriate, or may make the same kind of response without self-awareness and deliberation.

**Classification of Coping Strategies**

A number of investigators have been concerned with the classification of coping behaviour. Folkman & Lazarus (1980; 1985) differentiated problem-focussed from emotion-focussed coping. Problem-focussed coping is aimed at problem-solving or doing something to alter the source of stress. Emotion-focussed coping is aimed at reducing or managing the emotional distress that is associated with the situation. Problem-focussed coping tends to predominate when people feel that something constructive can be done, whereas emotion-focussed coping tends to predominate when people feel that stressor is something that must be endured.

Emotion-focussed responses involve denial, positive reinterpretation of events and seeking out social support. Problem-focussed coping involve several distinct activities: planning, taking direct action, seeking assistance, screening out other activities, and sometimes even forcing oneself to wait before acting. Active-coping is the process of taking active steps to try to remove or circumvent the stressor or to ameliorate its effects. Active-coping
includes initiating direct action, increasing one’s efforts and trying to execute a coping attempt in stepwise fashion. Planning is thinking about how to cope with a stressor. Planning involves coming up with action strategies, thinking about what steps to take and how best to handle the problem. The person may suppress involvement in competing activities or may suppress the processing of competing channels of information, in order to concentrate more fully on the challenge or threat at hand. Suppression of competing activities means putting other projects aside, trying to avoid becoming distracted by other events, even letting other things slide, if necessary, in order to deal with stressor.

Another strategy is restraint coping. Restraint coping is waiting until an appropriate opportunity to act presents itself, holding oneself back and not acting prematurely. This is an active coping strategy, in the sense that the person’s behaviour is focussed on dealing effectively with stressor, but it is also a passive strategy in the sense that using restraint means not acting.

Another coping strategy that can be considered as relevant to problem-focussed coping is the seeking of social support. Seeking social support for instrumental reasons is seeking advice, assistance or information. Seeking social support for emotional reason is getting more support, sympathy, or understanding. The tendency to seek out emotional social support is a double-edged
sword. That is, a person who is made insecure by a stressful transaction can be reassured by obtaining this sort of support. This strategy can thereby foster a return to problem-focussed coping. On the other hand, sources of sympathy sometimes are used more as outlets for the ventilation of one’s feelings.

Moos & Billing (1982), suggested three primary coping domains that can be identified in the literature of coping; (a) trying to modify or eliminate the source of stress; (b) problem-focussed coping, trying to modify or eliminate the source of stress; (c) emotion-focussed coping, managing emotions aroused by stressors and trying to maintain effective equilibrium.

Stone, et al. (1984), suggest grouping coping strategies in terms of several general themes, such as seeking social support, seeking information, situation redefinition, behavioural and cognitive avoidance, tension reduction and problem solving.

Danson Njogu Kibico (1993), in his study classified coping styles as negative (irrational) and positive (rational) ones on the basis of their likelihood of leading to other stressful situations (stressors), while the individual is striving to reduce stressful situations. Positive coping styles were those included in, “socializing factor”. The individuals using these strategies mainly in attempt to reduce stress are more likely to manage than those individuals who are using other strategies. Negative coping styles
were included in “Antisocial”, “Aggressive” and “Consummatory” factors. Those utilizing these coping strategies mainly in their struggle to alleviate stress are more likely to fail to reduce stress sufficiently. This may lead to overtaxing of the person’s adaptation energy resource, which is finite, exposing him to “stress decompensation”. Those using aggressive coping styles mainly are worse off, because active aggression is met with aggression. Even passive aggression may elicit aggression (passive or active). Those using consummatory coping styles mainly pose the danger of “addiction” and habit formation to drugs, alcohol and tobacco.

Andrew & Tenant (1978) defined coping responses including three main areas namely:-

i) cognitive coping abilities, which allow the person to neutralize the perception of stressors as problematic through subjective appraisal mechanisms and cognitive control strategies.

ii) Behavioural coping abilities which enable the individual to act directly to resolve the environmental stressors.

iii) Social support recruitment which provides the person with emotional support to buffer the impact of stressor.

I. COGNITIVE COPING

Cognitive coping includes the appraisal process and cognitive control strategies, both of which are responsible for
regulating emotional arousal in the face of stressors. Appraisal and cognitive control strategies involve the use of language (self talk) and both are temporarily and functionally distinct from one another. Cognitive control strategies occur after the appraisal process and are only used if the event or situation is appraised as threatening.

a) Cognitive Appraisal

Cognitive appraisal suggests that an individual’s cognitive appraisal of a socio-environmental stressor mediates the amount of stress generated by that event or situation. Lazarus, Averill & Opton (1970), showed that different cognitive appraisals used by subjects while viewing stressful films affected the level of stress induced by the films as measured by heart rate and self report.

b) Cognitive Control Strategies

The processes that people use to modulate their stress level by actively reinterpreting the meaning of the difficulty have been termed cognitive control strategies. “Denial” and “Sealing over” are two techniques widely used in cognitive control strategies. “Denial” is viewed as a conscious effort to remove from awareness certain fear arousing elements and characteristics of an event or situation to minimize emotional distress. “Sealing over” represents a cognitive control strategy similar to denial which some
individuals use to manage the acute stress of an episode of a major mental disorder.

II. Behavioural Coping

Behavioural coping entails the application of cognitively generated problem solving options in behavioural actions aimed at modifying, resolving or eliminating the source of stressful experience (Zubin & Spring, 1977; Pearlin & Schooler, 1978; Ilfeld, 1980). Behavioural coping can be viewed as a two step problem solving. First, perceptual and cognitive abilities are required for the receiving and subsequent processing of relevant interpersonal stimuli in order to generate and select alternatives. Spivack, Platt & Shure (1976), identified six cognitive abilities required for solving interpersonal difficulties — problem recognition, generating options, means-ends thinking, causal thinking, perspective taking and considering consequences. Second, social skills are required for the “sending” of appropriate messages during the implementation of solutions. Wallace (1982), has identified “sending skills” that are necessary for the implementation of goal-oriented problem solving (e.g., asking for a raise or renting an apartment) and for the resolution of interpersonal problems (e.g., expressing anger appropriately).

Social interaction also plays an essential role in resolving interpersonal stressors and attaining instrumental goals. Pearlin &
Schooler (1978), have found that remaining committed and involved in interpersonal relationships, when problems arise is a critical component of effective coping. Rectifying the changes and losses brought on by life events and resolving the sources of familial tension usually require the development of behavioural "plans of action" and the use of skilled social interactions to implement the cognitively generated solutions.

Behavioural coping deficiencies occurred during both stages of problem solving process. The processing of behavioural alternatives may be hampered by deficits in cognitive and information processing abilities and the implementation of solutions may also be impaired by specific “sending” skills deficits and other basic social skill deficits.

III. SOCIAL SUPPORT RECRUITMENT

Social support is a positive environmental factor that may serve as a buffer for stressful life events. Cobb (1976), defined it as, “information leading the subject to believe that he is cared for and loved, esteemed and a member of a network of mutual obligations”. Caplan (1981), defined social support as a form of cognitive guidance. Psychological stress may increase an individual’s vulnerability to mental and physical illness. This may be prevented if the individual receives social support in mastering the stressful situation in the form of cognitive guidance.
COPING RESOURCES/DIMENSIONS

Coping resources refer not to what people do, but to what is available to them in developing their coping repertoires. Coping resources are viewed as adaptive capacities that provide immunity against damage from stress (Baum & Singer, 1982). These authors consider a resource to be a social and psychological prophylaxis that can reduce the likelihood of stress induced disease.

There are three types of coping resources:-

i) Psychological resources,

ii) Social resources,

iii) Specific coping response resources.

I. PSYCHOLOGICAL RESOURCES

Psychological resources are the personality characteristics that people draw upon to help them withstand threats posed by events and objects in their environment. These resources, residing within the self, can be formidable barrier to the stressful consequences of social strain. The aspects of personality that represent potential psychological resources for coping are — Self esteem: refers to the positiveness of one’s attitude towards oneself; self denigration: refers to the extent to which one holds negative attitudes towards oneself; mastery: refers to the extent to which one regards one’s life chances as being under one’s own control in contrast to being fatalistically ruled; and others are denial, general
tendencies to move toward or away from people when problem or trouble arrived. General psychological resources are specific coping responses — the behaviours, cognitions and perceptions in which people engage when actually contending with their life problems. The psychological resources represent some of the things people are, independent of the particular roles they play. Coping responses represent some of the things that people do, their concrete efforts to deal with the life strains they encounter in their different roles.

II. Social Resources

Social resources are represented in the interpersonal network of which people are a part and which are a potential source of crucial support like family, friends, fellow-workers, neighbours, and voluntary associations.

III. Specific Coping Response Resources

Specific coping response resources have three main types of coping that are distinguished from one another by the nature of their functions. These are — (i) responses that change the situation out of which strainful experiences arise, (ii) responses that control the meaning of the strainful experience after it occurs but before the emergence of stress, and (iii) responses that function more for the control of stress itself after it has emerged.

From the above cited literature, it is concluded that coping is
a conscious or unconscious way of dealing with stress without changing one’s goal. There are many coping strategies which are used to deal with the stress: Problem-focussed strategies, emotion-focussed strategies, restraint coping, active and passive coping.

Out of all these coping strategies, the problem-focussed and emotion-focussed strategies are most effective and used widely in dealing with stress. Coping may not be good or bad, but the situation in which they are used make them effective or ineffective. Therefore, it is important to have flexible coping repertoire to cope with stress.

For the present study coping strategies have been used to assess how anxiety disorders patients and asthmatics differ in their coping behaviour as compared to their normal counterparts. The coping strategies which have been studied are active cognitive approach, positive approach, negative approach, religious and social support, avoidance positive approach, and avoidance negative approach.

ANXIETY DISORDERS

Over the recent years, because of modern life and advancement in technology, there has been a decrease in moral-cultural values. Religion, marriage, and the family hardly have any true bindings. Such life styles have given rise to increased number of maladaptive behaviour patterns. There are many anxious,
unhappy people who miss the realization of their potential because they cannot find adequate solutions or answers to problems that seem beyond them. The hassles of modern life are reflected in the massive amount of tranquilizing chemicals, excessive preoccupation with career success, etc., which have robbed many young people of their capacity for joy and spontaneity. The stressful nature of modern life, most of us seem to muddle through, leaves at least some psychological scars. Some of the more hardy among us seem to thrive on the multiple challenges our situation presents. For many of us, however, the test of our resources proves too great, and our attempts to cope become erratic and nonfunctional, perhaps even self damaging. This setback gives rise to mental disorders which in later stage, when become chronic in nature, involve physical aspects too. This stress can have undesirable effects on behaviour, thought and bodily functioning, because different people react to stressors in different ways.

The term neurosis was coined by an Englishman William Cullen (cf. Carson & Butcher, 1998) and first used in his system of Nosology, published in 1769, to refer to disordered sensations of the nervous system. After him, Freud postulated that neurosis stemmed from intrapsychic conflicts rather than disordered reactions in the nervous system. Freud held that neurosis is the outcome of an inner conflict involving an unbearable wish and
ego’s and super ego’s prohibitions against its expression. Anxiety, generalized feelings of fear and apprehension is central to this formulation. It is both a signal provided by the ego that a dangerous impulse has been activated and the motivational force behind the development of defenses. For Freud, neurosis consisted of an intrapsychic approach - avoidance conflicts, psychological in nature, acquired in the course of a developmental process, involving excessive impulse - generated anxiety and maladaptive efforts to cope with it. The symptoms traditionally ascribed to neurosis were thus the outward manifestations of the conflicts raging within. Overtime, Freud’s conception of neurosis tended to become its definition.

This disorder is functional in nature, there is no observable damage to nervous tissues. The symptoms manifested are consciously designed to protect the individual from further danger and the individual clings to his symptoms as long as they protect him against threats to his security. The sufferings associated with the neurotic symptoms are as real as those produced by symptoms of physical disorders. The symptoms are not developed voluntarily but their appearance is auto corrective, not at the will of the individual.

Diagnostic and Statistical Manual of Mental Disorders (DSM-III) intended to provide a comprehensive classification with
clear diagnostic criteria. But experience with DSM-III revealed a number of inconsistencies in the system and a number of instances in which the criteria were not entirely clear. Therefore, the American Psychiatric Association appointed a work group to revise DSM-III, and DSM-III-R was published in 1987. DSM-III represented major advances in the diagnosis of mental disorders and greatly facilitated empirical research. The development of DSM-IV has benefited from the substantial increase in the research on diagnosis that was generated in part by DSM-III and DSM-III-R. The DSM-IV has given a separate category of disorders under the heading of anxiety disorders.

As the term suggests, anxiety disorders are those in which unrealistic, irrational fear of disabling intensity is the principle manifestation. Anxiety is a pathological state characterized by a feeling of dread accompanied by somatic signs that indicate a hyperactive autonomic nervous system. The patients of anxiety disorders experience both physical and psychological problems such as trembling, backache, tension in muscles, and psychologically the patient has feeling of dread and is hypervigilant, finds difficulty in concentrating and also suffers from insomnia and upset stomach.

DSM-IV-R recognizes six basic types of anxiety disorders — Panic disorder and Agoraphobia; Generalized anxiety disorder;
Specific phobias; Social phobias; Obsessive compulsive disorder; Posttraumatic and acute stress disorder.

1) **Panic Disorders**

Panic attacks are severe anxiety attacks that occur unexpectedly and involve severe physical symptoms as well as very strong fears that often involve concern over dying, going crazy, or behaving in an uncontrolled way. Persons with panic disorder experience panic attack unexpectedly and therefore become very anxious as they worry that another attack may occur.

2) **Generalized Anxiety Disorders**

Anxiety is a vague, diffuse feeling that includes both worried thoughts and a combination of physical symptoms. A person with generalized anxiety disorder (GAD) experiences vague, but intense, feelings of fearfulness that persist over a long period, at least a month. The main symptoms are, motor tension, autonomic reactivity, apprehension about the future, and hypervigilance.

3) **Phobias**

Traditionally, a phobia is a persistent fear of some specific object or situation that presents no actual danger to the person or in which the danger is magnified out of all proportion to its actual seriousness. Phobias often develop gradually or begin with a generalized anxiety attack. Phobias are common disorders that affect women about twice as frequently as men. Phobias often
begin before adulthood and are likely to become chronic. Phobias are of many types like specific phobias, social phobias, agoraphobia, claustrophobia, etc.

iv) Obsessive Compulsive Disorders

People affected by an OCD (Obsessive Compulsive Disorder) are unable to control their pre-occupation with specific ideas or are unable to prevent themselves from repeatedly carrying out a particular act or series of acts that affect their ability to carry out normal activities. The inability to stop thinking about a particular idea or topic is called an ‘obsession’. The topic of these thoughts is often felt by the person involved to be unpleasant and shameful.

The need to perform certain behaviour over and over is called a ‘compulsion’. Many compulsions deal with counting, ordering, checking, touching, and washing. Compulsive rituals may become very elaborate and contain many activities. Like phobia, obsessive-compulsive disorder tends to begin before adulthood and is more common in women than in men.

v) Posttraumatic and Acute Stress Disorders

Anxiety produced by extraordinary major life stress events is relived in dreams and waking thoughts. The symptoms of reexperiencing avoidance and hyper arousal lasts more than one month. For the patients in whom symptoms have been present for less than one month, the appropriate diagnosis may be acute stress
disorder. There is excessive autonomic reaction with increased sympathetic tone along with increased norepinephrine metabolism. There is also decrease in Rapid Eye Movement (REM), latency and stage four sleep (similar to depression), and increased serotonin causes anxiety. Along with these factors, defense mechanisms are used to ward off anxiety, reaction formation, undoing and displacement produce obsessive-compulsive disorder and also breakdown of repression produces panic. Learning theory is also of the view that anxiety is produced by frustration or stress. Social learning theory quotes that this type of behaviour may be learned through identification and imitation of anxiety patterns in parents. Anxiety is also associated with some naturally frightening stimulus, e.g., accident, transferred to another stimulus through conditioning, producing phobia.

**ETIOLOGY OF ANXIETY DISORDERS**

In most cases, abnormal behaviour does not arise suddenly, out of the blue, in a person with faultless biological and psychological makeup, if any such person ever existed. There are certain patterns of factors that rendered the individual fragile or vulnerable in respect to the particular circumstances that surrounded the emergence of abnormality. There are several theoretical viewpoints concerning abnormal behaviour, each of which focuses on different origins or background events, that
contribute to maladaptive behaviour. These approaches are biological, psychosocial and sociocultural.

I. Biological Factors

Biological factors influence all aspects of our behaviour, including our intellectual capabilities, basic temperament, primary reaction tendencies, stress tolerance and adaptive resources. Thus, a wide range of biological conditions, such as faulty genes, diseases, endocrine imbalances, malnutrition, injuries and other conditions that interfere with normal development and functioning, are potential causes of abnormal behaviour (Cohen, 1974).

II. Sociocultural Factors

In our own society, anxiety disorders are found among all segments of the population. There are significant differences, however, in the incidence and types of patterns manifested by particular subgroups. In general, neurotic individuals from lower educational and socioeconomic levels show a higher incidence of conversion disorder, and also of aches, pains, and other somatic symptoms. Neurotic individuals from the middle and upper classes on the other hand are more prone to anxiety and obsessive-compulsive disorders. It is also found that people of underdeveloped countries are prone to conversion disorder, and people of technologically advanced societies are prone to anxiety and obsessive-compulsive disorders.
III. **Psycho-Social Factors**

Psychosocial factors are developmental influences that appear to handicap the person psychologically, making him or her less resourceful in struggle to cope. Psychosocial factors include anxiety defense, faulty learning, blocked personal growth and pathogenic interpersonal relations.

*i) Anxiety Defense*

Freud explained the neurotic disorder within the framework of anxiety-defense. According to this view, threats stemming from internal or external sources elicit intense anxiety. This anxiety, in turn, leads to the exaggerated use of various ego-defense mechanisms and to maladaptive behaviour. Aggressive impulses and sexual desires, blocked or inhibited by anxiety, lead to essentially defensive mechanisms and it ultimately results in maladaptive behaviour.

*ii) Faulty Learning*

Faulty learning is another important factor in the development and maintenance of anxiety disorders. Faulty learning is acquired in the acquisition of maladaptive approaches to stressful situations, as well as in the typical failure of the individual to learn the competencies and attitudes needed for coping with normal life problems. Individual who feels basically inadequate and insecure in a competitive and hostile world, making
the effort to become competent is especially vulnerable as he starts relying on defensive and avoidant life style which is less threatening. By doing this he adopts faulty patterns of coping which further leads to maladaptive behaviour (Ost & Hugdahle, 1981; Cook, Hodes & Lang, 1986).

**iii) Blocked Personal Growth**

Lack of meaning in life and blocked personal growth often appear to stem from a lack of needed competencies and resources. As a result, the individual’s main efforts are devoted to simply trying to meet basic needs, rather than to personal growth. According to the humanistic perspective, such a life style can ultimately bring feelings of anxiety, hostility, and futility feelings that may inspire neurotic behaviours.

**iv) Pathogenic Interpersonal Relationships**

Faulty interactions within the families and other early relationships set the stage for children to develop a neurotic life style in later life. Parents who overprotect or indulge their children prevent them from developing the independent, effective coping techniques required in their adult years. On the other hand, insecure parents instill their own excessive concern with ailments in their children which is a common background feature in somatoform disorder (Kellner, 1985). Much of what a person becomes in later life - attitudes, values, and often even particular
symptoms can be traced to interactions within the family during the formative years.

From the above discussion of causative factors it is clear that every factor plays a unique role in the development and maintenance of the maladaptive behaviours. These factors are interrelated in the causation of anxiety disorders. Apart from these, it is not necessary that every individual would develop anxiety based disorder under stress. Those individuals would be more prone to develop anxiety disorders, who are predisposed, because of their genetic or constitutional reasons. Apart from these, there are other factors that can precipitate the vulnerability/susceptibility of the individual towards anxiety based disorders. Faulty family interaction patterns, faulty learning methods, stress and inadequate coping resources for managing stressful situations also play a role in the causation of a mental illness.

Thus, it would be fruitful to probe and see how much role these factors play in increasing the vulnerability of the individual towards the development of such a disorder.

ASTHMA

Asthma is a respiratory disease. Asthma or reversible obstructive airways disease (ROAD) is defined as contraction of the bronchi, which results in breathing difficulties due to bronchial edema, secretions, and bronchoconstriction. In childhood, boys
tend to have the disorder two to three times more than girls (Weiner, 1985). Asthmatic patients of all ages reveal a multiplicity of causal factors, the three most important being:

i) Infections, particularly of the upper and lower respiratory tract.

ii) Allergic factors — In asthma the allergens commonly found are house dust, pollen and sometimes ingestants and injectants.

iii) Psychological factors — Emotional tension is the most important of the various psychological factors. It may be of any form - anxiety, indignation, resentment, humiliation, grief, joy, laughter, and even pleasurable anticipation of going out on a desired social occasion.

**Symptoms**

Many individuals with mild form of asthma never seek medical help, others have only occasional or seasonal wheezing as part of a mild allergy, and still others have life threatening problem. Symptoms may be triggered by a wide variety of stimuli, including cold air, allergens, infections (often upper respiratory tract viruses), irritants (dust, fumes), and emotions. Symptoms of wheezing may develop suddenly or slowly if the person becomes anxious and there is an increase in his or her respiratory rate due to fear of breathlessness or suffocation.
Emotional upset is one of the factors which may trigger an asthmatic attack in a susceptible individual. Although emotional factors are important in triggering asthma, they may be only the straw that breaks the camel’s back when other triggering factors are present. For example, if the person has an allergy or respiratory tract infection, an attack that otherwise would not occur may be triggered by a relatively minor emotional upset. Some patients may over react and try to learn “not to experience any emotions”. This may interfere with laughing, joking, sexual activity, and many other pleasant aspects of life, and a vicious cycle may be created. That is, the patient may develop strong emotional reactions to not being able to experience normal emotional responses and thereby, trigger more asthmatic symptoms (Plutchik, et al., 1978).

An infant or child with severe respiratory disease, whether asthma or cystic fibrosis, is likely to be perceived and treated differently by family, friends, and relatives. This may lead to significant alterations to the relationship between the mother and the child and adversely affect advancement throughout the early stages of intrapsychic development. This further leads to later susceptibility to the trauma of separation or other psychological impairments. Apart from these factors, personality traits have been found to influence the perception by patients of added resistive
loads in breathing. Those who are more dependent and anxious, whether or not they have asthma, tend to have greater thresholds both for inspiration and for expiration than do those who have more adaptive personality styles or who are rigidly independent (Hudgel, Cooperson & Kinsman, 1982).

Asthma may also develop in middle age or old age. It may disrupt the patient’s identity as primary wage earner, or when it occurs around the time of retirement, it can disrupt long standing plans, leading to acrimony in the family and sometimes contributing to depression in the person. Physical exertion may also trigger an attack and this may be particularly frustrating in today’s society.

Apart from these contributory factors, anxiety is also a common factor in respiratory illness. Anxiety is related to the sensation of dyspnea, fear of being placed on a respirator, and ultimately, a fear of death. Paradoxically, epinephrine and corticosteroids, the substances produced during states of anxiety or fear are also used to treat asthma. Yet, these states can induce an asthma attack. It is possible that some individuals respond to emotional stress with a parasympathetic response, involving increased release of acetycholine (Vingerhoets, 1985), or that some asthmatics do not increase production of epinephrine during stress (Mathe & Knapp, 1969).
Few respiratory patients due to low self esteem also may experience significant depression. This may range from an adjustment disorder with depressed mood to a severe and disabling major depression (Thompson & Thompson, 1984). Depression also has been found to suppress immune response, and thus it may cause more frequent upper respiratory infections (Reite, Harberk & Hoffman, 1981).

Apart from these factors, no definite personality type or set of psychological conflicts produces asthma. Most theories have related to asthmatic children, and few meaningful attempts have been made to draw parallels with psychodynamic issues in adults who develop asthma. The psychological profiles of asthmatics have ranged from shy, withdrawn, and overly compliant to hostile, angry, and rude. If one can reduce anxiety, the levels of asthma also reduce because asthmatics differ from time to time in their response to the same stress or mental techniques, including antogenic training and transcendental meditation, systematic desensitization and biofeedback may improve respiratory function in asthmatics.