Introduction:
Contains theoretical framework, rational of the study, review of updated and relevant researches. Objectives and hypotheses are required to be clearly listed.

Method:
Method section should include design of the study, sample description, assessment protocols, ethical considerations and procedure of data collection.

Results:
Present your results in logical sequence in the text, tables and illustrations (Figures). Do not repeat in the text all the data in the table or figures; emphasize on only important ones. Tables, Figures and illustrations must be placed on separate sheets after the references and prepared according to the APA's prescribed format. Each table must have a title, be numbered in sequence with Arabic numerals. Clear notes should be made by the author(s) at approximate point of insertion in the text.

Discussion:
Discuss major findings; emphasize new and important aspects of the study and implications and conclusion follow from them, Repetition of the material in Introduction section and Results be avoided.

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Role of Gratitude and Forgiveness in Spiritual Well-being of Teachers

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The present study was conducted to investigate the role of gratitude and forgiveness in the spiritual well-being of the lecturers in the region of Multan, Pakistan. Convenient sampling was used and the sample of 100 teachers, (60 males and 40 females) was drawn from the faculty members of Bahauddin Zakariya University in Pakistan. Gratitude Questionnaire comprising of six items (GQ-6; McCullough, 2004), Heartland Forgiveness scale (HFS; Thompson & Synder, 2003) and scale of Spirituality Index of well-being (SWBS; Daaleman & Frey, 2004) were administered to measure the relationship among gratitude, forgiveness and spiritual well-being. The findings indicated that gratitude and forgiveness are positively correlated with the spiritual well-being and the level of gratitude was greater in female lecturers. Gratitude and forgiveness are strongly associated with spiritual well-being of teachers.

Keywords: forgiveness, gratitude, spiritual well-being, lecturers

Gratitude is the nature of being grateful; status to show thankfulness for and to return consideration. It is a feeling communicating gratefulness, for what one has as opposed, to what one needs. In the Dictionary of Oxford English gratitude signifies "It is the condition or it can be considered a quality of thankful; appreciation to return toward kindness." Gratitude is a feeling of ponder, gratefulness and thankfulness, forever (Emmons, 2003). It is indicated by a number of researchers that gratitude is acknowledged as the parent of every

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single other virtues. Goodness is characterized, as a character that permits a man to think and to represent, advantage herself /himself and society (Chun, 2005; Shryack et al., 2010).

Moreover gratitude is an all-around regarded goodness in all the religions of the world, including Christianity, Judism and Islam. Christianity gives the message to Christians to be thankful for the wellspring of their lives. Also, people demonstrate their gratefulness in various setting. For instance, in United States, Thanksgiving Day is commended for indicating thankfulness. Judaism highlights the significance of saying thanks to God from old Israel. In Islam, in the Quran, the need of appreciation and gratefulness to Allah is stressed.

In the Quran Surah Al'Imran, Allah clearly stated Muslims that reward will be given to those that serve Him with gratitude.

Many researchers have given the concept that gratitude can be considered a state of emotion and it is directed to praise the other people's helpful actions (McCulloug & Larson, 2001). But this concept failed to describe the sources of gratitude which people report. Emmons and McCullough's (2003) did a study on gratitude and participants were instructed to maintain a list of daily events, for which they were grateful, participants consider it a source of gratitude (Emmons & McCullogh, 2003).

Forgiveness is a procedure (or the after effect of a procedure) that includes an adjustment, in feeling and disposition, with respect to a wrongdoer. Most of the researchers consider it as a purposeful and willful process. It is a matter of choice. The process of forgiving results in decreased motivation to maintain estrangement from an offender in spite of their actions, and the negative thoughts about the offender are also decreased.

Forgiveness is characterized as prevention of unforgiving emotions by encountering exceptional, positive, loving emotions while reviewing a transgression (Worthington, Berry, & Parrott, 2001). Forgiveness is not an easy and nuanced process including not just the demonstration of forgiveness or the sentiment of being excused, additionally thoughts about the conditions under which forgiveness can occur (Enright & Fitzgibbons, 2000). Forgiveness is a pro-social change which reduces the negative thoughts and events (and in some cases it is helpful in increasing of positives) like thoughts, motivation and emotions toward the offender that brings change in behaviors (Davis, Worthington, Hook, & Hill, 2013). Forgiveness is a virtue because it is

helpful in strengthening relationships and to maintain relationships (Dwiwardani et al., 2014).

Un-forgiveness consists of many negative outcomes and it results in very painful emotions like having a desire to seek revenge for a hurt, strong feeling of dislike, anger, hostility or extreme hatred towards an offender, and the desire to breakup from the offender (McCullough et al., 1998; Wade & Worthington, 2005).

Forgiveness is customarily an idea which is inserted in almost all the religion and all the significant religions talk about forgiveness. Ethicists and Scholars have discussed the theme of forgiveness and it has been conceptualized at a time as a value and as a weakness. Legislators and all the adorable personalities like Martin Luther King, Jr., and Nelson Mandela, all rehearsed forgiveness.

For some people, religious undertones go with the idea of mercy and compassion (McCullough & Worthington, 1999). Man significant world religious customs have since, quite a while ago, talked about forgiveness, including Islam, Hinduism, Budhism, Judaism, and Christianity (Rye et al., 2000). Many researches on psychological theme have inspected the part of religion and deep sense of being in interpersonal forgiveness. An assortment of research builds up that people with more religious inclincation give too much importance to forgiveness than the people with less spiritual inclination (Edwards et al., 2002).

Researchers have different conclusions in the matter of spiritual well-being. A school of thought accepts that there are no such differentiation among the spiritual well-being and religious practices, they agree that spiritual well-being includes a link with an unequivocally Christian God. While according to the other school of thought, divinity or higher power or the idea of God appears to have been completely extracted from comprehension of spiritual well-being, and it is characterized as an important or reason in life (Crisp, 2008).

Spiritual well-being is about wholeness, which includes the physical, enthusiastic, mental and profound measurement. This doesn't mean, however, that we should be well in each region to be spiritually well. For instance, somebody might be physically unwell yet, have a positive spiritual well-being which, helps them adapt to their physical challenges. A few researchers comment that, spiritual well-being can also be utilized to enhance the performance of organization (Ashmos & Duchon, 2000; Garcia-Zamor, 2003; Giacalone & Jurkiewicz, 2003a;

Fry, 2005); and spiritual well-being examination ought to show deep sense of being's connections with efficiency and benefit (Giacalone, Jurkiewicz & Fry, 2005).

Accorsing to literature, there exists a conceptual conflict in existing literature. People with high levels of well-being infer causes of their success to the circumstances which are short lived, uncontrollable, and are mostly due to the someone else's actions as well. This style of inferring causes results in depression, anxiety, and negative effect (Abramson, Alloy Whitehouse, & Hogan, 2006; Ralph & Mineka, 1998; Sanjuan, Perez, Rueda, & Ruiz, 2008). If the concept of gratitude is simply involved in interpersonal thankfulness, a person with high levels of gratitude may actually have deficits in well-being, because they attribute the causes of their success to the others' actions and do not take credit themselves (McCullough et al., 2002).

Gratitude is appeared to identify the origin of prosperity which emerges from the view point of humanistic counseling, it offer a substitute origination of human instinct and abnormality (Joseph &Wood, 2007). The concept to be genuine (Wood, Linley, Maltby, Baliousis, & Joseph, 2008) speaks to the Rogers concept of "Congruence", representing (1) not knowing oneself, estrangement from self, lacking in self-identity, conflicting beliefs, and not accurately described symbolization of experiences, (2) to accept the environmental influences, and (3) to behave in manners which are predictable with individual beliefs and values ("real living"); with genuine living being characteristic of genuineness, and self-distance. Wood et al. demonstrated that gratitude was strongly positively associated with real living and is inversely associated with self-alienation. The discoveries are fascinating in the presence of arguments that gratitude fills a developmental need. It is a peculiar social characteristics and it has the value of adaption to facilitate humans to cooperate with the people others than their families (McCullough & Hoyt, 2002) and to maintain reciprocal selflessness (Nowak & Roch, 2006; Trivers, 1971).

In the working environment setting, spiritual well-being has been characterized as our inner consciousness (Guillary, 2000). It is a feeling at workplace that motivates to do work (Dehler & Welsh, 1994), access to the holy force of life (Nash & Mclennan, 2001) and it is your exceptional inner strength for your personal growth (Delbecq, 1999).

Rationale of the Study

The aim behind this study is to discover the relationship of forgiveness, gratitude and spiritual well-being of the Muslim teachers in the area of Pakistan. Gratitude, forgiveness and spiritual well-being are essential in the conduct and the performance of the instructors. There are several researches conducted on forgiveness and gratitude with college, university students, and adolescents and on the population of managers concluding that gratitude, forgiveness and spiritual wellbeing are positively and strongly associated with each other (Kumari & Madnawat, 2016). All the past researches have been directed in western societies. But the teachers are ignored while without teachers there is no existence of any profession. This review will attempt to help in discovering this relationship in teachers of Pakistan in respect to gender differences also.

Objectives of the Study

- To investigate the co-relation of gratitude, forgiveness and spiritual well-being.
- To investigate the ratio of gratitude and forgiveness in males and females.

Hypotheses

- Gratitude and forgiveness are correlated to the spiritual wellbeing of teachers.
- There are significant gender differences in grateful and forgiveness.

Method

Research Design

Quantitative research strategy is used as a part of this review. Co-relational review is led and the sample was taken through non probability sampling procedure. In Non Probability sampling procedure, convenience sampling is used; because only those participant were selected who were convenient to respond.

Sample

The sample comprises of 100 members (N=100) 60 males, 40 females. The members were included into the study on their eagerness

to take an interest and were guaranteed that the data with respect to them would be classified.

Instruments

Gratitude Questionnaire six item scale (GQ-6). The Gratitude Questionnaire six item scale (GQ-6) is a short, comprehensive Questionnaire. It has six-item. It is a self-report questionnaire that judges the one's experience of gratitude. It is a 7 point Liker-style questionnaire with the ranges of (1 =strongly disagree and 7=strongly agree). The GQ-6 is linked positively to satisfaction of life, optimism, trust, spiritual well-being, forgiveness, sympathy and other's people helping behavior, and it is linked negatively to materialism, envy and anxiety. From the six, two items are reversed scored to inhibit reaction bias. The GQ-6 has reportedly great internal reliability and this questionnaire has alphas between .82 and .87 (Mccullogh, 2004).

Heartland Forgiveness Scale (HFS). The Heartland Forgiveness Scale (HFS) contains 18-item. It is a self-report scale. The purpose is to evaluate a man's forgiveness (e.g, one's usual style to forgive), instead of forgiveness of a specific occasion or individual. The HFS contains things that describe a man's tendency to forgive himself or herself, circumstances that are not in the control of person (e.g. Natural Disaster) and other people.It contains three sub scales. a) HFS forgiveness of other's subscales b) HFS Forgiveness of Self subscale c) Total of four scores are calculated for the HFS d) and HFS Forgiveness of Situations. One score is for the Total HFS and other three scores are for each of the three HFS subscales. The total Scores for the HFS can range from 18 to 126 while the range of scores for three others HFS subscales is from 6 to 42.

The factors of this questionnaire have Cronbach's Alpha changes in ranges from 0.76 to 0.83. The coefficient of the forgiving to others is 0.65 and forgiving in different situations is 0.52 (Akbari, Golparvar and Kamkar, 2008). In the recent research the Cronbach's Alpha was 0.85.

Spirituality Index of Well-being. Spiritual well-being is a feeling of significance or reason from an extraordinary source. It has 12-item. It measures one's view of their spiritual quality of life. The instrument is divided into two parts: (1) it measures the self-efficacy (2)

it measures the life-scheme. Each item is answered on a 5-point scale running from 1 (Strongly Agree) to 5 (Strongly Disagree). The Cranach's Alpha is greater than 0.85 and the questionnaire's repeatability result was 0.89 (Biglari, 2018). This questionnaire has also a good face validity. Its relationship with the other related measures like Crumbaugh test of Purpose for the life test (r=.68) and Allport's measure of the intrinsic religion is reported r=.79 (Schoenrade, 1995).

Procedure

The information is gathered through the survey method. The teachers were contacted in their duty time, in which both genders participated on their willingness. The study contains 3 set of questionnaires. Gratitude questionnaire 6 item scale, Heartland Forgiveness 18 items scale and Spiritual well-being (SWB) scale along with the consent form and demographic factors, which were available in the booklet given to the members. All the data about the study was given to the members and were ensured that their data will stay confidential. SPSS (Statistical Package of Social Sciences 21.00) is utilized for the examination of information gathered from the teachers.

Results

Table 1

Correlation of Gratitude and Forgiveness with spiritual well being (N=100)

Variables	GQ-6	HFS	SIWB
GQ-6	1	0.315**	0.721**
HFS	0.315**	1	0.683**
SIWB	0.721**	0.683**	1

Note. $^{**}p < 0.01$.

As the table above shows the correlation of Gratitude and Forgiveness with spiritual wellbeing is positive.

Table 2

Regression Analysis Showing Impact of forgiveness on gratitude (N=100)

Predictors	*B*	*S.E*	*Beta*	*t*	*p*
(Constant)	-1.427	.390		-3.605	.000
forgiveness	.369	.004	.961	70.557	.000

Note. R^2 = .926; Adjusted R^2 = .925; F = 139.336; *S.E* = Standard Error

Table 3
Differences in the scores of forgiveness and gratitude among males and females. (N =100)

Variables	Group	*N*	*M*	*SD*	t-statistic	p-value
GQ-6	Males	60	23.85	4.84	5.73	0.000
	Females	40	30.45	6.106		
HFC	Males	60	75.566	9.412	2.78	0.006
	Females	40	81.7	12.627		

Note. *M* = Mean; *SD* = Standard Deviation.

As the table above shows that the Gratitude in females is high and its mean gender difference is significant because p-value (0.000) is smaller than the level of significance (0.01), similarly, the ratio of forgiveness in females is not greater than males it mean HFC difference is not significant because p-value is greater than the level of significance (0.01).

Discussion

Gratitude and Forgiveness affect the Spiritual well-being of the teachers or some other utilize in the working scene. Gratitude means being grateful for everything and Forgiveness implies a version of unforgiving feelings by encountering serious, positive, cherishing feelings while reviewing a transgression.

The purpose behind this was to investigate the part of both Gratitude and Forgiveness on the spiritual well-being of teachers in Pakistan. The information was gathered through probability sampling in which everybody had an equivalent shot of being chosen for the study and the data given was guaranteed to be secret. The sample comprised of 100, both males and females took part in the study. It was directed to explore the connection amongst Gratitude and Forgiveness and to examine the proportion of Gratitude and forgiveness in both males and females.

The first hypothesis of the study was that Gratitude, Forgiveness and spiritual well being are correlated with each other. The results of the review support the hypothesis that Gratitude and Forgiveness are positively associated with spiritual well being. The previous studies done with the Turkish students also support the results of the present study (Uysal & Satici, 2014).

Gender differences in forgiveness may be normal for a few reasons. To begin with, gender difference might be an ancient rarity of methodological arbitrators. For instance in which way forgiveness is examined, not itself forgiveness might bring about the differences in male and female. The other thing is that innate predispositions might be a differentiating factor (McCullough, Rachal, Sandage, Worthington, Brown, & Hight, 1998). Thirdly attachment style can also influence the tendency to forgive (Bartholomew & Horowitz, 1991). Fourth, males might be more attracted to Kohlberg's (1984) justice based moral quality while females might be more attracted to warmth–based virtues, which are more in accordance with Gilligan's (1994) ethic of care. Religion may add to inclination to forgiveness as Freese (2004) shared that females are reported to be more religious than men (Freese, 2004). Our belief system and religion matters a lot. In our religion system it is taught to us to be thankful and to forgive others is admired. So forgiving and gratefulness are related to the spiritual well being of the teachers (Rye, 2005).

Furthermore, a meta-analysis regarding forgiveness and gender differences demonstrated that sympathy is a trait more prevalent in females than males. Potential methodological mediators such as focus of forgiveness, type of sample, and state, familial or trait forgiveness etc. were focused. No methodological factors directed the relationship amongst gender and forgiveness. Be that as it may, there were bigger gender differences on retribution than some other forgiveness–related measure. Other potential mediators were proposed as conceivably affecting the gender orientation distinction including, practical differences preparing forgiveness, differences in dispositional qualities, and situational signs (Freedman, Enright, &Knutson, 2005).

The second hypothesis of this study demonstrates that there are significant gender differences in males and females in the levels of forgiveness and gratitude. The results supported that female teachers are more thankful then males however; there is no difference between the levels of forgiveness between them. The previously mentioned study confirms this hypothesis.

Conclusion

The statistical analysis of the exploration confirms that there is a relationship between the two factors i.e. Gratitude and Forgiveness, which is positive. Gratitude and forgiveness are positively correlated

with the spiritual well being of the teachers. There are significant gender differences in gratitude. The females are more thankful then males but there are found no gender differences in forgiveness in males and females. It also expresses that the females are all the more lenient then males and there is no critical distinction in the levels of forgiveness in them.

Gratitude and forgiveness are basic for the spiritual well-being of each one, uncommonly, the teachers. Well-being is made out of being grateful for everything positive and to excuse each hateful thing done or said. This review demonstrates that being grateful and forgiving is essential for the prosperity of teachers.

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Quality of Life, Self Esteem, Coping, Rejection Sensitivity and Depression among Infertile Men and Women

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This study investigated quality of life, self-esteem, coping, rejection sensitivity and depression among infertile men and women of Lahore. Through purposive sampling data was collected from two private hospitals of Lahore from 120 infertile individuals, with female age ranging between 22-45 years (M=30.91; SD= 5.26) and male age ranging between 24-53 years (M_{age}=35.1; S. D=6.97). Correlation research design was used. Ferti Quality of Life Scale, Rosenberg Self Esteem Scale, Coping Inventory for Stressful Situations (CISS), The Adult Rejection Sensitivity Questionnaire (ARSQ), Beck Depression Inventory-II and Demographic Questionnaire were used for assessment. Results of Pearson Product Moment Corelation showed a significant positive relationship in quality of life, self-esteem,avoidance coping and problem focused coping among infertile individuals. A significant negative relation was found in the quality of life,depression and emotion focused coping. A significant correlation in the quality of life with depression, self-esteem and emotion focused coping and a non-significant correlation exist among individuals in the quality of life with rejection sensitivity, avoidance coping and problem focused coping was found. The regression analyses results predicted that depression, self-esteem and emotion focused coping to be strong predictors of quality of life in infertile individuals.

Keywords: infertility, depression, self-esteem, quality of life, rejection sensitivity, coping

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The present study examined the relationship of quality of life, self-esteem, coping, rejection sensitivity and depression among infertile male and female individuals from Lahore.

According to Fisher and Hammarberg (2017), infertility is the psychological and emotional changes experienced by a couple who gets diagnosis of infertility. Infertility has the potentiality of affecting couples who have certain feelings such as humiliation, mistrust, social withdrawal and anger (Datta, et al, 2016; Tulppala, 2002). Infertility has been perceived as a taboo and a sensitive topic to engage in. About 75% of the infertile couples feel that they are given appropriate support from the family or their close friends. Due to the nature of the topic of infertility, many couples keep the topic as secret even when attending clinics (Salzer, 1994). According to Marcia &Patrizio (2015) on his way of finding out infertility issues, claimed that approximately 186 million people are affected with infertility around the globe. On the other hand infertility ratio in Pakistan is 1:5 in married couples (Ali et al., 2011)

According to Cavdar and Coskun (2018) self-esteem indicates the extent to which an individual trust one's self for certain skills, worthiness and success. Drawing from this proposition, infertile individuals viewthemselves as dysfunctional, an attribute that may deteriorate their self-image and self-esteem (Miall, 1994).Tiitinen (2009) hypothesized that diagnosis of infertility also has psychological trigger which may lead to a sequence of deep emotional annoyance and insecurity accompanied by depression or anger. The mental trigger generates a feeling of hopelessness, guilt, depression, helplessness, defeat and mourning. Therefore, infertility leads to low self-esteem eventually leading to poor quality of life.

Dural et al. (2016) on the other hand define quality of life as a combination of love, happiness, joy, self-esteem and peace. Infertility impacts a person's quality of life and so does its management. In an effort to mitigate stress, infertile individuals use a number of coping mechanisms.

Various studies have focused on assessing the relationship between infertility and coping emotional distress. Coping mechanisms are imperative in averting distress related to infertility (Jahromi & Ramezanll, 2015) On the other hand, Stewart, Pasternak, Pereira and Rosenwaks (2019) noted that infertility is a unexpected event. Besides, men apply more separating and controlling approaches as compared to women. Jennifer, Marci, Silvina, James, and Lisa (2017) conducted a

study to examine the physiological and emotional concomitants of diagnosis of infertility in women. The study indicated that women who had primary infertility as a result of diminished ovary were more likely to experience depression and stress. They suggested that distress surrounding infertility has a significant association with the manner in which women responded to learning. From this viewpoint, coping strategies were seen to be associated significantly and positively with an individual's quality of life.

According to Carranza-Maman et al., (2015) individuals who are not aware of infertility related issues or did not seek any kind of help or are usually shy to ask their family or friends, is an attribute that leads to lower social support. Due to lack of awareness, individuals in a community may make senseless comments about their childlessness. This high level of distress increases even more when an individual feels lonely or feels there is low social support that culminates to a poor relationship with the infertile individual. Pasch and Sullivan (2017) argued that women from an infertile family attempt to absorb a significant proportion of husband's blame for infertility, this way women provide a support to their husband infertility related problems. In addition, men also become resistant to accompany their wives to infertility clinical setting and give excuses such as loss of time, increased expenditure, foregone opportunity cost in relation to income among others. Hence infertility may be linked with low quality of life in men and women.

Accrding to Tiitinen (2009), depression as a result of infertility significantly affects the quality of life of idividuals. He argued that infertility is caused by different reasons such as tubal issues (10-15%), breakdown of ovulatory system (20-30%), poor quality of sperms (10-15%) and endometriosis (10-20%). Winkelman et al., (2016) indicated that age of women is the most critical aspect regarding infertility as 25 years and above fertility reduces as age progresses. Chou (2004) indicated that infertile females experience high mental distress than ordinary partners. The occurrence of depression among infertile couples under infertility treatment is altogether higher with approximate assessments of real depression in the range of 15-54% (Chou, 2004).

Rejection sensitivity on the other hand is restlessness of an individual as a result of failed expectations of recognition and acceptance from certain others. In essence, the situation occurs when an individual receives strong negative rejections. This approach

predisposes such an individual to situation of being hyper vigilant that is related to aggressiveness and anxiety. According to Alosaimi, Altuwirqi, and Bukhari (2015), individuals with high rejection sensitivity are more likely to be displeased with personal relationships or becoming displeased with any signs of romance. This eventually leads to low self-esteem among such individuals, an aspect which negates with their overall quality of life. Ibrahim, Brackett and Lynne (2016) reported thoughts of rejection trigger negative attitude among individuals therefore culminating into poor quality of life. While rejection due to infertility may be linked to depression, it also has the ability to culminate into poor overall health.

Rationale

Various stressors associated with infertility including stress related to sexual functioning, fortitude, variety of affiliationand changes in family and social network has been reported by couples (Newton, Sherrard, & Glavac, 1999). In an effort to manage stress, infertile individuals use number of coping mechanisms. Various studies focused on the relationship of infertility with coping, emotional distress.Coping mechanisms have been linked to reduction of infertility related distress and stress (Tennen, Affleck, & Mendola, 1991). Infertile people may cope up with their loss by collapsing into depression and which may be health related, anxiety, distress and grief (Berghuis & Stanton, 2002; Van Den Akker, 2005). The findings of the present study provide basis for clinicians to design and develop educational and interventional programme for infertile individuals with a major focus on reducing depression, rejection sensitivity and elevation self-esteem and quality of life. Further, with a focus on adapting effective coping styles. Studying these variables can help clinical psychologists to improve quality of life through making effective and practical interventions and mental health of infertile individuals.

Objectives of the Study

- To check relationship of quality of life, self-esteem, coping, rejection sensitivity and depression among infertile men and women.

Hypotheses of the Study

- There is a significant relationship in quality of life and self-esteem among infertile individuals.
- There is a significant relationship in quality of life and the Coping styles ie. Avoidance coping, problem focused coping, emotion focused coping among infertile individuals.
- There is a significant relationship in quality of life and rejection sensitivity among infertile individuals.
- There is a significant relationship in quality of life and depression among infertile individuals.

Method

Research Design

Correlation research design was used to check relationship of the variables in the target population. This research design was implemented to investigate the relationship among two or more variable. Whole purpose of using correlations in research is to figure out which variables are connected (Miller,2003).

Sample

Through purposive sampling data was collected from 120 infertile individuals (females=68; males=52). The age range of infertile females was between 22 to 45 years (M= 30.01; SD 5.26) and the age range of males was between 24 to 53 years (M=35.1; SD 6.97). The data was collected from November 2014 to February 2015, it included participants from two infertility clinics/hospitals of Lahore. The inclusion criterion for selection of sample was being married and diagnosed with infertility with at least one year of their marriage.

Assessment Measures

The Demographic Questionnaire. A self-constructed demographic form was used to collect personal information from the participants, which include; age, education, years of marriage, years of infertility, reasons of infertility and family infertility. The participants had different educational level from matric (31.67%), F.A (26.67%), Bachelors (20%), masters (23.33%) to PhD. (0.83%). The infertility is also affected by age, family marriages (32.5%), infertile couple within

the family (32.5%) and various reasons of infertility i.e. Polycystic (21.67%), age factor (4.17%), recurrent abortions (10.83%), general medical condition (10%), oligospermia (21.67%), asthenospermia (15.83%), tubal blockage (3.33%) and others (7.5%).

FertiQuality of Life Scale (Boivin, Takefman & Braver man, 2008). Ferti quality of life scale,a 36 item scale with 5-point likert scale, will be used to assess the quality of life among infertile couples. The questionnaire is divided into 4 domains including overall, personal, interpersonal and healthcare. Moreover, it has 9 dimensions i.e., emotional, psychological, physical, values, partner relationship, and social network, occupational, medical and psycho educational. Higher scores indicate higher quality of life. The test retest has been reported ranging from 0.71 to 0.94.

Rosenberg Self Esteem Scale (Rosenberg, 1965). The Rosenberg Self-Esteem Scale is a 10-item scale using a 4-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. Scores falling between 15 and 25 indicate normal range. The higher score shows higher self-esteem and vice versa. Internal consistency ranges from 0.77 to 0.88.

Coping Inventory for Stressful Situation (Endler & Parker, 1999). The coping inventory for stressful situation is 21 item self-report questionnaire All items were answered on 5 point Likert scale ranges from '0' "not at all to '5' "very much". The test retest reliability has been reported as 0.85 and validity is 0.90.

Adult Rejection Sensitivity Questionnaire (A-RSQ) (Berenson, Downey, Rafaeli, Coifman & Paquin, 2011). The Rejection Sensitivity Questionnaire (RSQ) has 18 questions that seek to show the levels of interpersonal interactions. The ARSQ consists of nine hypothetical situations involving interactions with partners, family, friends, and strangers, with potential rejection. It consists of nine situations involving interactions with partners, family, friends, and strangers, with potential rejection. Respondents rate the degree of their concern or anxirty over their reaction and the expectancy to be rejected on a 6-point Likert-type scale ranging from 1, "very unconcerned" to 6,

"very concerned" and from 1, "very unlikely" to 6, "very likely". The alpha reliability coefficient is 0.89.

Beck's Depression Inventory (BDI)-II (Beck, Rush, Shaw, & Emery, 1979). Beck Depression Inventory consists of 21 items. It is rated on a 4 point likert scale ranging from 0 to 3. The BDI score was obtained by adding all the numbers marked suitable by the participant of all 21 items. The total score of depression on the scale range from '0' to '63' and normally divided into four categories. Lower scores ranging from 0 to 9 indicates normal whereas high score ranging from 24 to 63 indicates extremely severe depression. The higher the score the higher will be the depression. The questionnaire takes 5 to 10 minutes to complete. The Cronbach's alpha for BDI was 0.70.

Procedure

Written permission was obtained from the administration of respective hospitals and from the participants of study. They were briefed about the study. Furthermore, the participants were assured about confidentiality of data and that these would solely be used for the research purpose. The participants were informed about their right to withdraw from the study at any point in time. The participants were administered the measures of study individually, these included: Quality of life; Rosenberg Self Esteem Scale; Coping Inventory for Stressful Situation; Adult Rejection Sensitivity Questionnaire and Beck's Depression Inventory-II, respectively. Individual testing was conducted. The total administration time was 40-45 minutes approximately.

Results

Table 1

Quality of Life (QOL) with Depression (BDI), Self-Esteem, Coping and Rejection Sensitivity among Infertile Men and Women (N=120).

	1	*2*	*3*	*4*	*5*	*6*	*7*
1. Quality of Life	-	-.10	-.46**	.30**	.07	.11	.28**
2. Rejection Sensitivity		-	.09	-.05	.02	-.02	-.00
3. Depression			-	-.38**	.06	-.07	.44**
4. Self Esteem				-	.05	.07	-.34**
5. Avoidance coping					-	.06	.01
6. PFC						-	.12
7. EFC							-
Mean	56.14	36.18	15.64	18.04	17.08	23.45	21.28
SD	17.89	13.48	8.81	3.64	4.43	6.12	6.10

Note. ** $p < 0.01$; *M* = Mean; *SD* = Standard Deviation

Table 1 shows positive correlation between quality of life and avoidance coping and negative relationship between quality of life and emotion focused coping among infertile men and women. However, non-significant relationship was found in quality of life and rejection sensitivity in the sample.

Table 2

R*egression analysis for variables depression, self-esteem and emotion focused coping predicting quality of life among infertile men and women (N=120).*

Variables	B	SE	*β*
Depression	-.77	.19	-.38*
Self Esteem	.65	44	13*
Emotion focused coping	-.19	27	-.38*
R^2	.21		
F	11.89		

Note. B= unstandardized regression coefficient; SE=standard error for beta; *β*=standardized regression coefficient

*$p < .05$

Table 2 shows a simple linear regression carried out to ascertain the extent to which depression, self-esteem and emotion focused coping can predict quality of life scores. The overall regression model predicted

21% of the variance. The regression analysis of highly significant values predicted that depression, self esteem and emotion focused coping strongly predict quality of life in the sample.

Discussion

The diagnosis of infertility may bring along a horde of changes in the life of the individuals which may be reflected in the quality of life, self-esteem, and coping styles of individuals along with more sensitivity to rejection and manifestation of depressive symptomatology among infertile people. Our findings showed that the quality of life increased with the increase in the self-esteem among infertile men and women. Anate and Wischmann (2014)conducted research to investigate the relationship between self-esteem and the quality of life in females with infertility but had received sociological support. The findings illustrated that self-esteem helped boost the morale of the person suffering from infertility hence enhancing his/her quality of life. Most people who have infertility issues usually find it challenging to interact with other people fearing that community would judge them for their misfortunes. Thus, poor socialization ability adversely affects their quality of life.

Our results demonstrated positive correlation between quality of life and avoidance coping among infertile individuals which indicates that as the avoidance coping increases the quality of life also increases. Schmidt, Holsten and Bovein (2005) found that men and women develop various avoidance coping skills to overcome the social and emotional challenges associated with infertility. There are various strategies that people use to overcome stressful events due to infertility including engaging in personal work instead of interacting with other people. Such strategies have been found to have a positive impact on their quality of life as they help the persons forget their issues.

The findings of present study divulged a positive relationship between quality of life and problem focused coping. Rashidi *et al.* (2011) in their research found that infertility stress abridged when couples facing fertility issues develop their own exclusive coping strategies. The existing literature and present study revealed a non-significant relationship between quality of life and problem focused coping despite the fact that the results of correlation showed a positive relation. Infertile individuals do not stride towards implementing problem focused coping because they may view the issue of infertility to be untreatable.

Inverse relation between emotions focused coping and quality of life findings are in line with the previous findings of Butler and Nolen-Hoeksema (1994) as they mentionedthat women use worry as a strategy to deal with anxiety, called emotion focused coping, which is more likely to continue as depression than active emotion focused coping techniques such as drugs usually used by men. According to Berghuis and Stanton (2002) when men and women go under treatment for infertility they experience more emotional challenges. Though couples face infertility together, their emotional reactions differ a lot and this difference shows that how they cope up this stressful situation. Since emotion focused coping focuses more on denial and distraction especially in infertile individual, females feel better when using emotion focused coping. A women's experience of infertility produces a feeling of shock, refusal, dissatisfaction, self-doubt, disappointment, anger guilt blame, and even depression, hampering a better quality of life for infertile couple.

Result showed non-significant relationship in quality of life and rejection sensitivity among infertile individuals. Whereas, Palomba et al. (2018) found that an increase in rejection sensitivity among infertile women led to the decrease in the quality of life.The findings obtained from the study were in contrast the findings from the current study. This difference may be explained as in the light of cultural context and operational definition of the variable as Palomba et al. (2018) defined the quality of life in terms of emotional stability and social well-being. However, it was evident that women suffering from infertility require emotional support and a feeling of acceptance from the community. Thus, if they feel that they are not accepted by their families, they may experience emotional instability which affects their quality of lives.

Significant relationship was found in quality of life and depression which shows that the quality of life increases with the decrease in depression among infertile individuals. Results have been supported by the research conducted on the relationship between quality of life and distress among infertile couples by Aarts et al. (2010). They reported that infertile couples with high scores on quality of life scale revealed lower levels of depression and anxiety whereas infertile couples who had low quality of life showed more somatic complaints and distress. Aliyeh and Laya (2007) also conducted a similar research on the quality of life and depression on infertile Iranian women. The

study showed that women, unlike men, experience depression which adversely affects their ability to socialize or vice versa.

Implication for Future Research

The future implications of these findings can be that a mixed research design should be used in order to study the same variables in depth like rejection sensitivity and self-esteem along with coping styles. In order to decrease rejection sensitivity, depression, and increase self-esteem, quality of life and improve coping of infertile individuals, psycho-educational programsmay be introduced in the hospitals. A preventive programs can be designed by keeping in view the mental health of infertile individuals an intervention may be designed based on the principles of cognitive behavior therapies to help them cope with the situation of infertility.

Limitations and Suggestions

The data was drawn using purposive sampling therefore findings of the study could not be generalized. Only bilingual and educated subjects participated in the study because the tools used in the study were available only in English language. This exposed the study to selection bias. Additionally, the study only included people living in Lahore metropolitan city who have cultures that may be different from people living in other places. Thus, the findings may not be generalized to cover people from regions with cultures that are different from the culture and practices within Lahore. Sample from other cities should also be taken and Cross sectional study could be administered. Longitudinal study could be done. Further, mixed method approach may also be an effective strategy.

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Stress and Coping among Single and Non-Working Women

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The study investigated the relationship of perceived stress and coping among single working and non-working women. 50 single working women, teaching at two government and private universities of Lahore and 50 non-working women were taken, age ranging 25-40 years. Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983) and Brief Cope Scale (Carver, 1997) were used to investigate the association between the two variables. Results revealed that working and non-working women differ in terms of perceived stress ($M= 25.52$; $SD= 4.38$; $p<0.01$) and supportive coping ($M=15.34$; $SD=3.21$; $p<0.05$). Moreover, Perceived Stress in age range 35-30 and 31-35 years was higher than the later age range of 35-40 years ($p<0.05$), whereas significant differences were found on all kind of coping at all ages. Findings are discussed in terms of identification and resolution of stress, along with teaching and strengthening of coping skills of single working and non-working women.

Keywords: stress, coping, single, working women

Marriage has been a significant milestone of human society. One cannot survive in isolation without a partner and wishes to be in a lasting relationship. So, personal human life has many phases to pass through, and marriage is one of them. Different cultures conceptualize this period in various ways. Pakistan is an Islamic republic state which is rich in customs and culture. In Pakistani culture, marriage is considered as one of the most arguable topics. Different taboos and traditions have been emerging and signified throughout the history along with religious, moral and cultural concomitants (Importance of marriage in Pakistan, 2016).

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Currently, marriage has become one of the apparent problems in the culture of Pakistan. In 2012-13 Pakistan Demographic and Health Survey (PDHS), fifty-four percent were married by age twenty and thirty-five percent of women of aged between 25 to 49 were married by age 18. It is evident that age of first marriage is rising among women in Pakistan. The median age of first marriage in 2012-13 increased from 19.1 to 19.5 years. In recent centuries increase in the average marriage age of female is an observable fact. It has not only influenced the eastern countries but also has targeted the Muslim marriage culture. At present mean age for the wedding of a female is supposed to be 22 to 28 in the society of Pakistan but many women exceed this age, and it becomes problematic to get a perfect match (National Institute of Population Studies, 2013).

In Asia late marriage has become one of the striking issues. Only 2% of ladies were single in most Asian nations in the last thirty years. The number of unmarried ladies has increased twenty more times in their 30s in Taiwan, Hong Kong, Singapore and Japan. In Thailand, the number of ladies that are not married till the age of 40 is extended from 7% in 1980 to 12% in 2000. Rates of unmarried female are higher in few urban communities: 27% females in early thirtees married in Hong Kong. 20% among ladies matured 40-44 in Bangkok; In South Korea, young males criticize that ladies are on the strike of marriage (Beri & Beri, 2013).

Because of the competitive economic situations of fast and modern society young girls wish to find financially stable partners so that they may support their spouses and kids. In early ages it becomes problematic for males to have stable monetary assets to have a partner. Indeed, even employments are given to the knowledgeable and exceptionally skilled individuals and one can't expect youngsters under 30 years old to come up. Many of the females wait for such a person who is economically well settled to upgrade their standard which is one of the reasons for delaying marriage as well as males take time to reach up to the desired standard of financial stability. Moreover, formal education has also set a standard which has contributed toward the rise of normal marriage age. The females normally engage in studies for the most years of their life, and until the completion of their studies it becomes necessary for them to delay their marriage till they finish their education. In Pakistan, India, Brazil, Guatemala, Mexico and Paraguay

and so on, the average period of marriage is more in educated people than the uneducated individuals (Average marriage age, 2012).

Marriage becomes a great concern for over-aged ladies leading them toward mental stress and a lot of pressures from the society. An essential part is additionally performed by the community in animating stress among the females who are having single marital status and surpasses the mean time of marriage. Pakistani culture depicts marriage as the only source of safety and prosperity for female's future mainly. Literature has shown that marriage has a broad range of positive effects on prosperity that include good physical and mental health, improvements in the economic well-being of individuals, and the welfare of their children (Shabbir, Nisar & Fatima, 2015).

Chances of getting a good match for girls become crucial with time due to increase in their age so time is a significant factor that should be taken into account to choose the right partner. Because of the increase in age, girls suffer from selecting a life partner who might not be suitable for her. In Pakistani culture, parents and family contributes a lot in selection of a spouse with matching background in terms of values,family and upbringing. It is also observed that families with top financial status do marriage of their daughters in their late years. They want a man equivalent in status to their girl and do not show any leniency regarding the status of the guy (Sathar, Kiani, & Farooqui, 1986). Morally upright young people would obviously look for morally upright life-partners, and they put extra efforts and time to find a reasonable match which is a leading aspect toward late marriages (Bari, 2014).

In India, Pakistan, and numerous Muslim nations some wedding traditions have additionally assumed a vital part in expanding average marriage age. The reasons for this new rising trend are identified with socio monetary changes in Bangladesh since 1971. In a late review (1998), a similar writer has expressed that dowry is one of the reasons for expansion in the number of young ladies staying unmarried. Another real issue is of caste system. Guardians consent to bring girl of another cast in their family for their child, however, delay to wed their girl to another caste. Therefore they sit tight for a perfect proposal regardless of how much time is taken (Sathar, Kiani, & Soomro, 1998).

Another major factor that may cause hurdles in getting married at an appropriate age is that the females start working. It makes them independent financially after completing their education. Fitzgerald and

Spaccarotella (2009) explained that purpose for staying single is a chance of building up career without depleting the huge amounts of energy that may be a lasting relationship require. Parents from low socio-economic status also start depending on the earning of their daughter to upgrade their lifestyle rather than thinking of their marriage. Postponing marriage becomes more evident when a girl wishes to get more education. About fourty percent females in their mid to late twenties are single. Among university graduates of the same age range, fifty-four percent are single. Of the ladies in this age section with no more than high school education, just 25% have stayed unmarried (Rattani, 2012).

As to changing pattern towards marriage, work, training and single women, Kapadia (1954); Narain (1975); Desai (1959); Krishnakumari (1987); Ross (1961); Hate (1969); Borooah (1993); KrishnaMurty (1970); Merchant (1935); Salaff (1981); Rozario (1986); Rathaur (1990); Jethani (1994) and Palariwala; Rathaur (1990) have demonstrated that the behavior of educated ladies, have considered changed particularly as to claim status and as to marriage and the issues and limitations of the single ladies in particularly. In Bangladesh, Rozario (1986) found an expansion in the quantity of unmarried ladies among Hindus, Christian, Muslims and Bengalis since the mid-1970s (Beri & Beri, 2013).

Age of young females is much criticized when they cross the time of marriage and get a divorce or aged man to wed however then again the age of male is not considered as an issue of concern. Men are supposed to get a perfect proposal in any age. A single woman is always seemed to be available for him. Thus late marriages have become one of the major dilemmas of the modern age for females, particularly in our society. A trend has now set in Pakistani society where late marriages are now emerging as one of the main problem leading to stress and frustration (Sathar, Kiani, & Farooqui, 1986).

Dudhatra and Jogsan (2012) focused on Significant differences in and high correlation between mental health and depression in 80 working and non-working women. Studies depict that the stress has affected the female population in a bad way because of the environmental conditions threatening to their life satisfaction. A study was conducted among early and late married females on depression, stress, anxiety, and life satisfaction. 120 participants from Faisalabad (60 late married women and 60 early married females) were taken. The

results showed greater level of depression, anxiety, stress and life satisfaction level among early married females than late married females (Shabbir, Nisar, & Fatima, 2015).

Married women are found to be more satisfied with their life than unmarried females which show that status of their marriage has a major influence on mental health. A study was conducted to see the relationship between marital status and mental health of more than 25 years older women undergraduates. 584 of the 628 students were randomly selected and given questionnaires. Married students compared to unmarried students were found to be well adjusted and were less likely to be full-time students as well as major financial stress and poorer grades were found in single students than non-singles (Garima & Kiran, 2014).

Khanna (1992) studied a sample of 406 women in India and found out that among non-working women, positive life changes are related to anxiety and negative life changes to depression. Whereas among working women, positive life changes are related to depression.

Dealing with stress varies, depending upon the cognition of individual perception and the way how one takes the stress. Perception of stress is impacted by various social factors that a female is having. Among every one of those components marital status and their working status moreover, pick the level of their stress recognition. Ladies in working parts or the females at home see the stress level in their particular manner. Numerous ecological elements additionally indicate the perception of taking the stress. So the working females are having their intensity of stress, and as stated by it, their coping is distinctive and working adapt diversely as a result of their experiences that are different with non-working females (Patil, 2016).

Many females make work as their coping strategy to get rid of the stressors related to their marriage. Coping likewise relies upon those social components that are affecting as in the females who have crossed the mean age of their marriage. They will have marital status as the significant determinant of their stress and impact their coping contrarily. In working setup, there also come many stressors from the colleagues as well due to their marital status. Work related status is another variable that can upgrade or lessen their coping abilities. Females that are working will utilize distinctive coping skills than non-working females, and their level of stress will be diverse relying upon the stressors they are taking and how well they are beating those stressors.

For determining stress-coping behavior a study was done to explore the role on certain demographic variables of 150 female teachers. Significant determinants of stress-coping were found as age and marital status. Results have shown that married teachers between the age 40-60 years, experience better coping with their job stress (Chaturvedi & Purushothaman, 2009).

The study was done to investigate the sources and levels of stress among female teachers in four Chinese independent high schools in Kuala Lumpur, Malaysia on the variables such as age, marital status, length of teaching experience, coping strategies and the locus of control. Results of the study were that teachers perceived their stress level from mild to moderate however married female teachers were more stressful compared to single. It was found that marital status did not influence their choice of coping strategies. Teachers who were "internal" tended to utilize problem-focused coping than emotional focus coping (Bing, 1998).

Absence of encouragement by bosses, injustice in opportunities, imbalance among employment and power, strife with colleagues, part duties, long and tiring work hours, absence of sufficient equipment's, absence of time for family and pressures from the general public due to their single marital status with female workers makes them vulnerable toward stress. However the females that are at home having low coping skills, and because of that, they have high tendency of stress (Kumar & Yadav, 2014).

Purpose of the Study

Pakistan is one of the developing countries in which the average age range of marriage for a woman is considered to be in between 18 to 28. Marriage becomes a problem for a female who cross this expected age with the concern of not getting the suitable match. Due to this factor women are suffering from stress that is perceived differently. This study will help to investigate the problems of single working and non-working women with reference to their single marital status and related issues. It will explore ways for the better understanding of the psychologists to help single women dealing with their perceived stress. Single women who are at home can get knowledge for the improvement of their coping skills through this study. Moreover, awareness programs can be developed for general population concerning marital status and expectations for a match, as why a man can get a young girl to get

married with at any age but a girl becomes a woman when crosses 30 years and faces extreme difficulties in finding a suitable match.

Objective

To explore the effect of single marital status on the level of perceived stress and coping among the working and non-working women.

Research Hypotheses

1) It is hypothesized that single marital status would have significant relationship with perceived stress and coping skills among working and non-working women.
2) It is hypothesized that single non-working women would have high perceived stress than single working women.
3) It is hypothesized that working women would have better coping skills than non- working women.

Method

Research design. Correlation research design was used in the present study.

Sampling. Mixed methods of non-probability sampling technique (N=100) were used in this study. Purposive sampling technique was used to collect data of single working females (n=50) teaching at two government and two private universities. Snowball technique was used to gather comparison group of 50 single non-working women. The age range of both groups was from 25-40 years. Educational qualification for non-working women was minimum intermediate excluding divorced and separated women.

Assessment Measures. Following measures were used in this study:

Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983). PSS is comprised of 10 items. It employs 5-point scale ranging from never to very often. PSS's Cronbach alpha is between .84-.86. Test-retest reliability for the PSS was .85.

Brief Cope Scale (Carver, 1997). Brief COPE (Carver, 1997), a 28-item self-report questionnaire with two items for each of the coping strategies, measures 14 theoretically identified coping responses includingSelf-distraction, Religion, Substance use, Planning, Active coping, Behavioral disengagement, Denial, Use of Emotional support, Use of Instrumental support, Venting, Positive reframing, Humor, Acceptance, and Self-blame. Overall it has four higher-order factors including Focus is on the Positive coping, Support Coping, Evasive Coping Active Coping.

Procedure

All ethical considerations were followed for conducting the research. Formal permission for the study was taken through the concerned department/university to take sample of working females. Informed consent were taken and participants were having right to withdraw from participation any time. It was assured that there is no physical and emotional harm attached to the study All the participants were assured of the confidentiality of the information they provided. A protocol was presented to the participants with clear instructions. After completion of every form the participants of the study were thanked and asked about any query related to the study.

Results

This section enlightens the quantitative results of the study to explain the relationship between perceived stress and coping and comparison between single working and non-working females.

Table 1

Correlation Matrix of Perceived Stress Scale and Brief Cope subscales

Scales	*1*	*2*	*3*	*4*	*5*
1-Positive coping	-	.29**	.61**	-.09	-.25*
2-Supportive Coping		-	.33**	.32**	-.05
3-Active coping			-	-.16	-.11
4-Evasive coping				-	.05
5-Perceived Stress					-

Note. df=99.

Table 1 demonstrated that there is significant relationship between positive coping, supportive coping and active coping. Whereas there is significant negative correlation between positive coping and

perceived stress which means that individuals with higher level of positive coping will have less perceived stress.

Table 2

Means, Standard Deviations and t-values of females on Perceived Stress and Brief Cope scale (N=100)

	Working	*Non-working*	
Variables	*M (SD)*	*M(SD)*	*t*
Positive coping	14.58(3.49)	13.74(3.20)	1.25
Supportive coping	15.34(3.21)	14.02(3.84)	1.97*
Active coping	11.52(2.65)	10.48(2.88)	1.87
Evasive coping	12.08(3.28)	12.84(4.08)	1.03
Stress total	21.76(4.75)	25.52(4.38)	4.12**

Note= **p<.05; **p<.01*

Table 2 demonstrated that working and non-working females differ in terms of perceived stress and supportive coping. The perceived stress is higher in non-working females *M*= 25.52 (*SD*= 4.38) as compared to working females. The supportive coping is higher in working females as compared to non- working females *M*=15.34 (*SD*=3.21). Whereas there is no significant difference in terms of positive coping, evasive coping and active coping.

The main hypotheses of the study are accepted as calculated through the results of *t*-test that single non-working females have higher perceived stress than single working females. But significant differences are found only on supportive coping between single working and non-working females.

Table 3
Means, Standard Deviations, Frequencies and p Values of the females in Different Age Groups on Perceived Stress and Brief Cope scales (N=100)

	Age							
	25-30yrs (*n*=43)		31-35yrs (*n*=46)		36-40yrs (*n*=11)			
Scales	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*<
Positive coping	.58	.71	-.58	.71	-1.61	1.14	1.07	.347
Supportive Coping	.28	.73	-.28	.73	-.91	1.15	.32	.792
Active Coping	-.33	.59	.33	.59	-.54	.95	.47	.628
Evasive Coping	-.25	.79	.25	.79	-.89	1.26	.42	.656
Stress Total	-2.81	1.01	2.8	1.01	3.38	1.61	4.69	.011*

Note. Between group *df*=2; within group *df*=97; total *df*=99, *$p<0.05$.

Table 3 demonstrated that working and nonworking females are having significant differences on perceived stress in all age groups. In the first two categories of age range 35-30 and 31-35 stress is higher than age range of 35-40 years. No significant differences were found on any kind of coping in any age group. Hence it rejects the secondary hypothesis and indicates that females with single marital status have different level of perceived stress but may have similar coping strategies.

Discussion

In order to assess the association of single marital status with perceived stress and coping, the study was carried out by selecting 50 working (teaching in universities) and 50 non-working females of Lahore. For this purpose, 50 working females related to teaching profession, were taken from different private and government educational institutes of Lahore and 50 non-working females with single marital status; age ranging 25 to 40 years; were procured to compare the results between groups of single working and single non-working females. To evaluate the relationship, two scales were used i.e.

Perceived Stress Scale (Cohen et al., 1983) and Brief COPE (Carver, 1997). The accepting outcomes of the main hypotheses revealed that single marital status has significant relationship with perceived stress and coping .The statistical analyses showed significant negative correlation between positive coping and perceived stress as well as single non-working females have higher perceived stress than single working females. But significant differences are found only on supportive coping between single working and non-working females.

A study was carried out by Garima and Kiran (2014) revealed that marital status impacts the mental health of working women to a significant extent. Another study conducted by Nevin (2007) resulted that working women have a higher level of stress than non-working women. In 2016, Patil showed that the working women have more stress than the non-working women. Another study revealed that the stress level was higher in non-working women as compared to working women but significant association between stress level and age of the participants. The association between stress level and marital status was non-significant among working women but significant among non-working women. However the current researches prove that non-working women have high stress level than working women which supports the main hypothesis of the study that non-working women have higher perceived stress than working women (Devi, 2016). A study attempted by Dhurandher and Janghel (2015) found out the coping strategy of stress in employed women and non-employed women age ranging 25-40 yrs. It was conducted on 60 women, 30 were employed women in different professions and other 30 were non-employed women. For assessment brief COPE Scale was used (Carver, Scheier, & Weintraub, 1989). It was concluded that employed women used more technique of self-distraction, instrumental support, behavioral disengagement, venting and positive reframing in comparison to non - employed women. The secondary hypothesis was partially accepted and revealed significant differences on (p<0.05) perceived stress in all the age ranges but no significant differences were found on any kind of coping. That may be due to the more social interaction of single working women and hence receiving more comments on their status of being single.

Recommendations

This study will explore ways for the better understanding of the psychologists to help single women dealing with their perceived stress. Single women who are at home can get knowledge for the improvement of their coping skills through this study. Awareness programs through media, lectures and seminars in educational institutes etc. can be developed for general population concerning marital status and expectations for a match both for women and men especially why woman when crosses age 30 years, face extreme difficulties in finding a suitable match.

Suggestions for Further Research

Sample taken for this study was only teachers as working women so data can be distended by adding more females working in other occupations and comparison can be made with non-working, on each occupation.

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Customer Related Social Stressors and Mental Health of Sales Girls: Moderating role of Sexual Harassment

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The current study explored the relationship between customer related social stressors and mental health among sales girls by analyzing the dynamics of functioning of sales girls at the job with the customer. The study was conducted using non-probability convenient sample consist of 200 sales girls including evening and morning shift, with the age range of 20 to 35 years (M = 24.86, SD = 3.59) with at least 6 months sales job experience. The data collected from various Malls and shopping centers of Lahore. Customer Related Social Stressors (CSS) and Mental Health Continuum- Short Form (MHC-SF) were used as the data collection instruments. Pearson correlation and regression analysis was employed and the results showed that costumer related social stressors was found to be significantly negatively association with emotional wellbeing and social wellbeing whereas sexual harassment was found to be significantly negatively correlated with Social Wellbeing and Psychological Wellbeing. Sexual Harassment, Customer Related Social stressors and Interaction term of both were found to be negative and significant predictors of psychological wellbeing.

Keyword: customer related social stressors, sexual harassment, mental health, sales girls

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In recent years, women active participation in various fields is seen considerably high however, due to societal pressure they come underneath the influence of certain norms and customs (Livingston & Judge, 2008). Women working as a customer service provider experience dehumanization at the job due to inappropriate customer behavior that refers to the violation of norms of conduct by the customer behavioral acts (Morganson & Major, 2014) These behaviors comprise of vandalism, retaliation, and violence, illegitimate complaining, harassment and treating them as an object rather than a person (Keeffe, Bennett, & Tombs, 2006). To meet the customer expectation is perhaps not an easy task and failing to meet their expectations leads to intimidating customer behavior (Goussinsky, 2012). The customer related social stressors plays a significant role in a service provider profession and encountering negative or hostile circumstances at the job would escalate poor mental health among them (Fisk & Neville, 2011). Mental health is referred as a state of well-being where an individual realizes his or her ability to cope with daily life stressors and is able to work effectively to make contribution to the community (Slade, 2010).

Costumer behavior has been vastly researched in business and marketing studies in order to meet and access the emerging demands of the customers effectively (Shobeiri, Laroche, & Mazaheri, 2013) However, the customer behavior plays a significant yet very crucial role for the organizations to meet the rising challenges of today's world (Srivastava & Kaul, 2014). Meeting the customer demands and reaching their satisfaction level is a hub of every organization dealing with customers that mostly consist of retail business, airlines, hotel industry and call centers to name a few. Yet the customer behavior could be a very fruitful experience for an employee or at the same it could be quite devastating experience for an employee. The customer behavior refers to the attitude or treatment shown by the customers in relation to services provided or exhibit towards the retail company agents (Echchakoui, 2016). Customer behavior is a strong and powerful component of the service culture because failing to bring customer satisfaction would be an inevitable experience of business life (Echchakoui, 2016) and will eventually loses the potential customer. Hence, providing service with a smile and considering the customer rights are the key elements in the service culture. However, that could posit a high strain upon the employees dealing with the customers directly. Employees encountering negative circumstances while dealing

with customers such as humiliation, yelling, violation, vandalism, retaliation, violence, illegitimate complaining, disrespect (Keeffe, Bennett, & Tombs, 2006) towards the employee will ultimately leads to poor functioning, low self-esteem, low job satisfaction, poor wellbeing, puts more psychological burden and feel threats to their autonomy and personal control (Echeverri, Salomonson, & Aberg, 2012).

Women are in generally exercise lesser humanness than men (Fredrickson & Roberts, 1997; Haslam, 2006; McKinley & Hyde, 1996) and working as a service provider highly stigmatized their role and leads to dehumanization of them (Haslam, 2006). Dehumanization takes place when one person views the other person merely as a pleasure object rather than human being. Similarly, the high customer entitlement persuades dehumanization, disrespected, objectified or treated as an object among service employees. However, the existing research provide a comprehensive evidence that linked the high customer entitlement with a hostile behavior and facing such circumstances in a working environment would cultivate psychological negative well-being among the service providers (Fisk & Neville, 2011).

Moreover, the high job demand put service providers at a high risk of facing recurrent hostility and enmity from their customers, whom they are required to provide a service with a smile, with displaying suitable emotions at all time (Grandey, Dickter & Sin, 2004) decreased their emotional well-being and thus lead to mental health concerns such as depression, anxiety and stress. Exceeding customer demands triggers negative emotions and effect employee's mental health adversely (Fisk & Neville, 2011). Customer behavior is one of the chief determinants in a sales profession because it involves a dyadic relationship among the service provider and a customer that primarily involves a set of emotions during the interaction. Due to customer aggression negatively affects the frontline employees psychological well-being including, customer always right, social status, public context and social support

However, the employees enlist various factors encountering during their duty such as bad customer attitude, poor communication among the management and employees and for not permitting them to eat from the restaurants addresses their work-related problems (Esi, 2012). The research proposed that customer aggression negative affect the employees resulting in stress appraisal, low autonomy, burnout and emotional exhaustion. Employees use surface acting or vented emotions who felt threatened by the customer aggression and those who did not

feel threatened used deep acting at the job (Grandey, Dickter, Sin, 2004).

The literature revealed that the women working in factories, hospitals and call centers were seen low on the levels of psychological well-being whereas women working in educational institutes were found to have a high level of psychological well-being and women working in banks were seen at a medium level of psychological well-being moreover it was further revealed that work characteristics of the service providers were associated with low level of well-being and impeded job related attitudes. The service providers experience low control, low autonomy, job uncertainty and task complexity. Moreover, the emotional dissonance was seen as a major stress factor beyond other working conditions (Grebner, Semmer, Faso, Gut, Kalin, & Elfering, 2003). The finding of literature states that, while dealing with the customer aggression the frontline employees perceived threats to self-esteem, equity, sense of control, physical well-being and goal completion at work However, these cognitive appraisal factors negatively affect their psychological well-being in the form of depression, stress and anxiety. Moreover, the study found the four situational factors due to customer aggression negatively affects the frontline employees psychological well-being including, customer always right, social status, public context and social support (Akkawanitcha, Patterson, Buranapin, & Kantabutra, 2015).

The display of certain emotions is an essential aspect of an individual's job mainly in the customer related services where an employee had to display a set of positive emotions at the job. It has been seen that the emotional dissonance at the job leads to negative outcomes of the employees such as emotional exhaustion and job dissatisfaction. It was found that the expressed and felt emotion by the employees is seen harmful to their well-being (Pugh, Groth, & Thurau, 2010). Lastly, to meet the workplace demand is perhaps not an easy task for the employee. The results of the study stated that the negative social experience at the job and workplace demands particularly related to emotion exhaustion, self-efficacy and job strain promote lower levels of well-being among the employees particularly females. On contrary to this the workplace support was seen as good determinant of promoting increased levels of well-being, self-efficacy, less job strain and higher job satisfaction (Dimotakis, 2011). In Pakistan the sales girls are affected by the harassment of people at their workplaces. A study by

Yousaf (2014) stated that women are affected by various acts of harassment ranging from verbal to physical including threats and unwanted advances and such acts affect the girls' wellbeing as well.

Rationale

In last few years, customer related social stressors has been observed extensively in the study of gender, women empowerment, media influence, etc and its relationship with various indicators of health **(**Fredrickson, Roberts, 1997; Noll & Fredrickson, 1998; Tiggemann, 2003). Researchers have so far focused on measuring the mental health with customer related stressors while encountering distressing and upsetting events like sexual harassment across the different work settings (Calogero, 2013). However, it is essential to examine the customer behavior and mental health relation with sexual harassment among sales girls. It is pertinent to understand how a salesgirl endorses sexual harassment while encountering with different customer behavior and circumstances at the job by understanding her role in life. This is a significant and well researched question internationally. However, in Pakistan, sales girls are affected by the customer's behavior as well. In Pakistan, being a sales girl is not considered as a respectable job for women which has affected the morale and overall wellbeing of these girls. Moreover, harassment during their work by the customers negatively affects their wellbeing (Hussain,2009). Furthermore, very little researches are available in Pakistani cultural context to explain the effects of customer related social stressors, sexual harassment and mental health on sales girl.

Objectives of the Study

- To investigate relationship between customer related social stressors, sexual harassment and mental health in salesgirls.
- To explore the predictive role of customer related social stressors and sexual harassment on mental health in salesgirls.
- To determine the moderating role of sexual harassment between customer related social stressors and mental health in salesgirls.

Hypotheses of the Study

- There is likely to be a relationship between customer related social stressors, sexual harassment and mental health in salesgirls.
- customer related social stressors and sexual harassment will predict mental health in salesgirls.
- Sexual harassment will moderate the relationship between customer related social stressors and mental health in salesgirls.

Method

Research Design

Correlation research design was employed for the current study.

Sample and Sampling Technique

A total of 200 sales girls (Morning shift=100, Evening shift=100) with thte age range of 20 to 35 years (M = 24.86, SD = 3.59) were included in the study. The data was collected from different malls and shopping centers, by using a non-probability purposive sampling technique.

Table 1

Descriptive Statistics of Variables (N=200)

Variables	*f(%)*	*M(SD)*
Age		24.86(3.59)
Education		
Metric	26(12.9)	
Intermediate	140(69.7)	
Bachelor	34(16.9)	
Marital Status		
Married	169(84.1)	
Unmarried	31(16.9)	
Work Experience (in years)		3.62(2.20)
Daily Working Hours		9.48(0.96)
Monthly Income		16947.50(3182.63)
Sexual Harassment		
Yes	115(57.5)	
No	85(42.5)	
customer related social stressors		77.50(12.78)
Mental Health		-
Emotional Wellbeing		8.72(3.62)
Social Wellbeing		11.67(5.30)
Psychological Wellbeing		20.53(4.75)

Note. M=Mean*; SD*= Standard Deviation*; f*=frequency

Inclusion and exclusion criteria. At least six month of experience with education at least up to matriculation. Sales girls working in both morning and evening shift were included. Sales girls with any physical disability were not being included in the study and lastly younger than 20 years of age and older than 35 years of age were excluded.

Instruments

Demographic Information Sheet provided to the participants that simply consist of age, education, marital status, work experience, working hours, monthly income, family income and harassment experience.

The Customer-Related Social stressor (CSS) by Dormann and Zaff, 2004 is comprised of 21-items. Participants rated this 21-item measure on a 5-point Likert scale from 1=Not at all to 5= Absolutely True. The CSS comprised of four subscales: Disproportionate expectations, Verbal aggression, Ambiguous expectations, and Disliked customers. In the present study, it showed sound psychometric properties, with alpha of .88.

The Mental Health Continuum-Short Form (MHC-SF) by Keyes et al., 2008 is comprised of 14-items. This scale aimed to measure the three components of wellbeing: emotional wellbeing consists of 3 items, social wellbeing consists of 5 items and psychological wellbeing consists of 6 items. Participants rated this 14-item measure on a 6-point Likert scale, from "never" to "every day". The MHC-SF comprised three subscales: emotional well-being, social well-being and psychological well-being each demonstrating sound psychometric properties, with alpha of .83, .83, and .74, respectively (Lamers, Westerhof, Bohlmeijer, Klooster, & Keyes, 2011). In the present study, the reliabilities of its subscales of scale were .83, .79 and .81 respectively.

Sexual Harassment was measured through a single item (i.e., have you ever been harassed during your job?), using a dichotomous response where 0 indicated = no and 1 indicated = yes.

Procedure

To conduct this study the permission to use questionnaires were taken from the authors. Prior permissions were also sought from concerned departments of Lahore. Each participant was personally approached from different stores and malls in break time for their continence to collect data. Individual consent was sought from the participants after explaining the nature and purpose of the research. Questionnaires were personally given to the participants. Only those participants were included who voluntarily and willingly participated in the research. Hence the response rate was hundred percent. It took 10 to 15 minutes to each participants to complete the research protocol. All the queries were answered by the researcher. After data collection, questionnaires were scored and quantitatively measured.

Ethical Considerations

1. Permission from department head was taken before commencing the collection of data.
2. Informed Consent was taken from the participants that clearly explain the purpose and the nature of the study were explained to the participants with a clear assurance of privacy. The participation in the research was voluntary.
3. Keeping in mind the cultural constraints, the rights and welfare of the participants was not being affected.
4. Results were reported accurately.

Results

To investigate relationship between customer related social stressors, sexual harassment and mental health in salesgirls, Person product moment correlation analysis was carried out.

Table 2
Pearson Product Moment Correlation between Costumer Social Stressor, Harassment and Mental Health (N=200)

Variable	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
1. Age	-	.56***	.06	.61***	.49***	.09	-.30**	-.20**	-.13	-.08
2. Work Experience		-	-.06	.40***	.24**	.07	-.22**	-.06	-.07	-.01
3. Working Hours			-	.01	.12	.13	-.14*	.06	.07	.07
4. Monthly Income				-	.33***	.10	-.30**	-.15*	-.11	-.10
5. Marital Status					-	-.18*	-.17*	.04	.001	-.03
6. CSS						-	-.10	-.22**	-.21**	.03
7. Sexual Harassment							-	-.10	-.23**	-.26**
8. Emo. Wellbeing								-	.58***	.42***
9.Social Wellbeing									-	40***
10.Psych. Wellbeing										-

Note. CSS=Customer-Related Social stressor; Emo. Wellbeing= Emotional Wellbeing; Psych. Wellbeing= Psychological Wellbeing.
*p<.05. **p<.01. ***p<.001

Results showed that costumer related social stressors was found to be negatively associated with emotional wellbeing and social wellbeing whereas sexual harassment was found to be negatively correlated with Social Wellbeing and Psychological Wellbeing.

Moreover to explore the predictive role of customer behavior and sexual harassment and interaction effect of both variables on mental health in salesgirls, Hierarchical multiple regression analysis was conducted.

Table 3
Moderation through Hierarchical Regression Analysis Predicting Mental Health in Sales Girls (N=200)

Variables	Emotional Wellbeing		Social Wellbeing		Psychological Wellbeing	
	ΔR^2	β	ΔR^2	β	ΔR^2	β
Step 1	.073*		.031		.021	
*Control Variables**						
Step 2	.053**		.087***		.075***	
Sexual Harassment		-.08		-.21**		-.22**
Customer Related Social Stressor		-.21**		-.19**		-.10
Step 3	.013		.006		.053**	
SH_X_CSS		-.12		-.09		.04**
Total R^2	.139***		.124***		.149***	-.18**

**Control Variables.* Age, Work Experience, Daily Working Hours, Monthly Income, Marital Status

Note. SH = Sexual Harassment, CSS = Customer Related Social Stressor. Sexual Harassment, Yes = 1, No = 0, Marital Status, Married = 1, Unmarried = 0.

*p<.05. **p<.01. ***p<.001

The results revealed that, after controlling variables in step 1, Sexual Harassment and Customer Related Social Stressors in step 2 and interaction term of sexual harassment and Customer Related Social Stressor were entered in step 3. The overall model explained the 13.9% of variance for emotional wellbeing with *F (8, 191) = 6.58, p<.001*, whereas Customer Related Social Stressors was found to be significant negative predictor of emotional wellbeing. Moreover the overall model explained 12.4% of variance for social wellbeing with *F(8, 191) = 5.75, p<.001* whereas Sexual Harassment and Customer Related Social Stressors both were found to be significant negative predictors of social wellbeing.. Furthermore, for psychological wellbeing the overall model explained 14.9% of variance with *F (8, 191) = 7.52.40, p<.001* Sexual Harassment, Customer Related Social and Interaction term of both were found to be negative and significant predictors of psychological wellbeing. (See figure 1).

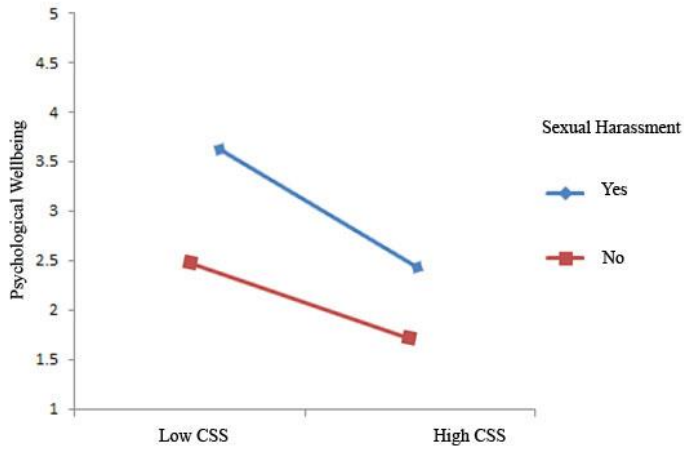

Figure 1. *Interaction Plot of Customer Related Social Stressors and Mental Health*

Plot showed that the relationship between Sexual Harassment and Customer Related Social Stressors become negative if sales girls not experience sexual harassment while the negative relationship between Sexual Harassment and Customer Related Social Stressors become stronger if they experience sexual harassment.

Discussion

The current study reveals that the sexual harassment was found to a negatively significant relationship among social wellbeing and psychological wellbeing of sales girls affecting their mental health Sexual harassment has been extensively researched in workplace over the past few years (Kelly, Sperry, Bates & Lean, 2009). The sexually harassment is practice profoundly in workplaces even in Pakistan and seen as a predictor of low self-esteem and low job satisfaction among working women (Malik, Malik, Qureshi & Atta, 2014). The harassment of employees by customer has been less overtly investigated however some previous researches showed it as significant problem the employees faced especially women during the course of their jobs (Hughes & Tadic, 1998; Harris & Daunt, 2013) and it leads to distress, disruption and workplace conflict (Murphy, Samples, Morales, & Shadbeh, 2015). Similarly, harassment has regularly being practiced in Pakistan and it takes place on daily basis, however both male and females becomes victim of it yet the ratio is seemingly high among

women especially those who work outside their homes. Living in a patriarchal society, women victimization or gender inequality are every day debates that comes in many different forms such as harassment, rape, domestic violence, acid attacks, etc because due to the heavy cultural influence the role of women is perceived as more traditional; serving the family, doing house chores and a symbol of affection and care. So from the very beginning both men and women are told about their roles in a society where males reminds of their dominance and women is seen as more fragile and vulnerable being and experiencing such negative social interaction thus decreases social wellbeing and psychological wellbeing among women (Nahum, Bamberger, & Bacharach, 2011; Lincoln, 2015). However, that is one potential explanation of women perceiving and seeing themselves from an external perspective.

Moreover, the customer related social stressors were also found to be significant negative in relation to sales girl's emotional wellbeing and social wellbeing. According to the prior researches, the interaction among customer and a service provider plays a key role in service job and the customer behavior is always been taking into consideration however, the negative interaction with the customer at the job will decrease employees wellbeing and could leads to emotional exhaustion. In addition, a series of emotions both positive and negative being experienced by the employees yet employees needs to persistently monitor and supervise their emotions in order to achieve the organizational goals (Grandey, 2000; Beal, Trougakos, Weiss, & Green, 2006; Huang, 2016). Therefore, displaying a particular set of emotions and always required to preserve positive customer relations at the job would lead to unnecessary emotional burden and experiencing negative treatment by the customer began endorsing poor wellbeing, poor health, emotional exhaustion and absenteeism among employees (Judge, Woolf, & Hurst, 2009; Grandey, 2000) and receiving positive treatment from the customer has been seen encouraging and strengthens the employees wellbeing (Harris & Reynolds, 2003).

The service culture around the world has been extensively studied and its principles are found to be similar everywhere, where all the organizations dealing with customer services are bound to the ideology of "customer is always right" (Grandey, Dickter & Pengsin, 2004). Dealing with the customer queries puts heavy strain and influence upon the employees making them vulnerable to the customer

misbehavior every now and then and also decreases their motivation to work (Grandey, 2000; Ilies & Judge, 2002). Moreover, the service providers feel immense pressure to their self-esteem, wellbeing, sense of control, fairness or equity and goal completion at work while dealing with customer's inappropriate behavior; providing the service with smile and going beyond to satisfied the customer needs put them on risk of developing psychological issues (Green, 2005).

Last, the interaction between both customer social stressors and mental health showed a significant negative relationship with psychological wellbeing of sales girls. The employees who deal with customers are referred to as emotional labor (Hochschild, 1983) which defines as the process of managing the expressions and feelings at the job as its requirement. During the interaction with the customers the employees are obliged to regulate their emotions and therefore made them suppress their truly felt emotions and expected to display such gesture that contradicts with their true personalities. Hence the job of a service provider opens gates to exploitation and manipulation of the employees by the customers where their true emotions are fully suppressed and withhold in the interests of the organizational profit and customer welfare. However, experiencing these sorts of circumstances would eventually lead to estrangement among their true self and their individuality (Williams, 2013). In addition, employees are required to adjust their roles according to the demands of the working world and due to heavy influence of culture where the role of working women is always been targeted pessimistically women tend to deal with their work values through their bodies and adjusting to their work lives they tend to change understanding of their bodies. Consequently, the bodies become a mechanism of transmitting their values to get along with the working culture (Melendez, 2001).

Conclusion

Findings of the current research supports the existing literature and researches on the customer related social stressor and mental health and fills the gap by investigating the prominent role of sexual harassment with regards to customer behavior in salesgirls. Therefore, it is concluded that sexual harassment has an huge impact on social wellbeing and psychological wellbeing. Lastly, the agenda of the current research was to present analytical evidence by taking into consideration the service culture and provided fruitful avenues for

future research and shed light on the service dynamics connecting it with psychological pursuits with an intention to enthuse people into further delving.

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Efficacy of Cognitive Behavior Therapy and Exposure Response Prevention for Obsessive Compulsive Disorders

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This article includes case study in an attempt to provide therapeutic intervention to woman brought to Government Hospital with presenting complaints of excessive hand washing, bathing, checking kitchen stove, cup boards and locks and anxiety. Informal and formal assessment was carried out which included Clinical Interview, Mental Status Examination, DSM-V checklist and Dysfunctional Thought Record and standardized tool (Y-BOCS), after which client was diagnosed with Obsessive Compulsive Disorder With fair Insight. The associate psychologist devised management plan which included Cognitive and Behavior Therapy (CBT) and Exposure and Response Prevention (ERP), it was completed in total 15 sessions. Patient was assessed again at post treatment level where she showed 80 % improvement as revealed by marked decrease in intensity of her symptoms. This study implies the efficacy of ERP and CBT for Management of OCD patients.

Keyword: Obsessive Compulsive Disorder, ERP, CBT

According to DSM-5 Obsessive Compulsive Disorder is diagnosed when obsessions or compulsions or both are present and these are time consuming and distressing for the individual. Obsessions can be defined as recurrent and persistent thoughts, urges, or images that are intrusive and not wanted, whereas compulsions are repetitive rituals manifested in the form of behavior or mental acts that an individual feels compulsory to perform in response to any obsession. There are many different sub types of OCD which involves different themes related to contamination, checking, ordering, sexual obsessions, and religious

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obsessions. Compulsions include neutralizing these obsessions by performing rituals in the form of checking, washing, counting, ordering etc. The worldwide prevalence of OCD in DSM-5 is reported to be around 1.1 %-1.8 %. Females are reported to be affected more than males in adulthood (American Psychiatric Association, 2013).

There are different causes for the development of OCD which are explained by different perspective including psychodynamic, behavior, and cognitive, socio-cultural perspective. The cognitive theory (Salkoviskis, Clark & Gelder, 1996) proposed that the OCD is characterized by cognitive distortion of "inflated responsibility" which combine with negative mood and motivate towards neutralizing actions which may include compulsive behaviors such as washing and checking.

The cognitive-behavioral model (Berman, Elliott, & Wilhelm, 2016) proposes that obsessions and compulsions arise from dysfunctional beliefs that one holds and strength of that belief. In people with OCD, these intrusive thoughts can become obsessions if they are appraised as personally. These appraisals will lead to high amounts of distress; which one then attempts to reduce with compulsions. These compulsions result in temporary anxiety reduction, but reinforces the maladaptive beliefs that led to the negative appraisal in the first place, thus the cycle of obsessions and compulsions continues as in this case the obsession of contamination resulted in high amount of distress which was removed by performing rituals of excessive hand washing that resulted in the temporary relief but it reinforced the negative appraisal in the first place thus perpetuating the cycle of obsessions and compulsions.

Objective

- To evaluate the effectiveness of Cognitive Behavior Therapy and Exposure and Response Prevention in the treatment of OCD.

Hypothesis

- Cognitive Behavior Therapy and Exposure and Response Prevention are likely to reduce the symptoms of OCD.

Method

Research Design

A×B×A single case research design was used to determine the efficacy of Cognitive Behavior Therapy and Exposure and Response Prevention in the treatment of OCD. The sample comprised of a single case (N=1).

Case Description/Sample Characteristics

The patient was 30 years old educated till intermediate, married woman, who belonged to lower class socio economic status, her father was a labor and her mother was a house wife, her relationship with her parents were satisfactory, there was indication of physical illness in her family, however there wasn't any psychological illness reported in them .She had 8 siblings and was 2nd last born among her siblings, all of them were married, the client had satisfactory relationship with all of them.

The client didn't have any history of any pre or post natal or any birth complications, she denied having any neurotic traits. She achieved puberty at the age of 12 years. She didn't have prior information about it thus it was very much disturbing for her but she eventually learned to manage it. No homosexual or heterosexual relationship was reported.

The client got her early education from Urdu medium school and completed her education up to F.A. she didn't persue her education further and started working as a teacher at a nearby school, there she worked for 12 years, then she got married at the age of 29 years, after marriage she left her profession and became house wife. It was an arranged marriage. She had been married for 1 year but didn't have any child however she mentioned that her physical relationship with her husband was satisfactory, however, there wasn't proper understanding between them as his husband was controlling, besides she also had conflictual relationship with her in-laws, who lived with her.

The patient was an introvert person. She didn't have many close friends and didn't like to talk much, however, she reported that she was capable of making her decisions on her own and didn't face any difficulty in this regard before the onset of problem.

She was referred to the clinical psychologist with the presenting complaints of excessive hand washing, bathing, checking kitchen stove, cup boards and locks, anxiety. She also had complaints of increased

need for sleep, decreased appetite and decreased self esteem; all these symptoms had caused significant distress in her life for around year.

History of Present Illness

The patient reported that her symptoms started 2 to 3 year earlier when for no apparent reason, she started spending more time in washroom for the purpose of cleaning, started checking cup board, locks and stoves, however these symptoms didn't cause any significant distress in her normal area of functioning. When the client got married, the intensity of the symptoms increased and it started to disrupt her daily life functioning. She started to spend almost 10 minutes to wash her hands when they were contaminated with dirt. She took almost 1 to 1 hour 30 minutes to take bath; her symptoms gradually intensified and with the fear of having excessive thoughts about contamination her diet and water intake gradually reduced as this would require going to washroom.

The patient sought psychological help one month earlier from Jinnah hospital but she reported no betterment in her condition so she started her treatment in Lahore General Hospital. The home environment was reported to be very much troublesome. There wasn't any proper understanding between her and her husband. And her mother in law was also very strict which lead to further more anxiety. Her husband had left her for 3 months and asked that she can come home after the complete treatment of her illness. She was determined to fight this disorder for which she had subsequent support of her parents and brothers.

Assessment Measures

The patient was assessed both formally and informally to gain detail insight about her problems and to confirm her diagnosis. The informal assessment was carried out with the help of Clinical Interview, Mental Status Examination; Subjective Ratings of the Symptoms, Dysfunctional Thought Record and by administering DSM-5 checklist for OCD translated in Urdu. The formal assessment was carried out with the help of standardized tool i.e. Yale Brown Obsessive Compulsive Scale (Y-BOCS). The summary of the results obtained from Subjective Rating of the Symptoms and Y-BOCS are given in table 1:

Table 1
Table for the severity of the symptoms

Symptoms	Severity of the symptoms
Excessive hand washing	10
Excessive bathing	10
Obsessive thoughts	10
Excessive checking of kitchen stoves. Cupboards and locks.	08
Increased sleep	05

Table 2
Yale Brown Obsessive Compulsive Scale scores

	Obsessions	Compulsions	Total	Inference
Score	10	13	23	Moderate level OCD

The patient obtained more score on the compulsion sub scale which meant that the performance of rituals were more disturbing for her as compared to obsessions , the total score of 23 indicated that she had moderate level of OCD. The patient was diagnosed with 300.3(F42) Obsessive Compulsive Disorder with fair insight.

Procedure

The procedure of treatment of the patient involved both medication and psychotherapy with the trainee clinical psychologist; both of these were planned simultaneously for the purpose of helping client manage her symptoms. The medication was prescribed by the psychiatrist and the trainee clinical psychologist devised a management plan for psychotherapy. A total of 15 sessions were conducted with the client the initial few sessions involved supportive work, detailed assessment, normalization and calming exercise. After proper establishment of rapport and thorough assessment the next sessions involved the introduction to the CBT and Exposure and Response Prevention (ERP). The SUDS (Subjective Unit of Distress Scale) were

obtained and then the patient was exposed to the contamination related obsessions in hierarchy of least to highest anxiety provoking situation, this involved exposure firstly at the imaginal level and then gradually to the highest anxiety provoking situation, during all this process she was taught the phenomenon of habituation and was asked to practice it during all the exposures, until her anxiety level reduced. Once the ERP was completed, the later sessions involved work on her cognitive restructuring which involved identifying her cognitive distortion through vertical dissent technique and then restructuring it by obtaining cost and benefit analysis, alternative thought record. The last few sessions involved managing her associated symptoms which involved anger management, assertiveness training and self esteem building exercise; they also involved guiding about the relapse prevention and providing therapy blue print and providing guidelines to the family. One follow up session was carried out to further check her condition. The session wise treatment is given below.

Table 3
Session wise management plan

Session No 1 Presenting Complaints Supportive Work Mental Status Examination DSM checklist Deep breathing Exercise	Session No 2 Feedback History Taking Formal Assessment (Y-BOCS). Diversion Technique
Session No 3 Feedback Activity Scheduling Psycho education about OCD Obtaining Subjective Unit for Distress Scale (SUDS)	Session No 4 Feedback of previous session Brief history Coping Statements
Session No 5 Introduction to the Cognitive Behavior Therapy (CBT) Identifying Cognitive Distortion(Vertical Descent)	Session No 6 Feedback History from informant Preparatory for Exposure and Response Prevention

Dysfunctional Thought Record Chart (DTR) Home work	Home work (DTR, Activity schedule)
Session No 7 Feedback Exposure and Response Prevention continued	Session No 8 Feedback Exposure and response prevention continued
Session No 9 Feedback Exposure and Response Prevention Cognitive Restructuring Guiding about checking compulsions Post assessment of subjective symptoms	Session No 10 Post assessment(Yale Brown Obsessive Compulsive Scale) Cognitive Restructuring continued
Session No 11 Feedback Cognitive restructuring continued Home work (Alternate thought record chart)	Session No 12 Feedback Cognitive restructuring continued
Session No 13 Feedback Relapse prevention Therapy blue print	Session No 14 Feedback Family Counseling
Session No 15 Follow up session	

Ethical Consideration

A verbal consent was taken from the patient to carry out intervention. The patient was educated regarding the procedure of therapy, approximate number and duration of sessions. The

confidentiality of the patient was ensured and the results were reported objectively.

Results

For the purpose of assessing effect of therapy on the patient, the post assessments were again carried out; this involved assessing again at informal level by means of subjective ratings of the symptoms as well as formal assessment of Y-BOCS again. The summary of these results are given below:

Table 4

Post Treatment Ratings for Severity of the Symptoms

Symptoms	Pre-treatment rating	Post –Treatment rating
Excessive hand washing	10	04
Excessive bathing	10	05
Obsessive thoughts	10	05
Excessive checking of kitchen stoves. Cupboards and locks.	08	03
Increased sleep	05	2

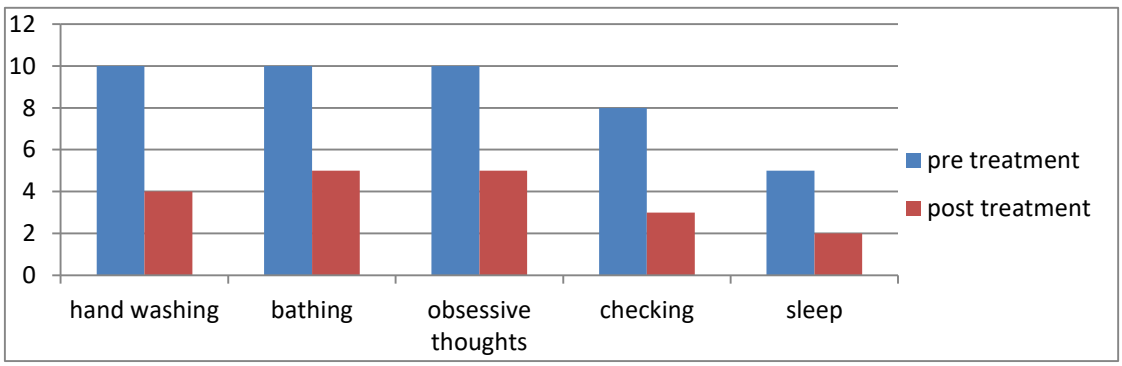

Figure 1. *Graphical Representation of pretreatment and post treatment ratings of Subjective Ratings*

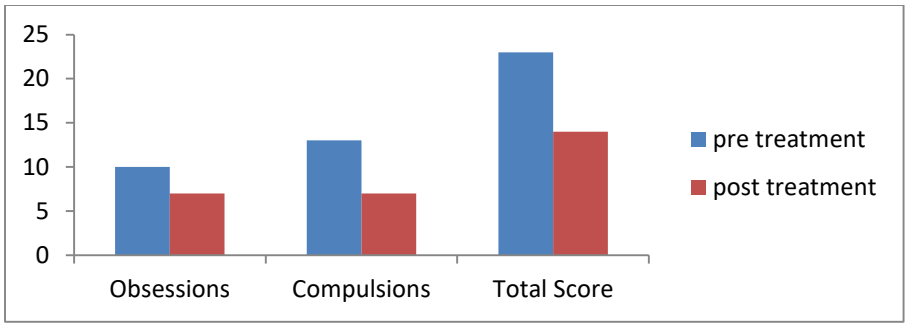

Figure 2. *Graphical Representation of pretreatment and post treatment ratings of Y-BOCS*

Discussion

There was 80 % improvement in the patient's condition after the application of different cognitive and behavioral technique which is evident from the post ratings as wells as formal assessment which indicated that she shifted towards low level of OCD after therapy. The total number of sessions carried out was 15. Reason for the betterment of her condition also included her compliance towards the therapy; she completed her homework assignments and worked very hard with motivation to counter her disorder, thus all these factors contributed to her improved condition.

Ponniah, Magiati, and Hollon (2013) reviewed different types of psychotherapies used for the treatment of OCD, and they concluded after reviewing forty- five studies that ERP and CBT were the most effective treatment method for OCD, the post treatment effect of our study shows the improvement in the condition of client, after administering CBT and ERP, thus our study is consistent with this study and proves effectiveness of these therapy.

McKay, Debbie, Fugen, Sabine, Stein, Kyrios, Matthews and Veale (2014) declared ERP to be first line evidence based treatment for OCD , which when administered simultaneously with cognitive therapy , targets specific symptom-related difficulties of OCD which increase tolerance from distress, adherence to treatment, and reduce drop out thus its treatment effect is durable thus the results of our case study is consistent with our finding as the CBT administration , involving ERP improved her adherence to the treatment and she responded to therapy well.

This study implies the effectiveness of CBT and ERP in the treatment of Obsessive Compulsive Disorder.

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