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Comparing the efficacy of EMDR and CBT in Reducing Examination Anxiety in Adolescents

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Introduction:

Test anxiety involves excessive fear and worry about situations involving formal evaluation of performance, particularly in academic domains. Although most people experience some form of test anxiety, estimates of the prevalence of functionally impairing test anxiety range from 20-35% in studies of college student populations (Zeidner, 1998), and severe test anxiety can significantly disrupt performance (Rothman, 2004)..

EMDR is a psychotherapeutic method that enables people to quickly process and heal from emotional distress. Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapeutic technique (Shapiro, 1989) acclaimed as a major breakthrough for a range of anxiety related symptoms. EMDR entails an information- processing mechanism rather than a simple desensitization treatment effect.

Cognitive Therapy-

Standard Beckian CBT, known as cognitive therapy (CT), is based on the so-called cognitive model, which links cognitions, emotions, and behaviors such that cognitions shape behaviors and emotions, and unrealistic cognitions can lead to inappropriate emotions and behaviors (Beck, 1967). CT aims to reduce test anxiety by identifying and restructuring biased or maladaptive cognitions such as those about the inevitability and exaggerated consequences of failure (Beck, Emery, & Greenberg, 1985). In addition, CT programs for test anxiety typically include relaxation techniques such as deep breathing and guided imagery.

METHODOLOGY

PURPOSE OF THE STUDY

The aim of this study was to compare EMDR as a therapeutic strategy with Cognitive behavioral intervention in high test anxious adolescents.

SAMPLE:

A total of 412 students across colleges were pretested on Test Anxiety Inventory (Spielberger, 1980). Out of this, 61 high test anxious students were selected for the study. The mean age for the whole group was 18 years and the male to female ratio was approximately 50%.

TOOLS OF DATA COLLECTION:

- Test Anxiety Inventory (TAI) for pre-test and post-test condition (Spielberger, 1980)
- Dissociation scale (DES) to measure dissociation level of the students for pre- test condition only (Carlson & Putnam, 1993).
- Protocol for individual EMDR intervention used during the sessions (Shapiro, 1989).

HYPOTHESIS:

- There will be no significant difference in the pretest scores on Test Anxiety Inventory (TAI) in the EMDR intervention subjects and CBT intervention subjects
- There will be significant difference in post TAI scores in students who were administered EMDR intervention and CBT intervention

PROCEDURE:

For the purpose of pretesting, Test Anxiety Inventory was administered to the subjects of the study. High test-anxious students were selected for the study. Subjects were randomly assigned to receive either the individual EMDR intervention or the CBT intervention.

Each session was of 90 minutes and both the groups were assigned the same time.

EMDR Intervention- Standard individual EMDR protocol procedure was followed.

CBT Intervention- Cognitive model was explained to the participants, followed by strategies like restructuring automatic thoughts. Three strategies were provided for identifying and correcting distorted cognition:

- 1) Eliciting thoughts
- 2) Examining thoughts
- 3) Identifying cognitive distortions

Subjects were taught breathing and relaxation techniques so that they could be used by them before or during examination

Table:1

Details of subject’s session by session details for CBT and EMDR

SESSION	EMDR	CBT
1	Psychoeducation and introduction of EMDR protocol on target memory with highest level of disturbance	Psychoeducation and identifying distorted thought pattern
2	Finishing reprocessing previous target, & start reprocessing next target memory	Learning breathing and relaxation exercises
3	Finishing reprocessing previous target, or start reprocessing next target memory	Cognitive restructuring and exploring and correcting undesired or unhelpful coping behavior
4	Installing future template	Relapse prevention

RESULTS & DATA ANALYSIS: Data collected from the students were prepared for analysis. Apart from descriptive statistics (measures of central tendency), 't'-test was applied for verification of hypotheses.

Table 2

Pre-test and Post-test difference in means and t values of TAI for Individual EMDR and CBT subjects

Type of Intervention	N	Pre TAI Means	Post TAI Means	Difference In Means	t-value
EMDR Intervention	31	61.93	43.10	18.83	14.42*
CBT Intervention	30	61.48	57.12	04.36	1.43

Note: * .01 level of significance

Paired 't' test was used to find the significance of the difference between pre and post-test TAI scores for the individual EMDR and subjects belonging to CBT intervention group. The above table shows that the mean difference in TAI scores for individual EMDR intervention was 18.83, which was found to be significant ($t(30) = 14.42, p < .01$), suggesting that there was a significant difference in test anxiety scores of the students in the post-test condition. The mean difference for the CBT intervention group indicated a marginal decrease in mean scores from the pretest mean value to post test mean value, which was 4.36. This was NOT found to be significant ($t(29) = 1.43, n.s$), suggesting that there was no significant difference in test anxiety scores for the CBT intervention subjects

Table 3

Post test means, SD and t values of TAI for EMDR Intervention group (N = 31) and CBT Intervention group (N = 30)

Post TAI	N	Mean	SD	t-value
EMDR Intervention	31	43.10	4.715	10.069*
CBT Intervention	30	57.12	6.059	

Note: * .01 level of significance

The mean test anxiety score in the post test condition for the EMDR intervention Group (N = 31) was 43.10 and SD was 4.715. For the CBT intervention subjects (N = 31) mean was 57.12 and SD was 6.059. To test the significance of the difference between individual EMDR and CBT intervention, independent 't' test of significance was used. On the variable of test anxiety the difference was found to be significant in the post test condition between the EMDR and CBT intervention ($t(59) = 10.069, p < .01$). It revealed that the scores of EMDR subjects and CBT differed significantly from each other.

Discussion:

Following is a discussion of hypotheses related to results:

Hypothesis: 1

There will be no significant difference in the pre test scores on Test Anxiety Inventory (TAI) in the EMDR intervention subjects and CBT intervention subjects

The present study was carried out to investigate the difference in pre test anxiety scores on Test Anxiety Inventory (TAI). The findings confirmed the hypothesis that there was no significant difference found in pretest scores of high test anxious students belonging to EMDR intervention group and CBT intervention group. Most of the research on test anxiety has been on its debilitating impact. The findings can also be interpreted in the view of the research studies which indicate that high test-anxious individuals perform poorly when a task is hard or when performance is to be evaluated (Hembree, 1988).

People's lives are influenced by test performance so much that anxiety during examination has become pervasive contemporary problem (Hembree, 1988; Peckrun, 1992; Sarason, 1980; Sarason and Sarason, 1990; Sharma, 1988; Sharma and Rao, 1984; Spielberger and Vagg, 1995; Sud 2001; Tobias, 1992). One of the most threatening events that cause anxiety in students today is testing. When students develop an extreme fear of performing poorly on an examination, they experience test anxiety

Hypothesis: 2

There will be significant difference in post TAI scores in students who were administered EMDR as compared to CBT intervention. The present hypothesis was formulated to study the differential effect of EMDR intervention and CBT intervention in the reduction of test anxiety scores. The findings of the study supported the hypothesis. There was a significant difference found in the post test condition (Table 3), suggesting that there was a reduction in test anxiety scores in subjects belonging to EMDR intervention. The mean posttest TAI scores of subjects belonging to EMDR intervention was below cut off score (51.00) as compared to post test TAI scores of subjects belonging to CBT intervention, suggesting that subjects belonging to CBT intervention did not experience the reduction in test anxiety the same way as it was experienced by subjects belonging to EMDR intervention.

Eye movement desensitization and reprocessing (EMDR) is a psychotherapeutic method for working through traumatic memories and related psychological problems (Shapiro, 1996).

The subjects belonging to individual EMDR intervention showed two marked changes:

1. Decreased anxiety levels, showing a pronounced desensitization effect
2. A marked increase in the subject's perception of how true their positive belief was, showing a strong cognitive restructuring.

While processing, subjects often indicated sequential emergence of new memories unrelated to the target memory but these memories surfaced temporarily during the set and the subject shifted back to the initial target memory. In some cases no new memories emerged consciously and the target incident was maintained consistently. The change was verbalized by

the subject in different aspects of memory. The subjects reported the change in Image, Emotions, Physical sensations and Cognitions.

EMDR is a structured psychotherapeutic methodology developed by Shapiro (1989, 1995). It is effectively used in dealing with distress produced by test anxiety (Stevens and Florell, 1999).

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Self efficacy

Neha Dalal

Self-efficacy is “Beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments”

Self efficacy plays a major role in how one approaches goals, tasks, and challenges. It is the center of Bandura’s social cognitive theory. There is a difference between self-efficacy & self-esteem. Although self-efficacy and self-esteem are often used interchangeably as though they represent the same phenomenon, they in fact refer to entirely different things. Self-efficacy is concerned with judgments of personal capabilities. Example: “I’m going to make this free-throw shot.” Self-esteem is concerned with judgment of self-worth. Example: “I’m a terrible person.” As quoted by Bandura “There is no fixed relationship between beliefs about one’s capabilities and whether one likes or dislikes oneself.”

Maddux describes self-efficacy as, “What I believe I can do with my skills under certain conditions.” Outcome expectancies are the judgments about what needs to be done in order to reach a desired goal. Efficacy expectancies are the analyses of one’s capabilities to complete the necessary actions to complete a task or reach a goal. According to Bandura, outcome expectancies are less important than efficacy expectations.

There are various sources of self-efficacy appraisals. Following are some of them:

Actual performance: efficacy perceived through performance experiences. Success builds a strong belief in one’s personal efficacy, and failure undermines it. Bandura believes this to be the most influential source of knowledge.

Vicarious experiences: appraising one’s capabilities in relation to the attainment of others.

Verbal persuasion: easier to sustain a sense of efficacy, especially when struggling with difficulties; if significant, others express faith in one’s capabilities than if they convey doubts.

Psychological cues: in judging their capabilities, people rely partly on somatic information conveyed by physiological and emotional states.

Hence, self-efficacy is a situational-specific form of self confidence. Bandura states that self-efficacy predicts actual performance when skill and motivation are equal. If you are as motivated as your opponent, whoever has the highest self-efficacy will win

Self efficacy can be improved through Bandura’s 4 component model:

1. Observation of others' performing – successfully, to encourage modeling of behavior/performance.
2. Goal setting – performance goals.
3. Ability to/knowledge of interpretation of own levels of arousal.
4. Visualization/imagery/positive self-talk.

It is believed that self-efficacy is learned over time. Self-efficacy is based on the premises of social cognitive theory. Social cognitive theory holds that humans are active participants in shaping their lives as opposed to passive reactors to environmental events.

Social cognitive theory is built on three ideas:

1. Humans have powerful symbolizing capacities for cognitively creating models of their experiences.
2. By observing themselves in relation to these cognitive models, people then become skilled at self-regulating their actions as they navigate ongoing environmental events.
3. People and their personalities are a result of these situation-specific reciprocal interactions of thoughts – environments – thoughts.

Neurobiology of self-efficacy has been recognized in recent years. The frontal and prefrontal lobes play a role in self-efficacy because of their responsibility for the prioritization of goals and planning. Self-efficacy or perceived control can be traced to underlying biological variables that facilitate coping.

Measuring self efficacy

Bandura strongly believes that self-efficacy should reflect beliefs about using abilities and skills to reach given goals in specific circumstances and domains. Given this situational view, several measures have been developed in the area of vocational psychology. Betz and colleagues have developed a 25-item career decision making self-efficacy scale. The occupational questionnaire was developed to assess students' mastery of various vocations. The career counseling self-efficacy measures counselors' confidence in deriving interventions for persons who are having difficulties with their career decisions. Although Bandura would not support a trait perspective, other researchers have developed such dispositional measures of self-efficacy. The self-efficacy scale is a 23 item trait-like index. It measures two factors: general self-efficacy and social self-efficacy. Internal reliabilities range from alphas of .71 to .86. Concurrent validity is supported with its positive correlations with scores on measures of personal control, ego strength, interpersonal competency, and self-esteem. The new general self-efficacy scale is an eight-item measure. Its scores relate positively to those on the self-efficacy scale

Areas where self efficacy affects are

1. Psychological adjustment: Self-efficacy has been found to be related to successful coping with a variety of psychological problems like overcoming eating disorders and abuse. Bandura emphasized enablement factors that help people select and structure their environments in ways that set a successful course. This is a positive, strengths-based approach that taps the positive psychology emphasis on enhancing strengths instead of lessening weaknesses.
2. Physical health: Elevated self-efficacy increases health-related behaviors and decreases unhealthy ones. It also helps to maintain these changes. Self-efficacy also has an impact on various biological processes that relate to better physical health.
3. Psychotherapy: Enhancement of self-efficacy in psychotherapy increases efficacious thinking for specific circumstances and shows how to apply such thinking across situations that the client may encounter.
4. Collective efficacy: Self-efficacy can operate at the collective level and involve large numbers of people who are pursuing shared objectives. Collective efficacy is defined as the extent to which we believe that we can work together effectively to accomplish our shared goals.

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