

CHAPTER – I

CONCEPTUAL FRAME WORK

Introduction

Human beings are endowed with the ability to constantly reflect and improve upon the conditions that surround them. The power of human beings goes through social and cultural patterning through out their childhood. It gives the human beings plasticity of nature and variability in thinking power and cultural responses.

Family is the primary and most powerful agent in the child's metamorphosis from an infant to a responsible adult member of the society. Family is the basic unit of society and contributes significantly towards the changing patterns, development process economic and political values, cultural and moral values and interpersonal relationships, coping behaviour social skills and other innumerable aspects of a person's personality.

It is old concept & was mostly prevalent in rural areas in ancient times. The idea behind this system was to provide security (social, economic and political) unity, higher degree of cooperation & low levels of anxiety & stress.

It is a modern age concept & symbolizes urban gentry living in modern cities. The idea behind this concept to pace up with modernization process & rapid progress in life. But here, the person has higher levels of anxiety & stress, lesser security & integrity.

But now again due to the changing trends of our society, passions, in need of greater cooperation cooperation & security from rising crime graph, ethics, cultural values & sense of behaviours more & more families are returning towards the older joint family system.

Further, about the grand parents in the above mentioned family system sharing their relations with grandsons, grand daughters & similar other relations, we will find that the life and personality traits of children is greatly influenced by their grandparent proximity. These adolescents are just like blank paper and very sensible towards the happenings and incidents and daily activities that are going on taking place around their physical environment and they often correlates and compares reason out all that which comes under their purview with a lot of interrogations like "Why "?, "What "?, "How "?, "When" etc.

In this above mentioned context it really becomes a big cause of anxiety that, how these raw and immature minds should be dealt with? What should be the approach to be adopted ? The answer to all these

questions lies in the adoption of a very selective, balanced and to the point approach.

India has been a country where a close joint family system has been prevalent through centuries the connotative meaning of term 'Family' has always included relatives like uncle, aunts, cousins and above all the Grandparents. The rapid industrialization Westernization and modernization have led to the gradual fragmentation of the joint family system. However, despite the negative influences the joint family has even now survived at times in the form of the extended family system. Thus , children in India may be living in different types of families systems the most prevalent being the joint, extended and the nuclear families children in such varying types of family system are exposed to influences of different types of family structure and family members.

One of the most important influence may be that of the grandparents with whom the child comes in highest level of contact in a joint family and some what lower level or medium level of contact in an extended family. There may also be situations where is no contact but usually this happens only when grandparents are no more and the family is nuclear grandparents in India generally quite activity involved in the rearing of their grand children. In this perspective it becomes exist

between the children who reared in the proximity of their grandparent's and those who have very rare or no opportunity to interact with their grandparent's.

Coping behaviours and Social skills has been considered to be closely associated with development of moral values and morality as both are conceptually related is more to do with personal judgement of right and wrong than behaviour with can not greater control over undesirable or non conforming behaviour

Grand Parental Proximity

Proximity of learned, experienced, aged and mature people helps in learning process, refinements of personality by rectification of mistakes, right knowledge and guidance at crucial times of life, system and disciplined approach with proper and timely encouragement and moral support.

Now as far as the relationship of grand children and grandparents is concerned we can not escape the prevailing generation gap. The ideology of modern generation, their thinking, social adaptability and style quotients are widely different as compared to their pedigree.

But, despite of these differences, the proximity of grandparents had a great role to play in the lives of youngsters and grand children and grandparent's relation's with them are indeed healthy and flourishing

one. It is the proximity of grandparents in terms of love, affection, caring and sharing nature which develops a greater affinity of the grand children towards them.

They grand children prefers to share every minute details and experiences that they come across with them and feels relieved. They are very comfortable with their grandparents to share their secrets because of their more friendly behaviour as compared to their parents.

But now if we look into the other aspects of this proximity, it some times gives rise to certain irregularities and lackings. The children often takes advantage of grand parents excessive liberties. caring nature and freedom thereby developing sense of wrong behaviour ignorance, carelessness, hiding facts, turning violent and adamant, this all happens when children gets some extra attention and care in certain respects without a proper restraint. These things some times invites big troubles in their lives and ultimately the whole yarn of life gets disturbed there by inviting depression and stress.

In our modern families we comes across these types of situations after which we need various remedial measures. The only tool left to deal with these situations from coming into existence is to become selective, balanced and defining our boundaries in all respects with right counseling motivation and strict vigil over grand children.

Gender

The influence of gender role socialization which starts from birth. From beginning boys & girls are socialized differently. Boys are expected to be aggressive, assertive and hostile and other stereotypical male characteristics. This finding is in tune with the research finding of Ameerjan (1994) where it was found that when compared to boys girls perceived that their parents showed more nurturance and instrumental companionship, expected more principled, discipline and predictability of standard, & rewarded more often for their achievement. That is boys at adolescence analyse and evaluate themselves as separate or individually where as in contrast not being so instrumental girls identify themselves in relationship to others. Instead of urging for separation they value connectedness.

Boys explored the world & then made commitments while girls adopted values, beliefs, goals of significant others in their environment without exploring. This might be due to reason that the gender role socialization that parent give from beginning encourages boys to have instrumental traits as assertive, bold, leadership independent and feminine traits among girls. Thus reaching at adolescents boys start questioning inquiring and exploring their own alternatives while girls follow whatever is being told rather than confronting with authority as parents. It might be

because parent links girls to be fragile and weak so they may give over protectiveness comparing to boys. Thus, since everything is being done for them they get habituated to receive whatever is being given rather than exploring themselves like boys. These findings can be supported by research finding of Moore (1987) found that girls are generally over socialized towards dependence on family while boys are over socialized towards independence.

Age

Adolescents fare better and their family relationships are happiest households where parents are both, supportive, and accepting of the child's needs for more psychological independence (Lerner & Steinberg 2004).

Adolescents marks an important turning point in the parent child relationship. The biological, cognitive & emotional changes of the teenage years spark a transformation in the relationship. In many families the transition into midlife. This too introduces addition at challenges into the family system that spill over into the parent child relationship (Nystul 1999).

Early adolescents covers roughly from this teen to 16 or 17 yrs. Majeres (1976) "Early Adolescents is usually referred to as the teens

sometimes the “terrible”. Although older adolescents are strictly speaking “teenagers” until they reach twenty years of age”.

Depression

The depression is part of our everyday language these feeling occur in all of us. The feeling of depression based on temporary situation usually fade away quickly. They are quite different from the feeling of being under a black cloud that accompany a depressive episode or major depressive disorder.

Depression feeling sad, frustration & hopeless about life accompanied by loss of pleasure in most activities & disturbances in sleep appetite, concentration & energy is the most common psychological problem of adolescence. About 15 to 20% of teenagers have had one or more major depressive episode.

The term depression covers a variety of negative moods & behaviour changes some are normal mood fluctuations & others meet the definition of clinical problems. The mood change may be temporary or long casting. It may range from a relatively minor feeling of melancholy to a deeply negative view of the world and an inability to function effectively. Technically when people say they feel depressed, “low down”, they are experiencing a depressed-mood. Usually these feeling are based on a temporary situation & fade quickly when the situation

changes. For instance people often feel sad around the holidays, when they believe that others are enjoying closeness & pleasure companionship. These feelings though unpleasant, are quite different from the feeling of being under a black cloud that accompanies a depressive episode or major depressive disorder.

People also use the term depression to describe the sadness that comes from a death in family. After the death of someone they care deeply about, most survivors experience a depressed mood that is usually called grief common features of grief include physical distress such as sighing tightness of the throat, an empty feeling in the abdomen, & a feeling of muscular weakness. In addition there may be preoccupation with the usual image of the dead person along with guilt & hostile reaction. These feelings of grief & entirely normal and are not classified as a depressive disorder. Divorce and separation may also bring about these feelings which are likely occurs to both participants regardless of who wanted to end the relationship such feeling often represent a short term response to stress.

Other kinds of life events like losing job, being turned down for a graduate school programme or losing everything in a fire may also bring about a depressed mood.

Depression signifies unhappiness so it is opposite to elation. If a person feels depressed due to some real happenings, his unhappiness so it is opposite to elation. If a person feels depressed due to some real happenings , his unhappiness should be considered as normal. But if a person shows sadness without nay unusual happening in his circumstances it may be sad that he is showing unwarranted depression. In a mood of depression the patient lacks a drive. He is not motivated to words doing anything he feels confused and be wildered. The individual does not find out the reason for his depressed mood, because the same is repressed.

In the area of psychological adjustment, depression is common among people at different age levels. In its severest form, depression is pathological and can lead to devastating effects on peoples lives. According to Diagnostic and Statistical Manual Disorders Fourth Edition (DSM-IV) of the American Psychiatric Association 1994, the diagnostic criteria for major depressive order are NINE: Depressed mood (which for adolescence population might be irritability) markedly diminished interest or pleasure in all or almost all activities significant weight loss or weight gain or change in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, diminished ability to think or concentrate and

recurrent thoughts of death or suicidal ideation or suicidal attempt. The diagnosis of depression requires the presence of five or more of these nine symptoms over a period of at least two weeks. At least one of the symptoms must be either depressed mood or loss of interest or pleasure.

Depression the feeling of being dejected, discouraged and "Down in the dumps" is usually accompanied by lowered initiative, listlessness and some degree of self-devaluation. Often the clinical picture also includes loss of appetite, sleep disturbances and a lowered sex drive. Most of us have probably felt depressed at one time or another as a result of a disappointment in love, an accident, a hurtful failure or the death of a loved one. In fact, there are literally hundreds of thousands of Americans estimated one person in seven who evidence "MILD" depression. Even in mild form, depression can lead to thoughts of suicide and markedly reduce one's personal effectiveness and joy in living.

Physiology of Depression

Negative emotions & feelings bring poisonous toxins to the organisms. Strong negations such as anger, spite, envy, jealousy, and fear make the endocrine system accumulate poisons in the blood. Anxiety, depression, and doubt can also cause poisoning in the blood.

The potential health benefits of engaging in regular exercise reduced cardiovascular and mortality, lowered blood pressure and the increased

metabolism of carbohydrates and fats, as well as a range of psychological benefits such as improved self esteem, positive mood states, reduced life stress, anxiety and depression. A growing body of research suggests that physically active people have lower rate of anxiety and depression than sedentary people (Statistics Canada 1999). Consider a classic study in which Mc Cann & Holmes (1984) randomly assigned one of group of mildly depressed female college students to an aerobic exercise programme, another third to an-treatemnt condition (the control group). Ten weeks later, the subjects in the exercise group reported the largest decrease in depression.

Norepinephrine & serotonin, the two nuero-transmitters that increase arousal & boost mood are low in depressed people. Aerobic exercise such as running may counteract depression in part by increasing the serotonin activity in the brain & thus replacing depression state of low arousal. In this manner, running does naturally that antidepressant drug such as Prozac, Zoleft & Paxil do (Jacobs 1994).

Marmot (2001) states 'the mind is a crucial gateway through which social influence effect physiology to cause disease. The mind may work through affects on health related behaviour such as smoking, eating, drinking, physical activity, or risk taking, or it may act through effects on neuroendocrine or immune mechanisms. The Whiteball II study showed

that level of control over one's work was an important predictor of the risk of cardiovascular disease and that it had an important role in accounting for the social gradient in coronary heart disease and depression Marmot et al., (2001). People who report feeling low control at home and over life circumstances have an increased risk of depression, especially among women in low status jobs.

Lenon 1987 examines 3 perspectives about menopausal depression. According to one the physiological changes of menopause result in increase psychological distress. The second proposes that menopause is most depressing for women who occupy traditional female gender roles. The third asserts that menopause is not especially depressive for most women. Result suggests with depressive symptomatically either directly or indirectly through traditional gender roles.

Pattersson & Lynch 1988 discusses sociological, psychological & attitudinal responses that account for negative responses to menopause and recommends strategies for counsellor interventions. It is associated with menopause may be related to the way women are socialized to view their self worth in term of sexual attractiveness and fertility. Personality changes associated with menopause are related to reactions to loss and coping with new social roles. Data suggest that middle aged women do not necessarily view menopause in a negative light. It is suggested that

counsellor should emphasize the midlife period as a time for continued growth and creative expression.

Notman 1984 describes the physical and psychological disturbances that may accompany menopause and the treatment of these disturbances disorders common to menopause include hot flashes, osteoporosis, depression, insomnia & prosthesis. These symptoms may be hormonal or psychosocial in origin, although depression is more likely to be associated with such psychosocial factors as family and socio-economic experiences of mid life than with endocrine changes.

Types of Depression

Major Depression

Major depression is characterized by the inability to enjoy life and experience pleasure. The symptoms are constant, ranging from moderate to severe. Left untreated, major depression typically lasts for about six months. Some people experience just a single depressive episode in their lifetime, but more commonly, major depression is a recurring disorder. However, there are many things you can do to support your mood and reduce the risk of recurrence.

Typical Depression

A typical depression is a common subtype of major depression. It features a specific symptoms pattern, including a temporary mood lift in

response to positive events. You may feel better after receiving good news or while out with friends. However, this boost in mood is fleeting. Other symptoms of a typical depression include weight gain, increased appetite, sleeping, excessively a heavy feeling in the arms and legs, and sensitivity to rejection. A typical depression responds better to some therapies and medications than others, so identifying this subtype can be particularly helpful.

Dysthymia, (recurrent, mild depression)

Dysthymia is a type of chronic "low-grade depression". More days than not, you feel mildly or moderately depressed, although you may have brief periods of normal mood. The symptoms of dysthymia are not as strong as the symptoms of major depression, but they last a long time. These chronic symptoms make it very difficult to live life to the fullest or to remember better times. Some people also experience major depressive episode on top of dysthymia a condition known as "double depression". If you suffer from dysthymia, you may feel like you've always been depressed. Or you may think that your continuous low mood is "just the way you are". However, dysthymia can be treated, even if your symptoms have gone unrecognized or untreated for years.

Seasonal affective disorder (SAD)

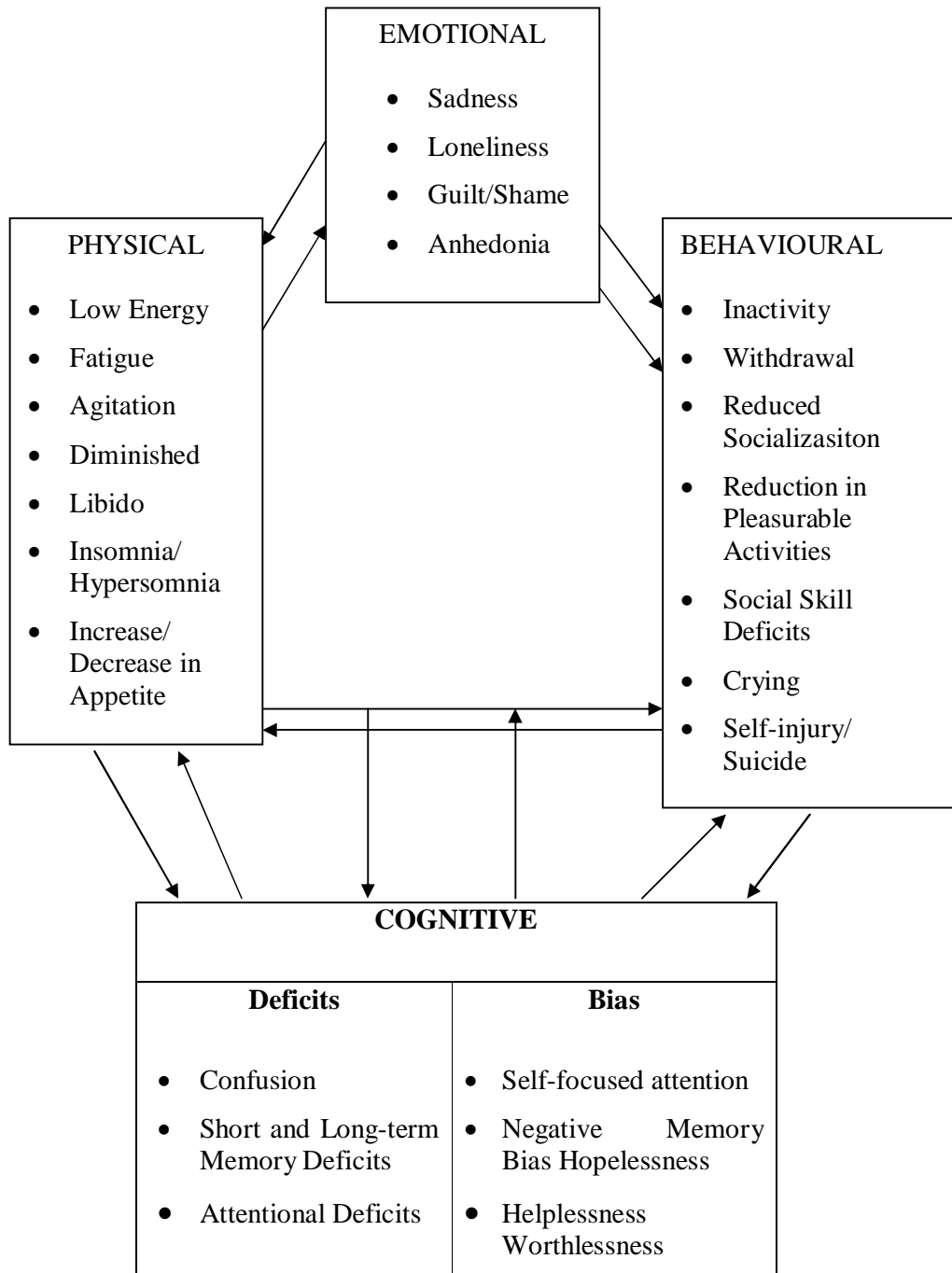
There is a reason why so many movies and books portray rainy days & strong weather as gloomy, some people get depressed in the fall or winter, when overcast days are frequent and sunlight is limited. This type

of depression is called seasonal affective disorder (SAD). Seasonal affective disorder is more common in northern climates and in younger people. Like depression, a treatment that involves exposure to bright artificial light, often helps relieve symptoms.

Symptoms of Depression

Depression varies from person to person, but there are some common signs and symptoms. It's important to remember that these symptoms can be part of life's normal laws. But the more symptoms you have, the stronger they are and the longer they've lasted, the more likely it is that you are dealing with depression. When these symptoms are overwhelming & disabling, that's when it's time to seek help.

Fig 1.1: The Symptoms of Depression



Common signs & symptoms of depression

- Feeling of helplessness & hopelessness – A bleak outlook nothing will ever get better & there is nothing yours can do to improve your situation.
- Low of interest in daily activities – no interest in former hobbies, pastimes, social activities, or sex. You have lost your ability to feel joy and pleasure.
- Appetite or weight changes – Significant weight loss or weight gain a change of more than 5% of body weight in a month.
- Sleep changes – Either insomnia, especially waking in the early hours of the morning, or oversleeping.
- Irritability or restlessness – Feeling agitated, restless, or on edged. Your tolerance level is low everything & everyone gets on your nerves.
- Loss of energy – Feeling fatigued, sluggish & physically drained. Your whole body may feel heavy, even small tasks are exhausting or take longer to complete.
- Self-loathing – Strong feeling of worthlessness or guilt. You harshly criticize yourself for perceived faults & mistakes.

- Concentration problems – Trouble focusing, making decision or remembering things.
- Unexplained aches & pains – An increase in physical complaints such as headaches, back pain, aching muscles & stomach pain.

It is a sense that the world is out of joint, & you yourself have lost all sense of balance and harmony. Like a massive dark haze that descends on your life, it distorts your impressions of events and people and makes body, mind and soul numb and cold. Feel dejected and sad most of the time, some depressions manifest themselves in emotional despair, while others are masked in physical symptoms similar to those we get when very stressed out. Stomach pain, headaches palpitations, and dizziness may all be signs of depression.

Depression continues & worsens

Lack of self-esteem, feeling unworthy

- Exhaustion
- Abandoning work and home responsibilities
- Abandoning personal hygiene
- Inability to communicate with others
- Feelings of impending doom, utter hopelessness
- Thoughts of death

- Lack of interest in activities & people
- Sadness & pessimism about everything
- Inability to enjoy yourself
- Testiness
- Difficulty concentrating
- Changes in appetite, weight and sleep patterns
- Loss of libidos
- Indecisiveness

The existence and definition of depressive disorder in childhood have been the subjects of considerable controversy (Lefkowitz & Benten 1978). However a clear consensus now exists that major depressive disorder & dysthymia are present in childhood & that the core symptoms closely parallel adult depression (Angold 1944) by the use of the same diagnostic criteria for children and adult. Implicit in this approach is the assumption that depression is the same coherent phenomenon at each illness. Research has indicated that increase in happiness leads to alleviation of symptoms of depression (Seligman, Steen, Park & Peterson 2005)

Stage of Development

Thus correctional evidence of preliminary validation of this construct. Indeed evidence suggests that depressed mood, anhedonia, & cognitive symptoms such as guilt & worthlessness correlate in similar ways across the age range (Angold 1993). However, consensus is growing that some symptoms of depression may be more common in children than problems like psychomotor retardation hypersomnia or delusion which tend to increase during adolescence (APA 1994).

Signs of Depression

- Persistent sadness & hopelessness
- Withdrawal from friends and activities once enjoyed
- Increased irritability or agitation
- Missed school or poor school performance
- Changes in eating and sleeping habits
- Indecision, lack of concentration or forgetfulness
- Feeling of worthlessness or excessive guilt
- Frequent physical complaints such as headaches and stomach-aches
- Lack of enthusiasm or motivation

- Low energy & chronic fatigue
- Drug and/or alcohol abuse
- Recurring thoughts of death or suicide

The risk factors for depression

- Children under stress who have experienced loss or who have attention, learning or conduct disorders are at a higher risk for depression
- Adolescent girls are more likely than adolescent boys to develop depression
- Youth particularly younger children, who develop depression are likely to have a family history of the disorder
- Four out of every five runaway youth suffer from depression

Some illnesses have a specific medical cause, making treatment straight forward. But depression is more complicated, depression is not just the result of a chemical imbalance in the brain and is not simply cured with medication experts believe that depression is caused by a combination of biological, psychological and social factors. In other words, your life style, choices, relationship and coping skills matter just as much if not more so than genetics.

- Loneliness

- Lack of social support
- Recent stressful life experiences
- Family history of depression
- Marital or relationship problems
- Financial strain
- Early childhood trauma or abuse
- Alcohol or drug abuse
- Unemployment or underemployment
- Health problems or chronic pain

Coping behaviour

We all have much in common in the way we face daily problem elements that are related to basic principles described in earlier, biological make up learning behaviour and social responses “coping behavior” also involves considerable individual difference. Some people learn how to perceive the world with a minimum of distortion while others have difficulty in doing so some people exhibit a low threshold for tolerance, while others show the reverse. And a person may react with calm and a liberate thought to some serious problems but fly off the

handle when faced with a minor inconvenience. Good mental health demands that each individual develop in his own style coping behaviour.

Some people find it useful to think of coping in terms of a system, composed of accurate perceptions, a memory bank of relevant experiences and behaviour strategies programmed for efficiency. Such a system includes some planning to see that appropriate alternatives for behaviour choice are included. It is also realistic to consider the possibility the personal coping system has to be debugged from time to time to prevent tension from mounting.

Coping is the process of managing demands (external or internal) that are appraised as taxing or exceeding the resources of the person (R.S. Lazarus & Folkman 1984). "Coping consists of efforts both action oriented & intrapsychic, to manage (that is master, tolerate, reduce, minimize) environment & internal demands & conflicts among them" (R.S. Lazarus & Launier 1978).

This definition of coping has several important aspects. First the relationship between coping & a stressful event is a dynamic process coping is a series of transactions between a person who has a set of resources, values & commitments & a particular environment with its own resources, demands & constraints (R.S. Lazarus & Launier 1978). Thus coping is not one time action that someone takes, rather, it is a set

of responses, accruing over time, by which the environment & the person influence each other.

Mc Grath (1970) has viewed coping as the covert & overt behaviour by which the organism actively prevent removes or circumvents stress inducing circumstances. Schregardus (1976) proposed two major style of coping namely repression & sensitization. He also found that patterns of defensive style were related to the perception & experiences of stress & to subsequent patterns of coping & adjustment.

Irving (1977) has presented a descriptive typology of distinctive patterns of coping that included vigilance, hypervigilance & defensive avoidance. On the other hand, Robbins (1978) has identified seven patterns of coping viz, seeking social support, dysfunctional behaviour narcotizing anxiety, problem solving, reliance on professionals bearing with discomfort, and escape. In recent years, attention has been given to coping with stressful events of day to day life. Broadly three major i.e. coping in terms of ego processes (Hann, 1979) Valliant (1977) coping as traits & coping as situation specific response.

According to Silver & Wortman 1980 coping refers to any & all responses made by an individual who encounters a potentially; harmful situation. In addition to overt behaviour psychologists have included cognitions emotional reactions (eg. Anger, depression) & psychological

responses (eg. Nausea & insomnia etc.) also as types of coping mechanisms. However most theorists restricts the term coping to efforts made by an individual in problem solving in order to master, control or overcome threatening situation.

When considered in relation to the concepts of stress & coping adjustment appears to overlap with coping behaviour. According to Lazarus (1976) coping is synonymous with adjustment in the sense that both are problem solving processes in the face of demand and difficulties. Adjustment is an even broader concept referring to all reactions to environmental and internal demands. Coping on the other hand, is restricted to “what the person does to handle stressful or emotionally charged demands” (Lazarus, 1976). Coping behaviour in this sense is a subset of adjustment behaviour.

According to Kobasa 1979, the person who is overpowered by stress may have lesser amount of “Hardiness the ability to have three ‘cs’ commitment, control & challenges. These people seem to thrive on stress & despite its negative trait/quality they are not deterred by but they seem to thrive on stress, because they find a ready excuse or a shame reclusive excuse for not developing adequate coping behaviour. The other category of person who are not overpowered by stressful stimuli react to stress with hardiness i.e. for them it is an opportunity for a chance to develop

appropriate coping strategies. Another possible explanation of poor or adequate coping behaviour found putatively to stressors & non stressors.

Pearlin & Schooler (1978) have suggested that “coping responses are the behaviour, cognitions & perceptions in which people engage when actually contending with their life problems. Coping responses represent some of the things that people do, their concrete efforts to deal with the life strains they encounter in their different roles”. Responses, that are directed at modification of the stressful situations are the most direct ways to cope with strain because they tend to eliminate the source of stress itself.

Process of coping

Lazarus & Folkman (1984) & others have suggested that the coping process consists of four steps. The first step is appraisal, which involves determining the meaning of an event or situation and its implications for one’s well-being. The second step involves assessing ones coping resources & the likelihood that various coping strategies will be effective, culminating in the selection of a coping strategy. The third step involves carrying out the selected coping strategy. Finally, the fourth step involves evaluating ones coping efforts with regard to their effectiveness ones response to the stressful event (Smith & Corlson 1997).

A fundamental component of the coping process is appraisal. Appraisal is defined as an assessment of the situation by the person facing it and includes an evaluation of both the demands of the situation & resources the person brings to bear on that situation (Lazarus & Folkman, 1984). Once a situation has been appraised as being threatening or stressful, the appraisal process continues. At this point, the person evaluates what might be done about the situation, including an assessment of the available coping alternatives, the likelihood that a particular action may have the desired result, and the degree to which the individual can actually carry out the desired action.

For therapeutic recreation specialist who are trying to impact coping skills, it is important to recognizing the importance of the appraisal process throughout the coping experience. In particular, the assessment of the resources a person has for coping is of particular importance for therapeutic recreation interventions. According to Lazarus & Folkman (1984), resources include such things as health & energy a positive belief system (including hope & high self-esteem), problem solving skills, social skills, social support & material resources all issues commonly addressed with in therapeutic recreation interventions. In summary, it is clear that interventions designed to facilitate improved coping skills

should be coupled with an examination of the appraisal process, & with the development of greater resources.

The controversy regarding treatment of coping as a trait or situation specific effort is yet unresolved. The complexity of coping cannot be captured through unidimensional measure. Lazarus & Folkman (1984) assert that coping is a shifting process where a person must at certain stages & certain times rely more on one form of coping (e.g. defensive strategies) and at other times on another form of coping (eg. Problem solving as & when the status of the situation changes. Trait measure assume that people are behaviourally & cognitively consistent in their coping behaviourally across situation. Cohen & Lazarus (1993) assert that trait measures are poor predictors of coping. Situations oriented research focuses on how people endeavour to cope with specific stressful situations (Visotsky et.al., 1961) Weisman & Worden (1976).

Theory of Coping

Lazarus & Folkman (1984) – leaders in the field of coping research, have defined coping as “constantly changing cognitive & behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person”. There are several parts of the definition that are important to reflect upon. First, the notion that coping efforts are constantly changing suggests that it would

be necessary for people to learn a variety of possible coping strategies & they need to learn to assess the situation in order to determine which strategies might work best in different situation. Second is the notion that the issues that give rise to the need for coping may originate outside of the person or from within the person; thus, facilitating improved coping may include examining the appraisal process (the assessment of the demands of the situation) as well as the teaching of coping strategies. Finally coping is seen to be context specific & thus, the process of coping is a function the connection between the person & his/her environment.

Coping concept

The concept of coping has been important in psychology for well over 40 yrs. It provided an organizing theme in clinical description & evaluation in the 1940s & 1950s & is currently the focus of an array of psychotherapies and educational programmes which have as their goal the development of coping skills. The subject of coping has also received widespread lay attention, as can be seen by scanning any magazine rack, best seller list, as broadcast schedule. Indeed, coping is as much a colloquial term as a scientific one. Despite the rich history & current popularity associated with coping. However, there is little coherance in theory, research, and understanding. Even the most cursory inspection of readings selected from scholarly & lay publications reveals confusion as

to what is meant by coping & how it functions in the process of adaptation.

A close perusal of literature reveals that coping has been viewed in diverse ways. Dave, Guest & William (1979) consider coping as an attempt to remove the feeling of discomfort. White (1974) defined coping as the process which involves efforts towards solution of problems. It occurs when a person faces a threatening or dynamic change or problem that defies known or usual ways of behaviour & might give rise to anxiety, guilt, grief & shame, and again forms the necessity for adaptation.

Singh & Pandey (1985) examined coping with problems in economic, family, personal & social aspects of life in a sample of university students. Using an open ended measure they identified five dimensions of coping namely appraisal focused coping, emotion focused coping, problem focused coping, secondary coping & collective coping. The use of coping dimensions varied with nature of problems faced by the individual.

Coping Styles

Those people who use the coping style of individuation from & strive towards guides on the basis of their own personal standards. While ignoring the discordant expectations of their other guides. These individuals are not likely to experience subjective conflict as a result of

conflicting standards because they do not look to their external guides for a definition of behaviour. The term individuation has a long history within clinical psychology and it refers to the process of forming one's own personal and unique characteristics or personality (Edward, Ruskin & Turrini, 1991, Jung, 1924). Similarly the term has been used to depict women who create their own compromise identities from the positive attributes of both masculinity & femininity (York & John 1992). In the current study, however, the individual's own standard or guide may reflect any amount of masculinity and/or femininity and need not be androgynous.

Alignment is another possible style. It involves aligning one's own behaviour with the expectations of one particular guide at the exclusion of all others. The guide that one chooses to abide by is likely to be one that carries particular significance for the individual, such as a parent. An individual who adopts this style would tend to behave consistently in the manner directed by the one chosen guide & would limit his or her choice of company and situations to those that likewise favour these behaviors – while these individuals do seek a definition of gender-appropriate behaviour in the expectations of others they are not likely to experience distress over conflicting standards because they ignore all but one of the potentially discordant guides.

Compartmentalization is another possible style. It involves behaving in accordance with particular guides when one is with them or in a corresponding context. The term compartmentalization refers to the tendency of some individuals to keep different aspects of themselves separate from one another (Meyers, 1989, Mullin, 1995, Showers 1992). The tendency to separate parts of the self into categories may come from an attempt to cope, either with negative self-information (Showers) or with radically divergent social contents (Meyers). Compartmentalization may represent a less adaptive style of coping because of its implications for self-concept coherence.

Finally the conflicted coping style is most clearly defined by how it differs from the other three styles. Unlike individuals with the individualated coping style, individuals with the conflicted coping style look outside themselves at the entire range of external guides for behavioural guidance, and unlike those with alignment style they do not reduce this range by focusng on only one particularly important guide. Furthermore, those with the conflicted style do not necessarily compartmentalize their behaviour by context, instead, they appear to be frozen in a double approach avoidance conflict, seeking a definition of gender appropriate behaviour in the expectations of others, but finding only a bewildering array of contradictory expectations.

The conflict between parental norms and personal will, described by York & John (1992), is more complex in that parental and societal norms are often contradictory and inconsistent among themselves. In other words, the developmental task of balancing one's own separateness against the norms of society and parents is now complicated by the need, to balance these norms with one another as well.

The handy personality, most of us cope with stress in a characteristic manner, employing a "coping style" that represent our general tendency to deal with stress in a specific way. For example you may know people who habitually react to even the smallest amount of stress with hysteria and other who calmly confront even the greatest stress in an unflappable manner. These kinds of people clearly have quite different coping style (Taylor 1991).

Among those who cope with stress most successfully are people with a coping style that has come to be called 'hardiness'. Hardiness is a personality characteristics associated with a lower rate of stress related illness. It consists of three components commitment, challenge, control (Kobasa 1979, Gently & Kobasa, 1984).

Rogers et al., 1989 differentiated between adaptive and maladaptive coping and discussed about four types of coping style –

1. Rational or Active coping realistically accepting the stressful situations without precluding the possibility of actions. It is task oriented coping style with planning and rational thinking and represents adaptive style.
2. Detached coping – feeling of detached does not lead to clinical or attempt to avoid stress Rogers (1992). Subject reported that the ‘less involved’ they felt with the event the more effectively they were able to cope. Detachment could be distinguished from task oriented strategies but detachment is considered to ‘be adaptive’ coping style.
3. Avoidance coping is considered as helplessness. It includes behavioural disengagement or giving up. It also includes denial. It is a negative kind of behaviour involving withdrawal and giving up.
4. Emotional control, one of the individual specific reactions is also one of the ways to deal with the stress just like various coping strategies.

Because of the diversity of problems that chronic disease pose people who are flexible copers may cope better, with the stress of chronic disease than do those who engage in a predominant coping style. Coping strategies may be most effective when they are matched to the particular

problems for which they are most useful. If people have available to them multiple coping strategies they may be more able to engage in this matching process than those who have a pre dominant coping style 'for exercise Cheng, Hui & Lam 2004.

In addition to personality traits which are general ways of responding across situation coping style represents a more specific individual difference in how people respond to stress coping style is a general propensity to deal with stressful events in a particular way. As an example, we all know people who deal with stress by talking lot about it. Where as other people keep their problems to themselves coping style, then are thought to be like personality traits in that they characterize an individuals way of behaving in a general fashion but they are thought to come into play primarily when events become stressful.

Social Skills

Social skill is a term that relates to a person's emotional intelligence, it is the study of an individual's personality traits, social graces, communication skill, language, personal habits, friendliness and optimism that characteristics relationships with other people.

Social skills are an important component of an individuals behaviour and affect multiple areas of functioning (Raymond & Maston 1989).

Social skills play an important role in academic. It is used in vocational functioning (Coe, Malson, Craigic & Gossen 1991).

Social skills include interpersonal behaviours. (accepting authority, conversation skills, cooperative behaviour, play behaviour), self-related behaviour (expressing feelings ethical behaviour, positive attitude towards self) and task related behaviour. (attending behaviour competing tasks, following direction, independent work). Peer relation refer to the result or product of a child's social skills. Peer relation as a by product of adaptive behaviour and social skills in extremely important given its high corresponding.

Positive Social Skill

Social skills are the tools with which positive and rewarding relationships are built and negative and deleterious relationship are modified or eliminated. Some children however lack the necessary tools to build, maintain or terminate interpersonal relationships in socially acceptable manner. As a microsm of society, the school is a place where children spend 6 hours per day. 5 days per week, and at least 180 days per year. At a minimum children spend approximate 5,400 hr. per year in school and are expose to numerous social interaction. Although most social skills instruction in school can be characterised in formal, there is a growing awareness of the importance of directly teaching social skills as

part of the schools curriculum given our current knowledge regarding the long term adjustment of children exhibiting social skills and performance deficits.

In a comprehensive review of the social status literature, Loie & Colleagues (1990) suggested that the basis for popular children's high levels of acceptance from peer are their positive social skills and personal competencies, such as being helpful and considerate, following rules and demonstrating good athletic and academic (abilities).

Rejected children often demonstrate aggressive disruptive or inattentive behaviour in addition to low levels of positive social skills such as cooperation, friendliness and leadership (Coie & Dodge, 1988, Loie et al., 1982, Dodge et al., 1982).

In comparison to their classmates neglected children display low levels of aggressive disruptive behaviours as well as low levels of social interaction and positive social skills (new comb et al 1993).

When peer relationship problem are evident, the clinician will need to continue the assessment process in greater detail and gather information on the child's positive social skill. Behavioural observations may be especially useful in this regard (a Greca & Stark 1986, Michelson Sugai, Wood & Kazolin 1983). However, observations are time-consuming together and difficult to obtain for older children. Thus, other

assessment methods have also gained favour in clinical settings. For example several rating scales have been designed to assess children's social skills such as the social skills rating system and the Maston Evaluation of Social Skills in youth.

The extent to which a child is viewed by a group of age mates, such as classmates as a worthy social partner. It is different from friendship in that it is not a mutual two person relationship. Rather it is a one sided perspective, involving the group's view of an individual. Although friendship & peer acceptance are distinct, we will see that some social skills that contribute to friendship also enhance peer acceptance consequently better accepted children have more friends and more positive relationships with them (Gest, Graham, Bermann & Hartup 2001). As with friendship, peer acceptance contributes uniquely to children's adjustment.

Social learning theorists have emphasized the acquisition and development of overt responses. Most of the human behaviour is learned, moulded and shaped by environmental events, especially rewards, punishments and modelling. A wide variety of responses, including fears, social skills, aggression and conformity, explain the development of social standards of behaviour. From early childhood onwards, nothing

is more important than having trust and respect for others, welfare feelings and practicing avoidance of conflict.

Heng Keng (2001) suggest that young children learn to regulate social responding when given opportunity to socialize, respect the rights of others, recognize their own development limits, and learn to resolve mutual conflicts.

In brief, the ideals of personal characters are cooperativeness, compliance and non-aggressive approach to people and situations.

Children who lack social skills to sustain good peer relationship are found to be 'at risk' for later development as suggested by Parker & Asher, (1987). It has also been found that rejected children are aggressive, disruptive, dishonest and inconsiderate of other children (Coie, Dodge, and Copp Otelli, 1982; Wasik, 1987).

Many children never learn 'appropriate behaviour' for social settings due to personal deficiencies. Children who get along well with agetates interpret social cues accurately, formulate goals that enhance relationships such as being helpful to peers, and have a repertoire of effective problem-solving strategies that they apply effectively. In contrast, children with peer difficulties often hold biased social expectations. Consequently, they attend selectively to social cues (such as hostile acts) and misinterpret others behaviour. Their social goals

(getting even with or avoiding a peer) often lead to strategies that damage relationships (Erdly & Asher, 1999; Youngstorm et al., 2000).

Poor social skills can occur as a result of poor modelling by adults close to children. Additionally, children who have experienced trauma, often develop socially inappropriate behaviours, they may become aggressive or overtly compliant, as suggested by Williams & Philips (2003). Aggression has been found to be a significant predictor of changes in hostile attribution and heart rate. Other children develop irrational and self-destructive beliefs which set them up to mistrust others and to misinterpret the behaviours of others. Hence poor social skills lead to problems, not only in childhood, but also later in life. Thus it is very important for children with poor social skills to receive appropriate attention and training to improve their skills, so that they can enjoy their social interactions and feel good about themselves.)

A child's self image and self esteem are dependent on the child's skills in relation to peers and adults. These skills contribute to self-esteem because a child with good social skills is likely to build satisfying relationship and receive positive feedback from others. A child with poor social skills is likely to have unsatisfactory relationships and receive negative feedback from people close to him.

Learning self-control and how to get along with others, is a part of how a child is brought up and the family environment he has received. Although school age children seem to have grown up, but their social skills are not well developed yet. Children need considerable help in learning skills like-how to make friends, trust others, work in a team and resolve conflicts. Children also need to be taught how to use good manners, ask for help, and negotiate with others.

Researches suggest that the social ability of children to establish and maintain social relationships are central to their social acceptance and social integration. Cognitive models measuring social competence continued to lead the research on the origins of social skills deficits in children, Ladd, (1999). Framework for social competence have been developed to measure the social behaviours and skills in young children when engaged in social interaction with their peers. These frame works help psychologists to understand how children acquire skills to process social information and the interactional difficulties. Social perspective within social goals and social tasks, which are present in the social environment, enables children to integrate skills across developmental domains.

Though accepted definition of social competence for children is yet to emerge, the social competence has been approached in two ways.

Social competence has been defined for children in terms of social skills by Sarason (1981).

Children who have learning difficulties, struggle with academics and may face impaired social skills, preventing them from having successful relationships with family members, peers and other adults. The extent and impact on social skills varies from child to child, depending on his temperament and nature of learning problems. It is important to develop social competence.

The work of Thorndike's (1920), on the construct of social intelligence remains the foundation of the recent work of social skills and other related constructs reflecting social effectiveness. Nomenclature used in the social effectiveness literature has been inconsistent (Asher & Taylor, 1983). "Social skills", as skill is "synonymous with proficiency, to denote the degree of mastery acquired in an activity" (Super and Cites, 1962). Riggio, (1986) described social skills as learned social abilities and strategies used to strengthen the effectiveness of interpersonal interactions. Meichenbaum, Butler and Gruson (1981) suggested that social skill involves the knowledge of what to do and how to display oneself as well as manifesting behavioural control and flexibility. Marlowe (1986) wrote that social skill is "the ability to understand the feelings, thoughts, and behaviours of persons, including

onself, in interpersonal situations and to act appropriately upon that understanding." However Schneider, (1996) and Heggstad, (2002) employed the label "social competence" and defined it as social effective behaviour that permits individuals to attain social goals as well as the effective and cognitive antecedents of that behaviour. Ferris, Witt and Hochwarter (2001) argued that social skills consists of social perceptiveness and adjusting one's behaviour by using that knowledge to influence others.

Social Skills Development in Childhood

The development of social skills, is equally impressive as physical development during infancy to childhood days. When the child crosses the age of fantasy based role playing and enters the stage of participation in friendship involving clearly defined rules and expectations, the initial learning of social skills starts. The most significant social change in children is observed during transition from a social world, defined by the family, to influential relations i.e. from parents and siblings to peers and teachers. The transition from infancy to childhood brings about a dramatic change in the roles. Parents no longer remain caretakers but assume directive role, encouraging the child to behave in appropriate ways and socially prescribed behaviour. During this period, the cognitive changes also take place and are closely related

to the processes of personality development. The relative importance of parents as socializing agents, is greatest in these years of childhood. Peers and television viewing also influence in these formative years. The extent and mode of expression, social competence, achievement orientation and sex role are all characteristics evident in childhood, and change over in succeeding years of life. Peers serve important functions in life, they contribute to feelings of emotional security, reinforce norms of appropriate behaviour and provide instructions in social skills.

Children need to be socially skilled to remain successful in all aspects of a life. There are a large number of children and young adults, who do not perceive the subtle social interactions around them or benefit from direct instructions of social skills. Social skills make children confident and independent adults, who function effectively in society. A child who exhibits appropriate social skills, gets the opportunity to gain and maintain success in life, individual growth and respect for others.

In the present era of fast changing society, the pressure is more on communication. Social interactions have become an important part of life. The social skills are numerous and can be learnt automatically by seeing, imitating and conditioning. Generally children learn social skills incidentally, without formal instructions. Several research reports

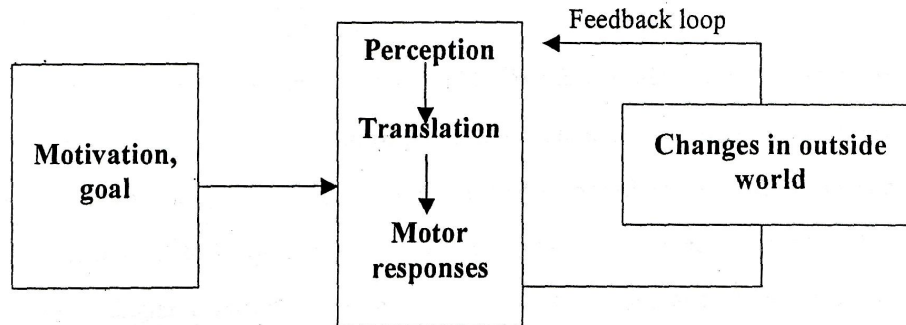
indicate that social and emotional skills are as important for academic success as cognitive skills.

Wolpe's (1958) defined social skills as assertiveness, he referred to the outward i.e. interpersonal expression of all feelings, both positive and negative, other than anxiety. In this context anxiety is the inhibitor of an appropriate response to one's feelings and to the interpersonal exchange. Wolpe further emphasized that assertive behaviour inhibits anxiety. With assertive behaviour, positive or negative, the exchange between persons is reasonably clear, with anxiety, assertiveness is largely blocked and the exchange between persons is vague, unresolved and often generates more anxiety.

Social skills model by Kendon (1967) and Argyle (1969) are pioneers and leaders of the field. Argyle (1969) noted that social skill results in the effectual application of persuasion and other influence, mechanism that control others. They described the phenomenon and drew attention to a number of analogies between social performance and the performance of motor skills, like driving a car (see Fig). In each case the performer pursues certain goals, makes continuous response to feedback and emits hierarchically organised motor responses. This model is heuristically very useful in drawing attention to the importance of

feedback. It also suggests a number of different ways in which social performances can fail the training procedures that may be effective.

Fig 1.2
The Social Skill Model (From Argyle 1967)



The model emphasizes the motivation, goals, plans of interaction and feedback process.

Libet and Lewinsohn (1973) defined social skills as the complex ability both to emit behaviours which are both positively or negatively reinforced and not to emit behaviours that are punished or extinguished by others. Gambrill (1978) relates this situational characteristic of much social skills to the degree of intimacy involved; whether the feeling generally is positive or negative and the asserted characteristics of persons involved such as status, age and sex and further how one regards oneself (role in a given context) and number of people present. There may be other dimensions such as knowledge of, or interest in topics under discussion, person valuing listening over verbal assertiveness, anxiety

over possible stuttering or other speech inhibitions and so on. Where as Asher, Miller and Hersen (1977) indicated operationally that more socially skilled persons speak louder, respond more rapidly to others, give longer replies, evidence more affect, are less compliant, request more exchanges and are more open minded in their expressiveness as compared to less socially skilled persons. Bellack and Hersen (1977) defined social skills as an individuals ability to express both positive and negative feelings in the interpersonal context, without suffering consequent loss of social reinforcement.

Welford (1980) further points out that social skills is the ability to shift and pivot according to a variety of demands, thus making skill to a matter of versatility rather than hard and fast contributions to a repertoire. Phillips (1978) defined social skill more broadly "the extent to which a person can communicate with others in a manner that fulfills one's rights, requirements, satisfactions or obligations to a reasonable degree without damaging the other persons similar rights, requirements, satisfactions or obligations and shares these rights etc. with others in free and open exchange". Therefore social skills is proactive, pro-social and reciprocally productive of mutually shared reinforcement. In social skills exchange reinforcement must be mutual even if not wholly equal

Those behaviours that are reinforcing only to the promulgator, at the cost of the recipient, are not prosocial skills behaviours.

Social skills deal with three main elements i.e. cognitive, behavioural and environmental. Gresham & Elliot (1984) defined, social skills are those behaviours which, within a given situation, predict important social outcomes such as

1. Peer acceptance and popularity.
2. Significant others judgement of behaviour.
3. Others social behaviours known to correlate consistently with
peer acceptance or significant others.

Gresham & Elliot (1990) measured social skills in children from preschool through high school (ages 3 to 18 years) using teacher & parent forms. The scale assesses positive social behaviours in five years viz- cooperation, assertion, responsibility, empathy and self control.]

All children require social skills, but only some possess the tools to use them. Hence lack of social skills can later lead to maladjustment such as delinquency, dropping out of school, low academic achievement, antisocial behaviour and alcoholism. As reported by Welsh, M. Parke, Ross (2001), academic achievement directly influences social competence. Christopher et al., (1993) suggested that

social integration may be critical for a child's adjustment in a number of ways such as-

- a. Establishing support systems for emotional and social needs.
- b. Developing moral judgement and social values.
- c. Improving or maintaining self-esteem.
- d. Promoting interpersonal competence and adult like behaviour.
- e. Developing independence.
- f. Recreation, including entertainment
- g. Enhancing status within the peer group
- h. Developing interests.

Therefore there is a need to develop social skills in children to bring out lasting impact on them.

National priority for children is that they should be socially and emotionally prepared well before entering school,

Michele Novatni (2002) recently asserted that, "social skills are all the things that we should say and do when we interact with people. They are specific abilities that allow a person to perform competently at particular social task."

Social skills is not a new concept, there is evidence that this area of understanding human behaviour is decades old. Belleck and Hersen (1977) state that social skills training stem from two sources : (i) The early work of Salter (1949), Wolpe (1958) and Lazarus(1971) as Psychotherapist and (ii) the work of Zigler and Philips (1960, 1961) on social competence.

The historical background of social skills stressed the importance of assertiveness. Wolpe (1958) differentiated between positive approachful behaviours and those that were assertive but critical and disapproving. Open, honest, self revealing are examples of assertiveness. In sum, social skills are more than assertiveness. Recent researchers have emphasized on "Positive" or pro-social behaviour and its relationship to morality and to altruism.

STATEMENT OF THE PROBLEM

**"Effect of Grandparental Proximity on Depression, Coping
Behaviour & Social Skills of School Going Children"**