In Indian society, the family is still a more significant unit than the individual. Individual family members find it difficult to visualize themselves as separate from or fully distinct within the family.

Globalization, industrialization and urbanization have introduced great changes in marriage and family relationships. Adults, couples, families and youth in India are experiencing many of the same personal and relational difficulties that globalization and modernization bring to any nation (Carson and Chowdhury 2000; Carson et al. 2009; Chowdhury et al. 2006; Das 2007; Kashyap 2004; Sonpar 2005). These problems include, but are not limited to: family and couple conflict stemming from a host of factors (including, for example, inter-caste marriages, and conflicts within or among families over dowries); sexual problems in marriage; disagreements over child-rearing and perceived under-involvement of husbands in dealing with domestic problems and issues; high expectations of parents (including academic pressures on youth to succeed academically and vocationally); child abuse and other forms of domestic violence; inter-generational conflicts; difficulties with in-laws (e.g., between the mother-in-law and the daughter-in-law); and a gradual loss or displacement of the role and function of the elderly. In addition to this, mental health illnesses and problems associated with physical illness, disability, and HIV/AIDS; adolescent conduct disorder; depression and suicide; anxiety and stress-related disorders; and alcohol and drug abuse.

One highly visible trend is of more and more women working outside the home and playing a dual role as homemakers. While working outside, they also have to perform almost all household chores, in addition to childbearing and rearing. This often causes stress and leads to marital maladjustment.

As women are gaining greater freedom, the recognition of the individual’s right to happiness is causing the concept of marriage as a social contract to evolve. There has been a shift in importance from self-sacrifice to satisfaction in the marriage. This new emphasis on personal happiness within marriage has changed the mutual
outlook of modern men and women. At the same time, grown-up children want to have a say in the decisions their parents make but which affect them personally.

The changes that are affecting the marital relationship in contemporary Indian society point to the increasing need for marital guidance and counseling for family-related conflicts and problems. Agencies which provide these services have a vital role to play in strengthening the stability of marriage and making it an enriching and satisfying experience for the husband, wife, family and society.

For most individuals with a healthy social support network, major stressors in life can be more easily handled. A proper support network consists of a reinforcing family and friends who can help the affected individual work through any problems, such as the death of a family member, loss of a job, major injury, or any number of other stressors that can contribute to psychological illnesses (such as depression) or lead to anxiety and distress. For individuals with an underdeveloped social network, or those with a negatively reinforcing social network, these major life events can cause great harm. An underdeveloped social network cannot handle the pressure of an individual looking for support, and a negatively framed social network can actually reinforce thoughts of hopelessness, failure and being worthless. Without a developed social support, it is more likely for the individual to develop symptoms of depression (Wade & Kendler, 2000).

Those without a supportive familial or social network, or otherwise unable to resolve conflicts within their circle of family and friends, sometimes opt for professional counseling. Family Counseling Centers started out with a mandate to provide marital counseling, which has now expanded to providing counseling and guidance for all family-related issues. Yet, marital counseling comprises at least 50% of all workload at FCCs.

Some of the other issues for which beneficiaries approach FCCs are: personal problems such as addiction and behavioral issues; intra-family conflict over issues such as finances, living space, bearing household responsibilities, having or not having children or male children; financial problems that have a bearing on family life; and so on.
2.1 REASONS OF FAMILY BREAKDOWN AND DISCORD IN INDIA

Research studies have indicated the following factors as influencing marital adjustment: personality characteristics, sexual relationships, extent of verbal communication between the spouses, their educational level, occupation, women’s employment, socioeconomic background, and number of children (Bhattacharya 2000; Bhatti 2003; Kapur 1972; Kumar and Rohatgi 1986, 1986; Mohan and Singh 1985; Srivastav, Singh and Nigam 1988).

The recent research suggests that one of the most common issues of conflict in Indian families is inability to have children. The social ostracism of the “barren” woman, threats of divorce and pressure on the man to remarry are very real problems (Sriram and Dave, 2009).

On the other hand, sex before marriage and pregnancy out of wedlock comprise social stigma for a woman and her family. Premarital sexual activity in such a society where sanctions against it are severe and socially supervised can have serious implications for women in terms of unwanted pregnancies, abortions and the resulting physical and social complications (Mehta, Schensul and Fall, 2004). The Third National Family Health Survey (IIPS and Macro International, 2007) reports that there is premarital sexual activity in the country with higher rates among men as compared to women. Similarly, sex before marriage is on the rise with the social and economic changes being brought about by globalization. Instances of people living in and having a child before marriage have been reported, albeit in limited numbers (Lekha, 2008).

Family violence, another major problem, occurs in different ways such as verbal, physical, emotional and material abuse and neglect as well as sexual abuse – which remains under-explored in the Indian context (Devi Prasad, 2001).

According to Gandhi (2001), violence against women within marriage is one of the most rampant forms of abuse and often assumes multiple forms, though Indian research has focused mostly on dowry-related violence (Mazumdar, 2001). Violence in the family is inter-connected. One form of family violence may be closely connected to other acts of violence in the home.
According to the Third National Family Health Survey (2007), a higher percentage of rural women (36%) were subjected to violence than women living in urban areas (28%) and more women with little or no education experienced violence compared to their educated counterparts. Violence was also found to be inversely related to the Wealth Index (Visaria, 2008). In a survey conducted by Kishore and Johnson (2004), 19% of the married women in India reported spousal physical abuse since the age of 15 and 10% of women within the past 12 months. The highest rates of violence occurred in moderately wealthy households and not, as often assumed, among the poorest households (Devi Prasad, Khasgiwala and Vaswani 2009).

The situation of the elderly in Indian society is becoming more critical in the context of the changing demographic scene and social values, and of late abuse and neglect of the elderly in the family context is emerging as a significant problem. In a recent community study in a rural context, an overall abuse rate of 48.2 per cent was reported, with physical abuse at 9 per cent during the preceding year (Devi Prasad and Vijaylakshmi, 2008). Even the status of elders within a family has drastically changed due to modernization. The physical, emotional and economic security that the elderly enjoyed is fast disappearing in today’s materialistic world. Indian families are presently grappling with issues related to continuity and change. Many families do not have appropriate role models, or adequate familial and/or social supports and resources to cope with the developmental tasks demanded of them at different family life-cycle stages (Parekh, Banerjee and Kashyap, 2009).

Substance abuse is one of the most serious problems in modern society (Devi Prasad, Khasgiwala and Vaswani, 2009). It is often regarded as a family illness, as there is no way family members can escape or ignore the abused. The fact of having a family member with the habit of substance abuse leaves family members with feelings of confusion, bewilderment, anger and anxiety and makes their responses as impaired as those of the abuser (Jejeebhoy, 1998).

Apart from this, a vast number of physically and mentally challenged individuals, as well as the terminally ill, have to be taken care of by their families. Diseases like cancer and HIV/AIDS are creating situations which challenge families’ resources and coping mechanisms. The family’s role in supporting such members during the treatment and rehabilitation process as an active partner in the multi-
disciplinary team is being emphasized by many researchers. The presence of such a family member disrupts family equilibrium. Therefore, families need guidance training and counseling to be able to meet their own needs and look after the family member in need of care (Kashyap, 2009).

According to Parekh, Banerjee and Kashyap (2009), “Marriage in India is still a socio-religious affair that takes place between two families rather than two individuals. It is arranged by parents and members of the kinship group with class and caste positions, religion, education, financial and employment status, amount of dowry and matching of horoscope as important considerations.” Studies have shown that even today young people desire parental support in mate selection, but expect greater participation in the process (Shah 1975). Though there are variations regarding pattern of mate selection in terms of the extent of choice given to the young man or woman, family approval is mostly considered essential for the marriage to actually take place.

Another feature of traditional Indian marriages is that the marital partners are often very young and emotionally immature. Even today, children are socialized into concepts of inequality by gender and age quite early in life. Boys are considered as economic assets and are indulged from an early age, while girls are trained and socialized to fulfill the demands of their adult roles as wives, daughters-in-law and mothers.

Socialization and development of human beings is still recognized as a significant function of the family and the concept of marriage remains very central to Indian culture. According to Parekh, Banerjee and Kashyap (2004), gender role socialization has played a major part in the devaluation and deprivation that women encounter. Women themselves have internalized sexist beliefs to the point that these beliefs are unrecognizable even to themselves. In a majority of dual-earner households, wives are considered supplemental earners rather than “providers” in their own right. As a result, most husbands and wives tend to see husbands as providers and wives as homemakers. Thus, many women themselves ask for and receive very little help in their domestic roles despite having taken on the economic role which leads to stress, strain, overload, conflict, tension and guilt. As a result, very few women are satisfied with their dual-role performance (Rani 1976 and Wadhera
Class differences are apparent in such a situation as some working women have been able to handle their role conflict by employing domestic help, purchasing gadgets and/or getting help from in-laws or relatives (Hemalatha and Suryanarayan 1983, Mies 1980, Rani 1976 and Srivastava 1978).

Indian families today are grappling with issues related to both continuity and change. Many families do not have appropriate role models or adequate familial and/or social supports and resources to cope with the developmental tasks demanded of them at different family life-cycle stages. More than ever before, families in the present times need help to adapt effectively to the rapid changes around them, to develop a more democratic family structure and to complete developmental tasks critical to a given life-cycle stage (Parekh, Banerjee and Kashyap, 2004).

To sum up, we can say that the problems in family and marriage faced by Indian couples are similar to those faced by couples anywhere in the world, such as alcoholism or drug abuse by a member, infidelity, desertion, verbal, physical or sexual abuse and sexual incompatibility. However, some of the distinctive factors that impinge on Indian marriages are more socio-culturally based and linked to expectations from the partner’s family such as those related to procreation or bearing sons (Chaudhary 1988; Kawale 1985; Pothen 1986); dowry demands by in-laws (Bhattacharya 2000; Ghadially and Kumar 1988; Parihar 1990); and interference by immediate and extended family members who exert power and control over the couple as a unit or individually on the husband or wife in a manner which is destructive to the marital relationship (Bhat and Surti 1979; Ghadially and Kumar 1988; Kashyap 2000).

Many studies in India have consistently cited as the cause of divorce such issues as poor communication, basic unhappiness, loss of love and incompatibility, infidelity, mental illness or emotional problems, conflict over men’s and women’s roles, and spouses’ personality traits (Rao 2011; Sonawat 2001; Chaudhary 1988; Mehta 1975).

Gottman (1993) identifies a “trajectory toward marital dissolution” in which couples who divorce “remain unhappily married for some time, seriously consider dissolution, actually separate, and then divorce.” The common conclusion of all studies on prevention of relationship breakdown and causes of divorce is that a
combination of factors, not one dimension, is responsible for marital dissolution. Hopper (1993) found that although divorced individuals usually mentioned only one or two motives for their divorce, “divorcing situations were immensely complex – so complex and indeterminate that any number of outcomes could have resulted.”

2.2 IMPORTANCE OF FAMILY FOR ITS MEMBERS AND SOCIETY

Marriage exists in virtually every known human society (Kingsley 1985; Fisher 1992). It is not known exactly what family forms existed in prehistoric society, and the shape of human marriage varies considerably in different cultural contexts. But at least since the beginning of recorded history, in all the flourishing varieties of human cultures documented by anthropologists, marriage has been a universal human institution. Traditionally, the institution of marriage has been about regulating the reproduction of children, families and society. While marriage systems differ (and not every person or class within a society marries), marriage across societies is a publicly-acknowledged and supported sexual union which creates kinship obligations and sharing of resources between men, women and the children that their sexual union produces.

Marriage, as one of the basic building blocks of society, is an institution that needs to be preserved in the interest of the individual and of societal wellbeing. Indeed, the results of various studies carried out all over the world show that divorce and parental inter-personal disputes have many ill-effects on children, adult men, women and society (Institute for American Values, 2002). These may be summarized as given here:

(i) Effects on Children

- Parental divorce reduces the likelihood that children will graduate from college, and achieve high-status jobs (Jeynes 1999; Cocket and Tripp 1994; Zill 1993; Amato 1991; Elliott and Richards 1991).

- Children who live with their own married parents enjoy better physical health, on average, than children in other family forms. The health advantages of married homes remain even after taking into account variations in socioeconomic status (Cocket and Tripp 1994; Mauldon 1990; Angel and Worobey 1985).
• Parental divorce approximately doubles the odds that adult children will end up divorced (Amato and De Boer 2001; Kirenan 1997).

• Parental divorce increases the chances of personality disorders coupled with conduct disorders among children and adolescents and continues till adulthood. (Anant and Raghuram 2013; Sundaram 2005; Bharat, Shrinath, Seshadari and Girimaji 1997; Swaminathan, Shrinath & Sharan 1986).

(ii) Effects on Adult Men

• Married men earn between 10 and 40 percent more than single men with similar education and job histories (Bachman et al 1997; Miller-Tutzaver 1987).

• Married people, especially married men, have longer life expectancies than otherwise similar singles (Wilson and Oswald 2002; Amato 2000; Waite and Huges 1999).

• Marriage increases the likelihood that fathers will have good relationships with children (Zill et al., 1993). According to Seltzer and Bianchi (1988), 65% of young adults whose parents divorced had poor relationships with their fathers (compared to 29% from non-divorced families).

(iii) Effects on Women

• Divorce and unmarried childbearing significantly increase poverty rates of both mothers and children. Between one-fifth and one-third of divorcing women end up in poverty as a result of divorce (Lupton and Smith, 2002; Hao, 1996).

• Married mothers have lower rates of depression than single or cohabiting mothers (Brown 2000; Hope, Power and Rodgers 1999; Kessler and Essex 1998; Marks and Lamber 1998).

• Married women appear to have a lower risk of domestic violence than cohabiting or dating women. Even after controlling for race, age and education, people who live together (without marriage) are still three times

(iv) Effects on Society

- Marriage appears to reduce the risk that children and adults will be either perpetrators or victims of crime. Single and divorced women are four to five times more likely to be victims of violent crime in any given year than married women (Waite and Callagen 2000; Sherman et al 1992; Stets 1991).

- Boys raised in single-parent homes are about twice as likely (and boys raised in step-families three times as likely) to have committed a crime that leads to incarceration by the time they reach their early 30s, even after controlling for factors such as race, mother’s education, neighborhood quality and cognitive ability (The Stationery Office 2002; Harper and McLanahan 1998; Coughlin and Vuchinich 1996; Sampson and Laub 1994, Sampson 1987).

2.3 INDIAN STUDIES

A cross-cultural study of divorced individuals in India and the United States reported that they experienced similar problems with economic adequacy, social support and psychological wellbeing (Amato, 1994). Furthermore, the predictors of divorce are similar in both societies. However, Indian women experience more problems than Indian men; they also appear to suffer more hardship than American women. Three factors are responsible for this pattern: Indian women’s economic dependence on men, Indian cultural beliefs about women and marriage, and the patriarchal organization of the Indian joint family (Amato, 1994).

Probabilities of divorce are high during the earlier years of marriage and decline sharply with the increase of marital duration (Thronton and Rodges 1987; Thakur 2009). There are various consequences of rising divorce rates at the individual level as well as at the family level.
Early marriage continues to be highly prevalent in India and is associated with a wide variety of marital and reproductive outcomes (Santhya, Ram, Acharya, Jejeebhoy, Faujdar and Singh, 2010). Early marriage tends to compromise women’s autonomy (Jensen and Thornton, 2003). It was also found that early-marrying women were more likely than other women to consider wife-beating justifiable, which reflects that women who marry at young ages tend not only to have a traditional family background but also to have gendered socialization experiences while growing up that continue to colour their gender-role attitudes (Jejeebhoy and Cook, 1997). They may also be less likely to have been exposed to modern ideas. (Santhya and Jejeebhoy, 2003).

Studies carried out by Jain and Kurz (2007) and UNICEF (2005) report that a number of social, economic and health outcomes are associated with early marriage. Early marriage tends to curtail young women’s educational opportunities. Women who marry young may be less capable than those who marry later of asserting themselves in their marriage, which may place them at higher risk of experiencing physical and sexual violence (ICRW, 2005). Moreover, early marriage typically coincides with early childbearing – and young, first-time mothers face an increased risk of maternal and infant mortality (Mathur, Greene and Malhotra, 2003).

Other studies in India that have found that married adolescent women are far less likely than women who had married when 18 or older to report having a close marital relationship with their husband (Barua and Kurz 2001; Santhya and Jejeebhoy 2003; Kulkarni 2003). Many other studies (ICRW 2005; Joshi et al. 2001; Jejeebhoy and Cook 1997; Khan et al. 1996) highlight that women who marry early have an elevated risk of experiencing physical and sexual violence within marriage. In another study it was found that marriage after the age of 25 years was better for the self-development of women (Sankalp and Agrawal, 2012).

An increase in single-parent families in India has contributed to a greater percentage of children and adolescents experiencing serious difficulties (Henry, 2010). Since more women in India are joining the labour force without proper support and assistance and often in the face of opposition from the extended family and the community, an increase in family difficulties is to be expected (Chowdhury et. al., 2006). Increased role strain, marital difficulties, parent-child conflicts, feelings of
guilt and status confusion are commonly observed among working women, even though there are some economic and self esteem-related advantages.

Srivastav, Singh, and Nigam (1988) studied the effect of demographic characteristics such as age differences, duration of marriage, education, occupation, socio-economic status and number of children on marital adjustment. They reported that age difference between husband and wife highly contributed towards marital adjustment. Secondly, differences in the educational level of the spouses were more evident among maladjusted couples. Shukla (1988) observed that as compared to single career couples, more dual-career couples expected that the husband and the wife should be about equally responsible for the provider and the housekeeper roles, and evaluated the wives more favourably in the provider role and the husbands in the housekeeper roles. It is interesting, though, that in both the groups, wives derived greater happiness in their marriages when they were satisfied with the housekeeper role and evaluated their husbands favourably in the provider role.

In another study, Mohan and Singh (1985) studied marital adjustment of rural and urban couples and found that rural couples were better adjusted than urban. Kumar and Rohtagi (1984) studied the dominance need of spouses and reported that husbands with high adjustment possessed a higher need of dominance, whereas wives with high adjustment were submissive. It was found also that couples with high adjustment were more intelligent, possessed high extroversion interests as compared to couples showing low adjustment. Kumar and Rohtagi (1985) examined the relationship of anxiety, neuroticism and security variables with adjustment in marriage and showed that anxiety affects one’s adjustment in marriage.

Surendra and Ramadevi (2012) carried out a study on the causes and consequences of divorce in Karnataka and found some serious consequences of divorce on men, women, children and society. On women, divorce can have such serious effects as to force them into prostitution and suicide; on the children, it can cause deviant behaviour; while it can cause a lot of social menace like juvenile delinquency and highway robbery on society.

Similarly, other studies in India have found that children in single-parent families report feelings of loneliness, withdrawal, fear and anger (Bharat 1986; Bharat 1988b; Upadhyay 1996). They face social and emotional problems (Sethi, 1994), and
parents of children who perceive them as a cause of distress argue a lot (Sood and Misra, 1995). Upadhyay (1996) reported that widowed mothers perceived the loss of interest in study and work on the part of their children; Gill and Singh (1991) found deterioration in health and feelings of insecurity in children of widowed mothers. Gill, Sharma and Verma (2003) found there were many behavioural problems among adolescents living in single-parent families.

The probability of divorce is high during the earlier years of marriage and declines sharply with the increase of marital duration (Ahmed and Chowdhury 1981; Thronton and Rodges 1987; Thakur 2009).

Many studies have found that marriage has a positive effect on the health and general wellbeing of married men. According to Srivastava, (2013) studies show that married men have a statistically significant delay in onset of psychotic symptoms in schizophrenic illness, when compared with single men. Married men are found to have the lowest rate of depression, as compared to divorced/separated men among whom these rates were the highest.

Data exists to support the fact that there is an association between marriage and lower alcohol consumption. In alcohol addiction, higher rate of divorce is seen in heavy drinkers probably due to a high incidence of domestic violence to the tune of 60-80% (Batra and Gautam, 1995). Family problems that are likely to co-occur with alcohol problems include violence, marital conflict, infidelity, jealousy, economic insecurity, divorce and fetal alcohol effect.

Marriages, particularly when reinforced by children, significantly lessen the risks of suicide. Suicide rate is 11/1,00,000 for married persons and double for those never married/single (Rao, Nambi and Chandrashekhar, 2009). On the other hand, marital and family problems can be important stressors leading to suicidal behaviour, especially in case of married women, for whom in the traditional Indian social fabric, separation/divorce is not a very feasible alternative to problems such as marital discord, dowry demand and ill-treatment/cruelty by in-laws in a joint family structure (Srivastava, 2013).

According to Henry and Parsatharthy (2010), many family issues eat into a person’s ability to perform or affect their cognitive and emotional state of being.
These issues need to be addressed by employing a promotive and preventive strategy rather than a curative one.

2.4 COUNSELING AND DISPUTE RESOLUTION

Formal interventions with families to help individuals and families experiencing various kinds of problems have been a part of many cultures, probably throughout history. These interventions have sometimes involved formal procedures or rituals, and often included the extended family as well as non-kin members of the community. With the passage of time, these interventions were often conducted by particular members of a community, for example, the chief, priest, physician and so on – usually as an ancillary function (Broaerick & Schrader, 1991).

Research suggests that marriage counseling and education may help many couples improve relationship satisfaction, reduce conflict and violence, and avoid divorce (Jacobson, et al 2000; Christensen & Heavey 1999; Bray & Jouriles 1995; Dunn & Schwebel 1995; Shadish et al 1993). Most of the research on this topic shows benefits of marriage interventions in high-risk circumstances, including among alcoholics (O’Farrell et al 2000, 1993) drug users (Fals-Stewart et al. 2001; 1996 Shadish et al 1993) domestic violence (O’Farrel et al 1999; O’Farrel & Murphy 1995; Johnson & Tutty 1998) and depression (Teichman et al. 1995; Jacobson et al. 1991). For example, a study of 88 male alcoholics and their wives (O’Farrel et al 1999) found that the proportion of wives reporting any violence by their husbands dropped from 48 percent before a special alcohol-focused behavioural marriage therapy to 16 percent two years later. Reports of severe violence dropped from 24 percent before therapy to 2.7 percent after. Levels of violence among alcoholics who remained sober dropped to a level not significantly different than a demographically matched comparison group.

Research also shows that during the divorce process, a surprisingly high proportion of divorcing couples are ambivalent about their divorce decision. In one major study of couples one year after the divorce, at least one spouse in three-quarters of divorcing couples reported second thoughts (Hetherington & Kelly, 2002). Various state polls in the USA confirm that even many years later, a significant proportion of divorced people believe their divorce may have been a mistake. In a New Jersey
study, for example, 46 percent of divorced people reported that they wished that they and their ex-spouse had tried harder to work through their differences (New Jersey Family Policy Council, 1999). In one Minnesota poll, 40 percent of currently divorced people say they have at least some regrets about their divorce (Hawkins et al., 2002). Sixty-six percent of currently divorced Minnesotans answered “yes” to the question “Looking back, do you wish you and your ex-spouse had tried harder to work through your differences?” (Minnesota Family Institute, 1998).

Thus, research suggests that a substantial number of couples filing for divorce may be candidates for successful reconciliation. Timing of intervention may be crucial. According to Gurman & Fraenkel (2002), couples seek therapy mostly because of relational concerns, such as emotional disengagement, power struggles, problem-solving and communication difficulties, jealousy and extra-relational involvements, value and role conflicts, sexual dissatisfaction and violence, and this kind of help-seeking is not a recent phenomenon. Even more strikingly, a large percentage of persons seeking help from therapists practicing individually-based therapy do so for marital difficulties. For instance, as early as 1960, Gurin, Veroff, and Feld found that over 40 percent of all people seeking psychological help viewed the nature of their problem as marital. Such concerns alone are sufficient to warrant the development of effective couple interventions.

2.5 MARITAL/FAMILY COUNSELING IN INDIA

Marital and family counseling in India is not new. Indian folk tales and scriptures make references to and present numerous examples of advice being given by a large range of persons such as family members, doctors, lawyers, and priests, to married individuals as well as to those on the threshold of marriage (Mane, 1991). However, the formalized discipline of marital and family counseling/therapy (MFT) has its theoretical foundation in the West. Indians experiencing emotional problems typically visit native healers, gurus, and exorcists before approaching a counselor or therapist (Davar, 1999).

Counselor or therapist services are mostly sought as either a last resort after trying various familial and extra-familial mechanisms or if people are obligated to receive help in cases of divorce, psychiatric and medical reasons (Mane 1991; Mohan 1972). With the community support in India rapidly weakening due to the advent of
urbanization, industrialization and globalization of the economy, these changes are leading to a nuclearization of Indian families and an increase in tensions between the old traditional and new individualistic values (Carson & Chowdhary 2000; Natrajan & Thomas 2002). Along with the disintegration of communities, many age-old mechanisms are being replaced by different mental health professionals who are most often trained in providing services that have been developed in the West.

In India today, counseling caters primarily to individuals and families belonging to the urban as well as semi-urban, middle- and lower-middle class sections of society (Kashyap, 2009). According to Sriram and Dave (2009), “A family counselor is often presented with a variety of issues at the level of individual families and their members which may actually be a reflection of changes taking place at the broader/macro level, affecting social, economic and political structures.”

### 2.6 FAMILY COUNSELING SERVICE PROVIDERS

The bulk of studies on the Indian family focus on traditional joint family structure and changes brought about in it due to urbanization and industrialization (Bharat, 1991). Marital and family practice research has and continues to receive little attention from Indian scholars (Desai, 1991). One of the reasons cited in literature for this dearth is that marital relations have slight import in the joint family system (Ramu, 1988). Mane (1991) reported from a meta-analysis on marriage counseling/therapy in India that most of the research in this area had been conducted from a psychiatric orientation wherein marital conflict has been identified as a predisposing factor.

The majority of the scant literature on marital and family practice research in India falls into two categories: needs and experiences of individuals and families with regard to family therapy and training programmes, and providers of marital and family counseling.

Natrajan and Thomas (2002) explored the main problems experienced by and needs of Indian middle-class families for family therapy services in southern India. The primary problems identified by the participants included: dual earner families, financial stress, high academic expectations for children, generation gap between children and parents, disagreement over child-rearing issues, and under-involvement
of husbands in household matters. When discussing the need for family therapy services in their communities, several participants highlighted that they or their families did not need these services because solving problems is the responsibility of families, they had strong values, and they knew the solutions to their problems. Those who wanted family therapy services focused on topics such as elders in extended family networks not being helpful and the need to discuss problems with an external person.

Mohan (1972) studied 57 cases to assess the value of directive and non-directive approaches in Psychiatric counseling when intervening in the area of marital discord. He concluded that with his Indian clients’ directive, didactic therapy was more helpful than the non-directive analytic approach.

Prabhu, Desai, Raghuram, and Channabasavanna (1988) assessed families who received services based on a brief, integrative, in-patient family therapy model and conducted a two-year follow-up with the same families. Nearly 40 per cent reported improvement in presented symptoms, change in problems for which help was sought, and satisfaction with changes introduced in the family. Narayanan (1977) presented information on psychiatric patients’ experiences of family and group therapy over two years. He reported improvement in patients who received group and family therapy over those who received none.

Channabasavanna and Bhatti (1985) studied the utility of the “role expectation model” in understanding the quality of marital life and treatment of marital problems. The main objective of their study was to examine the approach and outcome of marital therapy with 30 cases treated by the authors during seven years of practice.

Singh (1992) developed a treatment model for marital couples in conflict. His model aimed at helping couples differentiate between their real and pseudo selves in order to avoid blaming and feeling victimized. A major limitation of these research studies is their small sample size that limits their generalizability.

A few researchers have also studied the effectiveness of counseling and other services provided by FCCs. Devanathan and Suma (1995) in their study ‘Role of family counseling centers in the field of mental health care’ highlighted the role of FCCs in family therapy counseling, and highlighted the effect of marital dispute on children. They found that harmonious and happy relationships within the family are a
prerequisite for good mental health. Hence, breakup in family results in unstable mental health of children, which may draw them to substance abuse and violence.

The working of FCCs was studied by Apte, Dave and Adhikari (1990) in a quick appraisal of the FCC and Voluntary Action Bureau (VAB) scheme of the Central Social Welfare Board (CSWB). Another study by Dabir (1992) on the working of FCCs stressed upon the need to develop a new approach to help the women in familial distress.

In a research project sponsored by the Department of Women & Child Development, Ministry of Human Resource Development, Government of India, to study the ‘Functioning of Family Counseling Centers (FCCs)’ established by the Central Social Welfare Board, the Institute of Social Studies & Research, New Delhi, reported that the issues brought to the FCCs were mainly related to marriage: harassment, disagreement and need for legal help for divorce, and maintenance and custody of children. The other issues brought to the FCCs included desertion by spouse, alcoholism, physical and mental abuse and emotional disturbance. Most of the clients who approached FCCs were from the middle-class category, the study found. The conclusion was that marriage plays an important role in the issues brought to the FCCs and counselors have a major role to play in solving these problems (Institute of Social Studies Trust, 1996).

The case study-based work of Mitra (1999) entitled ‘Best Practices among Responses to Domestic Violence in Maharashtra and Madhya Pradesh’ critically analyzed the steps and initiatives taken by the states as well as the central government towards curbing the social problem of domestic violence. It concentrated on the social evils that crop up due to the menace of domestic violence and provided an in-depth study of the reasons and consequences of domestic violence. Case studies occupied most of the chapters, offering a detailed account of the various steps and initiatives taken by the government to combat domestic violence.

Another study, ‘Family Counseling in Family Court: An Analysis of the Psycho-social Dynamics of the Families with Special Reference to Family Court, Thrissur’ by James (1999) drives home the fact that incidence of marital breakdowns in Kerala was on the increase. The major findings were that not only are the couples affected adversely by marital breakdown, the other members of the family, especially
the children, also undergo severe traumatic experience. The major reasons for marital breakdown included physical and mental cruelty, extra-marital relationship, alcoholism, mental illness, suspicion, mental retardation, and suicidal attempts. It dealt with the need for setting up of Family Counseling Centers and ensuring their proper functioning with the objective of strengthening the family and not letting it break apart.

Sharma and Tiwari (1999) in their study ‘Domestic Violence on Women and the Role of Counseling Centers: With special reference to Women Counseling Centers at Indore’ described the role of the FCC in bringing down domestic violence against women.

In a study conducted by Jayaprakash Institute of Social Change, Vidyasagar School of Social Work, Kolkata (2000) entitled ‘Conflicts in marital relationship: A study from Family Counseling Center, Birati, Kolkata,’ it was reported that 93.3 per cent respondents were still married and dealt with their conflicts within the bonds of marriage. Only 6.7 per cent acquired divorce to gain respite from the major conflicting situation in their life. In 93.3 per cent cases, the relation went downhill from the initial stages itself. The reasons for straining of relationship included interference by in-laws; personality and cultural differences; extra-marital relations; alcoholism, etc. This study found that the main way to create adjustment was to make husbands understand that they should work towards the relationship. Some of the clients could not bear the pressure of the conflict and left the matrimonial home. However, many sought to adjust and stay married because they regarded marriage as a sacrament. Many women did not leave because they were worried about their children’s future. Others stayed due to a lack of economic independence and security. To cope with their problem, 33.3 per cent respondents sought some kind of legal help, 13.3 per cent engaged themselves in some economic activity, and 6.7 per cent reconciled with marital disharmony. The study suggests that to reduce atrocities and conflicts, education must be ensured: families should be educated about inter-personal relationships between couples and other members of family. A change in attitude among the police is needed, and awareness programmes should be organized by Family Counseling Centers (FCC), panchayats, State Social Welfare Boards (SSWB) and Central Social Welfare Board (CSWB) jointly. Seeking professional help in cases
of marital conflict should be popularized and more counseling facilities should be available to help couples in distress, the study said.

Nanivadekar (2004), in her study ‘Indian family: Trends and trauma: Summary of the desk study based on the data from Central Social Welfare Board’s Family Counseling Centers’ looked into the trends and traumas of family life in India, through a record of 16,270 cases out of a total of 3,00,000 cases registered with Family Counseling Centers (FCCs). About 72.88% cases were reported by women. Data was gathered from 91 FCCs from seven states, namely Maharashtra, Delhi, Kerala, West Bengal, Madhya Pradesh, Meghalaya and Manipur. The study reported that the main reasons for discord in the family were addiction, alcohol and drug abuse, and personality clashes, and suggested recruitment of counselors and mental health professionals as important steps for the FCC programme. The findings highlighted the need for a gender-sensitive family-centred approach in the counseling practices of FCCs, and suggested that activities like awareness-generation camps be organized in addition to pre-marital counseling for prevention of family discord.

Kashyap, Dabir and Akhup (2004), in an all-India study of FCCs found that an overwhelming majority of clients came to the FCC for help with marital problems.

Bhola (2006) in his study, ‘Inter-sectoral approach to Family Counseling Centers, Madhya Pradesh’ found that there is a positive impact of the FCCs on resolving of family disputes, addressing violence against women and thus improving their mental health. The types of problem reported to FCCs are related to dowry demand, domestic violence, tension, depression, illicit relations, alcohol/drug addiction, maladjustment between wife and husband, and so on.

Jain (2007) in a study entitled ‘Family Counseling in Indian Context’ studied the FCCs established in Delhi under the scheme of the Central Welfare Board in Delhi, and found that though FCCs are providing great help to families in distress, there are gaps in the scheme which need to be filled. The gaps include poor remuneration paid to counselors leading to quick turnover and impacting the quality of counselors hired.

Another study conducted by the National Institute of Public Cooperation and Child Development critically examined the scheme started by the Central Social
Welfare Board while conducting an in-depth study of 11 FCCs situated in six northern Indian states namely, Bihar, Jharkhand, Haryana, Himachal Pradesh, Uttar Pradesh and Uttrakhand. The study reported that the clients not only got psychological, rehabilitative and legal advice but were also successful in getting police cases registered with the help of FCCs in cases where victims were initially denied their rights. The study further concluded that the scheme is very useful in providing support to victims of domestic violence and offering a platform to aggrieved parties to settle their disputes so that families are saved from breaking up, as a number of families come to loggerheads on flimsy grounds so that functioning links between members snap. The study further pointed out that a majority of cases registered with FCCs received counseling services, referral, legal aid, etc, and FCCs were able to facilitate in sorting out family disputes (NIPCCD, 2011).

2.7 FAMILY COUNSELING CENTERS IN THE UNION TERRITORY OF CHANDIGARH

There are six voluntary organizations in Chandigarh which are running Family Counseling Centres.

1. Society for Social Health (SOFOSH). This NGO was established in May 1996 and since then is involved in social welfare activities for the poor and marginalized sections of the society with the help of dedicated volunteers and professionals including doctors, psychologists, yoga therapists and advocates. The organization started its Family Counseling Centre in the year 2004. Its FCC is situated in Sector 41A, Chandigarh.

2. Survival of Young & Adolescent Foundation (SURYA). This organization has its office in Sector 28D, Chandigarh and is involved in organizing awareness generation camps for adolescents in the urban slums of the UT. It also runs various vocational training courses for women like beautician, stitching and tailoring, etc. SURYA has recently also opened an FCC in Hallomajra village of Chandigarh UT.

3. Indian Council of Social Welfare (ICSW). The Indian Council of Social Welfare is a recognized branch of the ICSW’s Central Office in Mumbai. The Chandigarh Chapter started in the year 1976. This NGO is involved in
providing help to the needy and economically-weaker sections of society. It runs various projects including a family counseling centre, vocational training programme, school for street children, crèches, AIDS/legal literacy awareness camps and so on. The FCC of this organization is located in Karuna Sadan, Sector 11, Chandigarh.

4. Don Bosco Navjeevan Centre. The Navjeevan Family Counseling Centre was started in June 2006 in Sector 24, Chandigarh. The Don Bosco Centre offers life skills and personality development programmes for youngsters and also provides education to the young to secure a peaceful and happy married life for themselves.

5. Women & Child Support Unit, Chandigarh Police (W&CSU). Their FCC runs within the premises of the Home Guard Building, Sector 17, Chandigarh, within the Women and Child support Unit of Chandigarh Police. The scheme of FCC was applied by and was sanctioned to the Police Family Welfare Society, Chandigarh Police, in the year 2002.

Another Family Counseling Centre has been started for blind persons by the National Association for the Blind in Karuna Sadan, Sector 11, Chandigarh. The beneficiaries of this FCC were not included in the present study because it was started in the year 2010-11, which is later than the time period examined in the present study.

2.7.1 Role of a Counselor at the FCC

A counselor at the FCC performs the role an advisor, support service provider, facilitator and motivator. During counseling sessions, the counselor collects identification data, provides mental support, and creates a forum for the distressed persons to ventilate their problems and feelings. (S)he also builds rapport with the parties, while attempting to carry out problem identification. Identified problems are spelled out and available remedies are discussed. The parties are allowed to take reasonable time to think about various alternatives available to them. In solving matrimonial disputes, social support is essential. Hence, the involvement of family members and relatives is also ensured. When required, the counselor also pays a home visit or a visit to the employer or to the work place of the parties concerned.
2.8 CONCEPT OF SATISFACTION WITH SERVICE PROVIDED

Interest in client feedback originated with the consumer movement of the 1960s and 70s, which emphasized the rights of service recipients to be heard and included in decision-making. During this period, new models of healthcare started to evolve, based on concepts of participation, partnership and consumer consultation (Donabedian, 1992). The emphasis on consulting consumers further developed during the 1980s and 90s, with growing pressures on health systems to target programmes, improve efficiency and evaluate the effectiveness of services provided (Williams, 1994). Consumer feedback surveys became widely regarded as an important and integral component of the evaluation of health services (O’Neal, 1999).

Social workers have long advocated for recognition of “the client’s voice” in service planning and evaluation (Maluccio 1979; Mayer & Timms 1970; Rees & Wallace 1982), claiming that a consumer orientation shifts the focus of care more toward the client’s values, understanding, expectations and preferences (Rehr, 1983). Hospital-based social workers have strongly supported the transformation of health systems to become more consumer oriented.

The practice of social work in healthcare has also evolved with changes in health systems by responding to demands to demonstrate the quality and effectiveness of social work services (Pockett, Lord, & Dennis 2001; Rehr & Rosenberg 2000). Consequently, there has been a growing interest in finding appropriate and measurable outcomes for social-work interventions. Client feedback surveys focused on “satisfaction” represent a relatively easy method of evaluating services and are the most common way in which social workers in healthcare have assessed outcomes for clients. Satisfaction surveys have been used to assess the overall performance of a broad service and to identify aspects of the service most valued by clients (Garber, Brenner & Litwin, 1986). They have also been used to evaluate services to specific client groups, such as the elderly and the bereaved (Lord & Pockett, 1998), to modify the mode of service delivery to better meet the needs of clients (Fischer & Valley, 2000), and to explore reasons for “dropout” from established treatment programs (Primm, Gomez, Tzolova, Perry, Thi Vu, & Crum, 2000).

Client satisfaction surveys have also been used to determine the acceptability and appropriateness of new or controversial interventions and to compare the
effectiveness of different modes of service to a population group. For example, Locke and McCollum (2001) examined clients’ responses to live supervision of counseling within a marital and family therapy clinic. While some clients found live supervision intrusive, most reported being ‘satisfied’ that the helpfulness of this procedure outweighed the disadvantages. Wong (1999) reported on a comprehensive evaluation of a structured behavioural program for adolescents in treatment for conduct disorders, and concluded that the program was effective in terms of both behaviour change and acceptability to the adolescents themselves on the basis of the results of a satisfaction questionnaire.

As part of an evaluation of mental health services in New Zealand, Dykes, Murray, and Tinling (1990) assessed levels of satisfaction with services among clients and caregivers. They found no significant differences in the overall level of satisfaction between clients receiving community-based care and those receiving hospital-based care. Mitchell (1998) explored how clients with mental health problems perceived a time-limited, structured group program provided by managed care in the United States. He found no significant differences in satisfaction between clients participating in the group program and those receiving open-ended, individual therapy. Soskoline and Auslander (1993) found that a new discharge planning protocol for hospital patients in Israel delivered poorer outcomes in that it was associated with lower satisfaction with the service and a higher rate of return to emergency departments. These studies highlight some of the potential uses of client satisfaction surveys.

An organization needs some competitive advantage to sustain in this world of cut-throat competition. Customer satisfaction and loyalty could be considered an important tool to maintain a competitive advantage. An organization should give special attention to its service quality which can help it differentiate itself from other organizations, and results in long-term competitive advantage (Moore, 1987). “Delighting the customer” is the core message of the total quality approach (Owlia and Aspinwall, 1996).

A service is the intangible equivalent of an economic good. Service provision is often an economic activity where the buyer does not generally, except by exclusive contract, obtain exclusive ownership of the thing purchased (Kayastha, 2011). A
contemporary definition provided by Kotler et al. (1996) is: “A service is an activity or benefit that one party can offer to another that is essentially intangible and does not result in the ownership of anything. Its production may or may not be tied to a physical product.” Service is seen as a critical driver of customer retention and profitable growth Driver and Johnston, (2001) define that service is “a bundle of explicit and implicit attributes” perceived differently by customer segments. These attributes are perceived as either “search qualities”, (i.e. verifiable attributes), “experimental qualities” that cannot be evaluated until experienced, or “credence qualities”, those that consumers find difficult to evaluate due to limited expertise and understanding (Lovelock et al., 2001).

A service encounter always occurs between two parties (Shostack 1982, 1984, 1987; Czepiel 1990). It is bounded, has a beginning and an end or outcome, and some form of exchange takes place (Dwyer et al., 1987). Most researchers (Berry 1983; Solomon et al. 1985; Dwyer et al.1987, Czepiel 1990) agree that the term “service experience” relates to a number of contributory events and a number of transactions or interactions between a customer and provider in the exchange of the service. A service experience is not defined solely by any individual incident (Dwyer et al. 1987; Czepiel 1990; Singh 1991; Hume and McColl-Kenney 199). It is the interrelation of the incidents and encounter points that defines the experience.

“The provider creates an offering through the design of a series of encounters and interactions. The consumer interprets these encounters to construct an overall experience. The service description is the verbalization of the service offering from the provider by their design intent and from the consumer by experience. When describing and designing the overall service offering the provider must consider the Customers (Consumers) responses to the encounter in order to customer consumers satisfaction (Consumers) and service quality are then related to how closely these encounters, within the offering, are consistent with the Customers (Consumers) wants and needs. The challenge for researchers is to identify the important incidents within the experience and to understand the relationship to repurchase intention” (Hume et al. 2006).

2.9 QUALITY

“Quality has no specific meaning unless related to a specific function and/or object. Quality is a perceptual, conditional and somewhat subjective attribute”
According to Drucker (1985), “Quality in a product or service is not what the supplier puts in. It is what the customer gets out and is willing to pay for”. A quality is a comparison between expectation and performance (Parasuraman et al., 1985). As per Crosby (1979), “Quality is conformance to requirements.”

2.9.1 Definition of Service Quality

The concept of service quality is linked to the concepts of perception and expectations. Service quality perceived by the customers is the result of comparing the expectations about the service they are going to receive and their perceptions of the company’s actions (Parasuraman et al 1988; Gronroos 1994). Kasper et al (1999) defined service quality as the extent to which the service, the service process and the service organization can satisfy the expectations of the user. Sasser et al (1978) listed seven service attributes which they believe adequately embrace the concept of service quality. These include:

- Security – confidence as well as physical safety
- Consistency – receiving the same treatment for each transaction
- Attitude – politeness
- Completeness – the availability of ancillary services
- Condition – of facilities
- Availability – spatial and temporal customer access to services
- Training – of service providers

2.10 Definition of Satisfaction

“Satisfaction is a consumer’s post-purchase evaluation of the overall service experience (process and outcome). It is an affective (emotional) state of feeling or reaction in which the consumer’s needs, desires and expectations during the course of the service experiences have been met or exceeded” (Hunt, 1977). “Satisfaction is a post-choice evaluation judgment concerning a specific purchase decision. It can be approximated by the equation: satisfaction = perception of performance – expectations” (Oliver, 1980). “Satisfaction is a summary, affective and variable intensity response centred on specific aspects of acquisition and/or consumption and
which takes place at the precise moment when the individual evaluates the objectives” (Giese and Cote, 2000).

Most studies on customer satisfaction deal with situations where the subject is a paying consumer. At FCCs, however, the users are non-paying “beneficiaries” of a free government service. Yet, studies on customer satisfaction can be applied to beneficiaries as well when it comes to evaluating satisfaction with counseling services.

Pairot (2008) defined customer satisfaction as the company’s ability to fulfill the business, emotional and psychological needs of its customers. Furthermore, Engel and Blackwell (1982) have opined it to be “an evaluation that the chosen alternative is consistent with prior beliefs with respect to that alternative.”

Zeithaml et al (1990) defined satisfaction as an overall judgment, perception or attitude of the superiority of service. The judgment is based on the discrepancy between expectations and actual experiences of a customer.

“Satisfaction is the consumer’s fulfillment response. It is a judgment that a product or service feature, or the product of service itself, provided (or is providing) a pleasurable level of consumption-related fulfillment, including levels of under – or over-fulfillment” (Oliver, 1997).

Oliver (1997) further adds, “Satisfaction with a product/service is a construct that requires experience and use of a product or service. Individuals who pay for a product/service but who do not use this product/service should not be expected to experience the type of (dis)satisfaction that a product/service user (the consumer) will have. So we need to realize that the concept of customer satisfaction is about consumer satisfaction (that is user satisfaction), rather than about buyer satisfaction (which may include non-users)” (Oliver, 1997).

Thus it can be said that customer satisfaction is a judgment by the customer after the purchase has taken place. Satisfaction is the consumer’s contentment response. It is a considered opinion that either a product or service feature, or the product or service itself, endows with a pleasurable level of consumption-related
fulfillment. However, customers have different levels of satisfaction as they have different attitudes and experiences as perceived from the company.

Satisfaction is a subjective feeling. It is a short-term attitude that can readily change given a constellation of circumstances. It resides in the user’s mind and is different from observable behaviors such as product choice, complaining, and repurchase (Oliver, 1997).

Modern management science’s philosophy considers customer satisfaction as a baseline standard of performance and a possible standard of excellence for any business organization (Gerson, 1993). Moreover, customer satisfaction measurement provides a sense of achievement and accomplishment for all employees involved in any stage of the customer service process. In this way, satisfaction measurement motivates people to perform and achieve higher levels of productivity (Hill 1996; Wild 1977, 1980).

The first step in addressing a service is to identify where service delivery does not measure up to citizen/client expectations. Assessments of citizen/client satisfaction levels by public service organizations at all levels will provide valuable data to address these service gaps.

Survey of client satisfaction with services provided can serve numerous purposes in overall service improvement. Research of this nature can explore what components of service are not satisfactory to the citizen/client and to what degree, and can also identify what elements of service are the most important to clients. Data collected may be used to assess levels of satisfaction against areas of importance to target priorities for improvement. This enquiry can assist in identifying the most crucial areas for improvement in order to allocate resources to the appropriate priority areas. Satisfaction surveys of this nature can also provide information about the frequency of use of the service and the demographic/social data for cross-tabulation to reveal trends in relation to perceptions and expectations of service.

To reinforce customer orientation on a day-to-day basis, a growing number of companies choose customer satisfaction as their main performance indicator. It is
almost impossible, however, to keep an entire company permanently motivated by a notion as abstract and intangible as customer satisfaction. Therefore, customer satisfaction must be translated into a number of measurable parameters directly linked to people’s jobs – in other words, factors that people can understand and influence (Deschamps and Nayak, 1995).

2.11 SERVICE QUALITY AND SATISFACTION

According to Negi (2009), the idea of linking service quality and customer satisfaction has existed for a long time. He carried out a study to investigate the relevance of customer-perceived service quality in determining overall customer satisfaction in the context of mobile services (telecommunications), and found that reliability and network quality (an additional factor) are the key factors in evaluating overall service quality. He also highlighted that intangibles like empathy and assurance should not be neglected.

Fen & Lian (2005) found that both service quality and customer satisfaction have a positive effect on a customer’s re-patronage intentions, showing that both service quality and customer satisfaction have a crucial role to play in the success and survival of any business. This study proved a close link between service quality and customer satisfaction.

Su (2004) carried out a study to find out the link between service quality and customer satisfaction, and came to the conclusion that there is great dependency between both constructs and an increase in one is likely to lead to an increase in the other. It was also pointed out that service quality is more abstract than customer satisfaction because the latter reflects the customer’s feelings about many encounters and experiences with a service firm, while service quality may be affected by perceptions of value (benefit relative to cost) or by the experiences of others that may not be as good.

A study carried out in Sweden by Magi & Julander (1996) on grocery stores showed a positive relationship between perceived service quality, customer satisfaction and customer loyalty. It showed that customer satisfaction results from a
perception of high service quality, which makes the customer loyal. However, it could be possible that a satisfied customer does not necessarily become a loyal customer.

2.12 EXPECTATIONS AND SATISFACTION

Expectations are beliefs (likelihood or probability) that a product/service (containing certain attributes, features or characteristics) will produce certain outcomes (benefits/values) given certain anticipated levels of performance based on previous affective, cognitive and behavioural experiences.

The extent to which services meet customers’ needs or expectations is one measure of service quality. The fact that often little is known about customer expectations makes it difficult to interpret the ratings produced by satisfaction surveys.

Expectations are often seen as related to satisfaction and can be measured as follows:

i. Importance: Value of the product/service fulfilling the expectation

ii. Overall Affect-Satisfaction Expectations: Like/dislike of the product/service.

iii. Fulfillment of Expectations: The expected level of performance against the desired expectations. This is a respondent-specific index of the performance level necessary to satisfy.

iv. Expected Value from Use: Satisfaction is often determined by the frequency of use. If a product/service is not used as often as expected, the result may not be as satisfying as anticipated. For example, a motorcycle that sits in the garage, an unused year-long subscription to the local fitness center/gym, or a little used season pass to a ski resort would produce more dissatisfaction with the decision to purchase than with the actual product/service.

2.12.1 Measuring Expectations

As discussed earlier, customers go through five different stages when they evaluate service: need recognition, information search, evaluation of alternatives, purchase and consumption, and post-purchase evaluation. When purchasing products,
this usually is the order in which the process is evaluated, but with services this order may vary as the focus may be on information search and evaluation of alternatives (Olli, 2007).

(i) Need Recognition

The process of getting a service begins with need recognition. Needs may be of various kinds – physiological needs, safety and security needs, social needs, ego needs and self-actualization needs (Zeithaml and Bitner, 2003).

(ii) Information Search

When searching for information about services or products, people use personal sources such as friends and experts in the area and non-personal sources such as mass media. Unlike in products where these two sources are equal, when searching for information about services, people tend to rely more on personal sources (Zeithaml and Bitner, 2003). The opinions of people close to the decision-maker have great effect on the final decision. Nowadays the Internet is considered as the most important source of information.

(iii) Evaluation of Alternatives

In services, the group of alternatives is often smaller than in goods. This is because service providers usually do not offer competing brands of services as stores offer, for example, different brands of cereals. Also, in certain geographical areas there usually are not many different service providers. The third reason is that typically it is hard for a customer to obtain adequate information about services. This often drives the consumer to choose the first option they find out about without comparing providers against each other (Zeithaml and Bitner, 2003).

(iv) Emotions and Moods of the Users

In service situations, emotions and moods of the customer and the service person have great effect on service delivery and its perception (Zeithaml and Bitner, 2003). This might have an effect on the results of the conducted study; for example, a
customer hiring a car for a business trip might be tenser than the customer hiring a car for a vacation.

### 2.12.2 Service Expectations

A customer’s service expectations are based on search qualities they can find before using the service, whereas experience qualities are gained after using the service (Gilbert and Gao, 2005). For the service provider, it is essential to know the expectations, otherwise even if the service process goes as planned from the provider’s point of view, the customer may not be satisfied. Also, there is a chance that the provider spends money on features that do not add any value to the customer’s experience. It is essential for a service provider to find out what the service expectations are, how they are formed, how a customer changes expectations and how a company may meet or exceed these expectations (Zeithaml and Bitner, 2003). The services processes should be well planned and smoothly run, but the more important thing is the customer’s experience.

Studies have shown that it is seldom that the reason for disappointment with a service is extravagant service expectations. More often, disappointments are caused by customer distrust and intolerance due to inflated service claims, broken promises and insufficient care (Gilbert and Gao, 2005).

### 2.13 NEED TO MEASURE CLIENT SATISFACTION

Good service to customers is obviously one of the primary goals of service organizations. Customer focus in service delivery is essential for satisfying customers, and the success of any organization depends upon customers’ perception or judgment of the quality of products/services provided by the service provider in that organization (Manjunatha and Shivalingaiah, 2004). The service quality is the measure of how well the product/service delivery meets customers’ expectations. The definition of quality is subjective and personal – it changes from person to person, place to place, organization to organization, situation to situation and time to time.

Whereas studies in various fields have employed client satisfaction as a performance measure, agreement is still lacking as to how it may best be conceptualized. In a review of its use in the mental health field, Lebow (1983) defines
client satisfaction as “the extent to which services gratify the client’s wants, wishes, or desires for treatment.” In contrast, Young, Nicholson and Davis (1995) argue that satisfaction with treatment narrows the focus too finely on therapeutic services. They advocate a broader view that addresses satisfaction with multiple types of services, with service integration and coordination, and with the capacity of services to affect the client’s interactions with family members and others. This approach seems better suited to human services that may or may not involve therapy, as it meshes well with a person-in-environment perspective. Young et al. (1995) also note that satisfaction with services may intermingle with satisfaction with the provider, and thus, a broader conceptualization that recognizes this fact is important when developing a measure of customer satisfaction.

Sexton (1996) and Spinelli (1994) found that outcome research has investigated a wide variety of client problems and clinical techniques; however, there is little research regarding client satisfaction from a client perspective. The relevance of counseling outcome research was a resonating theme discussed by numerous authors (LaSala 1997; Sexton 1996; Sexton & Whiston 1996; Steenbarger & Smith 1996; Whiston 1996). Sexton and Whiston (1996) believe there is a gap between research and practice. The purpose of research should be to contribute in some way to understanding and action that can improve social circumstances (Rossman & Rallis, 2003).

Kelly (2003) reviewed numerous studies conducted in the 1970s and 1980s, and concluded that “satisfied clients are more likely to continue using an organization’s services and refer others to the organization.” Satisfied clients can help increase an organization’s growth rate while dissatisfied clients can dramatically hinder it. However, an improvement that needs to be made in client satisfaction research is placing assessments within an evaluation model that guides the purpose and the uses of the client satisfaction data (Lee & Sampson, 1990). Integrating research and practice is imperative to continually assess and improve client satisfaction and services.

2.14 THE SERVICE QUALITY THEORY

The service quality theory owes its origin to the product quality and customer satisfaction literature. Early theorists (e.g. Gronroos 1982, 1984; Parasuraman, Zeithaml and Berry 1985) used the disconfirmation paradigm employed in the physical goods literature (e.g. Cardozo 1965; Churchill and Surprenant 1982; Howard
and Sheth 1969; Oliver 1977, 1980; Olshavsky and Miller 1972; Olson and Dover 1976), which suggested that quality results from a comparison of perceived with expected performance (Gronroos, 1984). Gronroos (1984), in addition to adapting the disconfirmation paradigm to the measurement of service quality, identifies two service dimensions as shown in Figure 1, Panel A. Functional quality represents how the service is delivered – it defines customers’ perceptions of the interactions that take place during service delivery. Technical quality reflects the outcome of the service or what the customer receives in the service encounter.

Parasuraman, Zeithaml and Berry’s (1985) model (see Figure 1, Panel B) is also based on the disconfirmation paradigm. It views service quality as the gap between the expected level of service and customer perception of the level received. As compared to Gronroos’ (1982) two dimensions, Parasuraman, Zeithaml, and Berry (1988) propose five, namely, the reliability, responsiveness, assurances, empathy, and tangibility characteristics of the service experience.

Several studies have suggested modified versions of the SERVQUAL model (e.g. Boulding et al. 1993; Cronin and Taylor 1992; DeSarbo et al. 1994; Parasuraman, Zeithaml, and Berry 1991, 1994; Zeithaml, Berry and Parasuraman 1996). Cronin and Taylor (1992) drop the expectations dimension from the model altogether, while Boulding et al (1993) add further dimensions to the expectations portion of the model (such as “will” and “should”). Carman (2000) and De Sarbo (1994) use alternative methods (such as conjoint analysis) to assess service quality perceptions.

Another model relates to the structure of the service quality construct. Dabholkar, Thorpe, and Rentz (1996) identified a hierarchical conceptualization of retail service quality that proposes three levels: (1) customers’ overall perceptions of service quality, (2) primary dimensions, and (3) sub dimensions (see Figure 1, Panel C). This multilevel model recognizes the many facets and dimensions of service quality perceptions. In this model, retail service quality is viewed as a higher-order factor that is defined by two additional levels of attributes.

Yet another model offered by Rust and Oliver (1994) is in the shape of a three-component model: the service product (i.e. technical quality), the service delivery (i.e. functional quality), and the service environment (see Figure 1, Panel D).
Support has been found for this model in retail banking (McDougall and Levesque, 1994) and health care samples (McAlexander, Kaldenberg, and Koenig, 1994).

**Different Models of Service Quality**

![Diagram of Different Models of Service Quality](image)

**Figure: 2.1 Different models of service quality**

To summarize, we may say that scholars have advanced modified versions of either Parasuraman, Zeithaml, and Berry’s (1988) five factor American model or Gronroos’s (1982) two-factor European (Rust and Oliver, 1994). Service quality is
thus defined in the present study in terms of clients’ perception regarding (1) the service product, (2) the service delivery, and (3) the service environment, on which outcome of service encounter depends.

2.15 SATISFACTION WITH COUNSELING SERVICES

The client satisfaction survey has been identified as a relatively inexpensive and fruitful assessment of satisfaction with the services provided. The survey can identify which components of a program are not successful, although other evaluation procedures are required to identify the reasons for this lack of success.

Previous research on client satisfaction highlights the importance of the relationship between the counselor and the client (Elliott & Williams 2003; Lambert & Cattani-Thompson 1996; LaSala 1997; Nelson & Neufeldt 1996). Clients judge the quality of services they receive by assessing seven elements of their relationship with the counselor: respect, understanding, complete and accurate information, competence, access, fairness, and results. Organizations that strive to exceed client expectations in these areas will receive high ratings of client satisfaction. Nelson and Neufeldt (1996) stressed that one of the common factors in successful counseling is a strong working alliance between counselor and client. This includes an emotional bond between the two, an agreement about goals and counseling, and an agreement about how to accomplish those goals.

Lambert and Cattani-Thompson (1996) said that counselor empathy, rather than technique, is the best predictor of client satisfaction outcome. Elliott and Williams (2003) agreed by stating, “It would appear that the key factor in the development of an effective relationship is the counselor’s non-judgmental acknowledgement of the client’s feelings.” Elliott and Williams further stated that they believe insight and understanding are rated higher by clients than symptom reduction. Although the counselor-client relationship is extremely important with regard to client satisfaction, this study aimed to learn more about what other factors contribute to client satisfaction.

Clients’ expectations of counseling services have been researched from a number of perspectives. Two areas on which most researchers agree are the expectation process and the outcome of that process. Both theoreticians and practicing
counselors now agree that clients bring expectations and beliefs to the counseling situation. It is believed that these expectations influence both the counseling process and its outcome. It is widely believed that clients’ expectations exert an important influence on clients’ decision to enter into and remain in counseling and that their expectations influence the effectiveness of counseling.

Until the 1970s, client satisfaction, defined as “the extent to which treatment gratifies the wants, wishes, and desires of clients” (Lebow, 1982), was believed to be unrelated to service quality and outcome (Damkot, Pandiani & Gordon, 1983). However, client satisfaction surveys have now come to be linked to service quality and its outcome (Damkot, Pandiani & Gordon 1983; Parry 1992; Cape 1995) and are well-accepted by users and professional bodies. This external review procedure (Lavender et al., 1994) has now become a systematically studied (Larsen, Attkisson, Hargreaves & Nguyen 1979; Stallard & Chadwick, 1991) and most commonly used method of reviewing services (Stallard, 1996). As a form of audit (‘consumer audit’, Spencer, 1995) and systematic critical analysis of the quality of medical care (Parry 1992; Cape 1995), a client satisfaction survey aims at finding out if certain practices meet some pre-set standards (Paxton, 1995). It remains an economical (Fitzpatrick, 1992a) and systematic way of demonstrating concern for consumers’ involvement (Williams & Wilkinson 1995; Hutchings & Pope 1998) and satisfaction (Fitzpatrick, 1993). It is evident that policies that encourage user participation may, therefore, be desirable.

The determinants of satisfaction are context-specific and multi-dimensional (Stallard 1996; Brunning 1992; Fitzpatrick 1992a; Squier 1994). Usually three (e.g., Squier, 1994) or four (e.g. Brunning, 1992) but also up to 11 dimensions such as humaneness, informativeness, overall quality, competence, bureaucracy, access, cost, facilities, outcome, continuity, attention to psychosocial problems of client satisfaction have been identified (Fitzpatrick, 1992a).

Client satisfaction surveys with multidimensional measures, i.e. Likert summed scales have been found to be more reliable, precise and discriminative than individual items with ‘yes-no’ or ‘yes-unsure-no’ answers (Fitzpatrick 1992a, 1993, Squier, 1994). With additional open-ended questions, they have been found to
produce the most useful data (Damkot et al. 1983; Frith-Cozens 1993) and are in the best position to comment on certain aspect of services, e.g. “acceptability of treatment” (Firth-Cozens, 1993). It appears that consumers/clients’ opinions are a necessary element of self-review, service and programme evaluation, planning and development (Damkot et al., 1983) and outcome (Stallard 1996).

Quality of service is an elusive and imprecise construct and is difficult to measure, because services are intangible, heterogeneous, inseparable and perishable (Lovelock, 1996; Siddiqui and Khandaker (2007).

Coming to studies on Counseling Centres, existing literature has focused on how the working process in FCCs comprises two factors: counseling and the system (i.e. how the center organizes its administration, service delivery and so on). System encompasses the procedures and the environment in which beneficiaries are provided service, including frequency of repeat visits, setting of appointments, the setting of the waiting room, the length of waiting time, and the overall atmosphere of the center. According to Gilmer and Deci (1977), organizational rules and systems have an impact on people’s satisfaction. Eklund and Hansson (2001) found that the overall atmosphere of mental health/health settings (or say FCCs), including order and organization, is significantly relevant to clients’ satisfaction and therapy.

Beneficiaries begin to develop an impression of the service at an FCC right from the first step of seeking an appointment, or, if they are making a personal call (visit), the moment they step into an FCC. Hence, their satisfaction is broader than what is covered by outcome evaluations of counseling alone. Clients also form impressions from intake forms and problem checklists that they are asked to complete. Counseling centers also involve organizational processes such as scheduling, referrals and session limits for clients besides offering counseling services. Therefore, some researchers (Pascoe, 1983), have suggested adopting a broader definition of client satisfaction. Pascoe has emphasized that it is important to know how “the receptor reacts to context, process, and result of his or her service experience.”

Past research shows that clients can discriminate between different components that may enhance or detract from their overall satisfaction with a
particular service. In a study of consumer satisfaction with institutional and community care, Corrigan (2004) found that patients in both settings discriminated between four different dimensions of care: characteristics of staff, treatment services, the physical environment and activities that foster autonomy. Boot et al. (1994) note: “Satisfaction may be related to process rather than outcome, but in counseling, process and outcome are likely to be inextricably entwined.”

Previous research has identified the most important dimensions of service quality as (1) Access (2) Costs (3) Availability of services (4) Respectful and friendly treatment (5) Privacy and Confidentiality (6) Competence of service providers (7) Information and counseling and (8) Convenient schedules and waiting hours (Creel et al. 2002; The SENCS Report 2003). Various studies have dwelt in detail on these aspects.

Access to service is a vital element of quality of care since it determines whether a client even gets to the service provider. Studies have identified distance and cost as being among the major factors that constrain women’s ability to access services (Bongaarts and Bruce 1995; Stash 1999; Bulatao 1998). However, the degree to which these barriers limit access is strongly influenced by clients’ perception of quality (Creel et al., 2002).

Costs, including charges for transportation, services and phone calls can be another barrier to accessing services, as various studies have shown (for instance, NIS & ORC Marco 2000). Even low-cost healthcare services involve costs, including the opportunity cost of time away from income-generating activities (Abou-Zahr, 1996). Child care, food preparation, household chores and income generating work outside the home make seeking health care seem like a luxury for many (Creel et al., 2002).

Research has further shown that a healthcare service provider’s tone, manner and mode of speech are important to clients (Whittaker 1996; Matamala 1998). Courtesy is a sign that client is seen as an equal by the service provider. Additionally, clients report higher satisfaction with providers who keep their needs and personal information confidential (Whittaker, 1996).

Previous studies have found that clients value a service provider’s technical competence; they judge technical competence by whether their needs are met or their
problems are resolved (Creel et al, 2002). Clients want to receive information that is relevant to their needs, desires and lifestyles, vis-a-vis their problem. Providing complete and accurate counseling that is suitable to clients’ needs has been associated with higher levels of client satisfaction as well as client retention (Townsend, 1991). Identifying the problems, clear understanding of client needs and providing counseling are all related to clients’ satisfaction with services provided.

Long waiting times and inconvenient working hours of counseling centres can prevent clients from obtaining services. A client-centred approach in which clients identify, demand and receive the services, information and emotional support they need is helpful (WHO, 1996).

Keeping these studies in view, the present study conceptualized to include the dimensions of accessibility of FCC, general cleanliness of FCC and its surroundings, general facilities at the FCC, privacy and quickness of response, expertise of counselors and effectiveness of counseling /service provided by the FCC along with outcome of FCC service counter.

2.16 RESEARCH GAPS FOUND AFTER THE REVIEW OF LITERATURE

Most of the studies conducted on the family counseling centres so far have been carried out to critically examine the scheme of family counseling centres from the view point of service providers i.e. the funding agency (CSWB). The number and type of cases brought to the FCCs have been studied along with the efforts made to solve these cases; the role of the counselors in providing counseling and help to the beneficiaries’ has also been studied. However, there has been not a single study carried out with the perspective of beneficiaries for whom the FCCs have been established. No study has been found in which the beneficiaries’ opinion has been asked as to what type of services they expect from the FCC and whether the FCC services are fulfilling these expectations. Moreover, no study has been carried out so far to study the satisfaction of the beneficiaries with the services being provided by the FCCs.

The present study is an attempt to fulfill this gap.
2.17 **RESEARCH QUESTIONS**

After going through the review of literature and finding the gaps in literature, the following research questions were framed for the present study.

1. What is the socio-demographic profile of the beneficiaries who approach FCCs for help?
2. What are the efforts made by the beneficiaries to solve their problems before deciding to approach the FCC for help?
3. What are the reasons (problems) with which beneficiaries approach FCC?
4. What are the expectations with which beneficiaries’ approach the FCCs?
5. What kind of services are being provided to the beneficiaries by the FCCs?
6. What is the level of satisfaction of the beneficiaries with the services provided by the FCCs?
7. What is the effectiveness of FCCs in fulfilling the expectations and resolving the problems of the beneficiaries?

2.18 **LIMITATION OF THE PRESENT STUDY**

1. The subjects of the present study were predominantly woman beneficiaries of FCCs.
2. It is possible that the subjects of the present study could have been selective in their responses due to social desirability.
3. All beneficiaries visiting the FCCs were asked to participate in this study. Those beneficiaries who discontinued counseling or who did not wish to participate in the study (though very few in number) were not included.
4. The issue of seeking help from an outside agency, being a highly sensitive one involving feelings and emotions and sharing information correctly and honestly was not very easy for many participants of the study. Therefore, the honesty of their responses could be biased.
2.19 SUMMARY

The review of literature reveals that social welfare organizations in India need to be oriented and equipped to render such social, educational and counseling services as will strengthen family life in today’s society. There has been an increase in the number of suicides committed due to family problems by as much as 5.9% in 2010 as compared to 2009. Managing conflict in marriage is one of the most important factors for sustaining a marital relationship. In the present-day system of nuclear families, the sane counsel or intervention of elder members of the family is not available. The divorce rate in India is increasing rapidly and women are taking a lead in filing divorce cases. Research shows that divorce and marital breakdown have a serious damaging effect on children, adult men, women as well as society as a whole.

Research also shows that marriage counseling and marriage education may help many couples improve relationship satisfaction, reduce conflict and violence, and avoid divorce. Research has also revealed that during the divorce process, a high proportion of divorced couples are ambivalent about their divorce decision. Studies in this area have also shown that a fairly large percentage of divorced people wished that they and their ex-spouse had tried harder to work through their differences. Research also suggests that a substantial number of couples filing for divorce may be candidates for successful reconciliation. Marriage and family counseling can play an important role in helping couples to resolve their differences.

Marital and family counseling in India has a long history. Indian folktales make reference to numerous examples of advice being given to couples by elders of the family. It has also been found that Indians experiencing emotional problems often visit faith healers, gurus and exorcists before approaching the counselor or therapist.

The concept of Family Counseling Centers (FCCs) was developed by the Central Social Welfare Board in the 1980s. Each FCC is provided a financial grant of between Rs 1,28,000 and 1,92,000 each year depending upon its location. At present, there are more than 800 FCCs across the country and during the period under study there were five in the Union Territory of Chandigarh. The working of FCCs has been studied by various scholars. Most of the studies have examined the clientele, their
problems and the solutions offered to these problems by the counselors at FCCs. However, no study has been conducted from the angle of beneficiaries, i.e., what their expectations from FCCs are and whether these expectations are being fulfilled or not. The present study is an attempt to fill this void and critically examine the services being offered by these FCCs and the satisfaction of the beneficiaries with these services.

In the modern world, customer satisfaction is considered as the minimum standard of performance for any organization and measuring a customer’s satisfaction provides a sense of achievement and accomplishment for all employees involved in any stage of the customer service process. Therefore, measuring satisfaction motivates people to perform and achieve a higher level of performance.