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1.2.3 The Statement of the problem

“A study of adjustment, anxiety and neurotic tendencies of old age people”

Old age is characterized by diminished physical and psychic activity and plethora of problem. We broadly divide the problems of the aged in three categories as health problems, economic problems and socio-psychological problems.

The problem of adjustment is one of vital issues of the old age people in the modern world, so it needs serious consideration. It has been rightly estimated that 18th century was characterized by enlightenment, the 19th century by progress and development whereas the 20th and 21st centuries are characterized by anxiety and conflict because mechanical and busy life has exposed the old age people to greater stress affecting their adjective capacity.

Indian society provides a congenial set of condition for physically conformable and emotionally satisfactory old age. The extended family is the golden side of Indian social system. Strong kinship ties and religious values extolling the virtues of old age people have, for generations, acted as natural social security for the old people. (D. Souza 1982) Old aged people in India have enjoyed high status, respect and authority in the past in traditional Indian society because of the norms and values prescribed in the ancient scriptures. In Indian society, joint family system was being practiced from generation to generation and high status had been assigned to older members of the family. The old people never had to seek care and service outside the family and kinship group. This social security of the elderly flowed from their superior status in
the family and virtue of the fact that elderly parents enjoyed considerable authority matters particularly over family property. This provided the old people dominance in the family and in turn the children had to take care of their aging parent’s as an obligation and as a sign of reverence. It has been argued by many scholars (D. Souza 1982 Gangrade 1999, Khan 1999, Singh 1999) that the position of the elderly was very high in the pre-industrial social order. The scholars have also pointed towards a deterioring status of the elderly in contemporary India. Has transformed drastically. But there has not been a systematic description of the role and status of the elderly in each period of Indian history. There has been marked change in the treatment of elderly compared to earlier periods.

India is passing through a phase of rapid socio-economic transformation. As result, the joint family systems are gradually braking down giving way to nuclear family. These things began to change due to complete web of interlocking factors of westernization, industrialization, urbanization and changing values better employment technological development. Moreover increasing literacy amongst women accompanied by their employment outside the home in offices and in factories also leaves no time for these women to take care of the old at home. Also now there is greater investment by the family on education and upbringing of children. The high cost of living and changing priorities affect the intra-family distribution of income in favor of younger generation.

The changing scenario has brought out quite unpleasant and unfavorable impact on the elderly. Social position of the elderly people is much more insecure. All these things are shocking, particularly for the old people who lost their secured shelter
which prevailed in joint family. They were once the assets but today they have become the burden for the family. They are neglected by the family. Hence lack of personal care leads to constant search for new forms of care. A new trend is visible, where elders are increasingly moving into their own age cohorts in old age home in search of care and needed support.

In this kind of social situation, conflict and problem of adjustment has become a normal feature of Indian families. Many of the elderly parents are compelled to leave their children and stay in old age homes. The old age homes which were a rarity, have recently spread across the country which is a fact that indicates the growing rift between the generations. It is a social expectation in India that adult sons will take care of their aged parents and daughters take charge of the parents in case the parents do not have son (Vatuk. 1980) But in present time due to lack of such caring system taking care of the elderly has become a serious problem. (Bose and Shankar Dass. 2004).

Sometimes it is asserted that the absence of any such care will cause adjustment problem. Demographic transition accompanied by social and cultural transition gives rise to many psychological problems for elderly such as adjustment, anxiety. Living arrangement is very important component of the well-being of elderly. The elderly regard family residence as the most secure place (Biswas, 2004). The importance of relationship between living arrangement and well-being of the elderly is highly emphasized in the literature; Lazarus (1989) observed a significant difference between spouse living and spouse not living group. Lack of companionship provided by the family results in psychological problem among the elderly. Elderly persons are
habituated to staying with family members. After becoming of resident of old age home, they find difficulty to adapt the new setting which lacks warmth and security of the family environment. There are some studies, which have indicated these factors of loneliness, depression, and anxiety felt by the residents of the old age home.

But this does not mean that the elderly people living with their family members have no problem of adjustment in the family. They also experience intergenerational gap, interactional stresses, conflict with mother-in law or daughter-in law. (Ramamurti, 1995) and increased dependency on children (Sunanda and Ushasree, 1997) (Ramamurti, 1995). Even gender also plays an important role in the family. Indian family is a male dominant family. The family has to adjust, where there is adjustment between the male and the female, happiness is there. However for the happiness in the family, the female adjust much more than the males as they have high tolerance level. The old women have better ways of adjustment and therefore they have less problems of adjustment as compared to males.

Neuroticism is a personality trait that has been associated with several psychiatric disorders, and is considered one of the risk factors for development of anxiety disorder. Neuroticism refers to broad domain of personality traits of contrasting persons who are well adjusted and emotionally stable with those who are prone to mal-adaptive behaviours and to the experience of a variety of negative emotions including anxiety, anger, depression and shame under such labels as harm avoidance or negative affectivity (Markon Kreuger, and Watson, 2005)
1.3 Introduction to Adjustment

1.3.1 What is the adjustment

Psychology is often defined as a science of human behaviour. The psychology of adjustment is a particular part of the science that attempts to understand and explain the complex interpersonal behaviour which people exhibit in their daily lives. In our daily life there has been continuous struggle between the needs of the individual and the external forces since time immemorial. According to Darwin’s theory of the evolution those species which adapted successfully to the demand of the living survived and multiplied while who did not died. Therefore adaption or changing of it oneself or one’s surrounding’s according to the demands of external environment becomes the basic need for our survival. It is as true today with all of us as it was with Darwin’s primitive species. Thus psychologists who are interested in the process of adjustment attempt to use their knowledge of general psychological principles to improve our understanding of different ways in which people attempt to cope with the demands of ordinary living. The psychology of adjustment, then, is the application of the principles of psychology to the problem of everyday life.

1.3.2 Definitions of Adjustment

Adjustment generally refers to modification to compensate for to meet special conditions. In the dictionary the term adjustment means to fit make suitable, adapt, arrange, modify, harmonize or make correspondence. Whenever we make an adjustment between two things we adapt or modify one of both to correspond to each
other for understanding the adjustment as a process. It is important to examine some of the definitions of adjustment given by the various researches;

Adjustment is the established of a satisfactory relationship as representing harmony, conformance, adaptation or the like.

Webster, 1951

Adjustment is the continuous process in which a person varies his behaviour to produce a more harmonious relationship between himself and his environment.

Gates and Jersild, 1948

Adjustment is the process by which a living organism maintains a balance between its needs and the circumstances that influence the satisfactions of these needs.

Shaffer, 1961

From above definitions it is clear that in every definition the needs are incorporated one has to change one’s mode of behaviour to suit the changed situation so that a satisfactory and harmonious relationship can be maintained keeping in view the individual and his needs on the one hand and the environment and its influence on the individual on the other hand. Shaffer’s (1961) definition underlines one’s need and their satisfaction. Shaffer tries to maintain a balance between his needs and his capacities of releasing these needs and as long as this balance is maintained he remains adjusted. As soon as this balance is disturbed he drifts towards mal-adjustment. Gantes and Jersield (1948) mentioned that adjustment is a harmonious relationship between individual and his environment. In view of all these facts it could be stated that adjustment is a condition or state in which the individual behaviour
conforms to the demands of the culture or society to which he belongs and he feels that his own needs have been fulfilled. In this concern Arkoff (1968) had given an extensive definition of adjustment. He defined that adjustment is the interaction between a person and his environment. How one adjusts in a particular situation depends upon one’s characteristics and also the circumstances of the situation. In other words both personal and environmental factors work side by side in adjustment. An individual is adjusted if he is adjusted to himself and to his environment.

Numbers of researchers have made several attempts to measure the relationship between adjustment and other factors, for example the relationship between adequacy of social adjustment and adequacy of personal adjustment has been investigated in a large number of studies.

In the personal adjustment a number of other personality factor have been investigated as correlates of social status. In present study anxiety and Neuroticism are the factors whose effect on adjustment was examined.

To be adjusted on satisfactory, level it is necessary that the basic needs of the individual must be satisfied. Often it is seen that people develop critical or fault finding attitude in objects, persons or activity. As far as possible the observation should be scientific and objective but not critical. There should be flexibility in behaviour. Rigidity is likely to result in mal-adjustment. The individual must possess the capacities to deal with the other circumstances.

If the person is having a realistic perception of the world then there is possibility of satisfactory adjustment. In addition to this an individual. Must have a feeling to ease with his surroundings. Of course it’s very difficult to develop a
balanced philosophy of the life but especially after maturation one can have the established norms which could be treated as a balanced philosophy of life. No doubt one has to make special efforts in order to be well adjusted and successful in life. The psychology of adjustment is that aspect of the science of human behaviour which attempts to explain how people cope with demands and problems of everyday life. To develop an adequate understanding of psychological adjustment it is necessary to adopt a specific viewpoint regarding basic human nature. Three viewpoints have traditionally been held:

1. The moral view of adjustment.
2. The phenomenological view of adjustment.
3. The social – learning view of adjustment.

1.2.3 The moral view of Adjustment

In the moral view of adjustment, moral absolutes provide the guidelines for evaluating the quality of one’s adjustment. The Christian church provided one such set of guidelines, in which adjustment process was seen as a constant struggle against one’s basically evil nature. Sigmund Freud, who was probably the most influential of all scholars in the field of psychological adjustment, also took a negative view of human nature although later psychoanalytic scholars modified this view to increase the importance of social and cultural factors in the adjustment process. The view that humans are innately good rather than evil, has been put forward by humanistic psychologists, who consider that the highest level of adjustment is achieved when one has reached the stage of self – actualization, or fulfillment of one’s innate potential.
1.2.4 The phenomenological view of adjustment

Phenomenologist believes that it is possible to understand an individual only through his own subjective frame of reference. Thus each individual must ultimately judge for himself the adjusting quality of his actions. A major problem with the phenomenological view of adjustment process is its failure to provide a way of understanding the manner in which individuals can be influenced by objective reality, particularly those aspects of reality of which they are not aware. The existential view of adjustment process emphasizes that all people are uniquely responsible for their own destiny which is continually being shaped by the life decision’s that they make.

1.2.5 The social learning process

A social learning process is to study human problem solving or coping behaviour as people attempt to meet and master a variety of challenges to their existence including (1) direct challenges from the physical environment (2) challenges stemming from personal limitations and (3) interpersonal challenges. The behavioural view of adjustment is similar in some respects to the contemporary view divided from Freudian theory known as ‘Ego psychology’ which also emphasizes one’s competence in coping with the environment.

1.2.6 Concept of adjustment

The concept of adjustment was originally termed as adaption, term employed by the biological scientists. Adaptation explains an organism survival to physical
stress. The term adaptation has been, however renamed as adjustment by the psychologists.

Adjustment has two important aspects. One is achievement aspect and second one is adjustment as a process. Achievement aspect involves success in adjustment, while adjustment as a process deals with the modes and ways of adjusting to various demands (Lazarus 1976)

Psychology is systematic in making observation and carrying out experiments it measure, and this is helpful in both description and predication. Most behaviour has multiple causes. How a person respond’s depends upon both the individual and the situation. How an individual behaves in any particular situation depends upon what brings to that situation in terms of abilities, attitude, skills, desires, understanding and habits. The instructor brings into the classroom knowledge and experiences. The student brings desire to learn and skill in understanding. All the details of human nature actions, thought, feelings and abilities are processes that fulfill certain functions in the life of the whole man.

The idea of man living in his environment is clarified by the concept of adjustment. Every organism has many needs that must be fulfilled if it is to keep on living. These needs include certain basic bodily demands such as those for air, food and warmth and certain social needs such as those for security, approval and companionship. We require more than just getting up every morning and following the same routine. But the attempts to satisfy our needs encounter obstacles, people, things, even frustration within the individual himself. Consequently, the person has done more than be merely active in a constant and routine manner. In order to progress
indeed he has to modify and adapt his behaviour constantly in order simply to exist. This process by which organism and its environment are kept in balance in known as the process of adjustment.

**1.2.7 Nature of adjustment**

Psychological adjustment can be viewed as a continuous, dynamic process, involving two factors individuals and their need and skill and the situation and its demands. Each of us views a new situation in a different way perceiving different demands and different possibilities for need satisfaction. Most of us are reasonably aware of our needs and known how to respond optimally in most situations. Also we try to select situation in which we will be able to maintain our accustomed patterns of need gratification. There are Institutions which are so intervene that we have little or no opportunity to learn adaptive ways of responding such as accidents and other crisis. It is impossible to predict how a person will react.

Adjustment problems arise when there is a conflict between meetings one’s own need and the demand of the situation. There are no general rules to aid in resolving such conflicts but the effectively adjusted person tries to be fully aware of all relevant factors and to give each of proper weight in decision. A strict deterministic position would hold those all decisions which are pre-determined by persons by person’s social-learning history, however fails to consider the important role of thinking in determining behaviour.

The effect of good adjustment is that the individual gets as much real satisfaction out of his interaction with his environment as can be had without getting
unfairly in the way of other people, contempt to do the same. However, adjustment does not ensure complete happiness still it is the best means for achieving happiness.

1.2.8 Theoretical prepositions adjustment

After studying the concept nature of adjustment, and the factors that are related to successful adjustment, it is necessary to consider propositions related to adjustment. It is necessary because some people adjust to their environment successfully; many others cannot. It means that there are some factors that help in satisfactory adjustment and the other factors that hinder the satisfactory adjustment. In order to understand that, it is essential to examine some of the theories of models of adjustment.

- Psychodynamic theory

One of the modern pioneers in the study of human adjustment, and probably the most influential of any time was Sigmund Freud. Not surprisingly in light of the commonly held opinion of humans as basically evil, Freud took the view that people are governed by instinctive of biologically based forces of negative kind. In fact it might be considered that one of Freud’s important contributions to the advancement of knowledge of human nature was his adaptation of the theologically based notion of human as evil for the psychologically based nation of “bad motives” from his work with emotionally disturbed individuals. Freud developed his psychoanalytic theory in which the basic “driving forces” are biologically based, undifferentiated sexual and aggressive energies or drives. These drives, which are the core of traditional psychoanalytic theory, are the “bad motives”. In the process of socialization (which is
in some ways analogous to the theological concept of redemption), one learns socially acceptable ways to discharge these biological energies.

In addition Freud’s theory holds that a portion of the energy comes to be controlled by the ego, that aspect of personality which is conceptualized as being responsible for one’s rational and mature development.

Freud’s conceptualization of human adjustment shows the legacy of other scholarly work from earlier day’s particularly Newtonian physics. Freud also tried for some time to develop the notion of a life drive (Eros) with an opposing death drive (Thanaros) although these concepts did not play an important role in his theory of adjective behaviour.

- **Modern Psychodynamic theory of Adjustment**

Freud’s theories were not well received at the time he proposed them but they have gained wide acceptance in more recent years. However, his concept of human nature has troubled many scholars, and several attempts have been made to put forward views in which humans are seen in a more favorable light. For example one group of psychoanalysts referred to as the Neo-Freudians (Alfred Adler, Erich Fromm, Karen Horney, and Harry stack Sullivan) placed much less emphasis on the biological or innate components of basic human needs, and concerned themselves more with needs produced by the demands of the interpersonal and social environment. Another group of psychoanalysts who are usually referred to as the “ego psychologists” (Robert Lowenstein, Ernst Kris Hans Hartmann and Robert white) have disputed Freud’s view that human nature is innately evil. This group has also de-emphasized
the notion that humans have intrinsically negative biological motives and has chosen
to emphasize the adaptive and rational capacities, the ego aspects of personality.

- **Humanistic theory of Adjustment**

  Some contemporary investigators have offered other alternatives to Freud’s
  position on human moral nature. In this view people are seen not as innately evil, but
  as innately good. Carl Roger and Abraham Maslow are two exponents of this position.
  It is of particular interest that Maslow’s view, like Freud’s, places strong emphasis on
  the biological determinants of human nature, but then comes to the opposite
  conclusion about its basic direction. Maslow regarded all people as having the
  potential for positive growth and given a favorable environment as capable of
  intimately reaching the stage of self-actualization or fulfillment of their innate
  potentials. A rough analogy might be drawn between Maslow’s view of the growth
  and development of personality and growth and development of a seed in to a plant
  and finally, given favorable condition, into the flowers whose basic nature was
  originally contained in the seed. The ‘best’ of most well adjusted people are those
  who have developed successfully through their formative stages and have reached the
  highest stage, self-actualization, in which their basic potentials are expressed most
  fully and completely.

- **Existentialism’s theory of adjustment**

  A specific phenomenological position regarding adjustment is offered by existential
  psychology. Existentialists argue that we are each individually and uniquely
  responsible for our own destiny. Each person thus actively decides or is continually
deciding, upon a particular path of action. For the existentialists life is a constant series of decision some of which may appear trivial or inconsequential. It is the pattern of these decisions, and their consequences that really determine the quality of the individual’s adjustment. In making these decisions the individual’s “Free Will” is emphasized above environmental influence past experience or internal psychological or biological states. Thus, each person is seen as actively deciding his or her own fate and therefore responsible for the consequences of the decision that are made.

In examining the existential view of human adjustment behaviourly oriented psychologists, including the others find difficulty in translating it into practical psychology for understanding everyday behaviour. If behaviour is a consequence of truly free decision- making process, and if an analysis of behaviour need not concentrate on prior experience or stable personality characteristics, then human behaviour is beyond our understanding in traditional scientific terms. The existential point of view originated as philosophical position and has not yet been widely accepted in contemporary psychology at least in the United States. The interested reader will find more complete and sympathetic accounts in the work of (Bugental 1965 and May, Engel and Ellenberger 1958).

- Behavioural Theory of Adjustment

Behaviour psychology developed in part as a reaction against psychodynamic theory. Well-adjusted people are they who have learnt behaviours that help them to deal successfully with life’s demands, and maladjusted people are people who have learnt behaviour that prevents them from dealing successfully with life’s
demands. According to most modern behaviourist’s not just observational learning but many kinds of learning are influenced by purely mental processes.

- **Cognitive behaviourism**

The behaviourist's recent concern with mental processes has given rise to a whole new area of research, known as cognition behaviourism. This term is derived from cognition, which means mental proferring now us “now perceive, learn, and think about things. According to the concretive behaviourisms, good adjustment is the ability to interpret events in a realistic and positive manner so that the resulting behaviour will be self-fulfilling than self-defeating.

**1.2.9 Types of Adjustment**

Adjustment behaviour can be conveniently approached in terms of a dimension ranging from highly adaptive to highly un-adaptive. The dimension is also sometimes viewed as referring to acceptable versus unacceptable behaviour or normal versus abnormal behaviour because the concept of normal behaviour is so widely used in discussing psychological adjustment. It is difficult to define what is meant by adjusted versus maladjusted or normal versus abnormal behaviours and there is no single definition that is entirely satisfactory. One possible definition is statistical so that anything uncommon would be called abnormal. Also, what is normal would differ from one culture to another. There are also ideal definitions of normality, in which any natural function is normal, and there are religious prescriptions for what is normal. Each society tends to develop its own practical notions as to what is normal, and it is often simplest to take the practical approach.
A) Well-Adjustment

Human behaviour normally represents efforts on the part of the organism to avoid tension trouble and other unpleasant consequences. This process by which a living organism acquires a particular way of acting or behaving or changes an existing form of behaviour is called adjustment.

There are two types of adjustments: adjustment to external conditions and adjustment to internal condition. As the person grows older, adjustment to external conditions assumes more and more importance compared to adjustment to internal condition. Internal adjustment involves adjustment to different types of situation. First there are the physical conditions like weather, space, time and other material demands. The next sets of conditions refer to the people around us. Social adjustment can take place even in the absence of other social adjustment. It falls under two categories to other people who are directly present and to ascertain standards and norms of behaviours which are generally accepted by everyone.

Internal conditions also are of different types. A person who feels hungry eats the food to satisfy his hunger. This may be called biological adjustment. General Individuals are able to make effective adjustment.

Characteristics of Well–Adjusted People

Maslow focused his research on extremely well-adjusted person. He mentioned characteristics of well adjusted person as bellow.
1. Practical and realistic attitude towards self, other and the world

Well adjusted persons have a practice of the realistic attitude towards themselves. Most of the time they have a fairly clear idea of their capacities and weaknesses: they accept themselves with all their limitations.

2. Ability to accept people and world

Well adjusted people feel good about themselves. So they can accept other people even if they are different from them. Well adjusted people do not approach others with a prejudiced mind; they have basic trust on them.

3. Feeling of psychological security

Well-adjusted people feel psychologically secure they are not over anxious so they can accept unpleasant emotion such as anger and fear in themselves.

4. More efficient perception of reality

Well adjusted people perceive people and situation in a realistic way. They see things as they are and not as they wish them to be, so when problem arises they can solve it more efficiently.

5. Able to give and receive affection

Well adjusted people are able to develop intimate relationship with other so they express their feelings freely.
6. Empathy -

Well adjusted people can understand others, because they have a capacity for empathy. Due to this capacity for empathy well adjusted peoples relationships with others is fairly harmonious.

7. Ability to be productive

Well adjusted people are aware of their capacities. They use these capacities to a fuller extent. They attempt to solve problems, and not avoid them.

Further they are success-oriented. That is they approach work in a much more optimistic manner. So they can attempt new jobs or take.

They accept additional responsibilities without being afraid of failure.

8. Creativity

Mentally healthy people are creative. This creativeness need not be in the usual forms of writing book, composing music, or producing artistic works. It can be more humble. The creativeness of mentally healthy persons means that they tend to approach their work in their own special way.

9. Ability to control one’s environment

Well adjusted people try to change the circumstances in their favors. They have the courage to face to consequences of their actions and decisions.
10. Flexibility

Mentally healthy people have an ability to change themselves when the situation demands.

11. Independence from culture and environment

Mentally healthy people have their own judgment about what should be done in a given situation.

12. Democratic character

Maslow maintains that mentally healthy people are democratic. They practice democracy by recognizing the rights of others and by willingly hastening to their viewpoint.

13. Knowing when to worry and when not to worry

A mentally healthy person is realistic. He judges the situation to determine whether he has something to worry about.

The above characteristics of well-adjusted personality are based on the human potential movement. The main psychologists who are leaders of this movement are Abraham Maslow and Karl Rogers.

B) Mal-adjustment

It was pointed out above that in many instances adjusting behaviour is not effective. The effectiveness of adjusting behaviours can range from complete
effectiveness to total ineffectiveness. In extreme cases, the ineffectiveness may result in the individuals are known as being maladjusted. On the other hand in instances where the behaviour of the individual, while not contributing to effective adjustment does not, however, result in a disruption of existing conditions, the behaviours is said to be non adjusting..

In non – adjusting reaction the individual avoids the problem and his needs are ignored and not really satisfied. These needs, however very often, continue without the awareness of the person and no learning or growth takes place. Mal-adjustment behaviour is unrealistic and the problem continues instead of getting solved. The individual, instead of overcoming the problem, speeds, all his entry and resources in struggling against the demands of his needs as well as external reality.

Maladjusted reaction results because of a number of factors. Some of these factors are biological, some are social and situational and large majority of them are psychological. Prolonged illness, brain-injury etc. are some of the biological and organic causes.

**Characteristics of Mal-adjustment**

1. **Failure to problem solving techniques**

Due to the lack of self confidence a maladjusted person has poor capacity for dealing with everyday life situations.
2. **Excessive behaviour**

Maladjusted people do not react to situation realistically. Their reaction is excessive. This make them indulge in such activities as excessive drinking over irritability and over anxiety.

3. **Disturbance of thought**

Thought disturbance affects the perception and beliefs of maladjusted people. The main features of these are the occurrence of hallucinations and delusions. A person may see or hear things when there is nothing to be seen or heard or he may have beliefs which go against evidence when thought disturbances become serious.

4. **Emotional disturbance**

Emotional reaction of maladjusted people is extreme. They may in value apathy, complete lack of emotional feelings, excessive cheerfulness, or long-lasting depression.

5. **Rigidity of behaviour**

Maladjusted people find it difficult to change their behaviours.

6. **Psychosomatic disturbances**

These are broadly reactions which occur due to mental cause. Common examples of these are stomach ulcers, tension, headache and heart diseases caused by tension.
1.3 Adjustment in old age

Every human being passes through various stages in his life time - birth, infancy, childhood, adolescence, adulthood and old age. Ageing is a normal part of life span and biological process. It is associated with gradual reduction in the reserve capacity of the systems of the body. In other words we can define “aging” as a process characterized by progressive decline in all psychological as well as psychological functions. In every stage of life we have problems which are not restricted to old age. But it is possible that problems which we face in old age may be more severe than the ones that we face when we are young or in middle age. Another possibility is that we are less prepared to face the problem in old age and hence we think that they are overwhelming. This is true for almost all human-beings on earth. As age advances lot, of physical, mental and social changes may force dependency and mental condition may lead to adjustment anxiety, depression, poverty and economic insecurity may aggravate the situation.

Adjustment and mental well-being are outmoding concerns of gerontology. The term adjustment in gerontology literature tantamount to internal and external equilibrium of human beings. Burgess speaks of two aspects of adjustment in old age; personal and social. The existence of inner harmony is personal adjustment and a harmony with the world around us is social adjustment. The problem in the science of gerontology is to understand these harmonies, to describe them objectively to measure them if possible and to find how they are related to others also to other aspects of human life (Havighurst. 1961). Personal adjustment to aging may be defined as the restructuring of attitudes and behaviour to enable the person to respond to a new
situation to achieve integrated expressions and demands of society (Chawan. et. al. 1949). Social adjustment is related to adaptation of the individual in the context of social change personal adjustment finds its context in social adjustment.

The literature on aging suggests that the adjustment problems associated with the aged are the result of physical psychological, social, spiritual, environmental and cultural factors. With aging there is loss of adaptability as homeostatic mechanism underpinning adaptive responding to environmental challenges loses sensitivity and accuracy (Garland, 1993). However as Colman (1993) observes the capacity to adjust to life changes does not appear to be diminished in later life but is rather enhanced. Many older people do adjust to losses like bereavement (Lund 1989 Coleman 1993).

According to Taylor.(1983) adjustment process in old age centers around three themes, a search for meaning in the experience, and attempts to regain mastery over the event in particular and over one’s life in general, and an effort to restore self-esteem throughout self-enhancing evaluations. Taylor proposes a theory of cognitive adaptation to threatening events. Successful adjustment depends on a large part, on the ability to sustain and modify illusions that buffer not only against present threats but also against possible future threats.

Aging entails increased exposure to losses. An adaptation to losses becomes a principle task of the later stages of life (Pfeiffer, 1977). There is a risk for different types of losses for the elderly a situation that has led various others to refer to old age as a season of loss (Pfeiffer, 1976). The older people experience a loss in their level of income, a loss in their friends, a loss in their feelings or activity and productivity within the society, a loss in their roles, loss of identity, loss of power, and loss of
independence and so on. Hence the need for the ‘integration of loss’ is an important adjustment task of the aged.

Health status affects the emotional and social well-being of the elderly chronic health problems make the aged socially isolated and dependent ill health may lead to decreases mobility and increased feeling of helplessness and uselessness’ (Williams 1987) made it clear that physical disability in the aged may lead to emotional. Stress, which may result in the manifestation of anxiety with agitation restlessness, hopelessness and even depression it may also alter one’s self image. Increased dependency leads to a downward spiral of decreasing self-esteem. As a person becomes increasingly dependent his beings to feel guilty Which leads to withdrawal further result in dependency (Creen and Simmons). In the situation of the aged being alone or in the post parental stage the absence family or other support increases the burden of health problem and the management of household chores or taking up major responsibilities becomes very crucial (Cherian, 1990).

Emotional and mental well-being is important determinant of the adjustment of the old aged. Important psychological changes that occur in aging are due to steady decline in the speed of mental activity, decrease of memory power, gradual loss in the area of learning and cognitive functioning and an increased rigidity (Ramamurti & Jamuna, 1993).

Harkin 1978 observed that the empty nest stage is more problematic and critical for the elderly parents and widowhood in general results in social isolation and loneliness (Lopata, 1981) Increased dependency on children categorizes the problem in relation to adjustment of the aged (Ramamurti, 1995) This categorizes the problems
in relation to adjustment of the aged as (1) Physical fitness and health problem (2) Financial problems (3) Psychological problems (4) Problems of interaction in a social and familial setting.

1.3.1 Patterns of adjustment in old age

The concept of adjustment is very common and very old. Its goal has been described as “satisfaction” and smooth switch over from one status to other. Good adjustment is achieved primarily through a balance between the expected and enacted roles when the role playing individual attaches more value to one particular role than is expected / demanded of that role, the “role counter” does not appreciate it and it leads to role conflict. Adjustment is a balanced performance of all roles. Conformity with the role demands when a parson is able to make a smooth switch over from one role to another and his role behaviour is in consonance with the role expectations and his role does not obstruct the performance of other’s role. The person succeeds in integrating the various roles into an ordered sequence of roles, leading to adjustment. Good adjustment means that the person feels that he is neither over-performing nor under- performing a role in relation to the demands of the role. Symbolically, such adjustment may be described in terms of role demand and role performance. Thus “balance in environment” tried by the aged as a process of adjustment may be used as the focus of their development process.

The two diametrically opposite patterns to adaptation in old age, the activity theory and the disengagement theory do not account satisfactorily, for all aspects of a happy old age for there are some individuals with low role activity but high life
satisfactions and vice versa. This has led to the observation that different patterns of successful aging are possible (Ramamurti, 1978) and hence successful adaptation depends on individual life styles and perception (Ramamurti and Jamuna, 1993) and also personality differences. The following are some of the patterns of adaption in old age in relation to personality characteristics.

Perhaps the most significant study, carried out in this line is that of Reichard, Livson and Peterson using kanas cities data. the study identified five distinct patterns of adjustment in old age out of which three types were well adjusted group so (1) The mature, who had a constructive and flexible view of life and were relatively free from neurotic conflict, humorous, tolerant and were aware of achievements and limitations (2) The Rocking chair type who were relaxed, dependent on other and essentially rather disengaged, and (3) The Armoured, who strived to stay active, avoiding retirement and were over controlled, habit bound and conventional. The two poorly adjusted groups were (1) The Angry man, who blamed others for their own failures and were bitter, suspicious, resented their wives and had a great fear of death. Seclusion and withdrawal were their two modes of adjustment (2) the self-haters, who blamed themselves for failures were depressed and critical. They felt loneliness uselessness and welcomed to the prospect of death.

Neugarten described the aging individuals with following adaptation patterns (1) The reorganizers who substitute new activities for lost ones (2) The focused who were selective in their activities (3) The disengaged who were similar to those of rocking chair type (4) The holding on who appeared to defend themselves from perceived threats of aging by chining to their middle aged patterns (5) The constricted
who tried to erect defenses against anxiety through withdrawing (6) The succorance seekers who maintained themselves satisfaction as long as their dependency needs are met by others they could lean on (7) The apathetic who had perhaps been disengaged throughout their lives and were with patterns of passivity and low activity (8) The disorganized who had low activity and poor psychological functioning.

The above two patterns of adjustment to aging display some basic similarities. The reorganizers and the focused group could be subsumed under the mature agers described by Richard and associates both the disengaged and “Rocking Chair” man corresponds to the basic premise of disengagement theory. All these patterns seem to be associated with better adjustment and “Integrated” personalities the holding on and constricted group are similar to and armored pattern and such individuals seem to maintain relatively successful satisfaction. The last three patterns the succorance seekers the apathetic and disorganized appear to maintain low. Satisfaction and may correspond to the self-haters group described by Reichard and his associates.

Reisman explained three types of adjustment pattern to aging (1) The ‘Autonomous’ who reflexively keep themselves alive, physically and mentally despite the psychological change (2) The “Adjusted” who preserve themselves without losing their skills and (3) The “Anomic” who are characterized by premature wariness resigned attitude and show degeneration after retirement.

An altogether different pattern of adjustment to aging was developed by Williams and Wirths. Rather than describing reactions to aging process they focused on individuals life style, which may carried in to old age. The life styles in relation to adjustment are (1) “World to work”, which implies that meaning for one’s life derived
out of work (2) “Feminism” or couple hood in which life appears to revolve around the family as a whole or the marriage relationship (3) “Living alone” representing those who prefer a life style of relative isolation (4) “Easing through life”, in which the aged prefer minimum involvement in almost all the areas like work, marriage and family a pattern disengagement (5) “Living fully” in which the elderly are involved in a variety of areas, without focusing on any one as most important. Though this typology seems to be a new approach based on an individual’s life, the explanation of each pattern is closely linked to activity and disengagement theories. A similar pattern evolves in the review of an article by Johns (1961) according to him, the adjustment patterns related to individual style are; active, passive, social and asocial.

A project made by Buchler consider four different groups of elderly in terms of their adjustment they are (1) those who want to rest and to relax (2) Those who wish to be active (3) those who are dissatisfied with the past but resigned and 4) those who led meaningless lives and are now frustrated guilt and regretful Hamlin (1967) groups the elderly into ‘task oriented’ and non-task oriented member of the task oriented are energetic and have satisfaction and dealing with uncertainty and change. The non-task oriented elderly seek to avoid dissatisfaction, prefer to be placid and quiet, and dislike uncertainty and change. Thorough cluster analysis, Spence. (1968) has developed an adjustment scale which identified four types of elderly persons (1) Unsettled planners (2) Composed planners (3) Disgruntled (4) Complacent.

The typology focusing on both patterns of aging and predominant life style presented on the basis of a longitudinal data by (mass and kuypers 1974) in
noteworthy. Despite a relatively small surviving sample (142) ten different life styles were indentified

1) Family centered fathers
2) Hobbyist father
3) Remotely sociable father
4) Husband centered wives
5) Uncensored mothers
6) Visiting mothers
7) Work centered mothers
8) Disabled disengaged mothers and
9) Group centered mothers

They identified a difference in the life styles of fathers with that of mothers. Gender difference is partly because the man probably remains married while the women remain widowed and there is both stability and change in life style with women apparently being affected more by circumstances than man.

Among the several patterns noticed (Snow and Havighurst, 1977) indentified two contrasting patterns based on the differences in the attitudinal responses of the elderly to retirement and in the choice of activity after the age of 65. They are ‘The Transformers’ and ‘The Maintainers. Filsinger and Saur,(1978) located three main types of adjusters ‘Low Adjusters’ ‘Acceptors’ and Fighters and two female varieties ‘Low Adjusters and Moderate adjusters (Bushan and Sinha 1987) reported four alternative strategies of adjustment.

None of the theories, activity or disengagement, by itself sufficiently explains the various patterns of adaptation to aging. Variety of adaptive responses, rather than one single pattern may be associated with successful late life adjustment. This reflects the diversity in personality and socio-cultural context. Social and psycho-gerontology have moved away from earlier attempts to define ‘well adjusted’ or “correct old age” and measure successful aging against some ideal standard to understand the aging person’s adjustment in term of their needs, interest, past patterns, and the context of social changes. However, an understanding of the theoretical consideration regarding the various adjustment patterns could serve as a basis to understand the patterns of adjustment of the elderly in the context of different living arrangement.

1.3.2 Criteria of adjustment in old age

Criteria of adjustment refer to standards and norms employed to assess the degree and quality of personal and social adjustment of the aged. The focus of this
framework to analyze their family and social adjustment may include such areas of analysis.

1) Family adjustment

a. Satisfaction with the sibling treatment

b. Satisfactory relationship with wife and other family members, other than siblings in the family.

c. Satisfaction with home life.

2) Social adjustment

a. Favourable attitude towards social participation with others known and unknown.

b. Effective relationship with social realities and situations

c. Ability to get along with other persons.

d. Successful adjustment with different groups and subgroups.

e. Possession of socially desirable attributes (Description of self as sociable, likable, popular and able to get along with different kinds of people etc.)

3) Financial adjustment

a. Employment / no employment conditions and satisfaction.

b. Motivation in seeking – re-employment.

4) Political / Social work interests

a. Leisure time activities

b. Religious beliefs and practices

c. Participation in voluntary organization
5) Problems and Stresses

a. Financial / occupational
b. Familial, neighborhood
c. Health problems
d. Insecurity, loneliness and emotional support problems.

1.3.3 Factors Influencing Adjustment to Old Age

- Preparation for old age

Those who have not prepared themselves psychologically or economically for the changes that old age inevitably brings, often find adjusting to these changes a traumatic experience.

- Earlier Experience

The difficulties experienced in adjusting to old age are often the result of earlier learning of certain forms of adjustment that are not appropriate to this period of life span.

- Satisfaction of Needs

To be well adjusted in old age, the individual must be able to satisfy his personal needs and live up to the expectation of others within the framework of life provided for him.
- **Social Attitudes**

  One of the greatest obstacles to good adjustment in old age is society's unfavorable attitude towards the elderly.

- **Personal Attitudes**

  A resistant attitude is a serious obstacle to successful adjustment in old age.

- **Method of Adjustment**

  Rational method includes accepting the limitation of age, developing new interests, learning to give up one's children and not dwelling on the past. Irrational method includes denying the changes that come with age and trying to continue as before becoming preoccupied with the pleasures and triumphs of bygone days and wanting to be dependent on other for bodily care.

- **Health Conditions**

  Chronic illness is a greater handicap to adjustment than temporary illnesses even though the latter may be more severe while they last more than the former.

- **Living Conditions**

  When an elderly person is forced to live in a place that makes him feel inferior inadequate and resentful, this has an unfavourable effect on the, kind of adjustment he makes to old age.
- Economic Conditions

It is especially difficult for the elderly person to adjust to financial problems because he knows that he will have no opportunity to solve them, as he could when he was younger.

Studies of well-adjusted and poorly adjusted old people have shown that those, whom other consider well-adjusted, have traits one would expect in a person who has followed the activity theory, while those who seem poorly adjusted have characteristics associated with the disengagement theory. The characteristics of well-adjusted and poorly adjusted elderly people are as below.

1.3.4 Characteristics of good and mal-adjustment in old age

**Good Adjustment**

- Strong and varied interests.
- Economic independence, which makes independence in living possible.
- Many social contacts with people of all ages.
- Enjoyment of work which is pleasant.
- Participation in community organization.
- Ability to maintain a comfortable home without exerting too much physical effort.
- Ability to enjoy present activities without regretting the past.
- A minimum of worry about self or other.
Mal-adjustment

- Little interest in world of today or the individual's role in it.
- Withdrawal into the world of fantasy.
- Constant reminiscing.
- Constant Worry.
- A lack of drive, leading to low productivity in all areas.
- The attitude that the only activities available are make-work activities.
- Loneliness due to poor family relationships
- Involuntary geographic isolation.
- Involuntary residence in an institution or with a grown up child.

1.4 Anxiety

1.4.1 Introduction to Anxiety

Anxiety means "a state of being uneasy, apprehensive, or worried about what may happen." It is also described as a "feeling of being powerless and unable to cope with threatening events characterized by physical tension." Anxiety is a natural response and a necessary warning adaptation in humans. Anxiety can become a pathologic disorder when it is excessive and uncontrollable, requires no specific external stimulus, and manifests with a wide range of physical and affective symptoms as well as changes in behaviour and cognition. As outlined in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision DSM IV-TR, anxiety disorders include generalized anxiety disorder (GAD), social anxiety disorder
(also known as social phobia), specific phobia, panic disorder with and without agoraphobia, obsessive-compulsive disorder (OCD), posttraumatic stress disorder (PTSD), anxiety secondary to medical condition, acute stress disorder (ASD), and substance-induced anxiety disorder

Researchers say generalized anxiety disorder (GAD) may be the most common mental disorder among the elderly, "Due to the lack of evidence, doctors often think that this disorder is rare in the elderly or that it is a normal part of aging, so they don't diagnose or treat anxiety in their older patients, affecting as many as 10-20 percent of the older population, though it is often undiagnosed. When, in fact, anxiety is quite common in the elderly and can have a serious impact on quality of life,"(Lenze.) Anxiety disorders in elderly people have been relatively less studied compared to other disorders like depression, dementia disorders. However, the available evidence suggests that they are fairly common, both in community and hospital samples of the elderly population and also in special groups, such as nursing home settings. These disorders are associated with significant impairment in functioning and in quality of life. The symptoms of anxiety syndrome are evident in a variety of medical conditions, neurological disorders such as stroke or dementia, psychiatric disorders such as depression, and anxiety disorders themselves. The diagnosis and management of anxiety in geriatric populations has received less attention compared to other Disorders. However, the existing literature suggests that both pharmacological and psychological treatments may be safe and effective in treating anxiety in late life.
1.4.2 Definition of anxiety

The anxiety disorders are a group of mental disturbances characterized by anxiety as a central or core symptom. Although anxiety is a commonplace experience, not everyone who experiences it has an anxiety disorder. Anxiety is associated with a wide range of physical illnesses, medication side effects, and other psychiatric disorders. The revisions of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* that took place after 1980 brought major changes in the classification of the anxiety disorders. Prior to 1980, psychiatrists classified patients on the basis of a theory that defined anxiety as the outcome of unconscious conflicts in the patient's mind. *DSM-III* (1980), *DSM-III-R* (1987), and *DSM-IV* (1994) introduced and refined a new classification that considered recent discoveries about the biochemical and post-traumatic origins of some types of anxiety. The present definitions are based on the external and reported symptom patterns of the disorders rather than on theories about their origins.

1.4.3 Symptoms of Anxiety Disorder

Symptoms vary depending on the type of anxiety disorder, but general symptoms include:

**Cognitive**

- Worry
- Fearfulness
- Difficulty concentrating
- Problems of thinking clearly
- Distractibility
- Mental fatigue
- Memory problems
- Decreased problem-solving ability
- Negative thinking
- Dizziness, Nightmares

**Somatic**
- Heart palpitations
- Hyperventilation
- Muscle tension
- Shortness of breath
- Dry mouth
- Nausea
- Cold or sweaty hands and/or feet

**Behaviour**
- Avoid one of going out or doing something
- Only going to quiet places or being in very small groups
- Only going to places where you can get lost in a crowd and avoid being alone with people
- Problems of sleeping
- Crossing the street to avoid people
- Rushing out of places or situations when feeling anxious
- Going to the toilet to escape from things
- Not saying anything when with other people
- Talking all the time to avoid feeling uncomfortable
- Using 'props' before you go out - alcohol or drugs for example
- An inability to be still and calm.

1.4.4 Phobic disorder

The irrational fears reported by elderly people are similar to those in younger age groups: animals, heights, public transport, going out of doors, and so on (Lindesay, 1991). Unfortunately, much is made of the 'reasonableness' of some of these fears in the elderly, particularly those who live in run-down areas of inner cities, and clinically important fears may be dismissed as rational. In fact, the evidence from fear of crime surveys indicates that an individual's perception of vulnerability is determined principally by factors such as physical disability and the availability of social support (Fattah & Sacco, 1989). It is these, rather than age, that should be taken into consideration when judging the reasonableness, or otherwise, of fears. Very few elderly people with disabling phobic disorders receive any appropriate treatment for their problem (Lindesay, 1991).

1.4.5 Agoraphobia

Agoraphobia is the specific anxiety about being in a place or situation where escape is difficult or embarrassing. The term agoraphobia has been widely misunderstood. Its literal definition suggests a fear of "open spaces". However, this is an incomplete and misleading view. Agoraphobics are not necessarily afraid of open spaces. Rather, they are afraid of having panicky feelings, wherever. These fearful
feelings may occur. For many, they happen at home, in houses of worship, or in crowded supermarkets, places that are certainly not "open". In fact, agoraphobia is a condition which develops when a person begins to avoid spaces or situations associated with anxiety. Typical "phobic situations" might include driving, shopping, crowded places, traveling, standing in line, being alone, meetings and social gatherings.

Agoraphobia arises; from an internal anxiety condition that has become so intense that the suffering individual fears going anywhere or doing anything where these feelings of panic have repeatedly occurred before. Once the panic attacks have started, these episodes become the ongoing stress, even when other more obvious pressures have diminished. This sets up a "feedback condition" which generally leads to increased numbers of panic attacks and, for some people, an increase in the situations or events which can produce panicky feelings. Others experience fearful feelings continuously, more a feeling of overall. Discomfort rather than panic.

A person may fear having anxiety attacks, "losing control", or embarrassing him/herself in such situations. Many people remain in a painful state of anxious anticipation because of these fears. Some become restricted or "housebound" while others function "normally" but with great difficulty, often attempting to hide their discomfort. Agoraphobia, then, is a severe anxiety condition and a phobia, as well as a pattern of avoidant behaviour.
1.4.6 Social phobia

It is also called social anxiety disorder. Social phobia is when an individual feels overwhelmingly anxious and self-conscious in everyday social situations. An older adult might feel intense, persistent, and chronic fear of being judged by others and of doing things that will cause embarrassment. Some older persons suffer a social phobia because they are embarrassed about being unable to remember names or are ashamed of their appearance due to illness. A social anxiety disorder makes it hard to make and keep friends. Some with social phobia can be around others, but are anxious beforehand, very uncomfortable throughout the encounter, and, afterwards, worry how they were judged. Physical symptoms can include blushing, heavy sweating, trembling, nausea, and difficulty in talking.

1.4.7 Generalised anxiety disorder

One result of the recognition of specific anxiety disorders, such as phobic disorders and panic disorder, by the new psychiatric classifications has been the relative eclipse of the concept of generalised anxiety as a diagnostic entity. Indeed in ICD–10, generalised anxiety disorder may only be diagnosed in the absence of any other mood disorder. The current unpopularity of generalised anxiety is probably due in part to the lack of specific treatments (Tyrer, 1985), and in part to the current emphasis on the organic as opposed to psychosocial causes of anxiety disorders (Blazer et al, 1991). In particular, the role of chronic stress in the etiology of conditions such as generalised anxiety has been neglected in recent years. Concern has been expressed that the diagnosis of generalised anxiety disorder may be
inappropriately applied to elderly people because of their vulnerability and physical frailty (Shamoian, 1991). In fact, the epidemiological evidence indicates that only a small percentage of the elderly population meet diagnostic criteria for this disorder (Copeland et al, 1987a, b; Lindesay et al, 1989; Blazer et al, 1991; Manela et al, 1996). Whatever the nosological status of generalised anxiety, the condition appears to be associated with an increased use of both physical and mental health services (Blazer et al, 1991). If service use is regarded as a criterion of clinical importance then generalised anxiety remains a useful concept, particularly at the primary care level.

### 1.4.8 Obsessive–compulsive disorder

Of all the specific neurotic disorders OCD is the most persistent and stable diagnosis. It has a chronic, fluctuating course (Rasmussen & Tsuang, 1986), and the clinical features of OCD in elderly patients are similar to those seen in younger adults. Although a proportion of patients with OCD also develop significant depressive symptoms, other evidence suggests that OCD is a distinct disorder involving the orbitofrontal cortex, basal ganglia, substantia nigra and ventrolateral pallidum (Montgomery, 1980; Goodman et al, 1989; Insel, 1992). While the onset of OCD in old age is rare (Bajulaiye & Addonizio, 1992), a minority of cases present late, and many elderly patients with long-standing disorders have never been adequately treated (Jenike, 1989). Therefore, it is important that all elderly patients receive thorough evaluation and treatment when they come to the notice of services. The development of obsession orderliness and preoccupation with routines may presage the onset of dementia. Obsession symptoms may appear at any age due to head injury or cerebral tumor.
DSM-IV-TR criteria for obsession

**Obsessions are defined in the DSM-IV-TR by the following 4 criteria:**

- Recurrent and persistent thoughts, impulses, or images are experienced at some time during the disturbance as intrusive and inappropriate and cause marked anxiety and distress. Persons with this disorder recognize the pathologic quality of these unwanted thoughts (such as fears of hurting their children) and would not act on them, but the thoughts are very disturbing and difficult to discuss with others.
- The thoughts, impulses, or images are not simply excessive worries about real-life problems.
- The person attempts to suppress or ignore such thoughts, impulses, or images or to neutralize them with some other thought or action.
- The person recognizes that the obsession, thoughts, impulses, or images are a product of his or her own mind (not imposed from without, as in thought insertion).

DSM-IV-TR criteria for compulsion

**Compulsions are defined by the following 2 criteria:**

- An individual perform repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) in response to an obsession or according to rules that must be applied rigidly. The
behaviours are not a result of the direct physiological effects of a substance or a general medical condition.

- The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation. However, these behaviours or mental acts either are not connected in a way that could realistically neutralize or prevent whatever they are meant to address or they are clearly excessive.

1.4.9 Panic disorder

Panic attacks and panic disorder are rare in epidemiological studies of elderly community populations, although cross-sectional surveys may underestimate the true rates. The evidence from case reports, and non-psychiatric patients and volunteer samples, suggests that panic in old age is less common than in early adulthood, is more common in women and widows and is symptomatically less severe than in early onset cases (Sheikh et al, 1991). Elderly panic patients tend not to present to psychiatric services, but the prominent physical symptoms may result in their being referred instead to cardiologists, neurologists and gastroenterologists. In one study of cardiology patients with chest pain and no coronary artery disease, one-third of those aged over 65 years met diagnostic criteria for panic disorder (Beitman et al, 1991).

1.4.10 Somatoform disorders

a) Somatisation

The somatisation of psychological distress usually starts in early adult life, and once established, has a chronic, fluctuating course showing little improvement with
age (Pribor et al., 1994). Somatising patients are skilled at seeking medical treatment and avoiding psychiatrists, and it is not uncommon for these individuals to be present to psychiatric services for the first time in old age. They come with a very extensive history of complaints, referrals and investigations; are usually depressed and anxious and the clinical picture is often complicated by the presence of true physical illness. They are the epitome of the ‘heart sink’ patient, and a significant challenge to all involved in their care.

b) Hypochondriasis

In contrast to somatisation, hypochondriacal patients usually restrict physical complaints to one or two body organs or systems. Typically they are preoccupied with the possibility of serious physical illness and their demand is for investigation rather than treatment (World Health Organization, 1992). In the elderly, primary hypochondriasis is usually long-standing; hypochondriacal preoccupations that present for the first time in late life are more likely to be a secondary manifestation of depression or anxiety.

c) Malingering

Malingering is an abnormal illness behaviour that has yet to be dignified as a disorder by any psychiatric nosology. It is largely unresearched and there are no formal diagnostic criteria; nevertheless, it is well recognised and disapproved of by doctors who tend to ignore or dismiss what lies behind it. Doctors and other caretakers find malingering particularly irritating because the malingerer is clearly physically ill, or disabled, and yet the complaints and crisis, such as breathlessness, falls or episodes of incontinence, are timed to cause distress and inconvenience to those responsible for
their care. It is important to understand what is being communicated by such behaviour, such as distress, anger, fear or depression. Failure to address this can result in rejection by carers, and institutionalisation, with subsequent escalation in the patient’s distress and disruptive behaviour.

1.4.11 Treatment for Anxiety

Although the behavioural and cognitive approaches to psychological treatment are theoretically distinct, in practice most interventions involve elements of both. Cognitive–behavioural therapy is of proven effectiveness in the treatment of conditions such as phobias and OCD, in younger adults (Marks, 1978). Case reports and small series indicate that they are just as effective in the elderly (Leng 1985, Woods & Britton 1985 Woods 1995). Anxiety management training, involving instruction, relaxation and other control techniques (McCarthy et al, 1991) is an important approach to anxiety symptoms in the elderly, which can be applied in a wide range of settings to both groups and individuals. Further research is needed to establish which strategies are most effective in this age group; while the principles of cognitive–behavioural therapy are the same at all ages, the goals and techniques may need to be modified to make allowance for physical disabilities. In short in the acute state, anxiety management is useful as can be cognitive behavioural therapy .for chronic anxiety there may be a role. For psychodynamic psychotherapy.

Despite the effectiveness of behavioural, training and cognitive strategies in the management of neurotic disorders, most elderly patients with these conditions are treated with drugs. Sometimes this is appropriate, for example, if depression is a prominent feature then a course of antidepressant treatment should always be
considered. However, the pharmacotherapy of neurotic disorders is often merely an easy and convenient means of avoiding a more detailed and painstaking assessment of the patient’s symptoms and circumstances. The greatest problems with inappropriate and excessive drug treatment of neurotic disorders in the elderly have occurred in association with benzodiazepines. In spite of the fact that there have been relatively few formal controlled trials of benzodiazepine treatment in elderly patients, old people are the largest consumers of this class of drugs, particularly as hypnotics. Because of the altered handling of drugs by the body with increasing age, some benzodiazepines and their metabolites accumulate substantially in some elderly patients, with the result that apparently therapeutic doses can eventually cause persistent drowsiness, incontinence, delirium and falls (Evans & Jarvis, 1972. Fancourt & Castleden, 1986). Other problems in the elderly include increased central nervous system sensitivity to the effect of the drug, the presence of physical illness (particularly respiratory disease), interactions with other drugs and alcohol, and non-compliance (Salzman, 1991). At all ages, long-term benzodiazepine use can result in physical dependence, cognitive impairment and paradoxical excitement. In view of all these problems, benzodiazepine prescription in the elderly should be restricted to short courses of short-acting compounds without active metabolites, such as oxazepam. As a rule, long-term benzodiazepine users should be encouraged to withdraw from their medication, particularly if they have continuing neurotic symptoms. There is evidence that some of the new generation of anxiolytics and antidepressants are more effective in providing relief in neurotic disorders without unacceptable side-effects. Buspirone is an azapirone anxiolytic drug whose pharmacokinetics, safety and efficacy in the
elderly, are similar to those in younger adults (Robinson et al., 1988). It is well
tolerated by this age group, and it appears that short-term use is not associated with
rebound, dependence or misuse (Lader, 1991). Unlike other anxiolytics it takes two to
three weeks to have an effect, so it is not useful in the management of acute anxiety
states. Narcoleptic drugs have only a limited role in the management of anxiety
because of the risk of disabling extra pyramidal side-effects. Antihistamine drugs such
as hydroxyzine have a history of use as anxiolytics in elderly patients, and they may
be useful when respiratory depressant drugs are contraindicated.

1.5 Neuroticism

The term neurosis was first coined in 1769 by an Englishman, William Cullen,
to refer to disordered sensation of nervous system. It reflected the long held belief that
neurological malfunction must be involved in neurotic behaviour. This belief was
challenged by Freud who believed that neurosis was caused by intra-psychic conflict.
To Freud, neurosis was a psychological disorder that resulted when there was an
internal conflict between some primitive desire (from id) and prohibition against its
expression (from the ego and superego) Anxiety - a general feeling of apprehension
about possible danger was, in Freud's formulation, a sign of this inner battle.

In recent years Freud's views on the nature of neurosis has been criticized as
too theoretical and not sufficiently tied to the real world. The approach of editions of
the DSM since 1980 has used the term neurosis. The DSM has separated different
categories based on their symptoms because symptoms can be observed and measured
in this classification. Disassociate somatoform and now included mood disorders.
Neuroticism refers to a broad domain of personality traits contrasting persons who are well adjusted and emotionally stable with those who are prone to mal-adaptive behaviour and the experience of a variety of negative emotions (including anxiety, anger, depression, and shame) under such labels as harm avoidance or negative affectivity (Morken, Kreuger, & Watson, 2005). This dimension is found in almost all personality trait systems. As its name suggests, there is evidence that individuals traditionally diagnosed as having neuroses tend to score high on measures of neuroticism (Eysenck, 1960), but neuroticism itself is a general dimension of personality; most individuals fall in the average range and many of those with high scores would not have clinically significant psychopathology.

Retrospective studies of older people suggest that individual’s differences in neuroticism are highly stable in adulthood: “a mature, non-neurotic younger person is likely to be a well adjusted older person. The neurotic aged were most likely to have neurotic thoughts most of their lives” (Dibner, 1975). This conclusion is strangely supported by longitudinal studies showing high retest correlations over period of 6 to 30 years (McCrae & Costa, 2003). Although psychotherapeutic interventions may alter some personality traits, the normal course of aging has only small effects and marked changes in personalities in older adults may be a sign of organic pathology (Strauss, Pasupathi, & Chatterjee, 1993).

Some stereotypes of older persons suggest that the average level of neuroticism should increase with age. In particular, older persons are often depicted as irritable, depressed, or hypochondriacal. The empirical evidence does not support this view, however: both longitudinal and cross-sectional studies show that noninstitutionalized
older adults are no higher than young adult on measures of neuroticism. In fact, the most notable adult changes in neuroticism are the declines seen between ages 20 and 30: better psychological adjustment appears to be part of the maturations that occurs in this decade (McCrae & costs, 2003). Thereafter neuroticism declines very slowly until late life, when a small increase is sometimes observed (Mroczek & Spiro, 2003).

Neuroticism is of interest to gerontologists not because it shows stinking age related changes, but because it is a powerful co-determinant of many important behaviours and outcome. Morale, life satisfaction, and psychological well-being, which are often taken as indicators of adjustment to aging, can be predicted years in advances from measures of neuroticism. Similarly, long-standing neuroticism, rather than age appears to be responsible for many unfounded medical complaints (McCrae & costs, 1985). It is impossible to understand how the individual adopts to the problems and challenges of aging without understanding the individuals, and the level of neuroticism is an enduring and important element in every personality.

DSM-IV now calls this group of disorders anxiety disorders, not neurosis. The idea of "neurosis" has a long history and indeed it is still used in psychoanalytic professional circles and in casual conversation by the general public.

The traditional division between neurosis and psychosis that was evident in ICD-9 neurotic, stress-related and somatoform disorders. Except for depressive neurosis most of disorder is regarded as neurosis.
But it is true that Freud’s view is important to understand the causes of disorders and also useful for treatment plan of fear and anxiety as emotional states both of which have an extremely important adaptive value.

Overwhelming stress can produce psychological problem in anyone. Even stable, well adjusted people may break down if forced to face extensive combat stress, torture, or devastating natural disaster. But for some people, even everyday problems can be disturbing. Faced with the normal demands of life-socializing with friends, waiting in line for the bus, taking an airoplane trip, they experience serious fear and anxiety. With anxiety or neurotic trait, people are unable to leave the safety life or may spend much of their time in mal-adaptive behaviour.

Historically, anxiety disorders were considered to be examples of neurotic behaviour, which involved the avoidant behaviour and use of defense mechanisms. Although neurotic behaviour is mal-adaptive and self-defeating.

1.5.1 Definition of Neuroticism

"A psychological condition or state characterized by neurosis. Also one of the 'Big Five Personality Factors were ranging from one extreme of neuroticism including such traits as nervousness, tenseness, moodiness and temperamentality, to the opposite extreme of emotional stability". (Big five Personality Factors.)

"Neuroticism is generally concerned with emotional stability, especially the expression of negative emotions such as anxiety depression and anger; this trait has also been called negative affectivity". (Watson and Clark 1984).
Neuroticism is a fundamental personality trait in the study of psychology. It can be defined as an enduring tendency to experience negative emotional states. Individuals who score high on neuroticism are more likely than the average to experience such feelings as anxiety, anger, guilt, and clinical depression. They respond more poorly to environmental stress, and are more likely to interpret ordinary situations as threatening, and minor frustrations as hopelessly difficult. They are often self-conscious and shy, and they may have trouble controlling urges and delaying gratification. Neuroticism is related to emotional intelligence, which involves emotional regulation, motivation, and interpersonal skills. It is also considered to be a predisposition for traditional neuroses, such as phobias and other anxiety disorders.

1.5.2 Big Five, Five factor model of personality.

Many systems have been proposed to describe the fundamental dimension of human personality. One that has become quite popular is known as the five-factor model which includes basic traits known as neuroticism, extraversion, openness to experience, agreeableness and conscientiousness.

The popular five-factor model of normal personality has been recently advocated to account for underlying dimensions of personality disorder as well. However, the ability of the Five-factor model to account for the underlying structure of personality disorder has been tested primarily in non-clinical samples, and normal individuals. Five-factor model in clinical samples shows that neuroticism extroversion and low agreeableness predicts personality disorder. After controlling for age and depression only high neuroticism and low agreeableness remained as significant
predictors these two dimensions define personality disorder in nonspecific way as a general predisposition to psychopathology i.e. high neuroticism accompanied by an antagonistic behaviour facade. In addition neuroticism tends to be confounded with nonspecific factors such as depression and anxiety which reduce its ability to distinguish personality disorder, other psychopathology, e.g. mood and anxiety disorder and well-adjusted individuals with high neuroticism.

1.5.3 Emotional Stability

On the opposite end of the spectrum, individuals who score low in neuroticism are more emotionally stable and less reactive to stress. They tend to be calm, even tempered, and less likely to feel tense or rattled. Although they are low in negative emotion, they are not necessarily high on positive emotion. That is an element of the independent trait of extraversion. Neurotic extraverts, for example, would experience high levels of both positive and negative emotional states, a kind of "emotional roller coaster." Individuals who score low on neuroticism (particularly those who are also high on extraversion) generally report more happiness and satisfaction with their lives.

1.5.4 Some Important Studies Related to the Neuroticism

Some studies that have been able to make good assessment of personality before the onset of illness confirm at least some of these clinical observation for example, recent findings of low emotional strength and resiliency, and somewhat elevated levels of neuroticism in people who later became depressed (Hirschfeld et al, 1989) suggest that pre-depressive persons tend not to take an active approach to problem resolution and are somewhat more neurotic than persons who not become
depressed. In a recent review of many studies of this type, L. A. Clark and colleagues (1994) concluded that there was good evidence that neuroticism is the primary personality variable that serves as a vulnerability factor for depression and anxiety as well. Neuroticism or negative affectivity is a stable and heritable personality trait that involves a temperamental sensitivity to negative stimuli (Tellegen, 1985). That is, people who are high on this trait are prone to experiencing a broad range of negative moods including not only sadness but also anxiety, guilt, and hostility. In addition to serving as vulnerability factor, neuroticism is also associated with worse prognosis for complete recovery from depression. L. A. Clark and Colleagues (1994) also concluded that there is some evidence but more limited than for neuroticism that low levels of extraversion or positive affectivity may also serve as a vulnerability factor for depression.

Heterogeneous nature of the somatoform disorders, emphasized by Iezzi and Adelms (1993). It should perhaps come as no surprise that these problems are often accompanied by other psychiatric disorders as well notably depression and anxiety disorder (e.g. Boyd et al, 1984). As a group, then summarizing patients exhibit widespread difficulties in their emotional lives, exhibitions a pattern of negative affect and emotional vulnerability frequently referred to as neuroticism (Lipowski, 1988). Neuroticism as a personality trait has been shown to include "facets" of anxiety, anger, hostility, depression. Self-consciousness, impulsiveness, and vulnerability (Costa and Widiger, 1994). A combination of characteristics often associated with medical complaints that prove on careful examination to be spurious (Costa and McCr 1987).
1.6 Living Arrangement for the Old Age People

Patterns of living vary much more in old age than in middle age, when the pattern is well standardized. Five patterns are common among the elderly today: a married couple living alone; a person living alone in his home; two or more members of the same generation living together in a nonmaterial relationship such as brothers and sister or friends; a widow or widower living with a married child and perhaps grandchildren, and elderly people living in a home for the aged. Which pattern of living the elderly individual selects will depend upon a number of conditions: for example, Economic Status, Marital Status, Health, Sex, Children, Desire of Companionship. The needs and wants of elderly people vary greatly and thus not all of them will find the same living arrangement suitable. However, almost all elderly people have certain physical and psychological needs that must be met by their living arrangement.

When the health and economic status, or other condition makes it impossible for an elderly person to live in his own home and when there is no member of the family who can or will offer him a place to live, he must take up residence in an home for the aged.

How the old age people adjust to home for the aged, living depends upon three conditions. First, if the person enters an institution voluntarily instead of being forced to by circumstances, he will be happier and have a stronger motivation to adjust to the radical changes that home for the aged living brings. Second, the more accustomed the individual is to being with other people and taking part in community activities, the
more he will enjoy the social contacts and recreational opportunities provided by such old age homes.

Third, and perhaps most important, the elderly people will adjust better to living in an old age home if it is close enough to where he lived before so that family members and friends can keep up their former contacts with him. Moving to an old age home that is far away from the elderly people former homes is usually a traumatic experience and militates against good adjustment to old age home living and happiness in old age.

Regardless of where elderly people live, it is important that they feel they are still a part of the family. As his friends die or become unable to provide him with companionship, the old age person depends increasingly on his family. Gerontologists have long been interested in investigating the importance of maintaining strong social and family relationship during old age. A large body of research suggests that social and family integration and support are central factors in promoting well being among older persons. Social and family support as “key ingredients” in successful aging.(Rowe & Kahn, 1998).

1.7 Significance and Importance of Rational Study

The subject of aging of population is of relatively recent origin so it is important to focus the research on old age population to understand the problems faced by them due to the age related changes, elderly people have to go through various problem during the process of aging.
Now-a-days there are tremendous changes in social structure because of industrialization, computerization, and globalization and also the development in the field of medical sciences. The declining of death rate over births, victory over epidemics and control over morbidity makes the problem more acute. The Indian elderly population of sixty and older is currently the second largest in the world. China being the first. The majority of the world population resides in Asia (53%), while Europe has the next largest share (25%). Currently little less than one-fourth of the elderly ‘sixty years and above’ of Asia’s population are Indians. It is projected that by 2050 India’s elderly population will be more than four times, that is 77 millions will rise to 324 million (Population Aging, 1999, UN and Population Projection of India and States, 1996, GR, India) Due to all this changes, rise in the aged population needs urgent attention.

The Indian family has traditionally provided natural social security and care to the old people. But now-a-days the role of family in case of old people has declined due to structural change. The joint family system has collapsed. Now-a-days home for the aged are spread across the country which indicates the growing rift between the generations. It resulted in the rejection or neglects the old aged. There are many reasons to live in old age home for example loneliness that have lost their spouse, and have no child, economic problem, health problem; these are main reasons for adopting old any home. It is very painful for old age people when their children do not take their responsibility and do not support and misbehaviour of son or daughter-in-law. So they prefer to live in home for the aged. The home living elderly differs significantly from the institutional elderly. The institutional elderly have more psychological
problems than the home living elderly because the institutional setup is not conducive to psychological peace. The institutional elderly does not generally feel at home and this probably affects ones satisfaction in life and psychological well-being.

Because of this situation, old age people face too much adjustment problem due to change in situation. They are habituated to staying with their family members. They face difficulty to adapt to the setting of old age home which lack of warmth and security which they get in family environment.

Majority of research study is done on loneliness, depression in aged population of residents of old age home. Though all this study. Does not prove how the mal-adjustment in old age leads Neuroticism and Anxiety. It is very needful, regarding mental health of old age people, which the researcher attempts to do in this research.