CHAPTER-IV
RESULTS AND DISCUSSIONS

In this chapter obtained results have been discussed in the light of relevant research. Looking to the objectives and relevant hypotheses and methodology this chapter has been divided into three parts.

Part I

This part of the present research includes findings regarding effect of gender on

- Mental health
- Self-concept
- Adjustment

Part II

This part of this investigation considered those findings which are related to the effect of Rogerian group counselling on senior citizens psyche i.e.

- Mental health
- Self-concept
- Adjustment

Part III

This Part of this investigation considered those findings which are related to the correlation between

- Mental health and Self-concept
- Mental health and Adjustment
- Self-concept and Adjustment
Part I
Gender

• Gender & Mental health
• Gender & Self-concept
• Gender & Adjustment

4.1 Gender

A man's life is normally divided into five main stages namely infancy, childhood, adolescence, adulthood and old age. In each of these stages an individual has to find himself in different situations and face different problems. The old age is not without problems. In old age physical strength deteriorates, mental stability diminishes; money power becomes bleak coupled with negligence from the younger generation.

According to Erik Erikson’s “Eight Stages of Life” theory, the human personality is developed in a series of eight stages that take place from the time of birth and continue on throughout an individual’s complete life. He characterises old age as a period of “Integrity vs. Despair”, during which a person focuses on reflecting back on their life. Those who are unsuccessful during this phase will feel that their life has been wasted and will experience many regrets. The individual will be left with feelings of bitterness and despair. Those who feel proud of their accomplishments will feel a sense of integrity. Successfully completing this phase means looking back with few regrets and a general feeling of satisfaction. These individuals will attain
wisdom, even when confronting death.

In relation to old age different criteria were found to be influenced by persons’ biological aspect in which gender is prominent one. As an example

In most parts of the world, women live, on average, longer than men; even so, the disparities vary between 9 years or more in countries such as Sweden and the United States to no difference or higher life expectancy for men in countries such as Zimbabwe and Uganda.

The term gender is often used to classify the anatomy of a person's reproductive system as either male or female. In the social sciences, however, the concept of gender means much more than biological sex. It refers to socially constructed expectations regarding the ways in which one should think and behave, depending on sexual classification. These stereotypical expectations are commonly referred to as gender roles. Attitudes toward gender roles are thought to result from complex interactions among societal, cultural, familial, religious, ethnic, and political influences. Differences in gender have existed throughout history. Evolutionary theorists attribute these differences to the physiological characteristics of men and women that prescribed their best function for survival of the species. For example, masculinity and femininity may simply be sets of personality traits that can be exhibited by either sex. Current gender studies appear less concerned with establishing male or female superiority. The general consensus seems to be that gender is socially constructed rather than biologically determined. In this context many investigation has made its
effort to explore the gender role in determining ones’ psyche world within person.

Overall gender affects many aspects of life, including access to resources, methods of coping with stress, styles of interacting with others, self-evaluation, spirituality, and personas’ psychic world including adjustment, well being, mental health and self-concept either positively or negatively. Gender studies seek to better understand the relationship between gender and persons.

In this reference the present investigation has made its effort to advance the knowledge regarding following psychological criteria within older person in relation to their gender-

- Mental health
- Self-Concept
- Adjustment

4.1.1 Gender and Mental Health

Health is an indispensible quality in human being. Health is a broader concept including physical, social and mental health. Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a disorder. From perspectives of the discipline of positive psychology or holism mental health may include an individual’s ability to enjoy life and procure a balance between life activities and efforts to achieve resilience. Mental health is the capacity to express our emotions and adapt to a range of demands.
The World Health Organization defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” It was previously stated that there was no one “official” definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how “mental health” is defined.

Mental health has been reported as an important factor influencing individuals’ various behaviours, activities, happiness and performance. Mental health is associated with number of factors including biological, psychological social etc. Among these factors gender is a critical determinant of mental health and mental illness.

Gender differences in mental health are a recurrent field of research in social gerontology. Research on mental health has consistently found a gender gap in levels of psychological distress. Rates of psychiatric disorder (mental illness) are almost identical for men and women but striking gender differences are found in the patterns of mental illness.

Current studies focus on the ways in which extreme notions of masculinity or femininity affect mental health. Gender affects many aspects of life, including access to resources, methods of coping with stress, styles of interacting with others, self-evaluation, spirituality, and expectations of others. These are all factors that can influence mental health either positively or negatively.
Table 4.1
Mean values for Gender on Mental health

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>17.05</td>
<td>28.94</td>
</tr>
</tbody>
</table>

Figure 4.1
Bar Diagram Showing Mean Scores for Gender on Mental health

The above result table 4.1 and figure 4.1 illustrates the mean score of male and female senior citizens on the measure of mental health. The mean value show that male score (M=17.05) on mental health is less than female score (M=28.94). These mean values show the difference between male and female in their level of mental health and revealed that male having good mental health as compare to female as higher score on mental health check list indicaties poor mental health.
Table 4.2
F-value for Gender on Mental health

<table>
<thead>
<tr>
<th>F Ratio</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.07</td>
<td>0.05</td>
</tr>
</tbody>
</table>

The results of the present study (Table 4.2) show that the main effect of gender on mental health is significant (F=2.07, P<0.05). The results do not support Hypothesis (a) stating that “There will be no difference in mental health of senior citizens in relation to their gender.” Thus the considered null hypothesis has been rejected. It can be concluded that both male and female are not parallel on their level of mental health and the difference in their mental health is significant.

Mental health has been reported as an important factor influencing individuals’ various behaviours, activities, happiness and performance. Mental health is associated with number of factors including biological, psychological, social etc. Mental health is more delicate or impaired in old age. David J Vinkers, Jacobijn Gussekloo and others (2004). Gender is a critical determinant of mental health and mental illness. Research on mental health has consistently found a gender gap in levels of psychological distress beginning in adolescence. Rates of psychiatric disorder (mental illness) are almost identical for men and women but striking gender differences are found in the patterns of mental illness. The present finding consistent with the previous research regarding gender difference on mental health like. Further Martin P. Bakker, Johan Ormel, Frank C. Verhulst and Albertine J.
Oldehinkel (2009) also found difference in male and female on their level of mental health.

R. A. Schoevers, D. J. H. Deeg, C. Jonker and M. I. Geerlings and others (2000) studied the association between depression and increased mortality risk in older persons may depend on the severity of the depressive disorder and gender. Depression (Geriatric Mental State AGECAT) was assessed in 4051 older persons, with a 6-year follow-up of community death registers. The mortality risk of neurotic and psychotic depression was calculated after adjustment for demographic variables, physical illness, cognitive decline and functional disabilities. Results revealed a total of 75% of men and 41% of women with psychotic depression had died at follow-up. Psychotic depression was associated with in both men and women. Neurotic depression was associated with a 1.67-fold higher in men only.

In reference of gender difference on mental health Weisman and Klerman (1977) argue, women are more likely than men to be depressed. Yet Tarvis (1992) and Gilligan (1982) argue that it is not certain whether this is because women really are more depressed or because of a gender bias in the way depression is measured. It may well be that depression measures are only sensitive to the way in which women express depression. In this regard Australian Institute of Family Studies (2002) explain three important things about gender and the risk of mental disorders. First, there seem to be “female disorders” and “male disorders.” Women are more prone than men to mood and anxiety disorders while men are more prone to alcohol and drug
disorders. Second, for each disorder the gender difference is statistically significant. Women are almost twice as likely as men to suffer mood and anxiety disorders while men are roughly twice as likely as women to suffer substance use disorders. Third, men and women are equally at risk of having a disorder. Although men and women have different types of disorders they are just as likely as each other to have at least one disorder – 16.6 per cent of men and 16 per cent of women had all the symptoms of at least one classified disorder.

Margaret Denton, Steven Prus and Vivienne Walters (2003) examine the extent to which these inequalities reflect the different social experiences and conditions of men's and women's lives. They address four specific questions. Are there gender differences in mental and physical health? What is the relative importance of the structural, behavioural and psychosocial determinants of health? Are the gender differences in health attributable to the differing structural (socio-economic, age, social support, family arrangement) context in which women and men live, and to their differential exposure to lifestyle (smoking, drinking, exercise, diet) and psychosocial (critical life events, stress, psychological resources) factors? Are gender differences in health also attributable to gender differences in vulnerability to these structural, behavioural and psychosocial determinants of health? Multivariate analyses of Canadian National Population Health Survey data show gender differences in health (measured by self-rated health, functional health, chronic illness and distress). Social structural and psychosocial
determinants of health are generally more important for women and behavioural determinants are generally more important for men. Gender differences in exposure to these forces contribute to inequalities in health between men and women; however, statistically significant inequalities remain after controlling for exposure. Gender-based health inequalities are further explained by differential vulnerabilities to social forces between men and women.

The present investigation regarding difference between male and female in their level of mental health revealed the significant difference between male and female senior citizens on their criteria of mental health, male having good mental health as compare to female.

4.1.2 Gender and Self-concept

The core of personality is the self-concept, the concept an individual has of oneself as a person in relation to the world, which one lives in. Cattell (1957) referred to self-concept as the “Key stone of personality.” It’s important stems from its influence over the quality of a person’s behaviour and methods of adjustment to life situations. Rogers (1951) and his followers felt that the basic problem of many disturbed people is that their self-concepts are source of inner discord. In other words, self-concept can be defined as a person’s perception of oneself. This perception is formed through experience with the environment and influenced by environmental reinforcements and significant others (Chung, 1996). Self-concept is organized, Multifaceted, hierarchical, stable, developmental, evaluative and differentiable.
Gender is the single most salient individual variable in the socialization process, affecting how people think of themselves and how others respond to them [Ben, 1993; Katz 1986]. Differences in the social interaction based on gender begin in infancy and influence expectations throughout the life span. During whole life span, gender variable take on heightened significance and are frequently associated with persons’ self-concept.

Table 4.3
Mean values for Gender on Self-concept

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Concept</td>
<td>197.10</td>
<td>144.75</td>
</tr>
</tbody>
</table>

Figure 4.2
Bar Diagram Showing Mean Scores for Gender on Self-concept

Above result Table 4.3 and respective figure 4.2, present the Mean values on the self-concept of male and female senior citizens. It can be observed from above table and figure that the mean score of the male (197.10) are higher
than female (144.75) which revealed that male having higher self-concept as compare to female.

Table 4.4

<table>
<thead>
<tr>
<th>F Ratio</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.07</td>
<td>0.01</td>
</tr>
</tbody>
</table>

The above result Table 4.4 of F value for gender on self-concept elucidate the significant level at 0.01 level of confidence. As the main effect of gender was found significant, indicating that male and female senior citizens are significantly different as far as self-concept is concerned.

Results in table 4.4 show that the main effect of gender on self-concept is significant (F=68.07, PL 0.01). Since male score on self-concept is higher than female score, the results support hypothesis (b) stating that “male senior citizens have better self-concept than female senior citizens.” It can be concluded that both male and female are not parallel on their self-concept and the difference in their self-concept is significant. Hence the hypothesis is accepted.

Gender differences in self-concept are a recurrent field of research in social gerontology. Toni C. Antonucci; (2000). The present finding collaborate the earlier findings suggested that male scored higher scores as compared to female. O’Brien (1998) examined sex difference in self-esteem and reported that men scored significantly higher in global self-esteem than woman.
A majority of other researchers (Kelikangas-Jarvime n, 1990, Sekaran, 1983) have also observed that male scored higher on the self-esteem than female. Kling, Hyde, Showers & Bus well (1999) and Rabbins et al., (2002) have also reported that male have higher self-esteem than girls. Gender can also affect the level of self-esteem. Female experience low self-esteem as compared to male (Carlson, Uppal & Prosser 2000; DuBois et al., 2002). O’Brien (1991) examined sex difference in self-esteem and reported that men scored significantly higher in global self-esteem than women. A majority of other researchers (Kelikangas-Jarvimen, 1990, Sekaran, 1983) have also observed that male students’ scored higher on the self-esteem than female students. Kling, Hyde, Showers and Bus well (1999) and Rabbins et al. (2002) have also reported that adolescents’ boys have higher self-esteem than adolescent’s girls.

In same reference two analyses were conducted to examine gender differences in global self-esteem in the study of Kling KC, Hyde JS, Showers CJ, Buswell BN.(1999). In analysis I, a computerized literature search yielded 216 effect sizes, representing the testing of 97,121 respondents. The overall effect size was 0.21, a small difference favoring males. A significant quadratic effect of age indicated that the largest effect emerged in late adolescence (d = 0.33). In Analysis II, gender differences were examined using 3 large, nationally representative data sets from the National Center for Education Statistics (NCES). All of the NCES effect sizes, which collectively summarize the responses of approximately 48,000
young Americans, indicated higher male self-esteem (ds ranged from 0.04 to 0.24). Taken together, the 2 analyses provide evidence that males score higher on standard measures of global self-esteem than females, but the difference is small. Potential reasons for the small yet consistent effect size are discussed.

Again analysis of the 12,266 responses to the three Self Description Questionnaires, which measure multiple dimensions of self-concept in preadolescence, early-to-middle adolescence, and late adolescence and early adulthood, examined (a) age and sex effects revealed that sex differences in specific areas of self-concept were generally consistent with sex stereotypes and relatively stable from preadolescence to early adulthood. There was little support for the increased differentiation of dimensions of self-concept beyond early preadolescence. Herbert W. Marsh (1989)

Two meta-analyses by Haring, Stock, and Okun (1984) and Kling, Hyde, Showers, and Buswell (1999), however, reported a higher self-esteem in men than women ($r = 0.04$ and $d = 0.21$, respectively).

In another study meta-analysis was used to synthesize findings from 300 empirical studies on gender differences in life satisfaction, happiness, self-esteem, loneliness, subjective health, and subjective age in late adulthood in the study of Martin Pinquart and Silvia Sörensen (2000). Older women reported significantly lower SWB and less positive self-concept than men on all measures, except subjective age, although gender accounted for less than 1% of the variance in well-being and self-concept.
Though there are number of studied in which gender was found to be significant but in study of Polce (1996) contrast result was found. He concluded that self-esteem was similar for males and females in childhood and adolescence. Pandit (1969) also reported no significant difference in the self-concept of boys and girls, but the gender difference may be significant in interaction with other variables like age and self-concept domain in producing difference in rating of self-concept as found in a research by Gordiner (1996).


Overall it can be said that though gender differences in self-concept have been assessed in numerous studies, however, inconsistencies in the results make it very difficult to draw clear conclusions from these studies. As far as the result of the present study is concerned it can be concluded that there is significant effect of gender on senior citizens’ self-concept.

As shown in above result table of F-value, gender differences were found to be significant which revealed that when female compared with older men, older women reported slightly lower in self-esteem.
4.1.3 Gender and Adjustment

In psychology adjustment is the process by means of which the individual attempts to maintain a level of psychological and physiological equilibrium or more simply, adjustment refer to behaviour directed towards tension reduction. It also true that personality of individual consists of his persistent tendencies to make certain kind of adjustment between his need and situation. A balanced personality is the result of proper adjustment of an individual to his environment (Chouhan, Tiwari & others 1972). Further gender is the single most salient individual variable in the socialization process, affecting not only the way person behave towards various social situations but also their psychological characteristics they posses as all psychological characteristics including adjustment level is the result of their surroundings in which they interact. Though some heredity factors are also responsible for this but the external environment is most important factor whose effect take place within the individual. Differences in the social interaction based on gender begin in infancy and influence expectations throughout the life span. Gender variable take on heightened significance and are frequently associated with psychological characteristics in person.
Table 4.5

Mean values for Gender on Adjustment

<table>
<thead>
<tr>
<th>Area of Adjustment</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>23.66</td>
<td>21.90</td>
</tr>
<tr>
<td>Home</td>
<td>20.02</td>
<td>21.00</td>
</tr>
<tr>
<td>Social</td>
<td>17.75</td>
<td>18.82</td>
</tr>
<tr>
<td>Marital</td>
<td>14.66</td>
<td>13.09</td>
</tr>
<tr>
<td>Emotional</td>
<td>17.76</td>
<td>13.02</td>
</tr>
<tr>
<td>Financial</td>
<td>11.08</td>
<td>7.09</td>
</tr>
</tbody>
</table>

Figure 4.3

Bar Diagram Showing Mean Scores for Gender on Adjustment

Table 4.5 presents the mean values on health, home, social, marital, emotional and financial area of adjustment of male and female groups of senior citizen. It can be observed from this table and respective figure that
the scores of the Male subjects are higher than their counterparts on the health, marital, emotional and financial area of adjustment. Whereas on the home and social area of adjustment, female subjects obtained higher scores than male subjects.

Table 4.6

<table>
<thead>
<tr>
<th>Area of Adjustment</th>
<th>t Value</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Adjustment</td>
<td>0.06</td>
<td>NS</td>
</tr>
<tr>
<td>Home Adjustment</td>
<td>1.24</td>
<td>NS</td>
</tr>
<tr>
<td>Social Adjustment</td>
<td>1.09</td>
<td>NS</td>
</tr>
<tr>
<td>Marital Adjustment</td>
<td>1.89</td>
<td>NS</td>
</tr>
<tr>
<td>Emotional Adjustment</td>
<td>2.39</td>
<td>0.05</td>
</tr>
<tr>
<td>Financial Adjustment</td>
<td>11.03</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Table 4.6 depicts t values for gender on different areas of adjustment. Significant difference was found for only emotional and financial area of adjustment. Female senior citizens adjustment scores on the area of emotional and finance were found significantly less than male subjects, it revealed that female are less adjustable in the area of emotional and financial than male as low scores indicating lower level of the adjustment. Male and female senior citizens were not found significantly different on health, home social, and marital areas of adjustment. As obtained t value (2.39) for emotional area of adjustment found to be significant at 0.05 level it can be
said that male are significantly more emotionally balanced than female on their emotional problems. Since obtained t value (11.03) for financial area of adjustment found to be significant at 0.01 level it can be concluded that male are significantly more financially balanced than female on their financial problems.

Thus, Female adjustment scores on the area of emotional and financial were found significantly less than male subjects, it revealed that female are less adjustable in the area of emotional and financial than male as low score indicates poor adjustment. Male and female were not found significantly different on health, home, social and marital areas of adjustment. Thus, hypothesis (c) stating that “There will be no difference between male and female senior citizens in their level of adjustment.” is partially accepted. Because the null hypothesis has been proven true (Accepted) for health, home, marital and social areas of adjustment and rejected for emotional and financial areas of adjustment.

The results can be attributed somewhat on the two facts. One is that genetic makeup, time and rate of maturity differs between male and female. In Indian society norms and perception are different for male and female. Hence the adjustment of male and female will be different. Second on the gender role which adapt by all individual in their socialization process in which girls have been taught more adjustable practices.

Regarding of gender and adjustment, Pathak (1970) studied on adjustment (200 male and 200 Female). Saxena’s Vyaktiya Paraks –Prashnavali (MA-62)
was used to measure the adjustment and reported that female were facing more problems than male in the areas such as health, social and emotional adjustment. They were found to be comparable in the areas of home as there was no significant difference. A positive Correlation between the areas of adjustment was reported.

Krishna (1981) conducted a study on risk-taking and adjustment. Choice dilemmas questionnaire (Kogan and Wallach, 1964) and Hindi Adaptation of Bell’s adjustment inventory by Moshin and Hussain (1970) were administered. The findings revealed that sex contributed significantly to risk-taking in case of home adjustment only. Riskiness showed significant negative relationship with social adjustment for male and significant positive relationship with home and emotional adjustment for female. Similarly Leelavathi (1987) in her study in Dharwad city on 450 samples found that males had good social and total adjustment than females and age was associated with emotional adjustment. Thirugnanasambadam (1990) also supported where he reported that male were better adjusted than female on a sample. Similarly Dutta et al. (1997) reported male to be better adjusted than female in the areas of health adjustment. The same authors in another study on home adjustment (1997) reported female to be better. However Mythili et al. (2004) investigated the adjustment problems. The results reported that male have more adjustment problems compared to female.

Anita (1994) provided an insight into the gender-differences in persons’ self-concept and adjustment. It was depicted from the results that female
better adjusted in emotional, social, educational and total areas of adjustment compared to male. Similarly, Muni and Pavigrahi (1997) found that female were better adjusted in all the areas of adjustment pattern than male. Joshi (1998) studied the personality adjustment among the person of scheduled caste and non scheduled caste. Gosai (1975) personality adjustment inventory was used for data collection. Results revealed no significant effect of gender on maladjustment. Results revealed that area of residence and gender together affect the adjustment of subjects. He also found the type of family had no significant effect on the personality adjustment.

Kuruvilla (2006) found that sex and area of residence influenced the emotional adjustment of person. Female were found to have better adjustment than male.

Shalu and Audichya (2006) assessed and compared the adjustment of 60 rural subjects with reference to their emotional, social and educational sphere. They reported a significant difference in emotional adjustment among the subjects. Male scored better, whereas no significant difference was observed in social adjustment. However Hampel and Petermann (2006) investigated age and gender effects on perceived interpersonal stressors and psychological adjustment among adult and examined the associations of perceived stress and coping with adjustment. Self-report data on perceived stress, coping as well as emotional and behavioural problems, were assessed. Results revealed that compared with male, female evaluated a higher amount
of perceived interpersonal stress and used more social support. Additionally, female scored higher on maladaptive coping strategies and emotional distress and scored lower on distraction than male. Problems-focused and emotion-focused coping were negatively related to emotional and behavioural problems, whereas perceived stress and maladaptive coping was positively associated with adjustment problems. These relations were stronger in female than in male adolescents.

Mark D. Holmes M.D.1, Carl B. Dodrill Ph.D., Shawn Bachtler Ph.D., Alan J. Wilensky M.D., Ph.D., Linda M. Ojemann M.D. and John W. Miller (2002) examined the effects of gender on adjustment. They compared 57 women and 27 men, all at least 16 years old. They conclude that men have significantly worse patterns of emotional adjustment, as measured by the MMPI, than women.

Further on Gender role and psychological adjustment study the Three hundred subjects (158 males and 208 females) completed a three-part questionnaire in the study of Ronald A. LaTorre(1978). The first two parts consisted of self-report inventories to assess psychological adjustment (Eysenck’s Neuroticism Scale and Lanyon’s Alienation Scale). The third part assessed gender role (Bem’s Sex Role Inventory). Androgyny was scored as per both the Bem (1974) system and the Spence et al. (1975) system, and the groups obtained by these two systems were separately analyzed for differences in psychological adjustment scores. Feminine individuals (regardless of biological gender or system of classification)
obtained less adjusted scores, and this was especially significant for males. It was also found that the Spence et al. system had more predictive power than the Bem system for classifying individuals.

Aformentioned all studies revealed that difference exist between gender on adjustment. But in contrast C.P.Khokhar and Brijesh Kumar Upadhayay (2007) revealed that adjustment is independent of sex effect, but as far as the present finding is concerned, it can be concluded that there is significant effect of gender on two areas of adjustment i.e. emotional and financial. This finding also partially in line with a study of C.P.Khokhar and Brijesh Kumar Upadhayay (2007) in which they revealed that mean difference on adjustment between the male and female is not significant that confirms that adjustment is independent of sex effect. On the basis of the above finding it can be concluded that there is significant effect of gender on emotional and financial areas of adjustment i.e. and other area of adjustment are independent of the effect of gender like health, home, social and marital.

Part II

Rogerian Group Counselling

- Rogerian Group Counselling & Mental health
- Rogerian Group Counselling & Self-concept
- Rogerian Group Counselling & Adjustment
4.2 Rogerian Group Counselling

The stress and strain of modern life isn’t easy to cope with. Like every other period in the lifespan, old age is characterized by certain physical and psychological changes. The effects of these changes determine, to a large extent, whether elderly men and women will make good or poor personal and social adjustment.

Old age affects physical and mental structures and functioning. Decline comes partly from physical and partly from psychological factors. The physical cause of decline is a change in the body cells due to aging process. Decline may also have psychological causes. Unfavorable attitudes oneself, other people, work and life in general can lead to senility. Individuals who have no sustaining interests after retirement are likely to become depressed and disorganized. Motivation likewise plays a very important role in decline. The individual who has little motivation to learn new things or to keep up to date in appearance, attitudes or patterns of behavior will deteriorate much faster than one whose motivation to ward off aging is stronger.

Therefore it is essential to give attention on this group in order to maintain and enhance their psyche and for that various clinical, psychological and social intervention should be emphasized. Among these interventions group counselling is keep significance role.

Group counselling, as the name implies, is a type of counselling that is conducted with a group of people, rather than in a one-on-one session. In group counselling individual gain an insight and understanding into his own problems through listening to others, who will be discussing their difficulties, ideas, values may become more understandable and acceptable. The counselling group helps the individual to change and encourage his desires, abilities through their relationship in an accepting and meaningful social situation.
Rogers' group counselling (sometimes called person centred counselling) has caught on in a big way, and in 1998 the British Association for Counselling reported that over half its members were humanistic in orientation, the next-largest group being psychodynamic. Humanistic therapies which evolved in the USA in the 1950s. Carl Rogers proposed that therapy could be simpler, warmer and more optimistic than that carried out by behavioural or psychodynamic psychologists. His view differs sharply from the psychodynamic and behavioural approaches in that he suggested that clients would be better helped if they were encouraged to focus on their current subjective understanding rather than on some unconscious motive or someone else's interpretation of the situation.

The Rogerian group counselling rest upon the fundamental respect for the individual’s belief in person ability to solve personal problems with the aid of a sympathetic listener. Client i.e. the counselee is the pivot, he takes an active part in the process of therapy. He gains insight into his problem with the help of the counsellor. He only decides and takes necessary action. The counsellor’s role is passive. This type of counselling is a growth experience. The goal is the independence and integration of the client rather than the problem oriented. The counsellor creates an atmosphere in which the client can work out his own understanding. The emotional aspects are concentrated more; it leads to a voluntary choice of action.

Rogers strongly believed that in order for a client's condition to improve therapists should be warm, genuine and understanding. The starting point of
the Rogerian approach to counselling and psychotherapy is best stated by Rogers (1986) himself. “It is that the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes and self-directed behaviour and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided.”

Rogers rejected the deterministic nature of both psychoanalysis and behaviourism and maintained that we behave as we do because of the way we perceive our situation. “As no one else can know how we perceive, we are the best experts on ourselves” (Gross, 1992). Believing strongly that theory should come out of practice rather than the other way round, Rogers developed his theory based on his work with emotionally troubled people and claimed that we have a remarkable capacity for self-healing and personal growth leading towards self-actualization. He placed emphasis on the person's current perception and how we live in the here-and-now.

In Group therapy the social interaction and dynamics of group therapy sessions will provide each individual client with much-needed perspective on his or own own circumstances. One advantage of group therapy is the diversity of opinions. The relationship between an individual client and a therapist can become very insular. Thoughts expressed in these sessions are not often challenged by the therapist, only examined more closely. In a group therapy session, however, each participant is free to challenge or critique another participant's statements, within certain boundaries.
An experienced addict in recovery, for instance, may recognize another addict's denial and persuade him or her to face reality. By encouraging diverse opinions, group therapy can effectively motivate each participant towards more honest interaction with others.

Group therapy also facilitate the social interaction between different ages, cultures and sexes. Many group therapy leaders insist on a form of anonymity and discretion outside of sessions, so each participant is free to assign their own ‘identifiers’ to other participants. One may represent an oppressive parent, while another may be seen as a spouse. This diversity is helpful for those suffering from social anxiety disorders or self-esteem issues. For example, while in group therapy sessions, a person suffering from social anxiety disorder may learn how he is perceived by an attractive female, an older parental figure and a male his own age. When participants start to reconcile their irrational beliefs with reality, true emotional healing can begin.

Some participants in group therapy sessions may feel an improved sense of purpose or structure. By attending regularly scheduled meetings, some who suffer from social disorders may feel a sense of belonging. A participant who felt especially needy or helpless one week could become a confident group leader the next week. Participants can use their own strengths to bolster each other during times of crisis. Many people in counselling for anger management or social maladjustment disorders often benefit from group therapy, because they can see others who are facing the same difficulties.
While group therapy may not be an ideal arrangement for all who seek personal counselling, but have proven effective for improve psychy condition of person or can say participants. Group therapy sessions generally last a few months to a few years, and participation is almost always voluntary. A number of recovery groups, use group therapy techniques to help addicts find strength in numbers and realize that they are not alone in the world. Further as counselling aims to determine the causes of considered problem, find prevention methods, and possible interventioion to improve the persons’. It concerned with the integration of psychological principles and therapeutic processes. It adopts a reflective practitioner approach, combining formal psychological enquiry and understanding of the client-practitioner interpersonal relationship.

Through the integration of theory, research and practice, and with a sensitivity to multicultural issues, this speciality encompasses a broad range of practices that help people improve their well-being, alleviate distress and maladjustment issues, resolve crises, and increase their ability to live functioning lives.

Counselling work in the areas of vocational psychology, child development, adolescent development, adult development / aging, health psychology (including long-term care), mental health (for example, anxiety disorders) substance abuse, aggression/anger control, interpersonal relationships, community psychology and eating disorders.

The present investigation has made its effort to study the effect of Rogerian
group counseling on senior citizens’ psyche (Mental health, adjustment and self-concept).

Results related to each variable has been discussed under two following parts:

1) Within group comparison;

2) Between group comparison;

4.2.1 Rogerian Group Counselling and Mental health

Mental health is beginning to be grounded in psychologists’ empirical studies of a wide variety of patterns of adaptation to adolescence. Positive or holism discipline defines mental health as an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve resilience. Mental health is the capacity to express our emotions and adapt to a range of demands. In this regard it is essential that one should possess good mental health. In order to protect or enhance ones’ mental health various clinical and psychological approach is exist. Among them counselling is an efficacious and valid approach to treat persons who have psychosocial, affective, cognitive and communicative needs in order to improve their mental health. Research results and clinical experiences attest to the viability of counselling even in those who are resistive to other treatment approaches.
Table 4.7
Changes in Mental health outcomes among senior citizens in the
Experimental and Control Groups in pre and post test.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Mean Score on MHI</th>
<th>t-Test for Pre &amp; Post Test</th>
<th>t-Test for Control &amp; Experimental Group on Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Test</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Test</td>
<td>28</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improved Score</strong></td>
<td><strong>03</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Test</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Test</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improved Score</strong></td>
<td><strong>12</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS-Not Significant, *0.01 level of Significant, **0.05 Level of Significant
Figure 4.4
Comparison of Mean scores on Mental health in Pre & Post Test for Experimental & Control Group

![Bar chart showing comparison of mean scores on mental health between pre-test and post-test for control and experimental groups.]

Figure 4.5
Comparison of Mean Change Scores on Mental health between Experimental & Control Group

![Bar chart showing mean change scores on mental health check list for control and experimental groups.]

[175]
Within group comparison;

Above result table 4.7 and respective figure 4.5 indicate the mean score on mental health for the experimental group that was found to be 30 before the intervention introduce and after intervention of group counselling provided the mean score was found to be 18. The obtained t value for this mean difference (Pre & Post) was 8.73 which was significant at 0.01 level of confidence. Improved level of mental health of experimental group on their post test can be attributed to effectiveness of group counselling which was introduce to them after their pre test.

The mean score of control group before and after was found to be 31 and 28 respectively. As calculated t value (0.63) of this pre and post mean score difference was observed it was not found significant. It can be concluded on the basis of this finding that as subjects of the control group were not involved in group counselling so their score on mental health inventory was not increased in their post test.

Between group comparison;

The above result table 4.7 indicates that the subjects of the experimental group, which were given group counselling, showed improvement on their scores on mental health inventory measure as compare to the control group in their post test. The t value was found to be 10.11, which is significant at 0.01 level of confidence. It can be revealed from this finding that group counselling has a significant and positive role to determine or enhance senior citizens’ mental health.
Over all on the basis of comparison between groups and within groups it can be concluded that counselling serve as an significant approach in order to improve mental health of elderly. **Thus the results support the hypothesis (d) stating that “Group counselling program based on Roger’s theory help in developing good mental health in senior citizens in Thailand.”**

**Hence the hypothesis is accepted.**

The advantage of group counselling for mental health issues can be attributed on the fact that it helps a person realize that he or she is not alone that there are other people who have similar problems. This is often a revelation, and a huge relief, to the person.

Group counselling can also helps person to develop new skills to relate to others. The dynamics of a group often mirror those of society in general, and learning how to interact with the other members of the group can help you in your relationships outside the group. In addition, the members of the group who have the same problem(s) can support each other, and may offer suggestions to dealing with a particular problem that you may not have thought of. You may be uncomfortable at first when it comes time to discuss your problems in front of strangers. However, the fact that others are facing the same type of situation as you may help you open up and discuss your feelings. In addition, everything that takes place within the group counselling session is kept confidential. (Amal Chakraburty, 2009)
The present results regarding significance of counselling in older persons’ mental health gets indirect or direct support from the following empirical studies;

Elaine Ward, Michael King and others (2000) compared the clinical effectiveness of general practitioner care and two general practice based psychological therapies (non-directive counselling or cognitive-behaviour therapy) for depressed patients. 464 of 627 patients presenting with depression or mixed anxiety and depression were taken as an sample. Interventions used was general practitioner care or up to 12 sessions of non-directive counselling or cognitive-behaviour therapy provided by therapists. Main outcome measures was Beck depression inventory scores, other psychiatric symptoms, social functioning, and satisfaction with treatment measured at baseline and at 4 and 12 months. Results revealed that 197 patients were randomly assigned to treatment, 137 chose their treatment, and 130 were randomised only between the two psychological therapies. All groups improved significantly over time. At four months, patients randomised to non-directive counselling or cognitive-behaviour therapy improved more in terms of the Beck depression inventory (mean (SD) scores 12.9 (9.3) and 14.3 (10.8) respectively) than those randomised to usual general practitioner care (18.3 (12.4)). Overall they have concluded that Psychological therapy was a more effective treatment for depression than usual general practitioner care in the short term, but after one year there was no difference in outcome.
Churchill R.; Dewey M.; Gretton V.; Duggan C.; Chilvers C.; Lee A. (1999) examined indirect evidence from studies evaluating the overall effectiveness of counselling in primary care, and studies evaluating the effectiveness of psychological treatments, other than counselling, for depression. They have concluded that, while specific psychological treatments have been shown to have equivalent effectiveness as antidepressants, there is currently insufficient evidence to recommend that counselling should be used alone in the treatment of patients with major depression.

Teresa D. LaFromboise, Joseph E. Trimble and Gerald V. Mohatt (1990) studied Indian American social and psychological perspectives concerning the process and theory of counselling are contrasted with the individualistic focus, style, and outcomes of therapy as practiced today. Empirical studies are reviewed concerning the role of social influences in the counselling process as perceived by American Indians and the types of problems Indians present in counselling. The under use of mental health services is associated with the tension surrounding power differentials in counselling relationships and perceived conflicting goals for acculturation between counsellors and Indian clients. In addition, three types of psychological intervention-social learning, behavioural, and network—are reviewed and summarized for their contributions and implications for training counsellors in effective mental health service delivery with American Indians.

Aforementioned clinical and experimental research in the literature has demonstrated the efficacy of group counselling based on Rogerian to
promote relaxation, communication, creative self-expression, psychophysical activation, insight, and emotional processing which in turn influence mental health in a positive manner. On the basis of aforementioned statement as well as the present finding revealed that the group counselling has a significant role to determine persons’ mental health in their older age.

4.2.2 Rogerian Group Counselling and Self-concept

According to Rogers (1951), self-concept is a portion of the phenomenal field that has gradually become differentiated. It is composed of those conscious perceptions and values of “me” or “I”, some of which are a result of the organism’s own valuing of its experiences and some of which have been introjected or taken over from important others. Because the self-concept comes in part through others, the potential for dissociation or estrangement exists (and usually occurs to some degree). The self-concept, then, is an object of perception, It is the person as she or he perceives herself or himself.

Rogers’s theory of personality is called self-theory because of the central importance of self-concept in it. The therapeutic approach of Rogers is one of empathy, listening, acceptance and minimal intervention. For Rogers’s person-centered counselling is based around two related concepts: reflective listening and unconditional acceptance. In this manner, the counselor is able to listen and reflect the person’s narrative in space where the whole of their experience (affective, content, etc.) is unconditionally accepted by the counselor. This allows the person to become in increasingly comfortable with
aspects of themselves that may be threatening, shameful, scary, anxiety-causing etc., which facilitates growth and eventual change. Roger’s stated this process as follows:- “I can state the overall hypothesis as follows:- If I can provide a certain type of relationship, the other person will discover with in himself the capacity to use that relationship for growth, and change and personal development will occur” (Roger, 1995 a).

Table 4.8
Changes in Self-concept Scale outcomes among senior citizen in the Experimental and Control Groups in pre and post test.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Mean Score on SCQ</th>
<th>t-Test for Pre &amp; Post Test</th>
<th>t-Test for Control &amp; Experimental Group on Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Test</td>
<td>107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Test</td>
<td>116</td>
<td>1.07&lt;sup&gt;NS&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>Improved Score</strong></td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Test</td>
<td>103</td>
<td>18.09&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Post-Test</td>
<td>159</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improved Score</strong></td>
<td>56</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS-Not Significant, *0.0 level of Significant, **0.05 Level of Significant
Figure 4.6
Comparison of Mean scores on Self-concept Scale in Pre & Post Test for Experimental & Control Group

![Bar chart showing mean scores on the Self-concept Scale for Pre-Test and Post-Test for Control and Experimental Groups.]

Figure 4.7
Comparison of Improved Scores on Self-concept Scale between Experimental & Control Group

![Bar chart showing improved scores on the Self-concept Scale for Control and Experimental Groups, with Experimental Group showing a significant increase.]
**Within group comparison;**

It is evident from the above result table 4.8 and respective figure 4.6 that the mean score of the subjects in experimental group on self-concept questionnaire was found to be 103 before the participation and after participation in group counselling the mean score was found to be 159. The obtained t value for this mean difference (Pre & Post) was 18.09 which was significant at 0.01 level of confidence. Improved level of self-concept of subjects in experimental group on their post test can be attributed to the group counselling which was given to them after their pre test.

The mean score of control group before and after was found to be 107 and 116 respectively. As calculated t value (1.07) of this pre and post mean score difference was observed it was not found significant. It can be concluded on the basis of this finding that as subjects in the control group were not participated in group counselling their score on self-concept questionnaire was not improved in their post test.

**Between group comparison;**

The above result table 4.8 indicates that the subjects in experimental group, which were participated in group counselling, showed improvement on their score on self-concept questionnaire measure as compare to the subjects in control group in their post test. The t value was found to be 19.97, which is significant at 0.01 level of confidence. It can be revealed from this finding that group counselling has a significant and positive role in order to improve positive self-concept among people of old age. The participants in group
counselling scored significantly higher than those in the control group in self-concept at post test. Thus the results of the present study support the hypothesis (e) stating that “Significant positive changes will be brought in the self-concept of senior citizens in Thailand through Rogerian group counseling.” Hence the hypothesis is accepted.

Rogerian approach to counselling for positive self-concept and psychotherapy is best stated by Rogers (1986) himself. “It is that the individual has within himself or herself vast resources for self-understanding, for altering his or her self-concept, attitudes and self-directed behaviour - and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided.” Rogers rejected the deterministic nature of both psychoanalysis and behaviourism and maintained that we behave as we do because of the way we perceive our situation. “As no one else can know how we perceive, we are the best experts on ourselves.” (Gross, 1992)

Rogers claimed that person have a remarkable capacity for self-healing and personal growth leading towards self-actualization. He placed emphasis on the person's current perception and how we live in the here-and-now. Rogers noticed that people tend to describe their current experiences by referring to themselves in some way, for example, “I don't understand what’s happening” or “I feel different to how I used to feel.” Central to Rogers’ theory is the notion of self or self-concept. This is defined as “the organized, consistent set of perceptions and beliefs about oneself” It consists of all the ideas and
values that characterize ‘I’ and ‘me’ and includes perception and valuing of ‘what I am’ and ‘what I can do’. Consequently, the self-concept is a central component of our total experience and influences both our perception of the world and perception of oneself.

The self-concept does not necessarily always fit with reality, though, and the way we see ourselves may differ greatly from how others see us. For example, a person might be very interesting to others and yet consider himself to be boring. Rogers’ judges and evaluates this image he has of himself as a bore and this valuing will be reflected in his self-esteem.

The goals of Rogerian counselling seem to arise out of Rogers’ assumption of the actualizing tendency and his political view of the person as having the right to self-determination. The overall goal is for the person to become ‘fully functioning’ which may mean for some clients a total revision of their world-view and outlook. Such a person is characterized by being essentially optimistic, engaged in life, not defensive, accepting of themselves and of others, accepting responsibility and being creative in approaching life, prizing themselves and others and relating to the here-and-now in an undistorted way, savouring the richness. These attributes play a role in personal growth as well as being an end in themselves. As Nelson-Jones puts it, “these attributes are both the ends and the means of the actualising tendency and all involve effective self-conceptions. Self actualising people possess actualising self-concepts!”
Further various research or empirical studies also support the present finding. Among them few are following;

Aihie, Ose Ngozi and Ekiadolor (2009) investigated the efficacy of group counselling in enhancing the self-concept of participants. The influence of sex on the self-concept of these group was also investigated. A pre-test, post test, control group design was employed in the study. The results of the study revealed that group counselling had a significant positive effect on the self-concept of the subjects. There was no significant effect of sex on the self-concept of the person.

The findings also corroborate those of Jeffery and Reynolds (1994), Lane (1997), and Tobias & Myrick (1999), who reported positive effects of group counselling on the participants in order to enhance their self-concept in positive direction.

The significance of Rogerian group counselling for self-concept can be attributed as an fact that as its nature was non-directive the counsellor acts as a source of understanding and encouragement rather than the problem solver. Further the Person-centred approach allows clients to move at their own pace and to direct their own development.

This means they are aware that the counsellor believes in their capability to manage problems, which encourages them to believe in their own strengths, values and worth.

Therefore an individual’s self-concept is an important issue in this type of counselling; if someone has been brought up around negative experiences or
interactions, it is likely that the person’s self-concept will be damaged. With this method, it is not the counsellor’s task to direct or diagnose the individual; their role is to listen, understand and accept in a non-judgemental manner, thus allowing the clients to help themselves. This is thought to be extremely beneficial in repairing a person’s self-concept in order to facilitate the possibility of lasting change by modelling new relationship patterns.

4.2.3 Rogerian Group Counselling and Adjustment

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

Adjustment is harmonious relationship with the environment involving the ability to satisfy most of one’s needs and most of the demands, both physical and social that are put upon one (Anonymous, 1968). Adjustment is a state in which the needs of the individual on the one hand and the claims of the environment on the other are fully satisfied (Anonymous, 1972). Adjustment in old age is difficult, because of their limited capacity, diminishing energy & declining mental abilities due to the various characteristics of old age; old people experience different type of anxieties, fears & frustrations. With changing socio-economic compulsions young members of the family in our country too find it increasingly difficult to adjust with the old members & prefer letting them live all by themselves, or put them in homes for aged.
Even when old people continue to live within the family, they suffer from lack of care, companionship & due importance. In recent years, awareness of the multitude of social and psychological problems that contribute to the development exacerbate poor coping and lack of adjustment to illness and its treatment has led to an increase use of counselling. Many doctors, especially those in general practice and oncology, now emphasises on the psychological therapy and counselling for health care team.

Although provision of a counselling service seems intuitively reasonable and patients themselves often provide a great deal of anecdotal evidence attesting to the benefits of having been counselled, though scientific evaluation of efficacy is equivocal.

In this regards present study attempts make their effort to explore the relation between counselling and decreasing level of maladjustment.
Table 4.9
Changes in Adjustment outcomes among senior Citizens in the Experimental and Control Groups in pre and post test.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Mean Score on AI</th>
<th>t-Test for Pre &amp; Post Test</th>
<th>t-Test for Control &amp; Experimental Group on Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
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<td></td>
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</tr>
<tr>
<td>Pre-Test</td>
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<td></td>
</tr>
<tr>
<td>Post-Test</td>
<td>107</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Score</td>
<td>09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Test</td>
<td>79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-Test</td>
<td>110</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved Score</td>
<td>31</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NS-Not Significant, *0.0 level of Significant, **0.05 Level of Significant
Figure 4.8
Comparison of Mean scores on Adjustment in Pre & Post Test for Experimental & Control Group

![Comparison of Mean scores on Adjustment in Pre & Post Test for Experimental & Control Group](image)

Figure 4.9
Comparison of Improved on Adjustment Between Experimental & Control Group

![Comparison of Improved on Adjustment Between Experimental & Control Group](image)
Within group comparison;
It is evident from the above result table 4.9 and respective figure 4.8 that the mean score of the experimental group on adjustment inventory (SJOAI) was found to be 79 before the group counselling and after group counselling the mean score was found to be 110. The obtained t value for this mean difference (Pre & Post) was 16.09 which was significant at 0.01 level of confidence. Improved level of adjustment of experimental group on their post test can be attributed to group counselling which was introduced to subjects them after their pre test.

The mean score of control group before and after was found to be 98 and 107 respectively. As calculated t value (0.17) of this pre and post mean score difference was not found significant. It can be concluded on the basis of this finding that as subjects in control group was not provided group counselling their score on self-concept questionnaire was not improved in their post test.

Between group comparison;
The above result table indicates that the subjects in experimental group, who were participated in group counselling showed improvement on their score on adjustment inventory (SJAOI) measure as compare to the control group in their post test. The t value was found to be 18.97, which is significant at 0.01 level of confidence. It can be revealed from this finding that group counselling has a significant and positive role in the area of adjustment for senior citizens. The results support hypothesis (f) stating that “Rogerian group counselling will have positive effect on adjustment of the senior citizens in Thailand.” Hence the hypothesis is accepted.

On the basis of present finding it can be concluded that as psychological
maladjustment among person whether in adolescence, adult or old needs to be considered as a serious problem nowadays. The elements of the psychological maladjustment that always become a problem are anxiety-tension-stress, Compulsive-Obsessive-Rigid Behaviour, Depressive-Defeatist Thoughts and Feelings, Friendship- Socialization, Goals: Religious- Philosophical, Inadequacy: Feeling and Behaviour. These elements must be handled properly to avoid the negative effects to the person. Therefore in order to reduce the level maladjustment the group counselling serves its role in field of psychology or psychiatrist.

Following empirical studies gives support to the present obtained result; Noor Azniza Ishak and Dr. Hairul Nizam (2005) studied the maladjustment problems the 400 respondents using 48 ICET questionnaires (McMahon, 1971). The result shows that 192 respondents need counselling services because of the maladjusted problems, 114 respondents are under control, 49 respondent are normal and 45 respondents need to be referred to the psychiatrist. Distribution of the elements stated that anxiety- tension-stress 25.45%, Compulsive-Obsessive-Rigid Behaviour 29.86%, Depressive-Defeatist Thoughts and Feelings 22.75%, Friendship- Socialization 13.38%, Goals: Religious- Philosophical 45.67% and Inadequacy: Feeling and Behaviour 26.91%. Generally this survey manages to identify the maladjustment problems among the respondents in Malaysia. These results lead the researcher to perform a treatment to overcome the problems. This paper will discuss about the comparison between two brief group work
interventions that focused on REBT and behaviour approaches to help the maladjusted respondents to develop their life in campus. A sample of 288 male and female maladjusted respondents was assigned to one of three groups: REBT brief group work intervention, behavioral brief group work intervention and control group. According to the findings, both of the treatment, reduced maladjustment compared to control group. There are no significant different between REBT focused brief group intervention and behavioral focused brief group intervention but there are significant different between the two interventions and the control group.

Charles A. Maher and Christopher R. Barbrack (2006). The effectiveness of behavioral group counselling in preventing and remediating maladjustment was studied by Charles A. Maher and Christopher R. Barbrack (2006). Behavioural group counselling was provided to the participants. Results suggested that behavioral group counselling may be a cost-effective approach but effective intervention in order to reduce maladjustment level. Result also revealed that the behavioural group counselling intervention was a socially worthwhile and practical approach.

P.S.Fry (1990) presented a review of prevalent conceptions concerning the development of control and helplessness in older adults and the impact of these conceptions on the adjustment and well-being of older adults. Alternative formulations focusing on the significance of the person-environment transactional model are presented, and a conceptual framework based on congruence between the person and environment is utilized for
examining perceptions of control among older adults. Dimensions of congruence salient to the functioning of older adults are described with particular reference to their implications for counselling interventions and counselling approaches. It is argued that individuals are more likely to experience control and positive adjustment when their abilities, resources and needs are consistent with environmental demands and supplies and for that counselling is best resource.

Above results as well as empirical findings are consistent with the results of the present study which revealed that group counselling is a significant intervention in field of psychological therapy for enhancing level of adjustment among senior citizens.

**Part III**

- Mental health and Self-Concept
- Mental health and Adjustment
- Self-concept and Adjustment

To study the relation between mental health and adjustment, mental health and self-concept & adjustment and self-concept of senior citizens, correlation among variables were worked out for the pooled sample. Coefficients of correlation were calculated by the method of Pearson’s Product Moment. Obtained correlation coefficients have been presented in following table and its significant has been discussed.
4.3 Mental health and Self-Concept

Table 4.10
Correlation Coefficient between Mental health and Self-concept

<table>
<thead>
<tr>
<th>Correlation Coefficient</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>-0.72</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Above result table shows the correlation between mental health and self-concept. It which was found to be -0.72, which is significant at 0.01 level. As this correlation value was found significantly negative, it can be revealed that senior citizens who scored higher on self-concept scale (which shows positive self-concept) also scored less in mental health measure (which is indicative of sound mental health). The finding elucidates that senior citizens with positive self-concept were found with good mental health. The results support hypothesis (g) stating that “Senior citizens having sound mental health will be possessed positive self-concept.” Hence it is accepted.

Self-concept or evaluation is crucial to mental and social well-being. It influences aspirations, personal goals and interaction with others. The paper of Michal (Michelle) Mann, Clemens M. H. Hosman, Herman P. Schaalma and Nanne K. de Vries (2003) stresses the importance of self-esteem as a protective factor and a non-specific risk factor in physical and mental health. Mental health can be described as absence of symptoms of maladjustment, be they mild or severe. Mentally healthy person is free from all types of maladjustment (Klein, 1956). Jahoda (1958) has said that aspects of attitudes
toward self, growth and development, self-actualization, integration of personality and mastery of the environment must be considered in judging whether a person is mentally healthy or not.

Evidence is presented illustrating that self-esteem can lead to better health and social behavior, and that poor self-esteem is associated with a broad range of mental disorders and social problems, both internalizing problems (e.g. depression, suicidal tendencies, eating disorders and anxiety) and externalizing problems (e.g. violence and substance abuse). We discuss the dynamics of self-esteem in these relations. It is argued that an understanding of the development of self-esteem, its outcomes, and its active protection and promotion are critical to the improvement of both mental and physical health. They focused on self-esteem is considered a core element of mental health promotion and a fruitful basis for a broad-spectrum approach.

The relation between mental health and self-concept is also supported by psychiatric-medical and stress-social support models, and theories of self-concept and stigma in the study of Fred E. Marowitz (2001) examined social-psychological processes in recovery from mental illness. Using longitudinal questionnaire data from 610 persons in self-help groups and outpatient treatment. He has estimated a series of models of the relationships between key elements identified as part of the recovery process: symptoms, self-concept, and life satisfaction. The results show that these elements affect each other in a reciprocal manner. Moreover, findings indicate a key role for self-esteem, which mediates the effect of life satisfaction on symptoms. The
study suggests a general framework for examining processes involved in recovery from mental illness.

Marsh, Herbert W.; Parada, Roberto H.; Ayotte, Violaine (2004) also studied relations between self-concept and mental health which are best understood from a multidimensional perspective. For responses by 903 adolescents (mean age = 12.6) to a new French translation of the Self Description Questionnaire II (SDQII), confirmatory factor analysis demonstrated a well-defined multidimensional factor structure of reliable, highly differentiated self-concept factors. Correlations between 11 SDQII factors and 7 mental health problems (Youth Self-Report; YSR) varied substantially (.11 to -.83; mean r = -.35). Single higher-order factors could not explain relations among SDQII factors, among YSR factors, or between the SDQII and YSR factors. This highly differentiated multivariate pattern of relations supports a multidimensional perspective of self-concept, not the unidimensional perspective still prevalent in mental health research and assessment. (2010, APA)

Following research studies described the implications of self-concept in determining Mental-Health which indicating the correlation between these two variables.

An analysis of 104 hospitalized psychotics by Wittenborn (1951) revealed that extremely high levels of self-esteem (exaggeration of ability and well being and grandiose notions of oneself) as well as extremely low levels of self-esteem (self-derogation, feeling of helplessness) were clearly factors
associated with psychosis.

A group of 79 well-acquainted college students took a series of personality tests designed to measure each subject's self-concept, and a series of sociometric tests designed to yield a consensual group rating for each subject, from which the real self was inferred. According to the experiments, Calvin and Holtzman (1953), subjects who showed the best personal adjustment included those who showed the greatest accuracy of self-perception and those who showed moderate tendencies towards self-enhancement.

In a study by Brassard (1964), normal adults took the Tennessee self-concept scale in which subjects are instructed to describe a socially desirable person, as well as oneself, in terms of 100 self-reference statements. A lack of significant difference between the two measures, indicating a tendency difference between the two measures, indicating a tendency respond in a socially desirable manner, was observed at the individual level of assessment.

Perkins and Shannon (1965) in a study on pre-adolescent boys concluded that the greater the agreement between the boys self-concept (measured obtained by self-ratings, projective drawings and multiple choice picture identification tasks) and his teacher’s ratings of him, the more adequate his personal psychological adjustment.

In a study by Srivastava and Singh (1982) self-discrepancy correlated positively with psychoticism scores in subjects.
Above studies reveal that self-concept was significantly correlated with persons’ mental health. Thus, it can be concluded that senior citizen who is having sound mental health also found to be having positive self-concept.

### 4.3.1 Mental health and Adjustment

**Table 4.11**

<table>
<thead>
<tr>
<th>Correlation Coefficient</th>
<th>Level of Significance</th>
</tr>
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<tbody>
<tr>
<td>-0.68</td>
<td>0.01</td>
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</table>

Above result table show the correlation between mental health and adjustment problems of senior citizen. It was found to be -0.68. It was revealed that significant negative correlation was obtained with regard to mental health and adjustment problems. The negative correlation elucidates that person who scored less on their adjustment measure (higher adjustment problems) had scored higher on mental health check list (poor mental health) and vice versa. In other words persons who were found sound mental health (less Score) also found with highly adjustable (Higher Score). Overall on the basis of present obtained result, it can be concluded that sound mental health facilitate persons towards higher adjustment criteria in their personality. The results of the present study support hypothesis (h) stating that “Senior citizens having sound mental health will be found with highly adjustable criteria in their personality.” Hence the hypothesis is accepted.

The relation of mental health with adjustment can be best explained as
“Looking after one’s mind is as important as looking after one’s body.” As part of one’s overall health, mental and emotional health or well-being is a necessary condition to enable one to manage one’s life successfully or can say adjust with life circumstances. Mental health is the emotional and spiritual resilience that allows one to enjoy life through adjustment with situational or environmental demands. Further mental health is about How one feels inside, Balancing one’s emotions and having control on them, Self-esteem and confidence, Being comfortable with whom they are and Coping with one’s feelings and building up resilience on one’s “bounce-back ability” mental health is important as it affects everything one does – how one sleeps, what one eats, the risk one will take and the types of things one does to relax and enjoy oneself. Some of the criteria for good mental health are

- Adequate feeling of security
- Adequate self-evaluation
- Adequate spontaneity and emotionality
- Efficient contact with reality
- Adequate bodily desires and the ability to gratify them
- Adequate self-knowledge
- Integration and consistency of personality
- Adequate life goals
- Ability to learn from experience
- Ability to satisfy the requirements of the group
- Adequate emancipation from the group or culture
The National Association for mental health describes some of the characteristics of people with good mental health: comfortable feelings about one’s self, feeling ‘right’ about other people and being able to meet the demands of life. To attain these one should get well or adjust to the environment. Adjustment is a built – in mechanism for coping with the problematic or other realities of life. Adjustment has been considered as an index to integration; a harmonious behaviour of the individual by which other individual of society recognise person is well adjusted (Pathak, 1990).

In the modern society, life is becoming very complex and conflicting day by day. If a person is well adjusted only then one can survive without psychological stress resulting from maladjustment. Hence adjustment is important in one’s life in order to maintain their good mental health.

New psychopathological model of adjustment disorders (AJD) was also support the relationship between mental health and adjustment. In this model Andreas Maerckera, Simon Forstmeiera, Anuschka Enzlera, Gabriela Krüsia, Edith Hörlera, Christine Maiera, Ulrike Ehlerta (2008) proposed that adjustment disorder are particular forms of stress response syndromes, in which intrusions, avoidance of reminders, and failure to adapt are core symptoms. We aim to demonstrate that these AJD symptom groups constitute a disorder that is distinct from posttraumatic stress disorder (PTSD), complicated grief disorder, major depressive disorder, and subsyndromal depression, by estimating their prevalence and comorbidities.

A representative sample of elderly persons from Zurich, aged 65 to 96 years,
was assessed by standardized interviews or self-report questionnaires. Index events for AJD were indicated by 52% of the sample set, with a 2.3% current prevalence of AJD. Prevalence rates for other disorders were 0.7% PTSD, 4.2% subsyndromal PTSD, 4.2% complicated grief disorder, 2.3% major depressive disorder, and 9.3% subsyndromal depression. The comorbidity rate for AJD and other Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition disorders is 46%, and that between AJD and subsyndromal disorders is 38%. Use of mental health care for AJD is low. New psychopathological model regarding relation between mental health and adjustment has also been verified in many studies (Described below).

Bharadwaj and Helode (2006) who reported that emotionally stable person were better in adjustment.

Yeh (2003) investigated the association between age, acculturation, cultural adjustment difficulties, and general mental health concerns. The results determined that age, acculturation, and cultural adjustment difficulties had significant predictive effects on mental health symptoms. Further he revealed that revealed that cultural adjustment had significant predictive effect on mental health symptoms.

Lisbeth Jarama, (2002) tested the usefulness of a model developed for conceptualizing adjustment to disability with a sample of African Americans. According to the model, both risk and resistance factors contribute to adjustment to disability. The risk factors examined in this study were perceptions of severity of disability, functional limitations, and stress.
The resistance factors examined were self-esteem, social support, and active coping. Depression and anxiety were used as indicators of mental health adjustment. Data were collected on 113 African Americans with disabilities. Multivariate regression analyses indicated that risk and resistance factors were significant predictors of mental health adjustment to disability. Risk factors were associated with poor adjustment, whereas resistance factors were associated with favorable adjustment. Further, resistance factors contributed to the prediction of depression and anxiety after the influence of demographics and risk factors was accounted for. Functional limitations, stress, social support, and active coping emerged as major variables in adjustment. The findings support an integrative approach that considers the influence of both risk and resistance factors when investigating adjustment to disability.

Abraham (1985) studied on the relationship of psycho-social adjustment with mental health status. The results revealed that adjustment and other psycho-social factors (need for love, need for belongingness, need for acceptance etc.) were related to the mental health status.

Hiremani et al. (1994) studied on emotional maturity with the help of scale developed by Singh and Bhargava (1984) and adjustment with adjustment inventory by Reddy (1964). They observed that normal girls to be emotionally stable in comparison with the destitute or maladjustment girls.
4.3.2 Self-concept and Adjustment

Table 4.12
Correlation Coefficient between Adjustment and Self-concept

<table>
<thead>
<tr>
<th>Correlation Coefficient</th>
<th>Level of Significance</th>
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<tr>
<td>0.74</td>
<td>0.01</td>
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Above result table shows the correlation between adjustment and self-concept. It was found to be 0.74, which is significant at 0.01 level. As the correlation value was found significantly positive it can be revealed that level of adjustment was found to be higher in those senior citizens who were having positive self-concept. The results support hypothesis (i) stating that “Good adjustment is associated with positive self-concept in senior citizens of Thailand.” Hence the hypothesis accepted.

Research on the relation between the structure of the self-concept and psychological adjustment has produced seemingly inconsistent findings (Some research suggests that greater pluralism in self-concept structure enhances adjustment, whereas other research suggests that greater unity in the structure enhances adjustment) but as far as the present obtained result is concerned adjustment level and self-concept was found to be positive correlated with each other.

In study of Jennifer D. Campbell, Sunaina Assanand Adam Di Paula (2003) four studies examined the relations among measures of self-concept structure and their relations with adjustment. The measures of self-concept structure included two that we viewed as reflecting self-concept pluralism.
(self-complexity and self-concept compartmentalization) and four that we viewed as reflecting self-concept unity (self-concept differentiation, self-concept clarity, self-discrepancies, and the average correlation among participants’ self-aspects). The measures of self-concept pluralism were unrelated to one another, were unrelated to the measures of self-concept unity, and were unrelated to the measures of adjustment. The measures of self-concept unity were moderately related to one another and were moderately related to the measures of adjustment.

Monica Bigler, Greg J. Neimeyer and Elliott Brown (2001) presented two studies that tested the ability of self-concept differentiation (SCD) and self-concept clarity (SCC) to predict levels of psychological adjustment. In Study 1, 133 college students rated themselves on measures of Self-Esteem, Purpose in Life, Sense of Coherence, Affect Balance, General Contentment, Depression, Anxiety, and Self-Disclosure Flexibility. After controlling for SCD, the addition of SCC resulted in a 9% to 33% increase in the explained variance using hierarchical multiple regression. Study 2 extended these findings to an inpatient psychiatric population (N = 31), again finding that measures of psychological adjustment were more strongly related to self-concept clarity than to self-concept differentiation. Results are interpreted as extending and qualifying Donahue et al.’s (1993) position regarding the negative impact of a “divided self” on psychological adjustment.

Sonstroem, Robert J.; Potts, Stephanie A (1996) also tested relationships
between physical self-concepts and contemporary measures of life adjustment. University students (119 females, 126 males) completed the Physical Self-Perception Profile assessing self-concepts of sport competence, physical condition, attractive body, strength, and general physical self-worth. Multiple regression found significant associations (P < 0.05 to P < 0.001) in hypothesized directions between physical self-concepts and positive affect, negative affect, depression, and health complaints in 17 of 20 analyses. Thirteen of these relationships remained significant when controlling for the Bonferroni effect. Hierarchical multiple regression examined the unique contribution of physical self-perceptions in predicting each adjustment variable after accounting for the effects of global self-esteem and two measures of social desirability. Physical self-concepts significantly improved associations with life adjustment (P < 0.05 to P < 0.05) in three of the eight analyses across gender and approached significance in three others. These data demonstrate that self-perceptions of physical competence in college students are essentially related to life adjustment, independent of the effects of social desirability and global self-esteem. These links are mainly with perceptions of sport competence in males and with perceptions of physical condition, attractive body, and general physical self-worth in both males and females.

The present result also get indirect support from the study of June P. Tangney, Roy F. Baumeister, Angie Luzio Boone (2008) on What good is self-control? They incorporated a new measure of individual differences in
self-control into two large investigations of a broad spectrum of behaviors. The new scale showed good internal consistency and retest reliability. Higher scores on self-control correlated with a higher grade point average, better adjustment (fewer reports of psychopathology, higher self-esteem), less binge eating and alcohol abuse, better relationships and interpersonal skills, secure attachment, and more optimal emotional responses. Tests for curvilinearity failed to indicate any drawbacks of so-called over control, and the positive effects remained after controlling for social desirability. Low self-control is thus a significant risk factor for a broad range of personal and interpersonal problems.

Study on self-concept and its relation to adjustment and achievement, M.J. Arul (1972) revealed that the overall self-concept was found to correlate positively with personal, social and overall adjustment at $P < 0.01$ level of significance. The overall self-concept as well as self concepts on sociability, temperament and morality were found to correlate negatively with achievement. These correlations were, however, statistically not significant. All the six areal self concepts correlated positively with personal, social and overall adjustments. Many of these correlations were significant and a few of them were not: self concepts of physical appearance, intelligence and temperament did not correlate significantly with personal adjustment. Self-concept on status in the family did not show a statistically significant relationship with social adjustment.
The present study corroborates the tenet that one's personal and social adjustment in life is positively related to one's overall self concept. On the basis of present finding it can be concluded that both self-concept and adjustment are parallel in a sense that if one is increases the other one is also increases.