CHAPTER-I

INTRODUCTION

Old age is the closing period in the life span of the individual. The age which begins from the age of sixty extends to the end of life. This stage, like any other stage is characterized by physical and psychological changes in the form of decline which lead to poor adjustment and unhappiness. The physical cause of decline is a change in the body cells to the aging process. Aging involves a progressive showing down of all the body processes. As a result, older people eat less, exercise less, and have less zest for life. They also sleep less restfully, though they spend more time in bed compensating for this lack of sleep. Their senses become less efficient, and difficulties in hearing and vision (especially in the dark) are common problems at this age. The psychological causes of decline are unfavorable attitudes toward oneself, other people, work and life in general. The individual’s motivation is lowered partly because of retirement and partly because of less household responsibilities. As a result, elderly have plenty of leisure and many suffer from boredom. Aging affect different people differently because they have deferent hereditary endowments, different socioeconomic and educational backgrounds and different patterns of living e.g. the old people who try to be helpful in the household affairs accommodate them selves better. Among the other prominent characteristics, we can note that aging requires role changes.
The elderly have to learn to play a new role, which will be less active naturally because the efficiency, strength, speed and physical attractiveness are decreasing. Elderly find adjustment difficult because they develop feelings of inferiority. Sometimes, unfavorable attitudes towards them make feel useless and unwanted. Therefore, old age is a mental attitude developed during a life time. Happiness in old age is dependent on what is buildup during the previous years of youth and middle age. The cognitive abilities tend to hold up well in many old people, but in some there is a sudden drop in cognitive abilities and this indicates that their death is now very near. This is called “terminal decline”. Due to old age the brain cells and neurons become very weak in their functions. This may lead to organic mental disorder which is called senile dementia.

Fortunately, with the improved understanding of aging and the importance of health care and supportive environments, we find that older people can remain in reasonably good health and function better at the same age than their parents and grand parents did. We understand that many of the negative changes associated with aging are due to stress and disease rather than to the aging process itself. Senility, which is associated with such symptoms as impaired attention, memory loss, and disorientation in time or place, is actually a disease caused by a damage to brain’s cells and affects only a small number of old people.
1.1 Problems of old age

Old age may bring on a lack of mental sharpness. This can occur because of physical debility. Also, if the mind has been neglected, there will be a failure of the mentality. In old age, there can be a disorientation to life from the standpoint of success standards. A person looks back and regards life as a failure. Maybe he set goals, and now he is old and never realized the goals. There is a great danger of disillusionment. There is a tendency for great increase in mental attitude sins in old age, with emphasis on criticism and judgment. These things are often overlooked in youth; but they are horrible in the elderly.

There is often a lack of security in old age, especially if the old people can't take care of themselves financially. Their children are in the prime of their lives and often the children’s plans do not include them. Old age may bring an inability to concentrate, forgetfulness, inability to converse, to hear, to see. So the old person gets used to sitting in a chair daydreaming, vegetating, saying nothing.

There is sometimes a lack of motive to live, too much idle time, and too much time for complaining. There may be a desire to travel but no means to do so. So there is a lack of significant things to do. Old age brings future shock. Old age finds itself out of phase with the younger generations of children and grandchildren. Therefore a dangerous trend can get started toward hypercriticism. There is a tendency to think that getting old means that a person has some wisdom. So there is the garrulous senior citizen who
never stops talking and inflicts continuous boredom on his listeners with his platitudes and homely chatter.

### 1.2 Mental health

Like physical health, mental health is also an aspect of total personality. If a person is well adjusted, he has good physical health and desirable social and moral values. His mental health is likely to be good. As a matter of fact good mental health is indicated in such individuals as are happy, healthy hopeful and have harmonious personality.

According to Menninger (1945), “mental health is the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. It is the ability to maintain an even temper, an alert intelligence, socially considerate behavior and a happy disposition”. The chief characteristic of mental health is adjustment. The greater the degree of successful adjustment, the greater will be the mental health of the individual.

The White House conference in its preliminary report (1930) said, “mental health may be defined as the adjustment of individuals to themselves and the world at large with a maximum of effectiveness, satisfaction, cheerfulness and socially considerate behavior and the ability of facing and accepting the realities of life”.

English and English have stated that mental health is “a relatively enduring state where in the person is well adjusted, has a zest for living, and is attaining self-actualization or self-realization. It is a positive state, and not mere absence of mental disorder.”
It is defined by the Preamble of the World Health Organization, “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.”

A mentally healthy individual is one who is himself satisfied, lives peacefully with his neighbours, and do something for the benefit of society.

1.2.1 Characteristics of Mental health

1) **Self-evaluation:** A mentally healthy individual evaluates himself properly, is aware of his limitations, easily accepts his drawbacks and makes efforts to rid himself of them. He introspects so that he may analyze his problems, prejudices, difficulties etc, and reduce them to a minimum.

2) **Adjustment and Adaptability:** One special characteristic of a mentally healthy individual is that he adjusts with the situation effectively with the least disturbance. He makes the fullest possible use of existing opportunities and adapts to every situation.

3) **Maturity:** Intellectual and emotional maturity is another characteristic of mentally healthy individual. The mature mind is constantly engaged in increasing his fund of knowledge. He behaves like a balanced, cultured and sensible person.

4) **Good habits:** Habits are important elements in maintaining mental health. Forming proper and good habits in matters of food, clothing and the normal routine of daily life leads to his becoming systematic and regulated, which in the long run, economizes upon energy and time. Mentally healthy
person performs most of the common function of life with quick assurance without any problem.

5) **Absence of extremism:** Mentally healthy person lacks access in any and every direction, and the principle that excess of anything is bad, is a golden rule as far as mental health is concerned.

6) **Satisfactory interpersonal relationship:** A mentally healthy individual maintains good relationship with other members of society. He observes the principle, “I am OK, You are OK”, while maintaining interpersonal relationship. The greater the balance of these interpersonal relationship, the better will be the individual’s mental health.

7) **Job satisfaction:** For mental health, it is essential that everyone should find satisfaction from his job. A mentally healthy individual is satisfied with his job. Job dissatisfaction leads to many mental symptoms.

This description does not exhaust all the elements that a mentally healthy individual manifests, but it is sufficiently suggestive picture of mental health. Complete mental health is an ideal. There have been many attempts to describe mental health in ideal terms which have generally led to lists of qualities which characterized mature, healthy person.

### 1.2.2 The Healthy Personality

From her analysis of many definitions Jahoda (1958) gives the following as criteria of positive mental health:-
• Attitudes toward the self; they include the accessibility of the self to consciousness; the correctness of the self-concept; its relation to the sense of identity and the acceptance by the individual of his own self.

• Growth, development, and self-actualization; the extent the individual utilizes his abilities; his orientation toward the future and his investment in living.

• Integration; the extent to which the psychic forces are balanced; a unifying outlook on life and a resistance to stress.

• Autonomy; the aim here is to ascertain whether the self-reliant person is able to decide with relative ease and speed what suits his own needs best.

• Perception of reality; a relative freedom from need-distortion and the existence of empathy.

• Environmental mastery; under this heading is listed: ability to love, work, and play; adequacy in interpersonal relationships; meeting situational requirements; adaptation and adjustment; and efficiency in problem solving.

Maslow and Mittelmann (1951) have suggested the following criteria for normal psychological health:-

• Adequate feeling of security.

• Adequate self-evaluation.

• Adequate spontaneity and emotionality.

• Efficient conduce with reality.
• Adequate bodily desire 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.

Developmentally, the healthy person is highly differentiated and well integrated. He is more motivated by abundancy than deficiency needs. There is strong sense of personal identity, realistic self-esteem, detachment, and sensitivity to the self and others. He has a sense of competence and actual competencies in psychological functioning (i.e., learning, memory, problem-solving). His ego is strong, his behavior is flexible and adaptable and there is considerable stress tolerance. Coping devices are more evident than defenses. Within ecological possibilities, he is an autonomous agent mastering problems rather than being the passive object of the forces of the environment, the social order, or inner drives. With a secure sense of being and value, he can be compassionate, sympathetic, and loving toward others. Conscience and values are coherent, conscious, and well integrated. Finally, the healthy personality is comfortable with himself and valued by others. This is not to suggest that a person is without conflicts, worries, or anxiety.
Because of high ideals and self-confidence, he can overreach and know failure and frustration. He can hurt others and know guilty. As anyone, he is capable of foolish, thoughtless and self-defeating acts. In his spontaneity and desire for experience, in a readiness to accept challenges “because it’s there,” defeat and despair are predictable risks. But what distinguishes the healthy personality is that these do not lead to defensive retreat, hostile anger, or face-saving maneuvers. Instead, adversity is counteracted as possible, but above all it is the basis for further learning wisdom. It is in the capacity to continue growth, rather than being without pain or suffering, that the healthy person is best defined.

1.2.3 Philosophical Approach to Mental health

The various philosophies of life describe a happy person and the way to attain happiness. In India, the various philosophical points of view have presented a picture of balanced and mentally healthy individuals.

In the Bhagavada Gita, chapter sixteen describes the nature of the godlike and the demonic mind. Those of the Godlike nature possess “fearlessness, purity of mind, wise apportionment of knowledge and concentration, charity, self control and sacrifice, study of scriptures austerity and uprightness” (Radhakrishnan, 1956).

Further the godlike individuals are devoted to “non-violence truth, freedom from anger, renunciation, tranquility, aversion to fault finding, compassion to living being, freedom from covetousness, gentleness, modesty and steadiness.”
The above qualities indicative of godlike natures, are in modern psychological terminology, the traits and characteristics of a well adjusted, well integrated and mentally healthy person.

The Gita also emphasises some more qualities in this context. These are “vigour, forgiveness, fortitude, purity, freedom from malice and excessive pride.”

The most important religious and philosophical teachings for Hindus are contained in the Bhagavada Gita and the Hindus are encouraged through this philosophical approach to have a healthy and harmonious functioning of their total personality leading to good mental health and adjustment.

The teachings of Lord Buddha are contained in the little book The Dhammapada. In chapter fourteen, traits of the enlightened ones are described. Further, various aspects of human nature and conduct have been narrated in such a manner as enables a follower of Buddhism to attain good mental health.

The following extracts from The Dhammapada are indicative of the philosophical approach which and individual should adopt in order to attain real happiness in life:-

- Health is the greatest of gifts; contentment is the greatest wealth; trust is the best of relationships; Nirvana is the highest happiness.
- Eschew all evil. Cultivate and establish thyself in good. Cleanse thy mind. So teach the Buddhas.
• Good people move onwards whatever befall. They do not prattle, not yearn for pleasures. The wise are not elated in their happiness, nor are they depressed when touched by sorrow.

In modern India, Specially in the beginning of the twentieth century, spiritual leaders emphasized a way of life free from greed, anger, fear and pride. In the teachings of Sri Ramkrishna Paramhansa and Swami Vivekanand emphasis has been laid on service and sacrifice. These are the essential ingredients of good mental health. It is by giving that one receives; this is the principal condition of life.

Sri Aurobindo has laid great emphasis on three things for leading a peaceful and spiritual life. These are aspiration, rejection and surrender.

One should aspire for the Divine all the time, accompanied by unceasing effort to open oneself to divine grace.

One must reject the desires of his lower animal nature. In the words of Sri Aurobindo “rejection of the mind’s ideas, opinions, preferences, habits, constructions, so that the true knowledge may find free room in a silent mind, rejection of the vital nature’s desires, demands, craving, sensations, passions, pride, arrogance, lust, greed, jealousy, envy, hostility to the Truth, so that the true power and joy may pour from above into a calm, large, strong and consecrated vital being, -rejection of the physical nature’s stupidity, doubt, disbelief, obscurity, obstinacy, pettiness, laziness, unwillingness to change” (Sri Aurobindo, 1953).
The third requirement for a harmonious peaceful life, according to Sri Aurobindo, is complete surrender to the Divine. One must “surrender oneself and all one is and has and every moment to the Divine and the Shakti.” Thus even in modern times it has been emphasized by spiritual teachers that without faith in God and without the spirit of sacrifice, it is not possible for a person to enjoy peace of mind and harmony in life.

Sri Aurobindo says “to walk though life armoured against all fear, peril and disaster, only two things are needed, two that go always together -the Grace of the Divine Mother and on your side an inner state made up of faith, sincerity and surrender.

Let your faith be pure, candid and perfect. Let your sincerity and surrender be genuine and entire. The more is your faith, sincerity and surrender, the more will grace and protection be with you” (Sri Aurobindo, 1953). Thus the philosophical approach to mental health in India attaches great importance to faith in God, complete surrender on the part of the individual to the Divine will and work in the form of service and sacrifice.

The philosophical approach to mental health requires a sound philosophy of life. Without a sound philosophy of life none can have good mental health. Related with this philosophy of life is the concept of self. Self realization is the ultimate of many philosophies of life. Even Psychologists have gone into the discussion of the self and its realization. Thus they have emphasized adjustment to self in order to have good mental health.

According to William McDougall, the first maxim for good mental health is

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‘know thyself’. The ancient Greek philosopher Socrates (469-399 B.C.) also preached this maxim.

The Knowledge of self is further extended by acceptance of the self. This aspect has been emphasized by J.A. Hadfield. According to Hadfield, it is not enough to have self knowledge and accept oneself as he or she is. In other words, a person should be objective in regard to himself. It leads to the third aspect of the self triangle important from the mental health viewpoint. ‘Be thyself’ is the third side of the self triangle. Thus know thyself, accept the self and be thyself are three sides of a triangle based on the nature of self and its realization.

If a person has a realistic view of himself and a realistic approach to his environment he is bound to have peace, harmony, good adjustment and good mental health.

Finally, a word may be said about the great interest being shown in Yoga by modern philosophers, psychologists and sociologists in many parts of the world. A new branch of Yoga psychology is being developed as a check against anxiety and stress being produced by modern science and technology.

In the Bhagavada Gita the theory and practice of Yoga has been well described laying full emphasis on balance in life. ‘Yoga is balance’ according to the Bhagavada Gita. A person skilled in Yoga is free from mental conflicts because he is able to maintain his mental balance. There are different schools of ‘Yoga emphasizing one aspect or the other. Nevertheless
the Integral Yoga of Sri Aurobindo takes into account all aspects of life and presents a synthesis of all schools of Yoga so far known to us. The Yoga of Sri Aurobindo “teaches one, not only to rise in consciousness but also to bring down the lights and powers of the higher worlds into the lower spheres of consciousness and join both the higher and the lower. The meaning of the word ‘Yoga’ in its true sense is to ‘join’ – join our external consciousness with our true self – the Divine within ourselves – which is ONE everywhere. By the practice of Yoga, our consciousness expands as wide as the universe and far beyond” (Sri Aurobindo, 1975).

1.2.4 Some Conditions for Mental health

In the light of the philosophical approach to mental health discussed above, it is desirable at this point to consider some of the conditions which are necessary for positive mental health. According to Shaffer and Shoben, positive mental health can be achieved if the following conditions are kept in view:-

- **Good physical health.** Without good physical health it is not possible for a person to have good mental health. It is, therefore, a necessary condition for positive mental health to have good physical health also.

- **Self acceptance.** Shaffer and Shoben emphasise that the individual should accept himself in order to have positive mental health. This self acceptance depends upon a number of steps:
a) The first step is that the individual should understand himself.

b) Secondly, he must be able to recognize his strength and potentialities so that he is able to assess his achievements realistically.

c) Thirdly, the individual should try to avoid self deceit and rationalization. Thus he will be able to accept himself properly.

- **Accepting other people.** The extension of self acceptance is seen in accepting other people. In the words of Shaffer and Shoben, “understanding other people has an importance for mental health second only to understanding yourself. Accepting other people requires objectivity in the sense of understanding and tolerance” Thus accepting other people is a necessary condition for positive mental health. But it should be kept in mind that acceptance of others is positive step and not a negative one. In other words, accepting other people implies social adjustment and not submission and surrender to other.

- **A confidential relationship.** One of the necessary conditions of positive mental health is the development of a confidential relationship with some persons so that the individual is able to express his feelings, anxieties, fears etc. without any hesitation. It has been found that individuals enjoying confidential relationships have better mental health than those who do not have such relationship with others. In this context the importance of genuine friendship is clearly indicated.

- **An active attitude.** Shaffer and Shoben are of the view that in order to have integrative adjustment and positive mental health, the individual
should not merely talk about it but must do something also. He should be actively engaged in such activities as are emotionally and socially satisfying. “The active attitude must be correlated with other conditions of mental hygiene, specially with self understanding and realistic perception of external situations.” In other words, all the conditions of positive mental health are complementary and contribute jointly towards the growth of good mental health.

- **Social participation.** In order to have positive mental health, a person should be engaged in some such social service and activity as is of his liking. Since the individual is a member of a social group, he must not develop group feelings as well as make efforts to serve the group interests according to his abilities.

- **Satisfying work.** If a person is engaged in a job which he likes, he has good mental health. On the other hand, if he is required to do something under compulsion and has no liking for it, his mental health will be poor. Thus it is necessary to select such work for livelihood as leads to satisfaction. According to Shaffer and Shoben, “The sense of satisfaction and completeness that comes from work well done can be one of the strongest integrating experiences of your life.”

- **Creative experience.** Allied with the factors of social participation and satisfying work, the factor of creative experience is also extremely important for the maintenance of good mental health. It is through creation that recreation is possible. In other words, real recreation is never
possible without creative experience. Everyone has some talent and if that is properly developed he is able to create something worthwhile leading to full expression of the self. Self expression and creative experience are two sides of the same coin. Thus creativity is essentially a mode of self expression which is extremely important for positive mental health.

- **Scientific Approach.** Finally, for good mental health the individual should adopt the scientific approach to the problems of his life. The scientific approach requires objectivity and cool mindedness. The individual should be able to analyses his problems in a scientific manner, i.e., he should collect facts, weigh them and then draw conclusion for necessary action.

Thus positive mental health depends upon such conditions as lead to a balanced satisfaction of needs, interests, desires and motives.

### 1.2.5 Mental health is more than the absence of mental illness

Mental health implies fitness rather than freedom from illness. In 2003, George Vaillant in the USA commented that mental health is too important to be ignored and needs to be defined. As Vaillant pointed out, this is a complex task. “Average mental health” is not the same as “healthy”, for averaging always includes mixing in with the healthy the prevailing amount of psychopathology.

What is healthy sometimes depends on geography, culture and the historical moment. Whether one is discussing state or trait also needs to be clear – is an
athlete who is temporarily disabled with a fractured ankle healthy or unhealthy? Similarly, is an asymptomatic person with a history of bipolar affective disorder healthy or unhealthy? There is also “the two-fold danger of contamination by values” (Vaillant, 2003, p. 1374) – a given culture’s definition of mental health can be parochial, and, even if mental health is “good”, what is it good for? The self or the society? For fitting in or for creativity? For happiness or for survival?

Even so, Vaillant advocates that common sense should prevail and that certain elements have a universal importance to mental health; just as despite every culture having its own diet, the importance of vitamins and the five basic food groups is universal.

1.2.6 Mental health and behaviour

Physical health and mental health are closely associated through various mechanisms, as studies of the links between depression and heart and vascular disease are demonstrating. Many studies since the 1950s support the idea that medically ill patients with negative attitudes have worse outcomes than those with more positive attitudes. Now studies demonstrate that healthy people who are optimistic have lower death rates from heart disease than those who are pessimistic, even taking other risk factors into account (Giltay et al., 2004). The relevance of emotional status to the maintenance of good physical health and recovery from physical illness is now well substantiated, as is the converse. Physical ill-health is detrimental to mental health as much as poor mental health contributes to poor physical health.
For example, malnourishment in infants can increase the risks of cognitive and motor deficits, and heart disease and cancer can increase the risk of depression (Blane et al., 1996; Marmot & Wilkinson, 1999). Strong evidence establishes depression as a risk factor for heart disease, and some national health policies now assert that the causal link is undeniable.

The importance of short-term mental stress as a trigger for the development of myocardial infarction and sudden death in people with heart disease is no longer questioned. The notion that hypertension may arise through psychological stress, in turn related to occupational and other adverse factors in the environment, remains contentious, but the idea is an old one (Esler & Parati, 2004). Low control at work and poor social support have important influences on both physical health (e.g. cardiovascular morbidity) and psychological health (e.g. depression) (Kopp, Skrabski & Szedmák, 2000).

Many of the people living with HIV/AIDS and their families experience stigma and discrimination as well as depression and anxiety and other mental illnesses (WHO, 2001c). Persistent pain is linked with suffering and lost productivity around the world.

A WHO study across 15 centres in Asia, Africa, Europe and the Americas examined the relationship between pain and well-being in over 5000 individuals. Those with persistent pain were over four times more likely to have an anxiety or depressive disorder than those without pain (Gureje et al., 1998).
Research has pointed to two main pathways through which a person’s mental and physical health and functioning mutually influence each other over time (WHO, 2001c), interacting with social and environmental influences on health. The first pathway is directly through physiological systems, such as neuroendocrine and immune functioning. The second pathway is through health behaviour. The term health behaviour covers a range of activities, such as eating sensibly, getting regular exercise and adequate sleep, avoiding smoking, engaging in safe sexual practices, wearing safety belts in vehicles and adhering to medical therapies. The physiological and behavioural pathways are distinct yet interact with one another and the social environment: health behavior can affect physiology (for example, smoking and sedentary lifestyle decrease immune functioning) and physiological functioning can influence health behaviour (for example, tiredness leads to accidents). In an integrated and evidence-based model of health, mental health (including emotions and thought patterns) emerges as a key determinant of overall health. Anxious and depressed moods, for example, initiate a cascade of adverse changes in endocrine and immune functioning and increase susceptibility to a range of physical illnesses. For instance, stress is related to the development of the common cold (Cohen, Tyrrell & Smith, 1991) and delays wound healing (Kielcot-Glaser et al., 1999).

While many questions remain concerning the specific mechanisms of these relationships, it is clear that poor mental health plays a significant role in diminished immune functioning, the development of certain illnesses and
premature death. As WHO points out: Understanding the determinants of health behaviour is particularly important because of the role that health behaviour plays in shaping overall health status. Non communicable diseases such as cardiovascular disease and cancer are strongly linked to unhealthy behaviour such as alcohol and tobacco use, poor diet and sedentary lifestyle. Health behaviour is also a prime determinant of the spread of communicable diseases such as AIDS, through unsafe sexual practices and needle sharing. The health behaviour of an individual is highly dependent on that person’s mental health.

Thus, for example, mental illness or psychological stress affect health behavior (WHO, 2001c, p. 9). In young people, depression and low self-esteem are linked with smoking, binge drinking, eating disorders and unsafe sex, putting them at risk of a range of diseases including sexually transmitted diseases such as AIDS (Patton et al., 1998; Ranrakha et al., 2000). Depression in other age groups is linked with social isolation, alcohol and drug abuse and smoking (Hemenway, Solnick & Colditz, 1993). Mood disorders can lead to an increased risk of accidents and injuries and poor physical and role function (Wells et al., 1989). Other factors such as learning through experience or observation also have an effect on health behaviour. For example, it has been established that drug use before the age of 15 years is highly associated with the development of drug and alcohol abuse in adulthood (Jaffe, 1995). Environmental influences, such as poverty or societal and cultural norms, also affect health behaviour (WHO, 2001c).
1.2.7 Family Environment affects Mental health (Michael Rutter; 2005)

For many years there was an assumption that the extensive documentation of statistical associations between risky environments and mental disorders necessarily represented the operation of environmentally mediated causal mechanisms. Three considerations challenged that assumption.

First, psychosocial researchers recognised the need to differentiate between risk indicators (features that indexed risks but did not themselves provide the risk) and risk mediators (features involved in the actual risk processes leading to mental disorders).

Thus, in the 1970s it became apparent that the main risk for antisocial behaviour associated with ‘broken homes’ was a function of family discord and conflict, rather than family break-up as such. Similarly, in the 1980s it was shown that the risks of depressive disorders in adult life were a function of impaired parenting, rather than parental loss. As part of this same issue, it came to be appreciated that distal risks needed to be differentiated from proximal risks.

Thus, poverty constituted a distal risk for child mental disorder because it made good parenting more difficult, but the proximal risk mediator involved family malfunction rather than lack of economic resources.

Second, Bell (1968) emphasised that children had effects on their parents, just as parents had effects on their children. The association between family features and child disorder could not simply be assumed to reflect adverse
socialisation practices; instead it might derive from the effects of a difficult child on family functioning. Longitudinal data were essential to determine the direction of the causal arrow. Third, twin and adoptee studies showed that, even though risks were due to an environmental feature, the risks might nevertheless be genetically mediated in part (Plomin & Bergeman, 1991) because, if the environmental feature concerned anything that was influenced by parental behaviour (as would be the case with variables such as family conflict, divorce or parent–child interaction), individual differences in such behaviour were likely to be genetically influenced to some extent. Study designs were needed that could differentiate between genetic and environmental mediation. Twin and adoptee strategies of various kinds provide just that possibility, and they have produced good evidence of the reality and importance of environmentally mediated risks for psychological and psychopathological outcomes (Rutter, 2004a).

However, they are by no means the only relevant designs; psychosocial researchers have also pioneered the use of ‘natural experiments’ of diverse kinds, their common feature being that they involved a radical change of environment, and a pulling apart of variables that ordinarily go together, the effects of which could be studied by measuring within-individual change investigated through the use of longitudinal data. By these means, environmentally mediated risks have been demonstrated for various aspects of the family rearing environment, and also for peer group, school and community influences. Four features of the research findings need to be
particularly highlighted. First, despite some claims to the contrary, environmental influences have been found to operate within the normal range, and not just in relation to extreme environments (although, for obvious reasons, the effects of the latter are greater). Second, environmental effects have been shown not only for influences in infancy, but also for influences in middle childhood (Duyme et al, 1999) and even in adult life (Laub et al, 1998). Third, the environmentally mediated risks include prenatal influences (such as maternal drug and alcohol use and severe maternal stress) and postnatal physical influences (such as brain injury and adolescents’ heavy early use of cannabis). The span of risk influences is substantially wider than has sometimes been assumed. Fourth, with all known environmental hazards (both physical and psychosocial) there is a huge individual variation in response (Rutter, 2004b): some individuals succumb; some appear remarkably resilient; and a few even seem strengthened as a result of having coped successfully with stress and adversity. It might be supposed that the individual differences merely reflect variations in the severity and number of risks involved, but experimental studies in both animals and humans have shown that this does not account for the phenomenon of resilience (despite the fact that some studies were flawed by a failure to assess the severity of risk satisfactorily, and/or by a failure to examine an adequate range of outcomes).

The features underlying the individual differences include strengthening (or weakening) experiences prior to risk exposure, protective influences
operating at the time of risk exposure, and recuperative positive turning-point experiences subsequent to the experience of risk. However, a key influence that has been highlighted by recent research (see Rutter, 2004a) is genetically influenced vulnerability to (or protection against) environmental risk.

1.2.8 Mental health During Old Age

Old age may be a problem both from physical and mental health points of view, but if the necessary precautions have already been taken in the past one is bound to be healthy both physically and mentally. In fact, one must prepare himself or herself for old age. The one who does it, always enjoys good physical and mental health. For preparing for old age, one must have some hobby in order to fill in his so-called vacant time in a creative or constructive manner. One must save enough for his old age in order that he may not have to depend upon others for his maintenance. His expectations must be very few, if any at all; otherwise he will have to undergo frustrations. He must remember that his children like to carry any additional burden. Then one must keep in mind that a may desist from looking after one parent. So one must prepare himself for old age in such a manner that he may not have to depend upon his children for anything. Yes, physical inability and some unexpected illness during old age are things which may be beyond one’s control. But an old person with good mental health faces even his physical disabilities and illness cheerfully. If proper care of physical health,
through balanced diet and reasonably adequate physical movements, is taken, one is likely to maintain his physical health up to the end and physical health is the root of mental health. The inevitable death to a normal, physically and mentally healthy individual will come one day silently as normal sleep comes to him. Thus the death, that is, his eternal sleep, will be quite peaceful and solace giving.

Many people, both men and women, ponder over the issue. How will they engage themselves after retirement from their service? Many retired persons are heard complaining that they do not know how to fill in their time. This appears to be the greatest problem before them. As a result, due to their inactivity, they suffer from many physical ailments which eat out their mental health also. It is neither appropriate nor possible to give here a prescription as to how an old person should live in order to ensure his mental health. Needless to add that the basic ideas hinted at above may stimulate any affected person to think and undertake the right course of action for ensuring his mental health during old age.

1.3 Adjustment

The concept of adjustment was originally borrowed from biology. It was modeled after the biological term adaptation, which refers to efforts by a species to adjust to charges in its environment. Just as field mouse has to adapt to an unusually brutal winter, a person has to adjust to changes in circumstances such as a new job, a financial setback or the loss of a loved one. Thus, adjustment refers to the psychological processes through which
people manage or cope with the demands and challenges of every day life (Weiten and Loyd, 2007)

Life is a constant process of adjustment in which the individual has to learn to give suitable responses to inner and outer stimuli. It involves a complex relationship between the individual’s needs, the opportunities the environment provides for satisfying those needs. It is the relationship between an individual’s needs and his environment.

Before understanding the adjustment as a process, it is necessary to examine some of the definitions of adjustment.

Adjustment is a continuous process in which a person varies his behavior 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 satisfaction of these needs (Shaffer, 1961)

According to Arkoff (1968), “Adjustment is the interaction between a person and his environment.”

Adjustment is the outcome of the individual’s efforts to deal with stress and meet his need (Coleman, 1969)

From these definitions it is clear that in every definition the needs are incorporated. One has to change one’s mode of behavior 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 environment and its influence on the individual on the other hand.

1.3.1 The Process of Human Adjustment

There are two points of view concerning the process of human adjustment. According to one point of view, an individual is personally responsible for his attitudes and behavior in all areas of his life relationship. Emphasis is placed on the individual’s ability to chart his course of action; he is “master of his fate.” Proponents of the other school of thought claim that an individual’s beliefs, attitudes, and general pattern of adjustment at any one time are determined to a great extent by the effects on his developing personality of his previous experiences and his present environmental influences. In either, human needs must be aroused and then satisfied. An individual’s degree of successful life adjustment probably is closely related to past experiences, environmental influences, and personal strengths. An individual possesses the power to select, and to apply to himself the environmental elements and the experiences that may seem to him to be best suited to satisfactory adjustment. At the same time, however, the operation in a person’s life of scientifically evolved principles of cause and effect cannot be disregarded.

1.3.2 Basic Principles of Adjustment

To the lay person, adjustment often represents a relatively vague belief that that to achieve a desired condition or situation will result in successful
adjustment. The trained person recognizes the fact that human beings of all ages constantly are in the process of adjusting to this or that condition or situation, or to interpersonal relationships. They recognize also that the form of the adjustment may or may not be conducive to the attainment of personal success or social welfare.

An individual’s adjustment is adequate, wholesome, or healthful to the extent that he has established a harmonious relationship between himself and the conditions, situations, and persons who comprise his physical and social environment. An individual who is unable to surmount obstacles in his path to achievement or who is rejected by the members of his group may become inadequately adjusted. Complete rejection or repeated failure to achieve is likely to be conducive to maladjustment.

An individual’s patterns of behavior and attitudes generally represent his adjustment status. However, one or another characteristic attitude or form of behavior may constitute a significant factor of adjustment. Satisfactory adjustment includes personal and social value standards. Among the criteria that encompass the important components of adjusted behavior are the possession of (1) a wholesome outlook on life, (2) a realistic perception of life, (3) emotional and social maturity, and (4) a good balance between the inner and outer forces that activate human behavior.

**1.3.3 Cause and Effect Relationship**

Scientifically interpreted, the term adjustment implies a cause and effect relationship. The study of human adjustment poses a problem, in that the
kind and degree of adjustment achieved by an individual usually are
dependent upon a multiplicity of causes.

Moreover, human nature is so complex that it is almost impossible to assert
didactically that any combination of causes is certain to have a specific effect
upon an individual’s behavioral pattern. The same environmental factor may
become the cause of stress or strain for one individual but have little or no
effect upon another person.

Human beings are alike in many ways, but they differ from one another in
physical constitution and health status, degree of mental alertness, and
emotional status. Temperamental differences show themselves in individual
likes and dislikes, compelling interests and ambitions and attitudes and
behavior toward other people. Yet, there is one thing that most individuals
have in common–the desire to become contented and well-adjusted men and
women.

1.3.4 Interaction and Adjustment

No one lives unto himself alone. As an individual engages in his daily
activities he constantly is interacting with other people: members of the
family, school or work associates, friends, and acquaintances. He also
responds to other environmental influences, such as climatic conditions and
other physical features of the environment. Many examples could be cited to
illustrate differing patterns of interaction. The “only” child’s adjustment to
family life is different from that of a person who has brothers and sisters.
The highly intelligent student develops a different form of adjustment to
schoolwork than that of the slow learner. The employer adjusts to his position of authority and the employee learns to accept the authority of his employer.

An individual is likely to adjust differently to friends of the same sex than to friends of the opposite sex. Age differences among the members of a group also affect adjustment patterns. Appropriate adjustments are made to life in a cold or a warm climate. Urban living demands one type of adjustment; rural living may lead to another form of personal adjustment.

As one attempts to adjust in his interaction with environmental elements he may either attempt to adapt to them or try to change them in light of his own interests and needs. One function of schooling is to help the developing young person adjust his behavior according to community-accepted standards of behavior. The child or adolescent attempts to adjust to interpersonal relationships in such ways as to find a respected place for himself in his various groups.

Hence, he is encouraged, for example, to consider the interests and needs of other persons as well as his own. Concerning the process of interaction, Lehner and Kube state: Some people believe that to adjust means to conform. But conformity is only one kind of adjustment, one kind of interaction; and the quality of adjustment it produces depends on circumstances. In choosing a career, for example, one young man may be content to conform to his parents’ wishes because these correspond to his own desires and abilities and because he has confidence in his parents’
judgment. To another, who finds himself in conflict with his parents and suppressed by their authority, conformity may mean a surrender, damaging his self-esteem and leaving him in a state of doubt about himself. Still a third may lack the abilities for the career his parents want him to enter, and conformity to their wishes might mean job failure.

Interaction between ourselves and our environment is an integral part of living. At the outset our environment involves principally the members of our families. As we interact with these people we unconsciously acquire from them certain methods of adjusting, methods which we modify to suit our needs. As we grow older we interact with larger groups of people and acquire additional methods for adjusting. During this process of interaction—and often without being aware of what we are doing—we experiment with methods we have observed in others and so evolve the behavior patterns that constitute our own individual pattern of adjustment (Lehner and Kube, 1964).

1.3.5 Continuity of the Adjustment process

Adjustment is a continuous process that tends to bring out more or less changing attitudes throughout the individual’s life. As he is stimulated by differing environmental stimuli, he is likely to respond to them with his accustomed adjustment habits.

However, to the extent that the new stimulus differs markedly from past experiences, attitudes take on new patterns. For example, if a person becomes a teacher his attitude toward learning activities changes considerably from what it may have been as a student.
A person may have developed one attitude toward a racial or national group as a result of his indirect experience in reading about them or hearing others discuss them, but the attitude may change if he comes into direct relationship with one or more members of the group.

A person who has spent much of his life in rural areas removed from the meeting of various types of groups usually finds his attitudes affected toward these new groups by his moving to an urban community in which they are found. During his entire lifetime, every human being is struggling toward the attainment of one or another goal: self-expression, self-realization, self-esteem, adventure, economic and social security, and the like. Overt behavior responses are the expressions of inner desires, urges, wants, interests, ambitions, and attitudes.

A person’s compulsion toward activity and its overt manifestation are influenced by the interests, ambitions, and attitudes of other persons. When an individual and the other members of his group are motivated by similar interests and ambitions, their cooperative activities tend to be productive of individual and group satisfaction and interadjustment.

### 1.3.6 Areas of Adjustment

At this point, only a brief reference is being made to some of the problems that are inherent in human relationships that are experienced by the developing person. Later in the book, these are taken up in greater detail. Adjustment is an active process that occurs as the individual lives in his family situation, advances educationally, pursues vocational outlets, and
engages in social relationship. His adjustment is helped as he acquires new experiences, accepts ideas and behavior with which he may not agree, conforms to the ways of the members of the group or to the mores of society, and strives to attain self-realization.

Life consists of many experiences that need to be interwoven or integrated from day to day. A normal adult probably is, or at some time in his life has been, motivated by the desire to marry, rear children, experience a happy home life, and earn success in a chosen vocation. In addition, he desires to enjoy the companionship of friends and associates of his choice, and to spend his leisure time in interesting and relaxing activities. He also strives to achieve a position of respect among his associates, to enjoy democratic rights, and to establish the foundation of an economically and socially secure old age.

Children, adolescents, and adults are faced with the problem of so ordering their attitudes and behavior that they achieve maximum success and satisfaction in their home, school, work, and social activities, without interfering with or limiting the group. Adjustment to environmental conditions and human interrelationships is a gradually developing process that begins early in childhood and continues throughout life. Moreover, and understanding of what constitutes good adjustment and a willingness to become a well-adjusted person probably can be achieved best through the study and application of the psychological principles that are basic to the development of healthful living and wholesome behavior.

[34]
1.3.7 Family Adjustment

The family is the basic unit of society. It is generally agreed that as the home is so will be the larger social group. The intimate relations that are inherent in home and family life may build up either closely knit loyalties or disrupting discords.

Bickering, faultfinding, resentments, display of extreme individualism, disregard for the rights of others, and shirking of responsibility in the home are more than likely to be carried over into other group relationships. Through the centuries the home has changed gradually from an independent autocracy dominated by the “head” of the family into a more or less loosely organized social unit.

Former rigid parental control of child behavior and more recent child self-assertion can find a meeting ground through a conscious effort to build the home upon a foundation of cooperative family interrelations that are aimed at the healthful development of every member of the family group.

1.3.8 Educational Adjustment

A young person’s degree of successful adjustment in his learning experiences is affected by many factors: the learner’s degree of mental ability; learning readiness; interests and ambitions; appropriateness of curricular offerings; teacher attitudes, and teaching techniques. Problems of adjustment arise in the school life of a young person when or if any one of these factors is inadequate to help him select and engage in the kind of
educational experiences that will prepare him for successful participation in his present and future life activities.

To provide proper financial support for education is the responsibility of the nation, state, and local community. The value of education as a means of improved educational adjustment is receiving increased recognition. Better educational facilities are made available for children and adolescents; educational opportunities are being extended to meet adult needs for continued schooling. Adequate financial aid is needed to provide extensive and intensive education. Yet money alone cannot solve all the educational problems of the school community. Educational leaders are faced with the problem of supplying the kind of education that will help young and older learners achieve success in their marital, family, occupational, and social adjustments.

A well-balanced, forward-looking educational program is essential to the development of individual and group adjustment to personal and social demands. The task of organizing and administering such a program is tremendous. Will individual communities be able to meet this responsibility? How much state aid will be needed? Should the federal government give financial assistance when or if a community cannot meet its educational obligations? Are taxpayers willing to support nursery schools and kindergartens? To what extent is the public responsible for maintaining junior colleges, colleges, universities, and special schools? What is to be the content of study? How extensive can be the equipment? What is to be the
maximum of educational preparation and of remuneration for teachers? How can community facilities and resources be utilized as learning aids? These are some of the educational problems that are closely related to educational adjustment.

1.3.9 Occupational Adjustment

Job adjustment is dependent upon job conditions, worker attitudes, and degree of efficiency. A worker’s chances to perform adequately on the job and to experience personal satisfaction in the work are conditioned by: vocational selection based upon personal interest in the work and ability to meet its demands; appropriate and adequate preparation; available job opportunities; healthful working conditions; intelligent and understanding supervision; pleasant coworker relationships, and adequate financial remuneration. Poor worker adjustment in any one of these areas may give rise to worker inefficiency, discontent, resentment, feelings of frustration, or seriously maladjusted behavior.

This is a critical period of occupational and economic adjustment. High cost of living has brought about disagreement concerning adequacy of remuneration. Technological changes are opening new occupation fields and closing others. Fear of economic insecurity interferes with the occupational adjustment of the worker; uncertainty as to the most effective ways in which human resources and occupational opportunities can be integrated constitutes a serious problem of management adjustment.
1.3.10 Social and Community Adjustment

Participation in organized or informal group activity is a test of an individual’s power to adjust his own attitudes and interests to the interests, needs, or rights of other people. His interest in community welfare and his cooperative attitude toward community projects are as important as is the exercise of similar interest and attitudes in home and work relationships. In all these associations a person experiences many problems of adjustment that become increasingly serious as group needs and interests change with change with changing conditions.

Community problems that demand intelligent leadership and citizen cooperation include safety regulations, recreational facilities, health protection, adequate housing, and efficient transportation. Community well-being is dependent not only upon the provision of these environmental conditions, but also upon the displayed attitude and the behavior of community members. Good individual or group adjustment can be hindered by frequent occurrences of asocial acts committed by some of the group members. Accounts of burglaries, muggings, assaults, reckless driving, heavy drinking, fights, and illicit sex relations are featured in the daily newspapers. Apprehension of offenders and prevention of antisocial behavior constitute important areas of community concern.
1.3.11 Old Age: Level of Adjustment and Attitudes Toward Aging.

According to Herman Feifel (1954):

- It is quite obvious, from the favorable positions accorded childhood, adolescence, and the early years of maturity as contrasted with the negative perspective held toward the later years of life, that both groups of patients generally view old age with a gloomy eye.

- The degree of mental disturbance in the patients has little seeming effect on their over-all saturnine attitude toward old age.

- In both the closed ward and open ward patients, there appears to be little association between the age of the patients and their outlook on aging. This agrees with the reported findings in the literature for “normal” groups. It is notable that both groups of patients, with mean ages in the 30’s, regard this age period to be most favorable for the aspects of “living a full life,” “meaningfulness of life,” “job satisfaction,” “activity in family affairs,” and “clubs and organizations”; also, that many of them felt that for those in this age period the most favorable years for aspects like “happiness,” “freedom from worry,” “health,” “ability to learn,” “friends,” and “ambition” have already passed by.

- The negative orientation of the patients to the older years of life is also consonant with the attitudes reported in the literature for various “normal” segments of the population. The conspicuous feature of this
finding is that so little difference can be attributed to mental illness per se, of either moderate or severe degree. It seems that attitudes toward old age, at least on the level tapped by the questionnaire method used in this study, are heavily determined by a widespread social attitude or ideology, rather than by idiosyncratic experiences. It is often said that our culture highly values youth and sees little to admire or look forward to in old age. The findings of this study give substance to these impressionistic statements by sociologists. They emphasize the extraordinary degree of uniformity in attitudes toward aging which is maintained, even in the most deviant members of the community, as far as their mental health is concerned.

- There should be little doubt concerning the need for an educational program to train people for adjustment to old age. It could have the broad aim of anticipating and preventing the anxieties and maladjustments attendant on growing old. We possess mounting evidence that age changes are not uniform and that distinct individual differences exist; not only are there well-established inter-individual variations, but intra-individual ones as well. In addition, data increasingly suggest that the manner in which the culture treats and reacts to aging, as well as the person's own concept of what it means to grow old, may be responsible for more psychological difficulties than the aging process per se. An honest reevaluation of our thinking concerning old age is called for.
1.3.12 Perceived Status of the Elderly in the Family:

According to kamla-Raj (2007)

In traditional society, family has been the most natural and conducive social organization for the care and support of the old aged person. The care and support to old aged person was provided by the family embers, especially the wife, sons, daughters, sons-in-law, and daughters-in-law. This care giving was backed not simply by the emotional bonds of relationship emerging out of blood relationship or marital relationship but by the force of pervasive influence of traditional values, norms, and behavior which were not simply practiced as a matter of routine but also deified. The care of the elders was the moral imperative which was considered not only material bliss but also spiritual salvation (Gore, 1992).

However, this traditional bond between the elders and the younger members of the family is gradually becoming weak in Nigeria. The physical deterioration due to chronologically advancing age makes a person aged. In this process of becoming old, there are both intrinsic as well as extrinsic changes in the individual. The intrinsic changes are those which take place within the functioning of body organs. The basic deprivation gradually crops up initially in the form of reduction in the physical strength and energy previously enjoyed by the aged in the youth and adult age (Russell, 2003; Thurston, 2001). The aged is, therefore, deprived of smartness, promptness, dynamism, and confidence, which were basic personality features of youth and adulthood. Further, the optimistic outlook of the aged gradually turns
into Pessimism. Extrinsic changes among the aged are the effects of disorganized social institutions, values and norms arising out of surrounding, social forces of urbanization, industrialization, modernization, and globalization (Ushasnee, 2004).

Hence, the disorganized society, family, and personality produce deprivations to the aged in the contemporary society. The greater longevity of the elderly demands care and support for a longer period and also entails high cost of medical and health care. The rising cost of living and shrinking income pattern often makes it difficult for the family to provide adequate care and support. Rising individualism and liberalism in the family have often boosted up the selfish and egoistic interest of the individual members of the family. The blame is not entirely on the part of family members, but problems of maladjustment and strains in the family occur because of the typical personality traits and behavior pattern of the elderly also. The cynicism and eccentricism of the last phase of life, the excessive egotism of the elderly and resistance to change and adaptability result into crisis situation in the family (Blau, 1984). Family care for the elderly is believed to be culturally determined and socially reinforced (Neysmith and Edward, 1984; Kalache, 1990; Sijuwade, 1991). The principle of seniority translates the cultural rules that children and other junior family members should care for older persons. In the changing context of Nigerian society, the problem of strains and adjustment of the elderly has achieved pivotal importance. The elders in the family manage to live in the changed context. The response and
behavior provided by the family members to elderly persons are crucial for understanding their problem.

1.3.13 Mental health and Adjustment

The concept of mental health is closely related to the concept of adjustment. We know that when an individual has satisfactory personality adjustment, he is also likely to have good mental health. In the above discussion, the significant relationship between adjustment and mental health has been emphasized. Coleman has given a list of such personality traits as are indicative of good adjustment and positive mental health. These are given below:-

- Attitudes toward self
- Perception of reality
- Integration
- Competencies
- Autonomy
- Self-actualization

1.4 Self-concept

Although we usually talk about the self-concept as a single entity, it is actually a multifaceted structure (Mischel and Morf, 2003). That is, the self-concept is an organized collection of beliefs about the self. These beliefs, also called self-schemas, are developed from past experience and are
concerned with one’s personality traits, abilities, physical features, values, goods and social roles (Campbell, Assanand and Dipaula, 2000). People have self-schemas on dimensions that are important to them, including both strengths and weaknesses.

Essentially, the self-concept is the overall image or awareness we have of ourselves. It includes all those perceptions of “I” and “me”, together with the feelings, beliefs and values associated with them. The self-concept provides us with our personal identity or sense who we are. Self-concept is not innate, it is developed or constructed by the individual through interaction with the environment and reflecting on that interaction.

Every individual exists in a constantly changing world of experience of which he is the center. It is his basic tendency and striving to know and understand himself as well as his environment. He reacts to his environment as he experiences and perceived it. Due to constant interactions with his environment, gradually the form of his ‘self’ is differentiated and developed. In this process, an integrated, organized and unique self-structure comes out. All his behavior is directed towards actualizing, preserving and enhancing this self-structure. That part of self-structure which the individual perceives as a set of specific and relatively stable self-characteristics formulates his self-concept.

Rogers (1951) defined self-concept as “an organized configuration of perceptions of the self which are admissible of awareness. It is composed of
such elements as the perceptions of one’s characteristics and abilities; the perception and concept of the self in relation to others and to the environment; the value qualities which are perceived as associated with experiences and objects; and goals and ideals which are perceived as having positive or negative valence.”

The notion ‘self’ received utmost importance in Client – centered therapy, the pioneer of which was Carl R. Rogers (1951). According to him the best vantage point for understanding behavior is from the internal frame of reference of the individual himself. Self-concept is the central construct of Roger’s theory. It may be conceived of as an organized gestalt comprising:

- The individual’s perception of himself and the values attached to them.
- The individual’s perception of himself in relation to other persons and the values attached to them.
- The individual’s perception of various aspects of the environment and the values attached to them.

Among the most influential works in stimulating research on self-concept was that of Combsand and Snygg (1959). They presented a method of predicting individual behaviour in specific situations, which assumed that an individual’s personal frame of reference is a crucial factor in his or her behaviour.
Figure 1.1: Diagrammatic Representation of the ‘self-structure’ by Combs and Snygg (1959).

In particular, they declared the ‘phenomenal field’ that part which the individual experiences as ‘characteristic of himself.’ All behaviour is directed towards the goal of preserving and enhancing the phenomenal-self. It includes the self-concept and those aspects of life which are not a part of the ‘real-self’ but are in some way related to it: one’s family, career, home, school, clothing and the like. The environment that the individual perceives or notices is termed as the ‘phenomenal environment’.

The self arises in the course of interaction in a pre-existing symbolic environment; it is the most significant product of early socialization. Mead (1934) says that “There is a social process out of which selves arise and within which further differentiation, evolution and organization take place. Discussion of the development of self must also include the views of Cooley (1902). According to Cooley, the self is any idea or system of ideas with
which is associated the appropriate attitude we call self-feeling. The self is the result of the individual’s imaginative processes and emotions as he or she interacts with others; it is reflected or ‘looking-glass self’ composed of three principal elements; “The imagination of our appearance to the other person; the imagination of his judgment of that appearance; and some sort of self-feeling such as pride” In simplest terms, according to Mead (1934), to have a self is to have the capacity to respond to, and direct one’s own behaviour. One can behave towards oneself as one can towards any other social object. One can evaluate, blame, encourage and despair about oneself; one can alter one’s behaviour. And in the process of observing, responding to, and directing one’s behaviour, one’s structure of attitudes towards self is changing. It is important to keep in mind that behaviour towards the self does not occur in a vacuum; one is behaving towards oneself in the context of interaction with others.

Self-concept is often described as a global entity; how people feel about themselves in general, but it has also been described as made up on multiple self-conceptions, with concepts developed in relation to different roles (Griffin, Chassin & Young, 1981; Burkitt, 1991; Rowan & Cooper, 1998). Thus self-concept may be generally and situationally specific. Strang (1957) has identified transitory or temporary self-concepts also, besides the overall basic self-concept. These ideas of self are influenced by the mood of the moment or by recent or continuing experience.

There are several different components of self-concept: physical, academic,
social and transpersonal. The physical aspect of self-concept relates to that which is concrete: what we look like, our sex, height, weight etc. what kind of clothes we wear, what kind of vehicle we drive what kind of home we live in and so forth. Our academic self-concept relates to how well we do in school or how well we learn. The social self-concept describes how we relate to other people and the transpersonal self-concept describes how we relate to the supernatural or unknowns. Smith (1960) talked of the real, the perceived and the ideal selves. Real self includes both what the person is aware of and what he is not aware of—it is perceived self plus the unconscious self. Perceived self is the way one perceives and describes oneself or what one may think about himself. The ideal self is the image a person has of the kind of person he would like to be. James (1890) proposed ‘social self’ as the recognition one gets from his peers. The social self is our awareness of the way others think of us and perceive us to be.

1.4.1 Negative and Positive Self-concept

The Negative Self-concept

The self-concept has three dimension: knowledge, evaluation, and expectations. What does the person with a negative self-concept know of himself? The answer is: very little. There appear to be two characteristic types of negative self-concept. In one the person’s view of himself is markedly disorganized: he has no sense of stable and integrated self. The second type of negative self-concept is almost the exact opposite of the first
type. Here the self-concept is too stable and too organized—in the other words, rigid. Possibly as a result of a loveless, excessively strict upbringing, the individual creates a self-image that allows for no deviation from the set of iron laws that in his mind constitute ‘respectability’. In both types of negative self-concept, new information about the self is bound to cause anxiety—that is, a sense of threat to the self.

As far self-evaluation, a negative self-concept by definition involves a negative judgment of the self whatever the person is, it is never good enough.

What does the person with a negative self-concept expect of himself? Either too little or too much (Rotter, 1954). In both instances, there is probably a self-fulfilling prophecy at work. In its extreme form, a negative self-concept is characterized by inaccurate knowledge of the self, unrealistic expectations, and low self-esteem.

The Positive Self-concept

The basis of the positive self-concept is not so much admiration of the self as it is acceptance of the self. What makes this self-acceptance possible is the fact that the person with a positive self-concept is not too rigid and too loose but it is stable and diversified. It contains a large number of different “personality pigeonholes” in which the person can store information about himself—negative information as well as positive (Chodorkoff, 1954). Thus the person with a positive self-concept can understand and accept a great deal of disparate information about himself / herself.
Since the positive self-concept is large enough to accommodate the entire range of the person’s mental experience, his evaluation of himself is positive; he is able to accept himself for what he is. And by accepting himself, he accepts other people as well.

As for expectations, the person with a positive self-concept sets goals that are appropriate and realistic. Thus, a positive self-concept is characterized by a broad and diversified knowledge of the self, realistic expectations and high self-esteem.

1.4.2 Factors Shaping the Self-concept

A variety of sources influence one’s self-concept. Chief among them are one’s own observation, feedback from others, and cultural values.

1) One’s own observation

Our observations of our own behaviour are obviously a major source of information about what we are like. Individuals begin observing their own behaviour and drawing conclusions about themselves early in life. Leon Festinger’s (1954) social comparison theory proposes that individuals compare themselves with others in order to assess their abilities and opinions. People compare themselves to others to determine how attractive they are, how they did on psychology examination, how their social skill stack up, and so forth.

Although Festinger’s original theory claimed that people engage in social comparison for the purpose of accurately assessing their abilities, research suggests that they also engage in social comparison to improve their skills.
and to maintain their self-image (Wood and Wilson, 2003) People’s observations of their own behaviour are not entirely objective. Self observations tend to be biased in a positive direction. In other words, most people tend to evaluate themselves in a more positive light than they really merit (Taylor and Proown, 1994)

2) Feedback from others

Our self-concept is shaped significantly by the feedback we get from important people in our life. Early on, parents and other family members play a dominant role. Studies find a link between parent’s views of a child and the child’s self-concept (Berne and Svary, 1993; Burhans and Dweck, 1995). There is even stronger evidence for a relationship between children’s perceptions of their parent’s attitudes toward them and their own self-views (Felson, 1989, 1992).

Teachers, classmates and friends also provide feedback during childhood. In later childhood and adolescence, parents and classmates are particularly important sources of feedback and support (Harter, 2003). Later in life, feedback from close friends and marriage partners assumes importance.

3) Cultural values

Self-concept is also shaped by cultural values. Among other things, the society in which individuals are reared defines what is desirable and undesirable in personality and behaviour.

For example, American culture puts a high premium on individuality, competitive success, strength and skill. When individuals meet cultural
expectations, they feel good about themselves and experience increases in self-esteem and vice-versa (Cross and Gore, 2003). Members of individualistic cultures usually have an independent view of the self, whereas those in collectivist cultures often have an interdependent view of the self (Weiten and Loyd, 2007). Cultural values are also responsible for various stereotypes that can mold people’s self-perceptions and behavior. And stereotypes about gender, ethnicity, class, caste, and religion can influence self-conception.

1.4.3 Self-Esteem: The Evaluative side of Self-concept

One of the functions of self-concept is to evaluate the self; the result of this self-evaluation is termed ‘self-esteem’. Self-esteem refers to one’s overall assessment of one’s worth as a person. It is a global self-evaluation that blends many specific evaluations about one’s adequacy as a student, an athlete, a worker, a spouse, a parent or whatever is personally relevant. Specific elements of the self-concept may contribute to self-esteem. If a person feels basically good about himself, he probably have high self-esteem.

Thus it represents how much a person likes, accepts and respects himself overall as a person; it includes the judgment we make about our worth and the feelings associated with those judgments. Knowing who you are and liking how you are represent two different things. Although adolescents become increasingly accurate in understanding who they are (their self-concept), this knowledge does guarantee that they like themselves (their
self-esteem) any better. The cognitive sophistication -increased accuracy in understanding themselves, allows them to differentiate various aspects of self-esteem, for eg an adolescent may have high self-esteem in terms of academic performance but lower self-esteem in terms of relationship with others (Feldman, 1977).

According to Rosenberg (1979), “a person with high self-esteem is fundamentally satisfied with the type of person he is, yet he may acknowledge his faults while hoping to overcome them”. High self-esteem implies a realistic evaluation of the self’s characteristics and competencies, coupled with attitude of self-acceptance and self-respect.

Self-esteem ranks among the most important aspects of children’s social cognitive development. Children’s evaluations of their own competencies affect their emotional experiences and future behaviour and similar situations as well as their long-term psychological adjustment. Self-esteem originates early in life, and its structure becomes increasingly elaborate over years (Stipek et al, 1992).

It has long been thought that individuals with low self-esteem hold strong negative views about themselves. In reality, it seems that the self-views of these individuals are not more negative, but more confused and tentative (Campbell, 1990). In other words, their self-concepts seem to be less clear, less complete, more self-contradictory and more susceptible to short-term fluctuations than the self-views of high self-esteem individuals.
1.4.4 Gender Differences in SWB and Self-concept

SWB can be defined as positive evaluation of one’s life associated with positive feelings. In gerontology, general SWB has most often been assessed with measures of life satisfaction, happiness, and self-esteem. Whereas self-esteem and life satisfaction measure cognitive evaluations of one’s self and one’s life, happiness generally represents the emotional component (Rosenberg 1979; Kozma, Stones, and McNeil 1991). Although all three aspects of SWB are positively correlated (Pinquart 1998), they tend to measure different aspects of well-being.

1.4.5 Reasons for Gender Differences in SWB and Self-concept

There are five reasons why older women’s SWB might be lower and their self-concept more negative compared with men. The first three reasons focus on women’s disadvantages with respect to different sources of SWB. Previous research has shown that social integration, good health, competence, and a high SES are important predictors of SWB and self-concept in old age (Pinquart and Sorensen 2000).

First, women’s disadvantage with regard to health resources occurs because their morbidity rates are higher (Jette 1996) and because women tend to require more care in later life than men (Hobbs and Damon 1996). Despite the striking gender difference in longevity, a large part of women’s additional years are spent with illness and disabilities. Katz and colleagues 1983
estimated that women at age 65 can expect to live with disabilities for an additional 6.9 years compared with men.
Second, older women are more likely to be widowed than older men. For example, among women 65 years and older, about 50% are widowed; this percentage is about three times as high as for men (Hobbs and Damon 1996). In the United States, nearly four times as many older women than men live alone (Arber and Ginn 1994).
Third, older women have, on average, lower material resources due to inequity experienced at an earlier age. As a result of gender segregation in the labor market and women’s less stable employment histories, women are less likely to be covered by pensions (Golombok and Fivush 1994). Their pensions are, on average, lower than men’s (Moen 1996), and they are more likely to live in poverty than older men, especially in very old age. In the United States, for example, older women are almost twice as likely as older men to have an income below the poverty threshold (Arber and Ginn 1991, Arber and Ginn 1994).
Fourth, gender-specific response sets may contribute to older women’s lower SWB. Some authors have argued that women may report lower SWB than men because they are more likely to disclose negative feelings (Phillips and Segal 1969). With regard to old age, however, there is almost no research on gender differences in self-disclosure that could test this assumption.
The fifth reason why women’s SWB might be lower has been suggested by Sontag 1972: With increasing age, women are considered less attractive and
are therefore less valued, whereas men may gain social prestige with age. This, in turn, may lead to lower SWB in older women. However, although empirical studies have revealed that older women are rated as less attractive than younger women (e.g., Kite, Deaux, and Miele 1991), there is not much evidence that older women are evaluated more negatively than older men. In some dimensions, women were even rated more positively compared with their male age-peers (see Sherman 1997, for review). In addition, negative stereotypes seem to have only limited influence on seniors' self-concept (Filipp and Mayer 1999). Thus, we conclude that the “double standard of aging” may not be the main cause of negative self-concepts and lower SWB in older women as compared with men.

1.4.6 Reasons Against Gender Differences in SWB and Self-concept

There are two reasons why women may not have lower SWB and more negative self-concept than men. First, research on the protection of a positive self-concept in older adults has shown a considerable resilience of the aging self (Brandtstadter, Wentura, and Greve 1993). Wills 1992, for example, suggested that social comparisons mediate between objective circumstances of life and SWB.

When older adults are compared with persons of the same sex, gender differences in health problems, disability, SES, and widowhood are irrelevant for the psychological outcomes of social comparisons.
In addition, discrepancies between aspirations and success have been suggested as an important source of SWB (Brandtstadter et al. 1993). Thus, lower aspirations in older women compared with men may reduce gender differences in SWB.

A second reason why men and women may not differ in SWB and self-concept is that they may have different sources of SWB and self-concept. Women’s identities may tend to be more strongly tied to social network events, whereas men’s identities may be more strongly tied to their careers (Golombok and Fivush 1994; Whitbourne and Powers 1994). One might infer from this that lower previous career success, educational attainment, and income and other disadvantages of older women may not result in lower SWB and a more negative self-concept in older women than men because women's SWB is primarily based on other sources, for example, having close relations to others. For example, French, Gekoski, and Knox 1995 showed that for women but not men, undesirable events are negatively related to SWB (life satisfaction, positive affect).

However, women may also be more responsive to positive events. For example, French and colleagues 1995 reported some evidence that for women, more than for men, positive life events buffer or counteract the impact of negative events.
1.4.7 Age and Cohort Differences in the Association Between Gender and SWB/Self-concept

There is empirical evidence that gender differences in masculine versus feminine self-descriptions peak in middle adulthood and decline thereafter (Palmore 1997; Puglisi and Jackson 1980), it is less clear whether gender differences in SWB and global dimensions of self-description change with increasing age. Larger gender differences in SWB may be present in older samples because, first, some of women’s disadvantages increase at higher ages, such as the higher risk of chronic illness (Steinhagen-Thiessen and Borchelt 1999) and the risk of being widowed (Moen 1996). Second, compared with older women, older men represent a positive selection of survivors whose less hardy counterparts have died off. Thus, in old-old people there may be a high percentage of men with high psychological resources (e.g., coping abilities; SWB) but also with social and economic resources. The awareness of survivorship may be an additional source of high SWB in older men.

It is well-known that gender differences in physical fitness, marital status, SES, and many aspects of lifestyle are lower among younger cohorts (Moen 1996; Palmore 1997). In addition, Kling and associates 1999 suggested that role changes brought by the women’s movement may have improved women’s self-esteem. Because (a) gender differences in health and SES may account for gender differences in SWB and self-concept and (b) these differences are smaller in more recent cohorts.
1.4.8 Self-esteem and Adjustment

The clearest advantages of self-esteem are the emotional sphere. Namely, self-esteem is strongly and consistently related to happiness. Individuals with low self-esteem and a self-blaming attributional style are definitely at a disadvantage so far as their adjustment is concerned. For one thing, they become more demoralized after a failure experience than those with high self-esteem do.

For them, failure contributes to depression and undermires their motivation to do better the next time. By contrast, individuals with high self-esteem persist longer in the face of failure. Second, individuals with low self-esteem often have negative expectations about their performance. There is a vicious circle of low self-esteem and poor performance Brehm and Kassin (1993). Low self-esteem is associated with low or negative expectation about performance.

These low expectation often result in inadequate preparation and high anxiety, which heighten the likelihood of poor performance. Unsuccessful performance triggers self-blame, which feed back to low self-esteem.

1.5 Rogerian Counselling

The most significant construct underpinning Rogers’ theory of personality is that each human being has an inherent, biological tendency toward growth and development. This tendency is located at the level of the organism as a whole and is seen as the single, basic motivational force driving each
human being toward the fulfillment of their unique potential (Merry, 1995). Rather than providing a pre-determined blueprint of what each person would become in ideal circumstances, as is often assumed (Bozarth and Brodley, 1991), the actualizing tendency is defined as (Rogers, 1961: pp. 351); a directional trend which is evident in all organic and human life –the urge to extend, expand, develop, mature, the tendency to express and activate all the capacities of the organism or the self. It is a trend toward greater differentiation and autonomy, self-regulation and control (Roger, 1961) in whatever circumstances that arise.

Roger’s theory of personality posited in congruence between organismic experiencing and the self-concept as the sole cause of all psychological disturbances. Following on from such a view, it is the reduction of incongruence that is associated with greater psychological well being and, as such, provides the rationale for a person-centred approach to psychological therapy.

Rogers’ believed that the success of therapy or counselling has less to with the techniques used be the therapist as with the relationship that the therapist develops with the client. If you develop the right sort of relationship, then that gives the client room to examine their own problems, sources of unhappiness and ways of seeing the world. They can then decide what they want to change and take the steps to change it. According to Rogers, the counselor must have three important qualities in their relationship with the client:
<table>
<thead>
<tr>
<th>Congruence</th>
<th>Honesty and genuineness. The therapist must relate to the client as one human being to another, not as a professional, like a doctor would.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>The client must be able to feel what the client feels because this is the only thing that will allow the client to feel as if they are genuinely understood.</td>
</tr>
<tr>
<td>Respect</td>
<td>The therapist must show acceptance and unconditional positive regard for the client, as the lack of this is usually at the root of the client’s unhappiness.</td>
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**Core conditions in Rogerian Counselling**

**1.5.1 Empathy**

Empathy is perhaps the most well-known of Rogers’ therapeutic conditions, and is certainly the one which attracted the most attention in the early stages of the approach (Raskin, 1948, patterson, 2000). The key characteristic of empathy is understanding another person’s subjective reality as she experiences it at any given moment. This requires an orientation toward the client’s ‘frame of reference’, a phenomenological term used to describe the particular issues, concerns and values that are relevant to that individual in that moment. It is thus an attitude through which the therapist strives to ‘enter the client’s private perceptual world and [become] thoroughly and home within it’ (Rogrs, 1980: p.142). In other words, empathy is the experience of trying to fully understand another person’s world.
In contrast to sympathy, which involves a sharing of outlook or experience, empathy requires a ‘bracketing’ (Cooper, 2004) or setting aside, by the practitioner, of his own experiences, attitudes and ideas, with a focus, instead, on trying to understand how another person is feeling and thinking. From a therapist’s point of view, an empathic attitude is a desire to understand a client’s perceptual world as if it was his or her own (Roger, 1995). The term ‘as if’ is important here, for it denotes that empathy is about deeply understanding a client’s experiences while at the same time not forgetting that they reside within the client (Mcmillan, 1997). This recognition allows a counselor to maintain the separation between his or her own experiences and those of another (Tolan, 2003), something which is of paramount importance to avoid confusion and misunderstanding.

### 1.5.2 Being empathic

The most common method of experiencing empathy is to listen to closely to what a client is saying, not only through words, but also through all forms of non-verbal and bodily communication. For Brodley (2001, p.18) the targets of empathic understanding are thus a ‘client’s perceptions, reactions, and feelings, and the ways in which the client as a self or person is an agency, an actor, and active force –a source of actions and reaction’.

Empathic understanding is only effective in person-centred terms if it is effectively communicated to a client, a process that ensures the client knows that the therapist understands how he feels as well as checks the extent to which the empathy expressed is accurate. There are a number of common
mechanisms employed within person-centred therapy to achieve this. Perhaps the most familiar of these is reflecting back or paraphrasing, a client’s personal experiencing (which can include, thoughts, feelings and, indeed, motivations for future actions; Bohart & Greenberg, 1997). In order to ensure accuracy, however, any kind of empathic statement has within it the implied question ‘is this how it is for you?’ (Barrett-Lennard, 1998). Indeed, Rogers steered away from the use of the term ‘reflection’ in relation to empathy, preferring instead phrases such ‘testing understanding’ or ‘checking perceptions’. These he argued, were more accurate descriptions of what was actually occurring in the moment by moment tracking of a client’s frame of reference at any given moment (Rogers, 1986).

Despite the emphasis on reflection, Bozarth (1984) has suggested the attitudinal basis of empathy within the person-centred framework allows for a far greater range of empathic responses than often acknowledged. He argues that the person-centred therapist should actively strive to develop what he terms an idiosyncratic modes of empathy which are (1984; p.75) ‘not standardized responses but idiosyncratic to the persons and interactions between the persons in therapy sessions.

Such modes are learned by therapists as they are allowed to affirm their personal power as therapists the equating of reflection with empathy has restricted the potency of therapists. The focus on empathy as a verbal clarification technique limits the intuitive functions of therapists’.

In suggesting the empathic attitude is idiosyncratic, Bozarth makes it clear
that therapists must learn to use their intuitive experiencing as part of the empathy process, and hence employ methods such as metaphors, similes, questions, silences and personal reflections to relate their understanding to the client.

Such methods, which may often be experienced as risky as they do not offer a certain outcome (Bozarth, 2001) and can evoke (Rice, 1974) an aspect of organismic experiencing not previously acknowledged. Indeed, for Cooper (2001) empathy is not simply a cognitive or affective process but also a bodily one involving physical sensations (such as feeling of nausea). Bodily sensations, when experienced by a therapist, may empathically resonate with a client’s own bodily experiencing at a particular moment in time. Thus providing an important vehicle for empathic understanding. Forms of physical posture and gesture that mimic, intentionally or otherwise, a client’s bodily presentation may also be considered as inherent elements of a truly empathic relationship. Indeed, Cooper argues that there is much evidence to indicate such a mimetic process is what he terms ‘an innate and instinctive human capability’ (p.224). For the therapist, therefore, the issue is less of how to develop embodied methods of empathizing and more how can such natural forms of relating be (2001: p.224) ‘allowed to emerge’ in the context of a therapeutic process.

1.5.3 The role of empathy in facilitating change

When situated within a person-centred therapeutic relationship, empathy is seen by some to play a curative role (Warner, 1996) in facilitating
psychological growth. For Rogers (1959), this role links primarily to the act of clarifying and checking (i.e. reflecting back), a process which encourages a client to enter more deeply into his or her personal experiencing. As the therapist attempts to understand the client’s inner world, her empathic responses serve to assist the client to contact (Warner, 1996) personal feelings, for example, to clarify the extent to which the therapist’s description maps onto an aspect of organismic experiencing previously denied or distorted. As a result of the process, the client moves deeper into what is felt at an organismic level, perhaps for the first time recognising or conceptualising a particular experience (e.g. fear) that was not previously acknowledged within the self (i.e. something that I, as a person, feel). In doing this, she is potentially able to integrate these new felt experiences into her view of who she is (i.e. her self-concept). This process relieves the tension or anxiety produced by the incongruence between self and organismic experience, thus facilitating psychological change.

1.5.4 Unconditional positive regard

Although empathy is seen by many as the primary, change-relate dimension of person-centred therapy, unconditional positive regard has also been proposed by some (e.g. Bozarth, 1998; Wilkins, 2000) as the fundamental element of the relationship specified by Rogers (1957). In contrast to the long history enjoyed by empathy as part of Rogers’ approach, the concept of unconditional positive regard did not emerge until the mid-late 1950s, having previously been referred to as acceptance, warmth, prizing and
respect (Bozath, 2002). Indeed, the terms are still often used interchangeably, although for some (e.g. Purton, 1998) the differences in meaning between them introduces a conceptual confusion regarding what each actually involves.

For the majority of person-centred practitioners, unconditional positive regard, along with the various terms equated with is, simply refers to the experiencing and offering of a consistently accepting, non-judgmental and valuing attitude toward a client (Lietaer, 1984). For Brazier (1993) this may best be considered as a form of non-possessive ‘love’, a warm acceptance of the client as he is in any given moment, not judging, instructing or neglecting. The term ‘unconditional’ is thus used to denote this quality -nothing is required of a client for her to be viewed in a positively regarding manner.

1.5.5 Offering unconditional positive Regards

Unconditional positive regard is perhaps the most challenging of all the conditions to meet and thus to offer. Indeed, in discussing how to experience and communicate it, the majority of training materials (e.g. Tolan, 2003) concentrate on what is no unconditional positive regard, rather than what it is! Despite this, offering unconditional positive regard often relies on listening and responding non-judgmentally to whatever a client is experiencing at a given moment.

Although this may imply a passive quality, unconditional positive regard is a more active, openly warm, valuing process. Indeed, Freier (2001) argues that
the term positive is used deliberately to indicate the warm nature of the experience, rather than a cold form of passive acceptance indicating ‘neutral passivity’. What this means, in practice, is that in offering unconditional positive regard, the counselor actively strives to warmly value the client in all aspects of his or her experiencing.

As Brodley and Schneider (2001: pp.156) suggest: Client-centred therapists consciously cultivate a capacity for unconditional acceptance towards clients regardless of the client’s values, desires and behaviours. The UPR capacity involves the ability to maintain a warm, caring, compassionate attitude and to experience those feelings toward a client regardless of their flaws, crimes of moral differences from oneself.

1.5.6 The role of unconditional positive regard in facilitating therapeutic change

Unconditional positive regard works, as part of the therapeutic relationship, by diminishing conditions of worth which are at the root of the incongruence between organismic experience and the self. As conditions of worth are acquired through a conditionally valuing relationship, unconditional positive regard is seen to stimulate the exact opposite, a climate of unconditional acceptance and warmth. It is the very unconditionality of this climate that promote growth, for it enables the processes of psychological defence to be reversed. This reversal is simply a product of the degree of threat presented by conditions of worth being gradually eroded by the presence of an
unconditionally warm and accepting other (Rogers, 1959)

The role of unconditional positive regard is enmeshed with the processes of empathy. In contacting denied or distorted organismic experiencing that is then unconditionally accepted and valued by a therapist who is empathically attuned, the client is able to feel fully accepted and thus develop a greater sense self-regard. As Lietaer suggests (2001: p. 105), unconditional positive regard thus produces ‘a high level of safety which helps unfreeze blocked areas of experience and to allow painful emotions in a climate of holding self-acceptance, self-empathy and self-love are fostered’. When these are empathically received, the client is able to re-configure his or her self-concept to encompass greater levels of organismic experiencing, thus reducing the incongruence at the root of her distress.

1.5.7 Congruence

Like unconditional positive regard, the concept of congruence emerged in the 1950s and was first introduced in Rogers’ personality theory (1951) to denote the state in which the self and organismic experiencing are aligned (i.e. the opposite of incongruence). It was subsequently identified as of relevance to therapy within Rogers’ (1957) theory of the necessary and sufficient conditions of therapy. Congruence, as part of these conditions, is formulated as a state of being required of the therapist within the counselling relationship (i.e. ‘the second person, whom we shall term the therapist, is congruent or integrated in the relationship’ Rogers, 1957). By contrast, the client within such a relationship is incongruent (‘the client, is in a state of
incongruence, being vulnerable or anxious’ (Rogers, 1957).

He thus defined congruence in therapy as meaning: that the therapist is his actual self during his encounter with his client. Without facade, he openly has the feelings and attitudes that are flowing in him at the moment. This involves self-awareness; that is, the therapist’s feelings are available to him -to his awareness -and he is able to live them, to experience them, in the relationship, and to communicate them if they persist. (Rogers, 1996: p.185) Congruence thus refers to the therapist’s capacity to be aware of the full extent of her own organismic experiencing (unlike the client who is still incongruent). Although the term congruence was used interchangeably with other adjectives such as authentic and genuine, Rogers regarded the requirement for the therapist to be attuned to actual self as the most fundamental of all the three core conditions (Rogers and Sanford, 1984). He saw no role for professional façade nor the impersonal relating often associated with a lack of self-development (or incongruence) on behalf of the therapist.

1.5.8 Being congruent

The condition of therapist congruence is the least understood of all the core conditions and been open to considerable misunderstanding and misinterpretation over the years (Wyutt, 2000). Although the meaning of congruence is not in doubt, being a state where a therapist is not subject to incongruence between self and organismic experiencing, there are a number of areas of debate surrounding what this actually involves in terms of
therapeutic practice. Perhaps the most controversial of these is the extent to which a therapist communicates his or her inner organismic experiencing (e.g. feelings of anger, or sadness) to her client. This controversy stems right back to the work of Rogers, who viewed the expression of genuine feeling as part and parcel of being congruent within a therapeutic relationship (Rogers, 1959). Yet, for Lietaer (1993), a therapist’s inner awareness of her ongoing experiencing must be differentiated from the outer expression of this experiencing. For him, these are two different things, and only when taken together represent the therapist’s genuineness (or congruence) in the relationship. From such a standpoint, the congruent practitioner must be aware of these different elements and attend to each within the therapeutic encounter.

1.5.9 The role of congruence in facilitating therapeutic change

For Rogers, congruence was the most important therapist condition due to the way that it underpins the experiencing of unconditional positive regard and empathy. Without congruent awareness of his own organismic experiencing, it is highly likely that a therapist’s own experiences in relation to a client will be influenced by his own incongruence, and thus conditions of worth. This will inhibit his experiencing and communication of both empathy and unconditional positive regard in wary such as, a) his failure to recognise (and thus empathise with) a personally denied emotion that is
being expressed by a client, b) his reaction (e.g. anger) to a client which is
distorted into another feeling (such as excitement), and c) his judgemental
feelings about aspects of a client’s experiences (such as racist assumptions)
due to his own conditions of worth regarding race.

The roles of empathy, unconditional positive regard and congruence are
entirely interlinked with in Roger’s counselling, each supporting the others
to invoke the climate of safety and understanding that is pivotal to reducing
client incongruence.

Despite the importance of core conditions in Rogerian counselling, it is also
important to remember that three further attributes were also specified by
Rogers (1957) as ‘necessary and sufficient’ for change to occur. They are (a)
psychological contact between counselor and client being established, (b) the
client being in congruent and experiencing anxiety or vulnerability and, (c)
the successful communication, event to a minimal degree, of the counsellor’s
empathy and unconditional positive regard.

Although these conditions are less concerned with the actions and attitudes
of the counsellor, they are instrumental between client and counsellor, and
these fore of paramount importance in the counseling work undertaken. They
are often termed the “relationship conditions” (Sandess and Wyatt, 2001),
because they refer to the minimal requirements any therapeutic relationship
must meet in order for psychological change to occur.

1.6 Group Counselling

Group Counselling is a form of counselling in which a small carefully
selected group of individuals meets regularly with a counselor. The purpose of group counselling is to assist each individual in emotional growth and personal problem solving. The noted Group Counselling offers multiple relationships to assist an individual in growth and problem solving. In group therapy sessions, members are encouraged to discuss the issues that brought them into therapy openly and honestly. The therapist works to create an atmosphere of trust and acceptance that encourages members to support one another.

In today’s world, there is an increase in the use of the process of Group Counselling in all sectors of the society which include schools, colleges, community mental health clinics and other human service agencies. Group Counselling mainly involves a small group of members who come together forming their own specific goals, share their problems, provide empathy and support to the others and also in turn try and change their self defeating behaviors. The group members are also assisted in developing their existing skills in dealing with interpersonal problems.

The noted psychiatrist Dr. Irvin D. Yalom in his book (1995). The Theory and Practice of Group Therapy identified 11 “curative factors” that are the “primary agents of change” in group therapy.

(1) Instillation of hope
All patients come into therapy hoping to decrease their suffering and improve their lives. Because each member in a therapy group is inevitably at a different point on the coping continuum and grows at a different rate,
watching others cope with and overcome similar problems successfully instills hope and inspiration. New members or those in despair may be particularly encouraged by others’ positive outcomes.

(2) Universality
A common feeling among group therapy members, especially when a group is just starting, is that of being isolated, unique, and apart from others. Many who enter group therapy have great difficulty sustaining interpersonal relationships, and feel unlikable and unlovable. Group therapy provides a powerful antidote to these feelings. For many, it may be the first time they feel understood and similar to others. Enormous relief often accompanies the recognition that they are not alone; this is a special benefit of group therapy.

(3) Information giving
An essential component of many therapy groups is increasing members’ knowledge and understanding of a common problem. Explicit instruction about the nature of their shared illness, such as bipolar disorders, depression, panic disorders, or bulimia, is often a key part of the therapy. Most patients leave the group far more knowledgeable about their specific condition than when they entered. This makes them increasingly able to help others with the same or similar problems.

(4) Altruism
Group therapy offers its members a unique opportunity: the chance to help others. Often patients with psychiatric problems believe they have very little
to offer others because they have needed so much help themselves; this can make them feel inadequate. The process of helping others is a powerful therapeutic tool that greatly enhances members’ self-esteem and feeling of self-worth.

(5) Corrective recapitulation of the primary family

Many people who enter group therapy had troubled family lives during their formative years. The group becomes a substitute family that resembles -and improves upon -the family of origin in significant ways. Like a family, a therapy group consists of a leader (or coleaders), an authority figure that evokes feelings similar to those felt toward parents. Other group members substitute for siblings, vying for attention and affection from the leader/parent, and forming subgroups and coalitions with other members. This recasting of the family of origin gives members a chance to correct dysfunctional interpersonal relationships in a way that can have a powerful therapeutic impact.

(6) Improved social skills

According to Yalom, social learning, or the development of basic social skills, is a therapeutic factor that occurs in all therapy groups. Some groups place considerable emphasis on improving social skills, for example, with adolescents preparing to leave a psychiatric hospital, or among bereaved or divorced members seeking to date again. Group members offer feedback to one another about the appropriateness of the others’ behavior. While this may be painful, the directness and honesty with which it is offered can
provide much-needed behavioral correction and thus improve relationships both within and outside the group.

(7) Imitative behavior
Research shows that therapists exert a powerful influence on the communication patterns of group members by modeling certain behaviors. For example, therapists model active listening, giving nonjudgmental feedback, and offering support. Over time, members pick up these behaviors and incorporate them. This earns them increasingly positive feedback from others, enhancing their self-esteem and emotional growth.

(8) Interpersonal learning
Human beings are social animals, born ready to connect. Our lives are characterized by intense and persistent relationships, and much of our self-esteem is developed via feedback and reflection from important others. Yet we all develop distortions in the way we see others, and these distortions can damage even our most important relationships. Therapy groups provide an opportunity for members to improve their ability to relate to others and live far more satisfying lives because of it.

(9) Group cohesiveness
Belonging, acceptance, and approval are among the most important and universal of human needs. Fitting in with our peers as children and adolescents, pledging a sorority or fraternity as young adults, and joining a church or other social group as adults all fulfill these basic human needs.
Many people with emotional problems, however, have not experienced success as group members. For them, group therapy may make them feel truly accepted and valued for the first time. This can be a powerful healing factor as individuals replace their feelings of isolation and separateness with a sense of belonging.

(10) Catharsis

Catharsis is a powerful emotional experience -the release of conscious or unconscious feelings -followed by a feeling of great relief. Catharsis is a factor in most therapies, including group therapy. It is a type of emotional learning, as opposed to intellectual understanding, that can lead to immediate and long-lasting change. While catharsis cannot be forced, a group environment provides ample opportunity for members to have these powerful experiences.

(11) Existential factors

Existential factors are certain realities of life including death, isolation, freedom, and meaninglessness. Becoming aware of these realities can lead to anxiety. The trust and openness that develops among members of a therapy group, however, permits exploration of these fundamental issues, and can help members develop an acceptance of difficult realities.

1.6.1 Role of the Group Counselor

The role of the group counselor involves facilitating interaction among the members, help them learn from one another, assist them in establishing
personal goals and also provide continuous empathy and support to the members and also to check if the members have carried their learning experience from the group and practiced it in the outside world.

1.6.2 Group Process Techniques for Counselling

According to Cassandra Scheidies. Group therapy aims to encourage personal development and help people work through potential or current problems, according to the website Group Psychotherapy. This type of therapy helps clients work through relationship problems, as the therapy itself requires that the client participate in relationships. A counselor who understands effective techniques provides an important element in the development of a therapy group. Six group therapy techniques encourage the group toward personal growth and wellness.

1.6.3 Active Listening

Active listening requires that whenever a group member shares, the other members listen appropriately and ask questions. This practice encourages open communication and allows each group member to feel safe in the environment. The group members should decide at the beginning of the group whether they will raise hands to ask questions or simply ask them outright.

1.6.4 Cutting Off

This technique allows the counselor to stop a conversation if it veers off the
topic. The counselor should decide when it will benefit the group to use this technique. If a group member veers off the topic but shares something of importance, it may not benefit the group to cut off the conversation. However, if a group member continually veers off onto a different topic, cutting off encourages the group's effectiveness.

**1.6.5 Eye Contact**

This group process technique should occur on the first day of the group session. The group members split into groups of two, then each member looks at her partner in the eyes for 30 seconds. After this, the group should rotate until each person partners with everyone in the group. Practicing eye contact helps build trust in the group setting.

**1.6.6 Dyads**

The dyad technique pairs members of the group together. One member plays the role of the counselor, and the other plays the role of the client. After 15 minutes, the roles reverse. This practice teaches members of the group empathy as they listen to their partner's problems.

**1.6.7 Leadership Role**

Each group member can take on the role of the leader in the group by offering advice or concern to another member. As the group progresses, clients begin to look to their peers for empathy rather than just the counselor.
According to the website Mental Help, this practice allows the clients to have a wide range of people helping in their problems.

1.6.8 End-of-Group Comments

At the end of each meeting, the group should spend five minutes discussing how the group session went. This technique allows group members to feel they participated in their own therapy. Each member should share feedback about the session. The counselors should take each comment into consideration to help improve the next group session.

1.6.9 Phases of Counselling

Phase 1: Establishing relationship

It is the core phase in the process of Counselling. It affects the progress of the process and acts as a curative agent in itself. It includes each factor as respect, trust, and a sense of psychological comfort.

Phase 2: Assessment

Individuals are encouraged to talk about their problems: counsellor asks questions, collects information, seeks his/her views, observes and possibly help the individual to clearly state his/her problem.

Phase 3: Setting Goals

The major purpose of this phase is to provide direction to the individual and Counsellor. It involves making commitments to set of conditions, a course of action, or an outcome. Setting goals helps us to know how well counselling is working and when counselling may be concluded.
Phase 4: Interventions

After setting the goals question is “how shall we accomplish these goals”? The intervention used will depend upon the approach used by the counsellor, the problem and the individual. Hence the choice of intervention is a process of adaptation and the counsellor should change the intervention when selected intervention is not working.

Phase 5: Termination

All counselling should have an ultimate criterion a successful termination. It must be done without destroying the accomplishments gained and should be done with sensitivity, intention and by fading.

1.6.10 The Basic Encounter Group

Carl Rogers coined the term, The Basic Encounter Group to identify encounter groups that operated on the principles of the person-centered approach.

The fundamental assumption of the person-centered approach in groups is that each individual has the capacity to allow her or his innate potential (inner healer, inner self) to develop in order to become personally empowered to move in a constructive (albeit idiosyncratic) direction for self and society. The facilitator perpetuates this growth process by embodying and communicating his/her attitudinal qualities to the group without presupposing what its members should do, be like, or become.

The role of facilitator in the person-centered group is that of creating an atmosphere in which members are enabled to discover their power and to
own inner sources of healing. The facilitator does not necessarily expect that any particular process will occur, nor will he or she attempt to accelerate any particular process. If there are ground rules for the facilitator, they can be stated as openness to surprise and to their own surrender to unity (Wood, 1982). The facilitator acts on the assumption that participants have the power within themselves to resolve their problems, heal themselves, and move in positive constructive directions.