CHAPTER 2
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2 THEORETICAL OVERVIEW

The present study seeks to investigate the correlates of adjustment in old age in relation to living arrangement. Before proceeding to the presentation of related research on the subject, it is quite relevant to outline the literature covering the concepts, definitions and theories concerning aging, adjustment and their related factors. This chapter provides not only the theoretical overview in detail but also an overall glance on the general background of the topic under consideration.

2.1 Aging: Concepts and Definitions

Aging represents a peculiar phenomenon in human life. Human beings proceed through a predictable course of biological development from infancy to old age and ultimate extinction. In his development, man is subjected to a complex variety of influences both internal and external that add up to the process called 'aging'. In general, aging refers to a sequence of changes across a life span (Eisdorfer and Cohen, 1980). Harris (1980) is of opinion that aging begins when growth and development stops. Anantharaman (1982) defines aging in terms of the regularities or events, which occupy significant position of the life span, resulting in difference between younger and older individuals in structure and function. However, aging as a developmental sequence is not simply a biological one; it is also a social process, a process involves growth.
and decline. Human beings do not age as specimens in laboratories but rather in complex ways that include social and psychological processes as much as biological ones (Riley and Bond, 1983). The literature on aging, in general, suggests biological or physiological, psychological and sociological approaches that could be utilised for the purpose of defining aging.

2.1.1 Biological Aging

In biological sense, aging means changes in structure and function of some organs and systems of the body during the entire life span. According to Handler (1960), “biological aging is a deterioration of a mature organism resulting from time dependent, essential irreversible changes intrinsic to all members of the species such that, with the passage of time they become increasingly unable to cope with the stresses of the environment, thereby increasing the probability of death”. In the field of biological gerontology, Weiss (1966) and Shock (1977) consider aging as the sum total of changes during an individual’s life span which are common to all members of his species. Some biological gerontologists consider aging as any time dependent change or a progressive loss of functional capacity after an organism has reached maturity (Rockstein, 1974; Busse and Blazer, 1980). This change, according to them, may be distinct from daily, seasonal and other biological rhythms.

Aging and senescence are often used interchangeably by some biological gerontologists. Comfort (1964) preferred the term ‘senescence’ instead of aging. According to him, “senescence is a change in the behaviour of the organism with age which leads to a decreased power of survival and
adjustment”. He describes aging as an increased ability to die, or an increasing loss of vigour, with increasing chronological age. Similar view is also shared by Handler (1960). Birren and Zarit (1985) present a comprehensive definition in relation with adaptive capacity of the individual in the aging phenomenon. They define biological aging or senescing “as the process of change in the organism, which over time lowers the probability of survival and reduces the physiological capacity for self regulation, repair and adaptation to the environment”. All these definitions pinpoint to the life-limiting phenomenon, or to the probability of dying and to the differentiation of behaviour that may occur concurrently with an increasing probability of dying. Moreover, the definitions also stress the impact of aging on the adaptive capacity of the individual.

With regard to Biological aging, Busse (1969) speaks of ‘primary’ and ‘secondary’ aging. Primary aging is the result of inherited biological process, which is time dependent and detrimental to the survival of organism. Secondary aging is caused by the decline of function due to chronic diseases or other damage to the organism. Primary aging, which refers to biochemical changes that accompany chronological aging, is considered to some extent to be genetically determined; whereas secondary aging is primary aging that has been accelerated due to stresses – emotional tension, physical trauma, disease or other insults to the body.

Biological age can be regarded as ones position in relation to his potential life span (Birren and Renner, 1977). Biological age in terms of old age, Gray and Moberg (1962) states that physiologically a person is old when the
signs of wearing out of the body appears. There is no one age when all the physical functions of a given individual begin to show a decline. Deterioration of various parts of the body proceeds at different rates and is generally so slow that it cannot be measured accurately at weekly, monthly or even annual intervals. Except for certain purpose, it is therefore not yet practicable to use physical criteria as the basis for determining whether or not an individual is old. Somewhat similar views are expressed by many researchers like Harrell (1969) and Gupta and Adarsh (1987). However, ‘no biological parameter has been detected which clearly indicates when an individual person has become old’ (Harrell, 1969). Biological age can be looked as related to chronological age. Chronological age refers to calendar-clock age. Chronological criterion of age takes into consideration the biological process of aging. However, it does not consider the individual differences in the performance of age associated functions.

2.1.2 Psychological Aging

Psychological aging deals with the evolution of adult behaviour over the life span, which includes capacities, skills, feelings, emotions and behaviour. Psychologists are concerned with the changes in personality and the external behaviour of the aging person. They deal with the behaviour that is the product of both the biological and social systems (Birren and Zarit, 1985). Birren and Renner (1980) have defined psychological aging as “the regular behavioural changes that occur in mature, genetically represented organisms living under representative environmental conditions as they advance in
chronological age. However, this definition overlooks the persons who deviate from the population norms, either in terms of disease or environmental conditions. Psychological aging comprises changes in self-regulatory process including cognition and personality (Birren and Zarit, 1985). Psychological aging, associated with old age, includes those related to learning, reasoning, recalling, reminiscing, memory, creativity, sense of humour, vocabulary, sensory motor functions and mental rigidity. Accordingly, psychological aging refers to changes that occur in the ability of the organism to adapt its capacities, such as sensation, perception, memory, learning, intellectual abilities, drives, motivation, to alterations in the social and physical environment and within the organism itself (Birren and Zarit, 1985). In short, it refers to personality changes occur as a part of the aging process. For example, as age advances there is a decline in the intellectual process and short-term memory (Botwinick, 1977) and certain intellectual ability (Ramamurti, 1988). As age advances there is also an increase in rigidity (Ramamurti, 1970).

Psychological age, therefore, is a system where maturity is measured in terms of capabilities, adjustment and knowledge. In this sense, psychological age measures the behavioural capacity of individuals to adapt to changing environmental demands (Birren and Cunningham, 1985). In psychological sense, old age begins when objectively observable cognitive and perceptual changes and subjective feelings of weakness set in. Psychological age gives primary importance to the adaptive capacities, i.e., how well an individual adapts to changing environmental pressures or demands in comparison with
the average of his group. Since psychological age involves a mental process, psychologists often use mental abilities, such as memory, intelligence, attitude, changing emotional reactions and behaviour as base for demarcating aged. Closely related to psychological age is the concept of ‘functional age’. Functional age refers to the individual level of capacities for behaving in a specific society compared to the others of the same age (Birren and Renner, 1977). Here again, Gray and Moberg (1962) discussed the feasibility of using psychological age as a practical basis for determining who is old because as they observe, “the problems of measurement have not yet been surmounted”.

### 2.1.3 Sociological Aging

Sociological aging comes under the purview of changes in social roles, status and habits in relation to one’s group or society. According to Tibbitts (1960), sociological aging is concerned with changes in the circumstances or situations of the individual as a member of the family, the community and society. The changes and events associated with time, include age grading and social attitudes and behaviour of society towards the individual, completion of parental and work roles, reduced income, restricted activity and mobility, loss of spouse, loss of authority, decrease in social contact, large increments of free time and relative absence of clearly defined social expectations. Positively, sociological aging can also designate the elevation of status in the family, a greater participation in the management of the affairs of the family, community and religion (Mahajan, 1987). It follows that when some roles are reduced, some other roles are intensified.
Social age is to be understood as a system of segregating people into different levels of maturation according to social factors. It refers to social habits and roles of an individual in relation to the expectation of his group and society (Birren, 1964). Social age is always related to age status system that leads to expectation of how an individual should behave in relation to others. Therefore, social age is an important factor in determining how individuals behave in relation to one another (Birren, 1964). According to socio-cultural viewpoint, a person is termed 'aged' when he distances himself from those roles and statuses which he was performing as an adult or when he is unable to carry out some important social functions (Havighurst, 1961). Thus, social age is based on social positions and roles. For example, the progression through family roles from being single to married and to widowhood, from parenthood through empty nest to grandparenthood, provides markers for the definition of the individual as young, middle aged, or old.

The above discussion on the perspectives of aging indicates that aging corresponds with change in role and status of individuals. Proponents of biological approach associate the change in role performance with the decline in physical health whereas psychologists consider it with the decline in mental health. Sociological or culturological approach associates it with the expected norms and values of a particular society. Each of these perspectives represents a particular perspective, none explaining aging completely (Birren and Zarit, 1985). Aging is thus a normal developmental process in which biological psychological and socio-cultural phenomena interact. This interrelationship of
biological, psychological and sociological aspects determines to a great extent the level of individual functioning, adjustment and quality of life at a given point. Hence there is a need to integrate the different perspectives for a comprehensive understanding of the problem of aging in general and adjustment of the elderly in particular. Although various markers indicate aging, people of all ages commonly use chronological markers as boundaries of age grades, including old age. Hence, aging, whether viewed as "controlled or random process, determined by genes, environment or accumulated trauma and pathology, affects a wide variety of biological, psychological and sociological processes, and all of these can be roughly indexed by chronological age (Costa et al., 1980). In short, chronological age finds a prominent place in human life cycle and therefore, gerontologists regarded it a standard criterion for demarcating the aged.

2.1.4 Aging as Old Age

Though we can look at aging as a process and developmental phenomenon, most of the social and behavioural researchers have identified it in terms of old age. In this connection, Neugarten (1977) observes, "... aging should be seen as one part of the continuous life cycle. It is shaped by the individuals past, his childhood, adolescence and adulthood. Like earlier periods in life, aging brings new situations and new problems. It calls for new adaptations". Therefore, some gerontologists believe that any definition of 'old person' should be used on a life cycle criterion rather than on chronological age (Atchley, 1985). When we consider age as only an index of events in the life
cycle of an individual which occur at different periods of time, old age can be defined as the cumulation of developmental events at particular points of time in the life of an individual (Bengtson, 1973). However, chronological age is certainly a basis for judgements about an individual's 'stage of life'. There have been numerous attempts to classify the 'ages of adulthood' on the basis of life time and social time (Ward, 1979). W. H. O. (1967) defined old age as the period of life when impairment of mental and physical function becomes increasingly manifest by comparison with earlier periods of life.

Culture plays a powerful role in defining old age. In fact biological and social factors shape cultural definitions of old age. Old age is culturally a relative term (Biswas, 1987) and its definition depends much on its use in a particular context (Guha Roy, 1991). Some cultures use different social attributes, such as grandparenthood or physical fitness to define old age. Regarding the definition of old age in India, cultural basis related to the family developmental cycle is of special significance. In the Indian context, traditionally one is often considered old when one's eldest son gets married. Thus cultural aspect has an important bearing on when one feels and perceived by others as old, and this is particularly true in the case of women (Sharma and Agarwal, 1996). Moreover, chronological age, physical changes in later years, the role shift to retirement from employment, empty-nest stage, grandparenthood, all seem to be taken as the criteria in defining old age in India. Indian culture prescribes certain celebrations to mark old age. For example, among a few communities of South India, particularly, the Brahmins of Karnataka, Tamil
Nadu and Kerala, a ceremony called 'shashtyabdapoorthy' is observed to celebrate the 60th birthday of an individual. The concept of 'aged', therefore, varies with sex and other socio-economic factors.

Though there are differing concepts about who are elderly, in 1980 the United Nations defined '60 years' as the age of transition of people to the elderly segment of the population (U.N, 1982). However, most often researchers used the chronological age as standard to define the aged. In India for census purpose (Sharma and Agarwal, 1996) as well as most of the researches (Jamuna, 1984; Barai, 1991; Joseph, 1991; Patil et al., 1991; Pinto and Prakash, 1991), 60 years is taken as the cut off point with some exceptions (Marulasiddaiah, 1969; Subramanian, 1989), where it is 55 years. In majority of the third world countries also, 60 years of age is chosen as the cut off point to designate the onset of old age (Tout, 1989; Veras and Murphy, 1991).

The aged population is sometimes categorised according to age group. Neugarten (1975) suggested that elderly is best thought of in terms of two groupings: young old (55 – 75 years) and old old (above 75 years). Burnside et al (1979) classified old age as young old (60 – 69), middle-old (70 – 79), old old (80 – 89) and very old (90+). Some gerontologists (Brody, 1980) distinguish between the young old (60 – 74 years), the middle old (75 – 84 years) and the old old (above 85 years). Botwinick (1984) classified the aged as young old (55 – 64) middle old (66 - 74) and very old (above 85). Some of the Indian researchers like Venkoba Rao (1992) have divided the geriatric population as young old (60 – 70 years) and old old (above 70 years). He has
stated that generally three fourth of Indian geriatric population is ‘young old’ and the rest ‘old old’

2.2 Theories of Aging

The study of aging is a multidisciplinary endeavour. Each discipline brings its own theories, models and concepts to explain aspects of aging. There are numerous theories of aging, each based on some aspect of the whole process. Strehler (1977) states that any theory of aging must meet the three criteria: (1) The aging phenomenon being considered must be evident universally in all members of a given species; (2) The process must be progressive over time; and (3) The process must be decremental in nature, leading ultimately to the failure of the organ or system.

2.2.1 Biological Theories of Aging

Biological theories explain physiologic process and structural alterations in living organisms that determine developmental changes, longevity and death. Though numerous theories of biologic aspects of aging have been formulated and tested, no theory has produced an effective explanation of the various aging processes (Kumar and Pra$od, 1996). Biological theories can be broadly classified into: 1) Genetic theories, and 2) Non genetic theories.

2.2.1.1 Genetic Theories

Ultimately all biological theories of aging have a genetic basis. The fundamental assumption is that the life span of any animal species is ultimately determined by a programme of information contained in the DNA molecules of
gene (Shock, 1977). The focus here is that various genetic mechanisms have been postulated to account for aging phenomena and the determination of life span, and these view aging as "programmed" (Burdman, 1986). It suggests that aging is a programmed process and each species shows a predictable pattern of changes in the body, as it grows older. The following are some of the well known genetic theories on aging.

**DNA damage theory (Cellular genetic theories)**

This theory deals with breaks in the chain of DNA molecule, which results in the inability of the cell to manufacture essential enzymes. This would result ultimately in the death of the cell. This declining of cells is a sign that senescence occurs at the cellular level (Hayflick, 1980).

**Somatic mutation theory**

The proponents of this theory hold that the aging of cells in the senescent human is the result of an accumulation of chromosomal aberrations, also known as 'somatic mutation' (Burdman, 1986). According to this theory, exposure to non-lethal doses of radiation substantially shortens life span. Therefore, exposure to radiation accelerates aging.

**Error theory**

The error theory suggests that aging and death are the results of errors in the synthesis of proteins. It explains aging in terms of alterations in information in DNA and RNA. Replication is subject to an increased number of errors, which lead to accumulation of molecules that are unable to support the
cell's metabolism (Natarajan, 1996). Random events can cause damage to the body cells. This damage accumulates over time, which results in the synthesis of the enzymes and finally results in the decrease in protein synthesis to the point of failure.

2.2.1.2 Non Genetic Theories

Non genetic theories presume that with passage of time, changes take place in molecules and structural elements of cells which impair their effectiveness (Shock, 1977). Some of the important non genetic theories are:

**Wear and Tear theory**

This theory is based on the assumption that living organisms behave like machines (Kimmel, 1980). According to this view, aging is the result of the gradual deterioration of the various organs necessary for life, aging is a programmed process, and that cells are continuously wearing out. The process is exacerbated by harmful effects of stress factors, both internal and external, imbedding the deleterious by-products of metabolism. Basic metabolic process of the cells produce waste products, such as ‘lipofuscin’ or ‘age pigment’, that accumulate till they reach a critical level and cause a decrease in functioning. The cumulative effects of such damage to the cell contents with age, combined with the increasing failure of cells to replace damaged components, cause cell death in increasing numbers in advanced age.
Accumulation theory

This theory which is also known as 'Clinker' theory views aging in terms of accumulation of damaging substances like lipofucin, histones and free radicals within the cells of various tissues of the body with advancing age (Burdman, 1986). It has been argued that the presence of these particles interferes with the normal functioning of tissues and ultimately results in cell death.

Free radical theory

Free radical theory focuses on the damaging effects of free radicals (Harman, 1968). The damaging effects of the formation of free radicals cause the death of cells and aging. Free radicals are highly unstable chemical fragments produced during normal metabolism. These fragments readily react with and may damage other molecules. Free radicals exist only for very brief periods, one second or even less and may also cause mutation of chromosomes, thereby damaging normal genetic mechanisms.

Cross linkage theory

This theory proposed by Bjorksten (1975) speculates that aging results from an accumulation of cross-links in proteins. The theory states that irreversible aging of proteins like collagen is responsible for the ultimate failure of tissues and organs. Formation of cross-links results in the well-known loss of elasticity with advancing age in many tissues of the body. Due to this, skin texture changes and results in reduced ability to stretch and flex.
Physiological theories

Physiological theories of aging explain aging either in terms of a breakdown in the performance of a ‘single organ system’ or in terms of impairments in ‘physiological control systems’. There are ‘single organ system hypotheses’ indicating the cardiovascular system, the thyroid gland, the gonade, the pituitary gland, sex glands, etc., as possible determinants of aging (Shock, 1977). Some of the theories that come under this category are:

Stress theory

Selye et al (1966) proposed that aging is due to the accumulation, over time, of the effects of stresses of living. The basic assumption of this theory is that there is always residual damage, which persists and accumulates.

Immunological theory

Immunological function regulates genetic control of longevity. Aging has a marked impact on the capabilities of the Immune System. The Immune System is designed to protect the living organisms both by generating antibodies, which react with foreign organisms, proteins, etc., and by the formation of special cells, which engulf and digest foreign cells and substances. Therefore, changes in immune functions include an increasing failure to react appropriately to foreign agents or organisms (non-self) and a tendency to react against the body’s own tissues (self). The antibodies produced by an aged immune system may be faulty. Thus two types of error may occur: 1) foreign elements are not identified, and 2) normal elements are identified as foreign
and destroyed. The auto-immune theory based on the second type of error of aging proposes that aging results from the development of antibodies which react with normal cells in the body and destroy them. The autoimmune theory proposes that in later years defects arise in immune system so that the production of antibodies is directed toward the body itself rather than towards foreign substances that invades it. Hence, 'programmed decline in immune system function is thought to lead to aging and death. With a reduction in the body's ability to fight infection and cancer or to repair DNA damage, the immune system decline may be one of the most important events in the aging process (Robb, 1989).

The 'physiological control system hypothesis' occupies an important place in the development of physiological theories. According to this theory, aging and death of an organism are due to the failure of adaptive mechanisms (Frolkis, 1966). As age advances, many control mechanisms become less effective. In organisms it is believed that, the primary control mechanisms operate either through the endocrine system or the nervous system. The theory holds that with advance in age, both these systems experience a breakdown or reduction in the effectiveness of their control in terms of overall psychological effects, thus affecting the behaviour and function of the organism.

**Homeostatic imbalance theory**

Comfort (1964) proposed that the efficiency of important homeostatic mechanisms that maintains vital physiologic balances in the organism is unique in the process of aging. It follows that aging is characteristically an increase in
homeostatic faults. Shock (1977) observed that self-regulating feedback mechanisms decrease in efficiency, as age advances, for maintaining homeostasis of the organism. In this connection, Kimmel (1980) stated that emotional stresses that normally accompany the aging process, such as loss of spouse, launching of children, retirement or environmental changes are more likely to affect the physical health of the aged. Homeostatic Imbalance theory of aging in relation to stress may be the most general theory of aging which provides the clearest link between physiological, social and psychological aspects of aging (Kimmel, 1980).

2.2.2 Social Theories of Aging

Social scientists have developed a number of theories relevant to aging and adjustment. The three major theoretical formulations that attempted to explain psychological adjustment to aging are: 1) Disengagement Theory, 2) Activity theory, and (3) Continuity theory.

Disengagement theory

The disengagement theory expounded by Cumming and Henry (1961) holds that aging is a process of inevitable mutual withdrawal of the aging individual and society from each other. It is a usual occurrence and this disengagement is necessary for successful aging. This process is natural because psychological ego detaches from the outside objects and the person turns inwards. Therefore, Cumming and Henry argue that disengagement is a developmental process inherent in aging and not just the result of external pressure. The Kansas City studies (Cumming and Henry, 1961) noted a
significant decline in social interaction, current role activity, age involvement in current roles and activity changes with increasing age. Aging individual moves from social interaction to a more individualised interaction since the life space of an individual decreases with age. Once started disengagement has a movement of its own. According to this theory, both the individual and the society are gratified by this normally satisfying disengagement process.

This empirically based and theoretically interpreted work of Cumming and Henry provoked interesting controversy (Maddox, 1970). Cumming (1975) herself described the theory as 'poorly operationalised' and 'largely untested'. Disengagement on the part of some individuals was empirically supported, but the statement about society was primarily speculative. The principle of universality is not supportable against cross-cultural evidence (Leaf, 1973). The theory disregards personality differences in predicting the level of social role activity and life satisfaction (Neugarten et al., 1968). The theory is also criticised on logical grounds (Hochschild, 1975). The nature of the theory itself provides an 'escape clause' and to measure disengagement invokes practical difficulties. Disengagement cannot be seen as a unitary process when in fact there are different types of disengagement, such as social disengagement and psychological disengagement, and one may occur without the other. The theory also does not take into consideration the cultural and socio-economic factors (Rose, 1965).
Activity theory

The roots of activity theory were traced to studies reported by Cavan et al (1949) and Havighurst and Albrecht (1953). A considerable revision of the theory was made by Lemon, Bengston and Peterson (1972). Palmore (1968), Busse (1969) and Atchley (1985) provided helpful discussions of the theory. The theory basically holds that successful aging and adjustment can be achieved by maintaining the activity patterns and values typical of middle age in old age. It maintains that majority of the normally aging persons will maintain fairly constant level of activity and the amount of activity will be influenced by past life styles and socio-economic factors rather than by some intrinsic inevitable process. Moreover, the relationship between the social system and personality system remains stable to a great extent as individual passes from the status of middle age to that of old age. Except for the inevitable physical changes, older people are the same as middle aged people with the essential psychological and social needs (Havighurst, 1968). The theory also stresses the replacement of roles in the form of active participation in family and other social groups when activity drops. It is necessary to maintain substantial levels of physical, mental and social activity for successful adjustment in aging. Hence, Kausler (1982) called this theory as ‘engagement theory’.

Activity theory is not free from criticism. The idealistic or unrealistic nature of the theory is criticised by Mehta (1987) and Coleman (1993). It is unrealistic to expect that all, but a small minority of people can maintain the level of activity despite the limitations imposed by biological changes. The
theory disregards personality and other changes associated with normal aging that may alter activity needs. The assumption regarding the replacement of roles and relationship is also criticised on the ground that it fails to consider vocational, professional and fraternal association of the middle age. These may not be readily replaced by gardening or craft activities (Gubrium, 1973). Moreover, activity can decline without affecting morale (Maddox, 1970). The theory ignores qualitative changes accompanying life events, such as retirement or widowhood. Finally, preparation for death is not considered in the theory. Despite these limitations, the activity theory provides promise for the role of active aging in the development of the community.

**Continuity theory**

Continuity theory, an alternative approach to both the disengagement and the activity theory is based on the premise that the various stages of the life cycle are characterised by a high degree of continuity. Atchely (1977) explains the theory as follows: An individual may tend to react to the aging process by maintaining consistency in his/her characteristics, traits and disposition which he/she has already developed in the early phases of his/her life cycle. The predisposition to act in a certain way is always subject to change or modifications due to an ongoing and sometimes complex form of interaction individuals have with others and with the environment during all the stages of life cycle. Though there is a tendency towards consistency, the theory claims that people may also change their reaction towards aging adapting to new situations. However, longitudinal studies using objective personality measures provide evidences in
support of consistent personality throughout adulthood (Costa and McCrae, 1978).

In applying continuity theory to the adjustment of the elderly, individual's personality, characteristics, socio-economic status, health and also societal characteristics, such as flexibility, restrictiveness, age grading and age stereotypes need to be taken into consideration (Robb, 1989). The theory does not see old age as a distinct period of life but as a continuation of some patterns or responses set earlier, particularly coping strategies of acting, thinking and feeling. Continuity is, therefore, positively related to successful aging. Continuity theory considers the common features of old age and allows individual variation. As against the above two theories, the decision regarding roles to be maintained or not is largely determined by the aging individual's past history and preferred style of life. The theory, therefore, is considered as one of the most promising theories in social gerontology (Holzberg, 1982).

The major criticism against continuity theory is: it considers multiple variables and the term continuity has been defined variously as stability, persistence, life style and personality. Therefore, as Fox (1981-82) observed, a careful and systematic testing at both conceptual and operational levels is required.

In the light of the above discussion, the disengagement theory can be compared with the 'Vanaprastha Ashram' - a life of detachment for those between 50-75 years in the Indian culture. This is followed by 'Sanyasa Ashram' - after 75 years a complete disengagement from worldly affairs and a
person is expected to study religious books living away from his family. Therefore, Manusmriti (1932) advocates a certain degree of voluntary detachment or disengagement as one enters into 'Vanaprastha Ashram' for good adjustment. However, lack of support for the theory of disengagement in Indian elderly was observed by Venkoba Rao and Madhavan (1982) and the validity of the ashramas was questioned by Paintal (1969), on the ground of metamorphic changes taking place on the traditional attitudes and values of life due to rapid socio-cultural changes. To the Indian situation, Venkoba Rao (1989) suggested a midway between disengagement and activity theories, a situation which is named as 'consultative status'. By this, he meant that the elderly are neither disengaged completely nor continue to be active as they used to be. Their advice is sought by the younger generation especially in traditional matters where the benefit of long experience would be advantageous.

**Other social theories**

Other less often mentioned theoretical formulations related to social theories are: socio-environmental theory (Gubrium, 1972); labelling theory (Bengtson, 1973), social reconstruction syndrome theory (Kuypers and Bengtson, 1973), modernisation perspective theory, intergenerational linkage theory, the world-we-have lost perspective theory (Robb, 1989); and Sub-culture theory, exchange theory, age stratification model theory, phenomenological theory (Dhillon, 1992).
2.2.3 Psychological Theories of Aging

Psychological theories of aging are often considered as the extension of personality and development theories into the middle and late life. Personality theories attempt to explain the contradiction reported in the disengagement theory and activity theory. Havighurst (1968), one of the major proponents of the personality theory asserts that it is not the level of activity but rather the 'personality types' that is the pivotable variable in determining life satisfaction. Different personality types need different levels of activity for high life satisfaction. Personality theories suggest that the study of personality in old age must consider the possible alteration in the physiological process of the elderly person and the interacting relationship that exists between the individual and his/her environment. Personality and development theories of aging are to a remarkable degree complicated by the fact that as humans pass through their life experiences they become increasingly different rather than similar (Busse and Blazer, 1980).

Neugarten et al (1968) has noted some areas of personality that do change with age. There is a gradual shift from an outward - external to a more inward – internal orientation. With age, adults appear to become increasingly concerned with thoughts, feelings and ideas. There are sex differences in certain personality traits in late life. Men are more affiliative and nurturant. In contrast women become more individualistic, egocentric and more aggressive. Increasing cautiousness or conservatism is often associated with advancing age. According to Botwinick (1966), cautiousness does increase with advancing
age, but the degree of cautiousness is influenced by the type of problem and by when it is placed in the life span. However, a study by Okun, Siegler, and George (1978) suggests that cautiousness is strictly not an age effect but a 'multidimensional construct'.

Life span development theories

Among the psychological theories life span development theories occupy a prominent place. The psychological model of ego development formulated by Erickson (1959) is probably the most well known example of life span development theory. Erickson proposes eight critical phases in human development. Five of the eight stages deal with childhood and adolescence; the entire adult life span is covered in three phases: intimacy vs isolation, generativity vs stagnation and integrity vs despair. The emphasis on the integrity of the life span is Erickson's lasting contribution and the one that is vital to an understanding of old age. The crucial task during this stage is to evaluate one's life and accomplishments and to affirm that one's life has been a meaningful adventure in history; this would be the sense of 'integrity'. The opposite is the sense of 'despair' and 'disgust' – an existential sense of total meaninglessness and a feeling that one's entire life was wasted or should have been different than it was. In order to understand people in late life, it is necessary to see them in the context of their whole life history with the problem both successfully and un成功fully resolved from earlier periods in life.

Peck (1955) made an elaboration on Erickson's theory on adult life stages. In old age, Peck sees the following three issues as central: (1) ego
differentiation vs work role pre-occupation, (2) body transcendence vs body pre-occupation, and (3) ego transcendence vs ego pre-occupation. Successful resolution of each issue involves adaptation.

Buhler (1968) proposed a self-fulfillment theory, which delineates five phases of life that correspond to the five biological phases or courses of life. The theory emphasizes the process of setting goals at different phases of one's life cycle. Goals become gradually established during the first two decades of life that ideally lead to self-fulfillment during the culmination period. Last phase, according to this theory, contains experiences of retrospective nature and considerations about the future, i.e., oncoming death and one's past life. There are critical self-evaluation or lack of it in terms of life long accomplishments. Failure and losses are unavoidable, but many individuals attain practical fulfillment. Satisfaction is obtained in one or two basic areas of life. Considering these factors, Buhler coined this theory which assumes that when the amount of frustration experienced is large, resignation often marks old age.

Kalish and Knudston (1976) recommended the extension of theory of attachment, common in child psychology, to a life time conceptual scheme for understanding relationships and involvement of older people. They argue that the theory of disengagement is not functional. Attachment is a relationship established and maintained by 'social bonds' and is distinguished from 'social contact'. Elderly people lose significant early objects of attachment. New attachments are often much weaker and frequently not mutual and therefore, not dependable. They also pinpoint that an appreciation and understanding of
attachments will provide a better approach to explaining the psychological changes in elderly people.

Levinson’s (1978) study attempted to examine the interrelationship between family career and individual development. He proposed a normative theory of life structure which consisted of a series of altering stable (structure building) and transitional (structure changing) phases. Beyond the age fifty Levinson's data fade. However, he acknowledges that individuals continue to develop and change in late middle age and old age, i.e., there will be a continuing sequence of structure building and structure changing periods.

Sahaie (1977-78) has advanced what he calls ‘a stage theory of adult cognitive development’. The theory proposes four cognitive stages, such as acquisitive (prior to adolescence), achieving (young adulthood), responsible and executive (middle age) and re-integrative (old age). Sahaie suggests that during the life span there is a transition from "what should I know" through "how should I use what I know" to "why I should know" phase of life.

The above discussion on theories of aging brings home the fact that numerous theories have been proposed to explain the mechanism of aging. All have inherent drawbacks and there is no evidence for a single foolproof mechanism of aging.

2.3 Aging in relation to Family Support

In recent years social network and social support have become increasingly important concepts in gero-psychology. Caplan (1974) defines
social support in terms of human attachment, which promotes mastery of emotions, offers guidance, provides feedback and validates identity. Cobb (1976) viewed it as information from others that one is loved, respected, esteemed and involved. Gottlieb (1981) explained the concept in terms of the elderly. It encompasses a whole range of care, support and services. According to him, social network is a set of people with whom an elderly maintains contact and has some form of bond. Bowling et al (1991) distinguished social network from social support and defined social support as the interactive process in which emotional, instrumental or financial aid is obtained from one’s social network. Considering the Indian elderly, Ramamurti and Jamuna (1991b) explained social support in terms of concern and assistance from the family, community and from other social institutions. With the support the elderly may feel that there are significant people who are concerned about them in times of crisis.

Support network to an elderly person is available from both the formal and informal sources. However, in India, like in other developing countries, only a limited formal support system exists (Sung, 1991). In general, family is the most significant support network of the elderly. Family support for the elderly is believed to be culturally determined and socially reinforced (Gangrade, 1989; Nayar, 1992). As in other third world countries, Indian culture emphasises the family support and care for the aged. There are a few theories concerning the informal support networks of the elderly. These theories highlight the importance and uniqueness of family as a support system of the elderly. The
'hierarchical compensatory model', proposed by Canter in 1979, postulates that there is an order of preference for the groups selected by the elderly for support. The key factor that determines who provides which form of support is the primacy of the relationship. This model assumes that among elderly people, kin are usually the first choice, followed by friends and other formal institutions. Another model, 'task specific model' emphasises both the nature of the task performed and features of the persons in the support network. This model highlights the uniqueness of primary groups (Litwak, 1985). According to this model, some persons are best suited than others for meeting specific tasks, rather than all tasks, as posited by the hierarchical compensation model. It regards family as the most appropriate group for providing extensive long-term emotional and instrumental support. Weiss (1974) proposed 'functional specificity of relationship model' which views relationships that emphasise task or need specialisation, but is less concerned with specifying which person will satisfy which need. However, the results of an empirical test of the functional specificity model indicated that, among elderly persons, spouse and children are the key source of aid and security, spouse is the primary source of intimacy while participation in a group is primarily a source of self esteem (Simmons, 1983-84). This model emphasises diversity of social network for the elderly.

The family as a system, along with its elder members, confronts major adaptational challenges in later life: stresses of widowhood, retirement, grandparenthood, illness, all require family support. As an informal support system for the aged, the family can serve as a resource by helping with their
instrumental needs (Wenger, 1984; Antonucci, 1990) and by providing emotional support (Antonucci, 1990). In general, research shows that family members are more likely to provide older adults with instrumental support than others, even friends, when the needs are significant and chronic (Litwak, 1985; Antonucci and Akiyama, 1995), and older adults even express a preference for support from kin over friends, neighbours or others (Travis, 1995). Sussman (1976) pointed out that family structures, through network linkage activities and interaction provide intimacy and human worth, both are requisites for the survival and quality of living of the aged. It also serves as a buffer between stress and physical and mental impairment (Harel, 1988). The absence of family members may limit access to support within some domains, especially in late life when overall network size is reduced (Carstensen and Lang, 1994). Hence comparing non-kin network and close family network, researchers underlined the multiplicity of roles, such as high level emotional involvement and a wide array of instrumental functions by the close family relationships (Litwak, 1985). Non-kin support is typically associated with more discrete functions, such as social companionship or instrumental exchange (Rook, 1990). It follows that old people without immediate family members require more social partners to obtain comparable levels of need satisfaction and adjustment.

Surveys of elderly people have documented that most frequently mentioned family supporters are spouse followed by adult children and siblings of the elderly (Shanas, 1979; Miller, 1981). Friends or neighbours are
mentioned less often by the elderly as a source of support (Bowling, 1984; Black, 1985; Stroller and Pugliesi, 1988). Adult children are typically the main providers of emotional support for their parents who are widowed (Lopata, 1973; Suitor et al., 1995). In discussing the importance of children in the social integration of the aged, Rosow (1967) points out that while neighbours and friends are important in the integration of old people, they cannot take the place of children and family. In Indian culture, elder care and support by and large continues to be the familial responsibility and it is normative experience for adult children (Jamuna, 1996). Primary network in India includes spouse, children and in-laws. Older members are not only the recipients of support from family members but also contributors of family wellbeing. Their active involvement in family relations, their network participation and their emotional closeness towards other members, and grand parenting for the well being of the family system are stressed by Robertson (1995).

The above discussion underscores the importance of immediate family members — spouse and children — for the support of the elderly. The nurturance and emotional support, which can be given by the immediate family, cannot be replaced by other agency. However, the traditional support system — family — of aged persons is experiencing a change. Hence the Vienna International Plan of Action laid great stress on creating conditions which enable the aged to live with their immediate family members or close relatives as long as possible (D’Souza, 1993).
2.4. Aging in relation to Family Relationship

Importance of family relationships and familial ties in the lives of old people are very much stressed in gerontological literature. Researchers suggest that satisfactory family relationships are salient in late adulthood. They are related to one's life satisfaction (Medley, 1976) and play a dominant role in identity preservation (Kamptner, 1990). There is abundant evidence that family ties have remained important for the elderly despite the changes in the family pattern.

A satisfying husband-wife relationship contributes to good adjustment and happiness in old age. Most of the western studies on marital relationships across the family life cycle indicated marital satisfaction as 'curvilinear', high among young couples, declining after the birth of the first child through the launching stage and then increasing during the post-parental stage (Burr, 1970; Rollins and Feldman, 1970; Glenn, 1975). Simultaneously, others (Blood and Wolf, 1960; Luckey, 1966) showed marital satisfaction either reaching a plateau or declining after the birth of the first child. An increase in marital satisfaction in later years was reported by many researchers (Anderson et al., 1983; Johnson, et al., 1986) and one study (Gilford, 1984) concluded that older couples experience a 'honeymoon phase' after retirement. Jamuna and Reddy (1993) also pictured the same phenomenon in the Indian context. According to them, when a man completes 60 years of age, the event is celebrated as 'second honeymoon'. This stage involves a rediscovery of each other and
reestablishment of an intimate abiding relationship. However, the issue of marital satisfaction in later life is hotly debated and remains unresolved.

Along with other intimacies like emotional, recreational or spiritual intimacies, sexual intimacy also guarantees marital quality and well being of the couple in later years. Marital adjustment and sexual adjustment are highly related in married couples (Maison, 1982; Pearlman and Abramson, 1982). Sexual intimacy can be a reality in old age and a person who has had an active and satisfactory sex life in early adult years is most likely to find it continuing in later years (Clinebell, 1966; Masters and Johnson, 1966). Though there is a decline in sexual potency and interest during the sixth or seventh decades of life (Verwoerdt, Pfeiffer and Wang, 1968; Pfeiffer et al, 1970) no particular stage of life or age can be seen as a cut off point for sexual enjoyment or response (Masters and Johnson, 1970). However, the relationship between marital satisfaction and sexual adjustment vary in relation to age, sex, health, socio-economic status, number of years married, retirement, religiosity, culture and so on. Kennedy (1978) quotes Butler and Lewis to substantiate the view: "... that for those who desire it, satisfactory sexual experience is an important contribution to the health and well being of older person. In later stages both partners, especially wives need reassurance and affirmation from their mates of their sexual desirability and attractions". In short, marital satisfaction that involves companionship, mutual caring and sexual intimacy are powerful determinants of both family life satisfaction as well as life satisfaction.
Another most frequently encountered observation in the literature of the family life of elderly is the important role of children in their lives. The quality of parent-child relationships assessed by variables, such as communication and affection, is positively related to parental psychological well-being in their aging process (Mancini and Blieszner, 1989). However, memories of family problems from earlier years can affect the quality of relationship between adult children and parents (Webster and Herozog, 1995). Recently the impact of satisfying interpersonal relationships and intergenerational interactions on adjustment of elderly is being recognised by the researchers. Parent child relations in later life are increasingly determined by factors such as basic trust, respect, shared values and beliefs and social class. There are gender, marital status and social class differences in patterns of family contacts in old age. It is well documented in the literature that women are likely to take responsibility to maintain contact within the family over the life cycle, a pattern which continues well into old age (Langford, 1962; Komarovsky, 1964; Adams, 1968; Hill et al., 1970; Johnson and Troll, 1992). Widowers establish more family contact than the married elderly (Field et al., 1993) and widows, particularly living alone, have more frequent contact with their children, most frequently with a daughter (Shanas et al., 1968; Britton and Britton, 1972). There is also social class differences in the pattern of family contact and support (Bayer and Woods, 1963; Adams, 1968, Shanas et al., 1968). In the Indian family set up, spouse, married or unmarried children and daughters-in-law are significant and salient in the lives of the elderly. But due to several reasons the interactions and relationship between
family members and the elderly may not be as satisfying; at least in some cases, the relationships may be strained (Vijayakumar, 1990). The relationship between mother-in-law and daughter-in-law is crucial in determining the satisfaction of the elderly. Jamuna and Reddy (1992) observed that the traditional stigma attached to mother-in-law - daughter-in-law relationship, often affects the care giving relationship negatively. Moreover, the level of interaction in the past and the personality of the mother-in-law are some other factors that determine the quality of relationships and care. Hence in a care giving relationship, the son-father and mother-in-law and daughter-in-law equations are forces that determine the quality of relationship and care that the old members receive in the family environment (Jamuna and Reddy, 1992).

The literature on sibling relationship and interaction in later life also stressed the importance of siblings in the mutual support and well-being of the elderly. Sister pairs are the most salient sibling relations in the lives of the elderly (Cicirelli, 1985; McGhee, 1985; Gold, 1989; Bedford, 1995). The emotional closeness and attachment with the siblings, particularly sisters as an emotional and instrumental support system contribute to well-being in old age (Brubaker, 1990; Scott, 1990). The literature documents diversity in sibling relationship. Cicirelli (1982) identified three kinds of sibling interactions: mutual apathy, exceptional closeness and enduring rivalry. Gold (1989) observed five sibling styles of relationships: intimate, congenial, loyal, apathetic and hostile. Sibling relationship provides companionship, emotional support, the possibility of resolving sibling rivalries, and the provisions to meet the realities in life.
However, the sibling relationships sustain only if there exists mutual acceptance and approval. Gender, socio-economic status and residential proximity account a lot in predicting positive sibling relationship.

The topic of 'grandparenthood' has also emerged as an important area of study in gerontology. Grandparenting enhances psychological well being to the extent that it provides opportunities for older people to serve as kin keepers in fostering family contact and as fronts of family history (Troll, 1983; Brubaker, 1990; Robertson, 1995). However, their well being diminishes if grandparenting interferes with their health and tasks (Minkler et al., 1994). Different styles of grandparenting were observed by researchers. Neugarten and Weinstein (1964) give the most interesting identification of grandparenting style based on elderly interactions with their grandchildren. They are: 1) formal, 2) fun seeker, 3) distant figure, 4) surrogate parent, and 5) reservoir of family wisdom. Doka and Meritz (1988) suggested three aspects of grandparenting role: 1) personal and family renewal, 2) diversion in their lives, and 3) a mark of longevity. It is also to be noted that satisfaction out of grandparenting depends on age of the parent and child (Johnson, 1985), health (Cherlin and Furstenberg, 1985), and gender (Santhosh, 1994; Thomas, 1986). Overall, grandmothers have been always willing to take care of their grandchildren.

To conclude, familial relationship and interactions are important determinants to the adjustment and well being of the aged. However, the mere existence of relationships and interactions do not indicate that older people are
aging well. More important are the quality and the amount of solidarity in relationships and the thoughts, feelings and behaviour involved in relationships.

2.5 Aging in relation to Living Arrangement

One of the most influential factors in the adjustment of the elderly is the environment in which they live. Living arrangement is one of the important environmental factors that affect the personal and social adjustments of the elderly. The current situation of the elderly can be identified from their living arrangements (Kumar Panda, 1998), and it should be treated as an important component of the general well-being of the elderly (Bali, 1996).

Any study regarding the living arrangements of the elderly in India originates from the assumption of declining joint family structure in the Indian society. In this context Kumar (1991) observed, "nuclear families are being formed today, particularly in urban areas thereby causing much more concern about the living arrangement and social and economic support to the aged persons"

The terms 'living arrangement', co-residence pattern' and 'residential arrangement' or 'residential pattern' are often used synonymously (Wall, 1989). Rajan et al (1995) presents the following parameters towards understanding the different kinds of living arrangements among the Indian elderly: 1) their (elderly) extend of co-residence assessed in terms of the average household size; 2) frequency of their headship and ownership of immovable property in households; 3) the type of co-residence whether with own children, spouse or
relatives; and 4) on whom they depend for survival in economic terms or otherwise.

Usually the living arrangement of elderly is understood in terms of the family type in which they live, the headship they enjoy and with whom they stay, the kind of relationship they keep with their kith and kin, and on the whole, the extent to which they adjust to the changing environment. Family type can be joint, nuclear, quasi-joint, loosely knit or post-parental (Morrison, 1959; Ramachandran et al., 1981; VenkobaRao, 1981).

The family structure and the living arrangements of the individuals change as they pass through different stages of their life cycle. In this respect the living arrangement of the elderly usually reflect his/her position in the life cycle or family life cycle (Hicks, 1988). According to Hurlock (1975), the patterns of living arrangement varies much more in old age than in middle age when the pattern is well standardised. She identified five patterns of living arrangement: 1) Married couple living alone, 2) Elderly living alone in house, 3) Two or more members living together (siblings), 4) A widow or widower living with a married child or grand children, and 5) An elderly person living in a home for the aged.

Though different patterns of living arrangement can be identified, mainly three patterns of living arrangement in the context of Indian family life cycle are noted in the aging phase: 1) Aging with family members, 2) Aging in the empty nest stage, and 3) Aging in the single stage after the death of the spouse (Cherian, 1990). In the Indian situation, unlike in the west, the empty

Elderly living in old age home, an idea borrowed from the west, is a recent phenomenon in India. Though in the West, it is a common need for the elderly to seek help in institutions, even such communities are seriously considering the ill effects of institutionalisation. (Lieberman, 1969) has outlined in detail the terrible living conditions and psychological deterioration associated with long-term or short-term residence in an institution. A few Indian studies also found feelings of loneliness, depression or mal-adjustment among the institutionalized elderly (Joseph, 1991; Dhillon and Poduval, 1992). Indian studies revealed that socioeconomic forces such as poverty (Nair, 1993), stage of living alone (Dave, 1989), absence of social network or lack of proper care (Dandekar, 1993; Shah, 1993); and family quarrels (Rajan et al., 1995) were some of the reasons for the elderly to move into the home for the aged. Certain studies project the elderly’s preference for institutionalisation only as a last resort (Broady, 1978; Mathew, 1993; Nair, 1993) or in extreme cases like living alone (Vijayakumar, 1996). However, investigation of Smith and Bengston (1979) mentions some of the positive side of institutionalisation.
The discussion on institutionalisation reveals the importance of ‘home’ or ‘familial’ environment in the lives of the elderly. The need for remaining in one’s own home becomes more important as one becomes older (Cooper, 1976). The importance of ‘home’ in the lives of the elderly is pictured as a positive environment for shaping and maintaining personal identity, self esteem and social relationships (Howell, 1983). Home is the most desirable of all prosthetic environments in facilitating adaptation (Rowles, 1980). It is the center of domesticity, a place of intimacy and sometimes a place of solitude (Peace, 1988; Sixsmith, 1990). Home is often related to the idea of a family (Peace, 1988).

In India home plays an important role in the lives of the elderly. The traditional family system in our culture encourages the elderly to live with the family. It has always been recognised that mental and physical health are perhaps better when the elderly live along with the family (Channabasavanna, 1987). Generally the pattern of living arrangement in India shows that an overwhelming majority of elderly are living within a family context (Goyal, 1989). In the West, particularly in the U.S.A, elderly living with adult children is not a preferred living arrangement (Sussman, 1976). They prefer to live independently as long as possible (Troll et al., 1979; Troll, 1997) and the majority of parent-child co-residence is in response to the child’s needs rather than parents needs (Aquilino, 1990). However, separate residence does not mean separation from families. The families of the old are, what Litwak (1960) called, ‘modified extended families’. Most elders and their children sustain
frequent contact, reciprocal emotional ties, and mutual support bonds in a pattern of living arrangement that characterise ‘intimacy at a distance’ (Rosenmayr and Kockeis, 1963; Troll, 1971; Bengston and Black, 1973). Although co-residence is not common in the West, adult children are more likely to co-reside with mothers if they are widowed or widows prefer to live with an adult child (Cooney, 1989; Crimmins and Ingegneri, 1990; Raley and Roan, 1996). Often children give more support to widowed parents than to married parents (Eggebeen, 1992). There are also studies that suggest the continued presence of unlaunched adult children creating difficulties for parent - child relationships (Clements and Axelson, 1985; Aldous, 1987).

Coming to the Indian situation, as stated in Chapter 1.1.2, elderly prefer to reside in a familial environment. Indian census data do not provide a systematic information about the living arrangement of the elderly. However, from the fragmentary evidence available from various surveys, it is evident that more than three quarters of the elderly population live with their children (Martin, 1988). Various studies show that the majority of the elderly reside with adult children (e.g. Venkoba Rao, 1987; D'Souza, 1989; Nair, 1993; Shabeen, 1994). Family residential arrangement is desired by majority of the aged in India (Nandal, Khatri and Kadian, 1987; Biswas, 1994; Kumar, 1997). Living with their male children is the most important type of living arrangement preferred by the elderly in India (Cain, 1985; Biswas, 1987; Rajan et al., 1995; Kumar Panda, 1998). In this context, it is to be noted that the living arrangement pattern observed in India is quite similar to the one observed in many other developing
countries. Elderly living with their children, particularly adult sons is a unique feature in countries, such as Korea (Choi, 1985); Malaysia, Philippines (Andrew et al., 1986); and China (Qu, 1984).

The above discussion makes it clear that the co-residence of elderly with children is of particular interest in India. They are emotionally attached to this kind of living arrangement. This preferred living arrangement depicts the typical characteristics of a partilineal society, i.e., cultural norm of living with sons.

2.6 Adjustment: Concepts, Definitions and Terminologies

The concept of 'adjustment' was originally termed as 'adaptation', a term employed by the biological scientists. Adaptation explains an organism survival to physical stress, i.e., its ability to adapt to the hazards of the physical world. The term adaptation has been, however, renamed as 'adjustment' by the psychologists, for psychological survival of the individual. Though apparently adjustment appears to be a simple concept it is in fact a very complex one. The study of adjustment raises many problems, from its definition to measurement as it is a multidimensional concept both in terms of definition and aetiology (Savage, 1970). Adjustment is a relative concept, relative to age, philosophy, ideology, culture and community. Therefore, one finds it difficult to arrive at certain consensus regarding the definition to the criteria of good or poor adjustment.

Adjustment has two important aspects, namely, the 'achievement' aspect and 'adjustment as a process'. Achievement aspect involves 'success' in
adjustment, while adjustment as 'a process' deals with the modes and ways of adjusting to various demands (Lazarus, 1976). The former permits us to turn to such questions as how unsatisfactory adjustment can be prevented, or how it can be improved. Failure in adjustment leads to various forms of abnormal, neurotic and psychotic behaviour. On the other hand, the later deals with the genesis of the characteristic way in which a person copes with the life situation (Lazarus, 1976). The individual has to adjust continuously to maintain homeostasis with physical, social, psychological and environmental changes and one has to keep on adapting to the changed circumstances to maintain homeostasis. Hence, adjustment is a process leading to cause and effect (Lehner and Kube, 1964). The adjustment is made either by adapting to or altering environment. The process of adjustment involves a constant interaction between the individual and the environment, each modifying the other.

Definitions

Adjustment can be simply defined as a satisfactory interaction of a person with his environment. The environment may be threefold: the physical, the social and the self. According to Kuhlen (1959), adjustment may mean both a process and a state of the organism. It refers to how the individual satisfies his biological, social and psychic needs. Thorpe (1948) is of the opinion that adjustment refers to the satisfactory relationship of the organism to its environment and such a relation is obtained when its basic three needs, namely, physical well-being, security and personal worth are satisfied. Besides the demand of one's basic needs, society also demands a particular mode of
behaviour from members. Therefore, adjustment also needs one's conformity to the requirement of one's culture and society. In this way, Pollack (1948) defined adjustment as the efforts of an individual to satisfy his personal needs as well as to live up to the expectation of others. Adjustment, therefore, deals with an effective adaptation to the environment both external and internal, including conformity to group norms, moral deeds, values and so on. Adjustment is experienced when one feels that his needs have been fulfilled and his behaviour conforms to the requirements of a given culture. As long as one is aware of his environment and continuously and satisfactorily relating himself to it, he is making adjustment. 'Maladjustment' on the other hand, can be defined as behaviour, which does not completely satisfy the individual and social needs of the person, even though it may reduce his drive tensions. (Cavan et al., 1949)

**Different terms related to adjustment**

In the literature on aging, the concept of adjustment is usually used interchangeably with terms, such as successive aging, morale, life satisfaction, emotional or psychological well-being (Paintal, 1969; Bowling et al., 1991, Coleman, 1993). An operational definition of life satisfaction is forwarded to refer to the psychological well-being of the aged individual. Adjustment is found to be an indirect measure of life satisfaction or vice versa (Ramamurti, 1978). Life satisfaction reflects as to how adjusted an individual is or how he is aging successfully. More specifically it reflects the physical, social, emotional and financial adjustments. (Chadha, 1996). A well-adjusted elderly person
expresses higher level of life satisfaction (Ramamurti, 1978). Therefore, good adjustment is related to a feeling of satisfaction with own life, and it is a major marker of successful aging (Ramamurti and Jumuna, 1993a). Similarly, a feeling of satisfaction with the past life is a significant ingredient of general sense of well being (Neugarten, 1972). Successful aging means, being able to cope with physical and emotional stresses of aging, being able to exert some control over one's life, being able to stay connected to one's family and friends, and to see one's life as meaningful (Solomon and Paterson, 1994). The concept of successful aging has been equated with life satisfaction and morale (Havighurst, 1961; Williams and Writh, 1965; Coleman, 1993), sometimes with survival (Longevity) or good health (Ramamurti et al., 1996) and with adjustment (Maddox, 1970; Lissitz, 1970; Ramamurti and Jamuna, 1993a; Mishra 1996). Morale is the emotional component of life satisfaction. It may be defined as a reflection of an individual’s feelings about past, present and future (Chown, 1977). In this sense, it becomes synonymous with the degree of satisfaction with life. Acquiring and maintaining high morale reflects good adjustment. The behaviour reflecting unsuccessful aging necessarily depends upon one's model of adaptation in old age (Maddox, 1970). Thus, a comprehensive definition of adjustment to aging or successful aging would combine all the elements: survival, health, life-satisfaction, well being and morale.
2.7 Adjustment in relation to Aging

Adjustment and mental well-being are overriding concerns of gerontology. The term adjustment in gerontological literature tantamount to internal and external equilibrium of human beings. Burgess (1960) speaks of two aspects of adjustment in old age: personal and social. The existence of inner harmony is personal adjustment and a harmony with the world around us is social adjustment. The problem in the science of gerontology is to understand these harmonies, to describe them objectively, to measure them if possible, and to find how they are related to others and to other aspects of human life (Havighurst, 1961). Personal adjustment to aging may be defined as the re-structuring of attitudes and behaviour to enable the person to respond to a new situation to achieve integrated expressions and demands of society (Caven et al., 1949). Social adjustment is related to adaptation of the individual in the context of social change. Personal adjustment finds its context in social adjustment.

Havighurst (1950) defined adjustment in old age in terms of: 1) the quantity of interpersonal relationships, 2) the gradual tapering off interpersonal relationships as aging progresses, 3) a degree of congruence between interpersonal relationships and current personal vigour, 4) a retention of basic family ties and 5) the ability to recover from stress and illness with due speed. This definition is mostly centred on interpersonal relationship, particularly family ties.

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

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

Aging entails increased exposure to losses. Adaptation to losses becomes a principal task of the later stages of life (Pfeiffer, 1977). There is a risk for different types of losses for the elderly, a situation that has led various authors to refer to old age as 'a season of loss' (Pfeiffer, 1976). The older people experience a loss in their level of income, a loss in their friends, a loss in their feelings or activity and productivity within the society, a loss in their roles, loss of identity, loss of power, loss of independence and so on. Hence the need for the 'integration of loss' is an important adjustment task of the aged.
Health status affects the emotional and social well-being of the elderly. Chronic health problems make the aged socially isolated and dependent. Ill-health may lead to decreased mobility and increased feelings of helplessness and uselessness. Williams (1987) made it clear that physical disability in the aged may lead to emotional stress, which may result in the manifestation of anxiety with agitation, restlessness, hopelessness and even depression. It may also alter one's self-image. Increased dependency leads to a downward spiral of decreasing self-esteem: as a person becomes increasingly dependent, he begins to feel guilty, guilt leads to withdrawal and withdrawal further results in dependency (Creen and Simmons, 1977). In the situation of the aged being alone or in the post parental stage, the absence of family or other support increases the burden of health problems and the management of household chores or taking up major responsibilities becomes very crucial (Cherian, 1990). Hence adjusting to failing health is an important task of the aged in general and the aged in the empty nest stage or being alone in particular.

Emotional and mental well-being are important determinants of the adjustment of the aged. Important psychological changes that occur in aging are due to steady decline in the speed of mental activity, decrease of memory power, gradual loss in the area of learning and cognitive functioning and an increased rigidity (Ramamurti, 1970; Ramamurti and Jamuna, 1993a). Anxiety and loneliness are the most important emotional reactions of the aged. Soodan (1975) lists the following reasons for anxiety among the aged: economic
distress, health problems, gradual disappearance of near and dear ones, major liabilities remaining unfulfilled and fear that life will become a burden on others.

Harkin (1978) observed that the empty nest stage is more problematic and critical for the elderly parents. Widowhood, the major source of social isolation, is yet another crucial stage for the elderly. Widowhood has been conceptualised as a 'role-less role' and as a negative evaluated category where the individual loses the control source of identity, financial support and social relationship (Hiltz, 1981). Widowhood, in general, results in social isolation and loneliness (Lopata, 1973; Kiveh, 1978; Bowling and Cartwright, 1982); guilt and anger (Glick et al., 1974) and increased probability of physical and emotional illness (Fenwick and Barresi, 1981; Ferraro, 1985). Lieberman and Borman (1981) made a distinction between the early crises of 'bereavement stage' where adjustments are made and identities are formed. They reported that the 'crisis stage' can last for two years or even much longer. The 'transition stage' can last an additional year or more.

The aged living with the family may also experience intergenerational gap, interactional stresses and strains, conflict with in-laws (mother in law – daughter in law conflict) (Ramamurti, 1995), and increased dependency on children (Sunanda and Ushasree, 1987). Ramamurti (1995) categorises the problems in relation to adjustment of the aged as: 1) physical fitness and health problems, 2) financial problems, 3) psychological problems, and 4) problems of interaction in a social – familial setting.
2.7.1 Adjustment (Developmental) Tasks of Old Age.

Human development proceeds by stages. Every cultural group expects its members to master certain essential skills and acquire certain approved patterns of behaviour at various stages during the life span. Havighurst (1972) labelled them as 'developmental tasks'. According to him, developmental task is “a task which arises at or about certain periods in the life of an individual, successful achievement of which leads to happiness and to success with later tasks, while failure leads to unhappiness and difficulty with greater tasks”. The developmental tasks are to be understood in terms of adjustment tasks. Havighurst proposed the developmental tasks of an aging person as: 1) adjusting to decreasing physical strength and health, 2) adjusting to retirement and reduced income, 3) adjusting to the death of a spouse, 4) establishing an explicit affiliation with one's age group, 5) adopting and adapting social roles in a flexible way, and 5) establishing satisfactory physical living arrangements. Adjustment has to be made in the context where various changes take place in the aging individual physically, socially, emotionally, mentally, financially and spiritually. Stressing the importance of the needs accompanied by these changes, Singh et al (1987) discussed the following adaptive tasks for the elderly: 1) the aged must come to terms with the physical limitations that are inherent in their stage of life, 2) the older person must define the scope of his/her activities, 3) the older person must find new sources for satisfying his/her needs, 4) the aged must reassess the criteria for self-
evaluation, and 5) the aged faces the task of finding ways for their lives to have meaning and purpose.

Creen and Simmons (1977) identified integration of life and positive approach to death as the spiritual task of the elderly. Ego integrity is the growth task of old age according to Erikson (1959). In its developmental sense integrity means a sense of coherence and wholeness. Ego integrity is that in which a person finds his/her past life meaningful and affirms his/her life in its totality. The absence of integrity may lead a person to feel pity of him/herself and contempt for others and in turn lead him/her to despair. In the Indian context, particularly in Hindu terms, integrity is seen as the acceptance of one's 'sarvadharma' and there is an awareness of its counterpart, 'despair' (Kakar, 1979). In Sanyasa Asrama, the individual directs his mind towards the final liberation in order to obtain external happiness (Bhargava, 1989). Likewise, the final stage in old age is also devoted to the attainment of wisdom, integrity and to find meaning in life. In a sense it is the final preparation for the life beyond, i.e., eternal life, which is to be realised in this life itself according to the Bible. Thus the developmental task of the aged in the midst of physical, emotional and spiritual problems is that of achieving a sense of integrity by finding meaning in life.

Concurrently with the need to accomplish the individual developmental tasks, each couple, in the later stages of family life cycle need to achieve some marital developmental tasks. Quoting Carter, Erikson, Solomon and Rhodes,
Wolinsky (1986) summarises following marital developmental tasks in later stage of family life cycle.

1. The need to redefine intimacy and interactional patterns as the couple spend more time together and as physical space and roles are violated.

2. With the advent of retirement, a redefining of roles within the marital dyad, the extended family, and society, which provides a sense of meaning and productivity.

3. Setting new goals that are appropriate and attainable.

4. Validation of all stages of the marriage.

5. The capacity to live together as a couple (appropriate attachments) for as long as time and health permit without being unduly concerned about the illness or death of either spouse in the future.

6. The capacity to mourn self-losses, spouse losses and marriage losses while maintaining a meaningful relationship.

7. The capacity to nurture in new and creative ways if physical problems limit sexual expression and, as other physical or mental problems require more care from one spouse with limited ability of the other to give in return.

8. The capacity to live when one member of the couple is unable to function in the marriage any longer or when death intervenes.

9. The capacity to view oneself as an individual with a meaningful life that is separate from the spouse and that will continue if illness or death enforces separation.
2.7.2 Patterns of Adjustment to Aging

The two diametrically opposite patterns to adaptation in old age, the activity theory and the disengagement theory do not account satisfactorily for all aspects of a happy old age; for there are some individuals with low role activity but high life satisfaction and vice versa. This has led to the observation that different patterns of successful aging are possible (Ramamurti, 1978); and hence successful adaptation depends on individual life styles and perception (Ramamurti and Jamuna, 1993a); and personality differences (Neugarten et al., 1968). The following are some of the patterns of adaptation in old age in relation to personality characteristics.

Perhaps the most significant study, carried out in this line is that of Reichard, Livson and Peterson (Reichard et al., 1962; Bromley, 1975). Using Kansas city data, the study identified five distinct patterns of adjustment in old age, out of which three types were well-adjusted groups: 1) The Mature, who had a constructive and flexible view of life and were relatively free from neurotic conflict, humorous, tolerant and were aware of achievements and limitations, 2) The Rocking chair type, who were relaxed, dependant on others and essentially rather disengaged, and 3) The Armoured, who strived to stay active, avoiding retirement and were over controlled, habit bound and conventional. The two poorly adjusted groups were: 1) The Angry men, who blamed others for their failures and were bitter, suspicious, resented their wives and had a great fear of death. Seclusion and withdrawal were their two modes of adjustment. 2) The Self-haters, who blamed themselves for failures, were depressed and critical.
They felt loneliness, uselessness, lacked initiative and welcomed the prospect of death.

Neugarten et al (1968) described the aging individuals with following adaptational patterns: 1) The 'Reorganisers', who substitute new activities for lost ones. 2) The 'Focussed', who were selective in their activities. 3) The 'Disengaged', who were similar to those of rocking chair type. 4) The 'Holding on', who appeared to defend themselves from perceived threats of aging by clinging to their middle-aged patterns. 5) The 'Constricted' who tried to erect defences against anxiety through withdrawing. 6) The 'Succorance Seekers', who maintained themselves satisfactorily as long as their dependency needs are met by others they could lean on. 7) The 'Apathetic', who had perhaps been disengaged throughout their lives and were with patterns of passivity and low activity. 8) The 'Disorganised', who had low activity and poor psychological functioning.

The above two patterns of adjustment to aging display some basic similarities. The 'Reorganisers' and the 'Focused' groups could be subsumed under the 'Mature agers' described by Richard and associates. Both the 'Disengaged' and 'Rocking chair' men correspond to the basic premise of disengagement theory. All these patterns seem to be associated with better adjustment and 'Integrated' personalities. The 'Holding on' and 'Constricted' groups are similar to and 'Armoured' pattern and such individuals seem to maintain relatively successful satisfaction. The last three patterns – the 'Succorance-seeker', the 'Apathetic' and 'Disorganised' appear to maintain low
satisfaction and may correspond to the 'self-haters' group described by
Reichard and his associates.

Reisman (1954) explained three types of adjustment pattern to aging:
1) The 'Autonomous', who reflexively keep themselves alive, physically and
mentally despite the physiological changes, 2) The 'Adjusted', who preserve
themselves without losing their skills, and 3) The 'Anomic', who are
characterised by premature weariness, resigned attitude and show
degeneration after retirement.

An altogether different pattern of adjustment to aging was developed
by Williams and Wirths (1965). Rather than describing reactions to aging
process, they focussed on an individual's life style, which may be carried into
old age. The life styles in relation to adjustment are: 1) World of work, which
implies that meaning for one's life is derived out of work. 2) 'Familism' or
'Couplehood', in which life appears to revolve around the family as a whole or
the marriage relationship. 3) 'Living alone', representing those who prefer a life
style of relative isolation. 4) 'Easing through life', in which the aged prefer
minimum involvement or commitment in almost all the areas like work, marriage
and family – a pattern of disengagement. 5) 'Living fully', in which the elderly
are involved in a variety of areas, without focussing on any one as most
important. Though this typology seems to be a new approach based on an
individual's life style, the explanation of each pattern is closely linked to activity
and disengagement theories. A similar pattern evolves in the review of an
article by Johns (1961). According to him, the adjustment patterns related to individual life style are: Active, Passive, Social and Asocial.

A project made by Buhler (1961) considered four different groups' of elderly in terms of their adjustment. They are: 1) those who want to rest and to relax, 2) those who wish to be active, 3) those who are dissatisfied with the past but resigned, and 4) those who led meaningless lives and are now frustrated, guilty and regretful. Hamlin (1967) groups the elderly into 'task oriented' and 'non-task oriented'. The members of the task-oriented group are energetic and have satisfaction and like dealing with uncertainty and change. The non-task-oriented elderly seek to avoid dissatisfaction, prefer to be placid and quiet, and dislike uncertainty and change. Through cluster analysis, Spence (1968) has developed an adjustment scale which identified four types of elderly persons: 1) Unsettled planners, 2) Composed planners, 3) Disgruntled and 4) Complacent.

The typology focusing on both patterns of aging and predominant life style presented on the basis of a longitudinal data by Maas and Kuypers (1974) is noteworthy. Despite a relatively small surviving sample (142) ten different life styles were identified: 1) Family centred fathers, 2) Hobbyist Fathers, 3) Remotely sociable fathers, 4) Unwell disengaged fathers, 5) Husband centred wives, 6) Uncentered mothers, 7) Visiting mothers, 8) Work centred mothers, 9) Disabled disengaged mothers, and 10) Group centred mothers. They identified a difference in the life styles of fathers with that of mothers. Gender difference is partly because the men probably remain married, while the women remain
widowed and there is both stability and change in life style, with women apparently being affected more by circumstances than men.

Among the several patterns noticed, Snow and Havighurst (1977) identified two contrasting patterns based on the differences in the attitudinal responses of the elderly to retirement and in the choice of activity after the age of 65. They are 'The Transformers' and 'The Maintainers'. Filsinger and Sauer (1978) located three male types of adjusters, 'Low Adjusters', 'Acceptors' and 'Fighters' and two female varieties, 'Low Adjusters' and 'Moderate Adjusters'. Bushan and Sinha (1987) reported four alternative strategies of adjustment: 1) Intra-persistive approach mode, 2) Extra-persistive approach mode, 3) Punitive avoidance mode, and 4) Defensive mode. Carlsson et al (1991) identified seven patterns in the adjustment of the life experiences of non-institutionalised elderly with special reference to the subjective reality of the elderly people. The patterns are Self-realising, Mature aging, Adapting, Dependent, Resignedly accepting, Despairing and Withdrawing.

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

2.8 Intervention: Towards Adjustment in Old Age

The elderly are a large group, relatively neglected by psychologists and counsellors. Typically the literature on counselling psychology or family counselling have ignored the aging and their concerns (Fry, 1984; Van Amburg, et al., 1996). In general, particularly in India, training programmes for counsellors often emphasise early developmental stages and often limited exposure to aged individuals. However, several gerontologists and counselling psychologists (e.g., Britton, 1963; Butler, 1975a; Palmore, 1980; Pfeiffer, 1980; Spikes, 1980; Sherman, 1981; Garland, 1985; Becker, 1986; Ramamurti, 1995) cautioned that mental health practitioners and counsellors need to be alert to issues involved in counselling the elderly who are depressed, widowed, lonely, neglected and abused.

Intervention here refers to socially sanctioned practices of preventing, modifying or eliminating disordered or undesirable behaviour. Intervention may be physical, psychological, social, institutional and environmental manipulation (Eisdorfer and Stotsky, 1977). Intervention is generally in response to a crisis. Counselling intervention is an important approach to elderly population since more than any other client in a counselling relationship, the elderly need to experience unconditional positive regard so that they may able to achieve
‘integrity’- the major task in this stage (Fry, 1984). They need to experience a therapeutic relationship with counsellors in which they can verbalise their formerly unallowable feelings of pessimism, hurt, guilt and despair so inconsistent with self-esteem and previous cognition of self-confidence and pride. Collins (1988) outlines several levels at which counselling and psychotherapy for older people may be effectively approached. He points out that a basic requirement is what he describes as counsellor’s self-examination, which involves creating a positive attitude towards elderly without any prejudice or bias.

The goals appropriate for counselling the elderly are discussed by many authors (Becker, 1986; Collins, 1988; Lapsley, 1992). According to Collins (1988), the main goal of the counsellor or psychotherapist of the elderly is to stimulate realistic planning, realistic attitude, re-education and other activities and stimulate spiritual growth. Lapsley (1992) discusses the goals in terms of 'doing no harm, reducing discomfort, enabling decision making, clarifying vocation, consolidating the self, reconciling with family and friends, and providing a resource for the spirit in relation to the self'. Based on the developmental tasks of aged individuals, the principal goal of counselling for the elderly is to help them to achieve a sense of integrity by finding meaning in life.

Laycock (1961) identified some important counselling needs of the elderly. They are: 1) affection, 2) belonging, 3) independence, 4) achievement, 5) recognition, and 6) self-esteem. In recognising the 'search for meaning' as an integrating theme of this life stage, Sherman (1981) states 'the kind of anxiety
and potential for depression associated with concerns of mortality and the meaning of one's life and death become an important issue in counselling with the elderly.

A specific issue or need that should be recognised when counselling the elderly is 'cumulative losses' — normative losses like physiological losses (functional losses), losses of interpersonal relationships (relationship loss), loss of roles and meaningful activity (role loss), loss of status (social loss), and loss of self image (intrapsychic loss) (ref. Mitchel and Anderson, 1983). In line with this, Butler (1974) analysed some of the predictable issues that must be dealt with in caring the elderly. They include increased isolation as a result of loss of significant others, role changes and the loss of a sense of purpose as a result of loss of employment or aging in the family; the need to consolidate identity to prepare the need of life; and anxieties about increasing dependency because of chronic illness. In the order of counselling priority, Fry (1984) identified the emergence of several recurrent counselling themes centering on the elderly's need to: 1) strengthen a spiritual faith, 2) know their worth, 3) be useful and worthwhile to others, 4) restore their declining energy, and 5) feel that they will be remembered and cherished after death.

The older persons in the midst of physical, psychological, spiritual and environmental changes express a need for change. However, negative stereotyping of older people by mental health system and professions has led to the assumption that they are poor investment for therapy, too resistant to change, or simply untreatable. In contradiction with this, Butler and Lewis (1982)
that older persons often exhibit a strong desire to resolve problems, to put their life in order, and to find satisfaction and a second chance - thus making them prime candidates for therapy.

The diversity of the elderly is mirrored by the diversity of the counselling and psychotherapeutic approaches used. Ramamurti et al (1992a) advocates short term and long term counselling intervention strategies to handle the problems of the elderly. Promoting social interaction, improvement of self-concept, management of health and finance and enabling acceptance of life as it is are some of the short-term strategies. Long term strategies include mainly: pre-retirement counselling, development of HRD to meet the challenges of old age, health education, development of hobbies, development of alternative sources in old age, and using media to promote positive attitude towards old age.

Individual as well as group counselling / psychotherapy can be used with the elderly. While stressing the importance of individual psychotherapy, Butler and Lewis (1982) states that individual psychotherapy is least available to older persons and yet should be a part of any therapeutic relationship. Group therapy is also advocated as an ideal way to help old people to manage their stresses more effectively. Among the first gerontologists to endorse group therapy were Butler (1975b) and Busse and Pfeiffer (1977). They cited specific advantages of group therapy over individual therapy: 1) more efficient time use of professional personnel, 2) exchange learning among group members, and 3) group membership. Groups provide an opportunity to socialise, to share life
experiences and issues and also inter-personal opportunities to learn to handle the distressing feelings and anxieties. In the group, they sense both helpers and the helped. Members can thus experience their needs and feelings more safely so as to develop new ways to cope (Berland and Poggi, 1979). Group provides a ‘holding’ environment for those elderly who experience numerous losses. The group can provide restitution as a social system as well as a therapeutic milieu.

Counselling procedures and approaches suitable for young people are not necessarily applicable for the elderly. Therapeutic approaches need to be adapted to suit special conditions of maladjustment in later life. Deep psychotherapy is regarded as difficult, inappropriate and ineffective for elderly neurotic clients. Psychological counselling, on the other hand can help an older person to solve current intra-personal and inter-personal problems and perhaps to handle disturbing emotions (Bromley, 1975).

It is to be noted here that counselling is not a matter of technique, but a way of relating to another person. What is envisaged is a caring supportive relationship in which the counsellee is helped to become increasingly aware of, and to understand his or her own feelings and thoughts, and to take charge of his/her own life and relationships in a responsible way. Counselling in a sense is the utilisation of one-to-one or small group relationship to help people handle their problems of living more adequately and grow toward fulfilling their potentiality. This is achieved by helping them reduce the inner blocks which prevent them from relating in need satisfying ways (Clinebell, 1984). Counselling is helping the person to help himself. Different models of
psychological counselling are identified in the counselling psychology literature, viz., client centred and non-directive model of Roger (1951), integrative model of Carkhuff (1993) and developmental model of Egan (1994). All these models emphasise the basic skills such as empathy, respect, genuineness, concreteness, facilitative self-disclosure, immediacy of relationship and caring confrontation, as conditions of therapeutic growth in the counselling process. The quality of relationship is central to the therapeutic process. While dealing with the importance of counselling skills in the counselling process with the elderly, McDonald (1991) points out that there should be a movement from questioning, advice giving, problem solving approach to one based on empathetic listening, acceptance and responding.

The literature on counselling the aging suggests some of the unique approaches that can be used specifically for elderly clients.

**Supportive Counselling**

Supportive counselling or psychotherapy with elderly is advocated by many (e.g., Becker, 1986; Collins, 1988; Gurfein and Stutman, 1993). In counselling with the aged, since one can't expect radical changes in their personality, supportive care and counselling is more advisable method than 'depth' or 'insight oriented' counselling. Its goal is to help the aged gain strength to effectively cope with the 'here and now' problems. Through supportive counselling the elderly can receive guidance, information and reassurance, which helps them to handle their crises more constructively within all constraints that are imposed by their personality resources (Clinebell, 1984). Sometimes
the counsellor has to aid the 'ego defences' of the aged and the supportive counsellor becomes a 'parent figure' (a concept in Erikburns' Transactional Analysis) by gratifying the dependency needs of the elderly. To borrow Becker's (1986) phrase, supportive counselling is 'experienced compassion'. It is the awareness in the aged being helped that someone who cares about them is standing alongside and experiencing their hurts, fears and terror, even as they

The supportive therapy technique with its 'ego lending', is valuable for those who experience multiple losses, particularly for those who need grief counselling (Wolinsky, 1986).

**Insight Oriented Counselling**

This therapeutic modality most frequently used with the aged is based on the tenet that healing is 'understanding'. It aims at basic personality changes through growth in self-awareness and self-acceptance, which occur by means of uncovering and dealing with previously hidden aspects of oneself and one's relationships. This approach usually focuses on 'depth factors' — unconscious material and early life experiences as well as current relationships. Insight oriented therapies are usually used with active elderly. Supportive therapies are generally used with 'frail elderly'. However, some gerontologists have suggested an intermediate position or an integration of the two (Liederman et al., 1967).

**Life Review and Reminiscence Counselling**

Reminiscence counselling has been advocated as an intervention approach for adjustment of the elderly population (Butler, 1963; Lewis, 1973;
Sullivan, 1982; Garland, 1985; Thorton and Brotchie, 1987; Bachar et al., 1990). Reminiscence therapy was originally based upon Butler's (1963) concept of 'life review' taken from Eriksons (1959) developmental theory focusing on the psychological tasks involved in the final stage of human life cycle - a conflict between ego integrity and despair. Hildebrand (1982) suggests that older people need to explore and evaluate their past in therapy. As a counselling intervention, reminiscence is a planned strategy aimed at facilitating the recall experiences, thoughts and feelings (Synder, 1992). It is also aimed at finding meaning in 'memories' (Haight and Webster, 1995; Havighurst and Glasser, 1972). Hamilton (1985) conceptualised reminiscence as consisting of three components: memory, experiencing and social interaction.

The life review and reminiscence are not synonymous though the two terms have been used interchangeably. Haight and Burnside (1993) and Garland (1994) stressed the need to distinguish between 'reminiscence' and 'life review'. In life review, the therapist assists the aged person in achieving a sense of integrity. Life review includes reminiscence. Reminiscence has a variety of goals, including increased communication and socialisation and providing pleasure and entertainment. Reminiscence counselling may be 'individual' or 'group based', 'structured' or 'free flowing'. It includes more general memories than specific events or experiences. Evaluation of memories is not specifically encouraged and the focus is on relaxed, positive atmosphere. On the other hand, life review that includes reminiscence is much more likely to involve working through difficult and painful memories and experiences. The
process is a progressive return to consciousness of past experiences and particularly the resurgence of unresolved conflicts like guilt, regret, grief and unfulfilled dreams (Butler, 1963). Counsellors, by encouraging elderly clients in recreating periods of past accomplishment and satisfaction, can help them come to terms with the totality of their future prospective and thus re-motivate and stimulate aged individuals who are immersed in hopelessness about the future (Dennis, 1978). Life review should be undertaken, like any other personal therapy, with the person's consent and with a clear aim, by properly trained and supervised counsellors. Generally speaking, life review is more individual-based and is more appropriate for older people without cognitive impairment. Reminiscence therapy, on the other hand, is more appropriate for the demented elderly.

Wong and Watt (1991) proposed a taxonomy that includes the following six types of reminiscence that can assist counsellors in analysing reminiscence data: integrative, instrumental, transmissive, escapist, obsessive and narrative reminiscence. Integrative reminiscence focuses on the integration of past and present. It fosters a sense of meaning and self-worth, acceptance of self and others, and conflict resolution and reconciliation. Instrumental reminiscence preserves a sense of mastery and control by recalling memories of how one has coped with past difficulties and drawing from past experiences to solve present problems. Transmissive reminiscence is similar to story telling, recalling past experiences for the purpose of sharing information or entertaining the listener. Therefore, it is known as 'informative
reminiscing' (Coleman, 1974). Escapist reminiscence is a defensive process that glorifies the past and deprecates the present. Obsessive reminiscence is characterised by persistent rumination on unpleasant past events. Narrative reminiscence is more descriptive than interpretative or evaluative. It consists of statements that are autobiographical without embellishment.

Most of the researches concerning the functions of reminiscence, however, have focussed on its adaptational significance for the later stages of life. Examining the benefits of reminiscence for the elderly, research studies concluded that reminiscence generally increases self-esteem, reduces depression and confusion, increases autonomy and life satisfaction, enhances social interaction and assists in adapting to major life crises (Haight and Hendrix, 1995). Specifically, reminiscence has been found to increase ego-integrity and lower death anxiety in the elderly significantly (Boylin et al., 1976; Fishman, 1992). It improves psychological well-being of homebound elderly (Fry, 1991); enhances self-worth, self-esteem and identity (Lieberman, 1975; Merriam, 1980; Kaminsky, 1984; Sadavoy, 1994), and increases current adjustment (McMahon and Rhudick, 1964; Coleman, 1974). Lieberman and Tobin (1983) propose three major functions of reminiscence in the elderly: 1) to maintain self-concept in the midst of change, 2) to serve as a resource of consolation and gratification, and 3) to resolve past conflicts and achieve meaning. Randall (1986) explains the functions of self-narratives in reminiscence as: 1) providing a continuity of the self, 2) sustaining a meaning to continuity of the self, and 3) uplifting the self via hope. He discusses the
implication of counselling in terms of 'story listening', 'story stimulating' and 'story enhancing'.

Reminiscence can be an additional tool in the context of the elderly's marital or family counselling (Fontane, 1979; Hartman and Laird, 1983; Merriam, 1989; Hall, 1994). Reminiscence provides the counsellor with a longitudinal view of a family's past stages and experiences which has been referred to as 'intergenerational life review' (Disch, 1988). Merriam (1989) describes a four-stage model of reminiscence in the context of family counselling. They are: 1) Selection of the experience to be remembered, which in counselling, is parallel to the choice of family treatment goals. 2) 'Immersion', where the person becomes emotionally involved in the memory which is similar to 'probing' and 'exploring' in family counselling. 3) Withdrawal, where the person begins to distance himself/herself from the reminiscent experience and, in family treatment, the person would step back to have a more objective view of the family problem. 4) 'Closure', where the person shares some insight which is not at all different from the family counselling process of sharing new meanings and interpretations of family dynamics and behaviour.

Wolinsky (1986) proposes a four-stage model for marital therapy with older couples based on the marital life review therapy. The first stage involves evaluation, psychological testing and life review process. Stage two involves treatment techniques, such as marital life review therapy, insight-oriented therapy, supportive therapy and grief counselling. All these therapies are done on the basis of 'marital life review'. The third stage is a task and action oriented
one, which includes promoting life style changes, exploring options and developing role flexibility. Last stage is the termination, which involves a review of tasks, review of individual and marital strengths.

Though the reminiscence therapy is being widely used for the adjustment of the elderly there is still considerable confusion as to the aims, target population and techniques of the therapy. There is conflicting evidence for the efficacy of reminiscence in reducing depressive mood (Thorton and Brotchie, 1987). Revere (1971) noted that some people reminisced a great deal without moving to self acceptance and McMahon and Rhudick (1964) observed that reminiscence sometimes ended in depression. However, reminiscence through life review guided by professional therapists may serve as an adaptive function in the elderly.

**Logo Therapy**

Frankl’s Logo therapy (1963) concerning meaning of life could be applied to specific problems and needs of the elderly. Logo therapy is an analytical process to assist the client to be aware of the hidden logos (meaning) in his/her existence. This therapy tries to make the client aware of what he actually longs for in the depth of his being. The techniques of logo therapy are intended to help people explore and clarify their value systems, to guide them toward finding worthy and self-fulfilling goals, and to direct their attention at positive opportunities in their life situation. According to the theory, meaning in life can be discovered in three ways: by doing a deed, experiencing a value and by suffering. The theory seems particularly relevant when applied to the aging
people who experience crisis in retirement, in the death of the spouse or in the common limitations and sufferings of old age (Missinne and Willeke-Kay, 1985). At any age, a crisis experience offers a fresh invitation to search for meaning. Old age, with its particular crises, has many moments of suffering, many demands for adjustment and therefore, many opportunities for searching for meanings. Frankl’s theory helps to explain certain phenomena that observe in the elderly, e.g., depression, life review and renewed interest in religion. Moreover, the emphasis on the importance of discovering choices is perhaps the most significant practical aspect of Frankl’s theory when it is applied to the trials of old age. In short, logo therapy as an essential counselling approach is quite relevant for older people to achieve ego-integrity.

**Peer Counselling**

Peer counselling for the elderly as a conceptual model was advocated by many counselling psychologists (e.g., Bolston and Dignum, 1978; France and Gallaghar, 1984). The concept of peer counselling is based on the notion that a person will often seek out a peer when there is a common frustration or a problem. Carr and Saunders (1980) described peer counsellor as a person who is willing to listen to and talk to others about their thoughts and feelings and who genuinely cares about others. By offering support through listening with understanding, the peer counsellors could foster a therapeutic climate. The aged tends to depend more upon collateral (peer relationship) than on links with younger people or offspring (Clarke and Anderson, 1979). Peer counselling seems to foster ‘us’ syndrome instead of the service providers on one side and
the residents on the other. Therefore, peer counselling can make an important
collection by reducing the well-documented phenomenon of
institutionalisation as Lieberman (1971) stated. The peer-counselling concept
holds a great deal of promise for the elderly whose social world has decreased
and when their degree of social participation is dependent on their proximity to
friends. France and McDowell (1982) believe that the peer-counselling concept
represents a unique and promising method of providing mental health services
to the elderly in an economical and effective way.

Grief counselling

As stated in Chapter 2.7, older persons experience multiple losses
related to the aging process. Grief is the emotional reaction to loss. Grieving
may occur prior to a loss or following a loss. Threat of loss arouses anxiety and
actual loss gives rise to sorrow and each of these situations is likely to arouse
anger (Bowby, 1980). Grief in relation to bereavement in old age may be
normal or pathological. Helpful interventions range from simple actions, such as
a hug to long term counselling which may in turn range from cognitive therapy
to medical intervention. For any intervention approach to grief related to
bereavement, understanding the dynamics involved in grief is important.
Lindemann (1944), Kubler Ross (1969), Schneider (1984), Worden (1991), and
Rando (1993) have illustrated the dynamics or models of grieving. All these
models undergird the task of undoing emotional and psychological attachment
with the deceased, readjusting to an environment without the deceased and
rebuilding new relationships (Humphrey and Zimpfer, 1996). In the grief
counselling, the counsellor's primary objective is not to stop the grieving process but to facilitate movement towards this goal. Characteristics of the grieving older person like the client's physical and mental health, demographic factors, the person's belief system, previous loss experienced must be considered in assessing the grief process (Stroebe and Stroebe, 1987). Conway (1988) listed modes of helping and types of intervention in the counselling process with the older people who experience grief. Mode of helping includes mutual support group, individual counselling and family counselling. Type of treatment includes mainly reminiscence or life review counselling, existential psychotherapy, relaxation therapy, facilitating loss awareness, completing unfinished business and instilling hope.

Besides the above therapies, there are a few other intervention approaches that are applicable to the aged population. They are: 1) Reality orientation therapy (Hanley, 1984), an offshoot of reality therapy approach proposed by Glasser (1965). It stresses the passage of time by providing reminders of the time of day, the day of the week and dates, so as to keep the older person oriented, informed and connected. The therapist reinforces the client in exhibiting responsible and positive actions and in focusing on successful behaviours. It is applicable in individual as well as group counselling. 2) Validation therapy which is developed by Feil (1992) focuses on the emotional and psychological consequences of short term memory loss. The aim of validation is to restore dignity and to prevent deterioration into vegetation, through providing empathetic, non-judgemental listener who accepts the
person’s view of reality. Painful feelings from the past that are expressed, acknowledged and validated in this way are thought to decrease in strength; whereas if ignored or not expressed they are said to heighten. This intervention elaborates emotional content, rather than cognitive expression. The therapy is often applied in-group setting but can be used on a one-to one basis. 3) Behaviour modification or management approaches have been widely used with the elderly (Hussain, 1984). It encourages engagement of the elderly in activities of daily living. Behavioural approaches could be applied for grief counselling, particularly for bereavement counselling. 4) Bibliotherapy – As a counselling procedure, bibliotherapy is the process of using material to help the elderly solve their problem of personal and social adjustment. This therapy is advocated by gerontological counsellors as an important approach for the counselling with elderly (Garland, 1985; Lapsley, 1992).

The above discussion on intervention towards adjustment of the elderly provides a brief picture about the counselling needs of the elderly and specific intervention approaches that could be applied to maladjusted aged persons. The literature on gerontological intervention strategies pinpoint that the approaches – reality orientation, behaviour modification, reminiscence counselling, bibliotherapy and psychotherapy have been widely used but rarely evaluated thoroughly (Garland, 1985). Therefore, Sherman (1981) proposed an integrative model in which he finds that the repertoire of coping tactics can be uncovered, strengthened and developed through four levels of output: meeting material needs of the immediate situation; offering support and promoting
efforts to stabilise self-esteem and morale; assisting the client to feel more in control of his/her life situation; and building positive long term changes in self concept and self esteem.

The discussion in this chapter brought out an account of theoretical framework and a background information of aging and adjustment. This will help to deal with the topic in all its ramifications. Moreover, it will serve as a background for the review of related research presented in the next chapter.