Chapter II

Review of Literature
The review of literature is an important component in the research process. Related studies pertaining to the problems that are done systematically are analyzed and documented that contain information related to the problem. The studies, which were reviewed, have been classified into different related titles under the following major heads.

- Problems due to failing physical health.
- Retirement from work.
- Economic Problems.
- Status of Families- An overview.
- Depression and Hopelessness.
- Problems related to Adjustment.
- Social Status.
- Quality of Life and Life Satisfaction.
- Gender Differences
- Rural vs Urban Differences
- Young-Old and Old-Old Differences

**Problems Due to Failing Physical Health**

Soodan (1975) has expressed the view that the changes that occur with age are physical as well as psychological. The psychological changes that occur with age are 1] a steady decline in the speed with which mental as well as physical activity is performed. With decline in speed, however, other factors come into operation, e.g. older people tend to make a few mistakes more than the young; their long experience enables them for making sounder judgments ; 2] a serious and obvious loss in the realm of memory.... a third psychological change which occurs is a gradual loss in the area of learning. The acquisition of a new skill is very slow and poor. A fourth change is a loss of confidence in their ability and judgment. To compensate this loss of confidence the aged try to find scape goats for their own failures... There is also a tendency among old people to put the blame on others when things go wrong. Another escape resorted, to by the aged is withdrawal from social contact... Old people are also more easily and quickly tired than younger people.
Sen Gupta and Chakraborty (1982) found that 92% of the aged covered in their study were chronically ill. While Guptha and Vohra (1991) reported that for every 10 aged mental patients, one suffered from organic disorders and the rest from functional disorders.

Misra (1992) found that the problem of vision is foremost (82%) for the elderly followed by psychomotor problems (78.8%) born joint problem (78%) memory problem (58.8%) and sleeplessness (58%). Lemkar (1995), states that old age brings with it reduction in memory and subjects the aged to varied kinds of mental illness.

Janer Bryan et al. (2000) investigated the fluency performance as a mediator of age-related decline in incidental memory performance as both are thought to rely on strategic retrieval processes. A large sample of community dwelling older adults completed a battery of tests assessing fluency, verbal knowledge, speed of information processing, and incidental recall. Their results suggest that age-related decline in incidental recall is largely due to the speed and the strategic search of memory.

Ulman Lindebergar, et.al., (2000) studied the dual task of memorizing word lists while walking predicated that it would become more difficult with age because balance and gait need greater need of attention, resource. Mnemonic technique was applied to forty eight old (60-70) adults in this process. They were instructed to walk quickly and accurately on two narrow tracks of different path complexity. Then, the participants encoded the word lists while sitting, standing, or walking on either track. Dual-task costs increased with age in both domains; in the case of old adults (SD1.47). It is argued that sensory and motor aspects of behavior are increasingly in need of cognitive control with advancing age.

Sainani (2001) studied 270 elderly people who were living independently. An association was found between poor nutrition status (as indicated by low food intake or depressive levels of vitamins C, Vitamins B12, Riboflavin or Folic Acid) and poor
performance in cognitive tests. Thus it is now recognized that loss of functional and cognitive ability are not inevitable consequences of the ageing process.

**Retirement from Work**

Gumpert (1950) in a study entitled "You are younger than you think," suggested "most physicians agree that the essence of any treatment of the aged is to keep them at work. Idleness is the greatest enemy of the aged and presents them with their ticket to death."

Uhlig (1952) observes that managers, proprietors, officials and clerical or sales groups tend to retire somewhat later than other categories of employees. The most pronounced early retirement was noted among the unskilled workers while professional and semi-professional retired late. The studies by Chronister and Kellamas (1987) reveal that blue collar workers tend to be resistive to retirement. Landu (1955) highlights that retirement from a job is an important factor related to self acceptance, since it brings abrupt change in one's personal, social life, source of self esteem, success in work and community life and importance in the home are suddenly cut off by retirement.

Streib and Achneider (1971), in a classical study on retirement, found that people with large income, more education and occupation of higher social status prepared to continue working longer than those lower on the economic, educational and occupational scales.

Maddox (1974) points out that work after retirement does not depend on availability of jobs, but it is related to a personal dislike or retirement. Many researchers have highlighted the importance of one's health status as being a major determinant in deciding one's ability to enter into the work force.

Rowe Alon (1976) has studied 207 academicians. This study reveals that academicians continue to engage in professional activity, which helps them to avoid worthless feelings after retirement.
Kastenbaum, (1979) has opined “Some people have organized that basic sense of security around their sphere of work and activity for them, but the loss of employment is a threat because it closes an outlet for self-expression under constructive energy.” Thus, work is an essential factor for maintaining health and happiness after retirement.

Gondotra (1986), explored through 120 respondents from the low middle-income groups of Post and Telegraph Department and the Indian Air Force to know the money management practice of retired people. She has concluded that majority of the retired persons were able to save before retirement. Khanna (1993) in his paper “Second Career” explains how post retirement life is problematic due to drastic changes in society. He has stressed the need for employment after retirement in the modern world.

De Silva Indralal (1994), states that more and more old people are entering into the labor force after retirement and they prefer to remain productive and active. For majority of retirees, it is time to find a new career as well as experience new levels of social status and creativity. The study supports and substantiates the above idea, while explaining Sri Lanka’s ageing problem, he further notes that a significant proportion of the male aged (60-64) are employed and economically active.

In a study conducted by Jayashree (2000), 300 retired male respondents were taken. The major finding of this study is related to the respondents’ contentment in passing leisure time, health, financial obligation and adjustment after retirement. The study shows that 45.3% of the respondents were working after retirement. The review reveals that respondents who have obtained re-employment took less time to adjust to non-working life as compared to those who are not working after retirement.

Buys (2001), experimentally observed that among the 323 independently living residents of 25 retirement village sites were interviewed to know the amount and kind of contact they had with co-resident’s friends and community based friends.’. The result revealed that majority of the residents engaged in several weekly visits with village friends, maintain regular contact with the community through telephone calls. But a few residents engaged in community outings participated less either with village
or community friends. So the nature of living in close proximity with other people reduces isolation or loneliness. Hence, re-location to congregate style accommodation may increase their social contacts and have a positive impact on their well-being.

**Economic Problems**

Desai and Naik (1970) found that the majority of the respondents, both men and women experienced financial and socio-psychological problems during old age. Raj and Prasad (1971) conducted a survey of 327 aged person over 50 years of age belonging to 219 families from three villages in Lucknow district (U.P). Family organization, occupation, marital and socio-economic status, personal habits and addiction, disabilities and diseases and attitude towards life were investigated. Their results showed that 66.9 per cent of the cases were leading from poor to very poor economic life. 52.2 % still held the position of heads of the family, 88 % were suffering from various disabilities such blindness, deafness, paralysis of lower limbs 31.1% were to be found depressed because of the death of spouse or children, infirmity, crop failure and indebtedness.

Marulaidiah (1980) conducted a study in a village called Makunti, having a population of 1,630 persons with 145 older persons. The purpose of the study was to make a preliminary assessment of the roleplayed and the other problems encountered by the older people of the rural community in India. The results of the study showed that those who were above 65 years were usually passive members of the family and the community. The position of the aged person in his family was to a great extent determined by his economic position.

Bhatia (1983), revealed the adverse effect of reduced income, and pointed out that lower income was associated with other personal problems like loss of status and meaningful social relationship. Gomathi Nayagam’s (1987), study of the elderly revealed that higher income, the decision making level becomes high, the low income group suffer from malnutrition, lack of care, ignorance either of their own physical ailment or availability of health care facilities. Decision making level is low among the least educated whereas the highly educated influence decision making.
Mathur and Sen (1989) commented that successful and better adjustment in old age is associated with economic status of the individual. Lower income is the cause for decreased adjustment with advance in age.

**Status in Families - An Overview**

Havinghurst and Alberecht (1953) have observed: “People generally feel that it is right and proper for them to support themselves. Consequently, an aged person who cannot work and does not have enough savings to support himself suffers keenly. Aged with grown up children able to support them generally feel unhappy about accepting help from their children. A major problem of growing old is the feeling of being rejected by the society to which one has belonged all of one’s life. A special problem of the latter is the loss of husband or wife of having to face life without partner.”

Alfred D’Souza’s study (1982) also showed that 55% of both men and women were of the view that their children did not show the same respect to them as they had shown to their parents. The position of the adults in their attitude towards the old is no better. It has to be remembered that they belong to first generation and hence directly and immediately related to the old. Indeed, they may be considered to be the careers of the old (their parents) and tradition prescribed that this was the bounden duty (both maintenance and showing respect).

Fordel (1983) presented findings of two studies on the problems of elderly in Egypt. Results indicate that decline in the capacity of the family care for the elderly adequately decrease, due to the increase in the urbanization of society.

Desai (1985) identified from his study that even when they have independent income, old people may experience rejection and indifference by family members and that even in joint families the old feel insecure. The belief that children will take care of their parents in old age is also getting eroded. Chekki (1986) and Eswaran (1986) in Karnataka found that even where nuclearity of the family is seen, the nuclear family is dependent of the extended kinship configuration of the joint family.
According to Gopal (1987), due to socio-economic changes in the wake of urbanization and increase in the proportion of the aged in the population, the problem of the aged has become formidable. With the impact of industrialization of society, the traditional means of earning a livelihood and mutual aid institutions are rapidly dying out. The ultimate responsibility for supporting the aged is gradually shifting from family to the state.”

A study of a sample of urban adults (25-40 years) by Vermani and Sharma (1987) found that irrespective of educational background, the urban adults who had at least one older member in the household entertained the following notions about the old: 1] 63% of the old people spend too much time prying into the affairs of others and in giving unsought advice. 2] 81% of old people are constantly complaining about the behavior of younger generation. 3] 9.3% of old people make excessive demand for love and reassurance from younger people. 65% of old people are irritable, grouchy and unpleasant. Education is found to have some effect only on items 1-4. However, with one critical statement “It is foolish to claim that wisdom comes with old age” more educated persons (55%) than uneducated (45%) were found to agree.

Jeyarami Reddy (1989) in Tirupathy (Andhra Pradesh) also found that in the same trend 32% of old people in his sample did not expect a great deal of support from their working sons, and only 4.5% actually received good support. Usha Rani (1989) conducted a study in Andhra Pradesh and she found that 72% of the old people felt their sons are less willing to live with them after marriage and 76% felt their sons were less useful to them now than before.

Nayar (1992) indicated that the commonly held view that the aged in general enjoyed power and authority in rural society did not find much empirical support. Age did not confer either automatic headship in the family or status and authority. Other factors are also now playing an important role like health, presence of spouse, and an obedient daughter-in-law and above all, the ability to get along with the members of the family. Participation of the old in the family decision-making was also related to owning property or contribution to the family budget.
common in the older age group specially those afflicted by bereavement and disease. It adversely affects the outcome of treatment for the ailments. Depression is also more common in the lower socio-economic groups.

Besides trying to understand the reason for the depression in the elderly several investigators has explored the clinical manifestation of depression in this population. Cameron (1945) has remarked that “The feeling of being unwanted and unnecessary all at once will create an opportunity to become restless, weary, and dejection which in turn will lead to hypochondria, chronic fatigue states, or neurotic depression with resentment and self-deprecation.”

Cavan (1946) has made it clear that old age comes with worry over finance, anxiety over health, feeling of being unwanted, isolated and lonely, feeling of suspicion, narrowed down interests, loss of memory, mental rigidity, overtalkativeness, especially of the past, tendency of hoarding, feeling of inadequacy, feeling of guilt, irritation, untidiness, uncleanness, conservatism, inability to adjust to changed conditions and decreased social contacts and participation.

Lenhner and Kube (1955) have highlighted three fears that come with old age. They are: 1) Fear of dependence and uselessness. As a person ages, he begins to fear retirement, unemployment and financial insecurity, loss of mental keeness and manual skill, and the possibility of having to rely on children to support. 2) Fear of illness: As one gets older, fall in health often become a problem. An aged is no longer able to see or hear as he used to, he reflexes slow down, strength begins to ebb and such things as digestion and circulation grow sluggish. 3) Fear of Isolation: The aged develop the fear that in case they are afflicted by any infectious disease, they may be isolated. The unpleasant spectra of invalidism also moves step moves step by step, threatening them to shut themselves off completely from their already shrinking social contacts. The loss suffered due to death of friends; of spouses and of colleagues aggravate the older persons feeling of isolation and imminence of their personal death.

Hopelessness has been viewed by psychologists as a system of cognitive scheme in which the common feature is negative expectancy about the short and long term future as stated by Stotland (1969).
According to Kohli (1996), a sample of 450 aged (60+) shows that 48% of the aged were married and 50% were widows/widowers. Among female respondents, widows were 79%. A high percentage 79% was illiterate. Among female respondents, twenty-four percent of the males and forty-two percentages of the females had no income of their own. This study showed that 93% of the aged were living with their families.

**Depression and Hopelessness**

Among the psychological problems which more elderly people face is depression, pessimism regarding the future and loneliness has been widely reported in the literature. This section reviews a few studies related to these aspects. The reasons for depression in old age are due to many factors like mood change, medical treatment, chronic illness, death of the loved ones or friends or due to retirement, etc. Depression in older persons is often missed or untreated because the signs of depression are much more likely to be dismissed as crankiness or grumpiness. It can be hard for a doctor to diagnose depression but it can get better with the right treatment. Depression can be treated successfully by using talk therapies, drugs, or other methods of treatment can ease the pain of depression.

Incidence of depression in the elderly sudden deprivations, diseases or malignancies in an ageing individual can plunge him into depression if he is a loner, does not easily make friends and believes in non-interference into others’ affairs and vice-versa. Women tend to suffer less because they are involved in family affairs of their own as well as indulge in social work. Elderly women tend to get involved in caring for their grandchildren besides caring for their spouse.

These patients suffer from lack of concentration, confusion and inability to complete simple tasks. Milder forms of depression may present as querulous irritability and anxious clinging, a definite change from the previous personality. Withdrawal, an over complaining person, profound pessimism and phobias may be observed.

Elderly patients of depression coming for therapy are much smaller in number than those suffering in the community, unreported and untreated. Depression is more
There is evidence from both clinical experience and research (Gurland, 1976) that older people who become depressed show more hypochondriacal symptoms than young depressed people. Concern about health and bodily states may indeed be the most persistent symptom and is difficult to handle because of the close link between depression and physical illness. It is easy to reinforce depressed older people’s concern about their health.

Depression was the commonest diagnosis in the random sampling survey carried out by Ramachandran and Sarada Menon (1980) near Madras. Their prevalence rate for mental morbidity was 241 per 1000. Out of 98 cases of depressions, they noted 12 to be endogenous and 86 neurotic type. The depressive illness in the community is invisible due to the different factors like community tolerance, mistaking the withdrawal features of the older person to the process of ageing itself, failure to presume the depression as an illness by the family members and the society.

Venkoba Rao (1981), compared the symptomatology of 45 patients whose depression started first after the age of sixty (Group-A) with the symptomatology of 45 younger depressive aged below 40 (Group-B). The group B was subjected to unipolar depression with an average of 3.13 episode. Amongst those in group-A, 34 had only one episode while others had two or more episode the average being 1.38 episodes. In two-thirds of them, a period of more than three years had lapsed since the onset of the episode, which reduces the chances of a manic episode setting in.

In a series of seventy cases of endogenous affective disorders in persons aged over sixty, Venkoba Rao (1982) tried to identify the type of depression found among the thirty cases. The results showed that five had unipolar depression, six had bipolar depression, seven had unipolarmania and twelve were the cases of secondary depression. The view that unipolar mania and bipolars rarely have their inception in the older people did not find support in the author’s findings. But the male members are showed a higher level of depression. This is explainable by the fact that the males retire from their job on superannuation and leisure is forced upon them. This results in loss of income and self-esteem, which predisposes to depression. On the other hand
women are continuously engaged in household activities and in a sense there is no retirement for them. They withdraw owing to debility or illness. Their time is well filled and intra-family attachments continue. They are less susceptible to depressive illness compared to males or even to workingwomen.

Moreover, there is also evidence from British epidemiological surveys that there is a high prevalence of depression among older people, affecting one in seven of all people over the age of 65. This is not only true of Britain. Similarly high rates of depression have been recorded in the USA and in other countries (Gurland and Toner, 1982).

Gurland himself in his review of various studies states that 'the rates of clinically significant depressions are in the region of 10-15% of the general elderly population; 2-3% would fit the criteria for major affective disorder or manic-depressive disorder’ Garlond and Toner (1982, p.229).

Depressive illness is the commonest mental disorder of old age, affecting some 10 to 15 per cent of people over 65 years at any one time. There is scope for argument as to how much depressive symptoms in late life are a response to life-events and losses such as bereavement, and how much 'depression’ is an illness with a biological basis (Jacoby, 1981) (see also Chapter 5). Having said this, although minor depressive symptoms may be a common feature of old age, so too are ‘psychotic’ depressive illnesses with severe symptoms of withdrawal or delusions and an appreciable incidence of suicide. Such symptoms cause considerable distress which may be alleviated by treatment with drugs (or, in severe cases, electroconvulsive therapy), but not all cases make a good initial response and there is a significant relapse rate (Murphy, 1983).

A good example of this phenomenon is older people with failing hearing who avoid conversations with others because they find them too difficult to cope with. It is well documented as is its association with depression (Gilhome-Herbst, 1983).

It is also said that older people rarely come to the doctor saying they are depressed. Often this is because they think something else is the matter with them. It
may also reflect relatively unsophisticated thinking about psychiatric illness. This is likely to change in the future as older people gain greater expectations about their lives, and awareness that depressive illness can be treated very successfully in old age becomes more widespread (Godber et al., 1987).

Though persistent feelings of misery, hopelessness and inertia are the most characteristic symptoms of depressive illness, these are usually accompanied by vegetative symptoms, loss of appetite, weight loss and sleeplessness. The individual usually withdraws into himself, but may also appear very anxious and agitated.

Jamuna (1987) reports a wide gap between the expectations of older women and their caregivers. The results bring out the fact that old women’s emotional problems are seldom inside the household, their problems do not generally catch the public eye and are not understood by a proper magnitude.

According to Metalsky, Abramson and Alloy (1989), the hopelessness theory contends that prior to becoming hopeless the person has (a) a negative cognitive or attribution style (see next two theories) and (b) some unfortunate, stressful experience. Because both of these factors are involved, some with do not become depressed (by avoiding traumatic experiences) and some people go through awful experiences without getting depressed (by avoiding negative thinking).”.

Chowdhry (1992) has pointed out that an old person begins to feel that even his children do not look upon them with the degree of respect which he used to get some years earlier. The aged feels neglected and humiliated. This may lead to the development of psychology of shunning the company of others. Loneliness in turn may give rise to depression and may eventually lead to worsening of sickness.

Soneja et al. (1995) studied a sample of 260 elderly from the Geriatric Clinic of the All India Institute of Medical Sciences, New Delhi. There were 177 males and 83 females. Out of these 66 (25.4%) complained of depression, 65.5 % males and 34.8 % female, the highest incidence was in 71 to 80 years group. A positive attitude inculcated in childhood and the prime of life goes a long way in preventing depression.
in old age. However, all the elderly seemed to be suffering from depression and the need to be helped by psychotherapy and drug treatment wherever indicated.

According to Ilango and Padma Sheela (1996) who did a study on the institutionalized aged persons, a greater majority of the institutionalized aged suffer from physical ailments and especially females are more prone to the these ailments. According to Patil et al. (1998), economic conditions influence significantly the depression level among the aged.

Social Status Of the Aged

Cavan (1949) opines that old age does not differ much from middle age. He emphasized that most aged, are made role-less in the social world. According to him, the best way to avoid adverse effects of ageing is to continue to maintain the level of activities and contact with the middle age group as long as possible and to find a suitable substitute when one is force to relinquish the pre-ageing patterns. The keys to optimal ageing activity are outgoingness and involvement in social life.

Rosow (1967) states that the age peers of similar social status significantly affect the probability of social integration of the aged. Patak (1975), estimated that 2.5% of the aged from middle and upper classes of Indian society suffer from multiple disorders.

Muhs (1975), has highlighted the preferences of the elderly people in their family and their larger social system. He observes that the aged persons feel close to relatives more from the sense of obligation than of choice; prefer interaction and close emotional relationship with friends rather than relatives, need both adequate income and health, and prefer community settings where interaction with people of their own age is possible.

In a study of retired people of Greater Bombay, Desai (1985) noted that the pensioners had problems in getting along with the younger generation. 31% of gazetted officers, 44% non-gazetted officers and 45% of teachers expressed this difficulty in his study.
Kaur (1987) found that the presence of prejudice among the young towards the old is a basic fact. The old people were conceived as being suspicious (79%) “are a burden on the family” (70%) and “their presence in the family is annoying to others” (63%) . To be fair to the adults, they also recognized some of the positive qualities of the old. “Help others whole heartedly”. 84%, “Share house hold burden” (83%) and “must be honored”(80%).

A study in Kerala by Joseph (1990), indicated that while 46% of the old wanted to have interaction with young, only 16% of the young wanted to have interaction with the old.

Reddy (1991) studied the public perception of the social status of the elderly. The results revealed that the position of the elder persons depended upon how those around him, perceive him and his social status. The results indicated that there were no sex and age differences.

Hoffman (1996) has explained that older people are a very diverse group. Further, when they are exposed to varied social, cultural experiences extending over a long period of life span, and these differences tend to increase with age.

Fratiglioni (2000) has highlighted the importance of human contact for the aged. The results of her study of 1200 people, all over 75 years old and living in Stockholm, showed that an extensive social network seems to protect them from “dementia”. Also in her another study three years later 176 people were diagnosed with dementia. The result showed that a poor social network increased the risk of dementia by 60 %.

Problems related to Adjustment

As Rose (1962) puts in the level of self-acceptance varies from person to person. As the age advances it is required for a person to make one self think progressively physically and mentally. If the level of self-acceptance decreases, it makes a person completely dependent proportionately.
Hinton (1967) reveals in his study that less than one third of laying patients (above 60 years) were anxious while two-third of those under 50 showed a high level of anxiety. Part of the result for this finding is that the aged have fewer hopes and expectations to be disrupted by death.

Shanmugam (1970) has studied the personality traits of adolescent, adults and old-persons. Personality tests were administered to a selected sample of adolescents (n=590), within the age group of 12 to 19 years, adults (n=82), within the age group of 25 and 45 years and old persons, (n=30), within the age group of 60 and 75 years. The study indicated that no significant changes in the personality traits of the adolescents took place compared to the traits of the adults whereas significant changes were noticed during old age.

Raghani and Singh (1970) have surveyed the ‘adjustment’ problems of retired persons. They have reviewed a number of empirical studies conducted to explore the factors associated with successful adjustment in old age. They have pointed out a number of weaknesses in regard to the factors used for good and poor adjustment. One of their arguments is that there are cultural and socio-economic variations. Secondly, they pointed out that effects of retirement upon individual should be studied first rather than pre-determining and establishing characteristics of good and poor adjustment and then conducting the study. The data was collected from 100 respondents (50 gazetted and 50 non-gazetted) state government servants devoid of any basis of selection within the age-group ranging from 55 to 84 years. The study reveals that 63 per cent reported that although family kinship ties still persist, yet they feel dethroned and devalued in the realm of family relations. When asked to rank the problems of retirement, the respondents listed the various problem faced by them in the following order shortage of money, problem of passing time, widowhood, feeling of being physically weak, fear of death, mental tension, feeling of social neglect and feeling of neglect by family as well as by friends. The attitude towards the age of retirement was influenced by monetary towards the age of retirement was influenced by monetary or economic loss as 86 per cent told that 55 years of age is too low and upward shift in the age of retirement should be done by the government.
As stated by Hurlock, (1976) with old age, changes in personality come from changes in the psychological process of the individual acceptance of self. How much this self-acceptance changes and in what direction the change occurs will determine the quality of change in the personality pattern.

Hasnain and Kapoor (1981), studied 195 aged persons in the age range of 60-75 years of age, among them 166 had their spouses and 29 were alone. Also 58 were doing part time service and 137 were in their business. Their results showed that with regard to the adjustment in the society the respondents showed a better adjustment (20%) than adjustment at home (10.25%). Singh (1983) in the study mentioned that the problems of adjustment faced by elders were in the following order of the descendency : emotional; social, health and home.

Findings of the study revealed that habitat (rural-urban) was an important factor for better adjustment of aged people. Rural people in India live in a joint family, where old people feel more secure than urban aged people. Economically and socially rural aged people are in a more respectable position than the urban aged people, who are living in a nuclear family. In the joint family system, the old person used to be the head of household enjoying power, respect and status. The findings of the study are corroborated by the findings of Bhatia (1983), and Sharma and Dak (1987).

The findings of the study further reveal that gender is also a significant factor behind the adjustment of the aged people. Dominance of daughter-in-law in family affair increases the adjustment problems of aged women. Lack of involvement in family decisions are the major social problems of aged women. Majority of aged women have problems regarding health.

The studies of Nair (1989) and Subramaniyan (1990) show that elderly women have more adjustment problems than elderly men. Hyde, Robert and Sinclair (1997) investigated the effects of supported discharge after an acute admission in older people with undifferentiated clinical problems. It was finally included nine studies in the review, assessment of which revealed that bias was present, dictating the need for caution in interpreting results. Despite this, there was relative certainty that the
proportion of those at home 6-12 months after admission is greater with supported discharge. This was associated with a consistent pattern of reduction in admission to a long-stay care over the same period, without apparent increases in mortality.

There was uncertainty about the effect of supported discharge on hospitalization. There were no rigorous research data on functional status, patient and career satisfaction, and, in consequence, uncertainty about the overall effectiveness of supported discharge. The results of this review provide reassurance that supporting discharge from hospital to home is of value. However, important sources of uncertainty remain, suggesting the need for further research.

Challis et al. (2002) investigated dependency and general health status of a cohort of older people admitted to residential or nursing homes for long-term care. They assessed 308 aged people over 65 years, within 2 weeks of admission for long-term care to one of thirty nursing or residential homes in north-west England. Dependency was assessed using the Barthel activities of daily living index and the Crichton Royal Behaviour Rating Scale. Information was collected from the homes records on diagnosed conditions and current medication. Their results showed that 50% of the cohorts were in a 'low dependency' band (Barthel Score 13-20): 31% of those in nursing homes and 71% of those in residential homes. In nursing homes, low-dependency residents were more likely to be self-funding than those with higher dependency.

Quality of Life And Life Satisfaction

Argyles and Michael (1958) regard religion as a single quantifiable variable with institutional membership of attendance, devotional practice, and orthodoxy of beliefs as inter changeable indices. Empirical studies show that religion plays a primary role among the aged such as church affiliation and participation in its activity. Results have concluded that religious involvement is greater among women, less educated, members of the middle class, and those in the middle age.

Wallin (1962) states that the scientists of human development have identified different phases in the process of life such as, neonate, babyhood, childhood, adolescent, early middle and late adulthood (Old age). The changes that occur as age
advances are a natural process. Individuals are more or less generative from neonate to adolescence, productive during adulthood and degenerative during old age. The acceptance of changes becomes an important element of satisfaction and happiness in old age. The variation in self acceptance in old age comes from subjective awareness of ageing, the acceptance of the cultural stereo types of old age, and individuals’ recognition of attitudes towards him and the treatment one receives from others because of age.

Sharma (1969) studied the leisure time activities of retired persons. He found out that at 55 years of age, many barriers such as income, cost, education, and marital life influence and restrict their allocation of leisure time activities. He listed 20 leisure time activities and asked the respondents to rank first ten important activities. The mean rank order was reading newspapers, house hold activities, morning and evening walk, listening to radio, sitting and chatting with children- son or grandson, chatting and gossiping with friends, talking to wife, Kirthan and Bhajan, inviting and entertaining friends at home, and day sleeping.

Singh (1970) studied the religiosity among the aged. He conducted the study among 390 persons, aged 55 years and above belonging to different religious communities. The important finding of his study is that religiosity with increase advancing age.

Ramamurti (1970) has measured the life satisfaction in later years. Two scales of life satisfaction were administered on a randomly selected sample of 250 older men between 50 to 70 years in Madras city. The mean score at each age level from 51 to 70 was calculated. It was 20.50 at 51 years and reduces to a low point of 17.10 at 56 and then increases and reaches the highest point of 20.17 at 62 years. Thereafter, the life satisfaction declines till the 70th year was calculated as 17.10 (90% ) of the respondents included in the sample were below 55 years of age and all of them were employed, and respondents above the age of 55 years were employed to the extent of 20 to 25 %. The lowering of this score at 55th year might be because either they were retired at that time or on the verge of retirement, which reflected in the life satisfaction score at that age. And again the low score after 63 years may be due to
deterioration in physical capacities and onset of ageing effects. The earlier decline may be attributed to the physical and psychological effects of aging as such.

Sharma 1971 conducted a survey on happiness and unhappiness in old age. The study covered 44 retired male respondents in an urban setting. The results show that 87.7% felt interested in the activities pursued by them 56 % were pursing hobbies such as morning walk, radio listening, worship, carpentry, reading religious books and self study etc., only 20 % were pursuing hobby and 44 % did not mention any hobby, 10 % respondents fully unhappy and 2 % revealed happiness to some extent and stated that they were just dragging on. Happiness in old age depends upon the extent of busy life, good health, absence of the feeling or paucity of funds and having spouse and social contacts etc.,

Gail, (1974) states that the individual in the middle years of life begins the gradual process of coming to terms with the inevitability of his or her own death, which earlier has seemed impossibly distant. This awareness of death probably makes the person turn towards religion for consolation and emotional security.

Blazer and Palmore (1976) in their study noted a fairly constant decline over time in a church service attendance among Christians. The study indicates that after the age of 65, the older ones show a greater decline in the attendance at church services.

Ramamurti (1978) found that aged persons face significantly greater problems pertaining to finance and they were not satisfied with their life. Kumari (1989) observes the fact that recreational habits change with age. Further Russel (1990) indicates that the only significant direct predictor of quality of life was satisfaction with recreation.

A study was undertaken by Bhadwaj, sen and Mathur (1991) to compare the level of life satisfaction in 100 depressed and 100 non depressed aged. Their mean age was 63.01 years. Their results revealed that the mean life satisfaction scores of depressed aged were significantly less than that of non-depressed group. Distorted cognition and activities were significantly correlated to life satisfaction. The overall
study indicated that positive thinking and higher level of activities leads to positive mental health.

Chadha, (1993) have compared 180 elderly individuals who were from institutionalized settings with 80 individuals from non-institutionalized settings. A schedule was prepared to study the quality of life. They recommend that it is better to have more systematic family based or community based settings for the elderly people rather than to have old age homes. Devasena (1997) in her study that life satisfaction is higher among urban males when compared to urban females.

Gender Differences

Ralph Linton’s (1942) seminal article on age and sex categories noted that, while “old man” and “old woman” were designated in all societies, we actually know very little about the factors which affect the problematic or successful transition into late life.

Marulasiddaih (1966) studied ‘the declining authority of old people’ in a small village Makunti in Mysore. The description of the study contains the status of the older people within their families, among kinsmen and caste people. The sample consists of 154 persons (81 males and 73 females) above 54 years of age. He argues, that, contrary to the popular belief, the older person in India is found to be faced with severe health problems, economic adjustment and progressive relegation to an insignificant place in society. The results show that 21 percent males and 76.7 percent females were widowed, the traditional position of the old is declining in exercising authority, the kinship system is giving way to nuclear families and individualism, and the elderly prefer to live alone as long as they have enough property support. The respondents of 70 years and above in age are ignored by the Sociology of Aging and Review of Literature Younger generation, although they still perform some functions regarding the grand children, such as ceremonial driving away of evil spirit from children. The study also indicates that the younger generation is replacing the elderly in the village administration.

Joshi (1971) conducted a study on the medical problems of old age. He states that differential aging phenomena both physical and mental appear to depend on
environmental and social factors such as diet, type of education, occupation, adjustment to family, professional life and consumption of tobacco and alcohol. The results show that the elderly persons suffer from ineffective and parasitic diseases, diseases of respiratory system, symptoms of ill defined similarity arthritis and rheumatism, hyper-tension, congestion, heart failure, and diabetes mellitus.

Sinha (1971) studied the loneliness in the old men, and has emphasized the fear of death due to psychological deterioration. The psychological implications have been discussed due to changes in social status associated with old age, compulsory retirement, loss of status: occupation, income socio-economic, and family status consequent to the weakening of joint family ties.

Kuypers (1972) claims that with better living conditions and better health care, most men and women today do not show the mental and physical signs of aging until the mid sixties or even the early seventies. For that reason, there is a gradual trend toward using sixty five- the age of retirement in many business to mark the beginning of old age.

Concern that there is a ‘feminisation of caring’ with women being the major caregivers in both formal and informal settings (Havens, 1992) has caring for the Ageing: Implications for.....Stimulated a debate as to how to involve men, who are willing and prepared, in care giving so that women do not always end up in a family-care trap (Evers& Leichsenring, 1994)

Singh (1996) remarks, in a patriarchal society where ‘men mature and women grow old social workers need to be gender sensitive.

**Rural vs Urban Differences**

Sharma and Dak (1987) suggest that the urban and the rural aged differ in education, occupation, income of the household and personal earnings. Therefore, a common approach cannot be applied for the amelioration or their problems. Majority of the urban aged had migrated from rural areas in their youth. This trend of migration not only increases the proportion of the aged in rural areas but also draw the attention of social researchers and social welfare agencies as these migrants have a mix of rural
and urban values, thereby giving rise to value-conflict. Therefore, it is suggested that
the welfare agencies should chalk out the programmes according to the needs of the
specific clientele.

Nakazato and Shimonaka (1989) examined the cross-sectional pattern of
anxiety scores among 571 male and 663 female Japanese adults (aged 25-92 years).
Results reveal that anxiety declined linearly over the age groups; it was lowest among
subjects in the oldest age group (75+ years), who may be the most psychologically
stable group in adult life-span. Women were found to have higher anxiety at both age
groups. In the earlier study by Singh et al. (1983) mentioned earlier the problems
faced by elders was in the following order of descendency; emotional; social, health
and home. Results found in the present research, however, indicate that the most
problematic area of elders is health followed by psychological, financial and social
problems.

The purpose of this study was to see the effects of habitat (rural vs urban),
gender (male vs female) and caste (high vs low) on the adjustment pattern, i.e. in the
area of health, home social, marital, emotional and financial. On the basis of the
review of literature following assumptions were made.

The findings of the study further reveal that gender is also a significant factor
behind the adjustment of the aged people. Dominance of daughter-in-law in family
affair increases the adjustment problems of aged women. Lack of involvement in
family decisions are the major social problems of aged women. Majority of aged
women have problems regarding health.

**Young Old and Old-Old Differences**

It is very important to realize that the young old (60-75) can be a great
resource to the country and their trained modifiable manpower should not be wasted.
Suitable plans for the appropriate use of this human resource is urgently needed.

As Hurlock (1981) has indicated that the last stage in the life span is
frequently subdivided into early old age, which extends from age sixty to age seventy,
and advanced old age, which begins at seventy and extends to the end of life. People
during the sixties are usually referred to as ‘elderly’ meaning somewhat old and advanced beyond middle age-and ‘old’ after they reach the age of seventy meaning, according to standard dictionaries, advanced far in years of life and having lost the vigour of youth.

The review of literature has amply demonstrated the diverse problems faced by the elderly, which seem to be universal in nature. These problems besides several psychological ailments associated with the process of degeneration include others, such as financial crisis, lack of care, generation barriers, dependency, status loss, isolation, loneliness, pessimism, and various problems of adjustment. These were some of the issues highlighted in the review. It was seen that most of the studies focused just on one or two of these dimensions and comprehensive multidimensional studies are very few particularly in the Indian context. While the importance of understanding the phenomenon of ageing in India is steadily gaining prominence. There is a still a lot to be done in this regard. This study is a small effort in this direction.