Chapter-1

Introduction
Conception of ageing and position of the aged forms an integral part of the institutional and ideological culture of a society. In the traditional Indian value system the authority of the elders and sanctity of tradition were both supported in opposition to rationality and the right of individual conscience. The scriptures, the Epics, the Vedas-in sum, all the religious and literature eulogise parents as Gods. Thus, respect reverence for parental authority were embedded in the young that they could not think of differing from or protesting against them. The Hindu value system helps the continuance of the joint family by minimising conflicts in matters of religious practice; Brahmnic Hinduism emphasis ritual correctness.

Thus in traditional Indian society all the important attributes like social status, occupation and content of interpersonal relationships were within the same caste and the joint family. The traditional value system supports the authority of elders and upholds the sanctity of tradition. The general plan of life taught in the Vedas divided a man’s life into four stages: Brahamcharya (Student life), Grahstha (Married life), Vanapraetha (Life of retirements) and Sanyasa (The life of renuciation).

Historically, the joint family system has been considered characteristic of Indian life. Under this system as many as three
generations live together at any time in the same dwelling. Traditionally, the Indian economy has been one in which overwhelming majority of population depended directly on agricultural and allied occupations. The caste system forms one of the basic structural features of Indian society. The territorial unit within which an individual lived his entire life in the village. Cast and kinship were the basic structural components of the village. Thus the whole of individual’s life span was encircled by the concentric zones of family, caste and the village community, the major social control being exercised by religion through its precepts and its executive-cum-judiciary bodies and the policy and economy being relegated by two other institutions, the village Panchayats and the inter-caste economic relationship respectively (Kulkarni).

Indian society, however has been undergoing rapid transformation under the impact of several forces. Consequently, the traditional values and institutions are in the process of adaptation and have often led to sharpening of intergenerational differences.

i) The Selection of research problem.

The life expectancy in India has increased from 32 years since independence and improvement in health services will further
push up the longevity in future. The number of persons 60+ in (1901, was about 12 million, in 1951 which increased to about 20 million representing a 67 percent increase. In 1971, the number rose to 33 million and according to the 1981 census (5 percent) sample it is about 43 million. In 1991 this is expected to increase to about 51 million. In 1991 this is expected to increase to about 51 million representing about 155 percent increase over 1951. The main reason for longevity is the increase in life expectancy at birth from 23 years for males and 59.8 years for female projected for the period 1991-94. The marital status of the population 60+ shows a fairly large proportion of the population that has widowed status, the incidence of which as may be expected is much higher among females than males (Govt. of India, 1982).

The traditional Indian family has been projected as well integrated kinship unit with the father occupying the position of authority. The member of the unit who share the various routines, problems and joys of family living have strong feeling of mutual obligation during crises and regard of self interest as being antithetical with the welfare of a the family. Their respect for the wisdom of the eldest male permits him and his spouse to make decisions which affect each and every member of the unit.
Marulasiddaiah (1969) in his study of Makunti village of Karnataka state found that no sooner the son gets married than he wants to live separately and set up his own family. Of the 300 families there are hardly 18 joint families and those too are riddled with quarrels. The older people are losing grip on the young persons. They feel that neither are they properly cared for when ailing nor well fed and clothed by their sons and relatives. Gangrade (1978) in his study of intergenerational conflict in India found that majority of young prefer nuclear type of families. While a majority of parents still prefer joint families. The students (98 percent) want to honour their commitments and obligation to their parents and nearest extended family members. This favourable attitude is not nearly as strong on the question of giving assistance to relatives, which was approved by only 64 percent of students. There are 72 percent students and 63 percent parents who feel that parental authority is on decline and their sons no longer obey them.

The wage earning sections of the middle classes comprise members who pursue a variety of occupations, in industry, bureaucracy and professions in the formal sector of urban industrial economy. The value system of this section tends to be
influenced by their western-oriented education. Some of the sociological studies on family which proposed that family in India is developing in the direction of nuclear family are based on investigation in one section of Indian society. Interpersonal relations in the area of authority and decision-making are not based on the principle of seniority. Generally, senior members of the family become dependants on the junior earning members (Haribabu, 1984).

Mehta (1974) studied the attitudes and problems of divorced Hindu women reveals that nuclear family pattern of domestic life is the most preferred way of living. However, supporting of parents was considered to be a moral duty of children. All the respondent further stated that the nuclear family could not be relied upon in times of distress to support individuals on a long term basis and that this support had to be self-generated by women themselves. De Souza’s (1982) study of respondents’ perception of consistency of status in the family indicates that out of 296 old women and men, 50 percent were of the view that their status had not changed because of old age, of whom 59.30 percent were men and 41.70 percent were women. On the other hand out of 143 respondents who were of the view that their status deteriorated 39.3 percent were men and 56.4 percent were
women. In general, both old men and women (55 percent) were of the view that the children do not show them the same respect they themselves had for their parents (De Souza, 1982).

The old men and women stated that they experienced emotional distress such as loneliness, the feeling of not being wanted and depression. In general, women experience a higher level of loneliness, the feeling of not being wanted, and depression than men. The old people draw on their religious resources to cope with their emotional problems. The concept of Karma promotes adjustment because events take on the character of inevitability over which the individual has no control. The family developmental cycle brings about changes in the status and roles of both men and women because three is a transition from the role of provider to that of dependent. The degree of dependency varies according to the economic situation of the old people and in general it is characterised by a loss of role and limited participation in decision-making in the social, economic and cultural spheres of family activity. Thus the status of the elderly reveals that the factor determining the status of the elderly were his/her economic status, health status, intrafamilial interactions and the attitude of family members.

Older people often enjoy the time they spend with freinds
more than the time they spend with family members. The openness and excitement of relationships with friends help older men and women rise above worries and problems. Friendship give older people a sense of being valued and wanted and help them deal with the changes and crises of ageing.

Thus the researcher select the following research problem-

*A Study of Attitude towards Ageing, stress, adjustment and coping strategies of older people.*

ii) **Description of variables involved**

A) **Elders and Attitude Towards ageing**

Different definition and conceptualisations of ageing have been employed by scholars from time to time. Usage of the term “Elderly” is common both in popular and academic discourses. The use of such a blanket term to encompass a forty year range has contributed to the popular stereotype that the elderly constitute a homogeneous social group: one of the most persistent images of ageing is that all older people are alike.

Old age denotes a specific stage of life in a tripartite division of the life cycle, i.e. phase of prepartation, followed by the one of productive activity in economic/income generating terms, and finally the stage of retirement. The chronological criterion for classifying an individual or a collectivity as “aged” or “elderly”, is
generally employed for administrative purposes for example, pensions, retirement, insurance and the like. Here, old age is identified by the transition from salaried work to retirement.

Different nation-states and often provincial governments within nation-states define differently the age of retirement for their employed work force. As Pannu in his paper has stressed, there is no age of retirement for majority of those in the unorganised sector in India. No definite criteria is fixed by biologists to consider a person old, and for administrative purpose each country tends to fix an age limit for working life of person to suit its own interests.

The definition of the term “elderly” or “aged” varies from society to society and has undergone modification over the passage of time. Ancient Chinese scholars delineated seven phases in a man’s life and Pythagoras in the sixth century B.C. compared human life to the seasons. In both cases, old age was deemed to be beyond 60 years (Stub, 1982). Some societies still treat 40 or 50 years as marking the transition into old age.

In western industrialised nations the typical onset of old age is reckoned as 65 (Conception 1988: 399). Worach-Kardas (1982) argues that age must be viewed as a socio-cultural category as much
as it is a chronological and biological phenomenon, and advocates a life-course perspective in which youth, middle age, and old age are studied as separate entities with their own distinctive processes and problems.

The cultural markers for distinguishing an "aged" or "elderly", thus, vary from society to society, as they are dependent on the life expectancy as well as longevity of population in different societies. Partha Mukherji (1972) distinguished between biological and sociological or psychological age. Some scholars say, biologically a person may be old but if he possesses a youthful temperament, sociologically and psychologically speaking, he should be included in younger generation.

Dutt (1986) says the term ageing signifies the progression of changes in bio-chemical processes. The factors which cause the ageing process are mainly environmental, genetic, mutation and free radical theory. Dutt endorses the view that chronological age is a poor predictor of functional ability. Mahadevan (1986) states that traditionally, in India, old age begins at 60. The age of 60 has been adopted by the Census (of India) for the purposes of classifying a person as old.

Old age is determined by cultural norms prevailing in a
society. In Indian society, marriage of one’s children, particularly of a son, heralds the beginning of old age for women far more clearly than does a specified number of years. Accordingly, role expectations change for male and female members in a household.

In rural India, people are not classified as “aged” by any absolute biological and chronological criterion— as most of them do not know how old they are. They are, however, acutely aware of their relative age and of the category and activities appropriate to their contemporaries and to the progress through the life cycle of their kin in the adjacent generations. Age is sometimes recognised by association of a person’s birth with special historic events, or geo-climatic, astronomical or with socio-cultural events—festivals, rituals and the like. It is the changing status of these peoples, parents and children, that defines an individual as old, for this status is a relational one.

Old age is depicted positively in terms of wisdom and the potential for spiritual growth. For some, wisdom and serenity are positive aspects of being old. The best things about old age include freedom to do and to be what one wishes, i.e., freedom from responsibility and freedom from worry about other’s opinions. The “elderly” or “aged” sustain positive self-concepts by narrowing their
social contacts to avoid exposure to people who would reject them on account of ageing.

On the other hand, old age is also depicted negatively in terms of physical decline and decrepitude. Elderly people are characterised or stereotyped as ill, tired, mentally slow, self-pitying, unhappy and unproductive. They are often depressed by feelings of loneliness and alienation. The negative content of the condition of old derives from the relationship of individuals and society: the absence of a role, the isolation from the significant social life, the marginality in family relationships, and the lack of commitment, partly induced, partly forced on old people. Their problems include a feeling of material insecurity or dependence, and intergenerational relationships. The aged are also said to be losing gradually their decision making authority. Elders suffer from a sense of dispossession that reflects loss of roles and status, as they are deprived of the earlier identities defined by parental or employment functions. The hardest parts of being old are declining health and lack of finances, threat of dependence, and the loss of beloved ones.

Theories of Ageing

Several theoretical approaches have been advocated by scholars in their effort to understand the phenomenon of ageing. Since the
time when there ensured a lively debate between the proponents of the activity and disengagement theories, the field of social gerontology has been studied by such diverse points of view as socio-environmentalism (Gubrium, 1973), continuity theory (Atchley, 1971), the age-stratification approach (Riley, 1971; Riley, Johnson and Foner, 1972); symbolic interactionism (Marshall, 1980); exchange theory (Dowd, 1975); modernisation theory (Cowgill and Holmes, 1972); and political economy (Olson, 1982).

**Activity and Community Theories**

Social integration and participation are regarded as necessary criteria for satisfactory ageing in order that lost roles be replaced with other types of behaviour. Proponents of these theories contend that older people have social and psychological needs similar to those of younger people, or to themselves when they were middle-aged. Successful ageing requires finding new ways of being involved to compensate for losses of retirement or the death of long-time friends- in plain words, efforts not to let previous life-space shrink. Research evidence highlights the inadequacy of the activity theory as an interpretation of ageing. Indeed, data contradict the basic assumption that an active and engaged lifestyle will necessarily produce happiness. There are others who propose a developmental
model. They consider ageing as a sequential and accumulative process of becoming.

**Disengagement Theory**

A second theoretical approach to the understanding of the process of ageing is the disengagement theory. The proponents of this theoretical approach (Cumming, 1963; and Cumming and Henry, 1961) contend that as people grow older they have less energy, and sustain a diminishing number of interactions (as well as types of roles) with other persons. As they retire from work, lose dear ones and experience deteriorating health, they become more egocentric. This theory proposes that the elderly person and society undergo a process of mutual withdrawal which is explained as a natural and inevitable procedure of functional benefit both to the individual and to society. Thus, lowering regarded as indicators of ‘correct’ ageing.

Cumming and Henry’s theory has met with extensive criticism and has been described as the geriatric euphemism of social death (Platt, 1972). It serves as a justification for the exclusion of elderly people from social activities and does not regard their separation from society as a problem warranting concern but rather as a beneficial process.

This theory has many opponent. Shanas (1968) in her study
has found little evidence of either objective or subjective disengagement among the aged of Britain, Denmark and the United States. Similarly, Scholars like Hochschild (1975) have come up with the idea of differential disengagement.

Disengagement is an anathema to elderly Indians who seldom turn away from social life. From the perspective of the disengagement versus activity theory debate, the Ashramas, the ideal scheme of the Hindu Life-cycle, and Asian interpretations of it in practice, do appear superficially to be a form of prescription for healthy ageing via disengagement, since the last two stages tend to be less directly involved in the affairs of the material world and concentrate more on spirituality and preparation for the ultimate goal of life (Kapadia, 1966). However, it is not a withdrawal associated with a loss of status and emptying roles but a replacement of certain socially valued, material roles by others including spiritual roles.

A study of ageing and disengagement in India by Vatuk (1980) concluded that the influence of the ideal of withdrawal in later life was still apparent in Hindus, but that although a degree of social and psychological retreat look place, it did not mean a total of social activity. The existence of a normative prescription for a form of withdrawal from material power enabled older people to give in
gracefully to younger people and to avoid direct intergenerational conflict. At the same time this withdrawal did not imply social inactivity, though the elderly did not generally exercise authority.

**Development Theory**

The third major gerontological approach sees adjustment to old age as primarily determined by the individual’s personality characteristics. Developmental theory has resulted in the categorisation of the elderly. Such an analysis attributes minimal importance to the social context in which ageing takes place and disregards completely the external constraints which influence the ageing process. As Estes (1979) recognises, “None of the three theories takes a direct interest in the social structure and the cultural and historical context in which ageing process occurs, although lip service is often given to the importance of these factors.”

**Modernisation Theory**

Modernisation models of ageing have traditionally held that modernisation worsens the prestige and power of the old, maintaining that the life of the elderly people is characterised by disengagement, deculturation or alienation. The notion that industrialisation and urbanisation have eroded the status of old people everywhere is widely accepted. In fact, as several scholars point out, the issues
are not modernisation and status per se but the different ways in which change affects the old and the various dimensions of their status such as health status, authority, economic independence, ritual influence, household situation and so on, Foner (1984) and Simic (1983) maintain that the overall status of the elderly is multidimensional, and changes of status among the old are more complex and varied than this model suggests.

**Symbolic Interactionist Theory**

This theory says, Mead (1934) is Primarily concerned with the meanings which actors attach to their behaviour and experience and acknowledge the actions occur within the context of social rules (Goffman, 1959;1963). In interpreting the situation of older people symbolic interactionists do recognise the influence of external social factors, such as class, race, and sex. According to this perspective, conflict is assumed to be primarily a result of mistaken ideas about reality, and uncovering the actors’ own interpretation of their experience.

The social structure within which interaction and interpretation occur engenders beliefs as to what constitutes acceptable action, as well as it acts as a constraint upon the actors themselves.

**Exchange Thoery**
To Dowd (1980) this approach suggests that the lives of elderly people are shaped by the relative power resources of the social actors involved. "Thus, although exchange theorists recognise that old people in modern society tend to be disadvantaged because they generally possess power resources than young people, these theorists also recognise that there are exception: individuals often manipulate in innovative ways the few resources they do possess. Thus, although the long term 'exchange' view recognises that possession of resources also leads to power in social relationships, the short-term view appreciates the creative ability of humans to use resources in unique ways" (Dowd, 1980:19). Dowd argues that older people form a cohesive age stratum through their sharing of certain attributes (e.g. their exclusion from work roles). In old age, age interests once again become dominant. Age status becomes a permanent identity. There is no age stratum to move to after one has reached "old age."

For many years social gerontology has been dominated by narrow functionalist theories of ageing. These theories, in a variety of forms, have explained the process of ageing and the role of the elderly in terms of individual or group adjustment (Olson 1982; Marshall, 1987). These theories confirm ordinary life-style liberal or conservative sentiments and not radical or existential ones. These
possibilities suggest that scientific theories basically derive as much from the perspectives and values of the world they examine as from scientific enquiry. Elderly people are treated as a distinct homogeneous group in various stages of adjustment to the ageing process. Such theories are based on the implicit assumption that the status of older people can be explained in isolation from the rest of the social and economic structure in any society. It is as if the influence of the class structure ends at retirement age and all those beyond it face common problems. Most important of all, the stereotype of the elderly as a homogeneous group with special needs has exerted a considerable influence on both public attitudes and social policies towards this group.

In recent years the dominant functionalist paradigm in social gerontology has been called into question increasingly. The main reason is the failure of existing theories to explain some of the key experiences associated with old age, such as the marginalisation of elderly people and the differential impact of retirement. One aspect of this is the relative neglect of women in studies of the retirement process. This has meant, in turn, that social gerontology has not been able to make an adequate policy response to recent changes in the role and status of elderly people.

In recent years, a number of studies have advocated new
paradigms-under such labels as structuralism, the new structuralism or dual economy perspective. While there are a number of important differences generally these models lay stress on the fact that human capital variables including education, skill or age operate within the context of a segmentalised industrial order which serves to demarcate the lifeworld of individual workers or retirees quite independently of their personal attributes.

Scholars such as Gough (1979), Phillipson (1982) Townsend (1981), and Walker (1981) have made increasing calls for an alternative model which concentrates on the normative imperative of structural arrangements. Their concern has been the social creation of dependent status and the structural determinants of the competitive realtionship between elderly and younger adults in the labour job market. The logic of capitalism is portrayed as a social and productive system irreconcilable with the needs of the elderly people whose lives cannot be adequately analysed in isolation from the web of economic relationships, it is insisted, must be considered of primary significance in influencing both the way we think about the process of growing old and about the position of older people within the social structure. Thus, their focus is on how society and its systems of stratification influence and constrain the experience of old age.
The indifferences among elderly people been noticed. Those who are normally adjusted don't feel themselves diminished and keep themselves busy. Continuation of activities and attitudes of middle years into old age is conducive to happiness and successful ageing. The other theory which is applicable to those who do not want to keep and it shows their poor adjustment.

**Attitude towards old People**

Some of the major differences between the status of old people and that of the traditional minorities in the United States have been noticed. These differences stem from the fact that the aged do not constitute an independently functioning sub-groups. With these considerations in mind it in suggested that old people be designated a 'quasi minority'.

Proceeding upon the assumption that old people in American society are devalued 'Lindon' has outlined various cultural influences which are considered responsible for such devaluation. Illustrative of those influences according to Lindon are the diminishing acceptance of family, responsibilities towards own elders, the declining aspect towards the aged as a consequences of loss their position of physical and psychological attributes to youth. And in our youth oriented culture many older people come to perceive
themselves as obsolete and worthless and tend to behave accordingly. Not frequently children assume a patronising and protective attitude towards the ageing parents. In other ways they tend to deprive them of dignity, responsibility and feeling of importance. Many parents are treated as unwanted burdens and their children may secretly wish that they would die to relieve them of financial and other responsibilities. In a study of elder people in France, it has been pointed out that when the French go away for vacations they sometimes deposit their aged parents in rest homes, and on their return home, they forget to pick them up, abandoning them like dogs in a kennel. Undoubtedly in the United States, too many older people are ‘deposited’ in rest or nursing homes to die even though they may possess relatively good health. The effects of being cast aside, simply for ‘being old’, are likely to be devastating.

In western countries the attitude towards older people is quite different from our country. In India youth and the family members still owe respect to elderly people. However, the change in modern society due to scientific advances and the process of industrialization has brought the great change even in the family tradition and the culture of Indian people. There is a growing shift in the means of livelihood from rural to urban semi-urban occupation. Here most of the people living in rural areas had joint families. In a sense many
of them were self-employed in business, agriculture, and thus retirement was for the most part gradual and voluntary. In the large joint family even at home there is division of labour and the aged individual had some roles or other of play. This keeps him occupied and make his life more meaningful, and his maintenance is not undue burden on the family.

Today major population is in government organisation and industrial establishments, which come under some sort of statutory retirement at a fixed age with a sudden arrest of work and gross reduction in earnings and consequently affecting the individual’s socio-economic status. Added to this, there is the growing dissolution of the joint families with a shift in value and role of older people.

Some elderly people may be finacially well-off and comfortable but may not have their children alongwith them. In such cases also having sufficient money does not always solve the problems of old-age. The people at advanced age need protection, company and friends beside comfortable living.

In fact the healthy attitude towards ageing makes the person more adjusted. Hussain (1988) in one of the articles, ‘Old Age problems’, stated that the severity of the problems associated with old age may be determined by the attitude of the person towards old age and the life, in general. Hence, the family and the society
at large must consider old people as assets who are enriched with life experiences and have many things to give. An atmosphere is to be created which is psychologically healthy and in which an old person may develop healthy attitude towards himself and the society at large. He may not consider himself a burden upon others and suffer from extreme sense of isolation, helplessness and insecurity’. Various programmes should be chalked and implemented by the government and social organisation. However, while rendering services to old people, one must be very cautious that the former may not consider themselves to be alienated. The old people must be treated as active members of the society. They should develop the feeling that they are well and healthy and adjusted people in their societies.

**B) Adjustment**

The word adjustment has been described in many ways by different psychologists, biologists, mental hygienists and other behavioural scientists. Biologists take adjustment in terms of adaptation to the physical world. Some explain adjustment in terms of conformity to the environmental demands, some say that a normal or statistically average man is an adjusted man. Conflicting views are there because mostly no two behavioural scientists agree upon a common definition of adjustment. A scientific definition of adjustment ought to be objejective, precise and clear cut. Generally,
it has been argued that the concept of adjustment is a mere fiction, as people have always failed in giving a standard definition of adjustment, partly because of its many meanings, and partly because the criteria against which adjustment could be evaluated are not well defined; further, the boundaries between adjustment and maladjustment are never water-tight.

The mental hygienists take a more personal view of the adjustment process and consider it to be the need for a person's adjusting to himself, understanding his strength and limitations, facing reality and achieving a harmony within himself (Kaplan 1965). They give emphasis on the achievement of self-acceptance, freedom from internal conflicts, self-realization an developing a unifying set of values which make life purposeful and meaningful.

Social aspect of adjustment requires that the individual should achieve a reasonable compromise between his drive for self-realization and the demands of the society in which he lives. He should establish a satisfying contact with the other members of his group. His outlook on life should be socially oriented.

Clinical psychologists consider an organized behaviour to be adjusted behaviour and, therefore, freedom from fears, obsessions, phobias, hostilities, complexes, and other pathological symptoms, are
the criteria against which adjustment can be evaluated.

Counselling psychologists, while dealing with a maladjusted person, try to bridge the gap between the real-self and the ideal-self of the person. It means that maladjustment is taken to be a state of cleavage between the real-self and the ideal-self.

Personality psychologists define adjustment on the basis of self-concept or self-picture of the individual which should be in accord with reality, “Adjustment is the process of meeting life’s problems, and is personality and the self-concept aspect of personality in action”. (Glanz and Walston 1958). We may define the self-concept as the total psychological view that the individual has of himself in relation to the environment, or it is an organization of self meaning or ways of seeing self (Combs and Snygg, 1959). Maladjustment takes place when the individual’s psychologicsal view regarding himself is not in accord with reality. A well adjusted person has essentially positive attitude towards self and others. He has feeling of dignity and integrity, worth and self-actualization (Comb and Snygg, 1959).

Some psychologists have approached adjustment from quite a different angle and defined it in terms of integration of separate responses or acts. “..large units of behaviour in which several separate acts or responses are joined or integrated are called
adjustment (Asher, Tiffin and Knight, 1953); For example, when we talk of class room adjustment, we mean integration of separate accidental acts, like listening, reading, attending, reciting, remembering, etc., in which the student is engaged in the class room. Similarly, separate responses are involved in home, occupational and marital adjustment, etc. Thus, adjustment may be said to be a combination of the different reactions of the individual which is in tune with reality.

This aspect of adjustment has been also emphasized by Schnieders (1965) when he says that "...we can define it most simply as a process involving both mental and behavioural responses, by which an individual strives to cope with inner needs, tensions, frustrations, and conflicts and to bring harmony between these inner demands and those imposed upon him by the world in which he lives". While considering adjusutment as a process, we are interested in the ways the individual modifies or inhibits his internal impulses or alters the environmental demands to eliminate the conflicts (Lazarus, 1961).

Thus, while dealing with adjustment as a process we are confronted by two factors-environmental demands, and needs and motives to be satisfied. There is always a conflict between these two forces which call forth adjutive process. And that behaviour
has been considered adjutive behaviour which makes a compromise between these two forces and helps the individual in achieving harmonious, stable and satisfying relationship with his environment. Madigan (1962) states, “If the conflicts are solved to satisfy the individual’s needs within the tenets approved by society, the individual is considered adjusted”. Besides, adjustment also requires a harmonious inter-relationship within the individual of his various behavioural tendencies. The function of adjustment is to bring about a stable equilibrium among the various components of external and internal stimulations. The significant components of these two types of stimulations have been referred to as motivating stimuli which are perceived as uncomfortable or distressing. The individual’s behaviour is directed toward the reduction of such stimuli, facing external and internal realities (Sappenfield, 1961).

Smith (1961) goes one step further and suggests that good adjustment leads to general satisfaction of the whole person rather than the satisfaction of an intense drive at the expenses of others. Besides this, a well adjusted person always considers his long interest and not simply the satisfaction of one intense drive. This type of adjustment is both realistic and satisfying.

In short, every individual attempts at making adjustment to minimize frustration, and conflicts resulting from internal and external
demands. However, the difference lies in the quality of adjutivate
behaviour patterns.

  the above-mentioned different approaches to the concept of
adjustment can be simply analysed in the following ways :

a) Adjustment is a process.

b) By this process the individual tries to bring harmonious, stable
and satisfying relationship with his environment, i.e., by this
process the individual alters his impulses and responses to fit
the demands of his environment.

c) By this process the individual tries to satisfy his needs and
desires in accordance with environmental demands on the one
hand, and his abilities and limitations on the other.

d) A good adjustment always aims at long-term satisfaction instead
of satisfying an immediate intense need.

While studying adjustment, one should, therefore, be more
interested in the ways in which people respond to the demands and
stresses of their environmental as well as to the satisfaction of
their needs and desires in accordance with such temporarily and
long-range environmental demands.

The concept of good and poor adjustment
It will not be a simple matter of classifying individuals as adjusted and maladjusted. Adjustment is considered to involve a continuous variable, so the evaluation of individual’s in terms of this variable cannot be limited to two extremes. Moreover, psychologists, or for that matter even other persons, fail to provide scientific and objective criteria of healthy adjustment, or, contrarily, unhealthy adjustments. The reason for this has been enumerated. We know that standards of adjustive behaviour may vary with time, place, culture, circumstances and the characteristics of the individual. There is no single life style which is best for all people; there are many life styles of varying forms (Kaplan, 1956).

An individual may be called adjusted at one time but he may be maladjusted at another time in the same social complex. He may be adjusted to one aspect of life and not to another, for example, he may be emotionally adjusted but socially maladjusted. Criteria against which adjustment is evaluated either as good or bad are provided by a particular cultural context, based on its value systems. And this value system naturally differs from one culture to another, or from one generation to another. Some of the indices of good adjustment of present might become a sign of maladjustment in the future, as for example, in a few societies psychotic-hallucinations were identified as supernatural and God-gifted, whereas number of
other societies considered psychotic persons as possessed by the
devil and wanted to destroy them (Lazarus, 1961). Even today
psychoties are considered to be extremely maladjusted persons.

The difficulty is enhanced when it is observed that adjustment
is relative in character and it should be judged in terms of how
well an individual changes to cope with the demands that he
encounters, and naturally this capacity varies with the developmental
levels of human personality. Thus, it is better to judge adjustment in
terms of a person’s ability to meet problems appropriate to his
level of development (Anderson, 1949). It is of common observation
that even a well adjusted person finds it difficult on some occasions
to handle a situation which is beyond the scope of his adjustability.

To sum up, it is difficult to have a yardstick or norm against
which adjustment can be evaluated mainly because of the following
reasons.

a) The value system of one’s culture differs from another.

b) Even in the same culture value systems changed from time to
time.

c) Adjustment is to be evaluated considering an individual’s
developmental level.

d) Adjustment involves a continuous variable.
In view of the above discussion it seems rather difficult to evaluate adjustment as being good or bad. Nevertheless, we can take into consideration the overall characteristics of a well adjusted person and derive some general criteria constituting the basic core of adjustment. These criteria may be summarized as follows:

i) A well adjusted person establishes a harmonious, stable and satisfying relationship with the environment. He meets his needs and fulfils his desires with the resources available in the environment from the viewpoint of his own welfare and that of other. He has realistic self-perception, and appraises his own abilities as well as limitations realistically.

ii) He has control on impulses, thoughts, habits, emotions and behaviour in terms of self-imposed principles or of demands made by the society. He enjoys a mental life, which is free from depressions, intense fears, acute anxiety, hostility, sense of guilt, insecurity and disruption of thought etc., to a great extent.

In short, it can be said that his behaviour is not disturbing to himself and to the people around him. A maladjusted person behaves in a way which is severely disturbing to himself and/or to the other members of the society.
The problems of old aged persons.

The problem of old aged people has always been considered to be of much significance. However, the advances in the area of behavioural science and increasing industrialization have intensified the need for the study of problems relating to old-age. The childhood, adolescence and adulthood all have their own problems arising out of various demands and stressful situations. The problems of old aged persons may have some common boundaries but the way they see problems faced by them may differ from person to person. The same situation may not carry equal intensity of threat and stress to all the old persons. Reactions to threats depend upon the person’s perception of himself and that of the stressful situations and taxing demands. Still further, the tolerance developed within the person may also play a major role while he is exposed to unhealthy life situations. This is our common observation that the tolerance capacity is decreased because of degenerating nerve cells or lack of proper functioning of nervous system as well as accumulation of frustrations and helplessness. It has been rightly remarked that a person’s attitude towards old age is determined by the experiences, successes and failures which have been accumulated during early years of life. In other words, his early deposits determine has present attitude toward the growing problems.
Some of the general problems which are encountered by the old aged persons and tax their adjusitive capacity and happiness are examined from multiple angels in a psychological perspective.

The fear of old age is stressful, which mainly grows out of the two sources. First the thought that old age may bring poverty, and secondly, by the most common sources, false and cruel teachings of the past which have been well mixed with. Ageing is a major life change which is a psychological step or transition that alters ones relation to the world about him and demands new response.

In the basic fear of old age man has two very sound reasons-one for his apprehension growing out of his distrust of his fellowman who may seize whatever worldly goods he may process and the other arising from the terrible pictures in his mind of the world beyond.

The possibility of ill health which is more common as people grow older is also a contributing cause of this common fear of old age as no man cherishes the thought of diminishing sex attraction.

Another contribution of a cause of the fear of old age is the possibility of loss of freedom and independence and also the loss of both physical and economic freedom.

The common symptoms of the fear of old age are the
tendency to show down and develop an inferiority complex at the age of mental maturity around the age of forty, falsely believing one's self to be slipping because of age.

Little bites of death of the well being or the ill being of the elderly is the ultimate algebraic sum of manifold factors-health, economic, social, psychological, family, philosophical and spiritual amongst many others. Shakespeare's Hamlet remarked- 'when sorrow come they come not single but on battalion's. How true indeed it is for the old people, they are saddled with burdens devitalised by losses and nearer to death. Thirty percent of the elderly persons have mental health problems and nearly at eightyfive parents have bodily change. Multiple deprivations clowd the evening of their lives. The loss may be of the spouse, of children, friends or the use of a limb, of health, status, self-esteem, mental faculty or income.

The above noted psychological factors of fear and little bites of death in ageing and the other losses which occur in the old age, clearly present the problem of adjustment.

The mature individual has responsibility for his choices and makes his decision, rather than uncritically accepting those of others. If the idea of established authority seems inadequate, he
turns the experiments and reasons for a more valid solution.

The problems in later year of life and after retirement and typical in nature. The major responsibilities bring their own adjustmental problems. Recently there has been numerous publications on the problems of later maturity and some suggestions to causes and remedies. The causes revolve around the roles assigned to older person in our culture, reaction of the individual to his own, physical and mental changes, particularly those that intensify the problem of age rather than reduce it.

Another problem relates to retirement from the active life or even an apprehension of being isolated from engagements either in service, business, farming or other means of livelihood because of decaying energy and advanced age. This is most serious in the case of those persons who had been enjoying power in government services or private sectors. In such conditions the old aged persons may develop a sense of isolation and extreme passivity which may adversely effect their satisfying experiences. They may develop anxiety over their excessive dependency may be torturing to them and specially when they are neglected by the family members. The sense of being neglected makes them feel that they are alienated and are living at the mercy of others. This sense of alienation is further enhanced when they find themselves incapable of making
healthy interaction with the society at large. It has been also observed that the increasing sense of isolation is aggravated when the old people want to pass time in the company of youngsters who do not like to waste their time in their company. The younger people may not like their company because they start preaching and narrating their past experiences and deeds which may not appeal to them.

The problem relating to financial insecurity and dependence upon other family members is also vital. This is more applicable in the case of those old persons who have not saved some part of their earnings in their past.

One major psychological problem during old age is that the physical strength may not support the desires and motives of a man. He may like to do many things which he did earlier but at present because of decaying general health he may not do. So there is a lesser coordination between his desire and action. He may like to play certain games but cannot. In some extreme cases old people want to write letters to their relatives but their hands shake, they want to run but physical condition does not permit. The growing physical disabilities, limitations and various diseases prove to be an obstacle to the satisfaction of motives.

The chronic illness may be source of strain and stress.
Physical degeneration becomes a threat to the older person. If the person is suffering from prolonged illness he may not be properly cared and nursed which in turn make him worried, irritating, aggressive and fault finding. The sense of being neglected is generally intensified because of person’s own attitude towards other. The prospect of death is another source of tension. It becomes more intense when the old persons get information about the death of their friends and relatives. The prospect of death is more dangerous than the death itself. It has been reported that persons who are sitting near a dying person feel more threatened and afraid of death than the dying person himself. However, some psychologists are of the opinion that older people have fewer hopes and expectations and, hence, may not be highly disrupted by the fear of death. The stress of the anticipated death is associated with the philosophy of life and the richness or dareness, disappointment and bitterness of early life.

*Individual difference in Adjustment*

It has been observe that differences exist between individuals in their adjustment to old age. Those who make healthy adjustment in the later years, keep approximately busy to construct the work that is satisfying to them and allows them to retain and enhance their self-esteem. Some have arranged to shorten hours of
work and reduce heavy responsibility to adjust their physical condition. In general the older employees who make the necessary adjustment are regarded as quite good by their employers. The individual who sees at middle age the changes that are occurring in the roles he will have to play in the future and finds new outlets more suitable to these decades of life is preparing for better adjustment in later years.

Simons (1943) who studied the relationship between middle aged adults and their ageing parents among a sample of clients of Jewish family agency on the west coast found that social problems of the aged parents were a source of considerable distress and threat to the adult children. The most effective ‘solution’ was to include the parents in a social or family affairs but such an arrangement was barely welcome on consistent and prolonged basis. The parent’s distress whether explicit by direct demands or implicit by complaints or loneliness ungeared the respondents more than any other problem presented by the parents. It can be gathered that peak of the human developments lies in the attainment of social maturity. However, the ability to reciprocally function in a complex social milieu is not only an indication of social maturity but is also
associated with happy dispositions. It is an important aspect of adjustment.

C) Stress and Coping Strategies

Stress is an all pervading phenomenon in life. It is necessary and useful for personality growth when in optimum quantity. When this optimum level, which varies from person to person is exceeded, the costs are experienced in the form of health problems and illnesses besides many other consequences. Stress has been defined as a stimulus and also as a response. Stress stimuli or stressors are of three major types (Lazarus & Cohen, 1977): major changes or events that affect many, major changes or events (e.g. getting married, death of a family member) that affect one or a few and daily hassles or incident in daily living which irritate or distress one.

Psychological stress then is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well being. This reiterates French (1974) concept of person-environment misfit occuring as a result of the environmental demands which are made on the person and being appraised as a threat, thus leading to stress and affecting his or her well-being.
Stress affects an individual in a variety of ways like narrowing the span of attention, bringing about certain cognitive deficits, inducing helplessness and irritability, affecting performance adversely, affecting physical and psychological health and so on. Chronic stress has costs which are cumulative in nature and this is most common in relation to physical and mental health.

Stress effects on individual’s health may be of short term on long term nature. Elevation in blood pressure has been observed in cases of anger and anxiety, stressful interviews, loss of job and natural disasters. Prolonged rise in blood pressure is found in those who face stress for long periods.

Social stress arising from marriage and parenting have been found to be closely related to depression could be of a neurochemical kind and neurochemical changes may be triggered off by stress (Anismoan & La Pierre, 1982).

Adverse social conditions associated with stressors operate to create depression and these have been identified. Prolonged social conditions of the adverse kind tend to decrease the levels of self-esteem and self-confidence among people who tend to break during difficulties (Brown & Harris, 1978). Similarly, higher degree of psychiatric symptoms were found to be more frequent among the
lower class persons (Myers, Lindenthal & Pepper). Frequent adjustment to changes in life because of the occurrence of life events increase the proneness to diseases as a result of lowering of resistance to diseases (Holmes & Mausa, 1984). Similarly, greater number of hassles of daily living also contribute to stress experiences (Kanner, 1981).

These disorders have been the object of a great deal of research and rethinking in recent years. It was once thought that the psychophysiological or psychosomatic, disorder that is, physical disorder influenced by emotional stress-constituted a circumscribed group. The disorders that fell into this group (asthma, ulcer, migraine, hypertension, etc.) were accordingly listed as separate diagnostic categories in earlier editions of the D.S.M. Recent evidence strongly suggests, however, that almost any physical disorder, from the common cold to cancer, can be "psychological". That is, almost any physical condition can be affected by psychological conditions, whether in its cause or in its progress. In recognition of this evidence, the DSM now no longer contains a list of specially psychophysiological disorder. Instead, it has one comprehensive category, "Psychological factors affecting physical conditions", the implication being that such factors might affect any physical condition.
The relation that our psychological state affects our physical health has recently been responsible for the development of a new research discipline, behavioural medicine (sometimes called health psychology). Two major historical trends have met in behavioural medicine. The first is the recognition that our lifestyle and state of mind affect our physical well-being. The second, the discovery that a number of treatment techniques from the behavioural perspective (such as biofeedback and relaxation training) can be effective treatment components for stress-related physical ailments.

**Mind and Body**

Mind and body are essentially the same thing or, at most two aspects of the same thing. "Mind" after all, is simply an abstract term for the workings of the brain. The brain is not only part of the body but is directly connected by nervous to all other parts of the body. Therefore whatever is going on "mentally" inside a person is also going on physically, and vice versa. Yet the fact remains that for most of the time we are completely unaware of the activity going on in our brains. All we are conscious of is the activity-effects that we think of as "mental", not physical.

In recent years researchers have presented compelling
evidence of organic factors in schizophrenia and severe depression. There is also new evidence of psychological influence over organic processes. In the sixties it was discovered that psychological functions such as blood pressure and heart rate, which were once considered completely involuntary (i.e., the province of the body, not of the mind), could be controlled voluntarily. And if mind could affect the beating of the heart or the constriction and dilution of the blood vessels, why could it not also affect such process as the growth of cancer cells or the progress of infection? In fact, there is now much evidence by no means conclusive, but very suggestive that psychosocial factors do play a role in cancer, infections, and many other illnesses traditionally regarded as purely organic. In the face of this evidence, many physicians are now beginning to doubt the long-entrenched separations of the mind and body. The same trend is affecting mental health professions, as can be seen in the DSM. The list of psychological disorders has been replaced by a single broad category of “psychological factors affecting physical condition” - a category that can apply to any physical condition. Kept apart for centuries, mind and body are now increasingly being considered as one.

The Autonomic Nervous system (ANS)
The role of the ANS is to adjust the internal working of the body to the demands of the environment. ANS has two branches—the sympathetic division and the parasympathetic division—which are structurally and functionally distinct.

It should not be imagined, however, that the body alternates between periods of sympathetic and parasympathetic activity or that only the sympathetic nervous system responds to stress. On the contrary, both divisions of the ANS are responsive to stress, and both are constantly in operation. For example, when a person is anxious, there is strong sympathetic arousal, as indicated by increased blood pressure and rapid heart rate; but the parasympathetic system is also involved as indicated by upset stomach, diarrhea, and frequent urination. There are, of course, periods in which one division is much more active than other. In situations of intense fear, as we saw above, sympathetic activity dominates; the same is probably true of intense anger. In sleep, on the other hand parasympathetic activity is dominant. Yet most of the hours of our days are spent in situations that, in terms of stressfulness, fall somewhere between sleep and mortal danger. And in these middling situations, as stress ebbs and flows, the sympathetic and parasympathetic division work together, adjusting our internal functioning to the demands made on us by the world.
Determinents of autonomic Response

Because it mediates between emotional stress and such crucial biological functions as respiration, digestion, and blood circulation, the ANS has been a major object of study or researchers investigation the relationship between psychological processes and physical disorders. Several decades ago, (W.B. Annon/1936) proposed that stress results in a massive arousal of the entire sympathetic division, with the psychological consequences described above. Regardless of the nature of the stress or of the individual the psychological response.

General arousal in reaction to stress, however, does not explain why some people respond to such stress by developing ulcers, others migraine and others high blood pressure. The question is still not completely answered. In addition to general arousal, there are also highly specific patterned responses that very both according to the nature of the stress and according to the individual.

Stimulus Specificity

In 1947 a patient named Tom who had experienced severe gastrointestinal damage underwent surgery, and in the course of the operation a plastic window was installed over his stomach so that its internal workings could be observed. In later
sessions with Tom, the investigators found that his flow of gastric juices decreased when he was exposed to stimuli that aroused his anxiety and increased his anger. Thus this experiment not only showed that gastric activity was related to emotional stress, as researches had long suspected; it also established the principal of stimulus specificity that different kinds of stress produce different patterns of psychological response.

This principle has since been confirmed by other investigations. Fear and anger, it has been found, have a significantly different impact not only on gastric activity but also on heart rate, blood pressure, muscle tension, respiration rate, and numerous other physiological functions.

**Individual Response Specificity**

ANS response depends not only on the nature of the stressor but also on the nature of the person.

There is an apparent contradiction between individual response specificity and stimuli specificity, if individuals have characteristic patterns of response that carry over from stressor to stressor, how can response very significantly according to the nature of the stressor? This seems improbable only if we think of autonomic response as a simple process, which it is not. It is an extremely complex process, in which a number of different
variables influence the final response. In the case of the two variables in question the individual and the stressor it has been shown that they do operate simultaneously example, as we saw above, the flow of gastric juices tends to increase with anger and decrease with anxiety; this is stimulus specificity. However, the degree of increase and decrease will be subject to individual response specificity. That is “gastric reactors” may show extreme increase and decreases; “Cardiac reactions”, on the other hand, may show only mild gastric charges, concentrating instead on heart-rate changes.

Psychological Events and Physical Illness: A Disregulation Model

Disregulation can occur at one or more of four different stages.

Stage 1: Environmental Demands

The demands placed upon the person by the environment may be so great that he or she is forced to ignore negative feedback from the body.

Stage 2: Information processing In The Central Nervous System

Even if environmental demands are not unreasonable, the brain may be programmed, either by genes or by learning, to respond inappropriately either to these demands or to the body’s negative feedback.
Stage 3: The peripheral organ

Even if environmental demands are not excessive and CNS information processing is going smoothly, the principle organ may be incapable of responding in an appropriate manner to the brain's instructions.

Stage 4: Negative Feedback

Finally, even if environmental demands, CNS information processing, and the functioning of the principle organ are all normal, a problem may develop in the negative feedback loop.

Physical Disorders Associated with Psychological Factors

Ulcer

Ulcer usually develop either in the stomach, in which case they are called gastric ulcers, or in the duodenum (the area lying between the stomach and the small intestine) in which case they are referred to as duodenal ulcers.

There is strong evidence that duodenal ulcers are associated with excess secretions of gastric juices (Dragstedt, 1967). Gastric ulcers, on the other hand, seem to be associated with some weakness in the mucosal lining as well as with abnormalities in gastric secretions. Exactly what cause these conditions we do not know, but psychological stress is almost
certainly one factor, at least in the abnormal rates of gastric secretion.

**Obesity**

The “abnormality” of obesity would be related to the personal-discomfort criterion. It may sectors of our society, obesity is viewed as “a state verging on crime” (Rodin, 1977). As a result the obese suffer not only the consequences of their socially defined unattractiveness-consequences ranging from a mild sense of inferiority to total social and sexual maladjustment but they must also suffer the sense of responsibility for their condition. This is personal discomfort of the first order, and one that brings many people into therapy.

Yet obesity is due not to physiology alone, but to an interaction of physiological and psychological factors. A number of studies indicate that obese people are far more responsive than others to any food-relevant stimulus: the taste of food (Nisbett, 1968); the sight and smell of food (Schachter 1971), the clock indicating that it is meal time (Schachter and Gorss, 1968); and, presumably, television commercials and magazine advertisements.

**Essential Hypertension**

All the physical disorders commonly associated with psychological stress, chronically high blood pressure, known as
hypertension, is by far the most common and the most dangerous. As schwartz (1977) has pointed out, these proposed cause can be classified according to the stage in which the regulatory cycle is disturbed.

**Stage 1: Environmentals Demands :**

It is possible that essential hypertensives are to some extent victims of the principle of the stimulus specificity. That is, their environments are particularly rich in those kinds of stressors that tend to increase blood pressure.

**Stage 2: CNS information Procesing-**

Essential hypertension may also be due in part to individual response specificity. In other words, genes or experience may have programed the brain to respond to different kinds of stress with increases in blood pressure.

**Stage 3: The Peripheral Organ**

It has been suggested that chronic hypertension may eventually produce structural changes in the blood vessels, so that they can no longer dilate properly.

**Stage 4: Negative Feed Back**

Chronically high blood pressure may also, in time, affect the operation of the baroreceptors. Under the strain of chronically high pressure, the baroreceptors may eventually adapt
to this stimulus and thus cease to respond to it in such an extreme manner or they may simply were down. In either case, they would cease to send the appropriate “high-pressure” signals to the brain.

**Headache**

Stress related headaches seem to be two types. Muscle-Contraction headaches, also known as tension headaches, range from mild to severe and are usually described by their sufferers as an aching or tightness around the neck or head. In most case the pain is felt on both sides of the head, either at the front or back of the head or at the back of the neck. Migrain headaches are more intensive and are usually localized in one side of the head and usually described somatic disturbances: such as dizziness, fainting, nausea, and vomiting. Migraine attacks range from bearable discomfort to complete immobilization and last anywhere from several hours to several days.

Like hypertension migration is a cardio vascular disorder. It appears to be due to the following sequence of events. First the blood vessels in the brain constrict as a result of stress. Then once the stress is relieved, the arteries leading to the brain dilate, and more blood delivered to the area than can be comfortably accommodated. The result of this dramatic change
in the flow of blood to the brain is a sharp, painful, throbbing sensation in the head— in short, the migrain. Thus it is not actually stress but rather the period of relief after stress that ushers in the headache.

**Asthma**

Asthma is a disorder of the respiratory system, the functions of which is to bring air in and out of the lungs, so that the body can take in oxygen and give off carbon dioxide. During an asthma attack is that the body’s air passage ways narrow, which in turn produces coughing, wheezing and general difficulty in breathing. Asthma is normally divided into two classes: allergic and nonallergic.

The psychogenic theory of asthma is quite old. Indeed, asthma was one of the cornerstones of “psychosomatic” theory in general, particularly in psychodynamic quarters. Yet systematic researches has failed to show that psychological factors are a primary cause of asthma. There is even some doubt about psychological stress as a secondary cause— that is, as a trigger for attacks, whatever the original cause of the condition. Attempts to induce attacks in asthma sufferers by exposing them to emotional and stressful stimuli have resulted in slightly decreased air flow, but no actual attacks (e.g. weiss et al, 1976).
**Insomnia**

Insomnia the chronic inability to sleep, Abnormal psychology accept as a symptom of other, more pervasive disorders, such as depression. yet for an extremely large number of people, sleeplessness is the sole complaint, and one which occasions severe physical and psychological distress.

Between 14 and 25 percent of the population have sleeping problems. There is no way of establishing, however, what proportion of these people would report insomnia as their only psychological problem.

Insomnia can stem from many different factors, including drugs, alcohol, caffeine, nicotine stress and anxiety, physical illness, psychological disturbance, inactivity, poor sleep environment, and poor sleep habits (Bootzin et al., 1983)

**Cancer**

For years it was believed that whatever physical disorder might be associated with psychological stress, Cancer was not one of them. Then, a few decades ago, researchers began discovering what seemed to be correlations between susceptibility to cancer and certain kinds of psychological characteristics. One researcher, Caroline Bedell Thomas, gave psychological tests to a large sample of medical students in 1946 and then recontacted
them every year to check on their health. By 1977, forty-eight of her subjects had developed cancer, and according to Thomas those subjects showed a marked tendency toward emotional restraint, the “bottling up” of strong feelings, whether positive or negative. In subsequent studies of people already suffering from cancer, other researchers have found that those who were able to express negative feelings fear, horror, anger—about the disease were more likely to survive it than the more stoical types (Rogentine et al. 1979). Besides emotional restraint, other psychological variables suspected as possible contributors to cancer are a sense of “helplessness /hopelessness” and, possibly as a cause there of, the experience of severe personal loss (Schmale, 1966).

Psychological therapy for cancer patients is that developed by Carl and Stephanie Simontion, in which patients are encouraged to visualize defensive forces within their bodies attacking and devouring the cancer cells. The idea is to restore the patient’s sense of control, a psychological change which will presumably lead to actual, immunological control over the cancer.

**Biofeedback Training**

Biofeedback training has been used most effectively with tension, headaches, migraine headaches, and muscle retraining
following strokes or spinal cord injuries (Olton and Noonberg, 1980). Biofeedback has not been more effective than alternative procedures for hypertension, but it is often employed as one component of a multicomponent treatment. In order that individuals can practice coping with stress even when they are not attached to biofeedback equipment, biofeedback is usually combined with other techniques, such as relaxation training.

Biofeedback can also be used to provide people with information about what aspects of their lives are stressful. In one program, for example, hypertensives were given blood-pressure of their lives. From hearing the machine beep whenever they began to discuss their marriages or jobs or whatever, they learned what areas of their lives were causing their stress problems. This feedback gave them the information needed to help them lower their blood pressure (Lynch et al 1982).

**Predictability and Control**

Two variables that seem to be particularly important in stress reactions are the predictability of the stressful stimulus and the individual’s control over the stimulus.

As research has shown, predictable stimuli are less stressful than unpredictable stimuli. This principle was born out during London blitz of world war II. The Londoners, we were
bombed with great regularity, experienced very few serious stress reactions, whereas the people in the contryside, who were bombed for less frequently but unpredictability, often shows severe anxiety (Vernon 1941). That predictability can affect the conversion of stress into physical illness was shown in Jay Weiss’s ulcer experiments with rats (1977), discribed earlier. As we noted, the ability of many of the “executive rats” to survive the experiment without ulceration was probably due not only to their control of the shock but also to its predictability- the fact that it was always preceded by a warning signal.

The Psychodynamic Perspective

The psychodynamic school was first to recognize that physical illness might be due to psychological difficulties. Traditionally psychodynamic theorists have referred to stress-related physical disorder as “organ neuroses” As the term suggests, psychodynamic theory regards these disorders as caused by the same mechanisms, and treatable by the same therapy, as the anxiety, somatoform and dissociative disorders.

Organ Neuroses

Like the anxiety, somatoform and other dissociative disorders, physical disorders such as asthma, hypertension, and ulcer are regarded by psychodynamic theorists as stemming from
disturbances that psychosexual development-disturbances that generate conflicts in the unconscious. And according to psychodynamic theory, these physical symptoms serve the same function as defense mechanisms: they keep the nature of the underlying conflict from reaching the level of consciousness.

**Personality Theories**

A recent theme in the study of stress-related physical disorders has been the effort to link specific disorders with specific personality types—A psychodynamic approach, historically or specific attitudes towards life is there a typical migraine, hypertensive, or ulcer “personality”? For example, Dunbar (1935), on the basis of interviews with patients, sketched a number of such personality portraits. Eczema sufferers were self-punitive, frustrated, helpless, and hungry for affections; they were the children of conscientious but emotionally distant parents.

Nevertheless, the search for traits and attitudes that might predispose people toward specific disorders continues. An example is the book ‘Type A behavior and your Heart’ (1974), by Friedman and Rosenman. The thesis of this book is that hypertension, along with other cardiovascular disorders, tends to strike a specific kind of personality which they call Type A. Type A people are aggressive achievers. They talk, walk and eat rapidly, and are highly impatient. They fidget in frustration if kept waiting by a traffic or an elevator.
They finish other people's sentences for them. They pride themselves on getting things done in less time than other people, and they measure their own performance by rigorous standards. In short, they keep themselves under unremitting pressure—Pressure that eventually takes its toll in their cardiovascular systems.

**The Sociocultural Perspective**

Society that may contribute to stress-related disorders is the disruption of marriage and the family. The people who live without regular social support, are depriving themselves of patent protection against illness. There is considerable evidence that social support helps people to recover from injury and disease (Meyeromitz, 1980; Silver and Wortman, 1980, Sklar and Anisman 1981). There is even more evidence that disease. Among the leading causes of premature death in our society are heart disease, cancer, strokes, cirrhosis of the liver, hypertension and pneumonia. For every one of these disorders without exception, premature death rates are significantly higher in the unmarried than in the married for both men and women. In the case of heart disease our society's major killer, the death rate, depending on a group, is anywhere from two to five times higher among the divorced, the single, and the widowed than among the married (Lynch, 1977). High percentage of cancer patients whose diagnosis had followed soon after the loss of an important relationship.
The Neuroscience Perspective

As we noted earlier, disorders such as ulcer, asthma and hypertension are probably due not to stress alone but to stress operating on bodies at that are predisposed to these disorders by certain variations in their functioning. The effort of biological researches has been to identify those variations-

Somatic Weakness

According to the theory of somatic weakness, psychophysiological complaint is most likely to develop in a person’s weakest or most vulnerable organ system. This theory, then, focuses on stage 3 of the dis regulation model. Consider, for example, a person with a strong digestive system, an average vascular system, and a weak respiratory system. Severe stress of any kind would be likely to have a damaging effect on the respiratory system, possibly in the form of asthma.

The Concept of Coping: An Overview

A close perusal of literature reveals that ‘coping’ has been viewed in diverse ways. Dewe, Guest and Williams (1979) consider coping as an attempt to remove the feeling of discomfort. White (1974) defined coping as the process which involves efforts towards solution of problems. It occurs when a person faces a threatening or dynamic change or problem that defies known or usual ways of
behaviour and might give rise to anxiety, guilt, grief and shame. and again forms the necessity for adaptation.

McGrath (1970) has viewed coping as the covert and overt behaviour by which the organism activity prevents, removes or circumvents stress inducing circumstances. Schregardus (1976) proposed two major styles of coping namely repression and sensitization. He also found that patterns of defensive style were related to the perception and experiences of stress and to subsequent patterns of coping and adjustment.

Pearlin and Schooler (1978) have suggested that “coping responses are the behaviors, cognitions and perceptions in which people engage when actually contending with their life problems. Coping responses represent some of the things the people do, their concrete efforts to deal with the life strains they encounter in their different roles”. Responses that are directed at modification of the stressful situations are the most direct ways to cope with strain because they tend to eliminate the source of stress itself. Pearlin and Schooler (1978) found that this is not a commonly used mode of coping. Before the onset of action which is directed at the modification of stressful environment the person must recognize the problem. The action intended to modify a situation may at times lead to other unwanted outcomes. Thus at times a person is
rendered helpless in dealing with action oriented coping. According to them coping refers to behaviour that protects people from being psychologically harmed by problematic experiences. They have identified three protective functions of coping behaviour i.e. by eliminating or modifying the conditions that give rise to the problematic situation, by perceiving the meaning of experience in such a manner that it neutralizes its problematic character and by keeping the emotional consequences under control.

Irving (1977) has presented a descriptive typology of distinctive patterns of coping that included vigilance, hypervigilance and defensive avoidance. On the otherhand, Robbins (1978) has identified seven patterns of coping viz. seeking social, dysfunctional behaviour, narcotizing anxiety, problem solving, reliance on professionals: bearing with discomfort and escape. In recent years attention has been given to coping with stressful events of day-to-day life. Broadly, three major approaches to measurement of coping can be identified i.e., coping in terms of ego processes (Hann. 1977; Valliant. 1977), coping as traits and coping as situation specific response.

According to Silver and Wortman (1980) coping refers to any and all responses made by an individual who encounters a potentially harmful situation. In addition to emotional reactions (e.g. anger, depression) and psychological responses (e.g. nausea, insomnia etc.)
as types of coping mechanisms. However, most theorists restrict the term coping to efforts made by an individual in problem solving, in order to master, control or overcome threatening situations.

The controversy regarding treatment of coping as a trait or situation specific effort is yet unresolved. The complexity of coping cannot be captured through unidimensional measure. Lazarus and Folkman (1984) assert that coping is a shifting process where a person must at certain stages and certain times rely more on one form of coping (e.g. defensive strategies) and at other times on another form of coping (e.g. problem solving) as and when the status of the situation changes. Trait measures assume that people are behaviourally and cognitively consistent in their coping behaviour across situations. Cohen and Lazarus (1973) assert that trait measures are poor predictors of coping. Situation oriented research focuses on how people endeavour to cope with specific stressful situations (Visotsky et al. 1961; Weisman & Worden. 1976).

A critical and important distinction between the trait oriented and the process-oriented approaches lies in the importance attached to the psychological and the environmental context in which coping takes place. The trait approach assumes that coping is mainly a property of the person and variation in stressful situations is of not much significance. In contrast, process oriented approach assumes
that coping is a response to the psychological and environmental demand of specific stressful encounters.

The most comprehensive approach to coping has been developed by Lazarus and his associates over a number of years (1966, DeLongis. 1983; Folkman. 1984; Kanner & Folkman, 1980). It utilizes the transactional framework in which person and environment are seen in terms of a continuous ongoing relationship of actions which are reciprocal in nature. These psychologists have argued that appraisal and coping processes mediate this transactional relationship.

Appraisal is considered as the cognitive process through which an event is evaluated as the whether the event is relevant to his/her well being and in what ways. Coping responses are made after the appraisal of the stress episode. Also, appraisal and coping continuously affect the influence each other throughout a given encounter. Coping, as Folkman and Lazarus (1980) have defined, is the cognitive and behavioural effort made to master, tolerate or reduce external demands and conflicts. Coping, according to them, serves two main purposes, the management, change or modification of the source of the stress (problem-focused coping) and the alternation and control of stressful emotions (emotion-focused coping). These forms of coping were found in more than ninety-five percent of the stressful encounters reported by middle aged men and
women and college students (Folkman & Lazarus, 1980). Also, the episodes involving people at work generated more problem focused coping in comparison to the episodes which involved family members. The context of the episode (e.g. work, family, health related) also influenced the use and outcome of coping mechanism employed. For instance, work was found to be related to higher levels of problem focused coping, whereas health was related to emotion focused coping.

The empirical study of coping with stresses has drawn the attention of Indian researchers only recently. In a study of examination stress Caplan, Naidu and Tripathi (1984) examined the relationship of coping and defence with affective outcomes. Working within the framework of person-environment (P-E) fit model, they found that defence-like measures were associated only with poor objective fit. The measures of coping-like responses were associated with current subjective fit. These effects, however were weak. The effects of coping and defense, as indicators of being ill were generally stronger. The defenses were associated positively with the negative affects and somatic complaints whereas the coping-like measures were associated positively with positive affect. They also noted that defenses moderated the relationship between fit and being ill. They found that prayer, unlike withdrawal, appears to buffer the
effects of poor-fit on being ill. The measure of coping used in this study included diagnosis and mobilization and the measure of defense included resignation, aggression, withdrawal, prayer and cognitive change. Due to methodological limitations, this study as “likely to yield conservative estimates of the effects of situation specific coping and defense on poor fit and ill being” (Caplan, et al. 1984)

Sinha and Misra (1983) have studied the coping strategies of underprivileged university entrants. They noted that the disadvantaged students used conformity feeling of inadequacy, withdrawal and ignoring the situation as coping strategies more than the advantaged students. They also noted that there were some ecological differences in the use of coping strategies. It was found that the urban students adopted affirmation and evidenced successful acceptance in the university stream to significantly greater extend than their rural counterparts. The rural urban group did not differ significantly from other groups in most of the strategies except feeling of inadequacy and withdrawal which were in greater magnitude than the urban group. Conformity or changing with the situation was employed by rural students more than the urban students.

Misra and Ganguly (1984) have investigated coping with stresses resulting from cultural transition among a group of African
students studying in India. They found that the students with high psycho-social competence used more problem focused coping and less amount of wishful thinking and self-blame than their low competent counterparts. In addition, they showed greater amount of positive affect, positive self-perception and less amount of somatic complaints and negative affect than low competence students. The relationship of coping strategies with health measures also differed for the two groups.

Singh and Pandey (1985) examined coping with problems in economic, family, personal and social aspects of life in a sample of university students. Using an open ended measure they identified five dimensions of coping namely appraisal-focused coping, emotion-focused coping, problem-focused coping, secondary coping and collective coping. The use of coping dimensions varied with nature of problems faced by the individual.

Another important study of coping has been reported by Singh (1990) in relation to the stresses of executives. This study employed a measure of coping strategies involving four factors, namely-active problem soving, non-directional work approach, constructive deferred problem solving, and information seeking. He found that the high level executives experienced lesser stress and strain, utilized coping strategies, and enjoyed more positive outcomes. Also, a combination
of coping strategies forming a condition of passive coping strategy was related to high stress condition.

The significance of social manipulation along with fatalistic coping and religion are culturally relevant coping strategies. Pandey (1981) has indicated that ingratiating is a positively valued and expected behaviour in Indian society. He has attributed it to the large scale acceptance of feudal and hierarchical structure in Indian society. The studies of Tripathi (1981) also indicate frequent use of manipulation as one of the prevalent modes of social influence in Indian socio-cultural setting. The present results showed that this strategy was associated with other strategies irrespective of the fact whether they are problem focused or emotion focused. Social manipulation was positively associated with the strategies like affective regulation, emotional discharge and tension reduction. The strategies termed as rational effort, situation redefinition, problem solving, logical analysis and appraisal focused coping, with minor variations, went together. It was also observed that emotion discharge and tension reduction were not independent but related to other strategies.

It appears that the use of mixed form of coping in which problem focused and emotion focused coping strategies is the dominant mode. This situation might be due to the "encompassing
system (prevailing in India) where logically opposites peacefully co-exist... and where actions do not necessarily follow thoughts and emotions, nor they confront with each other. Instead they are balanced and accommodated. Such a composite frame”, as J.B.P. Sinha (1982) has characterised, “is seemingly irrational and inconsistent. It is often slow in adaptation and generally inefficient from the purely rational point of view. And yet, it manifests a resilience which has more than counterbalanced its inner contradictions, and it follows a logic which is rooted in the Indian intra-psychic affective cognitive structures which reflect the configuration of the Indian social-institutions, the Hindu religio-philosophical thinking, and the present socio-economic realities.

The linkage between effort and goals, as J.B.P. Sinha (1982), has indicated “is believed to be dependent on the interaction of some superior order power or supernatural forces to which a person tends to be devotionally committed”. This partly explains the close ties between religion and fatalistic coping and other problem focused coping strategies. Commenting on the strong need for power, J.B.P. Sinha (1982) has conjectured some interesting culture specific strategies. He argues that “a superior with power and status might feel a need to brag and to make his power and influence more visible and legitimate. Overt and exaggerated self-appreciation is
accompanied with strong demands for loyalty and compliance from the dependents”.

The findings implicate that individuals from higher socio-economic groups tend to utilize more adaptive forms of coping than the low socio-economic status individuals. This trend is consonant with the findings reported by Haan (1977), Pearlin and Schooler (1978) and Billings and Moos (1981). However, the role of type of stressful event and psychological and social resources cannot be ignored. It appears that the experience of control and support lead to the use of active behavioural coping and active cognitive coping: while lack of these resources results in adopting avoidance strategies. Finally, it is also important to note that at least for the relatively higher income group people type of stress is not significant while using active behavioural coping strategy and partly active cognitive coping strategy. The avoidance strategy on the other hand, was importantly related to the type of stress.

iii) Objective of the present study :-

Following are the objective of the present study-

1. To study the significant difference of attitude towards ageing between male and female elders.

2. To study the significant difference of attitude towards ageing
between elders and senior elders.

3. To study the significant difference of attitude towards ageing among good, average and poor adjusted elders.

4. To study the significant difference of attitude towards ageing among different psychological states related elders.

5. To study the significant difference of attitude towards ageing among good, average and poor coping strategies related elders.

6. To study the significant effect of gender (male & female) and types of elders (elders and senior elders) on attitude towards ageing.

7. To study the significant effect of gender (male & female) and adjustment (good, average & poor) on attitude towards ageing.

7.01. To study the significant effect of gender (male & female) and health adjustment (good, average & poor) on attitude towards ageing.

7.02. To study the significant effect of gender (male & female) and home adjustment (good, average & poor) on attitude towards ageing.

7.03. To study the significant effect of gender (male & female) and social adjustment (good, average & poor)
on attitude towards ageing.

7.04. To study the significant effect of gender (male & female) and marital adjustment (good, average & poor) on attitude towards ageing.

7.05. To study the significant effect of gender (male & female) and emotional adjustment (good, average & poor) on attitude towards ageing.

7.06. To study the significant effect of gender (male & female) and financial adjustment (good, average & poor) on attitude towards ageing.

8. To study the significant effect of gender (male & female) and different psychological states (high, average & low) on attitude towards ageing.

8.01 To study the significant effect of gender (male & female) and anxiety state (high, average & low) on attitude towards ageing.

8.02. To study the significant effect of gender (male & female) and stress state (high, average & low) on attitude towards ageing.

8.03 To study the significant effect of gender (male & female) and depression state (high, average & low) on
attitude towards ageing.

8.04 To study the significant effect of gender (male & female) and regression state (high, average & low) on attitude towards ageing.

8.05 To study the significant effect of gender (male & female) and fatigue state (high, average & low) on attitude towards ageing.

8.06 To study the significant effect of gender (male & female) and guilt state (high, average & low) on attitude towards ageing.

8.07 To study the significant effect of gender (male & female) and extroversion state (high, average & low) on attitude towards ageing.

8.08 To study the significant effect of gender (male & female) and arousal state (high, average & low) on attitude towards ageing.

9. To study the significant effect of gender (male & female) and coping strategies (good, average & poor) on attitude towards ageing.

10. To study the significant effect of gender (male & female), types of elders (elders & senior elders) and adjustment (good,
average & poor) on attitude towards ageing.

10.01 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and health adjustment (good, average & poor) on attitude towards ageing.

10.02 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and home adjustment (good, average & poor) on attitude towards ageing.

10.03 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and social adjustment (good, average & poor) on attitude towards ageing.

10.04 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and marital adjustment (good, average & poor) on attitude towards ageing.

10.05 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and emotional adjustment (good, average & poor) on attitude towards ageing.
10.06 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and financial adjustment (good, average & poor) on attitude towards ageing.

11. To study the significant effect of gender (male & female) and types of elders (elders & senior elders) and different psychological states (high, average & low) on attitude towards ageing.

11.01 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and anxiety state (high, average & low) on attitude towards ageing.

11.02 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and stress state (high, average & low) on attitude towards ageing.

11.03 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and depression state (high, average & low) on attitude towards ageing.

11.04 To study the significant effect of gender (male &
female), types of elders (elders & senior elders) and regression state (high, average & low) on attitude towards ageing.

11.05 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and fatigue state (high, average & low) on attitude towards ageing.

11.06 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and guilt state (high, average & low) on attitude towards ageing.

11.07 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and extroversion state (high, average & low) on attitude towards ageing.

11.08 To study the significant effect of gender (male & female), types of elders (elders & senior elders) and arousal state (high, average & low) on attitude towards ageing.

12. To study the significant effect of gender (male & female),
types of elders (elders & senior elders) and coping strategies (good, average & poor) on attitude towards ageing.

iv) **Hypothesis of the present study** :-

Following null hypothesis have been formulated in the light of above objecties-

1. There is no significant difference of attitude towards ageing between male and female elders.

2. There is no significant difference of attitude towards ageing between elders and senior elders.

3. There is no significant difference of attitude towards ageing among good, average and poor adjusted elders.

4. There is no significant difference of attitude towards ageing among different psychological states related elders.

5. There is no significant difference of attitude towards ageing among good, average and poor coping strategies related elders.

6. There is no significant effect of gender (male & female) and types of elders (elders and senior elders) on attitude towards ageing.

7. There is no significant effect of gender (male & female) and adjustment (good, average & poor) on attitude towards ageing.
7.01. There is no significant effect of gender (male & female) and health adjustment (good, average & poor) on attitude towards ageing.

7.02. There is no significant effect of gender (male & female) and home adjustment (good, average & poor) on attitude towards ageing.

7.03. There is no significant effect of gender (male & female) and social adjustment (good, average & poor) on attitude towards ageing.

7.04. There is no significant effect of gender (male & female) and marital adjustment (good, average & poor) on attitude towards ageing.

7.05. There is no significant effect of gender (male & female) and emotional adjustment (good, average & poor) on attitude towards ageing.

7.06. There is no significant effect of gender (male & female) and financial adjustment (good, average & poor) on attitude towards ageing.

8. There is no significant effect of gender (male & female) and different psychological states (high, average & low) on attitude towards ageing.
8.01 There is no significant effect of gender (male & female) and anxiety state (high, average & low) on attitude towards ageing.

8.02 There is no significant effect of gender (male & female) and stress state (high, average & low) on attitude towards ageing.

8.03 There is no significant effect of gender (male & female) and depression state (high, average & low) on attitude towards ageing.

8.04 There is no significant effect of gender (male & female) and regression state (high, average & low) on attitude towards ageing.

8.05 There is no significant effect of gender (male & female) and fatigue state (high, average & low) on attitude towards ageing.

8.06 There is no significant effect of gender (male & female) and guilt state (high, average & low) on attitude towards ageing.

8.07 There is no significant effect of gender (male & female) and extroversion state (high, average & low) on attitude
towards ageing.

8.08 There is no significant effect of gender (male & female) and arousal state (high, average & low) on attitude towards ageing.

9. There is no significant effect of gender (male & female) and coping strategies (good, average & poor) on attitude towards ageing.

10. There is no significant effect of gender (male & female), types of elders (elders & senior elders) and adjustment (good, average & poor) on attitude towards ageing.

10.01 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and health adjustment (good, average & poor) on attitude towards ageing.

10.02 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and home adjustment (good, average & poor) on attitude towards ageing.

10.03 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and
social adjustment (good, average & poor) on attitude towards ageing.

10.04 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and marital adjustment (good, average & poor) on attitude towards ageing.

10.05 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and emotional adjustment (good, average & poor) on attitude towards ageing.

10.06 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and financial adjustment (good, average & poor) on attitude towards ageing.

11. There is no significant effect of gender (male & female) and types of elders (elders & senior elders) and different psychological states (high, average & low) on attitude towards ageing.

11.01 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and anxiety state (high, average & low) on attitude towards
11.02 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and stress state (high, average & low) on attitude towards ageing.

11.03 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and depression state (high, average & low) on attitude towards ageing.

11.04 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and regression state (high, average & low) on attitude towards ageing.

11.05 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and fatigue state (high, average & low) on attitude towards ageing.

11.06 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and guilt state (high, average & low) on attitude towards ageing.
11.07 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and extroversion state (high, average & low) on attitude towards ageing.

11.08 There is no significant effect of gender (male & female), types of elders (elders & senior elders) and arousal state (high, average & low) on attitude towards ageing.

12. There is no significant effect of gender (male & female), types of elders (elders & senior elders) and coping strategies (good, average & poor) on attitude towards ageing.

V) Importance of the present Study.

Today, the more developed countries of the world have become the aged societies. The process of ageing of population has set in developing countries and if the United Nations Population Projections (1985) are any indication of the shape of things to come then, these countries will have a vast majority of the world's older persons at the turn of the century. In a recent study it was observed that the demographic transition to an older population structure is proceeding fast in many developing countries. By the year 2025, the proportion of elderly to the total population is projected to be more than 12 percent. In that year
nearly 71 percent of the world's elderly population are likely to be found living in the developing countries.

This global phenomenon also afflicts India. The process of population ageing in India is still in an early phase and is expected to gain momentum in the course of the next century. The period between 1951 and 1981, the aged population has doubled. According to the 1981 census, there were approximately 43 million persons who had attain the age of 60 or more. The estimates arrived at by the expert committee on population projection of the aged population in India in 1991 is 54.84 million. Since 1961 one has observe a steady increase in the proportion of old person and the growth rate of the aged population (for both sexes) has always outstripped that of the rest of the population.

The ageing of the population has many profound social and economic implications. The process of ageing affects all social groups and indeed every type of social relationship, in all societies. It should be emphasised that the issues of population ageing are not related only to the elderly but are also related to other age sector of the population. Furthermore, the problems of ageing are related to apart from the question of increasing cost of social security and medical care, education, labour force,
migration, level of human investment and stability of the family as an institution. With increasing awareness of ageing, the need to study its repercussions and assess various policy options and priorities is assuming great importance. In countries like India which contain diverse populations, the population explosion will no doubt worsen the problems of ageing.

Differential access to social and economic opportunities available to cultural, linguistic, religious, racial or ethnic groups is also likely to intensify competition and conflict among them. Such social tensions and conflicts would adversely affect the elderly who, in general are more vulnerable than younger persons to social and economic hardships.

The present study is an attempt to study the attitude towards ageing, stress, adjustment and coping strategies of older people. The present study would be valuable in policy and decision concerning ageing problems and fulfil the motto of the UNAssembly (1992) on ageing “Add life to years”. It also includes efforts to enhance a sense of well being, quality of life and happy or successful ageing.