CHAPTER- 1
INTRODUCTION

An enormous technological advancement in recent decade has generally transformed the standard of living of human beings in almost all aspects of life, but in specific it has altered the advancement within the medical arena and boosted human health. The spectacular achievements in medical health care created a situation in which it has provided a boon of longevity. The developing society is compelled with such a population which is fast growing whom it treats as unproductive, ill and disabled i.e. the elderly population. In recent years, industrialized countries around the world have experienced an unexpected dramatic increase in the number of older adults. Getting old is a common experience which is collectively shared by the majority of people as a result it imposes new confrontations for family, community and society at large to safeguard the physical, social, emotional and financial requirements of the elderly.

The Indian society in the past three to four decades is going through a revolution by the influence of so many variables with the result the conventional values and social institutions like marriage and family have transformed into widening a gap between generations. The age old Indian set up and the traditional joint family system have always been involved in the protection of the social and financial safekeeping of the old people in our country. But with urbanization, globalization and with the emergence of nuclear family system the needs and demands of the elderly people have been overlooked with the result they have been rendered with physical, psychological and economic insecurities. An article published in a prominent Newspaper “The Hindu” by Goswami (2016) on the basis of study conducted by Age well Foundation highlighted some awful realities about elderly people who are enforced to live in shabby conditions out of which 37% are being misbehaved or ill treated, 20% sacrificed their social lives, 13% are being physically or mentally tortured, 13% are being deprived of basic amenities followed by 9% of being abused and 8% with other types of pestering.

The Department of Economic and Social Affairs of the United Nations (2015) claimed an increase in number of elderly people worldwide to be expected to grow by
56% from the year 2015 to 2030 i.e. from 901 million to 1.4 billion, and by 2050, the worldwide population of elderly people is going to reach nearly 2.1 billion. The percentage of aged persons 80 and above is likely to increase between 1% and 4% of the population worldwide from today to 2050 (Gavrilov and Heuveline, 2003; The Department of Economic and Social Affairs of the United Nations, 2009). According to Ministry of Statistics and Programme Implementation, Government of India (2016) on the basis of census of 2011 out of the total population of India there are 103.9 million i.e. 8.6% are elderly people from which 8.2% are males and 9% are females.

**Defining Old Age**

Conceptualizing old age is complicated as age is considered to be looked from different angles. Physical age is the most widespread basis used to represent an individual's age (Stokes, 1992) which can be “divided into different age-spans e.g. young-old age (55-65 years of age), middle-old age (65-75 years of age), and old-old age (over 75 years of age)” (Brown, 1982; Duvall and Miller, 1985). Old age can be defined as decreased physical strength and vigour, diminished mental capability, declined social and economic activities, and dependence for financial, social, physical and emotional support. “Old age is called ‘dark’ not because the light fails to shine but because people refuse to see it” (Gowri 2003). According to Gerdes (1988) and Lowy (1985), several aspects of ageing need to be taken into account when defining old age; these are chronological, biological, psychological, social and developmental aspects. One aspect to consider while defining old age “is the biological or physical element which refers to the physical signs of ageing such as the deterioration of the senses and the changes in the structure and functioning of cells and organ tissue” (Kleinke, 1998). From the sociological view point, “ageing refers to the role changes of the elderly within the society. In other words certain roles are associated with certain ages” (Gerdes, 1988). According to Louw, Van Ede and Louw (1998) “the psychological age refers to an individual’s actual feeling regarding his/her age and the perception of how old he/she really is. In other words, an individual might feel younger or older than his/her chronological age”.

From the aforementioned information regarding the concept of old age, it can be established that ageing is an intricate process which starts with conception and ends with death of an individual. Birren and Schaie (1977) proposed a multifaceted model that
believed in the biological, social, psychological, emotional and developmental transformations in performance that take place during the lifespan and defined aging as "...the regular changes that occur in mature genetically representative organisms living under representative environmental conditions as they advance in chronological age". The life expectancy in India is below 60 years. Majority of Indians psychologically believe and treat themselves old quite before they attain the age 60 whereas “the Indian women consider themselves to be old even much earlier” (Montross et al. 2006). According to Mayor (2006) a number of people apply their physical age as a basis for aging on the other hand some evaluate their ageing in terms of some physical ailments like weak vision or hearing, enhanced exhaustion, diminished sexual activity etc. Some others make use of basis for ageing as their weak potentiality to work, their productivity as compared to their earlier years when they were young, their deficiency in competing with others, lack of enthusiasm to do new things. They start accepting the fact that they are old and develop the feeling of an ‘old age complex’ (Antonelli et al. 2002).

Old age can also be conceptualized keeping in mind two majors aspects of ageing. One most important aspect related to ageing is the positivity in terms of experience, knowledge and wisdom. The elderly people are free from responsibility and also from the attitudes of other people how they think about them. Wittiness, serenity, piousness are some of the positive characteristics which can enhance their self concept provided they have been regarded as such. On the contrary old age is usually treated to be associated with negativity because of diminished physical strength, economic dependency, unproductivity, lack of role in decision making, intergenerational communication gap and bereavement. In the present study the terms aged, older people and elderly people have been used interchangeably.

**Theoretical Background of Ageing**

Different theories have been advocated to address the dynamic process of ageing. The following section will review some of the theories of ageing in an attempt to present an outline for an improved comprehension of the latter phase of life.
1. Disengagement Theory

The most implicit theory initiated in the gerontological text is the disengagement theory. Cumming and Henry (1961) proposed this theory with the contention that with the growing age the elderly start disengaging themselves in almost all the activities they used to do in their prime age. This can be due to diminished physical strength, vigour, declined cognitive faculties and psychological and social withdrawal. This withdrawal from social interactions is mutually consented by the individual himself or by the society. The individual due to economic interdependence, loss of spouse, intergenerational gap, and other losses withdraw himself from the society and society also turns down these unproductive individuals and treats them as fragile, weak, disabled and sick. In other words this theory postulates that it is advantageous for both individual and society to contribute in the course of departure from significant roles, activities and relationships as that person is growing old. The theory is not directly in favour of that person should disunite from all the relationships which he made in his prime life and become a sage, rather it suggests that an elderly person shall be relatively less involved in the social interactions in which he/she was formerly bound, and a diminished level of participation will take place at four stages. Firstly, the number of persons would be reduced with whom he/she regularly used to meet. Secondly, the quantity of interactions with persons would also be reduced. Thirdly, the manner of interaction would be altered due to the distorted state which the elderly is carrying. And lastly, which is quite important is that the elderly person would focus entirely on his/her state of condition with withdrawing from society which in turn society would also withdraw from the individual.

But this theory has been criticized by behaviourists on the ground that the fundamental motive of the theory is faulty and as well as the basic postulates cannot be sufficiently verified by some empirical research. But Cumming and Henry argued on the basis that this theory of aging has created many scientific but social thoughts for continuously for a number of years devoid of being properly postulated or sufficiently verified. Nonetheless, this theory has posited a significant position in the area of gerontology as well as in the field of life span development. Moreover, disengagement theory has led to the materialization of other theories like continuity theory and activity theory.
2. Activity Theory

Activity theory of ageing was proposed by Havighurst in 1961 in which he emphasized with the contention that there exists a constructive association between an individual’s level of activity and satisfaction with life which results in enhancing the self concept of that person that how he/she positively perceives himself or herself which in turn enhances his/her adjustment in later years of life. The activity theory arises when elderly persons keep themselves busy for the whole day with different kinds of activities and preserve an optimal level of productivity for successful ageing. Basically this theory gives emphasis on the notion that “the more you do, the better you will age”. The elderly who maintain their activity level, engage themselves in one or the other activity and keep in touch with the latest updates have a tendency to live happy, healthy and for a longer period.

This theory was criticized on the basis that to some degree it is static in the sense that if a person rises up in the morning and do the same kind of chores like the routine work does not imply that he/she would age well. This also fails to believe in maintaining one's mid-life or making changes in the older life like if a person was quite active in his/her prime life and was able to handle high stress would not be able to age successfully by doing optimal level of tasks or vice versa. But this theory was made use of by many plan managers for the elderly people who made them keep busy in a number of activities besides their daily routine and found that when these persons have been kept busy and their activity level is heightened in some meaningful and fulfilling tasks they showed high self esteem and meaning in life.

3. Continuity Theory

The continuity theory ageing was proposed by Robert Atchley in 1971. This theory postulated that some elderly people maintain their lives with the same kind of activities which they used to do in their prime lives. They maintain similar kind of interactions with friends, relatives despite bereavement as they did when they were young. According to this, elderly people who not only maintain their interactions, relationships but also maintain the old habits, likings and disliking and their lifestyles age successfully. But it does not mean that the habits which were not good like excessive drinking, gambling or other such things and if they continue with the similar preferences, likings or disliking
which were not good for his life would not age successfully. Basically the persons who had comfortable life in their mid years and had almost all good habits would age successfully otherwise not. People who continue the good stuff to carry on for their later life would survive hale and hearty.

This theory was basically criticized on the grounds of its definition of normal ageing. The theory did not differentiate normal ageing from the pathological ageing in which the elderly people are not keeping well due to physical or mental ailments, how a person in this condition can continue with the similar kind of lifestyle by ignoring his health and well being. It was also criticized on the basis of being surrounded around a male approach. It also fails to emphasize upon the role of social institutions like family, marriage and the circumstances which can affect their lives in later years.

4. Lifespan Perspective

On the basis of life-span perspective, old age is an enduring process. During this process, there exist many changes and transformations which are related to loss or deterioration. According to this approach, with advancing age old people are required to accomplish various taxing developmental tasks for successful aging. For this purpose they have to adjust and make harmonious balance between changes they already made in their adulthood and the changes which are occurring during old age. At this stage of life the elderly person has to face many challenges and confrontations and he/she has to make maximum adjustments. It not only restricted to physical domain but also to the personal, social and economic domains. One of the chief developmental tasks acknowledged by old people associated with the challenges in hand are ill health, lack of physical vitality and vigour and approval and acceptance to avoid death and integration of certain issues related to their continued existence.

Taking into consideration of above sighted issues related to lifespan approach, generally one can perceive that during aging there are two major issues which need to be taken care of i.e. somatic and psychological confrontations. The somatic issue is contingent upon the unavoidable and irreversible changes due to degeneration with advancing age. On the other hand the psychological challenge is dependent upon the
feeling of being stigmatized and prejudiced from which they have to overcome in order to maintain the feelings of self esteem, efficacy, proficiency and mastery (Kleinke, 1998). But in particular, some of the issues which need to be taken care of include adjustment to biological degeneration, adjustment to living partner, adjustment to retirement process and decline in economic status, adjustment to present living arrangements, adjustment to decline in cognitive functioning, adjustment to new social roles, adjustment to family, community and society by making obligations and adjustment to new social relationships. According to Louw et al (1998) the above cited developmental tasks should be accomplished successfully and these are more or less dependent upon how the previous developmental tasks have been achieved that would in turn results in successful aging. According to Strumpfer (2001) “successful aging will be associated with an individual’s ability to live to an advanced age while holding on to the ability to function independently and remain mentally alert”.

The lifespan approach is in the realm of other psychological approaches on aging which give some productive knowledge about human development. These comprise of Erikson (1976), Peck (1968) and Levinson (1986) who all were involved in identifying various psycho-social developmental responsibilities whereas Piaget (1972) was interested in the cognitive development (Kimmel, 1974).

Erikson considered much popular and utilized theory which was related to the old age. In his theory there is a description of development which starts from birth and ends with death. This theory is very much related with components interconnected with old age.

5. Erikson’s Theory of Psychosocial Development

According to Erikson the development of an individual depends upon heredity and environment which act concurrently. The inheritance refers to the development that occurs in each stage is in congruence with specific age and manner. He talked about eight stages of mankind and called them psychosocial stages. Each stage has some specific peculiar tasks which are to be accomplished by interacting with society. Kimmel (1974) submitted that Erikson's first five stages are like "the building blocks upon which success
or failure in later life depends. Each stage presents a new challenge, a new point of turbulence in the stream of life that must be negotiated successfully”.

According to Erikson (1976) for every psychosocial stage the individual has to analyze the solution keeping in view the two poles instead of only the positive or the negative. When he/she achieves successfully he/she must go the next stage to get the solution. Erikson called the sequence of his theoretical framework as ‘epigenetic’. The eighth psychosocial stages proposed by Erikson have an importance at old age because it is related to the end of human life. The seventh stage is related to middle age. According to Kleinke (1998) “the life task associated with middle age is known as generativity versus stagnation. Generativity refers to “as being used to express the desire of two mature people, who have found a satisfying mutuality in their relationship, to combine their personalities and energies in the production and care of their offspring” as compared to stagnation which is related to non- productivity. Erikson's (1976) eighth psychosocial stage is called "ego integrity versus despair" which is of great significance to the present study as it is related to old age. Ego- integrity is the resultant to the outcome or successfully accomplishing the first seven stages which gives a meaning to life. Gerdes (1988) recommended that "integrity is based on the belief that one's life has been meaningful… it enables the individual to face death with greater equanimity, because what (has been) generated in life will not be negated by death".

The Erikson's Theory has been criticized on the grounds that this theory cannot be either be measured or replicated. This theory lacks scientificity which describes human development. Though it deals with many psychosocial aspects of development yet it does not touch the important aspects of development like cognition and emotions. In spite of the above criticism this theory is widely documented as an important theory of human development. According to Erikson (1963) the person who is maladjusted display anguish, hopelessness and discontentment with their lives and often is afraid of death. The old people host a large number of difficulties in their lives which have been underlined below.
Problems Faced by Elderly

Due to stress and demands of society every individual has difficulties in every phase of life. But the problems or difficulties faced by old people have constantly been an area of concern. Though a large number of elderly people encounter many problems in their lives yet it is dependent upon the speed of growing older and the coping mechanism they use to handle the challenges. These people should be made well aware of the negative aspects like deterioration in physical, cognitive and social domains related to their lives but the knowledge should also be provided about the positive aspects of aging like their potentialities in order to enhance their personal growth and well being. Comprehending the psychosocial problems faced by the aged would provide an insight into the physical and psychological needs of elderly people.

Getting old and the process involved in ageing is mainly the biological phenomenon which has its own drive and which is beyond the reach of one’s control. It is irreversible phenomenon which involves so many drastic changes which are sometimes are not accepted by the person getting old. Old people may lose physical vitality and vigour which many do not accept easily; besides this they may lose sensory abilities. They may lack ability to synthesize and analyze. They may find themselves out of place in many situations especially with the younger generation. With each passing day the difficulties and the problems get profound as the world is changing at a faster rate and they do not find any resemblance to what the elderly people were once used to. The elderly who adapted with the young oriented society were able to adjust and did not face much of the problems keeping aside the health issues but for many who due to certain disabilities were not able to cope faced many difficulties at most of the fronts.

With urbanization and changes in joint family system to nuclear family set up the dynamics of living arrangements of elderly faced dire consequences. More often there is a direct decline in the family sizes of family in India. In Indian society the elderly usually live with spouse, children and other family members and is a common culture practice. Normally the adult children or family members take the responsibility of caring the old parents by taking care of their economic, social, emotional and health needs. Living with adult children provides not only social support but also takes care of other kinds of support. On the return they have been expected to look after the grandchildren and help
them in household chores. Sometimes under pressure they have been forced to relocate their life-time savings and property to their adult children and their daughters-in-law and put themselves in a condition so they become dependent on them. Sometimes the adult children feel burdened to keep their parents with them and make other alternative arrangements where they only financially help them but socially and emotionally they are being abandoned. Many a times they leave them in old age homes to get rid of them. So that they are relieved of unwanted burden and enjoy their lives. For many elderly who are financially sound they prefer to live with spouse alone. In case they are single, living alone has become a way of life. They come face to face with many challenges of life which they have to deal with all by themselves like managing the house and household, looking after their health issues and keeping up the ever changing society and social norms. After their children grow up and move out for education or work and their spouses pass away, the left behind elderly are suddenly faced with dealing with rigors of living alone. While some may be financially supported by their children or other family members, most elderly depend upon their personal retirement savings/pensions to meet their loneliness and isolation that grips elderly people living alone which can be scary and unfathomable. They need to make different adjustments irrespective of their living arrangements. In the present study the researcher has taken adjustment, loneliness, hopelessness, death anxiety and depression for exploration among elderly people. Now each psychosocial factor would be investigated one by one. Adjustment is one of the problems as physically and emotionally the elderly experience many stresses, crisis and losses in addition to their need to cope with a devalued status.

**ADJUSTMENT**

A number of adjustments require to be done by different elderly individuals as they grow older; such as physical and sensory deprivations which demand external adjustments and cognitive, emotional, social and psychological changes which demand internal adjustments. The internal and external adjustments associated with old age may reflect the varied psychological reactions. The major psychological reactions at old age employ the requirement to go up the stigma of old age as being terrifying, gloomy, depressed and
disgusting thus retain one’s self-confidence and proficiency. Other adjustment in old age deals with the grief reactions related to bereavements. Out of which the most prominent one is the death of spouse followed by social isolation.

Adjustment usually deals with the alteration to recompense to meet special conditions. The term ‘adjustment’ denotes to the terms like to fit into, to arrange accordingly, to harmonize, to adapt, to vary or to make appropriate setting. This means for making adjustment between two things one has to change or settle in. Thus adjustment refers to the “capability to become accustomed to one’s own environment with changing conditions” (Ogunbameru, 2002; Santrock, 2006). According to Shaffer (1961) “adjustment is the process by which a living organism maintains a balance between its needs and the circumstances that influence the satisfactions of these needs.” Shaffer attempts to retain a balance between one’s needs and his/her capabilities to meet these needs. It is quite true that till the balance between demands and capacity is retained the person is said to be adjusted but as soon as this harmony is troubled the person would fall into the category of maladjustment. From above definitions it is quite obvious that for every demand the person has to modify his/her style of behaviour to go with the modified circumstances so that a reasonable and pleasant relationship can be retained taking into consideration of the person and his demands on the one hand and the surroundings and its impact on the individual on the other hand. Gates and Jersield (1948) mentioned that “adjustment is a harmonious relationship between individual and his environment”. Kulshrestha (1979) defined “adjustment as a way in which the individual attempts to deal with stress, anxiety, tensions and conflicts to meet his or her needs”. In this course, the person either formulates efforts to retain pleasant affiliation with environment or modify his/her behavior to fit into one’s desires. Taking into account of all these details it may perhaps be affirmed that “adjustment is a condition or state in which the individual behavior conforms to the demands of the culture or society to which he belongs and he feels that his own needs have been fulfilled”.

Psychological adjustment can be analyzed as an incessant, energetic process which includes two variables in the form of individuals and their demands as well as the circumstances and its needs. Every one of us perceives a new situation from a different
perspective as there are diverse needs and unlike possibilities for the need satisfaction. Majority of us are practically conscious about our needs and are acknowledged by the way of responding at an optimal level in many circumstances. Moreover we try our best to decide on the particular situation on which we would be able to retain our adapted outlines for need gratification.

Adjustment problems occur when there is a disagreement between congregation of one’s own goals and the demand of the situation. There are some specific rules to assist in solving such conflicts which an effectively adjusted person would attempt to put all pertinent factors and to give proper weightage in decision making. The result of an appropriate adjustment is that the individual gets as much real satisfaction of his life. However, adjustment is not the complete happiness but it is the best way for achieving happiness and satisfaction in life.

After getting the knowledge of concept of adjustment it becomes imperative to know the factors that might help in successful adjustment. It becomes essential to know the factors because many individuals adjust to their environment quite effectively but many others are not able to. It means that there are individual differences that make some individuals to have adequate adjustment and on the other hand it also makes other individuals to have maladjustment. There are certain factors that can enhance or impede the acceptable adjustment. In order to understand them, it is essential to look at the types of adjustment from different angles.

Types of Adjustment
Some researchers confer that adjustment can be expediently understood in terms of a continuum ranging from well adjustment through normal adjustment to maladjustment. This is entirely dependent upon how a person makes balance between his demands and the environment or the situations in which he lives. The type of facet is sometimes analyzed as refer to appropriate versus inappropriate behaviour or it can be referred to proper versus improper behaviour as the notion of normality is so extensively used while mentioning psychological adjustment. Here are few behavioural patterns of an adjusted person and a maladjusted person.
a) Adjusted Person
At times a number of persons have to face a large number of difficulties, frustrations, conflicts, disappointments, disagreement, discontentment, displeasure, disapproval and condemnation. Many a times it happens that in such situations persons may feel anxiousness, nervousness, incapable of tackling them but there are a number of persons who handle those situations very well and try to conquer and overcome those difficulties in an effective way. These types of persons are called well adjusted persons. The healthy and well-adjusted persons usually tend to hold/exhibit some noticeable behavioral patterns which are according to the normative pattern and social expectations. These persons possess maturation in thinking. They usually have emotional stability and have an affectionate and warm attitude towards other persons. They take their own decisions and are not dependent on others for decision making. They make healthy adjustments in the form of satisfying their needs which of course are in balance with the environment. The main focus of Maslow’s research was on tremendously well-adjusted person. According to him a well adjusted person possesses the characteristics like a well person knows his positive and negative points. He/she tends to have an optimal level of ambitions and personal social needs. This type of person is not judgmental and appreciates the good traits of others. These persons possess the quality of flexibility and acting in unfavourable conditions. “A well-adjusted person has a philosophy which gives direction to his life while keeping in view the demands of changed situations and circumstances. This philosophy is centered on the demands of his society, culture, and his own self so that he does not clash with his environment or with himself” (Mangal, 2006). They have a balanced mind that when to worry and when to not.

b) Maladjusted Person
An individual who is unable to accomplish his biological, psychological, economic, personal or social needs in a successful manner and fails to maintain a balance between his/her needs and the environment or the normative patterns of society is said to have maladjustment. These individuals who possess to have low self confidence tend to have deprived capability to deal with everyday life situations. They do not react to situation logically and their reactions are disproportionate. They sometimes involve in health
compromising behaviours like as excessive drinking, smoking, taking drugs, etc. This in turn affects the perception and beliefs by making them emotionally disturbed. They possess rigidity and find it difficult to modify their behaviour patterns. They tend to be withdrawn, shy, nervous, fearful, anxious, sensitive, isolated and emotionally disturbed. They lack self confidence and have strong feelings of inferiority. These individuals are not able to overcome their difficulties and are not able to compromise with them. Sometimes they develop such disorders in which they exhibit exaggerated and persistent responses which have a propensity to debilitate them and deform their feelings and behaviour.

**Adjustment among Elderly People**

A large segment of elderly people has difficulty in accepting that getting old is a natural phenomenon. There is a clear cut decline in physical strength and mental faculty. They have to adjust accordingly but it has been established that those elderly persons who are prepared to adjust themselves psychologically for the inevitable changes in the age as well as in the environment seemed to be active, satisfying, healthy and lead their rest of life successfully. But for those who are not able to make the balance between rapid changes and their adjustment appeared to be confused, dependent physically as well as psychologically and are insecure, detached, lonely and helpless. It has also been experienced that the previous learning of certain adjustments which the elderly used to do in their prime lives are not applicable and appropriate in this changing scenario. Therefore they need to adjust to the maximum.

In order to satisfy the personal, social and other kinds of needs the elderly people have to make expected kind of adjustments which sometimes they are not able to adhere to cause difficulties in their lives. They are expected to live according to the expectations of adult children, his family and others which should not beyond the structure of life provided to them. The demographic evolution is accompanied by certain psychosocial problems for which the elderly has to adjust accordingly. The personal, social and societal adjustments are nevertheless mild as compared to biological adjustments. The old people strive to get into their comfortable zone with the condition they make certain adjustments according to their surroundings. They need to make a
position in the family, community and society at large only then society will accept them as individuals. Otherwise the society treats them as frail, disabled, non-productive and sick people who are good for nothing. They need to make their own social networks to survive. The children and grandchildren do not have time to spend with them because of the generation gap. Moreover regarding the expectations from both sides create certain problems in their lives. They expect their children and grandchildren to look after them properly but on the other side children and grandchildren also expect them to be productive in the sense in helping in daily chores or looking after the home of grandchildren. In spite of incapability they had to adjust accordingly. Old people have certain hurdles with regard to their health, home, social, marital, emotional and economic domains. They want to maintain equilibrium among these areas. The most vulnerable fallacy is the society’s critical attitude towards the elderly which is quite unfavourable (Mundada and Hatkanagalekar, 2013). These people have to enhance their awareness about people and surroundings around them to meet their needs through social networking. If they become rigid and resistant in their attitude it would not help in successful aging. They need to keep compliance with their health, economic and living conditions otherwise their existence is not accepted in the society and they may develop the feelings of loneliness, anxiety and depression. “The urbanization and rapidly changing family values have made the position of elderly especially vulnerable, resulting in loneliness and increased death anxiety” (Desetttey and Patnam, 2000).

**LONELINESS**

Loneliness is an individual and pessimistic trepidation related to an individual’s own speculation of unsatisfactory social relations. Paplau and Perlman (1992) analysed 12 definitions of loneliness and concluded three rudiments. Firstly, “loneliness is a result of deficiencies in a person’s social relations. Secondly, it is a subjective feeling, not synonymous with isolation and thirdly, the feeling is negative and unpleasant”. Due to degeneration and advancement in age it becomes difficult to keep pace with the younger generation. Moreover they experience age-related losses which hamper the grip of social relationships. Their inability to participate in cultural and community activities results in
a higher incidence of loneliness. They feel neglected and lonely as the family members on which they are dependent are pre-occupied with their own lives and work. Loneliness is “an emotional and cognitive reaction to having fewer and less satisfying relationships than one desires” (Archibald, Bartholomen and Marx, 1995). Loneliness refers to a personal experience that what and how we feel about our interpersonal life. Loneliness “reflects an individual’s subjective evaluation of his or her social participation or social isolation and is the outcome of the cognitive evaluation of having a mismatch between the quantity and quality of existing relationships on the one hand and relationship standards on the other” (de Jong Gierveld, Fokkema, and van Tilburg, 2011). According to Victor (2012) “loneliness is a dynamic state that varies across the life course and is influenced by the resources available to individuals and their socio-environmental context as well as individual personality traits”.

It was found in a study accomplished in Netherlands that approximately 20 percent of its population of elderly people were found to be mildly lonely and 8 to 10 percent of oldest old were found to have severe loneliness (de Jong Gierveld et al. 2011). According to a report based on UK population cited by Canada’s National Seniors Council (2014b) stated that about 5 to 16 percent of elderly people are believed to have loneliness. Additionally, it was also projected that approximately 10 percent of the elderly population in the UK exhibit chronic level of loneliness. In another study from UK also confirmed that “the prevalence of severe loneliness among older people living in care homes is at least double that of community-dwelling populations” (Victor 2012). Another study showed that, factors like presence of chronic diseases or physical disabilities, use of medications regularly, lack of hobbies and living with a spouse were associated with increased feelings of loneliness among the elderly (Arslantas, Adana, Abacigilergin, Kayar and Acar (2015). Parikh (2013) in a prominent and leading newspaper ‘Hindustan Times’ reported that 34% of old people in India feel loneliness, 26% of old people have the feelings of emptiness and about 67% of the elderly people need assistance to deal with their daily routine.  

Most researchers agree upon that feeling lonely is not the same as being alone. One can expend longer periods of time without the company of others without having the
feeling of loneliness and on the contrary one can feel lonely in the company of others. In reality, studies have shown that one can not differentiate the lonely and non-lonely people on the basis of amount of their social interactions rather it can be differentiated on the basis of quality of social networks. Sometimes it has been observed that alone person can spend his time more with unknown people rather than with friends and family. Loneliness is an unavoidable state of being which refers to the incapability to retain the level of associations one wants to have. Loneliness is a personal and subjective feeling of being lost, uninvited, discontinuance, disengaged and detached and estranged from other people. The lonely person may have the feeling of pain in the form of sadness, gloominess, depression, sorrow, emptiness. Such people may feel no sense of direction, no person to praise to or support to, no sense of identity and no sense of affiliation. They persistently feel that they are being abandoned, secluded, isolated, desolated and deserted. This type of feeling is beyond their control and may burst into tears exhibiting the signs of helplessness, hopelessness and depression. Sometimes they wish to be dead and have constant suicidal ideations.

Types of Loneliness

A large number of researchers focused on the classification of loneliness and divided it from different point of view. First type of classification laid emphasis on the duration of loneliness and divided it into two types i.e. short-term loneliness and long-term loneliness. Short-term loneliness refers to a loneliness where an individual feels lonely on and off. That means their loneliness is short lived and for a short period of time but on the contrary long-term loneliness refers to a loneliness that lasts for a longer period. With the increase in long-term loneliness there is a drastic increase in comorbidity. It also increases the incidence of having depression and suicidal ideations which have the most debilitating and devastating effects in the well being in later life. On the basis of above mentioned typology loneliness can be classified as state loneliness and trait loneliness. State loneliness is momentary and is contingent upon the circumstances in which an individual is occupied in. For example, a person has been transferred to a new place and there he is not acquainted with anybody and the person is feeling lonely. This is called state loneliness.
Second type of categorization centered upon relationships as proposed by Weiss (1973). He divided loneliness into major categories as emotional loneliness and social loneliness. Emotional loneliness refers to the lack of emotional regard endowed with close relationships or the loss of significant figure in one’s life. Death of near and dear ones, divorce and break up marriages are the possible precursors of this kind of loneliness. The signs and symptoms of emotional loneliness contain a feeling of nervousness, anxiety, a sense of complete isolation, cautious about danger, risk and death, an inclination of misapprehending the antagonistic or loving intent of others. On the other hand, social loneliness refers to the lack of appropriate social interactions and contacts. “Weiss believed it to be about the absence of an engaging social network of friends, co-workers, and members of their community” (de Jong Gierveld, Fokkema, and van Tilburg 2011). For example some of the antecedents of social isolation include transfer, retirement, shifting from one place to another, fired from job, being secluded by friends, family members or peers, debarred, or to put in an old age home and a feeling of not belonging to a community. The signs and symptoms of social loneliness can be thoughts of boredom, feelings of impatience, uneasiness, restlessness, eccentricity and isolation. The affective components of emotional loneliness are more or less more strong, unapproved and inappropriate than the components of social loneliness. Weiss (1973) opined that emotional and social loneliness can co-occur simultaneously or can co-exist independently. It has also been assumed that personality of a person and his social networks also play an important role in the development of emotional and social loneliness. “Lack or low levels of social relationships, discontent with the quality of such relationships, or low levels of social engagement and participation are all linked to having damaging effects on the quality of life for elderly persons (Victor et al. 2005). “Intense loneliness is found to be more frequent in divorces, widows or widowers, individuals who are living alone or in deprived areas, or those threatened with deteriorating health” (de Jong Gierveld, Fokkema, and van Tilburg 2011).

The third type of classification is based on belief or judgment which pointed out two types of loneliness as objective loneliness and subjective loneliness. Objective loneliness refers to a pleasant experience that might be sought after an inspirational experience. This type of feeling is created by the community or the society in which the
Most elderly people who live alone have been forced to do so. More than half of elderly population asserted that they have been directed to do so and make them learn helplessness and make them to adapt that is why most of the old people prefer to live alone but due to some constraints most prefer to live with their children or families. It is also evident that when the feeling of loneliness is temporary it is more appreciated than when the feeling becomes somewhat stable it is painful. On the contrary subjective loneliness is experienced by many people who feel lonely and it is their personal and subjective feeling. Therefore, it is situation which is not intended situation as objective loneliness is but is always imposed by the person's personal feeling. Even though there is a clear cut distinction between objective loneliness and subjective loneliness but the two are also closely associated.

**Loneliness among Elderly People**

Loneliness is usually occurred in a large segment of elderly people in different types of situations. According to Forbes (1996) “the elderly persons who experience loneliness comprise of elderly married women, older people who live with married children, those living in residential care or in sheltered housing, older people who are care-givers, and older immigrants, particularly those who do not speak the language of their host country”. Holmén et al (2000) found that “women reported both social and emotional loneliness significantly more than men and older subjects in the older age group reported more frequent loneliness than their younger counterparts as females survive to a greater age and live without a partner for longer than men”.

Loneliness is a frequent and universal feeling among elderly persons. It may be triggered by different reasons. The elderly persons experience loneliness when their relations with adult children or family members are not cordial. The old people who hold very less social interactions and those who are not in favour of keeping social relations with relatives and friends experience strong feelings of loneliness. Those persons who keep themselves idle, who do not indulge in any kind of recreational or pleasurable activities, who do not utilize their leisure time properly and who do not use religious coping are being forced to have the feeling of loneliness. This loneliness always accompanied by negative and suicidal thoughts and depression as compared to the elderly
persons who claim to be active in their recreational and leisure time. They always indulge in some or the other activity and participate in social gatherings frequently. They indulge themselves in household chores, visit to parks and religious places or a club for retired people. The elderly people usually feel lonely when their children leave them for the good with the result they experience ‘empty nest syndrome’. They anticipate their children to support them when they fall sick or in other type of assistance. Next most important reason could be retirement. After retirement, old people may have more free time which they are not able to reschedule and they do not know how to spend it. Moreover, the pension impedes the potentials of enjoying the time. People in some jobs used to cultivate social interactions among colleagues and other professionals but after retirement they have to give them up. They feel helpless with financial interdependence as well as losing the role of decision maker. Still another reason could be the death of spouse which usually shakes the life of elderly persons because they are of the view that after doing all the responsibilities of life now they will live in peace with the spouse but this feeling shatters when they experience the loss of life partner as well as the death of close relatives and friends of their age. They also start feeling the fear of death. Research indicated that “the lack of social network and social support are associated with increased loneliness, complicated grief, poorer coping levels, lower levels of quality of life, increased levels of depression, poorer mental health and decreased psychological well-being” (Fry, 2001).

HELPLESSNESS

When an individual takes birth he is totally dependent on others and is helpless. Same kind of condition occurs when an individual gets sick or old. With passage of time and while interacting with society, the individual becomes self reliant and self sufficient. Certainly the course of life becomes tension free and smooth when the essential needs are gratified in an appropriate way but with technological advancement, urbanization and modernization the life of people, community, and society at large have drastically changed especially the life of elderly people which is enveloped by anguish, distress, helplessness and hopelessness. Though the modern people acquire best possible ease and
comfort from the luxurious lives yet they experience a number of mental and emotional problems such as depression, anxiety, helplessness and hopelessness. These psychological troubles of modern society spread darkness on the individual and society where today’s man is badly looking for an amicable answer to overcome them.

Helplessness is a sign of depression which is often associated with suicidal ideas. Helplessness refers to multifaceted emotional, impulsivity and cognitive predisposition which usually is a consequence of a negative evaluation about the prospects of the person. Helplessness can be understood in terms of distress which occurs when the person is in crisis and when a person is not able to deal with difficult situations like death of spouse, knowledge of having dreaded illness like cancer or HIV/AIDS. But these experiences are for a shorter period and can be dealt with the help of mental resources. Helplessness has been explained in terms of a building block of human subsistence. Helplessness is defined as an observation which a person makes when he feels powerless and vulnerable and is not able to change the adverse situation. The feelings and experiences which are being articulated with the help of helplessness are not perhaps independent of depressive feelings. Nevertheless, helplessness can be treated as an independent entity that can affect that how people identify and analyze the information and behave accordingly.

The concept of helplessness was earlier represented as an explanation of incapacitating impact of unmanageability. It states that whenever people identify the response they may confront to many shortcomings and these may be ‘motivational, cognitive and emotional’. The motivational shortcomings refer to “retarded initiation of voluntary responses which in turn diminishes the motivation to control the outcome”. Cognitive shortcomings refer to where a person experiences complication in learning the responses that generate outcomes. Actually it hinders the learning process that give rise to outcome. The emotional shortcomings refer to a depressed emotion whenever a person learns that there exists no association between response and outcome.

Learned helplessness is an emotional condition in which an individual has a feeling of powerlessness to change his/her self or circumstances. The concept of learned helplessness was first coined by Seligman and Maier (1967). Seligman’s concept of
learned helplessness has widened its scope from animal behaviour to an extensive range of human behaviour that is comprised of adolescent development, illness vulnerability, problems related to elderly people and depression (Seligman, 1975); intellectual growth (Dweck and Licht, 1980) and aged (Schulz and Hanusa, 1980). Learned helplessness takes place in circumstances which a person encounters which are beyond his control and he/she learns that their response is not associated with the outcome. It emphasizes on how learned helplessness plays important role in goal achievement and mastery. It is described as “passivity, giving up, procrastination, deceased problem-solving ability, frustration, low self esteem, decreased motivation, anxiety and sadness”. In the contemporary society people in their daily activities or in different situations, in family or in other settings undergo certain unpleasant dealings. When a person feels that his/her action have no control over unpleasant dealings, he/she is more likely to build up a feeling of helplessness. The most important negative life events a person usually experience is death of a spouse, separation, divorce, loss of near and dear ones, losing a job, betrayal from a friend, break ups, not getting a job, persistent job unhappiness, criminal persecution, imprisonment, caught in theft or robbery, accident, having a child with physical or intellectual disability, suffering from a chronic illness disease, financial crisis and the like. Whenever the above type of life events emerge which are beyond the control of an individual and which persist for a longer period, large a number of deficits have an effect on the individual which can result into collapsing the homeostasis of the body and mind which further result into divergent physical and psychological problems in an individual. These difficulties may lead to chronic ailments like depression, helplessness, anxiety, stress related disorders. Thus learned helplessness theory proposed that “clinical depression and related mental illness result from a perceived absence of control over the outcome of a situation” (Seligman, 1975). Further research in this direction suggested that learned helplessness interrupts the normal development and learning patterns of an individual and leads to psychological disorders, especially helplessness followed by depression.

Maier, Seligman and Soloman (1969) emphasized the cognitive explanation of learned helplessness which has an important role in the development of depression. According to them learned helplessness is a cognitive condition in human beings.
Cognitive theorists claim helplessness and hopelessness to be a trait other than a state because they considered helplessness and hopelessness as a cognitive unit which give rise to depression. The physiological foundation of learned helplessness emphasized upon the low levels of norepinephrine metabolism in the brain. Weiss disagreed on the fast indulgence of learned helplessness is not attributable to learning rather he emphasized upon some temporal biological imbalances which helps in correcting it with changing time. Abramson et al (1978) had given three domains of attribution related to learned helplessness. These three domains examined the different signs of helplessness. The first domain of learned helplessness on the basis of attribution can be distinguished into two types i.e. “universal helplessness and personal helplessness. Universal helplessness promotes external attribution whereas personal helplessness promotes internal attribution” (Abramson et al. 1978). Universal helplessness is described by the notion that a product is not the result of our responses but it is independent of that whereas personal helplessness is that where an individual considers that the responses are dependent upon product. The second domain on the basis of attribution can also be divided into two categories i.e. global helplessness and specific helplessness (Mc Dermolt Nelson and Quinless, 1988). In global helplessness the shortcomings in learned helplessness are basically occur due to wide range of circumstances but in specific learned helplessness the shortcomings in LH occur only in some specific circumstance. Those who attribute unmanageability to global factors which results in helplessness which is generalized to numerous different circumstances on the other hand those who attribute unmanageability to some specific factors also result into helplessness which is due to some particular circumstance. Third domain on the basis of attribution can also be divided into stable and unstable helplessness. The stable helplessness stays for a longer period whereas the unstable helplessness is short lived and for a shorter duration. According to Abramson et al. (1978) “an individual who develops the expectation that outcomes are uncontrollable, are at risk for developing cognitive, emotional and motivational deficits”.

**Helplessness among Elderly People**

A numerous studies stressed upon huge amount of urbanization, industrialization, mobilization and modernization which laid down diverse psychosocial, economic and
cultural changes in the society, deteriorating the family and community ties. These changes not only affected the family's traditional role of providing care and financial support to its members but also hampered the intergenerational ties. With infringement in the multigenerational cohabitation there is an emergence of a nuclear family. The roles and responsibilities which used to carry out by the members of traditional joint family have been taken over by the members of nuclear family but this also underwent drastic transformations due to the diverse occupations taken over by the family members. Disenchantment with life in villages and allurement, charm and attraction of life in city has led to urbanization, migration and mobilization of the younger generation leaving behind the old people or elderly parents at ancestral homes. Thus the old generation has left with no option but to stay alone leading to helplessness in them. The younger generation treats them as a burden and do not give any monetary, physical or emotional support to them. This change in living arrangement has shattered and diluted the obligatory norms and responsibilities of youngsters towards the elderly in the family and untied them from the obligatory social responsibilities. Many a times due to development of some chronic health problems the elderly have to struggle hard to adjust to those developments making them helpless. Sometimes due to lack of activity, vigour, vitality, strength and mobilization, the elderly people feel helpless as they are not able to move around and look for someone to take them along.

Moreover the sensory processes get weakened with age and limit the activities of the aged to make them dependent on others for each and every task. Bereavement is another major area in which the aged people experience helpless. The loss of spouse amongst them is the chief irreparable loss which shatters them to be in the condition of helplessness. Retirement is another area of concern for the aged. Leaving the locality or home in which they stayed for most of their life is quite difficult. They find it difficult to transit as sometimes they have to move to a smaller accommodation and had to sacrifice many things which make them helpless. After retirement the financial crisis usually starts and sometimes elderly have to literally beg to their children in order to meet their daily needs making them dependent, weak, reliant and helpless. Sometimes it also happens that due to economic dependence the elderly have been exploited, maltreated, oppressed and subjugated. This leaves them in a helpless, susceptible, pathetic and vulnerable condition.
Rigidity or stubbornness can be another possible reason which can make elderly people helpless. The aged people who tend to be quite rigid in their thinking and attitudes and usually practice the outlook of “my way or no way” get into troubles and difficulties in their later lives. The adult children due to intergenerational gap, stubbornness and inflexibility in their parents have been forced to leave them in another accommodation or old age homes making them helpless.

Thus hopelessness, helplessness, dependency, exploitation and maltreatment among elderly people forced them to think of dying or being dead. But it has also been observed from a large number of studies that the old persons who live successfully do not want to die and pray for more long years to live. They experience lot of anxiety regarding death.

**DEATH ANXIETY**

Although death is an inevitable part of life yet people usually are afraid of death. But optimism, hope as well as hopelessness play a dynamic role in the process of dying. Hope at old age contributes as a sign of cure, endurance, relief, comfort, self-respect, confidence and rescue. On the other hand hopelessness at this stage with no signs of hope make the elderly people more vulnerable to such situations where they experience anxiety related to death. Death is a dominant human apprehension which is theorized as an influential inspiring force behind every creative phrase and philosophical belief throughout the ages. Confronting death and death related anxiety created by awareness of its inevitability is a widespread psychological dilemma for human beings.

“Death anxiety is a term used to conceptualize the apprehension generated by death awareness” (Abdel-Khalek, 2005). Death anxiety is the gloomy, uncharacteristic or unrelenting terror of one's own death or the course of his/her dying. Death anxiety is an experience of fear, dread or worry (anxiety) when one has a thought of the course of dying or death. Death anxiety refers to “a negative and apprehensive feeling that one has when thinking about death and dying” (Richardson, Berman and Piwowarski, 1983). It also refers to a “vague uneasy feeling of discomfort or dread generated by perceptions of a real or imagined threat to one’s existence” (Moorhead, Johnson, Maas and Swanson, 2008). “Death anxiety is a negative psychological reaction to the perspective of
mortality” (Templer et al 2006). Death anxiety and fear of death are more of a common fear which can be developed by an individual without having an anxiety disorder. Majority of the people have a feeling of fear of death at one or other point in their lives. According to Azaiza, Ron, Shoham and Gigin (2010), “a morbid and persistent fear of death or dying is called death anxiety” It is also referred to as “thanatophobia (fear of death)” but usually can be distinguished from “necrophobia (fear of dead or dying persons and/or things”. Individuals give different personal meanings to death and associate them with sometimes with objects and events in their environment. They tend to give personal meanings on the basis of their attitudes which can be negative or positive for the individual. When the individual has positive attitude then the penalty of those meanings about death can be comforting like they think that once they have taken birth in this world they may die one day but when the individual has negative attitude it can cause emotional turmoil and anxiety in them.

Tomer (2000) elaborated upon the death anxiety model with main emphasis on three factors which included regrets related to past, dissatisfaction related to future and meaningfulness of death. Firstly, the regrets related to earlier stage are person’s disappointments for not achieving basic ambitions which have been remained unaccomplished. Secondly, the regrets related to person’s incapability to execute the basic goals in future. And thirdly, the person’s perception about death is meaningfulness. Accordingly the individual would have a feeling of high death anxiety after keeping in view his/her past and future related regrets.

**Types of Death Anxiety**
According to Langs (2004), there are three types of death anxiety:

1. **Predatory Death Anxiety:**
Predatory death anxiety takes place with the fear of being harmed. It is the most fundamental and deep rooted form of death anxiety, with its genesis stemming from the first unicellular organisms’ set of adjustive assets. They have receptors that have been developed to react to external threats and they also have self- defensive, receptive mechanisms prepared to ensure survival in the face of chemical and physical types of
assault or danger. In human beings this type of death anxiety is induced by a number of danger circumstances that place the person at risk or intimidates his/her continued existence. These threats can be psychological and/or physical. Predatory death anxiety is defined as the neurotic anxiety of loss of self and body. It goes by through five different phases like denial of being dead, anger related to death, bargaining for not to be dead, depression related to death and acceptance about death or dying (Kubler-Ross, 2011).

2. Predation or Predator Death Anxiety:
Predation or predator death anxiety is such type of death anxiety which occurs from a person physically and/or mentally harming another and is frequently accompanied by unconscious guilt. In turn, this guilt prompts and persuades numerous self-prepared decisions and dealings by the perpetrator of harm to others.

3. Existential Death Anxiety:
Existential death anxiety is the essential comprehension and understanding that ordinary life must end. It is believed that existential death anxiety straightforwardly associates to language as language has produced the foundation for this type of death anxiety with the help of communicative and behavioral changes. Existential death anxiety is recognized to be the most potent form. Individuals defend against this type of death anxiety with the help of denial of dying or death, which is caused through a broad range of mental mechanisms and substantial actions many of which also go unnoticed. In an exceedingly short duration of evolutionary time, human beings have produced a unitary basic mechanism through which they tackle with the existential death anxieties in the form of different denials. Hence denials to such varied actions include infringement of rules and disobeying outlines and surroundings, weird celebrations, hostility directed against others, efforts to achieve extraordinary wealth and/or power—and more. These chases frequently are stimulated by a death-related distress and these may lead to productive actions damaging to self and others.
Theories of Death Anxiety

1. Thanatophobia

Freud (1952) was one of the pioneer theorists to stress upon the concept of death anxiety. He suggested that whenever people express a fear of dying or death it is known as thanatophobia. According to him it was not in fact the death which people are afraid of but the belief that people do not have an idea of being dead or imagine own death. He was of the view that the unconscious mind does not deal with calculating the amount of time left in one’s life. “Our unconscious does not believe in its own death; it behaves as if immortal”. Moreover he believed that death-related fears in one revealed the unsettled childhood conflicts that one cannot move toward the terms with or express emotion towards.

2. Terror Management Theory

Becker (1973) proposed terror management theory on the basis of existential views who rotated death anxiety theories towards a new aspect and was of the view that “while humans strive for self-preservation, they are also aware of the inevitability of death” (Pyszczynski, Greenberg and Solomon, 1999). When individuals turned out to be more conscious about the inevitable nature of death, they will unconsciously strive to restrain it out of fear. The method of suppression frequently directs it to conventionally cultural beliefs, responsiveness for external maintenance rather than stepping alone. This kind of behavior might range from simple thinking about death or dying to severe phobias, apprehensions, anxieties and desperate actions. According to this theory, “those with greater self-esteem will have greater tolerance for death-related situations and that those with lower self-esteem will experience greater death anxiety. TMT has generated extensive research providing substantial experimental support for its basic hypotheses” (Bassett, 2007). Varied things can contribute to our feeling of self-worth and our beliefs on the flexibility of society, in turn determining how we handle the threat of terror induced anxiety. A person with weak concern of self-worth may very well be overwhelmed by anxiety. On the other hand if the person has a positive outlook of the humanity around him and of himself, he may recognize a decrease in fear of death and death-related feelings of anxiety (Tomer, 2003).
3. Posttraumatic Growth Theory

Another recent theory of death anxiety Posttraumatic growth theory (PTG) suggested that “facing a life crisis, in particular death of self or a loved one, can result in positive changes, such as a greater appreciation for life, a shift in priorities toward intrinsic goals, and improved interpersonal relationships” (Tedeschi and Calhoun, 2004). After comparing terror management theory and posttraumatic growth theory of death anxiety Lykins, Sergerstrom, Averill, Evans, and Kemeny (2007) suggested some methodological differences and outlined that PTG explains “that facing mortality can lead to positive intrinsic changes (described previously), whereas TMT posits that facing mortality increases striving toward extrinsic goals that are personally and culturally valued. TMT studies generally involve experimental manipulations of death reminders on a single occasion, such as briefly presenting death-related words. PTG research typically examines naturally occurring challenges, such as dealing with serious illness or natural disaster. Such threats are uncontrollable and may be present for many days, months, or years”. Lykins et al (2007) offered a series of three researches intended to investigate these issues and demonstrated that “when people encounter death over a longer period of time or in a manner consistent with their goal structure, they move to transcend their defensiveness, maintain or become more intrinsically oriented, and may end up healthier in the long-term”.

4. Psychosocial Theory

Erikson (1950) proposed the psychosocial theory in which he explained that people develop in the course of a series of crises as they grow up older. The theory also encloses the idea that once an individual reaches the later phase of his/her life, they attain the level which is called as "ego integrity". Ego integrity is the level where an individual comes to conditions with his/ her life and accepts it. It means that when an individual gets a meaning or purpose in his/ her life, he/she reaches the stage of integrity. On the contrary, when an individual analyzes his/ her life as a series of unsuccessful and futile opportunities, then he/ she does not reach the ego integrity stage. The elderly people who have achieved this stage of ego integrity are supposed to display less signs of death anxiety; it means they have lived a successful and meaningful life. But it has been shown
in many studies that the elderly persons, who had physical, psychological, emotional and financial problems in their lives, are not able to reach the stage of ego integrity supposed to be afraid of dying and death.

5. Death and Adjustment Hypotheses
Death and adjustment hypotheses (DAH), a theory postulated about death and dying which stressed upon death anxiety and adjustment to death was proposed by Hossain (2008) who was interested in finding an answer to the irresistible anxiety and anguish about death. In order to find out the assertion to death anxiety, DAH hypothesizes two major themes. The first theme emphasized that “death should not be judged as the end of life whereas the second theme stressed upon the faith in eternal pattern of human existence can only be adopted in a morally rich life with the attitude towards morality and materialism balanced mutually” (Meyers, Golden and Peterson, 2009). DAH recommended that “no one is free from this anxiety unless there is something significantly positive in the phenomenon of death for humans”. Hossain (2010) suggested the idea of ’cessation of existence' through death which is the key aspect accountable for commencing death anxiety in someone. According to him “death became more an issue for oneself than anyone else. It highlighted the phenomenon most prominently and clearly. Death was acceptable as long as there was no conflict, at a mass level, between morality and pleasure”.

Factors associated with Death Anxiety
The likelihood of death frequently creates people more anxious when they think that they have not yet and not able to achieve any affirmative task in their life which they are living. A large number of studies conducted in the area of death anxiety have “used healthy adults with attention given to their level of anxiety, gender, age, and other demographic variables” (Kastenbaum, 2007). Other studies emphasized on the impact of death anxiety in elderly people (Goebel and Boeck, 1987) as well as in small children and adolescents (Koocher, O’Malley, Foster and Gogan, 1976). The idea of death causes varied level of anxiety for different individuals, depending on many variables.
Many studies have examined the relationship between religion and death anxiety and found that people who have strong and integral religious beliefs are found to be low on death anxiety and high in death acceptance. It has been believed that people who believe in god tend to have decreased fear of death, meaning more religious people fear death less. People who visit and attend religious gatherings and meetings regularly have less death anxiety. “People who possess intrinsic religious motivation have significantly lower levels of various types of death anxiety than people with extrinsic religious motivation have” (Kraft, Litwin and Barber, 2001; Suhail and Akram, 2002).

Although every society, culture has some evidence of death anxiety but it varied widely in the magnitude. According to Kalish and Reynolds (1981), “some cultures appear to manage the idea of dying comparatively well that they are referred to as death affirming societies; in other cultures, the aversion to the idea of dying is so strong that they can be classified as death-denying or death-defying cultures. The United States and probably most of the societies in the West are death-denying/defying societies”. On the contrary, other cultures and societies are accepting death. Eastern cultural beliefs are said to perceive death as a simple transition and that people are of the view that the most efficient method to conquer death is to acknowledge it as a primary fact of life.

Another variable which is associated with death anxiety is age. A general point of view about death anxiety is that with the increase in age death anxiety and fear of death also increase as the distance between us and death becomes small. However, a number of researches have confirmed this notion wrong. A study on “people belonging to three age units: the adolescent (18-26), the adult (35-50), and the old (60 and elder) showed that even though demise concern was elevated in adolescents, but it was elevated in adults also and lesser in the old people” (Gesser, Wong and Reker, 1987). “It is during the years of young adulthood (20 to 40 years of age) that death anxiety most often begins to become prevalent. However, during the next phase of life, the middle age adult years (40–64 years of age), death anxiety peaks at its highest levels when in comparison to all other age ranges throughout the lifespan. Surprisingly, levels of death anxiety then slump off in the old age years of adulthood (65 years of age and older). This is in contrast with
most people’s expectations, especially regarding all of the negative connotations younger adults have about the elderly and the aging process (Kurlychek and Trenner, 1982).”

Some researchers have speculated the gender differences in death anxiety. The connection between death anxiety and the gender showed that females are more prone to death anxiety than males. Females are socialized to be more conscious about their thoughts and to reveal them, thus in turn making them more likely to account for death anxiety. “Women, who are the child bearers and are often the ones who look after children hold greater concerns about death due to their caring role within the family, it is this built-in mechanism in women that leads to greater death anxiety as it emphasize the importance to live for her offspring”. Females across all age groups endorsed elevated levels of death anxiety as compared to male counterparts.

Other factors include fear of crime, low ego integrity, life threatening diseases, uncertainty, lack of hope, pessimism, fear, despair, social support, marital status, family cohesion and low self esteem which can reduce or increase the death anxiety and fear of death and dying in individuals. It is well said that “the fear of death exists always and everywhere and it is so great that, most of the life energy is spent in the moment of death” (Yalom, 2000).

**Death Anxiety among Elderly People**

Death anxiety or fear of dying or death is a big challenge among elderly people. Due to death anxiety the well-being of elderly persons reduces and their will to live diminishes. Death anxiety is one of the major concerns experienced by elderly persons and operates as a obstacle against end-of-life interactions with health care givers. In a study conducted by Sridevi (2014) found that “47.5% elders are having mild death anxiety and 52.5% are having moderate level of death anxiety and 40% of elders are having mild level of death depression and 60% of elders are having moderate level of death depression”. Facing death and death related anxiety which is produced by understanding of its inevitability is a worldwide psychological dilemma for human beings. According to health care providers, death is ubiquitous reality in spite of increasing technologically sophisticated and advanced health care systems, longer patient survival, longevity and successful
treatment from life-threatening diseases. Though reservations from unfavorable physical consequences of aging can be linked with physical distress, fear of potential mental and psychological decline which further can be connected with symptoms of anxiety and uncertainties about future personal losses i.e. loss of spouse, friends and relatives of their age may lead to such kind of anxiety among elderly people. Lower ego integrity, more physical and psychological difficulties are predictive of higher levels of death anxiety in elderly people.

Death anxiety reported by elderly people is usually associated with when they had experienced death to be associated with pain, distress, anguish and punishment. They usually explain that they are scared of death because they are losing worldly contribution. Because of the consequences of religious offenses, sins and failures and being separated from loved ones they are scared of dying. Another potential reason of death anxiety could be fear from degeneration of body after dying. Most of the elderly people are scared of death because they feel that after their death who will take care of their spouse, children, relatives. In addition to that they do not want to die hence have anxiety about that as they feel that their assignments, duties and responsibilities have not finished yet and by living longer they can accomplish those duties. Moreover they do not want to leave their near and dear ones alone in the earth.

But many elderly people when experience social isolation, loneliness, financial dependence and crisis, dissatisfaction with life or no meaning and purpose in life tend to curse their lives and wish to be dead. They have relatively low death anxiety. The aged who lived successfully and who had achieved what they wanted to achieve in life do not have much anxiety about death or dying. Moreover the older old people who have confronted so many deaths in their lives and accepted death as inevitable tend to accept death as part of life. They usually believe that fear of painful and dreadful life is greater than fear of death. Some of the older people with their experience are of the view that death occurs arbitrarily and once one has taken birth has to go one day.

**DEPRESSION**

Loneliness, helplessness and hopelessness as well as deteriorating health have been discovered to be threatening symptoms for depression. Depression is a widespread but
often non documented or inefficiently treated state among elderly people (Cindy and Helen 2011). According to Kim, Byeon, Kim, Endo, Akahosh and Ogasawara (2009), “depression in elderly people is a widespread problem that is often not diagnosed and frequently under treated. Depression can be associated with an increased risk of incidence of dementia and ideation of suicide in the elderly” (Kim et al 2009). Generally speaking depression is a mental illness which can affect both the mind and the body of an individual and is a leading cause of disability, absence from place of work, diminished productivity and elevated suicidal rates (National Institute of Mental Health, 2001).

Depression is the most common psychiatric illness found in general practice which is presented with depressed mood, lack of interest or happiness, diminished energy, guilt feelings, feelings of worthlessness or hopelessness, disrupted pattern of sleep or appetite, and reduced attentiveness. Additionally, depression frequently appears with the symptoms of anxiety. These troubles become so persistent or intermittent that can lead to considerable deterioration in person’s capability to take care of his or her routine roles and responsibilities and hinders his/her performance. At its worst, in depression many people take extreme step of attempting or committing suicide. “While depression is the leading cause of disability for both males and females, the burden of depression is 50% higher for females than males. In fact, depression is the leading cause of disease burden for women in both high-income and low- and middle-income countries” (World Health Organization, 2008). It has been anticipated that “between 5 and 25% of the population will experience depression at some point in their life and up to 15% of severely depressed individuals will commit suicide” (Gotlib and Hammen, 1992). According to Bao, Sturm and Croghan (2003) “The overlap between symptoms of depression and symptoms of physical illnesses may lead to unnecessary utilization of medical services in an attempt to treat complaints that are actually caused by depression rather than physical illness”.

The essential characteristic features of clinical depression are gloomy mood and diminished interest and enjoyment in day-to-day activities. The persons with depression may have the feelings of sadness, emptiness, hopelessness, personal dissatisfaction, negativity, worthlessness, sluggishness and sometimes heaviness. They usually experience loss of appetite and weight. Besides this they may have a negative or
pessimistic attitude about everything. The eating and sleeping patterns of these people usually change, sometimes they eat a lot and sometimes they do not feel like eating at all. They suffer from sleep disturbances like insomnia and sometimes hypersomnia. The psychomotor activities in these persons vary like sometimes they get agitated and sometimes their psychomotor activity slows down. They have a strong feeling of guilt and shame and for that matter they sometimes try to commit suicide. Because of extreme guilt or worthlessness at times they end up their lives. They are preoccupied with their failures and wrong doings and feel that they are inadequate and incompetent and because of this reason they make silly mistakes in life. They hold themselves responsible for every mistake or wrong deed. They also may have an impractical feeling of personal liability and view most of the things as being their own fault. Moreover they tend to have the feeling of drained energy, tiredness and fatigue. This is sometimes accompanied by delusions and hallucinations. According to Pattanayak and Sagar (2014), “at an individual level, depression affects the mental and emotional wellbeing, lowers the overall quality of life and may increase the risk of other medical illnesses. It adversely affects the job and familial functioning and at a societal level, depression leads to loss of productivity and economic burden”.

Depression has a propensity to be prevalent more among people who are unmarried, widowed, divorced or separated, or without social networking or are living without families or living in institutions, are issueless and are aged. The elderly people having physical or medical difficulties with degeneration experience higher degree of having depression. The elderly people who live alone and do not have financial back up report more signs of depression. In an Indian study, “about16% of depressed subjects with suicidal ideation had a suicidal attempt and risk was especially higher for individuals less than 30 years of age, single men, married women, students and those with higher education” (Srivastava and Kumar, 2005). Depression can differ in degree of mild, moderate or severe which usually depends upon the quantity and severity of depressive symptoms. Most of the persons with severe depression may probably have unjustifiable and unacceptable guilt feelings or other psychotic symptoms like hallucinations, delusions, paranoia, etc. According to Sadock, Kaplan and Sadock (2007), “a good prognosis may be indicated by milder episodes, good social support, stable
familial and social functioning before onset of depression, absence of a comorbid medical or psychiatric disorder, while patients with a younger age of onset, co-existing medical illness, substance use or anxiety disorder, multiple episodes or poor functioning in the premorbid period are likely to have a poorer prognosis”.

**Theories of Depression**

1. **Behavioural Theory of Depression**
Lewinsohn (1974) contended that “depression is caused by a combination of stressors in a person's environment and a lack of personal skills”. More exclusively, the environmental stressors can make a person to obtain relatively less positive reinforcement. The positive reinforcement arises when people do something from which they receive pleasure and reward. According to learning theory, “receiving positive reinforcement increases the chances that people will repeat the sorts of actions they have taken that led them to receive that reinforcement. In other words, people will tend to repeat those behaviors that get reinforced”. For example, many people work with dedication and devotion in order to receive money or other perks or benefits. Many children study hard to get high grades in class. These examples clearly show that working and studying are behaviors that are motivated by perks or benefits and good grades respectively are called the positive reinforcers. According to Lewinsohn, “people with depression are those who do not know how to cope with the fact that they are no longer receiving positive reinforcements like they were before”.

2. **Beck’s Cognitive Theory of Depression**
Some theorists emphasized the role of cognitive processes in depression. This theory was postulated by Beck in 1976 in which he talked about negative triad. According to him when the primary symptoms are cured the secondary symptoms are resolved automatically. The triad involves "automatic, spontaneous and seemingly uncontrollable negative thoughts".
Figure 1.1: Beck’s Cognitive Triad

From figure 1.1 it can be understood on the basis of cognitive triad viewpoint that depression is caused by person’s worthless negative analysis of themselves, their knowhow (and the world in general), and their future. Persons with depression often perceive themselves as unadorable, vulnerable, destined or incomplete. They have a tendency to attribute their unlikable experiences to their acknowledged physical, mental, and/or moral insufficiencies. They experience extreme guilt, believing that they are useless, at fault, and redundant by self and others. They tend to have a complicated time perceiving themselves as people who could never accomplish something, not acknowledged, or feel inferior about themselves which in turn may lead to abandonment, loneliness and social isolation, which further deteriorates the mood. Cognitive behavioral theorists suggest that depression results from distorted thoughts and judgments. These can be learned socially as is the case when children in a dysfunctional family watch their parents fail to successfully cope with stressful experiences or traumatic events. Or, they can result from a lack of experiences that would lead to the development of adaptive coping skills.


Albert Bandura (1986) in social cognitive theory (SCT) pointed out that individuals are produced by the communications between their behaviors, thoughts and environment. Human behavior is totally explained by a product of learning which is through observation, as well as through direct experience. Bandura emphasized that the self-
concepts are different for people with depression and people without depression. Those individuals who are in depression have a tendency to blame themselves and hold accountable completely for every misdeed by self blaming. In addition to that they feel that success is caused by external factors which are beyond their control. People with depression experience low self efficacy as they think that they do not have the ability to influence the circumstances. These individuals also have a faulty hypercritical process, they have a tendency to lay down their personal aims too high, and when they are not able to achieve them they fall short of them. These kinds of repeated failures produce the dejected feelings which in turn lead to depression.

4. Learned Helplessness Theory of Depression

Learned Helplessness theory was postulated by Seligman (1975) in which he contended that individuals having depression are more likely to use a pessimistic justification when confronting stressful events than did individuals who were not having depression. On the contrary the individuals not having depression are more likely to use an optimistic explanation when facing some stressful events. The individuals who have a tendency to analyze the causes of negative events as ‘internal, global, and stable’ are supposed to have a pessimistic style whereas the individuals who have a tendency to perceive the causes of negative events as ‘external, specific, and unstable’ have an optimistic style. Individuals who become depressed are more likely to have pessimistic styles than optimistic styles. Furthermore the revised version of this theory suggested that the individuals with a pessimistic style are more likely to develop learned helplessness in them. Additionally, constant experience with unmanageable and unpreventable events can lead individuals to develop a pessimistic style. They become unenthusiastic and unresponsive even if they are not that way to start. This theory further suggests that depression is not the outcome of helplessness only, but it also derives from hopelessness. “The hopelessness theory attributes depression to a pattern of negative thinking in which people blame themselves for negative life events, view the causes of those events as permanent, and over generalize specific weaknesses to many areas of their life”.

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4. Diathesis-Stress Model of Depression

The diathesis-stress model was proposed by Monroe and Simons (1991) suggested two general factors that give rise to depression. First of these factors is a negative life event. These life events characteristically include the loss of some significant source of love, safety, identification, or self-respect. The examples can be death of a near and dear one, the breakup of a love affair, or an important personal failure. This model can be explained in fig 1.2.

![Diagram of Diathesis-Stress Model of Depression]

**Figure 1.2:** Representation of Diathesis-Stress Model of Depression

Figure 1.2 depicts that a depressive reaction takes place when a person experiences a negative life event. Besides negative life event this depressive thought is accompanied by feelings of hopelessness and/or worthlessness. The figure also indicates the dotted lines which suggest that this depressive reaction or thought may last for a short period and may resolve rapidly or it may convert into a long-term depressive episode. This further has guided to ponder upon certain variables that verify who turns out to be depressed when experience stress and who does not. These variables are formally called ‘diatheses’. A diathesis is a susceptible factor that can relate how much harm a stressful experience generates. It has been sorted out to recognize variables with which people turn out to be depressed when confronted with a stressful experience.

**Depression among Elderly People**

Depression is a public health problem which is more prevalent among elderly people. Depression in old age is more frequently related to significant physical, psychological and cognitive impairment which influence the functional deficit and disability. Due to
such conditions their well being and quality of life decrease which in turn result into having the feelings of helplessness, hopelessness and worthlessness. This may further “increase the rate of suicide, increase use of health care services and expenses and can result in early death and disturbance in the general state of wellness” (Serby and Yu, 2003). Loneliness as another major concern is associated with poor quality of life and well being confronted by elderly people. They are at higher at risk for loneliness as there are certain disturbances in their social life. Adult children move out on the pretext of their jobs or assignments another city or country leaving them behind to look after them independently. This type of ‘empty nest syndrome’ makes them feel lonely, helpless and depressed. Even after retirement the social relationships and interactions reduce which make them constricted and confined to limited social circle. Leaving the locality or home in which they stayed for most of their life is quite difficult. They find it difficult to transit as sometimes they have to move to a smaller accommodation and had to sacrifice many things which make them helpless. After retirement the financial crisis usually starts and sometimes elderly have to literally beg to their children in order to meet their daily needs making them dependent, weak, reliant and helpless. Disability, impairment, infirmity, immobility or ill health may prevent them from taking part in normal activities with others. This results in loss of independence which is required to keep in touch with friends, relatives, familiar people and communities.

Lack of social support in the form of family members mainly children makes more vulnerable to depression. Bereavement is another issue in which the aged people experience helplessness. The loss of spouse amongst them is the chief irreparable loss which shatters them to be in the condition of depression. Spousal bereavement is very distressing, life-changing event which becomes more prominent in advancing age. “Some elderly women experience the onset of depressive symptoms during a spouse’s terminal illness phase with symptoms persisting through the first year following the spouse’s death” (Stek, Vinkers and Gussekloo, 2005; Barg, Huss-Ashmore and Wittink, 2006). Sometimes it also happens that due to economic dependence the elderly have been exploited, maltreated, oppressed and subjugated. This leaves them in a helpless, susceptible, pathetic and vulnerable condition. And they really have to beg to their children or relatives for their daily needs.
Single and unmarried elderly people face with triple jeopardy like the old age, functional disability and impairment, and lack of companionship. According to Pinquart (2003) concluded that the “functional status affected unmarried older individuals more than married peers because partnership was an effective coping strategy of married couples. Seniors with functional restrictions may depend more on others for care and support, so they are more likely to experience social support deficits, especially when they withdraw from social life not to be a burden for others”. Hence tend to have more depressive feelings. The effect of childlessness on depression has also been presented in many studies. The elderly who do not have any children throughout their life repent for the curse or deeds of their previous life do not maintain a good quality of life. They always have and had a feeling of incompleteness in their life. This feeling of incompleteness becomes aggravated when they enter the old age and when they need some significant support for their personal care and other emotional needs leaving them with no option but to have the feelings of helplessness and depression.

Elderly people who are engaged in high levels of self caregiving, such as working all the day taking care of their own physical or mental health, can lead to isolation, stress or depression. Aged persons who live alone in community sometimes have to face hurdles related to transportation when they are supposed to visit hospitals and clinics or to some social events making them helpless and depressed. Moreover lack of autonomy is another important variable which plays significant role in developing depressive thoughts in older people. When they were in their youth they used to take decisions for all family and other matters which have been taken away from them making them feel depressed. The discrepancy between ‘what the children do and what the parents expect from them’ is another potential reason for the parents to have depressive feelings. Sometimes it happens that the parents build up the reputation from continual labour of years and the children do not hesitate to shatter the name and fame of their parents by indulging in antisocial activities, or the child does not come up to the expectation of parents. Another possibility of elderly to have depressive thoughts when their child is born with multiple disabilities, they are under extreme stress and anxiety that how the situation can be handled because due to their age, immobility or other physical difficulties they themselves are not able to manage themselves then what to talk about the management and caregiving of their child.
with disabilities. Moreover they are more worried about the future of such children that who will take care of them, hence tend to have depression and anxiety.

After considering the above stated background, we may continue to the next chapter of review of literature.