CHAPTER – 1

Introduction

Aging is a natural and universal phenomenon and human concern about it is old age. It is an inescapable part of human destiny and comes to everyone of us. Aging is a process which takes place during the entire life span of the organism and is the final phase of human development (Cumming & Henry, 1961), it must be seen as part of a continual process of change.

Every society has its own conception of aging. It begins from the very birth of individual and continues till death. In the early years of life and throughout young adulthood, people tend to view aging impersonally. It is something that happens to others, not to him. It is only when signs of aging occur such as greying of hair make their appearance that they realize that it is happening to them. Each and every stage of human development comes with certain hopes, aspirations and achievements and attaining to the old age, man tries to find out the last question of his life. No new hopes, aspiration are new for him. Aging can be considered as the sum of all changes: anatomical, physiological, biochemical and functional that occurs in man with passage of time and leads to functional impairment and eventually death. Aging is not a single process. Rather it consists of at least three distinct processes: primary, secondary and tertiary aging (Birren & Cunningham, 1985).

Primary aging is normal, disease free development during adulthood. Changes in biological, psychological, socio-cultural, or life cycle processes in primary aging are an inevitable part of the developmental process; examples include menopause, decline in reaction time and the loss of family and friends.
Secondary aging is developmental changes that are related to disease, lifestyle and other environmentally induced changes that are not inevitable (e.g., pollution). The progressive loss of intellectual abilities in Alzheimer’s disease and related forms of dementia are examples of secondary aging.

Finally, Tertiary aging is the rapid losses that occur shortly before death. An example of tertiary aging is a phenomenon known as terminal drop, in which intellectual abilities show a marked decline in the last few years before death.

Aging may be viewed as a process which universally independent of environmental factors, progressive, irreversible and likely to reduce functional competence (Mehta & Shringarpur, 2000). Coni & Webster (1998) in lectures series on geriatrics say, "old age is unfortunately often a time of loss". The potential losses varied but are often interrelated and the ones that accompany aging are the following: Health due to increasing pathology, wealth due to termination of employment, independence due to loss of controls over external and internal environment status due to retirement and loss of independence.

Through the process of socialization the society ensures the transmission of social and cultural values from one generation to another. As the individual grows, age related roles, privileges and exceptions are defined by the society. Social aging refers to the stage in the life span of the individual that is regarded as old age by the group often individuals have to give up certain roles with or without substitute roles, even through their biological and mental aging may not need such changes. The individual is never static instead he is constantly changing. During the early part of life these changes are evolutional in nature. They lead to maturity of structure and functioning. In the later part of the life span, the changes are mainly involution showing a regression to earlier stage. Some people use chronological age as a criterion for aging and others use their physical symptoms as a criterion of aging.
It is difficult to find a satisfactory definition of the point where middle age ends and old age begins. Most gerontologists tend to select a figure of 60 or 65 to denote the onset of old age, or the threshold age (Bromley, 1988; Rebok, 1987). Hamilton (1994) categorized older people in to the ‘young elderly’ (aged 65-75) and the old elderly (aged 75 and over). A variant of this theme is proposed by Burnside, Ebersole and Monea (1979) where in categories of ‘young old’ (60-69yrs.) ‘middle age old (70-79yrs.) and ‘old-old’ (90-99yrs.) have been suggested. Another method divides the over 65 into the ‘third-age’ (i.e. active and independent living in old age), ‘fourth age’ (a period of dependence on others). The cellular garbage theory observes that, besides free radicals, cells tend to produce a wide range of waste products which remain in cells, and are possible pollutants. Kermis (1983), Botwinick (1977) and Birren, Butler, Greenhouse, Sokoloff and Yarrow (1963) have argued that many changes in the elderly are due to disease rather than aging. There are theories of evolution, which argue that the body ‘chooses’ to age in a way called ‘programmed senescence’. The disposable soma theory argues that the body parts. Thus aging can be viewed as the cumulative, progressive and degenerative changes that occur over a period of life course (Ramamurthi, 1995).

Population aging refers to the increasing number of old people in the total population of a nation. Throughout the world, there is an unprecedented increase in the population of the elderly persons than ever before. Population aging is an inevitable consequence process of demographic transition and creates an imbalance in the age structure over a period of time. During the last ten decades, India’s demographic transition has also shown similar imbalance. The demographic shift is due to fall in birth rates and increased life expectancy, improved health condition and medical advancement.

PROBLEMS ASSOCIATED WITH OLD AGE

Old age comes to every one of us. For many people it comes as a phase of tranquility and serenity, as a phase of life in which a human being can still grow
towards completion of his personality and inner values. But it can also be a phase of life which is marked by physical and mental instability, by proneness to disease and by a steady escalation of misery and suffering. The problems of old age have gained importance in the contemporary society due to the rapid increase in the number of aged people in the society.

Old age is often viewed as a problematic period of one's life which brings numerous problems. The problems of aged are manifold. Moreover these problems vary from individual to individual and culture to culture but there are certain common problems experienced by most of the aged person across culture and geographical location. These have been categorized as biological, social, economic and psychological problems. These problems are interdependent and interactive in nature (Kapoor & Kapoor, 2000; Kumar, 1999). Therefore, aging needs to be studied with a holistic approach combining not only the biological and demographical viewpoints but also the psychological, economic, emotional, spiritual, social, political as well as cultural viewpoints.

**Physiological Problems:**

The process of life is consists of physical and mental changes characterized by growth and decline. It is during this period in life (i.e. old age) where individual begin to experience cumulative effect of such gradual alterations in physical status that have taken place throughout the adult years. These changes are associated with a number of diseases. Due to changes, such as loss of elasticity in muscle tissue, the ability to move about freely and comfortably becomes more restricted, the elderly people tire more easily, participate less in physical activities and cannot endure stress. Tooth loss is most common change, due to tooth loss the aged have dietary inadequacy which leads to nutritional deficiencies (Kapoor & Kapoor, 2000). Respiratory conditions affect the health and well being of elderly persons due to decreased lung efficiency. Circulatory problems include accumulation of faulty tissues in heart muscle. The most commonly reported
disorder of digestive system in old age includes peptic ulcer and frequent constipation (Hamilton, 1994). Biologically aging process is characterized by gradual decline in functioning of all the body’s systems.

Social Problems:

Every human being is a part of society and interacts with other members of society in a number of ways. At the time of birth, social network is very limited and in adulthood the social network is at its peak. When old age sets in, this network starts shrinking. Though, there are different kinds of explanations for this shrinkage. Modernization and urbanization have resulted in decline of the status enjoyed by the ignored, stressful, and economically dependent and out thrown. Breaking of joint family as well as decreased cohesiveness of family and social bonds with change in values and norms is also visible. The stress and strains of these changes have made the position of elderly vulnerable especially for sick and infirm, resulting into loneliness and increased death anxiety (Desetty & Patnam, 2000).

With advancing age, there is decline in health and individual can lose their independence become isolated and change their self perception. Social disengagement or withdrawal process may be initiated by the individual, which is often associated with decreased emotional involvement in the social network, lack of belongingness, lack of communication and mutual delegation in turn negatively affect their well being.

Psychological Problems:

Old age is also associated with a number of psychological problems. These problems are either due to old age or as a result of interactive effect of social and economic problems. Affective disorders such as alterations in normal mood states, depressive reactions, elation and bodily preoccupation are the most common psychogenic illness found in old age. Certain psychosomatic symptoms, such as loss of appetite, sleeping difficulties and fatigue usually accompany affective
disorders. Many people fear that senility is an inevitable curse of old age. Such persons have a limited ability to grasp abstractions, lack of ideas, think more slowly, unable to pay attention around them. Because of such mental deterioration, the aged may be unable to cope with such routine tasks as keeping clean and well groomed (Hamilton, 1994).

Intellectual ability has also been reported to decline to some degree in old age distinguishing between fluid intelligence and crystallized intelligence. Psychologists have observed that fluid intelligence is “culture free” based upon the psychological structure of the organism, while crystallized intelligence is acquired in the course of social experience. Traditionally, the elderly have been seen as retaining their wisdom (crystallized intelligence) whilst losing their wits (fluid intelligence). One aspect of cognitive functioning which is quite commonly observed in old person is memory loss. Memory loss among the elderly has many causes. Some of them are related to the retention of knowledge and still others to the retrieval of knowledge. Older people, for instance, tend to organize new knowledge less well and less completely than they did when they were young. They are not so effective in carrying out the elaborate encoding of information which is essential for long term retention. At present two theories: interference and neurochemical change in combination appear to be the best explanation for short term memory loss in older people (Kimmel, 1980). Some psychologists have suggested a ‘decay’ theory that forgetting is due to deterioration in the memory traces in the brain. Others have advanced on ‘interference’ theory that a retrieval cue becomes less effective as more and new items come to be categorized. Faulty retrieval information is also a major cause of memory loss.

With age, there is a decline in speed in both mental and physical performance. Reading skills also decline with age. Sensory changes also occur resulting in decreased vision and impaired hearing. Forgetfulness is also earliest manifestation of brain dysfunctioning (Bagchi, 2000).
Economic Problems

The economic position of the aged is closely associated with the socio-economic environment in which they live. In general, the economic status of a person is a function of his/her past work status, level of education as well as the present activity status. It is found that with increase in age the level of work participation among the elderly declines. This may probably be attributed to their competence and restricts their activity. Consequently, they may not be able to perform certain role and work, such disability decreases their earning capacity and forces them to depend on the family. Hence, the financial dependency is a predominant characteristic of the elderly. This feeling of dependency further complicates the attitude of the aged making them feel helpless, unwanted and segregated from the family. Due to economic hardship they may not be able to maintain their optimum standard of food, clothing and housing amenities. Depletion of purchasing power effects their health and nutrition and makes the aged susceptible to accelerated aging (Puri and Khanna, 1999).

Under usual circumstances most of the elderly are supposed to be out of labor force in old age, depending on their past income ( in the form of rent, pension etc. ), but some of them, however, continue to be in the work force because of financial necessity even as their physical strength gradually decrease with the increasing age. When the elderly person became dependent upon their grown up children who are by then having their own families the later spend more money on their growing children by decreasing the expenditure on their aged parents. Added to the physical disability, economic disability also leads to a serious depression among elderly persons. As they use to take all the major economic decisions for the family, but now not even consulted by their wards or children. The old age people living in rural and isolated areas and women may be more vulnerable to these.
Sadly, there is “what’s the use” attitude regarding the elderly. The society is youth oriented. Old age is just the end of life. The elderly are merely “invisible citizens” (Dixon et al. 2003). For the elderly compounded losses of spouse, siblings and friends cause tremendous changes, affects emotional well being and may have serious concerns about how this may affect their QOL.

QUALITY OF LIFE

Quality of life (QOL) relates to the total well being of people, including physical, mental, social, and spiritual component (Eckersley, 1998). The object of evaluation in QOL is the ‘life’ (Veenhoven, 2000), where the focus is on assessing the life of an individual. ‘Well being’, ‘happiness’ and ‘life satisfaction’ have all used as proxy indicators of QOL. Happiness tends to be more concerned with the psychological aspect of life and perhaps is state centered (that is, moods, feelings and emotions). QOL is thus a multi-layered and multi-dimensional concept (Marans and Rodgers, 1975; McCrea et al. 2005). It is multi-layered in the sense of its representation at the level of individual, family and community, and it is multidimensional in its reflection of various aspects of life.

World health organization (WHO, 2003) considers quality of life as the individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept incorporating in a complex way an individual, physical health, psychological state, level of independence, social relationship, personal beliefs and one’s relationship to salient features of environment in a complex way. This definition highlights QOL as a subjective self report from the individual which is not based on reports of judgment from others rather it is associated with positive aspects like feeling happy, energetic as well as negative aspects, as sadness and fatigue.

Campbell (1970) considered quality of life as a composite measure of physical, mental and social well being, happiness and satisfaction involving many
life situations such as health, marriage, family, work, financial situation, education opportunities, creativity, belongingness and trust in others. Similarly Cutter (1986) stated that quality of life is an individual’s happiness or satisfaction with life and environment including needs, desires, aspirations, life style preferences and other tangible and intangible factors which determine over all well being. Subjective quality of life is about feeling good and being satisfied with things in general. Objective quality of life about fulfilling societal and culture demands for material wealth, social status and physical well being. Quality of life reflects the individual’s subjective evaluation that does not distort or invalidate its assessment (Orley, Saxena & Herrman, 1998).

Quality of life may be expressed as the degree to which a person enjoys the important possibilities of his/her life. Enjoyment has two components: the experience of satisfaction and the possession or achievement of some characteristics or illustrated by the expression, “She enjoys good health”. Possibilities result from the opportunities and limitation each person has in his/her life and reflect the interaction of personal and environment factors.

**Understanding quality of life in old age:**

Although there is no agreement on these two vital issues, few would dissent from the idea that quality of life should be regarded as a dynamic, multifaceted and complex concept which must reflect the interactive of objective, subjective, macro, micro, positive and negative influence. Not surprisingly, there for, when attempts have been made to measure it, quality of life is usually operationalized pragmatically as a series of domains (Hughes, 1990; Grundy & Bowling, 1999).

Quality of life in old age is the outcome of the interactive combination of life course factors and immediate situational ones. For example, prior employment status and midlife caring roles affect access to resources and health in later life (Evandrou & Glaser, 2004). Fernandaz and Ballesteros *et al.* (2001) combined
both sets of factors in a theoretical model of life satisfaction. Recent research suggests that the influence current factors such as network relationship may be greater than the life course ones—although, of course, the two are interrelated (Wiggins et al. 2004). What is missing, even from the interactive approaches, is a political economy dimension. Quality of life in old age is not only a matter of individual life course and psychological resources but must include some reference to the individual's scope for action; the various constraints and opportunities which are available in different societies and to different groups, for example, by reference to factors such as socio economic security, social cohesion, social inclusion and social empowerment (Walker & van der Maesen, 2004).

Some of the factors which determine quality of life for older people are similar to those for other age groups particularly with regard to comparison between midlife and the third age. However, when it comes to comparisons between young people and older people, health and functional capacity achieve a much higher rating among the latter (Hughes, 1990; Lawton, 1991). The emphasizes the significance of mobility as a prerequisite for an active and autonomous old age, as well as the role of environmental stimuli and demands and the potential, mediating role of technology in determining the possibilities for a life of quality (Wahl et al. 1999). In practice, with the main exception of specific scales covering physical functioning, quality of life in old age is often measured using scales developed for use with younger adults. This is clearly inappropriate when the heterogeneity of the older population is taken into account, and especially so with investigation among very frail or institutionalized older people. Older people's perspective and implicit theories are often excluded by the common recourse to predetermined measurement scales in quality of life research. This is reinforced by the tendency to seek the view of third parties when assessing quality of life among very frail and cognitively impaired people (Bond, 1999). Communication is an essential starting point to involving older people and recent
research shows that this can be achieved successfully among even very frail older people with cognitive impairments (Tester et al. 2004).

The sources of quality of life in old age after differ between groups of older people. The most common empirical associations with quality of life and well being in old age are good health and functional ability, a sense of personal adequacy or usefulness, social participation, intergenerational family relationship, the availability of friends and social support, and socio-economic status (including income, wealth and housing) (Lehar & Thomae, 1987; Knipscheer et al. 1995; Mayer & Baltes, 1996; Bengtson et al. 1996; Tesch-Romer et al. 2001; Gabriel & Bowling, 2004a, 2004b). Still different social groups have different priorities. For example, Nazroo et al. (2004) found that black and ethnic minority elders valued features of their local environment more highly than did their white counterparts. Differences of priority have been noted in Spain between older people living in the community and those in institutional care, with the former valuing social integration and the latter the quality of the environment (Fernandez-Ballesteros, 1998b).

Dimensions of measuring quality of life in old age:

Quality of life is a rather amorphous, multi-layered and complex concept with a wide range of components- objective, subjective, macro societal, micro-individual, positive and negative-which interact together (Lawton, 1991; Tesch-Romer et al. 2001).

Models of quality of life:

Brown, Bowling & Flynn (2004) prepared a taxonomy and systematic review of the English literature on the topic of quality of life. In this Bowling (2004) distinguishes between macro(societal, objective) and micro(individual, subjective) definition of quality of life. Among the former, she includes the roles of income, employment, housing, education, and other living and environmental circumstances; among the latter, she includes perceptions of overall quality of life,
individuals' experiences and values, and related proxy indicators such as well being, happiness and life satisfaction. She distinguishes eight different models of quality of life which may be applied, in slightly adopted form, to the gerontological literature.

- Objective social indicator of standard of living, health and longevity, typically with reference to data on income, wealth, morbidity and mortality. Scandinavian countries have a long tradition of collecting such national data (Hornquist, 1982; Anderson, 2005). Recently, attempts have been made to develop a coherent set of European social indicator (Noll, 2002; Walker and van der Maesen, 2004) but, as yet, these have not been applied to subgroups of the population.

- Satisfaction of human needs (Maslow, 1954), usually measured by reference to the individual's subjective satisfaction with the extent to which these have been met (Bigelow et al. 1991)

- Subjective social indicators of life satisfaction and psychological well being, moral, esteem, individual fulfillment and happiness, usually measured by the use of standardized, psychometric scales and tests (Bradburn, 1969; Lawton, 1983; Mayring, 1987; Roos and Havens, 1991; Suzman et al. 1992; Veenhoven, 1999; Clarke et al. 2000).

- Social capital in the form of personal resources, measured by indicators of social network, support, participation in activities and community integration (Wenger, 1989, 1996; Bowling, 1994; Knipscheer et al. 1995).

- Ecological and neighborhood resources covering objective indicators such as levels of crime, quality of housing and services and access to transport, and subjective indicators such as satisfaction with residence, local amenities and transport, technological competence, and perceptions of neighborliness and personal safety (Cooper et al. 1999; Kellaheer et al. 2004; Scharf et al. 2004).
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- Health and functioning, focusing on physical and mental capacity and incapacity (for example, activities of daily living and depression) and broader health status (Verbrugge, 1995; Deeg et al. 2000; Beaumont and Kenealy, 2004).

- Psychological models of factors such as cognitive competence, autonomy, self-efficacy, control, adaptation and coping (Brandtstadter & Renner, 1990; Filipp & Ferring, 1998; Grundy & Bowling, 1999).

- Hermeneutic approaches emphasizing the individual's value, interpretations and perceptions, usually explored via qualitative or semi structured quantitative techniques.

While there are common associations with quality of life and well being, it is clear that subjective self assessment of psychological well being and health are more powerful than objective economic or socio-demographic factors in explaining variations in quality of life rating (Bowling & Windsor, 2001; Brown et al. 2004). Two sets of interrelated factors in critical here-on the one hand, it is not the circumstances per se which are crucial but rather the degree of choice or control exercised in them by an older person and, on the other hand, whether or not the person's psychological resources, including personality and emotional stability, enable him or her to find compensatory strategies, for example, in response to ill health, disability or bereavement, is associated with higher levels of satisfaction and quality of life (Freund & Baltes, 1998). Feeling of independence, control and autonomy are essential for well being in old age. Moreover, analyses of the Basel Interdisciplinary study of aging show that, compared to the young-old, among the very elderly psychological well being is more strongly associated with a feeling of control over one's life than with physical health and capacity (Perrig-Chiello, 1999).
Life orientation in old age aims to guide and equip them for meaningful and successful living in a rapidly changing and transforming society. By focusing more on positive things and avoiding negative ones, older adults are able to stay on an even emotional keel and feel good. Positive states of mind like optimism, hope etc. has long been associated with health and successful coping while depression, despair, pessimism and hopelessness have been linked to illness, capitalization and even death. Optimism has been regarded as a cognitive variable and it can be described as a generalized belief in good outcomes based on rational estimate of a person’s likelihood of success and a belief in personal efficacy.

**LIFE ORIENTATION**

Life orientation is the attitude of an individual in relation to self, others and to society. It is concerned with the personal, social, intellectual, spiritual, motor and physical growth and development of individuals, and the way in which these dimensions are interrelated and expressed in life.

Life orientation guides and prepares individuals for life, and for its responsibilities and possibilities. This addressed with the self, values, attitude and skills about the self, the environment, responsible citizenship, a healthy and productive life, social engagement, recreation and physical activity. It equips individuals to solve problems.

**Purpose**

Life Orientation equips learners to engage on personal, psychological, neuro-cognitive, motor, physical, moral, spiritual, cultural, socio-economic and constitutional levels, to respond positively to the demands of the world, to assume responsibilities, and to make the most of life’s opportunities. It enables learners to know how to exercise their constitutional rights and responsibilities, to respect the rights of others, and to value diversity, health and well-being. Life Orientation promotes knowledge, values, attitudes and skills that prepare learners to respond effectively to the
challenges that confront them as well as the challenges they will have to deal with as adults, and to play a meaningful role in society and the economy.

Scope

Life Orientation is a unique concept which focuses on the following:

➢ Requires learners to identify and confront challenges using acquired knowledge, values, skills and strategies;

➢ Prepares learners to be successful by helping them to study effectively and make informed decisions about subject choices, careers, and additional and higher education opportunities;

➢ Helps learners to exercise their rights, as well as their civic and social responsibilities, in order to contribute to society and to environmentally-sustainable living, while respecting the rights of others;

➢ Fosters self-awareness, social competencies and the achievement of a balanced and healthy lifestyle;

➢ Addresses changes during puberty and adolescence, responsible sexual behaviour, risky adolescent behaviour and attitudes regarding a range of issues including substance abuse, road use, dietary behavior and personal safety;

➢ Helps learners to make informed decisions about and to nurture personal, community and environmental health; and

➢ Exposes learners to and encourages them to participate in recreational and physical activities to enhance well-being.

Life Orientation acknowledges the multi-faceted nature of the human being, as well as issues like human rights, gender, the environment, all forms of violence, abuse, sexuality and HIV and AIDS.

Optimism and Pessimism

Optimism is a concept that is referred to often when relating to a person’s way of coping. As does hope, it refers to the person’s future orientation, but more
in tune with a general expectancy that good rather than bad will happen (Scheier & Carver, 1985). Thus, the optimist looks towards the future, attaching positive explanations even to negative outcomes. Indeed, optimists tend to use more problem focused coping strategies than do pessimists. When problem focused coping is not a possibility, optimists turn to more adaptive emotion focused coping strategies such as acceptance and use of humor. Pessimists tend to cope through overt denial and by mentally and behaviourally disengaging from the goals with which the stressor is interfering (Scheier, Carver & Bridges, 1994).

Dispositional optimism refers to generalized outcome expectancies that good, rather than bad, things will happen. Situational optimism refers to the positive or negative expectations of an individual for a specific situation.

Pessimism refers to the reverse tendency to expect the worst. Both types of optimism are stable dispositional resources that influence whether a person will be able to remain focused on reducing discrepancies between behavior and aspirations (Carver and Scheier, 1981).

Dispositional optimism has been reported to correlate fairly highly with self mastery, trait anxiety, neuroticism and self esteem (Scheier et al. 1994). In contrast to pessimism, it has been reported to positively correlate with reduced levels of hostility and depression, use of denial as a coping mechanism, postsurgical self rated QOL and faster recovery (Scheier et al. 1989). This may partly explain why people with serious disability often report their QOL to be good (Albrecht and Devlieger, 1999). Accordingly, Scheier and Carver's (1994) life orientation test (LOT), one of the most popular measures for this trait, is typically considered to be a uni-dimensional measure of optimism (Chang, 2000). However, other work suggests that dispositional optimism may consist of two separate sub-traits reflecting positively framed optimism and negatively framed pessimism. For example, Dember et al. (1989) proposed a bi-dimensional model of optimism and a level of pessimism. Within this theoretical perspective, the
rejection of pessimism is not the same as the endorsement of optimism. Empirical research supports this two factor model although there remains a disagreement as how to inter-correlate optimism and pessimism (Bryant & Cvengros, 2004).

Thus optimism is a disposition or tendency to look on the more favourable side of events or conditions and to expect the most favourable outcome. It is the belief that good ultimately predominates over evil in the world. In other words, it is an inclination to put the most favourable construction upon actions and events or to anticipate the best possible outcome. Feeling good about oneself not just boosts confidence but can help people stay emotionally and physically well. Individuals who have positive outlook towards life in general, even in their old age, are much more likely to be healthier and fitter than their counterparts with grim view of life. Interestingly, optimistic attitude not only helps in combating stress but can also effectively ease pain. Optimistic individuals are more likely to embrace contradictory emotions and could consciously focus on positive emotions instead of negative ones. Optimistic people manage to maintain their good health with the help of their positive outlook on life, and are also more likely to exercise and have a good night's sleep. Moreover, optimists' outlook not just helps people stay physically and emotionally healthy but also encourages people to avoid risky behaviours such as binge drinking, smoking that can harm their health. These healthy life style choices benefits older people more as their bodies become weaker and more prone to disease with each passing year.

**Benefits of optimism**

A few benefits of being optimist are:

- It reduces the level of stress experienced.
- It promotes happiness and gives a reason for living.
- It increases longevity that enables to handle emotions and further promotes self respect and integrity.
- It creates a positive anticipation of the future and promotes healthy living as it increases the level of productivity and creates a sense of fulfillment.
and satisfaction. It also forges persistence which is an essential trait required for achieving success.

- It allows dealing with failure constructively and gives peace of mind. It also allows in developing the attribute of patience.

On the other hand, if one is pessimist in the sense that when bad things happen one thinks they are going to last forever and undermine everything one does, then it is about eight times as likely to get depressed, one is less likely to succeed at work, one’s personal relationships are more likely to break up, and one is likely to have a shorter and more illness-filled life. Pessimists think that they are responsible for the bad things that happen to them. They think that one bad thing happening means that more are on the way. They see difficulty in every opportunity. Herzberg et al. (2006) found a negative correlation between optimistic and pessimistic expectations among young adults, this correlation was not seen in older adults. According to them, life experience makes older people develop more elaborated expectations regarding the future.

Over the years, psychologists have examined many aspects of pessimism and optimism. There are some advantages to optimism like it seems to make people feel better about life. But there are also advantages for pessimism in that thinking the worst help some pessimists cope better with the world. Being optimistic allows people to pursue their goals in a positive way; to dream a bigger and better dream, which they can work their way towards. Optimists also seem to respond better to positive feedback, and part of being optimistic may be generating this feedback for them i.e. thinking positive thoughts. On the other hand, being pessimistic may help people reduce their natural anxiety and to perform better. Also, pessimists seem to respond better to negative feedback. They like to hear what the problems were, so they can correct them. Again, part of why pessimists generate these sorts of negative thoughts is that it helps them perform better. So, optimism and pessimism are not just accidents; this evidence suggests
they are two different, but effective, strategies of coping with a complex and unpredictable world.

According to Styron (1990) Depression so mysteriously painful and elusive remains nearly in comprehensible to those who have not experienced it in its extreme mood, although the "blues" with people go through occasionally are of such prevalence that they do give many individuals a hint of illness in its catastrophic form. According to Karel et al. (2002) who stated that the greatest human cost of geriatric depression is the suffering of those elders who are depressed. To face the final years of one’s life feeling helpless, empty and hopeless is devastating. To watch one’s older mother, father, sibling or friend suffers from depression and to live or care for such an elder is similarly difficult. Not only the elderly is suffering from depression at the end of his life but the social networks surrounding the person have to deal with the compounded factors that decrease the QOL for the persons involved.

DEPRESSION

The term "depression" has been variably used to describe either a symptom, a syndrome, or a disease. In the present consensus statement, depression is used in the broad sense to describe a syndrome that includes a constellation of physiological, affective, and cognitive manifestations. As listed in the current American Psychiatric Association Diagnostic and Statistical Manual (DSM-IIIR), criteria for the diagnosis of depression include: (1) changes in appetite and weight; (2) disturbed sleep; (3) motor agitation or retardation; (4) fatigue and loss of energy; (5) depressed or irritable mood; (6) loss of interest or pleasure in usual activities; (7) feelings of worthlessness, self-reproach, excessive guilt; (8) suicidal thinking or attempts; and (9) difficulty with thinking or concentration. Depression may range in severity from mild symptoms to more severe forms that include delusional thinking, excessive somatic concern, and
suicidal ideation, over longer periods of time. The DSM-IIIR requires the presence of at least five of the symptoms listed above for a diagnosis of major depressive episode. Concurrent medical conditions are frequently present in elderly persons and should not preclude a diagnosis of depression.

Causes of depression in older adults and the elderly

- Health problems – Illness and disability; chronic or severe pain; cognitive decline; damage to body image due to surgery or disease.
- Loneliness and isolation – Living alone; a dwindling social circle due to deaths or relocation; decreased mobility due to illness or loss of driving privileges.
- Reduced sense of purpose – Feelings of purposelessness or loss of identity due to retirement or physical limitations on activities.
- Fears – Fear of death or dying; anxiety over financial problems or health issues.
- Recent bereavement – The death of friends, family members, and pets; the loss of a spouse or partner.

Signs and symptoms of depression in older people:

While the signs of depression in older people are often the same as for people in other age groups, there are a number of issues that can make depression more difficult to detect. In comparison with younger people, older people under-report depressive symptom and may not acknowledge being sad, down or depressed. Whether this is due to age itself or a reflection of the generation in which they were raised — where stoicism was a virtue — is unknown. Often, common depressive symptoms (such as a loss of interest in life, lack of enjoyment in normal activities, apprehension, poor sleep, persistent thoughts of death, chronic unexplained pain, poor concentration or impaired memory) are incorrectly attributed to old age, dementia or poor health. Too frequently, family, friends and
doctors see it that way as well, with the result that depression in old age may go undetected and untreated for a long time.

**Chronic unexplained physical symptoms:**

In this situation, the older person has been complaining of a range of physical symptoms for which no adequate medical explanation can be found. Common symptoms include dizziness, chronic aches and pains, constipation, weight loss and insomnia. Usually symptoms of depression become apparent on close questioning, though the older person may not see it that way and may deny that it could be the problem. In the extreme, the older person may become utterly convinced that they have an incurable illness, and won't listen to reason. This is not infrequently found to be the reason that an older person attempts suicide.

**Memory loss**

Depression in old age is often accompanied by memory changes but sometimes the memory impairment may seem to be the main problem and the older person and/or their family become concerned that this is dementia onset, and fails to see depression. Treatment of the depression usually improves the memory, though sometimes memory doesn't fully recover.

**Behavioural changes**

These can be quite varied and include: agoraphobia in which the older person becomes housebound with fear, refuses to eat, shoplifts, ‘accidentally’ overdoses, lives in squalor, or abuses alcohol situations in which an older person becomes preoccupied with changing their will, gives away personal possessions, talks about death, or takes an unprecedented interest in firearms should not only alert friends and family of the possibility of depression, but also of the risk of suicide.

**Types of depression in older people**

The most common type of depression in older age, and which occurs in nearly 10% of older people, is non-melancholic depression. Many researchers
have downplayed its significance but in recent years there has been good evidence that such depressive states cause considerable disablement and distress and may persist unrecognized for years. Possibly this is because many older people with such depressive disorders also have physical health impairments contributing to the depression, thus symptoms of depression, such as constipation, may be attributed to physical illness, and vice versa.

The Indian Society has traditionally provided natural social security to the old people. Sometimes the absence of familial care and surroundings induce feelings of loneliness, low self esteem, low QOL, pessimism and depression. For these reasons, there has been considerable interest in exploring the related review of literature.