CHAPTER - I

INTRODUCTION
Ageing is the final phase of human development (Cumming and Henry, 1961) and must be seen as part of a continual process of change. Sociologist sees this as a change in role and as a status passage. These changes in status occur throughout life, where an individual enters adolescence, becomes a parent in early adulthood, then enters into middle adulthood and finally enters into oldage. The passages of old age such as retirement, widowhood and adjusting to death, are, in a sense, the “end of the life” and unlike the previous passage, they may entail losses of power, responsibility, freedom and autonomy (Rosow, 1974).

It is difficult to find a satisfactory definition of the point where middle age ends and oldage begins. There are a variety of ways in which ageing may be defined. One is to consider the causes of the characteristics found in elderly subjects. These can be divided into features which are attributable to relatively distant events (e.g. lacking mobility because of childhood polio) known as distal ageing effects and those which are attributable to more immediate causes (e.g. lacking mobility because of a broken leg), known as proximal ageing effects. Universal ageing features are those which all elderly people share (e.g. wrinkled skin). Probabilistic ageing features are a likely, but not universal feature e.g. Arthritis (Hamilton, 1994). Most gerontologists tend to select a figure of 60 or
65 to denote the onset of oldage, or the threshold age (e.g. Bromley, 1988; Rebok, 1987; Ward, 1984; Kermis, 1983; Decker, 1980). Hamilton (1994) categorized older people into the young elderly (aged 65-75) and the old elderly (aged 75 and over). A variant on this theme is proposed by Burnside, Ebersole, & Monea (1979) wherein categories of 'young old' (60-69yrs), 'middle aged old' (70-79yrs) and 'old-old' (80-89yrs), and 'very 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) and the 'fourth age' (a period of dependence on others for basic welfare in old age). 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 & Yarrow (1963) have argued that many changes in the elderly are due to disease rather than ageing. 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 allocates resources to maintaining the somatic body parts. Thus ageing could be seen as the cumulative, progressive and degenerative changes that occur over a period of life course (Ramamurti, 1995).

Old age is beset with various kinds of problems - health, psychological, economical and interactional in a social, familial setting (Pyrek & Synder, 1978). These problems are inter dependent and interactive in nature (Kapoor & Kapoor, 2000; Kumar, 1999; Ramamurthi, 1995). Therefore, ageing needs to be
studied with a holistic approach combining not only the biological and demographic viewpoints but also the psychological, economical, emotional, spiritual, cultural, social, political as well as cultural view-points.

**Physiological changes and related problems:**

Due to normal process of ageing, the aged experiences the associated physical changes (Pathak, 1975; Darshan, 1987; Nagla, 1987; Sharma, Satija & Nathawat 1985). With these changes there are few diseases which have their onset early in life of the aged and get deteriorated, especially if neglected without regular and proper treatment, leading to deformities and disabilities. The problems that emerge due to normal ageing process are described here-

With ageing the ability to move about freely and comfortably becomes more restricted (Kapoor & Kapoor, 2000) due to changes such as muscle atrophy, loss of elasticity in muscle tissue, osteoporosis, kyphosis, scoliosis, back pain (Saxon & Etten, 1978), Arthritis (Bonham, 1978), muscle cramps, bursitis of the shoulder, elbow and gout and joint pain (Bagchi, 2000; Meena, 1996; Swarup, 1995). Diseases of the gums such as gingivitis and tooth loss are most common changes and ailments reported by the aged. Due to tooth loss the aged have dietary inadequacy which leads to nutritional deficiencies (Bagchi, 2000). Some individuals loose their capacity to maintain a long series of complex movements (Fozard, Nuttall & Waugh, 1972). Reductions in height in late adulthood reflect the compression of the spinal column and softening of
muscle and bone tissue. The hairline recedes and baldness increases as does graying of the hair. Respiratory conditions affecting the health and well-being of elderly persons due to decreased lung efficiency, poor circulation, and lowered resistance to infection are asthma (Guleria, Wadhwa & Pande, 1996), lung cancer, emphysema, cough and cold (Sivaraman, 1996; Kumar, 1995) and pneumonia (Hamilton, 1994). The circulatory problems includes accumulation of fatty tissue in heart muscle, valve thickening, hardening and loss of elasticity of the arteries (Goldman, 1971), arterio-sclerosis, increased blood pressure, hypertension (Kalra, 1996) etc. Due to these changes the elderly people tire more easily, participate less in physical activities and cannot endure stress (Timiras, 1978; Goldman, 1971). Aged individuals experience a variety of disorders and changes relating to the reproductive organs and urinary system (Kumar, 1999; Hamilton, 1994). Women experience more problems than men. The disorders includes problems of the vaginal area, prolapsed uterus, cervix and vulva cancer, gall stones and breast cancer (Saxon & Etten, 1978).

The most commonly reported disorders of the digestive system in oldage include peptic ulcer, dyspepsia (Sharma & Agarwal, 1996), frequent constipation, hernia, gall bladder conditions, stomach inflammation, diverticulitis (Drury & Howie, 1979). The eye disorders includes specks, cataracts, glaucoma, macular degeneration and drooping eyelids. Blindness increases considerably after the age of sixty. (Hamilton, 1994; Saxon & Etten, 1978). Hearing handicaps increase considerably as age increases in late
adulthood (Rowland, 1980). With increasing age, the taste buds on the tongue undergo atrophy and structural changes, which leads to change in taste threshold (Bagchi, 2000; Weiffenbach, Baum & Burghauser, 1982; Engen, 1977). It is commonly seen that sleep deteriorates and daily sleep time diminishes in old age. Increased wakefulness during the sleep period “sleep efficiency” induces the drastic reduction, and in some individuals there is complete disappearance of stage 4 sleep (Miles & Dement, 1980; Prinz, 1976; Chase & Sterman, 1967). The aged may not take longer to fall asleep (Williams, Karacan & Hursch, 1974; Zepelin, 1973), but are awake longer (Miles & Dement, 1980; Webb & Campbell, 1980). With increasing age both males and females report increased susceptibility to awakenings. Different researchers have explained different reasons for the wakefulness during old age. These reasons include such as wakefulness secondary to normal change in physiological processes other than sleep (Gerard, Collins, Dore & Exton, 1978; Feinberg, Koresko & Heller, 1967), physical or mental illness, e.g. sleep apnea, external stimuli (Zepelin, 1973; Williams, Hammack, Daly, Dement & Lubin, 1964), respiratory disturbances (Guilleminault & Dement, 1978), severe snoring (Lugaresi, Coccagna & Cirignotta, 1978) and apnea and hypopnea (Ancoli, Kripke, Menn & Messin, 1980) and impaired health status.

There is an agreement amongst researchers over the view that the brain decreases in weight by 10-15% in the course of normal ageing (Bromley, 1988). In many sections of the brain, neurons shrink in size and decrease the number of
connections with other cells (Hunziker, Abdel, Frey, Veteau & Meier, 1978) and the speed at which neurons can conduct signal declines. Elderly neurons may also absorb minute metallic fragments into their cell bodies especially in demented patients, either killing the neuron or reducing its efficiency. Hypothalamus is barely affected by ageing (Selkoe, 1992; Bromley, 1988). Most of the changes linked with cell loss or cell shrinkage occurs in the cortex (frontal lobe) and hippocampus, i.e. areas most strongly linked with intellectual functions and memory (Kermis, 1983; Adams, 1980; Meier & Hunziker, Iwangoff, Reichlmeier & Schultz, 1980). This has potentially serious repercussions for psychological functioning.

In general, the physiological ageing process called 'senescence' is characterized by a gradual decline in functioning of all the body's systems. There is no single cause of ageing (Birren, 1988; Bromley, 1988; Baltes, 1987). All areas of body are affected to some degree. But the various systems do not deteriorate at the same time and at the same rate, and neither has the similar pattern of decline for all persons (Bagchi, 2000). Both men and women suffer the impact but women live longer and accumulate more chronic diseases such as hypertension, diabetes, nutritional amenia ans avitaminosis, osteoporosis, arthritis, alzheimer, breast cancer and other cancers (Kumar, 1999; Puri & Khanna, 1999; Ramamurti & Jamuna, 1992; Strauss & John, 1992; Venkoba, 1990; Pathak, 1975; Viswanathan, 1969).
Cognitive changes and associated problems:

Traditionally, the elderly have been seen as retaining their wisdom (crystallised intelligence) whilst losing their wits (fluid intelligence). Crystallised intelligence compensates for losses in fluid intelligence (Craig, 1986). Many intellectual abilities decline to some degree in old age (Horn & Donaldson, 1976). Baltes & Schaie (1976) emphasized that there is a great plasticity in intelligence in oldage, depending on factors such as individual differences and age and cohort-related determinants. With age, there is a decline in speed in both mental and physical performance (Birren, Woods & Williams, 1980). Botwinick (1977) studied intellectual functions and remarked that elderly have slower reaction time, slower perceptual processing abilities, and slower cognitive processes. Reading skills also decline with ageing. These age related decline in skills are due to changes in intelligence and chronological age. Forgetfulness is also the earliest manifestation of brain dysfunctioning (Prakash, 2000; Bagchi, 2000). Older people have trouble in retrieving information once it is stored. The associations made during encoding may be poorly matched to the retrieval ones, indicating that the memory difficulties of oldage may be due to errors in processing. Craik (1977) suggested that there may be slight differences in memory, but most memory problems in the aged stem from other, deeper processes. Sensory processing works well if the information to be learned is simple and the aged individual has reasonably good hearing and vision. Fozard et al. (1980) confirmed that the ability to retrieve information from long and
short-term memory does not decrease in old age, older people may need time to retrieve the information. Craik (1977) in his study suggested that there might be major deficiencies in older people's long term memories. They perform relatively well on recognition tasks, they do poorly on recall tasks such as vocabulary lists, and do not use memory strategies, such as organisation and rehearsal (Perlmutter, 1978). Aged tends to remember only what is important in their lives, and are selective about what they want to retain. Labouvie & Schell (1982) and Hartley, Harker & Walsh (1980) have suggested that older people demonstrate a high level of ability to memorize and recall information that is ecologically valid or salient for them. Shukin & Neugarten (1964) have noticed trends toward increased eccentricity and lessenened sensitivity to others over the middle and late years of life. Salthouse (1982) showed that attention i.e. ability on sustained attention tasks is known to be quite well preserved in old age: there is some decline, but it is not appreciable.

Psychological problems:

Due to the normal process of ageing elderly experience the associated psychological problems (Prakash, 2000; Ramamurthy, 1995; Venkoba & Madhavan, 1982). In India about four million people aged 60+ are said to be suffering from mental illness and two-third are diagnosed as depressed. Majority of psychogenic disorders, found among elderly are of long duration, resulting from earlier maladjustment that may go unnoticed until the later years (Prakash,
Affective disorders such as alterations in personality or normal mood states, depressive reactions, elation and bodily preoccupation are the most common psychogenic illness found after the middle years. Certain psychosomatic symptoms such as loss of appetite, sleeping difficulties, constipation and fatigue usually accompany affective disorders. Involutional melancholia or postmenopausal syndrome may enable women to muster normal emotional responses. Sensory deprivations such as deafness may often carry a psychogenic component manifested in psychological distress, as the sufferer becomes increasingly isolated. Manic depressive disorders seem to afflict women more than men. The symptoms of obsessive compulsive reaction involve an inability to shake off disquieting thoughts and a need to repeatedly engage in ritualized behavior. Neurotic reactions are marked by considerable anxiety and may be interpreted as the patient’s futile attempt to grapple with unfavourable external circumstances beyond his or her control. Dissociative and conversion neuroses represent the serious breakdown of cognitive functioning and entail psychosomatic complaints of considerable magnitude. Somatic complaints reflect a preoccupation with bodily functioning and an exaggerated concern with normal aches and pains. After middle age, women are more disposed to hypochondriasis than men. Hallucinations, delusions, paranoid states are some other states effecting old people. Sensory impairment, as in the loss of vision or hearing or social isolation may also bring on paranoid fears. Self-destructive behaviour is a matter of concern in aged with increase in number of aged
attempting suicide. Organic brain damage may be superimposed on any of the psychogenic disorders or it may exist independently and precludes normal behaviour and thought process (Craik, 1977). Many people fear that senility (organic brain syndrome) is an inevitable curse of old age. Such persons have a limited ability to grasp abstractions, lack 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 (Kastenbaum, 1979).

Changes in personality during oldage are due to changes in one’s self which determines the quality and quantity of adjustment. The biological factors become the pacemakers of the personality changes in advanced oldage (Jamuna, 1989a, 1989b; Ramamurti & Jamuna, 1992). Women generally report more personality disorders (Dohrenwend & Dohrenwend, 1976; Goldman & David, 1980; Scheidt & Windley, 1983). Women are more vulnerable to mental disorders because the mental health among elderly women is frequently related to low income, widowhood and social isolation (Jamuna, Reddy & Ramamurti, 1991; Indira, 1987,1990; Vencoba, 1989; Ramamurti, 1989; Eisdorfer, 1979; Butler & Lewis, 1977; Dohrenwend & Dohrenwend, 1976).

SOCIAL PROBLEMS:

In traditional social setup, the elderly were respected and well looked after by their offspring and relatives. They were considered to be the reservoir of
accumulated knowledge, cultural heritage and wisdom (Sharma & Agarwal, 1996). Being the senior most family member they used to enjoy the headship status, took major decisions of family including that of property, monetary matters and those related to marriage decisions etc (Kauser & Begum, 2000; Kapoor & Kapoor, 2000). The concept of reverence to elderly was systematically ingrained during the upbringing of children as a matter of ones "religious" or "Karmic" duty rather than an issue of charity. Children were ingrained to look after the physical and psychological needs of the elderly with compassion, respect and without undermining their dignity (Sharma & Agarwal, 1996).

The rapidly occurring technological innovations and advancements, industrial productivity and related economic activity have resulted in several social changes such as migration, urbanization, individualism, lack of funds and resources to meet family needs, breaking of joint family system as well as decreased cohesiveness of family and social bonds with change in values and norms (Sureender, 1997; Kalache, Veras & Ramos, 1987; Nayar, 1992; Laxminarayan, 1982; Gupta, 1976). The stress and strains of these changes have made the position of elderly vulnerable especially for sick and infirm, resulting into loneliness and death anxiety (Desetty, Ramanamma & Patnam, 2000; Sharma & Agarwal 1996; Bose, 1982; Roth, 1978). In India also, modernisation and urbanisation have resulted in decline of the status enjoyed by the aged traditionally (Sharma & Agarwal, 1996; Kumar, 1995; Bhogle, 1992;
Family no longer remains the unit for providing emotional security, care and protection to the older persons (Soneja & Tyagi, 1999). The relationship between the aged and youngsters has become formal and the aged now does not have full authority over the familial or social matters. Their opinion is no longer being sought by the busy life style and independent views and ideas of the younger generation (Kapoor & Kapoor, 2000; Woods & Britton, 1985) which feels dignified and advanced by imitating the western culture (Soneja & Tyagi, 1999). This loss of status has made the aged feel helpless, isolated, ignored, stressful, economically dependent and out thrown (Kumar, 1995).

Another factor leading to the problems of the aged is the increasing interest towards building up a career, due to which people opt for marriage late and when they reach advanced age (say 58 years), their children are still young and depend on them for support. As a consequence the aged parents are working after retirement to earn adequate income to support their children. It is really pitiable that the aged have to working hard despite their physical frailty and mental limitations at the age when they should physically and mentally relax (Sureender, Vaithilingum & Khan, 1996). Such family responsibilities of education of the children and marriages causes trouble to the aged by draining away much of their terminal benefits leaving little for their sustenance in the old age (Swarup, 1995).
Due to widowhood the prior roles of women gets disrupted especially of their social involvement, which leads to isolation, loneliness and deterioration of their health status. (Sureender et al., 1996; Bell, 1963). Although this situation is hard for both sexes, it is harder for aged females than males. (Surrender et al., 1996; Jamuna & Ramamurti, 1995). Thus, women in general are subjected to social and economic marginalization and are victimized by their own family and society. Women played a role as the primary provider of care for the elderly at home. To increase the standard of living the married women has come out of their houses to join the employment stream and the aged are left alone without care. When they come back, they do not have sufficient time and energy to take care of the elderly. This sort of house arrest with no one to take care during the office hours creates a kind of depression in the minds of the aged citizens, which later affects their health status. Besides this, aged are forced to look after and care for the children of their employed daughter or daughter-in-law, irrespective of their health status.

Migration of rural people towards urban areas or abroad for employment has aggravated the problems of the aged. This has reduced the frequency and intimacy of contact, emotional sustenance, assistance, and resource in times of need for the aged parents and has effected their care and support (Vijaya, 1995). The aged people who are single, widow/widower or older couples but are in sound economic position, but are either childless or their children have settled down in far of countries, feel lonely and frustrated and long for company (Ara,
In such circumstances they have to depend on servants due to failing health. There are increasing evidences now a day, where servants try to exploit them or misbehaves and even go to the extent of murdering them for money (Karkal, 1999; Ara, 1995). Those who move with their children also encounter special stress due to new environment, which they perceive as less supportive to them. The rural society is especially more influenced. People want advancement and modernization and still do not want to move away from their roots. This dilemma has created a problem in the adjustment especially among elderly who find themselves unable to change their attitude and adjust with the changing norms at the final stage of life (Sureender et al., 1996).

Taking care of aged was not a problem in the joint family system but in the nuclear family the burden of providing care for the elderly parents has become heavier i.e. with less number of family members to share their responsibility. As a result of it, the elderly are not given adequate care, protection and attention and this has lead to greater alienation and isolation from their families and society and finally their care has been handed over to Homes For Aged (Sachdeva, 1995).

It appears that our attitudes, beliefs and traditions have crumbled before technological advancement. The spirit of craftsmanship, the divine ordering of social classes, traditions regarding the spheres of the sexes, all have felt the shock of mechanization and this has shown its impact even on well-being of the
The most golden period of life where the people have the tremendous experience and potential to show the younger generation right path in the way of life.

FINANCIAL PROBLEMS:

The financial position of the aged is often defined by their mode of living, family status, type of house they live in, economic position they occupy, the things they use, valuables things they possess, pension, income from property, house rent, contribution from children and that of ones own work (Kauser & Begum, 2000). The financial dependency is a predominant characteristic of the elderly (Walker, 1981). Due to the economic hardship they may not be able to maintain their optimum standard of food, clothing and housing amenities. Depletion of purchasing power affects their health and nutrition and makes the aged susceptible to accelerated ageing (Puri & Khanna, 1999). The financial help provided by the kith and kin is usually being sought by the aged people as their right and dignity (Kasthoori, 1996; Ara, 1995). In the process of ageing individuals grow old and their physical and mental strength gradually decreases. Consequently they may not be able to perform certain roles and work which they were previously performing. Such disability decreases their earning capacity and forces them to depend on the family. Otherwise they have to work to meet their monetary needs, even as their physical strength gradually decreases with the increasing age. This trend became socially important first in Western Europe and then in North America. There was an increase in the number of
older generation who were no longer employed and required retirement benefits (Hobman, 1971) to take care of themselves.

Retirement changes the life of an individual, which has a bearing on his role, status in the family and psychological well-being (Soneja & Tyagi, 1999). This feeling of dependency further complicates the attitude of the aged making them feel helpless, unwanted and segregated from the family (Rudkin, 1994). But this is not true at the age of retirement from formal work. The young old (61-70) are productive human resource. The non productive very old (80+), the disabled and the terminally ill, landless and the migrant, and the single aged in the cities, where community supports are weak and are more likely to be neglected, abused, marginalised and rendered as destitute. Single persons or couples without children faces financial crisis as they are no longer in a position to work and earn their income through pension or some other source is too meager to cover their needs. The problems are aggravated due to loosening social support. Oldage pension although given in many states does not fulfil the needs of the aged.

Earlier, majority of aged in rural India had no retirement because they were engaged in agriculture. So, there was no disengagement from work due to retirement and therefore no problem of finding ways to earn. Those who were not engaged in paid work, engaged themselves in household work and in taking care of kith and kin (Kasthoori, 1996). But now the scenario has changed. The transition from an agrarian to an industrial society has imposed financial
problems, as the younger generation very often moves away from their parents in search of lucrative employment making the aged financially vulnerable and deteriorating living conditions (Soneja & Tyagi, 1999; Ara, 1995). The economic position of the rural aged is relatively lower as they are neither supported by social security programmes of the state or by the family. Most of the rural families mainly suffer from economic crisis, as their occupation cannot provide income throughout years. Due to low income and limited resources the families are also unable to provide for the minimum need to their aged parents. (Rudkin, 1994; Bose, 1982). The urban aged draw the benefits of pension and other schemes adopted during their employment and hence face less difficulty whereas the social security measures provided by the state, the only benefit available to the elderly in rural sector is “Old age pension scheme”. The benefits under such schemes are extremely small. Due to cumbersome procedures the beneficiaries under this schemes are very limited and majority of the elderly are getting pension in irregular intervals. Both the formal and informal support systems are not adequately supporting the elderly in rural India to cope up with their socioeconomic and health problems and undoubtedly leaving them as one of the most vulnerable social group in the society.

The position of females is worse then males (Prakash, 1996). This may be due to the fact that men carry most of the financial dealings and are considered as the most productive sex, bread winners and organizers where as the women are often confined to the four walls and work at home and are economically
dependent on males (Gupta, 1997). Although the unpaid housework done by women in industrialized countries contributes twice as many hours as men (Prakash, 1996). There are contradictory studies which shows that men are more vulnerable to dissatisfaction when they become economically dependent in old age (Kauser & Begum, 2000; Rudkin, 1994; Barer, 1994). Women being always dependent financially on father, husband or son perceive this situation as less troubling, develop a better capability to weather most of the stresses and strain that occur in old age (Jamuna & Ramamurti, 1995). Their work is not considered as economically productive and their contribution throughout out their life span is not quantified or valued. So, when they grow old and no longer carry on with their tasks, they are treated as burden. Rowles & Johansson (1993) found rural women facing more financial difficulties due to limited resources, informal support system and an egalitarian community ideology. Majority of the aged from informal/unorganized sector continue to work for as long as their health permits. Due to low income they do not have the ability to save during the productive period, hence suffer most during old ages. Swarup (1995) found that problems of the aged belonging to the low-income groups tend to be overlooked, as they do not have an effective lobby. So, staying in the house becomes a nuisance as such families live in small accommodations with poor hygiene facilitates in the family and are confined to a corner in the house.

In the family development cycle 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 who also need some care. Added to the physical disability, economic disability leads to a serious depression among elderly persons. The tensions are likely to increase if more demands are placed on the younger generations. These demands for physical care, living space and for financial help can result in institutionalization.

Demographic trends show that women live longer than men. As a consequence, a majority of women may live right into a ripe old age, mostly as widows with a greater proportion suffering from some disability or other. Most of these women are subjected to economic marginalization. Those in the lower rungs of the society, who are not sure of their daily wages, old age itself is a curse and it is worse to be an aged women among them. Doughtless, they become a burden to the already fragile social security system of the country ravaged by poverty, unemployment and the population explosion. Thus the demographic picture of elderly women is highly disconcerting (Jamuna & Ramamurti, 1995). Further an increase in the proportion of the elderly people means a decrease in the proportion younger adults. This in turn means a smaller fraction of the population is working and hence paying income tax, national insurance contributions and so forth, to help maintain pension and social and medical care for the elderly. As a consequence, problems associated with ageing of population have emerged as one of the most serious financial issues that the country will have to deal within the near future.
WELL-BEING:

A few years ago the concept of health as being more than the absence of
disease was relatively new in research literature. But now health has become
widely accepted as a state of general well-being that includes both physical and
psychological components (Wheeler & Miyake, 1992). This is also reflected in
the statement of the World Health Organisation that health is “a state of
complete physical, mental and social well-being and is not merely the absence
of disease and infirmity. Emmons & Kings (1998) have mentioned that health
and general well-being are conceptually related. There are three conceptual
terms related to well-being viz. general well-being, psychological well-being
and subjective well-being. These are difficult to define and sometimes create
confusion. Hence, here an attempt is being made to review what researchers in
the area mean by these terms and to operationalize the concept of general well-
being as used in the present study.

General well-being refers to the harmonious functioning of the physical
as well as psychological aspects of the personality, giving satisfaction to the self
and benefit to the society. The person reporting low well-being means that
he/she is not having complete and harmonious functioning of the whole
personality in relation to physical and mental health. Diener & Diener (1996)
and Lykken & Tellegen (1996) defined general well-being as the subjective
feeling of contentment, happiness, satisfaction with life experiences and of one's
role in the world of work, sense of achievement, utility, belongingness, and no distress, dissatisfaction or worry etc.

Psychological well-being is a malleable concept which is concerned with an individual’s feelings about his daily life experiences. These feelings extend from negative state such as stress, worry or unhappiness to more positive states which are not simply states of absence of worry or unhappiness but are states which are related to sound mental health and include favourable self-esteem and success Warr (1978). Jahoda (1958) have also stated that such feelings may range from negative mental states or psychological strains such as anxiety, depression, frustration, emotional exhaustion, unhappiness, dissatisfaction, to a state which has been identified as positive mental health. The concept of psychological well-being and mental health focuses on an ideal state emphasizing “positive well-being” of the World Health Organisation charter rather than on disease, statistical or conformity criteria. Negative components of psychological well-being are relatively easily assessed through self-reports of anxiety, depression, frustration etc, but it is difficult to assess positive components of well-being. Psychological well-being depends upon how a person is valued by those around him. The status of the elderly may depend upon the evaluative perception of those around i.e. primarily the members of the family and secondarily the significant others, outside the family circle (Jamuna, 1986; Ramamurti & Jamuna, 1984). Campbell, Converse & Rodgers (1976) distinguishes three types of well-being - affect, strain and satisfaction. The
positive affect corresponds with greater social relationship and more new experiences, whereas negative affect was closely related to fear of a nervous breakdown, ill health, anxiety, and stress.

Subjective well-being (SWB) is an abstract superordinate construct causing the affective reactions of individuals to their life experiences along a positive – negative continuum (Okun, 1987). Subjective well-being has been operationalized (Okun, Melichar & Hill, 1990) by indicators of happiness, morale and life satisfaction. Diener, Suh, Lucas & Smith (1999) stated that subjective well-being is a general area of scientific interest rather than a single specific construct and is a broad category of phenomena that include people's emotional responses, domain satisfaction and global judgements of life-satisfaction. Each of the specific constructs needs to be understood in its own right. The components often correlate substantially, suggesting the need for higher order factors (Stones & Kozma, 1985). Diener et al. (1999) have reported four major components of subjective well-being viz. pleasant affect, unpleasant affect, life satisfaction and domain satisfaction. The parameters of pleasant affect are joy, elation, contentment, pride, affection, happiness and ecstasy. Whereas, the parameters of unpleasant affect are guilt and shame, sadness, anxiety, worry, anger, stress, depression and envy. Life satisfaction comprised of desire to change life, satisfaction with current life, satisfaction with past and future and significant other's view of one's life. The parameters of domain satisfaction, according to Diener et al. (1999) are work, family, leisure,
health, finances, self and one's group. Moods and emotions together constitute the 'affect' which represent people's on-line evaluations of the events that occur in their lives. As pleasant affect and unpleasant affect form two independent factors, these should be measured separately (Bradburn & Caplovitz, 1965). The degree of independence between momentary pleasant and unpleasant affect is controversial. The separateability of long term affective dimensions is less debatable because as the time frame increase, pleasant and unpleasant affect become increasingly separate (Diener & Emmons, 1984). Diener, Smith & Fujita (1995) found that the pleasant and unpleasant affects are clearly separable but are moderately and inversely correlated. Andrews & Withey (1976) found that life satisfaction formed a separate factor from the two major types of affect. Lucas, Diener & Suh (1996) have reported that pleasant affect, unpleasant affect, and life satisfaction are separable constructs.

Thus, for the present study the concept of general well-being has been operationalized as the harmonious functioning of the whole person (physical as well as psychological aspects of the personality), giving satisfaction to the self and benefit to the society. In other words, it is a state of complete physical, psychological and social well-being and is not merely the absence of disease or illness.
Correlates of Well-being:

Thus defined and conceptualized, the general well-being may show some degree of positive correlation with quality of life, job satisfaction/general satisfaction level, sense of achievement etc. and negatively related with neuroticism, psychoticism and other such variables. It should show relative stability overtime (reasonable time gap without any significant intervening life events). It is believed that oldage is a period of cumulative stress, deprivation and loss and therefore, old people must be the unhappy of all groups. The aged persons encounter several stresses including their deteriorating faculties, the high cost and increased need of medical care, economic exigencies, loneliness or alienation and the loss of spouse and friends. All these factors effect the well-being of the aged (Ramamurti, 1990). If that is so, they would be entertaining very poor subjective well-being or poor quality of life of all age groups. Rathore (1991,1992) found that old men scored significant higher on somatic anxiety, psychic anxiety, muscular tension, suspicion, inhibition of aggression and psychasthenia as compared to their middle aged male counterparts. These observations are in line with the negative stereotypes of aging. Factors like depression, suicide, serious physical illness, feeling of hopelessness, social isolation loss of loved ones and dire financial circumstances submit the elderly into poor quality of life (Pfeiffer, 1977).

It is very important to clarify the relationship between age and well-being because most of the studies have shown that older persons do not appear
unhappier than middle aged or younger persons, despite the decline in physical health, death of peers and spouses, and other objective rigors (Staudinger, Fleeson & Baltes, 1998; Filipp, 1996; Brandtstadter & Greve, 1994; Baltes & Baltes, 1990) and other adverse conditions (Schulz, 1985; Haug, Belkgrave & Gratton, 1984; Herzog, Rodgers & Woodworth, 1982; Borgatta & Foss, 1979; Larson & Ketelaar, 1991; Cameron, 1975) that accompany ageing. Some theorist have even suggested improvement in well-being with advancement in age (Carstensen & Tusk, 1994; Carstensen, 1991, 1995; Lawton, 1989, 1996; Labouvie & Balanchard, 1982). Lawton (1996), Carstensen (1991,1995) and Labouvie & Blanchard (1982) have investigated that shifts in social contexts and changing inner states provide the underpinning for the emotion regulation changes that leads to greater happiness in oldage. These theories are different from the social indicator movement, which predict worse well-being in older adulthood and focused not on social context or personality but on membership in particular demographic categories. Some determinants of ‘good quality old Age’ have been identified from cross-sectional studies and some of these are positive self-concept, a favorable perception of inner relationship with family members, a belief in karma philosophy and a flexible outlook and habits (Ramamurthi, 1990). These are related to culture as well as life style of individuals and need to be cultivated to ensure a livelier old age.

Survey research from the west has shown that the old people are not particularly unhappy. McCrae (1984) held that their answers depend on an
understanding of the relation between environment and cognition, affect and personality. Bader & Hoffman (1966) have remarked that older people are more diverse group, than their younger counterparts, because of differences in social, cultural and economic experiences extending over long period of time and these differences tend to increase with age. Tamir (1982) couldn’t find much evidence of mid-life crisis, and proposed that it could be accounted due to socially desirable responding of old men. Herzog, et al. (1982) also raised this as a possible explanation for the reported high life satisfaction or happiness or high well-being of the elderly.

Hence, there is a lack of systematic efforts to examine the state of subjective well-being and quality of life in the elderly (Rathore, 1991, 1992, 1995) and emotional problems (Ramamurthi, 1990). It is also opined that there is a lack of Indian data based on longitudinal studies depicting the influences of factors at younger age on the quality of life in later years (Venkoba, 1991).

Personality and well-being:

Personality factors determine happiness, which ultimately determines well-being (Diener & Diener, 1996; Costa, McCrae & Zonderman, 1987; Ormel, 1983). Personality dispositions are the most potent influences on average levels of happiness and the individual differences in well-being are highly heritable, particularly with regard to positive and negative affect (Lykken & Tellegen, 1996; Tellegen et al., 1988). If long standing, stable personality traits
account in large part for the individual differences in happiness, the influence of ageing or age cohort may be irrelevant or negligible. Stability in the traits that underlie well-being may overshadow the changes in affect, the ageing process may bring about (Daniel & Christian, 1998). Costa, McCrae, & Zonderman (1987) found high stability in affect over a 10-year period. Similarly, Watson & Walker (1996) and Headey & Wearing (1992) have found considerable stability in both positive and negative affect in 7 and 8 year longitudinal studies. There is a relative paucity of research studies showing the continuity of effect over the whole span of the adult years. Although personality has major effects on well-being, but other environmentally based variables should not be ignored from the studies related with happiness. The three categories of influences: personality, sociodemographic and contextual and situational factors should be included to bring out the complete explanation of the individual differences in happiness. Such multivariate approach is emphasized by many researchers. (Staudinger & Fleeson, 1996, Diener, 1996; Ryff & Keyes, 1995; Heidrich & Ryff, 1993; Brief, Butcher, George & Link, 1993). The role of personality traits of extraversion and neuroticism are being studied onto pleasant and unpleasant affect (Larsen & Ketelaar, 1991). The notion of separate emotion systems suggests that rewarding stimuli such as daily pleasures will be more strongly associated with variability between people in pleasant affect than unpleasant affect and that punishing stimuli such as daily hassles will be more strongly associated with variability in unpleasant affect. High hardy individuals are often
considered to be healthier physically and psychologically. Gallellen & Blaney (1984) found that persons with depression were less hardy than persons without depression, and women with depression had higher composite scores. Booth & Friedman (1987) have reported that high-hardy people show low anxiety and low depression. In each case a negative relation between hardiness and indicators of psychiatric strain was found. These studies seem to be related with measures of psychological well-being. Hardy personality may act as a resistance source against mental illness and hardiness may be more relevant to mental illness rather than physical illness (Schmid & Lawler, 1986). Hardiness protects health by existing as a buffer to stressful life situations. Hardy persons tend to engage most conscientiously in positive health practices (eg exercise, adequate rest and moderation in food and substance intake) whereas low hardy might exaggerate constitutional predisposition by engaging in negative health practices (Wieve & McCallum, 1986; Kobasa, 1982). Kobasa (1982) highlighted the cognitive differences between high and low hardy persons and suggested that the effects of hardiness on mental health or psychological well-being are mediated by appraisal and coping mechanisms. She added that hardiness is linked with a tendency to perceive potentially stressful events in less threatening terms. Studies (Pagana, 1990; Westman, 1990; Allred & Smith, 1989; Rhodewalt & Zone, 1989; Wiebe & McCallum, 1986) have reported that the components of hardiness contribute positively to mental health by means of coping and appraisal mechanism. Hardy person are also found to make a better
utilization of the social support in the management of stressful events (Kobasa, Maddi & Kahn, 1982; Maddi, Kabasa & Hoover, 1982) whereas low hardy persons might seek less social support. It appears that to be happy and maintain subjective well-being in oldage one has to be hardy as well as should have some source of social or emotional support. Hardiness seems to facilitate subjective well-being, positive affect and self-esteem in the aged men if they are getting social support as well. Pagna (1990) substantiated that a combination of hardiness and social support is ideal for the best mental health or psychological well-being outcomes under stress while low hardy and person with low social support have worst health outcomes in face of mounting stress.

**Spirituality and well-being:**

Spirituality also plays an important role in the enhancement of positive mental health. The “faith factor” emerges as a significant correlate of mental health indices of life satisfaction, happiness (Palmore & William, 1976), self-esteem, hope and optimism, and meaning in life. It is a response of aged to constant threats to their safety, security and future existence (Galloway, 1925). Takahashi, Keiko, Tamura, Junko & Tokoro (1997) assessed well-being using depression, self-esteem, life satisfaction and subjects health and rated highly the value or influence of religious beliefs in their lives, and identified that religious beliefs become increasingly important with age. Zorn & Johnson (1997) have examined the relation between religiousity and well-being in non-institutionalized elderly women and found that well-being was positively
correlated with religiosity and hope. Majority of women reported regular participation in religious activities and rated highly the value or influence of religious beliefs in their lives.

**Income and well-being:**

The studies pertaining to the relationship between income and well-being are not unequivocal. Diener, Sandvik, Seidlitz & Diener (1993) have found a positive correlation between income and subjective well-being but Clark & Oswald (1994) did not find a statistically significant effect of income in a representative sample from Britain. Associating the well-being with the income Brickman, Coates, & Janoff (1978) stated that increase in income resulted in increases in the well-being of the people. When income remains stable over an extended period of time, individual may adapt to a particular level of wealth. Smith & Razzel (1975) found that the effects of income were not always positive. Thoits & Hannam (1979) found that increased income often led to increased level of distress. Thus, even positive changes in income may result in more stress, mitigating the positive effects of wealth on well-being. Recently Dinear et al. (1999) in a review article have reported that over the years there is a linear increase in the income in America but did not find any increase in the well-being scores. Therefore, there appears to be a lack of consistency in the findings over the relationship between income and well-being.
Marriage and well-being:

Marriage and well-being correlate significantly even when variables such as age and income are controlled (Gove & Shin, 1989; Gove, Style & Hughes, 1990; Glenn & Weaver, 1979). Mastekaasa (1995), White (1992), Glenn (1975) and Wilson (1967) have reported positive relation between marriage and subjective well-being. The effects of marriage may differ for men and women (Mroczek & Kolarz, 1998; Lee, Seccombe, & Shehan, 1991). A kind of controversy over the question whether marital satisfaction is more important to overall well-being of men and women has been reported by Gove & Shin (1989), Wood, Rhodes & Whelan (1989), & Glenn (1975). Diener, Sapyta & Suh (1998) found that marriage held greater benefits for men and women who did not differ in life satisfaction. Jayashree (2000), Coombs (1991), Gove, Style & Hughes, (1990) and Kessler & Essex (1982) have reported that marriage acts as a buffer against the hardships of life and the emotional and economic support and hence, induces positive states of well-being. Headey, Veenhoven, & Wearing (1991) found significant causal influence of marital satisfaction on global life satisfaction. The influence of culture on the relation between subjective well-being and marital status has also been reported (Gohm, Oishi, Darlington, & Diener, 1998). Factors such as social change, cultural characteristics, and age-specific expectations might affect the marriage and well-being link.
SOCIAL SUPPORT AND WELL-BEING:

Embeddedness in a social network is vital for general well-being (Abrams, 1980). Social support has been generally characterized as the degree of support provided to individuals particularly in times of need by persons involved with them, spouse, family, friends, neighbours, co-workers and members of the larger community (Johnson & Sarason, 1979). Thoits (1983) argued that support is the degree to which an individual needs for the affection, approval, belonging and security are significantly met by others. The concept of social support has been addressed in terms of social bonds (Henderson, Bryne, Duncan, Adcock & Adcock, 1980; Handerson, Duncan, Adceck & Steeb, 1978), availability of confident, social network (Cobb, 1976), and "the help that helpers extend" (Gottlieb, 1981). Although these concepts are hardly identical, they share a focus upon the relevance and significance of human relationships. Social support and social networks exerts significant effects on health and functioning among elderly persons (Unger, McAvay, Bruce, Berkman & Seeman, 1999). The effects of social support and social network may vary according to the individual’s gender and baseline physical capabilities. Rao (1990) found that more than half of the rural elderly were socially well integrated and almost one third had moderate degree of social integration. For Cobb (1976) social support is the information that leads individuals to believe that they are cared for and loved (emotional support), are esteemed and valued (esteem support) and belong to a network of communication and mutual obligation (community support).
Sarason, Levine, Basham & Sarasen (1983) viewed social support as the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us. Krause, Liang, & Keith (1995) in a survey in United Kingdom, suggest that social contact tends to increase the amount of received support, and received support in turn tends to bolster perceptions of support availability in the future (i.e. anticipated support). The important correlates of social support in later life were found to be social roles (especially marital status) and social extraversion. Butler (1991) reported that both support sending and support receiving decline with age. Carstensen (1992) suggested that individuals begin narrowing their range of social partners long before oldage. Lansford, Sherman, & Antonucci (1998) studied the satisfaction with social networks and concluded that older were satisfied with the current size of their social networks rather than wanting larger networks. Takahashi, et al., (1997) studied patterns of social relationships and psychological well-being among the elderly and suggested that there were qualitative difference in supportive functions between family dominant and friend dominant affective relationships. They assessed well-being using depression, self-esteem, life satisfaction and subjective health and found no difference between the two except those who had lower scores in subjective well-being than did their family dominant and friend dominant counterparts.

Generally it is proposed that having supporting relationships to rely on can help people in dealing with stressful situations. Those who lack such
relationships are vulnerable to the effect of stress. (Greenglass, Fikrenbaum & Burke 1996; Dollard & Winefield, 1995; Cummins, 1990; Burke, Shearer; Deszea, 1984). Kaplan, Sandock & Grab (1974) also viewed social support as enduring interpersonal ties within a group of people who can be relied upon to provide emotional sustenance, assistance, and resource in times of need, provide feedback, and share standard values. Several theories (Thomae, 1994) have emphasized on “relying on others” in coping with crises and problems and situations like grief or dependency which leads to important psychological aspects in the social support process. Social support has often been identified as a moderator of stress (Greenglass et al., 1996; Cohen & Syne, 1985). There are limits to the beneficial effects of assistance provided by others and beyond a certain level support may exacerbate the noxious impact of stress. Krause et al. (1999) found contradictory results to the previous findings. He suggested that although emotional support initially reduces the effect of chronic financial strain on depressive symptoms, further increments in emotional assistance are associated with increased psychological distress. Cassel (1976) concluded that social network serves multiple functions in helping one adjust to the demands of the environment. The researches (Hoffman, 1980; Sandler & Barrera, 1984) have shown that individuals who belong to poorly functioning social support system and experience unresolved conflicts tend to develop emotional disturbances. Social support thus, seems to have buffering effect in coping with stress and effects the quality of life and the well-being.
ACTIVITY AND WELL-BEING:

Activity here refers to how active or inactive a person (particularly an old person) is. A person may be highly active that is he/she performs all his/her functions and is not dependent on others. An inactive person is one who does not perform his function either by habit or is not able to perform due to diseases, physical frailty etc. This has some times being referred to as the functional status or functional competence (Prakash, 1996). Attempts have been made to relate it with the well-being of the aged. In this study the word activity would be used for this concept. Earlier aging was considered as deteriorated process and that ‘successful ageing’ consisted in being as much like a middle-aged person as possible. As a reaction to the underlying theory of ageing current in American society, Cumming & Henry (1961) challenged this and started a study on ageing in Kansas City. They brought out the theory of disengagement which said that ageing was a normal and necessary process of disengagement whereby the individual withdrew from the major roles of life whilst society concomitantly ceased to depend on the individual for the performance of those roles. They argued that this social disengagement was universal, inevitable and healthy and did not lead to any loss of morale, well being or satisfaction with age.

Disengagement theory aroused immediate controversy. Opposing theories were established and research activity was dominated by the attempt to prove which was the most valid perspective. It was pointed out that disengagement is
not universal. Three criticisms have been leveled at the theory. First, by implication the theory suggests that disengagement is desirable and therefore condones a poly of indifference towards the problems of the older people (Shanas & Gordan, 1965). Second, disengagement is not inevitable and non-engagement in oldage reflects the long life pattern of social interaction for some people. Third, the data present in growing old has been incorrectly interpreted since cultural values and economic structure combine to create condition in which a large portion of older people is disengaged (Rose, 1965). Some studies have indicated that those who did not disengage but remained active and socially integrated had a greater degree of life satisfaction than those who disengaged (Bond & Coleman, 1990). Hunt (1978) and Adams (1975, 1980) have demonstrated that people continue active participation in all aspects of living well into oldage. Maddox (1970) criticized that the phenomenon may be natural extension of a particular personality type, not a universal feature of ageing. He presented a different picture of oldage called activity theory. According to this theory the pattern of withdrawal that characterizes aged people in last years is the result of society withdrawing from those individuals, usually against their wishes. Older people stay most satisfied with life if they remain active and involved, resisting the isolated effects of social attributes towards the aged. He argued that the older people are gratified by their ability to adjust to their changing life. Havighurst (1963) argued that happiness is achieved by denying the onset of oldage and where the relationship, activities or roles of
middle aged are lost, it is important to replace them into new ones in order to maintain life satisfaction.

Researchers Bagchi (2000), Hamilton (1994) and Maddox (1970) have argued that the best policy of the elderly is to keep as active as possible. They argued that the elderly usually want to keep as active and life satisfaction is greatest in old people with an active involvement. People who disengage from society have been doing so far most of their adult life. (Maddox, 1968; Neugarten, 1964). The modern consensus is that disengagement and activity theories describe the optimal strategy for some but not for all elderly individuals and which is better depends upon various factors such as financial circumstances, health and personality types. A number of studies have found increased social involvement only appreciable to improve feelings of well being in lower groups (Caspsi & Elder, 1986). There are different personality types in oldage as there are in youth. Some people may be happier if they remain disengaged from the outside world rather than participate actively in it (Bond & Coleman, 1990).

Kempen, Brilman, & Ormel (1998) studied functional status, well-being and need of care by others and showed main effects of psychological attributes, independent of pathology and impairments on disability and well-being. Stewart, Mills, Sepsis, King, McLellan, Roitz, & Ritter (1998) revealed that the aged who adopted and maintained a new physical activity over the six month intervention period experienced improvement in anxiety, depression and overall
psychological well-being relative to those who did not. Sherrard (1998) have
showed that the elderly relate well-being most strongly to the freedom to choose
activities and manage his own time.

GENDER AND WELL-BEING:

Several studies have suggested that the relationship between age and
well-being may differ between men and women. Glenn (1975) observed that
women in their 50's were less happy than women in their 40's. White &
Edwards (1990) have reported that women are less happy than men. Adelmann,
Autonucci, Crohan, & Coleman (1989) have found lower levels of well-being on
two of their three measures among women from a younger than an older cohort.
Women appear to be less happy and this seems to persist across different age
groups. One exception to this is increased rate of suicide among older men
(Daniel & Christian, 1998) which may indicate greater unhappiness. Haring,
Stock, & Okum (1984) also reported that men were only slightly happier than
women. Studies (Inglehart, 1990; Shmotkin, 1990) have reported that women
have better subjective well-being, but the differences disappear when other
demographic variables are controlled. Women are twice prone to depression as
men (Comer, 1992; Eaton & Kessler, 1981). On an average, both positive and
negative emotions are experienced more strongly and frequently by women than
men. Wood et al. (1989) and Lee, Seccombe, & Shehan (1991) found that
women report higher levels of positive affect on average and more often report
extremely high levels of subjective well-being. Thus in the general population, women's more intense positive emotions seem to balance their higher negative affect. Because women are more open to intense emotional experiences on average, and therefore, this may make them more vulnerable to depression if they encounter many lead or uncontrollable events. If their lives are good, women may experience more intense levels of happiness. Diener et al. (1999) provided a possible explanation of extreme emotionality in women by saying that the difference comes mainly from socially prescribed gender roles. The traditional female gender role includes greater care giving responsibilities that may encourage more emotional responsiveness in women than in men. As a result, women may be more willing to experience and express emotions (Diener, 1996).

A number of studies have shown that subjects' role involvement effect their psychological well-being but the source of this relationship is unclear. Some researchers have reported that multiple role occupancy is beneficial (Thoits, 1983; Epstein, 1980) while others found that conflicts among roles are detrimental to women's sense of well-being. Still others argued that it is not the number of roles occupied per se but the quality of experience associated with each role that is the key to well-being (Barnett and Baruch, 1987; Baruch & Barnett, 1986; Barnett & Baruch, 1985; Helson, 1947) Findings (Barnett, Brennan, Randenleush, Pleck & Marshall, 1995; Thoits, 1983; Epstein, 1980; Rodin & Langer, 1977) tend to show positive relationship between the number
of roles a person occupies and various indices of psychological well-being. Thus there seems to be consensus that gender difference exist in the well-being, especially for some of the indices e.g. women are more depressed than men but it is not clear why these differences exist. Moreover, there is a lack of consensus over the relationship between gender and general well-being.

INSTITUTIONAL CARE:

Not only in India but also in other cultures old people were regarded as carriers of old traditions and having great wisdom due to the accumulated knowledge and experience. References in Bible (Cowgill & Holmes, 1972) are found where elders have been considered to possess great wisdom. In American Indian tribes, the old people have traditionally been addressed as wise elders, the transmitters of culture, and a storehouse of historical lore and treasure. In Thailand, age is the greatest determinant of status, and old people are given seats of honor every where, from public meetings to the family dinner table (Cowgill & Holmes 1972). The aged were cared and looked after by their family members. It was the duty of the family to care for the physical and psychological needs of the elderly with respect and without undermining their dignity. In the western countries after 40’s or 50’s, several factors contributed to the institutionalization of the elderly. Due to changes in trends like an increase in the older population, changes in family living arrangements and changes in federal financing programs and industrialization, the aged were housed in oldage institutions, nursing homes, rest homes and houses for the aged. In some cases,
there may be frictions within the family whereas, in other cases, the family support system might have broken down because the family can no longer manage the burden loss of a support like sudden loss of a partner or a supporting relative or children gone abroad (Townsend, 1965) and presence of physical illness (Riley & Foner, 1968; Manard, Cary & Dirk, 1975; Palmore et al., 1976; Havighurst, 1991). Such factors contributed to the emergence of many types of institutions like chronic disease hospitals and mental hospitals, nursing homes, day-care institutions, old-age homes and the share of the older people residing earlier in mental hospitals declined from 24% to 10% between 1940 and 1970 and mostly such residents were women (Hing & Zappolo, 1978). Hence, these were the reasons for starting the institutional care for the aged where they may fulfill their basic amenities and live with dignity.

Institutions for the aged dates back at least to the gerontochia established by the Christian church in the third and fourth centuries, but the more typical pattern was to house them in 'pore houses' or work houses', along with the stick, mentally ill, destitute, and criminals (Townsend, 1964). Because of this, institutionalization of the aged, came to be viewed as the penalty for 'improvident or dissolute life'. Such attitudes linger on, contributing to a stigma attached to nursing home residence. For the aged it often meant substitution of a nursing home for a mental hospital, since there were few community services available to 'senile' older people. Most old people do not want to live in institution and often feels that going there means rejection by his or her children
(Butler, 1975) but the stereotype have little basis in fact. (Shanas & George, 1976). Many lack support because they have few children nearby (Shanas & George 1976; Palmore et al., 1976; Butler, 1975; Riley & Foner, 1968).

Traditional Indian culture has defined the roles of a man into four well delineated stages or ashrams of 25 years each), the 'Brahmcharya' ashram (0-25 years), the 'Grihastha' ashram (25-50 years), the 'Vanaprastha' ashram (50-75 years) and the 'Sanyasa' ashram (75 + years). So, it was well scriptured that the person after age of 50, detaches himself/herself from home and along with spouse work for upliftment of the society, for a social cause, and spread knowledge from wisdom in the society during the 'Vanaprastha' ashram. In the 'Sanyas' ashram, after 75 years, the person was narrated to detach himself from all the worldly matters and move to forest and work towards spiritual growth of self and towards salvation. However, there is no specific information that when this vedic 'Ashrama system' has given way to another system where people started living with their family members until death. In other words, the ashrama system was not practiced by almost all the persons after retiring from active life. They were being looked after and cared by their kith and kin in their families (Sharma & Agarwal, 1996; Ara, 1994,1995; Nayar, 1992; Shah, 1973; Marulasiddaiah, 1969; Bali, 1995).

The changes once incurred in western societies are now being reflected in India also. The material conditions of life are undergoing a metamorphosis with transformation in the values, belief system and the action patterns (Umesh,
Almost every aspect of social system is changing and the status and role of old aged persons are no exception to it.

Change in living arrangements, family structure and mode of sudden retirement has adversely affected the old, effecting the status and security and respect which they enjoyed in traditional Indian family structure which usually consisted of two generations living together wherein the elderly had a higher status in the household (Jayashree, 2000; D'Souza, 1989). Household support towards elderly has become more difficult among the poverty ridden households (Shah, 1993). With the adjustment problems, aged people are finally inclined to join oldage homes. A survey by Dandekar (1993) in Maharashtra and Rajan, Mishra & Sharma (1995) in Kerala and Tamil Nadu found that the prime reason for the aged moving into oldage homes is the lack of proper care for them within family set ups. Besides economic reasons, family quarrels and handicaps were found to have induced the elderly to move into oldage homes. Many aged males would not like to live with their daughters as they consider the daughters family to be not of their own. However, they admit that they are well looked after by their daughters but not by their sons (Rajan et al., 1995). The interpersonal relations changes after the death of the spouses of the elderly, especially women, who after losing their husbands, have to suffer the pangs and agonies of the widowhood. Kumar (1995) found that most of the widows expressed their unwillingness to live with their married sons, as they are sure of facing the adjustment difficulty especially with their daughters-in-law. But at the same
time they can not keep their independent house and have to depend upon their sons. Swarup (1995) and Shah (1993) reported that those who had pension or some other source of income wanted to retain their independence or felt aggrieved by changing status vis-à-vis their families opted for paid homes or oldage homes. It can be said that with the lack of familial support, the elderly resort to stay in oldage homes.

Oldage homes received much attention as a result of problems of poor care, abuse of patients and administrative negligence (Lanzer & Rodin, 1977). Although the services provided by such homes were not satisfactory and did not have adequate skills to cope-up with the demand of looking after the aged, though they had commitment. It was seen that even in United States the nursing homes were denoted as "houses of death", "human junkyards", Warehouses". The quality of care varies between the nursing homes. Studies by Kart, Matress & Matress (1978) and Kosberg (1985) have reported few differences depending on ownership.

In India, although we have old age homes to care for those left alone, the percentage of citizens who opt for these facilities is not encouraging. This is due to the social stigma attached to the issue of prestige for those opting for aged homes. Still people are not comfortable enough to leave their native place/home town and come to the oldage homes. They believe that their family name might be spoiled if their relatives come to know about their stay in the oldage homes. The proportion (per 1000) of aged willing to move to oldage homes among the
aged persons living alone are 191 and 176 respectively in the rural and urban areas of India (Kumar, 1996). This brings out the negative attitude regarding the oldage homes in India. Swarup (1995) in a case study indicated that in Madras the majority of the aged people are still living with their children or intending to stay close to their children, thus retaining emotional bond intact. It was found that only 5% of the people were in favour of institutions.

Despite the negative attitude of people towards oldage homes, these are mushrooming up and even government is funding the establishment of such homes. In recent years there is an increase in the number of people opting for joining institutions. Rajan et al., (1995) has reported that more than 60% of the institutes face heavy rush for getting accommodation. The rush to require a seat in religious institutions is much higher than any other institution, as such institutions provide everything free to the inmates (Rajan et al., 1995). It is further reported that Karnataka faces a heavy rush for accommodation in oldage homes (81% of the institutes), followed by Tamil Nadu (65%) and Kerela. In the state which has more existing oldage homes, the demand by elderly to stay in oldage homes is also more.

It appears that the changing family structure has effected the well-being of the elderly by depriving them of the familial support of a traditional joint family set-up as well as improving upon them to adjust to the changing values and norms of the younger generation. Thus, there seems to be a kind of paradox, i.e. there are conflicting reports over the quality of services being provided to
the aged on the one hand and a rapid shift toward the institutional care of the elderly on the other. Therefore, there is a need for conducting a study wherein the effectiveness for such care can be examined for the well-being of aged.

DEMOGRAPHIC TRENDS:

Ageing is a worldwide phenomenon (Yong, 1996). Throughout the world, there is an unprecedented increase in the population of the elderly persons than ever before. The demographic shift is due to fall in birth rates and increased life expectancy, improved health conditions and medical advancements.

The elderly population of India increased from 12 million in 1954 to 20 million in 1901 and there are now nearly 77 million old persons. As per United Nations classifications, the Indian society would progress from a "mature society" to an "ageing society" (i.e. elderly population more than 7%) by the turn of century. The elderly, in India, are fast growing population segment projected to grow (at 37.3%) more than double the growth rate of general population (16.8%). On desegregating the elderly, the 'young-old' (i.e. 60 to 74 years) were growing at rate of 4.7% and 5.3% in 1961 and 1981 respectively and are projected to grow at rate of 5.6% by 2001. The corresponding figure for 'old-old' (i.e.75 years +) are 1% and 1.2% respectively (Biswas, 1994). Thus, young – old have been increasing at a much faster pace than old-old in India, where as globally maximal growth is
recorded in the later and not in the former category of elderly (Kinsella, 1994). The most common and useful way of analyzing impact of age structure on economic well-being is through the demographic ‘Dependency ratio’ or ‘support ratio’. Elderly dependency ratio has steadily risen from 9.8 in 1951 to 11.3 in 1991, while child dependency ratio and total dependency ratio and total dependency ratio rose till 1971 and, there after, have fallen due to marked decline in fertility rates. “Index of ageing” expresses ratio of elderly (60+) to children (0-14) in the population. It is a useful measure of ageing process because it defines both the structure of the dependent population and is very sensitive to change in that age structure. This has been rising steadily from 1951 to 18.4 elderly for every 100 children in 1991. Life Expectancy has increased from 22.5 years in males and 23.3 years in females in 1901 to 32.4 years in males and 31.7 years in females in 1951 and has become 60.1 years in males and 59.8 years in females in 1991 and has resulted in the swallowing of the elderly segment. Further 90% of the elderly are from the unorganised sector with no social security. Over 73% of the 60+ are illiterate and dependent on physical labour. 40% live below the poverty line. The data on the trends in demographic, mortality, morbidity shows increased overall life expectancy for the elderly. Further this phenomenon is likely to persist with its effects magnified, because it is occurring during a period in which family size is shrinking and the usual providers of support, particularly women, will increasingly be in the paid labour force.
Thus, the demographic trends clearly indicate towards an increase in
the number of the elderly people in India. Therefore, there is an increase in
the demand for more and more institutions for their care as the traditional care
system is either not available or kith and kin are not able to provide care to
the aged. Further, there are studies which projects conflicting views about the
well-being of the aged and their care in institutions and at home.