CHAPTER - I
INTRODUCTION

The technology and scientific developments of present times brought attention on aging, the problems of aging, adjustments of aging and many other areas of aging, especially the wellbeing of the elderly. It has become a key issue in developed as well as developing countries particularly in the west. It has been viewed as a gigantic problem on account of the cultural and social taboos. Reduction in fertility rate, better standards of living, better sanitary conditions, and exhaustive development of medical technology are some of the causes for the increase of elderly people in the populations. The countries with more young and productive population earlier are now transforming into aging nations. The Asian nations along with the western countries have a larger population of elderly persons. It is projected that by 2025 the aged in China, Hong Kong, Singapore, Japan and India will constitute over 10% of the world population.

Table-1: Percentage of population aged 60 and over in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
<th>Nos. (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>6.5</td>
<td>40</td>
</tr>
<tr>
<td>1991</td>
<td>6.2</td>
<td>50</td>
</tr>
<tr>
<td>2001</td>
<td>7.1</td>
<td>70</td>
</tr>
<tr>
<td>2011</td>
<td>8.13</td>
<td>70</td>
</tr>
<tr>
<td>2021</td>
<td>10.05</td>
<td>70</td>
</tr>
<tr>
<td>2051</td>
<td>23.12</td>
<td>70</td>
</tr>
</tbody>
</table>

Source: Registrar General India 1981
Table-2: Life expectancy of Aged in India

<table>
<thead>
<tr>
<th>Year</th>
<th>Male 60+</th>
<th>Male 70+</th>
<th>Female 60+</th>
<th>Female 70+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1971</td>
<td>3.86</td>
<td>8.83</td>
<td>14.75</td>
<td>9.40</td>
</tr>
<tr>
<td>1991</td>
<td>15.01</td>
<td>16.25</td>
<td>9.97</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>15.74</td>
<td>9.70</td>
<td>17.05</td>
<td>10.45</td>
</tr>
<tr>
<td>2019</td>
<td>16.75</td>
<td>10.32</td>
<td>18.80</td>
<td>11.14</td>
</tr>
</tbody>
</table>

It is evident from the above data that life expectancy of the people in the population is increasing. It is bringing changes in the structure of the society and requires alterations in the functioning of the society.

By 2021, life expectancy is likely to increase among males by 17 years beyond 60 years of age and 10 beyond 70, and among females 18 beyond 60 and 11 beyond 70.

Significance of the study:

The changes in the societal structure and functioning need adaptation in everybody, especially in the aged for their wellbeing. Hence, the present study focuses on the target elderly population who has yet to make major changes in their life style for their wellbeing.
The recent social changes like urbanization, industrialization and migration shook the foundations of the strongest, well-developed Indian joint family system, creating further problems to the aged.

The other cultural and social changes, especially the employment of women in organized sector, caused many more difficulties to the elderly. Hence the present investigation attempts to study the level of wellbeing among the elderly.

There are distinctive roles for men and women in any society. People learn these sex roles during the process of socialization in childhood. Even during the present times of role fluidity, the gender differences exist. Hence the gender's impact on wellbeing in old age also needs to be studied.

It is usual among the elderly to review the successes and failures of life. They can be attributed to one's own ability or to powerful others or to luck. This attribution of the individual in turn brings satisfaction or frustration to the aged. The personality trait which denotes this character, is called "Locus of Control". It is aimed in this research to study the impact of the locus of control on wellbeing in old age.

It is also intended that to understand the activities suggested from among the elderly for their participation in the society. Further, an attempt is also made to identify the important factors experienced by the elderly for their wellbeing and their religious practices. Hence the present
investigation studied the impact of gender and locus of control on the wellbeing of the Aged. It is also expected that the outcomes of the research will help the elderly to enhance their wellbeing.

Wellbeing:

The World Health Organization defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Wellbeing is a multifactorial construct consisting of a complex interplay of cultural, social, psychological, physical, economic and spiritual factors. Human wellbeing is a complex product of genetic, developmental and environmental influence. Wellbeing is a state of mind one can control or alter in any direction as one desires.

The general conceptualization of wellbeing is vague (Warr '87). He used health in turn as a framework by suggesting that effective wellbeing is one component of mental health; the others being competence, autonomy and aspiration and integrated functioning. Effective wellbeing is conceptually similar to the medical criterion of ill or not ill, and has been found to be a multidimensional construct (Daniels, Vrough, Guppy, Been & Weatherstone, 1997)

Warr (1987) further suggested that affective wellbeing be treated as two independent dimensions called "pleasure" and arousal. Competence, autonomy and aspirations are aspects of a person's behaviour in relation to
the environment. The often determine the level of an individual's affective wellbeing, tend to be valued as indicators of good mental health and distinguished on both "Subjective and Objective Basis".

The concept of wellbeing refers to optimal, psychological functioning and experience. It is the focus not only on everyday interpersonal enquiries like "how are you" but also of intense, scientific scrutiny. The question "How are you" may seem simple enough but theorists have found the issue of wellbeing to complex and controversial. From the beginnings of the intellectual history, there has been considerable debate about what defines optimal experience and what constitutes the good life. How wellbeing is defined influences practices of Government, teaching, therapy, parenting and preachings.

Wellbeing research seems especially prominent in current empirical psychology. This reflects the increasing awareness that, just positive affect is not the opposite of negative affect (Cacioppo and Berntson 1999), wellbeing is not the absence of the mental illness. For much of last century psychologist's focus amelioration psychopathology over shadowed the promotion of wellbeing and personal growth. Beginning in the 1960s there has been a shift in focus towards prevention and continuing to the present a few researches have been studying growth (Deci, 1975), wellbeing (Diener, 1984) and the promotion of wellness (Cowen, 1991). Cowen suggested that wellness should be defined not simply as the absence of psychopathology.
but instead as an array of positive aspects of functioning that are promoted by attainment of strong attachments, relationships, acquisition of age-appropriate cognitive, interpersonal, and coping skills and exposure to environments that empowers the person.

**Varieties of wellbeing:**

Psychological wellbeing is a general term denoting feelings of high self-esteem, life satisfaction, and lack of negative symptoms (Atwater, 1994). Wellbeing or positive health can be defined as consisting of those physical, mental, and social attributes that permit the individual to cope successfully with challenges to heal and functioning (Stephens and Antonovsky, 1993). Three measures that capture this conception of wellbeing on the psychological dimension are sense coherence, self-esteem, and mastery. Sense of coherence is a view of the world the events are comprehensible, challenges are manageable, and life is meaningful. Self-esteem refers to the general sense of self-worth as a person, while mastery measures the extent to which individuals feel their lives choices are under their own control.

Ryff (1989) defined psychological wellbeing as self-acceptance, autonomic environmental mastery, purpose in life, positive relations with others and personal growth.
In social psychology, dimensions of psychological wellbeing, especially constructs including self-esteem and self-evaluation, are generally defined as function of one's actual characteristics relative to the characteristics or achievements one would ideally have (Carr, 1999). The concept of psychological wellbeing emphasizes positive characteristics of growth and development.

There are six distinct components of psychological wellbeing. These are:

a) Having a positive attitude towards one self and one's past life (self-acceptance)

b) Having goals and objectives that give life meaning (purpose in life) testing. Ego is also the organizing center for behaviour and experience and responsible for controlling and maintaining the adaptation of the individual to physical, mental and social environment.

According to Barron, Jarvick and Sterling (1964), ego tries to establish equilibrium and stability or predictability of a person. Fenichel (1945) attributed with the functions of perception, binding tension, judgments and synthesizing. Strength refers to the capacity of an individual to perceive a challenging situation realistically and to execute the response effectively. Thus ego strength can define as the total psychic energy at the disposal of an individual enabling then enjoy the strivings to master the environment. It includes the individual's ability control and creates events, which contribute to feelings of accomplishments, self-esteem and growth.
Components of ego strength include the following: Ego strength developed from positive self-regarding attitudes. Adequate feelings of security, confidence on personal worth are basic to a strong and healthy ego. Experiences that contribute generate ego strength. A strong ego is basic to self-confidence and the decision making process and to effective coping with every day problems.

Mental and social wellbeing include not only the absence of problems stress as mental disorders, alcohol abuse, anti-social isolation and violence but also progress toward fulfillment of work and family role obligation, participation social activities and social-emotional competence (Aboud, 1998).

Subjective wellbeing can be described as a profile of independently evaluated life concerns. These factors are not/or only slightly correlated (Sell and Nagpar, 1992). It includes the following:

Positive:

1) Transcendence is a feeling of wellbeing derived from ecstatic moments of meeting, beauty and of belongingness (rooted ness).

2) Expectation-achievement congruence: Includes good feelings of achieving success and a standard of living as per expectations i.e. satisfaction.
3) **Family group support**: comprises a positive feeling about the wider family support (beyond the primary group of spouse and children) as supportive, cohesive and emotionally attached.

4) **General wellbeing**: Refers to positive affect, happy feeling about life overall, as going smoothly and joyfully.

5) **Social support**: It includes positive feelings about the social environment beyond the family, as supportive in general and in times of crisis.

6) **Confidence in Coping**: Conceived as perceived personality strength, i.e. the ability to adapt to change and to face adversity without breakdown.

**Negative:**

1) **Inadequate mental mastery**: This is a worrisome feeling of insufficient control over certain aspects of everyday life that are capable of distributing the mental equilibrium.

2) **Deficiency in social contacts**: Worrying about being disliked and feelings of missing friends.

3) **General Wellbeing**: Refers to negative affect i.e. generally depressed outlook on life. Specific worries over the family, work or health do no load her. Depression is uniquely related to inadequate mental mastery i.e. worries over irritability and inability to cope.
4) **Primary group concern**: Happiness and worries about spouse and children are evaluated independently from the feelings about the wider family and the social support beyond the family.

Subjective wellbeing is believed to be a function of the degree of congruence between the individual's wishes and needs on the one hand and environmental demands & opportunities on the other. Equally important is the magnitude of congruence between the individual and group expectations and the perceived reality (Rajkumar and Kumar 1992). It is subjective as it encompasses both the presence of positive & the absence of negative measures & includes a global assessment of all aspects of an individual's life.

Quality of life is a multidimensional concept, which includes specific core domains including physical, psychological, social and occupational wellbeing. Physical – pain, mobility, sleep, appetite and nausea, sexual functions; Psychological-depression, anxiety, adjustments to illness, Social-personal and sexual relationships, engagement in social and leisure activities; Occupation-ability and desire to a carry out paid employment, ability to cope with household duties.

Perceived quality of life is the set of evaluations that a person makes about each major domain of his or her current life. Domains such as family life, friends, standard of living, leisure activities and residential environment
are domains salient to most people. Evaluations of the quality of one's life in such domains are substantially related to the psychological wellbeing sectors, the behaviour competence sectors and the objective environment sectors.

Review of Lawton, (1982) suggests that there are 4 dimensions that recur in the research of different investigations. They are the following:

1) Neuroticism or Negative affect - a diverse group of dysphonic feelings such as anxiety, depression, agitation, worry and so on.

2) Positive affect - feelings of active pleasure usually linked to a relatively short and recent period of time.

3) Congruence between desired and attained goals.

4) Happiness may itself be an outcome of the net of positive and negative affect.

Research by Kleban and Lawton, (1982) represents the following aspects of psychological wellbeing apart from the above four constructs, i.e., age related morale, perceived cognitive functioning, self-esteem, self-rated health and social desirability. Subjective wellbeing taken as a whole is inclusive of the domains from the set of perceived quality of life; residential satisfaction, quality of social relationships (family and friends separately) and perceived quality of time use.

Indices of subjective wellbeing include negative affect, psychological symptoms, expression/denial of negative affect, self-esteem, self-rated
health, satisfaction with family, congruence, social anxiety, happiness, residential satisfaction, positive affect, time use, wish to move and satisfaction with friends.

The factorial dimensions of psychological wellbeing were determined. Two-second order factors emerged, which were named interior wellbeing and exterior wellbeing. Negative affect was better predicted by intrapersonal factors (such as functional health) than by exterior environmental transactions (such as time use or friends interaction), while the opposite pattern was observed for the predictors of opposite affect. Interior wellbeing may be associated with the absence of negative events and a sense of personal causations while exterior wellbeing is associated with positive events.

If negative affect and positive affect constitute core indicators of two different kinds of experience, these 2 factors of psychological wellbeing were related to a third sector of the good life – behavioural competence. Competence is measurable in the domains of health, functional health (activities of daily living), cognition, time use and social behaviour.

Research in the psychology of wellbeing: personality, individual differences, and wellbeing:

Two closely related that frequently asked questions are, “Are there personality factors that consistently relate to wellbeing?” and, “can
wellbeing itself be thought of as a personality variable?" These questions have been actively researched with regard to subjective wellbeing.

De Neve (1999) suggested that subjective wellbeing is determined to a substantial degree by genetic factors, and argued that it is relatively stable across the life span.

De Neve and Cooper (1998) did Meta analysis involving more than 40,000 adults in which subjective wellbeing was a criterion variable related to various personality traits. Many personality traits were significantly associated with subjective wellbeing, suggesting a correspondence between chronic personality styles and individuals differences in subjective wellbeing of the "big five" traits (Costa and McCrae, 1992) namely Extraversion, Agreeableness, Neuroticism, Conscientiousness and Openness to experience.

Psychological wellbeing is a general term denoting feelings of high self-esteem, life satisfaction and lack of negative symptoms (At water 1994). Wellbeing or positive health can be defined as consisting of those physical, mental and social attributes that permit the individual to cope successfully with challenges to hear and functioning (Stephens and Antonovsky 1993). Three measures that closely this conception of wellbeing on the psychological dimension are sense coherence, self-esteem and mastery. Sense of coherence is a view of the world.
The term quality of life indicates general wellbeing. The wellbeing of the elderly is dependent upon health, status, functional ability, socio-economic status, housing and availability of services (Fredman and Hynse, 1985). Among the indicators of a good quality of life are health, sufficient funds, absence of psychological distress and availability of supportive family and friends. Simply we can say the quality of life means physical, psychological and social wellbeing. In other words quality of life is the physical fitness (actual and perceived by an individual) and psychological health (low in loneliness, helplessness and high on life satisfaction) as well as the leisure time activities and social support network derived from the environment by an individual.

All living beings human or animal yearn for happiness and bliss. Well-being means harmonious adjustments and an integrated living free from continuous internal conflicts. The basic factors of any individual include heredity, physical health status, happy home and healthy social influences.

Well-being is a condition, which is a characteristic of the average person who meets the demands of life on the basis of his own capacities and limitations. It denotes a quality of wholeness or soundness. Well-being is not mere absence of illness. But it is an active quality of individual's daily living. It governs how an individual feels about others, how he is able to face the realities of life. It is rooted in his ability to balance feeling, desires,
ambitions, ideas and competence. The individual’s condition or state of wellbeing is continuously changing depending upon his own actions and the factors and forces acting upon him.

The abilities of the individual to make personal and social adjustments to solve problems and make choices, to find satisfaction, success and happiness in the accomplishments of every day tasks to work efficiently and to live effectively with others.

**Health:** Although most elderly people are in good health, chronic medical conditions do become more frequent with age. Most of the older people have at least one chronic condition. The most common are arthritis, hypertension, heart disease, cataract and impairment of legs, hips, back or spine (AARP, 1989). People over sixty five have fewer colds, the infections and acute digestive problems than younger adults. But the danger with old people is that a minor illness along with chronic conditions and loss of reserve capacity may have serious repercussions. Old people need more medical care than younger ones. They go to doctor more often, hospitalized more frequently, stay in the hospital longer and spend more money on health care.

Despite their physical changes, most elderly people are reasonably healthy provided they take little care in eating, using the toilets, dressing and bathing. More affluent elderly people are likely to be healthier than the poor
elderly. Rural residents are most likely to have chronic conditions that limit their activity. A person’s chances of being reasonably healthy and fit in advanced age often depends on his life style. His practices like eating healthy need foodstuffs i.e., particularly low in cholesterol, no high fat and more fibrous and yellow and green foods with high vitamin A, vitamin C or both is mainly responsible for his health.

Exercise is one very important health practice. Exercise is just as valuable in the late adulthood as it is in the earlier life. Because many of the physical changes commonly associated with normal aging are now thought of as being caused by inactivity. The council of scientific affairs of the American Medical Association (1984) recommends a life-long program of exercise. Regular exercise seems to protect from hypertension and heart disease. It also helps to maintain speed, stamina, strength and the basic functions as circulation and breathing. It reduces the chances of injuries in old age by making joints and muscles stronger and more flexible. It helps to prevent or relieve lower back pain and symptoms of arthritis. It also improves mental alertness and cognitive performance and may help to relieve from mild pressure (Burren, Blair, Goodyear, Gibbons and Copper, 1984, Bromley, 1974; Clarkson Smith and Harlej, 1989, Pandini 1984).

Thus the physiological changes and the health problems of the aged play an important role for their wellbeing.
**Emotional Behaviour:** Emotional Behaviour is an important factor to assess the kind of adjustment elderly people make. Studies like Nordicht, S. (1975) and many others have shown that they tend to be apathetic in their affective life. They were less responsive than when they were young and show less enthusiasm. Mengarten B.L found that old people are likely to be irritable and quarrelsome. Fears and worries, disappointments and delusions are more common than the pleasant emotional states.

**Suicidal Ideas:** Suicide among the aged often occurs in conjunction with depression or with deteriorating physical illness. Some of the reasons are despair over a progression of irreversible losses that they are helpless to stop, of work, of friends, of a spouse, of children, of memory, of health and finally of self esteem and hope. Some elderly people may feel that the quality of life is too low to continue living. Older people sometimes feel hard to face the deprivations of old age because of their excessive identification with their work roles. Certain warning signals of suicide may be identified as

1. Withdrawal from family and friends.
2. Talking more about death.
3. Giving away their prized possessions.
4. Unusual anger, boredom and apathy.
5. More sleep or lack of sleep.
6. Complaints of physical problems and so on.
**Life satisfaction:** Life satisfaction is another criterion used to assess the wellbeing of the aged. According to Erickson, old age is characterized by either ego-integrity or despair. When the difference between the achievements of the elderly of their real selves and their ideal selves is small, they experience ego-integrity and are reasonably happy and satisfied with themselves and their achievements. On the other hand, elderly people who feel that they have fallen short of their earlier expectations, experience despair. Erickson further explained that the successful persons also develop dissatisfaction in old age. Despair is common to many elderly however much was accomplished by them. Neugarten B.S. stated that the life satisfaction in women is more than that in men.

**Finances:** Financial condition of the aged is also a criterion, which accounts for their wellbeing. Barrett quoted that the older people who are financially secure are able to utilize their free time constructively and are happy in their social contacts. An adequate financial situation to meet their needs and wants is a condition, which helps for better wellbeing.

**Occupation:** Occupation is important at all ages but especially so during old age. Having Hurst has pointed out that the attitude towards work is an important criterion for wellbeing. If they live in a society maintaining positive attitude towards their work, their leisure time will be more important to them than time on job. If, on the other hand, they have an ego involving attitude and the time they spend on job will take on greater
significance for them. The prevailing cultural attitude towards work also influences the older workers' attitude towards it.

**Family relations:** As the age advances, mutual interests are developed, the children grow up and leave the home, thus drawing the partners closer together, the illness or retirement on the part of the husband may make the wife feel useful again, as she did when the children were young, the death of demanding and dominating parents-in-laws may remove a force of friction in husband and wife.

**Gender:**

The make up of culture is intrinsically interwoven with the concept of masculinity and femininity. The social, economic and interpersonal structure of society is based on this fundamental difference between the sexes. Throughout the history of mankind, many different theories have been proposed to account for the fact that human beings develop a concept of themselves as male and female. The difference that appeared to exist between the psychological male and psychological female were at first accepted as a matter of fact and ascribed to the essential nature of men and women. However, it is realized that different cultures have different roles for men and women. This became clear in investigations of Mead (1949) and others that most cultures expect males and females to exhibit different behaviours and to assume different roles in society. Awareness of sex-role
standards occurs early in the life of an individual through a process known as sex-typing.

The belief is all universal that men and women as contrasting groups display characteristic sex differences in their behaviour and that these differences are so deeply seated and pervasive as to lend distinctive character to the entire personality. In modern culture at least the woman is believed to differ from the man in the greater richness and a variety of her emotional life and in the extent to which her everyday behaviour is emotionally determined. In particular she is believed to experience in greater degree than the average man, the tender emotions including sympathy, pity and parental love, to be more given to cherishing and protective behaviour of all kinds. Compared to man, she is more timid and more readily overcome by fear. She is more religious and at the same time more prone to jealousy, suspicion and injured feelings. Sexually, she is by nature less promiscuous than man. Submissiveness, docility, inferiority, steadfastness of purpose and a general lack of aggressiveness reflect her weaker connective tendencies. Her moral life is shaped less by principles than by personal relationships. Sentiments are more complex than man's. Certain set standards regarding male and female behaviour have been prescribed by society. These standards are in accordance with Parson's (1955) classification of the male role as basically instrumental and the female role as expressive. Males are expected to be powerful, independent,
aggressive and competent in manipulating the environment, in achievement situations and in decision-making. In social and sexual relations they are found to be competitive, assertive and dominant. Females are expected to be more dependent, socially sensitive and maturant, but to suppress aggressive and sexual impulses. Expression of fear under stress or affection in warm relationship is regarded as more appropriate for women then men (Benneth and Coben 1959; Parsons 1955).

Some writers have attempted to differentiate between the male and female role by stressing the greater demands for competence in the male role. It might be accurate to say that the areas of competence differ for male and female. Studies of Phyll and Richard Call (1973); Tedesco Maney (1974); Kashiwagi Kelko (1973) have shown that traits associated with masculine personality are independence, assertiveness, aggressivism, power, smartness, rationality, stability, activity, intelligence; while the female personality is associated with traits like submissiveness, elegance, attractiveness, sociability, warmth, happiness, peacefulness and youth.

Locus of Control:

Rotter (1966) proposed the concept of I-E. It forms relatively small part of more extensive personality theory incorporating many of the principles established in psychology of learning. This theory is known as social learning theory. He proposed that the degree to which people believe their lives to be under their own control is an important dimension of
individual version. People who are relatively internal believe that they are responsible for their destiny, whereas people who are relatively external believe that the good and the bad events that occur to them are determined by luck, chance or powerful others. Locus of control is not a typological concept and people are not internally or externally controlled type. Locus of control is a continuum and people can be ordered along that continuum. For the sake of convenience, we will refer people as internals and externals, that mean the person is relatively more external or more internal.

The concept of "Locus of Control" was proposed by J.B. Rotter, a leading psychologist and a social learning theorist. He emphasized the importance of the interaction of the individual with his meaningful environment. He explained the importance of environment in the development of personality. He assumes that personality can change with every new experience. Behaviour is goal directed and the movement towards the goal is directed by two variables, reinforcement as well as the individual's expectancy that the goal can be achieved. He developed expectancy-reinforcement model of personality in 1966. According to it, he proposed four basic concepts to predict behaviour:

1. Behaviour potential (B.P.)
2. Expectancy (E)
3. Reinforcement Value (R.V.)
4. Psychological Situation (S)
1. **Behaviour Potential**: It refers to the potential for behaviour to occur in a specific situation, as a function of its relationship to a specific set of reinforcement. For example, if Ravi wants to know his behaviour potential in studies, he would ask in his class (Specific situation) and then ask how important is it to get an A grade (Specific Reinforcement). Since, human behaviour is a complex phenomenon, Rotter introduced other concepts to increase the predictability.

2. **Expectancy**: Expectancy means the probability held by the individual that a particular reinforcement (A Grade) will follow a specific behaviour (studying) in a specific situation. This expectancy is to be independent of the value of the reinforcement i.e., there may be no relation between how valuable the reinforcement is and how confident one is in obtaining it.

3. **Reinforcement Value**: This refers to one's personal preference for one reinforcement over the other reinforcement if the possibility of occurrence for each reinforcement is equal.

4. **Psychological Situation**: It refers to any part of the situation to which the individual is responding in terms of his subjective reactions to that situation. The essential component of this concept is the meaning that the individual gives to the situation. According to Rotter, behaviour of the organism occurs in a situation and is influenced by his perceptions of that situation.
PREDICTIVE FORMULAE:

\[ BP_{X \cdot SI} \cdot R = f(F, V, S, R, SI) \]

\( BP \) = Behavioural Potential

\( X \) = Behaviour

\( SI \) = Situation

\( R \) = Reinforcement

It is a function of the expectancy (E) of the occurrence of reinforcement of (R) in situations 1 (SI). According to Rotter, this formula will allow one to predict whether or not a specific behaviour is likely to occur in a particular situation. To predict less specific Behaviour, the following formula has been used

\[ NP = f(FM \text{ and } NU) \]

The potential for the occurrence of a set of behaviours that lead to the satisfaction of some persons need Potential, which is a function (f) of the average levels of expectancies that these behaviours may lead to the reinforcement (Freedom Movement, FM) and the value of these reinforcements (NU). Rotter proposes a set of six general behaviors, which he refers to as needs.

1. Recognition – need to excel
2. Dominance – need to control
3. Independence – need to make one’s own divisions
4. Protection – dependency (need to provide protection and security)
5. Love and affection – need for acceptance
6. Physical comfort — need for avoidance of pain and desire for bodily pleasures.

The two other concepts proposed by Rotter are-1. Minimal Goal Level, 2. Generalized Expectancies. The Minimum Goal Level is the lowest goal in a continuum of potential, reinforcements for some life situations, which will be perceived by the person as satisfactory to him. There are two types of Generalized Expectancies in his theory Internal versus External (I-E) control. For reinforcements and interpersonal trust, I-E refers to differences in the belief that what happens to one is the result of luck, fate, chance or powerful others (external control) versus what happens to the same person is the result of his own behaviour attitudes (internal control). Rotter refers to this I-E as Locus of Control.

In this present study, the locus of control of the aged is taken as an independent variable and its impact on the wellbeing is studied. Many studies were conducted to study the impact of locus of control on wellbeing. In the present investigation, it is intended to study locus of control of the aged population.

Julian Rotter (1966) developed a questionnaire to measure internal versus external locus of control. It required people to choose between pairs of alternatives such as the following.

1. (a) Students who try their best should have little difficulty making grades in most classes.
(b) Grades in most classes are strongly influenced by teachers' bias and other factors beyond the students' control.

2. (a) I am the master of my fate.

(b) Most of the things that happen to me in life are caused by forces which are more powerful than I.

It is found by Burke, Uzzle, Woodfin, Camp and Aexiale that people who score as highly internal on this questionnaire often seek out learning experiences relevant to their life circumstances. For e.g., internal patients with high threatening illnesses have been found more likely than external patients to seek out information about their illnesses and to look for ways of treating it. As research on locus of control illustrates, we can learn useful things about people by focusing on a single trait.

Humans tested in the laboratory also differ in their susceptibility to the helplessness syndrome. The life experiences that make some people particularly likely to become helpless are not known. But differences have been shown to be related to people's answers on a personality test (Rotter, 1966) measuring belief in internal versus external locus of control of reinforcement (Hiroto, 1974); and Dweek and Reppucci (1973). External individuals believe that events are likely to cause them to be helpless after being exposed to inescapable noxious events. Internal individuals regard their destiny as largely being in their own hands.
Locus of Control in our daily lives:

Locus of control is a concept that has a significant effect on our daily lives. The way individuals interpret events has a profound effect on their psychological wellbeing. If people feel they have no control over future outcomes, they are less likely to see the solutions to their problems. Those with an external locus of control believe that their own actions don’t influence future outcomes. This makes individuals less likely to work, to reach their full potential due to the motivational, emotional and cognitive deficiencies. In fact people with an external locus of control are more likely to suffer from depression and other ailments, because they believe their actions cannot improve their current position. They believe that hard work and personal abilities will lead to positive outcomes. This makes them more likely to meet challenges and succeed in their future endeavors. Even though once actions may not have anything to do with an outcome, the belief they do can greatly aid one’s psychological wellbeing. Therefore those who attribute a sense of personal responsibility for their future thoughts and aspirations are much more successful.

The locus of control construct enables us to deal with a person as he/she views himself/herself in conjunction with the things that befall them and the meaning that one makes of those interactions between one’s self and one’s experiences. The belief that one operates “the buttons” when in fact many of the environmental reinforcements are beyond his capacity of control and delusional, undoubtedly incur some personal anguish. To feel helpless as if one were not an actor but a pawn is likewise costly in terms of psychological wellbeing. Whether people
believe that they are actors and can determine their own fates within limits will be seen to be of
critical importance. An individual perception of control seems to be central to the ability to survive
and enjoy life.

Theoretical Concepts of Aging:

a) Old age as developmental stage: Many developmental changes occur
during the life span of every individual. These changes occur from
conception to death. Development means a progressive series of changes
that occur as a result of maturation and experience. Van Deunacle said that
development implies quantitative changes. Two antagonistic processes in
development that take place simultaneously throughout the life are growth
or evolution and atrophy or involution. Both of these processes begin at
conception and end at death. In the early stages of life, growth predominates
and in the later part of life, atrophy predominates. The human being is never
static. The changes constantly take place in physical and psychological
capacities. Piaget explained, "structures are far from being static and given
from the start. Instead a maturing organism undergoes continued and
progressive changes in response to experiential conditions and these result
in a complex network of interactions." Bower has pointed out in the sense
that it is a cyclic process with competencies developing then disappearing,
only to appear at a later age. It is not continuous in the sense that it increases
constantly but rather in a sense of waves with whole segments of
developments reoccurring repetitively.
The goal of developmental changes is to enable people to adapt to the environment in which they live. Self-actualization is essential to achieve this goal. This is never static. It is an urge to do what one is fitted to do, the urge to become the person both physically and psychologically that one wants to be. How people express this urge depends on the individual's innate abilities and training, not only during the early formative years of childhood but also as he grows older and comes under greater pressure to conform to social expectations. Self-realization plays a major role in mental health or well-being. People who make good personal and social adjustments must have opportunities to express their interests and desires in ways that gives them satisfaction but at the same time conform to accepted standards. Lack of these opportunities will result in frustrations and generally negative attitudes towards people and life in general.

Although changes of a physical or psychological nature are occurring constantly many people are vaguely aware of them. Unless they occur abruptly or markedly, they do not affect the pattern of their lives. The changes of adolescence occur rapidly whereas the changes of old age occur slowly. So the elderly are aware of the fact that their health is failing and that their mind is slipping, they must make necessary readjustments. They must slow down as the incapacities and infirmities of old age catch up with them and they must frequently forgo some of the activities that formerly play important roles in their lives. Many factors influence the attitude towards developmental changes.
b) Changes in old age:

Physical changes in old age: Bischo said that aging proceeds from bifocals to trifocals and dentures to death. This suggests that the most obvious signs are the changes in the face. Hands also give away a person’s age. Changes in different regions occur differently and almost all the people show all or some of the signs of aging, nor do all of them simultaneously. Sooner or later they will become apparent if the individual lives long enough.

In the head region, the nose elongates, the mouth changes shape as a result of tooth loss or the wearing of debentures. The eyes seem dull and lusterless and often have a watery look. A double or triple chin develops. The cheeks become pendulous, wrinkled.

Hearing loss is very common late in life. About three out of ten people between the ages sixty five and seventy four develop this problem. Men tend to experience greater hearing loss leading to so many social problems in day-to-day life. Due to the atrophy of the taste buds of the tongue marked changes in taste occurs in the elderly. The sense of smell becomes less acute with age. As the skin becomes drier and harder, the sense of touch becomes less acute. The decline in sensitivity to pain occurs at different rates in different parts of the body. There is a greater decline in the forehead and arms than in the legs.

Changes in Health Conditions: Although most elderly people are in good health, chronic medical conditions do become more frequent with age. Older people have at least one chronic condition. The most common are
arthritis, hypertension, heart disease, cataract and impairment of the legs, hips, back or spine (AARP 1989). People over sixty-five have fewer colds, flue infections and acute digestive problems than younger adults. But the danger with old people is that a minor illness along with chronic conditions and loss of reserve capacity may have serious repercussions. Old people need more medical care than younger ones. They go to doctor more often, hospitalized more frequently, stay in the hospital longer and spends1 more money on health care.

Despite their physical changes, most elderly people are reasonably healthy provided they take little care in eating, using the toilets, dressing and bathing. More affluent elderly people are likely to be healthier than the poor. Rural residents are most likely to have chronic conditions that limit their activity. A person's chances of being reasonably healthy and fit in aged often depends on his life style. His practices like eating healthy needed foodstuffs i.e. particularly low in cholesterol, no high fat and more fibrous and yellow green foods with high vitamin A, vitamin C or both is mainly responsible for his health.

Exercise is one very important health practice. Exercise is just as valuable in the late adulthood as it is in the earlier life. Because many of the physical changes commonly associated with normal aging are now thought of as caused by inactivity. The council of scientific affairs of the American Medical Association (1984) recommends a life long program of exercise. Regular exercise seems to protect from hypertension and heart disease. It
also helps to maintain speed, stamina, strength and the basic functions as blood circulation and breathing. It reduces the chances of injuries in old age by making joints and muscles stronger and more flexible. It helps to prevent or relieve lower back pain and symptoms of arthritis. It also improves mental alertness and cognitive performance. It may help to relieve from mild pressure (Birren, Blair, Goodyear, Gibbons and Copper, 1984; Bromley, 1974; Clarkson Smith and Hartley, 1989; Pardini, 1984).

Changes in Mental Abilities: Nowadays, the popular beliefs and the stereotypes about the mental abilities of the elderly are challenged taking more positive direction. The popular stereotype of "mental decline" as one of the outstanding characteristic of old age is gradually being weakened. But still it exists and will do so until further evidence disproves it. In the past it was ascribed that mental deterioration invariably accompanied by physical deterioration. Lack of environmental stimulation affects the rate of mental decline. In mental abilities, as in motor learning, continuous practice through the years slows down the rate of decline. Those who continue to work as they reach the latter years of life have more normal brain functioning and do better on intelligence tests than those who are idle (Fisher D.H.). Scientists conducted many tests and proved that their capacities in various activities like learning, reasoning, creativity, memory etc. are reduced a little.
Behavioral disorders in aged (or) mental disorders: Confusion, forgetfulness, personality changes are sometimes associated with the old age, often have physiological causes. The general term for such apparent intellectual deterioration is “dementia”. It is not an inevitable part of aging although it affects many. The most common mental disorders are depression, delirium, intoxication caused by drugs and infections of metabolic disorders, malnutrition, anemia, alcoholism, low thyroid functioning and head injury.

Many older people suffer with depression. The symptoms are extreme sadness, lack of interest or enjoyment in life, loss of weight, insomnia, fatigue, feelings of worthlessness or inappropriate guilt, loss of memory, inability to concentrate and thoughts of death and suicide. Alzheimer’s disease which is an irreversible mental problem, a degenerative brain disorder that gradually robs people of intelligence, awareness and their body functions and finally kills them.

Suicidal tendencies among the aged often occur in conjunction with depression or debilitating physical illness. In the US about 15% of elderly depressed people kill themselves accounting for 30-70% of total suicides (USDHHS, 1990). The highest rate of suicides is among white men over the age of eighty five. The suicide rate of elder may be even higher than they seem to be, since many deaths may not be recognized as self inflicted. Some may look like traffic accidents, accidental overdose of drugs, unintentional failure to take life preserving medicines. Older people
who have committed suicides seems to plan carefully and to know just what they are doing. We can judge it by the fact that one out of every two-suicide attempt in the old age is successful. One of the proposed reasons is despair over progression of irreversible losses and that they are helpless to stop, of work, of friends, of spouse, of children, of memory, of health and finally of self-esteem and home. Some elderly people may feel that the quality of life is too low to continue living. Elderly sometimes feel hard to face the deprivations of old age due to their over identification with their work roles. leaving them without identity after they stop working. Psychotherapy medication or increased social contacts can often help to lessen a persons feeling of isolation. After the person has committed suicide, family and friends are usually over-whelmed not only with greed but also with guilt. Usually warning symptoms appear long before the suicide. To help and prevent suicide in elderly, we need to recognize certain warning signals.

1. Withdrawal from family and friends.

2. Talking more about death in their limited conversations.

3. Giving away their prized processions.

4. Personality changes can also be observed like unusual anger, boredom, apathy, more sleeping and sometimes no sleep.

5. Unusual neglected appearance, difficulty in concentrating on work, is the usual signs of depression.


7. Hopelessness, extreme anxiety or panic.
The counseling and guidance can be given if we identify the aged with the above symptoms. The most valuable counseling often comes from the family, friends and therapist.

Meaninglessness occurs as the individual becomes aged, usually, he completes his responsibilities and does not have any specific duties to perform. Hence, he feels meaninglessness for his survival and develops feeling of uselessness. This psychologically affects the individual's mental health. As his physical strength, muscle coordination, sensory abilities reduce, the health also shows downward movement, making the person feeling himself as burdensome.

Social change: with advancing age most people suffer increase in social laws or social disengagement. Social disengagement is commonly expressed in a narrowing down of the source of social contacts and a decline in social participation. It may be voluntary or involuntary. It becomes involuntary when elderly want and need social contacts but are deprived of the opportunities to have them because of conditions over which they have no control. The lack of transportation, the lack of strength, the limited income and the unfavourable social attitude are some of the reasons.

c) Cultural stereotypes: From mass media, people learn cultural stereotypes associated with different ages. They use these stereotypes to judge people of those ages. Every culture has certain values associated with different ages. In American culture there is a more favourable attitude towards more
productive age groups, i.e. early middle and adulthood and unfavourable attitude towards the aged when people change their roles in old age to less favourable ones as in case retirement and widowhood, social attitudes towards them are less sympathetic. Personal experiences have a profound effect on an individual's attitude towards old age.

All the above important changes in the physical, psychological and social conditions in old age lead to problems in old age, unless there is proper attitude and understanding regarding the changes of old age.

d) Successful aging theories: Successful aging is difficult to define. One aspect of successful aging relates to life satisfaction of the older people themselves. The positive attitude an individual develops about himself. The second aspect of it has to do with social roles, interpersonal obligations and responsibilities. Successful aging has an inner psychological criterion and an outer social one. It is expected that these two aspects of the personality will be somewhat consistent. There are two important theories of successful aging. (i) The disengagement theory, (ii) Activity theory

The Disengagement Theory: The theory of disengagement views aging as a mutual withdrawal process from the social system to which they belong. A gradual withdrawal from society is not a negative experience for the elderly. On the contrary, the aged frequently view disengagement in a positive light. As old age is a age of increased reflections preoccupation with the self and decreased emotional investment in people and in events. Because of this,
disengagement is viewed as a natural rather than an imposed process. Disengagement is generally initiated by the individuals themselves or by the social system, retirement. Rose (1968) offered three major criticisms for disengagement theory. Firstly he believed that disengagement in the later life is not a new adjustment process in later life, but most likely represents a continuation of an earlier life style. Secondly, he stresses that adults who remain active in their social environment are essentially happier than those withdrawn from social system. Finally, he contends that many of the social conditions that have forced the elderly into restricted environments are likely to change in the future.

The activity theory of successful aging suggests that retired individuals prefer to remain productive and active. In contrast to the theory of disengagement, this viewpoint suggests that the aged prefer to resist preoccupation with the self and distance from society. Happiness and satisfaction originate from involvement and the older persons’ ability to adjust to changing life events. Finding substitute activities for those roles that have terminated is a key feature of this kind of adjustment. It is believed that old age offers numerous roles that can prove to be psychologically devastating if no substitute activities are found. Thus, the greater the number of role resources with which individuals enter old age, the better off they will be in adjusting to the demoralizing effects of roles (Blau, 1973). The activity theory has received no empirical support.

Personality makeup and successful aging – Reichard, Levision, Peterson
(1962) developed a theory of personality for successful aging. Since some individuals are satisfied with disengagement while others prefer to maintain high level of social engagement, it is evident that a broader perspective is needed to provide gerontologists with a useful theory of successful aging. According to them there are mainly five personality types:

i. Mature (constructive)
ii. Rocking chair type (dependent)
iii. Armored (defensive)
iv. Angry (hostile)
v. Self-haters

The mature man seems to be ideally adjusted. They accept themselves (strengths and weaknesses and their past lives). They maintain close personal relations. The rock chair type has high level of self-acceptance but it is passive. They perceive old age as freedom from responsibilities. The armored rely mostly on defense mechanisms to cope with their negative emotions and get adjusted. The angry are not well adjusted. They blame others for their troubles and are frustrated. The self-haters are similar to angry but blame themselves for their difficulties and failures. They view old age as a demoralizing stage of life. Neugarten (1968) has conducted an investigation and identified similar personality types like Richard and Associates (1962).

e) Attitude of Asians towards elderly:

Aging in Asia: Due to the great reduction of fertility rate, better standards of living, better sanitary conditions and immunization programs, even the
Asian nations, along with western countries have a larger population of elderly persons. It is projected that by 2025, the aged in China, Hong Kong, Singapore, Japan and India will constitute over 10% of the world population. Asian nations have been a great respect for the aged and an accompanying expectation that when old people can no longer care for themselves, they will be cared for by their families. But today, while both these patterns are still more prevalent than in the west, they are eroding. Although about three quarters of the elderly Asians live with their children, they are less likely to want to do so than in the past. Family structure has been changed by social trends, urbanization, migration and an increase in women in the work force. Thus caring for the elderly at home has become less feasible and governments and private agencies are faced with a need to develop new policies. Korea conducted a survey in 1981 and found that only 7% of Koreans thought their children would care for them in their old age. 64% expected to care for themselves. Some Governments are trying to halt this erosion through legislation. China, Japan and Singapore have all passed laws obliging people to care for elderly relatives. Japan and Singapore provide tax relief to people who give their elderly relatives financial help.

Institutionalization is seen as a last resort to be used only for elderly people who are destitute or without families. All the Asian countries have a lower percentage of elderly people having in homes for the aged than the United States- Japan 1.5%, Singapore 2.5%, Hong Kong 1% and China 0.33%.
Most Asians can agree on goals — to help elderly people remain independent and productive as long as possible and when they do need assistance, to help their families care for them. But accomplishing these goals is a difficult challenge.

1) Policies and programmes for the wellbeing of the aged in India: As per the Directive Principles of the Indian Constitution (Article 42) “the State shall within the economic capacity and development, take effective provision for securing the right to work, to education and the public assistance in cases of unemployment, old age care, sickness and disablement and in other cases of undeserved want”. Some of the welfare policies implemented for the elderly in India are listed below.

1. Old age pension for the general public: The destitute, the poverty stricken and the infirm aged 60 and above are provided pensions at rates ranging from Rs.30 to 100.

2. National old age pension scheme (NOAP): This scheme was introduced on 15th August 1995 under the national security program.

3. Senior citizen unit plan.

4. Institutional facilities and other Programs: Many voluntary organizations are functioning for the care of the aged persons by establishing old age homes, day care centers and health centers.

5. Age Care India: This is voluntary organization established in 1980 in New Delhi. The source of income for the organization is admissions and
membership fees, donations and grants from the Government. The objectives are:

a. To help aged through residential and institutional services and provide them educational, recreational, social, cultural and spiritual services.

b. To arrange for medical services, part time employment to supplement their income and to organize tours, trips and pilgrimages.

c. To arrange for professional consultancy services like taxes, duties, property pension and other financial requirements.

d. To conduct research and studies on the problems of the aged and to arrange study seminars, rallies and so on.

e. To create a suitable climate for greater understanding and better social integration between the old and the young generations. These organizations arrange free geriatric health checkup camps for low income aged groups. It brought out a monthly publication "Age Care News" for the general education of the people.

Bharat Pensioners Samaj: This an all India federation of pensioners association established in New Delhi in 1960. It is for the pensioners of Central and State Governments and of Quasi Governmental Organizations seeking relief from various quarters and highlighting the difficulties of the aged pensioners and other senior citizens.
a. To stimulate the utilization of unused time, energy and other resources of
the pensioners and other senior citizens and direct them into various fields
of economic and social activities in the developmental plans of the country.

b. To arrange medical facilities.

c. To solve the grievances of its members through appropriate authorities.

d. To hold seminars and conferences from time to time, to focus on the
problems of pensioners and senior citizens.

Caritas India: It is a member of the CARITAS international established in
India in 1962 with Delhi as headquarters. It is an official national level
organization of the Catholic Bishop Conference of India. Its aim is to promote
care to the sick, crippled, handicapped, destitute and the aged.

Help Age India: A voluntary organization established in India in 1948 in Delhi
to improve quality of life of elderly. It has 20 offices all over the country. The
aim is to foster the welfare of the elderly in India, to raise funds for projects and
to create a social awareness about the problems of the elderly among the
younger generations. It runs on charity funds collected through various means
i.e., through motivating students and youth organizations for fund mobilization
and through collection of donations from private and public sectors. It receives
nominal grant from the central government as well as through sale of flags and
greeting cards.

Indian Association of Retired Persons: It was established in 1973, Bombay as
Head Quarters. The main objectives of the association are

a. To play an effective rôle in solving pensioners problems.
d. To undertake a number of programs for the welfare of the retired persons.

Under this organization, a well-equipped library is also established in Bombay.

Radio Programs for Senior Citizens: Presently, the programs for senior citizens are broadcast from 17 state capitals. The programs are related to geriatric care, pension problems, tax problems, legal advice relating to will and succession and resorts for the aged.

The center for developmental studies is playing an active role in conducting field studies, projects and research in the problems of the aged. In addition to the above mentioned programs, many other Government and voluntary organizations, academic research departments are playing a vital role in the development of programs and policies to enrich the conditions of the aged in India.

1.5 Religion and emotional wellbeing in later age:

Religion plays a very important role in the lives of elderly. It is used as the most common stress coping mechanism. In a study conducted by Koeing, George and Siegler, 1988. It was found that 45% of the sample expressed the activities related to religion as their stress coping mechanism. It contains placing trust and faith in God, praying and getting help and strength from God. Another
study was conducted by Koeing, Kvale and Fesrel (1988). 836 older adults from 2 secular and 3 religious oriented groups were studied. It was found that morale was positively associated with their kind of religious activity. It was found that the more the religious people are, the higher the morale and a better attitude towards aging. The lonely women and persons over 75 showed the strongest correlation between religion and wellbeing.

Chatters & Taylor (1989) conducted a study on a representative sample of 2107 African American adults aged 18 to 75, the highest levels of religious involvement of all kinds were shown by women and people aged 65 and older. For all ages and both sexes, the most common religious activity was the personal prayer.

In the light of the aforesaid conditions of social and technological developments and the increase of longevity of the people, the present investigation seeks to study wellbeing to the aged.