Chapter II

Review of the Relevant Literature
CHAPTER - II

REVIEW OF RELEVANT LITERATURE

2.1 Wellbeing:

As a backdrop to the present investigation, the relevant studies are examined to get deeper insight into the problem. The term wellbeing is defined by Fredman and Hyner (1985) as the quality of life indicating general wellbeing. For elderly it is dependent upon health, status, functional ability, socioeconomic status, housing and availability of appropriate services. According to them, the indicators of a good quality of life are health, sufficient funds, absence of psychological distress and availability of supportive family and friends. Simply the quality of life means the physical, psychological and social wellbeing. In other words, the 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.

Cowen (1991) suggested that wellness should be defined not simply as the absence of psychopathology but as a way of positive functioning that is promoted by attainment of strong attachments, relationships, acquisition of age-appropriate, cognitive, interpersonal and coping skills, and adjustment with the environment that empower the person. This survey on wellbeing
clearly indicated the meaning of wellbeing, the conditions that engender it, and how it differs across place and time. This study had yielded a rich and valued body of knowledge on human wellness.

Many factors were being identified as indicators of psychological wellbeing by different studies. Pinneau (1976) indicated that social support reduces psychological stress and strain. O.Rourke (1978) and Amero et al (1987) reported positive relation between income and mental health. Kasi (1978) reported that poor mental health was associated with inadequate income. Verma (1988) postulates dual factor theory that there are different sets of factors that contribute to negative and positive mental health. Among many, (Chandrika and Anantharaman, 1982; Mishra 1987)- lower life satisfaction; (Gurudas and Lakshminarayana 1989; Bharadwaja Sen and Mathew 1991; Chandha, 1991) - gender; (Jumuna, 1989; Asha and Subrahmanyam, 1990)- death of the spouse; (Gurudas and Lakshminarayana, 1989; Chandu Agarwal and Mangala, 1990)- institutionalization; (Chandrika and Anantharaman, 1982; A Reddy and Padmini, 1989; Nagpal and Chandha, 1991)- pre retirement, occupational type with concomitant economic status (Manachery, 1987) are the various indicators of psychological wellbeing.

Research on wellbeing had tended to fall into two groups. One focuses on subjective wellbeing, which is equated with happiness and is
formally defined as more positive affect and greater life satisfaction (Diener and Lucas, 1999).

The second viewpoint focuses on psychological wellbeing which is defined more broadly in terms of the fully functioning person (Ryst, 1989), as happiness and meaningfulness (Megregor and Little, 1998) or as self actualization and utility (Ryon and Pesi, 2000).

Despite division, these two groups complement each other, overlapping and providing extensive picture of personal and cultural factors for the promotion of wellness. Many researches are going on to find out the factors relevant to develop wellbeing of persons.

Many studies are conducted to relate wellbeing as a personality trait and also to find out the type of people who are likely to be well. In all these researches the subjective wellbeing (SWB) is studied. Deneve (1999) suggested that SWB is determined to a substantial degree by genetic factors and argued SWB is relatively stable across the life span.

The challenges Indian space today is that of care of the aging in a changing society. Several measures such as care of the community by the community hospitals with specialists in Geriatrics, health visitors as a link between the elderly and the hospitals; training of domestic people as
paramedical and a scheme similar to the “meal on wheels” are suggested to enhance the quality of life of the aging in India.

Differences among the aged in the use of health services has been linked with marital status and living arrangements. Vijayakumar, S (1990) conducted a study with 200 randomly selected aged respondents (60+) from a rural sector in Chittur Dist. All of them are interviewed. Results show differences in the health status of the aged. Living in joint, nuclear and post parental families, utilization of health services is seen to be related to economic conditions, marital status and personal care.

Nagaratnamma B. (2003) studied the mental health status of the retired university professors in which certain factors like age, income, physical health and social support were considered. It was found that the subject of the study had good social support and was using problem focus to coping styles and possessed good mental health.

Sandu P. and Baksi R. (2004) studied the view of elderly women on their social and mental wellbeing in modern society. The study on 120 elderly in six cities indicates both positive and negative impact of modern society. Better communication and transportation facilities are identified as positive factors, while loneliness and alienation, mental insecurity in the lives of elderly is fast growing due to changing society.
Madhu Jain and Anamika Sharma (2004) studied the quality of life of religious older people. Human beings have an innate urge towards personal growth to evolve through deeper self-knowledge and feel that they are valuable elements. The current research envisages the impact that productive engagement in work with high religiosity in old age can cast upon the quality of life of older people. The findings conclude that religiosity as well as productive engagement in work does play a pivotal role in individual daily life.

Neetha Bhave B.J., Subedhar and Deshpanday V.R. (2005) had undertaken a research to study the quality of life of the aged and revealed that in middle class families the quality of life of elderly is satisfactory on an objective scale. However, subjective study didn’t yield a satisfactory picture. Hence, the authors concluded that objective and subjective study can be at variance and moreover no firm definition of quality of life can be outlined.

2.2 Gender related studies on Wellbeing:

In any culture there are distinct roles assigned to men and women. These create differences in the behaviour patterns. From the prevailing research literature, it is observed that the prevalence of distress is more in aged women than in men.
Many studies are conducted in India to know the prevalence of mental disorders in men and women. In all these studies women are found to have higher rate of mental illness than in men.

**Table – 3: Gender and Prevalence of Mental Illness**

<table>
<thead>
<tr>
<th>Source</th>
<th>Place of Study</th>
<th>% Of people selected</th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Dube (1970)</td>
<td>UP Urban</td>
<td>1.58</td>
<td>3.38</td>
</tr>
<tr>
<td>Sethital (1972)</td>
<td></td>
<td>5.26</td>
<td>2.41</td>
</tr>
<tr>
<td>Verghese et al (1973)</td>
<td></td>
<td>6.04</td>
<td>7.29</td>
</tr>
<tr>
<td>Nandi et al (1975)</td>
<td></td>
<td>9.06</td>
<td>11.46</td>
</tr>
<tr>
<td>Carstairs and Kapur (1976)</td>
<td></td>
<td>31.69</td>
<td>39.65</td>
</tr>
<tr>
<td>Chakraborty (1990)</td>
<td></td>
<td>9.26</td>
<td>22.50</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td></td>
<td>10.48</td>
<td>14.45</td>
</tr>
</tbody>
</table>

The figures have been arrived by averaging out data presentation of the studies. All are community surveys and not hospital survey. It does not include the rates of incidence; it is only the prevalence of illness.

Contrastingly, Mohan (1970) observes that the male predominance in hospital sample. It could be because of our unconscious neglect of fair sex and the society’s feudal cultural values.

Indian community surveys between occupation and mental distress highlight the fact that marriage is stressful for women. All the surveys included “housewife” as an occupation. Sethi et al (1972) and Sethi et al (1974) found the highest common distress amongst housewives in both their urban as well as rural samples.
Nandi et al (1978) noted greater frequency of stress related syndromes among a dislocated community in West Bengal. Especially women were more symptomatic for depression than men. Unemployed and illiterate women, women in unpaid or badly paid jobs, women in unclassified job categories such as sex workers, household maids and beggars are also said to be vulnerable to mental distress. Social factors are statistically significant in rates of prevalence of mental distress among women.

Rama Chandran, Menon and Rama Murthy (1979) found a case rate of 32/1000 for organic disorders alone in people over 50 ages and an overall distress rate of 350/1000.

Guttentag et al. (1980) early review stated that nothing can be inferred about the rates of prevalence on mental illness across gender because of the serious diagnostic discrepancies between studies.

Rama Chandran (1985) linking the loss of spouse with psychiatric disorders found that widowhood correlates with feeling alone, feeling of loneliness and dissatisfaction with life.

Thoite (1986) tried to find out the association between individual social rules and rate of the most common mental disorders. He found common mental disorders are more complex for women than men. There is evidence
that both men and women with the most and fewest social roles experience these disorders.

Sumalatha and Upinderdhar (1989) reported the effects of age and sex on learned helplessness. The results show that the learned helplessness irrespective of sex is the function of old age. The results support an earlier study conducted by Chauhan (1983).

Venkoba Rao's survey (1989) in Madurai a semi urban area (Tirupparaum) showed that 15 to 20% of aged had mental health problems and majority of them suffering from depression. The prevalence of depression in old was noted to be 89 per 1000. His survey showed a male predominance in the prevalence of depression, and it is 3 to 5 times greater than in women. The study shows that generally speaking they were not socially isolated, they were not well integrated either and were like "lonely islands" within family.

Field T., Vardali H., Pierre F. et al (2000) conducted a study on screening for depression in mothers bringing their offspring for evaluation or treatment of depression. Results indicate that since depression prototypically begins in the teenage years and may persist for decades, disorders virtually present during women's entire reproductive life with serious consequences for the mental health of future generation.
Kornstein S.G., Schatzberg A.P., Thase M.E. et al (2000) results indicate important gender difference in instances of psychological impairments seen in chronic depression. The effects of depression on mothering and on the development of psychopathology in offspring have been conclusively demonstrated.

Rodes et al (2001) could not find gender differences in the overall prevalence of mental disorder within a reference period of one year. But women had more mood/anxiety disorders than men. And men were characterized by more substance abuse and antisocial behaviour.

Chakraborty A. (2001) conducted a field study in Calcutta and reported some important correlates of the common mental disorders in women. Age, marital status, economic status, occupation, education and family roles comprise these correlates. Neuroses increase with age for both gender but women have a much higher rate. Single women were found to have less illness compared to single men. The ratio was equal for married couples but widowed females had higher rate of illness. The influence of economic status was not very clear.

Weich S., Slogget A. and Leis G. (2001) made an attempt to find out the reasons for the prevalence of most common disorders among women. They failed to explain the gender difference in this regard.
Carol H. Gold, Gerald E. McLean, namely L. Pedersen and Steg Berg, (2002) conducted a study to assess gender differences in various measures of health conditions, symptoms and self-rated health among older persons by comparing brother and sister in a sample of unlike sex twins (605 pairs). No gender differences were found in somewhat life threatening health conditions total cardiovascular conditions or self-rated health.

Mohammad E., Irudayarajan S., Anil Kumar K and Saidu Mohammad P.M. (2003) conducted a study in Kerala with 1000 households on subjective wellbeing, general health questionnaire and a questionnaire prepared by the research team for eliciting specific stress factors experienced by both men and women. The results indicate:

1) Better sense of wellbeing in men than in women.
2) Women express greater mental stress.
3) Subjective wellbeing improves with education.

2.3 Locus of Control:

One of the basic personality characteristics that influence behaviour involves one's assumptions about responsibility for good and bad events. When a person believes that he or she is able to act so as to maximize the possibility of good outcomes and to minimize the possibility of bad outcomes is said to have internal locus of control. The antithetical assumption i.e. the outside situations, people, luck, fate and other uncontrolled factors
are responsible factors is said to have external locus of control. The concept of I-E was first proposed by Rotter (1966) in his social learning theory. This locus of control is a continuum and people can be ordered along that continuum. It is observed that the locus of control of an individual is determined by his age, experience, health, environment, his success so on. These personality traits are to certain extent stable but not permanent.

Graves (1961) found the difference among three community groups regarding their locus of control. He studied the differences among the Indians, children of Spanish-American Heritage and whites in an isolated ethnic community. He observed the Indians as externals, Spanish Americans in the middle and the whites more internals. The study showed the impact of culture on locus of control.

Hirschi (1962) found that the lower the status of fathers occupation the more likely the child was to be external.

Crandall, Kathavsky and Preston (1962) found girls to be more significantly internal than boys.

Lefcourt and Ludwig (1965) obtained significant differences between Negroes and Whites in means i.e. score on comparable samples even though there were no significant differences in social class, age, and intelligence. Negroes were significantly more external than whites.
Ganull, Kathovsky and Crandel (1965) noticed that the impact of social class on internal – external attitude scale accounted minimally.

Aggarwal (1965) reported the scheduled caste children were significantly more external than higher caste children on I-E scale.

Chance (1965) found that by and large parents who exhibit warm, protective, positive and nurturing child rearing practices showed children to develop an internal locus of control.

Rotter (1966) found that the characteristics of internally controlled individuals as more striving, more self-confident and less anxious and apathetic than externals.

Gruen and Ottinger (1969) found in the realm of ethnic and social class differences to be significant effects of I-E. In general it is possible that such differences can be reduced more often to explanations involving access to socioeconomic power and mobility. Such data very likely reflect differences in socioeconomic status and are simply another example of the fact. Middle class children are more internal than lower class children.

Joe (1971) and many others reveal that locus of control beliefs are related to psychological wellbeing or adjustment. The simple belief that the internals have in their own personal control leads to better personal adjustment and less anxiety. The number of studies supported that externality is associated
with maladjustment. The studies also suggest the relationship between I-E and maladjustment or anxiety is linear. The earliest hypothesis about the nature of locus of control suggested a curvilinear relationship. It was felt that extreme internals for example could be so obsessed with personal responsibility that lead to extreme guilt and remorse produce maladjustment.

Kuper (1971), in his study on older people, indicated that internals cope better and are less defensive than externals.

McGinnies, Nordholm, Ward and Bhanthumnavia (1974), Parson and Schneider (1974) found small differences in favor of greater externality in women. Whether the difference between early research and studies that are more recent studies is due to change in cultural role expectation in men and women is hard to assess. However, it must be noted that regardless of whether there is sex differences in I-E scores. Sex very often affects the magnitude of the relationship between I-E scores and other behavioral measures particularly achievement and defensiveness.

Dennis and Charles (1974) found that locus of control was related to both role ambiguity and satisfaction and that locus of control provides a greater independent contribution to satisfaction than for role ambiguity.
Strickland (1974) has commented on the significant and dramatic implication that locus of control offers for physical wellbeing. He points out that l-E appears to be related to prophylactic dental behaviour, use of seat belts in autos, preventive medical shops, participation in physical fitness activity, ability to influence post operative care and patient behaviour in variety of kidney diabetic and cardiovascular conditions.

Brim (1974) found a decrease in internality scores in older age cohorts.

Seligmans (1975) regards depressions as kind of positivity with a corresponding negative, cognitive set regarding the effects of the individual's behaviour.

Wolk and Kurter (1975) also found internality to be related to higher adjustment, satisfaction and involvement scores in a sample of non-institutionalized elderly. Contrary to expectations, the elderly sample was found to be much more internal than current younger samples.

Thukral (1977) reported that the scheduled castes children were significantly more external than higher castes children on l-E scale.

Phares (1978) summarized the research relating to l-E to a wide variety of behaviour. A distinct picture of the internal as compared to external people emerges. The internal person is more likely to be receptive to aspects of health care like giving up smoking, taking exercises and so on. Their desire
for determination is reflected in their greater resistance to social influence and attempted attitude change. In part this behaviour is a result of the internals superior knowledge since they are characterized by their efforts to seek out information, which enables them to exert greater control over their environment.

Kabul (1980): A significant relationship was found between locus of control and life satisfaction levels but non-significant relationship between intend/external scores and general health status and moral scores.

Dupont (1980): The pattern of internal/external control biases observed during the aging years has been more ambiguous.

Maqsud (1981) conducted studied (a) to examine the relationship between the scores on Ratter's internal and external (I-E) locus of control scale, age and measures of socio economic back ground of 120 Nigerian adolescent males (Mean age 15-89 years). (b) to see whether these means differ from one another in belief in personal control, (c) to compare I-E orientation of Nigerians with that of members of some eastern and western societies. He found that I-E scores were not significantly associated with subjects’ age or socio economic background. No significant differences were found in belief in personal control of individuals.
Brien and Gorden (1981) using partial correlations found that Rotter's internal, external locus of control scale was a significant predictor of most aspects of retirement satisfaction for males when age and self-reported health were controlled. For females, only life satisfaction was significantly predicted. Using path analysis they reported skill utilization was negatively associated with locus of control for both males and females but not a direct association with the life satisfaction.

Kobasa (1979); Fawcett Stonner and Zepelin (1980); Lefcourt (1980); Lefcourt Matrin and Saleh (1984) found internal locus of control as an additional buffer moderating the effect of stress on health and life satisfaction.

Kuhnkrishnan and P.S. Stephen 1992, studied the relationship between the locus of control and sense of general wellbeing. Locus of control scale and PGI wellbeing measure scales were administrated to 160 PG students of the age group 20-25 years. Results show that internality in locus of control is positively related to general wellbeing. Scores of men students and locus of control and general wellbeing sense do not differ in women. Women scored more towards externality in locus of control.

Kuhnkrishnan K. and Manikandan K. studied sex differences in locus of control. An analysis based on Calicut locus of control scale. Sex differences in locus of control are analyzed using response patterns of 400
subjects in Calicut locus of control scale. 200 men and 200 women of the age group 18-24 were the samples. Results show that out of the 53 items in the scale 37 items were sex related. Men and women differ significantly in all the four factors i.e., luck-chance, fatalism, powerful others and personal control and females scored more towards externality.

Asha Shukla (1995) studied to examine casual attribution of success and failure by internally controlled and externally controlled subjects under effort and chance conditions. The sample consisted of 200 female postgraduate students. It was a 2x2x2 factorial design with two levels of locus of control (internal/external) two conditions (efforts/chance) and outcome (success/failure). The dependent measure was attribution. The tools were locus of control scale, attribution scale and binary prediction task. The main findings were: (i) Internal subjects do not attribute more to internal causes as compared to externals. (ii) Subjects attribute to external factors more in effort condition. (iii) Subjects attribute success more to internal factors in comparison to failure whereas they attribute failure more to external factors. (iv) Interaction of locus of control and chance effort conditions does not influence performance attribution.
2.4 Wellbeing - Variables:

Many studies are conducted to provide the extensive picture of the personal and cultural factors of wellbeing. Family relations, social support, social relations, finances and so on are some of the factors of these studies.

a) Family Relations and Wellbeing:

Wilensky (1961) observes that a voluntary association helps the integration of the aged into community but that successful personal adjustment among the elderly is more closely related to primary attachments with family and friends.

Riley and Anne (1968) stated that the widowed report greater anticipation of death and their self-esteem also become negative.

Patel (1977) found in his study that old people without their life partner felt loneliness and are very much depressed. Widowhood often have negative consequences for older people.

Panek and Rush (1979) indicated that family and living conditions are significant factors affecting the mental health of elderly people.

Wister and Strain (1986) made comparison of older widow and widowers and investigated the informal support network and wellbeing of widows and widowers and no gender differences were observed.
Chandha and Rush (1989) indicated that non-institutionalized aged are better on psychological wellbeing and that their depression level is low as compared to their institutionalized counterparts.

N.K. Chadha, M. Easwarmorthy and Priya Kanwara (1993) studied the quality of life of the aged with reference to their residential setting i.e., institutionalized and non institutionalized with a view to provide better understanding of the problems and complexities of the elderly to the government policy makers and voluntary organizations. 160 elderly individuals (80 institutionalized and 80 non institutionalized) were studied with the help of the schedule prepared by the author. The results imply that emphasis should be given on more systematic and family based setting rather than on secluded old age home.

Sagar Sharma, Saloni Singh and Shivanath Ghosh (1996) conducted a study on relived army personnel on psychological wellbeing and family integration. The A-trait scale of state trait anxiety, inventory, self-rating depression scale, life satisfaction index (an indicators of psychological wellbeing). And two family integration assessment scheduled were administered to a group of 40 retired officers and other rankers all of them are 60 years and above married with a living spouse, not reemployed and lived with these families in there districts of Himachala Pradesh. The results show: (i) Ex-other ranks reported lower
psychological wellbeing than these Ex-officer counter parts (ii) Family
nuclearity or jointedness was unrelated to psychological wellbeing. (iii)
Irrespective of family structure (joint/nuclear), the ex-officers and, ex-
other ranks were either moderately integrated or well integrated with
their families in almost equal proportions. Thus living in a nuclear
family was not seen as a barrier against integration. The higher degrees
of family integration provided non-significant trends towards better
psychological wellbeing. Unlike well integrated groups the moderately
integrated Ex-other ranks reported significantly lower psychological
wellbeing or all its three measures than these ex-other counter parts.

Herig, Lawrence K. and Duff Rober. W (1997) studied the relative
importance of spouses, children and friends in the life satisfaction of
retirement community residents. 796 healthy residents of 7-retirement
community were examined. Results show that having a spouse was the
strongest predictor of life satisfaction followed by participating in
community activities and interacting with friends. Findings indicate a
bifurcation of elements. He explained it in the way of social life.

The findings of K. Sri Vastava and Swetha Agarwal (2002) reveal
that there is a significant relationship between the marital status and
level of self-esteem among aged people. Further it is found that the
widowed aged are more in negative self esteem than aged couples.
b) Social Relations and Wellbeing:

Fredman and Haymen (1985) recognized quality and quantity of social relations as important determinants of wellbeing.

Sharma and Dak (1987) located the geriatric lowered wellbeing within the contest of disintegration of joint family system with the help of these ICMR projects.

Venkoba (1989) showed the other aspects of importance of family and social relations for wellbeing. He concluded (i) Family jointness (physical composition of the family) does not differentiate the psychiatric from non-psychiatric groups. (ii) It is the lack of family and social integration than this isolation that is the lot of geriatric groups. Hence, it is found that the integration within the family rather than its numerical commitment would be a significant factor in determining the psychological wellbeing of the aged. Thus, the family and social support play major role in old age attachments and relatedness.

Hong Lawrence K. and Duff Robert W. (1989) studied the relative importance of spouse children and friend in life satisfaction of retired community residents. 796 healthy residents of seven retirement communities were examined. Results show that having a spouse was the strongest predictor of life satisfaction followed by participation in community activities and interacting with friends.
Nagpal and Chanda (1991) suggest that social network size of institutionalized elderly is significantly smaller than the non-institutionalized elderly. The non-institutionalized elderly have a higher life satisfaction than the institutionalized elderly. In another study at the same time, they studied the role of available social support in buffering stress effects and in enhancing wellbeing. In particular at present family is being increasingly accepted as a basic unit and serve as an important support system.

J. Steven and Molinari Victor (1995) studied the young old and the old old issues of wellbeing, the family and social support. This study highlights the differences between young old and old old especially as related to physical and mental wellbeing, family issues and formal and informal support system. A demographic overview sets the framework for the major thesis, emphasizing age distinction among the elderly as one important way of conceptualizing the significant variability in the social and psychological characteristics of people over the age of 65.

Baldwin (1996) found that most people exhibit different attachment styles with different figures in their lives.

Mikulincer and Florian (1998) confirmed that there is a validity of research that suggested that having stable satisfying relationship is a
general factor across the life span and one would expect strong universal association between the quality of relationship and wellbeing.

Myers (1999) stated that the like of relatedness to subjective wellbeing is manifold and of all the factors that influence happiness, relatedness is at the top of the list.

Deneve (1999) noted that affiliation and relationship enhancing traits are most strongly related with subjective wellbeing.

Diener and Lucas (1999) defined wellbeing more positive affect, less negative affect and greater life satisfaction. Further suggested that conscientiousness, agreeableness and openness to experience are less linked to subjective wellbeing because these traits have their source in regards in the environment, i.e., they are more a function of environment influences, whereas extroversion and neuroticism may be more a function of genetic factors.

Laguardia (2000) stated that person variability insecurity of attachment was predicted by the degree to which an individual experiences need satisfaction with particular partners, those with whom one experiences security are those who facilitate feelings of autonomy, competence and relatedness. The researchers further showed that to considerable degree, the positive effects of attachment security on wellbeing were mediated
by need satisfaction. Thus, it appears that secure attachment fosters wellbeing in large part because they represent relationships with in which a person satisfies needs for autonomy, competence and relatedness.

Nezlek (2000) reviewed a number of studies showing that where as the quality of interaction does not predict wellbeing, where as the quality of relatedness does. These studies found that individuals who in general have more intimate or higher quality relations’ life tend to demonstrate greater wellbeing.

Reis (2000) showed further that with in person day-to-day variation in feelings of relatedness over a two-week period predicted daily indicators of wellbeing. It is also found that people experienced greater relatedness when they felt understood, engaged in meaningful dialog or had fun with others.

Ryff and Singer (2000) defined psychological wellbeing viewing positive relations with others as an essential element in human flourishing.

Ryff (2001) reviewed evidence that positive relations predicated physiological functioning and health outcomes. The present study in concerned with the wellbeing of the aged people. In old age as the
physical movements i.e. the movements of the individual are naturally well restricted and reduced due to the decrease of physical steaming and strength. Hence, their relations with family members increase more than that in the earlier life stages. So, the attachment and relatedness with family members play a major role in the elderly wellbeing.

c) Leisure time activities and wellbeing:

Recreation is defined by Hornbyetal as refreshment of body and mind. According to George E. Myers recreation includes a wide range of activities namely physical activities like golf, tennis and so on, social activities, parties, entertainments, movies, radio programmes, still other hobbies or vocational type like contracting and so on. Leisure activities vary according to the age or period of the life cycle and depend on factors like - income, personality, interest, health, ability level, transportation and so on. These factors play an intricate role in deciding the kind of leisure activity opted by a person. The variable has been a vastly studied factor in the area of geriatric studies and has been established as an intervening variable playing determinant role in the lives of the aged.

Grossin (1961) suggests the ways in which leisure facilities tension management, adaptation and integration.
Videbeck and Knox (1965) have observed that persons in their 50's and 60's having relatively stable circumstances tend to reduce participation in voluntary associations where as those whose disrupted by widowhood, changing jobs or retirement tend to increase participation.

Dumazeder (1967) provides a view of five derived benefits of leisure activities such as relaxation, diversion, knowledge, social participation and creativity.

Atchley (1977) studied the leisure time activities of the elderly. He noted that the aged made effective use of these leisure since most of these had a sense of inner fulfillment. Though they had freedom of choice, they were limited by physical financial and transportation factors. T.V., reading, visiting, gardening, walking and hardwork were found to be the most relevant leisure activities. Autonomous activities like listening to music, painting were often discarded by many especially less educated. The investigator came to general conclusion that the aged found their self-actualization in a sense of personal worth rather than in leisure time activities.

Reid and Ziegler (1977) tried to determine the factors that contributed to perceived wellbeing among the elderly. They found that the important factors that contributed to happiness and psychological adjustment to
aging were found to be reading, house-work, daily chores, T.V., radio and walking.

Kirkendall (1977) reported that enjoyment in old age seemed to result from spending time energy and thought in learning to live creatively.

Paintal (1979) studied factors related to successful aging in medical men. It was found that adjustment decreased with aging. Good physical health was related to better adjustment particularly after 55. Participation in leisure and recreational activities distinguished the better-adjusted men after 65 years.

Steinkamp and Kelly (1985) investigated the effects of selected aspects of motivation on levels of leisure activities and life satisfaction in 217 persons (aged 40 - 89 years). Results indicate that three motivational orientations - challenge seeking, concern with recognition and rewards, and family focus were systematically related to life satisfaction.

Kelly et al, (1986) investigated leisure-activities in four age groups - 44 to 54 years, 55 to 64 years, 65 to 74 years and 75 years plus. Results indicate that there was a decline in overall activity level, sports and exercise, and outdoor recreation with age. Further there was continuity in a number of core activities such as family, social, and home based activity.
Russell (1987) investigated the role of recreation satisfaction on life satisfaction using 78 male and 132 female retired persons (aged 60 to 80 years). Satisfaction with recreation activities showed a significant and positive relationship with life satisfaction.

Lomranz, Bergman, Eyal and Shmotkin (1988) studied indoor and outdoor activities of the aged men and women (60 to 80 years) as related to depression and wellbeing. Results showed that reported levels of activity could predict both depression and wellbeing for men better than women, whereas satisfaction from activity did much better for women than for men.

Denis Coleman, Seppo E. Iso Ahola (1988) studied on leisure and health and the role of social support and self-determination. Leisure is believed to have beneficial consequences for psychological wellbeing and health.

Durcell and Keller (1989) examined the literature to illustrate that reciprocity and control are characteristics of leisure activities that help aged people achieve life satisfaction. Findings show that reasons for participation in leisure activity by adults are suggested as the need for companionship, novelty, escape, solitude and expressiveness.

Hull (1990) suggested that leisure activities influence health by
promoting positive moods. Leisure based social support and leisure generated self determination is identified as two important mediators of the influence of leisure on stress health relationship.

Chadha, Shah and Mahajan (1991) collected data from 60 males and 60 females from civilian and army backgrounds. It was found that these retired people engaged most frequently in solitary or family based activities. The differential occupational backgrounds and sex differences are also found to influence the types of various leisure pursuits of the aged in the study.

Bevil O'Connor and Mattoom (1993) identified the leisure activities of older adults to determine if a relationship existed between life satisfaction and leisure activities and health status. The results pointed that high life satisfaction subjects were engaged in a variety of leisure activities. Leisure participation also benefited physiological, socio-cultural and spiritual areas.

Bartalos (1993) suggested that all functions necessary for successful adaptation of the person to the environment could be improved by recreation activities.

Jaya Kumari S. (1993) reported that results of her study on recreational activities of the aged. A short inventory was given to 100 old people (50
men and 50 women) individually. They were asked to mark their interest in recreational activities. They were asked to mention the number of recreational activities in which they were interested and time spent on them per week. They were also requested to write the names of recreational activities they were interested in before the age of 55 and the average time they spent in each per week. It was found the recreation as a function of aging and the recreational habits change with age.

Searle and Mohan (1995) reported life satisfaction and reduced levels of boredom among elderly who receive leisure education.

Chadha and Nath (1995) took up a study in which the sample consisted of 323 males and 342 female elderly. It was observed that elderly persons are more involved in solitary activities. Males are more involved in cultural activities and also have more physical activities than the females. It was also reported that males have more social activities as compared to females.

Herzog A. Regula Franks, Melissám, Markus, Hazel. R and Holmberg Diane (1998) studied the activities and wellbeing in old age. The study was conducted in Detroit with 679 in the age group 65 and more. Findings indicate that the frequency of performing both leisure and productive activities yields an effect on physical health and depression, showing the positive effects of activities on wellbeing.
Guru Murthy (1998) reported that part time activities keep the elderly active and thus help in maintaining good health, contacts, and co-ordination of mind and body.

Griffin and McKenna (1998) examined leisure and life satisfaction of 104 elderly in good health living independently. Poor leisure participation was associated with old age, lack of transport and poor health. Adjustment of expectations in limited but valued activities contributes to maintenance of high life satisfaction.

Everard, Lach, Fisher and Baum (2000) assessed relationship between active engagement with life and social support with community dwelling adults (65-89 years). Hierarchical linear regression shows maintenance of instrumental, social and high demand leisure activity associated with high physical health and low demand leisure activities with lower physical health.

CB Asha (2001) reported that leisure time participation facilitates home, health, self and general adjustment. But it does not influence social and emotional adjustment.

Chadha and Easwaramoorthy (2001) in their study reported that the conception and coping with leisure are important contributors to life
Leisure time activities are strongly and positively related to general well being of the elderly.

Leisure time activities that the elderly engage in during their pastime does give one an insight into the lives they lead. The variable has emerged as a strong predictor of health, wellbeing and social lives of the elderly population. The studies reported from India and abroad put forth the point assertively.

d) Emotions and Wellbeing:

Roger (1963) suggests that the important issue concerning emotions is not feeling positive but rather is the extent to which a person is fully functioning. Thus under some conditions (e.g. death of a loved one) a person would be considered to be more fully functioning and ultimately to have greater wellbeing if he or she experienced rather than avoided the negative feelings of sadness. According to this view the repression, disclosure, and compartmentalization and over control versus under control of emotions are highly pertinent to what defines wellbeing.

Headey and Wearing (1989) found that wellbeing of the elderly is affected by positively and negatively emotionally loaded life events.

Chando (1989) indicated that non-institutionalized aged are better on psychological wellbeing and that these depression level is low as
compared to their institutionalized counterparts. The quality and quantity of social relations are recognized as important determinants of wellbeing.

V.P. Sharma and Prabhavathi Shukla (1993) with a view of the effect of specific stress stimuli characterizing the developmental definition at various cross sections of the developmental period, ten superannuated judges belonging to various disciplines were assigned four sets of screamed stress stimuli collected from four representative samples namely (i) Old (ii) Adult (iii) Adolescents (iv) Children. They were asked to rate the stress stimuli for each age group independently on the strength of their impact as contributing casual factors generating stress among the individuals of that group. The data was analyzed by Guilford rank order employing method.

The results revealed that fear of approaching death happened to be the most contributing stimuli for the aged people. The four stimuli used for elderly for rank ordering according to their ranks were (i) fear of approaching death (ii) feeling of social insecurity (iii) feeling of being isolated and lonely (iv) threat to his ego dictation and respect (v) feeling of dependency and helplessness.
Adkins, Geneva Martin Peta and Poon Leonard. W (1996) conducted a study on personality traits and stated as predictors of subjective wellbeing among centenarians, octogenarians and sexagenarians. Results indicated that low tension and high extroversion personality group has high psychological wellbeing among centenarians. Personality guilt played a major role in determining psychological wellbeing of 60 age group and gender and health are the factors for 80 age groups.

P.B. Patil V. Gaonkar, V.S. Yadav (1997) conducted a study in Dharward (North Karnataka) to find out the different correlates of depression. The sample comprised of 220 elderly male and female. The results revealed that a large proportion of respondents have low depression. A negative and significant relationship was found between depression level and economic status, health status, social status and family background.

Butzel and Ryan (1997) found wellbeing benefits to emotional disclosure. From their studies, it is clear that emotional access and congruence are important for wellbeing.

Karruth, Annk. Uday. S. M. Olfett. Barbara and Hill Karen (1997) studied the family satisfaction among 171 categories of elderly patients requiring assistance at least 3 times a week. Findings support that family
satisfaction directly or indirectly influenced by reciprocity, emotional wellbeing and family functioning.

e) **Physical Health and Wellbeing**: "Health" is a complex term to define as it has heavy subjective loading. The importance of the variable cannot be denied on every aspect of our lives. The following studies try to present an analysis of physical health relative to different chosen variables. There is an association between health status and wellbeing. Sickness is often associated with displeasure or pain, so the presence of illness might directly increase negative effects. Further illness often presents functional limitations, which can detract from opportunities for positive affect and wellbeing.

Among the psychological variables that have a documented effect on health status, there have been prominent in the literature. The number of symptoms and other measures of poor health status have been associated positioning with stress (Dohrenwend and Dohrenwend 1974), positively with external locus of control (Reid and Ziegler 1977, Brown and Haris 1978, Lefcourt 1985, Rodin 1986) and negatively with the size of the informal network of family and friends. Cassell 1976, Cobb 1976, Pilisuk 1982, Pilisuk and Park 1986, House Umberson and Loidis (1988). Moreover these variables have been associated with health even after controlling for income, gender and age.
Lofholm (1975): the aged ranked the following conditions as their most frequent medical problems- arthritis, hearing impairments, chronic sinusitis, mental and nervous conditions, genitourinary problems and circulatory problems.

Harris (1978): the aged are more afflicted by chronic conditions than younger age group. The chronic conditions that most frequently occur are: arthritis (20%), visual impairment (20%), high BP (20%), heart conditions (20%). It was noted that older men are more likely to be limited in activity by chronic heart conditions than are older women. In contrast older women are more likely to be limited in activity by arthritis, rheumatism, visual impairments and hypertension than are older men.

A Meta analysis report by Okum (1984) supported the above statement, he related the self-reported physical health to subjective wellbeing and found an average correlation of 0.32, but the relations are very complex. Some people with objectively poor health have high subjective wellbeing whereas conversely some people with low wellbeing have no signs of somatic illness. He also found that when health was rated by others (doctors), the correlation dropped noticeably to 0.16. This suggests that, one would expect it to be affected by personality and by interpretive and reporting style.
Rakowski, Julius et al. (1987): A sample of 172 communities residing older adults (aged 64 - 96 years) were interviewed to investigate correlates of their preventively oriented health practices. Four health practice groupings were used: information-seeking, regular health routines, medical and self-examination and risk avoidance. Results indicated modest associations among individual behaviour and among the four health practice groups. Gender (i.e. women) and a supportive family environment were among the consistent predictor of good health practices.

Chanana and Talwar (1987): The data collected in the NSS 36th round in 1981 concerning disabilities among the elderly revealed that around 10.9% of the elderly suffered from physical impairments. Among these nearly half were visually disabled and remaining half were suffering from disabilities related to hearing, speed or locomotor functions. It is estimated that around 8.2 million aged persons will suffer from some type of disability in 2001, which will be around twice the number in 1981.

Rao (1988) collected data from the geriatric clinic Madurai and the subject ranked the following as the most common complaints: visual handicap, joint pain, sleeplessness, vague body pain, backache, giddiness, cough, constipation, hearing deficit, chest pain and others.
Bowling and Edelmann (1989): A comparison of age and gender groupings revealed decreased mobility with age and greater physical impairment with age in females. Greater loneliness was equated to higher psychiatric morbidity, increased physical impairment, decreased life satisfaction, small social network and lack of confidence.

Chadha and Easwaramurthy (1992) studied 160 elderly (80 institutionalised and 80 non-institutionalised). Amongst the various aspects covered for quality of life, one was physical health. Both male and female subjects ranked the following as common health problems: joint pains, vision impairments, hearing impairments, diabetes, blood pressure and asthma.

Bagga (1994) analysed the health status of elderly Maharashtrian women. It showed the prevalence of disorders to be like: 52.23% blood pressure, 44.2% to be suffering from digestive disorders, and 43.3% suffering from arthritis. It was also found that the problems associated with blood pressure increased with age.

Bowling (1994) contends that there is a fairly strong empirical evidence of relationship between social support, network structure and health status, motility and risk of entry into institutional care.
Ryan and Frederick (1997) found that subjective vitality not only correlated with psychological factors such as personal autonomy and relatedness but that it also co varied with physical symptoms.

Ryff and Singer (2000) used both empirical and case study evidences to underscore how various dimensions of positive relationships with others were particularly critical to the promotion of health related process.

Hoeymans, Feskens, Daan and Van den bos (1999) investigated the contribution of chronic conditions and disability to poor self rated health forms from perspective of patients and population. From the population perspective 63% of poor self-rated health could be contributed to select chronic conditions, with respiratory symptoms, musculoskeletal complaints and coronary heart disease making the largest contribution.

Asakawa, Koyano and Takatoshi (2000) examined effects of declining functional status on social networks, life satisfaction and depression. Results show social network, life satisfaction, depression is significantly effected when functional health status changes. It is an important prerequisite for higher quality of life in old age.

Al shammari, Sulaiman and Mazrou et al, (2000): data on 6,139 elderly participants aged (60 - 90 years) was collected and analyzed. 64.2% of participants were males. The proportion of participants with
definite psychopathology was 33.8%. This increased with age, higher among females than males. Overall 18.8% were dependent on others for activities.

The physical health of the person is a subjective concept; one may define it as not merely as absence of disease or infirmity but a state of complete physical, mental and social wellbeing. This definition of the concept finds true resonance in the researches reviewed above. The old proverb 'healthy mind resides in a healthy body' appears to be true. The physical health of the person in old age forges a symbiotic relationship with the socio-psychological environment. The social environment, attitudes, personal experiences, general sense of wellbeing govern the physical health of the elderly, which in turn acts as the intervening variable for a number of other relationships.

f) Religious activity and wellbeing:

Brink, Green and Simon (1977) studies conclude that religion is a positive force for mental health.

Koeing, George and Siegler (1988) found that 45% of the elderly sample expressed the activities related to religion as their stress coping mechanisms. It consists of placing trust and faith in God, praying and getting help and strength from God.
Zorn, Cecelia. R. and Jhonson Mary. T (1997) studied religious wellbeing in non-institutionalized elderly women. He compared the religious wellbeing, religiosity and selected characteristics (hope, social support, health, age, education level and income) of life non-institutionalized elderly women aged 65+. A high level of wellbeing was found among participants. The majority of women reported regular participation in religious activities rated highly the value of influence of religious beliefs in their lives and identified that religious beliefs become increasingly important with age.

g) Studies on Social Support: Aging takes place within a social context. At each phase of human cycle, the individual belongs to a variety of kinship and social groups. The extent to which an older person is enmeshed within a social network of kin, friends and neighbours will greatly affect their experience of aging. This is a critical issue in gerontology that needs to be studied with the changing demographics in our country from public, state and personal viewpoints. Optimization of the role of informal social supports from family, friends and neighbours has thus emerged as an important social and public priority.

Desai and Naik (1969) conducted a comprehensive study and found that family support solves health and financial problems adequately. The younger members of the family perceive the need of family support and
provide for them. The researchers however did not paint a rosy picture of the aged and stressed that family patterns in India are changing.

Rai (1972) conducted a study on 400 elderly persons over 60 years in age. Subjects were mostly widowed, unemployed and frequently suffered from disabilities. It was found that family structure and “living alone” in old age is a cause for depression. It was also observed that 80 percent of those in nuclear families preferred to be living in a joint family for both emotional and economic reasons.

Conner et al (1979) found that both number and frequency of social ties were unrelated to life satisfaction although kin, children play central role in the support network of elderly; family availability and interaction exhibit little relation to subjective wellbeing.

Ramchandran (1980) selected a random sample of 170 subjects aged 60 years and above living within the community. The family structures and family cohesion of the subjects were intensively studied and it was noted that elderly living in nuclear families and those living alone were more prone to disorders.

Blazer and Kaplan (1983) conducted a study to assess social support in elderly community population. The following parameters of social support were described for the elderly.
Roles and available attachment

Frequency of social network

The instrument support from the network

Results indicate that roles and attachments, frequency of interactions and perception of social network each predicted a change in self-care capacity i.e., activities of daily living.

Fengler, Danigelis and Grams (1983) in a survey of 1400 older Americans over 65 years, two household structures, elders living with others and elders living alone, were compared with older married couples. Results indicated that elders living with others had a greater degree of incapacity and lower income than married couples, but on most indices there were few differences. Elders in three-generation families had somewhat lower life satisfaction but the greatest number of elderly people with low life satisfaction was the widows who lived alone as their income was inadequate, low prospects for emergency care and so on.

Ward (1984) assessed the association between subjective and objective network characteristics with morale. It was found that having contacts with children was important for wellbeing and understanding qualities of social ties helped clarify social involvement.
Baum and Buxley (1984) compared differences in perceived age and death anxiety in 301 elderly persons for community affiliated, community alienated and institutionalized. Single subjects were poorer in emotional health and had more death anxiety whereas community affiliated ones showed lesser death anxiety.

Loister et al. (1986) compared social support and wellbeing among older widows and widowers. 219 of the subjects were using home care services and others were not (the total being 354). The subjects were contrasted on a number of support variables indicators of wellbeing, socio-demographic and health related variables. While there were significant differences in length of widowhood, functional ability and some components of support network, no gender differences were found in the measures of wellbeing for either sample.

Kaur and Kaur (1987) carried out a study in Hissar on 60 males aged 55 years and above. The study revealed that the social support network of the aged was a major contribution to their general sense of wellbeing in spite of the age related problems.

Gangrade (1998) conducted a sociological survey of 190 parent youth pairs and found that 98% of the youth felt obligated towards their parents in providing financial support. However, 89% of them preferred nuclear families. This conflicting preference has given rise to quasi-joint
families, which are characterized by financial help and social responsibilities by absentee children. It can be concluded that the family support to the aged exists in the form of financial and social help while the elderly continue to feel relatively isolated and emotionally deprived.

Hawley and Klaukave (1988) investigated associations between social support, health practices and life satisfaction among 23 men and 41 women aged 60 and 75 years. Analysis showed that subjects satisfied with interpersonal relationships were more satisfied and engaged in more healthful practices than subjects who were not satisfied.

Seeman and Berkman (1988) investigated the relationship between structural characteristics of two types of support (instrumental and emotional) in community-dwelling individuals aged 65 years. For each type of support two dimensions were examined—availability of support and perceived adequacy of the support. It was seen that structural characteristics such as total network size, number of face-to-face contacts and number of proximal ties were associated with greater ability of both instrumental and emotional support. Perceived adequacy of both types of support was most strongly related to the number of monthly face-to-face contacts. Comparisons of specific types of ties show that neither one's spouse nor children were primary sources of support. Rather the presence of confidence was strongly associated with
both dimensions of instrumental and emotional support; the presence of the spouse was not.

Gray and Calsyn (1989) studied 70 subjects (60+ ages). Interviews were used to test the hypothesis derived from both social support and disengagement and activity theory:

- Stress has more of a negative impact on the life satisfaction of those under age 75 years than those over 75 years.
- Social support has more of a positive effect on life satisfaction in those under 75% than those over 75 of age.
- The buffering effect of social support is stronger in the under 75 group than over 75 age group. The analysis supported the first two hypotheses but the third one did not find any significant support.

Gurland et al (1989): A large cross-national project was conducted in London and New York on the health and social problems of social persons and their relationship with social and physical environment. As far as informal social support was concerned family members provided majority of care, primary providers being spouses, daughters, relatives and friends.

Kra’use (1990) presented findings from a nation wide survey in UK on old people, which suggest that social contact leads to an increase in the amount of received support. And received support in turn tends to
bolster perceptions of support availability in future with regard to the social roles and social extroversion emerged as potentially important correlate of social support in later life.

Chandha and Mangla (1991) investigated social network structure among institutionalized and non-institutionalized elderly across sex. Results showed that network size of institutionalized sample was significantly smaller than non-institutionalized counterparts. Similarly significant differences were found between institutionalized males and females.

Chadha and Nagpal (1991) conducted a study to find out differences, if any, between institutionalized and non-institutionalized subjects with respect to social support network and life satisfaction. The results of the study indicate –

- Social network size of institutionalized group is significantly smaller than their non-institutionalized counterparts.
- Non-institutionalized elderly had higher satisfaction as compared to the institutionalized.
- Social support and life satisfaction were significantly related to each other; males being significantly higher than females.

Cheng Sheung-tak (1992) examined the relationship between stress, loneliness, somatisation and health status and physician utilization
among the non-institutionalized elderly females and confirmed this relationship.

Johnson et al. (1992) studied the families and social networks of 150 adults (85 years and above) using both structured and open ended questions to determine the extent to which the family functions as a source of support for the oldest old. Subjects with children were significantly more active. 30 percent of the childless and unmarried were not active providers of support.

Heidrich et al. (1993) investigated how the self-system mediates for physical health and mental health among the elderly. It was found that social integration and social comparison mediated the effects of physical health and psychological health.

Bowling (1994) studied the implications of social networks and support among older people and their implications for emotional wellbeing and psychiatric morbidity. The study contends that there is fairly strong empirical evidence of a relationship between social support, network structure and health status mortality and risk of entry into institutional care.

Sugisawa et al. (1994) studied the direct and indirect effect of social relationships for the elderly in Japan. Among the five measures of social relationship, social participation is shown to have a strong effect on
mortality. Social participation, social support and loneliness effect chronic diseases, functional status and self-rated health.

Stull, Cosbey et al. (1997): the data came from 81 families who institutionalized their elders. The findings indicate that the families remain involved in the care of the elder after institutionalization, though to a lesser degree and in different ways. Involvement in personal care task is reduced. However concerns about financial and legal aspects continue.

Baxter et al. (1998) studied the demographic and social network factors associations with perceived quality of life in a sample of rural Hispanic and non-Hispanic white elderly. The findings suggest that network size and contact are important social factors that can improve the quality of life for both ethnic groups.

Chandha and Kanwara (1998) compared institutionalized and non-institutionalized elderly and found significant differences on social support, depression and loneliness. The study also returned negative and significant correlations between social support and loneliness.

Barrett (1999) examined the role of social support (measured as presence of confident, perceived social support and frequency of formal interaction) in determining life satisfaction among the never married.
Results indicate that age moderates the effect of marital status on social support. In the analysis of life satisfaction marital status and social support are significant predictors.

Sudha and Mutran (1999) examined attitude towards rest homes among 537 elderly American, Africans and whites. There is a dislike of rest homes, preference for family care. Results also suggest a cultural preference for family care can be determined by dislike for institutionalized care and social structural factors.

Antonelli, Rubini and Fassone (2000): The 60 institutionalized and non-institutionalized people when tested showed that the institutionalized elderly have more negative self concept, lower levels of self esteem and restricted interpersonal self as compared to non institutionalized.

Kivett, Stevenson and Zwane (2000) did a 20 year follow up study and examined the physical, psychological, social outcomes and social support of 49 survivors of an original study in 1976. The majority of adults lived alone but received regular family support adult children being primary support, very little formal support was used. Psychological wellbeing was good expressed through life satisfaction, morale despite health problems.
Chopra and Anand (2001) found that people living in families as compared to old age homes when measured on psychological and social aspects were better. Family residents were fully engaged in social activities and well connected with kith and kin. They had a positive outlook to life and power to fight against the odds.

The presented review of studies conducted in India and abroad amply demonstrates social support network to be a key variable in the area of geriatric studies. The variable seems to influence nearly all the aspects of elderly lives. One, however, cannot deny the basic cultural and socio-environmental differences that play important role while dealing with different sets of population. One can find the impact of different environments on the age-related processes in the elderly. Also sex appears to be an important intervening variable while studying the social network of the elderly population.

h) Studies on Subjective wellbeing:

Venkoba Rao (1982) stressed on the cultural, social, family, economic, philosophical and spiritual dimensions of aging.

Chadha (1989) studied the impact of institutionalization on the psychological wellbeing. It was found that older people in institutions as compared to others are worse on psychological wellbeing and their
depression level is high as compared to non-institutionalized older persons.

Antonucci and Akiyama (1991) suggest that social relationships in context of individual. Family and societal development have both a buffering and main effect on wellbeing depending upon situational and developmental characteristics of life episodes.

Connidis and McMillan (1993): The researchers studied the categories of parent status – close, distant, childless by choice, by compulsion. It was found that happiness, depression, satisfaction with life indicated subjective wellbeing of the elderly. Significant differences were found between the groups on wellbeing.

Sherrard (1994) Twenty-two elderly retired people were interviewed for their beliefs about the sources of wellbeing in old age. Manual and social class responses were compared, controlling for age, gender and health status. Respondents' free discourse was characterized by spontaneous social comparisons of the self with people. In social comparison theory, these serve as means of self-assessment or wellbeing enhancement. The comparison statements were analyzed by direction, target, dimension and wellbeing yield. Significant class differences were apparent. Both groups compared downward with others on the
dimensions of aging: longevity, keeping active, security and money. The manual group derived less wellbeing from their downward comparisons, many of which focused on entitlement to money benefits. The professional group made more upward comparisons. Neither group showed psychological defense against physical decline, using social comparison as a means to objective self-assessment rather than self-enhancement.

Prakash (1998) studied the urban and rural elderly on their quality of life. It was reported that health is considered as a resource that makes quality of life possible and enhances life satisfaction. Urban elderly males had greater sense of well being than females. Urban females have lowest well being score indicating distress and less morale.

Pei and Pillai (1999) investigated the relationship between social support factors and subjective wellbeing of elderly. 20,083 urban and rural Chinese were studied. Pension, health care, size of family and living arrangements are factors found to be significantly related to perception of happiness. There is a continuous role of family support and state support in promoting a sense of well being in elderly.

Gee (2000) examined role of living arrangements ir. quality of life in community dwelling elders. 830 persons were interviewed on three
dimensions of quality of life—satisfaction wellbeing and social support, for living alone, and with spouse and intergenerational. Findings highlighted the importance of living arrangements and quality of life. Few differences were found for married persons but for widows especially females; quality of life went down significantly with decreasing support.

Pinquart and Sorensen (2000) did meta-analysis to synthesize findings from 286 empirical studies on association of socio-economic status, social support network and competence on subjective wellbeing in elderly. All three aspects of life circumstances are positively associated with subjective wellbeing. Quality of social contacts shows stronger association than quantity of social contact. Having friends is strongly related to subjective wellbeing, than having children.

Chen and Silverstein (2000) explored relationship between intergenerational 3039 older Chinese parents. Findings revealed that providing instrumental social support to children and satisfaction with children directly improved parents’ wellbeing.

Shyam, Yadav et al. (2000): A sample of 60 elderly (30 institutionalized and 30 non-institutionalized) was administered well-being measure, health questionnaire and social support questionnaire.
The non-institutionalized subjects reported significantly high depression and life satisfaction was high in institutionalized subjects.

The pool of studies pertaining to subjective wellbeing highlights the importance of the variable in maintaining quality of life in the elderly population. The foreign as well as the Indian researches throw light on the fact that maintaining healthy social contacts, physical activities and spending enjoyable leisure time adds to the quality of life along with a conducive psychological and spiritual environment for the elderly.

i) Studies on Life Satisfaction:

Life satisfaction refers to the attitudes that individuals have about their past, present and future. Morale is considered to be the emotional component of life satisfaction. Very often the two terms are defined in such a way that they are interchangeable (Chown, 1977). In the last 25 years, the concept of life review as a rationale for reminiscence in old age has earned a well-established place in the theory and practice of gerontology (Moody, 1988). Gerontologists have thus taken a vigorous interest in late life memory and its potential for personal review.

Cavien (1949) studied relationship between life satisfaction and marital status in old age. The result of the study showed that married older people are more satisfied with their life than unmarried older people.
Ramamurthi (1970) measured life satisfaction in later years. Two scales of life satisfaction (Neugarten, Havighurst and Tobin, 1961) were administered to 250 elderly men in Madras City. The study indicated that there is an initial sharp decline in life satisfaction in the early 50's, a second decline beyond the 61st year and an improvement in the intermediate interval. It is suggested that the first decline may be due to the physical and psychological effects of aging and later decline may be attributed to retirement.

Sharma (1971) studied a sample of 44 retired males living in urban settings and found that happiness in old age depends on busy life, good health, absence of the feeling of paucity of funds and having spouse and social contacts.

Edward and Klemmack (1973) examined the effect of a wide range of variables on life satisfaction. Their sample consisted of middle aged and elderly persons. Their results indicated that the primary determinants of life satisfaction are socio-economic status, particularly family income, and non-familial participation, particularly neighboring. Perceived health status is also related to life satisfaction. They further suggested that activity in general does not contribute to life satisfaction but only certain types of activities have such an effect. Finally the relationship
between age and life satisfaction was found to be below a statistically significant level when socio-economic status was held constant.

Sprietzer and Synder (1974) investigated the correlation of life satisfaction among the elderly. Drawing on the data they found that health, financial status and social class were all determined by self-ratings and were all found to correlate to life satisfaction. It was found that up to the age of 65 years men tend to report higher rates of life satisfaction than women whereas after 65 years women indicate a higher degree of life satisfaction.

Dickie (1979) compared 30 institutionalized and 32 non institutionalized on the variables of life satisfaction and activity level. No difference was found between the two groups on life satisfaction. Self reported health status was related to life satisfaction. The health variables differentiated the satisfaction levels among the institutionalized.

Anantharaman (1980) conducted interviews with a group of 172 men (55-89 years). The life satisfaction index, interpersonal checklist and an inventory of attitudes and activities were used. It was found that subjects who have a positive self-concept were better adjusting and more satisfied with life than subjects who had a negative self-image.
Anantharaman (1981) conducted another study to investigate health and adjustment related differences between institutionalized and non-institutionalized elderly people. 50 men residing in a home for the aged, and 50 males living with their children were interviewed. It was found that the institutionalized had poor health perceptions, reported more physical and psychological problems and had more problems in adjustments than non-institutionalized subjects. Life satisfaction was significantly higher for the latter.

Chandrika and Anantharaman (1982) compared the adjustment and life changes in three groups of older people: non-institutionalised, institutionalised and geriatric patients. The life satisfaction index A showed that non-institutionalised older people are better adjusted than the other two groups.

Steinkamp and Kelly (1985) investigated the relative contribution of objective social integration, subjective social integration and total leisure activity to life satisfaction in the elderly. The results showed that the subjective integration contributed significantly to life satisfaction of males and females under and over the age of 65 Years. The total leisure activity contributes significantly to life satisfaction.

Morgan (1987) used four assessment scales including the life satisfaction index to generate profiles of mental health and
psychological wellbeing for 507 aged and 535 very aged subjects. The aged subjects portrayed higher depression and lower morale.

Russell (1987) studied the importance of recreational satisfaction activity, participation to the life satisfaction of aged people results indicate that frequency of participation had no significant positive relationship to life satisfaction. Rather it is the satisfaction with recreational activities that shows a positive relationship with life satisfaction.

Lohr (1988) examined a model specifying the causal links between physical, functional and subjective components of physical health status and life satisfaction in 281 elderly females (56-95 years). The results showed that the physical condition directly contributed to functional impairment and lowered life satisfaction. The positive cognition buffers the effect of physical conditions. Passive cognition has deleterious effects on health status though it prevents positive health assessment decreasing life satisfaction.

Faulk (1988) developed a hierarchy of needs model to help define the quality of life of 124 elderly people in 40 age care homes. Subjects showed that once the lower material resource needs were met, life satisfaction was significantly increased as higher level social integration needs were met.
Vijayshree (1988) investigated life satisfaction, depression, loneliness and death anxiety among family based and non-family based elderly subjects. The results showed that the family based aged have proved to be the most satisfied psychologically and socially as their life satisfaction scores stood significantly higher than those of others.

McConatha and McConatha (1989) examined the relationship between life satisfaction and wellness status among the retired teachers. The results indicated a significant positive relationship between perceived wellness and life satisfaction.

Gfellner (1989) examined retrospective, current and prospective perception of health, functional abilities and life satisfaction in 40 adults (80-96 years). Subjects expected greater decline in health projecting 5 years ahead than they retrospectively recalled 5 years back. More decrement in functional abilities was perceived to have occurred over the past 5 years that was expected in the future. Correlation suggested that subjects’ objective health condition was due to the influence of their past.

Purcell and Keller (1989) study illustrates that reciprocity and control are characteristics of leisure activities that help aged to achieve life satisfaction. Reasons for participating in leisure activities are suggested as need for companionship, novelty, escape and expressiveness.
Thomas (1989) interviewed 100 elderly Indian and English men. Subjects were encouraged to talk about themselves and their present situation. The qualitative analysis of the interview protocols indicated different patterns of psychological adaptation with Indian subjects exhibiting higher levels of life satisfaction.

Chadha and Aggarwal (1990) conducted a study on 109 elderly men and women. The measures were taken on life satisfaction, hopelessness and alienation. The results indicate females to be high on hopelessness and less satisfied with life as compared to the males. Also married older people were high on life satisfaction as compared to their widow/widower counterparts.

Hersch and Gayle (1990) studied the correlation between life satisfaction and leisure performance of older adults. The most frequently mentioned leisure activities were participation in formal and informal groups, travel, reading, visiting relatives and friends, watching and participating in sports, volunteer work and library visits. It was found that age and individual differences are present in health and satisfaction of elderly with their leisure pursuits and life satisfaction.

Nishi and Koseki (1993): This study used a cross sectional survey designed to obtain psychological information. It consisted of old people of 65 years. The life satisfaction and social relations of 236 non-
institutionalized and non-bedridden was measured on life satisfaction Index K. The subjects had a relationship between self rated health, religion and integrated support with life satisfaction.

Sato et al. (1993) conducted a study to assess factors affecting the degree of satisfaction in one’s life style. Subjects included 3097 males and females (50-74 years). Life style was conceptualized from two view points, one of which was one’s idea of what was the most important thing in one’s life and the other was how one spent the most of time in one’s everyday life. Both independent and dependent variables were positive and negative life events, extra version, social support, health and age.

Bradley and Fisher (1995) explored the meanings that the older people attach to successful aging and life satisfaction and how these two concepts can be differentiated. The subjects consisted of age groups 61 to 92 years. The respondents’ understandings of successful aging involved attitudinal or coping orientations nearly twice as often as those for life satisfaction. Content analysis confirmed five features of successful aging- interaction with others, a sense of purpose, self-acceptance, personal growth and autonomy.
Gueldner, Loeb, Morris Penrod (2001) did a comparison of life satisfaction and mood in nursing home residents and community dwelling elders. The sample consisted of 138 cognitively intact ambulatory elders, 70 in nursing homes and 68 in community dwellings. Community dwellers reported increase in life satisfaction while nursing home dwellers were high on depression and dejection.

Gaur and Kaur (2001) studied the institutionalised and non-institutionalised elderly. It was reported that non-institutionalised elderly had a higher score for life satisfaction than institutionalised elderly. The males as a whole had higher life satisfaction score than females. Also, the non-institutionalized elderly are much better adjusted and more satisfied than institutionalised elderly institutionalized elderly. Institutionalised elderly are isolated from community in a set up that does not give autonomy and independence.

The variable of life satisfaction has been perceived as the attitudes the individuals have about their past, present and future. The review of literature shows this to be affected by degree of satisfaction one has with the basic needs. Once the basic needs are satisfactorily fulfilled the higher order needs play an important role in increasing the life satisfaction level. Also, it has been reported that married people with financial security and sound health seem to enjoy a better quality of life.
The social support network, general wellbeing, physical health and leisure time activities all seem to have a symbiotic relationship with life satisfaction.

j) Wellbeing - Suggestions by aged:

Sherrond Carol (1998) conducted a qualitative analysis study to find out the strategies for wellbeing in later life. A 70 years old retired professional man with some health problems but a high measured level of wellbeing was interviewed for his perception of the sources of wellbeing. A grounded theory analysis showed that he related wellbeing most strongly to the freedom to choose activities and manage his own time. The others are (i) reconstructing time so that physical slow down was annihilated to positive values of leisure, patience and a steady pace of work, (2) social comparisons of self with others wellbeing in the context of age related symptoms was achieved explicitly through self monitoring and self management of physical and cognitive efforts implicitly through minimizing or distancing.

Evaluation of related studies:

The review of literature under different sub-titles discussed above points out the multifaceted behavioural domain of the wellbeing area on gerontology. A growing aging population has important implications both for micro and macro levels. These studies contribute to social and economic planning of the country. Research on wellbeing had tended to fall into two
groups. One focuses on subjective wellbeing, which is equated with happiness and is formally defined as more positive affect and greater life satisfaction. The second viewpoint focuses on psychological wellbeing, which is defined more broadly in terms of the fully functioning person, as happiness and meaningfulness or as self-actualization and utility. Despite division, these two groups complement each other, overlapping and providing extensive picture of personal and cultural factors for the promotion of wellness. Many researches are going on to find out the factors relevant to develop wellbeing of persons.

The presented review of studies conducted in India and abroad amply demonstrates social support network to be a key variable in the area of geriatric studies. The variable seems to influence nearly all the aspects of elderly lives. One, however, cannot deny the basic cultural and socio-environmental differences that play important role while dealing with different sets of population. One can find the impact of different environments on the age-related processes in the elderly. Also sex appears to be an important intervening variable while studying the social network of the elderly population.

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The present study focused on the exhaustive coverage of components of the wellbeing, to assess the current status of elderly wellbeing, and the locus of control are studied as powerful variables on wellbeing. Suggestions of the elderly are taken to identify the contributing factors of wellbeing. Reports of the aged regarding their services for the society are highlighted and the religious practices of the aged are evaluated.