CHAPTER 3
REVIEW OF LITERATURE

3.1 Old Age and Life Stress:
Much of the literature on older adults has focused on the extent and type of problems faced by them and on the consequences of such problems on their health and well-being. While the relevance of social ties have been acknowledged greatly in number of studies during the last few decades and while in some studies attempts have also been made to see gender differences on some individuals, research on negative mood regulation expectancies and social provision in relation to problems of older adults has been scarce here.

To date, no research has been done, to study the effect of supportive intervention on the stressful life events, loneliness, negative mood regulation, perceived availability and satisfaction with social support and type of social provisions. In the present chapter, effort has been made to review some of the research related to above mentioned dependent variable which might have some relevance for the present problem.

Oberoi & Dey (1991) further observed that senior citizens face various physical, economic, social and psychological problems. On a sample of 100 senior citizens, areas with (50 each living with families & living alone), data was collected through personal interviews methods. Results indicated that the older adult living alone were fully dependent for their financial needs. Those retired or widowed were overcome by feeling of futility and loneliness. They appeared to suffer from adjustment problems, experiencing differences in view point and feeling of being rejected by the family and society. Their psychological problems included old age worries, emotional unstability, lack of proper response, inadequate attention by
grand children and less number of children's visit.

**Old age and life events:**

Stressful events, such as death of a spouse, a major illness or accident, loss of job, etc. are usually thought of as may or catastrophe. These events are generally associated with a wide range of poor psychosocial and health outcomes and are risk factors for psychological and even physical illness (National Institute of Mental Health, 1981) that threaten self-esteem and well-being. Goldberg & Comstock (1980) reported that the frequency of life stress was related to age and the education of the individuals. In general older adults are more likely to experience life stress in terms of new illness, of family members, financial problems, hospitalization, retirement, bereavement and social loss (Krause, 1986; 1991; Norris & Murrell, 1990; Comway, 1988).

Kraaij, Arensman & Spinhoven (2002) reported in a meta-analysis of 25 studies, the relationship of both specific types of negative life events and the total number of experienced events among the older adults. Almost all negative life events appeared to have a modest but significant relationship with depression. The total number of negative life events and the total number of daily hassles appeared to have the strongest relationship with depression, where as sudden unexpected events were the only cluster of negative life events that seemed not to be related to depression scores.

Chadha & Easwaramoorthy (1993) conducted a study on the aged in India who were retired. Social network support, back hopelessness scale, life satisfaction & frustration scale were administered to elderly's. The study was undertaken to compare the life satisfaction, hopelessness, frustration and social network support of the elderly in relation to their pre-retirement, retirement and post-retirement years. The sample consisted of
218 male elderlies of Delhi, who were working oriented from government service. The sample was divided into three age groups to represent pre-retirement (aged 55 to 58, N=80), retirement (aged 58 to 63 years, N=80) and post-retirement (aged 63 to 79 year, N= 50), elderlies. The Eysenck Personality Questionnaire manifest anxiety scale and security insecurity inventory administered individually to the subjects. The results indicate that the pre-retirement group, more social support and thus had less of frustration and hopelessness as compared to the retirement and post-retirement elderlies. Retired people appeared to have encountered difficulty in adjustment primarily due to financial problems, health reasons and loneliness.

In a study Chowdary, Sushil & Krishna (2001) included equal number (200 each) of working and retired persons. It was found that the retired person experienced more psychological insecurity than those who were working. The analysis also revealed that the retired persons have antecedents of some psychological problems of introversion, psychotism and anxiety.

Relocation to an institution also serves as a major change in life leading to stress and anxiety. Sirtharthan and Anatharaman (1981) conducted a study in an attempt to find differences in health and adjustment between institutionalized and non-institutionalized older people. 50 older men residing in institutions for aged and 50 men staying in institutions for the aged and 50 men staying with their children. They were interviewed with life satisfaction Index-A and your activities and attitude inventory.

The institutionalized elderly's rated their health as poor and reported more physical problems such as poor sight, hard of hearing, heart trouble and high blood pressure etc. than their non-institutionalized counterparts. The institutionalized even more psychological problems as
sleeplessness, bad dreams, feeling blue and forgetfulness etc. Further, their adjustment level was also found to be compared to the non-institutionalized elderly.

Nandhini & Parvathi (1996) further conducted a study on the institutionalized and non-institutionalized senior citizens on their levels of depression and sense of well-being. The sample of 30 non-institutionalized and 21 institutionalized senior citizens were tested on Beck's Depression Scale and P.G.I. sense of well-being scale and were individually interviewed regarding their family, leisure activity and living arrangements. Institutionalized senior citizens were found to be significantly more depressed than the retired individuals living at home. It was explained the non-institutionalized elderly's usually live with their spouse and family members which provides them with emotional security that others are there to look after them. Whereas the institutionalized individuals have no friends or family members to look upto they had workers of institution to rely upon.

Among the various events, death of significant others appear to be the most stressful and likely to have the strongest impact. Gallagher, Thompson & Peterson (1981-82) found these events to require more readjustment among older than any other event.

Fitzpatrick (1998) reported life events as loss of spouse, adult child, parents, siblings or friends to be effect the health and well-being senior citizens. Increasing the risk of physical and psychological disorders.

Prigerson, Reynolds, Frank & Kupfer (1994) explored a possible casual linkages among stressful life events (SLE), social rhythm stability and levels of depressive symptomatology for 51 recently widowed and 30 healthy controls (age 60 - 80 yrs). Measures included a life event schedule, a social rhythm motive, the Homitton Rating Scale for depression, a cumulative illness rating scale and a measure of social support. Follow-up
assessments occurred 9-11 months after spousal death for widows and 12 months after initial assessment for controls. While the stressful life events were not associated with significant changes in social rhythm stability, social rhythm stability was a significant negative correlate of both baseline and follow-up levels of depressive symptomatology. Bereavement was found to be a significant positive correlate of depressive symptomatology both at baseline and at follow-up.

Bowling (1994) analyzed the mortality rates of a sample of 505 elderly. Elderly were interviewed after being widowed in 1979. Earlier analysis of this sample at 5 and 6 years after bereavement was replicated. Over more than 13 years, 62% of elders had died. Although 5% died within the first six months after the death of their spouse. Age over 75, sex, functional ability were the strongest predictors of mortality.

Norris & Murrell (1990) studied 3 samples of elders: 45 recently lost spouse, 40 lost recently lost spouse, 40 lost parents or child and 45 not bereaved. Assessment was done health remained stable but depression increased sharply. Changes were found to be minimal in the sample who lost parents and child in the non bereaved sample. Multiple regression procedure was used to identify factors that contribute to depression and health after spouse death. Post bereavement depression was associated with higher pre bereavement depression, higher level (10) of financial pressures, higher global stress, fewer new interests and lower level of support. Health was function of pre bereavement health, new interest, financial pressures and global stress.

Ferraro & Su (1999) studied a sample of senior citizens to test additive and multiplicative models of relationships among financial distress. Financial strain was found to be associated with higher levels of psychological distress. Subjective health and instrumental activities of daily living
were also found significant predictors of psychological distress.

Krause (1987-1991) opposed the entire relationship among stressful events, domain specific assessment of life satisfaction and global evaluation of satisfaction. The sample consisted of 922 elders. Results revealed illness and financial loss affect the level of stress among the senior citizens as well as bereavement was significantly correlated with depression.

Further Krause (1991) evaluated the relationship between life stress, financial fear and the kind of stressful experience one has. Such stressors may actually promote greater isolation. Data reveals that such chronic strains tend to promote distrust of others, and that this distrust in turn led to greater isolation from network members. Thus leading to reduction in social contacts and lowering ones social status.

Breckenridge, Gallagher, Thompson & Peterson (1986) reported depressive symptoms in 196 recently bereaved elders (67 yrs) as compared to their 145 control (70 yrs) counterparts. Ass the subjects were administered the Beck Depression Inventory. Results show that although the bereaved subjects reported symptoms of depression, the self-depreciatory cognitions were not greater among them. Bereaved subjects were likely to report heightened dysphoria, dissatisfaction and somatic disturbances. Further Blazer, Hughes & George (1987) reported more negative life events and poor social relations.

Catanzaro, Horaney, & Creasey (1995) studied 96 individuals with age 65 and above. Measures of daily hassles, situational coping responses, depressive symptoms and generalized expectancies for negative mood regulation scale were used. Findings revealed that negative mood regulation were associated with depressive symptoms.

McIntosh, Stufflett & Ricou (1989) examined a relationship
between stressors, social support and its relation to the institutional health in 170 virginian elders aged 60+. It was reported that greater financial stress accompanied greater nutritional stress leading to poor appetite where social served to buffer against such poor dietary intake.

Similarly, Horwath (1989) studied the effect of financial condition and behavioral factors to the food consumption pattern in old age among 195 (65 years) of age. Subjects were randomly selected. A self-completed food frequency questionnaire was used with low financial resources. Elders were identified as being at higher risk of poor dietray intake. The experience of specific life events had an adverse effect on food consumption patterns. Where life styles appeared to be an important predictor of dietary intake in old age.

Orrell & Davies (1994) discussed the psychological mechanism for the actions the life events have over the stressfulness that the older adults experience. The impact of negative events seem to vary depending upon the age of the individual. A check list was used to measure the events. Results suggest that the chronic difficulties related to health were reported more stressful than other events.

**Gender Differences** :

French, Gekoski, & Knox (1995) examined the extent to which there are gender differences in the relation between life events and well-being of 260 elders (145 women and 23 men) aged 65 years. The Recent Life Change Questionnaire, Older American Resources and Sources, Multidimensional Functional Assessment Questionnaire and the Life Satisfaction Index were used. Gender differences existed for different outcome measures. The negative nature impact of life event on physical and psychological well-being was found to greater among women than men.
Arling (1987) examined the relationship between life strain (physical health problems, economic deprivation and activities of daily living impairment), psychosomatic and emotional distress in old age. Taking into account the effect of age, race, sex and education. Findings reveal that women living alone and those who were educated faced greater strain. Health status and activities of daily living were the strongest predictor of stress.

Krause (1986) further studied the gender difference regarding the depressive symptoms among the older adults. Results have found that women were more depressed than men. Greater vulnerability among women to the effects of a chronic life strains explained the observed sex differences in distress.

3.2 Old Age and Loneliness:

A national poll of Havighurst USA (1978) found that elderly over seventies reported that not having a friend may be a serious problem. The quality of relationship is crucial. One close, confiding, intimate relationship may be worth any number of acquaintances. There have been suggestions that having a confidant (Lowenttial & Haven, 1969) or attachment bonds (Bergmann, 1978) may contribute to adjustment to the demands of aging.

The older adults because of their personal inadequacies, generation gap, loss of wife, peer group or family may feel isolated. Creecy. Berg & Wright (1985) have also found marital status, self-perceived health status, income, social activity level and a sense of social fulfillment to be directly related to feelings of loneliness and out of these various problems social fulfillment variables were found to be the most important predictors of loneliness.

Loneliness has also been found to be associated with a number
of negative factors as physical impairment, lack of confidant, low morale and low life satisfaction. Increased loneliness has also been associated with feelings of meaninglessness and hopelessness (Anders, 1994; Achet & Karha, 1986; Johnson & Mullins, 1989; Walton, Schultz, Beck & Walls, 1991; Lee & Ishu, 1987; Meller & Edelmann, 1988). A national poll of Havighrust, USA (1978) shows that elderly over 70’s reported that not having a friend may have serious problems.

Krause (1991) viewed that certain stressful experiences as financial strain or fear of crime may promote feelings of isolation and loneliness.

At times loneliness is a major problem leading to depression. Most of the aged express that they are socially isolated from their families and are subjected to loneliness due to social losses like death of spouse, friends and nearest kin. This loneliness and isolation is more among the aged who are living in nuclear families, post-parental families and single person household than those who are living in a joint family.

Monk (1988) conducted a study on older adults age 65 + to study the risk of isolation and loneliness. Loneliness was found to be compounded by various demographic factors resulting from decrease in fertility and mortality rates. Such lonely people often prefer to stay at their homes, isolated from the outside world.

Kim (1995) examined the inter-relationship of five late-life problems and the extent to which they have an impact on the lives of the elderly. These late life problems were found to be related to problem of working role loss, economic insecurity, health, family relationship with adult children and psychosocial reactions particularly with loneliness. The negative effect of these problems was studied by examining the relationship between these problems and suicidal thoughts.
According to these findings economic insecurity was found to be the most serious problem of the elderlies related to feelings of loneliness and suicidal thoughts. Following with family integration and economic & family integration.

The typology of loneliness indicates a strong relationship between emotional isolation and several indicators of social isolation. Where emotional and social isolation was found to be related to alleviation of loneliness (Dugan & Kivett, 1994; Mullins, Woodland & Putnam, 1989). Dugan & Kivett (1994) further reported that 3 in five subjects reported feelings of loneliness at one time or the other in their life. Where the emotional isolation was more specifically isolated to the loss of spouse which accounted for more loneliness than did social isolation. Along with this hearing activity and visits with siblings (social isolation variables) were also significant predictors of loneliness.

The older adults were found particularly susceptible to social isolation and loneliness due to physiological decline, stereotyping and loss of resources. Where loneliness was found to be enhanced by the effect of rapid urbanization leading to various adaptation problems to new way of life. All of which forced the elderly to take refuge in various nursing homes (Ravish, 1985; Abdel & Nazek, 1986).

Hall, Claudia & Mullins (1999) examined social interaction of older persons who live either with their children, spouse and friends. The perceived emotional closeness present in these social relationships and the extent to which these relationships influence loneliness was also studied. Data from 1303 subjects (mean age 75 years) were analyzed using Anova. Findings revealed that those who were married and had no children or friends experienced the greatest loneliness. Essex & Nam (1987) studied the effect of quality and quantity of relationship within the close family.
needs and close friends. Results show that 38.5% of the elderly subjects reported that they were lonely sometimes. Married and never married were lonely least frequently, whereas formerly married were found to be lonely most frequently. Findings also suggest that the frequency and source of loneliness were also determined by feelings of isolation.

Henderson, Scott & Kay (1986) studied 115 older adults who lived alone (mean age 81.5) and 153 matched elderly (mean age 78.2) who lived with other were interviewed to examine their social relationship. It was found that those elderly who live alone were generally widowed had more education and had markedly fewer close relations. Although the subjects reported that their personal network was as adequate as that of the counterparts, but they experienced more loneliness.

Krause (1991), viewed that certain stressful experiences as financial strain or fear of crime may promote feelings of isolation and loneliness. Thus promoting distrust and that distrust leads to greater isolation from the existing social network members. This lessening of contact with others was likely to lower their social status. Further the strain of lowered social status was related to depressive symptoms. Which in turn undermines the developmental maintenance of intimate social ties.

Hanley, Maxwell & Santos (1985) have found a relationship between loneliness and cognition about other people in interpersonal interactions by comparing 20 elderly & 20 younger females on the dimension of loneliness, chronic illness and negativeness of interpretation. A highly significant relationship was obtained among loneliness, chronic illness and negative interpretation of significant others in interpersonal interactions. Those experiencing loneliness were likely to express negative interpretations of the actions and intent of others as family members, neighbours and authority figures.
A positive relationship has been found to exist between communication apprehension and feelings of loneliness. Although the highly isolated elderly's consider themselves to be engaged in various social activities to a great extent even though they have contacts. Such social isolation has been found to be related to depression (Downs, Javidi & Nussbaum, 1987; Lumpin, 1990; Meddin & Vaux, 1988).

Gender Differences:


Anderson (1990) observed severe feelings of loneliness if the mother was a housewife. As there was a relationship between social positions and loneliness.

3.3. Old Age and Locus of Control:

Locus of control acts as a mediator, influencing the relationship between stressful life events, other stressors and impairment of physical and mental well-being of older adults (Denney & Frisch, 1981; Krause, 1986; Goldestein, Counte & Goldestein, 1995; Husaini & Neff, 1981; Lefcourt, Miller, Ware & Sherk, 1981).

Krause (1986) examined the role played by locus of control beliefs in mediating the effects of stressful life events on the psychological well-being of the older adults. Results reveal that elderly persons with either extreme internal or external locus of control beliefs were more
vulnerable to the deleterious effects of life stress. Extreme internal locus of control beliefs were found to have somewhat determinantal effect on the senior citizens. Such beliefs were also related to avoidance of stress.

Older adults were found to report significantly higher scores for external locus of control (Hale & Cochran, 1986; Lumpkin, 1986). Whitbourne & Powers (1994) studied 68 older adults (83-92 yrs) by administrating the life drawing, a projective technique in which one draws a time representing the life span, along with psychological well-being and locus of control tests. The findings indicate those who maintained external locus of control were found to be better adjusted, future oriented, invaded more with their families and were not prescribed in their post.

Further Cicirelli (1987) found that elders with external locus of control beliefs to adjust better to institutionalization Those elders with strong external locus of control beliefs were found to perceive loss constraints in hospital situation. Where as olders with strong internal locus of control perceived constraints and were likely to be poorly adjusted.

Hanes & Wild (1977) studied the locus of control and depression among older adults. It was observed that the depressed elderly perceived themselves to lack personal control. Where males with externality were found to be related with depression. Thus indicating that perceived locus of control was more depressing when it conflicted with expectations about self-reliance.

Mirowsky (1995) examined a cross-sectional association between age and sense of control among 2 random samples of adults. The main data was from 2031 subjects for pilot data. Results indicate that there was decrease in level of perceived control over time. Physical impairment and low education accounted for low sense of control among the older adults. With education accounting for age group differences than
impairment. Similarly, Arling (1987) observed decline in perceived control to be related to less education and more functional impairment among the older adults with more negative life events.

Goldestein, Counte & Goldestein (1995) observed that various life stresses as death of friend or relatives to influence the sense of control over their health among the older adults. Rodin (1986) further reported a relationship to exist between health and a sense of control that may grow stronger with age. This relation was found to be alleviated by age and age may influence the association between control and health related behavior. A determinantal effect on the health of elderlies was found when their control over the activities was restricted.

**Gender Difference**

Hickson, Housley & Boyle (1988) have revealed a significant correlation between the variance of life satisfaction and control. The life satisfaction among older adults was related to the degree to which perceive they are in control of reinforcing events. This was found more significantly related to females because they have learned more helplessness. Thus females were found to have externality.

**3.4.1 Social Support & Life Stress**

Various studies over the year have found the role of social support to have a buffering effect not only in maintaining health and well-being but also a buffer against various negative life events in the persons life (Sarason & Sarason, 1983, 1905; Gattlieb, 1981; Cohen & Wills, 1985) Johnson, 1994; Krause & Warry, 1992; Markides & Jackson, 1990; Fry, 1989; Preet & Uday, 1998).

Curtona, Russelí & Rose (1986) examined the perspective
effects of stress and social support on the physical and mental health of elderly. A sample of 50 elderly subjects was assesses at two points in over a 6 months period. Results indicated that social support was a significant predictor of physical health status, where as mental health was related to the stress x social support interactions terms. Higher level of social support interactions terms. Higher level of social support was found to reduce the negative impact of stress on mental health. Individuals who were in better mental health at the initial assessment experiences fewer stressful events and higher levels of social support over the subsequent 6 month period. Further Dean & Lin (1977) have suggested that it may not be possible for individuals to avoid stressful life events, provisions of support appeared to protect the older adults from harmful effect of stress. (Kiausal, 1989) suggested that events related to expansion of family role reduces depressive symptoms.

As reported earlier bereavement was found as one of the most significant factor causing stress to the older adults. Fitzpatrick (1998) revealed elderly's are like to experience loss os spouse, child, parents, siblings and friends which is seen to have a significant effect not only on the health but also is found to lead to have higher rates of psychological disorders. The findings indicate that social support appears to buffer the impact of stress on the health of the bereaved. Similarly findings reported by Brock & O' Sullivan (1985) indicate that the deprived status of widows lead to threatening their self-esteem and physical integrity. Where poor health was observed among such individuals. However, social support significantly reduced the life events and was a predictor of better health.

Bowling (1988-89) studied 503 elderly widowed aged 75+ to analyze the mortality rate. A bivariate analysis showed a significant relation with social, demographic, psychological and physiological variables and
mortality. The most powerful discriminating variables associated with mor­tality were age, and low happiness rates. Further Bowling (1994) reported social support, happy disposition and emotional adjustment to have as moderating effect on stress and quick recovery from bereavement and mortality risk.

Due to retirement and degradation in the physical health older adults are also likely to suffer from certain economic problems (Rajan, Mishra & Sarma, 1999). Ulbrich & Warheit (1989) examined the relationship and psychological distress among 741 older adults living in a community where financial strain was reported most stressful. Results have appeared to support the buffering hypothesis which states that friends and relatives are important source of support and were found to effectively cope with financial problems. Further Ferraro & Su (1999) examined multiplicative models of relationships among various financial strain, social relations and psychological distress among the senior citizens. It has been reported that although financial strain is quite likely to lead to psychological distress among the elderly, but this effect has been found to be mitigated by increased social contacts.

Krause (1993) studied 272 older adults who experienced financial strain. It was predicted that people who received aid during financial strain would reduce their emotional support and lead to negative interaction with social network. It was found that people with depressive symptom, somatic complaints and poor self-evaluation were positively associated with increasing economic difficulties and was negatively correlated with emotional support provided by the social network.

McIntosh, Shifflett & Ricou (1989) examined the relationship between social support and stressors and its relation to the institutional health in 170 older adults. It was reported that subjects with extensive
friendship network had more adequate diet. Where companionship served as a buffer against the negative effect of poor appetite on dietary intake.

**Gender Differences:**

Various studies have found women to have significantly larger and more extended informal social support than men. Along with which the number of confidants were higher for women. Where women were likely to confide in spouse, siblings and daughters (Kenlig, Coles, Pittelkow & Wilsen, 1988; Depner & Ingersoll, 1988; Barber, Marrow & Mitteness, 1998).

### 3.4.2 Social Support and Loneliness:

The elderly are at greater risk of experiencing the potentially harmful effect of loneliness. These included people who were older, in poorer health, not married and with lower levels of income and education.

Crecy, Berg & Wright (1982; 1985) indicated that marital status, self-perceived health status, income, social activity and a sense of social fulfillment have been found to be direct predictors of feelings of loneliness. But out of all the social and psychological variables have been found to have a significant relationship with feelings of loneliness. It has further been reported that increased contact with friends and family members serves to reduce feelings of loneliness.

Various studies have also reported that older adults who experienced greater feelings of loneliness were more prone to withdrawal and simplifying their conception of the surrounding world. But high level of social intervention and strong emotional bonds between elders and their extended families was found to facilitate emotional and social integration of the older adults in family networks (Ruth, Obergi, Mattlar, & Sandahl, 1990;
Taylor & Chatters, 1991). Further, in view of this Dykstra (1993) found that the effectiveness of support from various sources varied in providing protection against loneliness according to the availability of the relationship the older adults had. Supportiveness was found to be linked with the degree of closeness with kin and non-kin support was further found to be dependent on the availability of resources the elderly had to support them such as family members, neighbours etc.

Weeks (1994) reported that increased social contacts appeared to reduce the feelings of loneliness, the risk of serious health complications and feelings of meaninglessness. Whereas further such contacts were found to enhance self-esteem and trust among the senior citizens.

Van Baarsen (2002) conducted a study on 100 older adults aged (55-89) who were viewed before and after their partners death. Self-esteem and social support were found to play a significant role in adjusting to the loneliness experienced by the elderly. The older adults who experienced partners loss were found to have lower self-esteem resulting in high emotional as well as social loneliness. Thus leading to the perception of less social support. Finding indicates that a supportive, personal relation reduces emotional loneliness among such older adults.

Various studies have found loneliness to be related to morale and social integration. Elderlies were found to be at greater risk of experiencing the harmful effect of social isolation. But such feelings of loneliness and isolation were decreased and morale increased by interaction with friends, family members and to some extent by neighbours (Kaufman, & Adams, 1987; Lee & Ishu, 1987). Lansford, Sherman & Antonucci (1998) reported older adults to be more satisfied with their current size of their social network rather than waiting to enlarge their network.
Stathi, Fox & Mckeena (2002) have found physical activities to influence all dimensions of subjective well-being in older adults. Physical activity was found to contribute to the mental health of older adults through maintenance of a busy, active life, mental alertness and positive attitude towards life which helps in avoiding stress and loneliness.

3.4.3 Social Support - Locus of Control

Krause & Borawski (1994) examined the relationship among stressful events, social support, feeling of control, feeling of self-worth in later on stressful life events social support, global feelings of personal control and self-esteem. Findings revealed that emotional support may help the older adults to cope better with the various negative effects of stressors and replenishing feeling of control. Kiause (1988) has also found expansion in family role to affect changes in well-being by reducing external locus control.

3.4.4 Perceived Social Support:

Various studies have found a direct relationship between perceived social support and social relations as a predictor of health and well-being. Where lower level of perceived social environment was associated with an increased in the number of hospital visits and were found to be more isolated (Auslander & Letwin, Bosworth & Schaiv, 1997; Macullesh, 1995).

Bisconti & Bergman (1999) attempted to study the process by which social support facilities better health outcomes in older adults. Perceived social control from the family and perceived satisfaction with that support, friends was found to mediate the support relationships.

Krause, Liang & Keith (1990) examined psychological and social
factors on social support. The finding were found to suggest that social support and the received support was further found to bolster perception of support which could be available in the future.

Kiause (1995) reported that the satisfaction with social support is determined primarily by the amount of assistance provided by the various significant others and this satisfaction was strongly related in the face of negative interaction. Where the impact of negative interactions and received support depended on the amount of assistance provided.

Further Cutrona (1986) examined objective characteristics of peoples social network as a determinant of perceived availability of social support in 50 (60-88 yr) older adults. The network members and their frequency of contact with network member was taken into consideration as a predictor of loneliness and overall social support and 6 components proposed by Weiss. The finding reported kins to be more effective provider of support than kins and the network characteristics were better for those with higher perceived social support. Related to the above study Blazer & Kaplan (1983) studied the role of available attachment and frequency of social interaction, perception of social network and instrumental support from the network. The individual functioning was along 5 dimensions of social resources, economic needs, mental health, physical health and self-care capability. Findings indicate that the roles of the individual, attachment frequency of interaction and perceptions of the social network each was a predictor of change in self-care capacity during a period of 3 months.

Hawley & Klauber (1988) investigated the association between health practices and perception of social support. Results have found that those older adults who were satisfied with the personal relations enganged in more healthful practices than those who were dissatisfied. Thus health practices leading to greater satisfaction with the perceived social support.
Seeman & Berkman (1988) investigated the relationship between structural characteristics of social network and type of support (instrumental and emotional). It was measured along 2 dimensions of available support and adequacy of support. The findings indicate that perceived availability of support was strongly related to number of contact with children and spouse. Where the presence of a confident was strongly related to both instrumental and emotional support.

Further Lam & Powers (1991) reported that the overall level of support they perceived was related greater satisfaction from the family and close friends. Thus there was a higher expectation for both emotional and practical support from close family members. High emotional support was expected from the sibling and close friends who were of the same age group.

Curtona, Russell, & Rose (1986) conducted a study to see the effect of perceived social support with the social provision scales on the measures of stressful life events and physical and mental health. Results indicate negative life events did predict the physical health status, so did total scores on the social provision scale, where reassurance of worth and opportunity for nurturance were significant predictor of physical health.

3.4.5. Social Support, Health & Well-being:

Social support refers to the perceived comfort, caring, esteem or help a person receives from other people or groups (Gentry & Kobasa, 19874; Wallston, Alagha, De Vellis, & De Vellis, 1983; Wills, 1984). Having social support is seen to provide benefit to peoples health and well-being (Berkman, 1995). Lennartsson (1999) studies 537 older adults aged (77-98 yrs.) to examine the differences in the effect of social contact. The issue that
causality may possibly be reversed was also discussed. The results have indicated that older adults increased with social contact with friends enjoyed better health and well-being. Rather than those having fewer friends. As Adams (1986) viewed aging and friendship, he reported that while older adults often depend on friends for support, but they are also at a greater risk of losing friends due to change in position, as well as death. Thus further supporting the above view Chen (1994) has found that older adults valued friendship to a greater extent and experienced a sense of belongingness by having healthy communication with family members. Thus they are enlarging and strengthening the social network and making a community in reality.

McCamish, Samuelssen & Svenssan (1999) examined the relationship between social support provided by family and friends and health and life satisfaction. Results indicated that healthier older adults received greater social support and also were higher on the scores of life satisfaction. Such people were found to have close friends and their contacts with friends increased with age. Thus good health was associated with greater supportive contacts and enhanced satisfaction among the older adults.

Mendes, Glass, Beckett & Seeman (1999) examined the efficacy of social network for survival disability and other health outcomes. Where social network in the form of friends and family members has been found to be significantly associated with disability and recovery risks. Further such social networks are observed as a significant factor in increasing the recovery of the activity of daily living.

Various studies have examined the role of informal support in talking care of their health, carrying out daily activities and enhancing happiness and life satisfaction. Such studies report that older adults preferred informal support of friends, siblings and family members. Older
adults with such strong informal support perceived themselves to be healthy and happy. (Ehrlich, 1985; Sheehan, 1986; Thompson, 1989; Chatters, Taylor & Jackson, 1987).

Wister (1990) assessed the extent to which living arrangements as living alone, living with a spouse or living with others affect several dimensions of informal support. Results show that living arrangement to be a more important determinant of instrumental support than social contact. Those older adults who prefer to live alone tend to rely on friends to a greater extent.

The role of formal support services for the elderly has been examined by (Wolfsen, Barber & Mitteness, 1990). The formal support was maximally on the form of doctors, apartment, managers and social workers. Older adults were found to prefer such formal support as an important source of both instrumental and effective support in a wide variety of circumstances.

Kelman, Thomas & Tanak (1994) assessed the stability and changes in the use of formal and informal social support among the elders. They were interviewed to determine whether they receive informal, formal, both types of support or no support. The subjects were found to report stability with the form of support with most subjects using both formal and informal support changes in support were influenced more by initial levels of health and functional status than by social and economic conditions.

Sun (2000) reported that the physical health and well-being was affected by the number of children the elderly had during their old age. The children provide in formal social support thus enhancing their health and having a positive impact on the daily activities of the elders. Further Chatter, et al., (1986) revealed that presence of children decreased the likely hood that sibling or friends would be seen as a source of support.
Studies have found support from informal sources appear to buffer the effect of stress more effectively than the more assistance provided by formal social network. Where the informal support was found to reduce the deleterious effects of the perceived health problems. Data further revealed that the subjects were more likely to turn to informal social network than to formal sources of support when health problems arise (Krause, 1987; Black, 1985).

Bowling & Browne (1991) surveyed the health and social circumstances among 662 (85 +) year old subjects to analyze the structure of social support in relation to their emotional well-being (met as well as unmet needs) of practical help. Social network was found to be associated with the instrumental help and health status was found to be a significant predictor of emotional well-being.

Further Linquart & Sarason (2000) stated income to highly associated with health and well-being. Where the quality of social contact has shown stronger association with subjective well-being as having contact with friends. Thus the quality of contact was more important than the quantity.

Mukherjee (1997) examined the relationship of seven, socio-demographic variables (sex, race, marital status, education, financial status, religious memberships and religious attendance) and six attitudinal variables (satisfaction with neighbourhood, hobbies, family life, friendship, health, and physical conditions and financial situation) to the perception of well-being. Analysis revealed that marital status, education, financial status, religious attendance were significantly related to perception of health and well-being and five of the attitudinal variables increased the total variance accounted for perceived health and well-being.

Lawton (1983) has reported two dimensions of health and well-
being i) negative affect and ii) positive affect. Negative affect was more strongly related to inner aspects of a person while positive affect was more related to external, interactive aspects of the persons world (as life events, personal causation, neuroticism and internal/external locus of control).

Roberts, Dunkle & Hong (1994) conducted a study to assess the accentuating affects of physical, social, psychological resources on the relationship between stress, mental health and well-being. Physical resources include perceived health, independence in activities of daily living, while psychological resources included mastery, self-esteem and coping. Social resources are measured by frequency of social interaction and size of the social network. Among these subjects greater independence of daily activities and greater perceived control of events significantly accentuated the adverse effects of strain on psychological well-being.

According to Revicki & Mitchell (1986) social support is a multidimensional concept and that there is a direct relationship between the different social support and physical health, mental health, life satisfaction, self-esteem in the elderly. Antonucci & Akiyoma (1991) suggest that social relations exists with the context of the individual, family and societal development and change. These social relations have both a main and buffering effect on health and well-being depending on the developmental and situational characteristics. Similarly Wister & Strain (1986) found a strong relationship between informal social support network and well-being. It was found that senior citizens with increased number of social network variables indicated greater level of health, well-being and (Boxter, Shellery, Eby & Manson, 1998) can improve quality of life.

Emotional well-being can contribute substantially to our insight regarding the ability to deal successfully with adverse events that are inevitable at an advanced age. Where positive emotions seems to protect
individuals against physical decline and promote better health and well-being in old age (Oster, Markides, Black & Goodwin, 2000; Pennix, 2000).

Linquart & Sorensin (2000) have found three aspects of life circumstances that are positively associated with subjective well-being. Income is correlated more strongly with well-being than education. The quality of social contact shows stronger association with subjective well-being than does the quantity of social contacts. Whereas having contact with friends is more strongly related to subjective well-being than having contact with adult children. When compared with quality of friendship moderating influences of gender, age on the effect of socio-economic states, social network and competence are found.

Chou & Chi (1999) have found variables as age, gender, marital status, education, chronic illness, functional impairment, somatic complaints, vision, hearing, social network, social support and financial strain to be related to life satisfaction and psychological well-being. Where older adults with less financial strain, better social support, fewer somatic complaints and more education reported higher life satisfaction/psychological well-being.

A positive relationship between friendship activity and psychological well-being has also been found i.e. the increase in friendship activity improves psychological well-being and good psychological well-being causes and increases friendship activity. Where link may exist between community context, social interactions and well-being (Adams, 1988) Hong & Duff (1994).

Gupta & Korte (1994) started that the most important feature of a person's social network for the well-being of that person is whether or not the person has a confidant. Different persons are needed to fulfill the different needs of the person and that a confidant is important to the need
of intimacy and emotional security. A peer group of social friends is needed to fulfill sociability and identity needs. Thus confidant and peer group variables were of great importance to well-being. Where as Adams (1986) argued that secondary friendship are more likely than intimate primary type of relationship to involve older persons with the larger society. Result shows that a secondary orientation towards friendship contributes to positive effect. Thus, there should be increase in the opportunity for older people to interact frequently with others. Nezlek, Richardson, Green & Schatten (2002) found that life satisfaction or psychological well-being were positively related to how enjoyable interactions were how self-assured people felt when interacting, how much control they felt they had over interactions, how responsive others were to their needs and how socially active they were. Nakanishi & Talor (2000) examined the factors, associated with social participation and determined whether social participation is predictive of mortality. The results suggest that participation is social activities is closely associated with health and psychological conditions and may be an independent risk factor for mortality among community residing older people.

Various studies report good nutrition to promote health related to quality of life. High level of associative and functional solidarity with family members and others in the community were found to lower the dietary risks and enhance the dietary intake. Amarnztoo, Martinez, & Dwyer, 2001, Brunt, Schafer, Oaksland, 1999; Calasanti & Hendricks, 1986; Newman, 1985).

Religion is found to play an important role during aging (eldar, & Coates, 1985-86). Oman & Reed (1998) analysed the association between attending religious services and mortality. Interactions in terms of religion with social support were used to explore whether other forms of support
could substitute for religion and diminish its protective effects. Results indicate that persons who attended religious services had lower mortality than who did not. Those who attended religious services also tend to be slightly more protected than those who did not attend.

Thus religious convictions have been found to be important source of support (Chatters & Taylor, 1994; Krausa, 1992) and enhancing health and well-being by protecting older adults against anxiety, (Koeing, Kavel & Ferriel, 1998) as well as feeling of loneliness (Johnson & Mullin, 1998).

**Gender Differences:**

The aspects of health and well-being differed in both the gender (Kopac, 1988).

Krause (1989) examined the exposure to stress and gender differences in the use of social support 205 elderly were selected. 1.5 year of longitudinal study reported gender differences in response to chronic financial strain. Regarding support women were found likely to report that the support increase their feelings of personal control.

Barber, Marrow & Mitteners (1998) explored gender differences in informal social support of 45 urban community living (65 year & older) older adults. Women were found to have significantly larger and more extended informal social support network than men. Where adult children daughters in particular were key figures in the network for women. Men on the other hand were found to have smaller social network (Rennemark, & Hogberg (1999).

Studies report that elderly received lesser degree of support in the absence of siblings and close family member. During such times the older adults confined in more distant family and non-family members.
Results show that the number of confidants were higher for women than for men and women were found to have better social support than men particularly within friendship. Further women were likely to confide in spouse and children (Koeling, Coles, Rittelkow & Wilson, 1988; Depner & Ingersoll, 1988). Kluge (2002) reported that the physical active were associated with gender socialisation. Physically active women hung to the concept of themselves as physically active.

Rennemark & Hogberg (1999) investigated the relationship between social network and health for each gender separately. 107 men and 77 women aged 71 were studied. Results show that women in general were satisfied with their social network. Thus satisfaction in social participation and social encourage was associated with a higher frequency of health care utilization. Where as for men none of these health related behaviors were associated with social network.

HYPOTHESIS:

1. a) The supportive intervention will be significantly effective for males as well as females in reducing the impact of negative life events of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.
   
   b) There will be no significant reduction in life event scores of the control group over pre to post and follow-up assessments trials.

2. a) The supportive intervention will be significantly effective for males as well as females in reducing the loneliness scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.
   
   b) There will be no significant reduction in loneliness scores of the control group over pre to post and follow-up assessments trials.
3. a) The supportive intervention will be significantly effective for males as well as females in increasing the negative mood regulation expectancy scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

   b) There will be no significant increase in the negative mood regulation expectancy scores of the control group over pre to post and follow-up assessments trials.

4. a) The supportive intervention will be significantly effective for males as well as females in bringing about change in locus of control scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

   b) There will be no significant change in the locus of control scores of the control group over pre to post and follow-up assessments trials.

5. a) The supportive intervention will be significantly effective for males as well as females in increasing the perceived availability of social support scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

   b) There will be no significant increase in perceived availability of social support scores of the control group over pre to post and follow-up assessments trials.

6. a) The supportive intervention will be significantly effective for males as well as females in decreasing the dissatisfaction of the perceived availability of support of the senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

   b) There will be no significant change in the perceived satisfaction of social support scores of the control group over pre to post and follow-up assessments trials.
7. a) The supportive intervention will be significantly effective for males as well as females in increasing the perceived social provision of guidance scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

b) There will be no significant increase in the perceived social provision of guidance scores of the control group over pre to post and follow-up assessments trials.

8. a) The supportive intervention will be significantly effective for males as well as females in increasing the perceived social provision of reliable alliance scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

b) There will be no significant increase in the perceived social provision of reliable alliance scores of the control group over pre to post and follow-up assessments trials.

9. a) The supportive intervention will be significantly effective for males as well as females in increasing the perceived social provision of attachment scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

b) There will be no significant increase in the perceived social provision of attachment scores of the control group over pre to post and follow-up assessments trials.

10. a) The supportive intervention will be significantly effective for males as well as females in increasing the perceived social provision of reassurance of worth scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

b) There will be no significant increase in the perceived social provision of reassurance of worth scores of the control group over pre to post and follow-up assessments trials.
11. a) The supportive intervention will be significantly effective for males as well as females in increasing the perceived social provision of opportunity for nurturance scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

b) There will be no significant increase in the perceived social provision of opportunity for nurturance scores of the control group over pre to post and follow-up assessments trials.

12. a) The supportive intervention will be significantly effective for males as well as females in increasing the perceived social provision of social integration scores of senior citizens from pre to post intervention trials and these effects will be carried over to the follow-up assessments trials.

b) There will be no significant increase in the perceived social provision of social integration scores of the control group over pre to post and follow-up assessments trials.