CHAPTER - 2
CONCEPTUAL FRAME WORK

"Grow old along with me!
The best is yet to be,
The last of life, for which the first was made."

Aging is a process which takes place during the entire life span of the organism. It is a continuous process which begins with conception and ends with death. Old refers to far advancement in years and elderly means only having passed the prime of life. Thus old age is the closing period in the life span. It is a period of moving away from the desirable period-"the prime of life" where the individual looks back upon his earlier life, usually regretful and tend to live in the present ignoring the future as much as possible (Haus, 1976)

Though old age in man is associated with disease, loneliness and uselessness, but truth about aging is that it is a natural and a universal process. It is not at all a crisis which hits up suddenly and abruptly in middle age. It is a continuous cycle of change. With increasing age comes a decline, a regression or return to an earlier pattern of behavior and a simpler level of functioning. Parker (1961), emphasised that: "Aging is not a disease or a disintegrative force, nor is senescence, a state of pitiable decrepitude of mind and body to which we must all succumb-if we live long enough. Both aging and senescence are inherent parts of life that we must acknowledge, accept, seek to understand and there by enjoy.
2.1. Concept of Aging:

The term aging has three different, but inter-related connotations, namely biological or physiological aging and social aging.

2.1.1. Biological Aging:

According to Bhatia (1983), the process of life consists of physical and mental changes characterized by growth and decline. It is during this period in life, individuals begin to experience cumulative effect of such gradual alterations in physical status that have taken place throughout the adult years. It is at this point that the person may refer to as showing signs of aging (Comfort, 1969). The individual is never static instead he is constantly changing. During the early part of life these changes are evolutilional in nature. They lead to maturity of structure and functioning. In the latter part of the life span, the changes are mainly involutional showing a regression to earlier stages. From a rapidly increasing amount of research come some generalization which add up to saying that aging is associated with gradual decrease in performance of most bodily organs. There are 8 progressive changes of physiological nature which accompany aging, which are not due to any specific disease:

1) Gradual tissue desiccation;
2) Gradual retardation of the rate of tissue oxidation;
3) Gradual retardation of the cell division, capacity for cell growth and tissue repair;
4) Cellular atrophy, degeneration, increased cell pigmentation and fatty infiltration;
5) Gradual decrease in tissues elasticity and degenerative changes in the elastic connective tissues of the body.
6) Decreased speed, strength and endurance of neuromuscular reactions.
7) Progressive degeneration and atrophy of the nervous system, impairment of vision, hearing, attention, memory and mental endurance; and.

8) Gradual impairment of the mechanisms which maintain a fairly constant internal environment for the cells and tissues. Weakening in any one of the links in the homeostasis produces deterioration.

Physical aging, is not determined by the time elapsed since birth, but by the total amount of wear and tear to which the body has been exposed (Glimer, 1975).

Some of the most obvious changes associated with aging are related to an individual's physical characteristics. The hair grows thinner, turns grey and becomes somewhat coarser (Whit Baurne, 1986). It becomes so thin that the head is nearly balled, especially in men. The grey colour turns white, often with a yellowish cast. The skin loses its elasticity as it loses natural oils and gathers spot pigmentation (Grove, 1989; Kligman, 1989). A slight loss in stature accompanies these changes. The individual's stature decreases and there is a stooping of the shoulders. Thus making the individual appear smaller because of alterations in the disc between the spinal vertebrae and because the spine bows.

Some sensory abilities also decline with age. The majority of people registered as blind, slightly hard of hearing are elderly. Vision becomes progressively poorer for most old people which starts decreasing after 40 (Coffey, Edward, Ratcliff, Judith & Bryan, 2001; Lindenberger & Baltes, 1994; Moschner & Baloh, 1994; Marsiske, Kurmb & Balts, 1997). McCalley, Bauwhius & Juola (1995) observed that for elderly's with the increased difficulty of seeing objects close at hand primarily changes in the structure of the eye result in decreased vision frequently leading to blindness (Bulter & Lewis, 1977). Old people on the average require more light, they adapt more slowly to changes in illumination and they cannot
distinguish colours well (McMurdo & Gaskell, 1991). Significant reductions in peripheral vision may lead to difficulty in seeing objects approaching at an angle such as during driving. About 10% of people over 65, have visual problems severe enough to limit their activities.

A marked loss of hearing among older people (Lindenberger & Balts, 1994; Marsiske, Kurmb and Balts, 1997; Scheuerle, Jane, 2000; Williamson & Fried, 1996; Wensung, Vande, Van, Chris & Frank, 2001) unfortunately results in isolation of these people, who cannot readily understand the conversations of the people around them. Infections, injury and exposure to noise impairs hearing which may also affect the intellectual functioning of the elderly (Bulter and Lewis, 1977). Communication becomes difficult and at times they blame others for "mumbling" and do not in any way feel that the trouble lies within them.

It is therefore important for those who interact with older adults to recognize the following:

1) Hearing loss may often be accompanied by a sense of confusion and insecurity because the loss of "background noise" may create a sense of deadness in the environment.

2) Hearing aids may be necessary and should be encouraged.

3) When one is talking to - hard - of hearing adult, it is important to enunciate words clearly.

**Changes in Bone**:

There is a fairly widespread decrease in bone mass by adulthood (Aviole, 1976; Mc Calden, Mc Geough, Barker & Court - Brown 1993; Topin Kova & Eva, 1999). The bones become light in old age. Loss of bone mass in the later years of adulthood may be function of genetic factors (Dargent & Breart, 1993). Life styles also play a role in it, however
including factors as physical activity, smoking, alcohol, use, diet which can account for variation in bone density (Krall & Dowson - Hughes, 1993). Bone fragility has been found to be more intimately related to endocrine changes, decreased activity and loss of muscle tone than to the level of the individuals nutrition. Decrease in bone mass increases the susceptibility to fractures from falls or accidents also leading to disease like osteoporosis. Further degeneration in joint cartilage may lead to rheumatoid arthritis (Hahan, 1973; Hunt, 1979).

**Changes in Muscle:**

Both muscle size and strength declines with age (McArdle, Katchekatch, 1991; Over & Thomas, 1995; Schiamberg & Smith, 1982) found that older persons generally require a longer time to make movements, takes longer to start their movements and have less muscular strength than younger persons (Coffey, Ratcliff, Judith, & Bryan, 2001; Lindenberger, and Balts, 1994; Smith, Umberger and Manning, & Slevin, 1999). A number of factors like decline in maximum oxygen intake, ventilatory volume and pumping of blood by heart contribute to reduced motor performance (Mazaux, Dartigies, Letenneurch & Darrict, 1995). Due to decreasing activity and changes in connective and circulatory tissues next to the muscles reduce the individuals capacity for physical work and exercise.

A major reason for the slowness in motor performance of older adult results from changes in the central nervous system which slows down due to loss of cell and age changes in the nerve cells and fibers. Due to decline in taste buds older people frequently report impairment in their ability to enjoy food (Engen, 1982). Observations also indicate a decrease in the ability to identify foods and flavours in older
adults (Cain, Reid and Stevens, 1990; Stevons Cain, Demarque & Ruthruff, 1991) and preference for higher concentration of flavoring in certain kinds of food (De Graaf, Polet & Van Staveren, 1994; Carstensen, Edelstein and Dornbrand, 1996). Further the eating and elimination patterns are also affected by the slow functioning of the internal organs resulting in constipation. Elderlies cannot tolerate long periods of starvation because the blood sugar falls.

The structural changes in the cardiovascular system results in slow blood flow leading to hypertension, heart disease and other related problems (Lu, Tang, Wu, Yang, 2000; Kitzman and Edwards, 1990). Over 80% of old people are estimated to have at least one chronic disease, such as high blood pressure arthritis, diabetes, heart disease etc. Multiple ailments are common, leading to higher rates of self-medication particularly pain killers and cough mixtures which often result in accidental poisoning (APA, 2000).

2.1.1 a) Biological Theories of Aging:

Many theories seek to explain the biological process of aging, but so far none has been widely accepted by researchers (Shock, 1977). The process of aging may be too complex for any one factor explanation. According to Zanden (1978), the most prominent theories are:

1) Genetic Preprogramming: Some scientists think that deterioration and death are “written” into the fertilized egg by the hereditary language of DNA-RNA. Once the propagation of the species is assured and an additional 18 or 80 years is provided for the rearing of offspring, nature is ready for the organism to die and make way for newcomers (Comfort, 1976; Rosenfeld, 1976).
2) Mean Time to Failure:

Engineers contend that every machine has built in obsolescence and that its lifetime is limited by the wear and tear on the parts. In the same way, aging is viewed as a product of the gradual deterioration of the various organs needed for life (Hayflic, 1968).

3) Accumulation of Copying Errors:

According to this theory, human life eventually ends because body cells develop errors in copying. The prints taken from prints are thought to deteriorate in accuracy with the number of recopying events (Busse, 1969, Comfort, 1976).

4) Error in DNA:

Another line of evidence suggests that alterations occur in the DNA molecules of the cells which impair cell function and division (Busse, 1969; Comfort, 1976).

5) Auto-Immune Mechanisms:

Some scientists believe that aging has a marked impact upon the capabilities of the immune system. They are convinced that the body’s natural defences against infection begin to attack normal cells because the information is blurring or because the normal cells are changing in ways that make them appear “foreign” (Waldford, 1969; Comfort, 1970).

6) Accumulation of Metabolic wastes:

It has been suggested that organisms age because their cells are slowly poisoned or hampered in functioning by waste products of metabolism. Such waste products accumulate leading to progressive
7) **Stochastic Process** :

"Stochastic" implies that the probability of a random happening increases as the number of events increases. Radiation for instance, may alter a chromosome through a random ‘hit’ which either kills a cell or produces a mutation in it. The chance for such an event obviously increases with age. (Busse, 1969; Comfort, 1976).

Many of the explanations of biological aging can overlap one another. Further, the processes that they depict may coincide to produce similar outcomes. Although the effects of aging are often confounded with the effects of disease, aging is not the same thing as disease (Weg, 1973). However, some scientists view aging itself as a pathological condition and hence merely a special kind of disease (Rosenfeld, 1976).

2.1.1. b). **General Theories of Aging** :

Spence (1989) reported some of these theories. According to Spence all the theories can be placed into any of the two general groups:

1) Those theories which suggest that aging results from some form of damage or wearing out.
2) Those theories which suggest that aging is genetically programmed by some kind of neurological center which functions as a biological clock measuring the time left until death.

a) **Aging by Program** :

Since aging begins at birth and each species seems to have its own average longevity, there are strong arguments supporting the suggestion that aging is in some manner programmed into each species.
through the hypothalamus. Information originating from this center could be
carried to cells throughout the body by neurons and hormones. With age,
onorganisms ability to transmit information by either of means may decline.
Nerve conduction rates may decrease, the structure and amounts of the
hormones produced may be affected and the receptors for either the nerve
impulses or the hormones may become less capable of reacting appropri­
ately to the incoming message. These changes could alter the functioning
of body cells in various ways so that changes typical of aging could occur.

b) Gene Theory :

The gene theory states that aging is programmed but suggests
that the programming is due to one more harmful genes within each
organism which become active only late in life and alter the physiology of
the organism in ways which result in death. In altered state the gene may
be responsible for the functional decline and structural changes associated
with aging.

c) Gene-Mutation Theory :

The gene mutation theory suggests that the accumulation of cell
with altered structure and function which result from these mutations may
lead, with the passage of time to malfunction and eventually to death.
Radiation is known to cause mutation and shorten life span. Therefore, it
has been suggested that natural radiation might cause some acceleration
of the aging process. The theory assumes that with the passage of time
gene-repair mechanism within each cell becomes less efficient, some
mutation remains uncorrected, thereby causing structural and functional
aging changes.
d) Cross - Linkage Theory:

The cross-linkage theory proposes that with age and the formation of new-cross links, some proteins in cells are irreversibly altered structurally. This, in turn, alters the functioning of the protein and ultimately causes the failure of the cells as well as the tissues and organs which the cell forms.

The theory also suggests that some essential molecules other than proteins may become cross-linked with age including DNA. If DNA becomes cross-linked, its ability to direct protein synthesis may be adversely affected which could result in the disruption of normal immunological response by the body.

e) Free Radical Theory:

The free radical theory suggests that there may be a gradual accumulation of free radicals in cells with time. As they exceed threshold concentrations, they may contribute to changes associated with aging.

Free radicals are cellular chemicals containing an unpaired electron. They react chemically with other substances especially with unsaturated fat thereby altering them. This alteration of the membrane structure may cause the cells membrane to become more permiable to some substances and allow them to pass freely. The problem is accentuated by the fact that free radicals are self propagating. The production of which may be inhibited by anti-oxidants, which are compounds that prevent oxidation from occurring. Therefore, antioxidants like Vitamin C and E are suggested that might extend a person’s life span by reducing the amount of free-radicals in the person’s cells (Perrig, Perrig & Stahelin, 1997).
f) Cellular Garbage Theory:

The cellular garbage theory suggests that the gradual accumulation of both inert as well as reactive substances can interfere with normal cell functioning and contribute to aging by causing deleterious and irreversible changes in certain cellular components.

g) Accumulation-of-Error Theory:

The accumulation-of-error theory suggests that cellular dysfunction and ultimately cell death, could result from the accumulation of random error in the mechanism by which new proteins are synthesized. This theory suggests that aging is caused by an accumulation of error in protein synthesis with time. It is proposed that errors would cause the production of faulty enzymes, which in turn, would produce faulty protein.

h) Wear-and-Tear Theory:

The wear-and-tear theory support the concept that aging is a programmed process. It suggests that each cell has a specific amount of metabolic energy available to it. The rate at which this energy is used determines the length of life.

In addition to the depletion of available energy wear-and-tear theories include the effects of the accumulation of harmful byproducts of metabolism and of fertile enzymes due to random error as contributing to aging changes.

i) Auto Immune Theory:

Auto immune theories propose that, with advancing age, the immune system is no longer able to faultlessly distinguish foreign proteins from the body's own protein. As a consequence, antibodies against the
body's own protein may be formed in older persons. If this happens, the body's immune system will attack and destroy body cells.

Auto immune theories of aging fall into 2 categories: those which suggest that with age, new antigens appear and those that suggest aging is accomplished by an increase in auto immune response.

2.1.2. Psychological Impact of Disease in Old Age:

The various diseases may have many effects on the life of older people. Restriction in activities due to these diseases may have a psychological impact as well. Forcing the older persons to be more dependent than one wants to be, lowers self-esteem and makes "old age with integrity" a difficult achievement. When a national sample of people of all ages were asked for their opinion of the "worst thing about being over 65 years of age" 52 % cited poor health or poor physical condition (Harris, 1975).

In old age, there is a decline in the amount of sleep needed and in the quality of sleep. Most old people suffer from insomnia.

Further, the elderly react to illness in many different ways. Some of these individual differences are related to circumstances. People in the higher socio-economic status have fewer money worries and better medical attention than others less fortunate. Personality is a factor, too. People with defensive and anxious personalities react to illness as a major threat to their self-esteem, often withdrawing from society with a defeated attitude, while less defensive people, similarly disabled, maintain a more positive and active orientation of life (Mass & Kuypers, 1974).

It has been proposed that hardy people will remain healthier when under stress because they show less physiological strain under stress (Contarado, 1989) and are less likely to become anxious and
aroused by stressors (Kobasa, 1979; Kobasa, Maddi & Puccetti, 1982; Kobasa, Maddi, Puccetti, & Zola, 1985). Thus they can deal more effectively with stressful situations than people lower in hardiness. (Holahan & Moos, 1985; Williams, Wieke & Smith, 1992).

Among 70 to 80 years, Elizabeth Colerick (1985) observed that stamina in old age is characterised by a triumphant, positive outlook during periods of adversity. In contrast low-stamina people describe a negative outlook, feeling of helplessness and hopelessness in the face of changes they experienced in old age. High stamina individuals reported healthier past, more years of schooling and more activities in their current lives involving social service and personal growth.

2.1.2 a). Cognitive Functioning:

Cognitive changes with age concerned most societies. The link between decline in intellectual power and inability to cope with environmental ages is well reflected in the literature of most civilizations (Woods & Britton, 1985). According to Zanden (1978), for decades both popular opinion as well as psychological literature portrayed intellectual functioning as declining in advanced adulthood and old age (Christensen, Henderson Griffiths and Levings, 1997; Lindenberger & Baltes, 1997; Seeman, McAray, Merril & Marilyin, 1996). Such conclusions have recently become the subject of considerable controversy. Developmental psychologists like Baltes & Schaie, 1974, 1976; Volz, 2000) declare that it is a "myth" to assume that intellectual decline is inevitable on it occurs to all individuals. The memory and cognitive powers do not necessarily decline with age as traditionally thought. It has been found that adults continue to grow new brain cells throughout life. These late-generated cells, may allow older
people to bolster their learning and memory capabilities or stave off decline (Volz, 2000).

**Old age and Intelligence:**

According to Schiamberg and Smith (1982), research on the patterns of cognitive functioning in later adulthood indicates several directions of change. Abilities that require speed, physical activity or immediate memory seem to decline more than those that are untimed or are dependent on experience (Golomb, Kluger, De Leon & Ferris, 1996; Janker, Launer, Hoergir & Lindeboom, 1996; Rybash, 1996; Zelinskil, & Burnight, 1997). It does not mean that older adults are less intelligent than young people. Rather, it suggests that because of slower reaction time, measured intelligence score may be lowered than for younger adults (Kimmel, 1980). Baltes & Baltes (1974); Volz, 2002; Woods & Britton, (1985) state that deficits in the intellectual abilities of the elderly reflect lack of practice and familiarity with the task used. It has been suggested that many individuals can maintain or even improve some intellectual abilities well into old age (Baltes and Schaie, 1974; Volz, 2000).

Distinguishing between fluid intelligence and crystallized intelligence psychologists have observed that fluid intelligence is "culture free" based upon the physiological structure of the organism, while crystallized intelligence is acquired in the course of social experience. Often crystallized intelligence shows an increase with age or at least does not decline, while fluid intelligence shows a drop with age in later life (Christensin, Korten, Jorm & Mender, 1997; Horn, 1976; Horn and Donaldson, 1977; Woods & Britton, 1985).
Memory and Aging:

One aspect of cognitive functioning that in many cases is affected by aging is memory (Craik, 1977; Einstein, Smith, Mc Daniel, & Shaw, 1997; Horn, 1976; Mitchell, Johnson, Raye & Mathew, 2000; Montyla & Nilson, 1997). But it is incorrect to conclude that a progressive loss of memory necessarily accompanies advancing age. Not all aspects of memory appear to be equally affected by aging (Koivisto & Hannien, 1995; Shimamura, Berry, Mangels, Cherly, 1995; Smith, Peterson, Ivnik, & Malic, 1996).

Memory loss among the elderly has many causes. Some of them are related to the acquisition of new knowledge, others to the retention of knowledge and still others to the retrieval of knowledge. Older people, for instance, tend to organize new knowledge less well and less completely than they did when they are younger. They are not so effective in carrying out the elaborate encoding of information which is essential for long term retention.

At present two theories: interference and neurochemical change in combination appear to be the best explanation for short term memory loss in older people (Kimmel, 1980). Some psychologists have suggested a “decay” theory that forgetting is due to deterioration in the memory traces in the brain. Others have advanced on “interference” theory that a retrieval cue becomes less effective as more and new items come to be categorized. But these theories are speculative until confirmed by experimental evidence (Craik, 1977).

Faulty retrieval of knowledge is also a major cause of memory loss. Older persons may suffer in terms of break downs in the mechanisms and strategies by which stored information is recalled (Hultsch, 1975; Rees,

It is important to point that the way people regard themselves and the kind of things they tell themselves about the ability to remember is probably the most important factor. Older people might believe the memory and intellectual power is insufficient and may avoid learning and retaining new information (Volz, 2000). The elderly are able to organize their activities in a meaningful way when they perceive themselves as competent, self-regulating human beings and are treated that way by others.

2.1.2.b). Theories of Successful Aging:

Zanden (1978) reported some of the important theories pertaining to successful aging.

1) Disengagement Theory:

Cumming & Henry (1961) formulated the disengagement theory, which views aging as a progressive process of physical, psychological and social withdrawal from the wider world. On the physical level, people slow down their activity and conserve their energy. On the psychological level, they withdraw their concern from the wider world to focus on those aspects of life that immediately touch them. They shift attention from the outer world to the inner world of their own feelings and thoughts. On the social level, a mutual withdrawal is initiated, which results in decreased interaction between the aging and other members of the society.

According to Cumming & Henry; the process is one of double withdrawal. The individual disengages from society and society from the individual. Accordingly, they view disengagement as a gradual and mutually
satisfying process by which society and the individual prepare in advance for the ultimate "disengagement" of incurable, incapacitating diseases and death. They speak of the elderly as "wanting" to disengage by reducing the number of roles they play. Seerving many relationships and weakening the intensity of the relationship that remains. As a consequence of which they can face death peacefully, knowing that their social ties are minimal and they have said all their goodbyes, nothing more is to be done. Society encourages disengagement because it can gradually transfer the functions previously performed by the aged to the youngsters.

The theory has been widely attacked and defended. Scores of articles have presented evidence on one side or other. However, such studies tend to confuse generational differences with age differences. Major evidence seems to be against the theory (Hochschild, 1975; Palmore, 1975).

2) Activity Theory:

Havighurst, Neugarten & Sheldon (1968) have proposed the activity theory. These theorists agree that disengagement occurs as age increases after 60-65, with decline in level of activity, feeling of satisfaction, entertainment and happiness.

The proponents of activity theory assert that active involvement has a positive impact on morale, self-concept and a general sense of well-being. Successful aging is seen as requiring a substantial level of physical, mental and social activity. The majority of healthy older persons maintain fairly stable level of activity (Neugarten, 1973; Palmore, 1975). This theory is criticized for being over simple.
3) Continuity Theory:

Continuity theory has been introduced as a broader view of complex process of aging by Atchley (1972). It suggests that later adulthood may involve a combination of disengagement from some roles and a continued performance of other roles.

Atchley (1972) said that "continuity theory holds that in the process of becoming an adult, the individual develops habits, commitments, preferences and a host of other disposition that becomes a part of his personality." As the individual grows older, he is predisposed towards maintaining continuity in his habits, associations, preferences and so on. It also implies that there are many possible adaptations to aging.

The theory emphasizes the complexity of aging which is seen both as an advantage and disadvantage.

4) Role Exit Theory:

Blau (1973), formulated the role exit theory of aging. According to Blau, retirement and widowhood terminates the participation of the elderly in the principal institutional structures of society like job and the family. Thus the opportunities to remain socially useful are severely undermined. The loss of occupational and marital status, have been regarded as devastating, as these positions are core roles-enhancing points for adult identity.

The theory is criticized for exaggerating the social losses felt by most older people because many researchers indicate that most elderly's perceive little or no overall social loss. Many indicate that the loss of their work and parental roles is offset by the increased freedom and opportunities to do things that they had always wanted to do but had no time for (Palmore, 1976).
5) Social Exchange Theory:

Dowd (1975) has applied the social exchange theory to the aging process. According to this theory, people enter into social relationships because they derive rewards from doing so in terms of economic sustenance, recognition, sense of security, love approval and gratitude. In the process of seeking such rewards, they also incur cost in terms of unpleasant experiences (effort, fatigue, embarrassment and so on) or they are forced to abandon positive, pleasant experiences in order to pursue the rewarding activity. But the relationship exists only as long as both parties receive profit from it.

The theory suggests that the elderly find themselves in a situation of increasing vulnerability because of the deterioration in their bargaining positions. The theorists thus claim that their conceptions are supported by the inverse relationship which they find between modernization and the status of the aged. Industrialization undermines the importance of traditional knowledge and control. Thus the aged are assigned low status (Palmore, 1975).

2.1.3. Social Aspect of Aging:

Every society has its own conception of aging. Through the process of socialization, the society ensures the transmission of social and cultural values from one generation to another. As the individual grows, age related roles, privileges and expectations are defined by the society. Social aging refers to the stage in the life span of the individual that is regarded as old age by the group. Often individuals have to give up certain roles with or without substitute roles, even though their biological and mental aging may not need such changes. Some people use chronological age as a criteria for aging and others use their physical symptoms as a criteria for
aging. Thus a major aspect of the problem is said to be society itself. It is a social structure and political economy that "retires" people over 60, leaving them unemployed, useless and in some cases impoverished.

a) Retirement :

The term retirement has been differently understood by different people. It has been used to denote a specific stage in the developmental process of an individual, a withdrawal from most of the economic and social responsibilities of adult life. It is a particular mode of life where free time activates and "leisurely pursuits are the dominant goals of life. It is the end of a life-long career as employee or a self employed person. Retirement is an event, a process and a status. According to Atcheley (1976) retirement is a process "through which the retirement role is approached, taken up, learned, mastered and relinquished".

Personality Differences and Retirement :

According to Glimer (1975) 5 clusters of persons were found:

1) Mature : In this men, who understood the developmental processes reasonably well, accepted themselves realistically and grew old without regrets for the past. They were free from neurotic conflict and had little difficulty in spending their time meaningfully.

2) Rocking -chair type : These people welcomed freedom from responsibility. Old age provided the opportunity to indulge in their passive needs. It is a way of sitting still and moving at the same time.

3) Armored : They maintained a well-functioning system of defence against anxiety by keeping busy, always doing something that keeps down worry and anxiety.
4) **Angry** : These people are bitter over failures to achieve their life goals. They blamed others for their disappointments.

5) **Self-haters** : These people turned their retirement inwards. They blame themselves for their misfortunes.

Retirement traditionally has been seen to have profoundly negative consequences for the individual. In our society people are integrated into the larger society by their work roles. Work provides them with self-conceptions, many personal satisfactions, meaningful peer relationships and opportunities for creativity in some, the foundation for enduring life satisfaction. The loss of these experiences through retirement is therefore seen as being inherently demoralizing and a precursor of major problems in old age leading to the overwhelming adverse health effects (Kasl, 1977) and lowering the persons position in the family (Menchery, 1987; Rajan, Mishra and Sarma, 1999); increased mortality rates when it involves the relinquishing of a person's most valued social contacts (Palmore, 1971); and in the reduction of well-being among senior citizens (Fiske, 1980). Further, time which is scarce for working people, becomes suddenly excessive and acquires a negative value, making much of post-retirement life aimless. Many retirees people face serious economic problems (Rajan, et al., 1999; Bhatia, 1983).

But in the recent years the traditional view of retirement has been challenged. The attitude towards work and retirement has been changing in the U.S., although it remains some in India. Recent research suggests that it is money which is not missed in retirement, when people are assured an adequate income they go for early voluntary retirement in the west.
During old age, most people restrict their social roles, reducing the number and variety of their contacts. Old friends are lost, new friends do not quite take their place. For the problems of retirement one central thought emerges: formal disengagement from work means abandoning life's critical roles; this results in a reduced social life. For those with a past history of being able to adjust well, there is little or no crises or loss of morale, following retirement. Role change in retirement relates to one's own personality, life experience, habits, health and energy status (Glimer, 1975).

b) Economic Circumstances:

The financial and economic well-being of the elderly is often cited as a serious problem by many mini-surveys conducted on the elderly. The economic situation of the aged are closely associated with the socio-economic environment in which they reside. In general, the economic status of a person is a function of his or her past work status, level of education as well as the present activity status. Under usual circumstances, most of the elderly are supposed to be out of labour force in old age, depending on their past income (in the form of rentier, pensioner), but some of them, however, continue to be in the work force because of financial necessity or other reasons. Person takes on to retirement when one withdraws fully or partially from the labour force and begins collecting a pension or other retirement allowances.

The phenomenon of work participation has been judged in relation to individual characteristics as age, sex and marital status. It is found that with increase in age the level of work participation among the elderly declines. This may probably be attributed to their physical inability/incapacity which effects their competence and restricts their activity. However, there remains a greater degree of discrepancy in work status between
the gender. The participation rate is more among the females.

The information on work status among the elderly, analyzed according to their marital status, concludes that the elderly with spouse are more in work as compared to single and widowed/divorced. The majority of Indian widows are dependent, they are less found in work due to limited opportunity and the usual trend to reside with their children.

It is seen that the elderly more educated, are proportionately more into work. The illiterate or uneducated are found in work force in the rural agricultural sector which is usually not considered work force. The educated ones retiring from white collar professions have a better chance for re-employment or the other kind of marginally paid profession which supplement their sudden dip in income level as a result of retirement from a regular job (Rajan, et al., 1999).

The health of the individuals also play a predominant role in work status of the elderly. Less than 1/3rd of those reported to be unhealthy are also in work force. This is against the finding that elderlies are seen as dependents and liabilities. Moreover, the elderly engage in work not only to be self-sufficient and independent but also for contributing to household subsistence. The non-working elderly too contributes to the household expenses based on their capacity as a renter pensioner (Rajan, et al., 1999).

c) Bereavement :

Older people suffer multiple losses-mobility, physical health, work and so on. Among the various life events, death of significant others would appear to be the most intensely stressful and likely to have the strongest impact. Bereaved people experience that their lives have been disrupted and their basic assumptions about life may be overturned.
completely (Woodfield & Viney, 1984-85; Lendstrom, 1995). The loss of close friends or family members is particularly significant in changing the person's interpersonal environment that requires adjustment in later life. If the relationship has been intimate, the impact would be expected to be particularly great (Woods & Britton, 1985). At times some effect of loss may be expected but some losses are untimely at any age, for example, loss of a child is devastating when one is 85 and the child 60. Those losing children are especially vulnerable to complicated grief. Anxiety is one of the strongest emotional reactions following bereavement and is particularly found in early period characterized by shock, numbness and disbelief (Clegg, 1988).

Pregerson, Reynolds, Frank & Kupfer (1994) found a positive correlation of bereavement with depressive symptomatology due to change in the persons interpersonal environment. Fitzpatrick & Tanya (1998) indicated that those who experience loss of spouse, siblings, children, parents etc. are at higher rates of psychological and physical disorders. Parkes & Coen (1992) reported bereavement to be related to psychiatric problems among the elderly. Gallagher, Thomson & Peterson (1981-82) found that these events require more readjustment among older adults.

Avrerill & Wisocki (1981); Woods & Britton (1985) suggest that grief tends to be more mild in older persons, they complain more of loss of purpose and idealization of the deceased and report more physical symptoms. Murrel, Himmelfarb & Shifer (1989) studied the effect of 3 types of bereavement on health measures of older adults:

* attachment bereavement was the death of spouse, parent or child.
* non-attachment bereavement included death of close friends, siblings and grand children.
* Other loss were loss of house, job, business, money, divorce or friends moving away.

Attachment bereavement and loss have been observed to significantly increase depression (Himmelfarb & Murrell, 1985; Pearlin, 1982). The unfavorable environment shared by the deceased and the bereaved is responsible for the association between bereavement and health (Woods & Britton, 1985). Palmore, Cleveland, Nowlin, Ramn & Siegler (1973) stated that bereavement was associated with psychosomatic symptoms.

Woods & Britton (1985) emphasize that adaptation to bereavement in the elderly can be good with few changes in life-style and a stable social network. During stressful times like bereavement elderlies are greatly helped by their strong religious convictions. (Koeing, 1990; Martson, 2001).

**Widowhood:** According to Mussen, Cogner, Kagan & Geiwitz (1979) two are better than one because they have a good reward for their toil. For if they fall, one will lift up his fellow, but woe to him who is alone when he falls and has not another to lift him up."

The death rate of widowers over 45 years old has been found to be double than for married men. Since healthy widowers may remarry relatively rapidly, higher mortality applying to less healthy widowers (Cleveland & Gianturco, 1976). Widowed elderlies also struggle to reorganise their social life, where children and old friends are center of concern.

Women, 65 years and older tend to be more likely widowed than men (Crarter & Glick, 1976) and tend to have higher life expectancy than men. Elderly women whose husbands died, encounter a number of social economic and psychological problems. They have to struggle to find a new focus for their lives after the loss of their husbands.
The first report of a longitudinal study of widowhood in the elderly people (Gallagher, Breckenridge, Thompson & Peterson, 1983) observed that two months after bereavement, level of psychological distress were higher than elderly with no such loss. Women reported greater distress than men. Clayton (1979) also reported psychological distress for elderly's within the first year of bereavement. With no apparent gender differences related to bereavement. Studies including widowers indicate that men suffer more serious health consequences than women and the six months to 1 year post bereavement is a time of particular vulnerability of men (Stroebe & Stroebe, 1983). The health of the widowed typically suffers and the death rate rises sharply. Both men and women handle the events with minimal mobility and mortality.

In older people anticipating grief seems to be potentially harmful (Averill & Wisocki, 1981). Older widows have been found to adjust better to a sudden than to a lingering death. There are several factors contributing to this:

1) death in the elderly is seldom a complete surprise, most elderly people anticipate death to some extent and a sudden" death will be much less unexpected in an older adult.
2) the stress of caring for a dying spouse may affect the physical and mental health of the carer. Caring for the dying spouse may become the purpose of life, so the eventual death will be even more of a blow.
3) some ambivalence is likely to result from wishing the dying person to be out of their misery, of feeling relief at the end, at the same time as not wanting to lose a life long partner. George & Gwyther, 1984) found a modest increase in the well-being of care givers after the death.
Negative long term consequences of widowhood seem to derive from socio-economic deprivation rather than widowhood itself. Lopata (1973) found that higher the women educated and higher the socio-economic condition, more disorganised her self-identity and life becomes with her husband’s death.

These rather extreme effects reflect the grief, the loneliness and the anxiety that accompany the loss of a loved one and is expressed by crying, depression and sleep disturbances in the first month of bereavement. A sudden decrease in what we might call “interest in life” is often apparent in a lack of appetite, feelings of tiredness and the loss of interest in friends and clubs etc. Respondents in a survey felt some degree of guilt, believing that may be there was something they could have done to prevent the death of their spouse. Gradually, however, the widowed person organises his/her life. If one is healthy and his financial situation is adequate, chances of leading a happy and satisfied life are good (Cumming, 1969).

d) Institutionalization:

There are large institutions where most of the residents share a small bedroom with others, eat mass-prepared high carbohydrates meals in a large, linoleum-floored dining hall and watch T.V. in a common recreation room (Bloomgarden, 1977). More often the poor elderly are placed in public facilities frequently in state mental hospitals—which generally provides an inferior form of care (Kart & Beckham, 1976; Markson & Hand, 1970; Vani Reddy & Padmini, 1989). Generally, in such institutions there is no adequate staff for looking after the elderly.

Reddy & Padmini (1989) indicated that problems of those senior citizens living in institutions differ in nature and amount from those living in
residence. Those staying with children seem to be better in adjustment, move active tend to perceive their health as better than the institutional subjects (Anantharaman, 1979). However, sometimes they face loss of independence when having to move with their children.

Marlowe (1993) reported that the new environment of the institutions provides greater independence and opportunities for richer relationship. However, in many studies the highest death rates due to relocation in strange place have been perceived in the first 3 months of their relocation to institution (Blenker, 1976; Lawton & Nahemon, 1973). With regard to gender differences neither groups expressed greater fear of death and dying (Kimsey, Roberts & Layin, 1972). Carefully planned transfer may decrease post-transfer mortality by increasing the control over the situation.

e) Loneliness:

Generally, the term loneliness tends to evoke thoughts of an elderly person, isolated and alone or someone who is cut off from the mainstream of the society. The experience of loneliness transcends the whole spectrum of human life and is felt by various age groups. Like the common cold, loneliness is easy to catch, hard to cure, rarely fatal but always unpleasant, sometimes wretched almost beyond bearing. Although loneliness affects different people in different ways and to different degrees, it however touches every human being. It is something that we all deal with at one time or the other in our lives (Medora & Woodward, 1986).

The extent to which senior citizens feel lonely is another aspect of interpersonal resources. Loneliness is a subjective feeling of being cut off from meaningful social contacts. It is a mental state in which an individual experiences some sort of a vaccum (Bhatia, 1983).
The concept of loneliness was first used by Sheldon (1948) in his book “The Social Medicine of Old Age”. It conveys that respondents express acceptance to the fact that they feel lonely. Sheldon pointed out that loneliness can not be regarded as the simple direct result of social circumstances. It is an individuals’ response to an external situation to which other old people may react quite differently. The elderly, because of his personal inadequacies, generation gap, loss of spouse, peer group, family may feel isolated.

Definitions:

Ethel Shanas (1963), defined loneliness as “an unwelcome feeling of lack or loss of companionship.

Mijuskouc (1988) viewed loneliness as a universal condition of man who is intrinsically alone and lost. Loneliness constitutes a destructive form of self-perception or self-label.

Origins of Loneliness: The Imperatives:

1) The neurological imperatives: It dictates an optimal range of stimulation in the physical, cultural and interpersonal environments. There are also qualitative constraints: there must be meaningful human interaction, the lack of which accounts for feelings of loneliness in a crowd.

2) The psychological imperatives: It cautions against being rejected or left out, which will lead to feelings of being unloved and rejected, which lead in turn to feelings of guilt for self-mistreatment because previously valued close contacts have been lost.

3) The social imperatives: It dictates that if we are excluded from the group, we will not get what we need and what we want out of life. Such exclusion is viewed as a challenge to basic motives of seeking safely and
the satisfaction of physical and reproductive needs. Witness the lonely elderly who become obsessed with reminiscence of past action and experiences with others.

4) The cognitive imperative: It mandates that we be able to send and receive messages so as to survive in society. Barriers to communication like a foreign language lead to feeling of isolation, while loss of intellect impairs creativity and reminiscence.

The lonely feel left out, forgotten, unneeded and ignored. They have illogical thoughts as “I must be included” and “I must not be alone”. It places unreasonable demands on the individual. Such demands usually go unfulfilled, causing individuals to feel more isolated and to interpret their present conditions as catastrophic. Loneliness includes both cognitive and affective aspects (Williams & Solano, 1983).

Loss and Loneliness:

Illness and death rates are higher for the single, widowed and divorced. These higher rates may result from reduced endorphin, the body’s natural immunizes. Endorphin production seems to fluctuate with emotional well-being and depression. Alternatively, the higher illness and death rates could be due to some illogical self-fulfilling expectations of members of these groups based on a perceived lack of deserving happiness, of deserving only loneliness. An important contributor of loneliness is a sense of loss or separation from someone or something in the past once viewed as the essence for survival.

Volition and Loneliness:

Another component of loneliness is control. Having control over any given social situation decides the difference between feeling lonely and
being alone. Lack of control is the essence of loneliness. Hermits, scientists, artists, explorers are motivated and productive in their aloneness, but the abandoned, deserted, widowed, divorced and isolates like criminals are harassed and depressed by their seclusion.

A Cross-National survey found that loneliness was quite common. It was found that isolation and loneliness are two distinct concepts (Begmann, 1978). Many isolated people do not feel lonely and some socially integrated people do feel lonely. Therefore loneliness is not a necessary reaction of those who are isolated. Speaking of loneliness, what becomes evident in the individual is a forlone subjective experience of emptiness and loss. The nostalgic longing for closeness with people.

Personality plays an important role in the development of feelings of loneliness (Peplau & Perlman, 1979). This contributes to peoples desire and achieved level of social contact. Loneliness is found to be associated with various characteristics: low self-esteem, social anxiety, shyness, external locus of control belief that the world is not the right place (Perlman & Peplau, 1981; Moore & Schultz, 1983; Weeks, 1994; Van Boarsen, 2002). Loneliness is also associated with deficits in social skills (Jones, 1982; Mullins, Woodland & Putnam, 1989) as inappropriate self disclosure (Solano, Balten & Parish, 1982). Loneliness is also associated with boredom, restlessness and unhappiness (Walton, Schutlz, Beck and Walls 19991) and dissatisfaction with social relationship (Ruth, Obergø, Mattar & Sanchahl, 1990). Loneliness has been associated with a range of social network factors and appraisals, including in frequent contact with friends (Curtond, 1982), having few friends as well as spending time alone (Russell, Peplau & Cutrona, 1980).

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 or attachment bonds (Bergmann, 1978) may contribute to adjustment to the demands of aging.

At times loneliness is a major problem leading to depression and withdrawal (Wilson, 1995). 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.

Liang, Dvorkin, Kahona & Mozian (1980) demonstrated that objective social integration (amount of personal interaction, participation in organization as clubs, church, temples etc. ) are related indirectly to morale where as subjective social integration (feeling lonely, having significant others was directly related to the morale). Lee Gary, Kuntz & Masoko (1987) reported loneliness to have major effects on moral and social integration.

Having control over any given social situation decides the difference between feeling lonely and being alone. Lack of control is the essence of loneliness. There may be aspects of the elderly person's personality or behavior that might alienate family or friends. Some elderlies have always been loners having few social contacts. Gubrium (1975) suggested that single people who had a long term adjustment to isolation, may not be as susceptible to the negative effect of old age. Further staying in institutes also accentuates feelings of loneliness. Townsend (1962) found that nearly half of the residents say they feel lonely and isolated from family, friends and community.
f). Moods Disorders in Older Adults :-

Popular stereotype and personal challenges often associated with aging. Mood disorders are actually less common in older than younger persons (Weissman, 1988b; APA, 1994). Although there is substantial overlap in the symptomatology course, treatment and outcome of mood disorders in older and younger persons, there are subtle yet salient differences that are pertinent to accurate diagnosis and successful treatment of elders.

Mood disorders are divided into two broad categories: depressive disorders and bipolar disorders. The most common depressive disorders are major depressive disorders and dysthymic disorder. Central features of major depressive disorder are persistent depressed mood and diminished interest or pleasure in most activities other symptoms include sleep disturbance, weight or appetite disturbance psychomotor changes, fatigue, feelings of worthlessness or guilt, difficulty in thinking, concentrating and decision-making and suicidal ideation.

Dysthymia is a chronic, more moderate depressive disorder in which persistent depressed mood and other symptoms of depression (e.g. sleep disturbance, poor self-esteem, and helplessness) must have occurred on most days for at least 2 years.

Bipolar disorders typically consist of intermittent episodes of depression and mania or hypomania. The critical feature of a manic or hypomanic episode is a period of persistent elevated, expansive or irritable mood. Other criteria include decreased need for sleep, racing thoughts, distractibility, rapid speech or pressure to speak, increased activity and excessive involvement in pleasurable potentially risky behaviors.

Once a mood is diagnosed, the current episode may be further specified according to its severity (as mild, moderate and severe) and
specific symptom features (as psychotic, a typical, mixed).

Although the mood disorders are less prevalent in old age (APA, 1994). But one might expect older adults to have a higher lifetime prevalence of depressive disorders because the passage of time allows more possibilities for at least one episode; yet they have lower lifetime prevalence rate than younger persons.

Many studies report high prevalence rates of depressive symptoms. Self-reports of dysphorid and other symptoms decline with age until age 65, they then increase again for women but stay the same or decline for men (Leaf Berkman, Weissman, Holzer, Tichler, & Myers, 1988; Smith and Weissman, 1992). Thus, the depressive symptoms may cause problems for elders, particularly women. However, the disparity in estimates make it difficult to unequivocally determine the extent or effects of depressive symptomatology in old age (Carstensen, Claudia, Laura, 1996).

Thus lower prevalence should not be equated with lesser import, mood disorders can become a critical problem in old age. They account for a substantial proportion of psychiatric admissions among elders—particularly acute care (Wattis, 1990). The seriousness of mood disorders in older persons may be exacerbated by life events, physical health problems and health care atmosphere. Because primary care physicians, whom elders are most likely to visit, do not always diagnose or treat their older patients’ mood disorders, their condition may worsen and can even lead to hospitalization (Kir Mamer, Robbins, Dworkind & Vaffe, 1993). Concurrent physical illness and medicationside effects also can mask or worsen symptoms of depression. It has also been observed that in contrast to community dwellers, rates of depressive disorders and are high for institutionalized and hospitalized elders. (Ames, 1993; Parmelee, Katz; Lawton, 1992; Phillips & Henderson, 1991; Koenig, 1991).
Thus, although the rates of mood disorders are relatively low in older adults, it is important to recognise the potential pernicious effects mood disorders and depressive symptoms can have for elders particularly if misdiagnosed or mistreated.

**Risk Factors**: Factors that contribute to mood disorders are discussed in terms of the diathesis-stress perspective; Predispositional factors interact with stressors to produce a clinical syndrome. The biological, psychological and situational factors are important in the etiology, maintenance and cause of mood disorders.

**Psychosocial Stressors**: In older adults, the relationship is somewhat weak between stressors and depressive symptoms particularly when social support is available or physical health is relatively uncompromised (Phifer & Murrell, 1986). Research on older adults suggests that over 40% of depressed patients and over 60% of the depressed community dwellers experienced at least one major negative life event in the last year. This rate was two or three times greater than in the non-depressed groups. Acute and chronic stressors, poor health, death or serious illness of a loved one, relocation, and caring for a sick relative were associated with increased risk of depression. As noted earlier, death of loved ones occur more frequently in old age. Although the course and effect of bereavement is similar in old and young adults (Fasey, 1990), older adults may have unique problems due to their own health problems or diminished financial and social resources. Although, most older individuals cope well with bereavement than the younger people (Parkes, 1992).

Beyond the loss of loved ones, other losses such as inability
to maintain life roles, are implicated as risk for mood symptoms, particularly among older adults. Loss of ability to work or remain physically active may bring on feelings of inadequacy. In a society that values youthfulness, aging and loss of perceived, physical ability or beauty can take tolls on self-worth (Rodenheaver & Stohs, 1991). Role loss in terms of reduction in reinforcement -those previously obtained through jobs or social interactions, participation in hobbies or the accomplishment of physical tasks - and decreased reinforcement is associated with depression (Heilsy, 1983; Teri & Lewinshon, 1986).

Depression related to retirement may have more to do with physical health and income loss than with social factors; poor physical health often leads to retirement, so increased depression after retirement may be a result of medical illness rather than retirement (Pahkola, 1990).

Contrary to popular beliefs, changes in social contact, even diminished social contact, do not necessarily increase the risk of depression in elders (Carstensen, 1993). Rather, it is the quality of social relations, and whether friends and loved ones present more support than demands, that predict depression (Gallo, 1990; Hannappel, Calsyn & Allen, 1993).

**Demographic Characteristics**

There are no gender differences in bipolar mood disorders. However, the higher overall rates of most depressive disorders in women versus men are established (APA, 1994; Leon, Klerman & Wick Ramaratne, 1993). Similar studies with gender differences among elderly are found (Weissmán, 1991).

At all ages, there is an increased risk of mood disorders in lower socio-economic strata. The association between poverty and mood disorders may be explained in part by the uneven distribution of medical
illness and psychosocial stresses among the social strata. In elders, when medical illness or other stressors are considered, the relationship between socio-economic status and risk of mood disorders typically is reduced significantly, if not extinguished (Blazer, 1991; Weissman, 1991).

Race is not a consistent predictor of late life mood disorders, and when race emerges as a predictor, mood disorders often are better predicted by related risk factors as illness, other psychiatric conditions or negative events (Bulter, Lewis & Sunderland, 1991). Although race and socio-economic status are often considered risk factors for mood disorders, stressors such as medical illness or caregiving may prove more important in predicting mood disorders in elders.

Disabled and ill persons of all ages are at greater risk for depressive symptoms. Depression may be a psychological reaction to the limitations, discomfort, and demands imposed by physical illness (Koening et al., 1991). In studies of community-dwellings elders, those in poorer initial health or who later became physically ill are more likely to become depressed than those in better health (Phifer & Murrel, 1986).

Mood disorders, particularly bipolar disorders, run in families. This is true for all age groups. Even through the association between family history and mood disorders may be slightly weaker for older adults than younger when the first episode occurs in late life (APA, 1994), the assessment will suggest how family history will aid diagnosis.

Mood Regulation Among Senior Citizens :-

There are subtle differences in how mood disorders are present in older adults. Some depressed older people may present more memory complaints, more self-reproach, less guilt and less suicidal ideation (Mussetti, 1989). Older adults report milder mood symptoms, but are more likely to
report negative moods. They are likely to show more weight loss, more sleep disturbances, lack of appetite, more motor retardation, lethargy and fatigue (LaRue, 1992; Mussetti, 1989). Moreover when depressed, elders discuss feeling sad, down or helpless (Fogel, 1991).

To deal with such situations, more adaptive coping is required. Rippere (1979) found that many people try to cope with depression, behaviorally and cognitively in common sensical ways. They may make an attempt to see a friend or analyze the reason for their depression. Those individuals who made an effort to successfully cope with depression were found to make changes in their social environment and believed in the coping statement they made to themselves as “I’ll feel better soon” (Doerfler & Richards, 1981). Thus suggesting that a generalized expectancy for problem solving is an important dimension of effective self-regulation. This expectancy is a subjectively held belief that behaviors in the individuals repertoire will successfully solve a problem as it is encountered in a variety of situations. Franko, Powers, Zuroff & Moskowitz (1985) defined a generalized expectancy for affective self-regulation as an expectancy that some overt behavior or cognition will alleviate a negative state or induce a positive one. Kirsch (1985) stated that a response expectancy as the expectancies of the occurrence of a non-volitional (as autonomic, emotional and hypnotic) response and summarized evidence indicating that these expectancies are self-confirming. Therefore, the expectancy that the successful execution of a given behavior will change a mood state is itself likely to influence that mood state. Alleviating negative moods may be more precisely defined as a response expectancy that generalizes across situations in which negative mood states may be experienced. Self-regulation should, therefore, predict successful attempts to cope with negative mood states. Thus recently, Catanzaro & Mearns (1990) have defined generalized
expectancy for negative mood regulation as a belief individuals have that when they are in a bad mood, they can do something to make themselves feel better. Individuals with strong negative mood regulation expectancies reported higher level of adaptive active coping, lower levels of negative affect and fewer symptoms of physical illness (Brashares & Catanzaro, 1994; Catanzaro, 1993; Catanzaro, Horney & Creasey, 1995).

Attempts at negative mood regulation are hypothesised to have short term emotional consequences and long term consequences for adjustment and health. If a person has a low expectancy for alleviating negative moods, attempts to after such a mood will be feeble at best, and the negative mood state will continue or become worse. Failing to regulate these negative moods will serve to confirm expectations about the inability to do so. In contrast, positive expectancies should generate coping reasonses. These coping behaviors may or may not have intrinsic mood-altering properties, even if they do not, the belief that they will lead to mood enhancement (Krisch, 1985), thereby initiating a benign cycle.

High and low negative mood regulation scores may differ in the initial intensity of negative moods, the speed with which they recover from these or both. There are probably situations in which even the most confident mood regulator would be hard pressed to be successful and indeed may not expect or, possibly, want to be successful. Examples of naturally occurring situations in which mood regulation efforts might not immediately be appropriate are likely to be found when individuals are grieving deaths and other losses or reacting to traumatic stress.

Cognitive theories of personality, emotion and therapeutic change are consistent with the view that what people think will happen when they experience negative emotions has important implications for their experience of those states and the development and treatment of a number of
psychiatric and physical disorders.

g) Death and Dying:

Old age is the last phase in life, a period when individuals must face the fact of life. The personal realization that life has a limit on end has a marked effect on how adults interpret their life experiences. A middle aged individual who has attained family and occupational goals may wonder about the “meaning” of life in relation to the years remaining. The older adult who is near death may begin a “life review” process that involves the recall of previous life experiences and the attempt to organise these events into a meaningful pattern. The recognition of death as a result of human experience may be greeted by a variety of cognitive and emotional responses while thinking about someone else’s death or one’s own, people experience many thoughts and feelings. Some may think of death as a relief, a new beginning, a meaningless ending to the meaningless experiences, or a total mystery, to some only a few possible views. Feelings about death may also be variable leading to fear, resentment, loneliness, helplessness, peacefulness, awe, sadness, anger to name a few. To some extent reactions to death are both individual and personal.

Although death is a highly personal matter, its meaning tends to vary from individual to individual. Certain people look with resignation on death as “the end the cessation of being.” It is the fear which affects the psyche of the aged. A person’s attitude to death will be determined by his ability to face the unexpected. This is influenced by the extent to which a person has succeeded in accomplishing task he had taken in life. Narayana (1990) reported age and death anxiety to be positively and highly significantly associated in the case of elders.
Researchers agreed that only a relatively small position of the elderly (less than 10%) express fear of death (Zanden, 1978). Although death may seem less frightening for some older adults, they do talk and think about it more than younger adults whereas youngers fear death (Bengston, Quellar & Ragon, 1977). Several reasons have been suggested for a decline in the fear of death in old age (Kalish, & Reynolds, 1976):

* older adults may put less value on life. They may feel that they have completed their important life projects. They may also be in serious discomfort because of ill health.
* people who reach older ages may feel that they have lead a full life at least from the perspective of time and length.
* older people who experience death of a spouse and close friends may come to accept their own death as inevitable. At times individuals may prepare themselves for what may appear to be with the ultimate disengagement (Kastenbaum, 1977).

Perhaps the most influential research on the process of dying is by Ross (1969) a psychiatrist who observed and interviewed several hundred dying patients. Kubler-Ross identified 5 stages, each characterized by a particular attitude between the time one knows “for sure” that death is imminent and death itself.

1) **Denial**: Most people react with shock when informed that they are going to die. Even adults having cognitive skills to understand death are not ready to accept the fact they are dying; the patient says “No! Not me!” Denial is often viewed as a defence mechanism that helps the individual to cushion the initial shock of impending death.

2) **Anger**: Denial is followed by anger. When individuals come to realize that denial no longer works, they typically experience feelings of rage,
anger or resentment. The patients ask and say "Why me?" "Why now?" "How come its not happening to someone else." This stage is particularly difficult for the medical staff and for the family members because the anger of dying person is directed towards them. During this phase the dying person often makes life difficult for others, criticizing friends, family and medical personnel with little justification. It is therefore very important for people to be understanding and forgiving during this stage.

3) Bargaining: The individual in this stage hopes that somehow death can be delayed or even postponed. The patient may become very compliant hoping to earn a few more months of life "for good behavior" in return of an extension time. Example "let me live until x-mass, then I'll die peacefully." The bargaining generally is successful for only a short period, since the advance of the illness itself invades the agreement.

4) Depression: A sense of loss becomes unavoidable and pervasive. When the dying people realize that nothing can be done to deny or postpone their death and that they can only look forward to more pain and medical treatment, they may become engulfed in depression. Thus dying people begin to mourn their own death and the loss of all the people. They start thinking of the plans and dreams that remained to be fulfilled. They experience "preparatory grief" (Kubler-Ross, 1969).

Kubler-Ross (1969) identified 2 types of depression — reactive depression — resulting from a loss that has already occurred (i.e. health) and preparatory depression-resulting from an expected future loss (i.e. family relationships). One approach to help people at this stage is by being a good listener. Allowing the person to express his/her depression and feelings. To mourn past and future losses paves the way for the final stage.

4) Acceptance: During this stage the dying person shows little feeling or emotion. One has resigned to impending death. In most cases they are
tired and weak and no longer struggle against death but make their peace with it. It is not a happy stage. "It is almost void of feelings." It is as if the pain had gone, the struggle is over. Stewart Alsop say "A dying man need to die as a sleepy man needs to sleep, and there comes a time when it is wrong, as well as useless to resist" (Alsop, 1973).

Kastembaum (1975), points out that Kubler-Ross's theory neglects certain aspects of death process. One of the most important is the nature of the disease itself, which greatly affects pain, mobility, the length of the terminal period and the like, this view of dying process includes personality as an important factor to influence this process.

h) Religious Aspects:

Religious belief is often thought of as being more important to older people. It is here when the individual starts thinking of his journey back to his origin. Thus starts reflecting on his past life. Everyone fears death except a person who has reached a high level of spirituality.

Religious beliefs and habits are formed as one grows in his family and group like other aspects of an individuals personality, these are carried over from one stage of life to the next. The attitude of most older people about religion is probably most often that with which they grow up or which they have accepted as they achieved intellectual maturity. However, the realization of the place of religion in life is liable to change in the course of life (Soodan, 1975).

Studies relating to religious practices and beliefs in old age., indicate both an intensification of interest and also decline in it. No evidence of a large scale turning to religion as they grow old has been found. Generally, religious faith and practice increases in importance as death approaches.
The preoccupation with economic and social pursuits does not permit an individual to devote sufficient time and attention to religious pursuits. Although religious learning starts from childhood. The religious beliefs are formed during one's growth period depending on the environment in which one is nurtured. However, religious practices and beliefs for which a person may not have got sufficient time during his youth is one of the important aspects of life of an elderly person.

The relevance of religion can also be seen from two different, but mutually interrelated, goals of old people namely i) the desire to experience sociability and communality ii) the need to keep oneself mentally as well as physically engaged in socially acceptable activities (Courtenary, Poan, Martin & Claylon, 1992).

A large number of older adults visit temple regularly. Where they meet other people of their age, temperament and religious faith and thereby satisfy, their sense of belonging and community feelings. Further, regular visit to places of worship protect the aged from becoming lazy and motivates them to maintain regularity in life. Going to and coming from, the place of worship also means a good physical exercise.

Old people differ from each other in respect of their interest in religion. The modes of religious expression and experience include study of religious books, literature, listening to religious discourse, participation in spiritual discussion on religious values and philosophies, the performance of rituals and prayers in a prescribed manner. While religious pursuits are time consuming related activities they form the nucleus of the daily life of some aged. There are others who do not devote time to such activities may share their income in the form of donations to such causes and socio-religious institutions.
Not all aged visit places of public worship. Some of them cannot go there for reasons of health and physical disabilities. Others treat it as a personal affair and prefer to sit in their house and perform their worship. There by experiencing great peace of mind and satisfaction.

For many elderly people religious convictions have been found to be important source of support (Chatters & Taylor, 1994; Krauser, 1992; Taylor & Chatters, 1991). There is a strong element of potential social contact with others of similar outlook and characteristics (Gans, 1976). Markdies (1998) reported church attendance to be significantly related to life satisfaction among the senior citizens. Generally, it has been observed that religiousness changes health and well-being by protecting senior citizens against anxiety (Koeing, Kavel & Ferrel, 1998) as well as feelings of loneliness (Johnson & Mullins, 1998). A number of studies have also demonstrated the association of happiness and satisfaction among the elderly with religious involvement (Graney, 1975; Leonard, 1977).

i). Concept of Life stress ;

The concept of stress is one of the most significant concepts ever developed in social and bio-chemical sciences. Cumulative life demands personality traits and emotions lead to stress which may even contribute to various disease. There are many difficulties in reaching an acceptable definition of the term stress because of its widespread use and multiplicity of meaning.

Psychological stress has been conceptualized in three ways (Baum, 1990; Coyne & Holvoyd, 1982; Hobfoll, 1989). One approach focuses on the environment, describing stress as a stimulus. We see this in people's reference to the source or cause of their tension as being an event or set of circumstances --- such as having a high-stress job. Events
or circumstances that we perceive as threatening all harmful, thereby producing feelings of tension are called stressors. Researchers who follow this approach study the impact of a wide range of stressors, including i) catastrophic events, such as tornadoes and earthquakes ii) major life events, such as the loss of a loved one or a job, and iii) chronic circumstances, such as living with severe pain from arthritis.

The second approach treats stress as a response, focussing on people's reaction to stressors. We see an example of this approach when people use the word stress to refer to their state of tension, and when someone says, “I feel a lot of stress when I have to give a speech.” The response has two interrelated components. The psychological components involves behavior, thought patterns, and emotions, as when you “feel nervous”. The physiological component involves heightened bodily arousal-your heart pounds, your mouth goes dry, your stomach feels tight and you perspire. The person’s psychological and physiological response to a stressor is called strain.

The third approach describes stress as a process that includes stressors and strains, but adds an important dimension : the relationship between the person and the environment (Cox, 1978; Lazarus & Fokman, 1984a, 1984b; Mechanic, 1976). This process involves continuous interactions and adjustments --- called transactions --- between the person and the environment, with each affecting and being affected by the other. According to this view, stress is not just a stimulus or a response, but rather a process in which the person is an active agent who can influence the impact of a stressors through behavioral, cognitive and emotional strategies. Simply put , the concept of stress is seen as a dynamic inter-relational process rather than a single event or a set of response. In essence, stressors make some sort of demand --- physical and
psychological, or mixture of two which require the individual to assess and understand the situation and then respond to it.

Hans Selye (1950, 1956, 1974, 1976, 1978) defined stress as the non-specific response of the body to any demand." He emphasised that the sources of the demand are unimportant. The demands may originate in life events, in social relationships, in personal events such as thoughts and emotions. All demands, regardless of their sources, will mobilize certain neurological and hormonal structure. Which if chronically induced, can lead to degenerative disease. One of the most acceptable definition of stress is that it is anything which causes an alteration of the psychological homeostatic process (Selye, 1976).

**Life Stress:**

Out of a variety of ecological stressors, researchers have been mainly concerned with life stress or stressful life events (Dohrenwend & Dohrenwend, 1974). Wolf (1953) introduced the term "life stress" by which he meant the response of people to noxious stimulation and ego threats.

All the individuals in the course of their life, experience a variety of events or life changes which may be considered as potential stressors. Included here are such diverse events as death of spouse, friends, personal illness, illness of family members, marriage separation, divorce, change in residence etc. A life event may be considered stressful if it demands significant social readjustment and adaptation in an average persons normal routine (Holmes & Masuda, 1974; Dohrenwend and Dohrenwend, 1974; 1978; Rabkin & Struening, 1976). Thus life crisis is an objective situation which seems stressful and involves an experience which imposes pain or necessitates a role transformation. It is reasonable to state that no stimuli is a stressor to all the individuals exposed to it. The people...
react to their life situations in terms of the meaning of these situations to them. Folkman, Schaffer, Lazarus (1979); Hall & Hall (1980) and Coleman (1982) focus on the appraisal of any situation leading to stress depending on factors as personality, adjustive demands and circumstances.

Lazarus and Cohen (1977) stated 3 categories of stress:

i) Cactaclysinic phenomenon (the crises which affect the entire community like earthquake);

ii) the individual crises (the crises affecting only the individual like the death of a beloved person) and

iii) the daily ‘hassles (everyday non-crisis stress) such as discontinuing in life activities; conflict between important roles and role overload.

Such situations increase the pressure and cause disequilibrium. Thus an individual attempts to maintain a state of equilibrium and when one lack, the coping resources one undergoes stress.

In general life events have been found to be associated with symptoms of undifferentiated psychiatric illness (Myers, Lindenthat & Pepper, 1975; Myers & Pepper, 1972); depression (Katona, 1993; Kessler, 1997; Kraaji, 2002; Orrell & Davies, 1994; Paykel, 1994) and suicide attempts (Paykel, 1974).

Life events have also been associated with heart disease (Holmes & Masuda, 1974) and other anxiety disorders and illness (Affleck, Tennen, Oirows & Higgsins, 1994; Dohrenwend and Dohrenwend, 1978; Joiner & Schmidt, 1995; Pbert, Doerfler & DeCosino, 1992). There has been a large and expanding literature suggesting that both external events as well as internal states are linked to both disease and illness in some causal fashion. In the clinical arena links have been made between various illness and both major and minor life events (Weinberger, Hiner and tierney, 1987). Trait anxiety being a personal vulnerability factor affecting stress and
illness (Endler, 1988; Hobfoll, 1989).

Stressful events punctuate the life span. Some have more of them and some have less. Some develop a capability to effectively cope with stress while others do not. Although, experiencing high levels of life change may be some degree corrected with variables such as socio-economic status and minority group membership; no one is immune from experiencing such changes. Life changes represent ongoing sources of stress to which all the individual are subjected to a greater or lesser degree. However, a definite relation has been found to exist between major life events, more minor daily hassles and subsequent level of depression. Canner, Coyne, Schaefer & Lazarus (1981) stated that hassles are the irritating, frustrating, distressing demands that to some degree characterize everyday transactions with the environment. They included annoying practical problems such as losing things or traffic jams and fortuitous occurrences such as bad weather, as well as arguments, disappointments and financial or family concerns. It was further argued that major life events could operate by affecting the persons pattern of daily hassles. Hassles might function as critical event mediators of the life event health outcome relationship.

The role of stressful life events in the etiology of various disease has been a fertile field of research for the last 25 years. It is increasingly recognized that stress is one of the components of any disease, not just those labelled 'psychosomatic'. In fact researchers have established this point beyond doubt that there exists a positive relationship between stressful life events and subsequent illness. It is important to study the life event because the onset of illness and a recent increase in the number of stressful events that necessitate socially adaptive responses on the part of the individual. The underlying assumption is that such events
serve as predisposing and precipitating factors for the subsequent illness episode. (Pestonjee, 1992).

**Cause and Effect Issue in Life Stress Research**:

The idea that adverse life experiences cause psychological distress is neither new nor profound. Historical explanations of psychopathology are replete with references to the types of life events that precede the development of abnormal behaviours. Stress is a possible cause, concomitant and consequence of psychopathology. Individuals suffering from which are at risk for experiencing a variety of additional life stressors. Stressors depending upon their intensity, duration of exposure and the resources of person could then lead to disorder (Cohen, 1988). Even less severe level of psychiatric impairment entail a concomitant heightened risk for incurring further stressors. This is simply due to the fact that there is an impaired ability to cope with life's demands and consequently an increased probability of negative events occurring. Virtually adverse adaptive outcomes have been linked to life stress (Monreio, 1982). But not all disorders necessarily relate to stress (Depue & Monreio, 1986).

**Dependent and Independent Events**:

The distinction between dependent and independent event helps in establishing the direction of causation of life stress research. Dependent events are those that are at least partially attributable to the individuals own actions (interpersonal conflicts) where as independent events are clearly beyond the kind of the individual's influence (death) (Mc Miller, Dean, Ingham, Kreitman, Sashidharan & Surtees, 1986). These categories may encapsulate different forms of stress that possess different implications for subsequent psychological functioning. Events that can be
influenced by the individual may make up a different form of stress than events that cannot be influenced by the individual (Cohen, 1988).

At first glance, the distinction between dependent and independent events relatively seem straightforward. This stems from a common intuitive impression of life stress, that most stressors are clearly aleatory occurrences or clearly attributable to the individual's own actions. It is further suggested that independent events are most devastating (deaths, major loss beyond the individual's influence). While these externally imposed events readily come to mind, epidemiological work suggests that a large proportion of events that happen to people are frequently in part attributable to the individual's own actions (Goldberg & Comstock, 1980; McMillan et al., 1986).

Most events occur as a result of varying tensions between individual and environment. That is, the precise role the individual plays can vary greatly from individual to individual with respect to particular events. This is because life events are typically multi-factorially determined. The degree of influence by the individual is amplified if one considers a broader level of person event associations: that is, not only influence over the occurrence of events but also influence over the continuing sequel of experience (again, either heightening the problems or effectively dealing with them)

Specific individual and event circumstances:

Owing to the great degree of variability across the individuals in terms of life circumstances and perception of an event, however these determinants provides only a rough index for any particular individual. Depending upon the specific circumstances involving a particular event and
individual, variability in the impact ascribed to the incident exists across individuals.

A distinction among life events is found necessary. Certain events serve as markers of transition between life stages. These are events that are correlated with age, they are considered normal, and for most of us they happen at about the time it was expected. Other events occur that are not expected and are not related to life-stages also. These unexpected events have a stronger impact since they do not allow for preparation.

Several approaches to assess the concept of life stress has been employed:
a) In their attempt to construct the most widely used instrument in life stress research, the Schedule of Recent Experience (SRE), Holmes & Rahe (1967) assumed:
i) Life changes require adaptations on the part of the individual and are stressful;
ii) persons experiencing marked degrees of life change during the recent past are susceptible to physical and psychiatric problems, and
iii) that life changes per second are stressful regardless of the desirability of the events experienced. Although attempts have been made to quantify the impact of life change, but its adequacy has been questioned (Rabkin & Struening, 1976).

Since individuals vary how they are affected by events, the values derived from group rating may not accurately reflect the impact those events have on particular individuals. Further, even through life change units do seem to provide a quantitative measure of overall life change, in some cases they may not reflect the actual amount of stress resulting from experiencing a specific event. Therefore, several
investigations have questioned the logic of combining positive and negative events (Brown, 1974, a,b; Mechanic, 1975; Sarason, Dec Manchaux & Hunt, 1975). It has been argued that undesirable events may have a very different and possibly a more detrimental effect on individuals than positive events (Aggarwal and Naidu, 1988).

Vinokur & Selzer (1975) were able to determine significant relationship between negative changes and indices of depression, anxiety, paranoid, tension aggression and suicidal proactivity where positive changes were not found to be systematically related to any of these measures.

Related to this issue life stress scores based on self-ratings of the stressfulness of events are found to be better predictors than scores derived by using mean adjustment ratings. Similarly, evidence that psychological difficulties are related to undesirable and not desirable events has been provided by Mueller, Edwards & Yarvis (1977).

b) To Sarason, Johnson and Siegel (1978) it seemed necessary to take this desirability and undesirability dimension into account in the assessment of life change. They developed a new assessment measure, the Life Experience Survey (LES). LES is a 57 item self-report measure that allows respondents to indicate events that they have experienced during past year and rate separately the desirability and the impact they have experienced. Given the fact that individuals perceive events differently, it is somehow important to individualize ratings of the desirability of the events they experience.

These investigations found life stress scores based on self-rating of stressfulness of events through Life Experience Survey to be better predictors than scores derived by means adjustment ratings similar to those used with SRE.
The LES measures 3 characteristics of life stress:

i) it includes a list of events experienced with at least some degree of frequency in the population being investigated.

ii) it allows for ratings; by the respondents themselves of the desirability or undesirability of events.

iii) it allows for individualized ratings of the personal impact of the events experienced.

The total score is total amount of rated changes experienced in the past 1 year. But this total change score is less predictive of health related variables than an index of negative change (Vinokur & Selzer, 1975; Muller, 1977; Sarason et al., 1978). Undesirable life events such as major personal illness, psycho pathology, getting divorced etc result in neurotic traits and tendencies (Holmes & Masuda, 1974) and as such these negative events are more potent predictors of stress (Sarason et al; 1978).

Some important stressful life events in the life of an elderly:

The older adults face various changes in their life. Certain changes or life events as retirement, loss of friends and family members, economic problems are perceived by them as stressful and have a negative impact in their life. Affecting the health and well-being of the older adults.

Many of the ‘events’ in late life are distressing nor dramatic. The most stereotypical events for older persons are among the least frequently experienced. Murrell, Norris & Hutchins, 1984) observed that less than 390 of the sample had a spouse die, had a spouse retire or retire themselves within a year time. About fourth of these men and women had a new illness or injury within a years time. More than half either were hospitalized within the years time. Overall health events appeared to be the most important category of events for these older adults.
Life Events in Older Adults:

Even Hughes, Blazer & George (1989) found that elderly are more likely to experience a new illness, hospitalization, retirement or death of a spouse. The bulk of studies on older adults have been on particular types of life changes such as retirement or relocation. Retirement and the subsequent loss of income, abundant leisure without suitable avenues for occupation of time (Cohen, 1988; Reddy & Ramamurti, 1990). The elderly not only suffer from physical loss but also emotional losses, such as the death of spouse, family members. Among various life events, death of significant others would appear to be the most intensively stressful and would be likely to have the strongest impact. Gallagher, Thompson & Peterson (1981-82) found this event to require more readjustment among older adults than any others. Thus bereavement is found to have strongest impact. It is often the confluence of several or all of these factors that precipitate another crisis—that of changing environment of relocation. The elderly might be relocated to the institution, hospitals or nursing homes (Sarason & Spielberger, 1979). Such life events have a modest impact on the older adults. These impacts were somewhat stronger on mental health than on physical health of senior citizens. Further more, life events have been found to be significantly correlated over time (Norris & Murrell, 1987). Persons with poor mental health and weak resources expected, on the average and over time, to have more undesirable events than those with better mental health and resources. Thus aggregate measures of life events may well be the consequences and manifestations of personal and environmental characteristics, rather than random causal factors.

Post research has shown a significant but overall moderate relationship between negative life events and emotional problems (Katona, 1993; Kessler, 1997; Kraaik, Arensman & Spinhoven, 2002; Orrell &
Davies, 1994; Paykel, 1994). Not all people who are exposed to stressful life experiences develop emotional problems. Kraaij et al., (2002) observed that while elderly people constitute the age group with the highest possible accumulation of negative life events, the majority do not develop emotional problems (See also, Kraaij and de Wilde, 2001). An important factor that has been conceptualized as influencing vulnerability to stress is coping (Kraaij, et al., Reddy & Ramamurti, 1990).

Coping with Stressful Events:

The study of the nature of coping in old age becomes an important area of research and investigation for Geropsychologists. There are variety of ways through which people cope with stresses, depending upon the type of stresses they experience. In the ultimate analysis the typical manner in which the particular individual copes with stress may be unique to him. It is unlikely that several individuals put into similar stressful situations may always react in identical ways. Nevertheless, there have been a large number of ways on methods by which people cope with stress (Billings & Moos, 1982 a, b; 1998). These methods are referred to as coping styles.

The term 'coping' refers broadly to efforts to manage environmental and internal demands and conflicts among demands (Lazarus, 1981). However, recently Lazarus (1993, 1999) has defined coping as an ongoing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person. Thus coping refers to those actions and thoughts that enable individuals to handle difficult situations, which may be conscious or unconscious. Thus coping is made up of those actions and thoughts that work.
In general, two major functions of coping are distinguished dealing with the problem that is causing the distress (problem-focused coping) and focusing on distressing emotions (emotion-focused coping) (Folkman, Lazarus, Gruen & De Longis, 1986; Lazarus, 1993; 1999). Although no clear consensus exists in literature, in general the problem-focused coping is found more beneficial for well-being than emotion focused coping (Catanzaro, Horaney and Creasey, 1995; Essex & Klein, 1989; Felten & Revenson, 1984). Thoits (1995) Zeidner & Saklofske (1996) state that the theoretical and research advances on coping have mainly focused on non-elderly samples. For less studies on coping have been performed with elderly people (Kraaij, et al., 2002). While the strength and direction of the relationship between coping and well-being in elderly people is not entirely clear, several studies have found that problem focused coping strategies had a positive relationship with well-being in old age. Whereas, emotion-focused coping had a negative relationship with well-being in older adults (Felton & Revenson, 1984; Foster & Gallagher, 1986; Kalfoos, 1993).

Coping, however, cannot only be considered as a reaction to stressful experiences but can also be considered as a consequence of coping resources (Holahan, Moos, Holahan & Cronkite, 1999; Maes, Leventhal & Ridder, 1996). Coping resources can be seen as internal conditions (such as locus of control or coping self-efficacy or external condition such as social support that can be used to cope with stressful demands).

In the first place, some one's perception of one's ability to cope with environmental demands, may influence a person's reaction to stress and its outcomes. Person with internal locus of control might approach challenging situations in an active and persistent style, where as since persons with external locus of control might have lower level of coping self-
efficacy belief in themselves, they may direct greater energy at managing increasing emotional distress (Bandura, 1986, 1995, 1997).

In the second place, the perception of social support may influence the manner in which an individual copes with stress and the outcomes of these coping efforts (Holahan & Moos, 1987; Pierce, Sarason & Sarason, 1996). Findings suggest that the perception of social support may foster more accurate and more positive appraisals of self and of others and it may help people to confront challenges more effectively because they believe others will help them if the challenges exceed their personal resources. These findings suggest that when studying the effects of coping strategies, both internal and external coping resources, should be included (Kraaij, 2002b).

j) Locus of Control:

People generally like the feeling of having some measures of control over the things that happen in their lives, and they take individual action when they want to influence events directly. In doing these things, people strive for a sense of personal control—the feeling that they can make decisions and take effective action to produce desirable outcomes and avoid undesirable ones (Rodin, 1986). Several studies have found that people who have a strong sense of personal control report experiencing less strain from stressors (Elliott, Trief & Steen, 1986; Matheny & Cupp, 1983; McFarlane, Norman, Streiner & Roy, 1983; Suls and Mullem, 1981).

Stressful situations, can influence events in the person’s life and reduce stress they experience in various ways. These ways include four types of control (Cohen, Evans, Stokols and Krantz, 1986; Thompson, 1981):
i) Behavioral Control: involves the ability to take concrete action to reduce the impact of a stressor. This action might reduce the intensity of the event or shorten its duration.

ii) Cognitive Control: is the ability to use thought processes or strategies to modify the impact of a stressor. These strategies can include thinking about the event differently or focusing on a pleasant or neutral thought or sensation.

iii) Decisional Control: is the opportunity to choose between alternative procedures or courses of action.

iv) Informational Control: involves the opportunity to get knowledge about a stressful event - what will happen, why, and what the consequences are likely to be. Informational control can help reduce stress by increasing the person’s ability to predict and be prepared for what will happen and by decreasing the fear people often have of the unknown.

Each of these types of control can reduce stress, but one of them - cognitive control - seems to have the most consistently beneficial effect (Cohen et al; 1986; Thompson, 1981).

People differ in the degree to which they believe they have control over their lives. Some people believe they have a great deal of control and others think that they have almost none.

The judgement that we make about the causes (or sources) of events that we experience, including our success and failure as well as our assignment of credit or blame for those events depend on our idea of how much control we have over the things that happen to us, hence, it is the concept of locus of control (Solomen & Oberlander, 1974).

Certainly it is unrealistic for people to assure everything in their lives is under their control. But the degree to which they attribute responsibility to themselves, versus other forces, determines their locus of control.
Locus of control was propounded and developed by Rotter (1954, 1955, 1960 & 1966); Rotter Chance & Phraes (1972); Decharms, (1968); Weiner, (1973); Lefcourt, (1976). It deals with an important belief system inherent in an individual's mode of thinking viz., the extent to which the individual believes that he is self-motivated or controlled (internal frame of reference) or that the environment (luck, fate, chance, powerful others) plays an important role in influencing his behavior and in determining the rewards and punishment that he obtains. Formulated within the framework of social learning, locus of control forms one of the elements of a behavioural prediction formula, the other elements being situational determinants, reinforcement, value and behavior potentials (Rathore, 1954; Rotter, Chance & Phraes, 1972). The more precise phase for the beliefs about locus of control is internal -versus-external control of reinforcement (I-E)

Locus of control refers to a set of beliefs about the relationship between behavior and the subsequent occurrence of reward and punishment. It is defined as a circumscribed self-appraisal pertaining to the degree to which individual view themselves as having some casual role in determining specified events.

**Internal Locus of Control:**

When reinforcement (either positive or negative) are perceived by the individual as being the result of his or her own behavior, efforts or relatively permanent characteristics. When the individual believes that he or she can control his/her own success and failure is an example of internal beliefs.
External Locus of Control:

External beliefs involve perceptions that reinforcement occur as a result of luck, chance, fate. When the people believe that their lives are controlled by forces outside themselves. The intervention of powerful others are simply unpredictable because of the complexity of events (Phraes, 1987; Rotter, 1968). As a situational variable, those situations in a particular culture that produce the belief that the reinforcement was under outside control would be called external control situation, and those that produced a belief that reinforcement was under the subjects own control could be called internal control situations. Thus Miller, Lefcourt & Ware (1983) concluded that the locus of control examines perception of success and failure in life in terms of self-control as well as outside control.

Information people use in determining their personal control is usually retrospective, can be very complex and is not always clear-cut. As a result the judgement about our control are not always very objective or based on fact. We sometimes develop what Ellen Langer (1975) calls an illusion of control -- a belief in our control over an event that is really determined by chance, e.g. when people claim that they have control in winning a game of chance simply by performing part of the activity in the game, even though their actions obviously do not influence the outcome (Wartman, 1975).

Locus of control is conceived of as a belief that a response will, or will not, influence the attainment of reinforcement. However, locus of control is not an expectancy concerning a particular type of reinforcement, but a "problem-solving" generalized expectancy, addressing the issue of whether behaviors are perceived as instrumental to goal attainment, regardless of the specific nature of the goal or reinforcer. Locus of control is seen to influence the particular goal expectancy in any given specific situation.
depending upon the novelty and the ambiguity of the setting, as well as the degree of reinforcement that the individual has directly experienced in that setting (Furnhon & Steele, 1993).

Research on locus of control has obtained an important role in contemporary psychology (Marino & White, 1985; Malik & Sabharwal, 1999). It first began in the psychological laboratories of Ohio State University in the mild 1950's. Phraes (1957) made an effort to determine the differential effects of reinforcement on expectancies, in skill and chance situations. Phraes discovered that changes in expectancy following success in future were greater in situations that involved a person's skill than in situations where correct performance was chiefly dependent on luck. Any behavior is determined by two aspects: i) the individual's expectancy that the behavior in question will lead to a reinforcement and ii) the value of that reinforcement. The magnitude of the expectancy and the value of the reinforcement are conditioned in part by the nature of the specific situation to which we are predicting. Therefore, prediction of behavior involves three variables: expectancies, reinforcements and the psychological situation (Phraes, 1957).

Rotter (1966) suggested that individuals differ in the extent to which they perceive environmental reinforces as being under their control. Thus individual differences being an important factor. Some people learn strong generalized expectancies in internal control while others in external control. The generalized expectancies about locus of control of reinforcement constitute a dimension of personality along which people vary from one another (Walls & Smith, 1970; Zytoskee; Strickland & Watson, 1971).

In social learning theory, reinforcement acts to strengthen an expectancy that a particular behavior or event will be followed by reinforcement in the future. Internal-external is regarded as a generalized
expectancy, once an expectancy for such a behavior reinforcement is built up, the failure of the reinforcement to occur will reduce or extinguish the expectancy. Expectancies are generalized from a specific situation to a series of situation which are perceived as related or similar. Consequently, a generalized expectancy for a class of related events has functional properties and make up one of the important classes of variables in personal description. A generalized attitude, belief or expectancy regarding the nature of the causal relationship between one's own behavior and its consequence might effect a variety of behavioral choice in a broad band of life situations. The generalized expectancies will result in characteristic differences in behavior in a situation culturally categorized as chance vs skill determined and they may act to produce individual differences within a specific condition. Thus Johnson & Sarason (1978) reported that the locus of control construct appears to reflect the extent to which individual believes themselves capable of exerting personal control over environmental events.

Phares (1987) considered that when subjects perceived success at the task to be dependent on skill, they responded to a past experience of success or failure by appropriately wagering on their next judgement. It was also found that subjects predicted their potential success on a task according to whether or no they perceived task results as dependent on their performance or as being capricious and unpredictable because results were due to luck or chance. When subjects believed their performance to effect results, they made appropriate and realistic judgements based on their past experience. In chance or luck condition, subjects made judgements correlated to and independent of their performance.
Determinants and Development of Personal Control:

Throughout the life span, we assess our personal control through the process of social learning, in which we learn by observing the behavior of others (Bandura, 1986). During early childhood the family is particularly important in this process, with members serving as models of behavior. Parents who are caring, encouraging and consistent in their standard for behavior tend to have children who develop an internal locus of control. (Harter, 1983). During adolescence, the sense of personal control is strongly affected by, social and sexual relationships and decisions about higher education and career. People who reach adulthood with poor intellectual and social skills and many self-doubts often find these events and many others aspects of adult life stressful. From adulthood to old age, locus of control tends to become more external that is people’s beliefs that chance and powerful others affect their lives increases (Lachman, 1986). It has been observed that elderly’s are more inclined than younger people to prefer having professionals make health related decisions for them (Woodward & Wallston, 1987).

Sources of Control Expectancies:

1) Familial Origins: Locus of control is learned and acquired. It is inborn. A child starts learning the laws from early months. Hence mother is quite responsible for locus of a child. Family is the basic unit of society to impart social learning to child.

Following are some important characteristics:

i) Warm accepting and non-rejecting homes

ii) Protection and approval

iii) Independence

iv) Consistency in standards
v) Father's interest in child's activity
vi) Awareness of behavior reinforcement.

vii) Child’s perception of parental behavior is more related to his locus of control than parental attitude.

Internal locus of control is related to parental protectiveness, nurturance and the tendency to be non-rejecting and approving. Like wise parents of internals are more accepting and consistent disciplinarians than parents of externals.

2) Social Origins: Reviews of research in this direction leads to conclusions that class and cost related disadvantages result in the development of external control expectancies. Most studies show that blacks score in a more external direction (Strickland, 1972).

A number of studies have made explanatory efforts to assess differences in locus of control orientation cross-culturally. A major finding occur from research. There are systematic sex differences in control orientation that occur across a variety of countries indicating that females tend to be more external in their outlook because they have learnt more helpless attitude at younger age (Parsons & Schneider, 1974; Hickson, Housley & Boyle, 1983; Mirowsky, 1995).

In Rotter's theory a person’s action is predicted on the basis of his values, his expectancies and the situations in which he finds himself. According to him a person's behavior is directional or goal directed (Rotter et al., 1972). But although locus of control is fairly stable overtime, it has been found to change in certain naturally occurring situations as well as experimentally induced ones. It comes as no surprise that different environments, experience and social conditions lead to variations in personality characteristics.
Weiner (1973) introduced the notion of casual stability to complement locus of control. He argues that subject utilizes not only an internal-external dimension to explain their performance but also a stable-unstable dimension. Indeed, he contends that much research has confounded locus of control with stability. He employs four factors as determinants of perceived achievement: ability (internal-stable), effort (internal-unstable), task-difficulty (external-stable), and luck (external-unstable). He further asserts that the casual stability dimension influences expectancy for success and that of locus of control dimension influences affective responses to success and failure.

Seeman & Evans (1962) demonstrated that internal tuberculosis patients possessed more information about their physical condition and sought more information about their physical condition and sought more information from physicians and nurses than their external counterparts. In many ways internals seem more competent than externals. This stems from their more active efforts to acquire information that will enable them to have the effect on their environment, which they believe they can have (Kumar & Srivastava, 1985). They effectively seek more information than externals and they use it more (Auerbach, Martelli & Mercuris, 1983; Proceuik & Brein, 1977).

In the area of relations when others seek to exercise interpersonal influence, internals are expected to be more resisting than externals. The internals acceptance is more thoughtful and analytic than simply reflexive. Externals are more readily conditioned than internals. Sandler & Lakey (1982) found that persons with internal locus of control were less affected by high level of stress.

Theories of personal control have also focused on the perception of control over events as a determinant of psychological well-being.
A relation between people's locus of control and the effectiveness of social support has been observed in many studies (Sandler & Lakey, 1982; Sarason, Levine, Basham & Sarason, 1983). Effects of social support mediating stress has been observed to be more prominent among people with internal locus of control (Eckenrode, 1983; Sandler & Lakey, 1982; Sarason et al., 1983; Sud & Sud, 1998).

The perception of control is a useful construct which allows one to comprehend a diversity of human characteristics. However, Lefcourt (1976) suggested that certain points should be kept in mind while making influences on the locus of control construct:

First, in the locus of control construct, person should not be expected to account for a lion's share of the variance in most situations. The perception of control is, but a single expectancy construct. Other interesting variables of equal importance, if not more, include the value of the reinforcements in question as well as expectancy that one will obtain that desired reinforcement, whether by one’s own efforts or by external forces.

Secondly, people are not totally internals or externals. The terms are used as expressive short cuts. They are not meant to imply that perception of control is a process, the exercise of an expectancy regarding causation. The terms internal and external construct depicts an individuals more common tendencies to expect events to be contingent or not contingent upon their actions.

Thirdly, if one wishes to use the perception of control as powerful predictor, then it will always be profitable to design one's own assessment devices for the criteria of interest. If one were concerned about a particular aspect, such as the ability to maintain close relationship then the perception of control of love and affection responses would be more
salient that would control experiences pertaining to achievement.

Fourth, we must always bear in mind that there may be confronting elements in the term control. It has been contended by some that the construct was misnamed. The control was never the control issue, but rather the contingency was at the core of the construct. The term control connotes successful manipulation. The construct, locus of control on the other hand focuses upon the perceived contingency of events, whether they be positive or negative outcomes. The perception of control may be also differentiated between belief regarding one's role in selecting a goal and beliefs regarding the way goals are accomplished once they have been adopted. It is with this idea of greater differentiation of concepts related to locus of control that we arrive at one final point.

2.1.4. Concept of Social Support

Social support is a concept that is increasingly cited in the clinical and research literatures as moderates of stress Cohen & Symes, 1985; Greenglass, 1993; Greenglass, Fiksenbaum & Burke, 1996; Marshall & Barnett, 1992; Sud & Malik, 1999; Sud & Prabha, 1987; Sud & Sud, 1998). It has been observed that those who lack such relationships are vulnerable to the effect of stress (Burke, Shearer, & Deszea, 1984; Cummins, 1990; Dollard & Winefield, 1995; Greenglass et al, 1996; Richardson, Burke & Letter, 1992). Social support is usually defined as help that would be available to an individual in difficult or stress arousing situations. It refers to access of social resources in the form of relationship on which the individual can rely (Spielberger, 1978). A person who is high in social support has others whom he or she can rely in times of need. Someone who is low in social support lacks these interpersonal resources (Sarason & Sarason, 1982).
According to Bowlby (1980), social support is seen in the form of an attachment figure that is available early in life. This early support decreases the likelihood of psychopathology in later life. Social support was also found to bolster the capacity to withstand and overcome frustrations and problem solving challenges. The availability of childhood social support is related to personality development and adult behavior patterns, there is also evidence of the detrimental effects of lack of support among the adults. Studies have found that the combination of recent stressful life events, low level of social support and adverse childhood experiences to predict the occurrence of maladjustment in adults. There is also evidence that depressive tend to report the lack of availability of supportive others (Sarason, Levine, Basham & Sarason, 1983). A deficiency of social bonds have been observed to be a cause of some form of behavioral dysfunctions, leading to feelings of depression and loneliness (Henderson, 1980).

**Models of Social Support:**

Support has been implicated in the etiology of and recovery from both physical illness and psychological distress. During the last few years, there has been considerable interest in determining whether positive relationships between social support and health occurs because support enhances health and well-being irrespective of stress level (direct or main effect hypothesis) or because support protects people from the pathogenic effects of stressful events (buffering hypothesis) (Gore, 1985; Kessler & Mcleod, 1985; Cohen & Wills, 1985; Payne Lone 1987; Wortman & Dunkell-Schelter, 1987).

Although this issue is posed as if only one of these mechanisms is correct, recent research provides evidence for both direct and buffering effects of social supports on health and well-being.
Direct effect generally occurs when the support measure assess the degree to which a person is integrated within a social network, while buffering effects occur when the support measure assesses the availability of resources that help one to respond to stressful events.

The Direct Effect Hypothesis:

The direct effect hypothesis argues that support enhances health and well-being irrespective of stress level. Such a direct benefit could occur as a result of the perception that others will provide aid in the event of stressful occurrences or merely as a result of integrated membership in a social network. The perception that others are willing to help could result in an increased overall positive effect and in elevated sense of self-esteem, stability and control over the environment. In the extreme this implies that an increase in support will be beneficial to health irrespective of the existing level of support.

Membership in social network may also result in increased senses of predictability, stability and control. As they provide the opportunity for regularized social interaction and the concomitant feedback, that allows adoption of appropriate roles and behaviors.

According to Thoits (1986) there is a link between role involvement and health. According to this view role involvement provides with a sense of identity, a positive self-evaluation and a sense of control. Thus, health is enhanced as role involvement gives meaning and purpose to ones life and leads to reduction in anxiety and despair.

According to Cohen & Symes (1985) there are two ways in which buffer works. One way involves the process of cognitive appraisal. When people encounter a strong stressor those individuals with high level of social support may be less likely to appraise the situation as stressful.
than those with low level of support. Individuals with high social support may expect that someone they know can and will help. As a result, they judge that they can meet the demands and decide that the situation is not very stressful (Peirce, Frone, Russell, & Cooper, 1996). The second way social support can buffer the effects of stress is by modifying peoples responses to a stressor after they have appraised the situation as stressful. People with high social support might have someone to provide a solution to the problem whereas people with little support are much less likely to have any of these advantages - so the negative impact of the stress is greater. Maintenance and increases above that level may be unimportant.

Some evidence suggests that high level of social support may encourage people to lead more healthful life style than low social support (Broman, 1993). However, Cohen & Symes (1985) observed that there is at least some evidence, that only very low levels of support are associated with decrease in well-being. Hence, there may be some minimum threshold of social contact required for health.

The Buffering Hypothesis:

The buffering hypothesis argues that support exerts its beneficial effects in the presence of stress by protecting people from the pathogenic effects of such stress. In this model support may play a role at two different points in the stress pathology causal chain (Cohen & Mckay, 1984; Gore, 1981; House, 1981). First, support may intervene between the stressful event and the stress experience by accentuating or preventing a stress response. Resources provided by others may redefine and reduce the potential for harm posed by a situation and/or bolster the ability to cope with imposed demands. Thus prevent the appraisal of a situation as stressful. Second, support may intervene between the experience of stress
and the onset of the pathological outcome by reducing or eliminating the stress experience or by directly influencing responsible illness behaviors or physiological processes (Peirce, Frone, Russell & Cooper, 1996).

House (1981) suggested three ways in which support may alleviate the impact of stress experience:

1. Support may reduce the importance of the perception that a situation is stressful.
2. It may in some way tranquilize the neuro-endocrine system so that people are less reactive to perceived stress or
3. It may facilitate healthful behaviors such as exercising, proper nutrition, rest etc.

People with high levels of social support may have a greater sense of belongings and self-esteem than those with little support. This positive outlook could be beneficial to health independent of stressful experience. Some evidence suggests that high levels of support may also encourage people to lead more healthful life-styles than low social support (Broman, 1993). People with more social support may feel, that because others care about them and need them, they should exercise, eat well, and seek medical attention before a problem becomes serious (Sarafino, 1998).

**Issues In the Study and Application of Social Support:**

An Adequate (predictive) model of the relationship between social support and well-being must consider individual differences in need or desires for social support, as well as the social and environmental context in which support is perceived, mobilized, given and taken. Certain issues are as follows :-

a) **Who is providing the support?** The same support may be acceptable from one giver but unacceptable from another. A person
overwhelmed by job demands may be more affected by support from a co-worker or supervisor who has relevant information about the situation than any support from a non-job friend.

b) **What kind of support is being provided?** A monetary gift or loan may be invaluable in the face of unemployment and perhaps worthless in the face of bereavement.

c) **To whom is support provided?** What are the characteristics of the recipient that may be important in determining effectiveness of a supportive behavior including personality, social roles & support available to the receiver from alternative sources? The recipient's ability to attract, mobilize, and sustain support is also critical to the support process.

d) **For which problem is support provided?** The appropriateness of a specific kind of social support may be dependent on the match between the type of support offered and the type of problem encountered. For eg., marital conflict, unemployment and bereavement may elicit very different support needs.

e) **When is the support provided?** Social support that may be optimally effective at one point may be useless or even harmful at another.

f) **For how long is support provided?**
   * The ability of the givers to sustain support for long time.
   * Long-term provision of support may place demands on network that are beyond its capacity.

g) **What are the costs of giving and receiving social support?** The cost of giving and receiving support and perceptions of these cost can be critical in determining whether it is asked for, whether it is given, and the impact of support-giving relationship between giver and receiver. There has been considerable research on consequences of receiving support than on the consequences of providing it. Yet the deleterious consequences for the
provider may be substantial when provision of sustained high levels of support are required but recipient is unwilling or unable to reciprocate (eg. Indian male). The one-sided giving of support may not only become overburdening for the provider, it may also do a disservice to the recipient by fostering dependency and discouraging active efforts towards self-help.

Concept of Social Support:

The support process has been studied from two different perspectives. Support is conceptualized in terms of the structure of an interpersonal relationship or in terms of functions that a relationship or network serves.

Structural Measures: In order to understand the structure of only personal relationships structural resources are required. Structural measures describe the existence and interconnection between social ties as marital status, number of relationships. They are generally considered to measure objective characteristics of social networks. They provide information about properties of networks around an individual, independent of personal characteristics (Hammer, 1983). Structural indices of social integration that include number of contacts with family, friends and community, as well as number of active memberships in formal and informal groups, provide measures of embeddedness in social system. Which implies that one receives that feedback from others which helps to form self-identities and feelings of stability, predictability, and control over individuals lives. Individual characteristics of network structure can be used to determine whether various quantities and form of social contact influence health.

Functional Measures: Functional measures assess whether interpersonal relationships serve particular functions as to provide affection, feeling of
belonging on material aid. They generally ask people about their perceptions of the availability or adequacy of resources provided by other persons. Subjective functional measurement helps to top individuals psychological representations of their support systems. Since perceptions of support resources are affected by personal and environmental characteristics other than objective network structure, these representations may or may not be correlated with structural measures. It emphasises the role of perceived resources in determining whether support will effect health (Cohen & Symes, 1985). The relationship between support and health is mediated by psychological representations of available support. It is expected to provide better predictors of health and health behavior.

Kind of Social Support:

Cohen & Symes (1985) pointed out that advances in the ability to conceptualize and assess the kinds of support being provided are necessary to understand the support process and realize its clinical possibilities. In order to assess, manipulate or intervene with the appropriate kind of social support, a typology is required that would categorize interpersonal resources into classes that are relevant to the support process.

The multi-dimensional measurement of support functions is essential in determining the mechanism by which support effects health and well-being. Type of support may be especially important in understanding. When social support buffers the pathogenic effects of stress. Hence, buffering effects may occur only when the kinds of available support match the needs elastic by the stress a person is experiencing (Cohen & Mckay, 1984). However, issue is complicated because sometimes multiple needs are elicited by the same stressor and needs may shift over the course of
stress experiences. Within types of support, priority must go first to measuring emotional support and then to other aspects that are appropriate. This is because emotional support has been clearly linked to health and well-being in terms of both direct and buffering effects.

Social Support and Personality:

There are two important questions regarding the role of personality in the relationship between social support and health.

First, are there any effects of social support on health that occur above and beyond the effects of stable individual differences in sociability. It addresses the possibility that social support is a proxy process for personality factors, such as social competence and social anxiety, that are highly correlated with support. The possibility exists that some stable individual difference factor accounts for changes both in social support and in health. Social competence effects both support level and well-being, as well as feelings of personal control, social anxiety and introversion-extraversion.

Secondly, does personality play a role in determining support levels. Personality factors associated with sociability must play a significant role in the development of social networks, in the perception of support availability, and in the maintenance of mobilization of support (Hellere & Swindle, 1983).

It reasonable to expect: Certain sources of support are less dependent on the supportee's personality than others. For example, personality is probably of relatively greater importance in making and maintaining friendships, (Kith) than in maintaining family (Kin ties), since support from kin often is viewed as an obligation implied by the relationship.

In sum personality factors must be considered as an attempt to
understand the relationship between social support and well-being. First, we need to examine the possibility that personality factors associated with sociability are primarily responsible for the relationship between social support and well-being that have been attributed to support caused changes. There is suggestive evidence, however that social support does play an important role independent of personality in this relationship. Second, we need to understand how personality factors influence the development and maintenance of support network. It is important to recognize that the roles of stable individual differences probably vary somewhat across situations and across sources of support.

Perception of Social Support:

Social support is embedded in the individuals matrix of relationship with other people (Heller & Swindle, 1983). When this matrix is extensive and deep, the individual needs and respects others and is more likely to help them, as well as to feel that help is available for them. When this matrix is limited the individual feels less empathy for the problems and limitations of other people and a lessened sense of responsibility and lack of support.

The concept of social support may be related not just to what one gets from others, but also to a persons inclination to respond to the needs of others, to help them, &to exhibit tolerance of their behavior. It seems possible then, that people with good social support will also have more benign, less punishing, more helpful attitude toward other people and toward their behavioral deviance in particular. (Sarason & Sarason, 1982).

The perception of social support and the satisfaction with available support may vary depending on the individuals personality. Some people may think that only a large number of available helpers provides
sufficient possibles of social support. Others consider that even one person is adequate. How comfortable they feel with others may determine the number of supports they believe necessary. Satisfaction derived from perceived support available may be influenced by personality factors as self-esteem and a feeling of control over the environment (Sarason, Levine, Basham & Sarason, 1983). People feel that perceived social network is a major source of help.

Theories Relevant for Support Relationships:

Several different social psychological theories are relevant for considering the supportive aspects of interpersonal relationships.

1) Social Exchange Theory:

Interpersonal relationships are viewed as consisting of an exchange of benefits governed by norm of equality. The more rewards provided, the more supportive the relationship would be. The members in an exchange relation assume that a benefit is given with the expectation of receiving a benefit in return, and the very receipt of it encores a debt or an obligation to return a similar or comparable benefit. Lack of reciprocity, either in the form of not being able to return the benefits or not receiving benefits in return from others, can lead to negative affective reactions.

The rewards exchanged within the system are assumed to be as simple as economic goods services, or can be interpersonal rewards such as expressions of liking, or status enhancement. The shared interactions and exchanges within a relationship are supportive not only because more rewards are available but because the history of reciprocal exchanges makes individuals more confident that others would provide assistance in
time of need (Cohen & Symes, 1985).

An important factor influencing the importance of equity considerations is the type of relationship. Studies have shown the importance of global perception of equity for satisfaction in personal relationship (Hatfield, Traupmann, Sprecher, Utne & Hay, 1984; Van Yperen & Buunk, 1990).

2. Social Comparison Theory:

According to Schachter (1959) individuals under stress seek out others for reasons of self-evaluation, to assess the appropriateness of their own reactions. It was further stated that individuals have a tendency not to seek out the company of others under stressful situations, when one is confronted with embarrassing circumstances. Teichman (1973) showed that fear of social rejection was the predominant reason for wanting to wait alone when embarrassed and under strong emotions.

Individuals tend to compare themselves with others who are less well off. Wills (1981) suggested that when individuals are confronted with a threat, they engage in downward comparison with less competent others in an attempt to restore the way they feel about themselves. Various studies have indeed indicated that information about others being worse off can lead to mood improvement (Gibbons, 1986; Testa & Major, 1990) and perception of themselves as being worse off than most others facing similar stress (Buunk, Collins, Van Yperen, Taylor & Pakof, 1990; Taylor, Buunk & Aspinwall, 1990) can have the negative impact or mood.

3. Personal Control Theories:

These theories focus on the perception of control over events as a determinant of psychological well-being. This can be construed as a perception of internal locus of control or as a perception of general self-
efficacy and control over events. Social network may enhance feelings of personal control because of their availability for providing needed aid and resources in terms of crisis. It is the perceived reliability of network that provides a supportive function. The availability of a reliable network of social relationships might effect the stressful situation (Cohen & Symes, 1985) positively.

Supportive Functions:

As reviewed by several researchers six major types of functional social support has been examined on relation to stress and health (Cohen & Wills, 1985; House, 1981; Wills, 1985; Cohen & Mckay, 1984; Russell & Cutrona, 1990; Schaefer, Coyne & Lazarus, 1981).

Esteem Support: Esteem support is also called emotional support, ventilation or confidant relationship. It conveys that a person is esteemed, valued and accepted. An interpersonal resource with a strong effect for counteracting self-esteem threats is having someone available with whom one can talk about problems. As talking about important problems generally involves revealing negative aspects of the self. Most people tend and confide serious problem discussion to a person they feel particularly close to who may be spouse, family members or close friends. With whom there has been a mutual respectful and long-standing relationship.

An important element is the experience of feeling accepted and valued by another person, even through one is having difficulties in other life areas. Thus by receiving acceptance and approval from significant others a persons own self-evaluation and self-esteem are enhanced. It is relevant for a wide variety of stresses, because ego-threat is a common element in stressful life events and large proportion of negative events.
involve conflict in interpersonal relationship. Relationships in which a person is esteemed and valued provide a source of active self-enhancement and an accepting relationships which may serve as an antidote to resolve conflict.

**Status Support**: Social relationship serve a supportive function simply because of their existence. Levinger and Huesmann (1980) made distinction between behavioural reward and relational reward. Behavioural reward is based on specific behavioral exchanges of the participants. Relational rewards derive from the mere existence of the relationships. Relational rewards may be correlated with psychological well-being because of attributions made by observers about the participants personality characteristics.

Participation in certain formal social relationships provides evidence that a person is capable of fulfilling normative role obligations. Demonstrating that one person has the ability to initiate and maintain a close relationship with another. Status rewards may also occur through participation in community activities such as school boards, service organizations, social clubs or religious organizations. Participation in such activities, often involves some element of formal approval. It provides evidence of being a valued member of the community and of having the capacity to work effectively (Antonucci & Depner, 1982; Moos & Mitchell, 1982). When this type of support is measured by structural indices, buffering effects would not be expected.

**Informational Support**: It is applied to a process through which other persons may provide information, advice and guidance. Network members may serve a supportive function by providing independent assessments of
the locus of the problem, by giving suggestions about the problem-solving approach.

In actual help-giving interactions, esteem-enhancing behavior and advice giving typically occurs together (Barker & Lemle, 1984) so that esteem support and informational support derive from the same source. Under ordinary circumstances, most people probably have the information necessary for effective functioning. It is only when environmental stresses exceed the person’s available knowledge and problem-solving ability that additional information and guidance becomes necessary and network members may provide valuable assistance under these conditions. This support is most relevant for persons who are highly stressed.

**Instrumental Support**: Instrumental support is also known as tangible support. It includes a wide range of activities such as providing assistance with household chores, providing transportation, running errands, etc. It also includes financial and material assistance given by others, such as lending money, providing material goods, or giving help in times of physical injury which encompasses all these activities when the individual is unable to perform. Thus, instrumental support could be related to well-being because it reduces task load or provides increased time for leisure activities. This type of support is probably relevant for low-income persons, who often are overburdened with instrumental chores, have smaller social networks to be with, and are financially unable to buy assistance (Petton, 1982).

The relationship between instrumental support and well-being is straightforward. People have specific needs and other persons can help them to resolve these needs. What persons are responding to when considering instrumental support is reliability. The perception that if something goes
really wrong there is someone who is likely to help if called on. This is related to personal control. To the extent that the support measure indexed the provisions of instrumental assistance that was directly relevant to a particular stressor, a strong buffering effect would be predicted. For example, when friends and neighbors provide crisis assistance that would make it easier to care for a chronologically ill family members.

**Social Companionship**: Social companionship is also known as belongingness support. It involves both the spending of time with someone in social (recreational activities) and the fulfillment of that individuals psychological needs for affiliation and belongingness. This shows that social activity is a major contributor to positive mood. Leisure and recreational activities make a major contribution to global satisfaction. Having more social relationships increases the probability of pleasurable activities, entering into a new, significant interpersonal relationship which may be available for social and other activities. Thus, a relationship between the social companionship function and indices of well-being can be predicted.

**Motivational Support**: Motivational support operates as a pure buffering process. It may be difficult to obtain strictly independent measures of esteem support and motivational support because they probably are intercorrelated and tend to occur in the same helping transaction.

Motivational phenomenon is based on a person’s perception that he or she will be unable to overcome. Ongoing difficulties, that the process is no longer interesting or challenging and that things are not going to get any better with time. Thus social network may play an important role by providing motivational enhancement: encouraging persons to persist in their efforts at problem solution, helping them to endure frustration, and to
communicating their belief that "we can ride it through". By providing continuing support that is there everyday. Network members may help them to avoid the downward spirals that can lead to serious depression. Confident relationships include elements of motivational support in addition to esteem-supporting behaviors.

Robert Weiss's Model (1974) of Social Provision:


Weiss (1974) described six different social function or "provisions", that may be obtained from relationships with others. He contended that all six provisions are needed for individuals to feel adequately supported and to avoid loneliness, although different provisions may be most crucial in certain circumstances or at different stages of the life cycles. Each of the provisions is most often obtained from a particular kind of relationship, but multiple provisions may be obtained from the same person. Weiss's provisions may be divided conceptually into two broad categories: assistance-related and non-assistance related. In the first category fall the functions most directly relevant to problem-solving in the context of stress, guidance (advice or information) and reliable alliance (the assurance that others can be counted upon for tangible assistance). According to Weiss, guidance is most often obtained from teachers, mentors, or parent figures, whereas reliable alliance is most often provided by family members.

The non-assistance related provisions do not contribute directly
to problem-solving and would seem to have beneficial effects under condition of both high and low stress. Their effects are probably mediated by cognitive process (enhancement of self-efficacy, effects on causal attribution processes). Reassurance of worth (recognition of one’s competence, skills and value by others) is one such provision. Bandura (1977) has provided considerable evidence that self-efficacy beliefs are predictive of actual coping behavior. Thus, the individual whose self-efficacy is bolstered through the input of supportive others would be expected to cope more effectively and suffer fewer deleterious effects of stress than one whose support system does not provide such bolstering. In the absence of major stress, the individual with the abundant reassurance of worth would also be expected to function more effectively as a result of enhanced self-efficacy and self-esteem.

A second provision with implications for self-esteem is unique to Weiss’s theoretically model. According to Weiss (1974) an important aspect of interpersonal relationship is feeling needed by others. Thus, he includes opportunity of nurturance (the sense that others rely upon for their well-being) in his conceptual scheme. According to Weiss, the most frequent source of opportunity for nurturance are one’s offspring, although the spouse is another frequent source. Strictly speaking, this cannot be considered social support. In this the individual is the provider rather than the recipient of assistance. However, since our research has focused broadly on the effects of interpersonal relationships on health and how giving and receiving help may enhance health through some of the same cognitive mechanisms, we have retained this provision in our conceptual scheme.

The last two, provisions concern the presence of affectional ties, attachment (emotional closeness from which one derives a sense of
security) and social integration (a sense of belonging to a group that shares similar interests, concerns and recreational activities). According to Weiss, attachment is most often provided by the spouse, but may also be derived from close friendship or family relationships. Social integration is acquired most often from friends. Such ties may provide comfort, security, pleasure and a sense of identity, to the extent that such positive affects have an impact on health, attachment and social integration may promote well-being. However, as argued by Cohen & Wills (1985), these components of social support should not have any differential impact under conditions of higher versus low stress, unless the stress involves a specific loss or threat to such affectional ties. Otherwise, their effects should be independent of stress level.

As noted earlier, Weiss's (1974) relational provisions encompass all of the components of social support proposed by theorists in this area, with the addition of opportunity for nurturance. The six social provisions are listed in Table 1, along with the dimensions of support that have been described by other authors in the literature. As can be seen there are clear parallels in the dimensions of support that are described in these models.

Weiss's social provisions appear to capture all of the different dimensions of support that have been identified in these models.

Empirical support for drawing several of the parallels shown in Table 1 is provided by Rose (1986).

The conceptual overlap between these models as shown in Table 1, was supported. For example, helping behavior that reflected attachment in Weiss's model also classified as representing emotional support as defined by Cobb and affect as defined by Kahn.
### TABLE 1. COMPARISON OF COMPONENT MODELS OF S.S.

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Cobb (1979) defined active support as reflecting the receipt of care or "Mothering" by the target person. Whereas Weiss (1974) views opportunity for nurturance as reflecting the target person providing care to others.
Enhancing Social Support:

We have all turned to others for help and comfort when under stress at some time of in our life. Thus social support seems to very important by not only being helpful after stressors appear, it also can help avert problems in the first place.

Although there are people in all walks of life who lack the social support they need, some segments of the population have less than others (Antonucci, 1985; Broadhead, Kaplan, James, Wagner, Schenbach, Grimson, Heyden, Tibblin and Gehlbach, 1983; Ratliff-Crain & Baum, 1990). For instance:

* Although men tend to have larger social networks than women, women seem to use theirs more effectively for support.
* Many elderly individuals live in isolated conditions and have few people on whom to rely.
* Network size is related to social prestige, incomes and education: the lower the prestige, income and education level of the individuals the smaller their social network trends to be.

Furthermore, the networks of people from lower socioeconomic classes are usually less diverse than those of people from higher classes—that is, lower classes contain fewer non-kin members. Pilisuk (1982) states that geographic proximity and the functions of the modern extended family have changed substantially and do not typically provide the some protective buffer associated with large families in urban areas.

Does Social Support Always Help:

Social support does not always reduce stress and benefit health. For one thing, although support may be offered or available to us, we may not perceive it as supportive (Dunkel-Schelter & Bennell, 1990;
Wilcox, Kasl & Berkman, 1994). This may happen because the help is insufficient or we may not want help or are too emotionally distraught to notice it. When we do not perceive help as supportive, it is less likely to reduce our stress.

Another reason why social support does not always help is that the type of support we receive may not match the needs that the stressor has produced.

In summary, people receive various types of support from friends, family and others in their lives. Where social support has usually been found to reduce people's stress and benefit their health (Sarafino, 1998).

Peoples needs for, giving of, and receipt of support change over time. Some factors within the individual determine whether he or she will receive or provide social support when it is needed (Broadhead et al., 1983; Wortman & Dunkel-Schelter, 1987). One factor is temperament. People differ in their need for and interest in social contact and affiliation. Those individuals who tend to seek interaction with others are more likely to give and receive support than those who do not. To some extent, these tendencies are determined by the experiences people have. Children who grow up in caring families and have good relations with peers learn the social skills needed to seek help and give it when needed. Efforts to enhance people's ability to give and receive social support can begin in early childhood, particularly in school (Broadhead et al., 1983).

In adulthood, people can enhance their ability to give and receive support by joining, community organizations, such as social, religious, special interest and self-help groups. These organizations have the advantage of bringing together individuals with similar problems and interests, which can become the basis for sharing, helping and friendship.
Health and Well-being:

Health is one of those terms which most people find it difficult to define although they are confined of its meaning. We commonly think about health in terms of an absence of 1) objective signs that the body is not functioning properly, such as measured high blood pressure or 2) subjective symptoms of disease or injury such as pain or nausea (Birren and Zarit, 1985; Thoresen, 1984).

The most widely accepted definition of health is given by the WHO as “Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity”. Thus mental and social well-being are recognized to be important in their own-right, and in their effect on physical well-being. The mental and social health of people can affect not only their own productivity and enjoyment of life but also the development of their children, quality of their marriages and the safety of their communities.

Behaviour influences physical health directly as well as indirectly. Health behaviour are actions that directly influence one’s own and others behaviour. They include behaviour that promote physical well-being (good eating habits), prevent illness (getting immunized and washing hands with soap); managing illness and those that denote or health (drinking too much alcohol).

These health behaviors are acquired, maintained and with the help of psychological factors such as ones values, attitudes knowledge, personality as well as social institutes like one’s family, school and health professionals. Not all health problems are influenced by behaviour. Hubley (1993) suggests that first we conduct a behavioral diagnosis of the health problem, by which we look at the causes of a health problem. Then we
find out whether human behaviour is involved in its prevention or treatment (Park, 1997).

A: Dimensions of Health: Health is a multidimensional construct. The WHO definitions 3 dimensions—the physical, the mental and the social and spiritual dimensions can also be added to this construct.

1) Physical dimension: The state of physical health implies the notion of "perfect functioning" of the body. It conceptualizes health biologically as a state in which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body (Park, 1997).

Old age is equated with sickness. As elderly's are more susceptible to illness because of their lower resistance to disease and other ailments. The variation among the elderly in their physical health and in their degree of improvement is enormous. As stated earlier, as age increases there is decrease in the performance of the organs leading to various disease. The problem is further aggravated when aged do not consume a balanced diet and lose physical strength (Mahajan, 1987; Park, 1997).

2) Mental Dimension: Mental health is not merely the absence of mental illness. Good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose. Recently, mental health has been defined as "a state of balance between one-self and others, co-existive between the realities of the self, of other people and that of the environment (Sartaivis, 1983).

Researchers state that psychological factors can include all kinds of illness, not simply mental ones as hypertension, peptic ulcer, asthma (WHO, 1964). Some being common mental illness quiet common
among elderly is dementia and depression which have biological component. But there is behavioural, psychological and biological dysfunction (Eillenbaum, 1984).

Psychologists have mentioned certain characteristics of mentally healthy people:
1) a mentally healthy person is free from internal conflicts, he is not at war with himself.
2) he is well adjusted i.e. he is able to get along well with others. He accepts criticism and is not easily upset.
3) he searches for identity.
4) he has a strong sense of self-esteem.
5) he knows himself, his needs and goals.
6) he has good self-control: he has a balance between rationally and emotionally.
7) he faces problems and tries to face them intelligently.

3) Social Dimension: Social well-being implies harmony and integration within the individual, between each individual and other members of the society as well as between individuals and the world in which they live (Mish, 1984). Social well-being has defined as a quality and quantity of an individual's interpersonalities and the extent of involvement with the community (Donald, 1978).

The social dimensions of health includes the levels of social skills one possesses, social functioning and the ability to see oneself as a member of a society. But due to retirement there is decrease in the social sphere of the adults. There is loss of friends either due to death or transfer. Thus reducing the social contacts of the senior citizens. The problem is aggravated by rise in the number of nuclear families where older
adults have no one to talk and share their problems with (Rajan, Mishra, Sarma, 1999; Eileenboum, 1984).

4. Spiritual Dimensions: Spiritual health refers to that part of the individual which reaches out and strives for meaning and purpose in life. The elderlies are found to be very religious. Their religious conviction helps them to overcome their problems and provides support.

B) Determinants of Health: Health is multifactorial construct. The factors which influence health are both within the individual and externally in the society in which he or she lives. These factors interact and may be health-promoting or deleterious.

1) Heredity: The physical and mental traits of every human being are to some extent determined by the nature of his genes at the moment of conception. The genetic make-up is unique and cannot be altered after conception. The state of health, depends partly on the genetic constitution of man. The positive health is when a person is able to express as completely as possible the potentialities of his genetic heritage (Dubos, 1969).

2) Environment: Environment is classified as internal and external. The internal environment of man pertains to each and every component part, every tissue, organ and organ system and their harmonious functioning within the system. It is a domain of internal medicine. The external environment consists of those things to which man is exposed after conception. (Last, 1983). It can be divided into physical, biological and psychological social components.
It is established that environment has a direct impact on the physical, mental and social well-being of those in it. It ranges from housing, water supply, psychological stress and family structure through social and economic support system, to the organization of health and social welfare sources in community.

3) **Life Style**: The term life style is a diffused concept often used to denote “the way people live”, reflecting a whole range of social values attitudes and articles (World Health Organization, 1986). It is composed of cultural and behavioral patterns and life long personal habits (smoking, alcoholism) that have developed through process of socialization. Life styles are learnt through social interaction with parents, peer groups, friends and siblings and through school and mass media.

Health requires the promotion of healthy life style (Wingard, 1982). Many current day health problems especially in developed countries are obesity, lung cancer and drug addiction. These are associated with life style changes. It may be noted that not all style factors are harmful. There are many that can actually promote health e.g. adequate nutrition, enough sleep, sufficient physical activity etc. Thus the achievement of optimum health demands adoption of healthy life styles. Health is both a consequence of an individuals life style as well as a factor in determining it (WHO, 1986).

4) **Socio-economic conditions**: Socio-economic conditions have long been known to influence human health. For the majority of the world’s people, health states is determined primarily by their level of economic development eg. education, nutrition, employment, housing etc. (Kohli, 1996; Chowdhary, 1992).

Financial resources are a major problem among the elderly.
Over the time the elderly lose economic independence as they retire from their work. Thus even affecting or reducing their social status, security and health condition. It has been found that those who belong to low socio-economic status suffer from various health problems than the high socio-economic status.

Economic progress helps in reducing mobility, increasing life expectancy and improving the quality of life. Illiteracy closely coincides with poverty, malnutrition, ill health, high mortality rates. Employment in productive work promotes health because the unemployed status usually show a higher incidence of ill health and death. The main obstacle to the implementation of health techniques are political. Decisions concerning resources, allocation and the degree to which health sources are made available to different segments of the society. (Banerji, 1985) are made at political level.

5) Health Services: The purpose of health services is to improve the health status of the population. The health service must reach the social periphery equally disturbed (World Health Organization, 1978).

There should be adoption of policies in the economic and social fields in raising the standards of living. This would include employment opportunities, prepaid medical programs and family support for the elderly.

Responsibility for Health: Health is on one hand a highly personal responsibility and on the other hand a major public concern.

1) Individual Responsibility: Health is a fundamental human right, it is essentially an individual’s responsibility. It has to be earned and maintained by the individual himself, who must accept a broad spectrum of
responsibilities, known as “self-care.”

Self care are those health generating activities that are undertaken by the persons themselves (WHO, 1982). In promoting their own health, preventing their own disease and restoring their own health. The older adults should indulge in self care activities as following a balanced diet, doing some exercise, following the precautions related to their physical problem, going for regular medical examination and taking medication on time.

2) **Community Responsibility**: The individual and community responsibilities are complementary. It implies a more active involvement of families and communities in health matters eg. planning, implementation, utilization, operation and evolution of health services. Shifting the emphasis from health care for the people to health care by the people (Park, 1997).

The state should assume responsibility for the health and welfare of its citizens. There should be assistance to the elderlies of government service as Central Government Health Scheme, Medical Reimbursement Scheme etc. enabling the older adults to get medical attention both out-door as well as indoor and should be extended to dependent family members of the pensioners. In recent times, there has been a noticeable and depressing death of the services provided. At times there is also lack of kindness and courtesy extended by the doctors and attendants. Usually, there are long queues and meagre stock of medicines.

Psychological concept of well-being is somewhat malleable which has to do with peoples’ feeling about their everyday life activities (Bladbeun, 1969; Ware and Walls, 1975; Compbell, 1976). Recently psychologists have pointed out that the ‘well-being’ of individual or group of individuals have objective and subjective components. The objective
components include "standard of living" and "level of living". The subjective component of well-being refers to "quality of life (Park, 1977).

i) **Standard of Living** : WHO has given the definition as "income and occupation, standards of housing, sanitation and nutrition. The level of provision of health, educational recreational and other services may all be used individually as measures of socio-economic status and collectively as an index of the standard of living" (Park, 1997).

The financial resources is one of the major problems to be found among the elderly. This seems to be higher among females than among males (Dak and Sharma, 1987). The elderly lose economic independence with age. The financial problem is common among widows and elderly in nuclear families. (Rajan et al., 1999). According to Kata & Mann (1996) socio-economic status is one of the strongest predictors/determinants of health and well-being.

With persons higher on socio-economic status enjoy better health than those with lower socio-economic status. (Andler, Boyle, Cheshey, Cohen and Edikman, 1994; Wills & Collins, 1995). Not only is it related to physical health but it is also a powerful predictor of variations in mental health. Elderlies are looked down upon burden as they have less to contribute financially have a lower standard of life with no one to cater to their needs (Rajan, Mishra et al., 1999).

2) **Level of Living** : The parallel term for standard of living used in United Nations documents is "level of living (Park, 1997). It consists of components: health, food consumption, education, occupation and working conditions, housing, social security, clothing, recreation and leisure and human rights. These factors are believed to influence well-being. Health is
considered as an important component of level of giving as its impairment means impairment of level of living.

According to Rajan et al., (1999) due to decline in the participation of work/retirement the elderly feel losing the status and social security they enjoyed. Due to which they are perceived as a burden and are deprived of their needs and care. Making the elderly helpless and further deteriorating their health and well being.

3) Quality of Life: Quality of life is (Park, 1997) a composite measure of physical, mental and social well-being. It is evaluated by assessing a person's subjective life concerns as health, family, financial situation, self-esteem, belongingness etc.

Rising number of nuclear families puts the elderly in a state of helplessness isolation and economic dependency (Rajan, et al., 1999). At times financial security is provided by the children but the emotional requirements are not fulfilled. This brings about feelings of meaninglessness and unhappiness. Leading to negative mental state.

The feelings of well-being may range from negative mental state (anxiety, depression, unhappiness, dissatisfaction etc.) through to a more positive outlook which extends beyond the mere absence of dissatisfaction or illness into a state which has been identified as a positive mental health (Berg, 1975; Jahola, 1958). The definition of positive mental health includes such features as favorable self-evaluation or self-esteem growth and learning from new experiences, a realistic freedom from constraints and some degree of personal success in various pursuits (Warr, 1978). Where the negative component of well-being are assessed through self-report of anxiety, depression, happiness and self-esteem (Deo and Sharma, 1971; Spielberger, Sharma and Singh, 1976; Spielberger and Sharma, 1976;
Warr (1978) has examined three kinds of measures of psychological well-being. One reported anxiety about specific features of everyday life; second takes ratings of life in general and third obtains material about positive and negative effect. Positive effect was associated with higher levels of social contact and more exposure to new experiences. Whereas negative effect was found to be associated with various indices of anxiety, fears of a nervous breakdown and physical symptom of ill-health. Warr (1978) further pointed out that well-being is not the same as happiness, although the latter is a component of the former.

Various studies have found that availability or absence of social support is linked with the occurrence or non-occurrence of many disease (Plisuk & Forland, 1978); with the prediction of high well-being (Plutips, 1981) and improvement of mental health (William, John & Donald, 1981).

Physical and mental state of health have a great influence, not only on the physical and mental development, but also on the social position and function. On the other hand, psychological factors and individuals socioeconomic situation greatly influence his or her health (Holland, Ipsen and Kostrzewski, 1979), WHO.