A STUDY OF POSITIVE AND NEGATIVE CONTRIBUTORS TO MENTAL HEALTH IN OLD AGE

STUDENTS RESEARCH PROJECT

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PREFACE

Old age is the closing period of the lifespan when people move away from previous and desirable periods of usefulness. The organic process of ageing is called senescence, the medical study of the aging process is called gerontology, and the study of diseases that afflict the elderly is called geriatrics. The chronological age denoted as "old age" varies culturally and historically, thus making old age more of a "social construct" rather than a "biological stage". Just like any other stage of life, old age has its own unique challenges and problems. Vocational and family adjustments in old age are complicated by economic factors which play a more important role now than they did previously. In addition to this, there is a steady decline in the physical as well as psychological capabilities. Old people often have limited regenerative abilities and are more susceptible to disease, syndromes, and sickness than younger adults. Moreover, problems of loneliness, boredom, decreased self esteem, decreased subjective wellbeing; increased social isolation and increased dependence on others tend to predominate. All of these have an effect on the mental health of the aged, and ultimately contributing to their patterns of adjustment.

Thus the present research aims to study the positive and negative contributors to mental health in old age.

Chapter 1, highlights the developmental phase of old age and its unique characteristics along with the psychosocial correlates of Perceived Burdensomeness and Thwarted Belongingness such as Happiness, Self Esteem , Loneliness and Coping which bring a change in their life, either in positive or negative aspects.

A literature survey covering different facets of the life of old age and the selected variables of the study is highlighted in Chapter 2.

Chapter 3 delineates the methodological plan and procedural details adopted for the present research work.

Chapter 4 highlights the results section. It depicts age difference and gender difference with respect to Perceived Burdensomeness and Thwarted Belongingness, Happiness, Self Esteem, Loneliness and Coping. Correlational analysis for the entire sample is also provided.

Chapter 5 provides the necessary, relevant and logical explanations to the hypotheses of the present study along with supportive research evidences.

The conclusions of the study along with limitations, originality of the present work and areas of further research are described in Chapter 6.

The following section provides the bibliography of books, journals, e-journals, articles and dissertations in alphabetical order. Last, but not the least, at the end, a set of Appendices has been supplemented.

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CHAPTER 1

INTRODUCTION

1.0 INTRODUCTION TO HUMAN DEVELOPMENT:

Human life starts from a single fertilized cell. This cell is under constant interaction with the environment in the mother's womb and after birth with the outside world. This interaction leads to the Growth and Development of the child. 'Growth' and 'Development' are often used as synonymous terms. But, in fact, growth is different from development. Growth means an increase in size, height, weight, length etc. which can be measured. Development, on the other hand, implies change in shape, form or structure resulting in improved working or in functioning. Improved functioning implies certain qualitative changes leading to maturity. Growth and Development are the important characteristics of a living organism. Development involves a series of progressive, orderly and meaningful changes leading to the goals of maturity. Normally Growth contributes to Development. Generally process of Growth and Development goes on simultaneously.

1.1 DIFFERENCE BETWEEN GROWTH AND DEVELOPMENT:

After going through the meaning and concept of growth and development, now we are going to identify the relationship between the two, which are as follows:

1. The term growth generally refers to an increase in size, length, height and weight. Changes in the quantitative aspects come into the domain of growth. Development implies overall changes in shape, form or structure resulting in improved working or functioning. It indicates the changes in the quality or character rather than in quantitative aspects.

2. In a strict sense, development in its quantitative aspect is termed as growth. Development is a wider and comprehensive term. It refers to overall changes in the individual.

3. Growth does not continue throughout life. It stops when maturity has been attained. Development is a continuous process, continues throughout the life span of an individual.

4. The changes produced by growth are the subject of measurement. They may be quantified. Development implies improvement in functioning and behaviour and hence brings qualitative changes which are difficult to be measured directly.

1.2 HUMAN DEVELOPMENT:

Human Development involves a series of progressive and incremental changes from conception till death, i.e. across a lifespan. Life-span developmental psychology involves the study of constancy and change in behavior throughout the life course. One aspect of life-span research has been the advancement of a more general, metatheoretical view on the nature of development.

It is usually assumed that child development, rather than lifespan development, was the subject matter of the initial scholarly pursuits into psychological ontogenesis. Several historical reviews suggest that this generalization is inaccurate (**Baltes, 1983;Groffmann, 1970;Reinert, 1979**). Lifespan development has begun to be studied empirically only during the last two decades by researchers following the lead of early twentieth century psychologists such as **Charlotte Biihler (1933),Erik H. Erikson (1959),G. Stanley Hall (1922),and Carl G. Jung (1933).**

Life-span development is the Ontogenetic development is a life-long process. No age period holds supremacy in regulating the nature of development. During development, and at all stages of the life span, both continuous (cumulative) and discontinuous (innovative) processes are at work.

According to **Hurlock (2002)**, old age is the closing period of life span. It is a period when people move away from previous more desirable periods or times of usefulness. Age sixty is usually considered as the dividing line between middle and old age. In her book 'Developmental Psychology' tries to find out the characteristics of old age. She points out that 'old age' is characterized by mental and physical decline, and also the elderly have minority group status. That is a status which excludes them to some extent from interaction with other groups in the population and which gives them little or no power. She states that the minority status is the result of the unfavourable social attitudes towards the aged that have been fostered by the stereo types of them. She also signifies that poor adjustment is a characteristic of old age. Elders usually develop unfavorable self concepts. This tends to be expressed in maladjustive behavior of different degrees of security. Of the many adjustments centering around family relationships that the elderly person must make, the five most important involve relationship with a spouse, changes in sexually behavior, relationship with off-spring, parental dependency

and relationship with grandchildren **(Hurlock, 2002)**. According to her, the desire for rejuvenation is another characteristic feature of old age. They have to adjust with physical, psychological as well as economic conditions.

Old age is a vague and ill-defined term as it is difficult to draw a clear line to divide middle from old age (**Gajendragadkar, 1983)**. Old age means reduced physical ability, declining mental ability, the gradual giving up of role playing in socio-economic activities, and a shift in economic status moving from economic independence to economic dependence upon other's for support. Old age is called "dark" not because the light fails to shine but because people refuse to see it **(Gowri, 2003)**. The pattern of family life, established in old age, starts to change with the onset of middle age. These changes are made more pronounced by retirement, with the accompanying reduced income, or by the death of spouse in old age.

In common usage the terms "aged and the ageing" refer to a particular section of the population and the process. The ageing process is a biological reality which has its own dynamics, largely beyond human control. Ageing may imply a mental decline, or a loss of cognitive capacity **(Rohwedder and Willis, 2010).** Ageing can be considered as the sum of all changes anatomical, physical, biochemical, and functional that occurs in man with passage of time and leads to functional impairment and eventually death. The urge to live, the fear of death, the desire for youth, the distaste for old age and quest for rejuvenation have always interested mankind **.** It is a problem of almost every family, involving strains of caring and stresses of intergenerational interactions. This has become an important socio-psychological problem in our society today. Ageing is every body's problems as everyone is bound to age and experience its impact. Since ageing is a process rather than an event, it is not possible to set a point in life when it can be said 'starting today-you are old'.

1.3 AGE RANGE OF OLD AGE:

Old age is a period in a person's life when body systems start to diminish in functionality. There is no specific age to describe old age. According to **Robertson (1996)** in his discussion about 'what is old age', he stated that the age of retirement for judges in UK is 70 years and the age at which a woman is placed on pension would be raised to 65 years.

The Elderly could be referred to as people that are older than 60 years; some people set it to be 65 while some authors raised it to be person at his or her 70 years of age or older

(**Kotkamp-Mothes,Slawinsky, Hindermann and Strauss, 2005**). Therefore, old age could be described as a period in life of a man when he cannot not adapt properly to what he had previously adapted to (**Toner, Kampen and Scholz, 2003**).The notion of old age varies from one society to the other. In the developed world, chronological time acts as a determining factor. The age of 60 or 65, roughly equivalent to retirement ages in most developed countries is said to be the beginning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people; in some cases it is the loss of roles accompanying physical decline which is significant in defining old age. Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age in many developing countries is seen to begin at the point when active contribution is no longer possible **(Gorman, 2000)**.

There are three cut off for the aged-55years, 60 years and 65 years. In Indian context, people who have attended 60 years and above are considered old, though in developed countries it begins only at 65. But chronological age are not satisfactory criteria for determining old age because there individual variations in the rate of physiological ageing. Some people look old and behave young even at the age of 70 years, while others appear quite aged physically at 50 years or even below 50 years.

Most of the works related to ageing Issues have been done in the western countries. The Indian literature or ageing indicates that in India the study on ageing have started in South India which was mainly on psychological aspects of ageing. In India Gerontology and Geriatrics is passing through its infancy.

1.4 DEVELOPMENT TASK:

Havighurst (1953) prepared a developmental model in which he has presented the list of developmental tasks from birth to old age. Every cultural group expects its members to master certain essential skills and acquire certain approved patterns of behaviour at various ages during the life span. Havighurst has labelled them developmental tasks.

A developmental task is one that arises predictably and consistently at or about a certain period in the life of the individual **(Havighurst, 1948, 1953)**. According to him a developmental task is ‘a task which arises at or about a certain period in the life of the individual, successful

achievement of which leads to happiness and to success with later tasks, while failure leads to unhappiness and difficult with later tasks'.

The concept of developmental tasks assumes that human development in modern societies is characterized by a long series of tasks that individuals have to learn throughout their lives. Some of these tasks are located in childhood and adolescence, whereas others arise during adulthood and old age **(Heckhausen, 1999)**. Although most people would like to master these tasks at the appropriate time, some are unable to do so, while others are ahead of schedule. Though these tasks are applicable to American population, they are generally accepted to be applicable to all. Successful achievement of a certain task is expected to lead to happiness and to success with later tasks, while failure may result in unhappiness in the individual, disapproval by the society, and difficulty with later tasks.

Developmental tasks arise from three different sources **(Havighurst, 1948, 1953)**. First, some are mainly based on physical maturation (e.g., learning to walk). Another source of developmental tasks relates to sociostructural and cultural forces. Such influences are based on, for instance, laws (e.g., minimum age for marriage) and culturally shared expectations of development (e.g., age norms; **Neugarten, Moore, and Lowe, 1965**), determining the age range in which specific developmental tasks have to be mastered. The third source of developmental tasks involves personal values and aspirations. These personal factors result from the interaction between ontogenetic and environmental factors, and play an active role in the emergence of specific developmental tasks (e.g., choosing a certain occupational pathway).

Old age has often been characterized as a period of loss and decline. However, development in any period of life consists of both gains and losses, although the gain-loss ratio becomes increasingly negative with advancing age **(Heckhausen, Dixon, and Baltes, 1989; Baltes, 1987)**. A central developmental task that characterizes the transition into old age is adjustment to retirement. The period after retirement has to be filled with new projects, but is characterized by few valid cultural guidelines. Adaptation to retirement involves both potential gains (e.g., self-actualization) and losses (e.g., loss of self-esteem). The achievement of this task may be obstructed by the management of another task, living on a reduced income after retirement.

In addition, older adults are generally challenged to create a positive sense of their lives. They also have to adjust to decreasing physical strength and health. The prevalence of chronic

and acute diseases increases in old age. Thus, older adults may be confronted with life situations that are characterized by not being in perfect health, serious illness, and dependency on other people. Moreover, older adults may become caregivers to their spouses **(Schulz and Beach, 1999)**. Some older adults have to adjust to the death of their spouses. This task arises more frequently for women than for man. After they have lived with a spouse for many decades, widowhood may force older people to adjust to loneliness, moving to a smaller place, and learning about business matters.

The development of a large part of the population into old age is a historically recent phenomenon of modern societies. Thus, advancements in the understanding of the aging process may lead to identifying further developmental tasks associated with gains and purposeful lives for older adults.

The characteristic behaviours of older people often mistakenly considered mere symptoms of decrepitude, are in actuality what we call the Psychological Tasks of old age. These Psychological Tasks of old age are:

- Slowing
- Life review
- Transmission
- Letting go

1.4.1 SLOWING:

The most obvious mark of mortality we see in elderly is that they have slowed down. This slowing is an extremely gradual process, except in cases of physical trauma or illness. It begins in the thirties and continues throughout life. The physical slowing of advanced age is a completely pervasive experience. For extremely old person, a large part of the day is consumed by the tasks of bodily maintenance. This deceleration has powerful psychological implications. Our fast paced culture does little to accommodate the slowing of age and infirmity. The panic and confusion that older people experience when confronted with situations moving too quickly for them can have tragic results. They can lead to serious depression. In this configuration, moments of forgetfulness or disorientation create anxiety, which in turn creates dependence, more forgetfulness, more fear and anxiety, and finally the kind of confused, withdrawn behavior

that leads to the categorization of 'senility'. Given this scenario, it is not surprising that many elderly people withdraw increasingly into isolation.

1.4.2 LIFE REVIEW:

The process of slowing gives rise to what **Dr. Robert Butler (1975)** refers to as "life review". The term "life review" implies a conscious process of systematic reflection. This process may indeed be rational and systematic, as in the cases of older people who sort through all their possessions, deciding who will inherit them upon their death, or who undertake the writing of an autobiography. There is, however, a dream-like quality of the life review process, which gathers momentum from a growing awareness of mortality and from the growing weight of a lifetime of experiences and impressions. Dr. Butler describes "the progressive return to consciousness of past experiences, in particular the resurgence of unresolved conflicts which can now be surveyed and reintegrated".

1.4.3 TRANSMISSION:

The fruit of life review for the elderly is the accomplishment of transmission, or handing onto others the essence of their knowledge of the world around them: how to do things; how to think about other things; how to simply be. Transmission happens on many levels. Obviously, transmission is what is told and given, but it is also in the atmosphere shared.

1.4.4 LETTING GO:

All of the Psychological Tasks of old age are part of the letting go process. Slowing is a beginning, the gradual reversal of the momentum of a lifetime. It means a lot of shifting gears from the process of accumulation of experiences, objects, and relationships that characterizes the youth and middle age, to the old age process of sorting and giving away. Life review and transmission are a kind of tidying up before one goes. Letting go has been described as 'making one's peace' or the acceptance of death. The letting go process is marked by tremendous tenderness. It does not necessarily precede physical death. Sometimes there are obstacles to letting go, such as the aggression of an institutional environment, unresolved family issues or the absence of caregivers adequate to support and facilitate the process. Sometimes letting go happens in response not to one's own death, but to a loss or personal tragedy of some kind. Letting go may not be brief transition, it can take years. This process may be frightening both to

old people and to their families. What we think of senility-confusion, and physical and psychological frailty-often has to do with letting go.

The intrinsic structure observed in the Psychological Tasks of old age requires a specific stance on the part of the therapist, family member, or caregiver working with an elderly person.

1.5 THEORIES OF AGING:

Theories of ageing describe the ageing process and what ageing implies. These theories are, therefore, of interest for gerontological nurses. **Schroots (1996)** categorized these theories as psychosocial theories of ageing and described those most well known. Psychosocial theories of ageing attempt to explain human development and ageing in terms of individual changes in cognitive functions, behaviour, roles, relationships, coping ability and social changes. These theories do not describe how older people could be treated or what is important in care of older people. However, they are interesting because they describe what ageing implies and because we should, therefore, be able to derive from them factors that are important in nursing. One relevant study would be to analyse psychosocial theories of ageing to discover whether they could be used as theoretical bases for gerontological nursing care.

The care and treatment of older people are affected by the knowledge and views that staff and society have about the implications of ageing. What one considers as important in the care of older people depends largely on one's theoretical perspective. Nurses' theoretical perspectives on ageing have been learned through societal norms and values.

Two prominent theories related to ageing are:

1. Activity theory **(Havighurst,1961)**
2. Disengagement theory **(Cumming & Henry, 1961)**.

According to Activity theory, the maintenance and continuation of activities and attitudes of the middle ages, give satisfaction and thereby lead to adjustment in older ages. Actively participating in family affairs and other social group activities give them a sense of being useful to themselves and others. The basic idea of the activity theory is that there is a positive relationship between activity and life satisfaction that the greater the role loss, the lower is the life satisfaction but according to the disengagement theory, as individuals grow older,

both individuals and society withdraw from each other. People automatically avoid activities and social participation. This process is natural. Social disengagement involves less involvement with other people, a greater use of mental ability, and less participation in physical activity.

Well-being and health play an important role in old age. Mental health is a crucial component of overall health and well-being. Mental health is the positive ability to enjoy life and cope with its difficulties. It is a resource that enables one to grow and learn and experience life as enjoyable and fulfilling.

1.6 MENTAL HEALTH:

Several steps are necessary in defining positive mental health. The first step is to note that "average" is not healthy; it always includes mixing in with the healthy the prevalent amount of psychopathology in the population. For example, in the general population, being of "average" weight or eyesight is unhealthy, and if all sources of bio-psychosocial pathology were excluded from the population, the average IQ would be significantly greater than 100. The second step in discussing mental health is to appreciate the caveat that what is healthy sometimes depends on geography, culture, and the historical moment. Sickle cell trait is unhealthy in New York City, but in the tropics, where malaria is endemic, the sickling of red blood cells may be lifesaving. The third step is to make clear whether one is discussing *trait* or *state*. Who is physically healthier—an Olympic miler disabled by a simple but temporary (state) sprained ankle or a type 1 diabetic (trait) with a temporarily normal blood sugar? In cross-cultural studies such differences become especially important. Superficially, an Indian mystic in a state of trance may resemble a person with catatonic schizophrenia, but the mystic does not resemble someone in the schizophrenic condition over time. The fourth and most important step is to appreciate the twofold danger of "contamination by values." On one hand, cultural anthropology teaches us how fallacious any definition of mental health can be. Competitiveness and scrupulous neatness may be healthy in one culture and regarded as personality disorders in another. Furthermore, if mental health is "good," what is it good for? The self or the society? For "fitting in" or for creativity? For happiness or survival? And who should be the judge? (**Sadock, Sadock, Ruiz, 2014**).

Six different empirical approaches to mental health have been contrasted. First, mental health can be conceptualized as *above normal* and a mental state that is objectively desirable, as in Sigmund Freud's definition of mental health which is the capacity to work and to love.

Second, from the viewpoint of healthy adult development, mental health can be conceptualized as *maturity*. Third, mental health can be conceptualized in terms of *positive psychology*—as epitomized by the presence of multiple human strengths. Fourth, mental health can be conceptualized as *emotional intelligence* and successful object relations. Fifth, mental health can be conceptualized as *subjective well-being*—a mental state that is subjectively experienced as happy, contented, and desired. Sixth, mental health can be conceptualized as *resilience*, as the capacity for successful adaptation and homeostasis (**Sadock, Sadock, Ruiz, 2014**).

1.6.1 Model A: Mental Health as Above Normal

This first perspective differs from the traditional medical approach to health and illness. No manifest psychopathology equals mental health. In this medical model, if one were to put all individuals on a continuum, normality would encompass the major portion of adults, and abnormality would be the small remainder. This definition of health correlates with the traditional role model of the doctor who attempts to free his patient from grossly observable signs of illness. In other words, in this context health refers to a reasonable, rather than an optimal, state of functioning. Yet, as already pointed out, mental health is not normal; it is above average. Some believe that true mental health is the exception, not the rule. Moreover, until recently some believed that mental health was imaginary.

1.6.2 Model B: Mental Health as Maturity

Unlike other organs of the body that are designed to stay the same, the brain is designed to be plastic. Therefore, just as optimal brain development requires almost a lifetime, so does the assessment of positive mental health. The association of mental health to maturity is probably mediated not only by progressive brain myelination into the sixth decade but also by the evolution of emotional and social intelligence through experience. Erik Erikson conceptualized that such development produced a "widening social radius." In Erikson's model the adult social radius expanded over time through the mastery of certain tasks such as "Identity versus Identity Diffusion," "Intimacy versus Isolation," Generativity versus Stagnation," and "Integrity versus Despair." (**Sadock, Sadock, Ruiz, 2014**).

1.6.3 Model C: Mental Health as Positive or "Spiritual" Emotions

This model defines both mental and spiritual health as the amalgam of the positive emotions that bind us to other human beings. Love, hope, joy, forgiveness, compassion, faith,

awe, and gratitude comprise the important positive and "moral" emotions included in this model. Of great importance, these selected positive emotions all involve human connection. None of the emotions listed is just about the self.

1.6.4 Model D: Mental Health as Socio-emotional Intelligence

High socio-emotional intelligence reflects above-average mental health in the same way that a high intelligence quotient (IQ) reflects above average intellectual aptitude. Such emotional intelligence lies at the heart of positive mental health.

1.6.5 Model E: Mental Health as Subjective Well-Being

Positive mental health does not just involve being a joy to others; one must also experience subjective well-being. Long before humankind considered definitions of mental health, they pondered criteria for subjective happiness. For example, objective social support accomplishes little if subjectively the individual cannot feel loved. Thus, capacity for subjective well-being becomes an important model of mental health. Subjective well-being is never categorical. Healthy blood pressure is the objective absence of hypotension and hypertension, but happiness is less neutral. Subjective well-being is not just the absence of misery, but the presence of positive contentment. Nevertheless, if happiness is an inescapable dimension of mental health, happiness is often regarded with ambivalence. If through the centuries philosophers have sometimes regarded happiness as the highest good, psychologists and psychiatrists have tended to ignore it. Subjective happiness can have maladaptive as well as adaptive facets. The search for happiness can appear selfish, narcissistic, superficial, and banal. Pleasures can come easily and be soon gone. Happiness is often based on illusion or on dissociative states. Illusory happiness is seen in the character structure associated with bipolar and dissociative disorders. Maladaptive happiness can bring temporary bliss but has no sticking power. (**Sadock, Sadock, Ruiz, 2014**).

The mental health issues involved in subjective well-being are complicated and clouded by historical relativism, value judgment, and illusion. Europeans have always been skeptical of the American concern with happiness. Only in the last decade have investigators pointed out

that a primary function of positive emotional states and optimism is that they facilitate self-care. Subjective wellbeing makes available personal resources that can be directed toward innovation and creativity in thought and action. Thus, subjective wellbeing, like optimism, becomes an antidote to learned helplessness. Again, controlling for income, education, weight, smoking, drinking, and disease, happy people are only half as likely to die at an early age or become disabled as unhappy people. A distinction can be made between *pleasure* and *gratification.* Pleasure is in the moment, is closely allied with happiness, and involves the satisfaction of impulse and of biological needs. Pleasure is highly susceptible to habituation and satiety. If pleasure involves satisfaction of the senses and emotions, gratification involves joy, purpose, and the satisfaction of "being the best you can be" and of meeting aesthetic and spiritual needs. Subjective (unhappy) distress can be healthy. As ethologically minded investigators have long pointed out, subjective negative affects (e.g., fear, anger, and sadness) can be healthy reminders to seek environmental safety and not to wallow in subjective well-being. If positive emotions facilitate optimism and contentment, fear is the first protection against external threat; sadness protests against loss and summons help, and anger signals trespass.

1.6.6. Model F: Mental Health as Resilience

There are three broad classes of coping mechanisms that humans use to overcome stressful situations. First, there is the way in which an individual elicits help from appropriate others: Namely *consciously seeking social support.* Second, there are *conscious cognitive strategies* that individuals intentionally use to master stress. Third, there are *adaptive involuntary coping mechanisms* (often called "defence mechanisms") that distort our perception of internal and external reality in order to reduce subjective distress, anxiety, and depression (**Sadock, Sadock, Ruiz, 2014**).

1.7. SELECTED VARIABLES OF THE STUDY

In order to understand the nature of subjective well being in old age, certain variables have been considered for the present research.

1.7.1 PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS

"Thwarted belongingness is a psychologically painful mental state that results when the fundamental need for connectedness- described by **Leary, Terdal, Tambor, and Downs (1995)** as the "need to belong"- is unmet (**Cacioppo & Patrick, 2008**). Perceived burdensomeness is a mental state characterized by apperceptions that others would "be better off if I were gone," which manifests when the need for social competence that is posited by frameworks including self-determination theory (**Ryan & Deci, 2000**) is unmet. Thwarted Belongingness refers to a sense of profound alienation, including the feeling that one is not an integral part of any valued group, such as a family, a circle of friends, or society in general **(Van Orden, Witte, Cukrowicz, Braithwaite, Selby and Joiner Jr., 2010)**. The two main hypothesized components of thwarted belongingness are loneliness and an absence of reciprocal care, defined as relationships "in which individuals both feel cared about and demonstrate care of another" (**Van Orden, Witte, Cukrowicz, Braithwaite, Selby and Joiner Jr., 2010**). In contrast, perceived burdensomeness refers to a self-view that one is defective and flawed, to the point of being a liability to others (**Van Orden, Witte, Cukrowicz, Braithwaite, Selby and Joiner Jr., 2010**). The two main hypothesized components of perceived burdensomeness are liability and self-hate **(Van Orden, Witte, Cukrowicz, Braithwaite, Selby and Joiner Jr., 2010)**. This feeling of perceived burdensomeness and thwarted belongingness often leads to an overwhelming sense of loneliness and isolation.

The definitions used for both thwarted belongingness and perceived burdensomeness mentioned the importance of interpersonal connectedness, with thwarted belongingness signifying the absence of positively valenced connections and perceived burdensomeness signifying the presence of negatively valenced connections **(Van Orden & Conwell, 2011)**. The theory proposes that family discord **(Duberstein, Conwell, Conner, Eberly, & Caine, 2004; Heikkinen, Aro, and Lönnqvist, 1994)**, unemployment **(Brown, Beck, Steer, & Grisham, 2000; Heikkinen, Aro, and Lönnqvist, 1994)**, and functional impairment **(Conwell, Lyness, Duberstein, Cox, Seidlitz, DiGiorgio and Caine, 2000; Conwell, Duberstein, Hirsch, Conner, Eberly, and Caine, 2010)** are associated with suicide across the life span because these factors are likely to engender perceptions of burdensomeness on others. Thwarted belongingness and perceived burdensomeness are proposed to be the most proximal mental states that precede the development of thoughts of suicide—stressful life events, mental disorders, and other risk factors for suicide are relatively more distal in the causal chain of risk factors for suicide.

While the association between connectedness and suicide-related outcomes has received more research attention, much less is known about perceived burdensomeness. The few existing studies that examined perceived burdensomeness have shown that it is associated with higher suicide risk. In a study of suicide notes, the notes of those who died by suicide were found to contain more perceived burdensomeness compared to the notes of those who survived their suicide attempts **(Joiner, Van Orden, Witte, Selby, Riberio, Lewis and Rudd, 2009)**. In a study involving adult outpatients, perceived burdensomeness was also associated with current suicidal ideation and past number of suicide attempts; importantly, this effect was significant even after controlling for hopelessness **(Van Orden, Witte, Gordon, Bender and Joiner Jr., 2008)**. Late life is often associated with a number of interpersonal losses, including autonomy, relationships, roles, and status **(Segal, Qualls, & Smyer, 2011)**. These factors might help to explain the high rate of completed suicide among older adults as compared with the general population. Unfortunately, the scope of suicide among older adults is likely to grow in the future as the baby boom cohort ages **(Conwell, Van Orden, & Caine, 2011)** Whereas research on suicide among older adults has uncovered a number of demographic risk factors (**Heisel, 2006**), there is still a clear need for assessment of suicide risk that goes beyond demographic factors in order to improve suicide prevention efforts.

Further, thwarted belongingness and perceived burdensomeness are posited to be dynamic and amenable to therapeutic change. Implicit in our discussion thus far is the interpersonal theory's assumption that thwarted belongingness and perceived burdensomeness are distinct, but related constructs—that they occupy neighbouring, but separate spaces in the nomological net for suicidal behaviour **(Cronbach & Meehl, 1955)**, and thus, that they are no redundant constructs.

Thwarted belongingness, loneliness, the self-determination theory concept of relatedness **(Deci & Ryan, 2000; Ryan & Deci, 2000)** and social support should occupy neighbouring, but distinct positions in the nomological net for suicidal desire (i.e., related, but distinct constructs). These constructs can be conceptualized as measuring the higher order construct of social connectedness at varying levels of analysis **(Berkman, Glass, Brissette, & Seeman, 2000)**, including intermediate levels (i.e., loneliness and social support) and the most micro level that presumably measures inner needs or states (i.e., belongingness and relatedness). Similarly perceived burdensomeness, responsibility to family (as a reason for living), competence, and

autonomy should occupy neighbouring, but distinct positions in the nomological net, as responsibility to family involves beliefs that one is an important contributor to the family (i.e., rather than a burden), and competence and autonomy—both self-determination theory constructs—indicate a sense of self-efficacy and mastery across many domains, including academics, work, and so on.

1.7.2 HAPPINESS

Happiness is highly valued in present day society. Not only do people aim at happiness in their own life but there is also growing support for the idea that we care for the happiness of other people **(Bentham, 1789)**. Happiness is commonly understood as *how much one likes the life one lives*, or more formally, the degree to which one evaluates one's life-as-a-whole positively. A central element in this definition is subjective 'evaluation' or 'liking' of life, also referred to as 'satisfaction' with life. When used in a broad sense, the word happiness is synonymous with 'quality of life' or 'well-being"

Different *descriptive* theories of how we assess how happy we are have great implications for *prescriptive* theories of happiness. The Set-point theory sees the evaluation as a stable attitude towards life and focuses more on the mental processes that maintain this attitude than on the processes that have brought it about. The Comparison theory sees evaluation rather as a continuous judgment process involving the comparison of perceptions of life-as-it-is with notions of how-life-should be. Affect theory sees happiness also as a continuous mental process, but now as an appraisal of how well one feels usually. Set-point theory, and to a lesser extent also comparison theory, implies that there is little value in happiness and that there is also little chance of furthering happiness enduringly and this goes against the utilitarian tenet that we should aim at greater happiness for a greater number.

The various theories of happiness can be used to study how happy individuals are during the closing phases of their lives. During old age, when they feel that they are neglected by their grown children or other family members, when they develop a "nobody loves me" complex, it is inevitable that they would be unhappy **(Hurlock, 2002)**. Even though all these conditions contribute to happiness in old age, it is not essential that they all be present in order for the elderly person to be happy. Some studies show that the elderly may be more prone to depression

and loneliness, which can lead to higher rates of unhappiness, not a surprise given the health and emotional challenges that tend to accompany aging. Furthermore, because people have different needs, what bring happiness to one in old age may not bring happiness to another. On the other hand, because the pattern of life that bring happiness in old age is usually similar to the pattern that brought happiness in the closing year of life is the opportunity to continue the lifestyle that previously led to happiness **(Hurlock, 2002)**.

1.7.3 SELF ESTEEM

Often, high self esteem has been seen to be accompanied with high levels of happiness. The term **self-esteem** is used to describe a person's overall sense of self-worth or personal value. Self-esteem is often seen as a personality trait, which means that it tends to be stable and enduring. Self-esteem can involve a variety of beliefs about the self, such as the appraisal of one's own appearance, beliefs, emotions, and behaviours. Self-esteem is an outcome of, and necessary ingredient in, the self-verification process that occurs within groups, maintaining both the individual and the group. Verification of role identities increases an individual's worth-based and efficacy-based self-esteem. The self-esteem built up by self-verification buffers the negative emotions that occur when self-verification is problematic, thus allowing continued interaction and continuity in structural arrangements during periods of disruption and change. Last, a desire for self-esteem produced in part through self-verification, stabilizes the group because it motivates individuals to form and maintain relationships that verify identities. Self-esteem continues to be one of the most commonly researched concepts in social psychology **(Baumeister, Heatherton, Tice, 1993; Mruk, 1995; Wells & Marwell, 1976; Wylie, 1979)**. This focus on self esteem has largely been due to the association of high self-esteem with a number of positive outcomes for the individual and for society as a whole **(Baumeister, Heatherton, Tice, 1993; Smelser, 1989)**. Moreover, the belief is widespread that raising an individual's self esteem (especially that of a child or adolescent) would be beneficial for both the individual and society as a whole. Self-esteem refers most generally to an individual's overall positive evaluation of the self **(Gecas, 1982; Rosenberg, 1990)**. It is composed of two distinct dimensions, competence and worth **(Gecas 1982; Gecas & Schwalbe, 1983)**. The competence dimension (efficacy-based self-esteem) refers to the degree to which people see

themselves as capable and efficacious. The worth dimension (worth-based self-esteem) refers to the degree to which individuals feel they are persons of value.

Researchers have made it clear that there are three types of self esteem:

1.7.3.1 Global Self-Esteem (Trait Self-esteem): Sometimes self-esteem is used to refer to a personality variable that represents the way people generally feel about themselves. Researchers call this form of self-esteem, global self-esteem or trait self esteem, as it is relatively enduring across time and situations.

1.7.3.2 Feelings of Self-Worth (State Self Esteem): Self-esteem is also used to refer to self evaluative emotion reactions to valence events. This is what people mean when they talk about experiences that "threaten self-esteem" or "boost self-esteem." For example, a person might say her self-esteem was sky high after getting a big promotion or a person might say his self-esteem plummeted after a divorce. Following **James (1890)**, we refer to these self-evaluative emotional reactions as feelings of self-worth. Feeling proud or pleased with ourselves (on the positive side), or humiliated and ashamed of ourselves (on the negative side) are examples of what we mean by feelings of self-worth.

1.7.3.3 Self-Evaluations (Domain Specific Self-Esteem): Finally, self-esteem is used to refer to the way people evaluate their various abilities and attributes. For example, a person who doubts his ability in school may be said to have low academic self-esteem and a person who thinks she is good at sports may be said to have high athletic self-esteem. The terms self confidence and self-efficacy have also been used to refer to these beliefs and many people equate self confidence with self-esteem. We prefer to call these beliefs self-evaluations or self-appraisals, as they refer to the way people evaluate or appraise their physical attributes, abilities, and personality characteristics.

Theories of self-esteem development provide little direction, and, again, more general theories of aging might provide insights. According to role theories, the role losses experienced during old age are stressful and difficult to cope with **(Bush & Simmons, 1981)**, suggesting that life transitions such as retirement might contribute to deteriorating self-esteem. However, **Reitzes, Mutran, and Fernandez (1996)** failed to find that retirement produced a drop in self-esteem in their longitudinal data. Old age involves a number of other changes that might contribute to declines in self-esteem, including spousal loss, decreased social support, declining

physical health, cognitive impairments, and a downward shift in SES **(Baltes & Mayer, 1999)**. Moreover, it is difficult to reconcile why any of these factors might lead to deteriorations in self-esteem but not in other aspects of psychological adjustment. Several theories of aging suggest an alternative perspective**. Erikson (1968)**, **Neugarten(1977)**,**Levinson (1978)**, **Baltes and Mayer (1999)**, and others hold that persons in old age tend to be wiser and more comfortable with themselves.

1.7.4 LONELINESS

Loneliness, as defined by **Victor, Scambler, Bowling and Bond (2005)** is the 'deprivation of social contact, the lack of people available or willing to share social and emotional experiences, a state where an individual has the potential to interact with others but is not doing so and a discrepancy between the actual and desired interaction with others'. This is interesting given that some researchers and existential philosophers suggested that loneliness is a universal emotion; felt by almost (if not) all persons at some point in time or another **(Miujuskovic, 1979; Moustakas, 1961, 1972; Rotenberg, 1999)**. **Perlman and Peplau (1981)** view loneliness as "the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively". "Many of us in today's world are living on the verge of a lonely life. A significant number of us have experienced the ravages of loneliness; some of us have become debilitated, depressed and demoralized by it"**(Sadler, 1987).**

According to **Weiss (1973),** loneliness can be divided into experience of emotional isolation or of social isolation. Emotional isolation represents the subjective response to the absence of a close and intimate attachment figure, e.g. the lack of a loved one or a spouse. Emotional loneliness is a subjective feeling and it can only be quantified by the individual experiencing it (**Andersson, 1998**). **Weiss (1973**) defines social isolation as a situation where a person does not have a social network or is dissatisfied with the present social network (**Weiss, 1973**). Other researchers refer to social isolation by the number of contacts and integration of an individual into the surrounding social environment (**Cattan, White, Bond and Learmouth, 2005).**

Zimmerman (1985-1986) differentiated between a positive and a negative type of loneliness. The positive type of loneliness is related to situations such as the voluntary withdrawal from the daily hassles of life and is oriented toward higher goals: reflection, meditation, and communication with God. Nowadays, the positive type of loneliness is more frequently referred to by a separate concept: privacy. Privacy is voluntary; it concerns a freely chosen situation of temporary absence of contacts with other people. The negative type of loneliness is related to an unpleasant or inadmissible lack of personal relationships and contacts with important others. Both loneliness and a feeling of burdensomeness are negative aspects of life and strike a severe blow to the self esteem to the individual.

1.7.5 COPING

A crucial way to remain happy and satisfied with life by adjusting to problems is by coping to it. According to **Lazarus and Folkman (1984)**, who are considered the founders of the related research, coping is defined as "ongoing cognitive and behavioural efforts to manage specific (external and/or internal) demands that are appraised as taxing or exceeding the resources of the person." (**Lazarus & Folkman 1984)**.

Coping was given a proper definition in 1979 **(Cohen & Lazarus, 1979)** and described as a nursing practice. It was categorized under the word "mechanism" in relation to psychological adaptation (**Kaba & Shanley, 1998)**. Since 1979, coping has assumed an important position in nursing profession and lots of authors have contributed to its recognizability. "Coping consists of efforts, both action-oriented and intra-psychic, to manage (i.e. master, tolerate, reduce, minimize) environmental and internal demands and conflicts among them" **(Cohen & Lazarus, 1979).** The main axis of all the definitions which have been suggested at times is the "struggle" against external and internal adversities, conflicts and intense emotions. Coping differs from adjustment, a related concept, in that the latter is more general, has a broader meaning and includes diverse -not only intentional- ways of facing a difficulty **(Lazarus & Folkman, 1984; Chang, Hancock, Johnson, Daly & Jackson, 2005; Gil-Monte, 2005; Aldwin, 2007; Papazisis, Tsiga, Papanikolaou, Vlasiadis, & Sapountzi-Krepia, 2008; Papazisis, Vlasiadis, Papanikolaou, Tsiga, & Sapountzi-Krepia, 2008a; Zyga, 2010; Karasavvidis, Avgerinou, Lianou, , Priftis, Lianou & Siamaga, 2011; Zyga, 2013). Lazarus & Folkman (1984)**, using an individual's direction of actions as classification criteria, have suggested the known discrimination between problem focused strategies and

emotion focused strategies. A similar classification discriminates between approach strategies and avoidance strategies **(Herman & McHale, 1993)**. Both types of strategy have been called both engagement strategies and disengagement strategies, respectively **(Tobin, Holroyd, Reynolds, and Wigal 1989).**Researchers agree that how people cope makes a material difference to the impact which stressful life events (including illnesses and chronic medical conditions) will have on them, both concurrently and long-term. However, the nature of these coping processes and how to assess them remain issues of hot contention. Researchers are slowly coming to grips with the notion that coping reflects the functioning of an entire system. The simplest implication of this view is that it is not possible to understand coping by looking only at coping itself. Coping actions emerge from a coping system, the elements of which have been pretty well identified. They include the coping individual as well as the stressor, the person's appraisals, the personal and social resources and liabilities in the situation, and the history of outcomes of previous coping efforts. Because ways of coping emerge from (and are diagnostic of) this entire system, there has been controversy about how to interpret their meaning.

When coping was considered a manifestation of ego processes or of personality, maladaptive coping indicated an immature person or a neurotic personality. As coping came to be seen as situation-specific, no ways of coping could be considered 'maladaptive': they were all suited to their particular demands and contexts. However, considering coping as a system reveals a third alternative. On the one hand, some ways of coping are maladaptive, as recognized by any parent, teacher, spouse, or friend. These are ways of coping, such as helplessness, rumination, or exploding, which are detrimental in the long run, or developmentally maladaptive, because they weaken the coping system, robbing it of social and personal resources and consolidating liabilities, such as low self-efficacy or exhausted friends. On the other hand, these are not 'wrong' ways of coping or individual flaws; instead they are the result of a coping system that is overwhelmed. This can happen when personal vulnerabilities are high, when social resources are low, or when the stressor is simply too great. When adversity strikes, when mental and physical functioning and health are at risk, humans 'fight back'. Humans come with and develop a set of adaptive processes that gives them the potential to fend off disaster, to reshape challenges and to transform stressful experiences into psychological growth. Coping describes some of these adaptive processes **(White, 1974)**.

The elderly people face series of challenges such as illnesses and irreversible loses during the phase of ageing process. This process works against the will and interest of the elderly people. Acute illness comes with lots of problems and there may be a need to keep in shape one's emotions, self image, ability, relationship. Keeping in mind that the future ahead is no longer promising regardless of the condition of illness, it is the responsibility of the elderly to try and keep up with a good life **(Ridder & Schreurs, 2001; DeSouza & Nairy, 2003).** Nowadays, dependency in various elderly homes has raised a significant alert that needs a standard approach. Elderly people look up to healthcare officers for support in almost all their daily tasks.

Coping is categorized based on individual perspectives and its applications depend on the state of health and nature of the elderly people. Coping style could be problem focused, emotion focused, active, adaptive, avoidant, problem solving, corrective or preventive. Problem-focused coping is when the elderly can change the situation caused by aging process and direct efforts specifically to the main problem. When the elderly cannot change the situation, they rather change their perception about the problem and try to give it another meaning that is future promising; such coping is called emotion-focused **(Duner & Nordstrom, 2005; Towsley, Beck and Watkins, 2007)**. In active coping, idea is directed towards gaining control over one's problem. Besides, this could be a move to change an unfavourable condition, dealing with one's emotions through seeking beneficial information or by avoiding the situation from taking control over one's life. This is done by seeking for something else to do or by socializing with people **(Windsor, 2009; Cohen, Hassamal and Begum, 2011)**. Preventive coping is an effort to avert or delay the occurrence of the age related changes in the elderly while corrective is a measure(s) spelt out to put the situation back to normal after the occurrence. Ways of dealing with stressors that are associated with aging are not only controlled by corrective measures after finding ourselves in the situation. Preventive measures put in place before the situation occurs help the elderly in reducing the effect of the problems when they eventually occur **(Ouwehand, deRidder and Bensing, 2006)**. Most age related changes have tendency of leading to psychosocial problems. The reason is that whenever age related changes begins to manifest in the body system hope will be lost, disordered thoughts will be experienced, stress level goes higher and psychosocial problem would possibly set in. Coping with stress is mostly taken care of through avoidant attitude and getting busy with some simple tasks that could bring happiness **(Kotkamp-Mothes, Slawinsky, Hindermann and Strauss, 2005)**.

OBJECTIVES OF THE PRESENT STUDY:

1.8.1 To determine the effect of variation of age (Pre Retirement, Recently Retired and Post Retirement) on Perceived Burdensomeness and Thwarted Belongingness, Happiness, Self Esteem Loneliness, , and Coping.

1.8.2 To determine the effect of variation of gender (Males and Females) on Perceived Burdensomeness and Thwarted Belongingness, Happiness, Self Esteem, Loneliness and Coping.

1.8.3 To determine the relationship of Perceived Burdensomeness and Thwarted Belongingness with Happiness, Self Esteem, Loneliness and Coping.

With the basic frame of study being laid down, the progression of the work moves on to the detail literature review in the next chapter.

CHAPTER 2

SURVEY OF RELEVANT LITERATURE

2.0 Literature survey is an important step of any research activity. It provides us with information regarding the previous research endeavours undertaken in the present area of interest. Thus it serves as a guiding force to determine the nature and direction of the present research study.

2.1 STUDIES IN OLD AGE:

The meaning of age will continue to be a fluid concept and will be constructed through complex and iterative processes for decades, if not centuries, to come. As the odds of reaching advanced old age increase around the globe, people will gradually come to extend their individual time horizons and engage in more philosophical thinking about the meaning of lives that last far longer than ever imagined by our ancestors. The last century has witnessed a rapid increase in the population of the elderly people in the developed and industrialized countries. This phenomenon is not restricted to the western world only, but many countries such as ours are now feeling the impact of this transaction. This situation could be attributed to a combination of factors such as increase in age, longevity and decreased death rates due to advancement in the field of medicine, improvement of life expectancy at birth, and enhancement in the average span of life. India ranks 4th in terms of absolute size of elderly population .The country is not adequately equipped to look after their special health needs and the changing traditional value system. A feeling is now growing among the aged persons that the attitude of the younger generation towards them is not as desired.

Improvement in health care technologyhas resulted in increased life expectancy. In India, the elderly constitute about 7% of the total population and by 2016; the number is likely to increase to 10%. The problems of elderly are confined not only to their increasing numbers, but also include mental stress and physical incapability felt by them. The scenario is changing and creating its impact on the elderly. According to National Sample Survey Organization, 36.7 % of 70 million elderly want to shift to old homes because they cannot manage alone. **Saraswati (1976)** concluded in his study that the old age has started emerging as the social problem in Indian Society, due to the socio-cultural changes brought about by the Industrial revolution. The past recognition of old man or woman in the family, neighbourhood and community has been reduced to great extent in the Modern Indian Life and therefore, old people perceive low social worth or self esteem in certain family situations. Several studies reported that a large number of old men and women badly need health care, financial assistance, social

recognition and counselling services to cope up with stress for overcoming "death anxiety", "sense of isolation", "feeling of social deprivation due to negligence", "feeling of disability and dependency"," low self esteem and lethargic feeling" **(Dutta, 1989; Saha, 1984, Ananthraman, 1982; Agnihotri, 1976; Ram Murti, 1962)**.

In India as elsewhere, life expectancy has improved with better medical care and improved nutrition **(Kanwor, 1999)**. As a result, people are living longer. They constitute a vastly experienced human resource with tremendous potential to contribute to national development. Their well- being is the concern of both the society and the state. The traditional sense of duty and obligation of the younger generation towards their older generation is being eroded. The older generation is caught between the decline in traditional values on one hand and the absence of adequate social security system on the other **(Gormal, 2003)**.The traditional Indian family structure provides adequate mechanism for meeting their needs. Family is the main source of care giving to all its members. One's need for and ability to give care is negotiated by one's place in family life cycle. Illness increases with age. All else being equal, an older population has greater needs for health care. Ageing of population is an obvious consequence of the process of demographic transition. The expectancy of life in India is much less than 60 years. Psychologically too, most Indians appear to consider themselves old earlier than the chronological age of 60 years and the Indian women regard themselves to be old even much earlier **(Montross**, **Depp, Daly, Golshan and Moore, 2006)**. According to **Mayor (2006)**, "Some people use their chronological age as a criterion for their own aging whereas others use such physical symptoms as failing eye-sight or hearing, tendency to increase fatigue, decline in sexual potency etc. Still others assess their aging in terms of their capacity for work, their output in relation to standards set in earlier years, their lack of interest in competing with others, lack of motivation to do things or a tendency to reminiscence and turn their thoughts to the past rather than dwell on the present or the future." The acceptance of the fact that they are old develops in the aged an "old age complex" **(Antonelli, Rubini and Fassona, 2000).**

In a globalizing world, the meaning of old age is changing across cultures and within countries and families **(Bergeron, 2001)**. In India, migrants from the villages and towns to cities predominate, resulting in breaking up of families into nuclear families. The aged who are left behind have to fend for them. This is leading to an increased danger of marginalization of the geriatric population due to migration, urbanization, and globalization. Another impact of the

globalization is the increasing economic burden on the elderly, especially the women who have practically non-existent property rights and other social security measures **(Bhat, 2001)**.

It is important that the state, civil society and community recognizes the rights and needs of the elderly women and make suitable polices legislations and effective implementation of health and security schemes which already exist. Specific state interventions are required for the aged women, they being most vulnerable and for the aged who are below the poverty line. There is a need to protect the human rights of the elderly and have gender just laws and policies to ensure adequate economic and social protection during disability and old age, especially where the aged lack adequate family supports **(Bhat, 2001)**. The elderly citizens are in need of urgent attention. They do not need our pity, but the understanding love and care of their fellow human beings. It is our duty to see that they do not spend the twilight years of their life in isolation, pain and misery. Older persons are, therefore, in need of vital support that will keep important aspects of their lifestyles intact while improving their over-all quality of life **(Dandekar, 1993)**.

Life satisfaction continues to be an important construct in the psycho-social study of aging. It is one of the commonly accepted subjective conditions of quality of life and seems to be one of the facets of successful aging, both of which are key concepts in aging. Research reports that life satisfaction is strongly related to socio demographic and psycho-social variables **(Iyer, 2003)**.

2.2 STUDIES ON MENTAL HEALTH

Older adults, those aged 60 or above, make important contributions to society as family members, volunteers and as active participants in the workforce. While most have good mental health, many older adults are at risk of developing mental disorders, neurological disorders or substance use problems as well as other health conditions such as diabetes, hearing loss, and osteoarthritis. Furthermore, as people age, they are more likely to experience several conditions at the same time.

The world's population is ageing rapidly. Between 2015 and 2050, the proportion of the world's older adults is estimated to almost double from about 12% to 22%. In absolute terms, this is an expected increase from 900 million to 2 billion people over the age of 60. Older people face special physical and mental health challenges which need to be recognized. Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache

disorders) and 6.6% of all disability (disability adjusted life years-DALYs) among over 60s is attributed to neurological and mental disorders. These disorders in the elderly population account for 17.4% of Years Lived with Disability (YLDs). The most common neuropsychiatric disorders in this age group are dementia and depression. Anxiety disorders affect 3.8% of the elderly population, substance use problems affect almost 1% and around a quarter of deaths from self-harm are among those aged 60 or above. Substance abuse problems among the elderly are often overlooked or misdiagnosed. Mental health problems are under-identified by health-care professionals and older people themselves, and the stigma surrounding mental illness makes people reluctant to seek help.

Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time. As well as the typical life stressors common to all people, many older adults lose their ability to live independently because of limited mobility, chronic pain, frailty or other mental or physical problems, and require some form of long-term care. In addition, older people are more likely to experience events such as bereavement, a drop in socioeconomic status with retirement, or a disability. All of these factors can result in isolation, loss of independence, loneliness and psychological distress in older people.

Mental health has an impact on physical health and vice versa. For example, older adults with physical health conditions such as heart disease have higher rates of depression than those who are medically well. Conversely, untreated depression in an older person with heart disease can negatively affect the outcome of the physical disease. Older adults are also vulnerable to elder abuse - including physical, sexual, psychological, emotional, financial and material abuse; abandonment; neglect; and serious losses of dignity and respect. Current evidence suggests that 1 in 10 older people experience elder abuse. Elder abuse can lead not only to physical injuries, but also to serious, sometimes long-lasting psychological consequences, including depression and anxiety. **(http://www.who.int/mediacentre/factsheets/fs381/en/)**

Dementia is a syndrome in which there is deterioration in memory, thinking, behaviour and the ability to perform everyday activities. It mainly affects older people, although it is not a normal part of ageing. It is estimated that 47.5 million people worldwide are living with dementia. The total number of people with dementia is projected to increase to 75.6 million in 2030 and 135.5 million in 2050, with majority of sufferers living in low- and middle-income countries. There are significant social and economic issues in terms of the direct costs of

medical, social and informal care associated with dementia. Moreover, physical, emotional and economic pressures can cause great stress to families. Support is needed from the health, social, financial and legal systems for both people with dementia and their caregivers.

Depression can cause great suffering and leads to impaired functioning in daily life. Unipolar depression occurs in 7% of the general elderly population and it accounts for 5.7% of YLDs among over 60 year olds. Depression is both under diagnosed and undertreated in primary care settings. Symptoms of depression in older adults are often overlooked and untreated because they coincide with other problems encountered by older adults. Older adults with depressive symptoms have poorer functioning compared to those with chronic medical conditions such as lung disease, hypertension or diabetes. Depression also increases the perception of poor health, the utilization of medical services and health care costs**.**

It is important to prepare health providers and societies to meet the specific needs of older populations, including:

1. Training for health professionals in care for older persons;
2. Preventing and managing age-associated chronic diseases including mental, neurological and substance use disorders;
3. Designing sustainable policies on long-term and palliative care; and
4. Developing age-friendly services and settings.

The mental health of older adults can be improved through promoting Active and Healthy Ageing. Mental health-specific health promotion for older adults involves creating living conditions and environments that support wellbeing and allow people to lead healthy and integrated lifestyles. Promoting mental health depends largely on strategies which ensure the elderly have the necessary resources to meet their basic needs, such as:

1. Providing security and freedom;
2. Adequate housing through supportive housing policy;
3. Social support for older populations and their caregivers;
4. Health and social programmes targeted at vulnerable groups such as those who live alone and rural populations or who suffer from a chronic or relapsing mental or physical illness;
5. Programmes to prevent and deal with elder abuse; and

6. Community development programmes.

Prompt recognition and treatment of mental, neurological and substance use disorders in older adults is essential. Both psychosocial interventions and medicines are recommended. There is no medication currently available to cure dementia but much can be done to support and improve the lives of people with dementia and their caregivers and families, such as:

1. Early diagnosis, in order to promote early and optimal management;
2. Optimizing physical and psychological health and well-being;
3. Identifying and treating accompanying physical illness;
4. Detecting and managing challenging behavioural and psychological symptoms; and
5. Providing information and long-term support to caregivers.

2.2.1 Mental health care in the community

Good general health and social care is important for promoting older people's health, preventing disease and managing chronic illnesses. Training all health providers in working with issues and disorders related to ageing is therefore important. Effective, community-level primary mental health care for older people is crucial. It is equally important to focus on the long-term care of older adults suffering from mental disorders, as well as to provide caregivers with education, training and support. An appropriate and supportive legislative environment based on internationally accepted human rights standards is required to ensure the highest quality of services to people with mental illness and their caregivers.

WHO's programmes for Active and Healthy Ageing have created a global framework for action at country level. WHO supports governments in the goal of strengthening and promoting mental health in older adults and to integrate effective strategies into policies and plans. WHO recognizes dementia as a public health challenge and has published the report, "Dementia: a public health priority", to advocate for action at international and national levels. Dementia, along with depression and other priority mental disorders are included in the WHO Mental Health Gap Action Programme (mhGAP). This programme aims to improve care for mental, neurological and substance use disorders through providing guidance and tools to develop health services in resource poor areas. WHO organized the First Ministerial Conference on Global Action Against Dementia in March 2015, which fostered awareness of the public

health and economic challenges posed by dementia, a better understanding of the roles and responsibilities of Member States and stakeholders, and led to a "Call for Action" supported by the conference participants. **(http://www.who.int/mediacentre/factsheets/fs381/en/, WHO, 2016)**

2.3 PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS:

Media reports tell of the increasing global burden of an ageing population, both financially and in care provision **(Conway, 2010)**. In the U.K. the debate on euthanasia and assisted suicide has become more prominent with some disabled, elderly and physically ill people making trips to the Dignitas clinic in Switzerland to end their lives. Baroness Warnock stated that frail elderly people should think about euthanasia so as not to financially burden their families **(Templeton, 2004)**. This could suggest that to be dependent and in need of care is to be a burden. Those requiring help often say 'I don't want to be a burden' and when receiving help some experience themselves as a burden **(Angus & Reeve, 2006; Charmaz, 1991; Chochinov, Hack, Hassard, Krisijanson, McClemenet and Harlos, 2007)**. This is of interest as most people will require help at some point in their lives and so potentially could feel this way. Groups such as the elderly, the disabled and the physically or mentally ill who may need help in order to survive could be especially vulnerable to experiencing this sense of being a burden to others.

Meaning in life is also targeted in several psychotherapies to help clients reduce distress and manage crises effectively **(Chochinov, 2002)**. Given the challenges of aging such as social losses and role changes meaning in life is an especially salient component of well-being in older adulthood. Research indicates that older adults, on average, report higher levels of meaning in life and that an absence of meaning is empirically associated with, suicidal ideation, and premature mortality. Among older adults, the association between perceived burdensomeness and greater severity of suicidal ideation holds even after controlling for other risk factors for depression and hopelessness. Among older adults with advanced illness, perceived burdensomeness is associated with emotional distress, loss of dignity, and reduced well-being **(Simmons, 2007).** Perceptions of burdensomeness may reduce the degree to which relationships and interactions satisfy the need to belong, in turn reducing meaning in life. Other studies could attempt to identify moderators of the association between burdensomeness and meaning. One

possible moderator, inflexible goal pursuits may magnify the association between perceived burdensomeness and low meaning in life.

Feeling like a burden has increasingly been researched by those interested in end-of-life issues and terminal or chronic illnesses **(Chochinov,Hack, Hassard, Krisijanson, McClemenet and Harlos, 2002; Chochinov, Hack, Hassard, Krisijanson, McClemenet and Harlos, 2007; McPherson, Wilson, Lobchuk, & Brajtman, 2007a; McPherson, Wilson & Murray, 2007)**. This body of research focuses on participants in Western societies and is both qualitative and quantitative. The phenomenon, generally termed 'self-perceived burden' has been defined as: "empathic concern engendered from the impact on others of one's illness and care needs, resulting in guilt, distress, feelings of responsibility and diminished sense of self." **(McPherson, Wilson and Murray, 2007b)**. This proposes a psychological construct not linked to dependence. Although a previous definition proposed by **Cousineau, McDowell, Hotz and Hebert (2003)** was linked to feelings of dependence, **McPherson, Wilson and Murray (2007b)** demonstrated that people could feel they were a burden even when they were not dependent on others. As dependence is a subjective concept **(Verbrugge, Mehta & Wagenfeld-Heintz, 2006)**, although researchers may perceive participants were not dependent (using functional ability measures) this does not mean that they did not 'feel' dependent. Ideals of independence feature strongly in the literature as associated with feeling like a burden suggesting that 'perceptions' of dependence could be included in the definition. This body of research has explored the correlates of the phenomenon quantitatively and has elaborated the personal and social experience for individuals qualitatively. **Wilson, Curran, and McPherson (2005)** showed that a sense of burden, for terminally ill patients, did not occur on its own but correlated with many other concerns such as loss of dignity, loss of control, hopelessness, loss of quality of life, depression and a reduced wish to live. Physical symptoms were not the most important factors; the correlations with psychological distress were more salient suggesting that feeling like a burden is linked to psychological experience more strongly than bodily experience. **Chochinov, Hack, Hassard, Krisijanson, McClemenet and Harlos (2007)** also quantitatively assessed terminally ill patients' sense of burden and its correlates with similar results. Sixty percent of their participants experienced distress attributed to feeling a burden to others. The most significant correlations were to hopelessness, depression and outlook. They found no association between degree of actual physical dependence and sense of burden and suggested psychological and existential factors influence the perception. That some people

could be relatively able physically and still feel a burden and, contrarily, some who were very physically dependent not feel a burden would appear to indicate that there is a complex relationship between dependence and self-perceived burden. More recently, **McPherson, Wilson and Murray (2007b)** also showed how self-perceived burden affects the self. They used interpretative phenomenological analysis to look at 15 terminally ill patients' experience of feeling like a burden. Participants expressed concern for others around the physical, social and emotional burdens they perceived they were or might be in the future. Feeling like a burden to others aroused negative emotions such as guilt and frustration. The sense of burden was linked to dependence; the authors found that adjusting from a perceived sense of independence to a perceived sense of dependence led to feelings of uselessness and hence reduced self- worth. This had implications for participants' sense of self because requiring help changed their self-concepts, which was difficult for participants to accept. This research also linked feeling like a burden to social roles as participants described a sense of failure when unable to carry out important social roles such as parenting. Other researchers have also found that an inability to fulfill social roles is associated with feeling like a burden. **Brenner, Gutierrez, Cornette, Betthauser, Bahraini and Staves (2008)** found that failure to fulfil social roles caused returning veterans to feel they were a burden to their families and this was linked to a loss of sense of self. Participants used minimizing and concealing symptoms as a way of lessening the perceived burden on others. **Ch'Ng, French and Mclean, (2008)** found that for new stroke sufferers loss of social roles and reliance on others(suggesting a sense of burden) was linked to depression and even suicidal ideation. Finally, feeling like a burden is associated with shame. **Smith and Osborn (2006)** found an inability to maintain social roles caused individuals to feel they were a burden; which the authors suggest confirms a socially constructed facet of this illness. Individuals with chronic back pain described the shame felt about their condition as worse than the pain itself.

In his book *Why People Die by Suicide*, **Joiner (2006)** outlines thwarted belongingness as social disconnection to something larger than oneself. As human beings we are hardwired to be in relationship with others, and when those ties are cut or dissolve, we suffer in isolation. Joiner argues that a series of painful and provocative experiences over the course of a lifetime can disinhibit a person from the fear of pain and death associated with suicide. These experiences may be related to trauma and abuse, but they may also involve high risk behaviors,

injuries from contact sports, and a knowledge of and comfort with deadly means of suicide (e.g., firearms or lethal drugs).

2.4 HAPPINESS

The inclusion of happiness among older people as an outcome variable has become increasingly popular in studies examining aging as a lifelong process. This may be because happiness is a common goal, and previous research has demonstrated that happy individuals are successful in many life domains. Being happy leads to better health, increased longevity, decreased disabilities and reduced mortality **(Collins, Goldman & Rodriguez, 2008; Danner, Snowden & Friesen, 2001; Lyyra, Törmäkangus, Read, Rantanen & Berg, 2006; Maier & Smith, 1999; Ostir, Markides, Black & Goodwin, 2000)**. Based on a review by **George (2010)**, key predictors of happiness among older adults include at least five categories: socioeconomic status (e.g., income), health, social integration (e.g., community connectedness), social relationships and support (e.g., family and friend) and psychological resources. It can be argued that connection with family and friends should not be included in the same domain. This is because different contact partners do not have equal importance for happiness in terms of quantity and quality of relationships **(Pinquart & Sörensen, 2000).** Religion has also been found to be associated with happiness. Religious beliefs and practices lead to better physical health and better mental health for members of different religions **(Koenig, McCullough & Larson, 2001)**. Older adults who derive a sense of meaning in life from religion tend to have higher levels of happiness **(Krause, 2003)**.

Demographic factors have been associated with happiness in previous research. For instance, happiness increases with age **(Yang, 2008)**. Women are less happy than men (**Diener, Suh, Lucas & Smith, 1999)**, and married people are happier than unmarried, divorced and widowed people **(Layard, 2005; Pinquart & Sörensen, 2001)**. Many older people become increasingly vulnerable as they face various health problems as they age. In the same vein, they often face an increased risk of losing social contact and significant amounts of income. Thus, older people are more likely to require help and care than younger people **(Pinquart & Sörensen, 2000; Sotgui, Galati & Manzano, 2011)**.

Other studies have, however, found that not only quality but also quantity of relationships has a significant bearing on happiness by improving one's mood and relieving pressure and stress **(Silverman, Hecht & McMillin, 2000)**. Having a greater variety of family

and friends to provide for different needs could contribute to well-being **(Cheng, Lee, Chan, Leung & Lee, 2009)**. Economic factors are meaningful for the young old and the middle old. It is logical that those who have not yet reached advanced age will be more involved with the cash economy.

2.5 SELF ESTEEM

In recent years, a growing body of research suggests that low self-esteem predicts depression. Overall, the findings support the vulnerability model, which states that low self-esteem operates as a risk factor for depression **(Beck, 1967; Metalsky, Joiner, Hardin, & Abramson, 1993; Roberts & Monroe, 1992)**. Although a few studies have examined the longitudinal relation between self-esteem and depression in a wider range of adult samples **(Abela, Webb, Wagner, Ho, & Adams, 2006; Fernandez, Mutran, & Reitzes, 1998; Ormel, Oldehinkel, & Vollebergh, 2004)**, none of these studies directly tested for age differences in the effects of self-esteem in different life stages.

It is possible that low self-esteem is a risk factor for depression only at certain periods of the life span but not at others. The factors that contribute to self-esteem and depression might be different during midlife or old age than during young adulthood. As a result, the relation between self-esteem and depression might vary across the life span.

The studies that have examined age differences in global self-esteem in old age have been referred to here. **Jaquish and Ripple (1981)** found that adults report somewhat lower self-esteem in late adulthood (age 61–81 years) than in middle adulthood (age 40–60 years). **Tiggemann and Lynch (2001)** found that women age 70–85 years had slightly lower self-esteem than women in their 60s. Consistent with these two studies, **Ward (1977)** found a weak negative correlation between age and self-esteem in a sample of individuals' age 60–92 years. In contrast, **Gove, Ortega and Style (1989)** found the highest levels of self-esteem in the oldest cohort (age 75 years and older). Moreover, several studies have failed to find significant age differences, including **Trimakas and Nicolay's (1974)** study of individuals age 66–88 years, **Erdwins, Mellinger, Tyer (1981)** study of four cohorts ranging in age from 18 to 75 years, and **Ryff's (1989)** study comparing middle aged adults (mean age 50 years) and older adults (mean age 75 years). Reflecting the lack of consistency in previous findings, researchers reviewing the

literature on self-esteem and aging have failed to reach consensus on whether self-esteem increases, decreases, or remains stable in old age **(Bengtson, Reedy, & Gordon, 1985; Brandtstaedter & Greve, 1994; Demo, 1992)**.

Well-being and self-esteem are empirically related, but conceptually distinct, constructs **(DeNeve & Cooper, 1998; Robins, Hendin, & Trzesniewski, 2001)**.A number of life changes that tend to occur in old age might have a negative impact on wellbeing, including health problems, declining socioeconomic status, spousal loss and bereavement, loss of social support, and a decline in achievement experiences following retirement. However, some researchers have theorized that aging entails improved coping and emotion regulation that may protect against declining feelings of well-being (**Baltes & Baltes, 1990; Brandtstaedter & Greve, 1994; Carstensen, Isaacowitz, & Charles, 1999)**. Consistent with these divergent theoretical views, there appear to be few replicable age differences in well-being for samples over 60 years of age, with some studies showing improvements and others showing declines **(e.g., Carstensen, Pasupathi, Mayr, & Nesselroade, 2000; Charles, Reynolds, & Gatz, 2001; Diener & Suh, 1998; Smith & Baltes, 1999)**. Moreover, when age-related declines in adjustment are found, they tend to be quite small **(Smith & Baltes, 1999)**. Consequently, self-esteem may also remain intact in old age, despite the many profound physical and emotional changes associated with aging.

2.6 LONELINESS

Loneliness is very common among older people. The prevalence of loneliness in older populations has varied from 7% (**Victor, Scambler, Bond and Bowling, 2000**) to 49% **(Holmén, 1994**). The great variance in research findings may be due to the research context, the type of question or measurement and the method (survey or interview) may affect the findings **(Victor, Scambler, Bond and Bowling, 2000.)** In addition, it has been suggested that it is easier for older people to talk about their previous experiences than their present feelings of loneliness **(Rokach & Brock, 1997**). The feeling of loneliness is often experienced as shameful, and older people may also fear being or becoming a burden. Thus, they are reluctant to admit their loneliness. **(Killeen, 1998; McInnis & White, 2001).**In addition, some older people may live in their homes with very few contacts with the social and health care services. Therefore, the recognition of loneliness is a great challenge in health and nursing care.

It has been suggested that loneliness with its related concepts may be described in a continuum that includes alienation, loneliness, social isolation, aloneness, solitude and connectedness. This continuum takes into account the human's choice (no choice –total choice) and society's perception of the concepts (negative-positive) (**Killeen, 1998**). Particularly in old age, people may feel lonely as a result of living alone, a lack of close family ties, reduced connections with their origins and a reduce ability to participate actively in social community activities. When this occurs in combination with physical disablement, demoralization and depression are common accompaniments. A study by **Max, David, Jacobijn, Aartjan, Ross, and Rudi (2005**) revealed that the presence of perceived loneliness contributed strongly to the effect of depression on mortality. Thus in the oldest olds, depression is associated with loneliness only when the feeling of loneliness is present.

Several investigators have noted that the strength of loneliness is not evenly distributed over the life span of an individual. **Ernst and Caccioppo (1999)** asserted that there is an overall positive correlation between loneliness and age According to several studies, loneliness is more common among older than among younger older people **(Jylhä & Jokela, 1990, Mullins, Sheppard and Andersson, 1988; Baretta, Dantzler and Kayson, 1995; Fees, Martin and Poon, 1999; Jylhä 2004).** However, **Rubenstein and Shaver (1982)** pointed out that in their investigations that loneliness was negatively correlated with age, suggesting that it is a problem associated with youth. **Peplau, Bikson, Rook and Goodchilds (1982)** and **Brennan (1982)** have reported a similar trend. Loneliness is felt most acutely at specific times, especially during the evenings, weekends and holidays (**Victor, Scambler, Bowling and Bond, 2005**). Gender has been associated with loneliness as well. It has been found to be more common among older women than older men. **(Kivett, 1979; Berg, Melleström, Persson, and Svanborg, 1981; Holmén, Ericsson, Andersson and Winblad, 1992a; Holmén, 1994; Jylhä, 2004).** In some studies, there has not been a direct association between age and loneliness **(Creecy, Berg and Wright, 1985; Beck, Shultz, Walton and Walls, 1990; Holmén, 1994; Hector-Taylor & Adams, 1996; Tilvis, Pitkälä , Jolkkonen and Strandberg, 2000)**. It has been pondered whether age really is connected to loneliness or is the relationship explained through the changes occurring during older people's life, like widowhood or a decrease in functional status **(Donaldson & Watson 1996).** Loneliness may increase with age, not because of age per se, but because of increasing disability and decreasing social integration **(Jylhä 2004).**

Considerable diversity appears to exist among the coping strategies of the lonely **(Rook, 1988),** and as such people differ in their readiness to recognize or admit (to themselves and to others) that they are in pain due to feeling lonely **(Booth, 1983; Rook & Peplau, 1982).** Feared stigma and loneliness anxiety—defending against the fear of experiencing loneliness **(Moustakes, 1972**)—may result in attempts to deny the experience either outright or by distancing oneself from the pain, feelings of failure, and restlessness and desperation which loneliness entails **(Rook, 1988).**

2.7 COPING

There are many ways of coping with the body changes and type of coping style chosen by the elderly depends on the body condition and target, though in many cases, same coping strategies work for a number of different problems. Regaining back or adapting to age related changes requires input of efforts, strategies, actions and external resources. The elderly are found to rely more on the existing resources and comfortable coping strategies to keep on with life whenever they are going through ageing process **(Duner & Nordstrom, 2005; Wadensten, 2006)**. Research result of **Birkeland & Natvig (2009)** indicates that old people who are living separately consider acceptability as one of their main coping strategies. From a different angle, **Kahana & Kahana (2001)** sees surrendering roles to the other members of the family or society as a way of coping to overcome social losses.

Considering the understanding of the old people about the likely impossibility of treating pain, they prefer living with it as a method of coping rather than aimlessly working towards achieving the impossibility **(Watkins, Shifren, Park and Morrell, 1999)**. It was established by **Windsor (2009)** that continuous efforts, hope, general health, pleasing oneself and social interaction have a relationship with recovery from age related changes.

Results of a research on psychological solution as regards immune system confirmed that keeping body fit, having adequate rest and practicing openness are workable coping skills **(Olff, 1999)**.

In recent years, researchers have turned to the notion of higher order families of ways of coping to organize the hundreds of ways of coping identified in previous research **(Skinner, 2003)**. A family includes a variety of ways of coping that all serve the same functions in dealing with stress. For example, if problem solving is considered part of a family, it could include other

ways of coping that serve the same functions, such as strategizing, planning, repair, direct attempts, instrumental action and decision making. We have identified a dozen core families of coping based on action types **(Skinner, 2003)**. Although there is not complete consensus that these are the core categories of coping, several are not particularly controversial, such as problem solving, seeking support, and escape avoidance. Some represent the dominant ways of coping in specific domains, for example, information-seeking in the health domain, and negotiation in dealing with interpersonal stressors. Some reflect reactions to stress that have been studied extensively outside the field of coping, such as helplessness **(Seligman, 1975)** and dependency **(Baltes, 1997)**. Several reflect cutting edge ideas in the field of coping. For example, ways of coping have been identified that serve to direct attention away from the distressing features of a situation and toward more positive thoughts and activities. Referred to as accommodation **(Brandtstädter & Renner, 1990)** or secondary control coping, this family includes positive thinking, cognitive restructuring, focus on the positive, and distraction. It is structurally distinct from escape **(Ayers, Sandler, West, and Roosa, 1996)** and, unlike denial, does not interfere with effective action. Another family includes ways of coping that focus attention toward the negative features of a stressful situation. The best understood way of coping in this family is rumination **(Nolen-Hoeksema, 1998)**, a risk factor for depression. Sometimes referred to as submission, surrender, or involuntary engagement, this family also includes ways of coping such as perseveration and intrusive thoughts. Unlike constructive expression of emotions, however, these ways of coping exacerbate distress and interfere with problem-solving.

After completion of the relevant literature survey in the next chapter, the methodological details adopted for the present study will be discussed.

CHAPTER 3

METHODOLOGY

3.0 After delineating the objectives of the present study along with the related literature survey, in the earlier chapters (I & II), it is necessary to study in depth the methodological details of the present study which aims to see the relationship of different psychological factors with perceived burdensomeness and thwarted belongingness in pre retirement, recently retired and post retirement group.

Plato, the ancient Greek philosopher has divided lifespan into six stages, of which the last two constitutes old age viz. old age (62-69) and the advanced old age (70-death). Although when old age begins cannot be universally defined, the United Nations suggest that 60+ years may be usually denoted as old age. This stage is marked by reduced physical ability, declining mental ability, the gradual giving up of role playing in socio-economic activities, and a shift in economic status moving from economic independence to economic dependence upon other's for support. Along with the image of their own attributes (self-image), the aged have an image of the way the rest of the society perceives them (image of the social image). This perception is based on the societal attitudes towards the aged.

Ageing can involve not just superficial changes but decreased mobility and dexterity, decreased strength and stamina, and reduced sensory acuity. Statistically, the probability of morbidity or illness and some disabilities increases with age. The link between lifestyle and health in older age is well documented. According to a National Health Committee report **(National Health Committee, 1998a, 1998b)**, much of the physical decline associated with old age can be attributed to inactivity rather than the ageing process. The report concludes that between one sixth and one fifth of the 7,800 deaths in New Zealand each year from coronary heart disease, colon cancer and diabetes are attributable to physical inactivity. An extensive review of gerontological research shows quite conclusively that regular engagement in meaningful activities contributes to the overall health and welfare of older people **(Seedsman, 1991)**. Men are more at risk of mental illness than women **(Melding, 1997)**.

3.1. METHOD

3.1.1. SAMPLE

The present study has three groups which are described as follows:

1. Pre retirement group (N=48 which comprised of 24 males and 24 females in the age range of 50-60).
2. Recently retired group (N=54 which comprised of 26 males and 28 females in the age range of 61-70).
3. Post retirement group (N=50 which comprised of 25 males and 25 females in the age range of 71-80).

The three groups are matched on the basis of age, sex and socio-economic status. ***Purposive sampling*** is used for sample selection**.** The subjects are selected on the basis of the following criteria:

❖ **INCLUSION CRITERIA**

- Age Range: 50-80 years divided into different phases as mentioned above.
- Nationality: Indian
- Socio-Economic Status: Upper Middle Class (family's monthly income Rs. 20,000-40,000).
- Educational Qualification: Minimum Graduate
- Marital status: Married or widowed
- Employment status: Pre-retirement, recently retired and post retirement.

❖ **EXCLUSION CRITERIA**

- Subjects falling below age 50 and above age 80.
- Subjects who are not Indians.
- Subjects belonging to low and middle socio-economic classes.
- Subjects who are non-graduates.
- Subjects who are not married or are divorced.
- Subjects who have never been employed.

3.1.2 RESEARCH HYPOTHESES

1. There will be a difference between the pre-retirement, recently retired and post-retirement groups with respect to perceived burdensomeness and thwarted belongingness, happiness, self esteem, loneliness and coping.
2. There will be a difference between the males and females with respect to perceived burdensomeness and thwarted belongingness, happiness, self esteem, loneliness and coping.
3. There will be both positive and negative relationship between perceived burdensomeness and thwarted belongingness and its correlates like happiness, self esteem, loneliness and coping respectively.

3.1.3. TOOLS USED

3.1.3.1 INFORMATION SCHEDULE

The information schedule used for the present research comprised of the following items: Name, Age, Gender, Nationality, Marital status, Number of family members, Number of earning members in the family at present, Individual's own income, whether doing any job after retirement, How is leisure time spent? Your opinion or views about life and about oneself and the Ways of coping throughout life / most life situations.

3.1.3.2 INTERPERSONAL NEEDS QUESTIONNAIRE (INQ)

The INQ was derived from the interpersonal theory of suicide and was developed by **Van Orden, Cuckrowicz, Witte and Joiner, (2012)** to measure thwarted belongingness and perceived burdensomeness.

Thwarted belongingness (TB) is a psychologically painful mental state that results when the fundamental need for connectedness— described by **Leary, Terdal, Tambor & Downs (1995)** as the "need to belong" —is unmet. Perceived burdensomeness (PB) is a mental state characterized by apperceptions that others would "be better off if I were gone," which manifests when the need for social competence that is posited by frameworks including self-determination theory **(Ryan & Deci, 2000)** is unmet.

The INQ was derived from the interpersonal theory of suicide and was developed to measure thwarted belongingness and perceived burdensomeness—both proximal causes of

desire for suicide. The INQ was developed by the authors for use by researchers in the investigation of the etiology of suicidal desire/behaviour, as well as by clinicians as part of a risk assessment framework grounded in the interpersonal theory of suicide **(Joiner, Van Orden, Witte and Rudd, 2009).**

The original version of the INQ used in the current analysis contains 25 items: 10 items measure thwarted belongingness (e.g., "These days other people care about me," reversed), and 15 items measure perceived burdensomeness (e.g., "These days I feel like a burden on the people in my life"). Respondents rate how true each item is for them recently, on a scale ranging from 1 (not at all true for me) to 7 (very true for me). Subscale scores are calculated as the sum of all subscale items; items on the TB subscale are reverse coded so that higher scores reflect higher levels of TB and PB. Scores are coded such that higher numbers reflect higher levels of thwarted belongingness and perceived burdensomeness. Items 7, 8, 10, 13, 14, and 15 are reverse coded. In a previous study using a subset of the total item pool in order to manage multicolinearity **(Van Orden, Witte, Gordon, Bender & Joiner, 2008)**, comparable internal consistency coefficients were found for the belongingness items (α.85) and the perceived burdensomeness items (α.89). **Russell, Peplau, and Cutrona (1980)** reported high internal consistency for the scale (.94), as well as support for concurrent and divergent validity.

3.1.3.3 <u>OXFORD HAPPINESS QUESTIONNAIRE (OHQ)</u>

An improved instrument, the Oxford Happiness Questionnaire, developed by **Hills and Argyle (2002),** has been derived from Oxford Happiness Inventory (OHI).The OHI consists of 29 items, each involving the selection of one of four options that are different for each item. The OHQ includes similar items to those of the OHI, each presented as a single statement which can be endorsed on a uniform six-point Likert scale. The items of OHQ may easily be incorporated into larger questionnaires in random order, and the opportunity has also been taken of reversing about half of the items. The sum of the item scores is an overall measure of happiness, with high scores indicating greater happiness. Both the OHI and OHQ demonstrated high scale reliabilities with values of alpha being 0.92 and 0.91 respectively. The inter-item correlations for the OHI ranged from -0.03 to 0.58,mean 0.28 and the corresponding values for the OHQ were -0.04 to 0.65,mean 0.28.The validity of OHQ was satisfactory and the associations between the scales and a battery of personality variables known to be associated with well being were stronger for the OHQ than for the OHI.

3.1.3.4 ROSENBERG SELF ESTEEM SCALE (RSE)

This was developed for use in large-scale U.S. studies of the adaptation of youth **(Rosenberg, 1965; Rosenberg & Simmons, 1972)**, and was used by **Kaplan & Pokorney (1976)** and **Kaplan (1980)** in seminally important work on the predictive power of self-esteem. Self- esteem and self-concept can be measured in global terms or by more specific evaluations of role performance. Self-esteem, the manner in which an individual evaluates self-characteristics relative to the perceived characteristics of peers, is an important variable for understanding identity development, and often underpins mental health adjustment **(Mruk, 1999)**. Thus, self-esteem is a potentially important measure for screening problems of social adaptations which underlie and predict mental health problems. The Rosenberg Self Esteem Scale is a 10-item scale that measures global self-worth by considering both positive and negative feelings about the self. The scale is believed to be one-dimensional and all items are answered using a 4-point Likert scale format ranging from strongly agree to strongly disagree. Items 2, 5, 6, 8, 9 are reverse scored. "Strongly Disagree" is given 1 point, "Disagree" 2 points, "Agree" 3 points, and "Strongly Agree" 4 points. Scores are added for all ten items and kept on a continuous scale. Higher scores indicate higher self-esteem. The internal consistency reliability for the RSE range from 0.77 to 0.88 and the Test-retest reliability for the RSE range from 0.82 to 0.85. The Criterion validity is 0.55 and the Construct Validity, when correlated with anxiety, depression and anomie are-0.64, - 0.54 and - 0.43 respectively.

3.1.3.5 UCLA LONELINESS SCALE:

This was developed by **Russell (1996)** assesses how lonely a subject judges his or her experience**. Peplau, Russell, & Heim (1978)** indicated that loneliness is an emotionally unpleasant experience, particularly linked with feelings of general dissatisfaction, unhappiness, depression, anxiety, emptiness, boredom, restlessness and marginality. The questionnaire is a 20-item scale designed to measure one's subjective feelings of loneliness as well as feelings of social isolation. Participants rate each item as either O ("I often feel this way"), S ("I sometimes feel this way"), R ("I rarely feel this way"), N ("I never feel this way"). Scoring involves, considering all O's =3, all S's =2, all R's =1, and all N's =0. There was no reverse scoring and the scoring was kept continuous. This scale's total score is used in the model later described as an observed, continuous indicator of the loneliness construct. Higher numbers represent higher levels of loneliness, with scores ranging from 1 to 4. Results indicated that the measure was

highly reliable, both in terms of internal consistency (coefficient a ranging from .89 to .94) and test-retest reliability over a 1-year period (r = .73). **Russell, Peplau, and Cutrona (1980)** reported high internal consistency for the scale (α.94), as well as support for concurrent and divergent validity. Internal consistency was high in both the young adult sample (α.91) and older adult sample (α.90). Convergent validity for the scale was indicated by significant correlations with other measures of loneliness. Construct validity was supported by significant relations with measures of the adequacy of the individual's interpersonal relationships, and by correlations between loneliness and measures of health and well-being.

3.1.3.6 COPING STRATEGIES INVENTORY (CSI)

This was adapted from **Lazarus' *"Ways of Coping Questionnaire"* (1980)** it is designed to assess the coping thoughts and behaviours with regards to a specific stressor. "Coping is the process of managing demands (external or internal) that are appraised as taxing or exceeding the resources of the person" "Coping consists of efforts, both action-oriented and intrapsychic, to manage (i.e master, tolerate, reduce, minimize) environmental and internal demands and conflicts among them" **(Lazarus and Folkman, 1984b).** The Coping Strategies Inventory is a 72 items self report questionnaire designed to asses coping thoughts and behaviours to a specific stressor. The format of the CSI is adapted from the Lazarus "Ways of coping" questionnaire **(Folkman and Lazarus, 1980)**. There are a total of 14 subscales on the CSI including 8 primary scales, 4 secondary scales and 2 tertiary scales.

The **PRIMARY SUBSCALES** consist of specific coping strategies people use in response to stressful events. These include:

3 Problem Solving (Items 1, 9, 17, 25, 33, 41, 49,57,65)

4 Cognitive Restructuring (Items 2, 10, 18, 26, 34, 42, 50,58,66)

5 Express Emotions (Items 3, 11, 19, 27, 35, 43, 51,58,67)

6 Social Support (Items 4, 12, 20, 28, 36, 44, 52,60,69)

7 Problem Avoidance (Items 5,13,21,29,37,45,53,61,69)

8 Wishful Thinking (Items6,14,22,29,38,46,54,62,70)

9 Self Criticism (Items 7, 15, 23, 31,39,47,55,63,71)

10 Social Withdrawal(Items 8,16,32,40,48,56,64,72)

To calculate the secondary and tertiary subscales score, simply add together the primary scales that make up make up the subscales.

SECONDARY SUBSCALE ITEMS

Problem Focused Engagement = Problem Solving + Cognitive Restructuring

Emotion Focused Engagement = Social Support + Express Emotions

Problem Focused Disengagement = Problem Avoidance + Wishful Thinking

Emotion Focused Disengagement = Self Criticism + Social Withdrawal

TERTIARY SUBSCALE ITEMS

Engagement = Problem Focused Engagement + Emotion Focused Engagement

Disengagement = Problem Focused Disengagement + Emotion Focused Disengagement

The Cronbach's α has been the most frequently reported coefficient of reliability for measures of coping process. The α coefficient for the CSI ranges from .71 to .94(Mean=83). Two week test-retest Pearson's correlation coefficients reflect the effects of these different situations on coping; the correlations range from .39 to .61(mean=.73). Validity for the CSU has been assessed through Factor Structure, Criterion Validity and Construct Validity. The factor structure of the CSI supports hierarchical relationship between the proposed subscales **(Tobin, Holroyd, Reynolds and Wigal, 1985).** The CSI is particularly predictive of depressive symptoms for individuals who are under high levels of stress **(Tobin, Holroyd, Garske, Molteni, Flanders, Malloy, & Margolis, 1984).** The successful discrimination between symptomatic and normal samples from several different populations supports the CSI's clinical utility.

3.1.4 PROCEDURE:

To conduct the study, consents were first taken from both male and female subjects of the respective age groups to collect data. On the specified dates, the researcher introduced herself to the subjects and put forward a clear and precise description of the research purpose. They were assured complete confidentiality regarding the data obtained from them. The psychological questionnaires were administered in individual or small group sessions. The

questionnaires were filled in the presence of the assessor so that any clarification could be done immediately. Instructions were adequately provided and sufficient amount of rest was given in between each of the questionnaires to prevent the onset of fatigue.

The sequence of administration of the questionnaires followed a pre-determined sequence as:

1. **Information Schedule**
2. **Interpersonal Needs Questionnaire (INQ) -** The INQ was derived from the interpersonal theory of suicide and was developed by **Van Orden, Cuckrowicz, Witte and Joiner, (2012)** to measure thwarted belongingness and perceived burdensomeness.
3. **Oxford Happiness Questionnaire OHQ) -** by **Hillsand Argyle (2002),** this measures the happiness of the subject.
4. **Rosenberg Self Esteem Scale (RSE) -** developed by **Rosenberg (1965)** to measure positive and negative feelings.
5. **UCLA Loneliness Scale -** by **Russell (1996)** assesses how lonely a subject judges his or her experience.
6. **Coping Strategies Inventory (CSI) -** developed by **Tobin (1984)** is designed to assess the coping thoughts and behaviours with regards to a specific stressor.

It is to be noted that for each of the subjects, the following instructions were provided at the very beginning:

"You will be provided with a few questionnaires one by one, which requires you to give certain important information. Remember all the answers will be kept in strict confidence. Please do not hesitate in answering freely and frankly. After you finish answering, kindly hand them over to me. If you have any difficulty, please let me know."

3.1.5 PRECAUTIONS

1. Each respondent was asked to sit comfortably. The set of six questionnaires were administered to all of them in the same sequence. The respondents were assured that it was not a test; there was no right and wrong answers. The research purpose was clearly stated.

2. In order to get co-operation from the respondents, complete confidentiality was assured to each of them, and they were requested to answer freely and frankly.
3. While the selected tools were administered, it was ensured that each respondent was relaxed and willing to participate. However, no one was forced to give data.
4. There was no time limit for the questionnaires and each individual was instructed to finish answering the questions as fast as one could and honestly as well.
5. During the testing session, if the respondents faced any difficulties, it was clarified by the researcher without any extra cue.

The obtained data were then scored and subjected to statistical analysis.

3.1.6 SAMPLING – Purposive sampling

3.1.7 ANALYSES

3.1.7.1 SCORING, TABULATION AND STATISTICAL ANALYSES

Data for each of the questionnaires were scored following the scoring schedule for each of them accordingly. The scores were tabulated and statistical analyses were carried out that are presented in the chapter entitled "Results".

3.1.7.2 METHODS OF ANALYSES

Data analyses were done by the methods described below:

(i) Descriptive Statistics: Computation of mean, S.D., correlation

(ii) Inferential Statistics: Computation of "t" test

3.1.7.3. PLAN OF ANALYSES

PLAN OF DATA ANALYSES

Level of variables	Purpose	Mode of analyses
Univariate	Descriptive Testing inter-group difference in the selected variables	Mean, standard deviation, and correlation. t-test

The "results" of the present study will be detailed in the following chapter.

CHAPTER 4

RESULTS

4.0 The data obtained from the respondents were systematically arranged and properly tabulated with respect to each of the variables considered in the present study. The presentation of the data has reflected the measures of the obtained selected project variables and their statistical distributions on the basis of which suitable statistical techniques were applied to analyze and find out the necessary information to serve the objectives of the study.

To understand the nature of differences between pre-retirement, recently retired and post-retirement group, in the probe of psychological correlates of perceived burdensomeness and thwarted belongingness such as happiness, self esteem, loneliness and coping, Descriptive and Inferential statistics in the form of Mean, SD and 't' test respectively were calculated. With the help of these statistics, attempts were taken to locate age differences and gender differences with respect to perceived burdensomeness and thwarted belongingness, happiness, self esteem, loneliness and coping. Another Descriptive statistics of correlation was used to determine the contribution of different variables of happiness, self esteem, loneliness, and coping to perceived burdensomeness and thwarted belongingness. Age and gender differences were highlighted with the help of't' test. The findings are as follows:

TABLE 4.1: MEANS, STANDARD DEVIATIONS AND 't' VALUES OBTAINED BY PRE-RETIREMENT (N=48) AND RECENTLY RETIRED (N=54) GROUPS ON THE SELECTED VARIABLES

VARIABLES	PRE		RECENT		t
	Mean	SD	Mean	SD	VALUE
PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS	27.47	12.69	36.35	13.70	-3.378**
HAPPINESS	4.46	0.59	4.23	0.64	1.841
SELF ESTEEM	31.89	4.58	29.85	3.84	2.448*
LONELINESS	13.64	10.26	18.03	12.15	-1.958
PROBLEM SOLVING	32.93	6.24	29.98	6.13	2.408*
COGNITIVE RESTRUCTURING	32.83	5.99	29.40	6.21	2.825**
EXPRESS EMOTIONS	27.85	4.73	26.03	5.62	1.753
SOCIAL SUPPORT	30.72	6.05	27.14	6.84	2.784**
PROBLEM AVOIDANCE	24.47	5.44	24.46	5.75	0.015
WISHFUL THINKING	25.18	6.49	25.75	6.94	-0.428
SELF CRITICISM	20.83	6.93	21.44	7.15	-0.437
SOCIAL WITHDRAWAL	22.37	5.57	23.68	7.58	-0.984
PROBLEM FOCUSED ENGAGEMENT	65.77	11.21	59.38	11.93	2.773**

EMOTION FOCUSED ENGAGEMENT	58.29	8.18	52.51	11.19	2.941**
PROBLEM FOCUSED DISENGAGEMENT	46.67	10.41	50.22	11.35	-0.256
EMOTION FOCUSED DISENGAGEMENT	43.20	10.72	45.12	12.01	-0.848

*p< 0.05, **p< 0.01

- Pre-retirement group scored higher on happiness (M=4.46), Self Esteem (M=31.89), Problem solving (M=32.93), Cognitive Restructuring (M=32.83), Express Emotions (M=27.85) Self Support (M=30.72), Problem Avoidance (24.47), Problem Focused Engagement (M=65.77) and Emotion Focused Engagement (M=58.29).

- Recently Retired group scored higher on Perceived Burdensomeness And Thwarted Belongingness(M=36.35), Loneliness (M=18.03),Social Withdrawal(M=23.68), Problem Focused Disengagement (M=50.22) and Emotion Focused Disengagement (M=45.12)

- There is a significant difference between recently retired and pre retirement groups with respect to Perceived Burdensomeness And Thwarted Belongingness (t=-3.3788), Self Esteem (t=2.448), Problem Solving (t=2.408), Cognitive Restructuring (t= 2.825), Social Support(t=2.784), Problem Focused Engagement (t=2.773), Emotion Focused Engagement(t=2.941).

TABLE 4.2: MEANS, STANDARD DEVIATIONS AND 't' VALUES OBTAINEDBY RECENTLY-RETIRED (N=54) AND POST RETIREMENT (N=50) GROUPS ON THE SELECTED VARIABLES

VARIABLES	RECENT		POST		t
	Mean	SD	Mean	SD	VALUE
PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS	36.35	13.70	35.64	13.82	0.263
HAPPINESS	4.23	0.64	4.38	0.55	-1.227
SELF ESTEEM	29.85	3.84	30.66	4.20	-1.024
LONELINESS	18.03	12.15	17.82	10.96	0.095
PROBLEM SOLVING	29.98	6.13	31.78	6.05	-1.502
COGNITIVE RESTRUCTURING	29.40	6.21	31.24	5.92	-1.537
EXPRESS EMOTIONS	26.03	5.62	25.76	8.89	0.191
SOCIAL SUPPORT	27.14	6.84	27.98	6.67	-0.623
PROBLEM AVOIDANCE	24.46	5.75	26.26	6.73	-1.467

SOCIAL SUPPORT	27.14	6.84	27.98	6.67	-0.623
PROBLEM AVOIDANCE	24.46	5.75	26.26	6.73	-1.467
WISHFUL THINKING	25.75	6.94	28.68	10.77	-1.654
SELF CRITICISM	21.44	7.15	19.48	7.46	1.370
SOCIAL WITHDRAWAL	23.68	7.58	23.68	6.74	0.004
PROBLEM FOCUSED ENGAGEMENT	59.38	11.93	63.02	11.28	-1.591
EMOTION FOCUSED ENGAGEMENT	52.51	11.19	53.04	13.52	-0.215
PROBLEM FOCUSED DISENGAGEMENT	50.22	11.35	54.94	15.87	-1.753
EMOTION FOCUSED DISENGAGEMENT	45.12	12.01	43.16	11.51	0.852

- Recently retired group scored higher on Perceived Burdensomeness and Thwarted Belongingness (M=36.35), Loneliness (M=18.03), Express Emotions (M=26.03) Self criticism (M=21.44), and Emotion Focused Disengagement (M=45.12).

- Post Retirement group scored higher on Problem Solving (M=31.78),Social Support (M=23.68), Problem Avoidance(M=26.26), Wishful Thinking(M=28.68),Problem Focused Engagement(M=63.02),Problem Focused Disengagement (M=54.94) and Emotion Focused Engagement (M=53.04)

- There is no significant difference between the recently retired and post retirement groups with respect to Perceived Burdensomeness and Thwarted Belongingness (t=-3.3788) and the other respected variables.

TABLE 4.3: MEANS, STANDARD DEVIATIONS AND 't' VALUES OBTAINED BY PRE-RETIRED (N=48) AND POST RETIREMENT (N=50) GROUPS ON THE SELECTED VARIABLES

VARIABLES	PRE		POST		t
	Mean	SD	Mean	SD	VALUE
PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS	27.47	12.69	35.64	13.82	-3.039**
HAPPINESS	4.46	0.59	4.38	0.55	0.704
SELF ESTEEM	31.89	4.58	30.66	4.20	1.391
LONELINESS	13.64	10.26	17.82	10.96	-1.944
PROBLEM SOLVING	32.93	6.24	31.78	6.05	0.931
COGNITIVE RESTRUCTURING	32.83	5.99	31.24	5.92	1.323
EXPRESS EMOTIONS	27.85	4.73	25.76	8.89	1.446
SOCIAL SUPPORT	30.72	6.05	27.98	6.67	2.118*
PROBLEM	24.47	5.44	26.26	6.73	-1.436

AVOIDANCE				
WISHFUL THINKING	25.18	6.49	28.68	10.77	-1.933
SELF CRITICISM	20.83	6.93	19.48	7.46	0.929
SOCIAL WITHDRAWAL	22.37	5.57	23.68	6.74	-1.042
PROBLEM FOCUSED ENGAGEMENT	65.77	11.21	63.02	11.28	1.210
EMOTION FOCUSED ENGAGEMENT	58.29	8.18	53.04	13.52	2.314*
PROBLEM FOCUSED DISENGAGEMENT	49.66	10.41	54.94	15.87	-1.936
EMOTION FOCUSED DISENGAGEMENT	43.20	10.72	43.16	11.51	0.021

*p< 0.05, **p< 0.01

- Pre-retirement group scored higher on happiness (M=4.46), Self Esteem (M=31.89), Problem solving (M=32.93), Cognitive Restructuring (M=32.83), Express Emotions (M=27.85) Self Support (M=30.72), Problem Avoidance (24.47), Self Criticism (M=20.83) Problem Focused Engagement (M=65.77) and Emotion Focused Engagement (M=58.29).
- Post Retirement group scored higher on Perceived Burdensomeness and Thwarted Belongingness (M=35.64), Loneliness (M=17.82), Problem Avoidance (M=26.26), Wishful Thinking (M=28.68), Social Withdrawal (M=23.68) and Problem Focused Disengagement (M=54.94)

- There is a significant difference between recently retired and pre retirement groups with respect to Perceived Burdensomeness And Thwarted Belongingness (t=-3.039), Social Support (t=2.118),and Emotion Focused Engagement (t=2.314).

TABLE 4.4: MEANS, STANDARD DEVIATIONS AND 't' VALUES OBTAINED BY MALE (N=75) AND FEMALE (N=77) GROUPS ON THESELECTED VARIABLES

VARIABLES	MALE		FEMALE		T
	Mean	SD	Mean	SD	VALUE
PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS	33.65	14.01	32.98	13.93	0.294
HAPPINESS	4.34	0.602	4.36	0.607	-0.204
SELF ESTEEM	30.08	3.78	31.42	4.61	1.968
LONELINESS	16.26	10.59	16.88	12	-0.335
PROBLEM SOLVING	32.41	6.04	30.62	6.31	1.784
COGNITIVE RESTRUCTURING	32.16	5.87	30.05	6.31	2.129*
EXPRESS EMOTIONS	27.82	7.14	25.24	5.96	2.419*
SOCIAL SUPPORT	29.12	7	28	6.4	1.029

PROBLEM AVOIDANCE	25.06	5.97	25.05	6.11	0.015
WISHFUL THINKING	26.48	8.93	26.59	7.84	-0.086
SELF CRITICISM	21.72	7.4	19.51	6.85	1.903
SOCIAL WITHDRAWAL	23.34	7.02	23.19	6.42	0.139
PROBLEM FOCUSED ENGAGEMENT	64.57	11.21	6.67	11.96	2.072*
EMOTION FOCUSED ENGAGEMENT	56.48	11.7	52.59	10.91	2.116*
PROBLEM FOCUSED DISENGAGEMENT	51.54	13.52	51.64	12.34	-0.049
EMOTION FOCUSED DISENGAGEMENT	45.06	11.86	42.71	10.92	1.273

*p< 0.05

- The male group scored higher on Perceived Burdensomeness and Thwarted Belongingness (M = 33.65), Problem Solving (M = 32.41), Cognitive Restructuring (M = 32.16), Express Emotions (M = 27.82), Problem Focused Engagement (M = 64.57) and Emotion Focused Engagement (M = 56.48).
- The female group scored higher on Happiness (M= 4.36), Self Esteem (M= 31.42), Loneliness (M = 16.88), Wishful Thinking (M = 26.59), Problem Focused Disengagement (M = 51.64) .
- There is a significant difference between the male and female groups with respect to Cognitive Restructuring (t = 2.129), Expressed Emotions (t = 2.419), Problem Focused Disengagement (t = 2.072) and Emotion Focused Engagement (t = 2.116).

TABLE 4.5: CORRELATION VALUES OF PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS WITH ALL THE SELECTED VARIABLES FOR THE ENTIRE SAMPLE

VARIABLES	PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS
Happiness	-0.50**
Self Esteem	-0.527**
Loneliness	0.620**
Problem solving	-0.376**
Cognitive restructuring	-0.424**
Express Emotions	-0.164*
Social Support	-0.329**
Problem Avoidance	-0.070
Wishful Thinking	0.156
Self Criticism	0.137
Social Withdrawal	0.183*
Problem focused engagement	-0.423**
Emotion Focused engagement	-0.273**
Problem focused disengagement	0.069
Emotion focused disengagement	0.193*

* $p < 0.05$, ** $p < 0.01$

- The table shows significant correlation between Perceived burdensomeness and thwarted belongingness and the variables Happiness(r=-0.50), Self Esteem(r= -0.527), Loneliness (r= 0.620), Problem Solving (r=-0.376), Cognitive Restructuring (r= -0.424) , Express Emotions (r= -0.164), Social Support (r= -0.329), Social Withdrawal (r= 0.183), Problem Focused Engagement (r =- 0.423), Emotion Focused Engagement (r = 0.237)and Emotion Focused Disengagement (r= 0.193).

The obtained results need logical explanations to support the hypotheses of the study that is presented in the next section.

CHAPTER 5

DISCUSSION

The result presented in the earlier chapter has been discussed in the following fashion:

5.1 DIFFERENCES IN THE PSYCHOLOGICAL PROFILES OF PRE-RETIREMENT GROUP AND RECENTLY RETIRED GROUP:

Table 4.1 shows significant't' values for **Perceived Burdensomeness and Thwarted Belongingness** (t=-3.378), **Self Esteem** (t=2.448), **Problem Solving** (t=2.408), **Cognitive Restructuring** (t=2.825), **Social Support** (t=2.784), **Problem Focused Engagement** (t=2.773) and **Emotion Focused Engagement** (t=2.941) between the Pre-Retirement Group (N=48) and the Recently Retired Group (N=54).

5.1.1 PRE-RETIREMENT GROUP

Table 4.1 shows that the Pre-retirement Group (N=48) scored higher on the two variables of **Happiness** (M= 4.46) and **Self Esteem** (M=31.89) and lower in the variable of **Loneliness** (M=13.64) in comparison to the Recently Retired Group (N=54). In terms of coping, the Pre-retirement Group tended more towards **Problem Solving,** (M=32.93), **Cognitive Reconstructing** (M=32.83), **Express Emotion** (M=27.85) and **Social Support** (M=30.72), and less towards **Self Criticism** (M=20.83) and **Social Withdrawal** (M=22.37). Overall, **Engagement**, both **Problem focused** (M=65.77) and **Emotion-focused** (M=58.29), was higher in magnitude**.**

According to **George (2010)**, key predictors of happiness among adults include at least five categories: socioeconomic status (e.g., income), health, social integration (e.g., community connectedness), social relationships and support (e.g., family and friend) and psychological resources. It may be reasonable to assume that the greater score of this group for happiness (M= 4.46) may be because, for individuals in the pre-retirement group, all the five mentioned categories are stable. Income is steady although he or she may be preparing for retirement. Social integration is high owing to family and occupational commitments which in turn cause a reduction in feelings of loneliness and isolation. Also, there is abundance of social support and psychological coping resources in times of distress to fall back on.

By middle age, thoughts of retirement grow increasingly strong, not only because men and women find the burden of work becoming heavier and heavier as their strength and energy diminish but also because they realize that they are waging a losing battle in their competition

with younger workers. **(Haynes, McMichall and Tyroler, 1978). Denga (1996)** posited that the anxiety of the prospective worker is often heightened and compounded by a lack of security, especially among those who have little to fall back on after retirement. Occupational stress is accentuated by the employee's frantic effort to secure alternative job before the implacable finality of retirement. Some individuals' off-work time is spent in exploring possible businesses or trades in which they would be engaged following retirement, and these restlessness often prompts them to engage in positive coping strategies like **problem solving**(M=32.93), **cognitive restructuring**(M=32.83) and **emotion engagement**(M=27.85).

Jaquish and Ripple (1981) found that adults report somewhat lower self-esteem in late adulthood (age 61–81 years) than in middle adulthood (age 40–60 years).This is consistent with the obtained results where scores for self esteem are lower in the Recently Retired Group(M=29.85) than in the Pre-Retirement Group(M=31.89). Life transitions such as retirement might contribute to deteriorating self-esteem **(Gove, Ortega, & Style, 1989)** as old age involves a number of other changes that might contribute to declines in self-esteem, including spousal loss, decreased social support, declining physical health and cognitive impairments **(Baltes & Mayer, 1999)**. In the pre-retirement years, however, the individuals increasingly occupy positions of power and status, which might promote feelings of self-worth. Many lifespan theorists have suggested that midlife is characterized by peaks in achievement, mastery, and control over self and environment. Also, the personality changes that occur during adulthood tend to reflect increasing levels of maturity and adjustment, as indicated by higher levels of conscientiousness and emotional stability (**Trzesniewski, Robins, Roberts, & Caspi, 2004).**

Perceived burdensomeness (M= 27.47) and **self criticism (**M= 20.83**)** are less since the pre-retirement period is one of the most productive years of one's life. The individual contributes actively both socially as well as economically. According to Erikson's stage Theory, adulthood is marked by the conflict of Generativity."Vs. Stagnation and the challenge is to be creative, productive and nurturant of the following generation. With the focus primarily on the "the generation of new beings as well as new products and new ideas" **(Erikson, 1982),** the focus is shifted to those outside the self, leaving little or no scope for social withdrawal.

Thus, driven by generativity so as not to stagnate, it is not surprising for the individuals in the pre-retirement group to score high on the tertiary subscale of Engagement Coping.

Through these coping strategies, individuals engage in an active and ongoing negotiation with the stressful situation. **Happiness** (M= 4.46) and **Self Esteem** (M=31.89) boast up, **Loneliness** (M=13.64) diminishes and, altogether mental health indicates higher **Problem focused engagement** (M=65.77) and **Emotion-focused engagement** (M=58.29).

5.1.2 RECENTLY RETIRED GROUP

The Recently Retired Group (N=54) scored higher on the two variables of **Perceived Burdensomeness and Thwarted Belongingness** (M= 36.35) and in **Loneliness** (M=18.03) in comparison to the Pre-retirement Group (N=48). In terms of coping, the Recently Retired group tended more towards **Wishful Thinking** (M=25.75), **Self Criticism** (M=21.44), **Social Withdrawal** (M= 23.68)**.** Overall, **Disengagement**, both **problem focused** (M=50.22) and **emotion-focused** (M=45.12) was higher in magnitude**.**

Old age brings about reduced physical ability, declining mental ability, the gradual giving up of role playing in socio-economic activities, and a shift in economic status moving from economic independence to economic dependence upon other's for support. This increasing dependency on others can enhance **Perceived burdensomeness** (M= 36.35), a self-view that one is defective and flawed, to the point of being a liability to others **(Van Orden, Witte, Cukrowicz, Braithwaite, Selby, Joiner, 2010).** The two main hypothesized components of perceived burdensomeness are liability and self-hate **(Van Orden, Witte, Cukrowicz, Braithwaite ,Selby , Joiner, 2010)**.

Loneliness and an absence of reciprocal care are the two main hypothesized components of thwarted belongingness. **(Van Orden, Witte , Cukrowicz, Braithwaite ,Selby , Joiner, 2010)**. Already high on the variable of perceived burdensomeness and thwarted belongingness, members of this group also scored high on the variable of **Loneliness** (M= 18.03). The transition of life and it's changes to a different setup fully enhances feelings of loneliness. When individuals, especially older adults, feel that they are neglected by their grown children or other family members, they develop a "nobody loves me" complex **(Hurlock 2002).** This perceived quality of the relationship with children may have more impact on loneliness than the number of contacts with them (**Mullins & Dugan 1990).**Unfulfilled expectations of getting visits from relatives or friends have been found to increase the prevalence of loneliness **(Berg, Mellerström, , Persson, Svanborg, 1981; Bondevik & Skogstad 1996**), as did dissatisfaction with social contacts **(Creecy, Berg, Wright, 1985; Hansson, Jones, Carpenter, & Remondet, 1986-87;**

Mullins & Dugan, 1990, Holmén, Ericsson, Andersson, Winblad, **1992a; Holmén, Ericsson, Winblad 1994; Kim 1999; Cohen-Mansfield & Parpura-Gill 2007).**

Wishful Thinking (M= 25.75) and **Self criticism** (M= 21.44) as coping techniques are high among the recently retired group. Retirement entails a loss of status and prestige, a "roleless" situation where appropriate or at least clearly defined social positions and role expectations are notoriously absent. The Role theory of **Mead (1934)** states that work provides a sense of identity, worth and fulfilment for the individual Once a person is unable to perform his occupational roles, his former claims to prestige, competence, and social position are no longer valid, thus precipitating the likelihood of an identity breakdown **(Monk, 1971)**. Hence retirement may lead to loss of social role and emotional distress. Lack of zeal with this change and the lack of acceptance with oneself often results in high **Self criticism** (M= 21.44) and subsequently, high **Wishful Thinking** (M= 25.75).

Consequently, the re-directing of one's inner resources towards greater understanding of oneself causes one to learn to enjoy one's own company, thus favouring S**ocial Withdrawal** (M= 23.68). Although solitude is believed to promote individuality, creativity, and self-awareness by allowing the opportunity for contemplation, self-exploration, and insight, avoidance and solitude, may, however, take the form of self-imposed isolation and self criticism **(Weiss, 1973).** In that case, coping with stress resulting from a number of interpersonal losses, including autonomy, relationships, roles, and status is mostly taken care of through **avoidant attitude (Kotkamp-Mothes, Slawinsky, Hindermann, Strauss, 2005).** Older people tend to use less planful problem solving and more escape avoidance **(Folkman, Lazarus, Pimley and Novacek, 1987).** The Recently-Retired Group in the present study did score higher in both **problem focused disengagement** (M=50.22) and **emotion-focused disengagement** (M=45.12) as patterns of coping, therefore supporting the above mentioned research evidences.

Thus, the sudden transition of life at the said age level brings about a "retirement shock" **(Horowitz, 1965).** Unlike before, the sudden reduction in their active contribution to every aspect of life results in higher self criticism, social withdrawal, wishful thinking and loneliness. Moreover, their problem and emotion focused disengagement towards any crisis ultimately result in the reduction of healthy coping among the recently-retired group.

5.2 DIFFERENCES IN THE PSYCHOLOGICAL PROFILES OF RECENTLY RETIRED GROUP AND POST RETIREMENT GROUP:

Table 4.2 does not show significant t - values for any of the variables between the Recently Retired group (N=54) and Post – Retirement group (N=50).

5.2.1 RECENTLY RETIRED GROUP

The Recently Retired Group (N=54) scored higher on the variables of **Perceived Burdensomeness and Thwarted Belongingness** (M= 36.35), and **Loneliness** (M=18.03) in comparison to the Post-Retirement Group (N=50). In terms of coping, the Recently Retired group tended more towards **Express Emotion** (M= 26.03), **Self Criticism** (M=21.44). Overall, **Disengagement**, **Emotion-focused** (M=45.12) was higher in magnitude**.**

Leary, Terdal, Tambor, and Downs (1995) described thwarted belongingness as the "need to belong", which is a psychologically painful mental state that results when the fundamental need for connectedness is unmet. In order to meet this need, the individuals must frequently indulge in proximal and positive social interactions. The mean magnitude of **Perceived Burdensomeness and Thwarted Belongingness** (M= 36.35) is high in the recently retired group. Negative emotions predominate due to negative self perception, as a result of the individual's belief that one is a burden on others. Overcoming perceived burdensomeness involves beliefs that one is an important contributor to the family (i.e., rather than a burden). A large literature has also linked perceptions of burden on others with loss of dignity and desire for death among older adults nearing the ends of their lives **(McPherson, Wilson, & Murray, 2007)**.

The recently retired group has already scored high on the variable of **Perceived Burdensomeness and Thwarted Belongingness** (M= 36.35), and hence the mean magnitude for **Loneliness** (M=18.03) is also high for this group because of the loss of the social life that kept them busy and involved. Thwarted belongingness, but not perceived burdensomeness is associated with loneliness, lack of social support, and (lower) meaning in life. The individuals are reluctant to admit their loneliness because it is experienced as shameful, and older people may also fear being or becoming a burden **(Killen, 1998; McInnis & White, 2001).** A robust literature has linked meaning in life among older adults with both social support **(Charles & Carstensen, 2010; Krause, 2007)** and loneliness **(Golden, Conroy, Bruce, Denihan, Greene,**

Kirby, & Lawlor, 2009), and thus convergent relations between thwarted belongingness and meaning in life has been proposed.

Express Emotion (M= 26.03) and **Self Criticism** (M=21.44) as coping techniques are high among the recently retired group. **Express Emotion** are efforts to deal with stress by expressing one's emotion **(Wong and Wong, 2006).** Since the recently retired group have an inability to accept the new change in their lives, **Express Emotion** may involve irritability, remorse, guilt which may take a depressive trend. This finding may be supported by **Osborne (2012)** where he found that for those individuals with highly skilled and management careers, the loss of their status can leave them feeling like nobodies. The effects of such losses may linger for some time and be particularly troublesome during the transition. Passive acceptance, helplessness and depression are associated with worse adaptation **(Monat, Lazarus and Reevy, 2007).**

Self Criticism (M=21.44) is high in the Recently Retired group because of lack of self acceptance in terms of moving from the stage of generativity to stagnation. In generativity, one begins to see what life has turned to be. However in the stage of stagnation, one confronts the fact that there is only one life to lead, and there is not enough time to start over **(Slater, 2003)**. The transition to retirement can trigger both a looking back at one's life and a looking forward to its last chapter. However, the beginning of retirement can also be a time for reflection upon the past, without excessive nostalgia. Retirees may regret lost opportunities from the past. It is not easy for some retirees to accept that there may be no demand for them to return to the occupational niche they occupied for so long **(Osborne, 2012)**. **Self Criticism** gets an excessive preoccupation because of one's lack of ability to deal with the situation **(Wong and Wong, 2006).** Self-criticism may then be understood as a strategy to cope with shortcomings of an inadequate or inferior perceived self **(Gilbert, Clarke, Hempel, Miles, & Irons, 2004)**. However, this constant and cruel self-to-self harassment is highly linked to psychopathology, namely depressive symptoms **(Dunckley, Zuroff, & Blankstein, 2003; Gilbert, Clarke, Hempel, Miles, & Irons, 2004; Gilbert Durrant & McEwan, 2006).**

Since the mean magnitude **Self Criticism (**M=21.44) is high in the Recently Retired group when compared to the Post Retirement group, **Emotion Focused Disengagement** (M=45.12) is also high. In disengagement, the person is emotion-focused and seeks to escape their feelings of anxiety; this includes coping responses such as avoidance, denial, and irrational thinking. Disengagement coping is a maladaptive coping effort **(Wong and Wong, 2006)** which is

unhealthy if used in greater frequency. Engagement, on the other hand, seeks to deal with the stressor and/or the emotions associated with it through problem-focused and some emotion-focused strategies like seeking support, emotional regulation, and cognitive restructuring **(Meléndez, Mayordomo, Sancho, and Tomás, 2012)**. Unsupportive social interactions have been found to be positively correlated with denial or disengagement coping **(Song and Ingram, 2002)**. This finding is true for the present study where the recently retired group have scored lesser in the variable of **Social Support** (M= 27.14) as compared to the post retirement group.

Moreover retirees are confronted with important potential stressors in retirement often relating to loss of work and changes related to aging. **Friedmann and Havighurst (1954)** describe five benefits of work that people lose in retirement including income, a routine to provide structure to life, a context for social interactions, a significant basis for personal identity and status, and a meaningful experience that can provide a sense of accomplishment. Compounding these losses are the challenges of aging. For many retirees, the most important psychological challenge resulting from retirement is the loss of a work/life structure and the task of building a retirement/ life structure to replace it **(Van Solinge & Henkens, 2008)**.

5.2.2 POST RETIREMENT GROUP:

Table 4.2 shows that the Post-retirement Group (N= 50) scored higher on the two variables of **Happiness** (M= 4.38) and **Self Esteem** (M=30.66) and lower in the variable of **Loneliness** (M=17.82) in comparison to the Recently Retired Group (N=54). In terms of coping, the Post-retirement Group tended more towards **Problem Solving,** (M=31.78), **Cognitive Reconstructing** (M=31.24), **Social Support** (M=27.98), **Problem Avoidance** (M= 26.26) and **Wishful Thinking** (M= 28.68), and less towards **Express Emotion** (M=25.76). Overall, **Engagement**, both **Problem focused** (M=63.02) and **Emotion-focused** (M=53.04), and **Problem focused Disengagement** (M=54.94) was higher in magnitude**.**

Diener (2000) posits that happy people are in general more productive, more sociable, and have a number of other desirable characteristics. One factor that many studies find has a significant effect on happiness is individuals' sense of control over their life **(Batles and Batles, 1986; Lachman and Weaver, 1998; Reis, Sheldon, Gable, Roscoe and Ryan, 2000; Rodin, 1986; Sweeney, Anderson and Bailey, 1986)**. Hence, quite a few years after retirement after being settled in new roles, the individuals in the post retirement stage are well accepted in life by the people and hence more in terms of reality, which increases **Happiness** (M= 4.38). The

present finding can be supported by **Dolan, Peasgood & White (2008)** who suggested that an individual's perception of their circumstances can be a more important determinant of their happiness than the objective evaluation of those circumstances. Moreover, supporting this view**,** a recent survey of more than 300,000 adults found adults ranging between 65 to 79 years is the happiest age group for adults, according to Office for National Statistics research **(BBC News, 2016)**. The life satisfaction, happiness and feeling life was worthwhile all peaked in that age bracket. Meanwhile, those who were younger or retired had more free time to spend on activities which promoted their well-being, the researchers suggested.

Self Esteem (M=30.66) is high in the post retirement period. The Sociometer theory (**Leary & Baumeister, 2000**) posits that individuals feel good about themselves when they perceive inclusion. As workers retire they may use their former self-esteem as a reference or framework for constructing their current self esteem. Thus, individuals entering new situations or career stages may turn to the past, in this case their past self-esteem, to aid in efforts to structure and organize the present and future. This may continue until new identities in postretirement enable the person to engage in new lines of action which support a stable and consistent postretirement self-esteem. Personality theorists **(Costa and McCrae, 1980)** propose that the stability of general personality traits provides individuals with a framework to cope with (or adapt to) change. Given the uncertainties of being retired, former workers may rely on the ways they viewed themselves in the near-past to provide an initial reference point or benchmark in assessing themselves at a new stage in their lives. Rather than being directionless, or without a sense of self, individuals entering new situations or stages in their life cycle may use their past, in this case their past self-esteem, to guide them in the present **(Reitzes, Mutran and Fernandez, 1996).**

In terms of coping, **Problem Solving** (M=31.78), **Cognitive Reconstructing** (M=31.24), **Social Support** (M=27.98), **Problem Avoidance** (M= 26.26) and **Wishful Thinking** (M= 28.68) are high. The coping resources are used in old age to meet specific requirements. In a meta-analysis, **Penley, Tomaka, and Wiebe (2002)** found that **Problem solving** was associated with better health-related outcomes; **Avoidance**, distancing, and **Wishful Thinking** were associated with worse outcomes. In general, individuals who are experiencing more stressful life circumstances want to avoid unnecessary troubles and hence are more likely to rely on avoidance coping responses, such as selective ignoring, escapism,

Wishful Thinking, and resignation **(Aldwin & Revenson, 1987; Lohr, Essex, & Klein, 1988; Menaghan, 1982)**. In contrast, individuals in less stressful contexts tend to favour approach coping strategies, such as **Cognitive Restructuring**, seeking information, and negotiation **(Ducharme, 1994; Holahan, Moos, Holahan, Brennan 1997; Manne & Zautra, 1989; Taylor & Brown, 1988)**.

Dalton (2005) describes the importance of soliciting quality social support. Dalton found that elderly adults' use of social support strategies was particularly effective when employed to gain resources necessary for later problem solving. This is consistent with the present findings where the post retirement group has scored high both on Problem Solving (M=31.78) and Social Support (M=27.98).

The fact that subjective well-being increases with age suggests that many older adults engage in strategies that help to preserve well-being despite lower self-esteem. For example, older people may use more effective coping and emotion regulation strategies than younger people **(Baltes & Baltes, 1990; Brandstaedter & Greve, 1994; Carstensen, Isaacowitz, & Charles, 1999).** This finding is consistent with the present study where the post retirement group has scored high on Happiness, along with Problem focussed (M=63.02) and Emotion focussed Engagement (M=53.04)

According to **Wong and Wong (2006)**, Problem Solving, Cognitive Restricting, Express Emotions and Social Support represent engaged and adaptive coping efforts whereas Problem Avoidance, Wishful Thinking, Self Criticism and Social Withdrawal represent disengaged and maladaptive coping efforts. Since the Post retirement group combines both adaptive and maladaptive coping resources in different proportions, **Engagement**, both **Problem focused** (M=63.02) and **Emotion-focused** (M=53.04), and **Problem focused Disengagement** (M=54.94) was higher in magnitude. Some strategies, such as emotion-focused and problem-focused coping, appear more effective across more contexts than other strategies, and provide compelling evidence for ranking the helpfulness of particular coping strategies. Nonetheless, results across studies indicate that no coping strategies are ubiquitously effective or detrimental for older adults and retirees. This finding is consistent with results in other populations **(Lazarus & Folkman, 1984; Penley, Tomaka, Wiebe, 2002)**. Rather, more successful copers appear to have a repertoire of many complimentary coping strategies and strategically select combinations of coping strategies for use in particular situations. For example, problem-focused

strategies appear more appropriate for stresses caused by conflict and for goals that are attainable. Conversely, emotion-focused strategies and strategic avoidance may be more appropriate for loss-related stressors, when the external source of stress is uncontrollable, and when goals are unattainable. Avoidance and social support seeking strategies appear more beneficial when combined with re-engagement towards more appropriate goals and problem-focused coping **(Herzig, 2009).**

Mean magnitude of **Social Withdrawal** is same for both the Recently Retired and Post retirement groups (M= 23.68). Retirement in general results in Social Withdrawal which can develop when living at home causes a lack of communication with others. This results in the senior feeling lonely due to the loss of contact or companionship, as well as a deficit of close and genuine communication with others. It also can be the self-perception of being alone even when one is in the company of other people **(http://ageinplace.com/elderly-health/the-effect-of-social-isolation-and-aging-in-place/)**. Thus, having friends can contribute to life satisfaction in retirement. There is also the possibility that, as a function of aging, some retirees may prefer fewer but deeper friendships **(Carstensen, Gross, & Fung, 1997).**

5.3 DIFFERENCES IN THE PSYCHOLOGICAL PROFILES OF PRE-RETIREMENT GROUP AND POST-RETIREMENT GROUP:

Table 4.3 shows significant't' values for **Perceived Burdensomeness and Thwarted Belongingness** (t= -3.039), **Express Emotion** (t=2.11) and **Problem Focused Engagement** (t= 2.314) between the Pre-Retirement group (N=48) and the Post-Retirement group (N=50).

5.3.1 PRE-RETIREMENT GROUP:

The Pre-Retirement group has scored low on the variables of **Perceived Burdensomeness and Thwarted Belongingness** (M= 27.47) and in **Loneliness** (M=13.64) in comparison to the post-retirement Group. The Pre-Retirement group was found to be higher on the variables of **Happiness** (M=4.46) and **Self Esteem** (M=31.89) when compared to the Post-Retirement group. In case of coping, the Pre-Retirement group has engaged themselves more in **Problem Solving** (M=32.93) and **Cognitive Restructuring** (M=32.83). Overall, **Engagement**, both

problem-focused(M=65.77) and **emotion focused** (M=58.29.) were the coping strategies in which higher mean values were obtained by this group.

The last few years before retirement is rewarding to many people in different ways as they wind up all their contribution hence they are high on **Happiness(**M=4.46)and **Self Esteem**(M=31.89). People with high self-esteem experience more happiness, optimism and motivation than those with low self-esteem, as well as less depression, anxiety and negative mood **(Pyszczynski, Greenberg, Solomon, Arndt & Schimel, 2004)**. **Jaquish and Ripple (1981)** opined that adults report of somewhat lower self-esteem in late adulthood (age 61–81 years) than during their middle adulthood age (40-60 years). **Ward (1977)** found a weak negative correlation between age and self-esteem in a sample of individuals age 60–92.This is what has been the case for the Post Retirement Group whose mean score is (M=30.66)**,** which is lower than the mean score obtained by the Pre-Retirement group (M=31.89) on the variable of self -esteem showing that self-esteem decreases with increase in the age.

The high score on the dimension of **Social Support** (M= 30.72) for the Pre-Retirement group in comparison to the post retirement group is also a contributor to their **Happiness** during this age. Studies have, however, found that not only quality but also quantity of relationships has a significant bearing on happiness by improving one's mood and relieving pressure and stress **(Silverman, Hecht & McMillin, 2000)**. At this stage of Pre-Retirement social support increases as people nearing retirement get more social support from different avenues of life such as grandchildren and spending time with family. Having a greater variety of family and friends to provide for different needs could contribute to well-being **(Cheng, Lee, Chan, Leung & Lee, 2009)**.

To the younger person, whose days are so often overly crowded with duties and responsibilities years of retirement or semi-retirement seem like a golden period of life. With the onset of middle age, thoughts of retirement show a remarkable increase, this is not only because men and women find the burden of work becoming heavier and heavier as their energy and overall strength diminish but also because they realize that they are waging a losing battle in their competition with younger workers **(Haynes, McMichall, and Tyroler, 1978).** Pre-Retirement group is still into their job and their family structure is also more balanced, resulting in mature coping strategies. Thus, the Pre-Retirement group has healthy coping strategies than the Post Retirement group which is evident from the scores obtained by the Post-Retirement

group on the variables of **problem solving** (M=31.78) and **cognitive restructuring** (M=31.24) and the scores obtained by the Pre-Retirement group on the variables of **problem solving**(M=32.93) and **cognitive restructuring** (M=32.83), showing that the Pre-Retirement group is high on both the variables. As **Back (1969)** has explained, "the more retirement is looked on as a change to a new status, and less it is perceived as giving up of a prized status, the better the transition will be accomplished.

Self-Criticism (M=20.83) is more in the pre-retirement group as self-criticism sets in due to self-comparison across life thereby focusing gradually to the reduced capacity. Internalized self-criticism has been defined as a form of self-devaluation rising from a comparison between the present situation and internal personal standards **(Thompson & Zuroff, 2000).** Problem focused coping is generally viewed as an adaptive mode of coping that involves actively planning and engaging in a specific behaviour to overcome the problem causing distress **(Folkman and Lazarus, 1985).**Emotion focused coping may involve use of behavioural and / or cognitive strategies such as receiving emotional support from friends and family and positive reframing **(Ogden, 2004)**.As the pre-retirement group is more active and as they are still involved in their working life and due to increased social support their coping strategies are healthier than the post-retirement group. The overall healthy constellation of mental health parameters led to high **Problem Focused Engagement** (M=65.77) and **Emotion Focused Engagement** (M=58.29).

5.3.2 POST-RETIREMENT GROUP:

Table 4.3 shows that the Post-Retirement group scored higher on the variables of **Perceived Burdensomeness and Thwarted Belongingness** (M=35.64) and **Loneliness** (M=17.82) in comparison to the Pre-Retirement Group. In case of coping, the Post-retirement group tended more towards **Problem Avoidance,** (M=26.26) and **Wishful Thinking** (M=28.68). Overall, this group has obtained a higher mean value on the variable of **Problem Focused Disengagement** (M=54.94).

In the Post Retirement group, old age brings about reduced physical ability and the declining mental health among the retired individuals lead to their increased score in **Perceived Burdensomeness and Thwarted Belongingness** (M=35.64) and **Loneliness**(M=17.82) in

comparison to the Pre-Retirement group, who are comparatively low on these variables**. Ernst and Caccioppo (1999)** asserted that there is an overall positive correlation between loneliness and age. According to several studies, loneliness is more common among older than among younger older people **(Jylhä & Jokela 1990, Mullins, Sheppard &Anderson 1988, Barretta, Dantzler & Kayson 1995, Fees, Martin & Poon 1999, Jylhä 2004).**The feeling of loneliness is often experienced as shameful, and older people may also fear being or becoming a burden. Thus, they are reluctant to admit their loneliness **(Killeen 1998; McInnis & White 2001).**

In case of most elderly people there is a marked difference between expectations and the realities of retirement which is a major cause of reduced **Happiness** (M=4.38) in the Post-Retirement age. When retirement actually comes, however, it may seem far less desirable than it did earlier. Elderly people may find that their pensions are insufficient to enable them to live as they had planned and hoped to live **(Fine, 1975).**

The low **Self Criticism (M= 19.48)** among the Post-Retirement group is due to the fact that, it may be possible that people become more self-compassionate later in life, especially if they reach the stage of integrity proposed by **Erikson (1968)**which involves acceptance of self. **Problem avoidance** is greater for Post-Retirement group (M=26.26) than the Pre-Retirement group (M=24.47). The reduced capacity of the Post-Retirement group prompts them to take fewer challenges in life hence **Problem Avoidance** is more. Their increased physical problems, reduced mental ability, lack of energy, low motivation during the Post-Retirement period is a major cause of their problem avoidance at this age. **Demeyer & De Raedt (2013)**, was of the opinion that older adults showed avoidant behaviour toward the sad and happy cues more than neutral ones. **Demeyer & De Raedt** believes that this avoidant behaviour of the old people can be interpreted in several ways. First, older individuals may have higher levels of emotional regulation, which causes them to temper their emotional responses more than younger adults. Second, because older individuals are aware of their limited life span, they may choose to avoid any negative stimuli in particular, as they would rather only expend energy on positive things. Finally, their limited energy resources may cause them to have blunted emotional response to all stimuli in general.

Disengagement was found to be one of the most important coping strategy in the post-retirement period. This group is high on **Problem Focused Disengagement (M=54.94)**. In case of coping strategies, persons with a passive dependent, home centered life style will be best

satisfied with disengagement. Undoubtedly there is a disengaging force operating on and within people as they pass 70 and 80 (**Havighurst, 1961)**.This is consistent with the obtained results which shows that post retirement group tend towards disengagement. **Emotion Focused Disengagement** is almost same for both Pre-Retirement (M=43.20) and Post-Retirement Group (M=43.16), which may be because of primary coping resources and utilizing Emotion Focused coping in its own unique way. In disengagement, the person is emotion focused and seeks to escape their feelings of anxiety; includes coping responses such as avoidance, denial and irrational thinking **(Craver & Connor-Smith, 2010; Moos & Schaefer, 1993; Roth &Cohen 1986, Skinner, Edge, Altman, Sherwood, 2003).** Retirees who recognize a goal as impossible can disengage from their impossible goal and put their energy towards the pursuit of new fruitful goals, resulting in improved well-being **(Gagne, Wrosch, & Brun de Pontet**, **2011)**.

5.4 DIFFERENCES IN THE PSYCHOLOGICAL PROFILES OF MALES AND FEMALES:

Table 4.4 shows that the obtained 't' values of the variables (N=75) are P**erceived Burdensomeness and Thwarted Belongingness** (0.294), **Happiness** (0.204), **Self Esteem** (-1.968), **Loneliness** (.335)**, Problem Solving** (1.784)**, Cognitive Restructuring** (2.129*)**, Expressed Emotion** (2.419)**, Social Support** (1.029)**, Problem Avoidance** (0.015)**, Wishful Thinking** (-0.086)**, Self Criticism** (1.903)**, Social Withdrawal** (0.139)**, Problem Focused Engagement** (2.072*)**, Emotion Focused Engagement** (2.116*)**, Problem Focused Disengagement** (-0.049)**, and Emotion Focused Disengagement** (1.273) respectively.

5.4.1 MALES:

The mean score of **perceived burdensomeness and thwarted belongingness** is found to be of 33.65 for males (N=75) which is higher than that of females (N=77) whose Mean is 32.98. **Happiness** of the male group (Mean=4.34) is found to be slightly less than the female group (Mean=4.36). In terms of coping, the male group is found to be inclined more to **Problem Solving** (Mean= 32.41), **Cognitive Restructuring** (Mean= 32.16), **Express Emotions** (Mean=27.82), **Social Support** (Mean=29.12), **Self Criticism** (Mean=21.72) and **Social Withdrawal** (Mean= 23.34). As a result, **Problem Focused Engagement** (Mean= 64.57) and

Emotion Focused Engagement (Mean= 56.48) are also high, and can regarded as their primary coping strategy.

Perceived burdensomeness is a mental state characterized by the sense of "others are better off if I were gone," which manifests when the need for social competence that is posited by frameworks including self-determination theory (**Ryan & Deci, 2000**) is unmet. Thwarted Belongingness is the sense of deep feeling of estrangement, including the feeling that he doesn't belong to even the close group of relations, such as family, peer group or society in general **(Van Orden, Witte, Cukrowicz, Braithwaite, Selby, Joiner, 2010)**. People who require help often say 'I don't want to be a burden' and when receiving help some experience themselves as a burden **(Angus & Reeve, 2006; Charmaz, 1991)**. Higher sense of Perceived burdensomeness and Thwarted belongingness (M=33.65) in males may be attributed to the cause that as a superior gender, males are always more active, and more dominant in life circumstances, the age of retirement for male is a big change demanding adaptation, perception of burden and therefore thwarted belongingness is more. Among older adults with advanced illness, perceived burdensomeness is associated with emotional distress, loss of dignity, and reduced well-being **(Chochinov, Kristjanson, Hack, Hassard, McClement, Harlos, 2007**; **Simmons, 2007; Wilson, Curran, & McPherson, 2005).** High score in Perceived burdensomeness and Thwarted belongingness (M=33.65) may also be attributed to poorer mental and physical health, depression, and stressful life events, such as unemployment, have been found to be associated with perceived burdensomeness **(Christensen, Batterham, Mackinnon, Donker, Soubelet, *2014).*** Unemployment increases the risk for suicide in men but not in women **(Qin, Agerbo, Westergård-Nielsen, Eriksson, Mortensen, 2000)** and may thus affect burdensomeness in males more than in females.

Happiness is recorded to be slightly less in males (M=4.34) from that of females (M= 4.36). This may be attributed to the cause that men have less readily available means of deriving satisfaction to replace that which their work provided than have women. As a result, retirement is more traumatic for them and they adjust less well to the role changes necessitated by retirement **(Hurlock, 2002).** In speculating on the sources of gender differences in well-being, **Nolen- Hoeksema and Rusting (1999)** suggest that "males are socialized not to experience or express affect as intensely as females . . ." (p. 344) There is nothing here to contradict this speculation, but, as the authors recognize, other circumstances may also affect the relative

happiness of women and men. Among older persons of both sexes, retirement and income have positive effects on well-being, and widowhood and poor health, negative effects. As women and men age from their fifties onward, the incidence of retirement and widowhood differs markedly by gender. Men benefit disproportionately from the positive effect of retirement, while women suffer disproportionately from the negative effect of widowhood. For men and women in the same work and marital circumstances, however, females remain happier than men, as a result perhaps of the difference in socialization experience emphasized by **Nolen-Hoeksema and Rusting (1999).**

However, **Loneliness** score of the present group of male subjects (M=16.26) is found to be slightly lower than females (M=16.88). Loneliness is a subjective, negative feeling related to the person's own experience of deficient social relations. With increase in age, due to retirement, older men experience a loss of social ties, which is expected to lead them to the feeling of loneliness. Although the growing body of researches suggests that having few social contacts or living alone does not assure a state of loneliness **(Mullins, Johnson, & Anderson, 1988)**. Also, **Perlman (1988)** has two explanations for why older adults are not as lonely a group as stereotypes suggest. The first is that the desired levels of contact might drop as rapidly as the actual level of contact. The second is that older adults might have higher ratings of the quality of their relationships. They might be less lonely because they feel their social circumstances compare favorably in terms of earlier expectations or relative to peers. The above stated evidence may be attributed as a cause of recorded low loneliness score of males in the present case.

In the present case, for males, **Problem Solving** (M=32.41) and **Cognitive Restructuring** (M=32.16), is recorded to be high, thereby mean **Problem Focused Engagement** (M=64.57) is also recorded to be higher than females. Problem Focused coping is a coping mechanism that helps one to deal with stress by identifying the fundamental cause of the stress in an objective manner, without letting one's emotion get in the way. Problem focused coping mechanism usually involves problem solving, time management and strategy development. When major stressors are added to daily ones or everyday hassles (e.g., losing keys, misplacing eyeglasses, increasing difficulty in ordinary activities such as climbing stairs or reading fine print), old age calls for extraordinary powers of coping, and adaptation. Person's own sense of mastery and competence influence how stress is managed. Feeling that one is in control has repeatedly been proved to contribute to well being at any age. Research indicates that old people maintain high

levels of mastery in the face of difficult life circumstances **(Rodin, 1986)**. It is remarkable how many older people do cope well with life stressors **(Pearlin, & Skaff, 1996)**. Older people report fewer hassles than do younger adults **(Aldwin, 1990)**, and life events may also be deemed less stressful in later life **(Aldwin, 1991)**. One explanation may be that older adults, through their greater range of experience, may have developed more coping resources and thus judge problems as less stressful. Furthermore, to the extent that older adults have experienced extremely stressful events, such as the death of loved ones, everyday problems may pale in comparison **(Aldwin, 1994; Aldwin, Levenson, & Spiro, 1994)**.

The Mean score of **Express Emotion** is found to be 27.82 in males. Express emotion is an engagement strategy, but the focus is managing one's emotional reaction to the stressor through communicating and expressing one's emotions **(Tobin, Holroyd and Reynolds, 1984)**. Emotion regulation problems signify that how individuals regulate, or have problems regulating emotions, which plays an important role in how they cope with stress. People with high impulse control difficulties, lack of emotional awareness, limited access to emotion regulation and lack of emotional clarity – are associated with increased use of the express emotion strategy. This is consistent with earlier researchers' assertions that emotion regulation plays an unconscious role in perceiving and responding to stressful situations **(Compas, Connor-Smith, Saltzman, Thomsen, Wadsworth, 2001)**. These observations are aligned with **D'Zurilla, Maydeu-Olivares, and Kant's (1998)** findings which also suggested that older adults tend to adopt problem-solving coping strategies and that older adult have more effective coping resources. They also indicate that as people mature, they are better able to adopt a range of behavioural, cognitive and emotional strategies to cope with stressful life events. One explanation is that older adults may engage in a more differentiated approach to problem situations by using diverse strategies in handling stress.

The mean **Social support,** of the present male group is 29.12, as "coping assistance" **(Thoits, 1983)**, or as an "exchange of resources" perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" **(Shumaker & Brownell, 1984). Sarason and Sarason (1990)** note that "social support is best defined as the sense of acceptance, an inherent, stable personality characteristic that contributes to the perception of social support separately from what the environment actually offers at any particular time." In general, it has been found that there exists a gender difference in the structure of social network. Women appear to have large multi-faced network- i.e. larger variety of people are present in their

network and each of the people serve several function. In contrast the network structure of men are appears considerable limited, consisting predominantly, of a single person, wife, who performs most support function for them. As against this, the **Social support** of the present male group was recorded as Mean= 29.12, which was higher than that for females (Mean=28.00).

Due to high score in **Express Emotion** (M=27.82) and in **Social support** (M= 29.12), it can therefore be stated that the present group of male subject, resorts to Emotion Focused Engagement as one of their primary coping strategies. Emotion focused coping aims at reducing or managing emotional distress that is associated with (or cued) by the situation. Older males' high score in Emotion Focused Coping is generally similar to **Lowenthal's, Thurnher, & Chiriboga, (1975)**'s finding. They posited that such phenomenon may be accounted for by changes in personality when people reach middle age: men turn more dependent and women, more aggressive. As regards to men, this could be explained as a consequence of the negative effects of retirement. They lose their main roles at work which define their social identity. So, they spend more time at home doing secondary tasks such as repairing electric device, and shopping. In a way, this explains the fall of their autonomy.

Mean **Social Withdrawal** is recorded to be 23.34, in males, whereas it is 23.19 in females. Social Withdrawal is a major risk factor for functional difficulties in older persons. Loss of important relationships can lead to feelings of emptiness and depression. Social isolation tends to increase, partly due to the end of working life or the loss of a spouse or close friends **(Lelkes 2010).** "Persons involved with a positive relationship tend to be less affected by everyday problems and to have a greater sense of control and independence. Those without relationships often become isolated, ignored, and depressed. Those caught in poor relationships tend to develop and maintain negative perceptions of self, find life less satisfying and often lack the motivation to change" **(Hansson & Carpenter, 1994).** The primary loss for older persons to be the death of one's spouse, and other important events affects social networks that include the loss of friends, decreased involvement with family, and moving to a new residence can be attributed as a cause for social withdrawal in older men (M=23.34). In addition, it can also be mentioned that relationships between family members may be strained and an older person may not be able to rely on these members for support, which gradually makes them withdraw from social interaction in their old age. However, **Poser (1995)** points out that older people tend to make friendships predominantly with those within the same age cohort. Thus, with advancing age, it is inevitable that people lose their friendship network and that they find it more difficult

to initiate new friendship and belong to new networks. But, physical, material, and intellectual resources helps people to have more social "capital", which allows them to continue to seek out new relationships and forms of social involvement.

Mean **Self Criticism** of males is found to be 21.72. According to researches, the negative consequences of self criticism extend to old age where **Santor and Zuroff (1994)** found a negative relation between self criticism and accepting the past, conceptualized as a facet of ego integrity.

Because of increased **Self Criticism** (M=21.72) and **Social Withdrawal** (M=23.34), **Emotion Focused Disengagement** (M=45.06) also increases, which is unhealthy and misbalanced when used in greater frequency. One of the strategies for accommodating to situations that cannot be changed is to reappraise or remember past emotions as less intense than they actually were. Alternatively, underestimates of the intensity of past emotions might result indirectly from the use of coping strategies that involve disengaging from thwarted goals. One determinant of emotional intensity is *concern strength* **(Frijda, Ortony, Sonnemans, & Clore, 1992); (Sonnemans & Frijda, 1994)** or the amount of investment people have in the goals that have been attained or thwarted **(Stein & Levine, 1987, 1990).** If people cope with negative emotions by disengaging from thwarted goals, they may experience emotions of shorter duration or recall past emotions as having been less intense than they actually were. The capacity to accommodate or "let go," that is, to disengage from previously held goals or activities, is particularly important when dealing with extremely stressful events (such as traumatic loss) or serious normative losses, such as in very old age **(Brandtstädter & Rothermund, 2002)**.

5.4.2 FEMALES:

Table 4.4 shows that the mean score of **perceived burdensomeness and thwarted belongingness** for female (N=77) is calculated to be 32.98. **Happiness** of the female group (M=4.36) is found to be slightly higher than the male group (M=4.34). **Self Esteem** (M=31.42) is found to more in females compared to males (M= 30.08). **Wishful Thinking** (M= 26.59) of females is also found to significantly higher than males (M= 26.48).

Female are a softer gender, weaker sex hence tries different ways to keep oneself happy. Women, on the whole, adjust better to retirement than men. Primarily because the role change for women is not radical. Women always played the domestic role, whether they were married

or single, throughout their working years, in addition to their working roles. Secondly, because work provides fewer psychological benefits and social supports for women, retirement is less traumatic for them than for men. Thirdly, because few women have held executive positions, they do not feel that they have suddenly lost all their power and prestige **(Hurlock, 2002).** In light of researches demonstrating that happiness is linked with better coping, lower morbidity, and lower mortality **(Fredrickson 2001; Pressman and Cohen 2005; Salovey, Rothman, Detweiler & Steward, 2000)** older age is a time when happiness is particularly important. Fortunately, despite stereotypical notions that people get depressed as they age, there is little evidence to support a link between aging and diminished happiness **(Blazer 2003)**. Numerous studies demonstrate that there is either no decline or a small decline in average levels of happiness in old age **(Baltes and Mayer, 1999; Brandtstaedter and Wentura, 1995; Cantril 1999; Carstensen Pasupathi, Mayr, & Nesselroade, 2000; Mroczek and Kolarz, 1998; Ryff 1989; World Values Study Group 1994)**. Many studies report that happiness increases with age, particularly after midlife **(Cantril 1999; Diener and Suh, 1999; Ryff, 1989; World Values Study Group 1994)**. These findings may depend on the aspect of happiness under consideration, however, as happiness is a multi-faceted construct **(Diener Scollon & Lucas, 2003b)**. In later life, adults may experience slightly less positive affect than younger individuals, but that is accompanied by a decline in negative emotions, especially the higher arousal emotions such as anger and fear **(Gross, Carstensen, Pasupathi, Tsai, Goetestam Skorpen, & Hsu, 1997; Kunzmann, Little & Smith 2000)**. A decline in negative emotions suggests that older adults may be better at regulating their emotions than younger adults **(Carstensen 1995; Labouvie-Vief, Hakim-Larson**, **DeVoe** & **Schoeberlein, 1989)**.

Loneliness is found to be slightly higher in females (M=16.88) than males (M=16.26)**.** Loneliness is referred to as a subjective, negative feeling related to the person's own experience of deficient social relations. As people grow old, the likelihood of experiencing age-related losses increases. Such losses may impede the maintenance or acquisition of desired relationships, resulting in a higher incidence of loneliness. Many female experience loneliness either as a result of living alone, a lack of close family ties, reduced connections with their culture of origin or an inability to actively participate in the local community activities. Researches by **Ferguson (2011)** and **Beaumont (2013)** suggests that, older women are more likely to say they feel lonely than older men. It has been suggested that older women are particularly vulnerable to social isolation and loneliness because of their greater advantage over

men in terms of longevity, with the result that women are more likely to outlive husbands, other relatives and friends, to live alone, and to experience a greater number of chronic health problems which limit social interaction. **Hall and Havens (1999)** found, for example, that women, who were older, lived alone, reported their health as poor, and reported a high number of chronic illnesses, scored significantly higher than older men on measures of social isolation and loneliness.

For the present group of subject, **Wishful Thinking** (M= 26.59) and **Problem Avoidance** (M=25.05) is high and therefore **Problem Focused Disengagement** (M=51.64) is higher than the male group, and can therefore be regarded as a primary coping strategy for the present group of females. Coping is the operative concept in the stress matrix. Coping is not a fixed trait, but a dynamic ability to prevent or control stress by applying appropriate methods to manage intrapersonal, interpersonal and environmental demands. For **Folkman and Lazarus (1980)**, coping involves the cognitive and behavioural efforts to overcome or reduce stress-related conflicts and demands.

Wishful Thinking (M= 26.59) is found to be greater in females throughout all age ranges than males. In the closing years of retirement, along with loosening family ties, with a different kind of independence and experience, job demand falling- reduces adaptive **Problem Solving ability** (Mean=30.62), perceives lack of **Social Support** (M=28.00) and inhibited emotional expression (**Express Emotion**: M= 25.24). This altogether emotion expression pattern changes and Wishful Thinking (M= 26.59) increases. Whenever there is a perception of inferiority, one tries to fulfill it through wishful thinking. Researchers have found that people who experience more stressful situations in life prefer avoiding unnecessary trouble and resorts more to avoidance coping responses, such as selective ignoring, escapism, Wishful Thinking, and resignation **(Aldwin & amp; Revenson, 1987; Lohr, Essex, Klein, 1988; Menaghan, 1982)**. Females in this sample exhibited reluctance to symbolically alter the situation and instead hoped and wished that the situation would improve as a coping approach. Such a strategy involves **Problem-Focused Disengagement** (M=51.64), where the individual may deny or avoid the problem situation and does not become actively involved in problem solving. Furthermore, according to **Tobin, Holroyd and Reynolds (1985, 1989)**with this approach to coping, there is a failure to initiate actions that may change the stressful circumstances. While disengagement is not considered a healthy approach for long-term adaptation, it may provide short-term relief,

particularly when one feels helpless or lack of control in the face of stressors that involve social conflict, especially in the context of traditional gender roles **(e.g. Ntseane, 2004).**

Due to reduced adaptive Problem Solving ability (M=30.62) and a perceived lack of Social Support, Problem Focused Coping (M=60.67) is overall less along with Emotion Focused Engagement (Mean= 52.59) as because emotions appear inhibited, and with retirement, one feels greater inferiority.

5.5 CORRELATION VALUES OF PERCEIVED BURDENSOMENESS AND THWARTED BELONGINGNESS WITH ALL THE SELECTED VARIABLES FOR THE ENTIRE SAMPLE:

Table 4.5 shows the correlation values **of Perceived Burdensomeness and Thwarted Belongingness** with all selected variables for the entire sample (N =152). The correlation value of **Perceived Burdensomeness and Thwarted Belongingness** with **Happiness** is (r=-0.50). Thus there is a negative correlation between happiness and perceived burdensomeness and thwarted belongingness. In terms of **Self Esteem** there is also a negative correlation(r=-0.527). Positive correlation of (r=0.620) is found between **Loneliness and Perceived Burdensomeness and Thwarted Belongingness**. For coping resources the correlation values are**: Problem Solving** (r=-0.376), **Cognitive restructuring** (r=-0.424), **Express Emotion** (r=-0.164), **Social Support**(r=-0.329),**Problem Avoidance** (r=-0.070), **Wishful Thinking** (r=0.156**), Self Criticism** (r=0.137), **Social Withdrawal** (r=0.183), **Problem Focused Engagement** (r= -0.423)**Emotion Focused Engagement**(r=-0.273),**Problem Focused Disengagement**(r=0.069) and **Emotion Focused Disengagement**(r=0.193).

The variables which have significant correlation coefficient with **Perceived Burdensomeness and Thwarted Belongingness** are **Happiness** (r=-0.50), **Self Esteem**(r=-0.527) and **Loneliness** (r=0.620). There is a negative correlation of **Perceived Burdensomeness and Thwarted Belongingness** with **Happiness**(r=-0.50) and **Self Esteem** (r=-0.527). With increased and perceived burdensomeness and thwarted belongingness no individual feels happy or has high views about oneself. They generally have low and negative opinion about themselves. Among older adults, the association between perceived burdensomeness and greater severity of suicidal ideation holds even after controlling for other risk factors for suicide,

including depression and hopelessness (**Jahn, Cukrowicz, Linton, & Prabhu, 2011; Yerevanian, Feusner, Koek, & Mintz, 2004**). Among older adults with advanced illness, perceived burdensomeness is associated with emotional distress, loss of dignity, and reduced subjective well-being (**Akechi ,Okuyama, Sugawara, Nakano, Shima, Uchitomi., 2004; Chio, Gauthier, Calvo, Ghiglione, & Mutani, 2005).**

It is seen that with high **Perceived Burdensomeness and Thwarted Belongingness** there is a possibility for low self esteem as there is a negative view about oneself The elderly often believe that there is something innately wrong with themselves and have high feelings of inadequacy. Low self humour has been positively associated with self-reported depression, anxiety, symptoms of social anxiety, isolation, and general bad mood **(Martin**,**Puhlik-Doris Larsen, Gray,&Weir,2003; Tucker, Judah, O'Keefe, Mills, Lechner, Davidson, & Wingate, 2013**). Low self-esteem is directly related to depression. The vulnerability model states that low self-esteem is a causal risk factor for the development of depression and burdensomeness (**Beck, 1967).** It is seen that fluctuations in global self-esteem serve as an internal monitoring system of interpersonal inclusion or exclusion (thwarted belongingness). The theory posits that individuals feel good about themselves when they perceive inclusion and feel bad about themselves when they perceive exclusion (**Leary & Baumeister, 2000).**

Negative correlation is also found in **perceived burdensomeness and thwarted belongingnesswith Problem Solving** (r=-0.376), **Cognitive restructuring**(r=-0.424),**ExpressEmotion** (r=-0.164), **Social Support**(r=-0.329),**Problem Avoidance**(r=-0.070).Here problem solving capability is inhibited, solving of simple problems cannot be achieved efficiently. Due to negative correlation with **Cognitive Restructuring**(r=-0.424), re-thinking and decision making cannot be done effectively by the elderly. The lesser the problem solving ability of the elderly the more is the perception of being a burden develops. Small problems cannot be dealt effectively and dependence on others arises. The problem-solvingskills appraisal is decreased (i.e., weaker belief in ability to solve problems, higher tendency to avoid rather than confront problems, and external control of emotion) in the elderly, suicidal ideation and depression considerably increased in old age. (**Becker-Weidman, Jacobs, Reinecke, Silva, &March(2010); Bell &D'Zurilla (2009).** It is also seen that ineffective problem-solving abilities were associated with suicidal ideation in many older adults. Thus

Perceived burdensomeness may also arise from distress due to negative life events as found by **(Klionsky**, **Abdalla, , Abeliovich, Abraham, Acevedo-Arozena, Adeli., 2012**).

The higher the **perceived burdensomeness and thwarted belongingness** the lesser is the **Expressed Emotion**(r=-0.164).Results show that there is inhibited emotional expression and lack of social support amongst the elderly. Thus subdued emotional expression and lower level of hedonic well-being is experienced by the older adults. It is seen that older men who live alone at any point during a five-year period, for example, are twice as likely to experience cognitive declines and subdued emotional expression as those who live with others (**Van Gelder, Tijhuis, Kalmijn, Giampaoli, Nissinen, Kromhout, 2006)**. Thus it can be implied that the older adults who are lonely expresses emotions in a restrained way. The **emotion expression**(r=-0.164), decreases when the age increases and there is a decrease in activities in the life of the elderly. A research done in this field shows that there are upturns in negative affect after age 65 **(Diener & Suh, 1997)**, although another study found continued decreases level of functional limitation in the older population (**Kunzman, Little, & Smith, 2000**).

Lack of **Social Support**(r=-0.329) increases when the feelings of **perceived burdensomeness and thwarted belongingness** is high**.** Due to lack of **social support**(r=-0.329) the elderly becomes isolated, withdrawn and loneliness thus sets in. Poor perceived social support leads to poor mental health and elevated sense of **perceived burdensomeness and thwarted belongingness (Chlipala, 2008).** Due to lack of social interaction and support the elderly find themselves to be a burden to the society and as a result develop depression. A research shows that old age related losses, impede the maintenance or acquisition of desired relationships (emotional loneliness) of which depression is a common companion (**Singh &Misra, 2009).**

A negative correlation is established between **Perceived Burdensomeness and Thwarted Belongingness and Problem Avoidance**(r=-0.070). The increased feeling of burden causes the elderly to perceive themselves as the problem, so anything going wrong they consider it as themselves responsible and hence cannot avoid thoughts about it. It often occurs to the older adults that they are the problem creators and thus these thoughts keep recurring and hence they cannot stop thinking about it. In older adults a study posits that they cannot avoid experiencing high and sustained levels of emotional distress (**Gross, 2000**). Evidences show that

in the later stages of life of the elderly there is a decline in emotional wellbeing and an upturn in depressive symptoms and negative affect (**Charles, 2010**).

Increased **Perceived Burdensomeness and Thwarted Belongingness** results in increased **Loneliness** (r=0.620)**,** and greater **Self Criticism** (r=0.137), **Wishful Thinking** (r=0.156**), and Social Withdrawal** (r=0.183). Thus a positive correlation of **Perceived Burdensomeness and Thwarted Belongingness** is seen with these variables. Loss of important relationships and lack of support can lead to feelings of emptiness and depression. **Loneliness**(r=0.620) is the absence of an acceptable social network, that is, a wider circle of friends that can provide a sense of belonging of being a member of a community. This perspective on loneliness is based on the assumption that different types of relationships serve different, more or less unique functions and are barely interchangeable **(Dykstra & Fokkema, 2007**).

As one becomes old there is less connectivity with others and interpersonal relationships get distant. Thus in the older population, the probability of having an intimate attachment figure decreases with age (**Van Baarsen**, **Snijders, Smit, Van Duijn, 2001**). It is also revealed that **Loneliness**(r=0.620) was related to poor psychological adjustment, dissatisfaction with family and social relationships (**Hansson**, **Jones, Carpenter, Remondet** ,**1994)**

Adults high on **Perceived Burdensomeness and Thwarted Belongingness** have a disrupted self identity, hence they engage to **Self Criticism** (r=0.137). Socially isolated people and people dependent upon others have both higher levels of **Self-Criticism**(r=0.137) and lower levels of self-compassion. **Mongrain(1998)** found that self-critics experienced greater negative affect, perceived support worse than others, and made fewer requests for support and few interpersonal relationships. Those who were high in Self-Criticism(r=0.137) did not differ in the amount of support they received, only in how they accepted or requested it. Participants categorized as being higher in self-criticism had fewer interpersonal goals. It is seen that poor relationships and burdensomeness often tend to develop and maintain negative perceptions of self, find life less satisfying and often lack the motivation to change" (**Hansson & Carpenter, 1994**).

Persons involved with a positive relationship tend to be less affected by everyday problems and to have a greater sense of control and independence. Those without relationships often become socially withdrawn, ignored, and depressed and feeling of burdensomeness sets in.

Thus with advancing age, it is inevitable that people lose their friendship networks and that they find it more difficult to initiate new friendships and to belong to new networks. The negative effect of loneliness and social withdrawal in old age has been reported by researchers. Evidences show that the death of spouse and friends and social disengagement are some of the ubiquitous life-changing events contributing to isolation and withdrawal in older people (**Heikkinen, Berg, Avland, 1995**).

To reduce greater self negativity the elderly resort to more Wishful Thinking(r=0.183) because that gives them momentary happiness and increased self esteem. A positive correlation is found between **Perceived Burdensomeness and Thwarted Belongingness** and **Wishful Thinking**(r=0.183). Thus elder adults think more positively about future outcomes and things change for the betterment. They often engage in optimistic behaviour. Studies show that elderly adults typically believe that life gets better and better over time (**Ross & Newby-Clark, 1998**). Researches also prove that one's current life is typically evaluated more positively than is one's recollected past life, and the anticipated future is expected to be even more positive than is one's life at present (**Ryff, 1991; Shmotkin, 1991; Staudinger, Bluck, & Herzberg, 2003).**

The greater the **Perceived burdensomeness and Thwarted belongingness** the less healthy coping resources hence there is negative correlation with **Problem Focused Engagement**(r=-0.423) and E**motion Focused Engagement**(r=-0.273) **and a positive correlation between Problem Focused Disengagement**(r=0.069) and **Emotion Focused Disengagement**(r=0.193). Older adults who engage in positive relations with other develop healthy coping mechanisms. They are interactive to their surroundings, enjoy a good social life that those older adults who have isolated themselves from the society and perceive themselves as a burden to the society. Thus they develop negative coping strategies. Those with higher levels of personal and environmental resources are more likely to use engagement coping and less likely to use disengagement coping **(Billings & Moos, 1981, 1982; Cronkite & Moos, 1984; Holahan & Moos, 1991; Pearlin & Schooler, 1978**). When there is lack of social support, interaction, financial issues, relatively greater feeling of Perceived burdensomeness and Thwarted belongingness the elderly resort to maladaptive coping strategies. . Thus maladaptive coping have been found to be associated with high levels of psychological distress, such as symptoms of anxiety and depression, in both adolescents (**Jaser**, **Langrock, Keller, Merchant,**

Benson, Reeslund, 2005; Marcks & Woods, 2005) and adults **(Morillo, Belloch, & García-Soriano, 2007; Sarin, Abela, & Auerbach, 2005).**

After elaborate discussion of the obtained results, the brief overview and specific conclusion of the study are given in the next section.

CHAPTER 6

CONCLUSION

The discussion of the findings of the present study has lead to summarize the work and to draw the following conclusion.

The objectives of the present study was to draw a comparative profile of old age (pre-retirement recently retired and post-retirement) population, in terms of the psychosocial correlates of Perceived Burdensomeness And Thwarted Belongingness that is Happiness, Self esteem, Loneliness and Coping in old age.

For the purpose of the present study, 3 groups were selected - a Pre Retirement group consisting of 48 individuals in the age group of 50-60. years, a Recently Retired group consisting of 54 individuals belonging to the age group of 61-70 years and a Post Retirement group consisting of 50 .individuals belonging to the age group of 71-80.

A number of scales were used to assess the above mentioned selected variables. For collecting information regarding different socio-demographic variables about the respondents, an Information Schedule appropriate for the present research purpose was used. Other than this, Interpersonal Needs Questionnaire (INQ) by **Van Orden, Cuckrowicz, Witte and Joiner, (2012)**, Oxford Happiness Questionnaire (OHQ) by **Hills and Argyle (2002)**, Rosenberg Self Esteem Scale (RSE) by **Rosenberg (1965),** UCLA Loneliness Scale by **Russell (1996)**, Coping Strategies Inventory (CSI) by **Tobin (1984)** and were also used for the present research study. The data collected was scored using the appropriate scoring keys provided with each scale. After scoring, the raw scores were statistically analyzed using different measures of descriptive and inferential statistics. The samples in the present study were collected from family members, acquaintances of batch mates, and other old people residing in neighbourhood. The method of selecting the sample was purposive random sampling. The statistical analyses done after scoring the data comprised of Mean, Standard Deviation,'t' test and Correlation. Mean, Standard deviation and Correlation are Descriptive Statistics and t test is Inferential Statistics. 't' test was computed to find age difference (Preretirement, Recently Retired And Post Retirement) and gender difference (males and females) with respect to Perceived Burdensomeness and Thwarted Belongingness, Happiness, Self esteem, Loneliness and Coping. Correlation was computed for the entire sample consisting of 152 individuals to determine the magnitude and direction of relationship of Perceived Burdensomeness and Thwarted Belongingness with all selected variables for the entire sample.

Thus the **conclusions** drawn from the present study may be summarized as follows:-

1. ‘t’ test revealed significant difference between Pre-retirement group and Post-retirement group with respect to Perceived Burdensomeness and Thwarted Belongingness, Self Esteem, Problem Solving, Cognitive Restructuring, Social Support, Problem Focused Engagement and Emotion Focused Engagement. The pre retirement group scored higher on Happiness, Self Esteem, Loneliness, Problem Solving, Cognitive Reconstructing, Express Emotion, Social Support, Self Criticism, Social Withdrawal, Engagement and Problem focused, Emotion-focused Engagement. The recently retired group scored high on the variables of Perceived Burdensomeness and Thwarted Belongingness, Loneliness, Wishful Thinking, Self Criticism, Social Withdrawal, Problem Focused Disengagement and Emotion-focused Disengagement.

2. ‘t’ test revealed no significant difference between recently retired group and post retirement group. Recently retired group scored high with respect to Perceived Burdensomeness and Thwarted Belongingness, Loneliness, Express Emotion, Self Esteem and Emotion-focused Disengagement. The post retirement group scored higher on the variables of Happiness, Self Esteem, Problem Solving, Cognitive Reconstructing, Social Support, Problem Avoidance, Wishful Thinking, Problem Focused engagement, Emotion-focused engagement and Problem-focused Disengagement.

3. ‘t’ test revealed significant difference between the Pre-Retirement group and the Post-Retirement group on the variables of Perceived Burdensomeness and Thwarted Belongingness, Express Emotion and Problem Focused Engagement. The Pre-Retirement group scored higher on the variables of Happiness, Self Esteem, Problem Solving, Cognitive Restructuring, Problem Focused engagement and Emotion-focused engagement. The Post-Retirement group scored higher on the variables of Perceived Burdensomeness and Thwarted Belongingness, Loneliness, Problem Avoidance, Wishful Thinking, Problem Focused Disengagement.

4. There is a negative correlation of Perceived Burdensomeness and Thwarted Belongingness with Happiness, Self Esteem, Express Emotion, Problem Solving, Cognitive restructuring, Social Support, Problem Avoidance, Problem Focused Engagement, Emotion Focused Engagement. Positive correlation is found between Perceived Burdensomeness and Thwarted Belongingness and Loneliness, Wishful

Thinking, Social Withdrawal, Problem Focused Disengagement and Emotion Focused Disengagement.

6.1 LIMITATIONS OF THE STUDY:

Research in any field of study cannot be a complete contribution without limitations and scope for further research. Hence the present study also has its shortcomings which may be improved in future researches. Some of these limitations maybe described as follows:-

1. No institutionalized individuals were included in this study, as the sample was restricted to only community-dwelling old adults.
2. Unemployed and Self-employed people were not a part of the present study.
3. The present research includes a sample of 152 individuals. So generalization of the result might be unfelt here.
4. The researchers failed to crown the edifice of the research work since no other instrument other than questionnaires could be used in the present research work for the collection of information.
5. In the present research, individuals from low and middle socioeconomic statuses were not taken into account thereby limiting the area of findings and further generalizations.

The present study being a time bound project could not overcome the above mentioned limitations. However, it leaves open the scope for future research in this field of study.

6.2 ORIGINALITY OF THE PRESENT RESEARCH WORK:

The newness of the present research may be summarized as follows:-

1. In the present study, old age is taken on a continuum-working with three groups: pre-retirement, post-retirement and recently retired group.
2. The introduction of the new variable of perceived burdensomeness and thwarted belongingness is a precursor to understand old age suicides.
3. The present research is solely carried out in an Indian sample thereby predicting suicide due to perceived burdensomeness and thwarted belongingness strictly in the Indian context.

4. The present research wholly dealt with the retirement and the post-retirement sample in a family set up and unnoted the institutionalized set up.

Thus the originality of this comparative study is nothing but an addition to the continuous research investigations that are being conducted with "Old age".

6.3 AREAS OF FURTHER RESEARCH:

The researcher is of the viewpoint that the present study has opened different areas that are yet to be explored. The different studies which can be conducted in this area may be summarized as follows:

1. The subjective well being of people working in the post retirement years can be an area of further research.
2. The relation between the selected variables in the study can be found amongst the rural population.
3. The study can be conducted on bachelors, spinsters and divorcees.
4. The study can be conducted on the members of the LGBT Community.

Thus, the present research reveals the effects of perceived burdensomeness and thwarted belongingness, happiness, self esteem, loneliness, and coping among the various age groups of elderly people, with regard to pre-retirement and post-retirement samples. The purpose of choosing the elderly population as a sample for the present research is because of an increasing curiosity to understand the problems and predicaments faced by the elderly population in India. Each phase of life has its own unique challenges, old age is no different. Coupled with reduced physical ability there is declining mental ability, the gradual giving up of role playing in socio-economic activities, and a shift in economic status moving from economic independence to economic dependence upon other's for support. All these factors bring about significant changes in the individuals' temperament and marked differences can be seen in them over pre-retirement and post-retirement phases. These changes, with regards to perceived burdensomeness and thwarted belongingness, have been the focus of this present research.

CHAPTER 7

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CHAPTER 8

APPENDICES

APPENDIX A

INFORMATION SCHEDULE

1. **NAME:**
2. **AGE:**
3. **GENDER:**
4. **NATIONALITY:**
5. **MARITAL STATUS:**
6. **NUMBER OF FAMILY MEMBERS:**
7. **NUMBER OF EARNING MEMBERS IN THE FAMILY AT PRESENT:**
8. **INDIVIDUAL'S OWN INCOME:**

9. **WHETHER DOING ANY JOB AFTER RETIREMENT:**

10. **HOW IS (LEISURE) TIME SPENT?**

11. **YOUR OPINION OR VIEWS:**

    a) **ABOUT LIFE:**

    b) **ABOUT ONESELF:**

12. **WAYS OF COPING THROUGHOUT LIFE / MOST LIFE SITUATIONS:**

APPENDIX B

INTERPERSONAL NEEDS QUESTIONNAIRE (INQ)

INSTRUCTIONS:

Please respond to each question by using your own current beliefs and experiences, not what you think is true in general, or what might be true for other people. Please base your responses on how you have been feeling recently.

SL. NO.	STATEMENTS	1-NOT AT ALL TRUE	2	3 - SOME WHAT TRUE	4	5	6	7- VERY TRUE FOR
1.	These days people in my life would be better off if I were gone.							
2.	These days the people in my life would be happier without me.							
3.	These days I think I am a burden on society.							
4.	These days I think my death would be a relief to the people in my life.							
5.	These days I think the people in my life wish they could be rid of me.							
6.	These days I think I make things worse for the people in my life.							
7.	These days other people care about me.							

8.	These days I feel like I belong.							
9.	These days I rarely interact with people who care about me.							
10.	These days I am fortunate to have many caring and supportive friend.							
11.	These days I feel disconnected from other people.							
12.	These days I often feel like an outsider in social gatherings.							
13.	These days I feel that there are people I can turn to in times of need.							
14.	These days I am close to other people.							
15.	These days I have at least one satisfying interaction every day.							

APPENDIX C

OXFORD HAPPINESS QUESTIONNAIRE (OHQ)

INSTRUCTIONS:

Please read each statement below carefully and indicate how much you agree or disagree with each by entering a number in the column after each statement, according to the following scale:

1. Strongly disagree
2. Moderately disagree
3. Slightly disagree
4. Slightly agree
5. Moderately agree
6. Strongly agree

Please read the statements carefully. Do not take too long over individual questions; there are no "right" or "wrong" answers (and no trick questions). The first answer that comes into your head is probably the right one for you. If you find some of the questions difficult, please give the answer that is true for you in general or for most of the time.

SL. NO.	STATEMENTS	1	2	3	4	5	6
*1.	I don't feel particularly pleased with the way I am.						
2.	I am intensely interested in other people.						
3.	I feel that life is very rewarding.						
4.	I have very warm feelings towards almost everyone.						
*5.	I rarely wake up feeling rested.						
*6.	I am not particularly optimistic about the future.						
7.	I find most things amusing.						
8.	I am always committed and involved.						
9.	Life is good.						
*10.	I do not think that the world is a good						

	place.						
11.	I laugh a lot.						
12.	I am well satisfied about everything in my life.						
***13.**	I don't think I look attractive.						
***14.**	There is a gap between what I would like to do and what I have done.						
15.	I am very happy.						
16.	I find beauty in some things.						
17.	I always have a cheerful effect on others.						
18.	I can fit in (find time for) everything I want to.						
***19.**	I feel that I am not especially in control of my life.						
20.	I feel able to take anything on.						
21.	I feel fully mentally alert.						
22.	I often experience joy and elation.						
***23.**	I don't find it easy to make decisions.						
***24.**	I don't have a particular sense of meaning and purpose in my life.						
25.	I feel I have a great deal of energy.						
26.	I usually have a good influence on events.						
***27.**	I don't have fun with other people.						
***28.**	I don't feel particularly healthy.						
***29.**	I don't have particularly happy memories of the past.						

APPENDIX D

ROSENBERG SELF ESTEEM SCALE (RSE)

INSTRUCTIONS:

Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly agree or disagree with each statesmen.

SL NO.	STATEMENTS	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
1.	On the whole, I am satisfied with myself				
2.	At times I think I am not good at all.				
3.	I feel that I have a number of good qualities.				
4.	I am able to do things as well as most other people.				
5.	I feel I do not have much to be proud of.				
6.	I certainly feel useless at times.				
7.	I feel that I am a person of worth, at least on a an equal plane with				
8.	I wish I could have more respect for myself.				
9.	All in all, I am inclined to feel that I am a failure.				
10.	I take a positive attitude towards myself.				

APPENDIX E

UCLA LONELINESS SCALE

INSRUCTIONS

Indicate how often each of the statements below is descriptive of you.

O indicates "I often feel this way"

S indicates "I sometimes feel this way"

R indicates "I rarely feel this way"

N indicates "I never feel this way"

SERIAL NUMBER	STATEMENTS	O	S	R	N
1.	I am unhappy doing so many things alone.				
2.	I have nobody to talk to.				
3.	I cannot tolerate being so alone.				
4.	I lack companionship.				
5.	I feel as if nobody really understands me.				
6.	I find myself waiting for people to call or write.				
7.	There is no one I can turn to.				
8.	I am no longer close to anyone.				
9.	My interests and ideas are not shared by those around me.				
10.	I feel left out.				
11.	I feel completely alone.				
12.	I am unable to reach out and communicate with those around me.				
13.	My social relationships are superficial.				
14.	I feel starved for company.				
15.	No one really knows me well.				
16.	I feel isolated from others.				

17.	I am unhappy being so withdrawn.				
18.	It is so difficult for me to make friends.				
19.	I feel shut out and excluded by others.				
20.	People are around me but not with me.				

APPENDIX F

COPING STRATEGIES INVENTORY (CSI)

INSTRUCTIONS:

Please read each statement below carefully and choose the extent to which you used it to handle a chosen event in your life. Kindly tick one option from the following:

- Not at all
- A Little
- Somewhat
- Much
- Very much

SERIAL NUMBER	STATEMENTS	NOT AT ALL	A LITTLE	SOMEWHAT	MUCH	VERY MUCH
1.	I just concentrated on what I had to do next; the next step.					
2.	I tried to get a new angle on the situation.					
3.	I found ways to blow off steam.					
4.	I accepted sympathy and understanding from someone.					
5.	I slept more than usual.					
6.	I hoped the problem would take care of itself.					
7.	I told myself that if I wasn't so careless, this thing would not happen.					
8.	I tried to keep my feelings to myself.					
9.	I changed something so that things would turn out alright.					
10.	I tried to look on the bright					

	side of things.					
11.	I did something to get it out from my system					
12.	I found somebody who was a good listener.					
13.	I went along as if nothing were happening.					
14.	I hoped a miracle would happen.					
15.	I realized that I brought the problem on myself.					
16.	I spent more time alone.					
17.	I stood my ground and fought for what I wanted.					
18	I told myself things that helped me feel better.					
19.	I let my emotions go.					
20.	I talked to someone about how I was feeling.					
21.	I tried to forget the whole thing.					
22.	I wish that I never get myself involved with that situation.					
23.	I blamed myself.					
24.	I avoided my family and friends.					
25.	I made a plan of action and followed it.					
26.	I looked at things in a different light and tried to make the best of what was					

	available.					
27.	I let out my feelings to reduce the stress.					
28.	I just spent more time with people I liked.					
29.	I refused to think about it too much.					
30.	I wished that the situation would go away or somehow be over with.					
31.	I criticized myself for what happened.					
32.	I avoided being with the people.					
33.	I tackled the problem head-on.					
34.	I asked myself for what was really important, and discovered that things weren't so bad after all.					
35.	I let my feelings out somehow.					
36.	I talked to someone that I was very close to.					
37.	I decided that I was really someone else's problem and not mine.					
38.	I wished the situation had never started.					
39.	Since what happened was my fault, really chewed myself out.					

40.	I didn't talk to other people about the problem.					
41.	I knew what had to be done, so I doubled my efforts and tried harder to make things work.					
42.	I convinced myself that things aren't quite as bad as they seem.					
43.	I let my emotions out.					
44.	I let my friends help out.					
45.	I avoided the person who was causing the trouble.					
46.	I had fantasies or wishes about how things might turn out.					
47.	I realized that I was personally responsible for my difficulties and really lectured myself.					
48.	I spent some time by myself.					
49.	It was a tricky problem, so I had to work around the edges to make things come out OK.					
50.	I stepped back from the situation and put things into perspective.					
51.	My feelings were overwhelming and they just exploded.					
52.	I asked a friend or relative I respect for advice.					

53.	I made light of the situation and refused to get too serious about it.					
54.	I hoped that if I waited long enough things would turn out OK.					
55.	I kicked myself for letting this happen.					
56.	I kept my thoughts and feelings to myself.					
57.	I worked on solving the problems in the situation.					
58.	I reorganized the way I looked at the situation, so things didn't look so bad.					
59.	I got in touch with my feelings and just let them go.					
60.	I spent some time with my friends.					
61.	Every time I thought about it I got upset; so I just stopped thinking about it.					
62.	I wished I could have changed what happened.					
63.	It was my mistake and I needed to suffer the consequences.					
64.	I didn't let my family and friends know what was going					

	on.					
65.	I struggled to resolve the problem.					
66.	I went over the problem again and again in my mind and finally saw things in a different light.					
67.	I was angry and really blew up.					
68.	I talked to someone who was in a similar situation.					
69.	I avoided thinking or doing anything about the situation.					
70.	I thought about fantastic or unreal things that made me feel better.					
71.	I told myself how stupid I was.					
72.	I did not let others know how I was feeling.					