ASSESSMENT AND ENHANCEMENT OF PERSONALITY AND QUALITY OF LIFE IN ELDERLY THROUGH POSITIVE THERAPY

BY

S. VIJAYALAKSHMI

(03MP24)

A DISSERTATION SUBMITTED TO THE AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND HIGHER EDUCATION FOR WOMEN - DEEMED UNIVERSITY, COIMBATORE – 641043
IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF PHILOSOPHY IN COUNSELLING PSYCHOLOGY

AUGUST 2004

CERTIFICATE

This is to certify that the dissertation entitled **"ASSESSMENT AND ENHANCEMENT OF PERSONALITY AND QUALITY OF LIFE IN ELDERLY THROUGH POSITIVE THERAPY"** submitted to the Avinashilingam Institute for Home Science and Higher Education for Women (Deemed University), Coimbatore – 641 043, in partial fulfilment of the requirements for the award of the **DEGREE OF MASTER OF PHILOSOPHY IN COUNSELLING PSYCHOLOGY** is a record of original research work done by **S. VIJAYALAKSHMI** during the period of her study in the Department of Psychology, Avinashilingam Institute for Home Science and Higher Education for Women (Deemed University), Coimbatore-641 043, under my supervision and guidance and the dissertation has not formed the basis for the award of any Degree/ Diploma / Associateship / Fellowship or similar title to any candidate of any other University. It represents entirely an independent work on the part of the candidate.

Hemalatha Natesan 31-8-04	Syamala Sivam 31/8/04	N. S. Rohini	Bhuvaneswari. O. R.
Signature of the H.O.D.	**Signature of the Dean**	**Signature of the Guide**	**Signature of the Co-guide**

DECLARATION

I hereby declare that the dissertation entitled **"ASSESSMENT AND ENHANCEMENT OF PERSONALITY AND QUALITY OF LIFE IN ELDERLY THROUGH POSITIVE THERAPY"** submitted to the Avinashilingam Institute for Home Science and Higher Education for Women (Deemed University), Coimbatore - 641 043, in partial fulfilment of the requirements for the award of the **DEGREE OF MASTER OF PHILOSOPHY IN COUNSELLING PSYCHOLOGY** is a record of original research work done by me under the supervision and guidance of **Miss. N.S. ROHINI, M.A., M.Phil. (Madras), Lecturer (Selection Grade), Department of Psychology** and that it has not formed the basis for the award of any Degree / Diploma / Associateship / Fellowship or similar title to any candidate of any other University.

N.S. Rohini	Bhuvaneswari V.L.	S. Vyshali
Signature of the Guide	**Signature of the Co-guide**	**Signature of the Candidate**

Acknowledgement

ACKNOWLEDGEMENT

The researcher is grateful to many people who have helped in the creation of this thesis with great pleasure and appreciation. The researcher wishes to acknowledge individuals who in one way or another contributed to its completion.

The researcher expresses her reverential gratitude to **GOD ALMIGHTY** for his love and blessings. His strength and support has been a great source of encouragement which enabled the researcher to successfully complete this research.

The researcher expresses heartfelt gratitude and thanks for the encouraging support of her work from many authorities at Avinashilingam Institute for Home Science and Higher Education for Women, Deemed University, Coimbatore, especially **Dr.K.KULANDAIVEL**, M.A., M.A. (Ohio State), Ph.D. (Madras), Chancellor, **Dr.M.CHANDRAMANI**, M.Sc. (Baroda), M.Ed., Ph.D. (Madras), Vice Chancellor, **Dr.SAROJA PRABAKARAN**, M.A., Dip.Ed., (Madras), Ph.D. (Mother Teresa), Registrar, **Dr.SHYAMALA SIVANANDHAM**, M.A. (Nagpur), Dip.Ed., Ph.D. (Madras), Dean, Faculty of Humanities, for providing this opportunity to conduct this action research.

The researcher expresses her sincere gratitude to **Dr. HEMALATHA NATESAN**, M.A. (Mysore), B.Ed., Ph.D. (Madras), Professor and Head of the Department of Psychology, Avinashilingam Institute for Home Science and Higher Education for Women, Deemed University, Coimbatore, for her excellent encouragement, expert advice and criticism throughout the action research.

The researcher expresses her heartfelt thanks to her guide **Miss N.S. ROHINI** M.A., M.Phil. (Madras), Lecturer (S.G.), Avinashilingam Institute for Home Science and Higher Education for Women, Deemed University, Coimbatore. She was most instrumental in providing a sense of purpose and confidence to the researcher. The researcher expresses her deep appreciation and gratitude for the guide's efforts, dedication and extra-time which have certainly contributed to the quality of this thesis. Her many hours of dedicated work, resourcefulness and vision eased obstacles and helped in shaping the final product.

The researcher express her heartfelt thanks to her co-guide **Mrs. U.L. BHUVANESHWARI,** M.A., M.Phil., Temporary Lecturer, Avinashilingam Institute for Home Science and Higher Education for Women, Deemed University, Coimbatore, for providing invaluable feedback for many of the chapters as well as technical and valuable assistance,

creative ideas and friendly reality checks from start to finish. And the researcher wishes to thank the generous feedback and suggestions for the individual chapters provided by **Dr. S. GAYATHRI DEVI**, M.A., M.Phil., Ph. D. (Madras), Temporary Lecturer.

The investigator is also grateful to all those who served as **SUBJECTS** in this study for their kind co-operation.

Most special thanks go to her **FRIENDS**, who provided emotional support, encouragement and understanding.

The researcher also wishes to thank her **FAMILY MEMBERS,** whose steadfast support and tolerance for the demands and excesses that go into a project such as this, which was critically important and exceedingly strong.

(S. VIJAYALAKSHMI)

Contents

CONTENTS

CHAPTER	TITLE	Page No.
	LIST OF TABLES **LIST OF FIGURES**	
I	**INTRODUCTION**	1
II	**REVIEW OF LITERATURE** ➢ Personality ➢ Quality of Life ➢ Personality and Quality of Life ➢ Enhancement	25
III	**METHODOLOGY** ➢ Objectives ➢ Research Questions ➢ Null Hypotheses ➢ Area ➢ Sample ➢ Tools ➢ Procedure ➢ Analysis of Data	49
IV	**RESULTS AND DISCUSSION**	66
V	**SUMMARY AND CONCLUSION**	92
	REFERENCES	
	APPENDICES	

LIST OF TABLES

S.No.	TITLE	Page No.
1	DEMOGRAPHIC DETAILS OF THE SAMPLE	67
2	DISTRIBUTION OF THE ELDERLY IN DIFFERENT FACTORS OF PERSONALITY BEFORE AND AFTER TREATMENT	69
3	SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN PERSONALITY FACTORS OF THE ELDERLY BEFORE AND AFTER TREATMENT	73
4	SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN PERSONALITY FACTORS OF THE INSTITUTIONALIZED AND NON-INSTITUTIONALIZED ELDERLY	77
5	QUALITY OF LIFE OF THE ELDERLY	80
6	SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN QUALITY OF LIFE OF THE ELDERLY BEFORE AND AFTER TREATMENT	82
7	SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN QUALITY OF LIFE OF THE INSTITUTIONALIZED AND NON-INSTITUTIONALIZED ELDERLY	85
8	CORRELATION BETWEEN PERSONALITY FACTORS AND QUALITY OF LIFE	88

LIST OF FIGURES

S.No.	TITLE	Page No.
1	DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-C BEFORE AND AFTER TREATMENT	72 (a)
2	DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-E BEFORE AND AFTER TREATMENT	72 (b)
3	DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-L BEFORE AND AFTER TREATMENT	72 (c)
4	DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-O BEFORE AND AFTER TREATMENT	72 (d)
5	DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-Q_3 BEFORE AND AFTER TREATMENT	72 (e)
6	DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-Q_4 BEFORE AND AFTER TREATMENT	72 (f)
7	MEAN PERSONALITY FACTORS OF THE ELDERLY BEFORE AND AFTER TREATMENT	76 (a)
8	MEAN PERSONALITY FACTORS OF THE INSTITUTIONALIZED AND NON-INSTITUTIONALIZED ELDERLY	79 (a)
9	QUALITY OF LIFE OF THE ELDERLY	81 (a)
10	MEAN QUALITY OF LIFE OF THE ELDERLY BEFORE AND AFTER TREATMENT	84 (a)
11	MEAN QUALITY OF LIFE OF THE INSTITUTIONALIZED AND NON-INSTITUTIONALIZED ELDERLY	87 (a)

Introduction

INTRODUCTION

"As a white candle

In a holy place

So is the beauty

of an aged face "

- *Joseph Campbell*

Old age is the closing period in the life span. It is a period when people 'move away' from previous, more desirable periods – or times of 'usefulness'. As people move away from the earlier periods of their lives, they often look back on them, usually regretfully and tend to live in the present, ignoring the future as much as possible.

Age sixty is usually considered the dividing line between middle and old age. However, it is recognized that chronological age is a poor criterion to use in marking off the beginning of old age because there are such marked differences among aged individuals about, when ageing actually begins.

The last stage in the life span is frequently subdivided into early old age, which extends from age sixty to age seventy and advanced old age, which begins at seventy and extends to the end of life. People during the sixties are usually referred to as 'elderly'-meaning somewhat old or advanced beyond middle age and 'old' after they reach the age of seventy (Hurlock, 1999).

Ageing is not a single process. It consists of atleast 3 distinct processes : Primary, Secondary and Tertiary ageing. Primary ageing is normal, disease-free development during adulthood. Changes in biological, psychological, sociocultural or life cycle processes in primary ageing are an inevitable part of the developmental process. For example, menopause, decline in reaction time and loss of family and friends.

Secondary ageing involves developmental changes that are related to disease, life style and other environmentally induced changes that are inevitable, eg. Pollution. The progressive loss of intellectual abilities in Alzheimer's disease and related forms of dementia are examples of Secondary ageing.

Finally, tertiary ageing is the rapid loss that occurs shortly before death. An example of tertiary ageing is a phenomenon known as terminal drop, in which intellectual abilities show a marked decline in the last few years before death (Cavanaugh et al., 2002).

THEORIES OF AGEING

Ageing is a complex process influenced by heredity, nutrition, health and environmental factors. It is intriguing why people's body function less efficiently as they grow old. None of the many theories of biological ageing is

universally accepted, but most of them take one of two basic approaches – 'programmed' ageing or ageing as 'wear and tear'.

Programmed Ageing

The programmed ageing theory maintains that, in each species, the body ages according to a normal developmental pattern built into energy organism; this program is subject to only minor modifications. Since each species has its own life expectancy and its own pattern of senescence, this pattern must be predetermined and inborn. People may have genes that become harmful later in life, causing deterioration. One area of deterioration may be the immune system, which seems to become 'confused' in old age, so that it may attack the body itself.

Ageing as Wear and Tear

The wear and tear theory holds that the body ages because of continuous use and that deterioration is the result of accumulated 'insults'. In this theory, the human body is comparable to a machine whose parts eventually wear out. Wear and Tear theory suggests that internal and external stressors (including the accumulation of harmful materials, like chemical byproducts of metabolism) aggravate the wearing-down process (Papalia et al., 1995).

DEVELOPMENTAL TASKS OF OLD AGE

For the most part, the developmental tasks of old age relate worse to the individuals' personal life than to the lives of others. Various developmental tasks during old age are:

- Adjusting to decreasing physical strength and health.
- Adjusting to retirement and reduced income.
- Adjusting to death of spouse.
- Establishing an explicit affiliation with members of one's age group.
- Establishing satisfactory physical living arrangements.
- Adapting to social roles in a flexible way (Hurlock, 1999).

A common problem of the elderly is learning a new role. Becoming old means facing a time of transition. Thus, it is a state of life that increases the likelihood of psychological problems of low self-esteem and depression. These problems can be tempered by the adequacy of the individual's social support. Friends, fellow workers, family and neighbours can ease the burden. But, if one is cut off from work (retirement), from children and from a spouse (widowhood), the changes in personal trauma increase manifold.

In addition to the role transition in old age, three shifts within old age itself are especially traumatic: retirement, widowhood and death.

In many societies, including our own, performance in a work role bears witness to the traditional ethic of work and therefore commands respect. When that role is given up, respect diminishes. There may be residual esteem for past performance, but the base for generating new esteem is largely lost. Other gratifications are also removed. Apart from pension and social security payments, income derived from the role is gone. The comradeship and personal support of fellow workers is left behind. A familiar day-long routine has disappeared. Competencies of long standing no longer have a focus. It is not surprising that a good many face retirement with dismay and disorientation rather than happy anticipation.

The transition from wife to widow or from husband to widower is an especially difficult change for the individual. Not only is there the loss of loved one, but there are problems associated with taking on a new role, for example, that of a widow, that is negatively valued by society and by the individual. The widow is especially vulnerable to loneliness because she lives alone and lacks opportunities for interpersonal involvement. The meagre social support that widows experience is revealed by studies, which have shown that they have fewer contacts with children, greater unhappiness and higher rates of suicide and death than do married persons of similar age.

The anticipation of death is the last role transition people face. As one might suspect, this is an especially traumatic state. Compared to other transitions, the passage of death is especially devoid of social support (Chadha, 1997).

SOCIAL ISSUES RELATED TO AGEING

The ability to cope with challenges may be solely tested in late adulthood. On top of the physical problems that often accompany ageing, the social circumstances of many older people are very trying or even overwhelming. Two common issues are finances and living arrangements. A less common but growing problem is elder abuse.

Income

Women (especially widows), minorities, single people and people who worked at unskilled or service jobs are likely to be poor. Married couples rarely become impoverished after retirement, especially if they have pension benefits. A husbands' death, however, is a major risk factor for his widow. Older people can no longer work and inflation has eroded their savings and pensions.

Living Arrangements

About two-thirds of older people live with families; most with spouses, the rest with children or other relatives. The other one third live alone or with

non relatives. The probability of living alone rises with age and more women than men live alone. Majority of the older and poorer people live with someone else when compared to elderly people. They are also more likely to be depressed and to worry about the future.

Living Independently

Most of older people want to live in the community. Those who do, report higher levels of well-being than those in institutions, even when their health is about the same. But, living arrangements can become a major problem as people age. Older people usually want to stay in a familiar neighbourhood, to be independent, to have privacy, to feel safe and to have some social contacts.

Living in Institutions

The vast majority of older people do not live in institutions. Most do not want to and most of their families do not want them to. Older people often feel that placement in an institution is a sign of rejection and children usually place their parents reluctantly, apologetically and with great guilt. Sometimes, though, because of an older person's needs or a family's circumstances, such placement seems to be the only solution.

The elderly at highest risk of institutional living are those living alone, those who do not take part in social activities, those who perceive their health

as poor, whose daily activities are limited by poor health or disability and those whose caregivers are overburdened.

Abuse of the Elderly

A shocking way for ageing people to spend their final days is in the state of maltreatment - neglect, or physical or psychological abuse of dependent older persons. Although it can occur in institutions, it is most often suffered by frail elderly people living with their spouses or their children.

Such abuse can take the form of neglect, as in the withholding of food, shelter, clothing, medical care, money or other assets. It can involve psychological torment: tongue-lashings, insults, swearing or threats of violence or abandonment. It can also take the form of physical violence: beating, punching, burning or using weapons against old people who cannot protect themselves (Papalia et al, 1995).

PERSONALITY

The word personality in English is derived from the Latin 'Persona'. Every human being, whether a child, an adolescent or an adult possesses his or her own individual personality. This is reflected in all his or her activities and differs from individual to individual. (Chaube, 2002).

Personality is a persons' unique and relatively stable behaviour pattern. In other words, personality refers to the consistency in, who one is, has been

and will become. It also refers to the special blend of talents, attitudes, values, hopes, loves, hates and habits that makes each one a unique person (Coon, 2000).

Personality controls ones' behaviour, thoughts, emotions and even his/her unconscious feelings. Personality is the deeply fixed, consistent, distinctive and characteristic pattern of ones' thoughts, feelings and behaviour that define a persons' own style of interacting with the physical and social environment. It is the tendency to behave in a certain way under different circumstances and across time. Personality is actually the true nature that lies behind these elements (www.rcpsych.ac).

DEFINITIONS

According to Aswathappa (2003), "Personality represents the sum total of several attributes which manifest themselves in an individual; the ability of the individual to organize and integrate all the qualities so as to give meaning to life; and the uniqueness of the situation which influences behaviour of an individual".

According to Shepard (2002), "Personality is the relatively organized complex of attitudes, beliefs, values and behaviours associated with an individual".

Santrock (2000) believes that personality consists of enduring, distinctive thoughts, emotions and behaviours that characterize the way an individual adapts to the world.

Sternberg (2000) defines personality as "the enduring dispositional characteristics of an individual that hold together and explain the person's behaviour".

PERSONALITY TRAITS

The number and variety of specific personality traits or dimensions are bewildering. The term, personality trait, typically refers to the basic components of personality.

The early work in the structure of personality revolved around attempts to identify and label enduring characteristics that describe an individual's behaviour. Popular characteristics include shy, aggressive, submissive, lazy, ambitious, loyal and timid. Those characteristics, when they are exhibited in a large number of situations are called personality traits. The more consistent the characteristic and the more frequently it occurs in diverse situations, the more important that trait is in describing the individual (Robbins, 1999).

Traits are enduring dimensions of personality characteristics along which people differ. Allport (1937) has given three basic categories of traits which are as follows:

- Cardinal trait is a single characteristic that directs most of a person's activities.
- Central traits make up the core of a personality which are the major characteristics of an individual.
- Secondary traits are characteristics that affect behaviour in fewer situations and are less influential (Feldman, 1997).

Personality traits are stable enduring qualities that a person shows in most situations. Traits can be used to predict future behaviour (Asendorpf and Wilpers, 1998).

PERSONALITY AND PATTERN OF AGEING

As people age, they tend to be less active and fill fewer social roles. The four major personality types, with associated patterns of ageing are as follows:

- **Integrated**

Integrated people function well, with a complex inner life, a competent ego, intact cognitive abilities and a high level of satisfaction. They range from being very active and involved, with a wide variety of interests to deriving satisfaction from one or two roles, to bring self containment and contentment.

- **Armor defended**

Armor defended people are achievement-oriented, striving and tightly controlled. Those who stay fairly active and those who limit their expenditures

of energy, socializing and experience show moderate to high levels of satisfaction.

- **Passive-dependent**

Passive-dependent people either seek comfort from others or are apathetic. Some, who depend on others, are moderately active or very active and moderately or very satisfied. Others, who are passive all their lives, do little and show medium or low satisfaction.

- **Unintegrated**

Unintegrated people are disorganized, with gross defects in psychological functioning, poor control over their emotions and deteriorated thought processes. They manage to stay in the community, but with low activity and low satisfaction (Papalia et al, 1995).

PERSONALITY CHANGES

It is recognized that the personality pattern, prior to old age, influences people's reactions to old age. This, in turn, determines how much change will take place in their personalities when they become old. Although changes in personality do occur, they are quantitative rather than qualitative. This means that the fundamental pattern of personality, set earlier in life, becomes more set with advancing age. These are not new traits, rather are exaggerations of lifelong traits that have become more pronounced with the pressures of old

age. When pressures are too severe to adjust to and personality breakdown occurs, there is still evidence that the predominant traits, developed earlier, will be dominant in the pattern the breakdown takes.

CAUSES OF PERSONALITY CHANGES

Changes in personality comes in old age from changes in the core of the personality pattern, the self-concept. How much and in what direction the change occurs determines the quality and quantity of changes in personality pattern. Changes in the self-concept are due mainly to subjective awareness of ageing on the part of the elderly. When the elderly become aware of the physical and psychological changes that are taking place within them, they begin to think of themselves as "old". The treatment the elderly receive from others because of their age also contributes to changes in their self-concepts. In spite of the fact that the number of old people is increasing rapidly, they still constitute a 'minority group'. Many old people develop personality traits such as hypersensitivity, self-hatred, feelings of insecurity and uncertainty, quarrelsomeness, apathy, regression, introversion, anxiety, over dependency and defensiveness. It is important to recognize that not all older people develop these. Personality differences occur in old age as in every other period in life. However, those who are institutionalized, especially against their wishes, have poorer attitudes toward themselves.

EFFECTS OF RADICAL CHANGES

A radical change in the self-concept leads to breakdown of minor or major severity. In the milder forms, these consists of falsifications of memory, faulty attention, disturbances of orientation concerning time, place and person, suspiciousness, disturbances in the ethical domain, hallucinations and delusions especially of persecution type, anxiety, preoccupation with bodily functions, chronic fatigue, compulsion and hysterical disorders, neurotic depression and sex deviations.

Personality breakdown of a more serious kind, as in mental disease, increases greatly with advancing age. In the sixties, psychoses with cerebral arteriosclerosis and senile dementia predominate and these increase steadily to the end of life. After seventy, senile psychoses are more prevalent.

When a breakdown in personality occurs in old age, it may lead to criminal behaviour or suicidal tendencies. While the criminal tendencies are, on the whole, of a minor sort-larceny, theft and alcoholism-they lead to embarrassments for families. Income status from social security, pensions, etc., increases the suicide rate in old age (Hurlock, 1999).

QUALITY OF LIFE

Ageing is a universal phenomenon. However, not all old people are alike. There is considerable diversity among old people. Age, that is, whether a

person is young-old, old, old-old, does make a difference to health and well-being. Similarly, race, gender, social status and marital status determine the quality of life in later years (Prakash, 2001).

Quality of life is not easily defined due to element of subjectivity involved in it. It can, however, be said to be a 'general feeling of happiness' which is not a momentary experience but a long term sense of well-being. It consists of experience that cause a person to express his/her happiness. The conditions of happiness and satisfaction clearly depend upon the ability to survive, reasonable state of health and multiplicity of things that permit and cause the achievement of desires and aspirations.

The quality of life may be judged by how much one enjoys life. It may be described as net total happiness. Quality of life is a characteristic that makes life desirable. It is a concept related to happiness consisting of several sub components which are valued. That is why, it is meaningful to evaluate quality of life in terms of elements like per capita income, per capita caloric intake, literacy, health and shelter, since these are life support and operational systems which make life worth living (Gupta et al., 1995).

Quality of life is a subjective image that differs for everyone. Our vision about the meaning of quality of life is based on the way in which a number of basic values are translated in more or less concrete goals and expectations. The

course of life and our experiences with each phase of life play an important part in this. Even though everyone has their own qualitative expectations, there is a pattern that can be recognized that leads back to the eight basic values in the quality of life:

- Body integrity
- Feeling Safe
- Feeling self-worth
- Having a life structure
- A sense of belongingness
- Social participation
- Having meaningful daily activities
- Inner Contentment

Within these basic values, there is no fixed hierarchy. Everyone has his/her own priorities, based on one's life experiences and the culture he/she lives. By examining someone's course of life and by looking at the choices someone makes or has made, the personal quality profile can be aligned (http://www.gentleteaching.nl/qol-1.html).

Subjective well-being (SWB) is also taken as criterion of positive mental health or quality of life. One criticism in using this as criterion of quality of life is that a person might live an immoral life and nevertheless be

happy (Ryff and Keyes, 1995). When one observes, however, that 'Subjective well-being is atleast partially dependent on fulfilling one's goal, which in turn is related to one's values, it becomes defensible as an essential ingredient of the good life' (Diener et al., 1997).

Quality of life is measured by the freedom one has to enjoy what his heart desires politically, economically and socially. This includes the extent of political freedom, security of property and life, freedom of movement and association, cultural freedom. Some societies cherish their traditional institutions and cultural beliefs. If they are denied these, then their quality of life is reduced, but other societies may regard the same institutions as backward. Other things which determine quality of life include access to adequate food, freedom of worship, good health etc. (http://www.brrd.ab.ca/cchs/barclay/globweb/qolhtml/gayaza.html, 2000).

DEFINITIONS

Quality of life is an individuals' consciously perceived positive and negative, cognitive and affective experience (Naess, 1997).

Quality of life is the degree to which a person enjoys the important possibilities of his or her life (http://www.utoronto.ca/qol/concepts.htm).

There is also increasing recognition of the individual nature of quality of life, summed up in the WHO Quality of Life Group's (WHOQOL) definition:

'....an individuals' perception of their position in life in the context of the culture and value systems in which they live and relation to their goals, expectations, standards and concerns. It is a broad-ranging concept affected in a complex way by the persons' physical health, psychological state, level of independence, social relationships and their relationships to salient features of their environment'. (http://www.regard.ac.uk/ research_findings/L480254003/report.pdf).

The Parameters of Quality of Life are:

- Learning
- Health
- Environment

LEARNING

This is as much a basic human need as food. Learning is needed not just for the use we can make out of what we have learnt, but for the psychological satisfaction from learning process itself. Learning is a life long process and one continuously learns from every life situation. Learning becomes meaningful and enjoyable only when the learner internalizes the 'lessons' learnt for creating a better world. Unfortunately, both in 'poverty' and 'affluence', learning situations are manifold. This creates problems for both the individuals and society and ultimately for the quality of life.

It must be realized that all positive learning gives power and confidence. The joy of achievement, the confidence of living in control of ones' own affairs, a positive view of life and a creative world view of the future comes out of a 'learning attitude'. These are important factors of quality of life.

☙ HEALTH

It is quite obvious to everyone that one has to have good health to be able to do anything worthwhile. Good health is essential for proper growth of intelligence and a cheerful attitude. Good health again, may be a relative concept but it is better understood when ill health or physical pathologies are recounted. However, any person quite agile to attend to his work and daily chores, fit enough to enjoy life both physically and mentally, can be labelled as a healthy person. Good and sound health is much more dependent on good nutrition, cleanliness and knowledge about ill health.

☙ ENVIRONMENT

The concept of environment again, is a complex one. The environment includes natural, physical, socio-economic and psycho-cultural. The natural, physical environments are essential for human existence. But there is also a need for good social environment. A good social environment is characterized by lack of quarrels and social tensions and a co-operative and helpful attitude between community members.

The sound physical environment is indicated by cleanliness and orderliness, shelter from sun, rain and inclement weather, friendly and comfortable working conditions, unpolluted clean, fresh air and water. Good, comfortable and respectable working conditions are also contingent on these life sources.

Psycho Cultural Environment

Psycho cultural environment is also very important for good quality of life. Culture determines people's world view, their attitude toward life, work, pleasure and even death (Kalbag, 1995).

DOMAINS AND DIMENSIONS

Numerous taxonomies of life domains have been proposed by social, psychological, gerontological and health science researchers based on studies of general populations of both well and ill people. A typical taxonomy is that of Flanagan, which categorizes 15 dimensions of life quality into five domains

- **Physical and material well-being**
  - Material well-being and financial security
  - Health and personal safety
- **Relations with other people**
  - Relation with spouse
  - Having and rearing children

- Relations with parents, siblings or other relatives
- Relations with friends

- **Social, community and civic activities**
  - Helping and encouraging others
  - Participating in local and governmental affairs
- **Personal development and fulfillment**
  - Intellectual development
  - Understanding and planning
  - Occupational role career
  - Creativity and personal expression
- **Recreation**
  - Socializing with others
  - Passive and observational recreational activities
  - Participating in active recreation

    (http://www.atsqol.org/key.asp)

ENHANCEMENT OF PERSONALITY AND QUALITY OF LIFE

Ageing is a part of life, so getting old is normal. One's attitude about ageing can make a difference. Ageing represents a decline of physical abilities and for some, a decline in mental functioning. There is much more to ageing well, than how the body functions. A physical illness doesn't always mean a

loss of quality of life. Likewise, good physical health is no guarantee, an ageing parent will be at peace to enjoy life. As in other areas of life, ageing involves continual change.

The following areas are to be given importance for the overall mental and physical well-being of the elderly:

Social Interaction and Involvement

Daily conversation with others, seeking opportunities and outlets for interaction with others can improve the quality of life. Elderly can involve themselves in various activities to keep isolation and withdrawal at bay.

Recognizing Personality Traits

Ageing may complicate lifelong personality traits and behaviours. If there are major changes in personality, looking for the cause and trying to understand it may be helpful. A sense of humour can also be beneficial.

Health Nutrition, Hydration and Exercise

Numerous benefits come from maintaining regular, adequate nutritional meals, daily exercising and plenty of liquid intake. If these basic lifelines are not maintained, a multitude of problems can occur.

It is never too late to reinforce healthy living habits. Regular exercise, active physical care and healthy eating can lead to:

- Improved flexibility

- Better sleep habits
- Less time to worry
- Increased cardiovascular endurance
- Strengthened muscles
- Improved overall psychological functioning

Positive Mental Attitude

Healthy ageing is interconnected with how one feels about self-worth and self-image. A daily outlook on life provides the person direct, positive reinforcement for making plans, achieving goals or sticking to a recommended care plan.

Activities of Daily Living

Elderly people must follow their routine activities and learn self-learning habits to keep away boredom. They should have the interest to learn new hobbies and have access to all source of knowledge: formal, informal, books, massmedia etc. The elderly should be trained in house keeping including planning of meals, identification of physical pathologies and elementary care of illhealth. Elderly should have regular medical and dental check-ups to maintain good health.

NEED FOR THE STUDY

One of the serious problems our country is facing today is an apparent increase in the number of the aged in the population. Ageing has always been known as the final part of the life's journey. The aged face many problems like decreasing physical strength, disease, retirement, financial difficulties, death of spouse etc. The problems make the quality of life of the elderly worse. So, proper attention is imperative for the aged people.

This study is an effort to assess older people's personality and its effect in influencing their quality of life. The study was undertaken with the assumption that personality traits affects the quality of life. Areas like family relationship, material support, subjective well-being are reasons or important factors for better or poor quality of life. Finding of the study helps to know the problems of the elderly. Positive Therapy is used as an intervention in this study to facilitate and enhance personality and quality of life of the elderly. It is found to be a study of utmost relevance in helping the aged.

Review of Literature

REVIEW OF LITERATURE

The collection of early studies is a must in the case of any research to formulate an effective methodology. The literature pertaining to the research on, 'Assessment and Enhancement of Personality and Quality of life in Elderly through Positive Therapy' is reviewed and categorized under the following headings:

- Personality
- Quality of life
- Personality and Quality of life
- Enhancement

PERSONALITY

Ruiselova (2003) did an analysis of the relationship between the sense of coherence and personality traits: The big five, internality-externality, further of curiosity, anxiety, aggressivity and depression and level of self-esteem in elderly women attending a university of the Third Age-mean age 62.4 years. A part of the results were compared with those from a similar study on adolescent girls. These results support findings of a negative relation between effective coping and neuroticism. A higher level of conscientiousness and openness was found, as also higher internality, self-esteem and curiosity,

together with a lower level of anxiety, aggressivity and depression and a higher sense of coherence (SOC) in elderly persons of this specific sample.

It is surprising to note from the above study that older people of this study had low scores in all the aspects of the big five model. All the elderly women of the above study are presently attending a university course. The reason for their low scores in the big five model can be attributed to this. In the Indian context if we provide such educational facilities and enthuse the elderly to take part in such courses we also can improve their conditions.

Choudhary et al (2001) examined whether working and retired aged persons differed significantly in respect of their scores on extraversion, neuroticism, psychoticism, anxiety and security-insecurity. The sample consisted of an equal number of working and retired persons, i.e, 200 each, from both the sexes. The tools of the study were Eysenck Personality Questionnaire [EPQ] developed by Eysenck and Eysenck (1975), Manifest Anxiety Scale developed by Taylor (1953) and Security-Insecurity Inventory (S.I. Inventory) by Maslow (1952). The results of the study indicated that the retired persons had less extraversion than their non-retired counterparts. Retired males have significantly higher scores for neuroticism than retired females. Retired persons, both males and females have scored significantly

higher on anxiety than the working persons. Again retired persons feel more psychological insecurity than those who are actively engaged in their jobs.

This study shows that the retired persons have antecedents of some psychological problems. They suffer more from introversion, psychoticism, anxiety and insecurity than the working persons. This is because they face economic hardships, social and mental problems after retirement. Counselling and Stress Management can be promoted to solve their mental confusion and conflicts. The various techniques like Cognitive Restructuring and Auto Suggestion can also be given to improve their positive perception about life.

Patil et al (2000) conducted a study to find out the different correlates of depression. The sample comprised of 220 elderly persons including both males and females with the age ranging between 50 - 70 years. Ramamurthi's (1978) scale was used to assess the health status, economic status and social activities of the elderly. Hosmath's (1992) scale was used to elicit information regarding the participation in religious activities. The scale constructed by Karim and Tiwari (1986) was used to measure the level of depression. A negative and significant relationship was found between the depression level and economic status, health status, social status and family background. The religious activities were found to be positively and significantly related to the depression of the elderly.

This study is contradictory to the expectation that economic status, health status and social activities of the elderly cause depression. The results also contradict the fact that participating in religious activities by the elderly helps them to alleviate depression. Further, details about the tools used are not sufficient.

Yubo (2000) stated in his research that many factors can affect physiopsychological changes of aging, in which personality and social psychological factors are the most important ones. Three models were used to explain the relationship between personality and physical problems. Hostility, emotional suppression and neuroticism all have close linkages to physical diseases. Socio-economic status, social support, behavioural style and social psychological factors cast their influence on the health of the senior citizens.

The effect of personality on different factors is clearly evident in this study of the aged. Negative personality traits seem to have close association with the development of physical diseases. Psychological interventions like Counselling, Anger Management and Personality Development Programmes can be imparted to the elderly to elude the effects of the negative personality traits on their physical health. It is also necessary to encourage increased social support and positive behavioural style to have better physical health.

QUALITY OF LIFE

Borders (2004) studied the elderly rural population to identify those at risk of poor health and the effect of intervention. Five thousand, 65 years and older people were the sample. The data was collected on the need for assistance with activities of daily living, physical and mental health related quality of life. The results indicated that be it urban or rural, enhancement of good psychological, social and physical health of the older people requires medical care and social support services particularly among the most socially and economically disadvantaged.

The above study indicates that the place of domicile is immaterial provided the aged get the needed assistance. Irrespective of the place of domicile, it is a common observation that elderly people need lot of assistance to have improved physical and mental health. In Indian conditions, such assistance is always a serious lack. Hence, steps have to be taken at individual and government levels to provide increased assistance to the elderly.

Warr et al (2004) investigated affective well-being and life satisfaction between the ages of 50 and 74, as a function of varied types of activities undertaken. Activities in the family, social and religious domain were found to be important in this age range, while other activities of life satisfaction were less associated to affective well-being.

Warr et al (2004) studied the differences in the frequency of some activity types between men and women and between people in employment, unemployment and retirement. The association between activity and psychological well-being did not vary in men and women, while well-being was a significant indicator between employed and non employed individuals.

Spirituality appears to be an important activity of the aged irrespective of the gender. Life satisfaction in family and social areas were highly associated with affective well-being. Unemployment and retirement are factors of concern for the aged and it is imperative that aged should be taught various ways of spending their leisure time.

Bain et al (2003) examined the relationship in old age between Quality of Life, childhood IQ, cognitive performance and other variables. The results indicated that Quality of Life was better in men than women. Women reported more anxiety and depression. Quality of Life correlated significantly with cognition. Lower childhood IQ may contribute to coping less with late life. Lower Quality of Life is not indicative of cognitive decline.

It is very surprising to note that the childhood IQ affects one's later life and that quality of life is highly associated with cognitive performance. As women are emotionally sensitive than men, they experience comparatively higher levels of anxiety and depression during old age. One's ability to cope

with old age problems also depends his/her childhood IQ. Hence, the efforts must be taken to help old aged women and men face the difficulties of their age with courage and confidence. Stress Management, Time Management and Positive Therapy can be imparted to them.

Patel (2003) conducted a study to find out the effect of institutionalized living on death anxiety and psychological well-being of elderly. A sample of 80 institutionalized and 80 non-institutionalized aged were administered Tampler's Death Anxiety Scale, Psychological well-being Questionnaire and Personal Data Sheet. Results revealed that institutionalized living did not have any significant impact on death anxiety among elderly people. The institutionalized aged experienced poor sense of psychological well-being than non-institutionalized aged. A significant negative correlation was observed between death anxiety and psychological well-being.

The above study of the institutionalized aged indicates that perception of positivity towards life and death and living with similar others influence a person's death anxiety. Their poor psychological well-being of the institutionalized elderly may be attributed to lack of support and rejection from family members. Relaxation techniques and counselling can be given to the elderly to increase their sense of psychological well-being.

Hagberg (2002) identified the core beliefs that are important in experiencing quality of life and found that access to sources of power has significance of worth and meaning in old age. This study also showed that quality of life is based on five fundamental themes: engagement, balance, continuity, creating and transcendence.

The above study indicates the expectations of the elderly, where they long for engagement and peace while seeking for power which runs parallel creating incongruence.

Chao and Chadha (2002) studied the quality of life of the elderly from Nagaland, comparing male and female, rural and urban, widowers and those living with spouse, pensioners and non-pensioners. The results indicated that male, urban elderly, living with spouse and pensioners have better quality of life than female, rural, widow and non-pensioners.

Although determining quality of life is difficult, the parameters used in this study to measure quality of life like social support (SS), self-rated health (SRH) etc., seem highly predictive. Social support and economic independence during old age are influential in improving the quality of life of the elderly. Counselling programmes and awareness on having economic importance are the need for the present day old people.

Dos et al (2002) evaluated the degree of satisfaction in the elderly people regarding their quality of life. Among 128 elderly people, the authors verified an insufficient degree of satisfaction. The dimensions of the quality of life pointed out by the Flanagan's Scale were: personal development and fulfillment; family relations; social participation; welfare and material support, learning and friendship.

Quality of life is a subjective experience, in spite of its subjectivity, many elderly people have reported insufficient degree of satisfaction indicating poor quality of life. The trouble in certain dimensions of their lives can be alleviated through proper psychological interventions like Relaxation Training, Counselling and Behavioural Techniques.

Nathawat (2000) studied a sample of 120 respondents who were retired from government service (60-70 years age). They were tested on measures of hardiness, social support, subjective well-being, positive affect and negative affect with the aim of evaluating the influence of hardiness and social support on psychological well-being. The results of the study disclosed that aged man who scored 'High' on hardiness had significantly better psychological well-being than low hardy aged men, as they scored higher on subjective well-being and positive affect (PA). Aged men with high social support also

reported significantly higher scores on subjective well-being and positive affect but no difference was seen on negative affect.

Hardiness and social support play an important role in influencing the psychological well-being of aged people. Aged men with high scores of hardiness and high social support have high subjective well-being and positive affect. Being emotionally stable and alert to stressful situations can help the elderly people face their problems in a sound manner. Stress Management Techniques and Behavioural Assignments can be given to them to have better subjective well-being and positive affect.

Prakash (1998) investigated the social support in male/female, urban/rural elders and the relation of social support and functional competence to well-being. The sample constituted of 316 subjects (age 68 years) who were administered, an Interview Schedule, SSQ, BGC Morale Scale and Daily Activity Checklist. The results indicated that urban males are more advantageous. Subjective well-being was positively correlated to both social support and functional competence. Older women had more problems with daily activities, low social support and subjective well-being.

Sex is a contributive factor in subjective well-being. Social support functional competence and subjective well-being are interdependent on one another. These factors are dire necessities during old age. Gender differences

exist in relation to these factors, in that men are more advantageous than women. The place of domicile whether urban or rural is also indicative of the amount of social support for the elderly people. Behavioural assignments and group counselling can be given to increase subjective well-being of the elderly.

Ballesteros (1998) did a research on the differential conditions affecting Quality of Life. Subjects over 65 years of age living at home or in public or private institutions, of either gender and with different socio economic status were interviewed about various quality of life dimensions. The conclusion was that quality of life ingredients are dependent on lifestyle (at home or in institutions) and personal conditions (age and gender).

Quality of life is highly individualistic and cannot be generalized. It is a common observance that the elderly people living in public or private institution especially women have poor quality of life when compared to those living at home. Social skills training can be given to the elderly to accept their situations in positive manner.

Nathawat and Rathore (1996) conducted a study to compare life satisfaction and subjective well-being in 100 men and 100 women retired from government jobs, belonging to upper middle class. They were administered hardiness scale, social support questionnaire, life satisfaction scale, positive and negative affect scale and hopelessness scale. Old men were found to be

more satisfied than women. High social support and high hardiness led to high satisfaction in life. High social support also led to higher positive affect and lesser hopelessness in aged people.

It is heartening to note that the results of this study is similar to that of the above studies in that the social support and hardiness play an important role in influencing life satisfaction and positive affect. They are all directly proportional to each other. Being weak in emotional stability, women lose their physical capacity for daily activities and hence have less satisfaction. Problem Solving Skills, Stress Management Techniques and Personality Development Programmes can be taught to the elderly women as is the need from the results of the above study.

Sharma et al (1996) analyzed the psychological well-being and family integration in Retired Army personnel. A trait Scale of State-Trait Anxiety Inventory, Self-Rating Depression Scale, Life Satisfaction Index (as indicators of psychological well-being) and the Family Integration Assessment Schedule were administered to a group of 40 retired army officers and 40 other ranks. All of them were 60 years and above, married with a living spouse, not re-employed and lived with their families in three districts of Himachal Pradesh. The findings were: (i) The Ex-other ranks reported lower psychological well-being than their Ex-officer counterparts; (ii) Family

nuclearity or jointness was unrelated to psychological well-being; (iii) the higher degrees of family integration provided non-significant trends towards better psychological well-being (iv) the moderately-integrated Ex-other ranks reported significantly lower psychological well-being on all its three measures than their Ex-officer counter parts. However, the scores on the three indicators of psychological well-being were not in pathological ranges.

The above study clearly indicates that the status of an individual at the time of retirement facilitates better psychological well-being after their retirement. The degree of family integration also proves to be an important indicator of psychological well-being. Family counselling and Group counselling can be given to teach the importance of social support, communication and inter-personal interaction among the family members.

Nandhini and Parvathi (1996) conducted a study on the institutionalized and the non-institutionalized senior citizens on the levels of depression and sense of well-being. A sample of 30 non-institutionalized and 21 institutionalized senior citizens were chosen for the study. The institutionalized old people were from two old age homes in Chennai. The senior citizens were matched on age, occupational status and on pension. The tools used for the study include: (i) Beck's Depression Scale and (ii) P.G.I sense of well-being Scale. The results obtained from the study indicated that the institutionalized

senior citizens had a lower level of sense of well-being and a higher level of depression than the non-institutionalized senior citizens.

Nandhini and Parvathi (1996) compared elderly men and women on adjustment, depression and sense of well-being. The senior citizens chosen for the study were retired officers from nationalized banks in Chennai. The results obtained indicated that there were no gender differences in the level of adjustment, depression and sense of well-being among the retired senior citizens. The level of adjustment and sense of well-being were found to be positively related.

The results of the above studies are highly indicative of our culture, where the frame of mind of the elderly when separated from kith and kin is towards the negative side. The higher level of adjustment and subjective well-being of the sample may be attributed to the pension benefits which they are receiving. Skills improvement to facilitate better adjustment which leads to increased subjective well-being can be taught to the elderly men and women.

Tsai et al (2004) did a research on health-related quality of life among urban, rural and island community elderly in Taiwan. Interviewers collected information on subjects' demographics, medical history, use of health services and health related quality of life using the SF-36. A total of 4424 subjects over 65 years of age participated in the survey. The urban elderly population had the

greatest health-related quality of life and the remote island elderly population had the highest scores on the vitality and mental health scales. Whereas, the rural elderly population had the poorest health-related quality of life, particularly rural women.

The authors, having used a large sample size, have deduced that the health-related quality of life seems very poor in the rural elderly population than the urban elderly while the remote island elders seem to show high vitality and mental health. Nutritional awareness programmes and health education can be given to the rural elderly population especially women with the help of the government.

Ramamurthi (2001) made a survey of old age homes and day care centers in Andhra Pradesh. Beneficiaries (N=647) from 65 institutions spread over different districts of Andhra Pradesh were interviewed. The interview consisted of standardized questions covering reasons for joining old age homes, the level of satisfaction experienced by the elderly in their day to day transactions and general feelings regarding subjective quality of life, evaluation of their relationship with the staff of the institutions and an overall satisfaction with life at the moment. Most of the elderly people suffered from loneliness and emotional deprivation in their activities and their behaviour had to be so

organized as to promote sharing, camaraderie, spirituality and pleasant interactions. They were low in their quality of life.

From the above survey of the old age homes and day care centers, it is clear that psychological setbacks seem to engulf the elderly, resulting in low quality of life. The level of satisfaction in day to day transactions and the overall satisfaction with life seem to be lesser in the institutionalized elderly, which is not a surprising finding. Governmental and familial support can be sought to enhance the quality of life of the elderly living in public and private old age homes.

Aujla et al (2000) examined the life satisfaction of elderly by taking a sample of 120 respondents (60 males and 60 females) from 4 villages of Ludhiana district. Results revealed that old age was not being enjoyed by 36.67 percent of males and 38.33 percent of females. The reason for decline in life satisfaction of elderly were ill health, economic insecurity, being less useful, children neglecting them and settlement of children.

In the modern materialistic world, when people find no time to fulfill their own needs, taking care of the elderly seems to be the greatest burden. The natural accompaniments of the old age like ill health, insecurity, worthlessness etc., make them have poor life satisfaction. This low sense of satisfaction is not gender sensitive. Psychological and mental health counselor can be appointed

in hospitals and old age homes to improve the level of life satisfaction of the elderly.

Patel et al (1999) examined the role of age and gender differences in the feeling of loneliness among the elderly. The sample comprising 30 males and 30 females (age 50-82 years) completed a personal information schedule designed by the investigators and the Revised UCLA Loneliness scale (Russell et al., 1980). It was seen that increase in age did not increase the degree of loneliness among the elderly. Loneliness tended to increase between 50-60 years, then decreased between 60-70 years and again increased after the age of 70. Elderly men experienced less loneliness than elderly women.

Loneliness in later life is influenced by gender and not by age. The capacity of women to fight loneliness at all ages is much lesser than their male counterparts. Communication Skills Development and Social Skills can be given to the elderly especially women to have social interaction.

Dwivedi et al (1998) investigated the effect of biographical factors such as age, marital status, type of family and education on life satisfaction of 100 elderly persons (age 60-75 years). Subjects were interviewed according to a well prepared schedule and administered the Life Satisfaction Scale. Analysis revealed a highly significant difference in life satisfaction between single and married females but not between single and married males. It was concluded

that age, type of family and education had no significant effect on the subjects' life satisfaction.

The above study is indicative of gender differences in relation to marital status and life satisfaction. Elderly females who were married had more satisfaction than the singles. This is indicative of the need for social support during old age. Efforts can be taken to provide necessary support to the elderly.

PERSONALITY AND QUALITY OF LIFE

Condello et al (2003) in their study on the subjective assessment of personality traits and quality of life of the elderly, using linear regression analysis found that widowhood and divorcehood negatively influenced quality of life. Further, the scores on various personality traits were very low for the elderly.

The above study indicates that certain variables like loneliness due to divorce or being a widow, do influence quality of life. The elderly who are living alone are having low quality of life and poor personality traits. Interventions like Counselling with Behavioural Techniques can be taught to them for the betterment of their quality of life. And these people can be engaged in various activities to have interest in life.

Kovaci and Kuruc (2003) studied the subjective evaluation of an individual's quality of life by using the WHOQOL-BREF questionnaire,

K.Urban's Creativity Test and Eysenck's Personality Inventory. The results indicated that neuroticism negatively influenced the positive evaluation of the quality of life in both sexes. Females had more problems in the psychological and environmental domains of the quality of life, while males struggled more in the area of the physical way of life. Creativity is an important positive fact influencing the quality of life.

The study indicates how unstable personality traits and other factors influence quality of life. The authors noted that creativity also is a factor that influences quality of life. Cognitive Behaviour Therapy and the other psychological interventions like Counselling, Relaxation, Cognitive Restructuring and Thought Stopping can be given to the elderly to improve their quality of life. Family and Group Counselling can be given to the females to have better psychological health.

Parameshwari and Elango (2003) conducted a study to find out the relationship of self esteem and quality of life in the context of demographic variables in institutionalized elderly. 100 old people formed the sample for this study, who were randomly chosen from 3 different old age homes in Coimbatore city. Quality of life was measured by using QOL – The MOS short form 36 (Ware, 1994) and self esteem was measured using Rosenberg's Self Esteem Scale (1964). It was concluded that self esteem of elderly people had a

significant effect on their quality of life. The variables educational level, economic status and pension had significant effect on self-esteem. Whereas, sex had a significant effect on quality of life.

The study, using a single personality trait-self esteem boosted by certain variables, is found to have significant relations with quality of life. Counselling can be given to accept their situation as it is. The economic and educational status have profound effects on one's self esteem, which in turn influences his/her quality of life. The economic status of the elderly can be improved by teaching them simple jobs like tailoring and handcrafts etc.

Hagberg (2002) examined the relationship between quality of life and personality. The study facilitated a deeper understanding of how personality and core beliefs relate to the experience of quality of life in old age, with regard to shaping, meaning and worth. The results supported the hypothesis that personality traits were related to different dimensions of quality of life. The characteristics of personality that were of importance were trust factors that influenced the person's view of herself, her own ability and her view of other persons.

The study indicated the effect of personality traits on quality of life with no mention of specific traits. Personality development workshops can be conducted for the elderly people for better quality of life.

Martin et al (2000) examined the relationship between personality traits and states and subjective well-being in three age groups, sexagenarians, octogenarians and centenarians. The sample of 272 subjects were taken from the Georgia centenarian study. Ninety one participants were in their sixties, 93 in their eighties and 88 were one hundred years or older. Multiple regressions were computed to examine the separate and joint effects of personality traits and states upon subjective well-being. Several personality traits and states were particularly important in predicting subjective well-being. Low tension and high extraversion predicted high morale, life satisfaction and affect balance for centenarians. High emotional stability and low stress predicted high well-being for the 80's age group. Guilt was the most important personality state predicting well-being for the sixties age group.

The above study is interesting in that as old age advanced towards 80's and 100's one's morale is boosted while guilt disturbs the sixties. Reduction of tension and stress of the elderly is of utmost importance in improving their life satisfaction and subjective well-being. Yoga, Meditation and Relaxation Techniques will be very useful to make them relax and to improve their emotional stability. Counselling, Thought Stopping and Cognitive Restructuring will be very useful to change the guilt feelings for the 60's age group.

ENHANCEMENT

Matsuo et al (2003) did a research on effects of Activity Participation of the Elderly on Quality of Life. Quality of Life (QOL) and Personality were examined in 2 groups of elderly subjects with and without activity participation (AP). A survey was conducted with 321 elderly subjects over 65 years of age using a 24-item questionnaire regarding personality and depressive inclination and the visual analogue scale-happiness, to measure QOL. The AP group was involved in 5 types of activity such as community center activity course, learning and lecture participation, club activity, elderly manpower service activity and other activities. The QOL of the AP group was significantly higher than the non-AP group

The above study clearly indicate that being occupied is a sure way of increasing quality of life.

Menec and Chipperfield (1997) designed a study to examine the potential mediating role of exercising and participation in non-physical leisure activities, such as attending cultural events, involved in volunteer organizations, and so on, in the relation between perceived control and well-being in seniors. The results indicated that an internal locus of control was positively related to exercising and participation in leisure activities.

Exercising and leisure activity participation, in turn, were predictive of better perceived health and greater life satisfaction.

On the whole, the study points out to the potential benefits of increasing senior's sense of control as a means to promote exercising and to increase leisure activity participation and consequently, to enhance well-being.

Zauszniewski (1997) conducted a study to find the effects of teaching resourcefulness skills to healthy elders on measures of learned resourcefulness, anxiety, depression, adaptive functioning and life satisfaction using a quasi experimental pre-test-post-test design. The intervention group consisted of 20 elders and the placebo group had 17 elders. Those elders who received 6 weeks of group intervention which taught the skills constituting resourcefulness scored significantly higher on post test measures of learned resourcefulness, adaptive functioning and life satisfaction.

This study suggests that learned resourcefulness training is an important intervention for promoting healthy, independent and productive lifestyles among older adults.

Studies on ageing in India are very few. Though studies have been carried out, they did not have a clear picture about the problems of the elderly. From the above mentioned studies, it can be understood that ageing is a process which is affected by biological, psychological and sociological factors.

Ones' personality and quality of life are formed from these factors. The studies show that some personality traits namely Neuroticism, Psychoticism, Hostility, Emotional Suppression, Security – Insecurity, Internality and Externality influence ones' life.

Insufficiency in various dimensions of quality of life affects elderly's life. The factors like loneliness, low life satisfaction, insecurity, negligence and other factors affect ones' quality of life. Various studies indicate that some personality traits and quality of life are interrelated. Unstable personality traits influence the quality of life negatively and good personality traits makes the quality of life higher.

Some other studies examined the level of enhancement in the elderly life through various activities like leisure activity, club activity, exercise, education etc., which gave better life satisfaction.

Methodology

METHODOLOGY

The study on, 'Assessment and Enhancement of Personality and Quality of Life in elderly through Positive Therapy' was carried out involving the following steps:

- Objectives
- Research Questions
- Null hypotheses
- Area
- Sample
- Tools
- Procedure
- Analysis of Data

OBJECTIVES

The main objectives of the study are as follows:

- To assess various personality factors of the elderly.
- To find out the difference in personality factors between institutionalized and non-institutionalized elders.
- To assess the quality of life of the elderly.
- To find out the difference in quality of life between institutionalized and non-institutionalized elders.

- To find out the relationship between personality and quality of life.
- To ascertain the efficacy of Positive Therapy in the enhancement of personality in elderly.
- To ascertain the efficacy of Positive Therapy in the enhancement of quality of life in elderly.

RESEARCH QUESTIONS

- What is the nature of personality in the elderly?
- Do personality factors differ among institutionalized and non-institutionalized elderly?
- How is the quality of life of the elderly?
- Do quality of life differ among institutionalized and non-institutionalized elderly?
- Is there any relationship between personality and quality of life?
- Does Positive Therapy have any effect in enhancing personality in elderly?
- Does Positive Therapy have any effect in enhancing quality of life in elderly?

NULL HYPOTHESES

- The elderly have only negative personality factors.
- Personality factor do not differ among institutionalized and non-institutionalized elderly.
- The quality of life of the elderly is not poor.
- Quality of life do not differ among institutionalized and non-institutionalized elderly.
- There is no relationship between personality and quality of life.
- Positive Therapy has no effect in the enhancement of personality in elderly.
- Positive Therapy has no effect in the enhancement of quality of life in elderly.

AREA

Annai Muthiyor Illam, Mettupalayam and Missionaries of Charity, Coimbatore and the elderly people who were living in Mettupalayam were selected for the conduct of the study.

The reasons for selecting this area are as follows:

- Availability of the required number of sample for the study.
- Permission provided by the institutions to conduct the study.

- Convenience of the researcher to carry out the action research.

SAMPLE

Thirty eight subjects, 20 from Mettupalayam and 18 from the institutions namely, Annai Muthiyor Illam and Missionaries of Charity were selected by purposive sampling method to serve as the sample for the study. A single test group without control group was selected. The age range of the sample was 55-86 years.

TOOLS

Case Study Schedule developed by Hemalatha Natesan (2003) (Appendix I) was used to collect information regarding the personal history, family background and demographic details of the sample.

16 Personality Factors Questionnaire (16PF) developed by Dr. Raymond B. Cattell (1972) FORM A (1967-68 Edition) (Appendix II) was used to find out the personality of the subjects. It consists of 187 statements. Only those statements which were appropriate to the elderly have been taken. There are three possible responses to each of them. The responses differ according to the statements. The respondent is given a separate answer sheet to mark the answers. The subject has to fill the blocks in the answer sheet which suits him/her. There is no time limit. But the subjects are asked to respond as quickly as possible.

The reliability and validity coefficients of Cattell's 16 PF is very significant and ranges between 48 to 58.

Quality of Life Inventory developed by Thomas J. Leonard (1998) (Appendix III) was used to measure the quality of life of the subjects. It consists of 100 statements. Forty items which were found to be suitable for the elderly were taken from the 100 statements. There are 2 alternatives for each item namely, 'Yes' or 'No'. The respondent is asked to tick (✓) any one of the 2 alternatives which applies to him/her most. There is no time limit. But the subjects are asked to respond as quickly as possible. The validity and reliability of the test are 0.89 and 0.93 respectively.

PROCEDURE

Fifty two elderly subjects from the Annai Muthiyor Illam, Mettupalayam and Missionaries of Charity, Coimbatore and elderly from Mettupalayam area were selected initially for the study. The elderly subjects were in the age range of 55-86 years.

To begin with, a Case Study Schedule (Hemalatha Natesan, 2003) was used to obtain information from the sample individually. The information obtained include the personal history and family background.

After that, 16 PF was administered on the entire sample (N =52) to assess their personality. Each answer was scored either 2 or 1 as per the scoring key and interpreted according to the norms given by the author.

Then, Quality of Life Inventory was given to the entire sample (N=52) to measure their quality of life in 4 areas – Family / Relationships, Personal Foundation / Self–Responsibility, Personal Development / Personal Evolution, Self-care / Well Being. Each 'Yes' answer was scored as per the scoring key and interpreted according to the norms given by the author.

Based on the scores on the 16 PF and Quality of Life Inventory, 38 subjects were selected out of 52 subjects by purposive sampling method for the study. All the 38 subjects were given psychological intervention called Positive Therapy.

TREATMENT

POSITIVE THERAPY

Positive Therapy is a package evolved by Hemalatha Natesan (2004). It is a combination of the Western techniques based on the Cognitive Behaviour Therapy and Eastern techniques based on Yoga. Positive Therapy helps in the development of positive personality traits such as courage, confidence, cheerfulness, optimism, etc. Positive Therapy facilitates sound mental and physical health, leading to better adjustment.

STRATEGIES

Positive Therapy has four major strategies

- Relaxation Therapy
- Counselling
- Exercises and
- Behavioural Assignments

RELAXATION THERAPY

One cannot be tensed and relaxed at the same time. Relaxation Therapy helps people to have a relaxed state, which promotes a positive attitude towards life. In the counselling sessions, subjects respond better to therapy, when they are in a relaxed state. Hence, Relaxation Therapy was given as the first step in Positive Therapy.

Relaxation Therapy involves 3 steps

- Deep Breathing Exercise
- Relaxation Training and
- Auto suggestion

DEEP BREATHING EXERCISE

The subjects were asked to sit erect, with head straight, palms on the lap and feet placed on the floor, one foot apart. They were instructed to breathe in slowly for 4 counts (4 seconds) and breathe out gradually for 6 counts

(6 seconds). This was repeated 5 times with the subjects' eyes open and 5 times with their eyes closed. It was ensured that breathing in and breathing out was gradual, without any jerks and without any tension on the chest and shoulders.

RELAXATION TRAINING

After Deep Breathing Exercise, the subjects were asked to lie down flat on a mat without a pillow, with the head straight, lips slightly apart, hands comfortably placed on the sides, palms facing upwards and legs stretched, with feet, one foot apart. The subjects were asked to close the eyes and have a folded handkerchief placed on the eyes to ensure complete darkness. Then the following instructions were given :

"Breathe in slowly .....breathe out gradually....." (This was repeated 3 times).

"Now concentrate on the top of the head"

"Breathe in slowly......

Breathe out gradually..... Top of the head..... Relax......"

This was repeated 3 times followed by the suggestions:

"Now, top of the head is light and relaxed, no thoughts, no fears, no worries, no tension, no stress, no pain. Top of the head is light and relaxed, top

of the head is completely relaxed (two times). Breathe in slowly......breathe out gradually.

Similar instructions were given to the other parts of the body in the order given below:

- Back of the head
- Forehead
- Eyes
- Mouth
- Neck and Shoulder
- Back
- Chest
- Stomach
- Hands and
- Legs

Then the following directions were given to the subjects who were in a relaxed state.

- "Inhale Good Health. Breathe out all the aches, pains and sicknesses from the body.
- Inhale Happiness. Breathe out all the worries from the body.
- Inhale Positive Thoughts. Breathe out all the negative, useless thoughts from the body.

- Inhale Strength. Breathe out all the weaknesses from the body.
- Inhale Courage and Confidence. Breathe out all the fears from the body.
- Inhale Success. Breathe out failures and fears of failures from the body.
- Inhale Love. Breathe out hatred and anger from the body."

AUTOSUGGESTION

The subjects were asked to be in the lying down posture, enjoying the relaxed state when the following autosuggestion were given (3 times each)

- "I am healthy
- I am happy
- I love everyone; everyone loves me
- I am bold and confident
- I am independent
- I can do whatever I want
- I love my life
- I am living my life with full enjoyment
- Today is an excellent day, I will enjoy every minute of this day
- Thank you God for giving me all that I need – good health, wealth, happiness and success."

COUNSELLING

The subjects' personal, social and emotional problems were solved through counselling. In Positive Therapy, Counselling involves the following techniques:

- Rational Emotive Therapy
- Thought Stopping
- Symptom Stopping
- Cognitive Restructuring and
- Assertiveness Training

RATIONAL EMOTIVE THERAPY

The irrational beliefs and thoughts of the subjects such as, "Everyone hates me", "My life is worthless", "No one is there for me in this world" were removed by appealing to their reason. This in turn, helped them to be positive and realistic and face their problems boldly.

THOUGHT STOPPING

This is a process of controlling unproductive, debilitative and self-defeating thoughts and removing them.

The subjects were asked to tell out their recurring negative thoughts. The most common negative thoughts were as follows:

"I am weak"

"I am useless"

"No one loves me"

"My life is worthless"

"I don't want to live"

The subjects were asked to sit in a relaxed state, close their eyes, breathe in slowly and deliberately get the first disturbing negative thought and breathe out saying "Stop" and push the thought away and open the eyes. This practice was given 3 times. Then, they were asked to follow the same procedure and were asked to say "Stop" mentally and throw the thought out. This practice was also given 3 times. In the due course, the subjects learnt to throw out their disturbing negative thoughts automatically.

COGNITIVE RESTRUCTURING

This helps the clients replace their negative cognitions with positive self-enhancing thoughts and actions as shown below:

"I am healthy"

"I am useful to the society"

"Everyone loves me"

"My life is meaningful"

"I want to live and enjoy life"

The subjects were asked to strongly believe that they had acquired the positive qualities and start behaving accordingly. They were helped to remove the negative thoughts.

SYMPTOM STOPPING

The subjects were asked to tell out their recurring overt symptoms. The symptoms were as follows:

Shaking of the head

Trembling of the hands

Shaking of the legs

The subjects were asked to sit in a relaxed state, breathe in slowly, have the symptom deliberately, say 'Stop' loudly, stop the symptom and breathe out gradually. This practice was given five times. Then the same procedure was followed but the subject was asked to say 'Stop' mentally. This practice was also given five times. Thus, the subject was trained to have conscious control over his/her symptom, which in turn, lead to the control of the symptom whenever it occurs in future.

EXERCISES

The following exercises were given to the subjects to help them get rid of their tension and develop a cheerful state.

TENSION RELEASING EXERCISE

Stress may cause fear, anxiety, anger and / or worry, leading to tension. Tension Releasing Exercise helps people throw out all these. In this exercise, the subjccts were asked to stand with feet one foot apart, close the palms and bring them towards the chest breathing in slowly; then breathe out forcefully through the mouth (without involving voice), simultaneously throwing down the hands sidewise, opening the palms. As they breathe out, they were asked to think each of the following:

"Tension goes out"

"Fear goes out"

"Anger goes out"

"Worry goes out"

This practice was given 5 times. Then, they were asked to do the same exercise, making a loud sound (Ha) while breathing out. This practice was also given 5 times.

SMILE THERAPY

The subjects were asked to say (Eee) with a broad smile, breathing slowly through the mouth, with a sound (without involving the vocal cord), close the mouth smilingly and breathe out gradually through the nose without any sound. The subjects were asked to enjoy the cool breeze entering through

the mouth and feel the coolness spreading through the chest to the abdomen. This practice was given 10 times.

LAUGH THERAPY

The subjects were asked to sit, bend down the back and the head slightly, breathe in slowly lifting up the head and the back and start laughing loudly without any inhibition. They were encouraged to make gestures, clap hands, look at each other, etc., while laughing. They were asked to laugh louder and louder for a longer duration. This practice was given 5 times.

BEHAVIOURAL ASSIGNMENTS

The subjects were asked to resort to the following healthy behaviours.

- Have positive thoughts.
- Have positive attitude towards self, life and others.
- Live in the present.
- Eat healthy food.
- Regularly exercise (walking, yoga, meditation, etc.,)
- Enjoy every minute of each day.
- Practice Relaxation Therapy daily in the morning and evening.

Positive Therapy was given for one hour per session. Seven sessions were given over a period of 2 weeks. After two weeks, all the subjects were retested using 16 PF Questionnaire and Quality of Life Inventory.

EXPERIMENTAL DESIGN

A single test group without control group was selected and the dependent variables, personality and quality of life were measured before the introduction of the treatment. The treatment was then introduced and the dependent variables were measured again after treatment (Kothari, 2000).

	Time Period I		**Time Period II**
Test Area	Level of phenomenon before treatment (Personality) (X)	**Treatment Introduced** → **(Positive Therapy)**	Level of phenomenon after treatment (Personality) (Y)
	Level of phenomenon before treatment (Quality of life) (A)	**Treatment Introduced** → **(Positive Therapy)**	Level of phenomenon after treatment (Quality of life) (B)
Treatment Effect = (Y – X) – (B – A)			

ANALYSIS OF DATA

The data was analysed statistically based on the following:

I Personality

- Identify the personality factors of elderly.
- Comparison of the personality factors of the subjects before and after treatment.

- Comparison of the personality factors among institutionalized and non-institutionalized elderly.
- Identify the efficacy of Positive Therapy in the enhancement of personality among the elderly.

II Quality of Life

- To find out the Quality of Life among elderly.
- Comparison of the quality of life in the elderly before and after treatment.
- Comparison of the quality of life among institutionalized and non-institutionalized elderly.
- Identify the efficacy of Positive Therapy in the enhancement of quality of life among elderly.

III To find out the relationship between personality factors and quality of life

Results and Discussion

RESULTS AND DISCUSSION

The study on, 'Assessment and Enhancement of Personality and Quality of Life in Elderly through Positive Therapy' was conducted in Coimbatore District. Twenty subjects staying in Mettupalayam and 18 living in the institutions were selected by purposive sampling method. The age of the subjects ranged from 55 to 86 years. The methods adopted to collect the data included Case Study Schedule and Psychological Testing.

The results of the study are analysed, tabulated and discussed below.

TABLE I

DEMOGRAPHIC DETAILS OF THE SAMPLE

N = 38
Percentages are rounded up

VARIABLES	N	%
AGE RANGE		
55 – 70	26	68
71 – 86	12	32
OCCUPATIONAL STATUS		
Working	5	13
Retired	15	40
Non-working	18	47
MARITAL STATUS		
Married	23	61
Single	3	8
Widow/widower	12	31
INSTITUTIONALIZED	18	47
Male	11	29
Female	7	21
NON-INSTITUTIONALIZED	20	53
Male	12	32
Female	8	21

N. : Number **%. : Percentage**

Table I shows the demographic details of the sample. In the sample, majority of the subjects (68%) are in the age range of 55-70 years and 47% of elderly are not employed. Forty percentage of elderly are retried from various

jobs. The rest of the 13% of old people are working to compensate the financial constraints.

On retirement, elderly experience loneliness, financial problems, loss of status accompanied by a sense of alienation, emptiness and hopelessness. Both the working and non-working elderly have the feeling of unwantedness due to lack of emotional support from others.

Chadha (1997), in his psychological survey summarized the following problems of retirement as expressed by the elderly: retirement age was too early, retired without any plan, problems regarding the settlement of their children, deprived of income although willing to continue work.

Sixty one percent of married elderly live with their spouse, 31% are living without spouse and only 8% are living alone. Majority of the elderly feel neglected, lonely, emotionally deprived and lacking support from the spouse leading to a stressful living.

Fifty three percentage of the elderly people live with their families and 47% of elderly are living in the institutions.

According to the 2000 census, there are 33 million widows in India and 64% of them were above 80 years. In a survey of urban and rural areas of Bangalore district, it was found that an increasing proportion of urban widows were living alone. This trend of older women living alone has an impact on the quality of their lives (Modi, 2001).

TABLE II

DISTRIBUTION OF THE ELDERLY IN DIFFERENT FACTORS OF PERSONALITY BEFORE AND AFTER TREATMENT

N = 38
Percentages are rounded up

Personality Factor	Before Treatment						After Treatment					
	High		Average		Low		High		Average		Low	
	N	%	N	%	N	%	N	%	N	%	N	%
C	–	–	3	8	35	92	17	45	15	39	6	16
E	8	21	14	37	16	42	9	24	17	45	12	31
L	14	37	12	31	12	32	12	31	13	34	13	35
O	32	84	6	16	–	–	1	2	17	45	20	53
Q_3	20	53	13	34	5	13	25	66	8	21	5	13
Q_4	21	55	14	37	3	8	1	3	16	42	21	55

N. : Number **%. : Percentage**

Table II indicates the scores obtained by the elderly in selected personality factors. Personality factors signify the dimensions along which people vary from very low to very high. The elderly, with many years of experiential life, do get to differ in countless number of ways as age advances. The personality dimensions of the elderly seem to offset their strength, revealing positivity in life. Hence, the null hypothesis, 'The elderly possess only negative personality factors' is rejected. In the factor C, majority of the respondents had 'Low' scores before treatment (92%). However, after the treatment of Positive Therapy, the factor C, indicative of feelings and

emotionality, showed drastic improvement as 45% of the subjects had 'High' scores, while 39% had 'Average' and only 16% had 'Low' scores. Relaxation Training along with Auto Suggestions helped the subjects become more calm and accept reality.

In the factor E, 42% had 'Low' score, 37% had 'Average' and the rest 21% had 'High' score before treatment. This factor denoting submission or dominance, showed slight increase in the percentage of 'Average' and 'High' category (45% and 24%) wherein a decrease was seen in the 'Low' category (31%) after intervention.

Rational Emotive Therapy was very effective in modifying the subjects' perception and in improving their personality. The negative thought such as, 'Everyone hates me' was changed into positive one such as, 'Everyone loves me'. This helped the elderly to be more friendly with their inmates and family.

Thirty Seven percent of the subjects had 'High' score and 32% scored 'Low' in factor L, which denotes adaptability and self opinionated tendencies, showing no difference before and after intervention.

In the factor O, most of the subjects (84%) had 'High' score while 16% had 'Average' before treatment. This factor, characterizing self confidence and adequacy, showed good results after the intervention. It is satisfying to see the scores after intervention, where 53% of the subjects got 'Low', 45% got

'Average' and only 2% got 'High'. The techniques of relaxation with autosuggestion helped the elderly learn to tackle the worry and apprehension.

Cognitive Restructuring helped them gain confidence and change their negative and irrational beliefs. Counselling also helped them to perceive their problems in a right manner and handle it in a calm and cool manner.

Low scores in factor Q_3 indicating conflict and low integration and high scores indicating socially precise and high self concept show a promise trend in the elderly, in that majority of the subjects scored 'High' (53%), 34% had 'Average' score and 13% of elderly scored 'Low'. After Positive Therapy, the scores of the subjects increased in the 'High' category (66%), 21% of elderly got 'Average' score and the same number of persons scored 'Low' (I3%).

The factor Q_4 indicates the level of composure and relaxation or frustration and tension. Fifty five percentage of the elderly scored 'High', 37% scored 'Average' and only 8% got 'Low' score in this factor.

It is exciting to look at the results after the treatment of Positive Therapy, where majority have got 'Low' score and only 3% fall in the 'High' category. The rest of the subjects lined up at the 'Average' level (42%). Tension and relaxation cannot co-exist in an individual. Hence, when the subjects were given Relaxation therapy, automatically they became relaxed and

tension free. The elderly showed a credible reaction of decreased frustration and were rejuvenated with energy and openness to expedite life satisfaction.

Choudary (2001) analysed personality characteristics of working and retired aged people and examined whether this sample differ significantly in respect of their scores on extraversion, neuroticism, psychotism, anxiety and security-insecurity. The results showed that the retired persons were introverted and that they had more psychoticism and were more psychologically insecure than those who were working.

The above three main factors C, O and Q_4 clearly revealed the effect of Positive Therapy in facilitating change to augment better adjustment with self and others, striving toward satisfaction and peace. Hence, the null hypothesis, 'Positive Therapy has no effect in the enhancement of personality in elderly' is rejected.

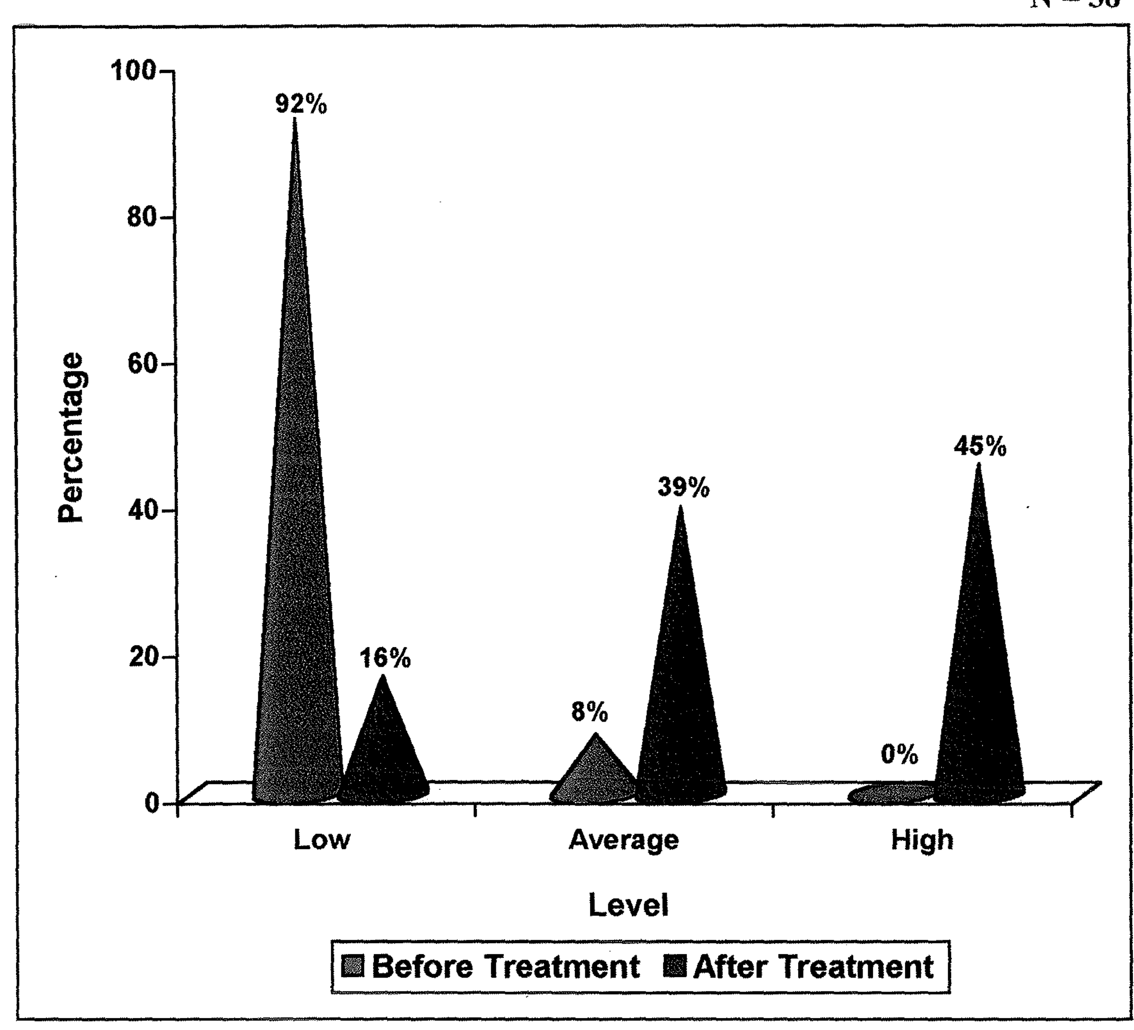
The following behavioural assignments involving healthy attitude and habits proved very beneficial to the elderly.

- Have positive attitude towards self, life and others.
- Enjoy every minute of each day.
- Practice Relaxation Therapy and Exercises daily in the morning and evening.

FIGURE I

DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-C BEFORE AND AFTER TREATMENT

N = 38



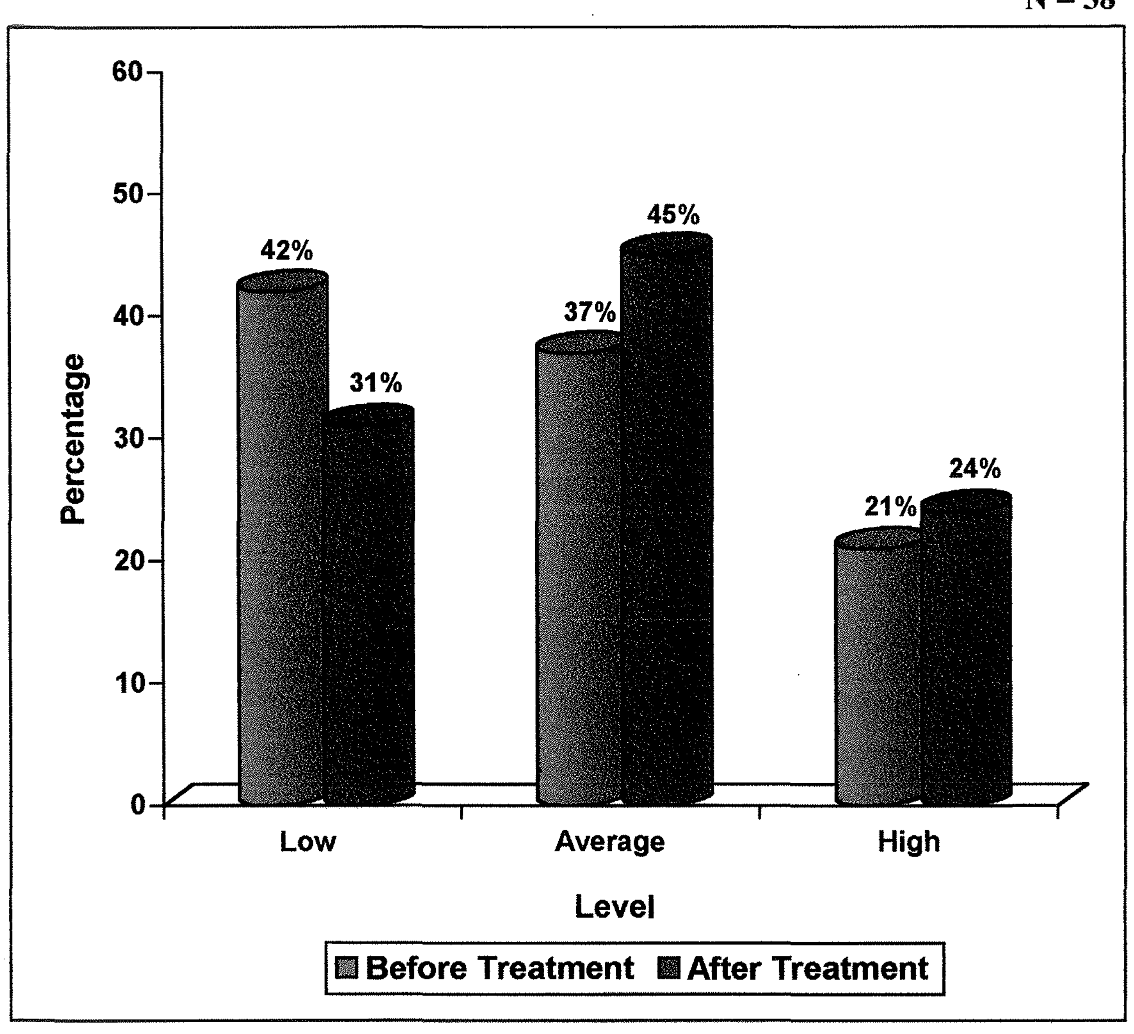
FACTOR C

Low	High
AFFECTED BY FEELINGS, EMOTIONALLY LESS STABLE, EASILY UPSET	EMOTIONALLY STABLE, FACES REALITY, CALM, MATURE
(Lower ego strength)	(Higher ego strength)

FIGURE II

DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-E BEFORE AND AFTER TREATMENT

N = 38



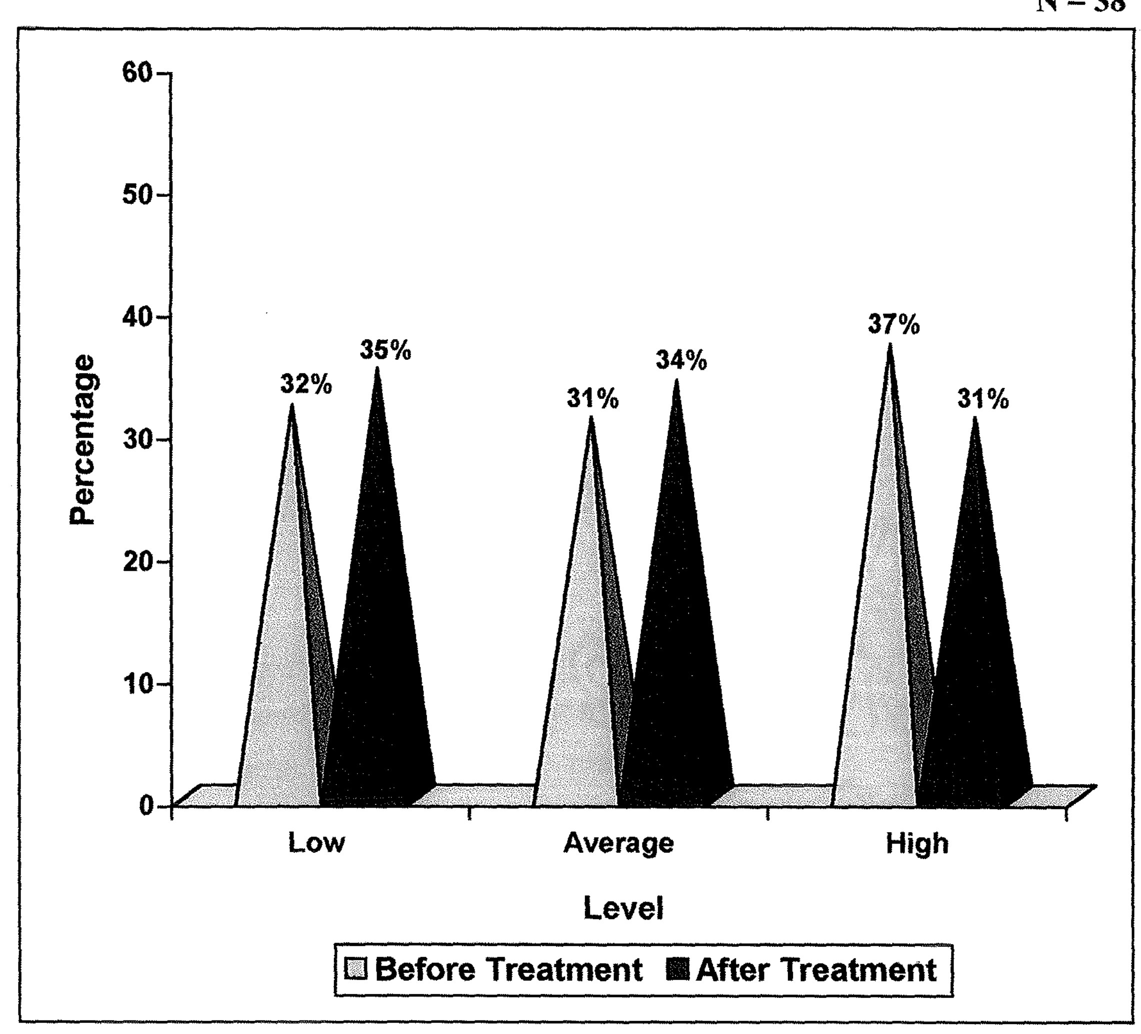
FACTOR E

Low	High
HUMBLE, MILD, ACCOMODATING, CONFORMING	ASSERTIVE, INDEPENDENT, AGGRESSIVE, STUBBORN
(Submissiveness)	(Dominance)

FIGURE III

DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-L BEFORE AND AFTER TREATMENT

N = 38



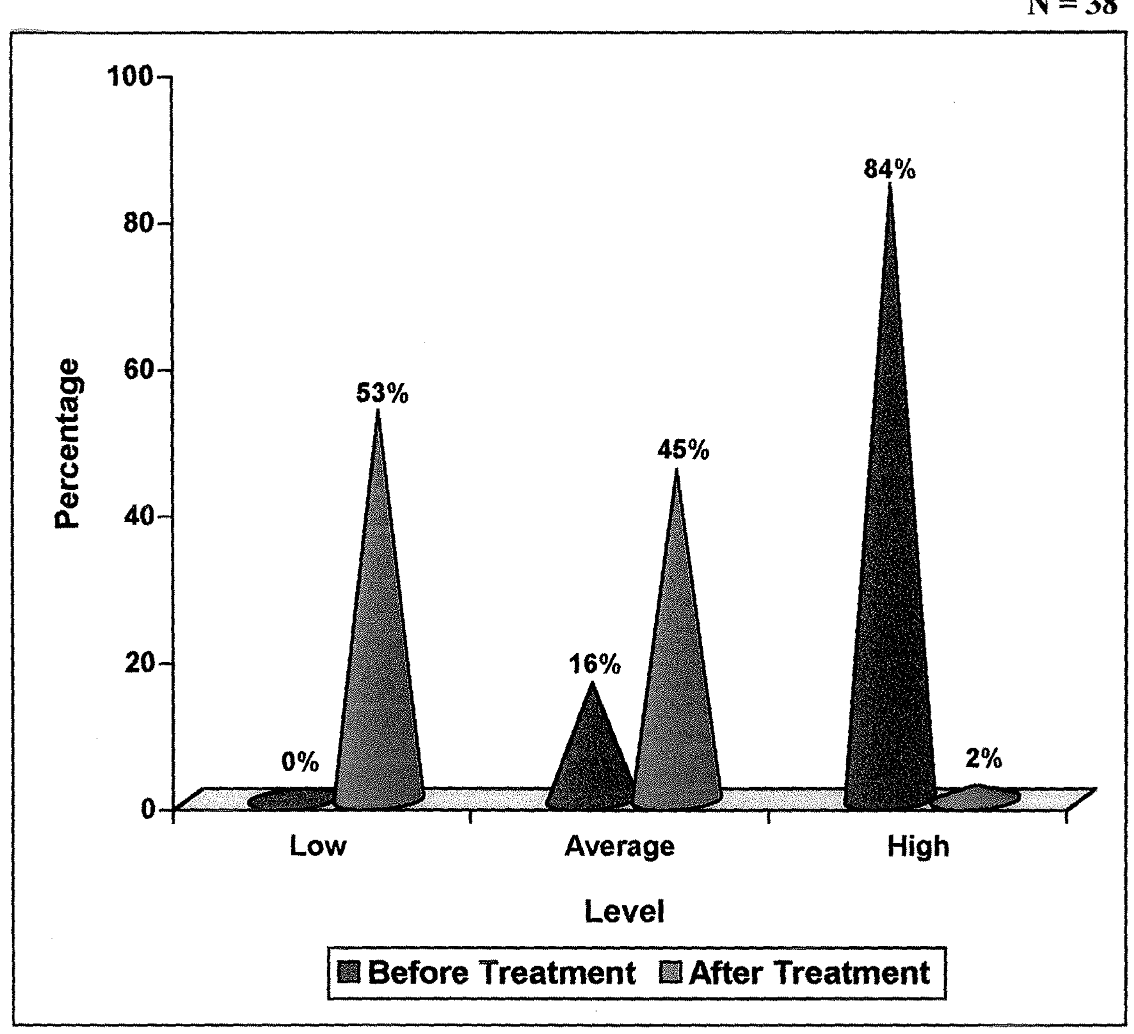
FACTOR L

Low	High
TRUSTING, ADAPTABLE, FREE OF JEALOUSY, EASY TO BET ON WITH (Alaxia)	SUSPICIOUS, SELF-OPINIONATED, HARD TO FOOL (Protension)

FIGURE IV

DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-O BEFORE AND AFTER TREATMENT

N = 38



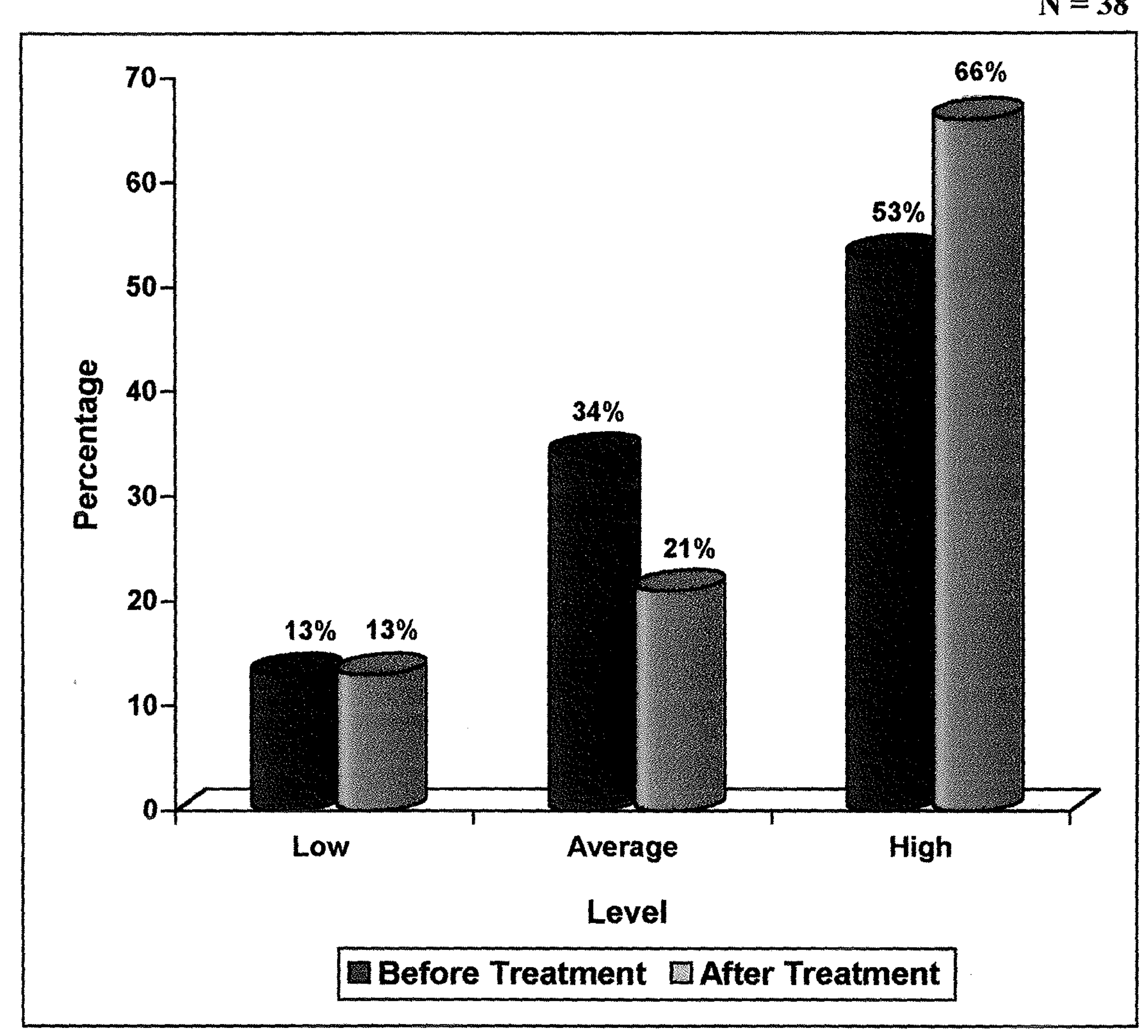
FACTOR O

Low	High
PLACID, SELF-ASSURED, CONFIDENT, SERENE (Untroubled adequacy)	APPREHENSIVE, WORRYING, DEPRESSIVE, TROUBLED (Guilt Proneness)

FIGURE V

DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-Q_3 BEFORE AND AFTER TREATMENT

N = 38



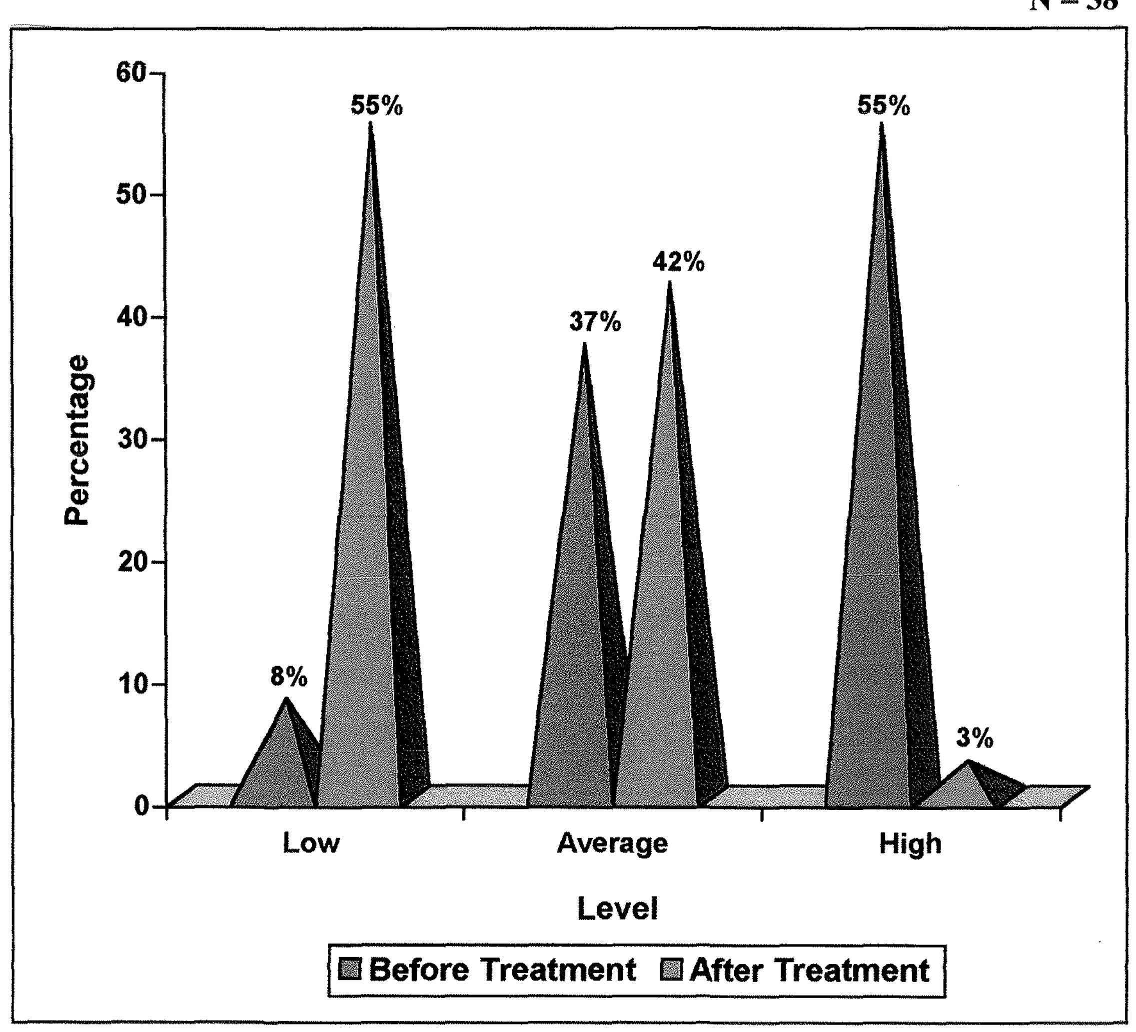
FACTOR Q_3

Low	High
UNDISCIPLINED SELF-CONFLICT, FOLLOWS OWN URGES, CARELESS OF PROTOCOL (Low integration)	CONTROLLED, SOCIALLY-PRECISE, FOLLOWING SELF-IMAGE (High self-concept control)

FIGURE VI

DISTRIBUTION OF THE ELDERLY IN DIFFERENT LEVELS OF FACTOR-Q_4 BEFORE AND AFTER TREATMENT

N = 38



FACTOR Q_4

Low	High
RELAXED, TRANQUIL, TORPID, UNFRUSTRATED	TENSE, FRUSTRATED, DRIVEN, OVERWROUGHT
(Low ergic tension)	(High ergic tension)

TABLE III

SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN PERSONALITY FACTORS OF THE ELDERLY BEFORE AND AFTER TREATMENT

N = 38

Personality Factors	Treatment	N	M	S.D.	t
C	Before Treatment	38	3.37	0.87	9.68*
	After Treatment	38	6.08	1.51	
E	Before Treatment	38	5.05	1.51	0.48 N.S.
	After Treatment	38	5.21	1.41	
L	Before Treatment	38	5.79	1.69	2.0 N.S.
	After Treatment	38	5.71	1.77	
O	Before Treatment	38	7.11	0.79	11.33*
	After Treatment	38	4.39	1.24	
Q_3	Before Treatment	38	6.24	1.39	1.57 N.S.
	After Treatment	38	6.79	1.62	
Q_4	Before Treatment	38	6.26	1.31	6.30*
	After Treatment	38	4.37	1.26	

N. : Number
M. : Mean
S.D. : Standard Deviation

*** : Significant at 0.01 level**
N.S. : Not Significant

Table III shows the mean personality factors of the subjects. In the factors C, O and Q_4, it is seen that the mean scores were statistically significant at 0.01 level whereas the mean scores for factors E, L and Q_3 were not

significant. Initially, the subjects scored 'Low' in factor C before treatment (M=3.37) which showed that they had less emotional stability. It is heartening to note that the subjects scored 'Average' after the treatment (M=6.08). It is proved statistically that the mean difference is significant at 0.01 level.

Boosting up their ego strength is very important for their emotional stability. This target is attained by using Positive Therapy especially by Auto Suggestions. Their negative emotions were effectively changed by Cognitive Behavioural Techniques namely, Cognitive Restructuring, Thought Stopping and Behavioural Assignments.

Before treatment of factor O, the elderly scored 'High' (M=7.11) which shows most of the persons were depressed and worried about life.

Luckily these persons underwent the psychological intervention, Positive Therapy, which helped them reduce their affective components of worry and depression. This is clearly visible in the table that after therapy, there is a significant reduction in the mean level from M=7.11 to 4.39. This difference is statistically significant at 0.01 level.

Relaxation Training with Counselling was found to be very effective in the reduction of scores. The elderly had negative thoughts like, 'No one loves me' and 'I am useless'. It was removed by using Thought Stopping technique, where in the negative thoughts were replaced by positive thoughts like,

'Everyone loves me' and 'I am useful to the society'. The subjects were asked to strongly believe in this. Autosuggestions directly made an impact in their minds that they have everyone and everyone loved them.

A similar study was conducted by Sangeetha and Vijayalakshmi (2001) to manage depression of senior citizens through Positive Therapy. A sample of 60 elderly was selected who were in the age range of 60-80 years. The results indicated that the entire sample had high depression before treatment. The depression level of the subjects in the experimental group showed drastic reduction after treatment.

In the factor Q_4, before treatment the elderly had 'Average' score ($M = 6.26$). After the treatment the mean scores had come down drastically from $M = 6.26$ to 4.37, which is statistically significant at 0.01 level.

The reduced scores indicate that Positive Therapy had been very effective in bringing down the tension. Deep Breathing Exercise and Relaxation Training was used to relax their mind as well as the body. It helped to reduce their tension and anxiety completely. Tension Releasing Exercise was also found to be very effective in the reduction of their scores.

In the factor E, the subjects have 'Average' score before treatment ($M=5.05$) and after treatment also the subjects remained in the same level ($M=5.21$). The elderly seem to be balanced on the factors of humility,

accommodation and conformity. After the therapy, there is no decrease or increase in the scores, which shows they developed these factors since birth and hence, not changeable.

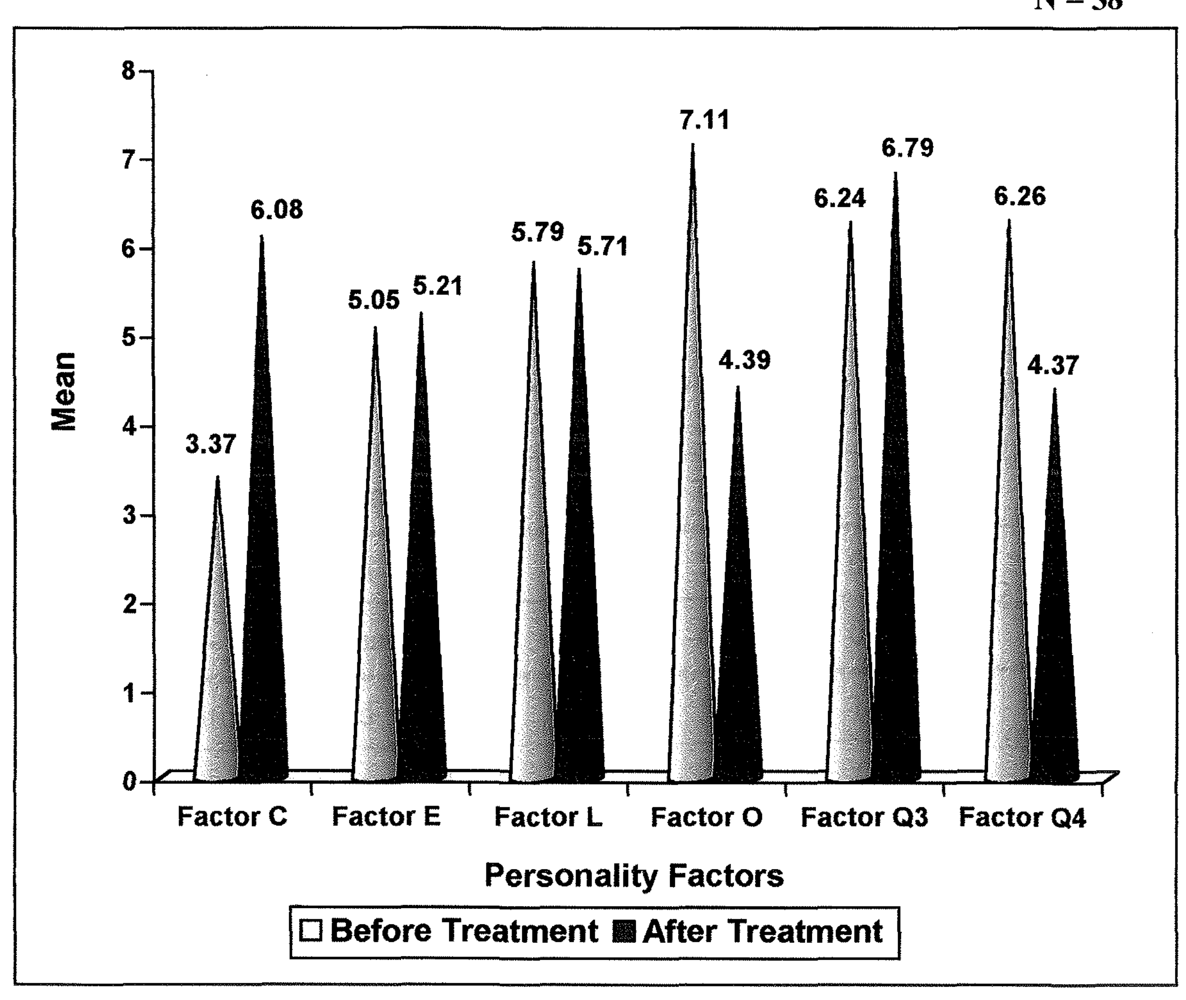
The elderly scored 'Average' in the factor L (M=5.79 and 5.71) before and after intervention, which is not statistically significant. These scores show that the elderly had low of suspiciousness and gave importance to their own views and were also careful.

The elderly subjects got an 'Average' score in the factor Q_3 before treatment (M=6.24). The subjects scored 'High' which is a slight difference in their numerical score after treatment (M=6.79) and the mean difference is not significant for this component.

FIGURE VII

MEAN PERSONALITY FACTORS OF THE ELDERLY BEFORE AND AFTER TREATMENT

N = 38



FACTORS	LOW SCORE	HIGH SCORE
C	Lower ego strength	Higher ego strength
E	Submissiveness	Dominance
L	Alaxia	Protension
O	Untroubled adequacy	Guilt proneness
Q_3	Low integration	High self-concept control
Q_4	Low ergic tension	High ergic tension

TABLE IV

SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN PERSONALITY FACTORS OF THE INSTITUTIONALIZED AND NON-INSTITUTIONALIZED ELDERLY

N = 38

Personality Factors	Group	N	M	S.D.	t
C	Institutionalized	18	3.28	0.99	0.60 N.S.
	Non- Institutionalized	20	3.45	0.74	
E	Institutionalized	18	5.33	1.41	1.17 N.S.
	Non- Institutionalized	20	4.80	1.36	
L	Institutionalized	18	5.56	1.71	2.80**
	Non- Institutionalized	20	6.67	0.44	
O	Institutionalized	18	7.33	0.57	2.55**
	Non- Institutionalized	20	6.90	0.70	
Q_3	Institutionalized	18	5.78	1.32	2.03 N.S.
	Non- Institutionalized	20	6.65	1.31	
Q_4	Institutionalized	18	6.22	1.27	3.15*
	Non- Institutionalized	20	7.67	1.54	

N. : Number
M. : Mean
S.D. : Standard Deviation

*** : Significant at 0.01 level**
**** : Significant at 0.05 level**
N.S. : Not Significant

Table IV signifies the difference between the means of selected personality factors amongst institutionalized and non-institutionalized elderly. It is observed that the factors 'L', 'O' and 'Q_4' are significant either at 0.01 or

0.05 level. Hence, the null hypothesis, 'Personality factors do not differ among institutionalized and non-institutionalized elderly' is rejected for the factors L, O and Q_4.

It is a well known fact that a familiar atmosphere amongst close kith and kin is satisfying to the elderly than an unfamiliar surrounding of the institution. The above table clearly indicates that differences do exist amongst institutionalized and non-institutionalized elderly. It is observed that certain personality characteristics facilitate low score in 'L' for the institutionalized elderly as they reconcile to adapt to the environment to avoid rejection. The non-institutionalized elderly show a mean score of 6.67 which is 'Average' according to the norms, revealing that they accept the need for adjustment when constrained.

The factor O clearly reveals that the institutionalized elderly are more prone to worry and depression than the non-institutionalized. This indicates the basic natural tendency that, 'Blood is thicker than water'.

Factor Q_4 shows vast difference between the institutionalized and non-institutionalized elderly, in that the non-institutionalized feel more controlled and bound by restrictions, specially when faced by financial constraints or financial dependence. The institutionalized, on the other hand, feel free to navigate in an institution.

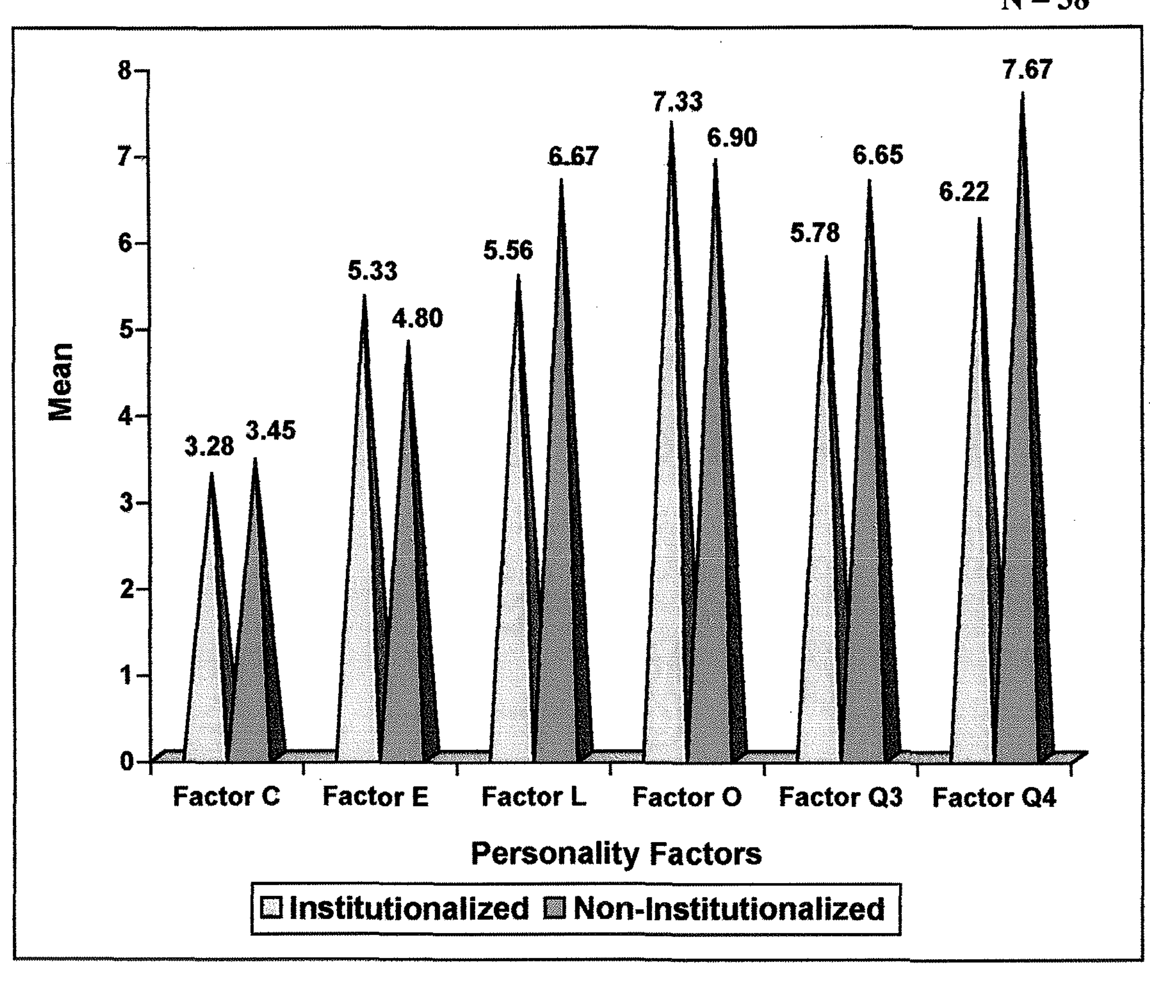
Factors C, E and Q_3 indicate no significance between institutionalized and non-institutionalized elderly, in that, both the groups experience heightened emotions, compulsion of submission and disturbed self-conflict on account of their age. Hence, the null hypothesis, 'Personality factors do not differ among institutionalized and non-institutionalized' elderly is accepted for the factors C, E and Q_3.

Raakhee and Raj (2003) examined the difference between institutionalized and non-institutionalized aged among certain selected alienation variables, viz, powerlessness, meaninglessness, normlessness, isolation and self-estrangement. The sample consisted of institutionalized (N=150) and non-institutionalized (N=150) aged belonging to Thiruvananthapuram district. The results showed that the institutionalized aged experienced more powerlessness and greater feelings of meaninglessness when compared to the non-institutionalized.

FIGURE VIII

MEAN PERSONALITY FACTORS OF THE INSTITUTIONALISED AND NON-INSTITUTIONALISED ELDERLY

N = 38



FACTOR	LOW SCORE	HIGH SCORE
C	Lower ego strength	Higher ego strength
E	Submissiveness	Dominance
L	Alaxia	Protension
O	Untroubled adequacy	Guilt proneness
Q_3	Low integration	High self-concept control
Q_4	Low ergic tension	High ergic tension

TABLE V

QUALITY OF LIFE OF THE ELDERLY

N = 38
Percentages are rounded up

Quality of Life	Before Treatment		After Treatment	
	N	%	N	%
Very High	–	–	4	11
High	–	–	16	42
Moderate	7	18	18	47
Low	31	82	–	–
Very Low	–	–	–	–

N. : Number **%. : Percentage**

Table V indicates the quality of life of the elderly. It is observed that before treatment 82% of the subjects had 'Low' quality of life and 18% had 'Moderate' quality of life. Hence, the null hypothesis, 'The quality of life of the elderly is not poor' is rejected.

It is very gratifying to see that the assessment of quality of life after treatment, revealed that 47% of the elderly had 'Moderate' quality of life, 42% had 'High' quality of life and 11% of subjects had 'Very high' quality of life. The intervention Positive Therapy had helped to improve the quality of life from 'Low' / 'Moderate' to 'Moderate' / 'High' / 'Very High' levels.

Quality of life is the amount of life satisfaction a person derives from his/her daily lives. A sense of loss shadowed by loneliness, lack of care, respect of self indicates low quality of life. The feeling of insecurity persists, coupled with high expectation, which are often childlike. Conflict arises when the individual is sick, tired in mind and body, cannot cope with psychological, emotional and physical stress.

Positive Therapy contributes in alleviating various physical and psychological problems of the elderly and help in improving their quality of life.

Browne et al (1994), on the basis of semi structured interviews using the schedule for Self–Evaluation of Quality of Life (SEOQOL) with people aged 65 and over in Ireland, reported that both family and health were nominated by people as most important to their quality of life, with almost equal frequency, followed by social and leisure activities.

TABLE VI

SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN QUALITY OF LIFE OF THE ELDERLY BEFORE AND AFTER TREATMENT

N = 38

Treatment	N	M	S.D.	t
Before Treatment	38	6.92	2.55	9.07*
After Treatment	38	17	5.12	

N. : Number *** : Significant at 0.01 level**
M. : Mean **S.D. : Standard Deviation**

Ageing has always been known as the final part of the life's journey. Adapting to old age is an arduous task in every society. The aged have to face many problems like decreasing physical strength, disease, retirement, financial difficulties, death of spouse etc. The quality of life of the elderly is affected by these problems.

The quality of life before and after intervention is shown in the table VI in which before intervention the subjects have scored 'Low' (M=6.92), indicating poor quality of life. It is heartening to note that after the intervention of Positive Therapy, their scores have increased to 'High' level (M=17). Hence, the null hypothesis, 'Positive Therapy has no effect in the enhancement of quality of life in elderly' is rejected.

The senior citizens of India are affected mostly by economic, physical, psychological and social well-being. Lack of money, poor physical and mental

health and lack of social support make them worse. They want immediate assistance to overcome these difficulties.

Farquhar's (1995) in depth interviews with people aged 65 and over in East London and Essex indicated that family, social activities and social contacts were the three commonly mentioned areas that strengthens the quality of their lives.

In the present times, the aged have become an insulated unit, the caring traditions of the youth have changed due to rapid industrialization, westernization and modernization of the Indian society- the major factor being the breaking up of the joint family system.

Guidance of the elderly is a necessity for every youngster. Instead of ignoring the old people, they can make a friendly relationship and learn many things from them. The elderly act as the pillar of strength in our country. It is disheartening to find them feeling low and sad for various reasons. This inturn, affects the progress of the country.

It is very important that efforts are made to improve the quality of life of the elderly. In this study, the intervention Positive Therapy was very effective in bringing about improvement in the quality of life of the elderly. Table VI shows that the mean difference of quality of life, before and after treatment is

statistically significant at 0.01 level. Hence, the null hypothesis, 'Positive Therapy has no effect in the enhancement of quality of life' is rejected.

In using the Positive Therapy Module, Relaxation Training, Counselling, Behavioural Techniques and Assignments, there is a sea change in elderly with regard to their quality of life. The elderly people who underwent relaxation training reported reduced physical complaints after treatment. Auto suggestion helped to improve the ego strength of each individual. Individual counselling tends to be very useful in helping them manage their personal problems and family counselling also helped for the betterment of support from the family members.

FIGURE X

MEAN QUALITY OF LIFE OF THE ELDERLY

BEFORE AND AFTER TREATMENT

N = 38

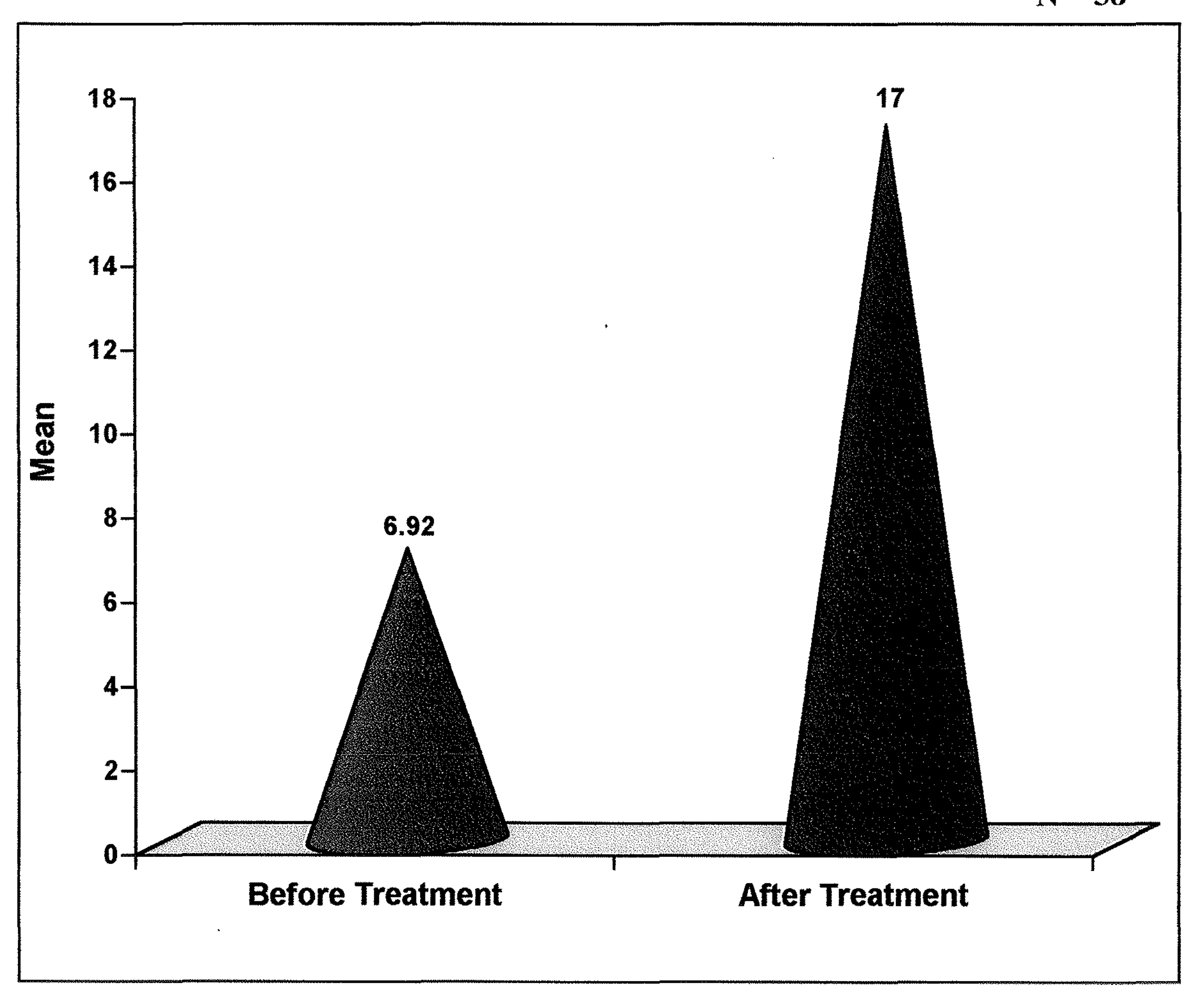


TABLE VII

SIGNIFICANCE OF DIFFERENCE BETWEEN THE MEAN QUALITY OF LIFE OF THE INSTITUTIONALIZED AND NON-INSTITUTIONALIZED ELDERLY

N = 38

Group	N	M	S.D.	t
Institutionalized	18	5.44	1.57	4.16*
Non- Institutionalized	20	8.25	2.45	

N. : Number *** : Significant at 0.01 level**

M. : Mean **S.D. : Standard Deviation**

Significance of difference between institutionalized and non-institutionalized quality of life is shown in Table VII, in that both of them had 'Low' scores, but institutionalized elderly had low mean scores than the non-institutionalized. The mean difference was statistically significant at 0.01 level. Hence, the null hypothesis, 'Quality of life do not differ among institutionalized and non-institutionalized elderly' is rejected.

Hema and Vijayalakshmi (1998) did a comparative study of the problems faced by the elderly in the institutions and in the families. The study consists of 30 subjects from institutions and 30 from non-institutions. The results showed that institutionalized elderly reported various physical problems like pain and psychological problems while the elderly living in the families (Non-institutionalized) experienced less physical problems and depression as

the only psychological problem. They experienced more family and sociological problems than the non-institutionalized.

Institutionalized elderly do complain of physical ailments. The psychological problems of the elderly outweigh the physical. Depression, feelings of insecurity, loss of interest in themselves and life, lack of care and love influence quality of life adversely. They are also emotionally affected by the family problems like loss of loved one and feel that they are being driven out by kith and kin.

A similar study was conducted by Sandhu (1995), to find the difference between the need satisfaction of the aged living with their 'families' and aged living 'alone' and found that the aged living alone perceived higher isolation and rejection, whereas the aged living with family perceived higher acceptance and co-operation.

Some institutionalized feel they are compelled to live with constraints separated from their kith and kin. They have the thought that entry into an institution represents a turning point in their lives which is commonly thrust upon them by unfavourable circumstances, such as lack of family support, a family unwilling or unable to take care of them.

Ramamurthi (2001) in his study stated several reasons for joining old age homes. About 91% respondents reported that their families were unwilling

to take care of them. The reasons stated by them were destitutions (47%), psychological conflicts (20% of men and 20% of women), emotional conflicts (19% of women and 10% of men) and poverty (51% of men and 50% of women).

The aged as a whole feel alienated in today's world. Alienation is a condition in which the person feels lacking in support and sympathy. This strangeness inturn affects their life. So, proper attention is needed for the elderly and assistance rendered for better life satisfaction.

FIGURE XI

MEAN QUALITY OF LIFE OF THE INSTITUTIONALIZED AND NON-INSTITUTIONALIZED ELDERLY

N = 38

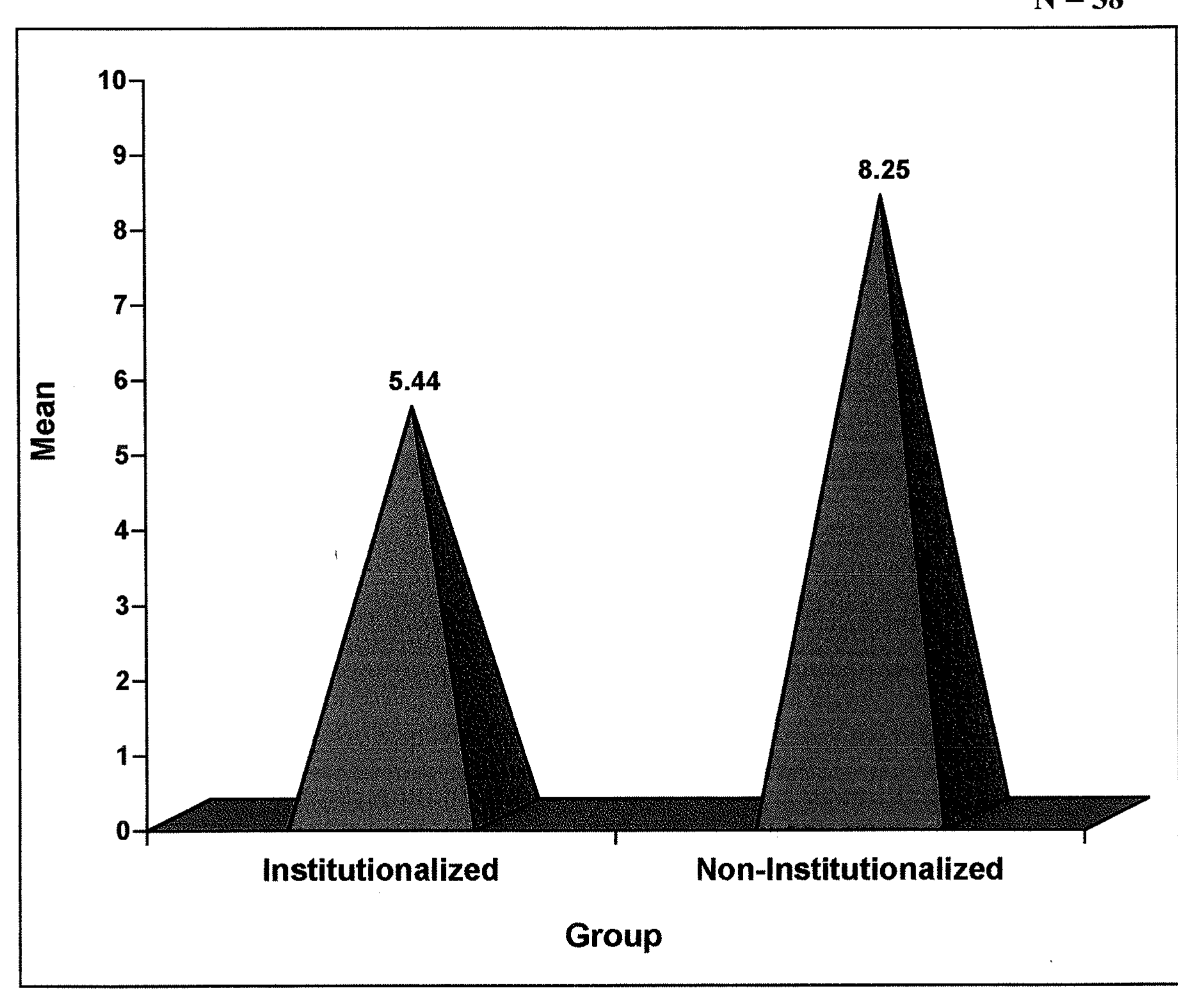


TABLE VIII

CORRELATION BETWEEN PERSONALITY FACTORS AND QUALITY OF LIFE

N = 38

Dimensions	Before Treatment	After Treatment
C and QOL	0.09	0.33**
E and QOL	0.31**	-0.12
L and QOL	-0.52*	-0.03
O and QOL	-0.20	-0.16
Q_3 and QOL	0.28	0.18
Q_4 and QOL	0.18	-0.05

QOL : Quality of Life

*** : Significant at 0.01 level**
**** : Significant at 0.05 level**

The quality of life is an important determinant of life satisfaction. The present era / decade is comparatively indicative of good quality of life in that the life style of many are in the comfort zone at all ages. Nevertheless, the life of the aged is found to have mixed reactions. The personality factors of the aged individuals do play a role in their lives and the intervention of Positive Therapy to the aged show interesting results.

The above table is indicative of the relationship between quality of life and selected personality factors of the aged. High scores in the factors C and Q_3 characterizes positive personality while low score in factors E, L, O and Q_4 characterises positive personality.

The Pearson's product moment correlation between Quality of life and each of the six factors before and after intervention reveals interesting outcomes.

The factor C characterizes emotionality of the elderly which was insignificant (0.09) before intervention while being significant (0.33) at 0.05 level after intervention. Hence, the null hypothesis, 'There is no relationship between personality (Factor C) and quality of life' is rejected.

The elderly are bound to experience low quality of life, given the constraints after retirement and also by virtue of ageing. The intervention has helped in boosting their ego strength.

Factor E shows a positive relation before and negative relation after intervention which indicates that their quality of life was demeaning due to characteristics of dominance and stubbornness which is in the inverse direction helping the elderly to become accommodative and submissive after the therapy. Cognitive Restructuring and Rational Emotive Therapy has helped the elderly to see reason. Hence, the null hypothesis, 'There is no relationship between personality (Factor E) and quality of life' is rejected.

Factor L indicates a high negative correlation, in that a high quality of life is bound to make a person self-opinionated. Hence, the null hypothesis, 'There is no relationship between personality (Factor L) and quality of life' is

rejected. It is interesting to observe that this characteristic has been considerably reduced after treatment in that the correlational value is very insignificant.

The factor O which characterizes confidence and serenity is rather disturbed in the elderly, inturn, revealing low quality of life. The degree and direction of the relationship after intervention does not show much of difference which may be due to certain other extraneous variables for low quality of life and not personality alone. Hence, the null hypothesis, 'There is no relationship between personality (Factor O) and quality of life' is accepted.

The factor Q_3 indicates positive relationship before and after intervention, where high scores indicate good personality. The elderly of this group, by reason of their age become dependent on others. There has been a minimal change in the quality of life of the elderly showing enhancement in this factor of personality. Hence, the null hypothesis, 'There is no relationship between personality (Factor Q_3) and quality of life' is accepted.

The factor Q_4 is very important to the elderly in that any disturbance is bound to trigger problems. It is important they learn to contain themselves and feel free from personal disturbance. It is observed that the correlation, as obtained in this group of elderly, has revealed that, given the intervention, this factor has been enhanced with the elderly becoming more relaxed and tranquil

on account of Positive Therapy. Hence, the null hypothesis, 'There is no relationship between personality (Factor Q_4) and quality of life' is accepted.

Hence, we find that the quality of life is not singularly dependent on the personality factors but may also be influenced by various other factors. Nevertheless, this study clearly indicates that the intervention of Positive Therapy does play an important role in enhancing both personality factors and quality of life.

Summary and Conclusion

SUMMARY AND CONCLUSION

Older people represent a valuable model with resourceful skills, knowledge and energy that we neither can be blind to nor afford to waste.

The study on, 'Assessment and Enhancement of Personality and Quality of Life in Elderly through Positive Therapy' was conducted in institutions and in the areas of Mettupalayam with the following objectives:

- To assess various personality factors of the elderly.
- To find out the difference in personality factors between institutionalized and non-institutionalized elders.
- To assess the quality of life of the elderly.
- To find out the difference in quality of life between institutionalized and non-institutionalized elders.
- To find out the relationship between personality and quality of life.
- To ascertain the efficacy of Positive Therapy in the enhancement of personality in elderly.
- To ascertain the efficacy of Positive Therapy in the enhancement of quality of life in elderly.

The sample consisted of 38 elderly people undergoing therapy. A single test group without control group was selected by purposive sampling method. The age range of the sample was 55 – 86 years.

To begin with, the Case Study Schedule by Hemalatha Natesan (2003), 16 PF developed by Raymond Cattell and Quality of Life Inventory by Thomas J. Leonard (1998) was given on the entire sample. The sample were selected on the basis of the scores. They were matched in age, quality of life and/or personality factors.

The treatment called Positive Therapy, a package developed by Hemalatha Natesan (www.hemalathanatesan.com, 2004) based on the Eastern techniques of Yoga and Western Techniques of Cognitive Behaviour Therapy were administered to all the subjects.

Positive Therapy consisted of 4 strategies namely:

- Relaxation
- Counselling
- Exercises and
- Behavioural Assignments

The treatment was given to the subjects in the group for one hour per session for 7 sessions over a period of 2 weeks. All the subjects were retested after 2 weeks, using 16 PF and Quality of Life Inventory.

CONCLUSION

- Majority of the subjects are in the age range of 55-70 years.
- Forty seven percentage of the subjects are non-working.
- Majority of the subjects were married and living with spouse.
- Forty seven percentage of the subjects in the sample were in the institutions, while 53 % were non-institutionalized.
- Among the personality factors most of the subjects scored 'Low' in factor C before intervention.
- Positive Therapy helped to increase the factor C to 'High' and 'Average' levels.
- Forty two percentage of the subjects scored 'Low' in factor E but, after Positive Therapy the scores came to an 'Average' level.
- There is no difference in factor L before and after Positive Therapy.
- Majority of the subjects scored 'High' in factor O (84%) while after therapy 53% of the subjects scored 'Low'.
- Many of the subjects scored 'High' in factor Q_3 before and after therapy.
- Majority of the subjects had 'High' scores in factor Q_4, but Positive Therapy reduced the scores to a 'Low' level.
- There is a significance of difference between means of personality factors (C, O and Q_4) before and after treatment at 0.01 level.

- The factors E, L and Q_3 show insignificance between the means before and after intervention.
- There is a 'High' significance of difference between means of personality factors (L, O and Q_4) among institutionalized and non-institutionalized at 0.01 and 0.05 level.
- The factors C, E and Q_3 show insignificance between means of institutionalized and non- institutionalized.
- In Quality of life, majority of the subjects had 'Low' score.
- After the intervention of Positive Therapy, the scores increased from 'Low' / 'Moderate' to 'Moderate' / 'High' / 'Very High'.
- There is a 'High' significance of difference between means of quality of life before and after treatment.
- There is a 'High' significance of difference between means of quality of life among institutionalized and non-institutionalized at elderly 0.01 level.
- There exists a significant positive relationship between quality of life and factor E before intervention at 0.05 level.
- There is a significant positive relationship between quality of life and personality factor C after intervention at 0.05 level.
- There exists a significant negative relationship between quality of life and factor L before intervention at 0.01 level.

- Positive Therapy has immensely enhanced personality and quality of life in the elderly.

RECOMMENDATIONS

- Psychologists can be appointed in old age homes to facilitate overall mental health and quality of life of the elderly.
- Personality development workshops can be conducted for the elderly people.
- As previous researches have proved the efficacy of Positive Therapy in enhancing mental health of the elderly, Positive Therapy workshops can be conducted.
- Programmes that facilitate interaction between the elderly and the younger generation should be conducted.
- Further studies with specification of gender can be carried out.

LIMITATIONS

The study was conducted with a sample selected from a specific area and institutions. Hence, the analysis is applicable only to this population. The results cannot be generalized.

NEED FOR FURTHER STUDY

The present study relating personality factors and quality of life was confined only to elderly. Further studies need to be conducted on larger sample with other traits of personality. The effect of Positive Therapy in enhancing of personality and quality of life can be carried out longitudinally.

References

REFERENCES

Allport, G. (1937). In Feldman, S.R. (1997). Essentials of understanding psychology. Third edition. Mc Graw Hill Companies. New York : 412.

Asendorpf, J.B. and Wilpers, S. (1998). Personality effects on social relationships. Journal of Personality and Social Psychology; 74(6): 1531-1544.

Aswathappa, K. (2003). Organisational Behaviour. Himalaya Publishing House. Mumbai: 72-95.

Aujla, P., Dhillon, P. and Sandhu, P. (2000). An analysis on the life satisfaction of elderly in rural Punjab. Indian Psychological Review; 54(1&2): 27-33.

Bain, G.H., Lemmon, H., Teunisse, S., Starr, J.M., Fox, H.C., Deary, I.J. and Walley, L.J. (2003). Quality of life in healthy old age : relationships with childhood I.Q, Minor psychological symptoms and optimism. Journal of Social Psychiatry and Psychiatric Epidemiology; 38(11) : 632-6.

Ballesteros, R.F. (1998). Quality of life - The differential conditions; 2(1): 57-65. http://theses.lub.lu.se/postgrad/search.tkl?field_query1=soc_385 &recordformat=display.

Borders, T.F. and Aday, L.A. (2004). Factors associated with health-related quality of life among an older population in a largely rural western region. Journal of Rural Health; 20(1) : 67-75.

Browne, J.P., O'Boyle, C.A., Mc Gee, H.M. (1994). Individual Quality of Life in the healthy elderly. Quality of Life Research; 3 : 235 – 244.

Campbell, J. (1996) . In Human Development Across the Lifespan. Third Edition. Mc Graw Hill. Boston: 482.

Cattell, R.B. (1972). 16PF. Personality and ability testing. Champaign. Illinois. U.S.A.

Cavanaugh, J.C. and Fields, F.B. (2002). Adult Development and Ageing. Fourth Edition. Wadsworth Thomson Learning. Australia: 12.

Chadha, N.K. (1997). Ageing and the Aged-Challenges before Indian Gerontology. Friends Publications, India: 92.

Chao, D. and Chadha, N.K. (2002). Quality of life of the elderly in Nagaland. Indian Journal of Clinical Psychology; 29(1): 6-12.

Chaube, S.P. (2002). Psychology of Adolescents in India. Concept Publishing Company. New Delhi: 1 – 5.

Choudhary, B.K., Jha, S. and Krishna, K.P. (2001). Personality characteristics of working and retired aged people. In Modi, I. (2001). Ageing and Human Development-Global Perspectives. Rawat Publications, Jaipur: 342-5.

Condello, C., Padvani, W., Uguzzoni, U., Caon, F. and Leo, D.D. (2003). Personality disorders and self-perceived quality of life in an elderly psychiatric outpatient population. Journal of Psychopathology; 36(2): 78-83.

Coon, D. (2000). Essentials of Psychology – Exploration and Application. Eighth Edition. Wadsworth. Australia: 318 – 321.

Diener, E.D., Eunkook, S. and Shigehiro, O. (1997). Recent findings on subjective well-being. Indian Journal of Clinical psychology: 24-41.

Dos, S.R., Santos. S., Costa. I.B. and Gracas, M.D. (2002). Elderly quality of life in the community: application of the Flanagan's scale; 10(6): 757-64.

Dwivedi., Vimal and Srivastav, A.K. (1998). Life satisfaction and biographical factors affecting aged persons. Indian Journal of Psychometry and Education; 29(1): 61-4.

Farquhar, M. (1995). Elderly People's definitions of quality of life. Social science and medicine; 41 : 1439-1446.

Feldman, S.R. (1997). Essentials of understanding psychology. Third edition. Mc Graw Hill Companies. New York : 412.

Flanagan, T. (2000). http://www.atsqol.org/key.asp

Gupta, A.K., Sharma, A. and Agarwal, B.K. (1995). In. Prasad, R. (1995). Science and Technology. Y.K. Publishers. Agra: 42 – 45.

Gustavsson, J.P. (1997). Stability and Predictive ability of personal traits across 9 years. Personality and Individual differences; 22(6): 783 – 791.

Hagberg, M. (2002). http://theses.lub.lu.se/postgrad/search.tkl?field_query1=pubid&query1=soc_385&recordformat=display.

Hema, J. and Vijayalakshmi, O. (1998). A comparative study of the problems faced by the elderly living in the institutions and in the families.

Hemalatha Natesan. (2003). Case Study Schedule. Unpublished Manuscript.

Hemalatha Natesan. (2004). Positive Therapy. www.hemalathanatesan.com.

http://www.brrd.ab.ca/cchs/barclay/globweb/qolhtml/gayaza.html.2000

http://www.gentleteaching.nl/qol-1.html

http://www.regard.ac.uk/research_findings/L480254003/report.pdf

http://www.utoronto.ca/qol/concepts.htm

Hurlock, E.B. (1999). Developmental Psychology. A Life Span Approach. 5th Edition. Tata Mc Graw Hill Publishing Company Ltd. New Delhi: 390 – 420.

Kalbag, S.S. In Prasad, R. (1995). Science and Technology, Y.K. Publishers. Agra: 26 – 30.

Kothari, C.R. (2000). Research Methodology – Methods and Techniques. New Age International (P) Ltd. New Delhi: 52.

Kovaci, T. and Kuruc, S. (2003). Quality of life : Some personality aspects in relation to data measured by the WHOQOL-BREF. http://www.elis.sk/psych/psy2002-03.htm#06.

Martin, P., Adkins, G., Poon, L.W., Clayton, G.M. and Johnson, M.A. (2000). Personality traits and states as predictors of subjective well-being in older adults. http://www.ucm.es/info/Psyap/231CAP/abstract/qerontology3.html.

Matsuo, M., Nagasawa, J., Yoshino, A., Hiramatsu, K. and Kurashiki, K. (2003). Effects of activity participation of the elderly on quality of life. Yonago Acta Medica;46:17-24.http://lib.med.tottori-u.ac.jp/yam/yam46-1/yam46-017-024.html

Patil, P.B., Gaonkar, V. and Yadav, V.S. (2000). Depression among the elderly and its correlates. Indian Psychological Review; 54 (1&2): 88-93.

Prakash, I.J. (2001) In Modi, I. (2001). Ageing and human development – Global perspectives. Jaipur: 333.

Prakash. I.J. (1998). Social network, functional competence and well- being of the elderly. Indian Journal of Clinical Psychology; 25(1): 6-12.

Rakhee, A.S. and Raj, H.S.S. (2003). Alienation among the institutionalized and non-institutionalized aged. Psychological studies; 48(2) : 65-68.

Ramamurthi, P.V. (1997). Evaluation of Old Age Homes Day Care Centres and Mobile Medical units in Andhra Pradesh. Report submitted to Ministry of Welfare (Government of India, New Delhi).

Ramamurthi, P.V. (2001). Insitutionalisation of elderly and Quality of life. In Modi, I. (2001). Ageing and human development-Global perspectives. Rawat Publications. Jaipur: 327-8.

Robbins, S.P. (1999). Organisational Behaviour – Concepts, Controversies, Applications. Eighth Edition. Prentice Hall of India Pvt. Ltd. New Delhi: 50 – 67.

Ruiselova, Z. (2003). Relationship between resistance to load and personality traits in elderly women. Insitute of Experimental Psychology. Slovak Academy of Sciences; 9(813):64.
http://www.elis.sk/psych/psy2002-03.htm#05.

Ryff, C.D. and Keyes, C.L.M. (1995). The structure of psychological well-being revisited. Journal of Personality and Social Psychology: 69, 719-27.

Sandhu, R. (1995). Need Satisfaction of the aged. Journal of Community Guidance and Research; 12 (2) : 145 – 150.

Sangeetha, E. and Vijayalakshmi, O. (2001). Assessement and Management of geriatric depression through Positive Therapy. Unpublished Thesis.

Santrock, J.W. (2000). Psychology. Sixth Edition. Mc Graw Hill Company Inc. Boston: 411 – 412.

Appendices

APPENDIX I

CASE STUDY SCHEDULE (2003)

DR. HEMALATHA NATESAN

Professor and Head, Dept of Psychology, Avinashilingam University, Coimbatore.

Name : Case Number :

Age : Date :

Sex :

Date of Birth :

Education :

Occupation :

Income :

Marital Status : Single / Married / Widow or Widower

Type of Family : Joint / Nuclear

Size of Family : Small (4 & below) / Big (More than 4)

Address :

Phone No. :

Family Background :

S.No	Relationship	Age	Education	Occupation	Income

APPENDIX II

16 PF

1967-68 Edition
FORM A

WHAT TO DO

Inside this booklet are some questions to see what attitudes and interests you have. There are no "right" and "wrong" answers because everyone has the right to his own views. To be able to get the best advice from your results, you will want to answer them exactly and truly.

If a separate "Answer Sheet" has not been given to you, turn this booklet over and tear off the Answer Sheet on the back page.

Write your name and all other information asked for on the top line of the Answer Sheet.

First you should answer the four sample questions below so that you can see whether you need to ask anything before starting. Although you are to read the questions in this booklet, you must record your answers on the answer sheet (alongside the same number as in the booklet).

There are three possible answers to each question. Read the following examples and mark your answers at the top of your answer sheet where it says "Examples". Fill in the left-hand box if your answer choice is the "a" answer, in the middle box I: your answer choice is the "b" answer, and in the right-hand box if you choose the "c" answer.

EXAMPLES

1. I like to watch team games
a. yes, b. occasionally c. no
2. I prefer people who:
a. are reserved
b. (are in between),
c. make friends quickly.

3. Money cannot bring happiness
a. yes, (true), b. in between c. no (false)
4. Woman is to child as cat is to:
a. Kitten, b. dog c. boy

In the last example there is a right answer-kitten. But there are very few such reasoning items.

Ask now if anything is not clear. The examiner will tell you in a moment to turn the page and start.

When you answer, keep these four points in mind:

1. You are asked not to spend time pondering. **Give the first, natural answer as it comes to you.** Of course, the questions are too short to give you all the particulars you would sometimes like to have. For instance, the above question asks you about "team games" and you might be founder of football than basketball. But you are to reply "for the average game", or.to strike an average in situations of the kind stated. Give the best answer you can at a rate not slower than five or six a minute. You should finish in a little more than half an hour.
2. Try **not** to fall back on the middle, "uncertain" answers except when the answer at either end is **really impossible** for you-perhaps once every four or five questions.
3. Be sure not to skip anything, **but answer, every question, somehow.** Some may not apply to you very well, but give your best guess. Some may seem personal; but remember that the answer sheets are kept confidential and cannot be scored without a special stencil key. Answers to particular questions are not inspected.
4. Answer as honestly as possible what is true of **you**. Do not merely mark what seems "the right thing to say" to impress the examiner.

DO NOT TURN UNTIL TOLD TO DO SO

1. I have the instructions for this test clearly in mind

   a. yes, b. uncertain, c. no.

2. I am ready to answer each question as truthfully as possible.

   a. yes, b. uncertain, c. no.

3. I can find enough energy to face my difficulties

   a. always, b. generally, c. seldom.

4. I feel a bit nervous of wild animals even when they are in strong cages

   a. yes (true), b. uncertain, c. no (false).

5. I hold back from criticizing people and their ideas

   a. yes, b. sometimes, c. no.

6. I make smart, sarcastic remarks to people if I think they deserve it.

   a. generally, b. sometimes, c. never.

7. I can generally put up with conceited people, even though they brag or show they think too well of themselves

   a. yes, b. in between, c. no.

8. Once in a while I have a sense of vague danger or sudden dread for reasons that I do not understand

   a. yes, b. in between, c. no.

9. When criticized wrongly for something I did not do, I:

   a. have no feeling of guilt, b. in between, c. still feel a bit guilty.

10. I occasionally get puzzled, when looking in a mirror, as to which is my right and left

    a. true, b. uncertain, c. false.

11. When talking, I like:

    a. to say things, just as they occur to me, b. in between,

    c. to get my thoughts well organized first.

12. When something really makes me furious, I find I calm down again quite quickly.

    a. yes, b. in between, c. no.

13. I sometimes can't get to sleep because an idea keeps running through my mind.

    a. true, b. uncertain, c. false.

14. In my personal life I reach the goals I set, almost all the time.

    a. true, b. uncertain, c. false.

15. An out-dated law should be changed:

    a. only after considerable discussion, b. in between, c. promptly.

16. I am uncomfortable when I work on a project requiring quick action affecting others.

    a. true, b. in between, c. false.

17. When I have been put in charge of something, I insist that my instructions are followed or else I resign.

    a. yes, b. sometimes, c. no.

18. I feel terribly dejected when people criticize me in a group

    a. true, b. in between, c. false.

19. If I am called in by my boss, I:

    a. make it a chance to ask for something I want,

    b. in between, c. fear I've done something wrong.

20. I keep my room well organized, with things in known places almost all the time

    a. yes, b. in between, c. no.

21. I sometimes get in a state of tension and turmoil as I think of the day's happenings

    a. yes, b. in between, c. no.

22. I sometimes doubt whether people I am talking to are really interested in what I am saying.

    a. yes, b. in between, c. no.

23. I have been let down by my friends

    a. hardly ever, b. occasionally, c. quite a lot.

24. I have some characteristics in which I feel definitely superior to most people

    a. yes, b. uncertain, c. no.

25. When I get upset, I try hard to hide my feelings from others

    a. true, b. in between, c. false.

26. If someone got mad at me, I would:

    a. try to calm him down, b. uncertain, c. get irritated.

27. When I read an unfair magazines article, I am more inclined to forget it than to feel like "hitting back".
a. true, b. in between, c. false.

28. There are times when I don't feel in the right mood to see anyone.
a. very rarely, b. in between, c. quite often.

29. People sometimes warn me that I show my excitement in voice and manner too obviously.
a. yes, b. in between, c. no.

30. I feel mature in most things.
a. true, b. uncertain, c. false.

31. I find myself upset rather than helped by the kind of criticism that many people offer one.
a. often, b. occasionally, c. never.

32. I am always able to keep the expression of my feelings under exact control.
a. yes, b. in between, c. no.

33. Some people seem to ignore or avoid me, although I don't know why.
a. true, b. uncertain, c. false.

34. People treat me less reasonably than my good intentions deserve.
a. often, b. occasionally, c. never.

35. The use of foul language even when it is not in a mixed group of men and women, still disgusts me.
a. yes, b. in between, c. no.

36. When bossy people try to "push me around", I do just the opposite of what they wish.
a. yes, b. in between, c. no.

37. Business superiors or members of my family, as a rule, find fault with me only when there is real cause.
a. true, b. in between, c. false.

38. If acquaintances treat me badly and show they dislike me:
a. it doesn't upset me a bit, b. in between c. I tend to get downhearted.

39. I find it embarrassing to have praise or compliments bestowed on me.
a. yes, b. in between, c. no.

40. In carrying out a task, I am not satisfied unless even the minor details are given close attention.
    a. true, b. in between, c. false.

41. Quite small setbacks occasionally irritate me too much.
    a. yes, b. in between, c. no.

42. I am always a sound sleeper, never walking or talking in my sleep.
    a. yes, b. in between, c. no.

43. When people are unreasonable, I just
    a. keep quiet, b. uncertain, c. despise them.

44. If people talk loudly while I am listening to music, I
    a. can keep my mind on the music and not be bothered,
    b. in between, c. find it spoils my enjoyment and annoys me.

45. I think I am better described as:
    a. polite and quiet, b. in between, c. forceful.

46. If I am quite sure that a person is unjust or behaving selfishly, I show him up, even if it takes some trouble.
    a. yes, b. in between, c. no.

47. I sometimes make foolish remarks in fun, just to surprise people and see what they will say.
    a. yes, b. in between, c. no.

48. I feel some punishment is coming to me even when I have done nothing wrong.
    a. often, b. occasionally, c. never.

49. The idea that sickness comes as much from mental as physical causes is much exaggerated.
    a. yes, b. in between, c. no.

50. I have periods when it's hard to stop a mood of self-pity.
    a. often, b. occasionally, c. never.

51. Often I get angry with people too quickly.
    a. yes, b. in between, c. no.

52. I can always change old habits without difficulty and without slipping back.
    a. yes, b. in between, c. no.

53. When the time comes for something I have planned and looked forward to, I occasionally do not feel up to going.
a. true, b. in between, c. false.

54. I can work carefully on most things without being bothered by people making a lot of noise around me.
a. yes, b. in between, c. no.

55. I occasionally tell strangers things that seem to me important regardless of whether they ask about them.
a. yes, b. in between, c. no.

56. If a good remark of mine is passed by, I :
a. let it go, b. in between, c. give people a chance to hear it again.

57. I am properly regarded as only a plodding half-successful person.
a. yes, b. uncertain, c. no.

58. If people take advantage of my friendliness, I do not resent it and soon I forget
a. true, b. uncertain, c. false.

59. I sometimes let my actions get swayed by feelings of journey.
a. yes, b. in between, c. no.

60. I believe firmly, "the boss may not always be right, but he always has the right to be boss".
a. yes, b. uncertain, c. no.

61. I get tense as I think of all the things lying ahead of me.
a. yes, b. sometimes, c. no.

62. If people shout suggestions when I'm playing a game it doesn't upset me.
a. true, b. uncertain, c. false.

63. I have vivid dreams, disturbing my sleep.
a. often, b. occasionally, c. practically never.

64. If the odds are really against something's being a success, I still believe in taking the risk.
a. yes, b. in between, c. no.

65. I like it when I know so well what the group has to do that I naturally become the one in command.
a. yes, b. in between, c. no.

66. I have sometimes been troubled by people's saying bad things about me behind my back, with no grounds at all.
a. yes, b. uncertain, c. no.

67. People regard me as a solid, undisturbed person, unmoved by ups and downs in circumstances.
a. yes, b. in between, c. no.

68. I like to go my own way instead of acting on approved rules.
a. true, b. uncertain, c. false.

69. I like to wait till I am sure that what I am saying is correct, before I put forty an argument.
a. always, b. generally, c. only if it's practicable.

70. Small things sometimes "get on my nerves" unbearably, though I realize they are trivial.
a. yes, b. in between, c. no.

71. I don't often say things on the spur of the moment that I greatly regret.
a. true, b. uncertain, c. false.

72. If I make an awkward social mistake, I can soon forget it.
a. yes, b. in between, c. no.

73. I am known as an "idea man" who almost always puts forward some ideas on a problem.
a. yes, b. in between, c. no.

74. I think I am better at showing.
a. nerve in meeting challenges,
b. uncertain, c. tolerance of other people's wishes.

SCORING KEY

Factor C			
Question Number	A	B	C
3	2	1	0
4	0	1	2
13	0	1	2
14	2	1	0
23	2	1	0
33	0	1	2
34	0	1	2
43	2	1	0
44	2	1	0
53	0	1	2
54	2	1	0
63	0	1	2
72	2	1	0

Factor E			
Question Number	A	B	C
5	0	1	2
6	2	1	0
15	0	1	2
16	0	1	2
24	2	1	0
25	0	1	2
35	0	1	2
45	0	1	2
55	2	1	0
64	2	1	0
65	2	1	0
73	2	1	0
74	2	1	0

Factor L			
Question Number	A	B	C
7	0	1	2
17	2	1	0
26	0	1	2
27	0	1	2
36	2	1	0
37	0	1	2
46	2	1	0
47	2	1	0
56	0	1	2
66	2	1	0

Factor O			
Question Number	A	B	C
8	2	1	0
9	0	1	2
18	2	1	0
19	0	1	2
28	0	1	2
29	2	1	0
38	0	1	2
39	2	1	0
48	2	1	0
49	2	1	0
57	2	1	0
58	0	1	2
67	0	1	2

Factor Q_3			
Question Number	A	B	C
10	0	1	2
11	0	1	2
20	2	1	0
30	2	1	0
40	2	1	0
50	0	1	2
59	0	1	2
60	2	1	0
68	0	1	2
69	2	1	0

Factor Q_4			
Question Number	A	B	C
12	0	1	2
21	2	1	0
22	2	1	0
31	2	1	0
32	0	1	2
41	2	1	0
42	0	1	0
51	2	1	0
52	0	1	2
61	2	1	0
62	0	1	2
70	2	1	0
71	0	1	2

16 PF Norms – Normalised Stens
General Population Females, Form A

STEN SCORE

Factor	1	2	3	4	5	6	7	8	9	10
C	0-7	8	9-10	11-13	14-15	16-17	18	19-21	22	23-26
E	0-2	3-4	5-6	7-8	9-11	12-13	14-16	17-18	19-20	21-26
L	0	1	2-3	4	5-6	7	8-9	10-11	12-14	15-20
O	0-3	4-5	6-7	8-9	10-11	12-13	14-15	16-17	18-19	20-26
Q_3	0-5	6-7	8	9-10	11-12	13-14	15	16-17	18	19-20
Q_4	0-4	5-6	7-8	9-10	11-12	13-15	16-18	19-20	21-22	23-26

16 PF Norms – Normalised Stens
General Population Males, Form A

STEN SCORE

Factor	1	2	3	4	5	6	7	8	9	10
C	0-7	8-9	10-11	12-13	14	15-17	18-19	20	21-22	23-26
E	0-4	5-6	7-8	9-10	11-12	13-14	15-16	17-18	19-20	21-26
L	0-4	2-3	4	5-6	7-8	9	10-11	12-13	14	15-20
O	0-2	3-4	5-7	8-9	10-11	12-13	14-15	16-17	18-19	20-26
Q_3	0-5	6-7	8	9-10	11	12-13	14-15	16-17	18	19-20
Q_4	0-3	4-5	6-7	8-9	10-12	13-14	15-16	17-18	19-20	21-26

SELECTED FACTORS OF 16 P.F. TEST PROFILE

Name : ______________________

Comments : ______________________

Factor	Raw Score Form	Raw Score Form	Raw Score Total	Standard Score	LOW SCORE DESCRIPTION	1	2	3	4	5	6	7	8	9	10	HIGH SCORE DESCRIPTION
						↓	↓	↓	↓	↓ (Average)	↓ (Average)	↓	↓	↓	↓	
C					**AFFECTED BY FEELINGS,** EMOTIONALLY LESS STABLE, EASILY UPSET (Lower ego strength)	.	.	.	.	. C	.	.	.	.	.	**EMOTIONALLY STABLE,** FACES REALITY, CALM, MATURE (Higher ego strength)
E					**HUMBLE,** MILD, ACCOMODATING, CONFORMING (Submissiveness)	.	.	.	.	. E	.	.	.	.	.	**ASSERTIVE,** INDEPENDENT, AGGRESSIVE, STUBBORN (Dominance)
L					**TRUSTING,** ADAPTABLE, FREE OF JEALOUSY, EASY TO GET ON WITH (Alaxia)	.	.	.	.	. L	.	.	.	.	.	**SUSPICIOUS,** SELF-OPINIONATED, HARD TO FOOL (Protension)
O					**PLACID,** SELF-ASSURED, CONFIDENT, SERENE (Untroubled adequacy)	.	.	.	.	. O	.	.	.	.	.	**APPREHENSIVE,** WORRYING, DEPRESSIVE, TROUBLED (Guilt Proneness)
Q_3					**UNDISCIPLINED SELF-CONFLICT,** FOLLOWS OWN URGES, CARELESS OF PROTOCOL (Low integration)	.	.	.	.	. Q_3	.	.	.	.	.	**CONTROLLED,** SOCIALLY-PRECISE, FOLLOWING SELF-IMAGE (High self-concept control)
Q_4					**RELAXED,** TRANQUIL, TORPID, UNFRUSTRATED (Low ergic tension)	.	.	.	.	. Q_4	.	.	.	.	.	**TENSE,** FRUSTRATED, DRIVEN, OVERWROUGHT (High ergic tension)

	1	2	3	4	5	6	7	8	9	10	
A Sten of	1	2	3	4	5	6	7	8	9	10	**is obtained**
by about	2.3%	4.4%	9.2%	15.0%	19.1%	19.1%	15.0%	9.2 %	4.4%	2.3%	**of adults**

APPENDIX III

QUALITY OF LIFE

Developed by Thomas J. Leonard (1998)

INSTRUCTIONS

Tick 'Yes' or 'No' for each of the statements.

S.No.	STATEMENTS	YES	NO
	I. Family/Relationships		
1.	I am both pleased and content with my spouse/partner, or happy being single.		
2.	I am close to my parent(s), alive or not. There is nothing in the way; nothing between us.		
3.	I have a circle of friends who I have a blast with, without effort.		
4.	I have a best friend and treat him/her extremely well.		
5.	I am very close to my children. There is nothing in the way; nothing between us.		
6.	I enjoy my family/extended family; we have worked through any dysfunction/past problems.		
7.	I am part of a professional network that stimulates me intellectually and emotionally.		
8.	I get along well with my neighbours.		
9.	I have at least 20 friends and colleagues who live outside of my country of residence.		
10.	I am loved by the people who mean the most to me.		
	II Personal Foundation/Self-Responsibility		
11.	I love my home; its location, style, furnishings, light, feeling and décor.		

12.	My boundaries are strong enough that people respect me, my needs and what I want.		
13.	I tolerate very, very little; I'm, just not willing to.		
14.	I don't see a cloud on my future's horizon; it looks clear to me.		
15.	My wants have been satiated; there is little I want.		
16.	My personal needs have been satisfied; I am not driven or motivated by unmet needs.		
17.	There is nothing I am dreading or avoiding.		
18.	My personal values are clear and my life is oriented around them.		
19.	I have resolved the stresses and key issues of my upbringing and past events.		
20.	I don't have a lot of unfinished projects, business or hanging items; I am caught up.		
21.	**III Personal Development/Personal Evolution** I could die this afternoon with no regrets.		
22.	I am living my life, not the life that someone else designed for me or expected of me.		
23.	There is nothing that I am not facing head-on; nothing that I am putting up dealing with.		
24.	I attract success; I don't have to strive for it chase it.		
25.	I have more than enough natural motivation, inspiration and synergy in my life; I am not stuck.		
26.	I am evolving, not just improving or evolving, because I continually experiment.		
27.	I have progressed beyond the notion of beliefs.		
28.	I am at that place in life where I initiate and cause events, not wait for others or events to do so.		

29.	I have learned to take the path of least resistance as I accomplish my goals.		
30.	I am beyond striving for success; I simply enjoy my life and focus on what fulfills me.		
	IV Self-care/Well-being		
31.	I take at least 4 vacations a year.		
32.	Life is easy; I have virtually no problems or unresolved matters affecting me.		
33.	My teeth and gums look great and are in top condition.		
34.	I have more than enough time during my day.		
35.	I eat food for sustenance and pleasure, not for emotional comfort.		
36.	I am not abusing my body with too much alcohol, television, caffeine or drugs.		
37.	Whatever health problems I have, I am receiving proper, effective care for them.		
38.	My body is in great shape.		
39.	I reduce stress daily by meditating, taking a long bath, exercising, walking etc.		
40.	There is nothing I am doing that is messing up my mind or heart.		

NORMS

SCORE	INTERPRETATION
25 and above	Very High
17 – 25	High
9 – 16	Moderate
1 – 8	Low
0	Very Low