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CONTENTS

YOU ARE INVITED TO JOIN US

We are Working to Protect the Rights and Social Welfare of the Elderly

Indian Gerontological Association (Registration No 212/ 1968) is an independent grassroot non-profit organization based in Jaipur (Rajasthan). Our efforts **empower** and **support** the underprivileged elderly in rural and urban communities.

We strive to **ensure social justice and welfare for people over 60**, focusing on those elders who are the most disadvantaged such as elderly women. We protect the civil liberties of elderly citizens as a part of the **struggle for individual rights and social progress** in India.

Currently, the elderly community comprises approximately 10% of the total population of India. This number will increase to nearly 16% within the next twenty years. **Neglected and abandoned by society and sometimes their own families, elders are increasingly subject to conditions of disease and poverty.** They lack access to health care, and often face serious discrimination as well as physical and emotional abuse.

As a public interest group, **we work for and with the elderly to protect their rights and access to a better quality of life.** We seek to both empower and serve by working directly with rural communities. By facilitating the growth of citizen's groups, raising public awareness on ageing, promoting public action and participation, and advocating public policy changes, Indian Gerontological Association hopes to alter the current trends in elder relations for the better.

Our work includes :

- **Community Centers for the Elderly** that Offer Communal Support and Interaction
- **Training on Legal Rights** by Offering the Elderly Practical Knowledge on Their Rights
- **Public Helpline for the Elderly that** Offers Legal Referrals and Assistance (Helpline : 0141-2624848).
- **Public Accessibility for the Elderly** Advocating More Available Access to the Public Sphere
- **Use of various forms of media** to Raise Public Awareness on Elder Rights
- **Counselling** and Helping elderly to Relieve Psychological Stress and Depression
- **Elder Women's Cooperatives** that Provide Grants and Assistance to Elderly Women
- **Public Awareness Raising** to Promote Public Action for Helping Disadvantaged Elderly
- **Field Study of Rural Areas** to Analyze Challenges Faced by Ageing Rural Population

Our plan of action includes:-

- **Campaign for Elder Rights**
- **Campaign Against Elder Abuse especially toward Elderly Women**
- **Training of Social Workers and Caregivers**
- **Capacity Building of Civil Servants or organizations Working on Ageing**
- **Research & Publication.**

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Lipase Activity During Ageing of Brinjal Shoot and Fruit Borer, *Leucinodes orbonalis* (Guenee)

Ramesh M. Gejage and Manisha R. Gejage*
Department of Zoology, K.R.P. Kanya Mahavidyalaya, Islampur Tal. Walwa Dist. Sangli-415 409 (MS)
*Department of Zoology, Vishwasrao Naik Mahavidyalaya, Shirala Tal. Shirala, Dist. Sangli-415 408 (MS)

ABSTRACT

The brinjal shoot and fruit borer, Leucinodes orbonalis (Guenee) is an important pest of brinjal in South Asia. The enzyme lipase in female adult revealed optimum pH 8.2, incubation time 30 minutes, temperature 37^0 C, enzyme concentration 1 % and substrate concentration 5 %. A gradual increase in lipase activity was observed from 1-day old female adults to 3-day old adults and decreases from 3-day old adults to 5-day old adults. The maximum lipase activity was observed in 3- day old female adults. In male adult, the lipase activity was 1.0548 folds more than 3-day old female adults. The physiological role of lipase during ageing of female adult brinjal shoot and fruit borer, L. orbonalis (Guenee) is reported in the present paper.

Key words: Triacylglycerol lipase, Insect, Female adult, *L. orbonalis* (Guenee).

Brinjal shoot and fruit borer, *Leucinodes orbonalis* (Guenee) is the most destructive pest of brinjal. The young larvae bore into tender shoots near the growing points into flower buds or into the fruits. The immature fruits are also damaged, which finally leads to the economic loss to the farmers. The adult developmental stage is of 5 days in August and September. The triacylglycerol lipase is an enzyme which is responsible for hydrolysis of triglyceride. Lipolytic enzymes are indispensable for the biological turnover of lipids. They are required as digestive enzymes in the transfer of lipid from one organism to another, that is from plant to animal and from animal to animal. Within the

organisms, they are instrumental in the deposition and mobilization of the fat. They are also involved in the metabolism of intracellular lipids Pol and Salunkhe (2001b).

Many attempts have been made to investigate lipase activity in few insect species (Nandanan *et al.,*1973; Price, 1975; Radha Pant and Sharma, 1978; Hoffman and Downer,1979; Male and Story, 1981; Wheeler *et al*., 1984; Soulages and Wells,1994 ; Pistillo *et al*., 1998; Pol and Sawant, 1999; Arreguin *et al.,* 2000; Pol and Salunkhe, 2001a, 2001b; Ponnuvel *et al*., 2003; Gejage and Awate, 2009; Horne *et al.,* 2009).The information on lipase activity during ageing of female adult brinjal shoot and fruit borer, *L. orbonalis* (Guenee) is rather scanty.

In the present investigation, an attempt has been made to measure lipase activity during ageing of female adult of brinjal shoot and fruit borer, *L. orbonalis* (Guenee) which is mainly concerned with release of energy for the development of eggs (oogenesis) and oviposition.

MATERIALS AND METHODS

The culture of *L. orbonalis* (Guenee) was maintained in the Laboratory on the natural food of brinjal fruit (Pol and Gejage, 2002). Female from developmental stages 1 day to 5 day old were taken for the study of lipolytic activity.

For the enzyme preparation, the female moths were isolated. The wings, antennae and legs were removed and cleaned with distilled water, weighed and homogenized in the cold double distilled water using a ground glass mortar and pestle. The homogenate were diluted with cold double distilled water so as to get 1% (wt/vol) concentration. Such homogenate were used for the assay of lipolytic activity. The lipase was assayed by the method of Hayase and Tapple (1970). The assay system contained 0.25 ml of 5 % substrate dispersed in gum acacia; 1.0 ml of 0.1 M tris-maleate buffer pH 8.2 and 0.25 ml of 1 % (wt/vol) enzyme solution in a total volume of 1.5 ml. The incubations were carried out in a shaker with a continuous shaking for 30 minutes in glass stoppered vessels at 37^{0}C. At the end of the incubation the liberated fatty acids were measured colorimetrically according to Itaya (1977).

RESULTS AND DISCUSSION

Adult developmental period of *L. orbonalis* (Guenee) is of 5-days. Lipase activity during ageing of female adult of *L. orbonalis* (Guenee)

is shown in figure 1. The adult lipase revealed optimum pH 8.2, incubation time 30 minutes, temperature 37^0 C, enzyme concentration 1 % and substrate concentration 5 %. A gradual increase in lipase activity was observed from 1-day old female adults to 3-day old adults but decreased from 3-day old adults to 5-day old adults. The maximum lipase activity was observed in 3- day old female adults. In male adult lipase activity is 1.0548 folds more than 3-day old female adults.

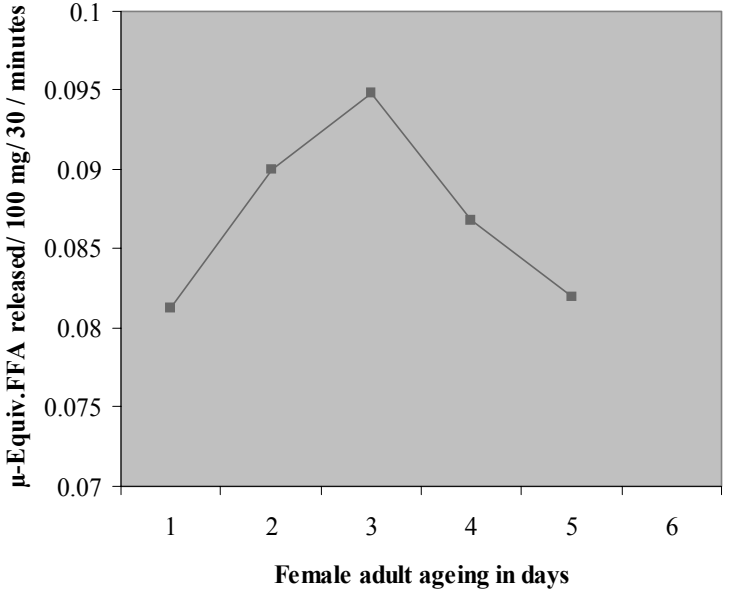

Fig.1. Lipase activity during ageing of female adult of *Leucinodes orbonalis* (Guenee)

In the flight muscle, a strong correlation was found between the activities of lipases and the known use of lipid as a fuel for flight in *Periplaneta americana*; *Locusta migratoria* and *Polia adjuncta*. Lipase activity was lowest in the Cockroach (carbohydrate based flight metabolism); intermediate in the *Locust* (both carbohydrate and lipid fueled flight), and highest in the moth, *Polia aduncta* (a non-feeding, lipid catabolizing adult) flight muscle (Male and Storey, 1981). Insects apparently are highly capable of utilizing fats and when necessary can

synthesize these from proteins and carbohydrates. The study of hemolymph components as well as of fat body deposits involved in essential metabolic processess related to supply of energy in insects for activities such as flight, reproduction, embryogenesis and metamorphosis which provide important information about physiology of members of the same or different species (Pant and Ghai, 1973).

The lipase activity of a homogenate of whole pupa was optimal at pH 7.6 (Nandanan *et al*., 1973). In 7-day blowfly larvae lipase activity in fat body was optimal at pH range 7.5 to 8.0 (Price, 1975). The fat body contains triglycerol which may be released into the haemolymph for distribution to other tissues in the form of diacylglycerol by the action of triacylglycerol lipase (Hoffman and Downer, 1979), Male and Story (1981) studied enzyme activities and isozyme composition of triglyceride, diglyceride and monoglyceride lipases in *Periplaneta americana*, *Locusta migratoria* and *Polia adjuncta*. Pol and Sawant (1990) studied lipolytic activity profile during larval growth of *Chrysomia rufifacies*. The fat body triacyglyerol lipase of *Manduca sexta* had a optimum pH 7.9 (Arrase and Wells, 1994).The lipase activity in fat body of *Chrysomyia rufifacies* during larval growth and metamorphosis was maximal at the broad pH range 8.5 to 9.0 (Pol and Sawant, 1999). Pistillo *et al*. (1998) studied *Drosophila melanogaster* lipase homologs: a gene family with tissue and developmental specific expression. Arreguin *et al.* (2000) studied purification and properties of a lipase from *Cephaloleia presignis* (Coleptera: chrysomelidae). The egg lipase of *L. orbonalis* (Guenee) showed maximum activity at pH 7.8 (Pol and Gejage, 2002). The larval fat body lipase of *Chilo partellus* showed maximum activity at pH 8.0 (Sakate and Pol, 2002). Ponnuvel *et al*. (2003) isolated lipase from the silkworm *Bombax mori* which showed antiviral activity against Nucleopolyhedrovirus. The triglyceride-lipase (TG-lipase) from the fat body of *Manduca sexta* has been identified as the homolog of *Drosophila melanogaster* CG855 (Arrese *et al.,* 2006). The larval fat body lipase of *L. orbonalis* (Guenee) showed maximum activity at pH 7.9 (Gejage and Awate, 2009). Lipases play key roles in insect lipid storage and mobilization and are also fundamental to many physiological processes in insect reproduction, development, defence from pathogens and oxidative stress and pheromones signalling (Horne *et al.,* 2009).

The hydrolysis of triglycerides by homogenate of female adult indicates the presence of triacylglycerol lipase (EC 3.1.1.3) in female adult homogenate of *L. orbonalis* (Guenee). Similar observations were reported in southern armyworm, *Prodenia eridania* by Stevenson (1972); in the adult Khapra beetle, *Trogoderma granaria* (Nandanan *et al*., 1973), in female *Aedes aegypti* by Geering and Freyvogel (1975); in adult tobacco hornworm, *Manduca sexta* by Soulages and Wells (1994); in flight muscles of *Locusta migratoria by* Wheeler *et al*. (1984); in muscles of American Cockroach, *Periplaneta americana* by Hoffman and Downer (1979); in pupae of blowfly, *Chrysomia rufifacies* (Pol and Sawant, 1995); in larvae and pupae of blowfly, *Chrysomia rufifacies* (Pol and Sawant, 1999); in pupae of *Chilo partellus* (Pol and Sakate, 2000), in female adult of Armyworm, *Mythimna separata* by Pol and Salunkhe (2001a); in pupae of armyworm, *Mythimna separata* (Pol and Salunkhe, 2001b); in eggs of *L. orbonalis* (Pol and Gejage, 2002); in pupae of armyworm, *Mythimna separata* Pol and Salukhe (2002), in larval fat body of *L. orbonalis* (Gejage and Awate, 2009).

Lipase activity was optimum in the 4-day old larvae of blowfly *Chrysomia rufifacies* (Pol and Sawant, 1999), in 3-day eggs of *L. orbonalis* (Pol and Gejage, 2002), in 7-day old larval fat body of *L. orbonalis* (Gejage and Awate, 2009). Lipase activity was decreased from 3-day old male and female adults of armyworm, *Mythimna separata* (Pol and Salunkhe (2001a), from 2-day pupae of blowfly, *Chrysomia rufifacies* Pol and Sawant (1995); and from 6-day pupae of armyworm, *Mythimna separata* (Pol and Salunkhe (2002).

In the present work, female adult ageing *L. orbonalis* (Guenee) showed maximum lipase activity at pH 8.2. This indicates that female adult lipase is maximally active at an alkaline pH. A gradual increase in lipase activity from 1-day old female adults to 3-day old adults indicates the utilization of triglycerides for the development of eggs (oogenesis). The female flies little after emergence needs only limited amount of fuel reserves for flight. The decrease in enzyme activity from 3 to 5-day old female adult suggests the depletion of lipid and inactive state of female requiring less energy. The maximum enzyme activity observed in 3-day female adult suggests active role of lipase in flight, oogenesis and oviposition. The oogenesis requiring energy and structural components are derived from break down of lipids and mainly from

triglycerides. In the male adult, lipase activity is 1.0548 folds more than 3-day old female adults suggests active role of male in search of vergin female for mating and sustained flight. The main source of energy during adult is lipid and lipolytic activity is instrumental in release of energy. Similar observations were reported by many.

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A Study of ENT and Head Neck diseases in Geriatric population at Tertiary Care Hospital

Darshan Goyal and Ritu
GGS Medical College, Faridkot (Punjab)

ABSTRACT

We live in an ageing world with the population of elder people rising steadily. The Indian geriatric population is currently the second largest in World. The present 18 month study was carried out to find disease pattern of ENT and head neck region in the geriatric population. A total of 3303 patients were examined. Old age patients were 7% of total ENT OPD. CSOM was the most common ear disease followed by presbycusis; whereas most common nasal disease was rhinitis followed by sinusitis. Malignancy of larynx was the most common cancer found in the study population. The number of geriatric patients examined in OPD was small as elder people have ardent belief in home remedies, traditional medicine and spiritual cures. So, by reforming policies and making innovative planning, we should try to change the quality of life of old age persons and add life to years increasing longevity by reducing morbidity.

Key Words : Geriatric, CSOM, Presbycusis, Malignancy

We live in an ageing world with the population of elder people rising steadily. The ageing process and the last stage of life is satisfying for some and disappointing for others (Afolabi, 2008). The advancement of medical science and increased awareness among the people have brought about a sharp decline in mortality and a steady decline in fertility. This has resulted in a worldwide shift in the demographic profile and has led to significant increase in the aged population. About two thirds of all older people are concentrated in the developing world and by 2025 this figure is projected to rise further (Aging and Life Course,

WHO)[3]. In India 60th year can be taken as the beginning of old age (Dev, 2001 and Edelstein, 1996).

The present scenario and the future appeal of geriatrics in India is such that there is need for change in the attitude of not only the government but also the people. The elderly should be considered not as a burden to the society but their valuable experience should be utilized fruitfully and it should be the responsibility of the society and the government to impart an improved and effective quality of life to them in return to their lifelong dedicated service towards their children and the nation.

Due to changing demographic trends in our country the geriatric population has already become the fastest growing segment of our society. The Indian old aged population is currently the second largest in World (Paliwal *et al*., 2007). According to Census [2001] 7.4% of total population was above the age of 60 years (Park, 2005).

Up to 1/3rd of patients examined by the otolaryngologist are either 60 years or above. ENT diseases in elderly are more difficult to treat because of degenerative and metabolic changes in the aged persons. The equilibrium between synthesis and decomposition of the connective tissue becomes less congruent with age and wounds heal slower due to fibroplasias, decreased soluble collagen etc. As sensitivity to drugs increases, renal clearance and hepatic metabolism both decreases with age. So proper use of medication is particularly important in the elderly.

The aim of this study is to present our observations on geriatrics otolaryngology as seen in India in tertiary care hospital in the regional area and to assess the current pattern, behavior of ENT disease and to define important areas for further development.

Material and Methods

This study was carried out in Department of ENT in S.P. Medical College and Associated group of hospitals, Bikaner from January 2005 to June 2006. In this study, geriatric patients above 60 years of age who attended ENT outdoor or got admitted in the ward were included. All patients were subjected to thorough examination including complete history of illness as per proposed performa. Rhinoscopy was done for the examination of nose and digital examination of the nasopharynx by

palpation. For the functional examination of the nose spatula test was carried out. Examination of larynx was done by indirect laryngoscopy. Direct laryngoscopy was carried out under general anaesthesia in operation theatre whenever required. Examination of the ear was done by Otoscope. Hearing assessment was done with tuning forks and by audiometery, impedence audiometery whenever indicated. Bronchoscopy and esophagoscopy was carried out in cases where it was required.

Results

Out of 3303 OPD patients of old age, 653 (19.77%) were those who were referred from other hospitals, whereas 1000 (30.28%) were referred from other departments of the same hospital, and 1650 (49.95%) consulted directly. Among total old age patients attending ENT OPD, 71% were males and 29% were female patients. Of indoor cases, 83% were males and 17% were females. The male patients (>60 yrs) were 5% of the total registered patients, while female patients (>60 yrs) were 2% of the total patients.

Out of the total 258 admitted patients, 175 (67.83%) were referred from other hospital, whereas 35 (13.57%) were referred from other departments of this hospital and 48 (18.60%) were for direct consultation. 9.1% of the males got admitted whereas only 4.6% of the females got admitted.

In the group I, the percentage of male was 70.6% whereas the females were only 29.4%. In group II, the males were 71.4% whereas females were 28.6%. In group III, males were 79.1%, whereas females were only 20.9% (Table 1).

Table 1 : Age and sex wise distribution of OPD patients

S. No.	Age group	Male	Female	Total	Percentage Male	Percentage Female
1	I (60-70yrs)	1807	752	2559	70.61%	29.39%
2	II(71-80yrs)	449	180	629	71.38%	28.62%
3	III (> 80yrs)	91	24	115	79.13%	20.87%
	Total	2347	956	3303	71%	29%

Table 2 : Age and sex wise distribution of indoor patients

S No.	Age group (yrs)	Male	Female	Total	Percentage Male	Percentage Female
1	I(60-70)	162	38	200	81%	19%
2	II(71-80)	49	05	54	90.7%	9.3%
3	III (>80)	03	01	04	75%	25%
	Total	214	44	258	83%	17%

The admitted patient of group I had 81% males and 19% females. Group II had 90.7% males and 9.3% of females and group III had 75% males and 25% females (Table 2).

B. G. Prasad's classification updated till Nov. 2002 was used for socioeconomic classification. It was found that 47% of the study group belonged to social class II, followed by 19% from social class III and 14% each for social class I and IV, and 5.6% for social class V.

Table 3: Distribution of geriatric patients according to socio-economic status

Socio-economy class (Probable income in Rs.)	Male No. (%)	Female No. (%)	Total No. (%)
I (2410 & above)	30(14.02)	8(18.18)	38(14.73)
II (1200-2409)	102(47.66)	20(45.45)	122(47.29)
III (720-1209)	40(18.69)	10(22.73)	50(19.38)
IV (360-719)	30(14.02)	4(9.09)	34(13.18)
V < 360	12(5.61)	2(4.55)	14(5.43)
Total	214(100.00)	44(100.00)	258(100.00)

Table 4 : Distribution of the patients according to type of family

Family type	Male No. (%)	Female No. (%)	Total No. (%)
Nuclear	60 (28.04)	10 (22.73)	70 (27.13)
Joint	154 (71.96)	34 (77.27)	188 (72.87)
Total	214 (100.00)	44 (100.00)	258 (100.00)

Majority (72.87) of the elderly were living in joint families. Proportion of elderly males living in nuclear families (28.04) was higher than that of females (22.73) (Table 4). 168 (76.74%) patients came from rural area and 60 (23.26%) belong to urban area.

Table 5 : Disease wise distribution of OPD Patients (Ear DS)

S No.	Disease	I	II	III	Total	Percentage
1	Impacted wax	144	80	4	188	12.5%
2	Pruritis	24	16		40	2.7%
3	Otitis ext.	104	18		122	8.1%
4	Otomycosis	88	16		104	6.9%
5	Trauma	08			08	0.5%
6	Asom	96	24		120	8%
7	Csom	346	36	20	364	24.2%
8	Sec. Om	52	16		68	4.5%
9	Presbycusis	172	106	39	317	21.1%
10	Vertigo	32			32	2.1%
11	Tinnitus	100	32	8	140	9.3%
	Total	1128	304	71	1503	100.00%

Most common presenting symptoms with ear pathology was hearing impairment (70%) followed by ear discharge (24%), itching in the ear (20%). In this study, it was observed that maximum number of cases were due to CSOM (24.2%), presbycusis was second most common (21.1%) and impacted wax was the third most common (12%) ear disease (Table 5).

Table 6 : List Of Patients Of Presbycusis subjected for Audiometery

S. No.	Age group	Patients of presbycusis	Audiometery Done	Mean Hearing Loss
1.	I	172	85	52dB
2.	II	106	70	55db
3.	III	39	20	57db
	Total	317	175	

Out of total 317 cases of presbycusis 160 (55%) patients were subjected to audiometery and mean hearing loss was 52 dB in first group, 55dB in second group and 57dB in third group(TABLE 6).

Table7 : Distribution of patients in diseases of nose

Disease	Group I	Group II	Group III	Total	Percentage
Rhinitis	128	20	04	152	37.6
Sinusitis	68	0	04	72	17.8
Vestibulitis	24	08	0	32	7.9
Nasal polyp	48	04	0	52	12.9
Tumors	12	04	0	16	4.0
Epistaxis	32	12	04	48	11.9
DNS	28	04	0	32	7.9
Total	340	52	12	404	100.00

The most common symptom in patients of nasal pathology was nasal obstruction (54%), followed by sneezing (37%), and nasal discharge (18%). Rhinits (37.6%) was the most common nasal disease in geriatrics patients followed by sinusitis (17.8%) and nasal polyp (12.9%) (Table 7). Out of total 404 patients with nasal ds, 50 underwent nasal endoscopy in which 37 were having positive finding.

Table 8: Distribution of patients in diseases of throat & head neck

Diseases	Group I	Group II	Group III	Total	Percentage
Stomatitis	100	16	12	128	9.3
URI	440	75	08	523	37.9
Tonsillitis	32	09	0	41	2.9
Laryngitis	60	12	0	76	5.5
OSMF	16	08	0	24	1.7
Malig. head neck	130	24	0	164	11.9
Voice changes	28	20	0	48	3.5
Malig. larynx	152	36	04	192	13.9
Dysphagia	60	08	04	72	5.2
Abscess neck	20	08	0	32	2.3
Nerve palsy	20	04	0	24	1.7
Injury & others	377	11	04	52	3.8

It was observed that upper respiratory infections (38%) was the most common disease in old persons(Table 8). Malignancy of larynx (14%) was the most common cancer followed by malignancy of head neck (12%) region. The most common presenting symptoms with throat and head neck pathology was cough (50%), followed by foreign body sensation (40%), pain throat (30%), hoarseness of voice (25%) and dysphagia (24%).

Out of total 258 admitted patients, direct laryngoscopy was done in 152 (58.91%), oesophagoscopy in 9 (3.49%) patients and bronchoscopy in 9 (3.49%) patients.

Discussion

The result of the present study revealed that out of total 3303 aged persons 2347 (71%) were males while 956 (29%) were females. Out of total 2347 geriatric male patients who presented with various ENT diseases in OPD 214 (9.1%) got admitted in ward and out of 956 female geriatric patients, 44 (4.6%) female required admission. The sex ratio of this study population was 407 females per thousand males; whereas the sex ratio for Rajasthan is 909 per 1000 males (Census of India). The cause of very low female patient of ENT seems to be being dependent of elderly female on other member of the family. So less number of elderly females report to tertiary hospital like ours. Majority of the elderly patients (77.48%) belonged to the age group of 60-70 years, followed by 19.04% in the age group of 70-79 years and 3.48% in the age group of >80 years (advanced old age group). Similar observation was noted in admitted patients. The reason being the geriatric patient in age group 60-70 years can report the hospital themselves whereas the patient above 70 years need helper to reach the hospital.

Ear disease and hearing loss associated with ageing is common among older people. Out of total patients, 24.2% had CSOM. Poor socioeconomic circumstances lead to increased prevalence of CSOM compared to that in more affluent population groups. As CSOM is known to be a childhood disease with high incidence rates in the first three years of life this suggests that adults with CSOM probably developed it at an early age (Sharp *et al*., 1990). Presbycusis was second most common of ear problem comprising 21.1% patients.

According to ICMR (1983) presbycusis comprises 38-40% cases of sensory neural hearing loss. Parving and Ostri (1991) found that hearing deteriorates most rapidly between age of 60 and 65. Minhas et al[22] conducted a study on 25 subjects of presbycusis and observed that mean hearing loss was 51 dB on pure tone audiometery.

Presbycusis is a complex disorder involving loss of speech processing and discrimination as well as perception of pure tones. A thorough hearing evaluation, careful explanation of the problems regarding the limitations of hearing aids, reassurance that the patients are not going deaf and motivation to continue participating in social functions are very important. Patients should be motivated strongly to use the aid mandatorily, if they want to receive the full benefits of amplification. Impacted wax was the third most common cause of hearing problems in 12% cases. Risk factors for cerumen impaction include anatomical nature of ear canal, ear canal hair, self repeated ear cleaning, hearing aids and bony growths such as osteoma and it needs careful cleaning of ear by experts to avoid perforation (Meador, 1995 and afolabi, 2008). Wax impaction in the ear tends to occur more frequently in older males than in woman and young males because larger tragus tend to prevent the natural dislodgement of wax. Secondly in females there is marked reduction in sebum production concomitant with significant decrease in gonadal activity after menopause. The superimposition of impacted wax and presbycusis may significantly alter the ability of the elderly person to function socially and many patients feel a subjective improvement in hearing after removal of the wax. Wax often blocks hearing aid moulds causing unnecessary difficulties to those whose hearing is already compromised.

In our study there were 32 cases (2.1%) with vertigo in age group 60-70 years. Abrol *et al.* (2002) found that vertigo is prevalent in 2.17% in age group 60-69 years and 1.37% in age group 70-79 years. Singh and Chaturvedi[28] found that vertigo is prevalent in 9.77% of patients in age group 61-70 years, 0.75% in 71-80 years and 0.75% in 81-90 years age group.

Like all body systems, the nose changes both internally and externally with age due to mucus variations, airflow patterns, inflammatory or infectious stimuli. In nasal disease in this study rhinits

(37.6%) was the most common disease in geriatric patients. Sinusitis (17.8%) was the second most common and nasal polyp (12.9%) was the third most common. Kushnic *et al.* (1992) concluded that factors which change the viscoelastic properties of the nasal mucus may predispose the elderly to nasal crusting leading to nasal problems. Catchell *et al.* (1993) concluded that patients over age of 60 years exhibit a decrease in the intensity and extent of immuno-reactivity within the [nasal] cells leading to more infections.

In a study conducted by Edelstein (1996) nasal complaints among elderly people may be explained by the loss of autonomic control. These included nasal drainage, postnasal drip, sneezing, coughing, olfactory loss, and gustatory rhinitis. No significant age-related increase in complaints of nasal obstruction, epistaxis, snoring or nasal sinus pain were identified in the study population. Age-related changes in taste and smell are well documented in most studies confirming that olfactory thresholds for a wide range of odorants progressively decrease with age (Doty *et al.,* 1982 and Feopold *et al*., 1989).

Estimates have been made that as high as 12% of elderly individuals have vocal dysfunction (Morrison and Gore, 1986). Ideally voice disorders in the geriatric population can be differentiated into dysfunctions due to structural and physiologic changes that are part of the aging process and second are dysfunctions associated with other pathologies. These include anatomical lesions and neuromuscular disorders, which are more commonly seen in the geriatric population.

Some of the perceived characteristic of the senescent voice includes altered pitch, roughness, breathness, weakness and hoarseness (Kent & Burkand, 1990). Fundamental frequency of voice increases from approximately 110 to 120 Hz in middle age to approximately 130 to 160 Hz after age 65, and for woman this frequency decreases from approximately 200 to 260 Hz in middle age to approximately 150 to 190 Hz after age 65. A decrease in the lung elasticity and compliance can impair the ability to control airflow necessary for speech production and result in the decreased vocal intensity with age (Linville and Fisher, 1985 and Ptacek *et al.,* 1966). The degenerative and atrophic changes in the laryngeal muscle reduce vocal cord tension and contribute to the development of the incompetent glottic closure and a breathy voice.

Head–neck cancers constitute a major health problem in India accounting for 23% of all cancers in males and 6% in female (ICMR 1992). In this study, malignancy larynx (14%) was the most common and malignancy of head neck (12%) region was the second most common. Out of total geriatric patients, 25% patients who had head and neck region problem presented with hoarseness of voice. So, malignancy must be excluded in these cases before rehabilitation of the senescent voice is done

Bakshi *et al.* (2005) conducted a retrospective study on 690 cases of malignancy larynx. They found that 50-80 years group was most commonly affected (67.9%) and 80-100 years group had incidence rate of 2.6%. The most common subtype of malignancy larynx was supraglottis (55.94%) followed by glottis (17.3%), transglottic (13.04%) and subglottic (3.62%). Ahluwalia *et al.* (2001) conducted a study over 5386 patients of head- neck cancer and majority was in the age group of 40-70 years. The most common site among males is mouth (23.58%), larynx (22.85%), tongue (14.28%) and oropharynx (13.83%) while in females most common site is mouth (21.93%), oesohagus (17.28%), oropharynx (12.55%) and larynx (11.78%).

Kamal and Samarai (1999) studied 91 cases of nasopharyngeal carcinoma and found incidence of 15 cases (16.48%) in age group above 60 years. In addition to all ENT & head neck ds, there is a gradual resorption of bone throughout the facial skeleton leading to loss of skin tone and elasticity and a relatively loose cervicofacial skin cover. The final result is a senile facial appearance.

Conclusion

During this period the total OPD of ENT patients was 46000 of all age group out of which 3303 patients are of geriatric age group above 60 years, which constitute about 7% of total OPD patients.

The number of geriatric patients treated is small as there is reluctance among the older people to seek medical treatment (Victoria *et al.,* 2006). They have ardent belief in home remedies, traditional medicine and spiritual cures (Lasisi and Ajuwon, 2002). Older people find it difficult to use public transportation and to stand in line for long periods to see a doctor in busy hospital (Michael *et al.*, 2004).

The elderly have their own distinct set of problems, be it medical, social, cultural or financial. A closure look is required to understand the characteristics of this population. Only then it is possible to embark on framing comprehensive policies to make ageing a comfortable experience. Almost all the diseases, which occur in children and adults, also can affect the elderly. From male to female ratio, it is evident that male geriatrics patients can more easily approach hospital than females although the disease affected both sexes equally. So, Social circumstances should be improved so that the females can also be benefited by medical facilities.

The problem of increasing number of presbycusis needs generalized screening of people above the age of 60. Malignancy of ENT region is more common in geriatrics patients that demand early diagnosis by applying screening measures and preventive steps in geriatric population. Treatable causes like impacted wax, otitis media, nasal polypi and laryngitis can increase the misery of the geriatric patients, which should be diagnosed and treated early. The diseases, which occur in old age like diabetes, hypertension and degenerative process, affect the clinical behaviour, prognosis and outcome of ENT diseases in geriatric population so these should be considered adequately. The challenges of population aging are global, national and local. Developing countries including India face a daunting task ahead to make substantive policy reforms and innovative planning to cope up with the increasing old age population and their problems. The motto should be to change the quality of life and add life to years increasing longevity by reducing morbidity and mortality.

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Perceptions and Risk Factors for Oral Cancers in the Rural Elderly

Pratibha Dabas and M.M. Angadi*
Department of Community Medicine,
Christian Medical College, Ludhiana, Punjab.
*Department of Community Medicine,
BLDEA's Shri B.M. Patil Medical College, Bijapur, Karnataka.

ABSTRACT

This paper aims to assess the magnitude of risk factors for oral cancers in the elderly. It also probes their perceptions on oral cancers. It was conducted in the village Shivanagi, north Karnataka. A total of 240 persons of 60+ age were randomly selected and interviewed. Information was obtained on a pre-tested questionnaire and summarized onto tables. Statistical analysis included percentages and Chi-square test or Fishers Exact test using Epi-info v 6. The sample consisted of 54.6 per cent males and 45.4 per centfemales. 71.7 per cent were in the age group 60-65 years, 17.1 per cent in 66-70 years and 11.3 per cent above 70 years. More than half of the elderly had at least one risk factor for oral cancers; smoking, tobacco chewing or alcohol. Prevalence of risk factors was more in males (72.5%) than females (31.2%); 42.5 per cent of the elderly chewed tobacco. More males (46.6%) than females (37.6%) chewed tobacco. One-third of the elderly males smoked beedis. About one-fifth of the elderly males drank alcohol regularly. None of the females smoked or drank alcohol. There were misconceptions about etiology of oral cancer. Less than half of the elderly had heard of cancer. Only one-third were aware of oral cancer. Of these, 30.3 per cent had tobacco chewing, 20 per cent smoking, 23.2 per cent betel quid chewing and 14.9 per cent alcohol as possible risk factors. Only one elderly (1.3 %) was aware of pre-cancerous lesions. As high as 77.5 per cent thought that oral cancers could not be treated. Though there were variations in perceptions with the socio-demographic profile, none of it was significant. The source of information for

the majority (56.2%) was through friends; only 8.7% had received information from health personnel. It was concluded that prevailing high risk behaviour coupled with low knowledge about prevention predisposes the rural elderly at risk for oral cancers. Health system has a huge responsibility and role to fill this gap of information.

Key words : Geriatrics, Elderly, Oral cancers, Perceptions, Risk factors

Oral cancer is a disease of old age (Shah, 2001). The A.A.A.R (average age adjusted rate) for oral cancers in Karnataka indicates that the peak incidence is at the age group 65-69 years in males and 60-64 years in females (ICMR, 2004). As per census 2001, 7.6% of population comprises elderly more than 60 years and 80% of them (60 million) reside in rural area (Park K, 2009). India has one of the highest rates of oral cancers in the world, one-third of total cancers in our country (ICMR, 2004). Oral cancers have well known risk factors and pre malignant lesions. They are highly amenable to prevention and early diagnosis (Horowitz, 2001). Treatment at pre malignant and early malignant phase is associated with improved survival rates. Cancers when diagnosed in advanced stages require aggressive treatment and are associated with higher morbidity and mortality rates (Reis et al., 2000).

Lack of awareness about oral cancers predisposes to late diagnosis. Late treatment leads to disability to speak, swallow, breathe and chew causing major functional, cosmetic and psychological burden. Knowledge about risk factors and signs of oral cancers will lead to early detection reducing their morbidity and mortality.

Objectives

1. To determine use of smoking, tobacco and alcohol in the elderly.
2. To assess the perceptions of elderly about risk factors, precancerous lesions, diagnosis and treatment of oral cancers.

Method

Setting

The geriatric population (age >60years) in village Shivanagi is the rural field practice area of Department of Community Medicine,

BLDEA's Shri B.M. Patil Medical College, Bijapur, Karnataka. The study was conducted during June to August 2008.

Sampling

The field practice area covers a population around 8000. The number of people aged 60 years or more, 7.6% as per census, 2001 (Park, 2009) was estimated to be 608. A 50% sample of the 60+years was decided for this study by systematic random sampling of houses through home visits. Those who did not give consent or were unavailable were excluded. Thus, the study sample was 240. The elderly were interviewed with a pre-tested questionnaire in his/her own house. The 80 elderly who had awareness about oral cancer were further interviewed about their perceptions.

The data obtained was manually transferred and summarized from the questionnaires onto tables. Statistical analysis included percentages and Chi-square test or Fishers Exact test using Epi-info v-6 software (Dean et al, 1994).

RESULTS

Table 1 : Socio demographic characteristics of elderly (n=240)

Age	**No.**	**%**
60-65 years	172	71.6
66-70 years	41	17.1
> 70 years	27	11.3
Sex		
Male	131	54.6
Female	109	45.4
Education		
Illiterate	203	84.6
Up to primary	22	9.2
Middle and above	15	6.2
Occupation		
Agriculture	200	83.3
Others	40	16.7

Religion		
Hindu	180	75.0
Muslim	60	25.0
Access to communictaion		
Radio	142	59.2
Television	40	16.7
News Paper	13	5.4

Of the 240 geriatric residents interviewed, 54.6°/o were males and 45.4% were females; 71.6% were in the age group 60-65 year, 17.1% in 66-70 year and 11.3% above 70 years. Majority (84.6%) were illiterate, 9.2% had education up to primary level and 6.2% had middle level education or above. Majority (83.3%) of the elderly had agriculture as occupation. Hindus were 75% and 25% were Muslims and 59.2% had access to radio, 16.7% to television and 5.4% to newspaper.

Figure 1 : Prevalence of risk factors in elderly (n=240)

A total number of 129 (53.8%) elderly indulged in a habit associated with risk for oral cancers; smoking, tobacco chewing or alcohol. The prevalence was more in males (72.5%) as compared to females (31.2%).

Tobacco chewing

Of the sample chosen 102 (42.5%) elderly chewed tobacco, majority (89.2%) had the habit for 10 or more years. More males (46.6%) than females (37.6%) used tobacco.

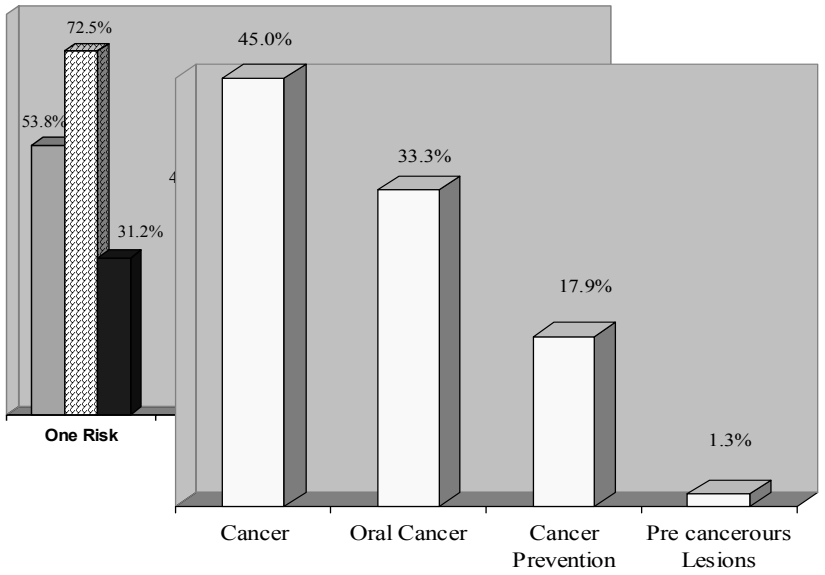
Smoking

None of the elderly females smoked. Smoking in the form of Beedi was prevalent in 79 (32.9%) elderly males. More than half (53.2%) of the smokers consumed more than 20 beedis per day and majority (89.9%) were smokers for 10 or more years.

Alcohol

None of the elderly females drank alcohol but 41 (17.1%) males drank regularly. Of these, 78% had been drinking regularly for 10 or more years.

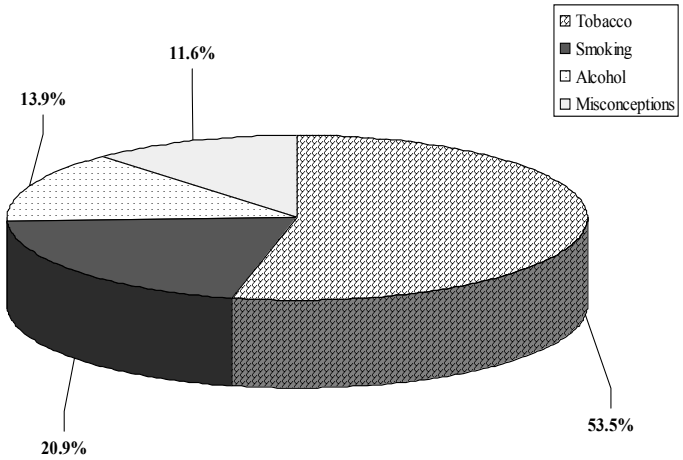
Figure -2 Awareness of Elderly about cancer (n=240)



Perceptions about prevention of oral cancers

Only 108 (45%) elderly were aware of cancer and 80 (33.3%) knew about oral cancer. Very few 43 (17.9%) thought that oral cancer could be prevented and indicated possible risk factors could be tobacco chewing, smoking or alcohol and just 1 (1.3%) was aware of the pre-cancerous lesions.

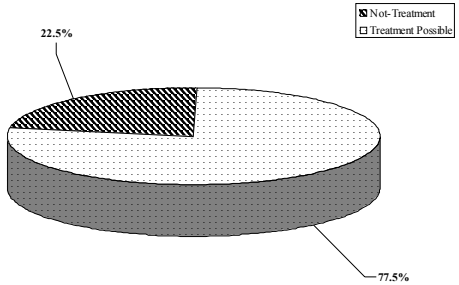
Fig-3 Perceptions about causes of oral cancers (n=43)



Perceptions about causes of oral cancers

Of the 43 elderly who related oral cancers with a risk factor were asked for one main cause of oral cancers and 23 (53.5%) thought that tobacco chewing caused oral cancers, 9 (20.9%) elderly related it to smoking. Only 6 (13.9%) elderly thought alcohol could be a cause but 5 (11.6%) had misconceptions that oral cancers were caused by past sins or God's curse.

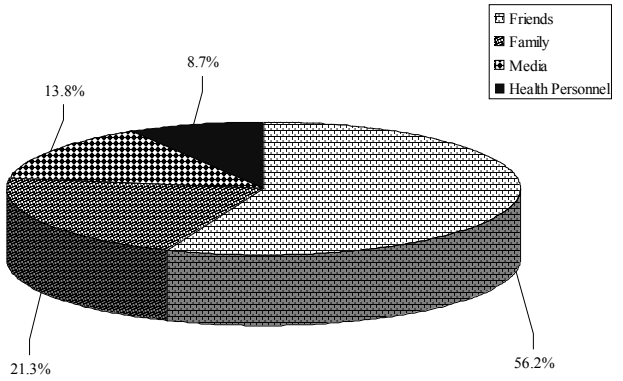
Fig-4 Knowledge about treatment of oral cancers (n=80)



Perceptions about treatment of oral cancers

Only 18 (22.5%) of the elderly thought that it was possible to treat oral cancers but 62 (77.5%) believed that oral cancers could not be treated. None of the elderly had ever been screened for oral cancers. Although, there were variations in perceptions about risk factors, prevention and treatment of oral cancers with disregard to gender, religion, literacy status and access to communication; none of these were significant.

Fig- 5 Knowledge sources for elderly (n=80)



Knowledge sources for elderly

Of the total sample, only 45 (56.2%) of the elderly had their information through friends, 17 (21.3%) got the information from a family member and 11 (13.8%) through media and just 7 (8.7%) had received the knowledge from health personnel.

Discussion

This study revealed that more than half of the elderly have at least one of the risk factors for oral cancers; tobacco chewing, smoking or alcohol. Nearly three-fourths of male elderly and one-third of female elderly have at least one high risk habit for oral cancers. Nearly half of the elderly chew tobacco and one-third smoked beedis. Tobacco chewing was similar in both the genders; alcohol consumption and smoking was prevalent in males only. Similar high prevalence of smoking beedis (57%) and alcohol use (16.3%) was found in the rural elderly in Haryana (Goswami, 2005). Smoking has been found to be a common phenomenon in the rural elderly (NFHS, 2001).

Less than half of the geriatric residents were aware of cancer and only one-third was aware of oral cancer. This was coupled with an alarming lack of awareness about the pre-cancerous lesions. As high as 98.7 % of elderly had no idea that a white / red patch or a non-healing ulcer in the mouth could be an early sign of cancer. Similar lack of awareness (70%) regarding early signs of oral cancers was documented amongst the South Asians adults living in London (Shetty *et al.*, 1999). 66% of New York residents (Gustavo *et al*, 2002)) and 86% of North Carolina adults were aware of oral cancer (Patton *et al.,* 2004). Lower knowledge (33.2%) in this study is attributed to the illiterate elderly subjects with rural background.

Majority (82.1%) of the elderly did not think that oral cancers are associated with a risk factor. Only 43 (17.9%) associated oral cancers with a cause. Of these, 53.5% of elderly linked them with tobacco chewing, 20.9% elderly linked them with smoking and 13.9% with alcohol. Curiously 11.6% had misconceptions that oral cancers were caused by past sins or God's curse. Similar lack of knowledge was seen in the community in Babol, Iran where 76% had no knowledge of risk factors for oral cancers (Mottallebnejad, 2009). The risk factor knowledge was higher among the South Asians in London (Shetty *et al.,* 1999). This reflects on lack of dissemination of the health education about cancers in India. Knowledge regarding treatment of oral cancers is lacking. Only about one-fourth of elderly think that oral cancers can be treated. Nearly three-fourth believes that cancer is a fatal disease without any possible treatment.

None of the elderly has ever had an examination done to rule out oral cancers. Use of health workers for early detection was advocated by Sankarnarayanana (1997). In Kerela, a randomized control trial of oral screening resulted in significant reduction in (21%) mortality from oral cancers (Sankarnarayanana et al., 2006). Yet, there is a lack of preventive dental care to the geriatric rural in India (Shah, 2001). In contrast, in United States, 13% of adults aged 40 years or older had an oral examination for screening of oral cancers (CDC, 1994).

Sources of information for most elderly are either friends or family. Though the availability of TV and newspaper is minimal to the elderly, more than half of them have access to radio. Despite this, only 13.8% have media as their knowledge source. Even fewer (8.7%) have received information from health personnel. Thus, the reliable sources of information are lacking.

Conclusion and Recommendations

The study concludes that the prevailing high risk behaviour and low knowledge about prevention of cancers predisposes the rural elderly at a risk for oral cancers. There is an alarming lack of awareness about oral cancers, their prevention and pre-cancerous lesions. There are lacunae about risk factors for oral cancers. There is extensive information gap about screening and treatment. This study also reveals that the health system has had an inadequate role in filling up of this gap and thus misconceptions exist.

Considering the vast population of the elderly in rural India, efforts must be made to sensitize the policy makers, health care providers and the community. Multi-pronged Geriatric oriented oral health education and promotion campaigns must be initiated at village level. Elderly-focused effective behavioural risk reduction strategies should be devised for cessation of smoking, tobacco chewing and alcohol intake. Screening programs for early detection of oral cancers in the elderly population with a simple torch light examination should be designed. Integration of

these campaigns with the current health system could be a cost-effective approach. There is a need to explore the role of the existing village level and primary health care providers towards the special needs of the elderly population. Effectiveness could be increased with the utilization of the media. There is a need to reorient the dentists and the clinicians on geriatric oral care. Research on ageing and age associated oral diseases must be strengthened.

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The Relationship of Locus of Control, Sociability and Impulsivity with Age

Uma Gupta, Ram Narayan[1] and B.S. Gupta[2]
Department of Siddhant Darshan Institute of Medical Sciences,
Banaras Hindu University, Varanasi (U.P.).
[1]Department of Psychology, G.D. Binani Postgraduate College, Mirzapur (U.P.)
[2]Department of Psychology, Banaras Hindu University, Varanasi (U.P.).

ABSTRACT

Personality assessments on locus of control, sociability and impulsivity were done on subjects in five age-groups, viz., young (25-29 yrs), middle age-groups (30-39 yrs and 40-58 yrs), pre-retirement age (59-64 yrs), young-old (65-74 yrs) and the old-old (75 yrs and above). The study led to the following conclusions : (1) people in the young and middle age-groups have significantly higher levels of internal locus of control than those in the older age-groups; (2) people in the young and middle age-groups are significantly less sociable than those in the older age-groups; (3) impulsivity is not associated with age.

Keywords: Ageing, Age differences, Geriatrics, Locus of control, Internality, Sociability, Impulsivity.

The stability of a trait over time has been a matter of great controversy in personality research. In fact, a distinction needs to be made between stability and reliability before the issue of stability of a trait is elucidated and discussed. Matthews and Deary (1998) emphatically point out that "stability is not reliability, though reliability is necessary for stability" (p.50). The authors further clarify that reliability generally refers to "internal consistency of the trait assessment over the short term, whereas stability may be measured in terms of years or even decades" (p.50).

Personality traits are known as people's stable dispositions. The implications of the word "stable" are that personality dispositions or

characteristics are consistent patterns of behavior and are not likely to change over time. McCrae and Costa (1994) suggest that mean trait levels change little after age 30, with some small decreases in extraversion, neuroticism and openness, and increases in agreeableness and conscientiousness from age 20 to 30. The authors also point out that activity level decreases after age 50. However, there might be a situation where the sample as a whole can rise or fall considerably in the mean score on a trait. The present study is an attempt to test this assumption.

Following a cross-sectional approach, the present study attempted to isolate young (25-29 yrs), middle age (30-39 yrs and 40-58 yrs), pre-retirement age (59-64 yrs), the young-old (65-74 yrs) and the old-old (75 yrs and above) groups. The subjects in each age-group were administered personality scales to measure locus of control, sociability and impulsivity.

MATERIALS AND METHODS

Subjects

Male subjects from six age-groups viz 25-29 yrs, 30-39 yrs, 40-58 yrs, 59-64 yrs, 65-74 yrs and 75 yrs and above, provided data for the present study. In each age-group there were 50 subjects. These age-groups were selected to isolate young (25-29 yrs), middle age-groups (30-39 yrs and 40-58 yrs), pre-retirement age (59-64 yrs), young-old (65-74 yrs) and the old-old (75 yrs and above).

Materials

Locus of Control

For determining locus of control a scale that included six (three "internal" and three "external") items (Lumpkin, 1985a, 1986) from Rotter's (1966) scale in a five-point Likert format (agree/disagree), was used. These sets reflected both the "internal" and "chance" dimensions identified by Levenson (1974). A number of studies dichotomize the respondents into internal and external groups. But it seems more likely that locus of control is a continuous construct – individuals differ in degree and it is difficult to classify them as internal or external (Lumpkin, 1986). The Cronbach's alpha coefficient for this six-item test as reported by Lumpkin (1985a) was 0.68 which compares

favourably not only with the 0.65 to 0.79 range reported by Rotter (1966) but also with the 0.66 for the one-dimensional ("internal") six-item scale developed by Bugaighis and Schumm (1983). The items used in the present study are given in table 1. The scale was scored such that a larger score on the five-point agree/disagree scale indicated a more internal locus of control (Lumpkin, 1985_a, 1986). The six-item test has already been used in Indian setting (Gupta & Gupta, 1998).

Table 1. Rotter's Locus of Control items used in the brief scale

Internal items ("Internal Control")

1. When I make plans, I am almost certain to make them work.
2. Getting people to do the right things depends upon ability; luck has nothing to do with it.
3. What happens to me is my own doing.

External items ("Chance")

1. Many of the unhappy things in people's lives are partly due to bad luck.
2. Getting a good job depends mainly on being in the right place at the right time.
3. Many a times I feel that I have little influence over the things that happen to me.

Sociability and Impulsivity

The Hindi version (Gupta & Poddar, 1979) of the Eysenck Personality Inventory-EPI, Form A (Eysenck & Eysenck, 1964) was used to determine sociability and impulsivity scores. The introversion-extraversion scale of the EPI is compoed of two major components, sociability and impulsivity. These components are by no means independent but show a reasonably close positive relationship ($r = 0.468$, $n = 300$, $\rho < 0.01$; Eysenck & Eysenck, 1969). The sociability scale contains 11 items, and the impulsivity scale contains 9 items. The Hindi version of the EPI, Form A, has been used quite extensively in India (Gupta, 1982, 1984, 1991, 1993; Gupta & Gupta, 1990, 1998).

RESULTS AND DISCUSSION

The means and standard deviations for the internal locus of control, sociability and impulsivity scores of subjects in various age-groups were worked out and are reported in table 2. The significance of differences between means was tested by the *t*-test, the results are given in table 2.

Locus of Control

The results as reported in table 2 clearly demonstrate that people in young (25-29 yrs) and middle (30-39 yrs and 40-58 yrs) age-groups have significantly higher levels of internal locus of control than those in older age-groups (65-74 yrs and 75+ yrs). In old age health declines, and activity and social interaction are reduced. It is not surprising, therefore, if the elderly have been found to exhibit more external beliefs. The present results are consistent with those of Cicirelli (1980) and Lumpkin (1986). It has also been reported that individuals with internal locus of control have greater life-satisfaction (Palmore & Luikart, 1972; Wolk & Kurtz, 1975; Lumpkin, 1985a, 1986), greater activity (Brown & Granick, 1983; Lumpkin, 1985b, 1986), and cope better (Kuypers, 1972; Vickers *et al.,* 1983; Parkes, 1984). These capacities are on the decline in old age; consequently the elderly become more external.

Sociability

People in the young (25-29 yrs) and middle (30-39 yrs and 40-58 yrs) age-groups have been found to be less sociable than those in the older age-groups (65-74 yrs and 75+ yrs). Individuals in the young and middle age-groups (up to the age of 50 yrs at least) are more career-oriented in the present competitive era, and thus have little time for other social activities. Contrarily, because of declining health the older people (65-74 yrs and 75+ yrs) have to depend, more or less, upon others for leading a smooth and comfortable life. Thus, by compulsion they are supposed to exhibit more sociableness in their behavior.

Impulsivity

Impulsivity does not seem to be associated with age. Although the levels of impulsivity slightly declined with age but such declines were not statistically significant.

In order to thrash out the issue further a longitudinal study in which the personality assessments are done at age-levels used in the present investigation, needs to be carried out. This will establish the relationship between personality variables and age more firmly.

Table 2. Internal Locus of Control, Sociability and Impulsivity by Age (n=50 in each age-group)

Age-group	Internal Locus of Control				Sociability				Impulsivity			
		t-test				*t*-test				*t*-test		
	Mean*	SD	Differing	Groups**	Mean	SD	Differing	Groups**	Mean	SD	Differing	Groups**
25-29 yrs	3.56	0.47	1 from	5,6	4.89	1.22	1 from	4,5,6	4.65	1.12		
30-39 yrs	3.64	0.49	2 from	4,5,6	4.85	1.19	2 from	4,5,6	4.71	1.07		
40-58 yrs	3.54	0.48	3 from	5,6	5.11	1.27	3 from	5	4.45	1.03		
59-64 yrs	3.45	0.44			5.39	1.27			4.48	0.98		
65-74 yrs	3.35	0.45			5.65	1.32			4.42	0.88		
75+ yrs	3.33	0.44			5.59	1.36			4.39	0.92		

* Based on a five-point scale where higher values indicate more internal locus of control
** Significant at the 0.05 level or better

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Psychoclinical Constraints of Morbidity Among the 80+ *vis-a-vis* Prospects of Healthy Ageing

Bhaweshwar Singh
P.G.Department of Zoology,
Samastipur College, Samastipur 848134 (India)

ABSTRACT

Enhanced morbidity in senile age appears to be the fallout of inescapable degenerative ageing. Older people, in all probabilities, are the 'soft target' of post-reproductive senescence. Increased susceptibility to disease and death with advancing age make the elderly life more miserable. The oldest old are believably the worst victim. Falling health and rising dependency on care providers appear to be more pronounced in elderly human subjects (80+) faced with a series of physical and mental incompatibilities. Global rising trend in the elderly population, urbanization and intergenerational conflict over the years have brought the plight of underserved older segment into focus. Age care has become the prime geriatric issue in present times. In the given perspective, case studies of seventy randomly sampled human subjects aged 80 years or above and residing in suburbs of Darbhanga, a commissionery town of North Bihar (India) were carried out with the help of prepared questionnaire and/or personal interviews. Psychoclinical morbidity constraints included distribution pattern of common age-associated disorders, dietary regimen, sleep cycle, degree of dependence and level of satisfaction among others. The present paper entails interesting findings and assesses their significant implications. It also attempts to emphasize on the prospects of healthy and productive ageing. Summarily, the paper brings forth definitive tips for improvement in the quality of life of rural elderly undisputedly the most vulnerable oldest old age segment inhabiting developing societies and concludes with a positive note.

Key words: Morbidity, Ageing, Geriatric, Psychoclinical.

Senility is the phase of life faced with a series of physical and mental incompatibilities. Older people appear to be the 'soft target' of post-reproductive senescence. In all probabilities, they are the inevitable victims of impaired homeostasis and weakened immunity. Enhanced morbidity in late life is seemingly the fall out of inescapable ageing. Diminished muscle power, reduced sexuality and raised susceptibility to disease and death make the elderly life highly miserable. Very often it is thought that old age is in itself a disease of incurable nature. Dysfunctional perturbations and psychic imbalances appear to be more pronounced among the uninstitutionalized and underserved 80+ population. In all probabilities, the oldest old with rural living and accompanying falling health and rising dependency on care providers are the worst sufferers needing utmost geriatric care and familial support. Further beside, it is highly embarrassing to note that the Old Age Dependency Ratio is increasing day by day.

Global rising trend in the elderly population, rapid urbanization and increasing intergenerational conflict over the years have considerably turned the plight of the oldest old from bad to worse. Unquestionably, their major concern have been identified as isolated living, ill health and compulsive medication.

It is in this backdrop that present study was undertaken. The paper entails devastating effects of psychoclinical morbidity constraints on the life pattern of the oldest old and takes into account prospects of their healthy ageing. The paper also brings forth definitive tips for improvement in the quality of life of the elderly as a whole and 80+ elderly, in particular. Obviously, it lays greater focus on needier rural elderly deprived of basic amenities and comforts as compared to their urban counterparts.

80+ LIFE: BASIC INGREDIENTS

In every likelihood, elderly subjects in the 80+ age group, variously described as the oldest old, represent the most vulnerable lot. Needless to say, from amongst a total of senile population comprising men and women aged 60 years and above, the age cohort representing the oldest old segment deserves utmost care and attention.

It is pertinent to mention that biological, clinical and psychosocial dimensions of ageing are not as elaborative in other eutherian mammals as humans probably as a result of maximization of development, socialization and civilization. Quite notably, It has been generally observed that elderly aged 80 years and above mostly aspire for maximal survivality, disease-free late life and ageing with dignity.

MATERIALS AND METHOD

Case studies of as many as seventy randomly sampled elderly men and women residing in suburbs of Darbhanga, a commissionary town of North Bihar (India) in the 80+ age group were carried out with the help of prepared questionnaire/personal interviews. Gender differences with regard to Mean present age, socio-economic status (low/middle/high), Food habit (vegetarian/non-vegetarian), Food regimen (adequate/ inadequate) and patterns of intoxication, obesity and widowhood were assessed. BMI of individual subjects were determined to find out within range/overweight/obese conditions.

Psychoclinical morbidity constraints included distribution pattern of the common age-associated disorders namely hypertension, arthritis, diabetes and asthma, sleeplessness, confusion, forgetfulness, mobility pattern and satisfaction level. Recorded data were analyzed on percent basis in order to obtain observations/conclusions. Messages from a few senior members with regard to their major concerns and personal opinion about happy long life were also recorded.

RESULTS

Tables 1 and 2 depict recorded values of the present study involving a section of the 80+ rural population.

Mean Present Age: Relatively higher MPA was recorded among elderly women (85.10 years) as compared with elderly men (82.53 years).

Socio-Economic Status: Elderly subjects were maximal in the middle order (43% men and 17 % women) Per cent population of the oldest old in low and high categories of socioeconomic status were marginally higher among men (15 % and 12 %) in contrast to women (6% and 7%) respectively.

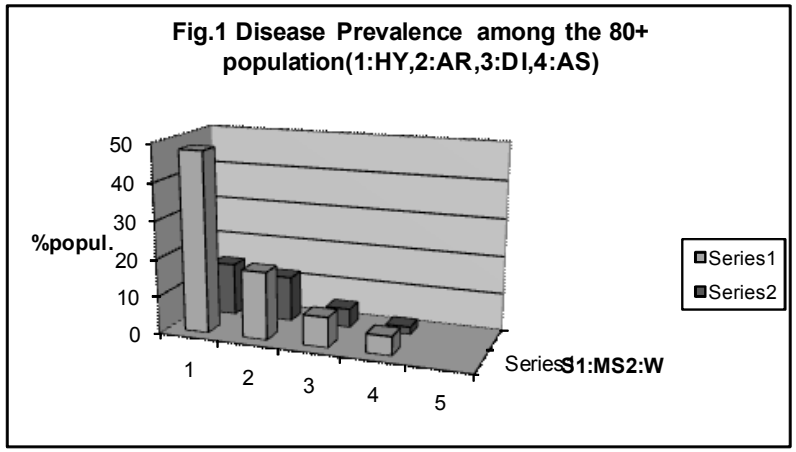
Table 1: Gender differences (% population) in chosen general features among the 80+ study group.

	Men	Women
Mean present age (year)	82.53	85.10
Spouse+	55.00	05.00
Spouse-	15.00	25.00
Socio-economic Low	15.00	06.00
Socio-economic Middle	43.00	17.00
Socio-economic High	12.00	07.00
Diet Veg.	07.00	25.00
Diet Non-veg.	63.00	05.00
Food regimen adequate	60.00	22.00
Food regimen inadequate	10.00	08.00
Tobacco user	62.00	18.00
Over Wt/Obese	32.00	08.00

Table 2: Gender differences (% population) in relation to chosen psychoclinical morbidity constraints among the 80+ study group.

	Men	Women
Hypertension	48.00	14.00
Arthritis	18.00	12.00
Diabetes	08.00	05.00
Asthma	05.00	02.00
Sleeplessness	08.00	12.00
Reduced mobility	22.00	12.00
Forgetfulness	15.00	11.00
Satisfaction low	07.00	13.00
Confusion	06.00	08.00

Food Habit: Men with non-vegetarian and women with vegetarian food habit comprised of 63.00 % and 25 % of the study group respectively indicating lower percentage of vegetarian men and non-vegetarian women.



Food Regimen: A sizeable segment of the elderly population (60% men, 22% women) affirmed intake of adequate food regimen. Conversely, a small section consisting of 10% men and 7% women reported sustenance on inadequate food regimen.

Intoxication Pattern: Tobacco use was prevalent among 80% of the oldest old population. Quite pertinently, gender bias was well depicted in the pattern of toxic addiction. Intake of tobacco through smoking or with betel was reported by 62% men and 18% women.

Obesity level: Relatively higher percentage of elderly men (32%) were categorized under overweight/obese group. Contrarily, a very small section of elderly women (8%) could be seen either overweight or obese.

Sleeplessness: It was fascinating to observe that majority of the elderly population among the oldest old affirmed sound sleep. Merely 8% men and 12% women were found to suffer from the trauma of sleeplessness, diminished and/or fragmented sleep.

Mobility Pattern: Reduced mobility was observed in 22% men and 12% women. In rest of the lot, movement appeared to be normal .It was thus apparent that age factor had little impact in majority of the cases. However, it was noticeable that physical activity level among women (88%) was higher as compared with men (78%).

Forgetfulness: Memory loss didnot appear to be a pronounced feature of the study group. A small group of subjects comprised of 15% men and 11% women affirmed frequent episodes of forgetfulness in day-to-day life.

Level of Satisfaction: Very low percentage of subjects (7% men and 13 % women) reported low satisfaction level. The population, in general, appeared reluctant to admit their miseries. It was explicit during study that only those older people in 80+ age group who lived in miseries and were least cared affirmed low level of satisfaction.

Confusion: The elderly population under study didnot indicate definitive influence of confusion while taking their decisions. This psychic parameter, a known denominator of mental imbalance was prevalent among 14% of the oldest old category. Interestingly enough, no significant gender difference was observed. Percentages of elderly men and women reportedly in a state of confusion were recorded to be 6% and 8% respectively.

Hypertension: This age-associated disorder characterized by raised systolic and diastolic blood pressure beyond the normal limit of 120/80 mmHg seemed to be more prevalent among elderly men in comparison to the women. A high of 48% men were found hypertensive as against 14% women.

Arthritis: The study suggested higher incidence of arthritic problems among men (18%) as compared with women(12%). The gender-irrespective prevalence percentage was undoubtedly alarmingly high (30%).

Diabetes: No significant gender difference was noticeable in respect of diabetes incidence among elderly men(8%) and women(5%) in rural life.

Asthma: A very small population of rural elderly comprised of 5% men and 2% women indicated asthmatic symptoms.

LATE LIFE PERCEPTIONS

Pertinent suggestions from a few respondents with regard to happy late life are listed below:

- Availability of adequate medicare facilities in villages is indispensable for rising longevity.

- Economic independence a precondition for better sustenance in late life.
- Bereavement of kith and kin liable for diminished interest in prolonged survivality.
- To stick to traditional food habit for healthy long life.
- Routine life for making late life enjoyable.
- Good conduct and self-discipline to be essential ingredients of active aging.
- Human longevity could be enhanced considerably, if the children treated elderly as an asset rather than a burden.
- There is a need of coping with old age blues patiently, minimizing day-to day stress through meditation and evolving greater compatibility with younger generation for enjoying late life.

DISCUSSION

Relatively higher mean present age for women determined in this study might be regarded as the natural consequence of feminization of ageing in Indian perspective. Quite notably, larger section of the study group represented middle order in socioeconomic status and affirmed intake of adequate food regimen and non-vegetarian diet. There is abundance of ponds and rivers in this region and general liking for fishes is a common feature. However, prevalence of higher percentage of widowed elderly women on vegetarian diet in this zone, the land of Mithila, appears suggestive of the rigorous practice of abstinence from non-vegetarian diet by widows of Hindu families.

Raised obesity level, non-vegetarian diet, high tobacco consumption through smoking or along with betel and diminished mobility among elderly men might be thought conducive for higher incidence of hypertension, arthritis, diabetes and asthma (Fig. 1). Gender bias in other morbidity constraints seems to be less pronounced. Findings indicate slightly higher degree of sleeplessness contrary to low level of confusion and satisfaction among elderly women. On the other hand, grater magnitude of forgetfulness among elderly men might have some link with their raised stress level as evident from their hypertensive state, arthritic seizures as affirmed by reduced mobility and diabetes-mediated complications.

By and large, problems of uninstitutionalized elderly residing in remote areas appear grim. Their plight might have been compounded on account of adoption of the practice of entering into old age by most of the people without a proper understanding of the problems they will have to face during the last years of their life .In majority of the cases, parents were not seen happy with the support their sons living at their work place provided. Mere good feel of a 'joint family of households' alone can not serve as panacea for old age distresses.

It was disheartening to observe that mostly sons left their parents high and dry in their villages and themselves moved to cities for livelihood. In a few cases surviving father or mother or both were found reluctant to accompany them. It was also found that prevalent social inhibition refraining hapless elderly from staying with married daughters at their place made the life of the oldest old having no sons or having lost their sons quite miserable.

SUGGESTED MEASURES

Graying of nations at a faster pace is viewed, on the one hand, as a welcome development, an upcoming challenge on the other. It is high time to formulate strategies for integrated age care and graceful ageing for all. Some of the steps deemed necessary towards improvement of quality of life of senior citizens in their terminal age segment are recommended for immediate implementation. This is worth mentioning that a collective effort by all the stakeholders would alone make a difference. Besides governmental and non-governmental agencies, people belonging to all ages and all sections of the society will have to sit together and find ways and means to register perpetual smile over the lips of all 'aged' inclusive of octogenarians and nonagenarians. Truly, gerontological mission of adding life to years rather than years to life as envisaged by ageing scientists could be fulfilled when centenarians would die a natural death and leave the world for their heavenly abode having lived a life free from ailments and full of contentment and satisfaction.

Some of the suggestions are summarized in the following lines:

- People in their forties and fifties must take a very good care of their food, life style and health and do 'Old Age Planning' keeping in mind their future security considerations.

- Gerontology and Geriatrics should be made compulsory component of U.G. and P.G. curriculum in all universities so that youngsters acquire necessary knowledge about elderly issues and develop acumen to find out solutions to geriatric problems in right earnest.
- Efforts should be taken to ensure accessibility to smart homes, elderly-friendly mobile phones and other geriatric appliances for needy ones among the oldest old.
- In the present era of 'Designer Food' and 'Designer Medicine', the central and state governments ought to secure food and health for all aged individuals.
- Social scientists may take lead for the replacement of intergenerational conflict by intergenerational happiness through mutual trust, love and respect.
- Psychologists' intervention towards generation of positive attitude, 'take it easy' approach and strong will power will definitely yield encouraging results.
- Establishment of age-friendly PHCs and deployment of mobile medicare services will be of great use in promoting 'Ageing at Place' in rural perspective.
- Setting up of Old Age Homes in every district as contemplated by MSJ&E, Government of India and run by committed office bearers and trained care providers may serve the purpose of economically deprived needy ones.
- Clinicians' initiative for establishing a healthy society by way of maintaining good sanitary conditions, perfect community hygiene and containing life style as well as contagious diseases inflicting the elderly masses could prove highly rewarding.

CONCLUSION

Conclusively, it may be suggested that optimization of community hygiene, medicare facilitation at doorstep and generation of trained care providers may be thought impending steps towards ensuring healthy aging of rural India. Sincere efforts under taken with heartiest zeal will hopefully change the scenario. There is every reason to believe that future of ageing humanity will be bright.

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Ageing and Vulnerability to Criminality in Nigeria

Olabisi James AYODELE
Department of Sociology & Anthropology,
Obafemi Awolowo University, Ile-Ife, Nigeria.

ABSTRACT

The elderly are a special social category. For their peculiar socio-physiological traits such as frailty, declining immune system and dementia, old people are vulnerable in many respects. This paper explores the criminality of the elderly as well as their victimization in Nigerian society. The data used for the study were sourced from selected national daily newspapers. It finds that old people in Nigeria constitute endangered species because they are both active players in the criminal sphere and victims of the crime game. It canvasses the need for value re-orientation and government's responsiveness to the plight of the elderly.

Key words : Ageing, Fraility, Victimization of elderly, Criminality, Plight of elderly.

Growing old is inevitable but feeling old is not. This is because ageing is both chronologically and socially constructed. Most countries of the world use the age of 60 as the baseline age for elderly individuals, and they are expected to disengage from active participation in the labour force at such age. However, one is as old as one feels and not as one's birth certificate states! The ageing process is accelerated and aggravated by many factors such as condemnatory societal disposition, depressed/insensitive national economy, political instability, and prolonged health challenges. Since ageing is related to stress, a Nigerian professor of psychology observed: "people in depressed economy, in incessant conflict and in political instability age faster than those in more healthy and stable economy" (Oluwadamilare, 1994). Nonetheless, experiences of old people differ across societies and historical epochs. In most precolonial African societies ageing was desirable as old age was

synonymous with wisdom. In fact, the relevance of the aged in daily affairs is couched in a Yoruba proverb: Agba ki i wa loja, k'ori omo tuntun wo (Ignore the expertise of the elderly to your peril). For their continued importance in modern societies, the UN declared 1999 as the International Year of Older Persons with the WHO canvassing that "Active Ageing makes the Difference." Until recent refutations, most of the myths concerning old people such as libidinal loss, being bedridden and senility had very potent influence. Ageing is, nevertheless, associated with certain undeniable physical and/or physiological characteristics such as diminished physical strength and dementia (Llewellyn-Jones, 2002) and social characteristics including alienation, depleted income, and bereavement due to spousal and/or children loss. Every year, over a million elderly people in Europe experience memory loss, with 80% developing dementia or Alzheimer's disease, within five years (Holford, 2005). Most elderly find hard or strenuous activities extremely difficult and unappealing though in varying degrees. This could be due to polymyalgia rheumatica (PMR) common in persons over 70 years with symmetrical aching and morning stiffness in shoulders and proximal limb muscles (Longmore, Wilkinson & Rajagopalan, 2004). Undeniably then, ageing is accompanied by certain radical alterations in personality.

In Nigeria, age 65 (or 70 for judges) launches citizens into mandatory retirement and full elderhood or elderstatesmanship. While most advanced capitalist/socialist nations have functional comprehensive social security services for their elderly citizens, arrangements in most developing nations leave much to be desired (Forbes, 2005). In Nigeria for instance, the Federal Government has consistently abdicated its responsibility (contained in Pension Decree 1979) of remitting the benefits due to her senior citizens most of who retired into penury (except few senior military officers) because incomes were too meager to warrant any personal saving. And with virtually non-existent pension scheme for private sector retirees and the erosion of indigenous familial cares/supports, the plight of elderly citizens in Nigeria is unenviable! These insensitivities put most Nigerian elderly citizens in precarious socioeconomic situation thereby making them constitute a significant proportion of the army of poor in the country (Ebong, 1999; Lasisi, 1999; Akpe, 1999; Adams, 1999; Fasua, 1999; Olabisi, 1999; Adisa, 2000). It is even more worrisome when one considers the fact that

some of the neglected persons are trained ammunition handlers who retired from the armed forces with or without surrendering all the weapons in their possession! Esai Dangabar, the Director of Police Pensions, recently lamented that many "police officers retire without receiving their pension and gratuities on time" (Daily Sun, July 3, 2008). Also, Brig-General Bitrus Kwaji, Chairman of the Military Pension Board gave credence to the appalling neglect. To him, … there were a lot of problems regarding the releasing of funds,… leading to outstanding arrears of both pensions and gratuities spanning over three to 10 years in some cases (The Nation, September 10, 2008). Although Nigerian laws adequately protect children from neglect and abuse (see Section 341 of the Criminal Code Act Cap C38 of 2004), elderly citizens enjoy no such legal protection. In contrast, laws of most States in America recognize and adequately protect older individuals (at least 65 years of age) and/or disabled (LexisNexis, 2008) while in Europe, about four workers statutorily support each pensioner (Forbes, 2005).

Globally, the population is rapidly shrinking towards ageing! This has been attributed to the increased life span and decreased birth rate. For instance, older citizens are living longer for both male and female with one person in six aged 65 years or more in most European countries (US Census Bureau, 2000; 2003) due to improved health facilities and social securities (Llewellyn-Jones, 2002; Forbes, 2005). Invariably, the elderly have blurred the age-boundary in crime by becoming increasing involved in criminal behaviour more than ever before. In Japan for instance, the crimes committed by elderly people have risen sharply in the past 15 years (Tokyo Reuters, 2006). Tokyo Reuters reports: "People aged 65 and older accounted for more than 10 percent of those arrested or taken into custody for crimes other than traffic violations in Japan in 2005, compared to just 2.2 percent in 1990." In the United States of America, a 76-year-old American was arrested in a Florida neighbourhood for sexually assaulting two middle-aged American women (Sunday Sun, April 2006). The aged man had feigned to be a medical expert moving from door-to-door offering 'free breast examination'! In another American State, a 54-year-old female psychologist with the Arkansas Correction Department was caught and sacked for having sex with an inmate in her office at the Cummins Unit (Sunday Sun, April 2006). In the US, it is illegal for correction officer to have sex with an inmate with or without the inmate's consent.

Like criminality, elderly victimization is a global phenomenon, and Nigeria is having a fair share. Victimization is the infliction of physical, economic or pecuniary injury on an individual by a person with criminal intent. Across and within societies, victims' experiences are influenced by socioeconomic characteristics such as age, sex, and occupation (Stafford & Gale, 1984; Ferraro, 1995; Miethe, 1995; Alemika and Chukwuma, 2005). Generally, criminal victimization has been linked to lifestyle, frequency of contact, routine activity, poverty and opportunity. Though Alemika & Chukwuma (2005) found that people who were 55 years or older reported slightly lower levels of victimization compared to younger people, the low rates of victimization could have resulted from what Lawton *et al.* (1976) called "adaptive responses to high-crime rate" in the city.

In Nigeria, elderly criminal victimization manifests at either individual or governmental/institutional levels. On the individual level, criminal victimization or elderly abuse in Nigeria disguises as abduction or hostage taking, homicide (fratricide or matricide), and fraud or Internet scam among others. For instance, contrary to Section 364(1&2) and Section 365 of Nigeria's Criminal Code Act C38 of 2004, many old people were taken hostage in the volatile oil-rich Niger-Delta in 2007 while some were gruesomely murdered by (un)known assailants contrary to Section 319(1) (Fasua, 1999; Etim, 2000; Dike, 2007). And though, the victimization of old people in Nigeria, varies across the federating states, most elderly retirees suffer the same fate of pension/gratuity denial/delay (Adams, 1999; Yakubu, 1999; Sampson, 1999) and pension-related death (Adams, 1999; Fasua, June 1999; Fasua, October 1999; Sampson, 1999). Indeed, it is not out of place to say that old people in Nigeria have remained a marginal group (Eroje, 1999).

This paper discusses the effects of some undeniable socio-physiological features associated with ageing in Nigeria, especially as they predispose elderly Nigerians to criminality. The discourse considers, in different sections, method/data reliability, theoretical insights into old people criminality, peculiar crimes of the elders, discussions/implications of findings, and suggestions towards reducing the proneness old in Nigeria to criminality

Method/Data Reliability

This study relied solely on secondary data drawn from selected national daily newspapers. This is because Nigeria has no reliable statistics on the trend and patterns of crime and victimization (Alemika and Chukwuma, 2004). Even the so-called official crime statistics prepared by the Nigeria Police are either not easily accessible or irrelevant for any meaningful criminological analysis (Alemika, 2004). With the dearth of reliable official statistics in every facet of the Nigerian society, Nigerian researchers are forced to rely on field surveys and/or secondary data from newspaper reports. Despite the fact that some newspaper reports could be sensational and exaggerated, crime reports constitute a special category and are more carefully presented to the public usually after the police had been contacted. Thus, because of legal implications of misreporting crime, crime reports by Nigerian newspapers are sourced from eyewitnesses, victims or arrested suspects and police stations or courts. This triangulation of data sourcing makes crime reports by newspapers not only accessible to the general public but also very reliable.

Purposive sampling technique was adopted for this study. To generate the required data, the researcher randomly selected only one daily newspaper with national readership to ensure adequate representation. Specifically, the Punch newspaper was randomly selected from a list of all national newspapers in Nigeria as the time of the study. The daily national newspaper selected for review is The Punch. The review covered a period of two years, that June 1999 – May 2000 and June 2006 – May 2007. The choice of these two years was strategic in that the researcher was interested in making a comparative analysis of erstwhile military and its immediate successive civilian government in Nigeria. However, apart from this detailed review, information on the incidence of criminality of the elderly was sourced from other national daily newspapers such The Guardian, The Tribune, The Sun, and The Nation. It must be noted that the guiding philosophy for crime reporting and the extent of such report vary: each devotes a particular day of the week to crime reports. Since the researcher was not interested on the trend, only reports on crimes committed by old people (at least 60 years) were extracted and used. Inferences were made from the extracted crime reports of the selected newspapers.

Theoretical Insights into Old Peoples' Criminality:

Crime is any behaviour the law of a sovereign nation proscribes and penalizes within its geographical territory. Elderly criminality is best captured by Clarence Ray Jeffery's (1959) Social Alienation theory. This theory, an outgrowth of E. H. Sutherland's Differential Association paradigm, emerged to fill the lacuna created by Sutherland's explanation, especially on the origins of deviance. Crime or deviant behaviour, the theorist posits, results from deliberate or systematic edging out of some individuals from scheme of things in their group. In other words, such individuals become socially alienated experiencing certain degree of normlessness, goalessness, nonbelonging and impersonality. In the words of Jeffery, "alienation is a tendency to retreat from active involvement with groups and to reject society's norms or social goals." A socially isolated individual dismisses the existing norms of his/her group and invariably becomes less ambitious and less attached. Literally, social alienation turns individuals to social pariahs or outcasts. Jeffery posits that alienated individuals "reject society's norms or goals, … reduce his commitment to, or involvement in, groups." Invariably, such rejection and withdrawal erode internalized norms (normlessness). Thus, social alienation presents a nursery for criminality before differential association aggravates criminal career.

Essential postulates of Jeffery's theory, as presented by Solomon (1973), are that:

- in every group some individuals are unattached, marginal, normless and/or isolated.
- a person becomes criminal with/without association with criminals.
- criminal behaviour patterns are high where social interaction is characterized by alienation, anonymity, impersonalization and anomie.
- criminal lacks interpersonal relationship, suffers from interpersonal failures, and is a product of impersonalization.
- criminal behaviour is an attempt to establish impersonal relationships that have not been established in a socially acceptable way.

- criminal or anti-social behaviour is caused by emotional or mental conflict.

Jeffery's theory has direct bearing on criminal behaviour of the elderly in Nigeria. In Nigeria, the social alienation of the elderly usually results from governmental insensitivity to the plight of nonpartisan elderly citizens, rural neglect occasioned by inequitable distribution of social amenities, familial absenteeism resulting from unbridled rural-urban drifts in search of greener pasture, erosion of indigenous care for the elderly without any replacement, and dwindling economic resources. All these would lead to one inevitable social condition – the ostracization of the elderly on whom existing norms demanding good behaviour hold no influence. The transition of retirees from steady monthly stipend to a penurious unsteady meager pension/gratuity inevitably leads to social irrelevance. Such alienation reduces their stakes in their country, as both the goals and means no longer appeal to them. In Sutherland's parlance, socially alienated individuals simply become retreatists. Having been thus rejected, such individuals create for themselves alternative unconventional means of survival (innovation) so as to regain the lost social relevance. Despite the useful insights of Jeffery's theory, it has limited utility. This is because it fails to account for the involvement of non-isolated and highly-integrated individuals in criminal behaviours such as white-collar or passion crime. This notwithstanding, social alienation theory aids our outstanding of the vulnerability of elderly Nigerians to crime.

Dynamics of the Criminality of the Elderly in Nigeria

This study has found, from the reported cases of crimes in selected national newspapers that not all crimes appealed to elderly citizens of Nigeria. The discernible pattern is that they got easily attracted to crimes that improve their economic wellness and/or relieve them of emotional tensions. Notable among these crimes are arms dealing, human trafficking, drug trafficking, financial fraud, rape/sexual abuse of tots, and receiving stolen properties.

Human trafficking: Human trafficking takes the form of child merchandisation (proscribed by Sections 364 and 371 of Nigeria's Criminal Code) and female commoditisation (punishable by Section 225). Sometimes in 2005, an elderly Nigerian father offered his son for sale.

Demonstrating the level of economic desperation of old people in Nigeria, Mosadomi (2005) carefully documents how the elderly father attempted to sell his 12-year-old boy for N5million in the northcentral part of Nigeria. He reports:

Luck ran out on those involved in the deal and the father of the child who was said to have staked his son for the amount (N5million), as they were rounded up by officers of the immigration (the Nigeria Immigration Service) while negotiation on the final price was on (Mosadomi, 2005:5).

After their arrest, one of the collaborators confessed in Hausa language: "babanshi ne ya kawo mana shi" (it was the father of the boy who brought him to us for sale).

Advance fee fraud/financial fraud: Nigerian government has been contending with how best to stem down the ever-increasing cases of advance fee fraud and financial fraud, which have dented its international reputation. This crime, proscribed by the Section 419 of the Criminal Code Act 2004, has gained notoriety in that both Nigerians and non-Nigerians alike have fallen victims. This crime, which until recently, has been perpetrated mostly by some unemployed youths, has now become pastime for some elderly Nigerians. Advance Fee Fraud or obtaining by false pretence is one of the top 10 "trends" in Web fraud globally, according to FBI's Internet Crime Complaint Center. The increasing usage of the Internet by perpetrators of this crime called "the Nigerian 419 scam" in international circle has delineated onshore scam from existing offshore scam.

Offshore scam usually manifests as white-collar crime. White-collar crime is a unlawful act of person of 'respectable' socioeconomic status in the course of his/her legitimate occupation (Sutherland, 1940). White-collar crimes are basically financial offences involving frauds (Williams, 1997) perpetrated under the guise of respectability and facelessness. In an offshore white-collar crime, a retired Inspector-General of Police (IGP) was arrested and prosecuted for financial crimes valued at over $13 million in 2005. This money laundering fraud landed him six months imprisonment for each of the count charges in addition to the forfeiture of his assets (BINLEA, 2006). Seizure and forfeiture

of property of persons convicted for financial crimes and/or official corruption are governed by the EFCC (Establishment) Act of 2004 (see Sections 20, 24, 25, 26). In another instance, a 61-year-old Harvard-trained Nigerian chief executive was arrested for fraudulent enrichment and sentenced to 163 years imprisonment (Agbaje, 2005). The 61-year-old former Managing Director of a new-generation bank was found guilty of 39 of the 43-count charge preferred against him by the Nigerian graft-fighting body, the Economic and Financial Crime Commission (EFCC). Beside the 163 years jail term, the court also ordered that he paid a fine of N7.5million and the N61million to the complainant. He was charged and convicted for … fraudulently converting the money entrusted in his care to purchase 3,786,710 units of shares of Nigeria-Arab Bank (NAB) Plc with the sum of N135million paid in six installments; … forging and altering documents with which he hoodwinked the complainant to part with money even when the one collected was not fully utilized for the purpose for which it was collected (Agbaje, 2005:4).

Ordinarily, the Nigeria's Criminal Code prescribes a jail-term of seven years if the thing obtained under false pretence costs at least N1,000. The culprit admitted to have purchased only 41,155 units leaving a shortfall of N61million worth shares. Notably, there were 23 money-laundering convictions in Nigeria in the year 2005.

Rape/Sexual Abuse of Tots: Nigerian law condemns pedophilia – consensual or non-consensual sexual relations of an adult with underaged girls. Specifically, Sections 218 and 358 of the Nigeria's Criminal Code Act 2004 prohibit "unlawful carnal knowledge of a girl under the age of thirteen years" and makes culprit "liable to imprisonment for life." Due to this prohibition, some elderly people in Nigeria have been arrested and prosecuted for the crime. Of recent, the Bompai Upper Sharia Court in Kano convicted two old men for rape-homicide (Oshunkeye, 2005). The men who were in their mid-sixties were accused of gang-raping a 4-year-old girl to death in the ancient city of Kano in northern Nigeria. Similarly, another elderly Koranic teacher was docked for "systematically raping several of the little female children entrusted to him to teach Quranic recitations" in another northern part of Nigeria. In addition, in the southsouthern State of Port Harcourt, an elderly randy

Pentecostal preacher was imprisoned for "having unlawful carnal knowledge of a 14-year-old girl in April 2005 while a fellow felon and so-called man-of-God charged to court in May 2005 for defiling an eight-year-old girl" (Oshunkeye, 2005). In another incident, an 80-year-old man was charged before a Kaduna Magistrate's Court for raping a five-year-old girl in Kaduna on July 2008 (The Nation, 2008). Even though Nigeria operates discriminatory Codes for both northern and southern parts of the country, both Codes prohibit rape of underaged. Section 283 of the Penal Code and Sections 121 & 140 of the Sharia Penal Code Law of 2000 operating in the northern part of Nigeria condemn the act. In spite of the heavy penalty that rape of minors attracts in Nigeria (life imprisonment under Criminal Code and death under Penal Code), pedophilia is becoming rampant among Nigerian elderly citizens, particularly in the northern part.

Receiving Stolen Good: Old people in Nigeria have made their marks in theft-related crimes. In June 2007, a grandfather, who had been on the wanted list of the Lagos State Police Command, was nabbed. "His stock in trade," police source reveals, "was to sponsor armed robbers to burgle big companies and he would thereafter sell their loot and share it between him and the gang" (Oji, 2007). Admitting his culpability, the old man claimed that it was the handiwork of the devil:

> The devil gave poverty to me. The poverty that is running in my family is too much. So, I had to look for a way to survive. It is the devil. … when the offer came from this gang that I should help to sell their loot, I did not object. Really, I knew that the goods were stolen but I had no choice. But I don't agree with the police saying that I am the sponsor of the gang. I did not go with them. Where they operated, … whether they went with gun or machetes, I don't know. My offence is that I received stolen goods (Oji, 2007: 35).

Though this old man might never have participated in the actual robbery, he has however aided it contrary to the spirit of Nigeria's Criminal Code Act. Section 427 of the Criminal Code states inter alia: "Any person who receives anything which has been obtained by means of any act constituting a felony or misdemeanour, … knowing the same

to have been so obtained, is guilty of a felony. … the offender is liable to imprisonment for fourteen year."

Drug trafficking: Traffickers in controlled drugs, the world over, are primarily motivated by the enormous profit potentials (Odejide, 1995). For instance, in the early 1990s, traffickers in Columbia purchased a kilogram of cocaine base in Bolivia or Peru between $650-$1,000 and processed it into cocaine hydrochloride for export at between $950-$1,235 and sold it (diluted to 83% purity) in the US for between $13,000-$40,000 (Higdon, 1995). And when further diluted to 72% purity, the same kilogram sold, in grams, at the retail street level yielded between $17,000-$173,000! Tempted by this sudden drug fortune, drug trafficking gained ascendancy in Nigeria during military regimes, especially from late 1980s. Consequently, many Nigerian youths were lured into the drugs business as covers for the influential members of the ruling military/political elites. In contemporary times, illicit drug trafficking trade has increased to a frightening level (Kehinde, 2006). However, active involvement, as carriers, has been restricted to the youths while the elderly people served as barons. The recent arrest of a 60-year-old pharmacist at the Malam Aminu Kano Airport by the National Drug Law Enforcement Agency (NDLEA) has opened a new phase in the illicit drug trade in Nigeria. The elderly pharmacist was said to have ingested (swallowed) 100 wraps of cocaine weighing 1,040 kg when he was apprehended, as he was to board a London-bound plane (Alechenu, 2006).

Suicide: Suicide is the unlawful killing of oneself or self-liquidation. The Criminal Code Act 2004 of Nigeria proscribes and punishes suicide, suicide attempt and aiding suicide (Sections 326, & 327). Suicide has the same status as murder under the Code because each involves taking of a life. For instance, just in October 1999, two suicide cases were reported among retirees by Punch newspaper (Fasua, 1999; Olabisi, 1999). Fasua (1999) reported how a 68-year-old retired teacher in Ekiti State committed suicide over his inability to pay a long-standing debt of N50,000. The father of 8 children "locked himself in a room and blew off his head with his own double-barrel gun." Olabisi (1999) captured the story of a 90-year-old farmer who committed suicide in Ondo State, Nigeria because he "had no wife or child."

Others crimes: Some old people in Nigeria have been arrested for crimes such as ritual killing (Ibrahim, 1999), oil-bunkering (Sampson, 1999), armed robbery (Omofoye, 1999; Yornamue, 1999), arms/ ammunition trafficking (Sampson, August 1999); stealing away (Umoren, 2000). Each of these acts is proscribed and punished by appropriate Sections of the Nigerian Law.

Discussion of findings and Implications:

Notable among the crimes of old people in Nigeria are arms dealing, human trafficking, drug trafficking, financial fraud, sexual abuse of tots, and receiving stolen properties. It is interesting to note that all these crimes have economic undertone. All, except sexual abuse of tots, have direct and logical linkage with immediate monetary gratification. There is even a remote nexus between the rape of underaged girls and financial benefit. This is because in Nigeria, particularly in the northern part where it is rampant, there is a prevailing belief that such act (pedophilia) has the potency of improving one's fortune (Laleye, 2007).

Other possible reasons for the increasing trend in pedophilia among the elderly citizens include opportunity-creating loneliness, inadequate parental care, frequent child-hawking, scarcity of adult prostitutes due to the full-fledged adoption of Sharia Legal system in northern Nigeria, the belief in the curative potency of sexual intercourse with virgins, and the difficult legal requirement of the burden of proof. Men, who no longer find prostitutes to satisfy their sexual urge, opt for young girls or minors. Another plausible reason for the high rate of pedophilia in the Northern Nigeria is connected with the burden of proof. In this regard, the Niger State Attorney General and Commissioner for Justice, Barrister Adamu Usman, disclosed that in the history of the state, there had not been single conviction for rape because convicting them had always been difficult due to lack of co-operation from the parties concerned (Nigerian Tribune, Oct, 2007). Interestingly, gerontophilia, the desire of young people to have sexual relations with old people, is not common in Nigeria.

The involvement of elderly Nigerians in criminal activities, is attributable to social alienation resulting from both governmental/ institutional and individual/familial neglect. Little wonder why some retirees have been arrested for arms dealings to eke out a living. Many

elderly pensioners in Nigeria have died hoping against hope (Olabisi, 1999; Fasua, 1999a; Fasua, 1999b; Adams, 1999) while the lucky survivors are usually subjected to incredible harrowing experiences during fruitless months-long verification exercises (Oni, 2006; Ojiabor, 1999; Akpe, 1999). For instance, in Edo State alone, "15 retired primary school teachers and four of their spouses died in January 1999 without receiving their pension" (Adisa, 2000), while in Cross Rivers 20 out of the 191 retired primary school teachers died awaiting their pension and gratuities (Etim, 2000). Only recently, the government only started paying the highly vulnerable police retirees (or their next-of-kins) in Nigeria their years-long pensions/gratuities, and about 4,688 benefited in Edo, Delta and Bayelsa States (Anucha and Folaranmi, 2008). The 27-month harmonized pension arrears for the retirees of Nigerian Railway Corporation was paid in 1999 (Yornamue, 2000), while the payment of the arrears owed Military Pensioners (The Punch, July 2008) commenced of recent.

Often times, the government usually set difficult-to-scale hurdles such as the presentation of first appointment letter and all salary-increment letters, as prerequisites for payment because reliable data base for pensioners is nonexistent. This has dire social consequences, particularly since most Nigerian retirees have had impoverished working careers with unreasonable take-home-pay and have no resources beyond pension. Other non-pensioning old people, especially farmers, have had their means of livelihood (e.g. farming, fishing, etc) destroyed by government's concentration on oil-wealth, non-existent improved storage facilities, and dwindled prices of farm produces. Only elderly members of the political class in Nigeria, especially retired military generals, and their cronies live in affluence. In fact, nothing evinces the post-retirement opulence of many retired senior military officers in Nigeria as their lifestyles and their state-of-the-art estates in choice Nigerian cities (Tell Magazine, May 2008). Little wonder why a retired army general was duped N500million (Egua, 1999) when many of their civilian contemporaries have more povery. The unprecedented governmental and familial insensitivity to the plights of elderly citizens in recent times, has made them become more self-centred and money-conscious (Eroje, 1999; Anyagafu, 2006). The fear of retirees becoming social vagrants and derelicts has earlier been expressed by Ogunbameru

and Adesina (2000). Giving credence to Ogunbameru and Adesina (2000), Mr. Esai Dangabar, the Director of Police Pension laments: "it is sad we don't take care of those who served this country. … those who served the country diligently and with the better part of their lives [are not] paid their entitlements when due" (in Daily Sun, July 3, 2008). Dementia could equally have contributed to increasing elderly criminality because one out of seven old people experience it and it is usually characterized by decreased judgement and personality alteration (Llewellyn-Jones, 2002). Only recently are some faith-based and profit-oriented organizations taking up the gauntlet to provide alternative cares for the elderly in Nigeria.

Nigeria's romance with unbridled capitalism (capital accumulation without responsibility or adequate cares for workers) has dealt a fatal blow on her citizens, especially the elderly with little or no means of livelihood. Though the International Federation on Ageing in Nigeria (IFAN) initiated the Senior Citizens Association of Nigeria (SCAN) with the major objective of welfare promotion, SCAN which had an incumbent President as member, usually watch helplessly while the elderly suffer hopelessly. Once, the Nigerian government under Chief Olusegun Obasanjo (an active SCAN member), boasted of unprecedented increase in foreign reserves of over US$46bn while over 70% of Nigerians lived below world's poverty line. As at September 2008, the foreign reserves stood at US$64bn but Nigeria was importing rice and other staple food! Obsessive individualism has also had corrosive effects on the aged as repository of wisdom. At both the governmental- and citizen-level, the dignity accorded elderly Nigerians has evaporated. The indigenous family-level care for elderly in Nigeria has been jettisoned without any governmental replacement thereby leaving the elderly in socioeconomic misfortune that makes unconventional means very attractive. In addition, elderly neglect in Nigeria is partly due to the age-old belief that "toothless and scanty-haired" old people are witches and wizards (Osagie, 2000). Bizarre events such as "a cat turning into an aged woman in Port Harcourt"(Ckukwurah, 2008) and a "vulture turning into a 75-year-old man in Port Harcourt" (Emuobor, 1999) have reinforced this belief in Nigeria. The world over, ageing is only enjoyable when society and relatives/friends are more supportive of old people, provided they have reasonable health and sufficient money for needs

(Llewelly-Jones, 2002). However, Nigerian elderly, especially in the southern and southeastern parts, usually suffer reckless abandonment from their wards that only make them "enjoy" befitting society burial upon death. And when naturally death is not forthcoming, some old people have resorted to suicide. Even though suicide can result from psychological disorder, most reported suicide cases in Nigeria have social undercurrent. That is, most suicide or attempted suicides cases are tied to frustration or social neglect. In fact, Durkheim (1897) has established very strong nexus between suicide and level integration in a group.

Conclusion and Suggestions

Old people in Nigeria constitute endangered specie because they are both active players in the criminal sphere and victims of the crime game. Nigerian elderly citizens have become increasingly alienated due to the absence of statutory provisions to guarantee their wellness. Successive federal governments have failed in ensuring prompt payment of their pensions/gratuities and in establishing social securities for them. At the family-level, children and relatives, most of who live far away without any steady and sufficient financial resources, have abandoned the elderly. Many old people in Nigeria have become more or less social outcasts with little or no stake in the country. And in response to the survival instinct, these old people have resorted to unconventional means.

In the light of the above, this paper suggests that the elderly should be treated as another special category in criminal justice administration like the juvenile offenders who are not usually held criminally liable. The realization that ageing is accompanied by decreased judgement resulting from dementia or memory loss should mitigate the punishments for elderly offenders. This is necessary because experts have found that the brain function develops progressively in infancy and regresses in elderly people thereby ruling out any calculative rationality. In addition, a victim's status as an elderly person should be an aggravating factor to be considered in imposing the sentence on the victimizers. Most importantly, Nigerian lawmakers should, as a matter of urgency, incorporate adequate protection for elderly citizens and criminalizes any form of abuse or neglect. Also, by statute, all Nigerians should be

mandated to report elder abuse or victimization to the law enforcement agents.

The failure of any citizens to report elderly victimization should attract severe penalty and interpreted as tacit aiding and abetting. In addition, concerted efforts should be made at value-reorientation so that the present ignominy around age and elderly would be removed. Nigerian government should evolve an automated system through which pensions/gratuity of retired elderly citizens would be paid directly into their accounts. Finally, residence-based facilities should be established by both governmental and non-governmental organizations to cater for the socioeconomic needs of all aged including non-pensioners. This is particularly so because such practice is in tandem with our culture and the fact that Nigeria's population is not ageing.

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Ageing and Family Support of Elderly in South India

A.K. Ravishankar
Department of Population Studies,
Annamalai University, Annamalainagar – 608 002, Tamilnadu.

ABSTRACT

The increase in the absolute and relative numbers of the India's older population rank among the most important demographic developments of 21st century, even though it is still in an early phase, however, it raises special challenges for the country for the next forthcoming century. The present paper is based on the report on 'Morbidity Health Care and Condition of Aged' released by NSSO during 2006. An attempt has made to explore the prospects of population ageing, the socio-economic profile of the elderly and the system of family support of the elderly in the southern region of India. The share of people aged 60 years and above to the total population was highest in Kerala (10.5 percent), followed by TN (8.8 percent). Invariably in all the southern states the elderly females were out number than the male elderly population. The rural areas had more number of elderly populations than urban areas. Aged females were out number both in rural and urban areas in all the parts of south India. It indicates the higher expectancy of life for females. In India, about 65 percent of the aged population had depended on others – partially or fully – for their livelihood. This proportion was little higher for rural elderly population (66 percent) and slightly lesser for urban elderly people (63percent). However a wide variation was recorded between the urban female elderly fully dependent populations in the southern states. In south India, more than 95 percent of the

elderly people were supported by their own spouse, children and grand children, irrespective of their place of residence and sex. It shows the strength of Indian custom of respecting and taking cares of the elderly people.

Keyword : Ageing, Economic independence, Living arrangement,

Population ageing is the most significant result of the process known as demographic transition. Population ageing involves a shift from high mortality/fertility to low mortality/fertility and consequently an increased proportion of older people in the total population. Many of the governments of developing countries, until the early 1980s, perceived that population ageing was an issue only among developed countries. However, as a consequence of their rapid fertility declines over the past few decades, these developing countries have been increasingly aware of various population ageing problems (United Nations, 2002).

A total of 418 million persons were at age 65 and over in the entire world and approximately 60 per cent of these elderly persons were residing in developing regions, and this proportion increased by 7.7 percentage points in the second half of the 20th century. In Asia the population aged 65 and over was 216 million in 2000, which corresponded to 5.9 percent of the total Asian population. This proportion in Asia was considerably lower than in Europe (14.7 percent). Owing to the large population size in Asia, however, the elderly residing in the Asian countries amount to 51.6 percent of the aged population of the world as a whole. According to the 2000 United Nations population projections, this percentage would be expected to rise to 57.9 percent in 2025 and to 62.1 percent in 2050 (United Nations, 2001).

The ageing trends of the Indian population have started gaining credence in the debate on an interface between emerging socio-demographic issues and the country's economic future. Today, it is fairly established that the country's population replete with faster ageing prospects and its attendant problems, due to sustained decline in fertility

and adult mortality (Alam, 1999). According to the latest estimates, the Indian aged population is the second largest in the world. India has a substantially large sixty and above population which appears smaller only proportionally. In absolute number it exceeds 75 million in 2001 which is about 7.2 percent of the total India's population. The recent UN projections reveal an remarkable four times increase in the number of ageing population in the country (324 million in 2050) by the middle of the 21st century. These demographic facts and trends make the elderly in India an increasingly important segment of the population pyramid in the coming years.

Further, this shift in the age structure coupled with rapid social changes (gradual breakdown of the traditional family system) and ever increasing financial constraints at the national level is likely pose serious problems for the elderly. Under this circumstance the present paper has made an attempt to investigate the Socio-economic status and family support of elderly population in Southern India.

The objectives of this research is to explore the prospects of population ageing in the southern region of India, and to study the socio-economic profile of the elderly and the support system of the elderly in the Southern region of India.

Materials and Methods

The data for the study were drawn from NSSO 2004 report. The total elderly persons surveyed for this study was 7835 (AP 2183; Karnataka 1529; Kerala 1766 and Tamilnadu 2357) from 16392 households. In the study, those who were of age 60 years and above were considered aged (aged, ageing, elderly, older etc are all used interchangeably and represent in 60+ age brackets). 'Morbidity and Health Care' schedule in the Sixtieth round of NSS (January-June 2004) was used to collect the information relating to aged persons.

Results and Discussion

Table 1 : Elderly population in India by sex 1901-2021

Census Year	Population 60+ (in millions)		
	Persons	Males	Females
1901	12.06	5.50	6.56
1911	13.17	6.18	6.99
1921	13.48	6.48	7.00
1931	14.21	6.94	7.27
1941	18.04	8.89	9.15
1951	19.61	9.67	9.94
1961	24.71	12.36	12.35
1971	32.70	16.87	15.83
1981*	43.98	22.49	21.49
1991*	55.30	28.23	27.07
2001**	75.93	38.22	37.71
2011	97.24	46.98	50.27
2021	141.80	68.26	73.56
2026	171.66	81.88	89.79

Source: Office of the Registrar General, India.

* Excludes figures for Assam in 1981 and J & K in 1991 where the census was not conducted.

** Excludes 3 sub-divisions of Senapati district of Manipur.

It is observed from the table 'Elderly population in India by sex 1901-2021' that the elderly population in India was continuously increasing from the beginning of the 20th century. Their magnitude, either in terms of number or share to total population is found to rise gradually. At the beginning of 20th century about 12.06 million people were in the age of 60+ years. At the middle of the century this elderly population increased to 19.61 million (1951). In the next thirty years (1951-1981) the aged population has increased more than doubled as it was in 1951 census (43.98 million). This population was further increased to 55.3 million in 1991 and at the turn of this century, about 75.9 millions

are elderly Indians, making up about 7.7 per cent of the total population and are expected to be 171.6 million (around 12 per cent) by 2026 (CSO, 2006).

Sex ratio is found to be adverse to women in the Indian population. But sex ratio in elderly population is expected to rise at faster rate than the sex ratio in total population over the next 16 years. The sex ratio in the population aged 60+ which was 928 as compared to 927 in total population in the year 1996 is projected to become 1031 by the year 2016, as compared to 935 in the total population. The rising sex ratio is due to increase in life expectancy of the females. The population of females aged 60 years and above which was 37 million in 2001is likely to go up three fold in 2026 (90 million). The population of males, which was 38 million in 2001, is projected as 82 million in 2026 (more than two fold). This clearly shows that, reversing the current situation there will be more females aged 60 years and above as compared to men of the same age.

Table 2 : Percentage of elderly population (60+) in Southern India, 1991-2001

Southern States	1991*	2001**
Tamilnadu	7.43	8.83
Kerala	8.81	10.48
Karnataka	6.87	7.69
AP	6.65	7.59
India	**6.67**	**7.45**

* Centre for Monitoring Indian Economy (CMIE), India's Social Sector, Feb. 1996 p.2

** Office of the Registrar General, India, 2004

The table 2 reveals the percentage distribution of elderly population in southern parts of India during two census periods. The share of people aged 60 years and above was increased during 1991–2001 census period in all the southern states. According to 2001 census, Kerala had the highest proportion of elderly population (10.48 percent) among all the states in India, which was increased by 1.67 percent from 1991 census

data (8.81 percent). The next highest older population was seen in Tamilnadu (8.83 percent), followed by Karnataka (7.69 percent) and Andhra Pradesh (7.59 percent). However, all these proportions were higher than the all India elderly percentage (7.45 percent).

Table 3 : Percentage of elderly population (60+) BY sex and residence, in Southern India, 2004

Southern States	Rural			Urban		
	Persons	Males	Females	Persons	Males	Females
Tamilnadu	8.6	8.7	8.5	7.9	7.3	8.5
Kerala	11.5	10.6	12.3	10.6	10.3	10.9
Karnataka	6.9	7.1	6.6	5.9	5.8	6.1
AP	7.5	7.3	7.7	5.8	5.3	6.4
India	**7.0**	**7.0**	**7.1**	**6.6**	**6.2**	**7.1**

Source: NSS 60th round, Morbidity, Health Care and the Condition of the Aged, Jan.-June, 2004

The share of elderly by residence and sex is presented in table 3, it shows a significant R-U difference among the southern states. It discloses that rural areas had the highest elderly population than the urban areas in all the four southern states. Further it is also observed that invariably in all the Southern states the elderly females were out number than the male elderly population. However, the proportions of female elderly in rural areas were comparatively higher than urban female elderly population in all the southern states. Male-female differences in the proportion of elderly peoples were found to exist and the differences were significant. The share of the aged females was higher than that of the aged males in the urban areas in all the four southern states as in India. Almost the same trends were also observed in rural areas of southern region except Karnataka and Tamilnadu.

It can be concluded that Kerala and Tamil Nadu had more number of elderly population among the southern states and the rural areas had more number of elderly population than urban areas. Aged females

were out number both in rural and urban areas in all the parts of south India. It indicates the higher expectancy of life for females.

The expectation of life gives a good idea about the general health status of the people. At a particular age, the expectation of life is the number of years a person is expected to live, on an average, after attaining that particular age. It takes care of the mortality experiences during the whole life cycle of an individual, which depends on the availability of health facilities, nutritional level of the people etc. With the rapid advancement in medical science and technology it has now become easier to control various dreaded diseases, which were the cause of high mortality earlier. This has resulted in a continuous increase in the expectation of life.

Table 4 : Expectation of life at birth and at age 60 by sex of Southern states, 1997- 2001

Southern States	1997-2001			
	At Birth		At age 60	
	Male	Female	Male	Female
Tamil Nadu	64.1	66.1	15.9	16.5
Kerala	70.8	76.2	18.8	20.6
AP	61.9	64.4	15.9	16.9
Karnataka	62.6	66.0	16.0	18.0
India	**61.3**	**63.0**	**16.0**	**18.1**

Source: Sample Registration System (SRS) Office of the Registrar General, India.

The above table gives a picture in relation to the general health status of the elderly population in the Southern states by analyzing the expectation of life at birth and at age 60. Kerala shows the highest expectation of life at birth (70.8 for males and 76.2 for females) followed by TN (64.1 for males and 66.1 for females). At the same time, all the southern states had higher expectation of life at birth than the national average irrespective sexes.

Table 5 : Age specific death rate for the elderly by age and sex, South India, 2001

Age-Group	Tamil Nau	Kerala	AP	Karnataka	INDIA
60-64					
Male	29.5	23.7	33.2	25.1	26.5
Female	18.1	10.8	19.2	13.2	18.3
Person	23.6	16.8	25.6	19.0	22.3
65-69					
Male	40.4	36.2	45.6	27.5	44.2
Female	32.6	17.9	29.8	46.0	33.4
Person	36.4	26.2	37.1	36.3	38.6
70+					
Male	85.9	90.6	81.8	85.4	84.5
Female	74.0	73.6	67.8	69.0	69.7
Person	79.8	81.0	74.0	76.4	76.8

Source: Sample Registration System (SRS); Office of the Registrar General, India

The interesting observation made from the above table is that a significant gap between male and female expectation of life at age 60 had observed in Karnataka (16.0 for male; 18.0 for female), and Kerala (18.8 for male; 20.6 for female) than in TN and AP. This is due to the fact that expectation of life at age 60 for females had increased at a faster rate as compared to that for males, particularly during the last decade. The expectation of life at birth as well as at age 60 was quite higher in urban areas as compared to that in the rural areas for both males and females in all the four states of the southern region. This may be due to easier access to better health care facilities in urban places as compared to rural areas in these states.

The above table shows a comparative look at the Age-specific death rates among the elderly population of South Indian states during 2001. The table clearly illustrates that the ASDR was highest in AP (25.6; 37.1) followed by TN (23.6; 36.4) both in the 60-64 and 65-69 age groups. However Age-specific death rate was consistently favourable to the female invariably to all southern states.

The changing household structure is a most prominent socio-economic change with important implications for the elderly. In India the joint family system has been traditional basis of support for the elderly people in the society, particularly those who have lost their spouses, depend on their children for maintenance. Under the impact of modernization and of increasing independence from the traditional family occupation more and more siblings are moving from the base family to distance place of work. Under this backdrop, this section focuses on living arrangement, type of family support systems and economic independencies of elderly people in southern India.

Table 6 : Percentage Distribution of Persons aged 60 years and above by number of surviving children by sex and place of residence for Southern states (2004)

Southern States	No Surviving Children								
	Rural			Urban			Total		
	P	M	F	P	M	F	P	M	F
AP	6.1	6.0	6.3	3.9	2.7	5.0	5.6	5.2	6.0
Karnataka	4.5	3.9	5.2	3.7	2.5	4.9	4.3	3.6	5.1
Kerala	3.9	2.8	4.8	7.8	4.1	10.9	4.8	3.1	6.2
Tamilnadu	4.3	2.5	5.9	7.1	6.2	7.9	5.2	3.7	6.6
India	5.5	5.3	5.6	5.8	4.9	6.6	5.5	5.2	5.9

Source: NSS 60th round, Morbidity, Health Care and the Condition of the Aged, Jan.-June, 2004

In India about 6 percent of the aged reported that they had no surviving children during the survey. The proportion of no surviving children ranges from 4.3 percent (Karnataka) to 5.6 percent (AP) among the southern states. According NSSO 60th round, the proportion of elderly females having no surviving children was more than the number of such males both in urban and in rural areas among all the southern states. A significant R-U difference was appeared among all the southern states except Kerala. The Tamilnadu shows the highest r-u difference (4.3 and 7.1 percent respectively) with respect to the proportion of

elderly who had no surviving children. In rural areas, the percentage of elderly persons having no surviving children was high in AP (6.1 percent) and was lowest in Kerala (3.9 percent). On the other hand in urban areas, Kerala had the highest population of elderly population (7.8 percent) and Karnataka had the lowest (3.7 percent).

Old age dependency ratio is defined as the number of persons in the age-group 60+ per 100 persons in the age group 15-59 years. According to 2001 Indian decadal census data, every 100 persons in the working age had to provide support physically or otherwise to 13 aged persons to maintain their daily life in India. The old age dependency ratio was the highest in Kerala (16.53) followed by TN (13.85) among the southern states. Old age dependency ratio of AP and Karnataka was slightly lesser to national old age dependency ratio.

Table 7 : Old age dependency ratio by sex and residence, Southern India, 2001

(in years)

Residence and Sex	TN	Kerala	AP	Karnataka	INDIA
Rural					
Male	14.98	15.53	13.09	13.13	13.59
Female	14.65	17.82	14.51	15.21	14.65
Person	14.81	16.72	13.80	14.16	14.1
Urban					
Male	12.34	14.42	8.94	9.44	9.93
Female	13.04	17.49	10.48	11.05	11.67
Person	12.69	16.00	9.69	10.21	10.7
Total					
Male	13.78	15.24	11.88	11.78	12.45
Female	13.93	17.73	13.36	13.74	13.77
Person	13.85	16.53	12.61	12.74	13.1

Source: Office of the Registrar General, India

The female old age dependency ratio was significantly higher than the male old age dependency ratio in all the southern states except Tamilnadu. In Tamilnadu only a slight variation was observed between

male and female old age dependency ratio (13.78 and 13.93 respectively). There was a considerable difference in old age dependency ratios in rural and urban areas. The old-age dependency ratio was comparatively higher in rural areas than in urban areas particularly in AP, Karnataka and Tamilnadu irrespective of sexes. Though the Kerala had the highest old age dependency ratio, rural-urban difference was not recorded (16.0, 16.7 respectively).

With the gradual breakup of joint family system and with decreasing financial and other support from their children, the economic status of the elderly population had become more critical. Financial dependencies among the elderly make their problems more complex and difficult. Many schemes and programmes are run by the government for the benefit of elderly people in order to ensure that senior members of the society do not remain dependent on others and live an independent life with dignity.

Table 8 : Percentage Distribution of Elderly Persons by State of Economic Independence for Southern States, 2004

State of economic independence	TN	Kerala	AP	Karna-taka	INDIA
Rural					
Not dependent	33.9	21.6	31.2	35.2	32.7
Partially dependent	16.2	19.2	11.2	12.5	13.8
Fully dependent	49.9	58.2	56.7	51.9	51.9
Urban					
Not dependent	35.7	31.7	39.5	34.0	35.9
Partially dependent	12.8	16.8	9.8	8.4	11.4
Fully dependent	51.4	50.4	49.8	56.9	51.6
Total					
Not dependent	34.5	24.1	33.1	34.9	33.5
Partially dependent	15.1	18.6	10.8	11.4	13.3
Fully dependent	50.4	56.3	55.1	53.2	51.8

Source: NSS 60th round, Morbidity, Health Care and the Condition of the Aged, Jan.-June, 2004

In India, about 65 percent of the aged population had depended on others – partially or fully – for their livelihood. This proportion was little higher for rural elderly population (66 percent) and slightly lesser for urban elderly people (63 percent). While looking to the states wise analysis, the TN (34.5 percent) and Karnataka (34.7 percent) were much better off that more than one-third of the elderly populations in these states were not depend on others for their daily maintenance than the rest of southern states. In Kerala the proportion of independent elderly population was only 24 percent. Comparatively the urban elderly populations were more independent in all the southern states than the rural aged people (except Karnataka). The independent proportion was ranging from 31.7 percent (Kerala) to 39.5 percent (AP) among urban aged people and 21.6 to 33.9 percent among rural elderly population.

The proportion of depend on others for their daily maintenance was worse for elderly females than the males. About 72 percent of elderly females both in rural and urban areas were fully dependent on others whereas this proportion of such males was comparatively much less (32.0 percent in rural areas and 30.1 percent in urban areas). However a wide variation was recorded between the urban female elderly fully dependent populations in the southern states; it ranges from 79 percent (Karnataka) to 64 percent (Kerala). Whereas in the rural female elderly fully dependent population, only a slight difference was registered between the Southern States (except in TN). It can be inferred that the economic condition of the elderly is much better among males in general, and more in urban sector.

A larger proportion of elderly males in urban areas were not dependent on others for their livelihood as compared to those in rural areas while reverse is the case for elderly females. In rural areas, the proportion of elderly males who are fully dependent on others was highest in Kerala (43.2 percent) and lowest in Karnataka (32.1percent). In urban areas, the situation was different with the highest proportion of fully dependent elderly males being 34.9 percent in Karnataka, closely

Table 9 : Percentage Distribution of Elderly Persons by State of Economic Independence for Southern States, 2004 (contd)

State of economic independence	TN	Kerala	AP	Karna-taka	INDIA
Male			**Rural**		
Not dependent	48.7	36.1	48.6	54.1	51.3
Partially dependent	15.9	20.4	11.1	13.7	15.2
Fully dependent	35.5	43.2	39.4	32.1	32.0
Female					
Not dependent	19.3	10.2	14.8	14.8	13.9
Partially dependent	16.5	18.3	11.2	11.2	12.4
Fully dependent	64.2	70.0	72.9	73.1	72.0
Male			**Urban**		
Not dependent	54.3	46.8	56.7	54.5	55.5
Partially dependent	13.9	18.3	10.4	9.7	13.4
Fully dependent	31.8	34.5	32.7	34.9	30.1
Female					
Not dependent	19.3	18.9	24.6	13.8	17.0
Partially dependent	11.9	15.5	9.2	7.1	9.5
Fully dependent	68.8	64.0	64.6	78.6	72.1

Source: NSS 60th round, Morbidity, Health Care and the Condition of the Aged, Jan.-June, 2004

followed by Kerala (34.5 percent) and lowest being 31.8 percent in TN. But for females, the situation was worse in urban areas with the highest proportion of fully dependent elderly females being 79 percent in Karnataka and the lowest of 64 percent in Kerala.

It can be concluded from the above analysis that in all the southern states, a large proportion of the elderly were economically dependent on others for their livelihood. It is, therefore, pertinent to know who the persons providing economic support to these elderly. It is seen that of the economically dependent aged, a significant proportion depend on their children (78 percent in urban and 80 percent in rural) in all the four states and a sizable proportion depend on their spouses for their economic support at both the points. Invariably in all the southern states only 3 per

cent were supported by their grandchildren and the rest (6 per cent) had to depend on 'others', including non-relations.

The proportion of the aged males and females depending on their children for economic support was higher in both rural and urban areas and more so in the males (ranging from 81-88 percent in urban males to 79-87 percent in rural males). The proportion of urban elderly females who depending on their spouses were comparatively higher than the proportion of rural aged females invariably in all the southern states. In contrast, the urban male elderly who depending on their spouses were lesser compare to rural male elderly in all the southern states. Others support a significant proportion of urban aged people in Kerala.

Table 10 : Percentage distribution of economically dependent elderly persons by category of person supporting them, Southern states, 2004

Category of person supporting	TN	Kerala	AP	Karna-taka	INDIA
Rural			**Total**		
Spouse	10.5	8.5	8.9	10.2	12.7
Own Children	81.9	84.0	81.3	79.2	78.4
Grand Children	2.3	2.0	2.3	3.3	2.8
Others	5.3	5.5	7.5	7.3	6.1
Urban					
Spouse	11.8	9.1	13.4	11.0	14.8
Own Children	77.7	78.1	79.2	79.0	76.2
Grand Children	2.9	1.1	1.9	3.6	2.6
Others	7.5	11.6	5.5	6.4	6.4
Total					
Spouse	11.0	8.6	9.8	10.4	13.2
Own Children	80.5	82.7	80.9	79.2	77.9
Grand Children	2.5	1.8	2.2	3.3	2.7
Others	6.0	6.9	7.1	7.1	6.2
Male			**Rural**		
Spouse	9.9	7.9	10.2	12.5	7.0
Own Children	86.7	85.6	83.5	78.8	85.0
Grand Children	1.2	0.8	1.9	2.6	2.2
Others	2.2	5.6	4.5	6.1	5.7
Female					
Spouse	10.9	8.8	8.2	8.9	15.9
Own Children	78.8	83.1	80.1	79.5	74.6
Grand Children	3.0	2.6	2.5	3.6	3.0
Others	7.2	5.5	9.2	8.0	6.3
Male			**Urban**		
Spouse	5.1	7.4	5.1	6.7	6.0
Own Children	85.6	81.0	88.0	84.7	86.5
Grand Children	2.5	0.0	1.5	2.5	1.8
Others	6.8	11.6	5.4	6.0	5.7
Female					
Spouse	15.2	10.1	17.5	13.2	19.2
Own Children	73.8	76.5	74.8	76.0	71.0
Grand Children	3.1	1.8	2.1	4.1	3.0
Others	7.9	11.7	5.6	6.6	6.8

Source: NSS 60th round, Morbidity, Health Care and the Condition of the Aged, Jan.-June, 2004

Interestingly, in rural areas of Andhra Pradesh, and Karnataka, the number of males who are dependent on their spouse (12.5, 10.2 percent respectively) is more than the number of such females (8.9, 8.2 percent respectively). This situation was reverse in Kerala and TN where the number of female who dependent on their spouses were out number. Invariably in all the four southern states, the number of females who are dependent on their spouses was more (ranges from 10.1 for Kerala to 17.5 for AP) than the number of such males (ranges from 5.1 for AP to 7.4 for Kerala) at urban areas.

It can be concluded that in southern India, more than 95 percent of the elderly people were supported by their own spouse, children and grand children, irrespective of their place of residence and sex. It shows

the strength of Indian custom of respecting and taking cares of the elderly people.

Living arrangements of older people are influenced by several factors such as gender, health status, presence of disability, socio-economic status and societal traditions. Generations of older Indians have found shelter in the extended family system during crises, be these social, economical or psychological. However, the traditional family is fast disappearing, even in rural areas. With urbanization, families are becoming nuclear, smaller and are not always capable of caring for older relatives. Under this circumstance this section explores the living arrangement of elderly people in south India.

Table 11 : Percentage Distribution of Elderly Persons by Type of Living Arrangement in Southern States, 2004

Type of living arrangements	TN	Kerala	AP	Karna-taka	INDIA
Rural					
Alone	12.3	2.9	9.2	5.8	5.3
With Spouses only	20.5	8.7	22.6	10.3	12.5
With Spouse & Others	35.9	46.3	30.9	44.8	44.2
With Children	24.8	36.3	31.4	33.4	32.0
With other relations	6.4	4.9	4.8	5.3	4.2
Urban					
Alone	8.1	3.5	6.2	4.0	4.3
With Spouses only	15.7	11.2	15.1	6.3	10.4
With Spouse & Others	38.1	42.8	37.2	46.8	46.8
With Children	31.2	33.4	35.8	37.8	32.2
With other relations	7.0	8.2	4.8	4.4	4.9
TOTAL					
Alone	10.9	3.0	8.5	5.3	5.2
With Spouses only	18.9	9.3	20.9	9.2	12.0
With Spouse & Others	36.7	45.5	32.4	45.4	44.8
With Children	26.9	35.6	32.4	34.5	32.1
With other relations	6.6	5.7	4.8	5.0	4.4

Source: NSS 60th round, Morbidity, Health Care and the Condition of the Aged, Jan.-June, 2004.

Information on living arrangement of the elderly shows in the above that reveals about 57 per cent of the aged were living with their spouses (12 percent with spouses and 45 percent with spouse & others) and another 32 per cent were living without their spouses but with their children, while about 4 to 5 per cent were living with other relations and non-relations. Nevertheless, only 4 to 5 per cent were still living alone. It is observed from the table that the proportion of living alone as high as 11 percent in TN and lowest in Kerala (3.0 percent). With respect to R-U difference again the TN registered a significant r-u difference than the rest of the states did not show much r-u differences.

An interesting gender-differential is observed in the living arrangement among the elderly and the pattern is similar in both rural and urban areas among all the southern states. In terms of proportions, more males than females lived with their spouses. On the other hand, compared to the males, proportionately more females lived either alone or with their surviving children or lived with other relations and non-relations.

Table 12 : Percentage Distribution of Elderly persons by Type of Living Arrangement in Southern states, 2004(contd)

Type of living arrangements	TN	Kerala	AP	Karna-taka	INDIA
Rural Male					
Alone	5.2	1.3	3.7	2.1	2.8
With Spouses only	30.2	12.7	32.4	13.8	16.2
With Spouse & Others	51.6	69.8	47.9	68.5	59.7
With Children	10.4	13.7	13.8	12.9	16.8
With other relations	2.7	2.3	1.2	2.6	2.7
Rural Female					
Alone	19.4	4.2	14.4	9.7	8.0
With Spouses only	11.0	5.6	13.4	6.5	8.7
With Spouse & Others	20.4	28.1	15.1	19.5	28.4
With Children	39.1	53.9	47.8	55.2	47.5
With other relations	10.0	6.7	8.2	8.1	5.6

Urban Male					
Alone	3.5	0.7	2.7	0.8	2.1
With Spouses only	22.1	16.8	21.5	9.6	13.3
With Spouse & Others	58.7	69.5	57.9	72.9	64.9
With Children	12.1	9.3	15.0	14.4	15.4
With other relations	3.6	3.6	2.5	1.6	2.9
Urban Female					
Alone	12.0	5.9	9.1	7.2	6.5
With Spouses only	9.9	6.4	9.5	3.1	7.5
With Spouse & Others	19.9	20.1	19.4	20.9	29.4
With Children	48.0	53.9	53.7	61.2	48.2
With other relations	10.0	12.1	6.7	7.1	6.7

The result indicates probably the impact of the higher incidence of widowhood among the elderly females than among the elderly males. The incidence of widowhood was higher among women because they live longer, and because in our society, men generally marry women younger than themselves. In TN (10.9 percent) and AP (8.5 percent) the proportion of elderly living alone was comparatively higher it indicates the rapid changes in the family system and reducing the availability of kin support. It can be concluded that with the modernization of the society, older values are being replaced by individualism.

It is obvious that under the impact of modernization, decline in family size, changing pattern of family structure, siblings are moving from base family to distance place, the immediate family support for the elderly may further weaken.

Conclusion

The Indian aged population is currently the second largest in the world. At the turn of the 20th century, Indian elderly making up about 7.7 per cent of the total population and is expected to be around 12 per cent by 2026. The share of people aged 60 years and above in the total population was highest in Kerala (10.5 percent), followed by TN (8.8 percent). Invariably in all the Southern states the elderly females were out number than the male elderly population. The rural areas have more number of elderly populations than urban areas. Aged females were out number both in rural and urban areas in all the parts of south India. It indicates the higher expectancy of life for females.

In India, about 65 percent of the aged population had depend on others – partially or fully – for their livelihood. This proportion was little higher for rural elderly population (66 percent) and slightly lesser for urban elderly people (63 percent). However a wide variation was recorded between the urban female elderly fully dependent populations among the southern states; it ranges from 79 percent (Karnataka) to 64 percent (Kerala). In south India more than 95 percent of the elderly people were supported by their own spouse, children and grand children, irrespective of their place of residence and sex. It shows the strength of Indian custom of respecting and taking cares of the elderly people. An interesting gender-differential is observed in the living arrangement among the elderly and the pattern is similar in both rural and urban areas. In terms of proportions, more males than females lived with their spouses. On the other hand, compared to the males, proportionately more females lived either alone or with their surviving children or lived with other relations and non-relations.

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Family in Transition and Challenges for Elderly Persons

Asiya Nasreen
Department of Social Work, Jamia Millia Islamia
New Delhi-110025

ABSTRACT

Ageing is an emerging social issue in contemporary society. The care and support to the elderly was never a problem in Indian society as all the members of the joint family group used to look after them. Gradually, the competence of the families in modern urban set-up to provide care to its aged members has reduced. Still, in difficult times the elderly rely on the family and it too pull out its resources to respond to its aged members. Organizing substitutive services could bring the sustainability of the family.

Key words : Care of elderly Family, Urban setup, Challenges for elderly.

Ageing : An Emerging issue

Ageing is a process of growing older, which is accompanied with deteriorative biological and psychological changes. These changes are irreversible and weaken the organism's ability for survival and adjustment, and eventually cause the organism's death. Ageing also signifies change in roles and status assigned to elders..

In recent years, ageing of population has become a global phenomenon. The average increase in the life expectancy has led to the increase in the proportion of persons above 60 years and decrease in the share of children and youth in the total population. Elderly or old people have never been considered a problem but it is ageing of population i.e. population of 60+ age group that has alarmed the demographers. The population of the elderly persons is continuously increasing in the overall general population (Census, 2001). Greying of population poses challenges not only for the nation, society but also to the family and to its stability as an institution.

Socio-Cultural Context of Ageing

A) Cultural Patterns

Older persons have always been an integral and important part of the family in Indian society. In the earlier times, the role and the authority of the elders was both supported and upheld. All ancient and sacred literatures including the Vedas and the epics portray parents almost as gods. The Puranic story of Shravan Kumar provides one example of a sacred rationale for a mutual sharing of life resources between the post productive and productive members in a family. The story glorifies the relevance and relation to old age and develops the logic to a point where, in the act of serving the old parents, Shravan Kumar and his wife not just lose their precious material possessions but even their lives. Old age is thus a part of a sacred cosmos, which in turn strengthens the intergenerational contract.

The story gives a fair idea of importance of elder's care in olden times in our country and the socio cultural context of ageing. The culture of traditional Indian society, the values and belief system that govern the rules of conduct in day to day life can be better understood if we review the guiding philosophy which directed the cultural patterns, religious beliefs and rituals, customs and traditions. This philosophy of the elders care is imbued in the trinity of:

(i) **Karma theory -** It is the theory of fate or destiny according to an individual's actions in previous life. Good actions of the past life ensure better fate in next life and make people incharge of their life. Karma contains the idea of endless circle of birth and death in which individual soul progresses or regresses through the levels of existence. It also implies balancing right and wrong actions of dharma and adharma. (Prakash, 1997).

(ii) **Caste system -** Caste system is an intrinsic part of stratification which is the hierarchical division of society into four major castes: Brahman, Kshatriyas, Vaishyas and Shurdra. It is present even today in India.

(iii) **Theory of Ashramas** - It is fourfold stages in the life of an individual. According to Dharamshastras and Smritis during one's life an individual passes through four stages- Brahmacharya (student life), Grastha (married life), Vanaparatha (life of retirement) and Sanyasa (the life of renunciation. The movement

from one stage to another was gradual with prescribed specific duties and observances associated with each stage.

Whichever caste to which an individual belong, he or she must pass through all the life stages. 'Vanaprastha' corresponded to the stage of life when an individual withdraws himself out of the status of the householder and gradually hand over the reigns of the family to his eldest son. Hence, the responsibility of welfare of the family passes down to the next generation. Each stage of life alongwith corresponding rights and duties were generally followed by the members of the family. The scope for any role conflict in the family was minimal. The role and status of the aged too was prescribed. They enjoyed high status due to their wisdom gained through experience and knowledge acquired.

B) The Role of the Family

The family as a social institution has always been regarded as a core element for the development of the individual, society as well as for the state. Family is regarded as the cornerstone of society and a basic unit of social organization. The characteristic feature of Indian society is the joint family system. Social traditions sustained and reinforced joint family system as primary social groupings. These joint family groups would among others, upheld socio-cultural norms, customs and social conventions. A joint family group was headed by *karta* who would be invariably eldest male responsible to oversee assets and liabilities, income and expenditure, adherence to rituals etc. Taken together joint family traditions preserved the position of the elderly in the family and society as well. Under this system three generations live together under the same roof and all social and economic affairs were controlled and managed within the domain of the household (Gangrade 1999). Hence, the joint family prescribed the way of life and deviation from it was not easy. All this reduces the chances of strain caused by differences within the family.

Family is that part of the society that performs different functions or fulfills social needs. The Joint family has always been regarded and considered as one of the pillars of Indian social organization. It is an ideal, cooperative and cohesive group of people living together in one household and bounded by the loyalties towards the family and its "honour". This is culturally idealized form of Indian family, which has set down the authority of the elderly.

Traditional India was ascription-based society. The roles and statuses were ascribed i.e. determined by birth. People were trained and socialized from childhood and guided through life by the rules of conduct set by the elderly of the family in preparation for roles they were destined to play later in life. Thus, the grandmother was the reigning female and a highly respected figure while the grandfather was the revered patriarch whose whim was the law for the family and controlled all the economic and social affairs in the joint or extended home. Older people were respected for their wisdom and were provided with security and companionship within a three or four generation household.

Contemporary Urban Indian Family

At the macro level numerous changes have taken place in the Indian society as a whole. Colonization of the Indian society exposed it to new cultural values and belief systems and erosion of the economic roots. This process has its concomitant echoes in the social and cultural fabric of the Indian society. After independence India vigorously moved onto the path of social progress and economic development. Industrialization, physical separation of parents from the adult children as a result of rapid urbanization and age selective rural urban migration affected the family's solidarity and competence in providing care to all its members. The notion that the family may look after its aged members gradually started losing meaning and reverence due to ongoing socio-economic and demographic changes. It has also been reiterated by Gangrade (1999) that Indian society however, had been undergoing rapid transformation under the impact of industrialization, urbanization, commercialisation, individualism etc. Consequently, the traditional values and institutions are under the process of adaptation and had often led to sharpening of intergenerational differences. Some of these changes are as follows:

- Commercialization, industrialization and modernization of the Indian society paved the way for replacing joint families by establishment of nuclear families consisting of only husband, wife and their children.
- Change in the status and role of women in the family and society together with the changing values of the younger generation towards the older people.

- The dependency of family on agricultural income has lessened due to which the centralized power structure of the family system has weakened. The absolute and unquestionable authority of elderly persons has started shrinking gradually.
- The increase in the life expectancy is not accompanied with health and well-being. With the onset of old age, health related problems increase making the elderly dependent on others for the fulfillment of their physical and psychological needs. The situation requires constant care and supervision but also drains the resources of the family.
- The paucity of dwelling units and high cost of living in cities and metropolitan areas makes difficult for the large family to survive. As such elderly are mostly not welcomed, in small houses with low income.
- Technological advancements have also adversely affected the older persons. Earlier, they were storehouse of anecdotes and stories for grandchildren before TV, videogames, comics and Internet robbed this role from them.

Challenges for the Elderly

Aged of all socio-economic strata face problems. The range of problems varies from psychological to the problem of survival. The affluent old usually suffer from psychological problems. Despite the fact that their primary needs are fulfilled and best of medical facilities are provided to cope with the problems of physical illness yet they are assailed by the feeling of neglect, loneliness and isolation. They therefore gets alienated from the family members. For a middle class aged person, growing old carries both psychological and physical problems. Psychological to the extent of loss of decision making power which shifts to the younger generation and physiological due to the limited resources of their families that makes it difficult to afford the best medical facilities for their health. While in case of lower income group it is the question of survival because of absence of any social assistance for them. Further the problems of aged living in rural areas are different than those living in urban areas and between the male and female aged.

In India, the needs of the aged for long were being met by their families. The problems of the older people were equally serious than those of other members of the family. Today's global economy and the simultaneous fast pace changes have put to test the long held traditions, values and belief system of the yester years. In the modern industrial societies where youngsters have different life style from the grandparental or even the parental way of life, they have to make independent choices and enter unfamiliar role unanticipated by their parents.

The situation is painful for many older people who have for decades played the role of decision maker and at many times feels lost in their own homes or families. This adversely affects their psyche perpetuating the feeling of despair and loss of wisdom to the younger generation. In situations like these the older people acutely feel the frailty and futility of their life.

Family and Care of the Elderly

The needs of the elderly has been often taken care by the immediate family members. Personal care, economic and emotional support are provided by the near kith and kin The task of providing care has traditionally been fulfilled by women in different capacities as spouse, daughter or daughter in law. In contemporary modern urban social set up women are performing the twin responsibilities of being homemakers as well as professionals beyond the four walls of the household. The potential of the family has been curtailed to support the elderly.

The care of the aged is emerging gradually as a major familial issue in the contemporary scenario as the moral and material values are fast changing in the rapid modern urbanized world. The aged find themselves at the cross road of life where neither institutional arrangements are available for them nor family has enough resources and time to provide holistic care and support them.

The three important domains where elder's require care are: a) Physical or chronic illnesses b) Social or Retirement c) Psychological. Ageing process is accompanied by numerous physical changes and ailments such as visual, auditory and other chronic ailments. These ailments not only impair the task of daily living such as eating, bathing, dressing or using the toilet but also require care and assistance from

the family members. The second aspect of elder's care is their social sphere. In a society under transition, respect for the aged is no longer the uniformly adhered norm. "Honour thy father and thy mother expressed the veneration of the elder's in our scriptures and literatures but with changing social scenario changes are also experienced in the position of elderly too. Retirement from economic life, generation gap has affected the family's role of care giving. The third set of influences is largely psychological in nature. Elders often experience depression, anxiety and other psychological disorders due to stress and tension of physical and social dependency. It all requires greater care for them by the family members.

In the absence of well developed systems for providing social services for the elderly, the option available is to rely on those with whom they live in close proximity for their social, economic and physical support. Empirically it has been proved that despite nuclearization of families and changing attitude and outlook of younger generation, no institution or agency is still considered important other than the family by the old people whether residing in nuclear or joint family system. Care of the aged is perceived as the responsibility of family members. To substantiate, Desouza (1982) in a study on the life of the aged persons among urban poor of Delhi, found that although changes have taken place in the family structure due to urbanization and migration but the family is still a source of security to the aged people. After a decade, Shabeen Ara (1994) found in her study that living with children is a preferred living arrangement of the aged slum dwellers. Needs like food, clothing of the aged parents and attending them in sickness was done by the children of the maximum respondents. In another research study conducted in Delhi by Nasreen, 2009 it was found that during old age, the overall capacity of a person decreases and level of dependency increases. The immediate family has been considered to be of great help for the elderly. The studied sample reported that all the requirements are taken care by the son, daughter, daughter-in-law or spouse. The immediate family provides support for their basic needs and also looks after them during illness. The family is like an umbrella that acts as safety shield for the aged.

Older people across regions, religion, gender or class distinctions provide assistance in household chores like baby-sitting, marketing for

grocery items, kitchen work and voluntary involvement in economic activities. In turn perceives care as the responsibility of family members.

Thus, at demographic and societal level changes are taking place. The population structure and family structure, institution of family are in the process to cope and provide assistance to its members. We have moved along the path of development with regard to lifestyle and longevity. Still, have not yet developed the institutional mechanisms that could address gerontological issues. So, what is required is building the competence of the family at both micro level and macro level. At the micro level, the potential of the individual itself and family need to be strengthened. While at the macro level, the government as well as the NGO's or voluntary organizations can enthuse in the institution of family, a level of confidence and zest for living by creating infrastructure facilities to facilitate older person's rehabilitation and adjustment process in the changed scenario.

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Resisting Commonsense Assumptions in Caregivers Talk

Isabella Paoletti
CLUNL, Universidade Nova de Lisboa
Avenida de Berna 26-C, 1069 - 61 Lisbon, Portugal

ABSTRACT

This paper aims to explore how common sense assumptions about family ties, attribution of caregiving duties are discussed and resisted, at times, in caregivers' talk, producing an account of their condition. The data analysed in this study consist of audio-recorded interviews aimed at understanding the living condition of family caregivers and their specific needs. The interactional data were transcribed and then analysed using a detailed discourse analysis within an ethnomethodological framework. The analysis shows the work done by interviewees in projecting a positive moral identity as caregiver, while contrasting commonsense assumption about caregiving.

Key words: Caregiving, Caregiving duty attribution, Ethnomethodology, Membership categories, Identity work.

Family caregiving is the most common form of assistance worldwide to older disabled people (Aronson, 1990; Taccani, 1994; Caro & Leventhal-Stern, 1995; Clarke, 1995; Mengani & Lamura, 1995; Jenkins, 1997; Williams *et al*., 1997; Stoltz, Udén & Willman, 2004; Paoletti, 2007). Support services for disabled older people are scarce in some of the most developed countries (Gori, 2002; Katz-Olson, 2003). Moreover, recent cuts in welfare spending are undermining those services even in countries that have an established tradition of state support services for the elderly (Gustafson, 2007; Pyysiäinen, 2007).

Within the family, women carry out the largest load of assistance (Clarke, 1995; Facchini & Scortegagna, 1994; Graham, 1983; Jenkins, 1997; Katz-Olson, 2003; Martin-Matthew & Campbell, 1995; Mengani

& Lamura, 1995; Najafizadeh, 2003; Neal *et al.,* 1997; Walker, 1995; Zhan & Motgomery, 2003). As Guberman (1999) points out: "All the authors recognize that one variable –the gender of the potential caregiver- is the most important and the most constant indicator of involvement in caregiving".

The older population is increasing at a fast rate (ECE-UNFPA, 1992; Gavrilov & Heuveline, 2003; UNDP, 1998; UNFPA, 1998; United Nations, 2001), so is the number of frail older people (Wolfe, 1993; Gavrilov & Heuveline, 2003), this is a fact. There are no signs that governments are up to face this challenge. The risk is that again women will be left alone to face it, reviving ideologies of caring as "naturally" pertaining to women.

In previous studies (Paoletti, 2001, 2002, 2007) I showed how caring duties are bound to kin membership categorizations and gender identification: being a daughter is a good enough reason to become a caregiver. This article describes how common sense assumptions about family ties, attribution of caregiving duties are discussed and resisted, at times, in caregivers' talk, projecting ordinary, that is morally and socially acceptable, identities as caregivers. My aim is to show that there is nothing "natural", about gender common sense assumptions, but that they are very powerful. Gender is not a monolithic or stable in its construction; innovation and resistance exist alongside more conventional expressions that reproduce the gender status quo. In this study (2007 ed) I described instances of resistance to "ordinary" constructions of caregiving as female duty, and the identity work done by interviewees in order to maintain a positive moral image.

What does it count as an "ordinary" account? What does it mean "being ordinary"? According to Sacks, "being ordinary" is not a condition, but the product of ongoing work: "Whatever you may think about what it is to be an ordinary person in the world, an initial shift is not to think of 'an ordinary person' as some person, but as somebody having as one's job, as one's constant preoccupation, doing 'being ordinary'. It is not that somebody is ordinary; it is perhaps that that is what one's business is, and it takes work, as any other business does" (Sacks 1984). All members are constantly occupied at "being ordinary",

in coordinated, reciprocally visible and verifiable ways. Such a work consists of accounting and descriptive practices of events and activities, in the first place, as "ordinary", "usual", "regular" events and activities. As Sacks points out: "the cast of mind of doing 'being ordinary' is essentially that your business in life is only to see and report the usual aspects of any possible usual scene. That is to say, what you look for is to see how any scene you are in can be made an ordinary scene, a usual scene, and that is what that scene is." It is a powerful perceptive mechanism that is particularly noticeable, Sacks (1984) says, in the occurrence of catastrophic events. People tend to interpret what is going on in an ordinary sense instead of in a catastrophic one; collecting articles on hijacking. He observed that passengers initially mistook a hijacking for a passenger showing a gun to a hostess, for example, or a filming of a television scene. "Being ordinary" is therefore both the product of constant members' work and a resource, a perceptive device, that members use in order to interpret, structure, make accountable what goes on around them. "Doing, being ordinary" is a basic prerequisite to maintaining the intelligibility of what happens and therefore to guaranteeing the possibility to communicate.

In this study I look at how commonsense assumptions about caregiving are resisted, while maintaining an ordinary and morally acceptable self identification. The analysis shows the work done by interviewees in projecting a positive moral identity as caregiver, while contrasting common sense assumptions about caregiving: being a good daughter, while sustaining that being cared for at home is not the best solution for her parents; being a good daughter-in-law while saying that it is not right that all the caring responsibilities are delegated to her.

The Study

This study is part of a wider research project (Paoletti, 1998a; 1998b; 2001; 2002; 2007), "The role of women in the family care of disabled elderly", conducted by the Department of Social and Economic Studies of INRCA (National Institute for the Cure and Care of Older People), Ancona, Italy, supported by a grant of CNR (Italian Research Council). This project comprises a survey study and an action research project. The action research project involved women from the Pensioner

Trade Unions in Ferrara in interviewing caregivers of older disabled relatives in order to understand their problems and plan support initiatives. At the end of the project I conducted feedback interviews. The data analysed in this paper refer to the action research project.

Researchers in various sociological traditions use interview data to provide relevant information in relation to the object of study or to gather the subjective perspective of the interviewee on a specific topic. This study refers, also, to the ethnomethodological use of interview data to document identity work (Antaki & Widdicombe, 1998; Baker, 1984; Garfinkel, 1967; Paoletti, 1998a; 1998b; Watson and Weinberg, 1982). In particular I will refer to different treatment of ordinariness in the interviews. In all passages that are analysed, ordinary constructions of caregiving are discussed and resisted, but in different ways according to the actual caregiving solution adopted. In the first interview, a daughter tells the story of how her mother entered a nursing home; in the other passages analysed, caregivers cohabiting with their cared for talk about alternative caring solutions. As we will see through the analysis there is a substantial difference between the identity work done in the first interview and the other two.

Caring at home is not always the best solution for the cared for

The first transcript is taken from the interview with Flavia who tells the story of how her mother entered a nursing home. Her mother had a serious accident and broke her limbs. Flavia cared for her during her stay in hospital and her convalescence. Her mother was 78 years old and was living alone in a flat on the third floor of a building without a lift. After the accident she gradually became self sufficient again, but she could not go back to her flat, it would have meant being confined at home. Flavia tried to find a house on the ground floor for her mother, but it was impossible in the small village where they lived. Her mother didn't want to intrude on her daughter 's life and was determined to go to a nursing home. In the transcript that follows, Flavia explains how she came to terms with the idea of her mother entering a nursing home. You can find transcript notations at the end of the paper; all the names of the women interviewed have been changed to preserve confidentiality.

Action Research Project, Interview

1234	Flavia	they do they make them do always gy mnastics (0.3) then heh who isinterested can also do some little work they keep them busy (0.3) now in June she is even going to the mountains my mother that I think that (0.4) she might have gone once or twice in all her life now she is going to the mountain (0.6) than she is also very happy
5	I	You mean she has found again [a life of her own after all
67	Flavia	[yes yes ( ) she's got her friends they can go out (0.3) they go for their strolls=
8	I	=hah I see therefore they're not let's say
9	Flavia	No
1011	I	where is this nursing home [where is it located
12	Flavia	[at Argenta (0.3) Argenta Don Minzoni in Gramsci street=
13	I	=therefore in the center of town=
14	Flavia	=yes yes yes (let you see let you see)
15		(2.0)
16	I	then after all it was a [solution
17	Flavia	[I was very lucky
18	I	Real[ly
19	Flavia	[( ) you see ( )
20	I	therefore if things work [then you cannot say
21		
22 24	Flavia	[yes yes yes no no she is really well it is a good little place they are not a lot they may be about [fifty
25	I	[good this is the main th[ing

2627	Flavia	there is their doctor there are the nurses (0.4) the food is very good
28	I	of course and therefore she is probably a lot more relax[ed
29	Flavia	[yes
30	I	[on the side
31	Flavia	[now (0.2) I start to get used to it a bit also because ( ) (0.5) when then she had to go to the day centre I didn't want and then Marta and Gaia were saying (0.8) come on that after well seeing her going away whe- (0.4) that the weather was bad I mean (1.6) I would have liked it but (my mom) no no if I have heh get some some points to get in I go (0.8) and she wan- she was really=
36	I	=deter[mined
37	Flavia	[determined to go (yes)
3839	I	Was she feeling to be a burden for you?This something [like that
40	Flavia	[my mom was always afraid to disturb
41	I[I see	
42	Flavia	[she sat in that corner and wouldn't move anymore

Flavia's tale can be understood on the background of commonsense knowledge about caregiving, in particular that "nursing homes are not a good caregiving solution", and "a good daughter provides caregiving for her mother". A precise normalizing work is done in this passage in reference to this cultural content. Flavia starts listing all the positive aspects of her mother's life in the nursing home; she mentions the activities that are organized, *they do they make them do always gymnastics (0.3) then heh who is interested can also do some little work they keep them busy (0.3)*. Then Flavia underlines the possibility for her mother of going on holiday in the mountain, that is in contrast with all her mother's past life, *she might have gone once or twice in all her life now she is going to the mountains*. Interviewer's

formulation (Garfinkel & Sacks, 1970), *you mean she has found again a life of her own after all,* clearly hints to a negative construction of the nursing home, in fact, notice the edging "*after all*" that accompanies the interviewer's positive comment. The understanding between the interviewer and the interviewee is based on the assumption that being in a nursing home is less than an ideal solution. Flavia continues elaborating on the prospect of "a new life for her mother" introduced by the interviewer referring to her mother's social life, *[yes yes ( ) she's got her friends they can go out (0.3) they go for their strolls=.* Interviewer's comment, *=hah I see therefore they're not let's say*, probably refers to possible restriction on mobility connected to living in a nursing home. Flavia's prompt acknowledgement, *no*, projects understanding of what the interviewer has not yet said. Several turns then develop to locate the nursing home within the town. The interviewer's comment , *then after all it was a solution,* again projects clearly an ordinary negative image of nursing home as a caregiving solution, as well as, *therefore if things work [then you cannot say;* The nursing home described here is just a special case.

The enthusiastic account of the nursing home continues, pointing out that the mother feels very comfortable in it, *[yes yes yes no no she is really well it is a good little place they are not a lot they may be about [fifty,* also because of the presence of medical personnel *[there is their doctor there are the nurses (0.4) the food is very good*

All this first part of Flavia's tale is focussed on constructing a positive image of the nursing home where her mother lives; from line 31 she starts telling how unhappy she was about her mother's decision to enter the nursing home. Flavia's resistance to accepting her mother's admittance to a nursing home is expressed very explicitly, *now (0.2) I start to get used to it a bit.* In particular Flavia tells about the period, prior to the admittance, when her mother went to the nursing home during the day. This was an institutional practice to familiarise the newcomer to the life in the home, and it meant being given precedence in the waiting list for admittance. Flavia underlines her pain on seeing her mother going out during the winter, *I didn't want ... seeing her going away whe- (0.4) that the weather was bad I mean (1.6) I would have liked it*. She contrasts these feelings with her mother's determination, *but (my mom) no no if I have heh get some some*

points to get in I go (0.8) and she wan- she was really ... determined to go (yes). Entering the nursing home is her mother's decision, only hers, this is very strongly spelled out. The prospected life in the nursing home for Flavia's mother, rich in activities, independence and new friendships, is contrasted with a less desirable life in her daughter's house, *my mom was always afraid to disturb… she sat in that corner and wouldn't move anymore*. I am not trying to say that Flavia is insincere. She is truly unhappy that her mother entered a nursing home, what I want to sustain is that her tale has a precise meaning in relation to moral identity construction. The positive description of the nursing home and the account of her sadness on seeing her mother going out in the winter are not produced by chance, they are produced in order to project a positive moral image for Flavia of a good caring daughter. Caring for one's own mother is felt as a duty, a moral duty, in particular for a daughter. In other studies, I have highlighted the moral and gender relevance of caring for close kin (Paoletti, 1999; 2001). Flavia telling of her mother's admittance to the nursing home is primarily hearable as a "moral tale" (Baruch, 1981; Silverman, 1987; 1993). Flavia portrays herself as willing to have her mother with her and unhappy at seeing her in the nursing home, that is, she is producing a moral image of herself as an ordinary good daughter. The interviewer sustains this moral construction all through the description of the nursing home, questioning the general negative attitudes towards nursing homes, that is, constructing the nursing home as a possible ordinary solution to a caregiving problem.

In the transcript that follows the prospected use of a nursing home as a caregiving solution is used by the interviewee to highlight the conflict within the family. In this case there are no attempts to portray the nursing home positively, nor to express sorrow or discontent towards parents' admittance to the nursing home.

If I won the lottery

Dina is young woman of 37. She had her parents coming to live in her flat, after that their condition deteriorated. Her mother has a very serious form of osteoporosis and arthrosis; although she is only 60 years old, she has serious mobility problems. Her 70 years old father is obese and suffers from cirrhosis. Dina has been helping her parents mainly modifying her house with a whole series of mechanical aids, such as electric blinder, chairs of different sizes for her mother to help her bending

down, a new bathroom with special handles etc…These adjustments were quite costly. With great effort, her mother still performs most of the housework and the cooking, because Dina is out all day working. In the transcript that follows Dina projects the nursing home as the best solution for both her parents.

Action Research Project, Interview

12 Dina I always say if I won the lottery I mean I would know how to make them (0.3) comfortable one in a nursing home hhhhh! one hhh! In an o- hhh!

3 II you think that in this way they would feel comfortable

4 Dina yes (0.6) yesyes if is I=

5 I =not together

6 Dina well if if if I had (0.5) the possibility I mean of not not caring about the [money

7 I [of course

8 Dina well I mean (1.0) of saying I can afford the luxury to spend six million liras a month for one and six million liras a month for the other and I know that I put them in a (0.3) comfortable place (0.5) then first of all they would feel rel- for the character they have (well) they would feel very well for the fact of being in an institution where a doctor is always present I mean there f- re- rela[xed

14 [relaxed (0.4) at the same time they would be relieved lightened of all the business

15 I ( )

16 Dina Of caring of of wash and iron of [of eh eh

17 I [of course

181920212223 Dina therefore they would (0.8) with their character (0.7) they would feel good (0.6) moreover as I say (0.4) winning the lottery I would (0.4) I would separate them and I know I would make their happiness (0.8) of both well basically my father is selfish I mean he doesn't need necessarily my mother's presence he needs the presence of ( ) somebody who looks after him that everything's ready [hhh! hh! hh!

24 I [heh well then one should see the the thing in actual fa[ct

25 Dina [heh ( ) I mean=

26 I =but well [yes that

2728 Dina w[ell well if I won the lottery I would do (0.4) I would do this (0.8) and and and for me it would be (1.1) I would be well I mean

29 I of course (you would see them [ )

30 Dina [I would see them when

31 I at ease

32 Dina I would be at ease

Not only does Dina project the nursing home as the best solution for her parents' caring needs, but she even thinks of separating them, *I always say if I won the lottery I mean I would know how to make them (0.3) comfortable one in a nursing home hhhhh! one hhh! In an o- hhh!!*; the cost of the nursing home seems to be the only obstacle to an ideal solution. In a joking tone Dina projects quite a cynical picture of her father, *basically my father is selfish I mean he doesn't need necessarily my mother's presence he needs the presence of ( ) somebody who looks after him that everything's ready*, and in so doing she uncovers serious family conflicts. The interviewer's several attempts to question this position, *you think that in this way they would feel comfortable; =not together*, are rejected by Dina, who reasserts her affirmation, *I would (0.4) I would separate them and I know I would make their happiness (0.8) of both*. Even the interviewer's third attempt is no more successful, *heh well then one should see the the thing in concre[te.*, Dina reasserts her position firmly, *if I won the lottery I would do (0.4) I would do this*. The interviewer is appealing to ordinary caring family relationship, while Dina describes conflicts and oppression, even though in a joking tone. But Dina can do this because she lives with her parents and cares for them. There is no need of accounting as we saw in the previous interview.

Dina is watching her life go by, she has various health problems and at the time of the interview she had just overcome a period of depression. She doesn't see much in her future but more worries about her parents' caring needs. Because of the dependency of her parents Dina had to give up the idea of buying a small flat in town where she works; now she has to travel a long distance each day to go to work, and her social life is very limited. We can sympathize with her wishes and her rebellion. She can be so abrupt in her remarks, maintaining a positive moral image, because she is sacrificing her life for her parents. A similar construction that contrasts with commonsense images of caregiving is produced in the next transcript, where a daughter in law describes her caring work for her husband's parents.

Distancing from caring as a feminine activity

Lina has to cope with a very difficult situation. She is caring for her 81 year old senile mother-in-law and for her father-in-law who has heart problems. In the passage below, the interviewer is asking Lina's opinion about the caring being chiefly a feminine activity, a version of this question was included in the list provided to the women of the Pensioner Trade Unions. Lina, with some hesitation, expresses disagreement.

Action Research Project, Interview

1 I why do you think that it should always be the woman (0.5) to have to

23 Lina but well sincerely (0.8) hh hh I don't think it's right so I the I didn't have a job (1.0) and therefore I did it I mean ( ) hh my husband also because

4 I ye yes yes

567 Lina he can't can't also because the type of job he's got he couldn't do it well (0.9) eh but I don't think it's right that (1.2) that it should be done by I mean [(by the woman in particular)

8 I [that it should always just the woman [in particular

9 L [no no [I don't think so

1011 I [well you say (0.4) one could (0.4) if one (0.3) if we both work try eventually to make the sacri[fice (0.7)

12 L [eh well

13 I a little [each

14 L [yes (1.0) I think so yes

The interviewer's question is produced in the form of an assessment, *why do you think that it should always be the woman (0.5) to have to*, this is quite a different version from the question contained in the above mentioned list "Why is it mostly women who perform caring tasks for older people?". Lina produces a typical disagreement turn, preceded by various delay objects (Pomerantz, 1984, 70), *but well sincerely (0.8) hh hh I don't think it's right so*. Then she gives a reason for taking up the caring, *I didn't have a job (1.0) and therefore I did it.* She also provides a justification for her husband's lack of involvement in caring for his parents, making him accountable for it, *I mean ( ) hh my husband also because he can't can't also because the type of job he's got he couldn't do it*. Lina clearly and explicitly moves herself away from a gendered construction of caring, *but I don't think it's right that (1.2) that it should be done by I mean ((by the woman in particular)*.

The interviewer, overlapping with Lina's turn, conveys alignment by a partial repetition of the last part of Lina's turn, [*that it should always just the woman [in particular*. The addition of the two adverbs "always" and "just"can be seen to mitigate the meaning of the assertion, and it is followed by a stronger disagreement turn with respect to the initial interviewer's assertion, *(no no (I don't think so*. The interviewer formulates the conversation so far prospecting the case of mutual involvement in caring, [*well you say (0.4) one could (0.4) if one (0.3) if we both work try eventually to make the sacrif[ice (0.7) ... a little [each*. Lina promptly agrees with it, *(yes (1.0) I think so yes*. Lina moves away from caring constructed as a feminine activity. She constructs caring not as a duty, but as a sacrifice that should be shared. In fact, though, she is caring for both her parents-in-law.

I want to argue that departures from commonsense understanding of ordinary scenes and activities are met with justifications, accounting

moves, when they consist of actual situations, but when the actual situation conforms to commonsense understanding, accounting practices are absent, departure from ordinary understanding of practices and are blatantly asserted.

Conclusion

In this paper I have examined some passages from the interviews with caregivers who were resisting commonsense assumption about caregiving. I have shown the work done by Flavia in maintaining an ordinary and morally acceptable self identification, telling of her mother's admittance to a nursing home. Flavia portraying herself as willing to have her mother with her and unhappy at seeing her in the nursing home is primarily hearable as a "moral tale" (Baruch, 1981; Silverman, 1993), that is, she is producing a moral image of herself as an ordinary good daughter.

In Dina's tale, on the other hand, commonsense assumptions are blatantly contrasted; there are no attempts to portray the nursing home positively, nor to express sorrow or discontent towards parents' admittance to the nursing home. She expresses this as a strong wish, but in actual fact she lives and cares for them. In a similar way, Lina moves herself away from a construction of caring as pertaining only to women, but in fact, she cares for both her parents-in-law.

The attributions of caregiving duties to female kin are very powerful commonsense assumptions, finely engrained in ordinary conversation, a matter of course, on which background understanding is achieved by interlocutors. In this study I have shown how these assumptions are at times actively contrasted in caregivers' talk. There is nothing "natural", "absolute", "essential" about common sense assumptions. They can be changed, they are ongoingly changed, but we cannot forget that they are very powerful.

We need to build a more age-inclusive society; in relation to family caregivers' support services: "The overriding issue is not to relieve stress but how to organize society to make care for the dependent population more just and humane". The well known fact, that we are the first generation in the history of humanity to have a large portion of population of aged people is still largely underestimated in terms of its implications.

In particular, we need to face the challenge posed by frail older people as a community, instead of leaving the problem to families, that is, mainly to women.

Transcript notations

. or ,	Stop or pause in the rhythm of the conversation
?	Rising intonation
!	Excited tone
( )	Word(s) spoken, but not audible
(dog)	Word(s) whose hearing is doubtful
((laugh))	Transcriber description
[	Overlapping utterances at this point
=	No gaps in the flow of conversation
(0.4)	Pause timed in seconds
:::::	elongation

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Fragile Flames: Challenges Experienced by Aged Destitute Women in Vrindavan

Neetu Rana and Gireshwar Misra
Department of Psychology
Delhi University, Delhi (India)

ABSTRACT

The present study uses grounded theory approach to understand narratives of six destitute women of Mahila Sah BhaginI Ashray Sadan, Vrindavan. The struggling experiences of participants revolved around the core categories of patriarchy, family dynamics, age-ism and widowhood. The women reported alienation and low self efficacy, which promoted withdrawl behavior and eventually weak interpersonal relations at ashram. However, unconditional acceptance received in Vrindravan in terms of food, shelters, dignity and freedom; made participants feel increasingly safe. Thus, shifted their focus from basic needs to mental peace and space for self. Image of Lord Krishna was highly therapeutic, which seemed to substitute for the lost relations. Similarly, the prism of karma, through which they understood their ordeals, was equally reassuring.

Key Words: Destitution, Patriarchy, Alienation, Institutional care, Lord Krishna

Indian girls grow up listening stories of virtuous women like Sita and Savitri. They are trained to be modest, kind hearted and submissive, who in return, become the victims of the ruthless customs of patriarchal society, leaving lasting scars on womanhood. Patriarchy is the rule by the father within family and the consequent subordination of his wife and children. Women live through various forms of oppression and devaluation inherent in patriarchal oppression. The question is not merely women being exploited and harassed, but of women thrown out of their

house as well. As a result Indian society has large number of socially disowned women. Destitution is basically an extreme state of poverty, in which a person is almost completely lacking in resources or means of support. There are a number of reasons that have been found like-poverty, sexual abuse, alcoholism, betrayal, illness and last but not the least ageism.

Traxelar (1980) says ageism is an as any attitude, action, or institutional structure which subordinates a person or group because of age or any assignment of roles in society. There are several myths that circulate in our society like that paint, old being "unproductive", "disengaged", "sexually impotent", "inflexible", "serine" and "senile". These myths misrepresent old age, and bring disrespect, isolation and lack of sensitivity towards them, leading to Age-ism. This negative and/ or stereotypic perception of aging and aged individuals is readily apparent in Indian culture through the medium of language, folk stories, songs, media and humor. Images of an old age are often invoked as paradigmatic signs of a disintegrating modern society. According to Cohen, (1998) the three main villains of modern afflictions are westernization, urbanization and women. The urbanization, modernization and globalization have brought about major structural and functional transformations in the family, the primary care agency (Chakraborty, 1997). The argument with urbanization goes with the urban houses, their walls more divisive and isolation, they are less likely to include old people, who are commonly left behind on village lands. Modern day daughters-in-law, are better educated, they go out and get jobs, they are interested in makeup and movies, they desire their independence, and they are not willing to serve their husbands parents as daughter in laws once did.

Registrar general's office based on census of India 2001 shows 39.4 million females and 37.2 million males, meaning sex ration being favorable to females, indicating beginning of feminization of ageing in India. And 70% of old women stay in villages.

Older women are also often viewed as ineffective, dependent, and passive. This is particularly true for older women whose sole identification has been with her husband (Payne & Whittington, 1976). This image of the older woman can also be a self-fulfilling prophecy,

particularly for new widows who are finding it difficult to deal with independence (Block *et al.,* 1981). In addition, as female, women continue to experience sexism during old age and are placed, thus, in double jeopardy. In India widow women has to perform the restrictive set of widows observance, like-wearing white, giving up jewelry, dietary restrictions. These were the defensive measures aimed at controlling a widow's sexuality. So, aged widow women suffer higher vulnerability, first because of being women, second because of their age and third because of being a widow.

According to the 1991 Census of India, there are 33 million widows in India. Large sections of these widows are living as destitutes at religious points like Vrindavan, Varanasi, Mathura, Hardwar and Puri. Study done by Ahluwalia (2002) reports that only 25 percent of them come there with the desire to become a devotee. For rest the reasons remain related to family dynamics and socio-economic factors. There are a number of institutions in India for care and protection of destitute women, their care is far from being adequate. In Vrindavan only 30 percent are living in free accommodation and their living conditions are inadequate. These destitutes are living in very oppressive conditions, depending mainly on begging, singing bhajjans for survival. (Ahluwalia, 2002). A study done on Kerala destitutes, by Razeena (2003) showed that many preferred to remain aloof, adopted critical attitudes, and expressed a sense of discomfort while relating to others. Prolonged institution care was found to cause identity confusions, feelings of insecurity, inhibitory patterns, and emotional hunger. So, there are negative effects on emotional and personality development. Against the backdrop this research was undertaken to address the following issues:

1. What is the idea of self identity for destitute women? What new identities a destitute women take during late adulthood? How does a psychologically shaken woman revise an old identity with new one? How her group identity helps?
2. Why did they only come to Mathura? What kind of healing, solace this place was provided to them? What is that, that is making them stay here despite of all the hardships?

Method :

Participants

Six females, from the age group of 50 to 76 yrs, residing in the Mira Sah-bhagini Mahila Ashray Sadan ashram; Vrindavan (Mathura), for a minimum of 4 years were interviewed. All participants were well versed with Hindi, belonged to North India, except for one. Majority of them belonged to Brahmin's families.

Measures

Qualitative method was used to give spaces to different individuals in their original environment. To this end interviews were taken. The first area of concern was their life story; their ideas of Moksha and their reasons for migrating to Vrindavan. Another important area of concern was their world views and their coping strategies, incorporated in it was their perception of being an old, single, destitute woman. A few open ended questions focused on *Psychological Alienations*.

Influenced by Seeman (1959), 4 indicators of alienation were used. *Powerlessness*, when the prerogative for decision making (in family matters) is expropriated by others (new generation/young family members) and they have little control over the outcomes. *Normlessness,* suggests that under some circumstances, norms will be disregarded in order to achieve desired goals. *Social isolation*, it occurs when an individual feels separate from the community/society in which s/he lives. *Self estrangement* Action is motivated by rewards which others control and the person feel separated from the inner real self. Along with this were few questions on *Self Efficacy,* beliefs in one's capabilities to mobilize the motivation, cognitive resources and courses of actions needed to meet the given situation. This involves persistence, initiative and effort. The main purpose of these questions was to see how psychologically dead/active they were and how much they identified and introjected the stigmatized identities.

Life narratives were analyzed using the grounded theory approach. Open coding was done as a first step, where line by line themes were extracted from the narratives. After that those themes where clubbed and reclubed under certain broader concepts. Followings this, axial coding was undertaken, where all the categories under each concept were

related. Group results were derived on the basis of the common themes that ran across all the individual analysis.

Results and Discussion

Based on the results of this study, destitution can be seen as a product, rooted into the patriarchal ideology. The structure of families give husbands the privilege of power over their wives. Hidden within each participant's narrative were stories of an overwhelming past. They felt deceived by parents for pushing them into the system of devaluation, by the husbands for never being supportive, by in-laws for not helping, by sons for not being considerate and finally the community for criticizing their actions when they tried to rise against the atrocities. As mentioned in table 1, entangled in the organization of patriarchy were; family dynamics, age-ism and widowhood as themes which elucidated the process of destitution.

"Kirkira subhav lagta hai unko,kuch kam kai nahi hai aur kuch bole tuo bache ki pittai karti hai…."(they think we have got irritable nature, we are useless, we don't work and when if we try to say something, she starts beating the child...) stated by one of the participant, clearly shows Age-ism, i.e., the discrimination against old people. Raheja (1998) also stated that as we grow old, we move from central position to periphery. Age brings changes in structure, function of social life and withdrawal of privileges. This makes old people disengaged, isolated and thus unproductive as considered by family members resulting into a dry attitude, leading to the feeling of unworthiness.

Modernization and urbanization emerged as the two main reasons for such neglect .It has also been reported by Lamb (1997) as well. When children shifted to towns, adjustment to the new environment made parents feel alienated as reflected in one of the participant's narrative also *"abb hame kehta hai chalo ,tuo hamara mann nahi lagta abb…aur vahan ja kar kya karengai…"*(They say you come along, but we don't feel like going…what will I do there). Thus, many times they were left in native places alone. Situation became worst when widows were left alone, who were still not out of the loss of their life support and identity of their dead husband, had to face migration. Modernized daughter-in-laws, liberal in their views were not ready to

accommodate and, preferred staying alone as articulated by one of the participant. This could be reflected in statement like- *"Arye aaj kal ki bahu kahan karti hai gobar,vo apnai admi ko khilane ko taiyar nahi hai……"*(Today's daughter's in law are not interested in doing household work. They don't even serve their husbands…..). Neglect along with the displaced anger by daughters-in –laws on the grand children made widows stay away from homes. So, these narratives showed that the lack of integration in the family was prominent than total absence of care.

Institutional care (referring to table 1) had its own problems in terms of infrastructural handicaps, lack of apathy, and humiliation and disgrace in terms of cremation rituals followed in ashram. Group dynamics was also visible in terms of stereotypes against Bengalis and lower caste inmates. In the interpersonal relations there was guarding of ruptured self which was reflected in terms of lack of trust, and withdrawn attitude.

The feeling of psychological estrangement was faced by the elderly because of the new altered demands put by the society. Hence, growing estrangement and declining efficacy raised existential self doubt and, signaled as a source of social withdrawal. Despite social withdrawal, what made them going could be answered in terms of coping skills, but the image of lord Krishna appeared to be highly significant.

In Hindu view of life, the disturbances of the self are usually related to the notion of workings of karma across the cycles of many lives. The continuing presence of "the sacred" in our lives provides a symbolic relation with gods.

The significance of lord Krishna emerged out of the common life patterns of the participants. Almost invariably every individual had gone through one or more experiences that had severely mauled their sense of self worth. Unable to rid themselves of the feelings, they had been on the lookout for someone, somewhere, to gain a sense of self worth and to counteract their hidden images of failing and depleted self. This someone eventually turned out to be the lord Krishna.

The search can be explained in terms of shared developmental experiences of all the women, which contributed to the intensification

of the fantasy of the lord –the healer. Women born in patriarchal society, with puberty lose close relations with their father. Since then they try to substitute that lost relation with their husbands, & and sons; but deception at every stage triggered the lifelong search for a mentorship. Deep personal crisis caused yearning for the guiding presence of the father who could rescue and take over the responsibility for the shattered life. As one of the participant also articulated that *"abb hamara tuo bas vahi hai,vahi pita-matta hai,swami bhi vahi hai……hamko vo bata deta hai koun acha hai aur kuon nahi"*(he is the only savoir, he is my father-mother, master as well…and he only tells me who is good and who is not) Thus, the lord-devotee relationship was provided another chance in life for obtaining the required nutrients for the cohesion of the self.

There was a fear of evoking self fragmentation and inquiry that made them, withdraw from other inmates. But the reassuring image of Lord in various texts and mythology sort the fear out and took the role not only of the lord but of Guru as well. He became the Master Image because when all traumas were deep buried that it rarely impinged on the conscious mind, covered up by sorrow, with layers of aggression, unspoken to anyone, not even acknowledged by self, were unmasked in front of him. Moreover, the ambience of affective acceptance, in terms of food, shelter, respect, dignity and freedom that they got in the land of Lord (Vrindavan); made them feel increasingly safe, shifting the inner balance of needs and gave way to the repressed needs.

In Kohutian terms, the very emergence and maintance of the self requires sustaining self object experience, absence of these experiences lead to a sense of fragmentation of the self (Kohurt,1977). As in present cases, the Lord took that cultural self object, which offered for the redressal of self injury. Idealizing transference is often found to be the core of healing process (Kakar, 1982). In Idealization individual projected one's goodness on to the God by willed depletion *"hum tu unkae peron ki dhool hain….moksha tu bahut door hai…."* (I am just like a dust on his feets…moksha is too far off..) Followed by identification where individual assimilated that goodness into part of self *".....hum usi ka tuo eak ansh hai..."* (…I am just a part of him…) Thus, this gave a sense of unity.

Table 1: Common themes derived from the open coding of themes

1. Struggles in life

Patriarchy
- Men as head
- Restricted behaviour for women
- Deceived by in laws, husband, parents, son, daughter, friends and community.
- Subordinate role played
- Stigma of being left by husband
- Childless

Family dynamics
- Modern brides
- Generational gap
- Innocent son
- Issues of property

Age-ism
- Unproductive
- Disengaged
- Physical and mental changes
- Isolation
- No respect
- Passive aggression by daughter in laws
- Positive side- no work, security and freedom

Widow
- Loneliness
- Burden
- Stigma
- Loss of identity
- Sense of loss
- Being dead

2. Life in ashram

Group dynamics in ashram
- Utilitarian ideas
- Cultural diversity and language barriers
- Stereotypes against bengolis and lower castes
- Cordial relation and cooperation

- diplomacy
- Sense of family

Psychological dead interactions
- Lack of trust
- Fear of being disclosed
- Fear of giving any one right to hurt
- Fear of being dependent
- Detached
- Self engrossed
- Living life as it comes
- Restricted self
- No interest left in learning

Problems in the ashram
- Infrastructural problems
- Longing for emotional support
- Bonds with family
- Absence of identification

3. Coping skills
- Withdraw from situation
- Talks with roommates
- Self talks
- Reading
- Writings
- Religious tours
- Comparison with worst cases
- Self presentation in high esteem
- Humor
- Auto suggestion
- Positive appraisal of situation

Image of Krishna
- Krishna as lord
- Krishna as companion
- Krishna as parent figure
- Pure surrender

4. Idea of Vrindavan
- Escape from family dynamics
- Facilities available

- Freedom to move around as a sanyasan
- Respected and dignified place
- Religious reasons
- Idea of karma-Undo sins and earn good deeds
- Negation for moksha
- Unconditional acceptance
- Freedom from cycle of loss and gain
- Search for peace, mental harmony
- Space for self.

5. Self Efficacy

- Outer locus of control-destiny, God, others responsible for bad situations
- No effort and persistence to understand things out
- Dependence on government.
- Living life as a spectator
- Escapism

6. Alienation

Normlessness

- Being immoral ,like in black business
- Injustice and unethical practices done to old parents, in-laws.
- Men women relation in old age.
- Contemporary daughter in laws
- Deceived by own children
- Wrong use of education

Social alienation

- Misfit in today's world
- No interest in life
- No stand in social society
- Generational gap
- Disbelief and disillusionment
- Freedom from family system
- Sense of life being no better
- Every thing being artificial

Self alienation

- Loss of identity being a widow destitute
- Discontent with life

- Life as disillusionment
- No purpose and meaning in life
- Rootless ness
- Sense of being trapped
- State of chaos in life
- Meaning in life-can be achieved through meaning full activities, staying happy in whatever you have, with living by what god wants.

Powerlessness

- Incapable being old
- Loss of control
- Hopelessness and helplessness
- Unpredictable life
- Trapped
- Modernization

Another significant point observed was the bhava with which participants related to the lord Krishna, according to their most long lost relations and needs. He had been addressed by various names – Bal Gopal (son), Krishna (master), and Thakurji (spouse). The reason could be the way in which the Krishna has been portrayed in the various religious texts, as a divine figure that had the capability to hold numerous wives/dasis in due respect or a dutiful son, who not only saved his parents from the clutches of Kansa Mama but had been good to the foster parents. This probably formed the basis of free association of companion/ spouse, son or the master.

Sri Aurobindo in Gita for Youth; has also talked of Krishna who stood in the Bhaghvat Gita as the secret centre and the hidden guide, and the counselor whose hand was felt by the protagonists in various crises. He had been the symbol of the divine dealings with humanity.

It's not just the image which was reassuring but the prism through which the participants understood karma across lives was equally consoling. Individual suffering did not connate any individual failure or deficiency, it is rather an act of a scrutable divine plan. As articulated by one of the participants *"yeh tuo hota hi kai jesa kiya pichlaye janam mai uska phal tuo milna hi hai…. Aur agar abhi tapasya kar lenge tuo badd kai leye hi acha hai."*(It happens that if you have got bad deeds from your past life,you will have to face them. And

if you face this hardship right now,later days would be better…) The Riddle of peace and happiness is elusive and that is the cause of suffering. If permanent peace is required, we need to take freedom from karma, seek the lord within. All attachments are mental and have consequences on our soul. Therefore the mind needs to be detached, controlled, and involved into God. Thus, as Mother in Compilation of Mother's Work (1972) also said Blows are needed to know that there is no entity without the divine consciousness and they are just ways to progress. It is by perfecting our faith in the divine grace that we shall be able to conquer the defeatism of the subconscient. In other terms one has to prepare through tapasaya (ordeals) to get that grace.

So, the lord is not only a human object but also has a function to serve. Ordeals were just ways to progress towards divine, which gave the participants a feeling of being integrated and a hope for a better life after death. As also presented in figure 1; the constant deception throughout the life in every significant relation, made all participants to look for an eternal relation which was ultimately found in the image of lord Krishna.

The grounded theory that emerges out of the data can be presented in the following diagram:-

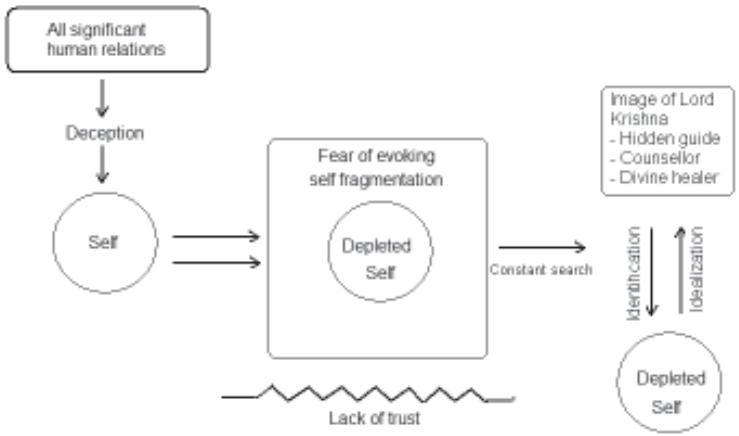

Figure 1: A grounded theory of destitution.

Concluding Comments

The present findings indicated that the destitution can be understood in the context of heterosexual patriarchal oppression. Within the patriarchal organization, the role of each participant in the study was defined in relation to men. When a woman looses her husband she not only losses her companion but also her identity. Age-ism further devaluated their existence. Low self efficacy and growing alienation acted as a precursor to withdraw from the assaulting environment and to look for eternal relations. This led to the retiring into ashrams of Vrindavan. There, the availability of basic needs, unconditional acceptance as a person and a presence of sacred and eternal bond with Lord Krishna or the real Self, acted as healing forces.

The issue of destitution is complex and warrants in depth exploration. Vocational trainings and Counseling are required to help the healing process go faster. Media can play a crucial role in bringing about social changes by outreaching people about women's issues, sensitizing about elderly people and their needs, and creating awareness about various laws.

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