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Psycho-Social Contributants to self-esteem among older widows

D. Jamuna, K. Lalitha, and P.V. Ramamurti

ABSTRACT

Widowhood, an inevitable life event for many older women has an impact on their psycho-social status. Consequent upon widowhood many older widows are vulnerable to the development of psycho-social problems and low self-esteem. This study is an attempt to investigate the psycho-social factors contributing to self-esteem of widows. The sample consists of 320 community dwelling elderly widows from the age groups of 60-89 years living in rural and urban areas of Chittoor and Cuddapah Districts. The results indicate that the economic status, age and psychological health were the significant contributants to self-esteem of widows. Implications of the findings in the context of intervention for the betterment of older widows are indicated.

Keywords : Widowhood, Selfesteen, Prycho-social, Problems, Interventions.

One aspect of the recent phenomenon of population aging is its feminisation. The chances of women surviving men in the later years is increasing over the decades leading to increased life expectancy at 60 years and longer years of dependency. The implications of women aging particularly in the developing countries have been focused in many international forums. The proportion of widows in the population of 60+ years is gradually increasing. Women in the later years of life have been subjected to many hardships like economic dependency, emotional insecurity, and social estrangement especially due to loss of spouse.

Women enjoyed equal rights with men during the Vedic Period (Altekar, 1973; Thapar, 1966). Today, the status of older widows in

the Indian culture is unenviable. They are viewed as inauspicious and tabooed in several social situations and rituals. Older widows are doubly affected due to the combined effects of aging and widowhood (Jamuna, 1989; Jamuna *et al.*, 1996; Prakash, 1997). India as a welfare state took several steps to improve the quality of life of widows. In all the States, there have been in existence schemes addressing the destitute old and widows since the 1960's (Gulati & Gulati, 1995).

Widowhood has meaning only in a psychological and social context in which it occurs. Social mores and norms of Hindu welfare have relegated the widow virtually to a hell on earth. If there is anything that a woman abhors in her life it is the loss of her spouse and becoming a widow (Jamuna *et al.,* 1996). In fact, all blessing given to married women invariably contain the phrase "Dheerga Sumangali Bhava." It is to say that "Dheergayushu" is useless if you are not a sumangali. So strong is the prejudice in favour of "Sumangali" and against "amangali". In the ultimate sense what matters is the state of mind. If one thinks of herself as a widow with all its associated paraphernalia, she is only doomed to depression. If on the other hand, she considers herself as a person with her own individual identity, she becomes "a woman of conviction" and self-esteem. The sacred texts have encouraged woman predeceasing the husband and if not, through sati, where she seeks to end her life along with her spouse. Therefore, living the life of a widow brim with woes and worries (Jamuna and Ramamurti, 1988; Ramamurti, 1989).

The practices and treatment associated with widowhood varies from culture to culture. Even within India different religions, different castes have different practices which are based on what the widow experiences in her relationships with others (others perception) and the manner in which she perceives herself i.e., what we call as reflected appraisal (Reddy and Jamuna, 1992). In essence it is the psychological status of the widow that matters most and torments her life. Several studies were carried out on psycho-social well being of elder widows in the West covering different psycho-social aspects (Bowlby, 1980; Lopata, 1996; Lund et al., 1985-86; Stroebe et al., 1993; Wortman and Silver, 1989; Wortman *et al.,* 1992) but periodical reviews on Gerontology (Ramamurti and

Jamuna, 1995) indicate very few empirical studies on psychological status of the elder widows in India.

Keeping this inview the present study was planned with an objective to examine what constitutes the psycho-social factors that affect self-esteem among older widows.

Methodology

A sample of 320 widows in the 60 to 80 years range were drawn by using purposive sampling from the rural and urban localities of Chittoor and Cuddapah districts (Table-1). The sample details show that 60% of the sample were living in rural areas. The subjects with no formal education (60%), with primary education (26%) and with high school (11%) education were included. It is evident that most of them were without formal education. Majority of widows belongs to lower middle income group (45%) and 52% of the total sample were living in nuclear family and 48% were in extended family.

Self-esteem Inventory (Rosenberg, 1965 adapted by Lalitha, 2000); Cornell medical Index to assess physical and pshycological distress (Ramamurti, 1989) along with the Social supports Inventory (Jamuna and Ramamurti, 1991) were used to assess self-esteem, self-reported physical and psychological health problems and perception of social supports respectively. The subjects were contacted individually and their prior consent was sought to administer the inventories.

Table 1 : Socio-Demographic Details of the Sample

S. No.	Sub Groups	Widows	
		N	%
1.	**Age Group**		
	60-69	122	38.12
	70-79	104	32.50
	80-89	94	29.80
2.	**Locality**		
	Rural	196	61.25
	Urban	124	38.75
3.	**Education**		
	No formal Education	201	62.81
	With Primary Education	87	27.19

	Above High School Education	32	10.00
4.	**Economic status**		
	Low income	95	30.00
	Low middle income	145	45.00
	Middle Income	80	25.00
5.	**Family**		
	Nuclear	170	53.13
	Extended	150	46.87

Results and Description

Many view old age as a dreaded period. Older people differ in many ways not only in the nature of problems but also in the type of adjustment they make. Many older persons suffer in silence with personal, emotional and social problems. But their perception about themselves always differs and that is a crucial factor for good psychological health.

Table 2 : Socio-Demographic Details of the Sample

S.No.	Sub Groups	Self - Esteem		
		N	M (S.D.)	%
1.	**Age Group**			
	60-69 (a)	122	14.06 (3.15)	2.51** (a-b)
	70-79 (b)	104	12.73 (3.88)	
	80-89 (c)	94	12.15 (4.35)	1.08@ (b-c)
2.	**Locality**			
	Rural	196	11.98 (4.06)	
	Urban	124	13.97 (3.59)	4.61**
3.	**Education**			
	No formal Education	201	12.21 (3.93)	3.00** (a-b)
	With Primary Education	87	13.83 (3.64)	
	Above High School Edu.	32	16.04 (3.02)	2.73** (b-c)
4.	**Economic status**			
	Low income (a)	95	10.81 (3.74)	2.80** (a-b)
	Low middle income (b)	145	12.41 (4.19)	
	Middle Income (c)	80	15.00 (2.91)	4.90** (b-c)
5.	**Family**			
	Nuclear	170	13.16 (3.84)	2.17**
	Extended	150	12.08 (4.21)	

@ - Not significant; **P<0.01 level

The data (Table-2) on sub-group differences suggests that with increasing age there was a gradual decline in self-esteem scores among widows. Urban older widows reported higher self-esteem compared to rural older widows, widows with higher level of education, and those who belong to middle income and living in nuclear families reported higher self-esteem (Figure 1). From this, one can infer that education and economic status play a significant role in the self-esteem of an older widow.

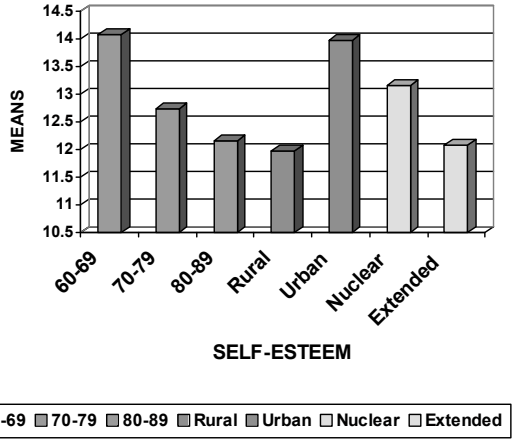

Figure 1. : Self Esteem in Different sub-groups

How an older widow perceives the transition during widowhood is dependent upon factors including the ego-strength of the survivor, the nature of the previous relationships with the spouse, availability of support from the family and others, health status, length of widowhood and the income condition etc., (Chakravarty *et al*., 1997; Jamuna and Reddy, 1992; Jamuna *et al.*, 1996; Lopata, 1996; Vokart and Michael, 1957). Thus, it is to state that though age *per se* is an important contributant, the life events like widowhood will have a significant impact on the psychological well being especially self-esteem of a widow (Jamuna *et al.,* 1996). The psychological problems like feelings of self-worthlessness, loneliness, emotional inadequacies and economic dependency which are brought on by widowhood makes older women more miserable and vulnerable to negative changes in their self-perception and self concept (Reddy and Jamuna, 1992).

Table 3 : Multiple Regression Analysis (Step-wise) of Contributants to Self Esteem Among Older Widows

Sl. No.	Variables	R^2	Increase in R^2	F-Ratio to enter /to remove
1.	Economic Status	0.18278	0.18278	71.12
2.	Age	0.20931	0.2653	41.95
3.	Psychological health	0.23058	0.2127	31.58
4.	Education	0.24446	0.1388	25.47
5.	Location	0.25443	0.00997	21.43

The feelings of self-esteem depend on the extent to which an individual gets attention and recognition in the socio-familial context. Self esteem refers to self-respect, autonomy used to seek attention and recognition. The MRA of contributants to self-esteem indicates that the economic status and age were significant contributants (F=71.12 and 41.95, respectively) followed by psychological health (F=31.58); the educational level (F=25.47) and locality (F=21.43). The other variable viz., self-reported physical health and social supports did not enter in the equation, which suggest that these were found to be not significantly related to the self-esteem among older widows in the sample.

It is obvious that the socio-economic condition is bound to be an important factor of self-esteem. More than three - quarters of older widows have no earning of their own due to their dependency through out their lives. Their role as a decision-maker in the family is drastically cut down especially on the issues of right to property and participation in social gatherings (Chakrvarty *et al.,* 1997; Reddy and Jamuna, 1992).

Keeping these contributants (Table-III) in view it would be worthwhile to plan and execute an intervention programme that would aim at enhancing their self-esteem. Since their economic status plays a crucial role, it is of paramount importance to conceive of and implement income generation programmes for these persons. The local/state authorities may be approached to bring the destitute widows under the widow/old age pension scheme. The capable among them may be organised into cooperative associations and involved in suitable income generation programmes (for e.g., cottage

industries for candle making, basket weaving, dehuskling, doll making etc.). Any income would boost their self-esteem immensely. They could also be advised to involve themselves in home making activities to be an asset to the family. Along with these activities, the older women could be exposed to psychological counselling to build a positive self-image and feelings of self-worth. Such field interventions are very essential to improve their self-esteem and over all quality of life.

Interventions need to be directed on a large sample to improve the self-esteem so that they can improve their over all quality of life. Effective use of visual and print media to bring attitudinal change towards widows in general and older widows in particular is important. Education on legal and property rights, income generation programmes and improvement of rural health services needs to be put in place to improve the status of older women.

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The Aged Populati7on in Bangladesh, 1911-2050

Md. Ripter Hossain

ABSTRACT

This paper investigate rapid growth trend of Bangladesh aged populations during the period 1911-2050. For describing and predicting the aged characteristics, age-sex patterns, labour force participation, marital status, retirement age, home for elderly and social support have been considered as the key factors. Some special policies have been forwarded for the well being of aged populations.

Key Words : Retirement, Home for elderly, aged population, well being.

Bangladesh is a country of young society but in demographic terms it is an aging society. The last few decades bear witness to the tremendous changes in population structure in Bangladesh. Among these changes two significant evolutionary process-population aging and break down of traditional family life are of great concern for the social scientists as well as for the governments and family members. As the share of the elderly to total population increases with time, more and deeper strains on socio-cultural values and on health care resources will be produced.

Because the general population of Bangladesh is relatively young, little attention has been paid to the population segment composed of the elderly men and women in either service or research activities. Although their percentage within the total population is

relatively small (5.75% male and 4.17% female) in 1991, the actual number of person aged 60 and over is large and growing rapidly. In 1911, such percentage was found to be 4 for population of both sex (Rahim 1969, p. 21; BPC 1991). In Bangladesh, there were 3298000 male and 2748000 female population (60+) in 1991 and 1023000 male and 834000 female population (60+) in 1951 indicating an annual growth of 5.5% for both sex, 5.6% for male and 5.3% for female (BPC 1991).

Viewing from the perspective of historical development, population of each community is being called upon to undergo a process known as demographic process - fertility and mortality - has not only caused sudden upsurge in population growth in Bangladesh but it has brought about a dramatic change in age structure. The proportion of population under age of 15 years and that of 60 years and above have increased at the cost of 15-59 years (Rahim 1969, p. 21; Sattar 1981, p. 41; BPC 1991). It implies that the dependency burden has increased, one productive person is to support more than one dependent on the average (BBS 1988, p. 189, table - 4.4). The crude death rate (CDR) has rapidly declined to 11 in the 1991s, while the crude birth rate (CBR) has not declined so much to develop a quick widening of the gap between CDR and CBR (BBS 1993, p. 61) unprecedented triumpha of medical science, rapid advancement in public health measures and other improved technological developments have led to a doubling of population size within one generation (BBS 1990, p. 41) because these welfare activities have resulted a striking increase in the expectation of life at birth which has more than doubled in the present century (Davis 1851, p. 62; Elahi *et al.,* 1981, p. 60; BBS 1990, p. 66; Kabir 1987, 1992; Kabir 1991, Rahman 1991). In the projections of the United Nations it is found that there is an increase of 103.8 percent in the number of the elderly between 1980 and 2010 and another increase of 92.3 per cent between 2010 and 2025, based on its medium variant assumption (UN 1992, p. 96). Life expectancy at birth is projected to increase from 50.7 years in 1985-90 to 65.6 years in 2020-2025. In UN projections it is found that CDR may decline from 15.5 in 1985-90 to

7.0 in 2020-2025 and CBR from 42.2 in 1985-90 to 20.0 in 2020-2025 (Un 1989, p. 291).

This paper makes an attempt to focus on the trend of growth of the elderly and to provide information about their characteristics and to discuss the policy implications thereof. Such knowledge is necessary to keep at program of intervention and formulation for the welfare of the elderly in state of preparedness. To analyse the dynamics of the demographic phenomena on the elderly over a longer period, the required data are not adequate and the quest for sources of such data has directed us to concentrate our attention to the period between 191 and 2025 for which secondary data have been obtained from the Statistical Yearbook of Bangladesh and projections of the United Nations.

Age Group and Sex Patterns

Bangladesh contains 1.09 percent of total world population and 2.15 percent of total elderly population of Asia in the year 1995. After a period of 25 years i.e. in 2020 the percentage of elderly population will be 1.38 and 2.41 respectively (UN 1992). According to UN estimates and projections (medium variant) proportion of elderly population in Bangladesh has been 4.9 percent and it would be 9.45 percent in the year 2025, an additional increase would be 4.55 percent. But in terms of absolute number, the increase seems to be amazing. There will be an increase of 864000 persons during 1995-2000 and 7299000 during 2000-2025 (UN 19920.

Table-1 provided the total population, the aged population and their percentage by sex in Bangladesh during the period 1911 to 1991. From the table it is evident that with the exception of 1951, total population of Bangladesh progressively went up in each census year. The lower figure in 1951 is explained by the fact that after partition of the subcontinent in 1947, many Hindus migrated to India during 1947-51 and also that people of different religious, particularly Muslims and Hindus tried to inflate their own sectorial population in the year 1941 census for political gains before the partition of India. The column of the percentages of aged people

shows an erratic trend. But on the average, the trend was upward. The percentage changes seem to be little, but in absolute numbers, Bangladesh consistently gained more and more elderly persons since 1941.

Table 1

Total and aged population by sex, 1911-1991 (In Thousand)

Year	Total population			Aged People (60+)			Percentage age of the aged (60+)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1991	16106	15419	31525	704	671	1375	4.37	4.35	4.36
1921	17071	16183	33254	689	654	1343	4.04	4.04	4.04
1931	18303	17281	35584	653	491	1144	3.57	2.84	3.21
1941	21757	20240	41997	807	741	1546	3.71	3.66	3.69
1951	21938	19995	41933	1026	836	1862	4.68	4.18	4.43
1961	26349	24491	50840	1462	1193	2655	5.55	4.87	5.22
1974	37072	34407	71479	2292	1765	4057	6.18	5.13	5.68
1981	44919	42201	87120	2751	2153	4904	6.12	5.10	5.63
1991	57314	54141	111455	3298	2748	6046	5.75	4.17	5.42

Sources: (a) An Appraisal of Census Population of East Pakistan from 1901 to 1961 by M.A. Rahim, Research Monograph No. 2, ISRT, Dhaka University, 1969.

(b) Population Census 1974, 1981, 1991, National Series, Bangladesh Bureau of Statistics, Dhaka, Bangladesh.

At this stage, a look at both the projected total and aged population of Bangladesh may be quite interesting and revealing. This is shown in Table-2. The most striking feature in the table is the fact that with the increase in total population over the ten yearly intervals, the percentage of the elderly persons will also be progressively increasing in the coming years. In absolute term, their numbers are simply alarming.

Table 2

Projected total and the aged population of Bangladesh by sex, 1995-2025 (In Thousand)

Year	Total population			Aged People (60+)			Percentage age of the aged (60+)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
1995	68095	64124	132219	3153	2856	6009	4.63	4.45	5.54
2005	87545	82590	170138	4002	3961	7963	4.67	4.80	4.68

2015	105186	99445	204631	5479	5610	11089	5.21	5.64	5.42
2025	120595	114391	234987	8847	9046	17893	7.34	7.91	7.62

Sources: The Sex and Age Distribution of Population : The 1992 Revision, Department of International Economic and Social Affairs, United Nations, New York, 1994.

As a result of increased longevity, successive decennial census has generally reported a higher proportion of persons in the various age groups among those aged 60 years and over (BBS 1990, p. 42). During 1951-2025, the growth trend of the elderly in the age group of 60 years and over is found to be upward (Table 1 and 2).

From Table 3, it can be observed that most of the countries have begun to experience a dramatic change in the age structure from a definite pyramidal shape to a rectangular shape. In 1990, the percentage of aged population varies from 4.8 percent in Bangladesh to 8.8 percent in China. China alone has 100 million aged persons, which is five times than the total population of Australia and twelve times higher than that of Swedden by the 2050, the total number of old persons in China, India and Bangladesh will be almost as large as the total population of percent Africa. This gives an insight into the emerging problem related with senior citizens, regarding assistance from the government and family.

Table 3

Absolute and percentage distribution of aged population (60+) for the selected Asian countries, 1990-2050.

Countries	1990		2000		2025		2050	
	A	B	A	B	A	B	A	B
Bangladesh	5330	4.8	6878	5.1	17893	9.5	45602	19.1
China	100646	8.8	126857	10.1	267886	18.2	403342	25.9
India	60724	7.1	79994	7.8	166651	12.1	328315	20.2
Indonesia	11488	6.4	14910	7.2	32705	12.3	63254	20.8
Malaysia	1022	5.7	1436	6.5	4005	13.1	8273	22.7
Philippines	3041	4.9	4248	5.4	11871	10.3	26126	18.2
R.P. Korea	3302	7.7	5007	10.7	11753	22.1	15481	28.6
Sri Lanka	1420	8.4	1758	9.2	4237	17.8	6813	25.6
Thailand	3177	5.6	4968	7.5	11476	14.2	21102	23.1

Sources: World population projection 1994, Oxford University Press.

a The total aged population in thousand.

b Percentage of aged population

Classification of countries based on the changing magnitude of aging population over time, Table-4 shows that very soon the countries like China, Republic of Korea and Sri Lanka will follow the aging pattern of western countries. By the end of this century, these three countries will achieve "double digit" figure. Rest of the countries will too follow the same pattern by or before 2025. It is interesting to note that by 2050, all these countries will have over 20 percent of their population as aged except Bangladesh and Philippines.

Table 4

Changing magnitude of aged persons over time : 1990-2050

Category	1990	2000	2025	2050
0 - 7%	Bangladesh Philippines Thailand Malaysia Indonesia	Philippines Malaysia Bangladesh		
7 - 10%	India China R.P. of Korea Sri Lanka	Thailand Sri Lanka Indonesia India	Bangladesh	
10-20%		R.P. of Korea China	India Indonesia Malaysia Philippines Sri Lanka Thailand China	Philippines Bangladesh
20%			R.P. of Korea	China India Thailand Sri Lanka R.P. of Korea Malaysia Indonesia

Sources : Same as Table - 3.

Labour Force Characteristics

In many communities in Bangladesh, we find many persons who claim to be older than 100 years and still strong enough to take

care of themselves in walking and doing their daily activities of life. Many persons aged 60 and over - both men and women are engaged in labour force and their number is highest in agriculture, forestry and fisheries. They are followed by sales workers, production and transport labourers and professional and technical people. Average weekly worked hours by the elderly (60+) are about 27 and there are sex differences, 27.6 male and 21.7 female, compared to 52.5 average weekly hours worked by persons of all ages (BBS 1988, pp. 27, 31 tables - 6.4, 7.1; BBS 1990, p. 104, table - 3.11).

Labour force participation of the elderly population presented in table-5, which indicates that nearly 80 percent of the aged population are still working. While, 80.6 percent of rural elderly population and 75.5 percent of the urban elderly population are still in the labour force. Marked difference in labour force participation between the male and the female elderly both in rural and urban areas is noticed. It is worth while to mention here that elderly constitutes 4.3 percent of total force in the country, of which 6.4 percent males and 3.4 percent females. As regards labour force participation of elderly from rural and urban areas, 5.3 percent is from rural areas and 3.3 percent from urban areas. Sex differential as well as residential differential are also noticed in the labour force participation of the elderly in the country as a whole.

Table 5

Labour force participation of the elderly population by sex : 1991 Census

Locality	Percentage					
	In total population			Among the Aged		
	Male	Female	Both Sexes	Male	Female	Both Sexes
Rural	5.4	3.6	5.3	87.3	72.1	80.6
Urban	3.8	2.7	3.3	82.5	66.1	75.5
Bangladesh	6.4	3.4	4.3	86.5	71.1	79.8

Source : 1994 Statistical Yearbook of Bangladesh, Bangladesh Bureau of Statistics, Dhaka, Bangladesh.

Marital Status

The marital status distribution of the elderly population presented in table-6, which reveals that about 95.10 percent of total elderly males and 42.90 of total elderly females are still in marital union. A large majority of the female elderly is in the widow

category. The data in the table further indicates both in rural and in urban areas of the country overwhelming majority of the male elderly (nearly 95 percent) are married. On the other hand, majority of the female elderly are not in marital union. Large percentage of male elderly in the married category may be due to remarriage of the male aged population.

Table 6

Marital status distribution of the elderly population by sex and locality : 1991 Census

Locality	Percentage by marital status							
	Male				Female			
	Never married	Married	Widow	Divorce/ Separation	Never married	Married	Widow	Divorce/ Separation
Rural	0.55	95.13	4.18	0.15	0.75	42.73	56.28	0.24
Urban	0.95	94.94	3.97	0.14	1.06	43.90	54.65	0.39
Bangladesh	0.60	95.10	4.30		0.80	42.90	56.30	

Source : Bangladesh Population Census 1991, National Series, BBS, Dhaka, Bangladesh

The percentage distribution of aged population of Bangladesh at different marital status categories, viz., single, married, widowed and divorced for males and females are presented in table-7.

Table 7

Percentage distribution of the aged population of Bangladesh 1951-1991 by sex and marital status

Year	Male				Female			
	Single	Married	Widowed	Divorced	Single	Married	Widowed	Divorced
1951	0.7	77.8	20.6	0.9	0.2	20.2	79.2	0.4
1961	0.4	84.2	14.8	0.3	0.1	17.4	82.1	0.14
1974	0.8	90.2	8.8	0.1	0.4	27.3	72.1	0.3
1975	2.0	87.0	10.6	0.4	2.9	24.8	71.8	0.3
1981	0.7	90.7	8.5	0.1	0.5	32.9	66.4	0.2
1989	0.4	92.0	7.5	0.3	1.2	30.8	67.8	-
1991	0.6	95.1	4.1	0.2	0.8	42.9	56.0	0.3

(-) Not available

Sources: (a) Bangladesh Population Census 1951, 1961, 1974, 1981, 1991. BBS, Dhaka, Bangladesh.

(b) Bangladesh Fertility Surveys, 1975, 1989, NIPORT, Dhaka, Bangladesh

The percentage of single and divorced aged population are very little. The maximum proportion of aged population are married. The married aged males population are slowly increasing but married females are more than a two-fold increase from 20.2% in 1951 to 42.9% in 191. In all censuses and surveys conducted in Bangladesh there has been higher proportion of widowed females than that of males. The difference in the incidence of widowhood between males and females is mainly due to age difference between them and partly accounted for by higher remarriage rates of males.

Retirement Age

Concern centers around the apprehension that traditional systems of joint family and socio-cultural support to the elderly may break down. For the developing countries, the resources may not allow government intervention in introducing the type of the care systems for the elderly of the more developed and industrialized countries (Rawls 1985, Rys 1974, Miller 19790. To deal with the problems of the elderly programs of the government of Bangladesh are very new and have been very slow to establish effective management for this purpose.

In Bangladesh retirement age varies for persons employed in different government, non-government, autonomous and private organizations. For self-employed persons there is no fixed cut off for retirement. Usually old age is considered to be accompanied by for feature of scheduled occupation and the elderly are obliged to retire.

The most common mandatory retirement age is between 57 and 60. Retirement age for a government employee is 57. In autonomous and private organizations it is 60. They however form a negligible fraction of the total elderly in Bangladesh. In some cases extension in a few autonomous organizations like universities is granted up to age 65. In some government organizations a retired person is sometimes allow to be selectively re-employed for one or two years after retirement at the age of 57 years. The self-employed persons work up to the time their health permits them to work. For poor families there is no support schemes for the self employed elderly. The government does not provide any old age invalidity and unemployment persons for daily labouries, self-employed or employed irregularly by private entrepreneurs.

Allowances of Honorarium

It was reveals that the family care-taker, it was revealed, carried out the tasks not for any economic gain or out of sympathy. They did not expect any payment for their work. Up to now due recognition was not given them as their devoted work was taken for granted. Some of these care takers have sacrificed much to care for the elderly parents. Both male and female care-takers have in some cases postponed marriages and some others never married in order to look after the elderly. At present their number may be small but many more such persons may follow suit, because of economic constraints and the increasing number of elders. But for the family careers and their dedicated work the burden would have fallen on the hospitals and homes for elders where space is the greatest constraint and limiting factor.

Even though reward is not expected, the economic situation of the country demands that some incentives be given to the households that provide care to the aged. The high income groups may qualify for a tax rebate, but the majority of care providers do not fall into this category nor do the households from which the majority of elders come. Hence, a reasonable assistance scheme (in cash or kind or both) covering such a household, as an incentive, is suggested.

Elderly Abuse in the Family

Abuse of the elderly in the family is increasing and it takes several forms and ranges from psychological torture to physical torture including insults, humilitations, and partial or total denial of food, clothing, shelter and medical help and emotional support. It was found that there is a pattern in the abuse of the elderly. Abuse is more in the case of those who are dependent on the kin's for support, have nothing or very little to contribute to the family either physically or materially, who are chronically ill and / or in constant need of care and who are widows. However, poverty, by no means, is the only cause of abuse though it is a major one. Old people are abused in affluent families as well. Abuse is also more from grand children and in laws than from own children. The major remedy in all cases is to make the old less dependent on the family, empower them through monetary or material grants, provide facilities for medical help.

Health and Nutrition

Many of the diseases of the old age could be considerably mitigated if not totally eliminated if proper knowledge of health care was imparted and appropriate life styles were adopted in younger years. We note that education on these aspects is absent even for the present youths. School syllabour should take care of this and public health authorities should carry the message of healthy aging. The school should especially drive into the minds of its pupils the basic principles of nutrition and health care. The present old people also need education on health and nutrition. The camp approach is quite appropriate for this. Either the community or government and voluntary agencies could organize these camps. They should be supplemented/reinforced by audio-visual publicity programmes.

Governments should subsidize the cost of medical services and medicines. Medical services should be geared to meet the special needs of elderly persons, in the context of general improvements in quality of care. Facilities and services should be made more accessible by providing more convenient infrastructure and administrative arrangements, for example, by designating special hours during off-peck periods for the care of the elderly so that they do not wait a long time for service. Medical services should be made more accessible by providing more convenient infrastructure and administrative arrangements, for example, by designating special hours during off-peck periods for the care of the elderly so that they do not wait a long time for service. Medical services should be accompained by appropriate information and counselling concerning the care provided.

Government should extend its health care services to the elderly, poor elderly, through primary health centres or similar grass-root agencies with extension service for the elderly who are unable to move out of their homes. There should be geriatrically trained nurses both for home services and for educating members of families with elderly even though they are sick or not.

Social Support

Various considerations of the cultural and ideological practice have econtributed to a broad spectrum of policies which provide social support to the elderly in Bangladesh. Though a wide range of

formal and informal practices are controlled by various socio-cultural groups, the traditional support systems now prevailed in Bangladesh, inspired by and evolving from two principal sources are (1) Islamic teachings, foremost among them the instituting of Zakat and Fitra (2) traditional practices of alms - giving (a traditionally determined expectations). The Holy Quran proclaimed various principles in support of the elderly. In many verses there are explicit commandment to show respect tot he elderly, treat them kindly and give them noble status in both family and community levels. These principles have had a far reaching impact on traditional values and practices. For instance, these commandments explain the important role played by the children in providing various forms of support to the elderly. But, due to mismanagement and undersirable practices these welfare systems have been embittered by numerous frustrations and tempered by various evil expectations.

Conclusion

In broad outline, this paper has shown that the proportion of the aged in Bangladesh will increase in the coming years and hence, their problems will assume added importance and impact on this agrarian society. It is true, many years before, the problems of aging in Bangladesh has reached the dimensions which the developed countries are facing at present.

The multi-dimensional implications of rapid growth of population aging are interrelated inherently with important and dynamic processes of demographic, psychological and economic changes encompassing all age groups of population at the household, community and national levels. Thus, there is a need to integrate the elderly in development planning in view of their wisdom, experience and linkage with the rapid changes in the socio-economic situation. Development policies and programs are required to take into account the rapidly changing social and economic scanearios both in rural and in urban communities. However, action relating to the elderly should not be taken at the expense of younger people.

In Bangladesh, the elderly are expected to be supported mainly by their family members (Kabir, 1991). The elderly have made valuable contribution to the overall national development through accumulated wisdom and rich experience during their active participation in labour force. Thus, it is the duty of their younger

relatives to recognize the previous contribution of the elderly and show respect and support to the elderly. In return for material support and mental satisfaction, the elderly should extent cooperation though their experience and knowledge for the well being of younger generation.

The aged population are the respected senior citizens of a country. Their needs and demands are different from other segments of the population. Thus, special policies are required for them.

Bangladesh is often faced with budgetary limitations, thereby it is not always possible to allocate money exclusively for this segment of population. Therefore, financial and material care of the elderly are left with their families. But the tradition system of joint family is breaking down with social changes. Changing trends in demography due to declining mortality rate and increasing life expectancy also sharply brings into focus the problem of aging in Bangladesh. In such a changing scenario, the government should take some measures to deal with the problems of aged population.

To address this situation, national, international, voluntary and community resources are being mobilized towards implementation of a decentralized, community managed, multidisciplinary and multi-sectoral programme of services for the health and welfare of the elderly.

The mandatory retirement age can be increased for the employed persons. The government should also introduce pension scheme or any sort of support scheme for the invalid day labourers and for the self employed at their old age. To meet the funds requirement, the government can collect ZAKAT and FITRA through instituting the same.

Qualified elderly may be absorbed in jobs as advisors and consultants to serve the dual objective of looking after them and sharing their technical experience and expertise with their younger colleagues. Time has come to look into such undertakings.

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Decay in the Family Dynamics of Interaction, Relation and Communication as Determinants of Growing Vulnerability amongst Elderly

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ABSTRACT

This conceptual paper traces the roots of vulnerability growing among elderly out of rapid changes in the dynamics of family, structurally and functionally. Structure refers to the type of family (i.e. joint, nuclear, extended) and functionally denotes to interaction, interpersonal relation and communication. The transition in all the three components of family is a serious threat for healthy ageing. Paper delineates that migration causes physical distance; and over the time, it reduces eliminates occurrence of interactions between potential care givers and elderly parents, a situation of interactional deprivation that causes psychological distancing (e.g. decay in emotional attachment, loss of expectations, unconcerned state of mind, reactions of different nature). Remote interaction through letter, phone, internet has its own limitation as far as emotional need satisfaction (ENS) of elderly is concerned. The paper emphasizes that psychological distancing is occurring in both joint and nuclear families. Circumstances emerging out of market driven

consumeristic culture are not in consonance with traditional and cultural realities. The age old traditional;, emotional and moral bondage and boundaries have already entered into risk zone, in the big cities particularly. Idiosyncratic behaviours and unconcerned attitudes in younger generation and youth towards elders are getting apparent. The need profile of elderly is unique and distinctive like women and children in the developing countries. Therefore, it is essential on the part of government to alter existing unfriendly attitudes and recognise elderly persons as vulnerable as women and children and creates infrastructure facilities accordingly. Preparing people for healthy ageing requires urgent and multifaceted initiatives on the part of government; obsession with the traditional heritage of family system as bacon of healthy ageing is denial to the rights of elderly. People need to be empowered to face irreversible developmental challenges of modernization and globalization of the world by changing the concept of old age planning and developing psychology for healthy ageing. The paper concludes that emotional vulnerability of elderly could be manged by preparing them in advance to take up physical distance of care givers as a reality and to remain productive to buy the quality care and emotional satisfaction from other than family members in case of vulnerable situations.

Keyword : Empowerment, Healthy ageing, Migration, Psychological distancing.

In the recent years, indignity, disgracefulness, embarrassment, dishonour, disheartening, disregard, indifference, injustice, lack of care, psychological torture and host of negative behaviours and attitudes are reflected in the society towards elderly. Millions of elderly are suffering emotionally from the growing phenomena of gross indifference, profit motive, selfishness and decay in the family system. Although family ties in India are still strong and an overwhelming majority of the old still live with their family members, the position of an increasing number of order persons is becoming vulnerable. In the present scenario they cannot take it for granted that their children will be able to look after

them when they need care in their old age; keeping in view the longer life span which implies an extended period of dependency (Reddy, 2003). In most countires of the world the older persons do not enjoy a decent status in society. This is all the more so in developing countries such as India which are economically poor and have been subjected to the ravages of demographic transition, migration, moderanisation, dwindling joint family, market economy, poor public health and hygiene and low social and income security (Ramamurthy, 2003).

The phenomena of individualism and collectivism in the behaviour of people are reshaping. The Indian society known for collective, normative and group-oriented behaviour is heading towards individualistic frame of living. The emphasis on individual choice of living and life styles regardless of its implication on the other family members is the demand of youth. Social and moral obligations for the care of others including elderly persons is deteriorating in the growing consumeristsic society. Elderly people are being thrown out from the ambit of family. More and more cases of divorce and dowry deaths indicating towards 'social malignancy' denotes decay of tolerance, living togetherness and care and concern for others. All these are living indices of idiosyncratic tendency growing in the modern society.

In the Indian social system, there is a rapid transition in the structure and functioning of family. The structure in the family refers to the type and functioning denotes to the dynamics of interaction, interpersonal relation and communication. These three dimensions are distinctive feature and not interchangeable. Healthy relations amongst family members grow only when healthy interactions amongst them are deliberately created and reinforced. Communication in the family is immensely contingent on the relations and interactions amongst the family members. The transition in all the three components is serious threat for healthy ageing.

The concept of 'family self' in the Indian context is traditionally conceptualized bigger than 'individual self'. In the bigger cities particularly, the interactional profile of the family members is changing; the thrust for 'individual self' is becoming stronger than 'family self'. Every member of the family wants to have his or her own choice of living. The youth particularly, has started asserting strongly for

individual self, and they are in great hurry to have every source of pleasure regardless of its legitimacy.

Market forces have already made its way in the Indian society. The social and cultural heritage of family as an institution of care of elderly has already entered into risk zone. The dynamics of relations in the family are undergoing unprecedented changes. Structural and functional dimensions of family are shaking to the family members. The emotional bondages, source of keeping family intact, united and forceful, are changing in both type of families, joint as well as nuclear.

However, the migration out of push and pull forces is stupendous source in devastating the dynamics of family. The migration as such, is not independent phenomena. It is only process, ways and means to hunt for a relatively good source of life. It is guided by motive for earning and developing. This process can not be reverted back no matter whatever cost the society has to pay. Because migration is reflection of the fact, that resources at place of birth are not sufficient to provide avenues for learning, earning and developing.

Permanent migration has got is constraints of time and resources. Therefore, all the children of one family for example, living at different places are bound to be away from the aged parents; and they can not make their presence at the time of need. In case of acute crises to the aged parents, children living far away visit their parents alone because of their own family constraints with which they are living; and they are bound to come back to their place of working and living. Such unavoidable circumstances are growing everywhere, in bigger cities particularly.

Village to town, city to city and country to country, all migrations lead to circumstances contrary to cultural realities of family as an institution to provide support and care to the elderly. Emotional deprivation resulting out of migration and break down of family system is serious threats to the ‘emotional health’ of the people, particularly elderly who had a taste of a quite different family system having strong bondage of emotional relations and care of each others. Migration is perhaps not only creating a physical distance among family member, it is equally causing emotional problem to which many of us may not realize at the moment. The general environment under the influence of

market oriented consumerist values is bound to have crack in the emotional paradigm of the family members. The satisfaction of emotional needs of the individual in the family requires closer interaction.

Elderly people are encountering both physical and psycho-logical distancing phenomena. In case of migration, mostly those who are bread earners go to distant places, somewhere-overnight journey and sometime two to three days by bus, train. First generation migrants generally make repeated visit to their parents and place of origin. As the time passes, their frequency to visit parents and place of origin reduces; it gets confined to very important function such as, marriage in the family. The interaction of elderly with family members drastically reduces on time scale of migration. Under such circumstances, culture of money order as economic support, letters, phones as somewhat emotional satisfaction survive. But it does not help aged parents. They face the consequences of both physical distancing and psychological distancing. Thus, interaction as an important component of family is loosing its root and causing enormous suffering to aged parents. Elderly like children demands more time of talking and sharing their emotions in addition to basic needs. But they are encountering deprivation due to 'physical distancing' between self' and 'care givers' and 'care providers.'

The psychological distancing is increasing in the family regard-less of migration because of several reasons. For example, life in big cities is fast; both men and women are out of house early morning and come late in the evening; they hardly spare quality of time with elderly. Families where individuality is a core value under the influence of consumeristic society, collective responsibility of providing quality care to the aged parents is gradually deteriorating. With a new mind set, every body, from child to young in family strives for individual freedom, prefer to live with individualized liking, thinking, living, eating and moving around etc.

Therefore, two major dimenstions of family i.e. concern and care need to be carefully elaborated in the context of care of elderly. It needs to be delineated from the point of care providers and expectations of elderly. The concern is generally depicted as a state of mind; it is rapidly changing. The care denotes to look after i.e. giving actual services to the

elderly. These two represent diferent dimension, which are crucial for healthy ageing. In case of physical distancing and reduction in close interaction between earning children and aged parents, both care and concern are very vital. Remote care providers, if possess strong state of mind for elderly, provide resources available for quality care. Except face to face interaction, which of course satisfy the emotional needs relatively more, quality care can be provided if the value related to care and concern are retained regardless of distancing. The glimpse of changes in the dynamics of can be traced from the selected tales of elderly persons being presented in subsequent paragraphs.

Mrs. Susheela (changed name). is a 71 years old lady, resident of Delhi, married and staying in old age have for the last five years. Her husband also stays with her. She is a graduate and held a government job in a hospital as administrative officer, before she retired at the age of 58 years. Her husband was also government employee and both are now pensioners. Her other members are a son and a daughter, both married and staying in Delhi with their respective families.

She left the house about seven years ago. She initially spent 2 years, in her brother's house (outside Delhi), then she came to live in old age home and was joined here by her husband who had continued to stay with the son's family. She described the circumstances preceding her departure from home as painful and complex; so much so that she wished not to talk about it. Recalling her earlier days when her children were young and they all stayed in government accommodation allotted to her, she said that she was very happy and contented. She had been engrossed in her duties as a mother and wife, providing the best of everything to her children, to the best of her abilities. She had never considered her "self-development" as an individual. Being a simple Indian lady (she presumes she must be one among so many) she had fullfaith in her husband regarding all her financial matters. She obeyed his advice in these matters as she had confidence in him and he took the decisions regarding purchase of property and investment; she even handed her salary to him. Her son was very ambitious and achieved success in his career very early in life. He married a girl of his choice, whom Mrs. Susheela knew for many years prior to their marriage. She was affectionate towards her daughter-in-law who had lost her parents as a teenager and she welcomed her daughter-in-law and her sisters,

who would often come and stay, in her house. In his school days her son was closer to her than her husband as the latter would be strict and unapproachable. She described both husband and son - as “egoistic” persons, who liked to enjoy luxurious life. Her son despises the “middle class, salaried folk.” After his marriage, unfortunately, his relation with her changed. She maintains close relationship with all relatives, specially her brothers (all three of them stay outside Delhi), who she consults in various matters. Due to some reasons, her son resents this. After her retirement, the relationship with her son worsened and her husband was to a large extent, responsible for this. She realized that her finances were totally controlled by her husband who was now dancing to his son’s tunes, because he was materially rich and influential. Without realizing the implications, she was persuaded into signing on property related documents and her husband sold the same, investing the returns in his own name. Her daughter-in-law resented her presence and did not help to improve her relationship with her son. The situation took a turn for the worse and her son manhandled her over property matters. Therefore, she left home, completely shaken and with her pension as her pension is her only support. Her health suffered, in the following years due to emotional stress. Now, she has lost faith in everyone, as her nearest relatives betrayed her. Although her husband stays with her, they are like strangers under the same roof - they pay room rent separately. Her monthly pension is her only income. She has no savings to fall back upon in emergencies. She hopes her husband will not desert her in such circumstance, on humanitarian grounds. After her retirement, her health deteriorated, she attributes this to constant, stressful situation in the house due to disharmony. She feels there is need for access to a specialist in orthopedics and cardiology, rather than general physician, for elderly inmates of the home. She responded affirmatively to the idea of a geriatric specialist’s services for the inmates.

She admits to have discovered many new aspects of her own personality after coming here. She has become a member of a religious group and attends daily meetings morning and evening - this is her most important source of peace and solace. She feels God has brought her closer to him, through sufferings. She has realizd the importance of developing oneself, as one cannot depend on others. She says home can never be replaced by institution. However, given her compelling circumstances, she has found security in the form of physical safety and

availability of help in case of emergency which is not the case if an old couple stays alone. She had never thought it necessary. Had she planned, she would not be in her present state. In retrospect, she thinks she should have saved as much as possible for her old age. As for advising others, she feels one should concentrate on having a good life oneself and not worry too much about future. She considers her good social network, during her lifetime, as an asset in her old age. She is in favour of awareness generation and counseling about post-retirement financial security for the old.

Mrs. Susheela has suffered abuse of psychological, physical and financial nature by her own family members. In her case, studies citing association between psychological distress and bodily illness, particularly in older people, is borne out well. Having been a victim of prolonged stress, she emphasizes the need for spiritual health and relaxation techniques like yoga and mediation, besides creativity (e.g. cooking). Inspite of illness, she is one of those elderly, who like to lead an active life. (Her lack of awareness and information well before one's retirement from job). She expresses fear and uncertain it regarding future social support, as there are no caregivers in sight. As long as she is mobile, health needs are being fulfilled. However, there is need for health security in advanced age. There is also a need for opportunity to work in the community as a volunteer in her areas of interests. Her greatest need is for love and respect from her son and of understanding from her husband. From her case, a need for counseling the family members emerges. Her confidence and trust has been hurt. She herself needs counseling for restroring confidence and for accepting her own responsibility for life. There is a broader need for community members to recognize and prevent elder abuse and respect the need for independence, participation and dignity of elderly.

Mr. Hemant Das (changed name) is a 75 years old man, resident of Delhi, married and staying alone in old age Home, for the last two years. His wife is alive and is staying with his younger son who stays abroad. Mr. Hemant is a commerce graduate and a retired pensioner, having served in a department under the Ministry of Education. He retired at the age of 58 years. Before coming to the Home, he had been staying with his neighbours or relatives for 5-6 years. He has two sons - younger one is doctor by profession and staying abroad with his family; older son is

staying nearby with his wife and three daughters. He was earlier staying with elder son's family in a house with three rooms. He had three older brothers, all deceased, at age above 85 years. The house mentioned above was allotted to to him as a government employee. He later got it transferred to his son's name as he is also a government employee. His wife was living with him, after he retired. About 12 years back, she agreed to her younger son's request to go abroad any stay with his family there. Mr. Hemant feels his position as an elderly member of the family was threatened from that point of time. Earlier he was the central decision-maker in the household matters and all others obeyed. His daughter-in-law, who now gained importance and independence, showed no regard to him as an elder. Mr. Hemant describes his daughter-in-law as an inconsiderate and unkind person, who is engrossed in pursuit of her own comforts, even at the cost of valuable issues like her daughter's education. She herself being an ordinary housewife, with high-school education, did not understand the importance of imparting higher education to her daughters who were not just meant for marriage according to him. He blamed the media (including literature, TV films with emphasis on material well being for the deterioration of value system of the younger generation.

His son is very obedient and God fearing, however he does not stand against his wife's decisions. Mr. Hemant was actively participating in household chores like fetching milk, escorting his grandchildren to school, shopping etc. He, however, sensed that his status was reduced to that of a domestic help, and his daughter-in-law was displeased with his presence. He had never asked for any material assistance from his children, whom he had given the best education possible, within his means but in his old age he was dependant upon his daughter-in-law for serving two meals a day. His daughter-in-law has a large number of siblings who came frequently. They stayed back often leaving him with no privacy or place to relax. His grand daughters are very fond of him as are many other children in his neighborhood and miss him even now. He had to leave home after serious arguments with his daughtrer-in-law in his son's presence.

For years, he was seeking shelter from his neighbors who were very helpful and understanding. He in turn tried to adapt in their houses

as a family member. Mr. Hemant never planned for the days after his retirement.

Mr. Hemant feels that the state should create more old age Homes in each city. He thinks such homes should have capacity for upto 200-400 people.

Case - II Sukhbinder 74 years aged, blessed with three sons, two daughters, living in middle of three floor building which he himself constructed during prime age, while narrating his life said, "Two sons are settled in his own home, one on ground floor, second on top floor. For two times meal, I get lunch on ground floor and dinner on top floor. I do not have any personal say; it is embarrassing life. I do not get even treatment of hotelier. I cannot offer even a cup of tea to any of visitors. I remain emotionally disturbed."

Case - III Ram Gopal while talking with friends in the Park said, "I have told my son and daughter-in-law that if they could give me dinner before 10 PM, it is alright, otherwise don't wake up if I sleep." Many times he sleeps without dinner, said Ram Gopal, family members remain occupied with TV serial.

Case-IV Shyam Sunder aged 78 was forced by his son to sign on the paper of property few years ago. After that scolding, blaming, abusing and giving bad treatment have become routine. Both son and daughter-in-law started tearing the aged father emotionally and forced him to live life in the car garage. His hand shakes, he tries to cook chapati sometime on his own and keeps on praying God to take his life.

Case-V An old lady Rukmani aged 60 have lost two young married sons. Both had died one from disease and another in accident. Both had left one child each. She has been nurturing both daughter-in-laws and their children. She has lost all the resources; she does not know what to do and started crying while talking.

Case-VI Sushma Devi aged 69 did not marry because she was the oldest amongst all three brothers, had to carry family responsibility due to untimely loss of father. She some how completed her graduation and opted for job in the government office. She poured all the resources in education of brothers. Two of them got scholarship after intermediate and completed their studies. They got good job. Sushma Devi is now

living a life of destitute and surviving on the food she gets from neighbours, nice people. She said, “All the brothers after their marriage have completely left me to live a life of destitute so far, I hardly manage my routine. I remain emotionally upset about the treatment from my brothers and their wives. They never threw me out of house, but they created scene of emotional torture - a sort of suffocating remarks, embarrassments completely unbearable. I don’t know where are they now.

Case-VII A riksha puller, Kumar, aged 35 years chatting while driving said, “we are four brothers, we all are living in one house; all have separate room. They all are separated, wife of each cook their own food and hardly share to each other. I am youngest, parents aged about 76 years live only with me”. Why I asked ? “My brother and their wives abuse and curse they force parents for division of land. I do not want; my wife is also not interested. All others are always pushing. Parents don’t like. They say, ‘what is that you all have done for us, we brought up with some hopes, with a great difficulty we had purchased land. Till we were capable we did agriculture and produced wheat, rice, fed you all, got of you married, after marriage you simply listen to your wife, you all don’t listen us and you abuse us, saying ye to budde ho gaye, enki budhi mar gayee Ab ye dono buk buk ke siva kutch nahi kar sakate’. (‘They have become old, they have lost their intelligence; they keepon shouting all the time, they can’t do anything).’ We will not give you anything till we are alive. My parents keep on saying ‘Ye kya Pariwar Hai’ (is it a family) said riksha puller whenever I am in the city I am always worried, we reached our destination.

A brief analysis of above mentioned cases :

Case I : Ambitious son of Susheela married with known girl with the consent of parents.

- He perceived interference from mother’s family of origin.
- He pressurized parents to hand over house in his name. Daughter-in-law fully supported the stand of husband and condemned mother-in-law for her resistance.
- Mrs. Susheela feels cheated by husband because he acted on the tuning of son.
- She strongly feels that her son and husband had led her down.

- Many episodes had happened after the property was handed over, and all these spoiled warm relation that existed in the family.
- Out of her humiliation, she opted for old age home.
- She feels threatened for future but somehow believe that her husband may not ditch her during emergency.
- She feels that knowledge for old age planning and preparedness might have helped her to retain her house in her name
- She never expected that her own son would torture her.

Case II : The privacy of Mr. Hemant has come into question by a large number of siblings of daughter-in-law who visit quite frequently and stayed back.

- Frequent serious arguments with daughter-in-law in the presence of son became base of humiliation.
- He feels that his status was reduced to that of domestic help.
- Daughter-in-law expressed her unhappiness about his presence in the family and questioned even his best possible help like fetching milk, escorting grand children to school and a little bit shopping etc.

Case III : Sukhvinder remains emotionally upset with the type of arrangements of two times meal. He feels that he is reduced to the extent that he can't even offer a cup of tea to his visitors.

Case IV : He is ignored completely. He feels that he can't even get food when he wants. Sometimes he sleeps without dinner.

Case V : The person had lost his position in the family complectely after he signed on the property papers.

Case VI : The case of lady is unique due to loss of both the sons and husband. She feels all the resources are exhausting. She said, "I don't know what will happen to me. I am left with no resources, all the time I am upset "thousand**s** and thousands are suffering with such type of problem.

Case VII : The unmarried women now destitute disowned by the brothers who grew and studied with her resources situation.

Case VIII : The case of Mr. Kumar represents how selfish motive, indifferent attitudes and right to claim the land of father have made the situations of rural elderly vulnerable.

A brief descrition of case studies provides glimpse of changes that are occurring in the family and effects the dynamics of relations, interactions and communications. These case studies tend to suggest how 'motive for self' is over riding the family, which is sole base of healthy ageing. In the big cities, many elderly couples are living a life of loneliness. They sometime get solace on phone from children living away/ abroad. Some of them are resourceful to buy care; and they pay for all the services. For them, the money is not issue. They are emotionally disturbed. Sunderdas said "I never imagined this; what for I sacrificed for children"? Instead of my problems they narrate their own problems on phone; they express their own helplessness. Mr. Sharma aged 73 said, 'Hell to children; they don't think about us; I do not know what to do ? When I need somebody, there is none. Millions of aged persons in villages are also living on the mercy of neighborhood. Their children have migrated to cities. There is nobody to take care. For few yeas, they get money order; this too stops coming when their sons migrate permanently along with their wife and children.

Severity of problems need to be studied on several dimensions. Demographic profile is one of it. It talks of number; it is valuable to knock the door of planners. (The growing number of elderl is likely to decline; and life style disease would become major source). Amongst all the diseases, emotional and mental health problems are penetrating in every house; the worst sufferers in the society are elderly people. It is related to new pattern of living.

Under such circumstances, what should be responsibility of government ? Is it right to depend fully on family tradition as a strong base for healthy ageing ? Or it should take up the note of emerging individualism, a sort of egocentric concept and imitate a new approach of managing the problems of millions ? How an age old values for elderly could be retained ? Whether millions of children while going through the socialization process and education should be given mind of providing quality care to their elderly ? Whether government should think that the problems of aged are not subject of welfare ? They need to be recognized as potential human resource, multipliers of nation's

developmental endeavors. If the process of dishonouring, disowning, degrading maltreating, pushing them to a life of vulnerability continues, and nothing substantial is done by the government the situation in coming years would be unprecedently complicated.

Aged are suffering emotionally from the growing phenomena of gross indifference, profit motive, selfishness, loss of family traditions in the society. Government spends millions on health problems. Under the arena of public health, highest priority has been given to women and child from the day one, and created the health system accordingly due to (a) the dominance of disease and (b) vulnerable section of population suffering with the diseases and dying into millions. The population of elderly was negligible at the time when planned programmes, started in this country. But the situation over the decades has changed; were and the population of elderly has reached around 80 million. i.e. about 8 per cent. The rapid migration is depriving millions of aged from essential care; and it is aggravating the complexity of the problems of elderly. Therefore, why elderly should not be treated as a distinctive group like women and children ? What is justification of ignoring a huge population of elderly ? Can we not think of elders empowerment and sound old age planning ? Can we not think of how children should be socially made responsible for healthy aging of parents ? Can we not design some regulatory mechanism to ensure responsible care of elderly ? Could it not be linked with the property right and career of their children ? How much health issues of a huge section of elderly could be dealt under shadow of old age home and 'old age care' ? How much human resource meant for managing the health issues of elderly are really trained ? India needs a multi-tiered structure of social security that already exists in a rudimentary form and needs to be expanded and strengthened (Subrahmanya, 2002). It needs to redraft national policy for health ageing and complete restructuring of existing health infrastructure facilities to make it elderly friendly. More than anything younger generation and youth need to be given mind set for the quality care of elderly; the natural rights of children on the parents property need to be linked with the quality care and healthy ageing of the elderly, which requires new legislation.

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Old Age Pensioners : A Socio-psychological Study

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ABSTRACT

The study was planned to understand the socio-psychological and economic conditions and level of depression among old age pensioners. It was carried out in Shahabad town and few villages of Gulbarga district in Karnataka state with a sample of 112 old age pensioners. The results showed that marital status, domicile, nature and composition of family, annual income, style of living, social contacts, having friends, involvement in decision making, adjustment with old age, feeling or isolation, time activities, recreation, sufficiency of food, satisfaction of needs, savings and feeling of insecurity had a bearing on geriatric depression. A non-signficant association was observed between geriatric depression and age, education,

gender, religion, nature of work, performance of rituals and intergenerational conflict.

Keyword : Old age pensioners, Geriatric depression, Intergenerational conflict, Adjustment, Social-participation.

The traditional welfare institutions and higher socio-cultural values of Indian society stress respect and provision of care for the elderly. The aged in the families were generally taken care of by the family itself (Raju, 2002). The religion caste groups and caste panchayat system looked after the welfare of the aged. During the unable conditions, they were protected, respected and taken care of even when they did not own property and assets, due to existence of higher socio-cultural values such as, non-materialistic approach, unselfishness, etc.

Increasing industrialization, modernization and urbanization have had a negative impact on the traditional welfare instituions and higher socio-cultural values (Mishra, 1979). These have resulted in deterioration of joint families, migration of childern in search of jobs, growing consumerism and communication facilities, etc. The absences of higher socio-cultural values have given way for materialistic approach, individualism, selfishness, etc., and thereby the life of elderly becomes vulnerable (Arora, 1993). Depression and emotional shocks are common among the aged. They feel isolated and side tracked by the society (Bajpai, 1998).

To be happy in old age one need to have sound health as defined by World Health Organization. The variations in one or more aspects have a bearing on the problems of human beings in general and the aged in particular. When we speak in terms of the aged, they need to have good social, physical and psychological health to have better living and greater life satisfaction.

The modern system of controlling diseases have lengthened people's longevity and reduced old age mortality (Mahanta, 1993). Males are expected to live 17 years beyond the age of 60 years and 10 years beyond the age of 70 and the corresponding year for females is 18 and 11 years respectively by lesser people to take care of the aged in the forthcoming years. Majority of the aged live slightly above (33%) and just below (30%) the poverty line. A

predominant proportion of the aged (80per cent) are living in rural areas and majority of the (73per cent). Among the aged women, 55 per cent are widows and most of them have no social support, whatsoever.

Present conditions become vulnerable for the aged, because on one side the traditional welfare institutions are deteriorating and on another side the population of the aged is increasing rapidly. There is a big gap between the problems of the aged and the available resources. The attempt made by the government and non-governmental organizations are nothing compared to the needs. It is to be noted that the psychological needs of the aged are largely excluded and the conditions of aged becoming increasingly vulnerable, not because of physical disabilities, but due to socio-economic, psychological and health related issues (Raju, 2002). The media takes note of the problems and issues of younger persons / youth, etc., but they neglect the concerns of the aged.

The National Policy on older persons trusted on the pre-retirement counselling, mental health services and other such services, etc., with regard to psychological aspects. Considering social needs, it aimed to develop and promote family values, short stay facilities and counselling services to sensitising younger generation for intergenerational bonding to strengthen and to resolve inter-familial stresses (Tyagi, 2000). Further, it has been suggested to provide, rebate for medical expenses and preference in allotment of houses to the children who co-reside with the aged parents.

Income security is prioritised for the aged, by elaborating public distribution system (PDS) and old age pension to cover all aged below the poverty line. It is suggested to revise the rate of monthly pension at regular intervals. Further, the taxation policy is proposed to be made sensitise. The looking at financial problems of older persons to meet increasing cost of medical care, nursing care, transportation, etc.

The National Old Age Pension Scheme (NOAPS) was introduced on 15th August 1995 under the National Social Assistance Scheme. Many States give the lowest pension amount of Rs. 60/- per month, while the State of West Bengal Pays the highest amount of Rs. 300/-. The Government of India introduced Annapurna scheme

on 19th March 1999 as another social assistance scheme. This scheme was aimed at covering those destitute who are otherwise eligible for Old Age Pension Scheme. In Karnataka this scheme is yet to begin (Rajan, 2001).

Voluntary organisations are given grant-in-aid to start old age homes. Concession is given to travel by train and flight by some States under Senior Citizen Scheme. Further, voluntary organisations are extending services for the aged such as, care centres, health-care geriatric care, voluntary home visiting, recreation, etc. (Gopal,1987)

Globalisation and economic liberalisation have had a negative impact on the traditional welfare institutions and higher socio-cultural values. Each of these institutions is being put at risk. The structural adjustment policies (SAPs) imposed on countries in economic difficulties by the International Monetary Fund and to a lesser, degree, the World Bank, have made these countries subject to the whims of multinational capital cut, protection for home industries, increased pollution threatened health and education and imposed public expenditure cuts. The collapse of local industries, disruption of agriculture, over-rapid urbanisation has only been accelerating the rates of poverty. The problem remains that safety nets are no substitute for sustainable social and human devlopment and until social solidarity is seen as more important than market freedom, globalisation will continue to be a threat to all who are old and poor (Wilson, 2000).

As stated earlier, the increasing processes of industrialization, modernization and urbanization have had a negative impact on traditional institutions. Patil (2000) finds signficant positive relationship netween social relationship, leisure time utilization and social security. Mahanta (1993) finds that education plays an important role as a determinant of the life-pattern and social status of the aged. Muttayya and others (1992) reveal that the aged perceived their importance in taking up family responsibility, being key decision maker and attending to household work. Ramamurthy (1970) explores that the aged persons living in joint family feel less lonely. He\she feels more secure due to the peculiar nature of the emotional and familial ties of the joint family. Barnabas (2001) says that earlier, the elderly dominated the informal panchayats. Further, he stated that positive partcipation of the elderly in various

organizations could provide an arena for the aged to contribute for the welfare of community.

The incidence of mental illness among older people tends to be much higher. The psychological problems encountered by people retiring from the formal sector tend to be much wider, and their impact on individuals is substantially different from that of those in the unorganized sectors. (Mohanty, 2001; and Raju, 2002). Gupta and Shankar (2002) say that the aged men spend their leisure time mostly in gossiping with their counterparts with whom they can share their sorrow and happiness at various places like village tea stalls, meeting pendals, etc. There is also a good number of aged men as well as women who simply sit at home and spend their time (Mohanty, 2001). Kariguda (2001) reveals that the problems of older women are not due to the ageing process. They are the results of the subordinate status of women through their life cycle.

It has been observed that the lower cohort of the aged had greater life satisfaction than their counterpart (Revati and others, 1993). The income and education have influence on life satisfaction either directly or indirectly. (Ballesters, 2001). The good psychological status and level of life satisfaction have a bearing on the problems of the aged. It is to be noted that the psychological problem for the aged is caused by a number of factors (Sonar, 2001; and Jaiprakash, 2000). Patil (2000) finds that the age had a significant positive relationship with psychological distress and significant negative relationship with attitude towards physical changes. Singh (1999) reveals that the aged male have got more liberty. power and privilege than females in tribal community. Chadha (1997) defines psychological ageing as the decline in the intellected and creative capabilities, personalities, potentialities, decrease of adaptive and survival skills, lack of flexibility, etc. Mental health of older persons is influenced not just by ageing changes in the body and brain, but by socio-economic and psychological factors as well (Jamuna, 1998).

There are evidences from the entire world that poverty and exclusion remain the greatest threats to the well being of older people (Shankardas, 2002). India, with its predominantly agrarian based economy has inadequate social security provisions for its older people. The concept of social security implies that the state should

make itself responsible for ensuring a minimum standard of material welfare to all its citizens (Jaiprakash, 1999). Mahanta (1993) finds that the aged from lower age cohorts have more property than their counterparts. Ramamurthy (1970) points that in case of the aged belonging to urban community, the economic stability for them directly contributes to the availability of better facilities in life, which makes life more pleasant. Muttayya and others (1992) in their study fond that, about one third aged do not have any monthly income of their own. Patil (2000) reveals that low level of income is responsible for dissatisfaction, health status and the level of depression amoung the elderly. Barnabas (2001) point out that only 10 percent of working population has means of old age security and that two-third of the elderly still need to be economically active indicates the need for income generation programmes.

Older widows are one of the most vulnerable groups needing special attention (Raju, 2002). Other vulnerable groups are the aged men and women who are disabled, frail, destitute and orphan, those who still try and work in the unorganised sector like landless agricultural workers, small and mariginal farmers, artisans in the informal sector, unskilled labourers on daily casual or contract basis, migrant labourers, informal self-employed or wage workers in urban sector, and domestic workers. The aged who are destitute and orphan, naturally face myriad of problems due to poor socio-economic conditions that ultimately results in mental stress and depression. Thus there is a need to study the socio-psychologial and economic conditions of the old age pensioners.

Objectives of the Study

The study intended to understand the socio-economic and psychological conditions of the old age pensioners in a town and few villages of Gulbarga district of Karnataka State. Further, this study attempts to understand the living conditions of the aged and trying to inolve possible social work intervention.

Hypothesis

It was hypothesized that the socio-psychological and economic variables have a bearing on geriatric depression.

Methodology

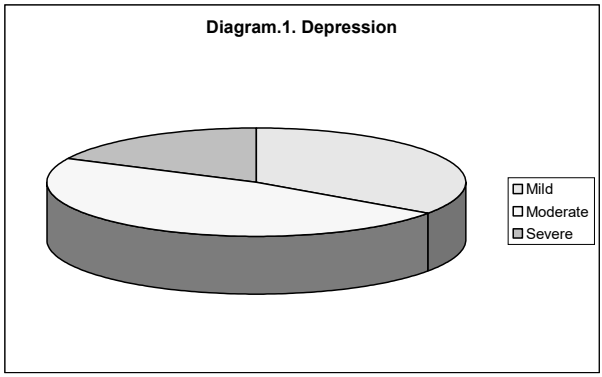
To satisfy the objectives of the study qualitative and quantitative methodologies were employed. The Deputy Tehsil Office of Shahabad town provided the list of the old age pensioners residing in Shahabad town and surrounding villages during the year 1997-2001. A total of 146 old age pensioners were identified. Among them 112, i.e., 23 males and 83 females were available at the time of face-to-face interview and the remaining 34 could not be found because a few of them have migrated while a few others are no more alive. To collect the information on socio-economic and psychological aspects, an interview schedule was prepared keeping in mind all the necessary parameters such as living arrangements, nature of family, family composition, housing, religion, social relations, nature of work, income, leisure time activities and socio-psychological and economic problems of the aged. Further, to measure the level of depression amoung the aged the geriatric depression scale (GDS 20) was employed. The scale contains 20 items, developed and standardized by Dr. Adarsh Kohli and Dr. S.K. Verma. The scores of the scale are categorized into mild (0-6), moderate (7-13) and severe (14-20) level of depression. The statistical analysis was employed to work out the frequnecy distribution tables, cross tabulation, pie diagram, mean and chi-square by using computer to analyse and test the association between the socio-economic and psychological indicators and geriatric depression.

Results and Discussion

The demographic findings of the study are that out of 112 respondents, majority of them are aged between 60-64 years, illiterate, females and living in semi-urban area. With reference to sociological characteristics, majority of the respondents are identified as hindus, and widow/widower and living with children/relatives. Most of them are living in (Joint) medium size of families (members between five and six). Further, most of them do not have friends, not involved in decision-making and not satisfied on social contacts. Also reported as they involve more inrituals.

While revealing psychological aspects, most of the aged reported that they are not well adjusted with old age and rated their life as tolerable. Further, they are not participating in leisure time activities, not getting recreation and feel isolated. Also reported that they do not have intergenerational conflicts. The economic characteristics of the respondents reveal that, majority of them do not have work to do or are not able to work and have an annual income up to Rs. 2400/-. Most of them have no savings and feel insecure and dissatisfied. Even although they getting food but it quality is very poor.

According to the GDS 20, of the total subjects 34.83% had mild, 47.32% had moderate while about 17.86% had severe kind of depression.



To see the association between the geriatric depression and other selected parameters, the chi-wquare test was applied. The variables such as, domicile, marital status, living arrangements, annual income, nature of family, family composition, satisfaction on social contacts, having friends, involvement in decision making, adjustment with old age, feeling of isolation, participation in leisure time activities, recreation, sufficiencyof food satisfaction on needs, savings and feeling secure are found to have significant association with geriatric depression. The aged living in semi-urban areas, widow or widower,living alone, have less income; those living in nuclear family (members between two to four), do not have social contacts and friends, not involved in decision making, not adjusted with old age, belonging to Hindu religion, feeling isolated, do not

participate in leisure time activities, do not have recreation, rated life as pitiable, do not have sufficient food, not satisfied on economic needs, not saved anything and feel insecure more depression than the others.

The variables such as, age education, gender, religion, nature of work, performance of rituals and intergenerational conflict are found to have no bearing on geriatic depression (See Table-1). The reason for non-significant association between age and geriatric depression may be due to more coverage of semi-urban respondents. It has been observed that the depression varies even within the different age cohorts, and it increases as the age increase.

Education is also found to have non significance association with geriatric depression. much variation of depression is observed within the ged who are literate and illiterate. This may be true because the aged living in urban or semi urban areas get better exposure, formally or informally, due to the availability of better infrastructure, communication, etc.

The gender difference does not have bearing on geriatric depression because, the problems for the aged irrespective of gender is mostly due to poor socio-economic, psychological, health and physical conditions. The religion and performing rituals have no association with the geriatric depression because, the respondents from the entire religious group studied are found to be more religious and perform rituals and bhajans. Belief in God leads them to have a will power, which makes them able in redressal of stress and depression.

The nature of work also does not have any bearing on geriatric depression. Most of the respondents enrol themselves in some kind of activities. They are tied with physical and mental activities. These in many cases make them not isolated and depressive. The intergenerational conflicts do not have bearing on geriatric depression may be because of the kind of respondents covered under the study. Since the respondents are destitute and orphan, due to poor socio-economic conditions they struggle for basic needs and they may not able to concentrate on intergenerational conflicts even when they exist.

Table 1

Assocation between Geriatric Depression and Other Parameters

Sl. No.	Attributes/ Variables	ψ^2 and level of of significnace	Result
	Demographic		
1.	Age	4.794/0.309	Non-significant
2.	Education	3.314/0.191	Non-significant
3.	Gender	1.037/0.595	Non-significant
4.	Domicile	23.505/0.000	Significant
	Sociological Variables		
5.	Marital Status	6.345/0.042	Significant
6.	Religion	4.912/0.296	Non-significant
7.	Living arrangements	30.679/0.000	Significant
8.	Nature of family	24.262/0.000	Significant
9.	Family composition	48.133/0.000	Significant
10.	Worshiping God	1.911/0.385	Non-significant
11.	Satisfaction on social contacts	54.027/0.000	Significant
12.	Having friends	57.413/0.000	Significant
13.	Decision Making	25.100/0.000	Significant
	Psychological variables		
14.	Adjustment with old age	12.408/0.002	Significant
15.	Feeling isolation	16.535/0.000	Significant
16.	Intergenerational conflict	1.713/0.425	Non-significant
17.	Leisure time activities	19.608/0.001	Significant
18.	Recreation	19.564/0.000	Significant
19.	Rate of Life	21.664/0.000	Significant
	Economic Variables		
20.	Nature of work	10.630/0.101	Non-significant
21.	Annual Income	27.262/0.000	Non-significant
22.	Sufficiency of food	50.120/0.000	Significant

23.	Satisfaction on needs	18.940/0.001	Significant
24.	Savings	13.204/0.010	Significant
25.	Feeling insecure	26.038/0.000	Significant

Conclusion

The socio-psychological and economic conditions of the old age pensioner are more vulnerable than the others. The social status is declining. They feel isolated, insecure, and neglected and rated life as pitiable. The poor economic conditions also made their life vulnerable. These conditions increasing more risk of depression among the old age pensioners.

Society and family members generally neglect the health of the aged.They feel the expenditure made for their health will be a waste investment. Many feel that physical and psychological problems of the aged are common due to old age. As observed earlier the impacts of globalisation and liberalization of economy have disturbed the traditional welfare institutions and higher socio-cultural values. The conditions for the aged become vulnerable. Mental health is ignored even by the aged for various reasons. The health care system is inadequate, inappropriate and expensive, especially the services related to mental health. This may discourage old people or their families from seeking assistance in coping with mental and emotional illness.

Gerontological Social Work is an area that has not been able to establish its identity in the country. Medical and Psychiatric social work as a specialised area of social work, needs to have significant role to tackle the problems and make a bridge between the health, socio-psychological and economic needs of the aged and existing resources. Social workers perform nine-fold roles in the family and institutional settings, that of an advocate, evaluator, broker, mobilizer, teacher, behaviour changer, consultant, community planner and care giver, to help in improving the social adjustment of the aged in the changing society. Further, the organizations working for the aged need to have professional social workers for better kind

of problem solving interventions. Para-professionals, volunteers and professionals serving in the agencies for the aged, need to have some training.

There is an immediate need for social work intervention to help the aged to overcome general socio-psychological and economic problems, in particular. To work with the aged, the Social Case Work method can be used effectively by using counselling, and other techniques to redress their problems. Further, the group work method may also help to deal with the problems of an aged individual in the group. Further, there is a need to have counselling centres with specialised counsellors exclusively for the aged. It is pertinent to note that there are no geriatric wards in government hospitals, and there is a need to have geriatric wards having specialised professionals with psychiatric and medical social workers. The aged are honourably called senior citizens. Only by calling them as senior citizens the honour does not come, it should come actually by providing a proper treatment to the old. All old are not useless. Hence, the potential and the experience of old men should be used for the development of the society.

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Health Problems of Elderly - An Intervention Strategy

Sushma Batra

ABSTRACT

The present study aims to study the health problems of the elderly belonging to varying socio-economic backgrounds. As the health problems are likely to increase with age, it has been taken as stratification variable. The elderly of both the sexes have been covered in the study. The findings of the study have been discussed with two-way tables using age or sex as one of the variables. Based on their need and nature of medical treatment being taken by them an attempt has been made to develop an intervention strategy to improve the health of the elderly.

Keyword : Elderly, Health problems, Intervention Strategy, Medical Treatment.

Gerontology has developed as a new discipline and is fast becoming a subject of great importance all over the world. It has attracted the attention of health planners, economists and demographers alike as there has been a steep rise in the world population of people aged 60 years and above in the last five decades and the demographers are predicting a steeper rise in the coming years. In 1990, developing countries had only 6.9% of population aged 60 years and above as compared to 17.1% in developed nations. It has been projected that compared to the 1990 figures, developing countries like India, China and Mexico will witness 200-280% increase in the population of the elderly by 2025, while in developed nations, there will be only an increase of 33.65% (Legare, 1993).

The change in the demographic picture can be attributed to lowering of birth and death rates and increased life expectancy. This positive out come is due to improved knowledge about preventive and curative health care, availability of health services to larger segments of population through both public and private agencies and improved delivery system. Thus, the dream to live long is now becoming a reality. Paradoxically when this dream is coming true, there are problems that arise and overshadow the joys of longevity and affect the social, economic and physical well being of individual, families and the societies in which they live.

The developed countries are in a position to meet the challenge but the developing countries are facing a resource crunch on one hand and rising unemployment, urban migration and population overgrowth etc. on the other hand. Hence, it is not going to be an easy task to provide proper health and fulfill other needs of the growing number of elderly, unless strategies and approaches are evolved that are cost effective and sustainable.

Ageing is a physiological process which is associated with progressive degeneration of all the organs and tissues of the body. The rate at which degeneration occurs does not strictly follow the

chronological age. There are ethnic, racial and genetic differences amongst individuals. The biological age and chronological age do not show any correlation, although they are closely related to each other. As age advances, the health problems tend to increase with age and often the problems aggravate due to neglect, poor economic status, social deprivation and inappropriate dietary intake, which often results in multiple nutritional deficiencies (Khan, 1995; Kumar, 1997).

In the later years of life, arthritis, rheumatism, heart problems, high blood pressure and diabetes are found to be the most prevalent chronic diseases affecting people. The poor elderly attribute their health problems on the basis of easily identifiable symptoms like chest pain, shortness of breath, prolonged cough, breathlessness/ asthma, eye problems, difficulty in movements, tiredness whereas the upper class elderly mentioned blood pressures, heart attacks and diabetes which are mostly diagnosed through clinical examination (Siva Raju, 2002).

Also there appears to be a relationship between the socio-economic status and health of an individual. The socio-economic parameters include economic, educational, cultural, age, sex, and occupational status. However, despite medical services being available at government health centres and hospitals, they are not easily accessible to the poor due to long distances, costs of treatment and time constraints. Many a times, they have to be contented with the services by unscrupulous doctors and comprise on the quality and cost of treatment (Mallya, 1996).

Thus, it is observed that health is not only biological or medical concern, but also a significant personal and social concern. Though the fact that majority of the aged are more susceptible to sickness, it is not denied or disputed that society generally considers old age unproductive. Due to this, the researcher found it essential to identify the health problems of elderly belonging to different age groups/socio-economic groups.

The present study has been divided into four sections. Section I gives the introduction of the problem. Section II explains research methodology used in carrying out the study. Section III deals with results followed by discussion. In this section the findings are described under the given domains by using tables and graphs and in the last section, an attempt has been made to evolve a plan for intervention.

Research Methodology

Objectives

The objectives of the study were to:

- Identify the health problems of the elderly. The variables with which they were associated included sex, religion, marital status, economic status, and self-perception.
- Type of medical treatment being undertaken by the elderly and the problems faced by them.
- Intervention strategy suggested to improve the health of the elderly.

Scope

The scope of the study was confined to NCT of Delhi. Thus the problems of elderly living in rural areas could not be studied.

Sample Design

The sample consisted of 150 males and 150 females belonging to two age groups less than 70 and more than 70 years.

- The sample was selected by non-probability sampling method using quota-sampling technique. Thus the stratification variable was age of respondents. The quota consisted of equal number of males as well as females. In order to give a wide coverage geographically, from each family only one elderly person was selected.

Tool

The main tool used for data collection was a semi-structured interview schedule. It was constructed after reviewing the past researches on elderly conducted in India covering the various health aspects.

Analysis

Quantitative analysis was used to calculate frequency within each domain. An attempt was made to construct two-way tables using age or sex as one of the variable. The data was used to present the results in a descriptive manner and evolve the strategies for intervention to improve health status of an important segment of our population i.e. elderly.

Results and Discussion

Table – 1 : Socio-economic Characteristic of the Elderly

Dimension	Males (n=150)	Females (n=150)	Total (n=150)
Age Distribution			
<70 years	75	75	150
>70 years	75	75	150
Total	150	150	300
Religion			
Hindu	80	89	169
	(53.33)	(59.33)	(56.33)
Muslim	30	26	56
	(20.00)	(17.33)	(18.67)
Sikh	15	15	30
	(10.00)	(10.00)	(10.00)
Christian	25	20	45
	(16.67)	(13.33)	(15.00)
Total	150	150	300
	(100.00)	(100.00)	(100.00)
Marital Status			
Currently Married	96	53	149

	(64.0)	(35.33)	(49.67)
Never Married	17	34	51
	(11.33)	(22.67)	(17.00)
Widow/Divorcee/ Separated	37	63	100
	(24.67)	(42.00)	(33.33)
Total	150	150	300
	(100.00)	(100.00)	(100.00)
Educational Status			
Illiterate	20	46	66
	(13.33)	(30.67)	(22.00)
Middle	25	20	45
	(16.67)	(13.33)	(15.00)
Matric	27	15	42
	(18.00)	(10.00)	(14.00)
Graduation	28	30	58
	(18.67)	(20.00)	(19.33)
Post Graduation	32	35	67
	(21.33)	(23.33)	(22.33)
Higher study	18	4	22
	(12.00)	(2.67)	(7.33)
Total	150	150	300
	(100.00)	(100.00)	(100.00)
Economic Status			
Lower	46	52	98
	(30.67)	(34.67)	(32.67)
Medium	59	63	122
	(39.33)	(42.00)	(40.67)
Higher	45	35	80
	(30.00)	(23.33)	(26.67
Total	150	15	300
	(100.00)	(100.00)	(100.00)
Occupational Status (Past)			
Self employed(Business)	55	10	65
	(36.67)	(6.67)	(21.67)
Employed (Govt./Semi Govt. /Public Servant)	68	50	118
	(45.33)	(30.33)	(39.33)

Employed (Private)	27	20	47
	(18.00)	(13.33)	(15.67)
Housewife	-	70	70
		(46.67)	(23.33)
Total	300	300	300
	(100.00)	(100.00)	(100.00)
Occupational Status(Present)			
Presently working	60	10	70
	(40.00)	(6.67)	(23.33)
Presently not working	90	70	160
	(60.00)	(46.67)	(53.33)
Now worked	-	70	70
		(46.67)	(23.33)
Total	150	150	300
	(100.00)	(100.00)	(100.00)

Socio-economic Characteristics of the Elderly

The sample consisted of equal number of elderly males and females (n=150). Out of this total number, in each category, 75 were below 70 years and the same number were more than 70 years of age. This was purposefully done to study the change in the nature of health problems with increase in age.

Religion

A majority of the respondents were Hindus (56.33%), followed by Muslims (18.67%), Christians (15%) and Sikhs (10%). The same pattern was exhibited in both the sexes.

Marital Status

A majority of the respondents were currently married (49.67%). The females who never married or were widows/divorcees was comparatively more as compared to males.

Educational Status

Except 22 percent respondents who were illiterate the rest were literate or above. Gender wise distribution of data showed that

illiteracy amongst women was very high (30.67%) as compared to their counterparts (13.33%).

Economic Status

Although economic status is a very relative term but for the purpose of the present study income of the elderly was taken as the parameter to determine the economic status of the respondents. Those whose income was below Rs.3000 per month were considered as belonging to lower economic strata, those whose income varied between Rs.3000 and Rs.8000 per month were considered as belonging to medium economic strata and those whose income was greater than Rs.8000 per month were undertaken in the category of higher economic groups. As per the data except one-fourth of the respondents, the rest of them belonged to lower/medium economic group.

Occupational Status

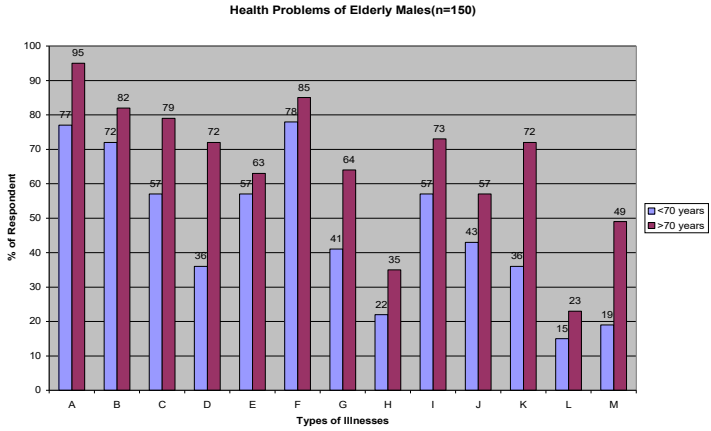
Nearly 50 percent of the women were housewives. The remaining were employed in Government/Private sector. Only a negligible percentage of them (6.67%) were self employed. Those women who were self employed were either running tailoring units or were involved in small-scale business at their residences. However in the case of men nearly 45 percent were employed in government/semi government/ public sector. Only 18 percent were employed in private sector. The 36 percent of males who were self-employed were mostly involved in their business.

However, at present, 40% of the males were still working whereas 60% had stopped working due to prevalence of poor health. Ten women who were working in the past continued to work at present also since they were either divorced/never married and had no stable source of income. They belonged to poor economic status.

Health Aspects

Figure I depict the age wise distribution of health problems faced by male respondents and figure II gives the health problems faced by female respondents. From figure I, the comparison of males

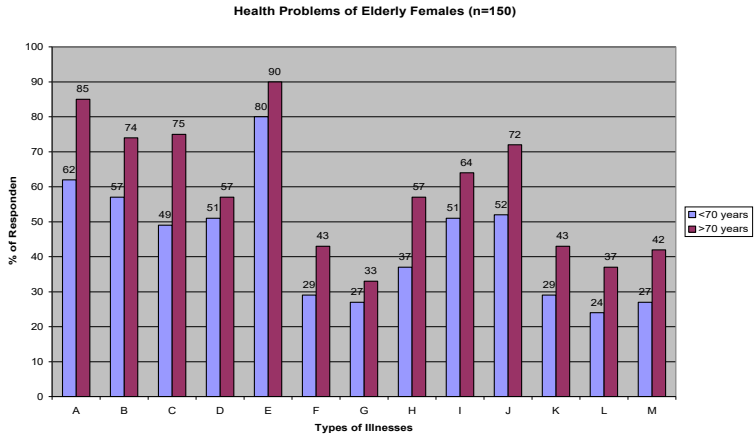
in two age groups show that with increasing age the frequency of elderly suffering from nearly all the ailments of all systems show a hike. These are diseases of the digestive system, respiratory system, circulatory system, renal system, nervous system, musculo skeleton system, Serious Ailmentsskin and subcutaneous system and diseases of sense organs. The number of mental disorders of various types also went up from 41 percent to 64 percent. It is significant to note that the persons suffering from serious ailments increased from 18.67 percent to 48.67 percent when they were 70+ years old.



(Figure-I)

Diseases of

A – Digestive System
B – Respiratory System
C – Circulatory System
D – Nervous System
E – Musculoskeletal System
F – Skin and Subcutaneous Tissues
G – Mental Disorder
H – Infectious and Parasitic Diseases
I – Endocrine and Nutritional Disorders
J – Diseases of Sense Organs
K – Diseases of Renal System
L – Cancer of Various Types
M – Serious Ailments



(Figure-II)

Diseases of

A – Digestive System
B – Respiratory System
C – Circulatory System
D – Nervous System
E – Musculoskeletal System
F – Skin and Subcutaneous Tissues

G – Mental Disorders
H – Infectious and Parasitic Diseases
I – Endocrine and Nutritional Disorders
J – Diseases of Sense Organs
K – Diseases of Renal System
L – Cancer of Various Types

Similarly amongst females also there was an increase in the frequency of respondents suffering from various diseases of all the systems. The significant variation in males and females was that nearly the entire group of females suffered from diseases of musculo-skeletal system. It increased to 90 percent after they were 70 years old. The mental disorders amongst females only showed steady rise from 26 percent to 33 percent after they were 70+ years old. The infectious diseases and the diseases of sense organs were also more prevalent in females with the increase in age. The diseases of circulatory system also showed a steep rise in females (49.33% to 75%). The diseases of nervous system did not increase as they rose in the case of males. Another significant aspect to be noted is that nearly 1/3 rd of females and 1/5th of males developed cancer after 70 years of age. Similarly nearly 50 percent of males and 42 percent

female suffered from serious ailments after they reached 70 years of age. The serious ailments were tumours/cancer/tuberculosis at terminal stage.

The digestive complaints in the elderly increased with age in both the sexes. These included anorexia, heartburn, gas, acid, dysphixia, flatulence, diahorrea and chronic constipation. Most of the digestive complaints in the elderly could be attributed to altered mortality and reduced recreation.

The diseases of the respiratory system in the sample included chronic obstructive pulmonary disease (COPD). The symptoms exhibited by the respondents included recurrent cough, mucoid/muscopurulent expectoration and dyspnoea on exertion or wheezing, respiration as in asthma. Pulmonary tuberculosis was also found in nearly five respondents of each sex.

The diseases of the circulatory system included hypertension, and coronary heart disease. It rose dramatically with age although atheroma and coronary artery diseases are not synonymous with process of ageing. (Chopra, 1993) The pressing feature in most of the elderly in the present sample was chest pain.

The diseases of the nervous system were found to be strokes, dementia, and Parkinsonism. Seven respondents were found to be suffering from brain tumor, which was malignant in nature.

The other common diseases were found in the effective functioning of sense organs. The problems relating to sense organs included difficulty in walking and standing, partial or complete blindness, partial deafness and difficulty in moving some joints etc.

The diseases of the endocrine system included diabetes and thyroid dysfunction.

Amongst females breast cancer and cancer of cervix was more common whereas males suffered from cancer of prostrate gland. A good number of respondents also suffered from diseases relating to renal system. Similarly pain in joints/arthritis and cervical spondalitis

were found to be most common problems of the elderly women and showed an increase with age.

Nature of Treatment taken by the Respondents

Nearly 50 percent of the respondents were resorting to allopathic system of medicine. This included little more percent of males as compared to females. The other common system of medicine was Homeopathic and Ayurvedic system. Amongst females, this system was little more popular as compared to males. It is significant to note that11.33 percent females and 7 percent males were not undertaking any system of medicine because of their poor economic status. Another significant aspect, which was noted, was that the respondents belonging to higher economic strata and those, for whom allopathic system of medicine was free, availed this facility or combined it with other two systems of medicine.

Table No.2

Nature of Treatment Taken by the Respondents

System of Medicine	Male	Female	Total
Allopathic	80 (53.33)	68 (45.33)	148 (49.33)
Homeopathic	15 (10.00)	24 (16.00)	39 (13.00)
Ayurvedic	20 (13.33)	26 (17.33)	46 (15.33)
A combination of two or more systems	25 (16.67)	15 (10.00)	40 (13.33)
No proper medicine	10 (6.67)	17 (11.33)	27 (9.00)
Total	150 (100.00)	150 (100.00)	300 (100.00)

Economic Status and Satisfaction from the Medical Care

The researcher applied her skills in establishing an association between the degree of satisfaction from the available services on medical care and economic status of the respondents. It was found that a major percentage of respondents (64%) expressed their partial satisfaction/dissatisfaction from the available services on health care. Respondents from low economic status expressed greater amount of dissatisfaction. But on the other hand, respondents from higher economic status expressed their satisfaction. It was only 33 percent who expressed partial satisfaction and dissatisfaction. The respondents belonging to medium economic status were also either partially satisfied or dissatisfied (71.31%).

Table 3

Relationship between economic status and satisfaction from the available services on Medical Care

Economic Status	Fully Satisfied	Partially Satisfied	Dissatisfied	Total
Low	20	35	43	98 (32.67)
Medium	35	70	17	122 (40.67)
High	53	17	10	80 (26.67)
Total	108 (36.00)	122 (40.67)	70 (23.33)	300 (100.00)

$X^2 = 71.7$ (4 df) Result = Sig (.01)

Further the Chi square between the two variables was found to be statistically significant at 1% level of significance.

Self Perception of Health and Nature of Health Problem

The self-perception of health was found to be associated with the severity of health problems. The respondents who had serious health problems had a poor self-perception of health. Chi-square was calculated to find out association between the two variables. It was found to be significant at 1 percent level of significance.

Table – 4

Nature of Health Problems and Self Perception of Elderly

Perception	Mild	Serious	Very Serious	Total
Poor	36	36	84	156 (52.7)
Fair	20	42	23	85 (28.33)
Good	9	34	16	59 (19.67)
Total	65	112 (21.67)	123 (37.33)	300 (41.00)

$X^2 = 33.02$ (4 df) Result = Sig (.01)

Only 20 percent perceived their health as good. But out of them again (50 out of 59) a majority, were suffering from serious/very serious health problems.

Nature of Family and Degree of Satisfaction from available Health Services

The dissatisfaction from the available health services was found to be more in nuclear family and those who were living alone. The elderly staying in joint families and extended families were found to be satisfied with the available health services.

Table – 5

Nature of Family and Satisfaction from Health Services

Nature of Family	Fully satisfied	Partially satisfied	Dissatisfied	Total
Joint family	25	15	10	50 (16.67)
Nuclear family	20	30	15	65 (2.67)
Extended	43	25	24	92 (30.67)

Living alone	8	48	37	93 (30.67)
Total	96 (32.00)	118 (39.33)	86 (28.67)	300 (100.00)

$X^2 = 42.54$ (6 df) Results = Sig.(.01)

The chi-square between nature of family and degree of satisfaction were also found to be statistically significant.

Problems faced by the elderly in making optimum use of available health facilities

With increasing age, the health problems increase but the economic resources of the elderly usually show a decline. For them, seeking medical aid is a costly affair unless it is from a public hospital. Most of the public health care centres face many problems like improper hygiene, over crowding and inadequate infrastructure in terms of health, human power, medicines and necessary medical equipment. Further, the elderly, generally is the last segment in a household to seek or to demand the medical aid, in view of the general perception in society that not much can be done about the health problems of the elderly.

Further health care system at various levels in our country is designed for the general population and no special provision/preferences are provided in the system to take care of the elderly. Unfortunately the middle class person and poor can afford only treatment facilities mainly from public health centres. The advantages by the respondents from upper economic strata of utilizing private health facilities were better quality of delivery of services, quick relief, less waiting time to see a doctor, cleanliness and adequate interest shown by the doctor, convenient time and nearness of its location (Siva Raju, 1997).

Lastly, many people living in remote rural areas do not make use of available facilities either because of ignorance, poverty or ignorance. Thus there is no optimal utilization of available health services.

Intervention Strategies- Role of Social Worker

The problems of elderly are multi dimensional, i.e. biological, social, emotional, psychological and economical. All these are inextricably linked with each other and can not be dealt in isolation. The health care needs of elderly vary from the young old (61-70) to the old-old (71-80) to the very old (81+). Most of the young-old are productive in the informal sector and are often the care-giver to their grand children or their very old parents. It is mostly after 70+ that health problems of one type or the other are aggravated and need attention. Of all the needs, medical health is on the top most priority, which should be attended to, to keep the elderly fit and fine to continue with their quality of life. Most of the time their health problem is multiple involving more than one system and requires inter-disciplinary case.

In India, due to the elite structure of health care facilities, there is a skewed distribution where the poor and the elderly, especially women are often neglected. Once the elderly fall sick, their visits to the out patient departments are more frequent compared to younger individuals. Once admitted to hospital, their stay is also longer and recovery slower.

Social work is mainly believed to be problem oriented but while working with the elderly it may be process oriented. In the entire process of working with the elderly, medical care/emotional support/counseling to patient and care-giver should form an important component of the process. The most appropriate place through which they can operate is while they are employed as social workers in public/government hospital or while they are employed in community based rehabilitation schemes in the communities.

The specific intervention strategies that can be undertaken by the social worker are:

- To create an awareness among the general public particularly the elderly for regular medical checkups to ensure prevention, and early detection of the disease.
- There is a definite need to review health policy depending on the geographic distribution of elderly in rural/urban areas. The far-flung areas are inhabited by the deprived and depressed classes of our society that are not only illiterate but also

ignorant and are poor. They do not know about the existing health facilities.

- There is a need to provide uniformity in availing health care services by service class/business class. The service class, which retires from government/semi government/public sector, can avail better health services though central government health scheme and other tailor made schemes made available to them.
- There is a need to train both indigenous and allopathic doctor to handle the specific illnesses associated with ageing.
- It is necessary to set up subsidized health care for the elderly with special units in hospitals and with free or highly subsidized medicines.
- There should be separate geriatric clinics in the private/government hospitals where OPD timings for the elderly should be in after noon.
- While the retiree is in active service, more deduction may be made from their salary regularly towards insuring their health by the government. Other suitable health plans are needed to be evolved under social security programmes so that uniformity is maintained in providing health services.
- Health check ups and other related services should be provided at the doorsteps for those who are immobile. Ambulance/mobile vans should be made available to them.
- Awareness about nutrition and health related issues of the elderly are of great importance. Programme focussing on the elderly women and poor need to be formulated and propagated.
- Booklets, videocassettes etc. on health and nutrition related issues need to be developed and information disseminated. Food guides and diet manuals need to be developed keeping in mind all the regional differences. Such guides should be available in all regional languages. The role of traditional foods, use of hereby, therapeutic foods need to be highlighted (Puri, S.; K Kumud, 1999).

- Social Gerontology should form part of the syllabus for medical professionals and para professionals so that they could integrate health education along with the health care provided to the elderly persons.
- More local NGOs should come forward and volunteer to work in the area of health for the elderly.
- There needs to be a better coordination between social workers working in hospitals, para-medical staff and doctors to discuss the problems of the elderly and evolve intervention strategies in order to provide individualized services.

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Counselling Needs of the Elderly

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ABSTRACT

The present study was planned to examine the psychological and social counselling needs in a sample of community dwelling middle aged and older men and women. They were individually tested using a Problem inventory. Analysis showed that with the increase of age, problems faced by them also increased. Based on the results, the counselling needs are discussed in different areas. The implications of the findings are discussed.

Key words : Elderly men and women, Physical and psycho-social problems, Counselling needs.

India is in the teeth of a demographic transition. Its elderly population (next only to China in the world) is 7.5 percent of total population (seventy five millions). The traditional caretaker of the elderly in India, which is the joint family, is a dying institution. Only 14% of the families are joint in the true sense (Singh 2003). Impact of western culture, industrialization, modernization, dual careers, migration, increasing individualistic values and a consumerist business outlook has threatened traditional elder care by adult children of the elderly. Added on to this, poverty and poor hygiene has made the lives of the elderly difficult and problematic. Understandably there is an urgent need for their problems to be attended to. Surprisingly there are few studies on the counselling needs of the Indian elderly. It is in this context that a study was planned to assess the problems and counselling needs of the elderly.

Despite some studies being available in the Western literature, the reviews on psycho - social gerontology (Ramamurti & Jamuna, 1984; 1993; 1995; 1999) indicate that there is a paucity of research on counselling needs of elderly in India.

Specifically the objective of the present investigation was

- To investigate the problems of the elderly of rural and urban origin and men and women in areas namely health, family, economic, personality, religious and social and betterment.

METHOD

Sample

The sample for the present study was drawn from the urban areas of Tirupati and the rural villages in Chittoor District through a multistage random sampling. In all 120 elderly in the age groups of 40-59, 60-69 and 70+ were drawn. The sample details are given in Table - 1.

The subjects were identified on the basis of electoral roles through house-to-house survey until the required numbers were enlisted. Majority of the sample were from middle-income group.

Table - I : Details of the Sample for the Study

Age Groups	Men		Women	
	Rural	Urban	Rural	Urban
40 - 59	10	10	10	10
60 - 69	10	10	10	10
70+	10	10	10	10
Total	**60**		**60**	

Tools

The Telugu version of the problem inventory for older people (Ramamurti, 1969) was administered to the sample to assess the problems of adjustment in different areas viz., health, family, economic, religious social, personality and personal betterment aspects. The test was individually administered at interview sessions depending on mutually convenient timings. The protocols were analysed age-wise, gender wise and locality wise. Simple t-tests were used to test the mean differences in problems between the groups. Results on the problems experienced by different sub groups and from different localities were compiled.

RESULTS AND DISCUSSION

To realize the health problems among various subgroups, the responses given to the statements regarding health were analyzed. The statements included problems regarding, visual, auditory, body pains, digestion, sleep disturbances and frequent illnesses

Table – II : Mean, S.D and t-values of Health Problems in Different Sub Groups

Sl. No.	Sub Groups	N	Mean	S.D	't' Value
1	**Age-wise**				
	40-59	40	12.47	3.10	3.45**
	60-69	40	14.47	4.34	
	70+	40	15.12	3.73	0.72@
2.	**Gender -wise**				
	Men	60	13.38	3.99	1.82@

	Women	60	14.14	3.72	
3.	**Locality -wise**				
	Rural	60	14.91	3.53	2.56**
	Urban	60	13.13	4.06	

***p< 0.05 level; ** p<0.01 level; @- Not significant**

Health is the major concern for many during old age. Maintenance of good health leads to over all well being of the person. Age-wise means show that with the increase of age the problems faced by the age groups also increased (See Table - II). It is evident that 40-59 and 60-69 age groups differed significantly (t=3.45**) and also the rural and urban subjects differed significantly (t=2.56**) in facing health problems. Gender-wise differences were not significant. Among the health problems, 66% reported eye and ear problems, 73% body pains, 69% reported sleep problems, 24% reported digestion problems and 40% reported frequent illnesses.

Table – III : Mean, S.D and t-values of Family Problems in Different Sub Groups

Sl. No.	Sub Groups	N	Mean	S.D	't' Value
1	**Age-wise**				
	40-59	40	12.30	3.75	1.46@
	60-69	40	13.30	3.58	
	70+	40	12.45	4.12	1.22@
2.	**Gender -wise**				
	Men	60	12.65	4.00	
	Women	60	12.85	3.63	0.28@
3.	**Locality -wise**				
	Rural	60	13.03	3.42	
	Urban	60	12.46	4.21	0.81@

@- Not significant

Family is the main concern during old age. There are significant changes in the family as the man grows. The events like loss of

spouse, retirement, marriages of children give the feeling of empty nest. The data (Table - III) clearly show that though there are differences in the family problems faced by the elderly they are not statistically significant. From the protocols it can be inferred that 30% reported differences with family, 47% reported decreased authority, 23% reported family interference, 57% reported more affection towards grand children than for their children and 50% reported problems with in-laws. From the data, it is clear that family problems faced by them are similar among all the sub-groups.

Economic problems are the main sources of stress during old age. Table - IV shows economic problems faced by the subjects. From the above, it is clear that with the increase of age their economic problems also increased and the 40-59 and 60-69 age groups were statistically significant in facing the economic problems (t=2.60**). Rural residents were facing more economic problems (M=15.46) compared to urban residents (M=11.81). The difference is statistically significant (4.67**) and there were no gender wise differences in facing the economic problems. Among the economic problems 53% reported no fixed income, 56% lack of finances, 51% reported financial dependency, 52% reported desire of own income, 53% reported lack of resources for regular income.

Table–IV : Mean, S.D and t-values of Economic Problems in Different Sub Groups

Sl. No.	Sub Groups	N	Mean	S.D	't' Value
1	**Age-wise**				
	40-59	40	11.95	4.01	2.60**
	60-69	40	14.40	5.05	
	70+	40	14.77	4.90	0.34@
2.	**Gender –wise**				
	Men	60	13.11	5.0	
	Women	60	14.30	4.46	1.35@
3.	**Locality -wise**				
	Rural	60	15.46	4.39	
	Urban	60	11.81	4.47	4.67**

**** p<0.01 level; @ - Not significant**

Table - V: Mean, S.D and t-values of Religious and Social Problems in Different Sub Groups

Sl No.	Sub Groups	N	Mean	S.D	't' Value
1	**Age-wise**				
	40-59	40	13.05	3.49	2.19*
	60-69	40	15.07	4.19	
	70+	40	14.65	4.54	0.43@
2.	**Gender -wise**				
	Men	60	14.35	4.19	
	Women	60	14.18	4.43	0.21@
3.	**Locality -wise**				
	Rural	60	15.68	4.03	
	Urban	60	12.85	4.11	3.81**

***p< 0.05 level; ** p<0.01 level**

In old age social supports play a key role. Among the religious and social problems faced by the elderly they are high during 60-69 and later decreased. The 40-59 and 60-69 age group differed significantly (See table – V). Gender wise differences were not significant. It is evident that rural residents are facing more problems (M= 15.68) compared to urban residents (12.85) and the difference is statistically significant. Among the religious problems 86% showed belief in God, 54% perceived decrease in their social status, 31% reported no proper facilities for worship, 61% reported problems of decreased interaction, 52% showed no interest in social life.

Table-VI : Mean, S.D and t-values of Personality Problems in Different Sub Groups

Sl. No.	Sub Groups	N	Mean	S.D	't' Value
1	**Age-wise**				
	40-59	40	12.62	3.49	1.20@
	60-69	40	13.52	3.32	

	70+	40	12.77	4.19	0.88@
2.	**Gender –wise**				
	Men	60	12.50	3.99	
	Women	60	13.43	3.35	1.39@
3.	**Locality –wise**				
	Rural	60	13.55	3.66	
	Urban	60	12.58	3.72	1.14@

@- Not significant

Table - VI shows the personality problems of the elderly. From the data it is clear that there were no differences among the problems faced by them. Among the personality problems 40% were worried about their physical appearance, lack of self-confidence, 54% reported more anxiety and worry, 61% reported inability to concentrate, and 58% reported feelings of loneliness.

Table - VII shows personal betterment problems faced by the different sub-groups. The 40-59 and 60-69 age groups differed significantly (t=2.58**) and later these problems decreased. There were no gender-wise and locality-wise differences. Among the personal betterment problems 31% showed desire to remain young, 52% reported poor memory, 61% reported the problems of behaviour in social settings, 49% poor personal efficiency, 28% expressed adjustmental problems.

Table – VII: Mean, S.D and t-values of Personal Betterment Problems in Different Sub Groups

Sl. No.	Sub Groups	N	Mean	S.D	't' Value
1	**Age-wise**				
	40-59	40	11.32	3.33	2.58**
	60-69	40	13.15	2.98	
	70+	40	12.25	4.18	1.11@
2.	**Gender -wise**				
	Men	60	11.96	3.63	
	Women	60	12.51	3.53	0.84@
3.	**Locality -wise**				

Rural	60	12.45	3.52	
Urban	60	12.03	3.65	0.64[@]

**** p<0.01 level; @- Not significant**

Implications

From the above discussion, it is clear that they are facing problems in the area of health, economic, religious and social life and personal betterment. So Health counselling and individual counselling needs are to be planned to cover the problems during old age. Group counselling interventions need to be planned to improve their health status. Culturally relevant activities towards their socio-economic and psychological empowerment through community development activities like senior citizens clubs, forming volunteer force and development of neighbourhood network programmes need to be planned to gain meaning in their life and to improve their quality of life.

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Building Society Through Intergenerational Exchange

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Intergenerational relationships are interactions between individuals of different generations or cohorts, that is, thousands of people who share similar but not identical experiences by the virtue that they are born, live and die within a common historical period but not at the same time. Family is that thread which links multiple generations together through a system of shared beliefs, norms, values and cultural traditions. Within a family these intergenerational ties are conceptualized as a lineage bridge between the children, parents and grandparents. Transactions between the different generations serve the following functions : (i) sharing of information and knowledge; (ii) power and responsibility or control over desired resources, (iii) power and responsibility or control over the desired generations; and (iv) welfare or care of the family members.

Thus intergenerational ties fulfill many functions within a family. Besides, transmission of appropriate information regarding behaviour,

life-styles and values; these ties help reduce marginalization between different generations; and are a source of support and identity for each individual.

In traditional Indian society, elder people lived within a multi generational extended family comprising one or more adult, children, grandchildren and other kin. The aged in these societies enjoyed unparalleled sense of honour, legitimate authority within the family or community, had decision making responsibilities in the economic and political activities of the family and were treated as repositories of experience and wisdom. The elderly acted as a link between traditions and customs and were responsible for enforcing them in day to day life. There was division of labour within the family and the aged had an important role to play which made their life meaningful. The elders in the intergenerational lineage played the role of a historian providing information about the cultural and familial past; that of a role model which the youngsters could follow; of a mentor who could guide the young with their valuable experiences and of a nurturant who cared for the kin in crisis. The youngsters also reciprocated by respect and reverence towards parents, teachers and the aged. There was a hierarchical organization of members within the family based on age, sex and generational status. Social interactions were characterized by a smooth bi-directional flow of information among the three or more generations, with respect between the generations being emphasized. As part of the family, members learnt to conform to these scribed or clearly defined roles.

Family Rituals and Older Person

Older people are very much involved in the marriage process. The initial contact is usually made by younger adults, such as the bride and groom's parents. Later as negotiations proceed, older members of the family are consulted and participate in the final decision. An older person may have substantial control over the outcome. Often, the eldest male will serve as a “point person” for interaction interaction between the two families. This may mean that the boy's grandfather plays a very important role in transactions.

When an agreement in reached, a brief ceremony called Roka is held and is sometimes referred to as the “initial fixing”. The name comes from the word “to stop” : with the Roka ceremony, the two families will stop looking for a suitable boy or girl. The Roka is usually conducted at an outside location like a temple or restaurant and seldom

at the boy's house. There is a minor presentation of sweets from the girl's side to the boy. The actual presentation of sweets which, is made by the girls' grandfather or father, is expressed with folding hands by the girl's grandparents and parents as a request to the boy's parents or grandparents to accept their daughter in their house.

In a few weeks to a month, the families meet again for presentations of gifts (sagan) to the groom's family. Prior to the visit, the girl's family discuss with the elders male who should get gifts of cash and the appropriate amounts. Sagan will be given to relatives such as grandfather, grandmother, father, mother, father's brothers and their wives, father's sisters and their husbands, mother's parents, mother's sister and brother. The sagan may be presented to the older male and distributed by him within the circle of sagan recipients.

A day after sagan, a ring is presented. A group, including the boy, from the boy's side visits the girl's house. They make a presentation of the gift of a gold ring and a scarf. The boy's family makes a cash sagan to the girl but not to any other member of her family. This is made by the elder member of the boy's family such as his grandfather. Food appropriate to the time of the day is served. The presence of the older males is very important.

Shaadi, the marriage proper, is usually held on the third day. Older people are intensively involved in the marriage. The eldest man in the boy's family, preferably the grandfather, plays an important ritual role. The older men and women are listed on the wedding invitation as the persons extending the invitation. During the wedding, the close male relatives of both families wear pink turbans.

An important part of the wedding is the seven circum-ambulations of the sacred hearth alter under the direction of the priest, who is the chief of rituals. These are referred to as the pherase. At each circumambulation a mantra is spoken along with a vow. The completion of each vow is marked by the removal of a line of atta (wheat flour) that had been placed on the floor earlier. Among the vows for the girls are two that are directed at her relationships with older members of the household. She is asked to promise to care for all the elders of the household and not to annoy them with bad behaviour. She is also asked to promise to treat her mother-in-law and father-in-law as she would treat her own parents. The boy does not take a vow to care for her parents. In addition, she vows to keep the secrets of her new family.

After these vows, the grandfather or father stands at back of the bride and groom holding their heads, joining them together as a kind of blessing. After that, the bride and groom get up and touch the feet of the grandparents. The bride also touches the feet of her father-in-law and mother-in-law and other elder close relatives on the boy's side.

After the marriage ceremony is over, the girl goes to the boy's house where she will be living for the rest of her life. Her mother-in-law greets her at the gate of the home and does worship with special oil lamps at the gate itself, pouring mustard oil on the two sides of the gate. After the first night in her new home, the girl, when she gets up in the morning, goes to the older person's rooms and touches their feet to get their blessings.

After a few days, the girl cooks her first food in the house, always a sweet dish, which she offers to her elders. Older people may be involved in the naming of children. The husband's elder sister might suggest names but only with the grandparents and parents approval. During hair-cutting ceremony for boys, the grandfather has a special role. The father typically holds the boy as the barber cuts his hair and the priest does puja.

About a week before Diwali, some families will do the Ahoi Mata Puja. During this day, women fast to help assure the long lives of their sons. This is done from dawn until the woman can see the stars. After the sun sets and the evening star rises, there will be a puja at home. The is concerned with the happiness of the family and the growth of the some. Importantly the puja is performed by the oldest male who, occupies the symbolically important role of the priest giving sacred marks (tikka), tying sacred threads (moli), giving consecrated food (prasad) and reciting mantras.

The hindu scriptures further reiterated these norms. Support and strength of the family ties was also promoted by the agricultural economy in which the poverty was held jointly and the eldest occupied the position of prominence. The community was yet another external system which reinforced the ability of the family to offer a caring environment for the aged and to maintain its strong intergenerational relationships. It imposed norms and moral sanctions on the family and the individual through unmitigated force of village ‘Panchayats’. In the events of a family or its younger member violating the norms with regard to the care of the aged or the dependents, the community power invariably came into play. It was only in exceptional circumstances that

the community itself assumed the responsibility of the care of the aged or the infirm through surrogate families or places as pilgrimage, religious sects and related philanthropic organizations. The role of the state in the care for the aged was negligible.

The family, thus was prominent in performing numerous functions for the elders. It assisted with medical and health care at the primary level. On the emotional and psychological level, it ensured that the elders felt loved and valued besides providing for their social and intellectual needs. The intergenerational cement or the lineage line enforced members of different generations to perform functions favourably in the maintenance of this solidarity and integral harmony.

Large scale industrialization and modernization however, brought about various economic, social and cultural changes, weakening the family and community bonds. These changes not only affected the family's traditional role of providing care and financial support to its members but also hampered the intergenerational ties.

Modernization led to large scale mobilization of family members, thus breaking down the multigenerational family to a nuclear family. The traditional concept of joint family as a residential unit underwent change because of the heterogeneity of occupations of the family members. Large scale disenchantment with rural life and the glamour and temptations of city life, have been important factors for the migration of the younger generations. The elderly were thus left behind without the traditional support they had from their children. Changes in the family structure and values led to the breaking of the norms of mutual obligation and resulted in the dilution of both the role and position of the elderly within the family.

It has been observed that changed values and living arrangements freed the individuals from their rigid hereditary social roles. Women started participating in activities outside the home and men gave a helping hand in household chores. Transformations also occurred at the ideological level which hampered the traditional values of filial duty, family obligations and mutual responsibility wherein one's well being was seen as inseparable from that of one's kin. This multiple normative confusion increased the vulnerability of the aged. Traditionally, where social-cultural arrangements cushioned the problems of the aged, new social order aggravated the troubles of the aged and increased the intergenerational gap.

Intergenerational Relations in the Contemporary Society

A recent Anthropological survey of Indian publication identified 4635 communities in India of which 4122 reported prevalence of one or the other form of extended family type within the unit of a nuclear family. In yet another study, Vatuk also pointed out that fundamental changes in the social, economic and political structure did not lead to significant changes in the family composition. Data from eight rural and urban studies in India, showed that between 54 and 78 percent of the elderly persons in these areas lived with a married son. From 92 to 100 percent elderly lived with some relative and less than 4 per cent lived alone.

Hence, as is evident that the extended family norm persisted, but the generational depth did not remain the same. The different changes had a detrimental impact on the intergenerational family relations. Changed values, hobbies, life-styles and beliefs brought about differences between the aged and their adult children thus hampering the good companionship and role relation shared previously.

Advancement in science and technology led to the transference of power from the elderly patriarch to a member of the younger generation who could deal with modern institutions. The dependence of young on the elderly for guidance was thus reduced and in fact a role reversal was observed. This subsequently led to the fragmentation of the family.

Changes in the value system of younger generations which were strongly inclined towards individualism and utilitarianism lead to intra-family sibling conflict. Conflicts occurred between father and son or among the sons in relation to the sale of land, its participation or use for non-agricultural investment. Migration to urban areas further disrupted the age old pattern of family relations between the elderly and the young.

In addition to changes in the structure, the family also underwent changes in the number of siblings and kin. A decline in the birth rate led to decrease in the number of children within the family and hence a decline in the number of potential caregivers. The problem was further compounded by the fact that the primary caregivers of the aged-the women of the family became active diminishing their availability on a full time basis.

Radical changes occurred into value systems, standards of behaviour and attitudes towards the aged, the care of the aged began to

be viewed as a burden and stress by the caretakers. What was previously a duty, became a burden and obligatory role today. This feeling of being a burden on the adult children precipitated feelings of stress among the elderly. They developed negative emotions towards themselves viz loss of employment, low income, and failing health; the newly added worries were feelings of neglect, loss of importance in the family, a feeling of inadequacy, loneliness and of being unwanted. Thus in turn affected their nutritional status, physical and mental health and their interactions with the other generations.

From the discussion above and as pointed earlier the maintenance of intergenerational relations depends largely upon the middle generation which acts as a linkage between the grandparents and the grandchildren. It is this mediating generation, that determines how often the other generations see each other and how they feel about each other. In contemporary society intergenerational differences developed due to numerous stressors within the family. On the part of the aged, it was observed that reduced/loss status role, deprivation of goods and resources was something that they could never reconcile with, because they had grown up in a different environment where the aged were highly respected and enjoyed high social status. Thus they had high expectations of their grandchildren and adult children that they would live up to the family heritage. The adult children and the grandchildren on the other hand resented the views and opinions being imposed on them. In fact, they experienced increase in workload, stress, curtailment of social activities and financial constraints in taking care of the elderly. Mutual love, respect and affection were thus no more spontaneous.

To bridge the gap the younger generations should take a bit of care of the aged. The aged on the other hand should be grateful for this care and should reciprocate with affection. This intergenerational solidarity must be nurtured keeping in mind the advantages it has for the aged, the young and the adults within the family and the community at large. These relations if not maintained, may cause a burden on the country's resources besides, creating a void in the socio-cultural processes.

India' Future if the Generation Fap Continues

In Western countries, the state provides financial support to the aged and the unemployed. The state in these societies is able to rechannelise the investment from education and health to the social security of the aged. However, today even in these societies state welfare policies are under pressure because of the ever expanding and

long time financial commitments are required for the care of the aged without settling productive, returns and this has forced them to rethink about their welfare policies.

In almost all societies, aging is being viewed as a social problem. Improvement in the medical facilities has increased the number of the aged on one hand and reframing of society on the other hand, has made the aged vulnerable. There has been a shift in the dependence of the aged from the family to the state. Keeping in mind the percentage increase of the aged in India, there is an apprehension that tremendous pressure could be exerted on our poor economy and scarce resources. Already, India is passing through a transitional demographic phase where the burden of education and health care of the young, the position of unemployed youth and the care of the aged population are all compounded. Therefore, it is all the more important that proper measures for the care of the aged, which can best be provided in the family are taken. The knowledge of aging and the development of positive attitudes towards old age can contribute to the improvement of intergenerational relations, combat stereotypes that promote ageism and develop a more realistic outlook towards one's own aging process.

Taking a cue from these interactions, number of programs were started to bridge the gap and benefit everyone. The prominent programs which we have started under the Aastha-foundation for welfare and development of generations are “Dil Khus Sabha”, “Neighbourhood Culture Watchdog” and “Slow leaner-helper” ahve been all these programs are basically meant to unite the generations and bridge the gaps.

About Aastha : It is a non-government organization, which was registered in September - 1993. The members of this organization are in the age group from 20 - 56 years. Most of the members are students and the advocacy body is constituted of academicians, policy makers and social scientist from the discipline like psychology, education, anthropology, human development, medical and social work. Members takes number of projects related to children, adult, women, and old people.

All the three programs referred above are the brain-child of the founder President, N.K. Chadha, who visualized the issue of strengthening the intergenerational ties. “Dil Khus Sabha” is a program conceived by the elderly in a neighbourhood in Delhi, with the initial purpose of meeting and spending the time together, to release their

stresses, worries away from the household setting at a common place in a park. Initially, it was started by six older people and gradually in a span of six months, the number got increased to 60. They meet everyday for one/two hours and discuss various issues of common interests like family, Indian values, raising children, strengthening family ties, educational system, political system and social cultural issues. They take the responsibility to help the members of the community irrespective of age, gender, caste and class. They help the poor and needy people in the neighbourhood, help the older sick person by bringing medicine, grocery, and by doing so make the family members free the responsibility of the aged at home.

Neighbourhood Culture Watchdog : It is a group constituting young Aastha members and a group of older men and women from the community. They help **focus groups** to discuss the Indian family traditions, cultural norms, rituals and their importance. The elderly tell stories from the various Indian religious books where the joint family, relationships between sibling, grandparent - grandchild relationship are discussed. The group work to ensure that cultural norms are preserved.

Slow learner - helper : This is the arrangements at the community level where, children who are also in learning the school curriculum are identified and then the older people from the community, who are very good in subject like Mathematics, English, Physics, Chemistry, Languages etc. are identified to teach these slow learner by visiting their houses. They help the child to cope with the school work and at the same time the older person gets the emotional need satisfaction by teaching the child whom he started perceiving as his own grandchild. This brings the lost dignity and respect of the older person in the community because now he/ she is contributing to the development of the child, family and community.

Bridging the Gap : Uniting the Generations

A cross sectional study by Willgen *et al.,* pointed out that friends, neighbours, co-workers and extended social network are important sources of support for the aged in India and should be capitalized upon for their rehabilitation. Another study on the institutionalized elderly by Chadha *et al.,* again retiterated the importance of the family. It showed that life satisfaction was more in non-institutionalized elderly than in institutionalized elderly. In fact, it was observed that entering the institution was the last resort considereds only after all the other

alternatives were exhausted and the family members had endured severe stress.

Over thirty years of research has documented that the parent-child relationship is important to both children and parents throughout the life course. Family members are the principal source of emotional support and socialization for their elderly members. It has also been pointed out that intergenerational ties have an important therapeutic role during family crisis. At the same time realizing that the family's traditional role of caregiver to the elderly and its solidarity is being subjected to various economic, social and psychological strains, it is necessary for the government to initiate policies and programs which support, protect and strengthen the family, so as to enable it to continue responding to the needs of its elderly members.

There is a need to promote and maintain intergenerational family solidarity. Some of the measures to encourage mutual cohesion between the generations are;

(i) Portrayal of a realistic picture of old age and associated problems through various media channels. This is important for developing a positive attitude towards the aged.

(ii) The individual should prepare himself/herself well in advance for the evening of his/her life. He/she should take appropriate measures to ensure proper nutrition and health and must develop correct mental and social attitudes to accept the changes with grace. Adaptability on the part of the aged is important to enable him/her to lead a happy life and enjoy satisfactory relations. He/she must accept the changing roles and life-styles and try and contribute positively to the society.

(iii) Family counselling, as it helps to resolve conflicts and misunderstanding and tries to improve inter-personal relations.

(iv) Joint activities, involving children, young and old, related to community development.

For the aged who cannot rely on themselves or on their families, the government should make provisions for public delivery system, and community-based programs including home maintenanced, home help, meals on wheels, day centers and senior citizens, clubs. Several voluntary organizations have come into play to provide support to the

elderly. These agencies are functional in spreading awareness about the problems of the elderly and in raising funds for their welfare programs.

Although formal services for the care of the aged are increasing in India, they should only supplement rather than replace the informal system of care provided by the family and extended kin network. The importance of intergenerational relationship must be relalized and, efforts made to strengthen it. Community and social support system which mediated and promoted family ties in the past must once again be activated in the intervention programs.

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The Status of Empirical Research in Issues Related to the Social Support of the Elderly

Monika Rikhi and N.K. Chadha

When only a small proportion of people experience poverty, illness or social isolation, we may not be aware of their problems. But as the number grows a challenge is directly posed to our social service system and the problem becomes acute enough to be discussed. An exactly similar explanation can be given to the recent

spurt in studies on ageing. The elderly population is now the focus of discussion for politicians, media and other concerned groups. A growing consciousness and sensitivity to the problems of older people is also reflected in the research studies. Gerontology more than any other subject matter utilises an interdisciplinary approach in explaining the lifestyles and behaviour patterns of the elderly.

Literature in any field forms the foundation upon which all future work will be built. It not only gives one an insight into future but provides better comprehension of the problems being faced.Study of the related literature implies locating, reading and evaluating reports of research as well as reports of casual observation and opinion that are researcher's planned project. The forthcoming paragraphs deal with the investigations carried out in India and abroad pertaining to the issues related to social support network of the elderly;giving an empirical account of the literature and also bring forth the related factors of the variables investigated.

The review of literature was carried out from a number of journals and the recent books on the related topics conducted in India and abroad on the elderly population on the chosen variables. In India there is a paucity of research on the psychological and social aspects of ageing simply because of a difference in the family set up; that seems to be changing now. However, there is a need now being faced for detailed studies in specific areas to throw light on the problems of the elderly .The present chapter takes into account various related variables under study, namely social support, subjective well being, life satisfaction, physical health, leisure activities.

The chapter has been divided and sub divided into various sections for easy reading and understanding of the emerging perspectives. There are five divisions of the chapter, as mentioned below each having two further sub divisions, namely, studies conducted abroad and studies conducted in India.

- Studies on social support network
- Studies on subjective well being
- Studies on life satisfaction
- Studies on physical health
- Studies on leisure activities

Studies on social support network

Ageing takes place within a social context. At each phase of human cycle, the individual belongs to a variety of kinship and social groups. The extent to which an older person is enmeshed with in a social network of kin, friends and neighbours will greatly affect their experience of ageing. This is a critical issue in gerontology that needs to be studied with the changing demographics in our country from public, state and personal levels. Optimisation of the role of informal social supports from family, friends and neighbours has thus emerged as an important social and public priority.

Studies conducted abroad

Conner et al (1979) found that both number and frequency of social ties were unrelated to life satisfaction although kin, children play central role in the support network of elderly; family availability and interaction exhibit little relation to subjective well being.

Blazer and Kaplan (1983) conducted a study to assess social support in elderly community population. The following parameters of social support were described for the elderly

- Roles and available attachment
- Frequency of social network
- The instrumental support from the network.

Results indicate that roles and attachments, frequency of interactions and perception of social network each predicted a change in self-care capacity i.e. activities of daily living.

Fengler, Danigelis and Grams (1983) in a survey of 1400 older Americans over 65 years, two house hold structures, elders living with others and elders living alone, were compared with older married couples. Results indicated that elders living with others had a greater degree of incapacity and lower income than married couples, but on most indices there were few differences. Elders in three generation families had somewhat lower life satisfaction but the greatest number of elderly people with low life satisfaction was the widows who lived alone as there income was inadequate, low prospects for emergency care etc.

Ward (1984) assessed the association between subjective and objective network characteristics with morale. It was found that having contacts with children was important for well being and understanding qualities of social ties helped clarify social involvement

Gurland *et al.* (1989) A large cross national project was conducted in London and New York on the health and social problems of social persons and their relationship with social and physical environment. As far as an informal social support was concerned family members provided majority of care. Primary providers being spouses, daughters, relatives, and friends.

Baum and Buxley (1984) compared differences in perceived age and death anxiety in 301 elderly persons for community affiliated, community alienated and institutionalised. Single subjects were poorer in emotional health and had more death anxiety whereas community affiliated ones showed lesser death anxiety.

Loister *et al.* (1986) compared social support and well being among older widows and widowers. 219 of the subjects were using home care services and others were not (the total being 354). The subjects were contrasted on a number of support variables indicators of well being, socio-demographic and health related variables. While there were significant differences in length of widowhood, functional ability and some components of support network, no gender differences were found in the measures of well being for either sample.

Hawley and Klaukave (1988) investigated associations between social support health practices and life satisfaction among 23 men and 41 women aged 60 to 75 years. Analysis showed that subjects satisfied with interpersonal relationships were more satisfied and engaged in more healthful practices than subjects who were not satisfied.

Seeman and Berkman (1988) investigated relationship between structural characteristics of two types of support (instrumental and emotional) in community dwelling individuals aged 65 years. For each type of support two dimensions were examined - availability of support and perceived adequacy of the support. It was seen that structural characteristics such as total

network size, number of face to face contacts and number of proximal ties were associated with greater ability of both instrumental and emotional support. Perceived adequacy of both types of support was most strongly related to the number of monthly face to face contacts. Comparisons of specific types of ties show that neither once spouse nor children were primary sources of support. Rather the presence of a confidant was strongly associated with both dimensions of instrumental and emotional support; the presence of the spouse was not.

Gray and Calsyn (1989) studied 70 subjects (60+ ages). Interviews were used to test the hypotheses derived from both social support and disengagement and activity theory-

- Stress has more of a negative impact on the life satisfaction of those under age 75 years than those over 75 years.
- Social support has more of a positive effect on life satisfaction in those under 75 than those over 75 of age.
- The buffering effect of social support is stronger in the under 75 group over 75 age group. The analysis supported the first two hypotheses but the third one did not find any significant support.

Kra'use (1990) presented findings from a nation wide survey in UK on old people suggest that social contact leads to an increase in the amount of received support. And received support in turn tends to bolster perceptions of support availability in future with regard to the social roles and social extroversion emerged as potentially important correlates of social supports in later life.

Cheng Sheung-tak (1992) examined the relationship between stress, loneliness, somatisation, health status and physician utilisation among the non-institutionalised elderly females and confirmed this relationship.

Johnson *et al.* (1992) studied the families and social networks of 150 adults (85 years and above) using both structured and open ended questions to determine the extent to which the family functions as a source of support for the oldest old. Subjects with children were significantly more active. 30 percent of the child less and unmarried were not active providers of support.

Heidrich *et al.* (1993) investigated how the self-system mediates for physical health and mental health among the elderly. It was found that social integration and social comparisons mediated the effects of physical health and psychological health

Sugisawa *et al.* (1994) studied the direct and indirect effect of social relationships for the elderly in Japan. Among the five measures of social relationship social participation is shown to have a strong effect on mortality. Social participation, social support and loneliness effect chronic diseases, functional status and self rated health.

Bowling (1994) studied the implications of social networks and support among older people and their implications for emotional well being and psychiatric morbidity. The study contents that there is fairly strong empirical evidence of a relationship between social support, network structure and health status mortality and risk of entry in to institutional care

Stull, Cosbey *et al.* (1997) the data came from 81 families who institutionalised their elders. The findings indicate that the families remain involved in the care of the elder after institutionalisation, though to a lesser degree and in different ways involvement in personal care task is reduces however concerns about financial and legal aspects continue.

Baxter *et al.* (1998) studied the demographic and social network factors associations with perceived quality of life in a sample of rural Hispanic and non-Hispanic white elderly. The findings suggest that network size and contact are important social factors that can improve the quality of life for both ethnic groups.

Barrett (1999) examined the role of social support (measured as presence of a confidant, perceived social support, and frequency of formal interaction) in determining life satisfaction among the never married. Results indicate that age moderates the effect of marital status on social support. In the analysis of life satisfaction marital status and social support are significant predictors.

Sudha and Mutran (1999) examined attitude towards rest homes among 537 elderly American, Africans and whites. There is a dislike of rest homes, preference for family care. Results also suggest

a cultural preference for family care can be determined by dislike for institutionalised care and social structural factors.

Antonelli, Rubini and Fassone (2000) the 60 institutionalised and non institutionalised people when tested showed that the institutionalised elderly have more negative self concept, lower levels of self esteem and restricted interpersonal self as compared to non institutionalised.

Kivett, Stevenson and Zwane (2000) did a 20 year follow up study and examined the physical, psychological, social outcomes and social support of 49 survivors of an original study in 1976. The majority of adults lived alone but received regular family support – adult children being primary support, very little formal support was used. Psychological well being was good expressed through life satisfaction, morale despite health problems.

Studies conducted in India

Desai and Naik (1969) conducted a comprehensive study and found that family support solves health and financial problems adequately. The younger members of the family perceive the need of family support and provide for them. The researchers however did not paint a rosy picture of the aged and stressed that family patterns in India are changing.

Rai (1972) conducted a study on 400 elderly persons over 60 years in age. Subjects were mostly widowed, unemployed and frequently suffered from disabilities. It was found that family structure and "living alone" in old age is a cause for depression. It was also observed that 80 percent of those in nuclear families preferred to be living in a joint family for both emotional and economic reasons

Ramchandran (1980) selected a random sample of 170 subjects aged 60 years and above living with in the community. The family structures and family cohesion of the subjects were intensively studied and it was noted that elderly living in nuclear families and those living alone were more prone to disorders.

Kaur and Kaur (1987) carried out a study in Hissar on 60 males aged 55 years and above. The study revealed that the social

support network of the aged was a major contribution to their general sense of well being in spite of the age related problems.

Gangrade (1988) conducted a sociological survey of 190 parent-youth pairs and found that 98 percent of the youth felt obligated towards their parents in providing financial support. However, 89 percent of them preferred nuclear families. This conflicting preference has given rise to quasi-joint families, which are characterised by financial help and social responsibilities by absentee children. It can be concluded that the family support to the aged exists in the form of financial and social help while the elderly continue to feel relatively isolated and emotionally deprived.

Chadha and Mangla (1991) investigated social network structure among institutionalised and non-institutionalised elderly across sexes. Results showed that network size of institutionalised sample was significantly smaller than non-institutionalised counterparts. Similarly significant differences were found between institutionalised males and females. Blood relationship and non-kin relationship.

Chadha and Nagpal (1991) conducted a study to find out differences, if any, between institutionalised and non-institutionalised subjects with respect to social support network and life satisfaction. The results of the study indicate –

- Social network size of institutionalised group id significantly smaller than their non-institutionalised counterparts
- Non-institutionalised elderly had higher life satisfaction a compared to the institutionalised.
- Social support and life satisfaction were significantly related to each other; males being significantly higher than females.

Chadha and Kanwara (1998) compared institutionalised and non-institutionalised elderly and found significant differences on social support, depression and loneliness. The study also returned negative and significant correlations between social support and loneliness.

Chopra and Anand (2001) found that people living in families as compared to old age homes when measured on psychological and social aspects were better. Family residents were fully engaged in

social activities and well connected with kith and kin. They had a positive outlook to life and power to fight against the odds.

The presented review of studies conducted in India and abroad amply demonstrates social support network to be a key variable in the area of geriatric studies. The variable seems to influence nearly all the aspects of elderly lives. One, however, cannot deny the basic cultural and socio-environmental differences that play important role while dealing with different sets of population. One can find the impact of different environments on the age-related processes in the elderly. Also sex appears to be an important intervening variable while studying the social network of the elderly population.

Studies on Subjective well being

The literature on subjective well being among the elderly population assumes importance considering the fact that it encompasses the lifetime approach. Although the lack of consensus on the definition of the underlying construct of well being has certainly proved to be a hindrance, but sincere efforts were made to present an in depth analysis of the available literature.

Studies conducted abroad

Korte (1990) studied the rural elderly population of North Carolina on dimensions like social support and social interventions in rural community. The well being of rural elderly seems to depend upon their health, financial security and social relationships.

Antonucci and Akiyama (1991) suggest that social relationships in context of individual, family and societal development have both a buffering and main effect on well being depending upon situational and developmental characteristics of life episodes.

Connidis and McMillan (1993) the researchers studied the categories of parent status – close, distant, childless by choice, by compulsion. It was found that happiness, depression, satisfaction with life indicated subjective well being of the elderly. Significant differences were found between the groups on well being.

Sherrard (1994) twenty two elderly retired people were interviewed for their beliefs about the sources of well being in old age. Manual and social class responses were compared, controlling for age, gender and health status. Respondent's free discourse was

characterised by spontaneous social comparisons of the self with people. In social comparison theory, these serve as means of self-assessment or well being – enhancement. The comparison statements were analysed by direction, target, dimension and well being yield. Significant class differences were apparent. Both groups compared downward with others on the dimensions of ageing, longevity, keeping active, security and money. The manual group derived less well being from their downward comparisons, many of which focused on entitlement to money benefits. The professional group made more upward comparisons. Neither group showed psychological defence against physical decline, using social comparison as a means to objective self-assessment rather than self-enhancement.

Pei and Pillai (1999) investigated the relationship between social support factors and subjective well being of elderly. 20,083 urban and rural Chinese were studied – pension, health care, size of family and living arrangements are factors found to be significantly related to perception of happiness. There is a continuous role of family support and state support in promoting a sense of well being in elderly.

Gee (2000) examined role of living arrangements in quality of life in community dwelling elders. 830 persons were interviewed on three dimensions of quality of life- satisfaction, well being and social support, for living alone, with spouse and intergenerational. Findings highlighted the importance of living arrangements and quality of life. Few differences were found for married persons but for widows especially females; quality of life went down significantly with decreasing support.

Pinquart and Sorensen (2000) did meta – analysis to synthesise findings from 286 empirical studies on association of socio – economic status, social support network and competence on subjective well being in elderly. All three aspects of life circumstances are positively associated with subjective well being. Quality of social contacts shows stronger association than quantity of social contact. Having friends strongly related to subjective well being, than having children.

Chen and Silverstein (2000) explored relationship between intergenerational, 3039 older Chinese parents – findings revealed

that providing instrumental social support to children and satisfaction with children directly improved parent's well being.

Studies conducted in India

Venkoba Rao (1982) stressed on the cultural, social, family, economic, philosophical and spiritual dimensions of ageing.

Chadha (1989) studied the impact of institutionalisation on the psychological well being. It was found that older people in institutions as compared to others are worse on psychological well being and their depression level is high as compared to non-institutionalised older persons.

Prakash (1998) studied the urban and rural elderly on their quality of life. It was reported that health is considered as a resource that makes quality of life possible and enhances life satisfaction. Urban elderly males had greater sense of well being than females. Urban females have lowest well being score indicating distress and less morale.

Shyam, Yadav *et al.* (2000) a sample of 60 elderly (30 institutionalised and 30 non institutionalised were administered well being measure, health questionnaire and social support questionnaire. The non-institutionalised subjects reported significantly high depression also life satisfaction was high in institutionalised subjects.

The pool of studies pertaining to subjective well being highlights the importance of the variable in maintaining quality of life in the elderly population. The foreign as well as the Indian researches throw light on the fact that maintaining healthy social contacts, physical activities and spending enjoyable leisure time adds to the quality of life along with a conducive psychological and spiritual environment for the elderly.

Studies on Life Satisfaction

Life satisfaction refers to the attitudes that individuals have about their past, present and future. Morale is considered to be the emotional competent of life satisfaction. Very often the two terms are defined in such a way that they are interchangeable (Chown, 1977). In the last 25 years, the concept of life review as a rationale

for reminiscence in old age has earned a well-established place in the theory and practice of gerontology (Moody, 1988). Gerontologists have thus taken a vigorous interest in late life memory and its potential for personal review.

Studies conducted abroad:

Cavien (1949) studied relationship between life satisfaction and marital status in old age. The result of the study showed that married older people are more satisfied with their life than unmarried older people.

Edward and Klemmack (1973) examined the effect of a wide range of variables on life satisfaction. Their sample consisted of middle aged and elderly persons. Their results indicated that the primary determinants of life satisfaction are socio-economic status, particularly family income, and non-familial participation, particularly neighbouring. Perceived health status is also related to life satisfaction. They further suggested that activity in general does not contribute to life satisfaction but only certain types of activities have such an effect. Finally the relationship between age and life satisfaction was found to be below a statistically significant level when socio-economic status was held constant.

Sprietzer and Synder (1974) investigated the correlation of life satisfaction among the elderly. Drawing on the data they found that health, financial status, and social class were all determined by self -ratings were all found to correlates of life satisfaction. It was found that up to the age of 65 years men tend to report higher rates of life satisfaction than women whereas after 65 years women indicate a higher degree of life satisfaction.

Dickie (1979) compared 30 institutionalised and 32 non-institutionalised elderly on the variables of life satisfaction and activity level. No difference wads found between the two groups on life satisfaction. Self reported health status was related to life satisfaction. The health variables differentiated the satisfaction levels among the institutionalised.

Morgan (1987) used four assessment scales including the life satisfaction index to generate profiles of mental health and psychological well being for 507 aged and 535 very aged subjects. The aged subjects portrayed higher depression and lower morale.

Russell (1987) studied the importance of recreational satisfaction and activity participation to the life satisfaction of aged people results indicate that frequency of participation had no significant positive relationship to life satisfaction rather it is the satisfaction with recreational activities that shows a positive relationship with life satisfaction.

Steinkamp and Kelly (1985) investigated the relative contribution of objective social integration, subjective social integration and total leisure activity to life satisfaction in the elderly. The results showed that the subjective integration contributed significantly to life satisfaction of males and females under and over the age of 65 years. The total leisure activity contributes significantly to life satisfaction.

McConatha and McConatha (1989) examined the relationship between life satisfaction and wellness status among the retired teachers. The results indicated a significant positive relationship between perceived wellness and life satisfaction

Lohr (1988) examined a model specifying the causal links between physical, functional and subjective components of physical health status and life satisfaction in 281 elderly females (56-95 years). The results showed that the physical condition directly contributed to functional impairment and lowered life satisfaction. The positive cognition buffers the effect of physical conditions and passive cognition has deleterious effects on health status though it prevents positive health assessment from decreasing life satisfaction.

Faulk (1988) developed a hierarchy of needs model to help define the quality of life of 124 elderly people in 40 age care homes. Subjects showed that once the lower material resource needs were met, life satisfaction was significantly increased as higher level social integration needs were met.

Gfellner (1989) examined retrospective, current and prospective perception of health, functional abilities and life satisfaction in 40 adults (80-96 years). Subjects expected greater decline in health projecting 5 years ahead than they retrospectively recalled 5 years back. More decrement in functional abilities was perceived to have occurred over the past 5 years that was expected in the future. Correlation suggested that subject's objective health condition their influence of the past.

Purcell and Keller (1989) study illustrates that reciprocity and control are characteristics of leisure activities that help aged to achieve life satisfaction. Reasons for participating in leisure activities are suggested as need for companionship, novelty, escape and expressiveness.

Thomas (1989) interviewed 100 elderly Indian and English men. Subjects were encouraged to talk about themselves and there present situation. The qualitative analysis of the interview protocols indicated different patterns of psychological adaptation with Indian subjects exhibiting higher levels of life satisfaction.

Hersch and Gayle (1990) studied the correlation between life satisfaction and leisure performance of older adults. The most frequently mentioned leisure activities were participation in formal in formal groups, travel, and participation in informal groups, reading, visiting relatives and friends, watching and participating in sports volunteer work and library visits. It was found that age and individual differences are present in health and satisfaction of elderly with their leisure pursuits and life satisfaction.

Nishi and Koseki (1993) this study used a cross sectional survey designed to obtain psychological information. It consisted of old people 65 years, the life satisfaction and social relations of 236 non-institutionalised and non-bedridden was measured to life satisfaction Index K. the subjects had a relationship between self rated health, religion and integrated support with life satisfaction.

Sato *et al.* (1993) conducted a study to assess what factors effected the degree of satisfaction in ones life style. Subjects included 3097 males and females (50-74 years). Life style was conceptualised from two view points one of which was ones idea of what was the most important thing in ones life and the other was what one spent the most of time in ones everyday life doing. Both independent and dependent variables were positive and negative life events, extra version, social support, health and age.

Bradley and Fisher (1995) explored the meanings older people attach to successful ageing and life satisfaction and how these two concepts can be differentiated. The subjects consisted of age groups 61 to 92 years. The respondent's understandings of successful ageing involved attitudinal or coping orientations nearly twice as often as those for life satisfaction. Content analysis confirmed five features of

successful ageing: Interaction with others, a sense of purpose, self-acceptance, personal growth and autonomy.

Gueldner, Loeb, Morris Penrod (2001) did a comparison of life satisfaction and mood in nursing home residents and community dwelling elders. The sample consisted of 138 cognitively intact ambulatory elders, 70 in nursing homes and 68 in community dwellers. Community dwellers reported increase in life satisfaction while nursing home dwellers were high on depression and dejection.

Studies conducted in India:

Ramamurthi (1970) measured life satisfaction in later years. Two scales of life satisfaction (Neugarten, Havighurst and Tobin, 1961) were administered to 250 elderly men in Madras City. The study indicated that there is an initial sharp decline in life satisfaction in the early 50's, a second decline beyond the 61st year and an improvement in the intermediate interval. It is suggested that the first decline may be due to the physical and psychological effects of ageing and later decline may be attributed to retirement.

Sharma (1971) studied a sample of 44 retired males living in urban settings and found that happiness in old age depends on busy life, good health, absence of the feeling of paucity of funds and having spouse and social contacts.

Anantharaman (1980) conducted interviews with a group of 172 men (55-89 years). The life satisfaction index, interpersonal checklist, and an inventory of attitudes and activities were used. It was found that subjects who ha a positive self concept were better adjusting and more satisfied with life than subjects who had a negative self image.

Anantharaman (1981) conducted another study to investigate health and adjustment related differences between institutionalised and non-institutionalised elderly people. 50 men residing in a home for the aged and 50 males living with their children were the interviewed. It was found that the institutionalised had poor health perceptions, reported more physical and psychological problems and had more problems in adjustments than non-institutionalised subjects. Life satisfaction was significantly higher for the latter.

Chandrika and Anantharaman (1982) compared the adjustment and life changes in three groups of older people: non-institutionalised, institutionalised and geriatric patients. The life satisfaction Index A showed that non-institutionalised older people are better adjusted than the other two groups.

Vijayshree (1988) investigated life satisfaction, depression, loneliness and death anxiety among family based and non-family based elderly subjects. The results showed that the family based aged have proved to be the most satisfied psychologically and socially as their life satisfaction scores stood significantly higher than those of others.

Chadha and Aggarwal (1990) conducted a study on 109 elderly men and women. The measures were taken on life satisfaction, hopelessness and alienation. The results indicate females to be high on hopelessness and less satisfied with life as compared to the males. Also married older people were high on life satisfaction as compared to their widow/widower counterparts.

Gaur and Kaur (2001) studied the institutionalised and non-institutionalised elderly. It was reported that non-institutionalised elderly had a higher score for life satisfaction than institutionalised elderly. The males as a whole had higher life satisfaction score than females. Also, the non-institutionalised elderly are much better adjusted and more satisfied than institutionalised elderly. Institutionalised elderly are isolated from community in a set up that does not give autonomy and independence.

The variable of life satisfaction has been perceived as the attitudes the individuals have about their past, present and future. The review of literature shows this to be affected by degree of satisfaction one has with the basic needs. Once the basic needs are satisfactorily fulfilled the higher order needs play an important role in increasing the life satisfaction level. Also, it has been reported that married people with financial security and sound health seem to enjoy a better quality of life. The social support network, general well being, physical health and leisure time activities all seem to have a symbiotic relationship with life satisfaction.

Studies on Physical Health

"Health" is a complex term to define as it has heavy subjective loading. The importance of the variable can not be denied on every

aspect of our lives. The following studies try to present an analysis of physical health relative to different chosen variables.

Lofholm (1975) the aged ranked the following conditions as their most frequent medical problems- arthritis, hearing impairments, chronic sinusitis, mental and nervous conditions, genito urinary problems and circulatory problems.

Harris (1978) the ageds are more afflicted by chronic conditions than are younger age group. The chronic conditions that most frequently occur are: arthritis (20%), visual impairment (20%), high BP (20%), heart conditions (20%). It was noted that older men are more likely to be limited in activity by chronic heart conditions than are older women. In contrast older women are more likely to be limited in activity by arthritis, rheumatism, visual impairments, and hypertension than are older men.

Rakowski, Julius *et al.* (1987) a sample of 172 communities – residing older adults (aged 64 – 96 years) were interviewed to investigate correlates of their preventively oriented, health practices. Four health practice groupings were used: information –seeking, regular health routines, medical and self examination and risk avoidance. Results indicated modest associations among individual behaviour and among the four health practice groups. Gender (i.e. women) and a supportive family environment were among the consistent predictor s of good health practices.

Bowling and Edelmann (1989) a comparison of age and gender groupings revealed decreased mobility with age and greater physical impairment with age in females. Greater loneliness was equated to higher psychiatric morbidity, increased physical impairment, decreased life satisfaction, small social network and lack of confidante.

Bowling (1994) contends that there is a fairly strong empirical evidence of relationship between social support, network structure and health status, motility and risk of entry into institutional care.

Hoeymans, Feskens, Daan and Van den bos (1999) investigated the contribution of chronic conditions and disability to poor self rated health forms from perspective of patients and population. From the population perspective 63% of poor self-rated health could be contributed to select chronic conditions, with

respiratory symptoms, musculoskeletal complaints and coronary heart disease making the largest contribution.

Asakawa, Koyano and Takatoshi (2000) examined effects of declining functional status on social networks, life satisfaction and depression. Results show social network, life satisfaction, depression are significantly effected when functional health status changes. It is an important prerequisite for higher quality of life in old age.

Al shammari, Sulaiman and Mazrou *et al.* (2000) data on 6,139 elderly participants aged (60 – 90 years) was collected and analysed. 64.2% of participants were males. The proportion of participants with definite psychopathology was 33.8% this increased with age, higher among females than males. Overall 18.8% were dependent on others for activities.

Studies conducted in India

Chanana and Talwar (1987) the data collected in the NSS 36th round in 1981 concerning disabilities among the elderly revealed that around 10.9% of the elderly suffered from physical impairments. Among these nearly half were visually disabled and remaining half were suffering from disabilities related to hearing, speed or locomotor functions. It is estimated that around 8.2 million aged persons will suffer from some type of disability in 2001, which will be around twice the number in 1981.

Rao (1988) collected data from the geriatric clinic at Madurai and the subject ranked the following as the most common complaints: visual handicap, joint pain, sleeplessness, vague body pain, backache, giddiness, cough, constipation, hearing deficit, chest pain and others.

Chadha and Easwaramurthy (1992) studied 160 elderly (80 institutionalised and 80 non-institutionalised). Amongst the various aspects covered for quality of life, one was physical health. Both male and female subjects ranked the following as common health problems: joint pains, vision impairments, hearing impairments, diabetes, blood pressure and asthma.

Bagga (1994) analysed the health status of elderly Maharashtrian women it showed the prevalence of disorders to be like: 52.23% blood pressure, 44.2% to be suffering from digestive disorders, 43.3% suffering from arthritis. It was also found that the problems associated with blood pressure increased with age.

The physical health of the person is a subjective concept; one may define it as not merely as absence of disease or infirmity but a state of complete physical, mental and social well being. This definition of the concept finds true resonance in the researches reviewed above. The old proverb 'healthy mind resides in a healthy body' appears to be true. The physical health of the person in old age forges a symbiotic relationship with the socio-psychological environment. The social environment, attitudes, personal experiences, general sense of well being etc. all govern the physical health of the elderly, which in turn acts as the intervening variable for a number of other relationships.

Studies on Leisure time Activties

Leisure activities vary according to the age or period of the life cycle and depend on factors like – income, personality, interest, health, ability level, transportation etc. these factors play an intricate role in deciding the kind of leisure activity opted by a person. The variable has been a vastly studied factor in the area of geriatric studies and has been established as an intervening variable playing determinant role in the lives of the aged.

Studies conducted abroad

Steinkamp and Kelly (1985) investigated the effects of selected aspects of motivation on levels of leisure activities and life satisfaction in 217 persons (aged 40 – 89 years). Results indicate that three motivational orientations – challenge seeking, concern with recognition and rewards, and family focus were systematically related to life satisfaction.

Kelly *et al.,* (1986) investigated leisure activities in four age groups – 44 to 54 years, 55 to 64 years, 65 to 74 years and 75 years plus. Results indicate that there was a decline in overall activity level, sports and exercise, and outdoor recreation with age. Further there was continuity in a number of core activities such as family, social, and home based activity.

Russell (1987) investigated the role of recreation satisfaction on life satisfaction using 78 male and 132 female retired persons (aged 60 to 80 years). Satisfaction with recreation activities showed a significant and positive relationship with life satisfaction.

Lomranz, Bergman, Eyal and Shmotkin (1988) studied indoor and outdoor activities of aged men and women (60 to 80

years) as related to depression and well being. Results showed that reported levels of activity could predict both depression and well being for men better than women, whereas satisfaction from activity did much better for women than for men.

Durcell and Keller (1989) examined the literature to illustrate that reciprocity and control are characteristics of leisure activities that help aged people achieve life satisfaction. Findings show that reasons for participation in leisure activity by adults are suggested as the need for companionship, novelty, escape, solitude and expressiveness.

Bevil, O'Connor and Mattoom (1993) identified the leisure activities of older adults to determine if a relationship existed between life satisfaction and leisure activities and health status. The results pointed that high life satisfaction subjects were engaged in a variety of leisure activities. Leisure participation also benefited physiological, psychological, socio-cultural and spiritual areas.

Griffin and McKenna (1998) examined leisure and life satisfaction of 104 elderly in good health living independently. Poor leisure participation was associated with old age, lack of transport and poor health. Adjustment of expectations in limited but valued activities contributes to maintenance of high life satisfaction.

Everard, Lach, Fisher and Baum (2000) assessed relationship between active engagement with life and social support with community dwelling adults (65 – 89 years). Hierarchical linear regression show maintenance of instrumental, social and high demand leisure activity associated with high physical health and low demand leisure activities with lower physical health.

Silverstein and Parker (2002) the study tested whether change in leisure activity over a 10 year period was associated with retrospectively assessed change in quality of life among older people in Sweden "ordered logit" analysis revealed that increased participation across domains leads to an improvement in life conditions. The effect was particularly strong among adults who are – widow, functionally impaired, and had relatively low contact with family.

Studies conducted in India

Chadha, Shah and Mahajan (1991) collected data from 60 males and 60 females from civilian and army backgrounds, it was

found that these retired people engaged most frequently in solitary or family based activities. The differential occupational backgrounds and sex differences are also found to influence the types of various leisure pursuits of the aged in the study.

Chadha and Nath (1995) took up a study in which the sample consisted of 323 males and 342 female elderly. It was observed that elderly persons are more involved in solitary activities. Males are more involved in cultural activities and also have more physical activities than the females. It was also reported that males have more social activities as compared to females.

Chadha and Easwaramoorthy (2001) in their study reported that the conception and coping with leisure are important contributors to life satisfaction. Leisure time activities are strongly and positively related to general well being of the elderly.

Leisure time activities that the elderly engage in during their pastime does give one an insight into the lives they lead. The variable has emerged as a strong predictor of health, well being and social lives of the elderly population. The studies reported from India and abroad put forth the point assertively.

The review of literature under different subtitles discussed above points at the multifaceted behavioural domains of the relatively under explored area of gerontology. However, one must not get confused and should see the emerging relationships that have surfaced from discussions.

A growing ageing population has important implications both for micro and macro levels. The studies in the area of gerontology contribute seriously to social and economic planning of the country. Not only this but the society gets benefit of the study by evolving better individuals and social relations. The individuals are also benefitted by the findings by learning to adapt and develop themselves according to the environment.

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Aging Brain and Medico-Legal Implications

O.P. Murty

ABSTRACT

Aging process is an integral part of our body mechanism and one has to recognize this natural process and its fallout . Majority are lucky to maintain good mental and physical health but few are at disadvantageous edge . According to the census of 1981, 6.5% of total population was above the age of 60 years among which 3.8% were above 65 years of age. With the current population of about 1 billion in India, 75 million are above 60 years of age and about 47.5 million are above the age of 65 Years.

This article discusses the major issues of testamentary capacity, consent, employment in hazardous jobs, driving, and decisions taken. The role of a medical officer is highlighted in this context . The limitations have also been discussed. It also highlights points to safeguard oneself in litigant world .

Key words : Old age, Aging Brain, Consent, Testamentary capacity

In India, life expectancy has gone up from 32 years in 1941 to 62 years in 1991. The aging of the population has affected the functions and structure of the families, working opportunities, socioeconomic policies, health and education etc.[10]

In geriatric cases, if there is no or minimal evidence of cognitive impairment, remain in charge of their own affairs and destiny, moreover there is mental clarity then social, medical and legal people should respect it. The main issue remains the “Money”, if a person is poor there is hardly any problem but if one has substantial property, such as ownership of a house, land, investments, incoming rents, pensions, trust, or any other moveable or immovable property then matter is more complicated.

Two important questions, which arise, are:

1. Is there is any **mental deficit**, which affects judgment, behavior, and decisions making ?
2. If there is a **mental illness,** is it such that it meets the criteria of the law regarding these specific issues.

The two major issues in medical terms are

A. Informed consents - Whether a person is fit?
B. Testamentary capacity

C. Occupation in hazardous work affecting self and others
D. Driving skills
E. Major decisions taken and its review

The important issues remain :

1. Person is inseparable of living an independent life, or
2. Person is unable to guard himself against exploitation
3. State mind arrested or incomplete development of mind

The essential ingredients of a sound disposing mind are

1. Proper orientation as to space, time and person
2. A knowledge of one's estate
3. An understanding of the nature and consequences of a will / consent
4. Recognition of those who have a rightful claim to his estate after his death.

Like in government employment, there should be age limit for making public-life decisions affecting a particular profession, art or public -related issues.

Mental confusion in old age is mainly due to vascular pathology, cerebral hypoxia due to cardiac failure, anaemia, respiratory disease or COPD, depression, alcohol, drugs like L-dopa, sedatives, digitalis, electrolyte imbalance, poor nutrition, frequent change of weather.

Changes in the **intellectual function** in old age is reflected as poor verbal expression, power to retain for new material is poor, abstract thinking, problem solving is well preserved . Problem solving breaks down quickly under time pressure or when distraction reduce concentration power.

Competency is always in question when a person suffers from senile dementia. The mental incapacity of varying degree is always present The loss of cognitive and behavioral capacities characteristic of dementing illnesses, have significant medical, legal, and ethical consequences for the patients.

The diagnostic criteria for dementia as APA, 1994 has:

1. Aphasia – difficulty in comprehension and expression of language
2. Agnosia – inability to recognize objects, places and people

3. Apraxia – inability to carry out motor functions
4. Deficit in executive functioning – planning, organizing, sequencing, and abstracting

All adults are presumed to be competent unless a court has determined otherwise, in older people mainly suffering from dementia competence is important issue in medical, legal, and ethical terms.

1. Testamentary capacity

Testamentary capacity denotes the ability of the individual to make a valid will.

Testamentary capacity presupposes that the person making will knows

1. That person is making will
2. The extent and nature of property of issue involved
3. About his natural heirs
4. The manner of disposal of property

In context of financial capacity he has

Ability to communicate

Consistent expression of preferences

Knowledge of income

Knowledge of expenses

Handling of everyday financial transactions, and

Ability to delegate financial wishes

Moral claimant

The legal criteria for a valid will are:

1. A sound disposing mind and memory of testator
2. The absence of undue influence
3. The presence and signature of two disinterested witnesses

Medical Practitioner's role in testamentary capacity is :-

1. Assess the compos mentis of the patient
2. He should acquaint himself with patient and family members and should avoid giving 3.without proper and repeated examination
4. A videotape or audiotape should be preserved

5. Two independent witnesses should be there
6. Psychological testing, if facilities are available
7. Detailed examination report
8. All findings should be recorded in a proper detailed manner
9. Report should have basis of his findings and observations
10. These should be preserved as may be required by the court.

In cases of doubt person should also be examined in isolation but never take this risk in terminally ill persons. Moreover, testamentary capacity a legal issue rather than medical one, medical practitioner's role is just to provide a report which assists the court in arriving to the decision.

Cognitive status

It is a complex process of information processing that includes comprehension, memory, orientation, attention, registration, and executive functioning like calculation, planning organizing, and abstract thinking.

Progressive cortical dysfunction is assessed by

General behavior, intellectual state, mood variation and reasons thereof, idiosyncrasy

Disorientation

Loss of recent memory

Dyscalculia

Inability to think clearly

Poor concentration and impaired judgment

Agnosia

Delusion of poverty, infidelity and persecution

According to Patterson and Bolger, in dementia four abnormalities are assessed, viz.,

1. Depression including apathy, withdrawal, listlessness and tearful
2. Psychotic feature like hallucinations, delusions and paranoia
3. Activities like wandering, agitation, eating and sexual disturbances, aggression, sleep disorders, rummaging, and hoarding

4. Anxiety

The Mental Health Act 1987 defines in section 2(f) - Mentally ill person as a person who is in need of treatment by reason of any mental disorder other than mental retardation.

Mental Disorder is mental illness, arrested or incomplete development of mind, psychopathic disorder or disability of mind.

Psychopathic disorder means a persistent disorder or disability of mind (whether or not including sub-abnormality of intelligence), which results in abnormally aggressive or seriously irresponsible conduct on the part of the patients, and requires or is susceptible to medical treatment.

Section 16, which defines "undue influence" takes into account the possibility of a person, whose mental capacity is temporarily or permanently affected by reason of age, illness or mental or bodily distress.

Indian succession Act 1925, Section 59 states that "every person of sound mind not being a minor may dispose of his property by will".

The doctor should explain the specific purpose and nature of the interview to the testator and should try to assess the specific legal components, which constitute testamentary capacity.

Suicide

If a person commits suicide after a will, it is suspected that his mental condition was not normal, if mental disorder is not proved then the will is valid.

Invalidation by Court

A court may invalidate a will if is proved that the person, at that time was not of sound mind and had in sufficient mental capacity to understand the nature and the consequences of his act. It sees that will is made in normal conditions or not.

2. Consent

The issue of consent arises in two situations

1) Therapeutic treatment

2) Research

Proxy consent by next of kin or guardian is sufficient for these purposes, if himself is unable to give such .

Reasonableness of a person is decided

1. Personality and temperament of the patient and his attitude
2. Whether patient wants information
3. Whether patient asks questions
4. Level of understanding of the patient
5. Nature of dealing or treatment
6. Possible harm and its magnitude idea
7. Degree of risk
8. Remoteness of the damage

One of the essential features of establishing a contract is consent, which has been defined as "an agreement, compliance or permission given voluntarily without any compulsion" (Vas, C.J. *et al.,* 1997).

Sec. 13 of Indian Contract Act implies that "two or more persons are said to consent when they agree upon the same thing in the same sense".

Sec. 14 of Indian Contract Act, consent is said to be free when it is not caused by coercion (Sec.15), undue influence (Sec.16), fraud (Sec.17), misrepresentation (Sec.18) and mistake (Sec.19).

Doctrine of informed consent

The essential components of informed consent are:

1. All the relevant information of the disease and treatment
2. All significant and material rsisks are to be disclosed
3. The patient also should be informed about other alternative treatments if available
4. Use simple language so that the patient can understand and take the necessary decision

The **Therapeutic privilege** enables the doctor to withhold from the patient some information (the risks), if it can be shown that, disclosure would have posed a serious threat to the psychological health of the patient. However, the doctor will be liable if he omits to warn where the risk is such that any person in the patient's situation would have regarded it as significant.(Vas, C.J. *et al.,* 1997).

Who is competent to give consent?

Age

Consent is a contract and to make a valid contract both parties must be major and should be of sound mind. **The Indian Majority Act, 1875** declares that every person domiciled in India shall be deemed to have attained majority when he/she has completed 18 years of age. **According to Sec. 11 of Indian Contract Act** "Every person is competent to contract who is of the age of majority according to the law to which he is the subject, and who is of sound mind and is not disqualified from contracting by any law to which he is the subject".

Mentally sound

As per **Sec. 12 of Indian Contract Act** "A person is said to be of sound mind for the purpose of making a contract, if at the time he makes it, he is capable of understanding it and of forming a rational judgment as to its effect upon his interest". Many tests have been devised to evaluate the competence of a person. Some of them are as follows:

Assessment of the orientation of the person to place, time, person and situation

Assessment of recent and past memory

Assessment of intellectual capacity, and

Assessment of behavior like agitated, anxious or any other abnormal behavior etc.

In addition to the above tests, a review of past history of psychotic illness including drug abuse has to be taken. To come to a conclusion that the person is mentally incompetent an overall assessment has to be done. Performance of only one of the above mentioned tests would not do.

Cases in which consent is not necessary

Besides medical emergencies the other situations where consent need not be obtained are when:

1. A person is suffering from notifiable diseases
2. Immigrants
3. New admissions to prisons
4. Examination under court order- especially to ascertain the mental condition of the person to be examined.
5. Request by a police officer under Cr.P.C. Sec 53 (1)

6. Members of armed forces
7. Persons handling food and diary products
8. Government programs like immunization.
9. Medico-legal autopsy

Extension Doctrine

The courts have consistently recognized that complete diagnosis of an internal ailment may not be possible until the incision is made and the organ is open. So when a surgeon is confronted with unanticipated condition and the immediate action is necessary for preservation of health of patient and it is not possible to take consent at that material moment, he is justified in extending the operation and in removing and overcoming the condition without the expressed consent of the patient. (Pallay, V.V. 2003)

Consent and religious beliefs

No person's religious belief even if it appears to be unusual should be ignored and utmost care should be taken to preserve his sentiment.

While the wishes of the adults must be adhered to, the courts have taken the attitude that public policy may be different for children. The decision has been, "Parents may make martyrs themselves but they are not free to make martyrs of their children". Under such circumstances it is best to get a court decree. (Gupta R.L. 1999)

Proxy consent

When a person in need of treatment is incapable of giving expressed consent (minors, insane, intoxicated), a substituted consent (proxy consent) should be obtained from the next kin. The generally accepted order for proxy consent is spouse, adult child, parent, sibling, and lawful guardian.

In case of minors consent of one parent is required vide 89 IPC. While treating the inmates of a hostel (in this case old homes) consent of the care taker should be taken (loco parents).

Or the purpose of transplantation of human organs, consent of the donor is required. But in case of cadaveric transplantation, consent of the next kith and kin is a must even though advanced directive is available mentioning his wishes about his organs to be transplanted.

Confidentiality and consent

Except in the circumstances of privileged communications, secret information about the patient should never be disclosed without the prior consent of the person. If the identity of the person is not disclosed, then a doctor can publish the relevant photographs taken from the patient, without his consent. (Francis, C.M. 1993)

Special circumstances

1. Sec. 53 CrPC

Sometimes an accused in police custody refuses to be medically examined for some or other reasons. In such cases the law provides that while making a medical examination of the accused at the request of a police officer not below the rank of sub-inspector, such forces as is necessary for the purpose may be used. Whatever discomfort may be caused when samples of blood and semen are taken from arrested person, it is justified by the provisions of Sec.53 and 54 CrPC and does not come within the mischief of testimonial compulsion within the meaning of Article 20(3) of Constitution. A person released on bail does not cease to be an arrested person and can still be subjected to medical examination. (Gazette India 2002).

2. Hunger strike

A hunger striker is a mentally sound person, who has indicated that he has decided to embark on a hunger strike and has refused to take food and/or fluids for a significant interval. As per the World Medical Association declaration on hunger strikers (1991), the ultimate decision should be left with the individual doctor without intervention of third parties whose primary interest is not the patient's welfare (Knight B. 1996). In our Constitution if a person is committing suicide, it becomes punishable act **Section 309**, abetment is covered by **Section 306 IPC.**

3. Biomedical experimentation

An informed consent is invalid, if experiment involved an appreciable risk to the health of the subject.(Subrahmanyam, B.V. 1999)

Rules for consent

i) **Free consent** i.e. it must not be obtained under coercion, undue influence, misrepresentation, fraud or mistake.

ii) **Capacity** to enter into contracts i.e. they must not be minors, they must not be of unsound mind, unconscious or intoxicated.

iii) **Incapacitated**, consent of guardian or person in lawful charge of the patient must be taken.

iv) The consent must be **specific.**

v) **No suppression** of any facts either by the doctor or by the patient.

vi) **Consents** duly witnessed and signed by uninterested third parties are more dependable legally, as the parties concerned cannot subsequently deny execution.

vii) Consent is not a defense against negligence.

viii) A person cannot be detained in a hospital without his consent.

4. Hazardous Occupation

Many people are in hazardous occupation where life and safety of other people is involved. They should be given this kind of employment or should be assessed on regular intervals for medical fitness-can a person be employed in Government or Public Sector, and what should be the age limit in this regard .

5. Driving

While a person is driving in public the safety of other people is also stake in front of inexperienced people . The reflexes of a person are slow and reaction to any emergency is delayed

6. Major Decisions in public and personal life

In our political system it is observed that persons of more than 70 years are dealing with very sensitive departments and take major decisions. In routine they have very rich experience which help them to decide on the major issues. It is also seen that many are very poor in reading, listening, and comprehending the matter in rightful manner. The work is mainly done by their assistants . The effect of aging can be seen in their work, speech, functions and at delivering end.

Whether medical Fitness should also be made a criteria before contesting a election or taking any important public office or not, is a question which require a serious thinking.

The common economic problems of the elderly are :

– Decrease income

- Increase in expenses
- Medical and health Expenditure
- Social and festival expenses
- Increasing price
- Various taxes
- Inadequate pension
- Less oppurtunities for reemployment
- Lack of financial support
- Faulty distribution system
- Increased financial liabilities.

Every individual /elderly persons always tries to avoid problems he has suffered to come up as constraints/hurdle in development of his children regarding health, education etc.

Today value is given only to the productive potential of the individual. In present days of modern industrialization and urbanization and increasing involvement of active young generation the role of old age person in a family has become less and they are made helpless.

After retirement, shifting from government house to rented house with decrease in source of income and increasing rental value has created social problems for elderly persons. This is likely to be aggravated by loss of friends and time taken in adjustment in new environment. This may lead to living in a overcrowded space and in a compromised situation.

This situation has caused increased hospitalization of the elderly person without any illness as they are lacking support of family and community and lack of employment.

Common social problems can be faced by the elderly persons are–

1. Welfare of himself-
   - Lack of contacts with friends (coldness in relation with family members community colleagues and community)
   - lowering of socioeconomic status- loss or decreased source of income may lead to inferiority complex in elderly in the society due to physical inertness
   - Inability to attend friends
   - Inability to attend educational meetings or seminars

- Inability to attend social or community meetings
- Inability to involve himself in happier or sad moments of relatives

2. Welfare of family members
3. Education and upbringing of children along with their settlement
4. Loss of life partner and feeling of isolation and neglect by children
5. Lowering of standard of living

All these problems are likely to erode or damage the social status of an elderly person to a great extent.

Public Assistance Act 1947 in UK is one way to compel public to do certain duties, in our country we Citizen Charter .

Old Age Abuse

It is also not very uncommon that older people face abuse at the hands of younger people or relatives in from of physical assault, verbal, physical, social neglect, and financial neglect.

Essential Care Concept

Hygeine and nutirtion

Provision of clean water, antibiotics and timely medical attention

In **old age screening tests** which are of high diagnostic value are

Urine for sugar, blood, and protein; blood urea, creatinine, electrolytes; blood Sugar, chest x-ray, ECG, urine and sputum for microbiology : serum albumin, Ca^{++}, alanine aminotransferase (ALT), and alkaline phosphatase .

Laws pertaining to elderly in India -

Constitutional provisions -

– **Article 41 of Indian constitution** – Government is bound to take effective steps to provide social security for the welfare of the old people. According to this “The state shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement and in other cases of undeserved want.”

- Entry 24 in list III of **schedule VII** in constitution of India deals with provident funds and old age pension beside others.
- **Item no. 9** of the state list and item 20,23 & 24 of concurrent list relates to old age pension, social security, social insurance and socioeconomic planning.
- Section 2 of the Hindu adoption and maintenance act 1956 recognizes the right of parents without means to be supported by children having sufficient means.
- Code of Criminal Procedure 1973, **Section 125(1)(d)**- order for maintenance of parents. According to this - If any person having sufficient means neglects or refuses to maintain them (parents) A first class magistrate on proof of such neglect may orders such a person to make a monthly allowance for their maintenance not exceeding rupees **500/-**in the whole or as magistrate thinks fit and to pay the same to such person as the magistrate may direct from time to time.
- Government of Maharashtra, Goa and Himachal Pradesh are in the process of preparing and implementation of "**Parents Maintenance Bill**" so that the parents who are ignored by their children, are given maintenance.

Legislative Provisions

- **Section 88 B** of Finance act 1992 (Income tax Act1961)-Provides rebate of income tax to senior citizens who has attained the age of 65 years at any time during the relevant previous year. From 1998-99 tax rebate under section 88B shall be-
  a. The amount of income tax before giving any rebate under section 88, 88B and 88(1) or
  b. Rs.10,000/- or 40% whichever is less (Rebate is available from assessment year 1998-99 even if total income is above Rs. 1.20,000.
- **Section 80D** (Finance Bill 1999).

An assessee is entitled to a deduction up to Rs. 15,000 with effect from year 2000-2001 where assessee, his/her spouse, dependent parents or any member of the family is a senior citizen (above 65 years of age)

and medical insurance premium is paid to effect or keep in force an insurance in relation to him or her.

- **Section 80DDB** (Finance Bill 1999)- Provide a separate deduction to a resident assessee being an individual or Hindu undivided family member for expenditure incurred for medical treatment for the individual himself or his dependent relative irrespective of disease. The deduction shall be limited to to Rs.40,000/- and in case of senior citizen a fixed deduction of Rs.60,000 will be available.
- **Section 80CCC(1)** of income tax act 1961- Contribution under Jeevan Suraksha upto **Rs./-10,000 Pera annum will be eligible for tax exemption.**
- **Income tax Payers Act-1974**- Some relief to elderly people was granted in the Compulsory Deposit Scheme. Under this act persons liable to make compulsory deposit did not include persons of more than 65 years of age. Earlier age limit was 70 years which was reduced to 65 years (Amendment 1983).
- **Delhi Rent Control Act 1958**- for retiring persons who are landlords, a summary scheme for eviction of their tenents was provided in Section 14B & 14 C of that act. The Ammendment made in 1988 cared out more classes of landlord to enable them to recover immediate possession of premises let out by the through introduction of section 14B to 14D. Released or retired persons from armed forces or the dependent of the members of armed forces who have been killed in action are covered by section 14 B, the retired employees of Central Govt. and that of Delhi administration are covered by Section 14C and widows by 14D.

Judicial Supervision

According to judgement given by Hon'ble Supreme Court of India in case D.S. Nakara vs **Union of India**- AIR-1983, SC130-it is mentioned that –

"Pension is a socio-economic justice measure providing relief when advancing age gradually but irrecoverably impairs capacity to stand on ones feet."

"If state considers it necessary to liberalise the pension scheme we found no rationale principle behind it for granting these benefits to those retiring subsequent to a particular date and denying the same to those retiring prior to that date as those who retired earlier can not be worst off than those who are retired later. In this equal treatment guaranteed under article 14 is wholly violated.

Welfare Schemes

Travel facility

1. Indian railway has given the facility of 75% concession in fare of sleeper class to a person more than 65 years of age, suffering from heart disease himself and an accompanying person for transfer to hospital for treatment from the residence .
2. Few states has given 50% concession in fares of the state roadways buses to the senior citizens.
3. Reservation of the seats for elderly persons in the buses of state transport corporation with 50% concession in the fares. Elderly women more than 60 years enjoy free travels in Punjab. Free passes are provided to old people who are freedom fighters.
4. Reservation of seats in few trains during specific hours for elderly persons.
5. Concession for senior citizens in fares for all classes upto 30% in trains of Indian railways.
6. Concession of 50% in basic airfare has been introduced by Indian airlines and Jet Airways for elderly persons or senior citizens.In Sahara airlines 50% concession to those above 62 years of age.

Financial

1. 100% rebate in income tax (max.10,000) irrespective of the income (Non-buisness persons and professionals do not even require the filing of return)
2. Small monthly pension to elderly persons of older age.
3. Fianancial assistance given by the associations of senior citizens.
4. LIC-Jeevan suraksha, Jeevan Dhara, Jeevan Akshay, Beema Nivesh and Jeevan Arogya. There scheme to cover medical facilities by UIT.
5. Exemption of profession tax implemented by govt. of Maharashtra. Sanjay Gandhi Niradhar Anudan Yojna and Indira Gandhi

Bhumihin Vrudh Sheth-Majdoor Sahayay Pension scheme to the retired government employees, and their surviving spouses receive the benefits lifelong.

6. Pension, Gratuity and dearness relief to government employees on retirement.
7. Annapurna Project- by Ministry of Rural development and Ministry of Food and Civil supplies (Govt. of India), has been initiated to provide 10 kg food grains per person per month to those eligible for pension under National old age pension scheme but are not getting the same.
8. Financial assistance of Rs.30 lakhs to social welfare organizations for constructing old age home/multiservice centre for elderly persons.
9. OASIS scheme- Old age social security and income security (Ministry of social welfare and Empowerment)–provide recommendations for quantitative improvement of customer services of Public Provident Fund, Employees provident fund, Planning of LIC and UTI and to design extensive pension programmes for elderly persons especially those who are not in government jobs.

Medical

1. Arranging free medical camps by various social organizations/government
2. Medical insurance covers for elderly person upto 70 years of age from general insurance corporation
3. Geriatric clinics in various government Institutions
4. Reimbursement of medical expenses of senior citizens by various organizations
5. Effective utilization of services of alternative medicines.
6. Supply of Educational material regarding health .
7. Government has prepared a scheme of Rs.5000 crore for free health coverage of senior citizens, who are neither prisoners, nor covered through any private health scheme.Average per capita expenditure incurred by the defence ministry to provide health care facilities to retired defence personnel and their families worked out to be Rs.1200 per patient per year.

Accomodation

1. Government providing financial assistance to NGO for providing shelter homes to elder persons of low socioeconomic status.
2. Concessions for eldely persons on tourist places by various government bodies.
3. Government/Non government organizations providing free homes to elderly persons.
4. Old age homes in various cities.

Social

1. Senior citizens welfare organizations for welfare of elderly persons.
2. Institutional research work on various medical social and economic issues pertaining to elderly.
3. Association of retired govt. employees for look after the welfare of their families.
4. Service organizations .-Helplines
5. Special considerations in services of Telephone, Railway/Bus booking counters, at bank counters, etc.

Occupational rehabilitation

Effective utilization of knowledge and experience of elderly persons on honorary basis and thus providing financial assistance.Financial assistance from various agencies for occupational rehabilitation.

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Elderly Person : A Medical Overview

K.C. Mathur

Generally speaking, aging is the process of merely growing older in a temporal sense. The term does not imply the presence of disease or any abnormality. Aging is characterised by an overall decline in the organism's capacity for adaptation. Furthermore, senescence or aging is the sum total loss of functions and structures, when a person grows older (Harrisson, 2001).

The following description gives an update on their common ailments with the initiation of aging and the intervention needed.

Physiological Changes In Process Of Senescence

(a) ***Cardiovascular system.*** The changes include decrease in number of myocardial myocytes and increase in volume, decrease in s.a. nodal discharges, disruption in a-V conduction, rigid and narrowed blood vessel, prolonged duration of cardiac contraction and relaxation, decline in maximal heart rate response to exercise, blunted cardiovascular reflexes, tendency towards bradycardia which is because of increasing vagal tone with age.

Hypertension, ischaemic heart diseases, syncope, chronic cardiac failure, complete heart block, peripheral vascular diseases, atrial fibrillation are ailments by which an elderly is exposed.

Pigment granules appear in aging heart. Other factors being equal, the heart of a 60 year old man is better prepared to withstand the effects of coronary occlusion than that of a man at 20 years.

ECG changes in elderly (Shawney *et al*., 2001). The ECG shows no specific changes with age but ECG abnormalities are common in old age. Almost all changes are accompanied by adverse prognosis in elderly population. In an elderly, minor changes include - low voltage R and S wave, isolated abnormal left axis deviation - 30° or more, increased P-R interval, atrial/ventricular premature beats. It was suggested that 50% of elderly individuals have heart rate within normal range; the tachycardia was found in 16%, bradycardia in 6% and arrhythmia around 20%. QRS duration also tends to increase with age. Low amplitude QRS complexes also increase in frequency with age. LAD has got an anatomical basis; the

elevation of diaphragm in old age causes heart to assume a horizontal position. Ventricular repolarization increases with age. There are higher incidences of atrial fibrillation than atrial premature beats. Non specific ST-T and T wave changes are frequent in elderly patients. The percentage of missing P waves increases with age and P wave notching/slurring is common.

Isolates systolic hypertension in elderly (ISH). It keeps increasing with age, in persons around 60 years or above. Epidemiologic studies have demonstrated an increased risk of stroke, other cardiovascular diseases and death for those with ISH, independent of other risk factors.

(b) ***Respiratory system.*** They include decline in the number of glandular epithelial cells in the large air ways and consequent decline in the production of protective mucous, reduction in alveolar surface for gas exchange, decline in respiratory muscle strength and stiffening of thoracic cage, decline in vital capacity and ventilatory response to hypoxia and hypercapnia, decrease in cough reflex and ciliary action in the lungs, loss of supportive tissues and dilatation of smaller airways and airspace. All these finally terminate into higher risk of infection, reduced exercise tolerance and greater risk of respiratory failure. The common diseases creating problems in elderly include - pneumonia, COPD, tuberculosis and lung cancer. As the age advances chest wall becomes less mobile and elastic recoil of lung is reduced - so called fixed chest.

(c) ***Gastro-intestinal-tract.*** The senile changes are - loss of teeth, weakness of muscles of mastication, atrophy of oral mucous membrane, decrease in number of taste buds, delay in gastric emptying along with reduction in gastric acid secretion, reduction in liver volume along with its perfusion and blood flow and decline in regenerative capacity of hepatocytes, reduction in absorptive capacity of nutrients by small intestine.

The common gastro-intestinal diseases include - constipation, peptic ulcer, hiatus hernia and gastro esophageal reflux. Symptoms include heartburn, dysphagia, pain in lower sternum, belching. Older

persons frequently complain of constipation. Bowel motility does not decrease with age. This explains the use of laxatives in old age.

(d) ***Reproductive system.*** Menopause is a physiological process which takes place between early 40s and 50s in which ovaries reduce their production of female sex hormones. Sexuality is a normal and a healthy part which continues throughout the older years. It is strongly associated with the need for inter personal relationship, the need for physical and emotional intimacy, the need for love and affecting and one's self image.

(e) ***Endocrine system.*** These functions start declining from the time of sexual maturation. Decline occurs in hypothalamic releasing hormone, basal-circadian and maximal levels of gluco-corticoids as well as circulating levels of mineralo-corticoids are maintained within the normal range. Aging is associated with glucose intolerance. The diseases occurring commonly include - diabetes mellitus, hypo- and hyperthyroidism. Obesity, deafness, coarse skin, cold intolerance, hoarse and slurrede voice, fatigue, arthralgia, low cardiac output states including bradycardia are other common features of old age.

(f) ***Musculo-skeletal-system.*** The normal age related changes iclude - loss of muscle strength, bone loss at menopausal time, decreased strength of the joint, loss of tensile strength of ligaments and tendons, gradual decrease in water content volume and mechanical resistance of inter-vertebral disc. The common diseases related to this system include - osteoarthritis, rheumatoid arthritis, osteoporosis etc.

(g) ***Urinary system.*** Age related changes normally occurring include - decline in number of nephrones, 50% decline in GFR between 20-90 years, less responsiveness of kidney towards sodium loss.

(h) ***Brain aging and cognitive impairment.*** Normal age related changes include - loss of neurones, reduction in size of brain, enlargement of ventricles, reduced transmission efficiency. Age

associated memory impairment (AAMP) is characterised by gradual onset of memory dysfunction, intact global intellectual function absence of dementia, absence of any neurological/psychiatric/medical disease. Dementia is a clinical syndrome characterised by persistent impairment of multiple cognitive capacities including impaired memory, disturbance of language function and visuospatial skills and variety of behavioural problems.

(i) ***Sensory functions.*** The thickness of epidermis decreases which leads to dry and rough skin. The number of melanocytes decreases and so is against infection.

In the dermis fibroblasts decrease along with production of extra cellular matrix which terminates into wrinkles of skin. Growth of nails slow down and hair turns grey due to loss of melanin. Common skin manifestations in old age are infection (herpes zoster, scabies, decubitus ulcer, pyoderma), pruritus and, xerosis (due to dryness), seborrheic dermatitis, drug reactions, cancer (basal cell carcinoma, squamous cell carcinoma, malignant melanoma).

Eye lids become lax, lachrymal gland secretion is reduced leading to dry eye, sub-conjunctival haemorrhage due to fragility of vessels of conjunctiva. Different layers of retina undergo degeneration, chronic closed angle glaucoma due to distortion of anterior aspect of uveal tract, presbyopia due to rigidity of lens. Common diseases are cataract, glaucoma, muscular degeneration, diabetic retinopathy.

In ear, decreased number of hair cells and gaglion cells in organ of corti along with decrease in number of sensory nerve fibre are noticed. Uncompensated loss of hearing occurs.

Others Common Problems of Elderly

(a) ***Depression in elderly*** (NIH Consensus Conference, 1992). Depression in the aged is a major public health problem. Depression in late life frequently coexists with multiple chronic diseases and disabilities e.g. cardiovascular diseases, neurological disorders,

arthritis, cancer, metabolic diseases etc. Furthermore, depression in late life occurs in the context of numerous social, developmental and biological diversities which includes the instances like death of spouse, retirement (social level); variability in regulation like disturbed homeostasis (biological level).

Criteria for diagnosis of depression include - Changes in appetite and weight, disturbed sleep, motor agitation, depressed or irritable modd, loss of interest or pleasure in usual activities, fatigue and loss of energy, feeling of excessive guilt, suicidal attempts/thinking, difficulty with thinking/concentration.

Depressed elderly people should be treated vigorously with sufficient doses of antidepressants. Maintenance treatment with anti depressants should be continued. ECT may be helpful, Psycho-social treatment can also play a leading role.

(b) ***Prevention of falls in elderly*** (Mary, 1989). Injury is the sixth leading cause of death in persons over the age of 65 years. Serious soft tissue injury includes - hematomas, sprains and joint dislocations.

The neurologic conditions associated with fall include - Parkinson's disease, hydrocephalus, hemiparesis. Visual states with fall include cataract, glaucoma, macular degeneration etc. Medicines related with vestibular dysfunction are amino glycosiders, aspirin, furosemide, quinine, quinidine, alcohol, tobacco etc. Cervical spondylosis, injury or arthritis may disturb postural control and predispose persons to fall because of damage to mechanoreceptors in apophyseal joints. Foot problems including calluses, toe deformity, ill fitting shoes may be underappreciated cause of instability and falls. Abnormalities in balance and gait have been repeatedly associated with falling. Majority of fall occur during usual activities like walking or changing the position.

The medications responsible for fall in elderly include - diuretics, vasodilators, Benzodiazepines phenothiazines, opioids etc.

The majority of falls among elderly occur at home, an assessment of safety of home environment can be helpful. Ill fitting shoes, too long pants, slippery floors must be avoided, bed should neither be too high nor too low, chair should be high and firm and other furniture should be carefully assessed. History of previous falls should be carefully reviewed.

(c) ***Management of drug therapy*** (Stephen *et. al*., 1989). Drug therapy in elderly is complicated by many factors unique to this age group. Because it requires careful individualisation, such therapy should be based on the principles of pharmacokinetics.

The overall incidences of adverse drug reactions in the elderly is two to three times that found in young adults. The drugs most commonly implicated in adverse drug reactions are taken more often by the elderly than by other patients. In many cases, these are drugs with a low therapeutic index like digoxin. Other drugs commonly implicated in adverse drug reactions in elderly include beta blockers, calcium entry blockers, sympathomimetics, methyldopa, furosemide, thiazides, NSAID, steroids, benzodiazepines, theophylline etc. Concomitant use of an NSAID can exacerbate hypertension.

The best documented alteration in pharmacokinetics with age is the reduction in rate of elimination of drugs by the kidney. Both the glomerular filtration rate and tubular secretion rates correlate with decline in creatinine clearance that occurs with aging. Drugs with predominantly renal elimination and potentially serious toxic effects in elderly include aminoglycosides, amantidine, lithium, digoxin, procainamide, chlorpropamide and cemetidine.

(d) ***Senile osteoporosis*** (Neil *et. al*., 1989). Although osteoporosis is a devastating condition for woemn of all ages, its ravages are felt most acutely by the elderly.

There are also age related differences in vitamin D metabolism. Serum levels of calcidol and calcitriol are lower in older woman than in perimenopausal women. The lower level of vitamin D metabolites may be related to decrease in milk and bread consumption, sunlight

exposure. Defining an abnormal level as one associated with osteomalacia may be misleading since subclinical vitamin D deficiency may cause secondary hyperparathy roidism, which is turn can lead to osteoporosis without histological or biochemical evidence of osteomalacia. Furthermore, because of the age related decline in ability to convert vitamin D to its active metabolite (calcitriol), the generally accepted vitamin D deficiency (<20 m mol/L) may be too low for older women. Finally, there is evidence that vitamin D contributes to muscle strength so that a relative deciciency might exacerbate muscle weakness and gait instability, further contributing to fall and fractures.

Many risk factors for osteoporosis in perimenopausal women are important. Diabetes mellitus, thin and tallness, smoking, inactivity, early onset of menopause, low levels of sunlight exposure are independent risk factor for hip fractures in elderly women. It was found that several medicines like long acting hypnotics, tricyclic antidepressants, antipsycotics increase the risk of hip fracture in women above the age of 65 years.

Postural hypotension, sway, impaired thermogenesis, sensory-motor and vestibular malfunction, poor balance, slow reaction time and demential all contribute to fall and fractures in elderly women.

General Screening for Functional Disability in Elderly Persons (Mark *et. al*., 1990)

1. ***Vision.*** The standardises Jaeger card is a quick, easily administered test. Fundus examination, tonometery (not in routine examination), pupillary responses are to be tested routinely.

2. ***Hearing.*** The whisper test against audiometery is an excellent simple check of hearing.

3. ***Urinary incontinence.*** The problem should be sought in a non-judgemental manner by a simple question. Do you ever loose you urine and get wet ?

4. ***Nutrition.*** Aside from other parameters, an elderly patient should have their weight and height measured routinely. Poor nutrition in elderly may reflect depression, illness (medical), etc.

5. ***Mental status.*** Dementia is the most common disturbance in mental status. A sensitive indicator of cognitive impairment is loss of short term memory and calculational ability, either of these can be used as a screening test.

6. ***Home environment.*** The most troublesome obstacle in mobility for an elderly is stairs inside and outside the house. Other spots for fall include slippery bath tubs etc. Appropriate measures for safety should be undertaken.

7. ***Arms.*** The functions of arm is divided into proximal and dista. Proximal function is involved in transfer (from sitting to standing, or from standing to sitting), - raising the arms to comb the hair or to brush the teeth or putting on a coat. Distal function includes - writing or using eating utensils.

   A man who cannot touch the back of head with both hands may have arthritis or frozen shoulder. A person who cannot pick up a spoon has an impairment of lower arm and hand that impedes the dexterity needed for most essential manual activities.

8. ***Legs.*** Its function is evaluated well by watching the patient rise from the chair, walk about ten feet, return and sit down. If any difficulty arises in this task, a complete musculo-skeletal and neurological examination is suggested.

9. ***Vitamind D.*** (Nordin *et.al*., 1980). Supplemental vitamin D should be beneficial for an older women. Cholecalciferol treatment clearly increases intestinal absorption of calcium, but it increases bone resorption as well. Elderly women may require higher doses of cholecalciferol because of their impaired ability to convert it to calcitriol.

10. ***Calcium.*** It is often debated whether to recommend calciu or not? (a) Supplement calcium is expensive; (b) high doses of calcium may decrease bone turnover limiting the ability to increase bone cross sectional area and to repair micro fractures, perhaps increasing the risk of overt fractures; (c) supplement additional calcium may produce some side effects like hypercalcaemia, acute confusional states, hypercalciurea and kidney stones (d) calcium supplement must include an increase in fiber intake, since supplemented calcium may exacerbate constipation.

11. ***Estrogen.*** (Hutchinson *et. al.*, 1979). The treatment with estrogen slows bone loss and prevents osteoporotic fractures in perimenopausla women. If continued, its efficacy is sustained until at least age 70 years.

    An additional benefit of oestrogen for perimenopausal women is its protective effect against cardiovascular disease.

12. ***Exercise.*** (Gill *et. al.*, 2000). Inactive elders are at a greater risk for diseases than a physically active elderly. Physical activity protects against diabetes mellitus, cardiovascular disease etc. Its components are strength training (isolated muscle group contraction), endurance training (walking, cycling, swimming) etc. Total 30 minutes activity daily is to be planned on an average.

13. ***Cancer screening.*** Screening for colon cancer through sigmoidoscopy. For breast cancer through annual mammography certainly protects against cancer.

The basic principles of medicine and surgery hold well in all ages. However, the finer details greatly vary in extremes of age. The discipline of geriatric medicine is meant to prevent avoidable death and improve the quality of life in old age.

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Senior Citizens
Investment and Tax Planning

Who is a Senior Citizen ?

The dictionary meaning of a senior citizen is, "an older person especially somebody who has retired from work". According to section 80 DDB of the Income Tax Act, "Senior citizen means an individual resident in India who is of the age of sixty-five years or more at any time during the relevant previous year". The Varishtha Pension Bima Yojana recently launched by the Life Insurance Corporation of India is meant for the senior citizens who have attained the age of 55 years The U.N.O. has categorised person above the age of sixty-five years as elderly but in developing countries sixty years of age has been considered as reasonabe for this classification, since, this is also the age of retirement in most of the services. In India there is no uniform age of retirement. In Central Government services, the age of retirement is sixty years but in banks and government owned corporations it is only fifty-eight years. In Indian judiciary, the retirement age varies from sixty years to sixgty-five years while in some tribunals and regulatory authorities it is from sixty-five years to seventy years. However, the status of a senior citizen is awarded to all who are above the age of sixty-five years irrespective of the fact whether somebody has retired from work or is still in active service. So gone are the days when an elderly person used to be treated like a second-class citizen.

As per the census of 2001, the population of elderly persons in India is nearly 76 millions and it is expected to increase 100 millions in 2013 as the life expectancy is believed to rise from present 77 years to 85 years by that time. This large force of elderly persons would generate problems not only for the government to provide the adequate social securities but also for these persons themselves as to how they would maintain their life-style which they used to lead before their retirement.

Social Securities in India

So far a large number of studies have been conducted on men and their adjustment to retirement but there is hardly any study or

research on retired women, especially in India when women have considerable freedom today to choose their career. As more and more women are entering the workforce now a days to pursue their career, they are also facing the same sort of problems which are being faced by men after retirement. It is observed that to give a more dignified status to elderly women, attempts are being made to give them the status of a senior citizen earlier than men. For example, the Indian Railways allow concessional travel to women of the age of sixty years and above.

Hardly 11 per cent of the working population in India and that too in government services or in organized sector only has some sort of social security for old age. Professionals, self employed persons, people in the unorganized sector and those engaged in the agriculture sector have no source of guaranteed post-retirement income. It is, therefore, very necessary for the government to adopt comprehensive programmes and long ranging schemes to ensure that this vast number of untapped population also gets some form of social securities during their old age. As a first step to this direction the government may give incentives to thesse people to encourage regular savings every year during whole of their working years so as to accumulate sufficient funds to maintain a comfortable life-style after their retirement.

Investment in annuity product and planning for retirement

Before proceeding further in the matter, it is important to note the difference be4tween investing in an annuity product and planning for retirement. The former is a once-in-a-while response at a time close to retirement while the latter is a sustained investment pattern over a number of years. The aim of planning for retirement is to encourage regular saving over all of one's working year so as to accumulate enough money that will enable one to maintain current lifestyle even after retirement. The Varishtha Pension Bima Yojana launched recently by the central government falls within the first category while a new Contributory Pension Scheme announced for the central government employees who joined service after October, 2002 can be categorized as a planning for retirement. The other

instruments used for retirement planning include provident fund, gratuity, superannuation, life insurance and even mutual funds. But the largest single reason is that consumer awareness about the realities of post-retirement life is poor. Many are just not aware of how much they must save, how much they will require later, how inflation will impact them or have not considered the possible changes in their lifestyle.

Varishtha Pension Bima Yogana

Under this scheme senior citizens above the age of 55 years can get a monthly pension ranging between Rs. 250/- and Rs. 2000/- with an option to receive the pension quarterly, half yearly or annually depending upon one's convenience. This scheme assures an annual return of 9 percent on the investment i.e. the purchase price. But the return can even be more than that if a longer period of interval of payout is selected. For example, one actually earns a yield of 9.067 perc ent for the quarterly option, 9.17 percent for the half-yearly option and 9.38 per cent for an annual option. For the option of annual payment of pension, the amount of investment will be lower than the amount of investment to be made if the payment of pension is opted on monthly basis. To make it more clear, if the maximum amount of pension of Rs. 2000/- is required to be paid monthly then the investment will be Rs. 2,66,665/- but in case total sum of Rs. 24,000/- of the pension is paid annually, the amount of investment will be Rs. 2,55,845/- only. So far as the liquidity is concerned, the lock - in period is 15 years. If one needs funds before the lock - in period is over, there is a liquidity option available in the form of loan to the extent of 75 per cent of the purchase price after the third year. The interest rate on such loan will be 10.5 per cent subject to any variation in the rate made in future. Those who are unable to invest the maximum amount at one time, can buy more than one policy subject to the over all ceilling which applies to the family as a whole.

New Contributory Pension Scheme

The scheme is mandatory for the central government employees but voluntary for other workers. It is expected that state government employees may join this scheme soon.

Under this scheme central government employees who joined service after October, 2002 will contribute monthly 10 per cent of their basic pay and dearness allowance and government would also contribute an equal amount. This scheme will be market based, have different fund managers and an independent regulatory authority. An individual will have only one retirement account number for life irrespective of his job status. However, he will choose one of the two pension accounts - normal tier-I account which bars withdrawals and the other tier-II account which will permit withdrawals. No tax benefits will be allowed in the withdrawal account. After retirement, 40 per cent of the accumulated amount will have to be invested in buying an anxuity from a life insurance company and 60 per cent will be paid to the retiree in lump sum. Pension contribution upto a certain limit for a period of 42 years will be tax free but withdrawals will be taxed. There will be a central record keeping and accounting agency directly under the control by the regulator. It would be like mutual funds. There will be three categories of fund managers. The first one will invest bulk of the corpus in government securities and small portion in equities. The second one will invest major portion of the corpus in government debts and balance in equities whereas the last one may invest as much as 50 per cent of the corpus in equities and out of the balance, 25 per cent in government debts and 25 per cent in corporate bonds. The employees can opt for one of these three avenues. The first will be the play - safe option, the second avenue will be like a mutual fund and the last one is for the risk takers. However, an employee can freely shift from one fund to the another fund.

The worst drawback of this scheme is that in case of mismanagement or fraud by the fund managers, there is no minimum risk guarantee provided by the central government. It is an experience that mutual funds in India have not been successful and even than the government is taking risk to run huge pension funds of

such a large number of its employees in similar lines without standing a risk - guarantor.

An another important element which requires attention in this contributory pension scheme is the fees and charges that will be shaved from the hard earned savings left with the fund managers. Only few people in financial field, leave alone general public, are aware of the total fund management charges and their components.

Where to invest ?

During the past few years, senior citizens are a hard hit lot. They lost their hard earned money in the share market and mutual funds. Even the government of India owned Unit Trust of India schemes have also cheated them. In the present falling interest rate scenario their income has squeezed to minimum which is hardly sufficient to sustain them. The list of safe and profitable avenues for investment of the retirement savings is limited. The incentives for savings forthcoming from the government are also poor. Under section 80 CCC (1) of the Income - Tax Act, deduction of an amount of Rs. 10,000/- is allowed from the total income of an individual who keeps in force a contract for an annuity plan of the L.I.C. for receiving pension from the fund. This amount of incentive is too meager to encourage an individual to participate in such a plan. Further, the annuity and bonus received by the individual is to be included in his total income for purposes of income-tax. So the crucial question now not only before the senior citizens but before every body is - where to invest the savings ?

At present return on bank deposits is around 5 to 5.5 per cent, on bonds of financial institutions it is around 7 per cent while small savings schemes give a higher return of 8 per cent. The RBI bonds attract a return of 8 per cent (taxable) and 6.5 per cent (tax free).

Factors to be looked at before investment

Till recently, investment decision making was very simple as most of the avenues such as bank deposits, bonds from financial institutions and even small savings were providing high returns

along with safety and security. The situation has changed now as there is a noticeable difference between various avenues in terms of yield and hence, the old principles of investment process no longer work. Thus, one cannot just look at the different avenues and then choose the one which gives highest return because there are a lot more factors which are required to be looked at before taking an investment decision.

The first factor to be looked at is whether the specified rate of return is pre-tax or post - tax and the next factor is that of tax benefits. Investors in the recently launched Varishtha Pension Bima Yojana are now realizing that the additonal income from this scheme shall result into more tax if the total income crosses the limit of Rs. 1.50 lakh and, thus, the return from this investment will be lower than that announced for the senior citizens those are between the age of 55 - 65 years. Further, there will not be any benefit for them of sec. 88 B of the Income - Tax Act which allows tax benefit of Rs. 20,000/- to senior citizens above a age of 65 years. For a senior citizen who is in the category of 55-65 years of age and falls in the highest Income Tax slab of 30 per cent, the return of monthly payment post- tax will be 6.3 per cent only.

Being received from an employer, the pension is treated as salary income under the income - tax law and standard deduction of Rs. 30,000/-or Rs. 20,000/-, as the case may be, is allowed out of it under section 16 (i) of the Income - Tax Act. Pension under the Varishtha Pension Bima Yojana will be received from the L.I.C. and the pension under new Contributory Pension Scheme will be paid by the fund managers. So there is an apprehension that no standard deduction will be allowed from pension received from the above agencies as there being no relationship of an employee and employer between the receiver and the giver of pension. Return from this Yojana, if treated as interest even than it would not have the benefit of deduction of Rs. 12,000/- under section 80L of the Income-Tax Act unless the Yojana is notified under Sec. 80 L (1) (iii). There is no scope for deduction under Sec. 80 CCC for the contribution, since, it relates to a different anxuity plan, though also understood as

pension plan. The return is liable for tax deduction at source under sec. 194 A subject to the purchaser filing a self-declaration of non-tax liability in form 15 G under sec. 197 A of the Income Tax Act.

Investment in Post Office (monthly income) Account receives a return of 8 pe cent plus 10 per cent bonus on maturity. But when the post-tax return is calculated, it is just marginally lower than the post-tax return from the Varishtha Pension Bima Yojana. Investment in National Savings Certificates also gives a return of 8 per cent but when converted to a post tax base it falls below that of the Varishtha Pension Bima Yojana.

Apart from the deduction of Rs. 10,000/- under section 80 CCC (1) from the total income for keeping in force a contract for annuity from the L.I.C., there are some other incentives under Income-Tax law which encourage people to save more. Deposits in the P.P.F., N.S.C. and other small savings schemes yield a high rate of interest of 8 per cent. The interest is also compounded. Further, the interest received from P.P.F. is totally free from Income Tax. Out of the interest received on deposits with banks, financial institutions. Post Office (monthly income) Account, N.S.C., debentures etc. an amount of Rs. 12,000/- and out of interest received on govt. securities a sum of Rs. 3,000/- are exempted under section 80 L. Life insurance premia, deposits in P.P.F., N.S.C. and other small savings schemes and infrastructure bonds to the extent of rupees one lakh also get tax benefit of 20 per cent i.e. Rs. 20,000/- under section 88 of the Income - Tax Act.

The next factor to be looked at is the limit of investment. Deposits in P.P.F., N.S.C. and other small savings schemes which provide high return and also attract tax benefit under sec. 88 are restricted to a total sum of Rs. 70,000/- only and the rate of interest on them is also liable to be changed. Investment in the infrastructure bonds of the ICICI Bank and the H.D.F.C. Bank can be to the extent of Rs. 30,000/- only as the total limit of investment in the above avenues is restricted to rupees one lakh for the benefits of sec. 88 of the Income Tax Act.

After exhausting these limits, there are some investors who have surplus funds and they are on the look out for the high -yielding avenues which do not impose limits. For such investors, there are options like RBI 6.5 per cent (tax-free) and 8 per cent (taxable) bonds. There are a number of mutual funds schemes. But people prefer to invest in debt oriented mutual funds only.

The other factors to be taken into account before the investment are safety, liquidity and lock- in period. On bank deposits the return is lowest but it ensures safety and liquidity. Some of the investors need money at short notice. In a situation like this, a bank deposit can be enchased immediatel. Investment in small savings schemes is locked in for a longer period but safety apart the return is also quite high compared to the other avenues. Bonds of financial institutions provide an element of stability to the portfolio as there are mostly medium term investments maturing after three to five years. A number of mutual funds announce attractive schemes and the dividend option in a debt mutual fund is also tax free but there is no safety of funds and surety of return from them.

All these factors change in their relative importance for different investors and the investors have to choose very carefully their assets allocation between these avenues according to their requirements.

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