

Indian Journal of GERONTOLOGY

(a quarterly journal devoted to research on ageing)

Vol. 32 No. 3, 2018

EDITOR
K.L. Sharma

EDITORIAL BOARD

<i>Biological Sciences</i>	<i>Clinical Medicine</i>	<i>Social Sciences</i>
B.K. Patnaik	Vivek Sharma	Uday Jain
P.K. Dev	Prashanth Reddy	N.K. Chadha
S.P. Sharma	Shiv Gautam	Yatindra Singh Sisodia

CONSULTING EDITORS

A.V. Everitt (London), Harold R. Massie (New York),
R.S. Sohal (Dallas, Texas),
Sally Newman (U.S.A.), Lynn McDonald (Canada),
L.K. Kothari (Jaipur), S.K. Dutta (Kolkata), Vinod Kumar (New
Delhi), V.S. Natarajan (Chennai), B.N. Puhan (Bhubaneswar),
Gireshwar Mishra (New Delhi), H.S. Asthana (U.S.A.),
Arun. P. Bali (Delhi), R.S. Bhatnagar (Jaipur),
D. Jamuna (Tirupati), Arup K. Benerjee (U.K.),
Indira J. Prakash (Bangalore), Yogesh Atal (Gurgaon),
V.S. Baldwa (Jaipur), P. Uma Devi (Kerala)

MANAGING EDITOR
Monica Rao

Indian Journal of Gerontology

(A quarterly journal devoted to research on ageing)

ISSN : 0971-4189

Approved by UGC - No. 20786

SUBSCRIPTION RATES

Annual Subscription

US \$ 80.00 (Including Postage)

UK £ 50.00 (Including Postage)

Rs. 600.00 Libraries in India

Free for Members

Financial Assistance Received from :

ICSSR, New Delhi

Printed in India at :

Aalekh Publishers

M.I. Road, Jaipur

Typeset by :

Anurag Kumawat

Jaipur

Contents

1. Impact of Membership to Groups on Subjective Well-being and Spiritual Intelligence in Elderly 231
Sobita Kirtani and Vijayalaxmi Aminabhavi
2. Is Total Lymphocyte Count a Good Marker of Nutritional Status? An Experience among Elderly Women of Kolkata 246
Bidisha Maity, Debnath Chaudhuri, Indranil Saha, Arup Kumar Das and Minati Sen
3. Suicide Among the Elderly in Ogida Community in Southern Nigeria: A Criminological Analysis 258
Emmanuel Imuetinyan Obarisiagbon
4. Quality of Life of Elderly Cancer Patients as Predictor of their Caregivers' Quality of Life 273
C. Vanlalbruaii, Padmaja, Gadiraju, Swarajya Kopparty and Tiamongla
5. A Comparative Study of Anxiety among Young Adults and Elderly 282
Aachal Taywad and Rupashree Khubalkar
6. Elderly and Changing Role of Families in Punjab 290
Bali Bahadur
7. Forced Displacement and Its Impact on Older People in Jammu and Kashmir 306
Sudesh Kumar, and Anindya Jayanta Mishra
8. Human Rights of the Elderly: An Awareness Study Among Youths 318
Ankitha Shobhakumar, Sucharitha Suresh, and Sweta D'Cunha

FOR OUR READERS

Announcement

Dr. Prasanth Reddy has joined us as a member of Editorial Board (Clinical Medicine). Dr Reddy is a Consultant Geriatrician at King's College Hospital (KCH), a major teaching hospital in London, with a special interest in movement disorders. He qualified from Bangalore Medical College in 2000 and moved to the UK for specialist training. He obtained his MRCP qualifications in 2005 and joined specialist training in 2006. He then pursued a research MD degree from King's College London and Institute of Psychiatry and obtained his MD (Res) qualifications. This was awarded to the work he did on non motor outcomes and patient reported outcomes with advanced therapies in Parkinson's. He also has experience dealing with stroke and dementia patients. He has integrated the care provided for patients with Parkinson's, Dementia and Stroke under one roof in a novel Neurogeriatric clinic, first of its kind in the UK. He has a vast experience (10 years) with advanced therapies for Parkinson's disease (Apomorphine infusion and Duodopa infusion) and supports the MDT and PD nurse specialists involved with the advanced therapies at KCH. Research and teaching: He has a research interest in the field of Parkinson's disease and is able to continue his research interest with the help of the Clinical Research Network (CRN) in London. He has regular teaching commitments at King's College London (KCL). He has 4 years of research experience as a research fellow at KCL and completed his research MD at KCL in 2015.

Management: He is the clinical lead for the Acute health and Ageing unit and for Risk and Governance in Clinical Gerontology department at King's College Hospital.

Special interests

Restless Legs Syndrome, Parkinson's disease, dystonia, Stroke, Dementia, Delirium, Comprehensive geriatric assessment?

New Life Member

L 613. Dr. Neetu Batra, Post Doctoral Fellow,
Giri Institute of Development,
Aligang Housing Scheme, "O" Sector, Lucknow-226024 (U.P.)

Indian Journal of Gerontology
2018, Vol. 32, No. 3, pp. 231–245
ISSN: 0971–4189, UGC No. 20786

Impact of Membership to Groups on Subjective Well-being and Spiritual Intelligence in Elderly

*Sobita Kirtani and Vijayalaxmi Aminabhavi**

Department of Psychology, Parvatibai Chowgule College, of Arts and
Science (Autonomous), Margao – Goa

*Department of Studies in Psychology, Karnataka Arts College, Dharwad

ABSTRACT

In this study an attempt was made to understand the influence of membership to groups on subjective well-being and spiritual intelligence of elderly. Subjective well-being refers to people's evaluations of their life. These evaluations are both emotional as also cognitive judgments. Spiritual intelligence refers to as a set of mental capacities which contribute to the awareness, integration, and adaptive application of the non-material and transcendent aspects of one's existence. A sample of 200 elderly people residing in South Goa who were divided into three groups namely, no-membership, membership to social/cultural and membership to religious/spiritual groups. A comparison was made between the groups with respect to subjective well-being and spiritual intelligence using one way ANOVA. Post hoc analysis was done to compare significance of difference between groups in all possible pairs. Results revealed that having membership or not does not influence subjective well-being of elderly. But having membership to either social/cultural or religious/spiritual groups contributes to higher spiritual intelligence than those who do not have any membership.

Key words: Subjective well-being; Spiritual Intelligence; Membership to groups; Elderly.

There is no clear demarcation or marker that suggests entry to or exit from a certain stage of life. The construct of ageing is context specific i.e. it varies according to different cultural perspectives (Channa, 2015). In India, the social meaning of ageing is linked to one's marital status – unmarried people are generally considered young and married people are considered mature. Similarly parents having older children are considered 'old'. Thus, the way one's life cycle matures affects the social process of ageing. On one hand a woman's age is perceived in relation to her social relations, men's age is seen to be related to his occupational status i.e. a retired man is seen as old.

Ageing has two sides, positive and negative. The positive side includes wisdom and experience. The negative side pertains to decline and deterioration as a result of diseases and impairment. Accordingly, different viewpoints exist based on which side of ageing is highlighted – the positive or negative. Ageism is a result of attention centred on the negative aspect of ageing. A contrasting view is that of successful or optimal ageing. This view acknowledges the loss of abilities in old age but focuses attention on how people engage in various other activities. Many people actively try to fill the void created by retirement from active duties by engaging in various activities such as pursuing hobbies, leisure activities and participation in formal or informal groups. Formal groups are organized, registered associations that provide a platform to attain certain goals. For instance, the Lions club, Rotary club and the likes. These are social groups that encourage people to get together and also work for a cause. Many elderly turn to spiritual groups as also religious groups. Spiritual groups such as the Chinmay Mission impart philosophy of life and hold spiritual discourse. Religious groups such as affiliation to temples and churches allow people to nurture religious ideologies and practices. On the other hand many do not seek active membership to or participation in any group. These people may rely on family members and friends to provide security and a sense of belongingness. Research shows that people who have more social contact tend to be happier. Contact with friends is more beneficial than contact with relatives (Diener E., 1984). Besides, both quantity and quality of social relationships strongly correlate with Subjective well-being (SWB). However, people differ in social needs. While quality of contact with friends is strongly linked to SWB,

quality of contact with family especially adult children is strongly related with life satisfaction. According to Mathews (1986 cited in Pinqart and Sorensen, 2000) this could be a result of older people staying away from or disengaging from unsatisfactory friendships.

The technical term used to refer to happiness is well-being (Baumgardner, 2009). Normative definitions of happiness state that certain criteria underlie happiness. Thus, possessing desirable quality is in itself happiness. Social scientists have defined happiness as positive evaluation of life. This refers to whether a person perceives his/her life to be satisfying according to his/her own standards. Such a definition considers happiness to be a subjective experience. Yet another meaning of happiness is presence of positive emotions over negative emotions. This does not mean absence of negative emotions altogether. It suggests experiencing more positive emotions during a specific period of time or a disposition to experience such emotions (Diener E., 1984).

The study of Subjective Well-Being (SWB) involves study of life satisfaction and positive affect. SWB refers to people's evaluations of their lives – evaluations that are both affective and cognitive (Diener, 2000). These evaluations are subjective in nature. "People experience an abundance of SWB when they feel many pleasant and few unpleasant emotions, when they are engaged in interesting activities, when they experience many pleasures and few pains, when they are satisfied with their lives" (Ibid.). Life satisfaction is a cognitive judgment about how satisfied a person is with his or her life.

Indian tradition calls for detachment in old age from all worldly pleasures and a movement toward spirituality. Often people seek refuge in practice of religion. Religions provide the philosophical basis to life and path to lead life in the most appropriate manner. Religion is a system of beliefs, values, practices and rituals. Religiosity has often been equated to spirituality and the terms have been used interchangeably. However, spirituality refers to a person's belief in a power apart from their own existence. Helminiak (2001 as cited in King 2008) describes the relationship between religion and spirituality as religion being "the social vehicle that, at its best, proclaims and supports spirituality".

David King (2008) defines Spiritual intelligence as a set of mental capacities which contribute to the awareness, integration, and adaptive application of the non-material and transcendent aspects of one's existence, leading to such outcomes as deep existential reflection, enhancement of meaning, recognition of a transcendent self, and mastery of spiritual states. Four core components are proposed to comprise spiritual intelligence: (1) critical existential thinking, (2) personal meaning production, (3) transcendental awareness, and (4) conscious state expansion.

According to this model spiritual intelligence is a set of mental abilities that are distinct from behavioural traits and experiences, thereby satisfying established intelligence criteria (David B. *et al.*, 2009).

Critical Existential Thinking: This is the first component of spiritual intelligence. Critical existential thinking is defined as the capacity to critically contemplate the nature of existence, reality, the universe, space, time, death, and other existential or metaphysical issues. Existential thinking refers to thinking about one's own existence. Thinking about one's own existence involves thinking about such matters as life and death, reality, consciousness, the universe, time, truth, justice, evil, and other similar issues. Behaviours such as reading about existential topics is excluded from the definition. This component is termed Critical existential thinking and not just existential thinking as it involves critical thinking. This refers to "the ability to analyze facts, generate and organize ideas, defend opinions, make comparisons, draw inferences, evaluate arguments and solve problems" (Chance, 1986 as cited in King, 2008). This ability varies from person to person. Theologians and philosophers are at a higher level with respect to this ability.

Personal Meaning Production: The second component of this model is personal meaning production, which is defined as the ability to construct personal meaning and purpose in all physical and mental experiences, including the capacity to create and master a life purpose. While Critical existential thinking involves thinking about existence, personal meaning production refers to finding meaning in one's existence. One can derive personal meaning from different sources.

The highest level of this ability is to create meaning in all mental and physical experiences.

Transcendental Awareness: The third factor, transcendental awareness, is defined as the capacity to identify transcendental dimensions of the self (e.g., a transpersonal or transcendental self), of others, and of the physical world (e.g., non-materialism, holism) during the normal, waking state of consciousness, accompanied by the capacity to identify their relationship to one's self and to the physical. The word transcendental refers to the awareness of that which is transcendent. Transcendent is defined as "going beyond normal or physical human experience" (English Oxford Living Dictionary). The term transcendental dimension refers to any aspect of reality that is beyond the physical. It describes the capacity to recognize transcendental dimensions of reality in objects, activities, experiences, and events on a daily basis.

Conscious State Expansion: The final component of spiritual intelligence is conscious state expansion, defined as the ability to enter and exit higher/spiritual states of consciousness (e.g. pure consciousness, cosmic consciousness, unity, oneness) at one's own discretion (as in deep contemplation, meditation, prayer, etc.). Complete control over entering and exiting higher states would represent the high end-state of this ability.

Spiritual intelligence is the ability to leverage spirituality to enhance functioning. Amram and Dryer (2008) found SI scores to be strongly correlated to SWLS. They also observed that older participants had higher mean scores across the domain scales than did younger participants. In some cases, however, the oldest participants reversed this trend. According to Amram and Dryer, this could be a result of real decline in spiritual intelligence or increased modesty and humility for people over the age of 65.

The objective of the present research was to study subjective well-being and spiritual intelligence in elderly across membership to groups.

Research questions:

1. Is there a significant difference in the spiritual intelligence of elderly people who have membership to social/cultural, religious/spiritual groups and those who do not?

2. Is there a significant difference in the subjective well-being of elderly people who have membership to social/cultural, religious/spiritual groups and those who do not?

Hypotheses

- H_{a1}: Elderly people who have membership to social/cultural, religious/spiritual groups and those who do not, differ significantly in their subjective well-being
- H_{a2}: Elderly people who have membership to social/cultural, religious/spiritual groups and those who do not, differ significantly in spiritual intelligence.
- H_{a2.1}: Elderly people who have membership to social/cultural, religious/spiritual groups and those who do not, differ significantly in Critical Existential Thinking
- H_{a2.2}: Elderly people who have membership to social/cultural, religious/spiritual groups and those who do not, differ significantly in Personal Meaning Production
- H_{a2.3}: Elderly people who have membership to social/cultural, religious/spiritual groups and those who do not, differ significantly in Transcendental Awareness
- H_{a2.4}: Elderly people who have membership to social/cultural, religious/spiritual groups and those who do not, differ significantly in Conscious State Expansion
- H_{a2.5}: Elderly people who have membership to social/cultural, religious/spiritual groups and those who do not, differ significantly in total spiritual intelligence

Method

This study followed an exploratory design wherein participants were administered two questionnaires. The first questionnaire administered was the Satisfaction with Life Scale (SWLS) developed by Diener, *et al.*, (1985) to measure subjective well-being. The other questionnaire used was Spiritual Intelligence Self Report Inventory (SISRI, 24) by David B. King (2008) to measure spiritual intelligence. Both the scales have favorable psychometric properties. Since the study was based on elderly, purposive sampling was done. Elderly refers to that group of people who have reached old age. While there

are different ways of defining old age, in this research 60 years of age (and above) is considered as old age. People undergoing treatment for serious illness; and institutionalized elderly were excluded from the study. Data regarding participants' membership to any group was obtained. The group could be a formal or informal group. Participants were clubbed on the basis of their affiliation to either social/cultural or religious/spiritual group. A third group consisted of elderly who have no membership to any group. A comparison was made between the three groups with respect to subjective well-being and spiritual intelligence using ANOVA.

SWLS measures global life satisfaction and the items in it are completed on a seven-point Likert scale with a response range consisting of 1-strongly disagree to 7-strongly agree. Numerous research studies found acceptable content and criterion related validity. The internal consistency of the scale is good with coefficients of 0.8 and more.

SISRI uses a 4 point scale (A – Not at all true of me; B – Not very true of me; C – Very true of me; D – Completely true of me). Higher the score, higher is an individual's spiritual intelligence. It measures four dimensions of Spiritual Intelligence, Critical Existential Thinking, Personal Meaning Production, Transcendental Awareness, and Conscious State Expansion. The scale has Cronbach's Alpha .95 for all items, .88 for CET, .87 for PMP, .89 for TA, and .96 for CSE.

Results and Discussion

Comparison of Groups with Respect to Subjective Well-being

Table 1
Mean, standard deviation and F ratio of subjective well-being across membership to groups

<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>F ratio</i>
No Membership	88	26.02	5.20	0.620
Social/Cultural	73	25.36	5.01	
Religious/Spiritual	39	26.44	5.63	
Total	200	25.86	5.21	

p > .05

The above table shows that mean SWLS score is highest in those people who have membership to religious and/or spiritual groups, followed by those who have no membership to any group. The least mean SWLS score is seen in those who have membership to social and/or cultural groups.

ANOVA was computed to study the significance of difference in the mean scores of the three groups (Table 1). It is observed that there is no significant difference in the subjective well-being of the three groups ($p > .05$). Thus the hypothesis stating that there will be a significant difference in the subjective well-being of elderly people across membership to groups was rejected. This hypothesis was based on the assumption that people who have some membership be it to social/cultural group or religious/spiritual groups get an opportunity to socialize and also nurture a feeling of being productive. However it is seen that those who have no membership to any formal/informal group too have high subjective well-being. Fancourt and Steptoe (2018) found that membership to religious groups may support well-being in old age. Krause (2002) explains how membership to religious group is beneficial to the elderly. People often receive emotional and spiritual support from the religious group members in old age. However, people differ in their need for social affiliation. Having good quality relationship with family and friends may have a more beneficial effect on SWB. Besides, Diener (1996) reports that most people are happy irrespective of their life circumstances.

Comparison of Groups with Respect to Spiritual Intelligence

Table 2
Mean, standard deviation and F ratio of CET across membership to groups

<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>F ratio</i>
No Membership	88	14.83	4.65	F(2,197) = 1.407
Social/Cultural	73	16.14	5.21	
Religious/Spiritual	39	15.74	5.54	
Total	200	15.49	5.05	

$p > .05$

The above table shows that mean CET score is highest in those people who have membership to social and/or cultural groups, followed by those who have membership to religious and/or spiritual groups. The least mean CET score is seen in those who have no membership to any group.

ANOVA was computed to study the significance of difference in the mean scores of the three groups (Table 2). It is seen that there is no significant difference in the CET of the three groups ($p > .05$). Thus, the hypothesis stating that there will be a significant difference in the CET of elderly people across membership to groups was rejected.

Table 3
Mean, Standard Deviation and F ratio of PMP Across Membership to Groups

<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>F ratio</i>
No Membership	88	12.06	3.75	6.55**
Social/Cultural	73	14.18	3.84	
Religious/Spiritual	39	13.51	3.72	
Total	200	13.12	3.88	

**p < 0.01: Highly significant

The above table shows that mean PMP score is highest in those people who have membership to social and/or cultural groups, followed by those who have membership to religious and/or spiritual groups. The least mean PMP score is seen in those who have no membership to any group.

ANOVA was computed to study the significance of difference in the mean scores of the three groups (Table 3). It is seen that there is a significant difference in the PMP of the three groups ($p < .01$). Thus the hypothesis stating that there will be a significant difference in the PMP of elderly people across membership to groups was accepted. Personal meaning production refers to finding meaning in one's existence. One can derive personal meaning from different sources. In old age there are no major goals to be met in life. Participation in social/cultural and religious/spiritual groups gives meaning and purpose to life.

Table 4
Mean, Standard Deviation and F ratio of TA Across Membership to Groups

<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>F ratio</i>
No Membership	88	16.17	4.41	F(2,197) = 5.73**
Social/Cultural	73	18.27	4.10	
Religious/Spiritual	39	18.33	4.91	
Total	200	17.36	4.51	

**p < .01: Highly significant

The above table shows that mean TA score is higher in those people who have membership to some group than those who have no membership to any group.

ANOVA was computed to study the significance of difference in the mean scores of the three groups (Table 4). It is seen that there is a significant difference in the TA of the three groups ($p < .01$). Thus the hypothesis stating that there will be a significant difference in the TA of elderly people across membership to groups was accepted. The term transcendent refers to any aspect of reality that is beyond the physical. It describes the capacity to recognize transcendent dimensions of reality in objects, activities, experiences, and events on a daily basis. According to Krause (2002), older respondents who receive more support from group members, have a more personal relationship with God; older people who feel more closely connected with God are more optimistic.

Table 5
Mean, Standard Deviation and F ratio of CSE Across Membership to Groups

<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>F ratio</i>
No Membership	88	10.94	3.87	0.45
Social/Cultural	73	11.12	4.16	
Religious/Spiritual	39	11.13	5.13	
Total	200	11.05	4.23	

p > .05

The above table shows that mean CSE score is higher in those people who have membership to some group than those who have no membership to any group.

ANOVA was computed to study the significance of difference in the mean scores of the three groups (Table 5). It is seen that there is no significant difference in the CSE of the three groups ($p > .05$). Thus the hypothesis stating that there will be a significant difference in the CSE of elderly people across membership to groups was rejected.

Table 6
Mean, standard deviation and F ratio of total SISRI across membership to groups

<i>Groups</i>	<i>N</i>	<i>Mean</i>	<i>Std. Deviation</i>	<i>F ratio</i>
No Membership	88	54.00	14.05	3.207*
Social/Cultural	73	59.71	15.21	
Religious/Spiritual	39	58.72	16.66	
Total	200	57.01	15.17	

* $p < .05$: significant

The above table shows that mean total SISRI score is highest in those people who have membership to social and/or cultural groups, followed by those who have membership to religious and/or spiritual groups. The least mean score is seen in those who have no membership to any group.

ANOVA was computed to study the significance of difference in the mean scores of the three groups (Table 6). It is seen that there is a significant difference in the total SISRI of the three groups ($p < .05$). Thus the hypothesis stating that there will be a significant difference in the total SISRI of elderly people across membership to groups was accepted.

Thus a significant difference was found along PMP and TA dimensions of SI as also the total SISRI.

The differences noticed between elderly in SWLS and SI are further checked for their significance in terms of Scheffe's 'S' values. The obtained S values and their significance are presented in Table 7.

Table 7
Significance of between Group Differences in Terms of 'S' Values

<i>Variables</i>	<i>Groups</i>	<i>Mean Difference (I-J)</i>	<i>Std. Error</i>	<i>Sig.</i>
PMP	No membership-membership to social/cultural group	-2.12126*	.59824	.002
	No membership-membership to religious/spiritual group	-1.45600	.72693	.137
	membership to social/cultural group-membership to religious/spiritual group	.66526	.74951	.675
TA	No membership-membership to social/cultural group	-2.10352*	.69691	.012
	No membership-membership to religious/spiritual group	-2.16288*	.84682	.040
	membership to social/cultural group-membership to religious/spiritual group	-.05936	.87313	.998
TOTAL ISRI	No membership-membership to social/cultural group	-5.7123	2.3756	.058
	No membership-membership to religious/spiritual group	-4.7179	2.8867	.265
	membership to social/cultural group-membership to religious/spiritual group	.9944	2.9763	.946

p < 0.05 Significant

An inspection of Table 6 reveals that:

No membership-membership to social/cultural group differ significantly in PMP ($p < 0.05$). No membership-membership to religious/spiritual group and membership to social/cultural group-membership to religious/spiritual group do not differ significantly from each other in PMP.

No membership-membership to religious/spiritual group differ significantly in TA ($p < 0.05$). No membership-membership to social/cultural group and membership to social/cultural group-membership to religious/spiritual group do not differ significantly from each other in TA.

No membership-membership to social/cultural group differ significantly in total SI ($p < 0.05$). No membership-membership to religious/spiritual group and membership to social/cultural group-

membership to religious/spiritual group do not differ significantly from each other in Total SISRI.

It is seen that having membership (either to some formal or informal group) or not does not influence subjective well-being of the elderly. However, having membership to social/cultural or spiritual/religious group contributes significantly to higher spiritual intelligence than having no membership to any group. This significance of difference is not seen between membership to social/cultural group and membership to religious/spiritual group. Membership to social/cultural group makes a significant difference to PMP and Total SISRI score, while membership to religious/spiritual group makes a significant difference to TA.

Personal meaning production refers to finding meaning in one's existence. One can derive personal meaning from different sources. In old age as people retire from major duties of life, having a purpose or meaning to life ahead becomes important. It is observed that in the sample studied, being a member of social/cultural group gives personal meaning to life.

Transcendental dimension refers to any aspect of reality that is beyond the physical. It describes the capacity to recognize transcendental dimensions of reality in objects, activities, experiences, and events on a daily basis. Membership to spiritual/religious group provides an opportunity to people to explore the spiritual side of their life, to understand life beyond normal or physical human experience. It provides for the development of personal philosophy of life and death, existence, connectedness with the universe as a whole. All religions and spiritual groups discuss life in terms of reality that is beyond the physical. Thus membership to religious/spiritual groups may contribute significantly to transcendental awareness.

Conclusion

Having membership (either to some formal or informal group) or not does not influence subjective well-being of the elderly. However, having membership to social/cultural or spiritual/religious group contributes significantly to higher spiritual intelligence than having no membership to any group. This significant difference is not seen

between membership to social/cultural group and membership to religious/spiritual group.

Thus, the study implies that being members of some religious/spiritual and or social/cultural group enhances the spiritual intelligence of elderly people and thereby it may have positive impact on their mental/holistic health as well.

References

- Amram, Y., & Dryer, C. (2008): The Integrated Spiritual Intelligence Scale (ISIS): Development and Preliminary Validation, Paper Presented at 116th Annual Conference of American Psychological Association, Boston, M.A. U.S.A.
- Baumgardner, S. R. (2009): *Positive Psychology*. New Delhi: Dorling Kindersley India Pvt. Ltd.
- Channa, S. M. (2015): Imagining Old Age: Cultural Interpretations. In P.T. Renu, *Caring for the Elderly* (pp. 206–221). New Delhi: SAGE Publications India Pvt. Ltd.
- David B. King and Teresa L. DeCicco (2009). A Viable Model and Self-Report Measure of Spiritual Intelligence, *International Journal of Transpersonal Studies* 28, pg. 68–85
- Diener, E. (1984): Subjective Well-being. *Psychological Bulletin*, 95 (3), 542–575.
- Diener, E., (1996): Subjective well-being in cross-cultural perspective In *Key Issues in Cross-cultural psychology*, (eds.) H. Grad , A. Blanco, J. Georgas, Liese, The Netherlands, Swets and Zeitlinger, pp. 319–30.
- Diener, E. Emmons, R.A., Larsen, R.J. and Griffin, S., (1985): The Satisfaction with Life Scale, *Journal of Personality assessment*, 49, 71–75.
- Diener, E. (2000): Subjective Well-Being The science of happiness and a proposal for a national index. *American Psychologist*, 34–42.
- English Oxford Living Dictionary <https://en.oxforddictionaries.com>

- Fancourt, D., and Steptoes (2018). Community Group Membership and Multidimensional Subjective well being in older age group, JECH online, Produced by BMJ publishing group.
- King, D.B. (2008): Rethinking claims of spiritual intelligence: A definition, model, & measure. Unpublished master's thesis, Trent University, Peterborough, ON, Canada.
- Pinquart, M. and Sorenson, S. (2000): Influences of Socioeconomic Status, Social Network, and Competence on Subjective Well-Being in Later Life: A Meta-Analysis, *Psychology and Aging*, Vol. 15, No. 2. 187–224, DOI: 10.1037//0882-7974.15.2.18.
- Yosi Amram and D. Christopher Dryer (2008): The Integrated Spiritual Intelligence Scale (ISIS): Development and Preliminary Validation, Paper Presented at the 116th Annual Conference of the American Psychological Association Boston, MA August 14–17, 2008.

Indian Journal of Gerontology

2018, Vol. 32, No. 3, pp. 246–257

ISSN: 0971–4189, UGC No. 20786

Is Total Lymphocyte Count a Good Marker of Nutritional Status? An Experience among Elderly Women of Kolkata

Bidisha Maity, Debnath Chaudhuri¹, Indranil Saha², Arup Kumar Das³ and Minati Sen⁴

Department of Food and nutrition, Netaji Nagar College for Women, Kolkata

¹ Department of Bio-chemistry and Nutrition, All India Institute of Hygiene and Public Health, Kolkata

² Department of Community Medicine, IQ City Medical College and Narayana Hrudayalaya Hospitals, Durgapur (W.B.)

³ Department of Bio-chemistry and Nutrition, All India Institute of Hygiene and Public Health, Kolkata

⁴ Department of Home Science, University of Calcutta, Kolkata

ABSTRACT

Malnutrition is common but often neglected problem among elderly (aged = 60 years). Like albumin, total lymphocyte count (TLC) is thought to be a better marker for the assessment of nutritional status, although few evidences have been found among elderly population. With this background the study was conducted with the objective to find out whether Total Lymphocyte Count (TLC) is a good bio-chemical marker for the assessment of nutritional status of the elderly or not. A cross-sectional study was conducted among 249 elderly women aged 60 years and above in Kolkata city between June 2012 to September 2014. 125

participants were selected from old-age home and 124 participants were selected from the community. Nutritional status was assessed by Mini Nutritional Assessment (MNA) scale, Body Mass Index (BMI), Calf Circumference (CC), Serum albumin level and Total Lymphocyte Count (TLC). Participants were categorized as normal (28.9%), at risk of malnutrition (53.0%) and malnourished (18.1%) according to the total scores of MNA. Significant positive correlation ($p < 0.05$) was found to exist between MNA scores and BMI, CC and serum albumin level. But no such correlation ($p > 0.05$) was found between MNA scores and TLC. Therefore, TLC may not be a good marker for the assessment of nutritional status among elderly women.

Key words: Elderly women, Mini Nutritional Assessment, Anthropometry, Serum albumin, Total lymphocyte count

Malnutrition is a major problem in old age (WHO, 2002). People aged 60 years and above are vulnerable to malnutrition, which can be found in old-age homes as well as in the community (Murphy, *et al.*, 2000; Soini, H., *et al.*, 2004; Kabir, Z.N., *et al.*, 2006; Maity, B., *et al.*, 2012; Maity, B., *et al.*, 2015;). In elderly, malnutrition is defined as faulty nutritional status or under-nourishment characterized by insufficient dietary intake, poor appetite, muscle wasting and weight loss (Chen CCH., *et al.*, 2001). It was found in both developing (Kabir Z.N., *et al.*, 2006; Jose S., *et al.*, 2014; Maity B., *et al.*, 2015; Mathew, A.C., *et al.*, 2016) and developed countries (Guigoz, Y., *et al.*, 2002; Soini, H., *et al.*, 2004; Torres, M.J., *et al.*, 2014;). Since over the years, life expectancy at birth has been rising. Proportion of geriatric population has also increased steadily throughout the world. Population ageing is a major concern for both developed and developing countries (Ministry of Statistics and Programme Implementation, Govt. of India, 2016). Therefore proper assessment of nutritional status among elderly population is very much essential to address their health needs.

Mini Nutritional Assessment (MNA) is a validated tool that is used to assess the nutritional status of the elderly (Vellas B *et al.*, 2006; Bauer JM *et al.*, 2013). Anthropometric parameters like Body Mass Index (BMI), Calf Circumference (CC), Mid-arm circumference and

some bio-chemical tests are used for the assessment of nutritional status, either together or solely (WHO, 2002; Cuervo M *et al.*, 2009; Jose S *et al.*, 2014)

Albumin and lymphocyte counts are most commonly used blood parameters for the assessment of nutritional status. These are used in combination or separately. Albumin level is used to assess the protein status of the body. Lymphocyte counts are associated with immune function of the body and they may be decreased in malnourished individuals and that is why it is used as a marker for nutritional assessment (WHO, 2002; Basu, I (*et al.*, 2011; Lu J *et al.*, 2016).

With this background the present study was conducted to find out whether Total Lymphocyte Count (TLC) is a good marker for the assessment of nutritional status of the elderly selected from old age homes and community in Kolkata, India.

Methods

Study design: It was a cross sectional study conducted from June 2012 to September 2014. Total 249 elderly women, age varying from 60 years and above were randomly selected from different parts of Kolkata. Out of them 124 participants were selected from community and rest 125 participants were selected from old-age homes.

Exclusion Criterion: Elderly women who were suffering from severe cognitive impairment, or unable to stand up, seriously ill, or unwilling to participate were excluded from the study.

Ethical Clearance: The study was approved by Bioethics committee for Animal and Human Research Studies, University of Calcutta (No. BEHR/1099/2304). All participants signed an informed consent form before the commencement of the study. Their participation was purely voluntary as per ethical guidelines of Indian Council of Medical Research (ICMR).

Blood sample collection: 5 ml venous blood was collected in the morning after 8–10 hours fasting, in clot vials for the estimation of albumin. For TLC a thin blood smear was prepared on glass microscope slides.

Assessment of nutritional status: Nutritional status was assessed by long version of Mini Nutritional Assessment (MNA[®]) questionnaire. According to MNA[®] nutritional status was classified as normal (24–30 points), at risk of malnutrition (17–23.5 points) and malnourished (< 17 points) (Vellas B *et al.*, 2006). BMI was calculated from height and weight using standard formula (weight in Kg/height in Meter²). For this purpose, elderly women who had degenerative change in their spinal-cord, standing height was not measured. Demi-span was used as alternative process for calculation of height. BMI cut off points for South East Asian were considered as standard (WHO, 2004). Calf Circumference (CC) was measured using non elastic fibre plastic tape. Serum albumin was estimated from blood serum, using bromocresol green end point assay method (Gustafsson EC, 1978). TLC was measured from the blood film using Leishman's stain (Hudgens J, 2003).

Data analysis: Data were entered into Microsoft excel worksheet and accuracy was checked. Normality of data was checked by Kolmogorov Smirnov test. Significant p value was suggestive of skewed data distribution. Thus, continuous data were expressed in median values and dispersion of data was expressed in Inter Quartile Range (IQR). Kruskal Wallis test, Chi-square test and Spearman's rho were used for analysis of data to find out significant difference, association and correlation, respectively. Mann-Whitney U test was done to compare differences between two median values. All tests were done using SPSS (Statistical Package for Social Sciences) software, version 19.0. p value = 0.05 was considered as statistically significant.

Results

Median age of the participants was 68.0 years (IQR \pm 11.0). According to MNA score 72 (28.9%) participants had normal nutritional status, 132 (53.0%) were at risk of malnutrition and the rest 45 (18.1%) were malnourished.

According to Body Mass Index (BMI), 29 (11.6%) participants were underweight (BMI < 18.5 Kg/m²), 62 (24.9%) had normal body weight (BMI 18.5–22.99 Kg/m²) and 158 (63.4%) were over-weight (BMI > 22.99 Kg/m²). 134 (53.8%) participants had normal Calf

Circumference (CC = 31 cm) and the remaining 115 (46.2%) had low Calf Circumference (CC < 31 cm). Normal albumin level (=3.5 g/dl) was found among 210 (84.3%) participants while low albumin level (<3.5g/dl) was found among 39 (15.7%). According to TLC, 194 (77.9%), 26 (10.4%), 23 (9.2%) and 6 (2.4%) participants were having normal nutritional status (= 1,800 cells/mm³), mild malnutrition (1,500–1,800 cells/mm³), moderate malnutrition (900–1,500 cells/mm³) and severe malnutrition (< 900 cells/mm³), respectively.

Table 1

Distribution of the participants according to Age, Body Mass Index, Calf Circumference, Albumin Level and Total Lymphocyte Count (N= 249)

Age (Years)	MNA Median ± IQR	BMI (kg/m ²) Median ± IQR	CC (cm) Median ± IQR	Albumin level (gm/dl) Median ± IQR	TLC (mm ³) Median ± IQR
60–64	21.75±6.2	25.0±7.3	30.7±5.2	4.1±0.6	2,530.0±1,046.5
65–69	20.5±6.5	25.0±7.2	31.0±5.0	4.1±0.7	2,064.0±1,210.0
70–74	22.2±7.4	24.7±7.6	31.2±4.2	4.2±0.6	2,521.7±1,280.3
75–79	20.5± 7.5	24.2±9.2	32.0±5.0	4.0±0.9	2,400.0±1,598.0
≥ 80	22.0±4.0	24.7±3.7	32.0±3.0	4.1±0.9	2,262.0±1,509.0
Spearman's rho p value)	- 0.198 002)*	-0.273 (0.000)*	-0.243 (0.000)*	-0.220 (0.000)*	-0.033 (0.602)
Kruskal Wallis test p value)	19.32 (0.001)*	14.691 (0.005)*	13.495 (0.009)*	18.573 (0.001)*	1.661 (0.791)

* Significant

Table1 depicts distribution of the participants according to Age, MNA scores, BMI, CC, Albumin levels and TLC. Differences of median values of MNA scores, BMI, Calf-circumference and Albumin levels across five age groups were significant according to Kruskal Wallis test (p < 0.05). But, no significant association was found in TLC (p > 0.05). Age has negative significant correlation with MNA, BMI, CC and Albumin levels (p < 0.05), but no significant correlation was found between Age and TLC (p > 0.05).

Table 2
Association of nutritional status with MNA, Body Mass Index, Calf Circumference, Albumin Level and Total Lymphocyte Count (N= 249)

<i>Nutritional status according to MNA</i>	<i>BMI (kg/m²) Median ± IQR</i>	<i>CC (cm) edian ± IQR</i>	<i>Albumin level (g/dl) Median ± IQR</i>	<i>TLC (cells/mm³) Median ± IQR</i>
Normal (72, 28.9%)	26.35±5.4	32.9±3.6	4.1±0.7	2,525.0±1,283.7
At risk of malnutrition 132, 53%)	24.6±7.0	30.0±4.4	4.2±0.5	2,213.0±1,217.8
Malnourished 45, 18.1%)	19.9±5.5	29.0±3.0	4.0±0.8	2,546.0±1,120.0
Spearman's rho p value)	0.464 (0.000)*	0.493 (0.000)*	0.129 (0.042)*	0.079 (0.132)
Pearson's chi-square p value)	67.038 (0.000*)	64.756 (0.00.0*)	0.368 (0.832)	4.988 (0.083)
Kruskal Wallis p value)	62.195 (0.000)*	64.495 (0.000)*	0.367 (0.832)	5.670 (0.059)

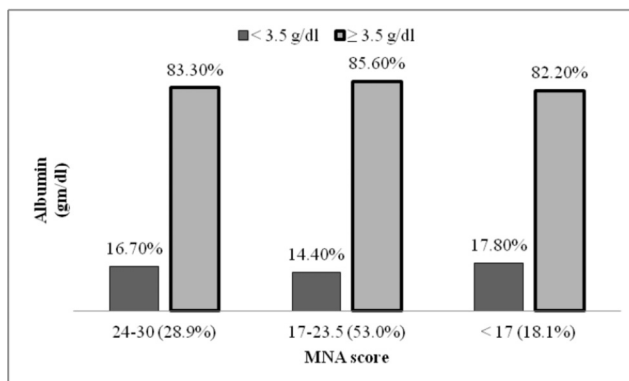
* Significant

Table 2 shows distribution of the participants according to MNA scores and BMI, CC, albumin level, TLC. Kruskal Wallis test shows significant difference ($p < 0.05$) between median values of BMI and CC among three groups of the nutritional status according to MNA, but no significant difference exists ($p > 0.05$) between median values of albumin levels and TLC in these three groups. Significant positive correlation has been found between MNA scores: BMI, MNA scores: CC and MNA scores: albumin levels, as shown by the spearman's rho correlation coefficient ($p < 0.05$), but no correlation was observed between MNA scores and TLC ($\rho = 0.079$, $p > 0.05$). Association between different categorical data was analysed by Pearson's Chi-square test and significant association ($P < 0.01$) was found to exist between MNA: BMI and MNA: CC, but non-significant association ($p > 0.05$) was found between MNA: albumin levels and MNA: TLC.

In Figure 1, distribution of elderly women according to their MNA scores and albumin levels has been shown. Albumin levels have been distributed categorically among normal (24–30), at risk of malnutrition (17–23.5) and malnourished (< 17) groups. Albumin level = 3.5 g/dl has been found higher than albumin level < 3.5 g/dl among

Figure 1

Distribution of the study participants according to MNA score and serum albumin level (N=249)

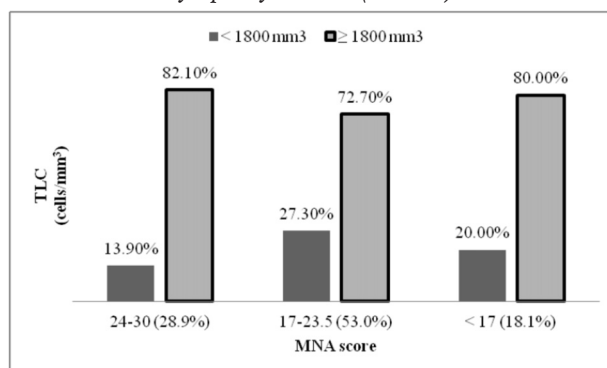


Pearson's Chi-square = 0.368, df = 2, p = 0.832

three groups, according to MNA. No significant association ($p > 0.05$) has been found between MNA scores and albumin level.

Figure 2

Distribution of the participants according to nutritional status and Total lymphocyte count (N=249)



Pearson's Chi-square = 4.988, df = 2, P = 0.083

In Figure 2, distribution of elderly women according to their MNA scores and TLC has been shown. TLC has been distributed categorically among normal (24–30), at risk of malnutrition (17–23.5) and malnourished (< 17) groups. TLC = 1,800 mm³ has been found

higher than $TLC < 1,800 \text{ mm}^3$ among three groups, according to MNA score. No significant association ($p > 0.05$) has been found between MNA scores and TLC.

Mann-Whitney U test was done to compare the differences between lymphocyte counts of old age home and community data, and it was found to be significant ($Z = -2.092, p=0.036$).

Discussion

In this study median age of the participants was 68 years, indicating most of the participants as 'young old'. Results from MNA revealed prevalence of poor nutritional status among 71.1 per cent of the participants (at risk of malnutrition: 53%; malnourished: 18.1%), but according to BMI overweight (increased risk for non-communicable diseases) was observed among 63.4 per cent participants. Most of the participants had normal Calf Circumference (53.8%) and albumin levels (84.3%). Depending on the lymphocyte counts, 76.7 per cent participants had normal nutritional status, whereas according to MNA scores 28.9 per cent participants had normal nutritional status.

Malnutrition among elderly is associated with various risk factors like – poverty, social isolation, loneliness, psychological disturbances and disorders, multiple medications, functional impairment, poor dietary practice and other age associated changes. Malnutrition can alter health status and quality of life. Prolonged hospital staying, decreased immunity and susceptibility to infection and other diseases are consequences of malnutrition. This condition may increase morbidity among elderly and it is related to decreased immunity and frequent infections (Murphy MC *et al.*, 2,000; WHO, 2,002; Hajjar RR *et al.*, 2004; Soini H *et al.*, 2004; Majumder M *et al.*, 2014;). Elderly people are found to have decreased immunity as well as protein-energy malnutrition. Their dietary practice may alter protein status and lymphocyte counts (Grzegorzewska AE *et al.*, 2005; Woods JL *et al.*, 2013).

Robinson R (2015) reported that majority of the elderly patients who were readmitted in hospitals within 30 days of discharge had protein-energy malnutrition accompanied by low albumin and TLC levels. A study conducted by Lu *et al.* (2016) among hospitalized

Chinese elderly men and women showed that low serum albumin and low lymphocyte counts were associated with their nutritional status. Leandro-Merhi VA *et al.* (2017) also found correlation between TLC and nutritional risk of the hospitalized older adults. In another study Symeonidis *et al.* (2006) showed that albumin and lymphocyte counts can be used as screening tools for the assessment of nutritional status among hip-fracture elderly patients.

In the present study, participants were not suffering from any serious illness nor were they hospitalised. They were living either in their houses or in the old age homes. Result of the study revealed that BMI and CC have significance association ($p < 0.05$) with nutritional status (Table 2). Correlation between MNA scores and albumin levels was positive and significant (Table 2), indicating participants had normal albumin levels when their nutritional status was normal. Albumin levels = 3.5 g/dl were found among 82.2 per cent–85.6 per cent of the participants in all three nutritional groups (normal, at risk of malnutrition and malnourished) and no significant association was found from Chi-square test ($p > 0.05$) between MNA scores and albumin levels (Figure 1). About 82.0 per cent, 72.7 per cent and 80.0 per cent participants from normal, at risk and malnourished category respectively had TLC = 1,800 mm³, whereas no significant correlation and association was observed between MNA scores and TLC (Table 2 and Figure 2).

In general, during the ageing process lymphocyte count does not change in numbers but may change in their proportions (Whittinhan S *et al.*, 1973). In this study no significant association was found between age and TLC (Table 1).

Kuzuya *et al.* (2005) stated that TLC is not a good marker for the assessment of nutritional status among elderly as they did not find significant difference of MNA, albumin and anthropometric measurements with regard to different TLC groups. Alzahrani *et al.* (2016) also did not find any significant difference of TLC in the normal and poor nutritional groups of MNA.

Present study also did not observe any significant association between nutritional status and TLC. Therefore, it can be stated that in general TLC may not be a good marker for the assessment of

nutritional status for this age group, particularly when they are not suffering from any kind of serious illness.

References

- Alzahrani, S.H., El Sayed, I.A., and Alshamrani, S.M., (2015): Prevalence and factors associated with geriatric malnutrition in an outpatient clinic of a teaching hospital in Jeddah, Saudi Arabia. *Ann Saudi Med*, 36(5), 346–351.
- Basu I, Subramanian P, Prime M, Jowett C and Levack B (2011): The biochemical parameters as nutritional screening tool in surgical patients. *Surg Sci*, 2, 89–94.
- Bauer JM (2013): The MNA in 2013 – Still going stronger after almost twenty years. *J Nutr health Aging*, 17(4), 288–289.
- Chen CCH, Schilling LS and Lyder C (2001): A concept analysis of malnutrition in the elderly. *J Adv Nurs*, 36(1), 131–142.
- Cuervo M, Ansorena D, Gracia A, Gonzalez MA, Astiasaran I and Martinez JA (2009): Assessment of calf circumference as an indicator of the risk for hyponutrition in the elderly. *Nutr Hosp*, 24(1), 63–67.
- Elderly in India (2016): [https://mospi.nic.in/sites/default/files/publication_reports/Elderly in India_2016.pdf](https://mospi.nic.in/sites/default/files/publication_reports/Elderly%20in%20India_2016.pdf). Accessed on 25.12.2017.
- Grzegorzewska AE and Leander M (2005): Total lymphocyte count and subpopulation lymphocyte counts in relation to dietary intake and nutritional status of peritoneal dialysis patients. *Adv Perit Dial*, 1, 35–40.
- Guigoz Y, Lauque S and Vellas JB (2002): Identifying the elderly at risk for malnutrition the Mini Nutritional Assessment. *Clin Geriatr Med*, 18(4), 738–757.
- Gustafsson EC (1998): Automated serum albumin determination by use of the immediate reaction with bromocresol green reagent. *Clin Chem* 1978, 24(2), 369–373.
- Hajjar RR, Kamel HK, Denson K. Malnutrition in aging (2004): *Int J Geriatr Gerontol*, 1(1).<http://ispub.com/IJGG/1/1/4920>. Accessed on 28.12.2017.

- Hudgnes J (2003): Better nutritional status as measured by the Mini Nutritional Assessment tool is associated with increased immune response in elderly nursing home residents with pressure ulcers. Dissertation, University of Florida.
- Jose, S., and Kumari, K.S., (2014): Validity assessment of MNA among an elderly population in Kerala, South India. *Int J Adv Res*, 2(2), 214–221.
- Kabir ZN, Ferdous T, Cederholm T, Khanam MA, Streatfield K and Wahlin A (2006): Mini Nutritional Assessment of rural elderly people in Bangladesh: the impact of demographic, socio-economic and health facts. *Public Health Nutr*, 9(8), 968–974.
- Kuzuya M, Kanda S, Koike T, Suzuki Y and Iguchi A (2005): Lack of correlation between total lymphocyte count and nutritional status in the elderly. *Clin Nutr*, 24(3), 427–432.
- Leandro-Merhi VA, Bráz VN and Aquino JL (2017): Is total lymphocyte count related to nutritional markers in hospitalized older adults? *Arq Gastroenterol*, 54(1), 79–82.
- Lu J, Chen Y, Li L Z and Wang C (2016): Laboratory nutritional parameters predict one-year mortality in elderly patients with intertrochanteric fracture. *Asia Pac J Clin Nutr*, 25(3), 457–463.
- Maity B, De S, Saha I, Sen M and Chaudhuri D (2015): Association between nutritional status according to Mini-Nutritional assessment and Body Mass Index for community dwelling elderly women in Kolkata, India. *Int J Sci Res*, 4(9), 46–47.
- Maity B, Sen M, Saha I and Chaudhuri D (2012): Risk for malnutrition among elderly women belong to old age homes of Kolkata, India and its relationship with depression. *IST J Business Technol*, 5(1), 147–149.
- Majumder M, Saha I and Chaudhuri D (2014): Assessment of nutritional risk in community-dwelling older adults (65–75 years) in Kolkata, India. *J Nutr Gerontol Geriatr*, 33(2), 126–134.
- Mathew AC, Das D, Sampath S, Vijayakumar M, Ramakrishnan N and Ravishankar SL (2016): Prevalence and correlates of malnutrition among elderly in an urban area in Coimbatore. *Indian J Public Health*, 60 (2), 112–117.

- Murphy MC, Brooks CN, New SA and Lumbers ML (2000): The use of Mini-Nutritional Assessment (MNA) tool in elderly orthopedic patients. *Eur J Clin Nutr*, 54(7), 555–562.
- Robinson R (2015): Low serum albumin and total lymphocyte count as predictors of 30 day hospital readmission in patients 65 years of age or older. *Peer J*, 3, e1181.
- Soini H, Routalsalo P and Lagstrom H (2004): Characteristics of the Mini-Nutritional Assessment in elderly home-care patients. *Eur J Clin Nutr*, 58, 64–70.
- Symeonidis PD and Clark D (2006): Assessment of malnutrition in hip fracture patients: Effects on surgical delay, hospital stay and mortality. *Acta Orthop Belg*, 72, 420–42.
- Torres MJ, Dorigny B, Kuhn M, Berr C, Barberger-Gateau P and Letenneur L. Nutritional Status in Community-Dwelling Elderly in France in Urban and Rural Areas (2014): *PLoS ONE*, 9(8), e105137.
- Vellas B, Villars H, Abellan G, Soto ME, Rolland Y, Guigoz Y, *et. al.* (2006): Overview of the MNA[®] – Its history and challenges. *J Nutr Health Aging*, 10(6), 456–465.
- Whittinham S and McKay IR (1973): Depression of cell-mediated immunity in Old Age and the immunopathic diseases, lupus erythematosus, chronic hepatitis, and rheumatoid arthritis. *J Clin Exp Immunol*, 14, 193–202.
- Woods JL, Iuliano-Burns SI and Walker KZ (2013): Immunological and nutritional factors in elderly people in low level care and their association with morbidity. *Immun Ageing*, 10: 32.
- World Health Organization, (2002): *Keep fit for life: Meeting the Nutritional Needs for Older Persons*, Geneva,; http://www.who.int/nutrition/publications/en/nut_older_persons_2.pdf. Accessed on 25.12.2017.
- World Health Organization (2004): Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies. *Lancet*, 363, 157–63.

Indian Journal of Gerontology
2018, Vol. 32, No. 3, pp. 258–272
ISSN: 0971–4189, UGC No. 20786

Suicide Among the Elderly in Ogida Community in Southern Nigeria: A Criminological Analysis

Emmanuel Imuetinyan Obarisiagbon

Department of Sociology and Anthropology, Faculty of Social Sciences,
University of Benin, Benin City (Nigeria)

ABSTRACT

Suicide among the elderly is universal and not restricted geographically even though some nations are worse hit by it. Regrettably, in spite of its prevalence, incidence and effects, this social phenomenon is grossly understudied in Nigeria as there appears to be little or no available records. This study therefore examined the risk factors in elderly suicide in Nigeria. The study follows a quantitative research design where a self-constructed questionnaire was administered to 700 respondents. This was complemented by a qualitative design where interviews were conducted for 25 respondents. Descriptive statistics was used to analyse the data collected through the questionnaire while the qualitative data was content analysed. The study revealed that physical health challenges, social isolation, changes in social roles and depression were always the risk factors in elderly suicide. It was recommended that relations and children of the elderly should play a more active role in the lives of their parents.

Key words: Suicide, Isolation, Depression, Health challenges, Elderly

Suicidal behaviour generally is a serious social issue in the world today. While statistics on suicidal and para-suicidal behaviour are available in developed societies of the world, the very opposite is the case in less developed countries, particularly in Nigeria, where records of the occurrence of suicide is hardly ever found or kept. The reason for this lack of records is the social stigma usually associated with suicide or suicide attempts. Consequently, most Nigerians shy away from reporting its occurrence or attempt to the appropriate organ of government yet, the incidence and prevalence of this social problem remains not only unabated but continues to be on the increase. This global phenomenon which cuts across race, religion, gender and age are particularly more common amongst the elderly. In fact, Westefeld, *et al.*, (2005) note that, the highest suicide rates are seen among the aged and more worrisome is that there is an increase in suicide rate for people over 75 years, with the age group of 85 and older having the highest prevalence of successful suicides.

Alluding to the alarming rate of suicide amongst the elderly, Shields, *et al.*, (2005) observe that, overall suicide rates among the elderly have been rising in the past. It must be pointed out that even though suicide among the elderly is a global social phenomenon, there is however, a variability of the overall rate of suicide among nations (Moscicki, 1995). Lapierre *et al.*, (2005) provided statistical evidence, illustrating that, suicide among the elderly is most likely to rise especially as there is better and improved health care. When this is juxtaposed against the projection made by Magagna, *et al.*, (2013) which indicates that those above 60 years by 2025, will be 1.2 billion individuals, one cannot but be very worried at the social menace staring humanity at the face with little or no documentation of it in Nigeria.

Review of Literature

Suicide is a universal problem which has to do with a person acting violent or non-violent at himself with the intention of terminating his life and dying as a result of the action. It is a significant social problem in Nigeria though statistical records of its prevalence and incidence are not accurate if at all any exists. To date, no definition of suicide exists that is universally accepted by scholars. Defining the

concept suicide is more difficult than the simple words 'killing one's self' and it remains doubtful if scholars will ever be able to give a definition of the concept that will be flawless and acceptable universally. One thing is however clear and that is, attempted suicide is a criminal act in Nigeria. It is an offence pursuant to Section 327 of the Criminal Code (2004). The section states:

'Any person who attempts to kill himself is guilty of a misdemeanor and is liable to imprisonment for one year'.

This implies that anyone who attempts suicide in Nigeria is a criminal. This law interestingly does not cover successful suicide attempts. Instead, it would appear that the punishment is essentially designed at the 'failure' in the act because 'success', i.e. death, obviously frees the victim from the long arm of the law and its wrath.

Ogunlesi, *et al.*, (2015), in their study note that about one million people commit suicide all over the world annually with about 3,000 of such acts occurring daily. It is a major cause of death for individuals above 65 years in most countries of the world today (Conwell and Brent, 1996). Suicide as an act of killing oneself deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome (World health organization, 1998). Suicide as an act with a fatal outcome which the deceased knowing or expecting a fatal outcome had initiated or carried out with the purpose of provoking the changes he desired (World health organization/EURO, 1980).

The term suicide which is derived from the Latin word 'Sui' (of oneself) and 'caedere', came into its first usage in the 17th century by Sir Thomas Browne in his *Religio Medici*. This new concept as it were, reflected a genuine desire to distinguish between when a person commits homicide against himself and against another person (Minois, 1999).

Durkheim (1951) classically defines suicide as all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result. On his part, Baechler (1980) opines that suicide is all behaviour that seeks and finds the solutions to an existential problem by making an attempt on the life of the subject. Schneidman's (1993) explication of the term suicide

is worth noting; he says that suicide relates to a conscious act of self-induced annihilation, best understood as a multi-dimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution.

A cursory look at the above definitions point to four features of suicide viz:

- Occurrence of death
- Self-initiated and performed
- Intentional act
- Passive or active agencies

Methods of Suicide

How an individual terminates his life varies from one person to another just like the motive for such termination. The method adopted to end one's life is a function of age, gender and socio-cultural factors. Cattell (2000) observes that on a general note, elderly men use more violent methods than women. In Nigeria, just like industrialized societies in Europe, suicide by hanging remains the preferred means by which elderly men take their own lives; whereas the women prefer the less stressful, or so it may seem, method of self-poisoning. It is to be expected due to its relaxed laws of firearm, in America, guns are most commonly employed by the aged (Ibid). In Nigeria, some elderly persons have been reported to go into the forest where they pluck leaves, chew them and die as a result of the toxins in the leaves. How they know the leaves and the quantity to chew and swallow remains a mystery.

Predisposing Factors in Suicide among the Elderly

There appears to be a lack and paucity of empirical studies and statistical data on suicide among the aged (Cornwell and Bent, 1995, Pearson and Conwell, 1995). The reason scholars have advanced for this trend has to do with the inherent difficulty of studying suicide. This difficulty is associated with the unwillingness of family members to admit that their aged parents committed suicide. Admitting such, is to put the family into public ridicule and social isolation or ostracism. In spite of these difficulties, the discussion below is a review of some

related literature on the predisposing factors in suicide amongst the elderly.

Health Challenges

An elevated risk of suicide exists among the elderly where there is the presence of a medical condition in the elderly. Scholars appear to agree on the fact that debilitating physical ailments have a correlation to suicide amongst the aged. This has been attributed to the fact that adjusting to a new health challenge can make the aged to be vulnerable for possible suicide (Myers and Sohrabi, 2012; Robinson, *et al.*, 2009).

Closely related to major physical health challenges is the issue of chronic pain. In Nigeria, like in other nations of the world, chronic pain is a very common experience of the aged and as Tang and Crane (2006) noted, elders who suffer chronic pains due to arthritis or rheumatism are more predisposed to suicide compared to the general population. It is needful to also point out that, the risk of suicide due to severe pain also depends to a large extent on the nature of the pain; severity, period and lack of sleep associated with the pain. Marson and Powell (2011) contend that illness often encourages individuals towards a fatalistic risk condition when such situation occurs. The life of the aged is thus regulated and regrettably, there is nothing the aged can do about it and so daily bemoans his predicament.

Social Isolation

The elderly are the most socially isolated individuals in the society and unfortunately, this is a risk for suicide in them. Most elders after retirement do not get engaged in any other form of work. They are commonly found sitting in their balcony (or front of their houses) watching people moving about without any form of interaction with them. The house is usually empty as most tenants or occupants have gone to their places of work. Loneliness sets in and as Barraclough (1971) notes, this becomes the important social risk factor in elderly suicide.

Depression

Another risk factor in elderly suicide has to do with depression which could be a factor of loneliness and social isolation. Most times, depression in the elderly which is not a normal part of ageing is usually

not diagnosed and so remains untreated. The difficulty in identifying depression amongst the elderly is attributable to the dovetailing of the signs usually noticeable with aging and poor health and the somatic manifestations of depression (Yin, 2006 and Help guide.org, 2004). Studies indicate that among the aged, a major predisposing factor in suicide is depressive illness (Barraclough, 1971). In fact, Menza and Liberatore (1998) report that over 75 per cent of the aged who actually committed suicide earlier had been diagnosed of depressive disorder. In addition to the above risk variable in elderly suicide is bereavement. Guohua (1995) contends that bereavement plays a significant role in elderly suicide. With time and age, the elderly starts to lose their contemporaries, friends, relatives and significant others. Most severe of this loss is that of a confidant or a spouse through death (Ojagbemi, *et al.*, 2013).

Changes in Social Roles

Once the elderly retire from work, there are usually social implications and these range from problems with accommodation, finances, loss of self-worth due to retirement to dependency on others for basic chores. At a certain age and particularly in Nigeria where the payment of pension to senior citizens are in several months of arrears, these elders have no option but to rely on the goodwill of their children for their livelihood and survival. Wilson, *et al.*, (2005) in their study reported that, aged who see themselves as parasitic on either their children or extended families are more predisposed to suicide. This is often times referred to as altruistic suicide where as a result of the close affection that exist between their children, extended families and them, they take to suicide in order to remove the burden of having to keep caring for them.

Theoretical Explication

This study adopted the psychache theory in its explication of the social phenomenon under study. This theory was propounded by Shneldinan (1993) and it states that suicide is more likely to take place when a person finds his psychache to be intolerable and unbearable. Implied in this, is the fact that, it is a means by which a person avoids severe psychological pains. To Scheidman (1993), psychache is a psychological pain, hurt or anguish which overtakes the mind and is usually marked by intense feelings of shame, guilt, fear, anxiety in

loneliness. He notes further that, this psychological pain that often results in suicide is linked to an individual's psychological needs which when blocked, makes the psychache to rise. Interestingly, a number of studies have validated the views of Shneidman (1993) as they discovered that psychache is a predictor of suicide (Olie, *et al.*, 2012).

Although there appears to be no studies which have been done to specifically determine the relevance of this theory to the elderly, it is correct however, to assert that the severe psychological pain, hurt and anguish which is the main thesis of this theory is nonetheless applicable to the understanding of suicide in older persons (Stanley, *et al.*, 2016). Specifically, the usefulness in adopting this theory to explain suicide among the elderly, lies in the fact that social isolation, loneliness, and depression are deep hurt, pains, anguish which the elderly face. Unfortunately, the psychological needs of the elderly for social interaction is more often than not blocked, leading to a rise in psychache which is a causative agent accounting for suicidal thoughts and behaviour.

Statement of the Problem

Unarguably, one of the contemporary social problems facing the world today and particularly African states (Nigeria inclusive) is the alarming rate of suicide, not just in the general population but among the elderly also. In fact, Conwell and Brent (1998) note that in many countries of the world today, more elderly persons commit suicide than the younger generation

Confirming this incidence, the World Health Organization's (2014) claim on a global note that more suicide are committed by people who are above 75 years of age and by its calculation about 8,00,000 commit suicide daily. The frightening state of the problem was succinctly described by Lapierre, *et al.*, (2011) when they observed that with significant rise in the number of the elderly in the population of the world, suicide is most likely to be the tenth most common cause of death among the elderly by 2020.

This social problem starts initially as a thought and moves on through the planning behaviour up to an attempt or completion. The question is what are the predisposing factors in suicide among the elderly? Why would an elderly person decide to end his life? Is it depression, mental ill health or an impulsive act? The truth remains

that these questions are not easy to answer, especially against the background that suicidal behaviour of the elderly is a complex social issue that is influenced by several predisposing variables. Suicidal behaviour, though a personal tragedy to the family of the elderly, is worth examining, especially, as it is preventable and impacts the most vulnerable and criminally victimized of the world's population – the elderly.

Objective of the Study

This study examined the predisposing factors in suicide among the elderly in Ogida community, Southern Nigeria.

Research Question

What are the predisposing factors in suicide among the elderly in Ogida community, Southern Nigeria?

Methods and Materials

The research followed a quantitative descriptive research design. The principal intention of this study was to investigate the risk factors in suicide among the elderly. This research used a sequential explanatory design in which mixed method approach whose characteristics is collection and analysis of quantitative data followed by the collection and analysis of qualitative data (Owenga, *et al.*, 2018). The essence is to employ qualitative data to help explain the results or finding of the quantitative data. The study explores, explains and interprets the social menace.

A sample size of 725 respondents was used for this study. Data collection instrument included the questionnaire, for general data collection from 700 respondents and in-depth interview for 25 respondents. In order to ensure the validity of the research instrument, 3 experts from the department of Educational foundation of the University of Benin were consulted. The study ascertained the reliability of the instrument used by conducting a pilot study in the study area which was not part of the study. A cronbach reliability coefficient of 0.732 was reported. Data collected from the questionnaire were analysed using descriptive statistics in form of percentages and frequency counts as well as inferential statistics. Quantitative data collected from the in-depth interviews were organized into categories and sub-categories and thereafter, content analysed.

Table 1
Demographic Characteristics of Respondents

	<i>Frequency</i>	<i>Percentage (%)</i>
Sex		
Male	481	69
Female	212	31
Total	693	100
Age		
26–35	59	9
36–45	166	24
46–55	142	20
56 and above	326	47
Total	693	100
Educational level		
Primary education	66	10
Post primary education	142	35
Higher education	385	55
Total	693	100
Religion		
Christianity	656	94
Islam	7	1
ATR	30	5
Total	693	100

Source: field survey, 2018

Table 1 depicts the results of the demographic characteristics of the respondents. It reveals that among the 693 respondents who participated in the study, 69 per cent of them were male while 31 per cent were female. 9 per cent were in the 26–35 years age range, 24 per cent were between 36–45 years while 20 per cent were between 46–55 years and 47 per cent were 56 years and above. On educational level, 10 per cent of the respondents had primary education, 35 per cent had post primary education while 55 per cent had higher education. 94 per cent of the respondents were Christians, 1 per cent Muslims and 5 per cent practiced African Traditional Religion.

Table 2
Motivation for Suicide

	<i>Frequency</i>	<i>Percentage (%)</i>
Chronic pain/physical health challenges	75	11
Social isolation, losses and bereavement	125	18
Depression	30	4
Changes in social roles	55	8
All reasons stated above	408	59
Total	693	100

Source: field survey, 2018

Table 2 reveals that 11 per cent of the surveyed population believed that chronic pain/physical health challenges are motivating factors for suicide, 18 per cent held on to social isolation, losses and bereavement, 4 per cent had depression while 8 per cent were for changes in social roles and 59 per cent for all reasons stated above. The finding on chronic pain and debilitating physical health challenges is in tandem with the studies of Meyers and Sohrab (2012) and Tang and Crane (2006) as both studies reported that adjusting to new health challenges and coping with chronic pains make the elderly more vulnerable for possible suicide. The views of one of the interviewees further corroborated the above position when he said:

My father keeps complaining about his inability to move about due to the stroke he had two years ago and worst still the injections he has to take every time to control his diabetic state. Most times, he laments and asks what is the essence of living in this kind of condition and often, he wishes that death would just come and take him away. (IDI, female, 39 year old civil servant, Ogida Community, Benin City)

Another interviewee noted that:

Personally, I would prefer to die rather than suffer untold hardship due to pain and ill health. What is the meaning of life when one lives it in pain and ill health. God forbid, if I were in that situation, I would quietly take 20 tablets of paracetamol and go to my maker. (IDI, male, 72 year old pensioner, Ogida Community, Benin City)

The finding on social isolation and bereavement also concurred with the views expressed by Barraclough (1971) who noted that

loneliness and social isolation are risk factors in elderly suicide. This view is supported by the opinion of one interviewees who opined that:

Every day I sit outside in my compound doing nothing but just staring at the sky. My children are all grown up and have left me in the care of a ten year old child who goes to school herself. I do this sitting outside from morning till evening until mosquitoes drive me back inside the house. Well, I feel sometimes like just ending this misery. (IDI, male, 78 year old, ex-taxi driver, Ogida Community, Benin City)

Guohua's (1995) studies support the finding of this work when he observed that bereavement plays a significant role in elderly suicide and this view is validated by the comment of one interviewee who opined that:

My dad, every now and then says it is my mum that has put him in this pitiable state when she died before him. As if the death of my mum was not enough, his only surviving sister died three months after. He complains that there is nothing to look forward to. In addition, he sometimes refuses to eat and take his anti-hypertensive drugs. (IDI, female, 41 year old banker, Ogida Community, Benin City)

The study's finding on the relationship between depression in the elderly and suicide validates the previous research work of Menza and Liberature (1998) whose report revealed that over 75 per cent of the aged who successfully commit suicide had previously been diagnosed with depressive disorder. The observation of one the interviewees lend credence to this finding:

Papa frequently goes into depression. His sleep is often disturbed (insomnia) and he has very low appetite, constantly wishing that death would come his way. I personally diagnosed his depressive illness and I'm treating it. (IDI, female, 50 year old medical doctor, Ogida Community, Benin City)

The finding of this study replicates the work done by Wilson, *et al.*, (2005) where they reported that changes in social roles which make the elderly dependent on their children and extended families are more predisposed to suicide.

May God never allow me live to a stage where I have to be dependent on my children for food, clothes and shelter. For what? I would better die than live to witness that day.

(IDI, male, 45 year old school teacher, Ogida Community, Benin City)

This excerpt points to the fact that changes in social role is a risk factor in elderly suicide.

Conclusion and Recommendations

Suicidal and para-suicidal behaviour is a serious social problem among the elderly although very grossly understudied. The study revealed that there are several risk factors in elderly suicide which are unnoticed by the families and care givers of the aged. Thus, giving room to the alarming increase in the rate of suicide among persons 65 years of age and older in Nigeria. In the light of the findings of this study, the following suggestions are put forward:

- Relations and children of the elderly should endeavour to give the best medical attention to their aged parents particularly, those with visible health challenges. Efforts should be made by such relations to personally purchase prescribed drugs for their parents as well as ensuring compliance to the doctor's prescribed dosage.
- It is important too for the relations and children of the aged to socially network with their parents. Frequent visits should be made while at the same time, grand children should be made to spend quality holiday time with them. Even though they live in the same town where known friends and old acquaintances of the elderly reside, relations and children should take time out of their crowded schedule to drop the elderly off at the homes of such old friends and pick them up at an agreed time. This will erase the feeling of loneliness, isolation and losses due to bereavement.
- With close observation and interaction, depressive disorder can be noticed in the elderly. Once noticed or diagnosed, efforts should be made to treat it. The best is to eliminate all the risk factors in depression among the elderly that could lead to suicide or its contemplation.
- Changes in the social roles of the elderly have been observed as a potential source or cause of suicide and therefore, efforts should

be made to ensure that changes in social roles of the aged due to retirement are cushioned. The changes are more visible in the ability of the elderly to maintain or keep the standard of life they had before retirement. Financial supports by relations and children of the elderly should be given without waiting for them to make the request which when made, tends to reduce their self-worth and esteem. Where possible, less tasking or demanding ventures that could create wealth should be established for the elderly. This will make them have a feeling of relevance as they will have a feeling of being in charge and their ego thus massaged.

References

- Baechler, J. (1980): A strategic theory. *Suicide and Life-threatening Behaviour*. 10, 70–99.
- Barracough, B. (1971): Suicide in the elderly. In *Recent Developments in Psychogeriatrics* (Eds.). D.W.K. Kay and A. Walk. Headley Brothers, Ashford, Kent: Royal Medico-Psychological Association.
- Cattell, H., (2000): Suicide in the elderly., *Advances in Psychiatric Treatment* (2000), Vol. 6, pp. 102–108.
- Conwell, S.Y., Draper, B., Quinnett, P. (2011): International Research Group for Suicide among the Elderly. A systematic review of elderly suicide prevention programs. *Crisis*. 32(2), 88–89.
- Conwell, Y., Brent, D. (1995): Suicide and aging: patterns of psychiatric diagnosis. *Int. Psychogeriatrics*. 7, 149–164.
- Conwell, Y. and Brent, D. (1996): Suicide and aging: patterns of psychiatric diagnosis, Inc: Pearson, J.L., Conwell, Y. editors. *Suicide and Aging International Perspectives*, New York: Springer Publishing, 6, 15–30.
- Criminal Code Act, Cap C 38 Laws of the Federal Republic of the Federation of Nigeria, 2004.
- Durkheim, E. (1897): *Suicide: A Study in Sociology*. New York; Free Press.
- Guohua, L. (1995) The interaction effect of bereavement and sex on the risk of suicide in the elderly: An historical cohort study. *Social Science and Medicine*, 40, 825–828.

- Helpguide.org. (2014): Depression in older adults and the elderly. <http://www.helpguide.org/articles/depression/depression-in-older-adults-and-the-elderly.htm>.
- Lapierre, S., Erlangsen, A., Warren, M., De Leo, D., Oyama, H., Scocco, P., Gallo, J., Leadbetter, P. (2005): Violence and nursing. *Practice, Policy and Training, Advanced Hospital Management*. 3, 18–23.
- Magagna G., De la Fuente E.I., Vargas, G., Lozano, L.M., Cabezas, J.L. (2013): Bayesian estimation of the prevalence of suicide risk in institutionalized older people. *Omega Westport*, 66(2), 121–133.
- Marson, S and Powell, M (2011): Suicide among elders: a Durkheimian proposal. *International Journal of Ageing and Later Life*, 6(1): 59–79.
- Menza, M.A., Liberatore, B.L. (1998): Psychiatry in the geriatric neurology practice. *Neural Clin* 16(3), 611–633.
- Minois, G. (1999): *History of suicide: voluntary death in western culture*. Maryland Johns Hopkins University Press.
- Moscicki, E.K. (1995): Epidemiology of suicide. *Int. Psychogeriatry*. 7, 137–148.
- Myers, W. and Sohrabi, F. (2012): Help for seniors with depression. Everyday Health, www.everydayhealth.com/hs/major-dehression/help-for-seniors-with-depression.
- Ogunlesi, A., Adebawale, T. and Ogunwale (2015): The summary of hopelessness. Retrieved on the 29th July, 2015 from www.medicalworldnigeria.com
- Ojagbemi, A., Oladeji, B., Abiona, T., Gureje, O. (2013): Suicidal behaviour in old age – results from the Ibadan Study of Ageing. *BMC Psychiatry*.
- Olie, E., Guillaume, S., Jaussent, I., Courtet, P. and Jollant, F. (2010): Higher psychological pain during a major depressive episode may be a factor of vulnerability to suicidal ideation and act. *Journal of Affective Disorder*. 120, 226–230.
- Owenga, J. Aloka, P. and Rabur, P. (2018): Relationship between selected personal determinants and examination cheating among Kenyan secondary school students. *A.J.I.S*: 7(1), 73–82.
- Pearson, J.L. and Conwell, Y. (1995): Suicide in late life: challenges and opportunities for research. *Int. Psychogeriatry*. 7, 131–136.

- Robinson, D., Renshaw, C., Okello, C., Moller, H., Davies, E.A. (2009): Suicide in cancer patients in South East England from 1996 to 2005: a population-based study. *Br J Cancer*, 101 (1), 198–201.
- Shields, L.B.E., Hunsaker, D.M., Hunsaker, J.C. (2005): Trends of suicide in the United States during the 20th century. *Forensic Pathology Reviews*, 3, 305–335.
- Shneidman, E.S. (1993): Some controversies in suicidology: toward a mentalistic discipline. *Journal of Suicide and Life-threatening Behaviour*, 23(4), 292–298.
- Stanley, I.H., Hom, M.A., Rogers, M.L. and Joiner, T.E. (2016): Understanding suicide among older adults: a review of psychological and sociological theories of suicide. *Aging and Mental Health* 20(2), 113–122.
- Tang, N.K, and Crane, C. (2006): Suicidality in chronic pain: a review of the prevalence, risk factors and psychological links. *Psychol Med.* 36, 575–586.
- Troister and Holden (2012): A two-year prospective study of psychache and its role to suicidality among high-risk undergraduates. *Journal of Clinical Psychology*, 68(9), 1019–1027.
- Westefeld, J.S., Range, L.M., Rogers, J.R., Maples, M.R., Bromley, J.L., Alcom, J. (2000): Suicide: an overview. *The Counselling Psychologist*. 28, 445–510.
- WHO/EURO (1980): Multicenter study in parasuicide. Facts and figure centre for suicidological research. Odense: Denmark
- Wilson, K.G., Curran, D. and McPherson, C.J. (2005): A burden to others: a common source of stress for the terminally ill. *Cognitive Behaviour Therapy* 14(2): 115–123.
- World Health Organization. (1998): Primary prevention of mental, neurological and psychosocial disorders. *Suicide*. Geneva.
- Yin, S. (2006): Elderly white men afflicted by high suicide rates. Retrieved the 13th March from <http://www.prb.org/PublicationArticles/2006/ElderlyWhiteMenAfflictedbyHighSuicideRates.aspx>.

Indian Journal of Gerontology

2018, Vol. 32, No. 3, pp. 273–281

ISSN: 0971–4189, UGC No. 20786

Quality of Life of Elderly Cancer Patients as Predictor of their Caregivers' Quality of Life

C. Vanlalhruaii, Padmaja, Gadiraju, Swarajya Kopparty and Tiamongla

Centre for Health Psychology, University of Hyderabad, Hyderabad (A.P.)

ABSTRACT

The study was conceptualized to find out the association between quality of life of cancer patients and their caregivers and to assess whether patients' quality of life predicts their caregivers' quality of life. Sixty two dyads (N=124) of elderly cancer patients and their caregivers were selected through correlational design. Results showed that with an increase in the social functioning of the patient there is decrease in their caregivers' quality of life. Again, with an increase in cognitive functioning of the patients, there is an increase in their caregivers' quality of life. Stepwise regression analysis showed that social functioning and cognitive functioning of the patient predicted significant amount of variance in the quality of life of their caregivers.

Keywords: Cancer dyads, Social functioning, Cognitive functioning, Quality of life

Cancer as a disease has a life altering impact on the people affected by it. Both the patient and the primary caregiver are to brave the treatment and the survival phases. By the year 2026, India will witness an increase of 5.5 per cent (i.e. from 6.9% to 12.4%) cancer cases in the

age group of 60 years and above of the total population (D'Souza *et al.*, 2013). The incidence of cancer increases with age and more than 12 per cent–23 per cent of all cancers occur after the age of 65 years (Nand Kumar, 2001, and Agrawal, *et al.*, 2002). Cancer is reported to be 11 times more likely to develop in people above 65 years compared to younger people (Ries, LAG *et al.*) Although more than 25 per cent of cancers are diagnosed in people over 60 years, this group is less extensively investigated and probably receives less appropriate treatment than younger patients (Sarkar and Shahi, 2013). Though the advancement in healthcare has contributed to the increased life expectancy, it also increases the number of people suffering from cancer, given the high prevalence of cancer in the older age group. Reduced DNA repairing ability, genetic instability, decreased carcinogen metabolism and decreased immune surveillance are some of the risk factors for developing cancer among the older people (Cicero, 2005).

Primary caregiver (PC) is the main provider of physical and emotional support for the patient. PCs are mostly the patient's spouse, partner or closest relatives, but significant others can also take on that role and function (Grover *et al.*, 2005). The role of caregiver is very challenging when it comes to giving support in terms of physical, psychological, spiritual and emotional, and in particular, care tasks over time, medical management, and decision-making (Goren, *et al.*, 2014). This alters the various aspects of their life, such as physical and mental health, quality of life, financial resources, change in roles, etc. The sudden challenge in the caregiving has been shown to have both positive and negative effects on their quality of life (Kim and Given, 2008). This takes a toll on their health (Ibid) and quality of life (Given and Given, 1992). Caregivers' burden, distress (Grunfeld, *et al.*, 2004) and poor quality of life have been closely linked with the cancer patient's physical health (WHO, 1947).

Quality of life of patients with cancer has been extensively researched. Patient's quality of life can also impact their caregivers' quality of life and vice versa. However, the caregivers' quality of life is often neglected. In fact, this lacuna is considered as a serious gap in health care system. Quality of life doesn't possess a means-end definition; it can rather be defined as a measure of how happy and healthy an individual feels within himself and his environment. It

correlates to his physical and psychological health, his social relationships, his environment, his spiritual beliefs and his expectations about himself and others (Ibid.).

Health-related Quality of Life (QoL) – both of the patients and their caregivers has been recommended as one of the hard end-points for clinical cancer research. In fact, their QoL are interdependent. Research also shows that family caregivers in cancer care experience higher levels of distress and depression as compared to the patients themselves, which can inversely impact the patients' QoL (Grover *et al.*, 2005). As the patients' QoL deteriorates, caregivers' quality of life also worsens. However, they may be reluctant to raise their own health issues, making their physical and emotional burden invisible to the professionals who can actually intervene. Assessment of the caregiver's well-being is not formally assigned to any one team member (Glajchen, 2012). Hence, they suffer as the hidden patient and thus, focusing on the family caregiver QoL becomes significant (Lim and Zebrack, 2004).

Impaired health related quality of life (HRQoL) is often associated with care giving in the context of cancer. Longitudinal studies have also indicated that when family caregivers are highly distressed, it has a negative effect on the patient's long-term adjustment (Hodges, *et al.*, 2005). Given the prevalence rate of cancer among the older population, geriatric oncology is going to become a major component of oncology and geriatric practice, and therefore appropriate consideration and support needs to be developed in public health, institutional and educative policies around the world.

The study objectives were to explore the relationship between the quality of life of elderly patients and their caregiver's quality of life and to examine if the quality of life of patients predicted the quality of life of the care givers.

Method

Sampling

The sample of this correlational study consisted of 62 dyads of elderly cancer patients and their caregivers. Among 62 cancer patients, 51 per cent were men and 49 per cent were women whereas among their family caregivers, 37.9 per cent were men and 62.1 per cent were

women. The age of cancer patients ranged from 60 to 80 ($M = 64.61$) whereas, the age of their family caregivers ranged from 18 to 74 ($M = 43.46$). The family caregivers included the spouse (52.4 %), children (32 %), siblings (12.2 %), in-laws (0.5 %), and relatives of the patients (2.9 %). The inclusion criteria of the study were – cancer in-patients below stage IV and their primary caregivers within the age range of 18–80, both without any history of mental ailment or cognitive impairment. Exclusion criteria included cases above stage III, any comorbid condition, mental ailment or cognitive impairment and cases above 80 years of age. Demographic details of both the patients and their family caregivers were also obtained.

Measures

European Organization for the Treatment and Research of Cancer Quality of Life Questionnaire-QLQ-C30, version 3.0. (EORTC QLQ-C30 version 3.0)

The EORTC-QLQ-C30 (Aronson *et al.*, 1003) was used to assess the HRQOL for cancer patients. It consists of 30 questions and is designed to cover a range of health-related QoL issues relevant to most cancer diagnoses. The questionnaire is organized into five functional scales (physical, role, emotional, cognitive, and social), three symptoms scales (fatigue, pain, and nausea/vomiting), a global health status and QoL (GHS/QoL) scale, and a number of single items assessing additional symptoms (dyspnoea, sleep disturbance, constipation, and diarrhea) and perceived financial impact. Each item has a 4-point response scale (1 – not at all, 2 – a little, 3 – quite a bit, and 4 – very much) with the exception of the two items measuring GHS/QoL, which have 7-point response scales such as 1 – very poor to 7 – excellent. The scoring was done as per the procedure prescribed in the manual. For the functional and global health, and QoL scales, a higher score indicates better functioning, while for the symptom-oriented scales and items, a higher score corresponds to a higher level of symptomatology. Cronbach's alpha of the questionnaire ranges from 0.52 to 0.89.

Caregiver Quality of Life-Cancer

The Caregiver Quality of Life-Cancer (Weitzner, *et al.*, 1999) was used to measure the levels of QoL of the family caregivers of cancer

patients (e.g., My sleep is less restful). It consisted of 35 items which were scored on 5-point scale ranging from 'Not at all' (0) to 'Very Much' (4). Total score was found by summing up the item scores and it ranges from 0 to 140. Higher the score, the better is the QoL. The test-retest reliability was 0.95 and internal consistency coefficient was 0.91; the scale also possesses adequate validity.

In addition to the measures, the demographic details such as age, gender, types of relation between the cancer patients and their family caregivers were obtained from the participants.

Procedure

Approval from the Ethics Committee of the University where the authors worked and the appropriate hospital authorities were obtained prior to starting of the study. The selected hospitals from the States of India (Mizoram and Telangana) were visited and rapport was established with the patients with cancer who were in-patients of the hospital and their family caregivers, who signed informed consent forms. Such cases were dropped where the informed consent forms were not obtained from the pair – the patient and their caregiver. Each participant – patient and caregiver – was also informed about the measures and how long it would take to complete them. The measures were administered individually on the participants. During administration, the doubts of the participants regarding any of the items of the measures were clarified. The average period of administration of the measure was 15 to 20 min per participant. After the completion of the administration of the measures, each participant was debriefed.

Results

Multiple stepwise regression analysis was run to identify the predictors of quality of life of caregivers' of patients with cancer. The analysis resulted in two Models, in the first Model social functioning of patients with cancer predicted 8.4 per cent of variance for caregivers' quality of life $F(1, 60) = 6.61, p < .05$. In Model 2, cognitive functioning dimension was added and the Model significantly predicted more variance, R^2 change was .062. Therefore, Model 2 significantly predicted 16.2 per cent of variance for caregivers' quality of life $F(2, 59) = 5.68, p < .01$.

Table 1
Summary of Multiple Stepwise Regression Predictors of Caregivers' Quality of Life

<i>Model and predictor variable</i>	β	<i>SEB</i>	β	<i>R</i> ²	ΔR ²
Model 1 (C = 52.83, F = 6.61*)				.084	
Social Functioning	-.19	.07	-.31*		
Model 2 (C = 30.83, F = 5.68**)				.162	.062*
Social Functioning	-.23	.07	-.37**		
Cognitive Functioning	.26	.12	.25*		

Note: * $p < .05$, ** $p < .01$

Discussion

The objective of the study was to find association between quality of life of patients with cancer and their respective caregivers. Result shows that in Model 1 social functioning is the predictor of caregivers' quality of life, this result suggested that with the increase in social functioning of the patient there is a decrease in quality of life. This finding contradicts the conventional thought that if the patients cope well with the disease and are able to have social interactions with others, their caregivers' quality of life will improve. However, in the current finding decrease in caregivers' quality of life could be due to fact that when the patients are up and about doing their own thing, the caregivers are worried about the patients. The caregivers expected that the patients being elderly and diagnosed with cancer will always need their assistance and attention. So when the patient appear independent and able to have social interaction with others which is the opposite of what the caregivers expected, they may feel that their role as a caregiver is not properly carried out which leads to decrease in their quality of life.

In Model 2, when cognitive functioning is added to the model there is significant increase in prediction of variance. Model 2 suggested that when there is an increase in cognitive functioning there is increase in caregivers' quality of life. This finding is in line with previous studies which suggested that with the increase in performance of the patients there is also an increase in the caregivers' quality of life. Literature also suggested mental functioning decline with age and considering that the sample is consisting of elderly patients 60 years and above, their caregivers may expect them to depend on them

in terms of cognitive functioning such as remembering things decision-making regarding issues related to their treatment and so on. But when the patient is independent to perform activities related to cognitive functioning this may reduce their anxiety and stress towards the patient's wellbeing this in turn results in increasing quality of life for the caregivers.

Conclusion

It is seen that social and cognitive quality of life of elderly cancer patients predicts the quality of life of their caregivers. With the recent rise of geriatric cancer population, research on these aspects is indicated. Geriatric population becomes dependent by default. On top of that, getting diagnosed with cancer is a major challenge both for the patients and their caregivers. Research has also shown the various negative impacts of cancer on the quality of both the patients and their caregivers. Hence psychological interventions are suggested. A more comprehensive, holistic approach is indicated, one that gathers to the biopsychosocial needs of the dyads.

Limitations and Future Directions

Larger sample size is suggested for higher generalizability. Qualitative approach could have given more insight into the perspectives of the dyad and hence a better understanding of the problem is assured.

References

- Aaronson, N.K., Ahmedzai, S., Bergman, B., Bullinger, M., Cull, A., Duez, N.J., Filiberti, A., Flechtner, H., Fleishman, S.B., de Haes J.C.J.M., Kaasa, S., Klee, M.C., Osoba, D., Razavi, D., Rofe, P.B., Schraub, S., Sneeuw, K.C.A., Sullivan, M., Takeda, F., (1993): The European Organisation for Research and Treatment of Cancer QLQ-C30: A quality-of-life instrument for use in international clinical trials in oncology: *Journal of the National Cancer Institute*, 85: 365–376.
- Agarwal S.P., Rao Y.N., Gupta S., (2002): National Cancer Control Program (NCCP) 1st ed. *Fifty Years of Cancer Control in India*; pp. 41–7.

- Cicero, M.T. (2005). Cancer in the elderly—Get ready for the ‘epidemic’. *medicine*, 828.
- D’souza, N.D., Murthy, N.S., and Aras, R.Y. (2013): Projection of cancer incident cases for India-till 2026. *Asian Pacific Journal of Cancer Prevention*, 14(7), 4379–4386.
- Given, B. Given C.W. (1992): Patient and family caregiver reaction to new and recurrent breast cancer. *J Am Med Womens Assoc.* 47: 201–206.
- Glajchen, M., (2012): Physical well-being of oncology caregivers: an important quality-of-life domain. In *Seminars in oncology nursing*, Vol. 28, No. 4, pp. 226–235. WB Saunders.
- Goren, A., Gilloteau, I., Lees, M., and daCosta DiBonaventura, M. (2014). Quantifying the burden of informal caregiving for patients with cancer in Europe. *Supportive Care in Cancer*, 22(6), 1637–1646.
- Grov, E.K., Dahl, A.A., Moum, T., and Fosså, S.D., (2005): Anxiety, depression, and quality of life in caregivers of patients with cancer in late palliative phase. *Annals of Oncology*, 16(7), 1185–1191.
- Grov, E.K., Dahl, A.A., Moum, T., and Fosså, S.D. (2005): Anxiety, depression, and quality of life in caregivers of patients with cancer in late palliative phase. *Annals of oncology*, 16(7), 1185–1191.
- Grunfeld Eva, Doug Coyle, Timothy Whelan, Jennifer Clinch, Leonard Reyno, Craig C. Earle, Andrew Willan, Raymond Viola, Marjorie Coristine, Teresa Janz, and Robert Glossop. (2004): Family caregiver burden: results of a longitudinal study of breast cancer patients and their principal caregivers. *Can Med Assoc J.* 170: 1795–1801.
- Hodges, L.J., Humphris, G. M., and Macfarlane, G., (2005): A meta-analytic investigation of the relationship between the psychological distress of cancer patients and their carers. *Social Science and Medicine*, 60(1), 1–12.
- Kim, Y., Given B.A., (2008): Quality of life of family caregivers of cancer survivors: across the trajectory of the illness. *Cancer* 112(11 Suppl):2556–2568. doi:10.1002/cncr.23449.

- Lim, J. W., and Zebrack, B., (2004): Caring for family members with chronic physical illness: a critical review of caregiver literature. *Health and Quality of Life Outcomes*, 2(1), 50.
- Nanda Kumar A. (2001): *National Cancer Registry Programme* (NCRP), Indian Council of Medical Research. Aug.
- Ries LAG, Kosary CL, Hankey BF, Miller BA, Clegg L, Edwards BK (eds.). (1999): *SEER Cancer Statistics Review, 1973–1996*, National Cancer Institute. Bethesda, MD.
- Sarkar, A., and Shahi, U. (2013): Assessment of cancer care in Indian elderly cancer patients: A single center study. *South Asian Journal of Cancer*, 2(4), 202–208. <http://doi.org/10.4103/2278-330X.119904>.
- Weitzner, M.A., Jacobsen, P.B., Wagner, H. Jr, Friedland, J, Cox, C., (1999): The Caregiver QoL Index–Cancer (CQOLC) scale: development and validation of an instrument to measure QoL of the family caregiver of patients with cancer. *Qual Life Res Int J Qual Life Asp Treat Care Rehab* 8(1–2):55–63.
- World Health Organization (1947): *The constitution of the World Health Organization*. WHO Chron. 1:29.

Indian Journal of Gerontology
2018, Vol. 32, No. 3, pp. 282–289
ISSN: 0971–4189, UGC No. 20786

A Comparative Study of Anxiety among Young Adults and Elderly

Aachal Taywad and Rupashree Khubalkar¹

Amity Institute of Behavioral and Allied Sciences,
Amity University Mumbai (Maharashtra)

¹Post Graduate Department of Psychology, Rashtrasanta Tukdoji
Maharaj Nagpur University, Nagpur, (Maharashtra)

ABSTRACT

The present study was conducted to compare the levels of anxiety between elderly and young adults. For this purpose, by incidental sampling, 40 young adults (mean age=31) and 40 old age (mean age=70) elderly were administered Depression Anxiety Stress Scale individually. The mean anxiety score of young adults and old individuals were 10.2 and 5.33 respectively. To test the significance of difference between the mean scores of young adults and elderly 't' test was calculated. The obtained 't' value was 2.45 which was significant at the level of $p < 0.05$. Anxiety level of young adults was significantly higher than elderly. Lower levels of anxiety in elderly can be due to reduced responsibilities, mental adaptation with stress, maturity, high intellectual functioning, routine activities, good SES, social contact, family support, etc. Anxiety levels are higher in young adults due to work stress, insecurity, financial status, lack of exercise, lack of social support, etc.

Keywords: Young Adults, Elderly, Anxiety.

Anxiety is a basic negative emotion along with anger, sadness, disgust and perhaps others. Freud defines anxiety 'as an ego function

which alerts the person to sources of impending danger that must be counteracted or avoided. It is the price we pay for civilization. It helps the person to react to threatening situation in an adaptive way' (Freud, 1926). Anxiety is defined by subjective awareness of anxious feeling and situational anxiety in addition to symptoms of autonomic arousal (Lovibond and Lovibond, 1995).

The chronological age denoted as 'old age' or 'elderly' varies culturally and historically. Thus, old age is 'a social construct' rather than a definite 'biological stage'. Old age comprises 'the later part of life; the period of life after youth and middle age, usually with reference to deterioration' (Oxford English Dictionary). Anxiety is a common illness among older adults, affecting as many as 10–20 per cent of the older population, though it is often undiagnosed.

A young adult, according to Erik Erikson's stages of human development, is generally a person in the age range of 20 to 40. Among adults, anxiety is the most common mental health problem for women and the second most common for men, after substance abuse (Briner, 1999).

Fukukawa, *et al.*, (2004) suggested that anxiety is at least as common as depression in older adults. Overall, 13 per cent of respondents experienced case level anxiety symptoms while 29 per cent reported sub-threshold levels of anxiety. In contrast only 5 per cent of respondents reported a doctor's diagnosis of anxiety suggesting a marked under-diagnosis of anxiety in older Irish adults. Only 15 per cent of people who were classified as anxious according to the HADS-A reported a doctor's diagnosis of anxiety. The prevalence of case level and sub-threshold anxiety was highest in the 50–64 year age group and decreases with advancing years.

Jorm, *et al.*, (2005) collected data on anxiety and depression symptoms in a community survey of 7,485 persons aged 20–24, 40–44 or 60–64 years. Depression, anxiety and psychological distress showed a decline across age groups from 40–44 to 60–64 years. Some of these age differences were accounted for by other risk factors, with the most important being recent crises at work and negative social relationships with family and friends.

Jorm, (2000) examined the occurrence of anxiety, depression or general distress across the adult life span. This study involved general

population sample ranging in age from at least 30s to 65 and over. The most common trend found was for an initial rise across age groups, followed by a drop. He concluded that ageing is associated with an intrinsic reduction in susceptibility to anxiety and depression. Twenge, (2006) in his book entitled 'Generation Me' said that although our life expectancy and quality of life have improved over the past 50 years, the same period has also created a sharp increase in anxiety levels. These changes suggest that most anxiety disorders stem from perceived, rather than actual, threats to our well-being. Rubio and López-Ibor, (2007) concluded that by age 50, generalized anxiety disorder becomes fairly rare. It is most likely to develop by age 7 to 40 yrs., but its influence may in some cases, lessen with age.

Rationale of Study

Most of available literature about various problems faced by elderly and young adult people discuss about health, lifestyle, stress, depression, anxiety and many other things. Death anxiety among old age is also widely studied topic at present. At the same time the middle age group of today is living under a lot of pressure as they have to run their families and grow in this highly competitive world. This results in heightened anxiety among them as well. Both the age groups have high anxieties for different reasons. Zeidner and Matthews (2010) in their book 'Anxiety 101' mention that there is a controversy among researchers about age as the factor in anxiety. So it is interesting to see which age group has high anxiety and try to find out reasons behind each.

The aim of the present study was to comparatively assess and compare the anxiety level between elderly men and young adults. It was hypothesized that:

I- there is a difference in the level of anxiety between elderly and young adults.

And II- Young adults have higher anxiety than elderly.

Method

Sample

The present study was undertaken to find out the level of anxiety between elderly and young adults. A total number of 80 participants were selected by incidental sampling from different areas of Nagpur

city. Out of 80 male participants 40 were young adults between 25 to 35 years of age and 40 were elderly above 65 years of age. Prior appointments were fixed and the test was administered as per convenience individually.

Tool Used

Anxiety scale from DASS, the Depression Anxiety Stress Scales was used for present study. The anxiety scale consists of 42 self-report items, each reflecting a negative emotional symptom. Each item is rated on a four-point Likert scale (from 0, 1, 2 and 3) on the severity of the participants' experiences over the last week. The instructions given to the participants were: 'Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement'. The total number of scores a participant may get from 0 to 126. The sum of scores of all items for anxiety scale constitutes the participants' scores for Anxiety.

The mean scores of Anxiety scale of both the groups were calculated and 't' test was used to find out the significance of difference between the mean scores of the two groups: young adults (N=40) and elderly persons (N=40).

Result and Discussion

Table 1
Showing the Scores of Each Group – Old Individuals and Young Adult Individuals

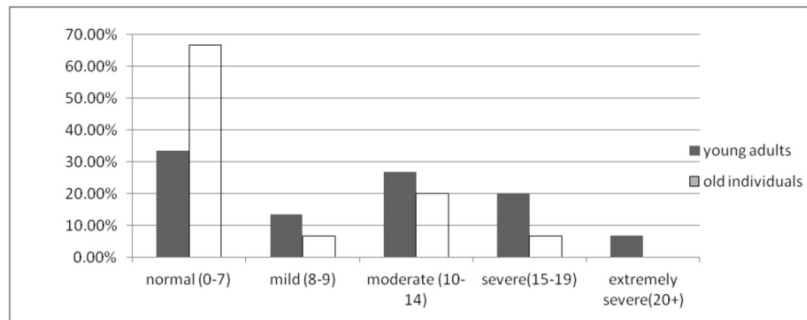
<i>Group</i>	<i>N</i>	<i>Mean (M)</i>	<i>t value</i>	<i>Df</i>
young adults	40	10.2	2.39*	78
old individuals	40	5.33		

The mean scores of anxiety of young adults and elderly is 10.2 and 5.33 respectively. To see if this difference in the mean values is significant or not, 't' test was run. For df=78, the value of 't'=2.39 is significant at 0.05 level (P<0.05). Therefore, it can be said that there is a significant difference in the anxiety levels of elderly and young adults. As mean score of anxiety of young adults' group is almost

double of elderly's score; young adults have higher anxiety than elderly. The data thus obtained clearly indicates significant difference in anxiety levels between young adults and elderly. To see how many individuals of each group fall in which category of anxiety described in the test, scores of all individuals were grouped in these categories. This score is represented in the diagram below. The diagram clearly shows that 33.33 per cent of young adults and 66.66 per cent of elderly fall in normal range of anxiety, i.e. maximum elderly and young adults fall in this category. 13.33 per cent of young adults and 6.67 per cent of elderly fall in mild category, 20 per cent of young adults and 6.67 per cent of elderly have severe levels of anxiety, whereas, 6.67 per cent young adults are suffering from extremely severe anxiety and there is not a single case of old adults in this category. This percentage clearly shows that on anxiety scale of DASS, greater percentage of elderly stand in normal range. However, in mild, severe and extremely severe category, greater percentage of young adults fit in.

Figure 1

Bar Diagram showing Percentage of Old Individuals and Young Adults in Each Category of Anxiety



Young adults have significantly higher levels of anxiety than elderly. Elderly have lower levels of anxiety due to various factors. Some studies that emphasize on these factors are mentioned here.

Jorm., (2000) in his study called 'Does old age reduce the risk of anxiety and depression', found that aging is associated with an intrinsic reduction in susceptibility to anxiety and depression. He associated this reduction with factors like decreased emotional responsiveness

with age, increased emotional control and psychological immunization to stressful experiences.

Jorm, *et.al.*, (2005) in another study on anxiety symptoms among age groups 20–24, 40–44, and 60–64 years of age concluded that anxiety declines with age. Gall, *et al.*, (1997), in their study, ‘The retirement adjustment process’ stated that retirees who make the best adjustment have an adequate income, good health and an extended social network of family and friends.

The elderly who participated in the present study were well educated (at least post graduates), all were scholars and great achievers in their respective fields. All of them were actively involved in various activities, they had a good number of friends, and they were affiliated with some old age groups in their reach. They were from good SES, many had their personal tablets, others were very friendly with modern smart phones and they were very active people on social networking sites. These factors are very essential to understand low anxiety levels in the present sample of old age people. After retirement, elderly have little responsibilities, their children settle down in their lives, due to a bunch of varied life experiences, they get well adapted with stressful events and know better ways of coping, they become more mature and emotionally stable, and as they are prepared for death most of them develop detached attachment. All these factors come together and hence, result in reduced anxiety levels.

The lower levels of anxiety in elderly can thus be associated with good intellectual functioning, Healthy routine activities, good SES, social contact, family support, lesser responsibility, maturity, and learning adaptive ways of coping.

The present study shows that young adults have higher levels of anxiety. There are various studies that support this result.

Jorm., (2000) in his study ‘Age differences in psychological distress’ said that anxiety in adults is accounted by various risk factors like crises at work, negative social relations with family and friends. Twenge, (2006) calls the present generation as ‘Generation me’. The improved life expectancy and quality of life over the past 50 yrs has also created a sharp increase in anxiety levels. He further says that

these changes suggest that most anxiety disorders stem from perceived rather than actual threats to our well-being.

The young adult participants of present study were post graduates between 25–35 yrs of age, most of whom were working at good posts in big companies, pursuing good businesses.

The nature of problems faced by young adults is much different from other age groups. This age is very much a crucial stage in one's life. It is full of major life transitions like gain, loss or changes in job, promotion, marriage, divorce, childbirth, various responsibilities of children like getting them admitted to good schools, their fees, death of parents, etc. In this age, a person gives his/her best efforts in gaining stability in one's personal as well as professional life. Most people have heavy work load, and emotional and financial demands from family. While managing all this, one gets exhausted and gets little time for himself/herself if any. At present, due to recession many people have insecurity in job, many work for less salary than they deserve. Due to inflated prices of basic needs and increasing demands of present lifestyle, people face many difficulties in managing their budgets. Hectic schedules, lack of exercise, junk food, excessive use of technology, also contribute to emotional instability. Most people at present live in nuclear families which has brought reduced social support for the new generation and increased family responsibilities.

The higher levels of anxiety among young adults can be due to high responsibilities, lifestyle changes, work stress, insecurity, financial status, lack of exercise, lack of social support, etc.

On the basis of present findings it may be concluded that there is a difference in the level of anxiety between elderly and young adults as young adults have higher anxiety than elderly.

References

- Briner, Martin, Erik Erikson page, (1999): on Briner's site about learning theories, USMA Department of Mathematical Sciences, Center for Assessment and Program Evaluation (CAPE), United States Military Academy at West Point. Accessed 24 November 2006.

- Freud, S. (1926): Inhibitions, symptoms and anxiety. In J. Strachey, and A. Freud (Eds.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (pp. 77–175). London: The Hogarth Press.
- Fukukawa Y, Nakashima C, Tsuboi S, Kozakai R, Doyo W, Niino N, Ando F, Shimokata H. (2004): Age differences in the symptoms of anxiety. *PsycholAging*. Jun; 19(2):346–51).
- Gall, T. L., Evans, D. R., and Howard, J. (1997): The retirement adjustment process: Changes in the well-being of male retirees across time. *Journal of Gerontology: Psychological Sciences*, 52, 110–117.
- Jorm, A.F., (2000): Does old age reduce the risk of anxiety and depression? A review of epidemiological studies a cross the adult life span, *Psychol Med*. Jan, 30 (1) 11–22.
- Jorm AF, Windsor TD, Dear KB, Anstey KJ, Christensen H, Rodgers B., (2005): Age group differences in psychological distress: the role of psychosocial risk factors that vary with age. *Psychol Med*. Sep; 35(9): 1253–63
- Lovibond, S.H. and Lovibond, P.F., (1995): *Manual for the Depression anxiety Stress Scales*. (2nd Ed) Sydney: Psychology Foundation.
- Rubio, G., and López-Ibor, J. J. (2007): Generalized anxiety disorder: A 40-year follow-up study. *Acta Psychiatrica Scandinavica*, 115, 372–379. (p. 614).
- Twenge, J. M. (2006): *Generation Me: Why today's young Americans are More Confident, Assertive, Entitled – and More Miserable than Ever before*. New York, NY: Free Press, (p. 548).
- Zeidner, M. and Matthews, G., (2010): *Anxiety 101*, Springer Publishing Company.

Indian Journal of Gerontology
2018, Vol. 32, No. 3, pp. 290–305
ISSN: 0971–4189, UGC No. 20786

Elderly and Changing Role of Families in Punjab

Bali Bahadur

P.G Department of Sociology, Guru Nanak College for Girls,
Sri Muktsar Sahib (Punjab)

ABSTRACT

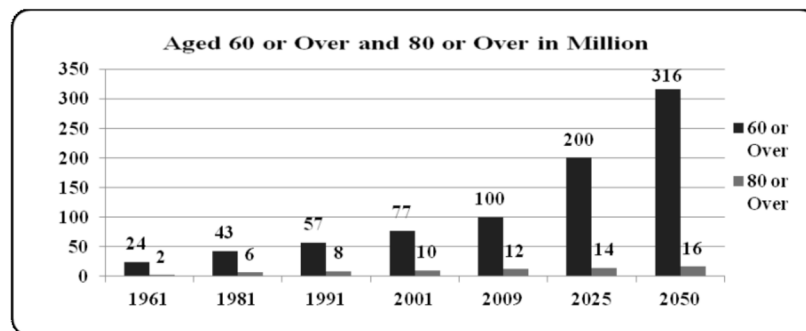
The paper aimed to highlight the correlation between changing roles of families and their negative impact on the elderly people. 110 elderly age varying from 60 years and above, belonging to different socio-economic status were randomly selected from two tehsils of Sri Muktsar Sahib district of Punjab. An interview schedule was prepared and these elderly were interviewed individually. Information from secondary sources was also collected. It was found that 1.7 per cent elderly were living alone, 23.3 per cent were living with their spouses and 75 per cent respondents were living with their children and grand children. Gender difference in access to rooms of house was also noticed. Approximately 52.33 per cent respondents reported that the elderly's traditional role in the family has changed. Loneliness, physical abuse, economic dependency, lack of social support, disrespect in the family and food problem were the major problems reported by these respondents.

Key words: Problems of elderly, Changes in the family, elderly abuse

Ageing in India is exponentially increasing due to the impressive gains that society has made in terms of increased life expectancy. With the rise in the elderly population, the demand for holistic care tends to grow. In 1961, the elderly population was only 24 million, which

increased to 43 million in 1981 and to 57 million in 1991 and 100 million in 2009. In 2010, India had more than 91.6 million elderly and the number of elderly in India is projected to reach 158.7 million in 2025. According to UNPF report (2017) by the end of the century, the elderly will constitute nearly 34 per cent of the total population in the country.

Figure 1.1
Elderly Population in India

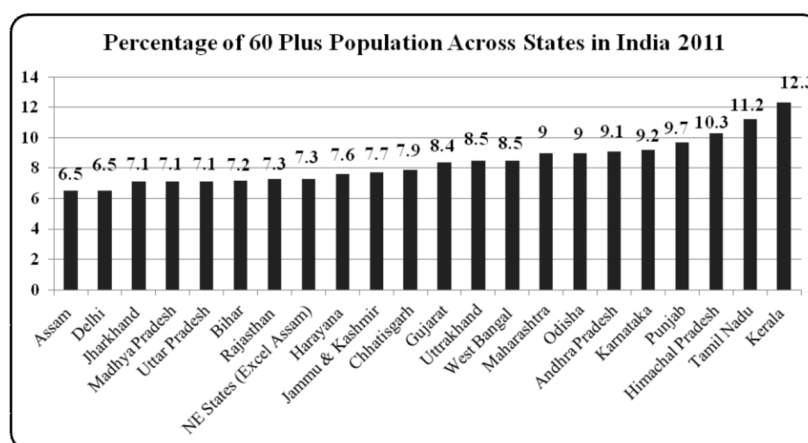


Source: Population Reference Bureau 2009

According to UNPF (2017) India has also significant interregional and interstate demographic diversity based on the stage of demographic transition, variations in the onset and pace of fertility transition. Consequently, there are considerable variations in the age structure of the population, including the ageing experience. For instance, the southern states are the front runners in population ageing along with Himachal Pradesh, Maharashtra, Odisha and Punjab (Figure 1.2). The central and northern states such as Madhya Pradesh, Bihar, Jharkhand, Chhattisgarh, Uttar Pradesh, Rajasthan and Uttarakhand have much lower proportions of aged population as compared to Kerala and Tamil Nadu. State wise data on elderly population divulge that Kerala has a maximum proportion of elderly people in its population (12.3%) followed by Tamil Nadu (11.2%) and Himachal Pradesh (10.3%) (MOSPI, 2016). This may be due to the lifestyle and better medical facilities in respective states. The least proportion is in Dadra and Nagar Haveli (4.0%) followed by Arunachal Pradesh (4.6%) and Daman & Diu and Meghalaya (both

4.7%). The comparison of 2001 and 2011 Population Census data reveals that the average increase of the elderly population among states is 1 per cent. The maximum increase is 3 per cent in Goa. In Daman and Diu there is a decrease in elderly population by 0.4 per cent (ibid).

Figure 1.2
Percentage of 60 Plus Population Across States in India 2011



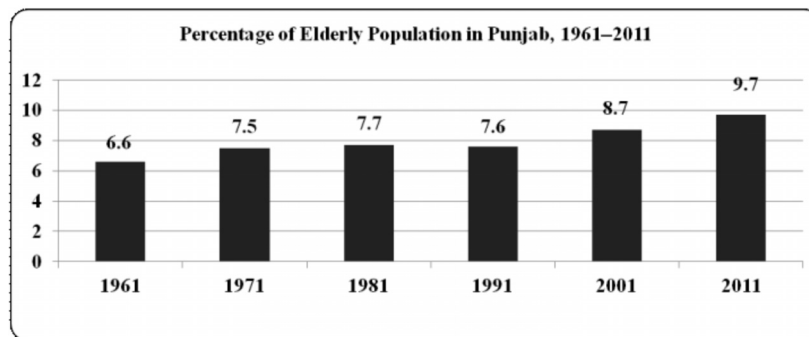
Source: United Nations Population Fund 2017

Socio-Demographic Status of Elderly in Punjab

The population of present Punjab, after its formation as a separate state in 1966, increased from 13.55 million in 1971 to 27.74 million in 2011. During this period, the number of elderly (aged 60 and above) in the state grew from 1.01 million to 2.87 million, which constitutes 9.7 per cent of the total state's population (Figure 1.3). The current population projection suggests that the share of the elderly population is expected to rise further (UNFPA, 2011). As per the social status of the elderly in Punjabi society is concerned this society has always stood for high value, respect and dignity of human life. In the traditional Punjabi society old age is regarded as a mark of esteem, wisdom and piety. This could be attributed to the strong ties that existed in the joint family system nurtured by religious values, dignifying the status of the elderly segment of society. Punjab predominantly is a state where the majority of the population belong

to the Sikh religion by virtue of this family system is influenced by Sikh culture and values, where respect, care and sharing for each other are basic norm. The elderly had a high status in our society, but now the status of the elderly has declined for several reasons. Perhaps, due to the influx of western culture triggered by the media, which gives more emphasis on the individualism and other external influences we see and find western family patterns being more attractive. It is widely believed that the youngsters want to be more independent and the new married couples like to live separately and do not want to live with their parents for reasons of privacy.

Figure 1.3
Percentage of Elderly Population in Punjab, 1961–2011



Source: United Nations Population Fund 2017.

In addition to the rise in the percentage of old people in India, another important factor that attracts the scholars working in gerontology is the problem and challenges faced by the elderly in the modern society. Many scholars believe that the changing social structure and cultural system of the society which are the inevitable consequences of modernization, urbanization, migration in the Indian society, made the life of the elderly people quite problematic. On the other hand gerontology, which was coined by a Russian zoologist *Ilya Ilyaich Mechnikov* in 1903 is still at its initial stage in India. It was just started in the 1960s. A number of scholars such as Ara (1994), Khan (1997), Randhawa (1990), Rajan (2003) have studied the issues relating to the problems of the elderly in India. Although scholars have identified ageing as a major issue in the Indian society, very few of

them concentrated on the impact of the changing roles of family and its impact on the elderly people, especially the inter-generation responsibilities and supporting system on the ageing population. This part of the research in gerontology has grossly been neglected by the scholars.

Objectives of the Study

The purpose of this study was to find out the various problems faced by elderly population of Punjab and the challenges faced by them to live their life respectably. How far changing family structure, role of modernization and lac of social security etc, are responsible for the miseries of the elderly.

Method

The universe of the present study comprises of elderly in two tehsiles of Sri Muktsar Sahib district, namely Sri Muktsar Sahib and Gidderbaha of Malwa region of Punjab. For proper representation of elderly 110 respondents, age varying from 60 years and above, representing different socio-economic status from each Tehsil were selected randomly. Voter list of the area was used to identify 60 + age individuals. Structured Interview Schedule was prepared and each respondent was interviewed individually. Secondary data were collected from various books, newspapers, census records, reports published by government and non government agencies about the elderly in Punjab state.

Findings and Discussion

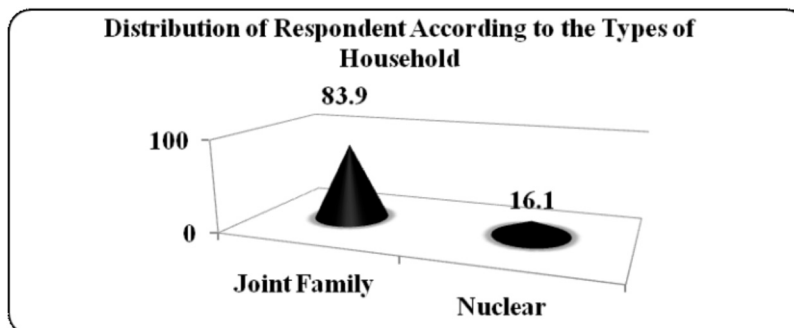
Transformation in Structure: Nuclearization of Family Structure

Family is the cornerstone of all human societies which has been observed in every human culture. Family as a social institution is closest to us and its influence can be felt in everyday lives. (Morgan and Kunkel, 2006). Ageing was not a major issue in the traditional Punjabi society with an age-old joint and extended family system which has been instrumental in safeguarding the social and economic security of the elderly people. The strong family system has played an important role in influencing an individual's living, social role, profession and decision-making. The elderly used to form a central beacon in a traditional Punjabi family, where they were treated with reverence and

where they held an authoritative place. The traditional norms and values of Punjabi society also laid stress on showing respect and providing care for the elderly. But in this modern era the nuclear family system is the call of the day. Most joint families have broken into pieces and independent and single families have emerged.

However with the emerging prevalence of nuclear family set-ups in recent years, the elderly are likely to be exposed to emotional, physical and financial insecurity in the years to come. Kumar *et al.*, (2011) in their study noted that there is an upward trend in the living arrangement pattern of elderly staying alone or with spouse only from 9.0 per cent in 1992 to 18 per cent in 2006. Family care of the elderly seems likely to decrease in the future with the economic development of the nation and modernization. A large number of studies noted that rapidly changing family structure is creating problems for the elderly. In order to understand the role of family and its impact on the life of elderly it is pertinent to study their living arrangements. As Shah (1999) in his study noted that more elderly are now living in joint families. Similarly Rajan and Kumar (2003) also found that a large majority of the elderly in India are living with their kin and only a few of them are living only with their spouses. Kumar, *et al.*, (2011) in their study found that elderly are less vulnerable in rural areas as compared to their urban counterparts, due to higher prevalence of joint families in villages. They also believe that the age-old joint family system has been instrumental in safeguarding the social and economic security of the elderly people in India.

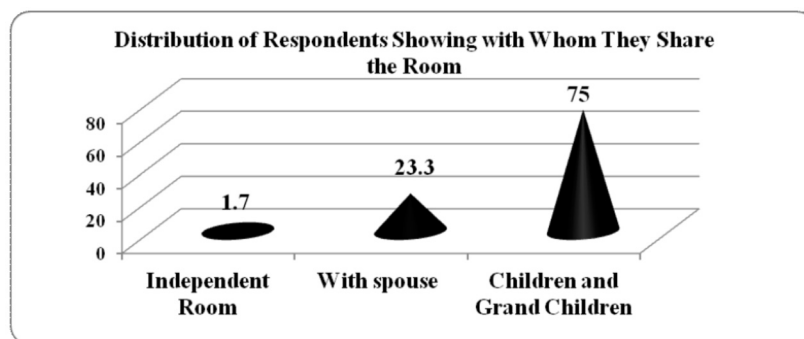
Figure 1.4
Distribution of Respondent According to the Types of Household



It is clear from the Figure 1.4 that the majority of the elderly in Sri Muktsar Sahib and Gidderbaha cities are living in joint households and a negligible percentage live in the nuclear families. Families have undergone a major change over the years and in this regard Punjabi society is not an exception. After careful analysis of data one major change observed was changing nature of family from joint family structure to the nuclearization of families. Some of the respondents reported that though they are living in the joint family, but their extended family does not cook food for them therefore they have a separate kitchen for them. There is a close relationship with the changing structure and functions of families and elderly abuse. Although studies show that elderly are more secure and safe and living with dignity in joint families, it was found that even in the joint family elderly people are facing a number of abuses by their own children. Help Age India research report (2015) highlight the perception of youth with regard to elderly abuse in India found that 34.7 per cent youth perceive primary abuser of elderly in families are the daughter-in-law and 23 per cent perceive it to be the son. Interestingly, 86.9 per cent youth advocate 'living in large joint families' as a measure to prevent elder abuse even in today's social scenario of a rising graph of nuclear families.

Figure 1.5

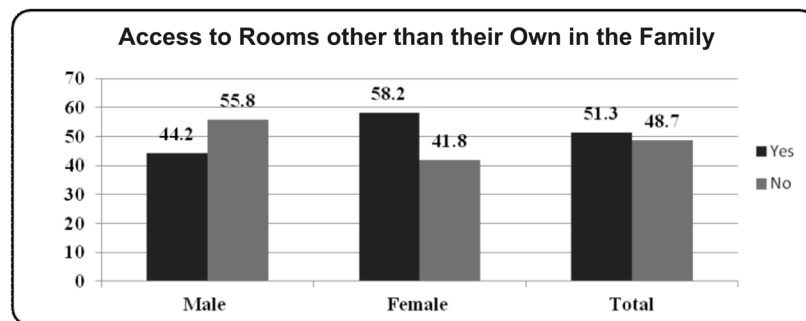
Distribution of Respondents showing with Whom They Share



It is clear from Figure 1.5 that very few of elderly (1.7%) have independent room for themselves in the family, 23.3 per cent share the room with their spouse and 75 per cent of the respondents share the room with children and grandchildren statistical analysis also shows a

significant association between sex composition and response category data clearly shows that more male elderly share their room with their spouse as compared to the female elderly. On the other hand more female elderly share their room with their children and grandchildren. The elderly who share their room with their children and grandchildren are likely to be widows. Kumar, *et al.*, (2011) also noted that there is an upward trend in the living arrangement pattern of elderly staying alone or with spouse only from 9.0 per cent in 1992 to 18.7 per cent in 2006. Now let us try to find out whether elderly have access to other rooms in the family or not or their space in their household is restricted.

Figure 1.6
Access to Rooms other than their Own in the Family



The data clearly depict that approximately half of the respondents (48.7%) are not allowed access to rooms other than their own. The data shows that more female elderly have access to other rooms of the house as compared to the male elderly. So we can say there is a gender difference in the space available to the elderly in the household. The female have access to larger space in the house whereas male elderly are living in limited space in their household. It was also found that if the relations of elderly with the other members are cordial, then they feel more comfortable and adjusted, but generally younger generation does not like them to interfere in their personal matters.

Transformations in the Roles and Functions of Family

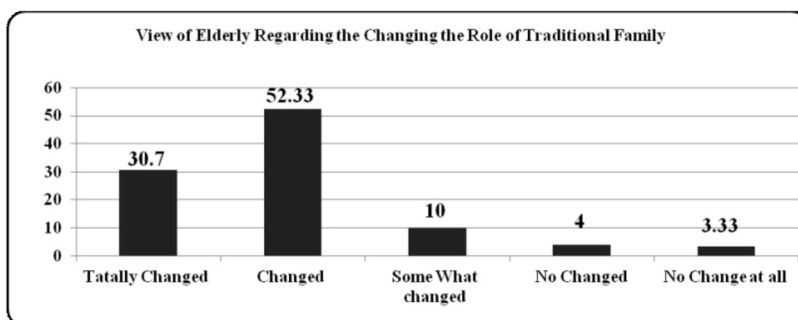
Discussions of the changing roles and transformation of the family as a social institution are inevitably complicated by the fact that it is an institution with which every human being has long and

in-depth experiences. Those uniquely individual experiences surely affect the way in which families are perceived to function and the judgments about different family structures that people often make. Therefore, this aspect of this social institution makes it all the more important to obtain an understanding of its transformations and consequences of those transformations on the different category of people living in this institution.

Family transformation occurs when traditional forms of the family are being transformed to the modern form that exists today. Various scholars (Gupta, 1978; George, 2000; Singh, 2004) have examined the features of traditional and modern family because family transformation can be observed as a result of changes occurring in these features. They observed that the traditional family has changed its features, compositions and functions towards a different type of family in modern society. The traditional Punjabi family had a large number of members, male oriented, and the main production unit and elderly people were respected by the family and society, in contrast, modern family has fewer members comprising immediate family members. The life style of the modern family has changed. The main income is generated from the external sources, education has become a priority and more female members are employed with increased education. Employment of females has deteriorated the support of elderly in Punjab, as a result of this the respect and care of the elderly has gradually eroded. Figure 1.7 clearly shows that more than 85 per cent of the elderly respondents are in the opinion that the family roles have significantly changed from traditional to modern family.

Figure 1.7

View of Elderly Regarding the Changing the role of Traditional Family



Major Problems Faced by the Elderly

Elder abuse and neglect are increasingly acknowledged as a social problem internationally and India is no exception. The responsibility of caring for elderly in Punjab is traditionally borne by the immediate family and most often by sons. However, with a trend towards the changing role of family and its setup, the vulnerability of elderly is considerably increasing. The younger generation has little or no time for the aged because they are in the race to make both ends meet. The elderly expect more time and support from the younger family members, but most often this does not happen. As a result, there is friction within the family, which often results in abuse and neglect of elderly. The elderly are not given adequate care and attention by their family members. This trend is fast emerging partly due to the growth of 'individualism' in modern industrial life and also due to materialistic thinking among the younger generation. These changes lead to greater alienation and isolation of the elderly from their family members and from society at large. Niharika (2001) also noted that due to the changes in the family structure and the value system, respect, honour, status and authority, which the elderly used to enjoy in traditional society, has gradually started declining, and in the process the elderly are relegated to an insignificant place in our society.

Table 1
Major Problems Faced by the Elderly Respondents

<i>S. No</i>	<i>Problems of Elderly</i>	<i>Percentage</i>	<i>S. No</i>	<i>Problems of Elderly</i>	<i>Percentage</i>
1.	Loneliness	48	7.	Health Related Problem	78
2.	Physical abuse	12.3	8	Verbal Abuse	32.5
3.	Financial or material exploitation Due to Economic Dependency	67.8	9	No Respect	35.6
4.	Lack of Social Support	13.5	10	Negativity Regarding Judgment	15
5.	Disrespect by the family members	57.5	11	No Problem	2.4
6.	Food Problem	12.7			

Note: The Table 1.2 shows the multiple responses of the respondents

There are multiple factors responsible for the problems of elderly in Punjab. These factors include family situations, economic conditions, caregiver issues and cultural aspects. Family situations that can contribute to elder abuse include discord in the family created by the older person's presence, the financial burden of paying for health care for an ageing parent, living in overcrowded houses, stress of the family members, etc. Personal problems of the caregiver that can lead to abusing a frail older person include caregiver stress, mental or emotional illness, addiction to alcohol or other drugs, job loss or other personal crises and financial dependency of the older person, etc. A recent study conducted by Help Age India in eight districts of Punjab, Haryana, Kerala and Tamil Nadu also revealed that Punjabi families do not look after their elders nor does the Punjab government. The study, which selected the districts of Ludhiana and Amritsar due to the large number of cases filed under the Maintenance and Welfare of Parents and Senior Citizens Act, 2007, found that Punjab had the highest number of petitioners in the age group of 80-plus compared to only 9 per cent in Haryana. Surprisingly, almost 70 per cent of the cases under this act in Punjab and Kerala were filed against sons, while in Tamil Nadu, Haryana and Kerala, 21 per cent of the cases were against daughters. Most of the cases were filed at the office of the sub-divisional magistrate. The maintenance-related petitions were the highest in Punjab, while property-related petitions were high in both Kerala and Tamil Nadu. Unfortunately, half of the elderly surveyed reported experiencing physical and mental abuse. The perpetrators were none other than their own offspring. The same study also shows that almost 57 per cent of the elderly attributed the reason for filing the petition to neglect by children (in Punjab, Haryana and Kerala), while 36 per cent said they were propelled by physical abuse and mental torture (in Kerala and Tamil Nadu). According to a report published in Hindustan Times, in Punjab, 50 per cent of elderly people face abuse daily (Manraj, *et al.*, 2018). Surprisingly 74 per cent of those who face abuse live with family, and they do not report the abuse to avoid disgracing the family name. The report also highlighted that most of the abuse came from the most trusted of sources, with the primary abuser being the son, followed by the daughter-in-law, and

the most shocking part is that they are verbally abused daily. Another survey done by the NGO *Age well Foundation* reported that on an average, 25–30 per cent of India's elderly population goes through abuse (Sanjeevil, 2015). From the above discussion, we can clearly see that the elderly abused in and around the Punjab region reported the matter to a close family member, and the second choice was to confide in a relative. So it is clearly seen that the elderly avoid going to the police because they don't want any bad name for their family

Similarly, most people in the present study felt ashamed of the fact that they are being ill treated by family members. They were also afraid of retaliation by the family members if the agencies come to help. A large majority also felt that the social agencies could hardly do anything to help them and the major fact was that it was emotionally satisfying to at least be able to 'see' their children. Govil and Gupta (2016) also noticed that emotional and economic dependence and changing ethos in the society are the main reasons of elderly abuse in our society.

Another reason is the economic dependency of the elderly on their family. As per the census of India 2011 the old-age dependency ratio climbed from 10.9 per cent in 1961 to 14.2 per cent in 2011 for India as a whole. For females and males, the value of the ratio was 14.9 per cent and 13.6 per cent in 2011. Sanjeevil (2015) also mentioned that those elderly who have no income at all go through a lot of abuse. Their children think that they are a waste of space and time. UNFPA (2011) report also suggested that vulnerability among the older population can be measured by ascertaining the economic dependency of the elderly. The report found that 29 per cent of the elderly in Punjab are economically independent while 37 per cent are completely dependent. In the present study, 67.8 per cent elderly were financially dependent on their children. They have scarce savings and they lack social security or health insurance coverage, especially those who have spent their lives toiling in the informal sector. In this scenario, the entire burden of caring for the elderly is placed onto the shoulders of their offspring. Children are also socially obligated to take care of their parents, no matter how desperate their own circumstances are. Yet, just because the elderly reside with their families does not mean that

their needs are being fulfilled. Also, the increasing economic and psychological hardship created by the illnesses of the elderly is also understandably hard for their families to deal with. Social support and family interaction can increase and boost the dignity of the older adults and such support has a protective role in the maintenance of mental health. On the other hand, Punjab has one of the lowest old age pensions in the country, it's been recently revised to Rs 750 a month. Himachal Pradesh and Haryana provide old age pension of Rs 1,200 and Rs 1,600 a month, respectively. Both Punjab and Haryana lack an old age policy, which entails a home for the aged in every district. As of now, Punjab has only one state-sponsored home for the elderly in Hoshiarpur. Soneja (2012) also noted that the dependence of the older parent on their children due to extreme physical and mental impairments, requiring a constant support of a caregiver is one of the major causes of elderly abuse. The 'burden' was perceived both in the capacity of time and money. Caregivers became non caring or not caring enough for the older parents and subjecting them to neglect. Although the majority of the respondents are living in the joint families, they are physically, verbally and economically abused and mistreated by their family members. 12.3 per cent of the respondents reported that they are physically abused by their family member especially by the daughter in law, and that they had faced the same kind of physical abuse in which slapping, hitting and injury were very severe. Data in the Tale 1.2 shows that elderly people in modern families have faced a number of problems even in their own in the families. Many respondents (48%) said that they were being neglected by their family members. Almost all of the respondents reported they were feeling loneliness as they were being ignored by their children. A few respondents reported that they feel themselves isolated from their society. They were not allowed to have communication with their friends and relatives. Mostly widow women were facing loneliness and isolation. It might be due to the fact that they are not allowed by their sons and daughters to move out or visit their friends and relatives.

In the past, elderly used to enjoy a very influential and high status due to their strong financial status and cultural norms, but now the status of the elderly has declined due to the changing trends of family

life. The elderly do not have a strong hold in household economy as children are no longer dependent upon their parents for their livelihood since they are capable of making a living by adopting a profession that is independent of their parents.

Conclusion

Changing value system, roles and functions of the family institution are closely associated with the emerging problems of senior citizens and elderly abuse in Punjab. Elder abuse in any form of mistreatment is a social problem and raises many ethical, cultural and psychological questions for the academicians as well as for the government of the country. It has challenged the role of culture in defining family's responsibility, society's obligation for its members and norms for the elderly. From the above discussion, it is clear that elderly people are losing their importance in the modern family. It is evident from the number of abuses they face even in their own family by their own children. This situation is sufficient to make us feel ashamed. Careful analysis of the different reports of government and non government organizations reveals that incidence of crime by unknown persons and professionals is quite high, but the alarming situation for us is the substantial incidence of elderly abuse by family members, relatives, caregivers, nears and dears and even in some cases by the neighbours. In most of the cases reported so far perpetrators of crime are daughter-in-law, son and daughter. The present study found that changes in the family due to modern education and western individualistic ideology are responsible for changing the value system and structural functional changes in Punjabi family which further becomes the major cause of elderly abuse. It is also true that nowadays survival is causing stress, especially in joint or extended families, as houses are getting congested. Increase in life span, physical, functional disabilities creating the need for assistance, generation gap, etc. are some of the issues challenging the well being of elder people in the country. Therefore, in the present scenario, there is a need to give serious consideration to the well being of senior citizens with special consideration to socioeconomic, financial, health, shelter and emotional needs.

References

- Ara, Shabeen., (1994): *Old Age among Slum Dwellers*. New Delhi: South Asian Publication.
- George, P.O. (2000): 'Family as Focus', *The Hindu Sunday Magazine*, March 12. pp. 42–43.
- Govil, P. and Gupta, S. (2016): Domestic Violence amongst elderly People: A Case Study of India, *Advances in Ageing Research*, 5, pp. 110–121.
- Gupta, Giri Raj. (1978): 'The Joint Family', in Man Singh Das and Panos D. Bardis (eds.). *The Family in Asia*. London: George Allen and Unwin, pp. 72–87.
- Khan, M.Z. (1997): *Elderly in Metropolis*. New Delhi: Inter India Publication.
- Kumar, S., Sathyanarayana, and K.M., Omer, A., (2011): *Living Arrangements of Elderly in India: Trends and Differentials*. International Conference on Challenges of Population Aging in Asia, UNFPA, New Delhi: India.
- Manraj, Grewal and Sharma (2018): Punjab worst offender a map four states in abuse, *Hindustan Times*, 1 January, 20.
- Morgan, Leslie A and Kunkel, Suzanne R. (2006): *Aging Society and the Life Course*. New York: Springer Publishing Company.
- Niharika Gupta (2001): *Successful Ageing and its Determinants: a Study of Elderly in Kolkata*, TISS, Mumbai.
- Rajan, S. Irudaya, U.S. Mishra and P.S. Sarma. (1999): *India's elderly: burden or challenge?* New Delhi, Thousand Oaks, London: Sage.
- Rajan, Irudaya, S. and Kumar, S., (2003): Living arrangement among elderly, *Economic and Political Weekly*, 38, No. 1 Jan.
- Randhawa, Maninder. (1991): *The Rural and Urban Aged*. New Delhi: National Book Organization.
- Sanjeevil, Kaviya., (2015): '30 per cent of India's elderly abused: Report'. *Times of India*. Jun 15, 2015. Available at: <https://timesofindia.indiatimes.com/india/30-of-Indias-elderly-abused-Report/articleshow/47669397.cms>. Retrieved on 20 January 2018.

- Shah, A.M., (1999): Charges in Family and Elderly, *Economic and Political Weekly*, Vol. 34, No. 20, pp. 11179–82.
- Singh, J. P., (2004): ‘The contemporary Indian Family’, in Bert N. Adams and Jan Trost (Eds.), *Handbook of World Families*. California: Sage Publications Inc., pp. 129–166.
- Soneja, Shubha., (2012): ‘Elder Abuse in India: Country Report for World Health Organization’, *Help Age India*. New Delhi Available at http://www.who.int/ageing/projects/elder_abuse/alc_ea_ind.pdf. Retrieved on 08 January 2018.
- United Nations Population Fund. (2011): ‘The Status of Elderly in Punjab, 2011’ Available at <http://india.unfpa.org/publications/status-elderly-punjab-2011>.
- United Nations Population Fund. (2017): ‘Caring for Our Elders: Early Responses’ *India Ageing Report-2017*. UNFPA, New Delhi, India.
- World Health Organization. (1984): ‘Use of Epidemiology in the Study of the Elderly: Report of a WHO scientific group on the epidemiology of ageing’. *WHO Technical Report Series* No. 706. WHO, Geneva.

Indian Journal of Gerontology

2018, Vol. 32, No. 3, pp. 306–317

ISSN: 0971–4189, UGC No. 20786

Forced Displacement and Its Impact on Older People in Jammu and Kashmir

Sudesh Kumar, and Anindya Jayanta Mishra

Department of Humanities and Social Sciences, IIT Roorkee, (UK)

ABSTRACT

In the State of Jammu and Kashmir, a large number of hydropower projects have been constructed which have resulted in the displacement of a majority of people from their native land. In the present descriptive study, an attempt has been made to highlight the various issues and problems of older people who have been displaced from their ancestral land. The investigators have made use of case studies to examine the issues concerning the older people. In the study, it has been found that the older people suffer from loss of social services, loss of social identity, poor health, loss of political authority, and also face conflict within the family. They feel alienated and lonely at the new place because of the loss of kinship, and absence of traditional social relationship.

Keywords: Displacement, Old People, Social issues, and Baglihar Dam

Displacement is one of the biggest challenges throughout the world. Every year millions of people are displaced from their native place, because of development projects and other reasons such as earth quake, construction of infrastructure dams, industries, parks, etc.). Forced displacement has been a companion of development throughout history and it occurs both in industrial as well as developing countries (Verma, 2004). But it is also true that the problem of displacement is considered seriously when it is forced displacement.

The reason is that the forced displacement leads towards landlessness, homelessness, loss of common property resources, etc. (Baviskar, 1995).

After independence of India the development policies pursued by successive governments have steered widespread displacement of population. It is estimated that some five lakh persons are being displaced every year, as a direct consequence of administrative land acquisition (Mishra, 2002). India's post-colonial experiences of State sponsored development projects unmistakeably signals that the benefits of such projects have been seen largely by the economically and politically dominant section of society. In many cases, it has been brutal, ruthless and inhuman in its consequences (Hussain, 2008). Today it is quite clear that the economic development in India has been largely nurtured at the cost of marginalised section of the society. People are forcibly displaced from their native place where they had lived for generations together. Family system and social network which frequently guard people against different kinds of crises situations are torn apart. People are alienated from their ancestral shrines, forests, and holy rivers (Mishra, 2002).

State of Jammu and Kashmir

In the state of Jammu and Kashmir, there are large number of natural resources due to which a number of dam projects have been constructed such as Baglihar dam, Dul Hasti Project, Uri project, Karthai project, Salal project, Namboo Bazgo project, Dumkar project, Chutak dam, Bursar dam, Pakal dul dam, etc.

The present study was focused on Baglihar dam, where a large number of people were displaced in Pul Doda (Doda district). Baglihar dam is constructed on Chenab River in the Ramban district of Jammu and Kashmir. It was started in 1999 and completed in 2008. In the name of development projects thousands of people were forcibly displaced from their ancestral land and Pul Doda is one of them. It was the business hub in Jammu and Kashmir and was connected with national highway between Batote and Kishtwar District. It is a hilly area covered with big mountains and thick forests. People of the region were living simple life and most of the people were dependent upon their business. Kashmiri is main language in Doda district,

besides this people also speak folk language such as Sirzi, Gojari, Bhaderwahi. In Pul Doda, the present study has been carried out in June, 2017 where the displaced people are living. The study was particularly focused on older people through some case studies. Because there is hardly any study in Jammu and Kashmir which has focused on displaced older people.

Cernea, M.M. (2004) in his study found that there are eight fold model risk of displacement, these are Landlessness, Joblessness, Homelessness, Marginalization, Food insecurity, increased morbidity, Loss of access to common property resources and Community disarticulation. Cernea found that all displaced people face these kind of problems. His study was focused on common people which include men, women, etc. He did not talk about the older people. The older people face quite different problems as compared to common displaced people. The present study found some different kind of problems among older people which the existing literature did not mention.

Findings and Observations

Loss of Social Interaction/Social Services or Inter-personal Relationship

Social services means informal network of reciprocal help (Cernea, 2004). In a village the researcher found that people came forward and helped each other during social and cultural functions. But it became a problem among displaced people after the displacement, because now most of the people/relatives and friends were living in different places. It was not possible for displaced people, specially for elderly, to visit their friends and relatives who were living distant places and to continue their social activities. As the village structure got affected similar way the social services were also affected. It was noticed by the researcher in Jammu and Kashmir, where people were displaced due to the construction of dams.

Jagat Ram, 67-year-old person lived in Basohali village in Jammu and Kashmir. He reported that 'displacement has resulted in loss of their social interaction. In ancestral place, they used to help each other at the time of social functions, like marriage ceremony and cultural

festivals. Earlier at the time of marriage whole village used to come and offer help to the concerned family. There was a lot of barren land available in village for organizing marriages. No outside help was sought and villagers among themselves used to share all the work of marriage and lessen the burden of the concerned family. But, now a days, at the new place no one is concerned or bothered about one another. Nobody comes forward to offer help, the family is left alone and they have no option, but to take the help of caterers to organize marriage functions. It becomes an additional burden of the family as caterers charge around 5–6 lakh for a single marriage’.

He further, said ‘that at their ancestral place they knew all the shopkeepers who used to give them goods on debit many times for which they could make payment later on. In the time of financial crisis the shopkeepers used to give them goods without money, they treated them as their own family members. But at the new place they do not find any such relationship. The shopkeepers do not trust them and they hardly talk to them in a familiar way, because they think that they are jobless, helpless, homeless and so they may not be able to pay them money afterwards. After the displacement what he saw was that social services were biggest loss in their social life. Because at the new place they were living in unfamiliar environment. He has been living in Kathua since, last 15 years and he didn’t see any one helping each other during social function. At the new place different caste group were living and nobody bothered for others.

‘In urban area what he saw was that one neighbour did not know the other person. In fact, the kinship system was also weak as the relatives just came and attended the function and then left. He further reported that at the harvesting time many of their neighbours used to come to their house and help them in agricultural activities. The religious functions most of the relatives and neighbours celebrated together’.

Another person also talked about similar kind of problems. Des Raj, 64-year-old person living in Pul Doda of Jammu and Kashmir. said, that in ancestral place they shared their sorrows and happiness and every one came forward and helped each other at the time of emergency. In ancestral place every villager, family members and relatives used to come together at the time of birth rituals or occasions

of bereavement. But after the displacement it is not seen in the resettlement site. People do not actively participate in the birth and death rituals, because of the loss of social bond, kinship relation and social services'. He also said 'that earlier in village they used to have lot of rooms in their houses where relatives used to come and stay for 5-6 days at such occasion but now a days neither they have so much space nor the relatives have so much time to stay'.

Loss of Social Identity

Social identity plays an important role for all human beings, it may be ascribed or achieved but it is necessary for social life. People are known by their identity, but the identity does not remain same through out the life. It may vanish due to one or other reasons. The present study has revealed how displacement has resulted in the loss of the social identity among displaced older people.

Hira Lal, a 70-year-old person lived in Basohali. He was a big land lord in ancestral place. He said that he used to cultivate cash crops like bean, onion, potato, etc. and sell them in the market. He has three sons and all were involved in business and agricultural activities. He lost 30 Kanals of agricultural land which was the main source of earning. He reported that in the new resettlement site he faced identity crises, because what social identity he had in ancestral place was not possible to maintain in the new site. He said that after the displacement he had become a landless person and also had lost his social status, since social identity is also linked with social status. In the new resettlement site they were helpless as they had no social identity at the new place. Different caste group people were living there and no one mixed with other groups.

In his ancestral place he was recognised as a big land lord and different caste group people used to come to his house and take his help and suggestions with regard the agricultural activities. There were some other caste group of people who were working in his house as tenants and he used to give them food and money. In his native village there was a jajmani system and the people of different caste groups were working in his house before the displacement. The relationship of jajmani system also got affected due to displacement. But after the displacement they not only lost the social identity but also lost the neighbourhood and caste association group. He further added that

social identity is one of the biggest problems in their social life and also in a family because without identity nobody knows you and no one recognises you. In the new place they faced identity crises.

Another similar case was found in other place of Gulam Mohd, 65-year-old person who was living in Pul Doda. He was a big business man. He was whole seller distributor. He has two sons and both were involved in business. He said, that he was doing business since last 45 years in Pul Doda, and everybody knew him. But after the displacement he had lost his whole business and his social identity with which he had earned in his entire life. He further reported that after the displacement he tried to open his business at the new site but due to the hostile attitude of host community he was not able to make a beginning. Some unidentified men burnt his shop so he migrated in other place where he opened a petty business to earn his livelihood.

Displacement not only resulted in loss of his house, property but also his social identity was lost which he had earned throughout the life. It is very difficult for him to maintain social identity at the new place. In the host community they faced lot of challenges with regard the identity and status. In the native place they were closely associated with their traditional culture and the culture expressed their identity, but when they shifted to a new place there was a change in the thinking process of others about them. He felt that day by day their social values were decreasing due to the economic loss and that they had now become fully dependent upon their sons. They are constantly missing their lost home land and their assets, at the new place that was adversely affecting their health. After the displacement the elderly generation felt loneliness in the family and there were also changes in the intergenerational relation which resulted in conflict within the family. They were facing problems in adjusting with the new values and norms they were being offered at the new place.

At the new place they had become increasingly isolated as their family members and friends had shifted to different places after displacement. At the end he said, that he had not only lost his identity but also lost everything like house, property, income resources and also family. The problem of social identity was one of the biggest challenges in their social life. Because at the new place they were unable to regain their social identity.

Family Relation and Conflict

Family is referred to as a 'group of persons of both sexes, related by marriage, blood or adoption, performing roles based on age, sex, and relationship, and socially distinguished as making up a single household or a sub household' (Ahuja, 1999). The findings of this study have revealed how, due to displacement, the family relations got affected and conflict emerged among members of the family.

Bibmla Devi, a 65 year old widow was living in Pul Doda of Jammu and Kashmir. She said that she has three sons and they were living as joint family and each son used to give her 2,000 rupees for her personal expenses. She reported that before the displacement they enjoyed their social life and did not face any kind of problems. But after the displacement all her family relation got affected and conflict began within the family. Her husband received 15 lakh as compensation money and he distributed 4 lakh to each son and he took three lakh for his personal spending. But after getting money all her sons quarrelled with her and her husband for the money which was kept by us for our use. With this family conflict started. Due to this attitude of their sons and their family members her husband faced heart problems'. The old lady further added 'that her husband died due to the depression and long illness. None of her sons supported her and neither helped her husband. Due to the family conflict she was also facing psychological depression since last 6 years. Her health status also got affected because of tension and family conflict. After the death of her husband her sons did not care for her life, she was living with younger son but he and his family also do not care for her life. She felt alienated within her own family'. She also talked about intergenerational conflict within family. 'Because of changes in the traditional norms and values her grandson and granddaughter also argue with her and also do not respect her. They don't like her presence in the family. If she said anything they feel as if she is interfering in their private lives. After the death of her husband she was totally left alone and there was nobody with whom she could share her joy and sorrow, even her son also did not talk to her properly'.

'After the displacement her sons' attitude towards her has changed, they spent more time with their own families and neglected her. The old lady also said that before the displacement she used to

spend time with other women in her neighbourhood. They used to go to the field together and talk for hours together. Now at the new place there was no one with whom she could talk as their new neighbour were not friendly with them. Social stigma was also attached with them because of homelessness and landlessness'. She further said 'that the younger generation had changed their traditional norms and values and they have no manners how to talk to elderly people. Her grandson and granddaughter always quarrel with her and they always hurt her'.

Another person also faced similar kind of problems, his name was Atta Hussain. This 70 year old person was also living in Pul Doda of Jammu and Kashmir. He said that he has two sons and two daughters. He talked about how his sons left him alone after getting compensation money from him. He got 7 lakh compensation and distributed 3 lakh among each son. After receiving the compensation money his two sons migrated to Delhi and left him alone with his wife and two young daughters. Both the sons quarrelled with him for sharing the family responsibility. In fact daughter-in-law and grandsons also quarrelled with him. The family relation got affected day by day and after two years of displacement he and his two younger daughters started living separately on rented house and he started a petty tea stall near bus stand and earned livelihood. He further said that in these days no one came forward and helped them. His wife and his one daughter died because of psychological depression and family conflict. Now he is living with his daughter on rented house and five year have had passed but his two sons did not come to him'.

When he was narrating the story his eyes were full of tears. At the end he said' in his own language (jis ke pass hota hai paisa log usi ko pouchtey hai tu hai kesa, mere apne bachoo ne chod diya hai log kya kare gey). Which means that society is only concerned about those who have money. He further said that my own children left me alone what can I expect from others'.

Loss of Political Authority

The study has found how the displacement has led to the loss of political authority among displaced people. Before the displacement panchayat was an important political institution in the village and Sarpanch and Panches enjoyed great political authority over the villagers. Their decision was final and binding upon all the villagers.

Nobody could question their authority and they used to solve almost all the problems of the villagers.

Jodh Ram 68 year old person was living in Basohali village in Kathua district of Jammu and Kashmir. He said that in ancestral place he was the Sarpanch of his village and enjoyed political power. He had solved so many family issues in his native place and also worked for village development. He said that every community member came to his house and discussed so many issues which were related to rural development. On many occasions he invited the politicians in the village and discussed so many problems, in fact many politicians were also connected with him regarding the block level election. But after the displacement he lost his political authority because of the submergence of his village and most of the displaced people migrated to different places in the state of Jammu and Kashmir. Whatever political status he had achieved in his village, he lost it after the displacement. Now he migrated to Kathua district and in the new place there were different caste group people living together and nobody knew each other. In the new resettlement site there were different caste groups of people who had become Sarpanch and panch now he was one among the common people at the new site. If there was any discussion and meeting with regard the village development nobody took his suggestion seriously. The political structure has totally changed after displacement and it is the biggest lost for him and his community. At the new resettlement site there were different caste groups of people who controlled the political power and they were not in position to regain the social and political power. They were helpless at the new place, and they only focused on their livelihood'.

Another similar kind of case found in Pul Doda. Gulam, Mohd, 64 year old person was a Sarpanch in native place. He said that he enjoyed the political power in his village and people always supported him during the Panchyat election. He had become a Sarpanch 5 times in his native village. He always used to come forward to help his neighbours and he had done so much work in his village. But after the displacement he had lost his political power which he had in ancestral place. Now he was living on rented house since last 9 years. As a Sarpanch he was not able to solve his village problems after the displacement. Since the Pul Doda was not in the revenue record and with the passage of time he lost his political power and also his social

status which he had earlier. Due to displacement he not only lost his political career but also his social life’.

Health Issues

A part from economic status, mental and physical health is a major indicator of the standard of living and well-being of people (Mahapatra, 1999). Studies have revealed that there has been increase in water borne diseases like malaria, diarrhoea, and dysentery at the resettlement site.

In the present study, the researchers found that there has been tremendous increase in the health problems of older people after displacement mainly due to alienation, psychological depression and physical ailments.

Meraj-u-din, 67 year old person was living in Pul Doda of Jammu and Kashmir. He was a businessman (wholesaler distributor). He said that he earned 40,000 rupees per month with his business before the displacement and now after he had opened a small kiraana store and earned 10,000 rupees. He has three sons and all were involved in business activities and they never faced any kind of problems. But after 2008, when the displacement took place, their social life got affected, because he lost all his earning. After the displacement they had now become homeless, jobless. He is has been living near river Chenab in ancestral place for last 9 years without basic facilities, and his sons shifted to Delhi with their own families, they are doing private jobs.

‘He always faced ailments like heart problem, diabetes and his wife is also suffering from diabetes. They have been living under depression for last 9 years and there were no any health facilities in this place where they could go for the treatment of their health. The hospital were located in Doda city, which is about 15 Km from his home. It has become very difficult for him and his wife to care for their health. In this age it has become a problem for them as they are living alone and also feel alienated from their family members. There was no transport facilities in their village, if he were to die there would be no one near him to do his last rites. He further added that his health was constantly deteriorating day by day because of the lack of safe drinking water, lack of good nutritional food and lack of safe environment. In this place most common diseases are malaria, typhoid, diahoria, etc. because of the badly affected area. He said that

what he had earned from his petty business, he had spent that money on health’.

Another case was also found in Pul Doda, her name was Poli Devi 67 year old lady. She said that she did not face any kind of problems in her life. She used to get up early in the morning and started working in to field. She collected medicinal plants from the forest and sold in the market. Her husband was a businessman, and they were earning 30,000 rupees per month, they never faced any kind of health problems. But after the loss of ancestral home and business her husband faced psychological depression and he died after long illness. Nobody came forward to help them, in fact the government also did not help them during last 10 years. She also faced health problems like back pain, joint pain, and also suffering from diabetes. She was living with younger son in rented house, he has own family some time it was very difficult for him to arrange 2,000 rupees per month for her health. He was running small business near bus stand. Due to the psychological depression her health got more affected day by day, it all happened because of forced displacement and now they were living under poverty line. There was a time when they earned thirty thousand and now they were earning five thousand. She said that displacement not only affected her health but also her whole family. Her husband died and her two sons were living in Jammu and they were working in a factory. Her whole social life got affected after the displacement’.

Conclusion and Suggestion

In the name of national development every year millions of people are forcibly displaced and their social life gets affected. In the state of Jammu and Kashmir large number of dam projects were constructed which displaced large number of families from their ancestral place. It was observed that the policy maker did not pay adequate attention towards displaced old people. The older people had to face different kind of problems as compared to younger generation. After the displacement the older people have no social security, because of the loss of social relations, family relations and also the social network.

The state government gave only monetary compensation and forgot them forever. What about their social life, social security and their income sources, nobody is concerned about that. In fact elderly

face lot of problems after the displacement. It is difficult for them to adopt new social environment and regain the social identity which they had earlier.

In India, there is special need to focus on older people who are displaced from their ancestral place due to the construction of developmental projects. Both the Central and State governments should try to find ways so that the displaced older people do not face any kind of problems after the displacement. Before constructing any development project, proper survey should be conducted and the older people should be kept in the mind while preparing resettlement and rehabilitation policy. It is the responsibility of the State government to think about the older people and their issues.

References

- Ahuja, Ram., (1999): *Society in India: Concepts, Theories and Recent trends*. Rawat Publications, Jaipur.
- Baviskar, A., (1995): *'In the Belly of the River'. Tribal conflict over development in the Narmada valley*, New York: Oxford University Press.
- Cernea, M.M., (2004): *Impoverishment risk, risk management, and reconstruction: A model of population displacement and resettlement*. Presented at UN symposium on hydropower and sustainable development, 27–29 October. Beijing, China.
- Hussain, Monirul., (2008): *Interrogating development: State, displacement and popular resistance in North East India*. New Delhi: Sage Publication.
- Mahapatra L.K., (1999): *Resettlement, Impoverishment and Reconstruction in India: Development for the Deprived*, Vikas Publishing House, New Delhi,
- Mishra, O.P., (2002): *Displacement, human rights and conflict resolution*. Published Centre for Refugges Studies, Jadavpur, university of Kolkata.
- Verma, M.K., (2004): *Development, displacement and resettlement*, Rawat Publication, New Delhi.

Indian Journal of Gerontology
2018, Vol. 32, No. 3, pp. 318–332
ISSN: 0971–4189, UGC No. 20786

Human Rights of the Elderly: An Awareness Study Among Youths

Ankitha Shobhakumar, Sucharitha Suresh, and Sweta D'Cunha
Department Hospital Administration, Father Muller Medical College,
Mangaluru (Karnataka)

ABSTRACT

The present study on the awareness of human rights of the elderly is a descriptive and cross section study with a sample size 400 youths. A questionnaire was prepared to collect the data and the data was analysed statistically using descriptive statistical methods. It was found out that the youths were aware (> 70%) of problems and difficulties of the elderly and also basic rights of elderly. But awareness regarding facilities/privileges for protection/right of the elderly and welfare measures of government for elderly was poor among the youth (< 30%). It may be concluded that there is a need to improve the awareness of the youth regarding the issues of elderly as they can play an instrumental role in protecting and promoting the rights of this venerable section of the society.

Key words: Elderly, Human rights, Youths, Rural, Urban

Population ageing is a worldwide phenomenon, and India is no exception. As per analysis of census 2011 data, population of elderly in India has already crossed the unique mark of 100 million. Indian population has approximately tripled during the last 50 years, whereas number of elderly Indians has increased more than fourfold.

It took more than 100 years for the aged population to double in most of the countries in the world, but in India it has doubled in just

20 years. Today, with advancement of medical science and due to a better standard of lifestyle and overall development in the country, the portion of the elderly are growing rapidly and their life expectancy has also gone up to over 70 years (Mandal, 2011). A report of Helpage International, (2009): reveals that in the future one-fifth of the entire population in the world would fall under the age group of over 60 years and almost an equal proportion, one-fifth of older persons would fall under the age group of over 80 years. The life expectancy on an average would be about 90 years.

The elderly need family support and care but with increasing popularity of nuclear family system and continuous migration they are constantly being marginalized and isolated, particularly in urban areas. Despite the advancement, the support ratio of the elderly in both more and less developed countries the demographic trends create unique challenges for all the people, particularly for the governments of nation-states around the globe. As per article 25 of *Universal Declaration of Human Rights*, 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control'. Basically Human rights refer to notion of equality, equity, dignity and respect among human beings. Older men and women have the same rights as anyone else; it will not change as we grow older. In absence of family support and care, sense of security is missing among older persons, which is making life of elderly painful and insecure day by day. Apart from being neglected, the elderly individuals are often subjected to discrimination and abuse because they are perceived as easily taken advantage of. In highly industrialized as well as commercialized areas of the country, most of the older persons find themselves isolated and marginalized as their old age related needs remain unattended at all levels. There is also a prevalent belief among many that elderly persons are worthless in today's fast-paced, globalized and increasingly industrialized world. Despite growing share in population they are not getting due attention in the society. Emotional, social, financial, medical and legal security structure gets diluted and eventually it leads to continuous denial of their human rights. With the number of elderly people on earth at any

one time rising rapidly, there is an increased urgency to address the rights and roles of elderly persons in the world.

Agewell Foundation (2011) conducted a survey to understand the status of human rights of older persons. 29,000 elderly from rural areas and 21,000 elderly from urban areas from 300 districts of 25 states of India were studied in this survey. It was found that more than 75 per cent of the older persons were living in inhuman conditions such as living all by themselves and were found living alone within the family. Violation of Human Rights of older persons was found higher in urban areas of the nation compared to rural areas. Over 20 per cent of the older persons were facing violation of their human rights in old age such as not getting a decent meal to eat, no access to proper medicine or health care, not treated with regard and respect by their family members, relatives and by their society. The study revealed that senior citizens need financial support and stressed upon the need of involvement of the Government to support them. And the study clearly mentioned that people lack awareness about human rights of older persons. Unawareness of the rights of older persons is the main reason behind the increasing cases of violation of human rights of older persons. More than 80 per cent of the elderly in rural areas and more than 70 per cent of urban areas never heard about human rights of older persons. In continuation with this study, to understand the state of the senior citizens who are not so active, Agewell (2009) conducted a study on bed-ridden seniors at Delhi and the neighborhood with an aim to understand the condition of bedridden patients and found that almost 4 per cent of them and their major issue were pertaining to absence of caregivers, mental depression, nervousness, cleanliness and hygiene, bedsores, high blood pressures, etc. and that it is necessary to arrange for the development of a strong volunteer's network or caregiver agencies network who can work as care takers for older persons. To analyse if the elderly were willing to adapt to changing times and environment, further in their study Agewell (2010), it was observed that more than 90 per cent of the aged people preferred a change in the present environment to improve their living conditions. Factors mainly responsible for the speedily changing trends of old age, included the social environment, Medical set up, Legal set up, Financial status, Psychological condition, Interpersonal relations and Religion/spirituality. However the biggest concern that the older people were facing was about their health and they were in

favour of a revamp of medical facilities for their well-being in their old age and they were jointly voicing their opinion regarding their priority. Their major health-related concerns were requirement of more medicines for a longer period, Long-term medical care, Extensive medical checkups and Medical Insurance for the Old age.

Followings are the National Policies and Programmes for elderly persons:

A. *Relevant constitutional provisions are:*

1. Article 41 of the Constitution: Article 41 of Directive Principles of State Policy has particular relevance to Old Age Social Security.
2. Article 47 of the Constitution: Article 47 of the constitution of India provides that the state shall regard the raising of the level of nutrition and the standard of living of its people and improvement of public health as among its primary duties.

B. *Legislations*

- (i) Maintenance and Welfare of Parents and Senior Citizens Act, 2007

The Maintenance and Welfare of Parents and Senior Citizens Act, 2007 was enacted in December 2007, to ensure need based maintenance for parents and senior citizens and their welfare.

Various other policies and programmes of Central government for elderly people

National Policy for Older Persons (NPOP) 1999

National Council for Older Persons (NCOP)

A National Council for Older Persons (NCOP) was constituted in 1999 under the chairpersonship of the Ministry of Social Justice and

Empowerment to operationalize the National Policy on Older Persons.

Central Sector Scheme of Integrated Programme for Older Persons (IPOP)

Inter-Ministerial Committee on Older Persons

National Old Age Pension (NOAP) Scheme

National Programme for Health Care of Elderly (NPHCE)

National Policy on Senior Citizens 2011

Keeping in mind the various programmes for elderly and the fast changing socio-economic scenario such as: industrialization, rapid urbanization and higher aspirations among the youth and the increased participation of the youth in the workforce play, the present study was planned to find out awareness of the youths towards human rights of the elderly with the following objectives:

- To find out the awareness level of youths regarding the problems faced by Elderly among the Youth.
- To find out the awareness level of youths regarding the facilities available to the Elderly.
- To find out the awareness level of youths regarding the Human Rights of the Elderly

Materials and Methods

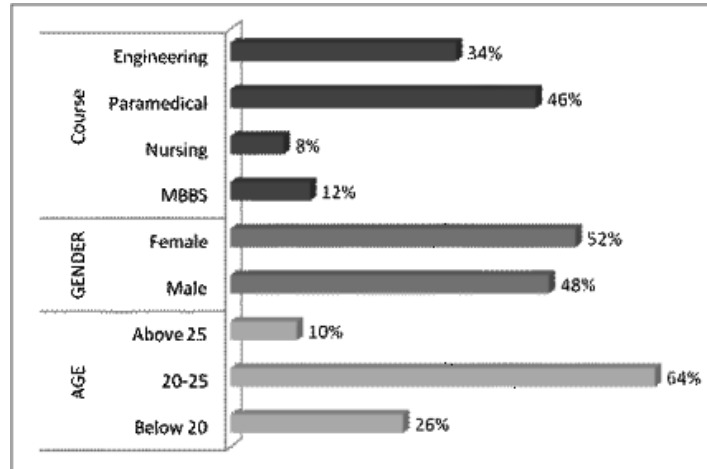
This is a descriptive and cross sectional study. The data was collected from 400 youths (age varying from below 20 years and above 25 years), particularly students of professional colleges, pursuing undergraduate degree in MBBS, Nursing, Paramedical and Engineering. A questionnaire was developed and content validity and reliability (Cronback alpha=0.745) of the questionnaire was ensured. The Questionnaire included questions on demographic details of the respondents, problems/difficulties faced by the elderly, facilities/privileges provided for the protection/rights of the elderly, welfare measures set by the government for the elderly and about basic rights of the elderly. Collected data was analysed by descriptive statistical methods such as frequency and percentages and analysis was carried out in SPSS Statistics for Windows, Version 23.0

Results and Discussion

Demographic Profile of the Respondents

To measure the awareness of the youths regarding problems and difficulties of the elderly in their day-today life, six questions were included and youths were asked to tick on the agree/disagree scale. And survey result showed that (Table 1) 94 per cent of the respondents

Figure 1
Distribution of respondents according to demographic parameters



Problems and Difficulties faced by the elderly

were aware that elderly have economic problems and economic insecurity. 76 per cent of the respondents were aware that elderly have physical and physiological problems, which includes health, medical problems and nutritional deficiencies.

Table 1
Youths awareness regarding problems and difficulties faced by the elderly

<i>Problems/Difficulties</i>	<i>No. of respondents agree</i>
Economic problems: such as loss of employment, income deficiency and economic insecurity	94%
Physical and physiological problems: including health, medical problems and nutritional deficiency	76%
Psycho-social problem: which cover problems related with their psychological and social maladjustment as well as the problem of elder abuse.	77%
Do not have the opportunity to work neither they have the right to leave the work force	71%
Do not have access to health care to help them maintain the optimum level of physical, mental and emotional well-being	71%
Are not exposed to pursue opportunities for full development of their potential and have access to educational, cultural, spiritual and recreational resources of society	64%

While 77 per cent agreed that the elderly today face severe psycho-social problems which cover problems related with their psychological and social maladjustments as well as the problem of elder abuse.

According to a study conducted on human rights of the elderly in 2014 (Agewell), reported that elderly face the economic, psycho-social, physical and physiological problems in the society which specifically included marginalization, abuse and neglect in old age as the most common problem. Our study revealed that more than 75 per cent of the youth were aware of these problems of the elderly. Even though percentage of awareness is high remaining 25 per cent is not a small number, they need to be made aware as neglected life, and lack of respect and poor health in old age of the person causes many problems in their life and is a violation of human rights all together.

Further, regarding awareness of the youth regarding difficulties of elderly, 71 per cent of them were aware that the elderly do not have very much opportunity to work, neither have they the right to leave the workforce depending on their convenience if they are working. 71 per cent of the respondents agreed that elderly do not have an access to health care to help them to maintain the optimum level of physical, mental and emotional well-being. While 29 per cent were unaware of the situation. Therefore increasing the awareness level in targeting the youth can help in achieving the objective. 64 per cent of the respondents reportedly agreed that the elderly are not able to pursue opportunities for full development of their potential and have access to educational, cultural, spiritual and recreational resources of society while 36 per cent respondents were unaware of this fact. According to a survey conducted by Agewell foundation (2013) on perception towards human rights of the elderly among all age groups, older persons are discriminated at the workplace, when they go for any work in old age. The survey also found that majority of them was not aware about Human Rights or heard about Human Rights. More than 60 per cent of the youth were aware about the difficulties of elderly regarding their employment, educational, cultural, spiritual and recreational needs, while, over all about 40 per cent of them were unaware of the difficulties elderly undergo in their day today life.

In general, both formal as well as informal levels, the elderly face discrimination in varying degrees. The discrimination of elderly is due to their age at the workplace, and this is not limited only to career progression but may also reflect in the way people interact at the inter-personal level as well. As per the survey elderly face all types of physical and mental abuse (Schiamberg, and Gans D., 1999). Cases of elder abuse are on rise but people hardly complain. Family members take their elderly family members for granted and older persons are forbidden from reporting about it. Incidents of violation of human rights and elder abuse are increasing in the society leading to severe violence and deaths as well. Older persons face many health related problems. It is not easy and convenient, specially for poor elderly, to undergo treatment and checkups at various hospitals and clinics of Government or privately owned especially in our country.

Facilities/privileges provided for the protection/rights of the elderly

The Hindu Law, is the first personal law statute in India, which imposes an obligation on the children to maintain their parents. As it is evident from the wording of the section, the obligation to maintain parents is not confined to sons only; daughters also have an equal duty towards parents. And only those parents, who are financially unable to maintain themselves from any source, are entitled to seek maintenance under this Act. Almost three-fourth (74%) of the respondents were not aware about the statements under the Hindu Law and Muslim Law, less than 30 per cent of them were aware of the fact that there is such a provision in Hindu and Muslim laws.

Table 2
Youths awareness regarding Facilities/privileges provided for the protection/rights of the elderly

<i>Statements</i>	<i>Aware</i>	<i>Not Aware</i>
1 As per the LEGISLATIVE LAW, (A) Hindu Laws: Part IX – Personal Law (Hindu), Adoption and Maintenance Act, 1956), A Hindu is bound during his or her life-time, to maintain his or her legitimate/illegitimate children and his or her aged or infirm parents.	25%	75%
(B) As per the protection under Muslim Law		

Cont'd...

Cont'd...

Children in easy circumstances are bound to maintain their poor parents	25%	75%
Children in easy circumstances are bound to maintain their poor parents	26%	74%
A son though in strained circumstances is bound to maintain his mother	25%	75%
A son, who though poor, is earning something, is bound to support his father who earns nothing	28%	75%
2. As per Criminal Procedure Code, 1973,		
(A) A Person has to make a monthly allowance for the maintenance of his, father or mother	27%	73%
(B) Section 125(3): If any person who fails without sufficient cause to comply with the order, for every breach of the order, fines will be applicable, and may sentence such person, to imprisonment for a term which may extend to one month or until payment is made.	38%	62%

About criminal procedure code, 67.5 per cent of the respondents were unaware of the sections under the Criminal Procedure Code. The code says 'The right of parents, without any means, to be supported by their children having sufficient means has been recognized by section 125(1) (d) of the Code of Criminal Procedure 1973, and section 20 (1 and 3) of the Hindu Adoption and Maintenance Act, 1956. That a person has to make a monthly allowance for the maintenance of his, father or mother and that as per Section 125(3)'

Any person who fails to comply with this order would be liable for fines and may get imprisonment for a term until the payment is made. While only 32.5 per cent respondents were aware of the law. This law is a secular law, that is, it is applicable to the people belonging to all religions and communities. Daughters, including married daughters, also have a duty to maintain their parents. As per a previous study conducted on perception on the legal provisions of the elderly, only 5.5 per cent respondents were aware of legal provisions for older persons in India to a great extent, 7.2 per cent respondents had some knowledge of legal provisions for older persons (Alam, 2004). No change in the awareness level regarding legal provisions of the elderly.

Welfare measures set by the government for the elderly

Table 3
Youths' awareness regarding Welfare measures set by the government for the elderly

<i>Statements</i>	<i>Aware</i>	<i>Not aware</i>
(A) The welfare measures set by the government for the elderly (The National Policy):		
Setting up of a pension fund for ensuring security for those persons who have been serving in the unorganized sector	73%	27%
Construction of old age homes and day care centers for every 3–4 districts	33%	67%
Establishment of resource centers and re-employment bureaus for people above 60 years	29%	71%
Concessional rail/air fares for travel within and between cities, i.e. 30% discount in train and 50% in Indian Airlines	68%	32%
Enacting legislation for ensuring compulsory geriatric care in all the public hospitals	27%	73%
(B) Government attempts to sensitize school children to live and work with the Older persons	30%	70%
(C) Setting up of a round the clock help line and discouraging social ostracism of the older persons are to be taken up.	31%	69%

According to the present analysis, 73 per cent of the respondents were aware about the existence of the provident fund facility, to ensure security in old age, for those persons who have served in the unorganized sector. Only 27 per cent were unaware of this facility. 68 per cent respondents were aware of the concessional rail/air fares for travel within and between cities, i.e. 30 per cent discount in train fares and 50 per cent in Indian Airlines flights is applicable for the elderly which is quite significant. On the other hand 70 per cent of the respondents were completely unaware of the provisions set by the government to sensitize school children to live and work with the older persons. Hence, awareness regarding this has to be initiated right from school.

As per our survey, 69 per cent respondents were unaware that setting up of a round the clock help line was under the guidelines of the National Policy set by the Government and 67 per cent were unaware of a welfare measure set by the government on construction of old age homes and day care centers for every 3–4 districts while 33 per cent were aware of the facility. According to a study conducted by

Agewell in 2011, on the rights of the elderly among the different age groups, more than half the respondents said that the government or society does not support older person's right. 13.8 per cent strongly disagreed with the fact that government/society support the elderly with regard to providing them with old age home and day care centers.

71 per cent were unaware of the fact that the government has set measures for the establishment of resource centers and re-employment bureaus for people above 60 years. Like mentioned in studies conducted on the awareness of human rights among all age groups 85 per cent of the respondents believe that old people are productive in post retirement period and it indicates the stand that retirement is superfluous and not restricted purely by age. With a keen mind, higher life expectancy and full of knowledge and experience under their belts, today's elderly generation is ready to go in the second innings of their life. Only a miniscule percentage of respondents genuinely believe that older persons may not be productive after retirement.

As per the present survey, 73 per cent of the respondents were not aware of the compulsory geriatric care provisions set in all the public hospitals. And according to study conducted by Agewell in the year 2011 among all the age groups, almost 2/3rd respondents agreed that older persons have to depend upon their family members for medical expenses as they are unaware of the provisions for geriatric care.

By conducting awareness programmes to youth as well as to elderly regarding rights of elderly and Welfare measures of government to elderly and setting up measures in order to promote the same will help the government in implementing the guideline as well as educating children right from a young age which further would lead to better enforcement of the strategies.

Other Basic Rights of the Elderly

Table 4
Youths awareness regarding other basic rights of the elderly

<i>Statements</i>	<i>Agree</i>	<i>Disagree</i>
Under the Right To Information (RTI) ACT;		
Appeals filed by senior citizens and differently able persons under the Right to Information Act (RTI) are taken on a high priority basis	68%	32%

Cont'd...

Cont'd...

Regarding health schemes;		
There is a provision for separate queues for senior citizens at hospitals and health care centers when they visit for any health related concerns or clinical examinations	82%	18%
Regarding finance and taxation;		
A rebate is admissible to senior citizens under the Indian Income Tax Department for the current slabs of Income Tax	66%	34%
Regarding banking and insurance;		
A higher rate of interest to senior citizens on certain Savings schemes which it runs through its large network of Post offices (Senior Citizens Savings Scheme) and Public sector B banks provided.	81%	19%
Life Insurance Corporation of India (LIC) has provided several schemes for the benefit of aged persons, such as: Jeevan Akshay Yojana, Senior Citizen Unit Yojana, Medical Insurance Yojana.	81%	19%
Travel facilities for the elderly include:		
Indian Railways is 30% cheaper for all Senior Citizens who are 60 years in age or above	80%	20%
There are separate Counters/Queues for Senior Citizens at all Railway Stations for purchase, booking or cancellation of tickets	80%	20%
Indian Railways have specially designed coaches with hand rails and specially designed toilets for handicapped persons. They have space for wheel chairs.	80%	20%
State Road Transport Undertakings have provision for senior citizens for reservation of 2 seats in the front row of all buses	83%	17%
Some state governments give concessions (in fare) to senior citizens, some have specially modeled buses for the elderly	81%	19%

68 per cent of the respondents were aware and agreed that appeals filed by the elderly under the RTI Act are given high priority. A specific provision for providing security of residence, like in Domestic Violence Act, should be incorporated in the Act. Government should take appropriate measures to give wide publicity about rights of the elderly. Public-private partnership via media is necessary to spread awareness. Society should be aware of its moral and legal responsibility towards the elderly and this is ultimately possible through the youth who are the present and future of the society.

As per the data collected, 82 per cent of the respondents were aware that there existed special provisions, separate queues for the elderly at hospitals; clinics, etc. and 18 per cent were unaware that such facility existed. As per analysis of a study conducted by Agewell

foundation among the elderly in 2011, it was found that only 68.8 per cent of older persons have access to necessary medicines, health care and medical facilities while 31.2 per cent older persons opined that they are not getting proper medicines/health care in old age. And as per the data collected in the study (Agewell, 2011) among all age groups on the perception on human rights of the elderly, 92.6 per cent respondents opined that health insurance and healthcare facilities are important beyond the age of 60 and there should be provisions for health insurance of older persons in the country.

Most of the respondents, 66 per cent were aware regarding rebates and concessions applicable for the elderly under the Income Tax Department. 81 per cent of the respondents were aware of the policies and provisions provided by banking and insurance companies. And compared to the awareness level being low regarding all the problems, difficulties, provisions set, benefits and rights available, 3/4th of the respondents were aware of the various travel facilities provided for the elderly. In brief, the concerns of older persons are cross-cutting, relating to many different departments and ministries within the government and the society as a whole. The holistic approach toward older persons is sustained in the policy by identifying priorities such as social assistance and security, health, shelter, education, freedom from abuse and exploitation, research, training and manpower, besides several others (UN 2002). And some of the organizational groups such as National Council for Older Person's (NCOP) members are experienced and well-known individuals from a wide range of backgrounds, including NGOs, citizen's groups, retired person's associations, law, social welfare and security, research, and medicine contributes in promoting the rights of the elderly.

Conclusion

Ageing is a natural phenomenon, which inevitably occurs in human life cycle and it brings challenges in the life of the elderly, which are mostly engineered by the changes in their body, mind, thought process and the life style. Care and respect for elder is part of humanity. In India unlike other countries young population is larger in number and they are the one to look after their elders and they are the ones who grow older. This study infers that youths were aware of

problems and difficulties of the elderly and also basic rights of elderly. But awareness regarding facilities/privileges for protection/right of the elderly and welfare measures of government for elderly was poor. So this study underlines the relevance of creating awareness among the youth and government need to take action in this respect. Awareness of basic human rights and various Welfare activities brought out by the government helps elderly live happily and utilize the facilities provided by the government to the maximum.

Limitations

In this study factors affecting the awareness level has not been studied and even awareness was not compared across the courses as number of respondents were not evenly distributed. Further study can be taken up to compare the awareness level across different demographic parameters.

References

- Agewell (2009): *Bedridden Patients of Delhi NcR*, A study by Agewell Research & Advocacy centre, Delhi.
- Agewell (2010), *A Study on Isolation in old age*, New Delhi
(visit: www.agewellfoundation.org)
- Agewell (2011): *On Human rights of Older people in India – A national study*, Agwell Foundation, New Delhi.
(visit: www.agewellfoundation.org)
- Agewell (2013): *Study or Perceptions towards Human Rights of Elder Persons*. A Study by Agewell Research and Advocacy Centre Delhi.
- Agewell Foundation (2014): *Human Rights of Older Persons in India*, New Delhi (visit: www.agewellfoundation.org)
- Alam, Moneer. (2004): Ageing, Old age Income Security and Reforms. *Economic and Political Weekly*, pp. 3731–3740.
- Bhagat, R.B., and Kumar, K. (2011): Ageing in India: Trend and Patterns. In *Ageing in India: Some Emerging Issues* (Edited) by K.N.S. Yadava and Alok Kumar. New Delhi: Manak publications, pp. 19–37.

- Mandal, S.N. (2011): Protection of Rights of Old age Person in India: A Challenging Facet of Human Rights. *Global Jr. of Human Social Science*, Vol. 11, No. 5.
- Schiamberg L.B., and Gans D. (1999): An ecological framework for contextual risk factors in elder abuse by adult children. *Journal of Elder Abuse and Neglect*, 11:79-103.
- United Nations, (2002): *World Population Ageing: 1950-2050*. Population division, department of economic and social affairs [Desaj, New York, United Nations.

**ICSSR JOURNAL OF ABSTRACTS AND REVIEWS:
GEOGRAPHY (Half-yearly)**

The Journal publishes abstracts of research work as well as book-reviews. It was started in 1977. The following volumes are available for sale:

Subscription Rates	Individuals	Institutions
Volume 1-8	Rs. 15.00	Rs. 20.00
Volume 9-21	Rs. 30.00	Rs. 50.00
Volumes 22 & 23 (1996 & 1997)	Rs.150.00	Rs.250.00
	US\$ 120.00	US\$ 120.00
	£ 80	£ 80
Volume 24 & 25 (1998 & 1999)	—	—

**ICSSR JOURNAL OF ABSTRACTS AND REVIEWS: POLITICAL
SCIENCE (Half-yearly)**

This journal publishes abstracts of articles in Political Science published in Indian Journals, book reviews and a list of reviews published in Political Science Journals. It was started in 1977. The following volumes are available for sale:

Subscription Rates	Individuals	Institutions
Volume 1-12	Rs. 15.00	Rs. 20.00
From Volume 13-24	Rs. 30.00	Rs. 50.00
Volume 25 (1998) onwards	Rs. 150.00	Rs. 250.00
	US\$ 120	US\$ 210.00
	£ 80	£ 80

Upto Volume 28 (1) (Jan - June, 2001)

**ICSSR JOURNAL OF ABSTRACTS AND REVIEWS:
(Half-yearly) (New Series)**

The journal commenced publication in 1972 for the dissemination of relevant research-based information in the form of abstracts and review articles on contemporary issues in psychology and related disciplines in India. The new series started in 1994.

The following volumes are available for sale in the ICSSR Volume 2-10, 11, 15, 21 to 28.

For subscription and trade inquiries of new series, please write to M/s. Sag Publications India Pvt. Ltd., Post Box No. 14215, M-32, Block Market, Greater Kailash-1, New Delhi - 110 048.

Subscription Rates	Individuals	Institutions
Volume 1-24	Rs. 20.00	Rs. 30.00
Volume 25-28	Rs. 30.00	Rs. 50.00
Volume 1 (1994) New Series	Rs. 270.00	Rs. 545.00
	US\$ 61	US\$ 155
	£ 39	£ 90

Onwards upto Volume 8 No. 2 (July-Dec.2001)
(Volume 1 and 13-14, and 16-17 are out of print)

**ICSSR JOURNAL OF ABSTRACTS AND REVIEWS:
SOCIOLOGY AND SOCIAL ANTHROPOLOGY
(Half-yearly)**

This journal publishes selected reviews of publication in the broad fields indicated in the title of the journal as well as abstracts of research works. The following volumes are available for sale:

Subscription Rates	Individuals	Institutions
Volume 1-6	Rs. 12.00	Rs. 12.00
Volume 7-13	Rs. 16.00	Rs. 20.00
Volume 14-23	Rs. 30.00	Rs. 50.00
Volumes 24-25, 26-27 (Single issue)	Rs. 150.00	Rs. 250.00
	US\$ 120	US\$ 120
	£ 80	£ 80
Volumes 28 No. 1 & 2	Rs. 150.00	Rs. 250.00
Volumes 29 No. 1 & 2 (Jan. - June, 2000)		
(July - Dec., 2000)		
	US \$ 120	US \$ 120
	£ 80 £ 80	

(Volumes 5 to 13, 16 are out of print)

The journals/publications are supplied against advance payment only. Payment should be made through Cheque/D.D. drawn in favour of **Indian Council of Social Science Research, New Delhi.**

For outstation cheques, please add Rs. 15.00 towards the clearing charges,

For Subscription / order and trade inquiries, please write to:

Assistant Director (Sales)
Indian Council of Social Science Research
National Social Science Documentation Centre
35, Ferozeshah Road, New Delhi - 110 001
Phone: 3385959, 3383091
e-mail: nassdocigess@hotmail.com
website: www.ICSSR.Org
Fax: 91-3381571

Dissemination of Research Information through journals of Professional Organisations of Social Scientists.

The ICSSR provides financial assistance, on an *ad hoc* basis, to professional organisations of social scientists for running their journals (as also for the maintenance and development of organisations).

Proposals for grant, in the prescribed proforma, should to reach the Council in the beginning of the financial year.