Indian Journal of
Gerontology
a quarterly journal devoted to research on ageing

VOL. 22, NO. 2, 2008

Indian Journal of Gerontology

(A quarterly journal devoted to research on ageing)

ISSN : 0971-4189

SUBSCRIPTION RATES
Annual Subscription
US $ 50.00 (Postage Extra)
UK ˆ 30.00 (Postage Extra)
Rs. 400.00 Libraries in India

Financial Assistance Received from :
ICSSR, New Delhi

Printed in India at :
Aalekh Publishers
M.I. Road, Jaipur

Typeset by :
Sharma Computers, Jaipur
Phone : 2621612

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Indian Journal of Gerontology
2008, Vol. 22, No. 2, pp 129-153

CHD Risk among Elderly with Metabolic Syndrome-X : An Ayurvedic Option of Management

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ABSTRACT

Cardiovascular risk factors are clustered into metabolic syndrome i.e. hypertension, obesity, dyslipidemia, and glucose intolerance. This syndrome leads to an increased risk of diabetes and cardiovascular diseases. A number of pro-inflammatory markers like C-reactive protein (CRP), fibrinogen, Interleukin-$_6$ (IL-$_6$), Tumor Necrosis Factors-α (TNF-α) are significantly associated with metabolic syndrome-X. Oxidative stress is pointed out to show association with this syndrome. Statin, nicotinic acid, fibric acid derivates, ezetimibe etc. are the drug of choice for the management of metabolic syndrome but their application is restricted due to risk profile. In view of the above, a plant based formulation containing the hydro-alcoholic extract of Triphala (Emblica officinalis, Terminalia chebula, Terminalia belerica) and Saptachakra (Salacia reticulata) in effective doses was evaluated among 121 diagnosed elderly metabolic syndrome-X cases showing dyslipidemia, high BMI with impaired glucose tolerance, with age range of 60-70 years of both sexes. In this study 61 cases received the test formulation and 60 cases were put on conventional drug Statin for six months. The test formulation reduced the blood glucose level, modified abnormal lipid content including apolipo-B and triglycerides and the pro-inflammatory markers like CRP, IL-$_6$. TNF-α also reduced significantly. As

synergism, the test formulation exerted anti-oxidant and immunomodulatory effects.

Key words: Metabolic Syndrome, CHD, Obesity, Dyslipidemia, Triphala, Saptachakra, TNF-α, Interleukin-6, C-reactive protein.

Metabolic syndrome-x is a heterogeneous group of disorders manifesting as obesity, hypertension, dyslipidemia and hyperglycemia. Insulin resistance is one of the key components of metabolic syndrome-X. These disorders increase the risk of developing diabetes and cardiovascular diseases. It affects a large number of people and prevalence increases with age.

The National Cholesterol Education Program (NCEP) and others have recently suggested the use of the term metabolic syndrome to identify the common cluster of metabolic abnormalities defined as three or more of five criteria i.e. abdominal obesity (waist circumference >102 cm in men and >88 cm in women), hypertriglyceridemia ≥150 mg/dl, low HDL-c (<40 mg/dl in men and <50 mg/dl women), hypertension ≥ 130/85 mmHg and elevated fasting glucose ≥110mg/dl (National Cholesterol Education Programme 2001). Even normal weight individuals with increased amounts of abdominal adipose tissue can be metabolically obese, with insulin resistance and dyslipidemia (Fujimoto *et al.,* 1994, Ruderman *et al.,* 1998).

The most important factors for development of syndrome-X includes aging, genetic predisposition and lifestyle i.e. low physical activity and excess calorie intake. A recent study suggested that daily intake of milk and equivalent dairy product has increased the risk of metabolic syndrome (Elwood *et al.,* 2007). So, strategies have been proposed to prevent the development include physical activity and low calorie diet (Feldeisen et al., 2007). Studies have indicated that the syndrome is very common in developed countries and varies with age, ethnicity and body mass index (Lakka *et al.,* 2002, Alexander *et al.,* 2003, Meigs *et al.,* 2003).

The increased focus on the metabolic syndrome has drawn attention to the identification and treatment of the dyslipidemia associated with abdominal fat accumulation. The changes in lipid metabolism with abdominal fat accumulation have been well defined

which includes hypertriglyceridemia, reduced HDL-c cholesterol and increased number of small dense LDL-c particles. An increased number of small dense LDL particles is a constant feature of the dyslipidemia of abdominal adiposity as they are associated with insulin resistance, intra-abdominal fat and hypertension (McNamara *et al.,* 1987, Austin *et al.,* 1990). LDL comprises a spectrum of particles that vary in size, density, chemical composition and atherogenic potentials. The presence of small dense cholesterol-depleted LDL particles is associated with an increased risk of mycordial infarction (Stampfer *et al.,* 1996, Lamarche et al., 1997) and further worsen due to severity of cardiovascular disease (Gardner *et al.,* 1996). The small dense LDL particles enter in to the arterial wall more easily (Bjornhedev *et al.,* 1996), bind to arterial wall proteoglycans more avidly (Hurt-camejo *et al.,* 1990) and are highly susceptible to oxidative modification, leading to macrophage uptake (Tribble *et al.,* 2001), all of which may contribute to increased atherogenesis.

The evaluation of apolipo-B in the metabolic syndrome can help in targeting patients for aggressive lipid-lowering therapy. High levels of LDL-c are generally accepted to be one of the strongest risk factors for cardiovascular disease. Insulin resistance is associated with increased numbers of small VLDL-c and LDL-c particles, reflected by higher apolipo-B levels, with decreased triglyceride to apolipo-B ratios compared with those in individuals with normal insulin sensitivity. Studies have shown that increased apolipo-B and apolipo-B-containing lipoproteins (VLDL-c and LDL-c) are related to an increased risk of cardiovascular disease (Lamarche *et al.,* 1996, Walldius *et al.,* 2001). Bonora *et al.* (2003) found significantly higher apolipo-B levels in individuals with the metabolic syndrome. Other studies have shown that individuals with metabolic syndrome-X had increased risk of cardiovascular disease than the individuals without syndrome (Lakka *et al.,* 2002, Alexander *et al.,* 2003, Meigs *et al.,* 2003).

Obesity is another important risk factor associated with an increased risk of cardiovascular disease, type-II diabetes mellitus, hypertension, stroke and dyslipidemia (Shoff *et al.,* 1998). Obesity tends to drive the development of insulin resistance and therefore, predisposes a person to a much higher risk of developing type-II diabetes and CHD. Insulin resistance has a negative effect on lipid production, increasing VLDL-c, LDL-c and triglyceride levels and

decreasing HDL-c in the blood stream, lead to fatty plaque disposition in the arteries which causes hypertension (Ferrannini *et al.,* 1997). In addition to blood glucose elevation, a pro-inflammatory state is present in a majority of these individuals, which is manifested by high levels of c-reactive protein, Interleukin-6 and other cytokines (Das, 2002).

Various factors like adiponectin, resistin, leptin, TNF-α and IL-6 are associated with insulin resistance. Adiponectin, which is produced only by white adipose tissue is reduced in states of insulin resistance such as obesity and type-II diabetes mellitus and increases insulin sensitivity (Beltowski, 2003). Resistin which is also secreted from adipose tissue has been shown to enhance insulin resistance in rodents (Rajala *et al.,* 2003).

C-reactive protein, a pro-inflammatory biomarker and as an indicator of vascular inflammation and a predictor of future events in patients with the metabolic syndrome-X (Ford, 1999). CRP levels are also significantly correlated with BMI, waist circumference, systolic blood pressure and insulin resistance (Festa *et al.,* 2000). Several evidence also indicated that c-reactive protein play an important role in the pathogenesis of type-II diabetes mellitus (Festa *et al.,* 2005).

The treatment of the dyslipidemia of the metabolic syndrome should be focused on lowering LDL and apolipo-B and increasing HDL-c. Statin treatment has been shown to reduce cardiovascular events in person with metabolic syndrome-X (Sniderman *et al.,* 2003). Although, LDL-c has remained the primary target of lipid-lowering therapy, raising HDL-c levels is now an important secondary target to reduce cardiovascular risk (National Cholesterol Education Programme, 2001). Nicotinic acid and fibric acid derivatives are both used to treat dyslipidemia in metabolic syndrome-X as it reduces the triglycerides levels and increases HDL-c (Meyers *et al.,* 2003).

Type-II diabetes mellitus is often associated with metabolic syndrome and several studies have shown that life style modification which includes physical exercise and calorie restriction, and metformin therapy can delay the onset of diabetes (Lindstrom *et al.,* 2006). Hypertension associated with metabolic syndrome should be of serious concern and needs to be managed effectively. B-blockers and thiazide diuretics including salt restriction and dietary regulation can

be applied to lower the blood pressure in metabolic syndrome cases. As mentioned above these conventional drugs have capacity to reduce the complications of metabolic syndrome-X but all have several adverse effects like gastrointestinal disturbances, anorexia, vomiting etc.

In Ayurvedic system of medicine, metabolic syndrome-X can be correlated with medo-roga (obesity) and its association with prameha (diabetes) can be established for which a specific regimen of life (āhara and vihāra) have been prescribed. It includes both pharmacologic and non-pharmacologic methods. A number of plant based drugs are mentioned which are in practice since centuries for the prevention and management of obesity, diabetes and dyslipidemia. Keeping the facts in view the combined effect of Triphala, which contains three plants namely Emblica officinalis (Amla), Terminalia chebula (Haritaki), Terminalia belerica (Bahera) and (Saptachakra) Salacia reticulata was evaluated on various bio-markers associated with metabolic syndrome-X, among elderly people.

Materials :

Emblica officinalis known as amla belongs to family Euphorblaceae, is found throughout India. The medicinal properties of amla (fruits) have been mentioned in Charaka and Sushruta Samhita. Amla is highly nutritious as it contains Vitamin C, minerals, amino acids, Glutamic acid, aspartic acid, alanine, Gallic acid and tannin.

Terminalia chebula included in Triphala belongs to family combrataceae also known as Haritaki. It is found all over India. Fruit part is used for medicinal purpose which contains tannin, chebulic acid, chebulinic acid, ellagic acid, gallic acid and resin and used mainly for heart diseases.

Terminalia bellirica known as Bahera belongs to family combretaceae, commonly found at lower hills in South East Asia. B-sitosterol, gallic acid, ellagic acid, ethylgallate and chebulagic acid are the important chemical constituents found in this plant. Fruits are used for medicinal purpose.

Salacia reticulata, one of the important ingredients of the present test formulation belongs to family Hippocrateaceae, distributed in Sri Lanka and India. Root and Stem has been used for medicinal purpose.

In Indian system of medicine this plant has widely used for the treatment of obesity and diabetes. Salacinol, Katalanol and mangiferine are some of the important molecules isolated form root of Salacia reticulata.The rational of selection of above plants is based on their hypolipidemic, hyperglycemic, anti-oxidant, anti-obesity and anti-inflammatory properties as all have been significantly involved with metabolic syndrome-X.

Under mass screening programme a comprehensive field surveys was conducted to isolate the elderly showing evidence of metabolic syndrome-X where minimum 3 risk factors out of 4 prescribed by WHO was present i.e.

1. Blood pressure ≥140/90mmHg
2. Dyslipidemia
   a. Triglyceride ≥ 150mg/dl
   b. HDL-c < 40mg/dl
3. Central obesity:
   a. Waist hip ratio >0.90 (male)
   b. Waist hip ratio >0.85 (female)
4. Body mass index >30 kg/m^2

The elderly persons who had 3 or more of the above factors with age range of 60-70 years (both sexes) were selected for the evaluation of a combined Ayurvedic formulation. The Ayurvedic formulation contained the hydro-alcoholic (30:70) extract of Triphala, [equal quantity of three plants namely Emblica officinalis (Amla), Terminalia chebula (Haritaki), Terminalia belerica (Bahera)] and Salacia reticulata (Saptachakra) in effective doses. Before starting the clinical trial of test formulation, a pre-clinical study was carried out to determine the safety profile, and informed written consent of the selected elderly syndrome-X cases were obtained to participate in the clinical trial.

After a preliminary screening of the subjects the initial BMI, blood pressure, blood glucose level, lipid profile including apolipo-B, TNF-α, C-reactive protein and Interleukin-$_6$ were measured. The subjects were divided into two groups:

Group I: 60 cases (36 male, 24 female) were advised dietary regulation and treated with conventional drug Statin 15 mg/day for 6 months.

Group II: 61 cases (41 male and 20 female) were treated with combined Ayurvedic formulation along with dietary regulation. The parameters were repeated at the end of 3 months and 6 months. Only those cases were included who followed up for 6 months regularly.

Methods:

Body mass index was calculated following formula {weight (kg) ÷ height (m^2)} and anthropometer was used for circumference measurement. Lipid profile and blood glucose level was estimated by standard laboratory kits. Apolipo-B was measured following standard method. TNFα and interleukin-$_6$ was measured by ELISA kit. CRP was estimated by utilizing kit for quantitative nephelometric determination of CRP in human serum or plasma by Turbox/Turbox analyzer.

Method of Preparation of Test Formulation

The hydro-alcoholic (30:70) extract of Triphala, [equal quantity of dried ripe fruits of Emblica officinalis (Amla) (175 mg/day), dried seeds of Terminalia chebula (Haritaki) (175 mg/day), dried fruit of Terminalia belerica (Bahera) (175 mg/day)] and dried root and stem of Salacia reticulata (Saptachakra) (425 mg/day) was prepared by adding additional additive to make capsule as 500 mg and given in two divided doses for 6 months.

At the end of the study period, the values of the parameters obtained at the baseline were compared with the findings of 6 months treatment. Students paired 't' test were applied to find the level of significance.

Observations & Results:

It was observed that maximum elderly cases of metabolic syndrome-X belonged to the urban community of educated class. The elderly when treated with test formulation, BMI reduced significantly after 6 months of treatment. A decrease in BMI was also noticed in group-I but the difference are more marked in group-II (Table-1).

Table 1: Reduction in BMI following test drug treatment in metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	Aerage age (years)	Body Mass Index			Initial vs 6 months therapy
				Initial	After 3 months therapy	After 6 months therapy	
Dietary regulation	36	Male	64.48 ±4.08	37.46 ±4.22	36.14 ±3.93	35.73 ±2.28	P<0.05
+ Conventional treatment	24	Female	65.23 ±3.42	38.63 ±3.11	37.11 ±4.03	36.54 ±3.41	P<0.05
Dietary regulation	41	Male	65.22 ±3.71	36.94 ±3.75	33.21 ±2.85	30.69 ±2.31	P<0.001
+ test formulation	20	Female	66.24 ±4.01	37.98 ±4.10	34.81 ±4.14	32.04 ±3.16	P<0.05

Normal range: 18-24

The test formulation showed beneficial effect on blood pressure regulation also. A decline in both systolic and diastolic blood pressure was recorded during six months of study period in both the groups (Table 2 and 3; Fig. 1 & 2).

Table 2: Effect of test formulation on systolic blood pressure among elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	Body Mass Index			Initial vs 6 months therapy
			Initial	After 3 months therapy	After 6 months therapy	
Dietary regulation	36	Male	146.34 ±8.01	141.85 ±6.92	138.71 ±5.43	P<0.001
+ Conventional treatment	24	Female	142.85 ±7.92	138.97 ±5.23	136.43 ±5.08	P<0.01
Dietary regulation	41	Male	144.97 ±6.93	138.71 ±7.08	133.84 ±6.02	P<0.001
+ test formulation	20	Female	138.97 ±6.35	132.14 ±5.19	128.92 ±5.35	P<0.001

Normal range: 18-24

Table 3 : Effect of Test formulation on Diastolic blood pressure among elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	Diastolic blood pressure (mmHg)			Initial vs 6 months therapy
			Initial	After 3 months therapy	After 6 months therapy	
Dietary regulation	36	Male	93.84 ± 2.11	88.72 ± 2.17	89.35 ± 3.01	P<0.001
+ Conventional treatment	24	Female	91.82 ± 2.84	86.34 ± 2.92	88.01 ± 2.72	P<0.001
Dietary regulation	41	Male	94.14 ± 2.86	91.38 ± 3.11	86.34 ± 2.82	P<0.001
+ test formulation	20	Female	93.72 ± 3.17	90.98 ± 2.90	84.84 ± 2.16	P<0.001

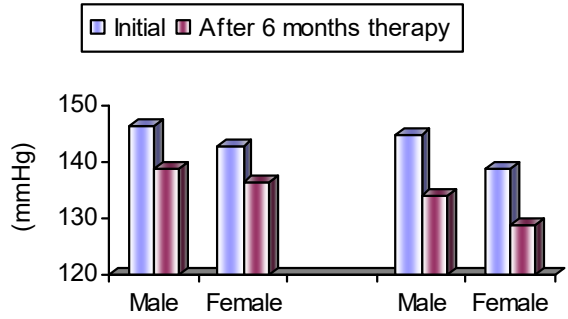

Fig. 1 : Effect on systolic blood pressure

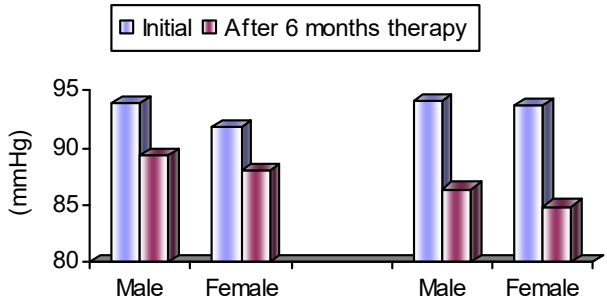

Fig. 2 : Effect on Diastolic blood pressure

A high blood glucose level both fasting and postprandial was estimated at initial level in syndrome-x cases. After 6 months of treatment, the levels declined significantly in both the groups but reduction is more marked in test formulation treated group (Table 4-5).

The hypolipidemic effect of test formulation is apparent in the present study. The LDL-c and triglyceride reduced in both the treatment groups. On comparison, the changes are significant in both male and female series ($P<0.001$). A moderate increase in HDL-c is also noticed. Though, it is observed that the changes in various lipid contents including Apolipo-B is more marked in conventional treatment group but test formulation treatment group also exerted its beneficial role in the modification of abnormal lipid metabolism (Table 6-9, Fig. 3 & 4).

The pro-inflammatory markers like c-reactive protein, Interleukin-$_6$ and TNF-α have shown significant association with metabolic syndrome-x. A high value of these inflammatory markers at initial level indicated the risk of an adverse cardiac event among the elderly. The test formulation exerted its beneficial role in reducing the levels indicating improvement in atherogenic injury and endothelial dysfunction. The differences in the values of parameters are significant in test formulation treatment group (Table 10-12, Fig. 5).

The test drug has shown anti-obesity, hypolipidemic and blood glucose lowering effect without any side effect.

Table 4: Decrease in fasting blood glucose level following test drug therapy in elderly metabolic syndrome-x cases

Treatment	No.	Sex	Fasting Blood Glucose	Initial vs

groups	of cases		level (mg/dl) Initial	After 3 months therapy	After 6 months therapy	6 months therapy
Dietary regulation	36	Male	128.14 ± 10.92	118.31 ± 9.34	116.13 ± 7.75	P<0.001
+ Conventional treatment	24	Female	123.97 ± 8.82	114.34 ± 8.14	110.98 ± 8.66	P<0.001
Dietary regulation	41	Male	126.34 ± 11.14	114.09 ± 7.93	106.35 ± 8.82	P<0.001
+ test formulation	20	Female	129.75 ± 9.35	122.82 ± 9.03	108.87 ± 7.08	P<0.001

Table 5: Decrease in Postprandial blood glucose level following test formulation treatment in metabolic syndrome-x elderly cases

Treatment groups	No. of cases	Sex	Postprandial blood glucose level (mg/dl) Initial	After 3 months therapy	After 6 months therapy	Initial vs 6 months therapy
Dietary regulation	36	Male	184.93 ±12.34	164.34 ±8.16	158.39 ±12.98	P<0.001
+ Conventional treatment	24	Female	191.84 ±9.16	178.80 ±14.45	162.97 ±11.13	P<0.001
Dietary regulation	41	Male	178.34 ±11.01	157.82 ±13.34	143.31 ±10.14	P<0.001
+ test formulation	20	Female	185.11	162.31	152.83 ±13.38	P<0.001 ±10.14 ±8.97

Table 6: Reductionin Triglyceride content under test formulation treatment in elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	Triglyceride (mg/dl) Initial	After 3 months therapy	After 6 months therapy	Initial vs 6 months therapy
Dietary	36	Male	314.92	254.84	183.97	P<0.001

regulation			±32.84	±27.99	±28.88	
+ Conventional	24	Female	336.92	288.73	225.77	P<0.001
treatment			±35.83	±30.94	±28.44	
Dietary	41	Male	328.71	293.94	267.34	P<0.001
regulation			±28.97	±31.11	±25.11	
+ test	20	Female	289.73	258.48	223.92	P<0.001
formulation			±30.93	±25.71	±27.35	

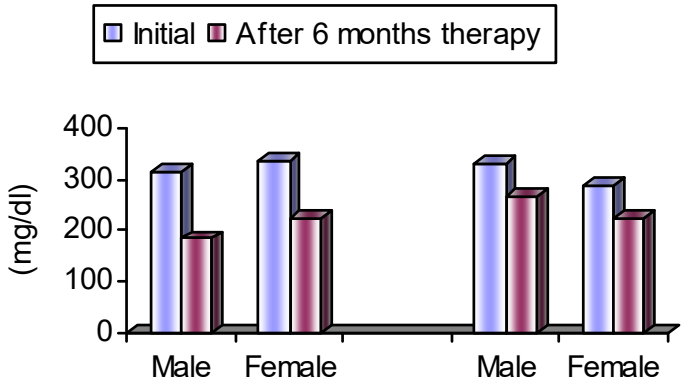

Fig. 3 : Effect on triglyceride

Table 7: Reduction in LDL-c following test formulation therapy in elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	LDL-c (mg/dl)			Initial vs 6 months therapy
			Initial	After 3 months therapy	After 6 months therapy	
Dietary	36	Male	138.11	118.71	102.94	P<0.001
regulation			±5.34	±4.97	±3.85	
+ Conventional	24	Female	141.84	132.97	98.35	P<0.001

treatment			±6.71	±6.12	±4.16	
Dietary	41	Male	134.84	128.91	118.87	P<0.001
regulation			±5.97	±6.13	±4.88	
+ test	20	Female	139.72	130.84	116.80	P<0.001
formulation			±7.02	±5.38	±4.96	

Normal range : ≤ 100 mg/dl

Table 8 : Elevation in HDL-c following test formulation treatment in elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	HDL-c (mg/dl)			Initial vs 6 months therapy
			Initial	After 3 months therapy	After 6 months therapy	
Dietary	36	Male	46.92	48.84	51.39	P<0.001
regulation			±3.14	±2.91	±2.73	
+ Conventional	24	Female	48.35	52.77	55.11	P<0.001
treatment			±2.85	±2.17	±3.01	
Dietary	41	Male	44.97	45.82	48.35	P<0.001
regulation			±3.14	±2.92	±2.84	
+ test	20	Female	47.96	48.38	50.91	P<0.001
formulation			±3.11	±2.85	±2.28	

Normal range : ≥ 45 mg/dl

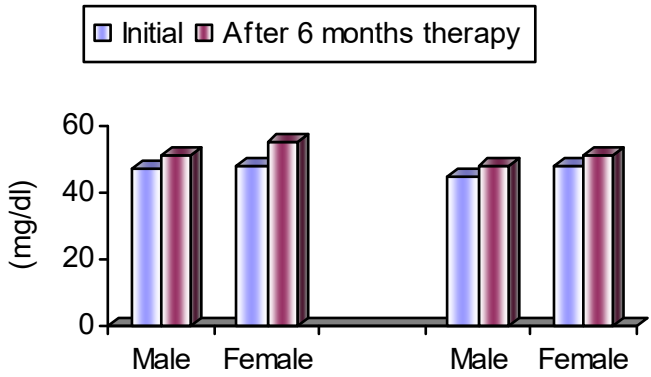

Fig. 4 : Effect on HDL-c

Table 9 : Decrease in Apolipo-B under treatment of Ayurvedic formulation in elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	Apolipo-B (mg/dl)			Initial vs 6 months therapy
			Initial	After 3 months therapy	After 6 months therapy	
Dietary regulation	36	Male	145.73 ±22.84	118.24 ±21.97	97.39 ±17.82	P<0.001
+ Conventional treatment	24	Female	161.72 ±27.14	112.91 ±20.82	86.84 ±23.75	P<0.001
Dietary regulation	41	Male	161.82 ±29.31	138.94 ±22.84	120.32 ±24.75	P<0.001
+ test formulation	20	Female	168.73 ±31.01	145.28 ±25.82	119.34 ±23.84	P<0.001

Normal range : 55-159 mg/dl

Table 10: Decrease in C-reactive protein level following test formulation in elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	Apolipo-B (mg/dl)			Initial vs 6 months therapy
			Initial	After 3 months therapy	After 6 months therapy	
Dietary regulation	36	Male	3.92 ±0.38	3.34 ±0.41	2.65 ±0.52	P<0.001
+ Conventional treatment	24	Female	3.75 ±0.75	3.22 ±0.68	2.83 ±0.61	P<0.001
Dietary regulation	41	Male	3.85 ±0.52	2.81 ±0.36	2.13 ±0.41	P<0.001
+ test formulation	20	Female	3.69 ±0.43	2.86 ±0.62	1.98 ±0.37	P<0.001

Normal range : 1-3 mg/L

Table 11: Reduction in Interleukin-$_6$ following Ayurvedic formulation in elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	Interleukin-$_6$ (pg/ml)			Initial vs 6 months therapy
			Initial	After 3 months therapy	After 6 months therapy	
Dietary regulation	36	Male	2.11 ±0.42	2.06 ±0.31	1.78 ±0.29	P<0.001
+ Conventional treatment	24	Female	1.87 ±0.51	1.54 ±0.32	1.37 ±0.35	P<0.001
Dietary regulation	41	Male	2.23 ±0.44	1.73 ±0.37	1.08 ±0.32	P<0.001
+ test formulation	20	Female	2.03 ±0.29	1.67 ±0.31	1.10 ±0.32	P<0.001

Normal range : < 1pg/ml

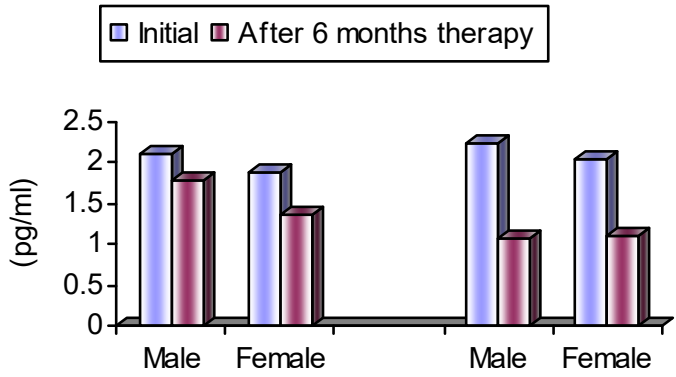

Fig. 5 : Effect on Interleukin-$_6$

Table 12: Decrease in TNF-α following test formulation therapy in elderly metabolic syndrome-x cases

Treatment groups	No. of cases	Sex	TNF-α (pg/ml)			Initial vs 6 months therapy
			Initial	After 3 months therapy	After 6 months therapy	
Dietary regulation + Conventional treatment	36	Male	598.97 ±52.84	528.93 ±47.01	487.73 ±56.82	P<0.001
	24	Female	487.35 ±64.97	372.85 ±55.22	329.88 ±61.73	P<0.001
Dietary regulation + test formulation	41	Male	611.87 ±58.34	515.92 ±61.92	438.75 ±68.72	P<0.001
	20	Female	520.93 ±59.84	432.84 ±41.26	373.84 ±54.39	P<0.001

Normal range : 25-800 pg/ml

Discussion:

Cardiovascular risk factors like hypertension, obesity, dyslipidemia and glucose intolerance are often associated with metabolic syndrome-X (Defronzo *et al.,* 1991, Liese *et al.,* 1998). Development of these risk factors leads to an increased risk of diabetes and cardiovascular disease which needs a prompt therapeutic intervention.

Chronic inflammation is a major process for the progression of atherosclerosis and atherothrombosis (Ross, 1999, Libby *et al.,* 2002). Smoking, high blood pressure, dyslipidemia, hyperglycemia, and obesity play a pro-inflammatory role in the initiation of endothelial dysfunction and atherosclerotic plaque formation (Yeh and Palusinski, 2003).

Elevated C-reactive protein levels are associated with diminished expression of endothelial nitric oxide synthase, which attenuate production of nitric oxide and promote oxidative modification of LDL-c and induce expression of plasminogen activator inhibitor-1 (Verma *et al.,* 2002). Studies suggested that elevated level of CRP is associated with acute cardiovascular and cerebro-vascular events (Crea *et al.,* 2002). CRP is an indicator of vascular inflammation and studies have indicated age adjusted prevalence of elevated CRP in approximately 29 percent among people with metabolic syndrome-X. Further, CRP is correlated with BMI, waist circumference, blood pressure and blood glucose levels (Festa *et al.,* 2000) and elevated CRP is also related to insulin sensitivity. As pointed out identified subjects of metabolic syndrome-X are at greater risk of CHD and each clinical element have a link to inflammation, development of atherosclerotic cardiovascular diseases and diabetes (Grundy *et al.,* 2005). Inflammatory mechanism play a major role in the cascade of events resulting in rupture of atherosclerotic plaque, impaired glycemic control and leading to increased atherosclerosis. In the present study, at the initial level measurement of CRP provided prognostic information of elderly metabolic abnormalities and a significant decrease in the level during trial period indicated the reduced risk of adverse future consequences particularly cardiac events.

Further, Interleukin-6 and CRP both are strong predictors of cardiovascular disease in apparently healthy people. Altered levels are associated with hyperglycemia, insulin resistance and type-II diabetes (Ridker *et al.,* 2000). The major principle behind the management of syndrome-X includes glycemic control, modification of abnormal lipid contents and reduction of high blood pressure. The currently available therapy for syndrome-X improved life expectancy of patients but long term application of these synthetic chemicals produces several side effects.

In Ayurveda several plant based drugs have shown immense therapeutic potentials for the prevention and management of particular clinical condition present in metabolic syndrome-X. As this disease is a cluster of various clinical conditions therefore it was thought to combined four plants with their immense therapeutic potentials as a single combination therapy.Thus, the present test formulation contains the hydro-alcoholic extract of plants Emblica officinalis (Amla), Terminalia chebula (Haritaki), Terminalia belerica (Bahera) and Salacia reticulata (Saptachakra), which covered all the abnormalities associated with metabolic syndrome-X and exerted beneficial effect without any side effect.

It is observed that the test formulation acted as a proliferator activated receptor agonist, improved insulin sensitivity through glycemic control and reduced the inflammatory process. Further, it acts as a TNF-α regulator and thus reduced CRP significantly and also improved other inflammatory markers like interleukin-6 and adiponectin among metabolic syndrome-X cases resulting in reduced CHD event. The cases with high LDL-c showed reduction in the level following test therapy suggesting improvement in atherogenic injury and endothelial dysfunction. One study reported that Terminalia chebula protects the cells against free radical scavenging activities (Hossain *et al.,* 2001). The hydro-alcoholic extract of Terminalia chebula has shown anti-inflammatory and immunomodulatory properties (Saleem *et al.,* 2002). Rao *et al.* (2006), have reported the anti-diabetic and nephroprotective properties of Terminalia chebula seed in streptozotocin induced diabetes in rats. Terminalia chebula is a potent anti-oxidant and potentiate liver function also (Naik *et al.,* 2004, Lee *et al.,* 2005). *Terminalia belerica* decreased cholesterol

levels in experimentally induced atherosclerosis and also decreased fat deposits in the liver and heart (Shaila *et al.,* 1995).

Emblica officinalis is used as a potent anti-oxidant agent (Scartezzini *et al.,* 2005) and protects the body against radiations (Singh *et al.,* 2005). Further, it reduces the oxidation of LDL-c and prevents formation of plaque on blood vessel walls (Duan *et al.,* 2005). The anti-diabetic and anti-inflammatory actions of this plants is also reported (Nadkarni *et al.,* 1999). *Emblica officinalis*, *Terminalia chebula* and *Terminalia belerica* are the constituents of Triphala and one of the recent studies have shown that Triphala boosts immune system (Sri Kumar *et al.,* 2005).

Gallic acid and its derivatives ellagic acid are found in Emblica officinalis. Terminalia chebula and Terminalia belerica play an important role in human nutrition. Ellagic acid ($C_{14}H_6O_8$) is a natural occurring phenolic compound act as a anti-oxidant (Maas *et al.,* 1991). It has a beneficial role in various heart diseases (Aviram *et al.,* 2004). Gallic acid ($C_7H_6O_5$) has a wide range of biological activities like anti-oxidant, anti-inflammatory including immunomodulatory effects (Bachrach and Wang, 2002).

In Indian system of medicine the root and stem of Salacia reticulata have been used for the prevention and management of diabetes mellitus. Salacinol and katalanol the two important chemical constituents isolated from Salacia reticulata root have shown α-glucosidase inhibiting properties (Yoshikawa *et al.,* 1997). It also prevents obesity, decreases BMI and suppresses postprandial hyperglycemia (Kajimota *et al.,* 2000). Anti-oxidant property of *Salacia reticulata* has been reposed by Yoshikawa *et al.* (2002) on Carbon-tetrachloride (CCI-4) induced liver injury in mice. In the present clinical trial the test drug enhanced the satiety, decreased appetite and fat absorption as it has shown its anorexic effects through regulation of 5-HT and acting on leptin receptors involved in appetite mechanism (Yoshikawa *et al.,* 2002). It is observed that the Ayurvedic test formulation has potentiality in long term weight control, healthy cardiovascular function with a better behavior adjustment and improved cognitive functions.

As a target of a lipid lowering therapy should exert reduction of LDL-c with increase in HDL-c. The present test formulation seems to

be a safe monotherapy agent that corrected the dyslipidemia of metabolic syndrome-X. Maximum cases showed an elevation of blood pressure before therapy which regulated under treatment without any specific anti-hypertensive agent. Thus, it is noticed that test formulation alone can reduce the mild to moderate hypertension.

It is concluded that elderly subjects with metabolic syndrome-X are at high risk of CHD, can be selected for a drastic intervention of lipid lowering and anti-inflammatory therapy through various pharmacologic and non-pharmacologic procedures. It is proposed that present Ayurvedic formulation may be an option of therapy for lipid lowering, anti-inflammatory, anti-oxidant, anti-obesity and reducing the glycemic index among metabolic syndrome-x cases. As its synergistic role it improved the sleep pattern and overall feeling of well being. The preparation is safe and can be given for longer time without any side effect.

Acknowledgement

The authors are grateful to Tulsi Ayurvedic Product and Research Pvt. Ltd., Bhadohi for providing standard extract of the above mentioned plants.

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Indian Journal of Gerontology
2008, Vol. 22, No. 2. pp 154 -162

Study of Neurological Disorders with Emphasis on Stroke and Risk Factors in Hospitalized Elderly

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ABSTRACT

Prevalence of stroke in India is about 5 per cent with an annual mortality of 1.25 per cent of all deaths. The purpose of this study

was to assess the incidence, mortality and to correlate risk factors of stroke in hospitalized elderly subjects. Three hundred twenty two patients with various neurological disorders were analyzed in a tertiary hospital-based registry. Analysis of data was based on sex and various age groups. Attempts were made to associate blood pressure, and the other risk factors: hypercholesterolemia, diabetes mellitus and smoking in these patients. Major risk factors were hypertension (50%) and diabetes mellitus (30%) and the mortality after stroke was higher in males compared to females. Hypercholesterolemia was observed only in 24.65 per cent elderly. Our finding suggest that the blood pressure is directly proportional to cholesterol levels. Thrombolytic therapy was instituted in 9.82 per cent elderly with stroke. Overall mortality with various neurological disorders was 4.65 per cent out of which 3.57 per cent was due to stroke. The study shows that control of blood pressure, education and timely thrombolytic therapy in stroke results in better outcome in hospitalized elderly.

Key words: Elderly, Stroke, Hypertension, Diabetes mellitus, Cholesterol, Mortality.

Prevalence of stroke in India is about 5 per cent with an annual mortality of 1,00000 that represents 1.25 per cent of all deaths (Anand *et al.,* 2001). Blood pressure (BP) plays an important role in cardioembolic stroke (Marcheselli *et al.,* 2006). Effective control of hypertension has the potential to reduce the risk of primary stroke by nearly 40 per cent (Chobanian *et al.*, 2003). The purpose of this study was to assess the incidence, mortality and to correlate risk factors of stroke in hospitalized elderly subjects.

Methods

Incidence of stroke and other neurological disorders were assessed in hospitalized elderly patients during January 1998 to December 1998 from the database of the Bombay Hospital. Three hundred twenty two consecutive patients with various neurological disorders were analyzed in a tertiary hospital-based registry. Analysis of data was based on sex and various age groups: (60-64, 65-69,70-74, 75-79 and over). Attempts were made to associate blood pressure, and the other risk factors: hypercholesterolemia , diabetes mellitus and smoking in these elderly patients.

Results

In hospitalized patients with various neurological disorders, the incidence of stroke was higher in men than in women in the age group of 60-64 and 65-69 years compared to other groups (Table1). Among various risk factors for hospitalized patients, stroke constituted the most followed by prolapsed disc, hemiplegia, Parkinsonism, hematoma, peripheral neuropathy etc.(Table 2). Major risk factors were hypertension and diabetes mellitus (Table 3) and the mortality after stroke during hospitalization was higher in males as compared to the females.

Risk involved was different among the various age groups analyzed, showing a decline in older patients (75 years +). Both the systolic blood pressure 149.80±23.83 and diastolic BP 91.12±13.55 were within the normal limit. However, present finding shows that blood pressure is directly proportional ($r^2 = 0.543$, $p < 0.001$) to the cholesterol levels (Fig 1).

Table 1. Demographic data for stroke

Age Groups	60-64	65-69	70-74	75-79	80+	Total
Males (n)	21	26	16	10	5	78
%	26.92	33.33	20.51	12.82	6.40	
Females (n)	3	10	7	6	8	34
%	8.82	29.41	20.59	17.64	23.53	

Table 2. Various neurological disorders in elderly

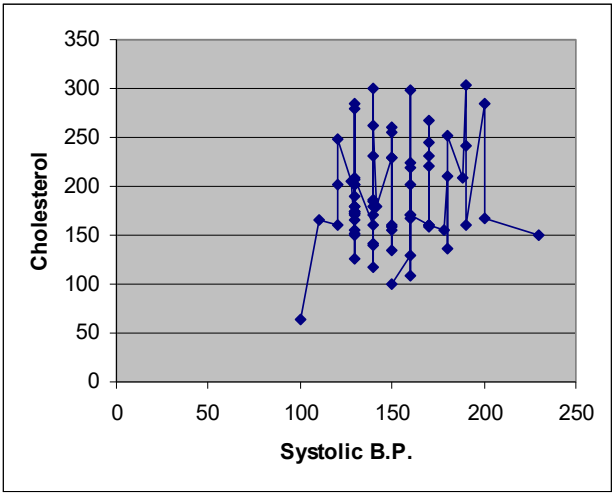
Age Groups	60-64	65-69	70-74	75-79	80+	Total
Strokes	24	36	23	16	13	112
Prolapsed disc	24	11	12	1	5	53
Hemiplegia	8	6	11	5	2	32
Parkinsonism	11	3	5	4	3	26
Hematoma	13	7	4	3	-	27

Table 3. Risk factors in stroke

	Diabetes mellitus	Hypertension	Diabetes + Hypertension
Males	17	33	9
Females	4	17	3

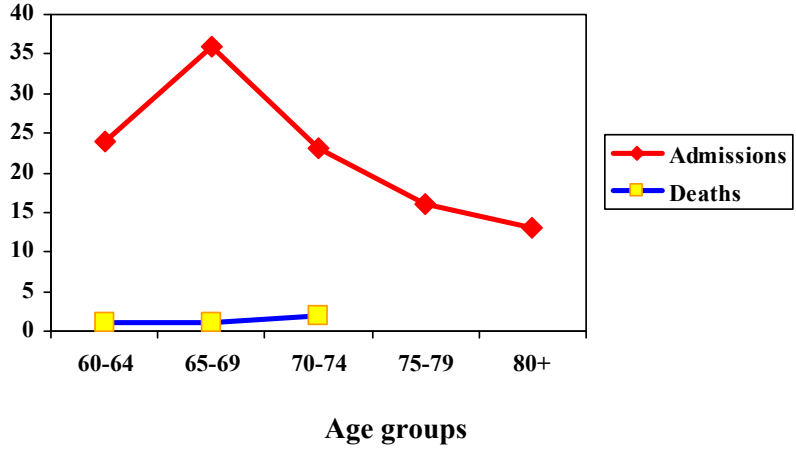
Hypercholesterolemia was observed only in 24.65 per cent elderly with the average cholesterol levels of 190.80±50.41 mg%, associated with hypertension (50%) and diabetes mellitus (30%). Left haemiplegia was more prevalent (66%) compared to right hemiplegia (35%). In both the groups males predominated. Thrombolytic therapy was advised in 9.82 per cent elderly with stroke.

Fig. 1. Correlation between blood pressure and cholesterol



Overall mortality with various neurological disorders was 4.65 per cent out of which 3.57 per cent was due to stroke (Fig 2) and it was associated with thrombolytic therapy in one subject.

Fig 2. Age-wise Admissions and Deaths (%)



Discussion

Results show that among the various neurological disorders, incidence of stroke was highest in elderly subjects out of which ischemic strokes was 56.14 per cent. However, higher incidence of ischemic strokes (76.8%) has been reported (Padma *et al*., 2007a) in lower age group (<60). Out of ischemic strokes, there was significant difference amongst the causes: cardioembolic strokes predominated with an increase in entire middle cerebral artery (MCA) and posterior circulation strokes together and a decrease in superficial middle cerebral artery stroke. In patients with hemorrhagic strokes, the thalamic localization increased, with decreased striatocapsular hemorrhage in higher age groups (70+) and decreased mortality. Similar findings have been reported by Careera *et al*. (2007).

In our analysis, hospitalized patients with ischemic stroke/TIA had hypercholestremia only in 28.57 per cent, though dyslipidemia plays an important role in strokes (Smith *et al*., 2007). However, Padma *et al,* (2007) observed dyslipidemia in 33.6 per cent younger subjects. It seems that dyslipidemia is more significantly involved with younger subjects as compared to the elderly .

Present findings show that in elderly with stroke, hypertension is an important risk factor in 50 per cent followed by diabetes mellitus (30%). Higher incidence (77.5%) of hypertension has been

reported in lower age groups(<60 years) (Padma *et al.*, 2007a) with similar incidence of diabetes mellitus. In another study (Padma *et al*., 2007b) higher incidence of hypertension (65%) and diabetes mellitus (41.2%) was reported in patients with average age of 66 years.

Both the systolic blood pressure (149.80±23.83 mm Hg) and diastolic BP (91.12±13.55 mm Hg) were within the normal limit in this study which was lower compared to those reported by Padma *et al.* (2007b). Our finding suggests that the blood pressure and cholesterol levels are inter-related in ischemic strokes.

Another study by Marcheselli *et al.* (2006) reported that both systolic and diastolic BP were higher on admission than during monitoring for 7 days, in those after cardioembolic (CE) stroke. It has been stated that stroke is associated with lower BP (systolic and diastolic) values during the acute phase and CE patients were characterized by poorer outcome. History of diabetes was a predictor of higher systolic and diastolic BP on the first day of monitoring; higher systolic and diastolic BP values were related to a history of hypertension and with male predominance.

We did not find any correlation between atrial fibrillation (AF) and warfarin related ICH as reported by Shen *et al.* (2007) in nonwhites with AF and great risk for warfarin related ICH. However, Blacks, Hispanics and Asians were at greater ICH risk than whites as reported by Padma *et al.* (2007b). Among patients with atrial fibrillation receiving anticoagulants mostly warfarin, intracranial hemorrhages occurred in 15 out of which 3 (20%) died and rest were disabled. However, Fang et al. (2007) reported the higher warfarin associated deaths (90%). While considering anticoagulant therapy patients and clinicians need to weigh the risk of intracranial hemorrhage far more than the usual risk of all major hemorrhages. The incidence of anticoagulant-associated intracerebral hemorrhage quintupled in our population during the 1990s. The majority of this change could be explained by increasing warfarin use. Anticoagulant-associated intracerebral hemorrhage now occurs at a frequency comparable to subarachnoid hemorrhage (Flaherty *et al.,* 2007).

Patients who improved clinically within the first four days of hospitalization in our study could be due to remarkable inhibition of all three cell adhesion molecules that were measured (E-selectin,

ICAM-1, and VCAM-1). Hence, measuring cell adhesion molecule levels may predict clinical outcome in hospitalized patients with acute ischemic stroke (Blum *et al.,* 2006).

Most of the patients hospitalized with ischemic strokes/TIA had normal levels of LDL with better outcome. However, Smith *et al.* (2007) reported high LDL as the main risk factor in stroke. Thrombolytic therapy was received by 9.82 per cent elderly with stroke. Low mortality in our study on anticoagulation therapy could be due to reduction in post-stroke complications as suggested by Anderson (2007) in ischemic stroke and AF.

A good stroke programme making thrombolysis accessible and attainable for patients is of critical importance in the Indian subcontinent where stroke rates are amongst the highest in the world (Muhammad *et al.,* 2007). Mortality was very low (3.57%) with male predominance (3 males, 1 female) in this study. However in an Hungarian study (Gulacsi *et al.*, 2007), risk of death in the first year after stroke, was 5.17-fold in women and 4.70-fold in men in the total sample, and 10-15-fold in the 45-64 group. There are wide discrepancies by gender, particularly in men of the working age groups (25-44, 45-64), whose mortality was twice as high as that of women of the same age groups. Lower mortality might be attributed to well controlled blood pressure in the elderly subjects.

Consciousness about stroke in our population was high resulting in better outcome. However, Samal *et al.* (2007) reported that poor outcome was partly associated with educational level leaving much room for improvement by educational campaigns. Furthermore, it was observed that there is a gap between knowledge of the increased risk for stroke in patients with hypertension and awareness of their own risk

Our findings suggest that though diabetes mellitus was observed in elderly, they were better controlled resulting in better blood pressure control and protection against renal damage. However, Toyoda et al. (2006) reported poorly controlled diabetes mellitus and advanced renal damage appeared to correlate with acute hypertension after stroke. Since intracranial arterial stenosis also seemed to contribute to high acute blood pressure, one should be careful not to induce cerebral hypoperfusion by the early use of anti-hypertensives.

Conclusion

Study shows that better control of blood pressure, education and timely thrombolytic therapy in stroke results in better outcome in hospitalized elderly.

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Indian Journal of Gerontology
2008, Vol. 22, No. 2. pp 163 -174

Adjustment and Spousal Support Among Male School Teachers in Pre-retirement Phase

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ABSTRACT

The present study aimed to asses the changes in the level of adjustment and spousal support among male school teachers approaching retirement. Adjustment Inventory which assess adjustment related to five areas, viz., health, emotional, self, home and social (Ramamurti, 1968) and Social Support Scale which assesses four functional aspects of perceived support, viz., emotional, informational, practical and companionship (Arora and Kumar, 1998) were administered to a sample of 62 male school teachers (Mean age 58yrs) in two pre-retirement phases, viz., "Close-to-Retirement" (Ss with 1-4 yrs to retirement, N=34) and "Distant-to-Retirement" (Ss with 5-8 yrs to retirement, N=28). Results indicated no difference between Ss in the two groups on total adjustment scores as well as on various areas of adjustment and perception of spousal support. It appears that as the Ss approach retirement event the importance of spousal support increases significantly in all the areas of social support for maintaining adequate levels of adjustment. Results have been analyzed in context to importance of spousal support for smooth transition from pre-retirement to the retirement phase.

Key words :Pre-retirement, Spousal support, Adjustment, Social support

Retirement is a crucial but an inevitable event in the life of an employed person. It can be conceived as the end of the most important phase of the life. Retirement ushers in a period of phenomenal changes calling for adjustment both in the retired person's life schedule and in the attitude of the family members. It brings in its wake, feeling of uselessness, sense of being a non-entity, causing heart-burns, depression, and soul searching. Adjustment to retirement may often be difficult since it requires adjustment to a new life style characterized by decreased income and reduced activity and increased free time (McGee, 1979). Tinsley and Bingler (2002) commented on how changing life style and increased diversity contribute to changing needs associated with retirement. Retirement is non-employment rather than unemployment and to stop working in a work oriented society is a mile stone event and a sensitive process (Bischof, 1976). The change from middle age to old age is rather drastic among the old people who retire than for other old people who are not required to retire (Desai and Naik, 1969). Thus there is a greater potential for

decreased psychological well being and adjustment following retirement (Hayslip and Panek, 1989).

The retirement event itself can be emotionally traumatic and it brings a number of changes, like attitude changes in family members and society towards the retired person, may pose a threat to the overall adjustment of the retiree. One of the major changes that occur for an individual approaching retirement is the reduction in activities related to work and their importance. The status that had been acquired as a productive member of an organization may also be threatened. There is also a growing realization for the need to redefine one's identity in terms of other roles than the work role which usually is the central role for a working person and more especially for men. The coworkers may start withdrawing their involvement and support. During the working life, the coworkers are the most significant persons in the social net-work to the extent that family and family concerns may be disregarded during the active work life. However, with approaching retirement there is a possibility that the coworkers, for whom the basis of relationship has been work related activities, may gradually start distancing away. It is during this phase that men may start seeking support from the family and availability of support from family especially the spouse may become crucial for maintaining an adequate level of psychological functioning in terms of adjustment and well-being.

Retirement can be as fundamental a change for partners/spouses as for the person retiring and may have negative repercussions on home adjustment of the retiree. Cliff (1993) found that most of the early retiree men (50-59 yrs) felt that they had had to adjust to spending more time at home with their wives and often used the expression "being under each other's feet" to describe the state of affairs at home. Mein, Higgs, Ferrie, and Stansfield (1998) interviewed recently retired civil servants as part of the Whitehall II study, found that adjusting to a new role and relationship with their wives was the most difficult and unexpected part of retiring.

Studies related to social support generally indicate a growing need to seek support from the spouse by the retirees. Conner, Powers,

and Bultena (1979) interviewed 218 non institutionalized persons aged 70 and above and concluded that that the quality, rather than quantity, of social interaction is crucial to understanding adaptations to old age. Pei and Pillai (1999) conducted a study on a sample of 20,083 urban and rural Chinese elderly and reported that there is a continuous role of family support and state support in promoting a sense of well being in elderly. Gall and Evans (2000) investigated the impact of pre-retirement expectations for satisfaction and financial status on quality of life. Participants were 109 male residents aged 61 to 75 years of London. Interpersonal relations emerged as important predictors of quality of life apart from satisfaction with respect to activity, finances, health.

Johnson (1992) studied the families and social networks of 150 adults (85 years and above) using both structured and open ended questions to determine the extent to which the family functions as a source of support for the oldest old. Subjects with children were found to be significantly more active as compared to childless and unmarried subjects. Barrett (1999) examined the role of social support (measured as presence of a confidant, perceived social support, and frequency of formal interaction) in determining life satisfaction among the never married. Results indicate that age moderates the effect of marital status on social support. In the analysis of life satisfaction, marital status and social support emerged as significant predictors.

Ramamurti (1992) measured life satisfaction in later years in the Indian context. Two scales of life satisfaction were administered to 250 elderly men in Madras City. The study indicated that there is an initial sharp decline in life satisfaction in early 50's, a second decline beyond the 61st year and an improvement in the intermediated interval. It is suggested that the first decline may be due to the physical and psychological effects of ageing and later decline may be attributed to retirement. Ramamurti's (1989) list of variables predictive of happiness, contentment and successful aging in the Indian context include - self perceived physical and mental health, positive self concept, and functional ability, perception of social support,

intergenerational amity, religiosity, activity level, externality, flexibility and economic level in the order of significance.

In present study an attempt has been made to explore adjustment, perceived spousal support and their relationship among male school teachers in the pre-retirement phase. The following hypotheses were proposed to be verified.

1. There will be a decrement in level of adjustment with approaching retirement.
2. There will be a decrement in perception of spousal support with approaching retirement.
3. Relationship between perceived spousal support and adjustment will be stronger with approaching retirement.

Method

Sample

The sample consisted of 62 male school teachers aged 55-64 years. Teachers who had only 1- 4 years to retirement were included in the 'Close-to-retirement" (CLRT) group (N=34) and those who had 5-8 years to retirement were included within "Distant-to-retirement" (DISRT) group (N=28). The educational and socio-economic backgrounds of these two groups were similar.

Scales

Two scales were administered to the 62 school teachers. The Adjustment Inventory developed by Ramamurti (1968) containing 100 items was used to assess adjustment in various areas, viz., home, social, emotional, health, and self, each having 20 items. Each item has two alternate responses - Yes/No. A score of '1' is given for a positive response and no or '0' score is given for the negative response. Sores are added for each area as well as for the total scale. Lower the score better the adjustment. The test-retest reliability has been estimated at 0.88 and the validity has been determined using two criterion groups- well adjusted and poorly adjusted aged persons.

Social Support Scale, developed by Arora and Kumar (1998) was used to assess four functional aspects of perceived social support from spouse, namely emotional, informational, practical and companionship.

Data were collected individually after explaining the purpose of the study and establishing rapport with the participants.

Results

Mean and SD were computed for the scores obtained on the measures of adjustment and perceived spousal support. Between-group comparisons were done by applying t-test. Correlations were worked out to assess the relationship between scores on various areas of adjustment and scores on various aspects of social support.

The mean scores and SD's of the groups on the measures of adjustment and social support and't' values have been presented in Table 1. None of the differences between CLRT and DISRT groups were statistically significant on the measures of health, emotional, self, home, and social adjustment. The groups also did not differ significantly on measures of emotional, informational, practical and companionship support.

Table 2 presents the values of correlation between various areas of adjustment and perceived spousal support for total group. The findings reveal a significant relationship of emotional adjustment with emotional support ($r = -.40$, $p<.01$). Home adjustment significantly correlated with emotional support ($r = -.45$, $p<.01$), informational support ($r = -.40$, $p<.01$), practical support ($r = -.35$, $p<.01$) and companionship support($r = -.29$, $p<.05$). Social adjustment significantly related only with emotional support ($r = -.35$, $p<.01$) and practical support ($r = -.29$, $p<.05$). Similarly Total adjustment scores were related with emotional ($r = -.40$, $p<.01$) and practical support ($r = -.29$, $p<.05$).

Table 1. Mean, SD and 't'-Values indicating differences between sScores of close-to-retirement (CLRT) and distant-from-retirement (DISRT) groups

Variables	Retirement	N	Mean	SD	't'-value

	Status				(df=60)
ADJUSTMENT:					
Health	CLRT	34	3.68	4.04	0.15
	DISRT	28	3.54	3.29	
Emotion	CLRT	34	5.59	4.21	0.83
	DISRT	28	4.75	3.64	
Self	CLRT	34	8.38	2.12	0.22
	DISRT	28	8.50	2.10	
Home	CLRT	34	4.91	3.53	0.55
	DISRT	28	4.46	2.70	
Social	CLRT	34	7.53	3.53	0.89
	DISRT	28	6.82	2.55	
Total	CLRT	34	30.09	14.40	0.64
	DISRT	28	28.04	9.66	
SOCIAL SUPPORT :					
Emotional	CLRT	34	83.03	17.53	0.49
	DISRT	28	80.96	15.29	
Informational	CLRT	34	31.79	7.82	0.61
	DISRT	28	30.57	8.00	
Practical	CLRT	34	58.76	14.29	0.22
	DISRT	28	59.54	13.42	
Companionship	CLRT	34	29.62	7.90	0.12
	DISRT	28	29.36	8.71	

**High Scores on Adjustment measures indicate poor adjustment*

Table 2. Correlations between Various Areas of Adjustment and Perceived Spousal Support for Total Group (N=62)

	Emotional Support	Informatio-nal support	Practical support	Companion ship support
Health Adjustment	- 0.25	- 0.06	- 0.13	- 0.21

Emotional Adjustment	- 0.40**	- 0.23	- 0.24	- 0.16
Self Adjustment	- 0.02	0.01	- 0.07	0.13
Home Adjustment	- 0.45**	- 0.40**	- 0.35**	- 0.29*
Social Adjustment	- 0.35**	- 0.12	- 0.29*	- 0.14
Total	- 0.41**	- 0.22	- 0.29*	- 0.20

High Scores on Adjustment Measures indicate Poor Adjustment
*** Correlation significant at 0.01 level*
**Correlation significant at 0.05 level*

In the DISRT group, only self-adjustment scores were significantly correlated with emotional ($r = 0.46$, $p < .05$) and companionship($r = .55$, $p < .01$) support. None of the other correlations were significant. Contrary to these results a number of correlations were significant for the CLRT group. In this group health adjustment scores were significantly correlated with emotional ($r = 0.55$, $p < .01$), informational ($r = 0.34$, $p < .05$), practical ($r = 0.42$, $p < .05$) and companionship ($r = 0.39$, $p < .05$) support scores. Emotional adjustment scores were significantly correlated with emotional ($r = 0.67$, $p < .01$), informational ($r = 0.43$, $p < .05$), practical ($r = 0.50$, $p < .01$) and companionship ($r = 0.37$, $p < .05$) support scores. Home adjustment scores were significantly correlated with emotional ($r = 0.59$, $p < .01$), informational ($r = 0.47$, $p < .01$), practical ($r = 0.46$, $p < .05$) and companionship ($r = 0.43$, $p < .05$) support scores. Social adjustment scores were significantly correlated with emotional ($r = 0.63$, $p < .01$), informational ($r = 0.36$, $p < .05$), practical ($r = 0.60$, $p < .01$) and companionship ($r = 0.37$, $p < .05$) support scores. Self adjustment score were significantly correlated with emotional support only($r = .37$, $p < .05$). Total adjustment scores were significantly correlated with

emotional (r =0.70, p<.01), informational (r =0.46, p<.01), practical (r =0.57, p<.01) and companionship (r =0.46, p<.01) support scores.

Table 3. Correlations between Scores on Various Areas of Adjustment and Perceived Spousal Support for Distant-from-Retirement Group (N=28)

	Emotional Support	Informatio-nal support	Practical support	Companion ship support
Health Adjustment	0.26	0.36	0.32	0.03
Emotional Adjustment	0.01	0.02	0.17	0.10
Self Adjustment	0.46*	0.30	0.24	0.55**
Home Adjustment	0.23	- 0.32	- 0.16	-0.12
Social Adjustment	0.17	0.24	0.26	0.20
Total	0.18	0.17	0.25	0.19

Discussion

The findings of the study suggest that as such no significant differences exists between teachers who are close to retirement and those who are distant to retirement on scores on various areas of adjustment and perception of spousal support. These findings go against hypotheses 1 and 2.

Table 4. Correlations between Scores on Various Areas of Adjustment and Perceived Spousal Support for Close-to-Retirement Group (N=34)

	Emotional Support	Informatio-nal support	Practical support	Companion ship support
Health Adjustment	- 0.55**	- 0.34*	- 0.42*	- 0.39*
Emotional Adjustment	- 0.67**	- 0.43*	- 0.50**	- 0.37*
Self Adjustment	-0.37*	- 0.24	- 0.31	- 0.24
Home Adjustment	- 0.59**	- 0.47**	- 0.46**	- 0.41*
Social Adjustment	- 0.63**	- 0.36*	- 0.60**	- 0.37*
Total	- 0.70**	- 0.46**	- 0.58**	- 0.45**

High Scores on Adjustment Measures indicate Poor Adjustment
*** Correlation significant at 0.01 level*
** Correlation significant at 0.05 level*

However, correlational analysis revealed some interesting results. When all the subjects were considered together, it appeared that home adjustment was related with all types of perceived support from spouses, viz., emotional, informational, companionship and practical supports. Total adjustment and adjustment in emotional and social areas were associated only with the emotional support from spouses. Social adjustment and total adjustment were also related significantly to practical support.

However, when the two groups were considered separately, different findings were obtained for those distant and distant to retirement. For those subjects who were distant to retirement the spousal support did not seem to be associated with adjustment except for self-adjustment which was related with emotional and companionship support. Whereas, for the male teachers who were close to retirement self-adjustment appeared to be associated only with emotional support from the spouse but high level of emotional, informational, companionship and practical support from spouse appeared to result in better adjustment in areas of health, emotional, home, social, and total adjustment. It appears that as the teachers

approach retirement event the importance of spousal support increases significantly in all the areas of social support for maintaining adequate levels of adjustment and the third hypothesis seems to be supported by the results.

The results seem to suggest that as such the level of adjustment and perception of spousal support are not contingent upon closeness to retirement event. It also appears that role of spousal support becomes all the more crucial as the retirement event approaches nearer. In the stage when retirement almost becomes imminent, all types of support from spouse becomes important but the role of emotional support seems to be most marked as it seems to influence adjustment in every area of the individual's life.

The results seem to be supporting the findings obtained by Barrett (1999), Pienta, Hayward and Jenkins (2000), Nezlek, Richardson, Green, and Schatten-Jones (2002), Whisman, Uebelacker, Tolejko, Chatav, and McKelvie (2006) who have emphasized the significance of presence of and cordial relations with spouse for life-satisfaction among elderly and retirees.

The results highlight the need to strengthen the family network and mutual support system within the family and especially highlight the importance of marital accord for promoting better adjustment, and a healthy and fulsome life for the retirees. The study also has important implications for counselors dealing with pre-retirement planning and older people. Counselors can help their clients to realize the importance of nurturing the relationship with their spouses which usually tends to get neglected during the years of active employment. They can help them to strike an appropriate balance between job and family commitments to ensure availability of spousal support at a time when it is most needed by the retiree to remain adequately adjusted to the various significant areas of his life.

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Indian Journal of Gerontology
2008, Vol. 22, No. 2. pp 175 -195

Factors Influencing Sense of Security Among Elderly Women

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ABSTRACT

The present paper is an attempt to look into the sense of security among 350 urban aged women. A structured interview schedule was developed covering such dimensions as personal information, social economic condition, sense of security, type of family, decesion making. The findings of the present study reflected that socio-demographic variables like religion, caste, marital status, educational level and occupational status do not significantly influence sense of security among aged women. It was found that aged women cared for and respected by their family members, possess sense of security. It is suggested here that efforts should be made to enhance mutual caring and sharing between the aged and their significant others for ensuring their sense of security as well being.

Key words: Aged women, Sense of security, Mutual caring and sharing, Well being

Older persons occupy an important place in society. Earlier on, they would invariably head the family and occupy a place of prominence in the community. Agricultural economy, patriarchal social structure and joint family system would sustain and reinforce their importance. However, the social situation has undergone a radical change. The process of industrialization, coupled with other social changes, has overshadowed agricultural economy. Also, joint family households have given way or are fast giving way to nuclear family system. It has profoundly affected the situation of older persons. Often times, they appear to have been socially marginalized. In this regard, the situation of elderly women merits a pointed attention.

Since the beginning, women have a social status less than equal to that of men. In many cultures, they were taken to be physically weak and intellectually imperfect, requiring the protection of father in infancy and childhood, of husband during their adulthood, and of sons, in their old age. Ironically enough, in modern times, social changes seem to have aggravated the situation. Women's participation in education, remunerative work and community affairs is patently and woefully low. In most rural and urban areas, elderly women have to contend with yet another exigency — migration. More often than not,

adult and able-bodied persons migrate to industrial-urban centers for work, leaving behind elderly women, say, to their own device. What steps are being taken to look after women in their evening of life?

At present, the world's elderly population is nearly 600 million and by the year 2025, it is expected to rise to 1,100 million (see also United Nations, 1999). Most developing countries of Asia, Africa and Latin America are fast heading towards a 'grey world'. Further, the trend of feminization of ageing is also clear in most developing countries. There would be 604 million elderly females in the world by the year 2025, out of which 70 per cent would be in these developing countries. Moreover, Africa and Asia have an especially high proportion of widows (de Alvarez, 1991). Against this backdrop, the situation of elderly females, in developing societies, gives rather a dismal picture. Illiteracy, poverty, social and economic dependency deprive, these elderly women, of the skills and personal resources to cope with the changing physical, social and economic conditions. Also, developing countries are often characterized by indifferent economic conditions, lack of adequate health-care, education and welfare system. For these countries maintaining elderly population is often difficult, ostensibly for want of resources.

India is no exception to these trends. At present, India has nearly 76 million elderly and in about two decades the number will go up to a mind-boggling 150 million or more. Added to this, lower work participation rate among the elderly has increased their dependency ratio (proportion of the population aged 60 and above to that of the working age population in the age group 15-59 years). Elderly dependency ratio has risen from 9.8 in 1951 to 12.3 in 1991. Another indicator called index of ageing expresses ratio of elderly (60 plus) to children (0 to 14 years) in the population. In 1951, it was 14.3 elderly per 100 children. In 2001, the corresponding figure rose to 24.72. Indeed, the sharp rise in the index of ageing demands readjustment in the welfare and development policies of the country.

It may be reiterated that the elderly and their problems need priority policy attention. For this, there are several social and ethical justifications. Elderly, while in the prime of their life, have contributed to the development of society. In old age, when their capacities wane, it is obligatory for the society to stand by them and provide them support and security. The International Plan of Action

on Ageing, 2002, aims to ensure that persons everywhere are able to age with security and dignity, and to continue to participate in their societies as citizens with full rights.

Security in old age has many dimensions. It ranges from physical independence, psychological support, social integration to economic security. Sense of security is the confidence aspiring assurance for affection, attention, satisfying interaction, expectation to fulfill basic needs, like food, shelter, clothing, health care, and relational needs like visits to friends and relatives and symbolic gift-giving. Indeed, security is a broad concept with economic security being only one of its several dimensions.

In yester years, the issue of security of the aged was not as serious. Agrarian economy would encourage and support the joint family system. Staying together of three to four generations under one roof was common. In the joint family system, *karta*, the eldest male member in the family, would control family's property, income and expenditure. Among others, it would ensure security and power to the aged. Often the status and security of the aged women would be directly related to their husband's position in the family. However, the present day condition is markedly different. Industrialization has, by and large, changed the earning pattern of family-members. Modern technology and accompanying changes have made the know-how of the elderly somewhat outdated. In many situations, the elderly are seen, more or less, dependent on their offspring. In many instances, the headship of the family, *de facto*, has shifted from the oldest to the bread-earner, usually the young. In urban areas, the situation is a little more serious. In towns and cities, the status and authority are determined mainly on basis of one's earning capacity. Due to these factors, the ascribed status of the aged is slowly getting eroded. They are fast becoming a vulnerable group. In such a scenario, what would be the situation of aged women, who have even otherwise been taken as dependents, would be anybody's guess.

Traditionally, a woman, in Indian society, identifies herself with her husband. In fact, dependency, economic as well as social, on father, husband and subsequently on son, low level of education and access to health care, and all other factors associated with it, make an elderly female much more vulnerable than her male counterpart. "If men, who were once active in the labour force", observes Prakash

(1996) "and had made substantial tangible contribution, are considered as 'burden', then how will women, who always had been invisible contributors, be treated when they are no longer useful"?

Indian work force is male-dominated, in that only 31 women are in the work force for every 100 men. Interestingly, the primary sector is dominated by women, with female-male ratio being 127.9 per cent. In contrast, the secondary and tertiary sectors are predominantly male-dominated (Srinivasan and Shariff, 1997). Also, due to decreased activity in work place during old age, more and more elderly women have to stay back at home and engage in domestic activities like cooking, house-keeping, child-caring, fetching water, etc., thereby making a significant contribution to the family economy. However, their economic value is invisible as it is neither remunerated nor acknowledged. Thus, their productive role on the domestic front is unnoticed, unaccounted and is not viewed as a resource in national development (Ramamurti, 1991). In spite of their involvement in direct or indirect income generating activities, women generally remain economically dependent. Does it affect their economic security?

Leibenstein (1951) observes that one of the salient motives that determine the fertility behaviour is old age support motive. The Third All India Family Planning Survey reports that almost two-thirds of the couples consider children as their main source of old age security (ORG, 1990). In India, 'son-preference' appears to be synonymous with old age security motive. However, due to several reasons, the aged today cannot take for granted that their children would look after them. It is especially in view of longer life span requiring a longer period of dependency and higher costs to meet health and other needs. It is usually held that a person over 75 years uses eight times more health and social services than a normal adult (Getzen, 1992). These additional expenses start impinging upon the family budget. Due to higher costs of bringing up and educating children and pressures for meeting their (fancy) needs, old parents tend to get lesser share in family income. The situation becomes more precarious in the case of widows, majority of whom may have no independent income, may not own assets and may be substantially dependent (Prakash, 1994). In a metropolis like Delhi, many elderly couples live alone, with relatives paying a few visits in the name of providing care and security.

Sometimes children opting to build career abroad, leave their parents behind. They may send money to compensate for their providing care and physical support. Such old persons are often soft targets for criminal elements. Also, it is not uncommon that old people become victims of deceptive dealings and of physical and emotional abuse within the household by family members who may force them to part with their ownership rights (see Jamuna, 1995). It is important that security and protection is available to such old persons.

Security means safety, freedom from danger and anxiety. Does the sense of security only depend up on the financial position of the aged? Barge, et al., (1994) observe that irrespective of economic development, progeny, particularly son, is considered some kind of a guarantee for old age security and support. D' Souza (1990) observes that those aged who are economically dependent up on their children often have tension and anxiety. Paintal (1991) reports that financial insecurity tends to increase with advancing age. Soodan (1975) highlights that in old age economic stringency brings insecurity and loss of social status. These studies bring out that age, children, financial position and economic dependence are associated with the feeling of economic security-insecurity.

Though these studies provide invaluable information, these hardly pay a focused attention on questions like what are the factors that lead to feeling of security or insecurity among the aged women and what is the impact of security or insecurity the elderly females have on their well-being, especially in an urban setting. These information=gaps heavily tell upon a proper and systematic understanding of elderly women, and upon a balanced evolution of social intervention strategies. The present paper attempts to look at the gender-differences in terms of security in old age.

The paper attempts to look into the sense of security among aged women particularly those in urban setting. Towards this, the paper first analyzes the level of sense of security among the aged women and then examines the linkage between sense of security and various social and economic factors. A comparative analysis, wherever possible, has been carried out between the situation of elderly women and elderly men, in order to gain an insight into the gender differences.

The sense of security is taken to mean the feeling of assurance an aged woman has that, irrespective of her economic dependence-independence, her kith and kin would take care of her needs and wants. It is her confidence that she would have access to resources she needs. Her family would come forward for her help whenever required.

Method

Sample :

350 aged women were selected randomly from Pushp Vihar and other areas from South Delhi. For data collection, a structured interview schedule was developed covering such dimensions as identifying information, social and economic condition, sense of security-insecurity, type of family, etc.

Distribution of Sample

1.	**Religion**	
	Hindu	74.9%
	Christian	6.3%
	Muslim	3.4%
	Sikhs	10.3%
	Others (Jains & Budhists)	5.1%
2.	**Caste**	
	Brahmins	37.8%
	Kshatriyas	15.6%
	Vaishya	27.1%
	ST, SC & OBC	19.5%
3	**Marital Status**	
	Married	46.9%
	Widows/divorced/single	53.1%
4.	**Education**	
	Illiterate	29.7%
	Read and write	23.7%
	Upto Middle class	38.0%
	Up to P.G.	8.6%
5.	**Type of Family**	
	Nuclear Family group	2.9%

Join Family group	81.7%
Adopted family group	15.4%

For analysis, a composite variable, sense of security-insecurity was developed by combining the scores of the above seven variables. Score '1' has been given if the respondents have replied in the negative and score '2' in the affirmative. Theoretical as well as observed range of these scores is 7 to 14. Mean score is 11.5 (standard deviation, 2.1). For the purposes of analysis, the score has been divided into three broad groups — insecure (7 to 10), average (11 to 12) and secure (13 to 14).

Findings :

Sense of Security: In order to measure the sense of security-insecurity, elderly women have been asked whether they feel that they can get money as per their needs or wishes, say, for going to pilgrimage, for buying fruits, confectionary, for their medical treatment, etc. Data show that 86.3 per cent respondents feel that they can buy clothes for their grandchildren whenever they want to do so. Similarly, 55.7 per cent respondents feel that they can spend money on giving dole or donation as and when they feel like. Further, 78.6 per cent respondents think that they can buy dresses for themselves whenever they wish, and 89.7 per cent feel that they can purchase fruits, confectionary, etc., when they feel like. On medical treatment, 65.4 per cent respondents feel that they can spend large amounts if the need arises and 49.1 per cent can go for pilgrimage or to their relatives, etc. whenever they want to. On the issue of managing separate living, one fourth are comfortable and the rest do not think in these terms.

Social indicators:

Religion: Religion, according to MacIver (1974), is the relation between man and some higher power. Religion also, indirectly, provides a sense of security among the elderly by their active involvement in ritual performance in events like marriage, child-birth and death (also see Gangrade, 1989). Is religion having an impact on the sense of security-insecurity among elderly women?

The relationship between religion and sense of security-insecurity among elderly women was studied in this study. The results show that religion has virtually no role to play in influencing the sense of security among the aged women (tau = -0.02). Apparently, while religiosity is an important component, religious affiliation does not seem to influence the sense of security and well-being of the elderly females. Studies done on elderly males also reflect similar results (Khan, 1997). Perhaps, problems of senescence outweigh the confidence- giving role of religion or religiosity.

Caste: Caste is a unique characteristic of Hindu society. In the present form, it is rigidly hereditary. The caste-system imposes restrictions on its members in the matter of occupation as well as social intercourse. Though, in urban areas it appears to lose its rigid boundaries and restrictions, still, in the case of elderly it may have a strong influence on their psyche.

In the present findings the variables — caste and sense of security show statistically no significant association (tau = +0.03).

Marital Status: Ramamurti (1989) observes that the loss of husband, in later years, leaves elderly women high and dry and dependent on her children. In some cases she finds herself almost deserted. The loss of husband not only creates a psychological vacuum but also brings loss of status and lowering of self-concept among females. The loss of husband makes a female insecure financially, emotionally and socially. *"Jab tak aadmi jinda hota hai,* Kalawati (name changed), a resident of Pushp Vihar, bemoans, "*hum tabhi tak maalkin hate hain, baad main to sirf bache-kuche din katne hote hain"* (we feel we are mistress till our husband is alive; after that we somehow manage to spend remaining days of our life). Do widows feel insecure more often than their married counterparts? Table 1 shows the association between the feeling of security-insecurity among the respondents and their marital status. The findings show that among the widow respondents, the proportion of those having feeling of insecurity is almost three times higher than those who feel secured. However, among the married respondents this difference is not so peculiar. Relevant statistics confirm the association between the two variables (coefficient of contingency = 0.22). It corroborates with the popular belief that a

female is more or less dependent up on her husband to meet her needs and she feels insecure after the death of her life partner.

Table 1: Association between feeling of security-insecurity among the elderly respondents and their marital status.

Security-insecurity	Married separated/divorced	Widow/
Insecure	31.7	54.3
Average	39.0	28.5
Secure	29.3	17.2

The widowhood brings grief and insecurity among the aged women and men. It may be, thus, inferred that feeling of insecurity among women is more common, and this feeling further intensifies with widowhood.

Education: Education is generally assumed to be a definitive aid in making individual, whether men or women, autonomous and independent. Is it generally the case? Aggregate data show that literacy and educational rates among women in the country are markedly low. This particularly stands out for aged women. What is more notable is the fact that educational status of the elderly women and their sense of security-insecurity do have a positive relationship ($r = 0.154$), yet it is not very significant. How do we explain this? Apparently, tradition and collective mindset tend to overshadow the liberating impact of education on women.

This apart, the possibility cannot be ruled out that old age is often accompanied by sense of insecurity among women and men alike. Many studies on elderly males show that insecurity often sets in as old age approaches, irrespective of their educational level. It has been observed that illiterate aged males in unorganized sector are invariably surrounded by a sense of insecurity. Paintal (1991) reports feelings of insecurity even among medical men. This reflects that educational status is not a critical variable in the sense of security, especially among women.

Type of family: Family is taken to be bastion of human civilization. It has also been a safe haven for the elderly. In the present study, family groups have been classified into three broad categories — first, nuclear families are those where an aged woman stays with her husband and/or unmarried children; second, joint families where the aged woman stays with married children; and, third, the aged woman with an adopted family, that of her sister-in-law/friend/son-in-law, etc. An aged woman staying in her friend's house, laments, "*Everything seems to be okay here, still, I feel afraid, insecure and sad*". Again, analysis brings out unclear linkage between type of family and sense of security among the aged women. However, aged women who are not staying in their natural families (whether nuclear or joint) more often feel insecure.

Being loved and cared for seems to provide positive self-esteem and sense of security among the aged. The elderly women in the study have been asked about the behaviour of their relatives towards them when they enter the household — whether they just wish them or sit and talk to them casually or share their feelings and problems with them. These responses are in order of increasing level of respect and love for the respondents. Results show quite interesting trends. The aged women who are respected by their family members often score high on sense of security (see Table 2).

Table 2: Association between the respect given by family members and feeling of security-insecurity among the elderly respondents

Respect by family members	Behaviour	Sense of security		
		Low	Medium	High
Son/son-in-law	Come & wish	20.6	6.2	1.8
	Sit & talk	18.3	16.8	10.6
	Consult	3.5	10.6	10.6
	None	0.9	0.0	0.0
Daughter-in-law /daughter	Come & wish	16.0	5.5	1.8
	Sit & talk	14.1	14.7	9.5
	Consult	4.6	11.0	11.7
	None	9.2	1.5	0.3
Spouse	Come & wish	3.4	2.7	0.7

	Sit & talk	17.7	15.6	7.5
	Consult	2.7	21.8	25.9
	None	2.0	0.0	0.0
Grand-children	Come & wish	13.1	2.3	0.4
	Sit & talk	20.4	14.6	5.8
	Consult	7.3	13.1	17.3
	None	5.4	0.0	0.4

Data show that elderly women whose sons/sons-in-law share with them their problems and feelings often feel secure as compared with those whose sons/sons-in-law just come and wish them (tau = +0.42). A similar trend is observed in the case of their relation with their spouse (tau = +0.39) and with their grandchildren (tau = +0.34). However, exception is in the case of their relation with their daughters-in-law/daughters (tau = +0.16). Stated differently, elderly women's relationship with their daughters-in-law as a variable is not strong enough to affect their sense of security. The reason for this trend could be traced to the age-old prejudice as defined by *saas-bahu* relationship.

Khan (1997) also reports that almost two-thirds of the elderly males share amicable relationship with their grandchildren and daughters-in-law. Kumar (1996) observes that most of elderly males (80 per cent) are 'loved' by their family members. It appears that maintaining cordial relationship with *significant others* is a crucial factor in feelings of security and well-being among elderly women.

Decision-making: It may be restated that in agrarian societies, the aged would take decisions in important family matters, which would be carried out by younger family members. In fact, most researchers have taken participation in decision-making as an indicator of their acceptance and integration in the family, which significantly influences their sense of security (Khan, 1997;). Aged females who are engaged in the decision-making process in the family generally have a feeling of security as compared with those who are not consulted. However, in the present-day situation, the aged do not have the full authority to take the decisions, yet they are often consulted on important family matters. Luthra (1991) reports that while respect is shown to older people in rituals, in everyday life their views get often ignored. In the study, the respondents have been asked about various issues on which family consults them while taking decisions that range

from giving gifts to relatives and friends to marriage of grandchildren. One respondent, during interview, states, "*Hamari zarurat to bas shadi-byah main reet riwaz batane ki hi rah gayi hai"* (our importance is restricted only to guide in rituals during marriage ceremonies).

Apparently, aged women who are accepted in the family often feel secure. Taking involvement of the respondents in decision-making as one of the indicators of acceptance, analysis shows a strong association between the feeling of security-insecurity and consultation. Table 3 shows this linkage with relevant statistics.

Table 3 : Association between economic security-insecurity among respondents and their consultation in family matters.

Consultation in the	Per cent		Rank
Family matter	**Yes**	**No**	**correlation**
Gift giving	81.5	18.5	+0.41
Purchase of new clothes	58.9	41.1	+0.44
Purchase of household assets	62.7	37.3	+0.49
Purchase of property	39.6	60.4	+0.53
Children's education	8.9	91.1	+0.29
Grandchildren's marriage	69.2	30.8	+0.24

Could these findings be generalized to the aged males? Dak and Sharma (1987) observe that 76 per cent of the elderly males in contrast to 21 per cent of elderly women are always consulted in household matters. This indicates that aged women are in a relatively disadvantageous position in household decision-making process.

Economic factors:

Occupational Status: Often occupation is an important indicator of the economic position, self-confidence and life-style of a person. Focusing attention on the situation of elderly women, it may well be kept in view that the women who have been housewife are generally considered as non-workers as the economic value of their work, being invisible, remains often unacknowledged. Contrarily, the proportion of women engaged in some income-generating activities is too low, 4.1 per cent in organized sector and 16 per cent in un-organized one. Sahayam (1988) observes that the proportion of aged women working as agricultural labourers is almost one and a half times higher than their male counterparts. It appears that patriarchal social milieu, often, aggravates the life-long dependency in old age. Prakash (1996) finds that, though most females have had contributed significantly in the family occupation of agriculture, 90 per cent of the aged women are financially dependent on their family with few property rights. Does employment enhance sense of security?

The data, on the past occupational status, show that 92 per cent of the elderly women have been housewife only. Looking at the present occupational status, 14 per cent of the respondents are getting pension. Only 1.5 per cent respondents are currently involved in some economic activity and the rest 84.6 per cent continue to be housewife or non-worker. The drop in the proportion of housewife or non-worker, from the past to present occupational patterns, among the respondents, may be due to inclusion of those females who receive pension after their husband into the category of 'government service'. Does occupational status enhance sense of security among the aged women? Sense of security among them has been analyzed in terms of their past and present occupational status — there is a positive correlation between the two (tau = +0.17; in both the cases); however, it is not sufficiently strong. It follows that the elderly women who have in the past or who are at present engaged in economically identifiable or quantifiable occupations are likely to have a greater sense of security. Is it peculiar to elderly women only?

Several studies show the impact of economic condition of the elderly on their physical, psychological and social well-being. Bhogle and Reddy (1996) observe that the aged belonging to high socio-economic status often experience less depression. Dhillon and

Chhabra (1989) highlight that the elderly belonging to lower income group most often tend to escape from the challenges in life. Similarly Paintal (1991) observes the sense of insecurity among the medical men. Bhatia (1983) studies gazetted and non-gazetted officers of Udaipur and finds almost two-thirds of the elderly males were unsatisfied with their retirement from the job. It appears that sense of security-insecurity among elderly males also varies with their occupational status.

Income: A steady source of income is essential for meeting needs and maintaining the quality of life. Certain gender discriminating socialization practices like priority to males in the matters of education, employment opportunities, etc., have left the women with minimal skills to earn. They are, thus, more or less, dependent on their family for their maintenance. Apparently, families with abundant resources often do not feel the financial strain, while caring for their aged relatives. On the other hand, when resources are scarce, youngsters receive priority over the aged. So, the socio-economic background of the household becomes an important factor in meeting the economic needs of elderly females and ensuring their security. Let us first pay attention to the total monthly income of the household of the respondents.

Data show that the range of the monthly income of the household is from Rs.1000 to Rs. 26,000 (mean Rs. 9968.2). Contrary to expectations, high range of household income does not ensure security among the elderly women (tau = +0.041). This may be attributed to imbalanced resource distribution weighed against women and elderly women in the family, almost a common feature of patriarchal social structure.

It is often believed that married aged women first look at their husband to meet their economic needs and then on their children. Old age, especially in unorganized sector, means loss of financial independence. Without any economic security, the aged become dependent on their relatives. If the family fails to care for them, they turn destitute.

Data show that, in the present study, 48 per cent of the aged men (respondents' husband) were working in government or public sector undertaking. Rest of the 52 per cent elderly men (respondents'

husband) did not receive any retirement benefit. What was the income pattern — when they and their husband were young? In this regard, only two-fifths of the elderly women have furnished information. The range of past income earned by respondents' husband is from Rs.1000 to Rs.10,000. Average monthly income is Rs.4466.6, with wide variations. Higher income of the husband appears to bring a feeling of security among the aged females.

Coming to the present income of the respondents' husband, the range is from Rs.1000 to Rs.30,000. The average income per month is Rs.3303.2, but with a wide dispersion (standard deviation = 2896.2). It implies that though a sizable proportion of the respondents' husband are presently generating income, their income is highly variable. To what extent husband's income influences the feeling of security-insecurity among the aged women? The analysis shows that husband's past and present income has some bearing on the sense of security-insecurity; however, the trend is not very strong (tau = +0.14).

Do elderly females who have their personal source of income feel more secure? It seems that elderly women exercise considerable control over situations influencing them, should they have their own income. They can maintain respect, status and security if they are financially self-reliant. It may be restated that only 8 per cent elderly females were involved in some kind of the economically gainful work. The range of past income of the respondents is from Rs.200 to Rs.5000 a month. Average income of the respondents is Rs.2069. It suggests that though economic self-reliance might contribute to feeling of security, the proportion of respondents who were earning is too small. Majority of the respondents depend upon others for the fulfillment of their needs. Let us look into the present level of income of elderly women.

A large proportion of the respondents (83.1 per cent) have reported to have no income at present. Remaining 16.9 per cent of the aged women earn Rs.1000 to Rs.6000 per month. Average income is found to be Rs.1822, with wide dispersion (standard deviation = 1169). Statistically, respondent's own income is also no assurance for feelings of security. Out of 23 respondents earning in the past, 13 feel secure, 7 average and 3 insecure. However, data are too small to make out any dependable statistical trend.

Economic assets: Possession of economic assets symbolizes authority and power. It provides confidence and security to the possessor. In old age, ownership of valuables seems to influence care giving in the family. In the simplest terms, if property is owned and is at the disposal of the elderly, chances are that better care would be provided if nothing else, in the hope of inheritance. Dak and Sharma (1987) observe that aged women in Rattangarh (in Punjab) have to resort to somewhat coercive techniques to ensure their care and control which included keeping property intact, secret purchasing of gold and silver ornaments and promising favours with valuables to those female members of the family who serve them best. Those elderly women who tend to distribute their property or other assets early to their children or daughters-in-law often run a risk of neglect in later life.

In the present study respondents have been asked whether they have any immovable property in their name such as house, shop, land, orchard, etc. It is seen that 78 per cent of the elderly women have no immovable property and 19.1 per cent have some property in their name. Rest of the 2.9 per cent respondents remained quiet on the issue. Further, among those women having economic assets, only 10.6 per cent receive some monthly income from their property.

Does possession of economic assets bring a sense of security among the aged women? One respondent expresses the role of economic assets in ensuring security, "*Are beta! Aajkal apni aulad bhi tabhi tak apni hai jab tak aapke paas paisa hai"* (now-a-days, one's own offspring takes care only till the time you have money). May it be noted that possession of immovable property is positively related to the feeling of security-insecurity among elderly women (tau = +0.20).

As is well known, women have a fancy for jewelry. In fact, in a society where a woman commonly does not play active role in money transaction, possession of jewelry seems to endow her with a sense of control and power. It is a traditional means of economic security. In old age, when a female experiences change in her status and authority, ownership of silver, gold and diamond jewelry, to some extent, gives her some kind of a 'bargaining power' in family. In the study, 53.4 per cent women possess no jewelry. Next, 21.1 per cent have jewelry costing up to Rs.10,000 and 25.5 per cent up to Rs.20,000 and above. As would be expected, possession of jewelry does have a mild

relationship with economic security among the elderly women (tau = +0.19).

It is surmised that having a bank balance may provide economic security to the aged women. It is observed that 43.7 per cent of women have no bank account and the rest 56.3 per cent have account in one or more than one bank. Focusing on the bank balance, more than 42 per cent of the women have provided information in this regard. It is seen that 14.6 per cent aged females have a bank balance between Rs.5000 to Rs.10,000; and 14 per cent between Rs.15,000 to Rs.50,000. Another 14 per cent have Rs.60,000 to Rs. 8 lakhs. What is the impact of bank balance on the feeling of security-insecurity among the aged women?

Table 4 : Association between the feeling of security-insecurity and having bank account among the respondents.

Feeling of security-insecurity	No bank accpimt	Having bank account(s)
Insecure	60.8	30.5
Average	27.5	38.1
Secure	11.8	31.5

As would be expected, elderly females having bank accounts feel economically secure as compared with those who do not have any. Table 1.04 shows the association between the feeling of security-insecurity and having one or more bank accounts. It shows that, among those elderly women not having any bank account, the proportion of those feeling insecure is almost five times higher than those having feeling of security. On the other hand, the proportion of secure and insecure among elderly women having bank account is almost equal. That bank balance has a positive and strong influence on the sense of security is indicated by the value of rank correlation (tau = +0.23).

This dimension has been pursued further and it has been analyzed in terms of bank balance the elderly women have. Among the women having a low bank balance (Rs.5000 to 10,000), 47.1 per cent feel insecure and 19.6 per cent secure. On the other hand, among the respondents with a bank balance of Rs.60,000 and above, only 18.4 per cent feel insecure and 44.9 per cent secure. Relevant statistics (tau

= +0.27) reinforce the relationship between the feeling of security-insecurity and the bank balance. The trend is strong that the possession of both immovable and movable property has a contributory role in providing or reinforcing the sense of security among elderly women.

Discussion and Conclusion

Sense of security is one of the crucial needs of the elderly. It has a direct and strong bearing on their well-being. The findings of the present study reflect that socio-demographic variables like religion, caste, marital status, educational level and occupational status do not significantly influence sense of security among the aged women. Their orientation with the 'home' makes the social variables largely insignificant in influencing their sense of security.

Sense of security is a multi-dimensional concept. Economic security is only one of its dimensions. Data trends show that feeling of security-insecurity is positively associated with the ownership of immovable property and jewelry the aged females have. It is also related to the occupational and income patterns of the elderly women as well as their husband, although the trend is not strong. It may be noted that despite strong positive association between sense of security-insecurity and bank balance, it is difficult to infer that possession of economic assets would always ensure security among aged women.

On the other hand, relational variables like their acceptance in the family in terms of respect given by the family members and their participation in the decision-making process show a positive association with sense of security-insecurity. To aged women, sense of security comes when their family members share their feelings and problems with them, that is, they are loved and respected by their significant others. In contrast, strained relationships not only psychologically disturb the aged women but also add to their feeling of insecurity. In order to enhance the sense of security, efforts should be directed towards harmonious relations along with interventions for economic self-reliance of the aged females.

National Policy for Older Persons, 1999, and International Plan of Action on Ageing, 2002, highlight special measures to provide security to elderly women. Many social assistance and insurance

programmes have be laid down to ensure security among the aged. These would include Old Age Pension, senior citizens saving scheme, social security scheme for unorganized sector, Annapurna, post retirement benefits (individual pension, family pension, gratuity, provident fund, etc.), tax rebate, health security, travel concessions, Old Age Homes.

The present study brings out that aged women cared for and respected by their family members possess sense of security, irrespective of their or family's economic status. Therefore, efforts need to be directed to enhance mutual caring and sharing between the aged and their significant others for ensuring their security and well-being.

It might be added that social welfare professionals have a major role to play in this direction. Through various platforms like Self-Help Groups, Resident Welfare Associations, and NGOs, aged women can be helped to enhance their communication and relational skills. Schools of social work may well initiate intervention programmes to revive dwindling values of caring and respecting the grandparents. Counseling and support services may be utilized to maintain harmonious inter-generational relationships. There is an urgent need to evolve ways and means to create an environment conducive to ensure security and well-being of senior citizens.

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Indian Journal of Gerontology
2008, Vol. 22, No. 2. pp 196 -212

A Study of the Family Linkage of the Old Age Home Residents of Orissa

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ABSTRACT

The tremendous growth of old age homes in India draw attention to the disjunction in relationships between ageing parents and children. Nowadays there is a marked shift in the preference of living arrangement among both parents and children. This paper looks at the family linkages of the old age home residents. The paper is based on the study conducted in four coastal districts of Orissa. It was found that the poverty and lack of money was one of the prime reasons for conflict with children. The residents did not prefer "intimacy - but - at - a - distance" as a form of living arrangement as is found in the European countries. They were of the opinion that either the parents should live with children or they should live away from children in some distant place.

Keywords**: Living arrangement, Elderly, Family, India**

The ageing of the population along with changes in the family structure and shifts in intergenerational relations has brought into focus issues pertaining to the elderly in India. The growing visibility of old age homes in India points to the needs of elderly, which were not recognised earlier. The old age homes have sprung up to cater to the needs of the elderly from different socio-economic backgrounds. The interests of the elderly to spend their old age in sacred places, the migration of children in search of employment opportunities, their maladjustment in family and poverty of the elderly are the major reasons for the Indian elderly to shift to old age homes. But since the idea of living in old age homes is relatively new in India, the adjustment process of the old age home residents, their feelings of satisfaction and dissatisfaction and expectations from family members provide an interesting field of inquiry. The aim of this paper is to study

the reasons for the elderly to shift to old age homes and look at family relationships of the residents in these old age homes (Homes hereafter) in Orissa.

Objective of the study

The paper attempts to look at the reasons for the elderly to come to Homes in Orissa. It further examines the family linkages of the residents of the Homes. The relationship of the residents with their family members and the issue of care and reciprocity between parents and their adult children is the main focus of this aspect. It is investigated how far the residents maintained contact with their children, their relatives and their friends. The feeling of satisfaction of the residents in terms of staying away from their children is also examined. The residents' preferences of living arrangement and their expectations from their children form another focus of this paper.

Method

This section describes the method of the study, the tools of data collection, the categorisation of Homes, samples for the study and the process of data collection.

Sample

Six Homes for the purpose of this study were chosen. These six Homes are in four coastal districts of Orissa. The coastal districts are Puri, Khurda, Ganjam and Jagatsinghpur. Out of the six Homes, four Homes which are run by the government with the help of NGOs, and two Homes, which are run by the Christian missionaries. From these six Homes, 55 residents for the purpose of this study by using convenience sampling were selected. A convenience sample consists of a group of individuals who are readily available to participate in a study. The main features of a convenience sampling are availability, convenience and accessibility. Out of these 55 residents, 32 were males and 23 were females. The ratio in terms of religious distribution is 44 Hindus to 11 Christians, i.e., 80 percent of the residents are Hindus as compared to 20 percent Christians.

As for the composition of the Home residents by their last place of residence, the majority of the residents were from villages (37) whereas 17 residents came from towns. Only one male resident from

government run Home was residing in a city before coming to the Home. There was no difference between the Homes run by the government and the Homes run by the Christian organisations as far as the last place of residence was concerned as in both cases the residents predominantly came from villages and towns. There was no gender difference as both male and female residents were predominantly from villages and towns.

Tools of Data Collection

Both primary and secondary data were for the purpose of my research. A semi-structured interview schedule was to tap the subjective perception of the residents of the Homes in Orissa. The semi-structured interview schedule has both open and closed questions. The observation method was also used whenever possible which yielded results untapped by the interview method.

The author of this paper interviewed the residents, who were willing to speak and who were able to spend one to two hours for the interviews. Since many of the residents of the Homes were ill or physically immobile or too old to speak for long periods of time or would not remember anything, could not interviewed.

The investigator also had informal discussions with them regarding the functioning of the Homes, their opinion about the residents of the Homes and their assessment of the perception of the Home residents towards the staff and the working of the Homes.

Data Collection

The fieldwork began in the first week of December 2001 and the interviews conducted from December 2001 to April 2002 with a gap of one month during the month of March. Old age home directory brought out by Helpage India was used to locate Homes in Orissa.

Of the six Homes whose residents were allowed to interview, the investigator received permission to stay in four of them. In the case of two of the Homes, which are run by Christian missionaries, the investigator did not get permission to stay in the Homes. However, he was able to be with the Home residents and conducted interviews from morning to evening. In the case of the Homes he was permitted to stay in; and could spend his entire time with the residents, observing their daily activities. The investigator had food with the residents as well as

with the staff of the Homes and participated in their daily morning and evening prayers.

The residents of the Homes were encouraged to narrate their life histories for the purpose of building case studies of a few residents. Usually the interviews took about one hour to one and half hours. In many cases the investigator took the help of other residents or the staff to clarify certain questions. Sometimes the staff or the other residents explained questions in their colloquial language in order to help the residents comprehend the questions.

Findings and Discussion

Reasons for Coming to the Homes

Before analysing the reasons behind the shift of the elderly to Homes, it would be pertinent to know about the marital status of the elderly and current status of their spouses which would enable us understand the passage to Homes.

The marital status of the residents showed that 46 residents were married whereas nine were single. The data further showed that of the 46 residents, who were married, most of them were widows or widowers. The number of such residents whose spouses were dead was 35.

It was also found that all the female residents had come to the Homes only after the death of their spouses. On the other hand, some of the male residents came to stay in the Homes while their spouses were still alive and were staying with either sons or other relatives. The number of such male residents was six. This finding indicated that the female residents managed to stay with their children till the death of their spouses. After the death of their husbands, misunderstanding and maladjustment occurred between the female residents and their children and consequently they came to the Homes. But the male residents of the Homes found it difficult to adjust with their children even while their wives were staying with them at home.

The residents were asked about their decision to come to Home. It was found that 41.8 percent residents (23) came to the Homes because they had no other choice, while 32.7 percent residents (18) said that they voluntarily came to the Homes. The rest of the 14 residents felt that they had been forced to come to the Homes. Since all the Homes

studied were meant for the destitute, it was not surprising that a large number of residents replied that they came to the Homes as they had nowhere else to go. No difference was found in two types of Homes studied, i.e., the Homes run by the government and the Homes run by the Christian missionaries regarding the decision to come to Home.

The residents cited a variety of reasons for coming to the Homes. Most of the residents gave more than one reason for their shift to the Homes. While 28 residents said it was the lack of money that compelled them to come to the Homes, 26 said that since there was nobody to take care of them back home, they took the decision to come to the Homes. The factor of disagreement with their respective sons found echo among seven residents. Another six replied that continuous conflict with their daughters-in-law was a predominant reason for leaving home.

There were four residents who complained of ill treatment and cruelty meted out to them that forced them to seek shelter in the Homes. Many of the residents were working on daily wages before coming to the Homes. Some of them could not work due to poor health and ageing. As they could not work to cover their daily expenses, they had no other choice but to seek refuge in the Homes. There were four residents in my study, who fell into this category. Another five residents said that since the income of their sons was not sufficient to run the family, they considered themselves a burden to their sons. So they decided to move into the Homes. Another three residents found it difficult to adjust to their family members in old age, which was a reason for coming to the Homes. One resident said that her son-in-law, with whom she was staying, constantly harassed her. That prompted her to come to the Home.

There were also many unique reasons for which the residents left home. In one case the villagers drove the family out, as a result of which the father landed in the Home while the son tried to settle down in a different place by starting a new business. In another case, the resident was advised by his spiritual *guru* to disengage from family matters and stay somewhere else. So he came to the Home. One resident said that while he was staying in a rented house with his wife, the landlord created a lot of problem for them. They finally decided to leave the house. While the wife went back to stay with her parents, the husband decided to come to the Home. He did not like to stay in his

in-laws' house. When he was asked further why he did not seek another rented house, he replied that he was quite fed up and did not want to take the trouble any more.

One of the residents, who was a construction worker left home because he did not want to be a burden to his son. This resident used to go to Kolkata, stay there for five to six months and work at different sites. He broke his back in an accident and had to come back home. By then his son had found a job as a construction worker in Kolkata and so could support the family. But after sometime, he could not send money regularly because of the temporary nature of the job. So the son and the daughter-in-law requested him to find a place for himself as they could not take care of him anymore. Afterwards the son came to meet his father and said, "You come back home. We will manage somehow." But the resident said, "I am well-settled at the old age home. Do not worry about me. When I become too old and ill, then take me home."

But the case of another resident was worse. His son refused to give him food saying it was profitable to give food to dogs than to him. He contemplated committing suicide, somehow decided against it and started begging to feed himself. His wife was still staying with his son. He said he had nothing to do with his wife now. And they did not visit each other.

One could see from the responses that a large number of the elderly persons came to the Homes due to the lack of money and an absence of any one who would care at home or both. When the two types of Homes were compared, the lack of money and the absence of any one who would look after emerged as the major factors for the residents to leave home. There were no gender differences when the reasons for coming to the Homes were compared. It was the same set of factors such as the lack of money and the absence of any carer that drove both the male as well as female residents to the Homes. Dandekar's (1996) study also cited similar reasons for the elderly persons' decision to take shelter in the Homes. She found that 64 percent of the residents had nobody to take care of them and 45 percent of them had no money to support themselves.

Pushpa Rani (2001) interviewed 40 residents of a Home run by the Little Sisters of the Poor located in Secunderabad, Andhra Pradesh.

She looked at the socio-economic background of the residents, their reasons for coming to the Home and the facilities provided by the Home. She found that most of the residents came to stay in the Home because there was nobody to take care of them or they could not afford to sustain themselves elsewhere.

A study with similar objectives was conducted by Ramamurti (2001) in 65 Homes across the state of Andhra Pradesh during 1997-98. His findings also showed that most of the residents came to the Homes due to the lack of money or carer at home. The residents had strained relationships with their children.

The finding was also in line with the observations made by Mishra (1993) and Nalini (1997) that the elderly persons opted to stay in the Homes to avoid conflict and domestic quarrels at home. There are as many as 17 residents in my study, who cited conflict and frequent bickering with their children as the factor behind their move to the Homes. Mishra mentioned in her study that the children of the elderly residents did not object to and expressed no sadness at the decision of their parents to reside in the Homes. Rather, they felt relieved. The elderly residents, however, felt that they had been driven out of the family. But in the case of most of the residents, it was the lack of money and care given at home that drove them to take shelter in the Homes.

The findings also showed cases of elder abuse. The nature of abuse varied from verbal abuse to physical assault. It also involved denying food to the elderly and refusing to attend to them during illness. There are a couple of studies in India that have examined elder abuse. Srinivas and Vijayalakshmi (2002) have conducted a study of 140 elderly persons drawn from different socio-economic backgrounds and contacted at geriatric centres, hospitals, pensioners' associations and informal gatherings in parks and beaches of Vishakhapatnam, Andhra Pradesh. They found that the victims were mostly widows, elderly with poor economic background and the dependants. They also discovered that the perpetrators of the elder abuse were sons, daughters-in-law and spouses in that order.

Another study, which reported elder abuse, was Rosamma Veedon's (2002) paper based on the analysis of 200 telephone calls. This study reported that the instance of abuse ranged from forceful

occupation of the elderly person's property to emotional blackmail in order to extract money from their savings to the neglect of care of the parents. In my study, apart from four cases where physical assault, verbal abuse and neglect of parental care were recorded, in seven other cases, the elderly persons found their land, house and other assets usurped by relatives and villagers.

In one case, an unmarried male respondent was working as a truck driver in Kolkata leaving his ancestral house and land in the hands of his brother and sister-in-law. When he came back, he found his property occupied by the children of his brother. They refused to hand over anything to them. They allowed him to stay in the house but refused to take care of him. He came to Puri, a religious town in Orissa, and started begging till the staff of a Home rehabilitated him. In another case, the foster brother of the female resident, a spinster, compelled her to leave their father's house. Her foster brother started treating her badly after their father's death. He continually harassed her for staying at home and forced her to do manual work. He also dispossessed her of property. Initially, she sold off household articles to survive. Soon she left home and began selling hand-made toys to earn a living. While selling them in the street, she came across a Home and took refuge there.

Family Linkages of the Residents

The family linkages of these residents were examined. The aspects that were studied under the broader heading of family relationships were the mutual visits of residents and children as well as friends and relatives and the nature of conflict between parents and children. The residents' preference of living arrangement and their expectation of care and reciprocity from children formed another focus of this study.

Visits to Children and Relatives

Before I asked the residents about their visits to children and relatives, I asked them about their feelings of isolation from family members and family surroundings. I also inquired whether they felt isolated from their friends. The residents strongly disagreed that they felt isolated from family and from family surroundings. Though they did not miss their friends and acquaintances much, but compared to

family and family surroundings, the residents from both types of Homes missed their friends and acquaintances more.

When it came to maintaining contact with children and relatives through letters, very few residents were writing letters to or receiving letters from their children. Just four residents wrote letters to their children and another four residents got letters from children but the frequency of letters was very less. In the case of relatives, none of the residents received or wrote any letters to their relatives. Neither did the residents make any phone calls to their children or relatives nor did the children or relatives make any phone calls to the residents.

But the residents of the Home made visits to their relatives and the relatives, in turn, also visited them. But the number of such mutual visits between residents and relatives was not very high. Dandekar (1996) found from her study on Homes in Maharashtra that the visits of relatives to the residents was more in number than the residents of the Homes visiting them. My finding differed from this trend indicated by Dandekar. It was the residents who outnumbered their relatives in terms of mutual visits, though the difference was minimal. But the two studies share the result that the mutual visits of the residents and the relatives were rare in terms of frequency of visits.

The visits to children and visits from children were not different either. As far as the comparison between both types of Homes in terms of mutual visits of residents, children and relatives was concerned, there was very little variation in percentage.

Conflict with Children

I asked the residents if they had conflicts with their children when they were at home. Apart from 25 residents who did not have any children, 18 residents said that they had conflicts with their children. The rest of the 12 residents denied having any conflict with their children.

The reasons for conflict showed that six of the residents were maltreated either by their sons or daughters-in-law or both. Three residents cited no clear reason. Another three residents felt that it was the lack of money and the inability of the elderly parents to contribute to the family income that resulted in quarrels. Similarly, two residents said that fights always occurred over small matters. The difference in

thinking between the father and the children was the prime factor in one case. There were two residents, who did not answer the question.

A larger number of residents belonging to the government run Homes had conflict with their children as against the residents from the Christian run Home. There were just two residents from the Christian run Home who had conflicts with their children. While most of the residents from the government run Homes cited maltreatment by sons and daughters-in-law as the reason for conflict with their children, it was the lack of money and poverty which drove the two residents from the Christian run Home to fight with their children. Many of the male and female residents cited the same factors such as the mal-treatment by the sons and daughters-in-law and the paucity of money as the reasons behind conflicts with children.

The residents, except 25 residents, who did not have any children, were asked if they liked staying away from their children. There were eight residents who felt highly satisfied staying away. Another 10 expressed satisfaction and six more said they were partially satisfied not residing with their children. While three residents noted dissatisfaction, the rest of the three residents were highly dissatisfied being away from their children. One of them grumbled, “If the children do not take care of us, what is the point of staying with them. It is better to be in the shelter of the government.” He further added, “I disposed of the property to educate my children. Now they are not taking care of us.”

When I compared the two types of Homes, I found that though most of the residents from both types of Homes expressed satisfaction staying away from their children, the overall relationship with their children was much more strained in the case of residents from government run Homes. There was not much gender difference regarding satisfaction in the context of staying away from their children as most of the male and female residents were quite satisfied staying away from their children.

Intimacy-But-At-A-Distance

One question was framed to find out whether the Indian elderly preferred “intimacy- but -at-a-distance,” a trend marked in the Western countries among the elderly parents regarding living arrangements.

Rosenmayr and Kockeis (1963) looked at the relationship between old people and their families of procreation and the problems of intergenerational cohesion in their study conducted in Vienna. One of their findings suggested that the elderly parents preferred to keep frequent contact with their offsprings but wished to maintain a distance. They wanted social contact but resented interference. These elderly people tended to stay in the vicinity of their children's houses. This phenomenon was characterised by Rosenmayr and Kockeis as "intimacy-but- at-a -distance."

In my study, the response pattern did not indicate any shift in favour of the trend. Rather, most of the residents constituting 61.8 percent did not approve of the idea at all saying either one should live with one's children or should stay far off. One of the residents added that if you lived in separate houses within close proximity, it would give rise to unnecessary gossip in the neighbourhood, which was not good both for the parents and the children. Only one male resident strongly agreed to such an arrangement saying that they would like their children to stay near them so that they could visit each other frequently and easily and could come to each other's help. But there were 20 residents constituting 36.4 percent of the total number of residents interviewed who did not answer the question. The majority of the residents from the Christian run Homes did not answer the question.

Living Arrangement

To the question as to whether children were the main support in old age, the response pattern clearly demonstrated a positive reply barring six residents who did not think so. As many as 85.5 percent of the residents felt that their children were the main support in old age. When I compared both types of Homes, I found that a large percentage of residents from the Christian run Homes replied that children were not necessarily their main support in old age. Such a response was not unexpected as most of the residents from Christian run Homes were childless and they had lived a large part of their lives without children.

A related question to the earlier one was as to whose responsibility it was to take care of the elderly parents. The preference for sons as carers was dominant as 32 residents preferred sons to daughters. Just five residents thought daughters should take care of in

one's old age. One of them said, "If the sons take care, it is fine, but they do not do it nowadays. The daughters are more caring." While 16 residents thought both sons and daughters must take care of the elderly parents, one resident replied that whoever was ready to take up the responsibility should take care of the elderly. It could be anybody even from outside the family. Compared to government run Homes, more percentage of residents from Christian run Homes thought daughters should take care of the elderly parents.

When the response of the male and female residents was compared, it was found that most of the residents, male or female, said that the sons should take care of the elderly. While one female resident felt that daughters should take care of the elderly parents, four male residents thought that daughters should take care of the elderly parents. One female resident held that whoever was ready to take the responsibilities of the elderly parents should take care of them.

A supplementary question to the previous one was what, in the opinion of the residents, was the best place to stay in old age. Not surprisingly, 43 residents felt that sons are the best options to stay with. Just five residents indicated a preference for staying with daughters. Another five residents held that Homes are the perfect place for the elderly. All of these five residents were females. Again, the resident who had earlier replied that anyone who was interested should take care of the elderly repeated that the elderly should reside with anybody they were comfortable with. One resident remained undecided. Again, compared to residents from government run Homes, a higher percentage of residents from the Christian run Homes said elderly parents should stay with daughters.

Vatuk (1981) has examined the cultural norms of social services for the aged in India. She analysed the social security available to the elderly and sought to find how far the prevailing social services for the elderly met the requirements of the elderly. She found that it is culturally accepted that the children would take care of the elderly parents. Her study of living arrangement of the elderly Indians corroborated the fact that a majority of the elderly were, infact, living with their children, particularly, sons.

Bhat and Dhruvarajan (2001), while discussing the living arrangement of the elderly Indians also mentioned that parents prefer

to reside with their children. In particular, they prefer to stay with their eldest sons and they go to live with their daughters only when they do not have any male issue. Further, the decision to come to Homes is the least preferred option for them. But the study by Pati *et al.* (1989) who investigated the socio-economic status of 76 elderly persons of the low-income families and slum dwellers in Bhubaneswar came up with a significant finding that the elderly people of low-income group preferred to stay with their daughters and sons-in-law rather than with their sons as the former take better care of them. Similarly, Rajan *et al.* (1999) who have studied five groups of the elderly, each group consisting of six to 10 elderly persons in the states of Kerala and Tamil Nadu, found that while the female residents showed keenness to reside with their children, the males felt they would not be respected in the family.

Care and Reciprocity

In my study, I sought to find out the residents' expectation of care and reciprocity from their children. The finding showed that the majority of the residents, who had children, expressed a desire to being shown respect by their children. Only four residents said they were not bothered whether their children showed them respect or not.

The residents were further asked if their children actually respected them. While 12 residents said yes, the remaining 18 residents replied in the negative. Those who said that their children showed respect to them were asked the possible reasons for it. Out of 12, nine residents thought that they commanded respect from their children because of the very fact of being their parents. One resident thought that it was his good behaviour that drew respect from his child. A couple of residents did not answer the question. A large percentage of residents from the government run Homes said that their children did not respect them.

When the male and female residents were taken into account with regard to respect by the children, 8 male residents said that they were respected by their children compared to 4 female residents who said that they were given respect by their children. While seven of these male residents thought that they commanded respect from their children because of the very fact of being their parents, two female residents subscribed to this view.

Vatuk's (1990) study conducted in an "urbanised former village" near New Delhi from 1974 to 1976 explored the long-term intergenerational reciprocity and the elderly parents' expectation of care and respect from children. Vatuk found that the elderly parents do not attach any negative meaning to physical and economic dependence on the children in old age since it is culturally accepted that the children will take care of their elderly parents in old age. To be cared for by sons and daughters is a matter of pride and satisfaction for the elderly. But the parents, who were on the threshold of old age were concerned and anxious as to whether they would receive such care and respect from their children to which they were rightfully entitled to by cultural values once they grew older.

Van Der Geest (2002), in his study of the Kwahu community of rural Ghana, found that children's respect towards their parents depended upon the care provided by the elderly to their children in their early years. If the children had been looked after well by their parents, the children took care of their ageing parents. Geest noted, "Respect is earned. It is given to those who deserve it because of what they have done in their lives. To respect an older person is no longer a 'natural' thing to do."

The present findings revealed that a majority of the residents of the Homes were never consulted by their children while relating to decisions in the family. There were six residents, who asserted that their suggestions were solicited in family matters. One resident did not give any response. None of the residents from the Christian run Homes were consulted by their children.

Conclusion

It was found that the lack of money and the absence of any caretaker at home was one of the main reasons why the elderly residents studied in Orissa shifted to the Homes. The residents came to the Homes as they had nowhere else to go to. Some of the residents had conflicts with their children of varying nature that forced them to look for alternative residence. Majority of these residents came to those Homes, which were nearer to their places of residence.

The residents from both types of Homes expressed disagreement that they felt isolated from family members and family surroundings

but agreed that compared to family members, they missed their friends and acquaintances more. Their contact with children and relatives were more through mutual visits than through letters and phone calls.

The residents also reported having conflicts with their children. While the residents from government run Homes attributed it to their maltreatment by sons and daughters-in-law, the residents from Christian run Homes located their conflict with children to poverty and the lack of money. They also expressed their satisfaction in staying away from their children. The residents did not prefer "intimacy - but - at - a - distance" as a form of living arrangement as is found in the European countries.

The residents stated that sons should take care of the elderly parents and that they are the main support in old age. But compared to government run Homes, a higher percentage of respondents from the Christian run Homes said elderly parents should stay with daughters. The majority of the residents also expressed a desire to being shown respect by their children and many of them admitted that they did not get respect from their respective children. Those who said they commanded respect from their children said that they felt it was because of being their parents.

Acknowledgement

The author would like to thank Dr. Munmun Jha of Department of Humanities and Social Sciences, IIT Kanpur for commenting on an earlier version of the paper.)

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Indian Journal of Gerontology
2008, Vol. 22, No. 2. pp 213 -226

Mental Health Needs of Elderly Living in Old Age Homes in Delhi

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ABSTRACT

In view of the rapid changes in the family, structurally and functionally, need for institutional care is becoming more prominent in the big cities, particularly in cosmopolitan cities, which are relatively more urbanized and greatly affected with the consumerstic culture and varied market forces. With variety of reasons the elderly are forced to live in Old Age Homes. NRI children, only daughters, unmarried, adjustment problems in the family, destitute are a few examples from the long list of the reasons of the elderly spending their lives in Old Age Homes.The spell of ongoing transition in the Institution of family is being experienced in every section of Indian society. Most visible impact of such inevitable transition due to globalization, industrialization and modernization has come in the life of older persons. The problem of isolation, alienation and loneliness leading to depression amongst the older people living in Old Age Homes is becoming more perceptible (Khan & Bhattacharya, 2005). They need special care and attention in terms of guidance and counselling. The present papers is reflecting on the Mental Health needs of these elderly living in Old Age Homes and to what extent Homes are able to full fill those needs.

Key words: Mental health needs, Elderly old age homes, Loneliness, Care, Counselling

Growing old and the challenges that arise thereafter, especially in the area of behavioural and emotional health of elderly living in Old Age Homes, have not received the attention they deserve, the reason being that 'ageing' has been viewed as a state which is 'characterized by decay and deterioration' rather than as on of growth and

development. The elderly who are living in Old age Homes have worst conditions for mental health than the ones living in the Families. These elderly are either destitute, or the persons staying away from the family willingly or unwillingly.

It is also clear that ageing cannot be viewed as a uni-dimensional process, since a number of factors interact in the lives of older people, making this phase of life as challenging as any other, if not more. It is important to consider 'ageing' in its various dimensions because, firstly, this allows for a greater understanding of personal change in the elderly; and secondly, because there are no clear markers to indicate an individual's transition into this phase of life. Viewing old age biological allows the consideration of bodily functions; the psychological aspect incorporates mental and emotional processes; social ageing considers interpersonal relations and roles in old age as well as attitudes towards ageing; and the spiritual aspect focuses on the continuous search for a meaning in life (O'Leary, 1996). In tune with this multidimensional nature of old age, care of the older person too, needs to go beyond a simple disease orientation and involve the total well – being of the older individual, taking into account psychological, social and spiritual domains as well.

Need for counselling in the elderly

The psychological consequences of growing old are frequently overlooked by society, being regarded simply as part of the old age. The direct provision of human services during times of dependency and crisis for older people would seem to be an unchallengeable and appropriate response, yet psychological interventions continue to be subjected to searching questions of validation.

Older persons need the opportunity to talk and to have a listener. They need the counselor's support in their efforts to "seize the day" and build a "life" during the remaining time available. They have essentially the same needs as anyone else. Many of these can be addressed by adequate counselling, and counsellors can have a major role to play in improving the well-being and quality of life of older people. Counselling need not always be linked to mental illness. This is because not all problems of older people represent mental disorders, or arise from increased illness and neuropathology in late life. As part

of the broader developmental continuum of the life cycle, ageing in itself is a dynamic process that challenges the individual to make continuous behavioral adaptations (American Psychological Association, 1996).

Many psychological issues in late life are similar in nature to difficulties at earlier life stages; for instance: Coping with life transitions such as retirement or changes in residence; Coping with widow-hood; Social discrimination; Facing traumatic events; Social isolation events; Marital discord; Issues of modifying one's self-concept and goals in the light of altered life circumstances, or continuing progression through the life cycle.

Other issues, however, may be more specific to late life, such as :-Grand parenting problems; Need for coming to terms with one's lifetime aspirations, achievements and failures; Sense of loss/ bereavement; Lifestyle changes due to disease; Coping with pain and disability; Fear of further physical deterioration or dependence; Anxiety and depression; Boredom/ loneliness; Dissatisfaction with children; Poor concentration and memory loss.

Among the special stresses of old age are a variety of significant losses. Loss, whether of significant persons, objects, animals, roles, belongings, independence, health or financial well-being, may trigger depressive reactions, particularly in individuals predisposed to depression. Among older people, losses are often multiple, and their effects cumulative. Nevertheless, confronting loss in the context of one's long life often offers multiple possibilities for achieving reconciliation, healing or deeper wisdom. In the face of stressful life events, interpersonal conflicts and developmental challenges, many older persons can benefit from psychological assistance (American Psychological Association, 1996).

The equilibrium between the load-bearing capacity of the individual living in Old Age Homes and the burdens imposed by the environment is probably the key to 'health'. Persons in a state of stress nearly always end up developing some illness or disability. This outcome is usually the result of a cycle of misinterpretation of events

leading to exaggerated emotional reactions, faulty ways of coping and reappraisal of the self in the light of these maladaptive reactions. The process of Counselling can be utilized to understand the typical reactions of an individual residing in Old Age Home, to intercept those situations that may exceed the person's tolerance level and to prepare the individual in advance to cope in a better manner.

On the flip side, often both family members and Institutions providing care estimate the load-bearing capacity of older people at too low a level, so that many tasks and responsibilities are unnecessarily taken away from them. This may lead to psychological stress, depression, invalidation, subjective complaints and inter-current diseases. The solution, thus, lies in striking a balance between stress reduction and prevention of a sense of redundancy as a result of de-loading. Therefore, an effort has to be made to involve the aged as much as possible in the treatment process and to make them increasingly responsible for their own well-being.

Method

The present study has been conducted in the Delhi covering 23 old age homes. Out of these 23 only 19 were having the residential old age home facilities. Therefore the total sample size of the Homes (both Govt. and non-Govt. homes) was 19. Based on the pilot study observation of homes, experiences gained during discussion in addition to review of literature, a semi structured interview schedule was constructed and tested. It was used on sample of 285 inmates (104 male and 181 females) of Old Age Homes selected for the purpose of in-depth interview. The study also included the managers of the Homes and officials associated with it. For the qualitative data Focus Group discussions were also conducted. The study is exploratory in nature.

Results & Discussion

Table 1: Sex of the respondents (N=285)

Sl. No	Sex of the Respondents	Frequency	Percent
1	Male	104	36.5
2	Female	181	63.5
	Total	285	100.0

The total number of respondents from 19 different Homes were 285. It has been found in the study that the numbers of female inmates are more than the male inmates in various Homes. Exclusive Homes for the elderly females are also there. The Study reflects the fact that needs of homes for females is relatively double as compared to males. Data in above table is representative of that proportion i.e. 63.5% females and only 36.5% males are residing in these homes.

Table 2: Age and Sex of the respondents (N=285)

Sl. No.	Age of the Respondents	Sex of the Respondents		Total
		Male	Female	
1	60-65 Yrs.	34	41	75
		12.%	14.4%	26.3%
2	65-70 Yrs.	45	82	127
		15.8%	28.8%	44.6%
3	70-75 Yrs.	15	48	63
		5.3%	16.8%	22.1%
4	75-80 Yrs.& above	10	10	20
		3.5%	3.5%	7.0%
	Total	104	181	285
		36.5%	63.5%	100.0%

If we further subdivide the data according to the sex as well as age-group interval, majority of elderly (44.6 %) irrespective of the sex fall under the Category of 65-70 Yrs of age. The table also shows that 3.5 % of male and 3.5% of female who are staying in Homes are under the age group of 75-80 Yrs. of age.

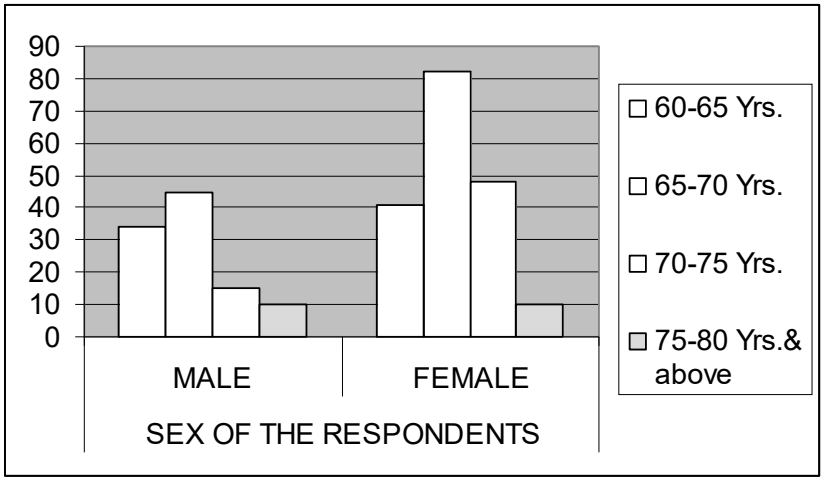


Figure-1 : Representation of sex of respondents in different Age groups

Table 3 : Number of years of stay in Old Age Home

Sl. No.	Number of Years of Stayin this Home	Sex of the Respondents Male	Female	Total
1	Less than 1Yrs.	28	19	47
		9.8%	6.7%	16.5%
2	1-3Yrs.	49	73	122
		17.2%	25.6%	42.8%
3	3-6 Yrs.	16	50	66
		5.6%	17.5%	23.2%
4	6-9 Yrs. And above	11	39	50
		3.9%	13.7%	17.5%
	Total	104	181	285
		36.5%	63.5%	100.0%

The above table shows that most of the respondents are living in Home Since 1-3 Yrs i.e. 42.8% reflecting the fact that more people are in need of joining Homes as their shelter of living; 17.5 % of the respondents are living since 6-9 Yrs.

Table 4 : Reasons for joining the OAH

Sl. No.	Reasons for joining the OAH	Sex of the Respondents Male	Female	Total
1	Separated and nobody to take the responsibility + Security	4 1.4%	11 3.9%	15 5.3%
2	Adjustment problem with son	7 2.5%	15 5.3%	22 7.7%
3	Death of spouse and nobody else is to take the responsibility+security	18 6.3%	60 21.1%	78 27.4%
4	NRI Children + security	8 2.8%	19 6.7%	27 9.5%
5	Destitute /came from other Govt. Institutions	23 8.1%	44 15.4%	67 23.5%
6	Any other (Destitute/HomeTown is far off lower economic family)	33 11.6%	19 6.7%	52 18.2%
7	Socially not acceptable to stay with the daughter's family	11 3.9%	13 4.6%	24 8.4%
	TOTAL	104 36.5%	181 63.5%	285 100.0%

The table shows that either destitute or separated (like destitute) total (19.7%) male and (41.7%) female are fully destitute for one or the other reason. This shows the Vulnerability of this Second Category i.e. destitute. Similarly 16.1% respondents have problems with children which forced them to stay in OAH parents of NRI children is another need to be attended 9.5% respondents are alone staying in Home because of that. Widow hood is another issue where person feels alienated, 27.4% of respondents are staying in homes due to this reason. Following are the other major and important findings of the study:

- The destitute (41.7%) respondents living in Homes are majorly from rural area of other states.
- Feminization of aged population in OAHs: (1991) 27.32 million 60+ women (48.2% of elderly) the UN estimate says 42.46 million in 2002 (52.36%). The present study shows the same

thing. Percentage of women living in OAHs is more than the men counter part.

- It has been found that the marital status of the elderly is closely associated with their age. For instance, in the age group, of 70+, fewer men and still fewer women are currently married. This reinforces the common observation that the probability of widowhood goes up with age and is one of the reasons of joining OAHs.
- The study shows that 40.2 % of the elderly living in Old Age Homes are uneducated.
- According to NSS 52nd Round of 1995-96, 58% of the elderly women were widows. Our study shows that out of total married respondents 70.5% (25.3%-Male, 45.3 %Females) respondents were widows.

In each Home (total 19) one group discussion was also conducted on the specific issue : *Why in general people opt for Old Age Home*? The discussion came up with the following points.

(i) Most people live alone because of lack of options rather than by choice.
(ii) Problems of loneliness and fear of declining health are commonly noticed.
(iii) More number of women are living alone than men.

The groups also stressed that this problem is likely to become serious as days go by unless an alternative that is socially and culturally acceptance is worked out.

Change in the Status: Economic and Emotional Dependence

As age advances, dependence on "others" be it adult, children, grandchildren or relatives, increases and this is accompanied by compromise with dignity, independence and participation. As is clear from the data quoted above, most Indian elderly work, well after the age of 60 years, but need less to emphasize the obvious that their contribution to family declines as compared to their adult children. This, at times, result in decline in status in the family.

When asked about their issue of worry it was found that 42.5% of the inmates are worried about their ill health. 27.5% are still worried about the family related matters.

Table 5. Issue of Worry

Sl. No.	Issue of Worry	Sex of the Respondents		Total
		Male	Female	
1	Wealth	2	8	10
		.7%	2.8%	3.5%
2	Health	51	70	121
		18.0%	24.6%	42.6%
3	Family	13	36	49
		4.6%	12.7%	17.3%
4	Any Other	6	23	29
		2.1%	8.1%	10.2%
5	Health & Family	24	42	66
		8.5%	14.8%	23.2%
6	Wealth + Health	7	2	9
		2.5%	.7%	3.2%
	TOTAL	103	181	284
		36.3%	63.7%	100.0%

This reflects that family and its members are still matter of concern for them. But these people have lost their status in the families. This loss of status is more pronounced in middle class families. Where the elderly have been in the organized sector and retire at the mandatory age of 60. This abrupt departure from the active and productive work creates a void in their life, unless he/she had diverse interests and activities in the field or art, literature science, sports, religion etc. The individual's life style is also likely to be adversely affected, owing to reduction in income and loss of the 'position'. The pinch of these changes is felt more by people who have good health and feel they can contribute more to the society because of their experience and knowledge. These people, in most cases are unable to find employment due to what is termed as 'ageism'. Despite awareness at all levels to harness the potential of the elderly population not much has been done to explore this possibility.

Structure of the family and relationship has also undergone tremendous change. Inter-country migration of the young adult, lack of adjustment in multi-generation households has increased the vulnerability of the aged. However, intergenerational bonding though

weakened has not been severed. It has been found that most of the inmates (leaving 27.5%) even the destitute living in Old Age Homes have some link or other as far as relations are concerned. Irrespective of the fact that either they have maternal links or family of the spouse, somebody is there who can take care of them provided if they want.

Table 6. Who are in family who can take care if they (relatives/ self) want

Sl.. No.	Who all in family who can take care if they want	Sex of the Respondents Male	Female	Total
1	No One	25	53	78
		8.8%	18.7%	27.5%
2	Only Married Daughter	15	26	41
		5.3%	9.2%	14.4%
3	Only Married Son	10	21	31
		3.5%	7.4%	10.9%
4	NRI Children	13	9	22
		4.6%	3.2%	7.7%
5	Parental Relatives	10	27	37
		3.5%	9.5%	13.0%
6	Married Daughters + Sons	29	44	73
		10.3%	15.5%	25.7%
7	No Children	2	1	3
		.8%	.4%	1.2%
TOTAL		104	181	285
		36.3%	63.7%	100.0%

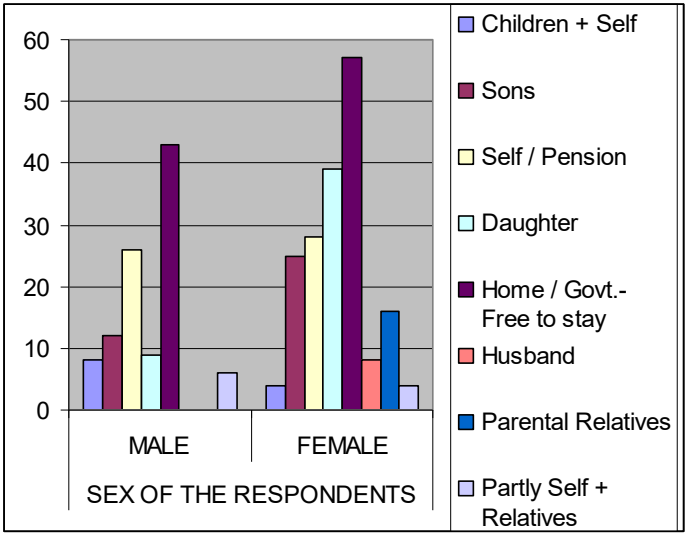
A major source of stress in middle-class is the changing family situation. Now in modern days the probability of living without the children is more. Extended, if not joint families were common in early Indian society. The table above shows that there is somebody in the family of respondents to take care if needed. 27.5% said nobody, but friends or distant relatives are there. There is 51.5% have either Son or Daughter or both but with various reasons staying in the Old Age Homes; only 1.2% don't have any children. This shows that with modern times the definition of family is changing. Youngsters don't wait to take the responsibility of their old parents.

The individual with this kind of situation bear mental tension & Stress. The elderly feel alienated and many a time goes into depression. The study has also shown that these elderly are bearing the pain of loneliness. They don't talk to each other much, likes to be alone in their rooms, and do not go outside of the Home many a times.

Who bears the expenses for the upkeep of the respondent and sex of the respondents

The elderly who were in organized sector support themselves but the persons involved in unorganized sector are always dependent on some or the other. In this view the following table is trying to find out the kind of economic support for their upkeep. As we have seen that only 26.3 % respondents were in organized sector getting retirement benefits. What about other respondents? Someone must be sponsoring them for their upkeep.

Fig. 1 : Who bears the expenses for the upkeep of the respondent and sex of the respondents



Out of total 51.5% of the children 34.0% are paying for the upkeep of their parents. They can pay for the upkeep but cannot allow them to stay within the family. 35.1% are destitute to whom free services are being given. Only 18.9% are self-sufficient.

The children under various conditions force their parents to chose to live in Old Age Homes.

The lower economic, social background and emotional unequilibrium the elderly reside in these Old Age Homes emphasizes the need of counselling facilities for them so that they may lead their rest of the life satisfactorily.

Mental health needs

It is generally accepted that mental health is profoundly influenced by socio cultural milieu. Traditions, customs and usages affect individual and group behavior. In some cultural, these suffuse individuals with unrealistic or even irrational ideas, which eventually give rise to mental aberrations (Backwalter, 1986). In old age counseling becomes the need especially for the ones living in Old Age Homes, suffering from loneliness & depression. The study tried to find out the facility of Counselling if at all been practiced in these Homes. The following tables are emphasizing on these issues.

Table 7 : Professional counselling

Sl.. No.	Professional Counselling	Sex of the Respondents Male	Female	Total
1	Trained social worker	24	44	68
		8.5%	15.5%	23.9%
2	Not the professional but care takers listens to them & console them	45	60	105
		15.8%	21.6%	36.8%
3	Person from religious sect.	20	12	32
		7.0%	4.2%	11.3%
4	Psychologist	9	63	72
		3.2%	22.2%	25.4%
5	Not at all	25	29	54
		8.8%	10.2%	19.0%
	Total	103	181	284
		36.3%	63.7%	100.0%

36.8% respondents said no professional counseling is there. 23.9% having the facility of trained social worker but not fully utilized. Social worker is busy in taking care of day-to-day activities of

the Home. Whereas 25.4% get the facility of psychologist. These elderly belong to high income – Pay & Stay Homes. 19% inmates reflected the fact that "they are stay in the Homes not living". There is no human touch as such. The focus group discussions conducted in these Homes also put forth the fact that major reason of leaving their own people was that now they don't have time to listen to them. Now in Homes again they are living under loneliness and alienation. Most of the elderly want the facility of Counselling in Old Age Homes. They expect somebody to listen to them, as they want to release their pent-up emotions.

"Sari jindagi nekal di roji roti ke chakkar may.Bachhe kuch layak ban jaayen yahi socha tha.who to etne layak ban gayen ke hum unke layak nahi reh gaye" said mishra Ji 69Yrs. old widower. "Humne bachhon ko chalna sekhaya jena sekhaya ab jab who kuch ban gayen to hum unke status se mach nahe karte" said retired teacher from a govt. school,who lost her husband just 5yrs. after marriage. Only because of her children she sacrificed every thing in her life. what she says now is that 'her children have sacrificed her'.

Conclusion

The findings of this study clearly depict that the elderly living in Old Age Homes are not under good mental health. They are living there because they have no other choice. It is now the time that policy-makers reorient their views about the needs of older people living in Old Age Homes. Psychosocial dimensions not only have a direct bearing on the mental health of older persons, but they also indirectly influence all other realms of their lives as well. The need and effectiveness of counselling interventions in older people have been amply demonstrated, though they still need to be further researched and consolidated. In addition, counsellors, social workers and other mental health practitioners dealing with older people need to give up ageist attitudes and prejudices and put in their best efforts and resources to help older people help themselves. The well planned recreational facilities as well as socially and productive uses of these elderly people are the need of the hour. Only shelter and food is not going to serve the purpose. The need of the hour is that the govt. should make mandatory norm for the homes to have either trained social workers or counsellors who should work with each and every individual elderly with the help of different methods of social work.

While planning counselling for the elderly living in Old Age Homes, the following points need to be kept in mind: -

1. Older people generally suffer from problems that are multidimensional in nature, hence their psychosocial assessment should be comprehensive and counselling interventions should be integrative in nature.
2. Older clients often suffer from various sensory and cognitive deficiencies and, hence, extra efforts need to be made to put information across to them and to get them to adopt desirable behaviors.
3. In view of vast individual differences among older people, it is essential to tailor interventions in order to cater to the individual needs of each client.
4. In the field of psycho-geriatric counselling, creativity needs to be made the rule rather than the exception. Due to the severe dearth of research on this topic and the rarity of approaches dealing specifically with the elderly, the counsellor has to adapt and apply existing approaches to meet the needs of the elderly client or create newer techniques as and when required.

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Indian Journal of Gerontology
2008, Vol. 22, No. 2. pp 227 -232

Health Status of Institutionalized Elderly

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ABSTRACT

Elderly are recognised as distinct group all over the world. Health status of 500 institutionalized elderly was assessed. Data was collected by interviewing the subjects using an interview schedule. Results suggest that majority of selected elderly were suffering from health problems such as impairment in vision (61.6%), arthritis (47.0%), loss of memory (46.4%), insomnia (42.6%), headache (39.4%) and impairment in hearing (38.4%). Comparison of health problems between men and women indicates a significantly high prevalence of health problems in elderly women as compared to men. Prevalence of health problems such as constipation, insomnia, nocturia, arthritis, impairment in hearing and impairment in vision increased with advancement of age.

Keyword: Health problems, Institutionalized Elderly, Sex differences, Health Care

The aged or the elderly belong to post-mature group of adult population and can be recognised as distinct group all over the world (Thimmayamma, 1993). Elderly become more vulnerable to malnutrition and ill health due to economic dependency, social deprivation and change in the behavior towards diet and health care. Majority of the health problems among the aged are diet related and nutrition dependent. General undernutrition is a common problem in the elderly as they are at a risk of poor nutrition due to economic

pressures, poor dentition, reduced mobility, depression and inadequate food consumption (Srilakshmi, 2003). There is a greater susceptibility to infections among the elderly due to lowered immune functioning. Elderly are prone to degenerative diseases like arthritis, blindness due to cataract, hearing loss, dementia and slowing down of intellect. The combined effect of ageing, social changes and diseases leads to decline in health status of elderly. Hence, the present investigation was carried out to assess health status of selected institutionalized elderly.

Method

500 institutionalized elderly were selected from 19 old age homes of different regions of Marathwada (Maharastra state).

These subjects were interviewed individually to elicit information on commonly prevalent health problems such as anorexia, stomach pain, indigestion, constipation, loss of memory, insomnia, heart burn etc.

Statistical analysis of collected data was carried out after consolidation and computation to interpret the results and conclusions from the present study. The statistical significance between different parameters was determined by applying 'z' test (Panse and Sukhatme, 1957).

Results and Discussion

Health status of the institutionalized elderly was assessed in the present investigation. Prevalence of different health problems in the selected institutionalized elderly is presented in Table 1. Majority of the selected elderly complained of impairment in vision (61.6%) followed by arthritis (47%), loss of memory (46.4%), insomnia (42.6%), headache (39.4%) and impairment in hearing (38.4%). Constipation, anorexia, stomach pain, indigestion, nocturia and heart burn were reported by 20.8, 30.2, 27.8, 25.2, 26.2 and 28.2 per cent elderly respectively. Vasantha Devi and Premakumari (1998) also observed that cataract, hard of hearing, headache and constipation were major health problems prevalent among aged.

Table 1. Prevalence of various health problems among the selected institutionalized elderly

Health problems	Percent prevalence of health problems among institutionalized elderly (n=500)	
Anorexia	30.2	(151)
Stomach pain	27.8	(139)
Constipation	20.8	(104)
Indigestion	25.2	(126)
Loss of memory	46.4	(232)
Insomnia	42.6	(213)
Headache	39.4	(197)
Nocturia	26.2	(131)
Arthritis	47.0	(235)
Heart burn	28.2	(141)
Impairment in hearing	38.4	(192)
Impairment in vision	61.6	(308)

Figures in parenthesis indicate number of elderly
* Multiple responses

Table 2 explains prevalence of different health problems in the selected institutionalized elderly men and women. Impairment of vision was major health problem reported by high per cent of elderly men (64.06%) and women (59.47%) which was statistically at par in both sexes. Majority of elderly women suffered from arthritis (57.99%), headache (48.69%), anorexia (40.89%), stomach pain, (35.31%) heart burn (35.31%) and constipation (26.02%) which was statistically significant ($P<0.01$) as compared to their counterparts. Nocturia (31.16%) and impairment in hearing (44.15%) were more prevalent in elderly men which was statistically significant ($P<0.05$) as compared to elderly women. No significant difference in elderly men and women suffering from indigestion, loss of memory and insomnia was observed. Vasantha Devi and Premakumari (1998) while studying health problems of the aged observed that females were suffering more from health problems as compared to males.

Prevalence of different health problems in the selected institutionalized elderly in different age groups is presented in Table 3. Elderly subjects in different age groups suffering from impairment in hearing exhibited highly significant difference ($P<0.01$). Impairment in hearing increased with advancement of age, whereas headache

decreased with advancement of age. Elderly below 60 years of aged suffered more from headache as compared to other age groups. Nocturia (38.25%), loss of memory (55.03%), constipation (30.20%), insomnia (49.66%) and impairment in vision (77.18%) were more prevalent in elderly above 70 years aged as compared to other age groups which was statistically significant. Elderly below 60 years of age suffered more form anorexia (40.69%) and heart burn (30.23%). On the other hand health problems such as stomach pain, indigestion and arthritis were at par in all three age groups of elderly.

Table 2. Prevalence of various health problems among selected institutionalized elderly men and women

Health problems♦	Percent prevalence of health problems among selected institutionalized elderly men and women		'Z' value
	Men(n=231)	Women(n=269)	
Anorexia	17.74	40.89	5.92**
Stomach pain	19.04	35.31	4.17**
Constipation	14.71	26.02	3.19**
Indigestion	23.80	26.39	0.66 NS
Loss of memory	48.91	44.23	1.42 NS
Insomnia	41.99	43.12	0.25 NS
Headache	28.57	48.69	4.73**
Nocturia	31.16	21.93	2.33*
Arthritis	34.19	57.99	5.49**
Heart burn	19.91	35.31	3.92**
Impairment in hearing	44.15	33.45	2.45*
Impairment in vision	64.06	59.47	1.05 NS

** Significant at P<0.01 * Significant at P<0.05
NS Non significant ♦ Multiple responses

Table 3. Agewise prevalence of various health problems among selected institutionalized elderly

Health problems♦	Percent of selected institutionalized elderly subjects in different age groups			'Z' values		
	< 60 (n=86) A	60-70 (n=265) B	> 70 (n=149) C	A vs B	A vs C	B vs C
Anorexia	40.69	27.54	28.85	2.20*	1.83 NS	0.28 NS
Stomach pain	33.72	25.66	28.18	0.14 NS	0.88 NS	0.55 NS
Constipation	19.76	15.84	30.20	0.80 NS	1.83 NS	3.28 **
Indigestion	24.41	25.28	25.50	0.16 NS	0.18 NS	0.04 NS
Loss of memory	30.23	46.79	55.03	2.84**	3.86**	1.61 NS
Insomnia	34.88	41.13	49.66	1.04 NS	2.25*	1.67 NS
Headache	56.97	39.62	28.85	2.83**	4.32**	2.25*
Nocturia	16.27	22.64	38.25	1.34 NS	3.90**	3.30 **
Arthritis	41.86	44.90	53.69	0.49 NS	1.76 NS	1.72 NS
Heart burn	30.23	27.54	28.18	0.47 NS	0.33 NS	2.25*
Impairment in hearing	11.62	30.94	67.11	4.33**	10.73**	7.56 **
Impairment in vision	36.04	61.13	77.18	0.41 NS	6.62**	3.52 **

** Significant at P<0.01 * Significant at P<0.05
NS Non significant ♦ Multiple responses

Revanwar (2002) also observed that more people suffered with health problems as the age increased. Ensminger *et al.* (1994) stated that as individual becomes older and older, the loss of hearing, loss of memory increased because of the decreased activity of nerve cells, decreased brain mass and deposition of varying amount of age pigments which is associated with no formation of new cells.

Conclusion

It can be concluded that majority of elderly were suffering from health problems such as impairment in vision, arthritis, loss of memory, insomnia, headache, impairment in hearing and anorexia. Prevalence of health problems was significantly high in elderly women as compared to men. Prevalence of health problems increased with advancement in age.

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Indian Journal of Gerontology
2008, Vol. 22, No. 2. pp 233-234

A Note on Social Support as a Function of Life Satisfaction

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ABSTRACT

The present study aims at exploring the relationship between social support and life satisfaction among elderly people. Generally older people are seen as loosing interest in social interaction but simultaneously social support provides a buffer against stress in their lives, including the age related stress of retirement and bereavement. The sample consists of randomly selected 100 elderly above the age of 60 years. A scale of measuring social support by Sarason, Levin, Basham and Sarason (1983) and for measuring the life satisfaction, P.G.I Well-being scale by Moudgil, Verma, Kaur & Pal (1986) was used. Result indicates that there is significant positive correlation between social support and life satisfaction among elderly. It shows that elderly people who have more social support are more satisfied with their lives in comparison to those elderly who have less social support. It suggests that people who can identify several close friends or family members ith whom they can share their concerns freely, experience higher levels of wellbeing.

Key words : Social support, Life satisfaction, Elderly, Social interaction.

Life satisfaction among aged is an important concept that gives us over all view as to how the person is aging successfully. According to estimates by United Nations the projected population of India will be 1,445.6 million in 2025. This will be about 17.1% of the total world population at that time (Siddhu & Bargoti, 2003).The population of elderly in India in the year 2021 will be 137 million (Begda & Kanthoria, 2006), and hence the matter of life satisfaction of elderly

will be of more importance. Life satisfaction is accounted by many factors but the social support may be one of the most crucial determinant for life satisfaction in elderly life. Older people often feel alienated, neglected and marginalized and helpless. Many men and women in their old age 'feel lonely' even in the midst of people. They express that they do not have people with whom they can relate themselves to pour out their woes and get emotional support. As person grows older and older they gradually lose their cohorts and peers. The longer they live , the more the loss. People with high levels of social support may experience less stress when they confront a stressful experience and they may cope with it more successfully.

The present study tries to explore the relationship between social support and life satisfaction among elderly.It was hypothesised that there is no significant correlation between social support and life sastisfaction.

METHOD

Sample:

The sample consisted of randomly selected 100 elderly of 60 years and above from Dayalbagh area of Agra city. Individuals in this sample were at least class 10^{th} passed. Subjects were financially independent from their offsprings. Subjects were belonging to medium and high socio-economic status.

Design of study : Correlational design was used in this study.

Variables : (1) Social support
(2) Life Satisfaction

Measures :

(1) To measure the wellbeing of subjects *P.G.I Well Being Scale* by Moudgil, Verma Kaur and Pal (1986). Five more items were added to this scale from the Life Satisfaction Test constructed by Diener (1985) by the investigator to make it more comprehensive.

(2) *Social Support Scale* by Sarason, Levin, Basham & Sarason (1983)was used to measure the social support. This consists of 25 items. The intercorrelation among the various indexes of

availability or amount of support were generally high, most had correlations greater than 0.70.

After the collection of data correlation between P.G.I. Wellbeing scores and scores of Social Support Scale was found out.

RESULT AND INTERPRETATION

N	r	Level of significance
100	.28	P<.01

The r value of .28 (between the two variables) is significant at .o1 level. It shows that there is significant positive correlation between social support and life satisfaction. It means that those who are having high social support are more satisfied with their lives in old age. It indicates that social support is related to overall wellbeing because it provides positive affect, a sense of predictability and stability in one's life situation and a recognition of self worth. To the extent elderly perceive that others will support them and come to their rescue at the time of their need, they feel secured (Chaddha *et al*., 1990; Jamuna & Rammurty, 1991). Increasing mortality reduces the number of contemporary friends and kin such as siblings as well as spouses . This state may make them alienated and helpless but if they have strong social support, it may enhance their wellbeing. The social support net works of older adults may be viewed as patterns of continuous ties and interchanges of assistance that play a significant role in maintaining the psychological, social and physical integrity of old people over time (Cantor & Little,1985).

CONCLUSION

It can be concluded that social support plays a vital role in the life satisfaction of elderly. People may feel that they are people with whom they can share their feelings and demands and may rely on them. Social support is conceptualized as including both social embeddedness and emotional support that demonstrates to individuals that they are valued. Supportive interactions and the presence of supportive relationships in peoples' lives play a major role in their emotional wellbeing and physical health (Dalal,2001; Latha,1998; S.Sharma,1999).

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Indian Journal of Gerontology
2008, Vol. 22, No. 2. pp 237 -250

Old Age is not a Sickness

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ABSTRACT

Old age in Western society is defined as a social problem, and even defined as illness, or as an undesirable condition that through personal efforts can be deferred. People should be educated throughout their life to accept aging and to view it as part of the life cycle. Old age has a positive aspect which can be learned about from the literature. The elderly should view themselves in a positive light, and must feel vital, and that they contribute to their community, and society will also see them as such.

Key words: Old age, Productive, Literature, Positive light.

The meaning of old age

Aging is a biological, natural and universal process, which applies to any living creature. On the one hand, the attitude towards aging is highly subjective and depends on society and on personal needs. On the other hand, the attitude of the aged is related to his or her feelings of being productive, that s/he is needed, and the respect and treatment given by his or her family.

According to legends, books and films, every old person belongs to one of the prototypes characterizing this age group. Sometimes, s/he is rich and miserly, a tyrannical, wicked, bitter soul who estranges him/herself from his or her family, drives his or her workers crazy and threatens to exclude his or her family from his or her will. At other times, s/he is poor, lonely, neglected, homeless and penniless,

submerged in depression and longing for the family that abandoned him. In real life, an old person is first of all a human being.

A song by David Avidan reads:

An old man – what does he have in his life?
He wakes up in the morning, and sometimes not,
He drags himself to the kitchen, where
The tepid water will remind him,
That at his age, his age, his age,
An old man – what does he have in his mornings?

(Avidan, 1964)

As already said, an old man is not a character, but first of all a person. Usually, s/he is what s/he was all his or her life, only older, feebler, of poorer memory and slower in his or her movements. S/he cannot manage without his or her glasses, and it is difficult to run to catch the bus. Usually, the aging person does not change his or her character; the only difference is that some of his or her qualities are diminished while others become more salient. For example, a person who was always stringent will be excessively stringent when s/he is old; if temperamental, she/he will become more annoyed by every little thing, and so on.

The younger society tends to judge the old harshly and is not tolerant of their faults. What was once part of the person's personality becomes with age a dominant and irritating trait. In modern society, there is an inter-cultural phenomenon called "ageism". "Ageism" is a systematic process of creating stereotypes and discrimination against people on the basis of age. In this perception, old people stop being the people they were when they were young and are assigned to a different race (Bytheway, 1995). Geriatric experts say that every person has more than one age. It is customary to discriminate between four types of "age": chronological (years of life according to birth date), biological (the estimate of the years of life based on the physical buildup of the body), psychological (functional, expressing changing states of compatibility, such as memory, the ability to learn, energy and will power, refreshed feeling, flexibility and adjustment to changes) and social. Society expects people at a certain age to behave in a certain way: to study, to marry, to work, to become a grandparent,

etc. That is, at the certain age, certain events "should" take place in the person's life, which are appropriate to his or her age.

Usually, there is no overlap between the different types of age in the same person. She/he could be younger than the average in his or her psychological age, but older than the average in his or her social age. She/he could, at the age of 72, work from 6 in the morning to midnight and make crucial decisions. She/he could, at the age of 81, go bowling but not read, because she/he never remembers where she/he left his or her glasses.

Aging and old age

Aging and old age create problems for any aging person, and also for the individuals and the society among which she/he lives, eventually becoming a problem for society at large. The changes experienced by the aging person, such as decreased physical stamina, health problems, decreased libido, weakened sight and other senses, deteriorating memory and concentration and decreasing working ability cause tension in the life of the aging individual and may disrupt his or her relationships with his or her environment.

The problems of aging were exacerbated in the 20th century for two reasons:

a) The respected social position of the elders was undermined as a result of socio-economic developments, related to the processes of industrialization and urbanization and their influence, which were expressed by changes in the structure of the family and other traditional institutions.

b) The relative number of old people in society increased as a result of demographic developments.

Aging, in both physical and mental terms, is expressed in different people in different ways, depending on sociological and biographical factors. Although psychology has developed tests to identify and even measure the processes of mental deterioration that usually occur in old people, it is still impossible to know in advance how the individual will respond to the aging processes, which differ from one person to the next.

Aging is an inevitable mental process, the signs of which cover a wide area and begin to be apparent in the individual from the late

fifty's to the late sixty's of his or her life; in most cases, in the second half of the sixth decade. However, the time when they will appear in the individual cannot be accurately or clearly envisaged, because the phenomenon itself and its physical, social and mental are still not sufficiently known.

The appearance of mental aging and its intensity depend, first of all, on biological aging. However, mental factors play an important role as well, the most important of which is the individual's awareness of the aging process: "Man is old to the extent he considers himself to be old". The more the individual is troubled by the awareness that he or she is getting older, and the more s/he notices the signs of aging, the greater will be the anxiety it causes him or her, the faster will be his or her pace of aging, and the greater his or her willingness to give up life activities.

Most of the elderly are not engaged in professional work by the end of their sixth decade, and have plenty of time to reflect on their condition and notice the signs of aging. Retirement from work is actually a formal announcement of the entry into the old age, and might catalyze the awareness of being old.

Who is old?

The question we wish to consider here is: Who is actually an "old man or woman"? This question cannot be expected to have any one clear answer, since it depends on the specific approach guiding the person asking the question in the first place. The word "aged" can be defined in accurate chronological terms. The definition is then bureaucratic, reflecting the interest of the institution or of the authority responsible for the definition. For example, according to the National Insurance Institution, a man of 65 and a woman of 60 are old and are entitled to an old age pension. Here, being old is defined in terms of chronology and functioning, or, more accurately, lack of functioning, that is, the cessation of active work (Nizan, 1977). This definition provides a basis for a series of decisions of a legal and economic nature, such as those that concern the tax authorities, various discounts, services, etc.

The term "old" can be defined in terms of physiological changes. These include changes in the body posture, facial wrinkles, color and amount of hair, various physiological functions, acuity of the senses

and so on. In this respect, the level of general health is one of the criteria used for the definition of "old".

Since physical changes are reflected in behavior as well, the term "old" can be defined according to specific behaviors that are identified with old age: the phenomenon of forgetfulness, especially when accompanied by organic impairments, such as slower reactions, slower and less coordinated motor activity, changes in sleep habits and so on (Turner, 1995). Sometimes, ideologies and social perceptions define what is "old". Many stereotypes of old people present them as being conservative, hostile to the young, obsessed with religion and opposed to social change. "Old" can also be defined in terms of social functions: a person who has retired from work, one who lives in a protected residence ("golden home", "nursing home", etc.), or is a grandparent is thought of as "old" (Hazan, 1995).

These assumptions, too, are simplistic. There are many who either choose to take early retirement or are "pensioned off" by their employers while still in their fifties. Many people who are not old live in protected residences, including even children and youth. Today, it is not uncommon for a person to become a grandparent during his/her fourth decade of his/her life and people of 60 years and older attend educational institutions.

There is also a personal-subjective definition of age: I am as old as I feel, and according to my feeling I choose how to behave. When the chronological definition of age is used arbitrarily – age 65 and over – then this group includes hundreds of thousands of people, making it clear that this is a meaningless generalization in terms of anything but chronological age. This group includes people whose health is excellent and people who suffer from poor health; people with extremely high intellectual levels and those with senile dementia; those who are actively employed and those who do not work at all. Many people in this group continue to be active and involved in all fields of society, in the economy, in sports and in physical activity, as consumers of culture and art, in politics and in all fields of life. It is possible to reach old age and still be functioning normally, in good physical shape, with sharp senses and with a general feeling that is optimistic and positive.

In Israel, less than 5% of the people aged 65 and more are institutionalized. In addition to these, about 10% of the old people with different disabilities live in a protected community, so that about 85% of the population of 65 years old and older are defined as being independent.

It can be concluded that it is very difficult to rely on chronological age as a variable that defines being old. A person does not become "old" on his or her 65th birthday. Professor Marian Rabinowitz, in the book *The Age of Man*, writes: "Actually, such a thing called 'old age' does not exist" and it would not be accurate to call a person "old". Professor Rabinowitz has developed a theory that a person's "age" is judged by his/her capacity in at least six fields of performance: chronological, biological, cognitive, emotional, social and functional. These are a person's six "ages". Only a few people age uniformly over all six. He suggests abandoning the "young-old" dichotomy and considering instead "changes in compatibility" (Rabinowitz, 1985). The person's position on each of the six age curves indicates the level of his or her competence. Whether we accept Rabinowitz's theory or not, society has to change its attitude towards the aged, without ignoring the aging processes as these are expressed in terms of health and biology. The elderly person should be valued just as the young one is: according to his or her character, qualities, behavior and skills, and regardless of his or her age.

Old age is not a sickness

Old age in Western society is defined as a social problem, as a condition that should be fought against and postponed for as long as possible. Old age is even defined as illness, or as an undesirable condition that through personal efforts – changes in diet, in life style and in physical activity – can be deferred. Society allocates resources and attention to find new ways to combat old age and erase its external marks, those caused not by age-related diseases but by aging itself, such as wrinkling of the skin and uneven pigmentation. Commercial companies encourage consumers (mainly female) to devote huge financial and mental resources to staying young forever. People use linguistic terms to distance the aged. Old people are physically distanced, by being put away in institutions and special dwellings and by barriers which deny them entry to places because they cannot

afford to pay the entrance fee or cannot stand in line long enough or climb.

Many people are ashamed to admit how old they are, and to ask a person's age is taboo. The feeling is that we have to hide our age, as if aging were a shameful and malignant disease. The following paragraph clarifies this point:

> *Since our facelift a new chapter has opened in our lives. Now we love how we look and feel much better about ourselves. We have even started to appear in movies as actors and no one can guess how old we are.*
>
> *What can be said, life is smiling at us…*
>
> (Bodar & Bodar, 1999).

Society's attitude towards aging is shaped by the stereotyped characteristics of old age: disease, disability and deteriorated functioning. People tend to see the elderly as conservative, as people who are incapable of changing. They are physically ill, senile, unable to learn new things, depressed most of the time, lacking in libido, ugly, and unable to think and solve problems (Harrigan & Farmer, 1992).

Sickness in the sense of disability, invalidism or defect serves as a means to describe situations and dictate the passive or active coping strategies of the individual or of the general society. Sickness can be perceived in two contrasting ways: on the one hand, as a metaphor of social disorder and as a limitation, and on the other as a virtue. A society comprises a collection of individuals, each having his/her own character and particular way of behaving. This individuality is expressed in variety, in being special and in coping or not coping with the self and with the society of which he/she is a part. Society is capable of accepting the "other", in this case the aged, or it can stigmatize him/her, depending on its condition and on the individual's condition. The analysis of the individual means the analysis of his or her personal state and perception of him/herself in relation to his or her surrounding society. Studies indicate that the self-image of old people is projected on society. Old people having a good self-image will be perceived as such by the society in which they live, while those who feel sorry for themselves will be seen as pitiful.

Analysis of the society's moral attitude to the aged means how it treats them, with all that that implies, both social and mental. Is society's attitude towards the aged cold and alienating, manifested by rejection and non-acceptance, or, is the society open and willing to accept the aged, to reach out to him/her and treat him/her with patience, tolerance and as an equal? Sickness can serve as a metaphor for the social, political, national or moral state of society. Since the 19th century, the term "sickness" has been used to describe a state of disorder or "any state that is disrupting" (Sontage, 1977). In addition, in 1920, communism was condemned as follows: "Communism is the evil of the bureaucratic cancer, that has always destroyed humanity. A German cancer, the outcome of the German obsessive character. Any pedant preparation is anti-human" (Sontag, 1977). These words imply a metaphoric description of sickness, in which communism is perceived as the cause of oppression and destruction of the humanity. Sickness is used to describe a state of disorder while Machiavelli, whose words appear also in Sontag (1977), is using a metaphor of a curable disease. "In the beginning, consumption is easy to cure and difficult to understand; but if not detected on time, and not treated according to the suitable principle, it is easy to understand but difficult to cure. The same it true of state affairs. If it is envisaged in advance from a distance (which can be done only by the talented), the evils emerging from them can be cured at once. However, if, because of lack of foresight, they are allowed to grow to such an extent that anyone can notice them, there is no cure. Machiavelli presents consumption as a disease whose development can be arrested if it is detected early enough. With foresight, it is possible to prevent the disease, and the same is true concerning impairments in the political body. He suggests a metaphor of a disease which relates less to society and more to statesmanship (which is perceived as the art of prevention): just as wisdom is necessary to stop serious illnesses, a need exists for foresight to prevent social crises".

If the authorities provide for the aged from the health, social, moral and occupational perspectives, and see them as equals, the self-image of the aged themselves will improve. They will feel wanted, loved, productive, contributing and not alienated.

The positive side of old age

Old age has a positive aspect, which can be learned about from the literature. To demonstrate this point, I will present the story of Rabbi Nahman of Braslav "A Story about Seven Beggars" (Dan, 1975). The story is about the marriage of two young people who as children had wandered in the forest and met seven crippled beggars who helped them. The beggars came to their wedding and brought with them gifts. The defects of the beggars are their virtues. For example, the blind one had good inner sight and saw reality from beginning to end with one glance. Another beggar stammered and therefore sang well. The one-armed beggar knew how to stretch a bow and the seventh beggar, who had no legs and whose story is not told (because it belonged to the counting of salvation), worked well. The first beggar, the blind one, bestowed his virtue, i.e., blindness in the sense of sobriety and longevity, as a wedding gift, from which it seemed that the disability is perceived as a positive attribute that could contribute and give both to the giver and to the receiver, as we have seen in places where the aged is valued as a wise and experienced person.

Reading the Bible in search of support for praising disability, one finds in the book of Exodus (Ch. 3, v. 5) God's revelation to Moses in the burning bush: "And God called unto him out of the midst of the bush, and said, Moses, Moses. And he said, "Here *am* I". At this stage God commands Moses to free the Jewish people from its enslavement in Egypt. Moses is delayed on the task and at a certain point says: "O my Lord, I *am* not eloquent, neither heretofore, nor since thou hast spoken unto thy servant: but I *am* slow of speech, and of a slow tongue" (Exodus, Ch. 4, v. 6). The rabbinical tradition interprets this as saying that Moses suffered from a speech impediment, the result of the blow he had suffered in his childhood. Moses answers that he is unable to do what God expects of him, because he is disabled. In response, God answers: "Who hath made man's mouth or who maketh the dumb, or the deaf, or the seeing, or the blind? Have not I the LORD?" (Exodus, Ch. 4, v. 11). Continuous protests on Moses part cause God to suggest that Aaron, Moses' brother, serve as his voice. Moses has to transmit the words of God and it is Aaron who actually delivers them. In this case, the disability is not perceived as a punishment of God or as a heavy burden for a brave man to carry, nor

does this concern a God who creates people with defects as a result of his limited powers. The conversation between Moses and Aaron indicates that disability should not prevent the person from making his or her unique contribution to humanity. On the contrary, God is trying to help Moses discuss the arrangements that will help him succeed in his life mission. Moses refuses to accept the role of the leader because: "I am not a man of words". Deuteronomy, however, begins with the words: "These *be* the words which Moses spake unto all Israel" (Deuteronomy, Ch. 1, v. 1). With this deed, Moses has achieved spiritual fulfillment in the field in which he has defined himself as a cripple.

Finally, let us remember the event in which God told Moses: "for the place whereon thou standest *is* holy ground" (Exodus, Ch. 3, v. 5). Not only is Moses standing on holy ground, but also anywhere we stand is our holy ground. This is where God has put us and this is where He wants us to be at this moment. It can be concluded that one's holy ground is different from that of one's neighbour, and if God has put one here, this is where one has the opportunity to struggle and grow and turn one's disability into a virtue, for one's own sake and for the sake of one's surrounding environment.

If the definition of aging is considered to be a disabling illness, or a "disorder" and a "lack of balance", the same attitude as is presented in the Bible should be applied to the aged and the understanding of the meaning of these terms for both the individual and the society. The individual is the mirror of society and part of it. If s/he differs from it in certain ways, it reflects, of course on his or her social relations in terms of acceptance, help, rejection or ridicule by his or her surroundings.

Leisure in old age

As mentioned earlier, a person should be productive at any age, and specially when he is retired and has leisure time. Leisure is the time at the individual's disposal, when s/he is free of work and other activities required for daily living. It is accompanied by a feeling of freedom and related to cultural values. Work and leisure comprise the elements of daily functioning of most people. In defining leisure, it also possible to consider a continuum, one of the poles of which is pure leisure and the other quasi-work leisure. Pure leisure is an activity

or a situation that has one or more of the following characteristics: the activity is selected out of a feeling of freedom; inner motivation; the activity is a goal, not a means. Conversely, leisure-work is an activity or state that has one or more of the following characteristics: the activity is not selected out of a feeling of freedom but out of a sense of commitment; external motivation; the activity is a means to attain or realize a certain desire.

An occupation defined as work for one person could be the other's leisure. The subjective dimension of leisure allows a distinction to be made between the two on the basis of the idea that leisure is everything that the individual defines as leisure.

A historic review highlights the relation between leisure, work, religion and the establishment. The more puritan the society and the more dominated by religion, the more work is accorded supreme importance and leisure is perceived as a low-status value. Conversely, the more liberal and democratic the society, the more value and significance it gives to leisure.

The perception of leisure in old age has been developed in the modern Western world. In the past, the old were seen as respectable and adored family members who, when they could no longer continue with their physical work, took care of their grandchildren. At that time, old age was perceived as another stage of work in which other roles are adopted, not as a stage in life that allowed the person to avail himself of a variety of activities (Markus, 2000).

Today, with retirement from the cycle of work, after a long pursuit of leisure time for desired activities and/or rest and relaxation, the old person is left with plenty of free time. In old age, this free time means the time left as a result of retirement and the children having left the house, after fulfilling basic daily tasks (Wacker, Roberto & Piper, 1998).

Leisure as a mental state in old age

The importance of leisure in modern society is increasing the more people are in control of their time, and the more the traditional boundaries of leisure become blurred. Modern society has changed beyond recognition the time allocation of the individual, allowing more time for leisure activities. Technical and scientific developments,

the shortening of working hours, the limitations on the age of starting to work, retirement and pension laws, the prolongation of life expectancy and the search for sources of pleasure and entertainment are some of the factors which acknowledge and validate the importance of leisure in Western society. Moreover, despite social mobility and globalization, significant differences still exist between groups, communities and social strata, creating sub-cultures within the general culture and variety in the patterns of modern leisure.

In light of this, a broader approach to leisure is developing, which no longer settles for considering leisure only (the time free from the pursuit of existential needs), but considers the total life quality of the individual, who lives in an environment that is characterized by accelerated processes of technological progress and a borderless world. This creates plenty of stimuli and opportunities to use spare time for personal development and to realize one's potential.

Leisure and a life of leisure are one of the goals pursued by people in the modern era. Being free from the burden of work, doing what the heart wants and investing time in satisfying activity is a normal objective. To live and act according to the subjective perception is a major concern of the Western society.

Aristotle considered leisure as a state in which activity takes place for its own sake and this is actually the classing aspect of leisure (Weinblatt, 2000). We use the term leisure in three meanings:

A. Free time: the time that is at our disposal after fulfilling our duties at work and in the household and after we have satisfied our basic needs for survival, such as sleep and food. The spare time can be at the end of the day, the week or after retirement. Leisure is free time, in which we are allowed to do whatever we want.

B. Leisure activity: activities defined in a certain culture as leisure activities. For example, in our culture, activities in the field of art such as painting, social activities such as family visiting, physical activities such as sports, and intellectual activities such as studies.

C. A mental state of enjoyment from the activity, a feeling of self-enrichment and relief resulting from the fact that the person engaged in the activity is doing it from his/her personal choice.

The two first definitions, the objective ones, contrast leisure with work in terms of time or of content. The third definition adds the qualitative dimension and the meaning of leisure in terms of the individual, thus shedding some light on the multi-dimensionality of the leisure issue in retirement, since plenty of free time may lead to a feeling of boredom and depression if not filled with enjoyable content, while work can provide possibilities of creativity, enjoyment, friendship and other experiences that characterize leisure.

When people are still working, leisure plays a marginal role in their lives, but with their retirement, the role that leisure plays in the life of a person changes as follows:

A. In the absence of work, various occupations that are not work fill the time.

B. The different activities structure the individual's time, creating a new routine. Creating regularity, such as, for example, swimming every morning, participating in artistic groups on different days, a family outing at the weekend, create a distinction between morning and evening, between weekdays and weekends, and between certain days in the week, and prevent the feeling that each day is similar to the next and that time is uniform and continuous.

C. The field of leisure presents also new challenges to activity and social involvement for people what were previously immersed in their work.

D. Being active in leisure activities creates a buffer zone between the pensioner and aging and prevents him/her from being pushed into the margins of society. The image of old age in our consciousness is associated with passivity and inactivity. If the pensioner "proves" to society and to himself that s/he is still active, s/he will not enter the "old age" category. The pensioner no longer works, and because of this is perceived as someone who is no longer productive (it is known that productivity is a major value of our culture). However, if s/he will prove again to society and to him/herself that s/he is busy in non-work activities, and preferably become very busy, s/he will be then "forgiven" for leaving the circle of work and will retain his/her social recognition. Often, it is possible to find pensioners who, in

response to the question: “How are you? What are you doing these days?” Answer: “I’m so busy now that I don’t know how I had time for work earlier”. In many cases, the answer reflects the way in which the respondent wishes to present himself in the eyes of the listener (active, busy, as in middle-age), not necessarily factual truth.

As we have noted, leisure as a mental state is a perspective based on the assumption that when a person is busy in a leisure activity, s/he feels relief, enjoyment, self-expression and self-enrichment. The person who is engaged in leisure activities is aware that s/he is doing so out of personal choice and for reasons that are related to the experience of the activity, not for achieving any other goal.

Maimonides wrote on this subject: “If a person is deeply depressed, he can relieve the depression by listening to songs and other music and by taking a walk on the roofs and through luxurious buildings with nice shapes and so on, things that lift the spirit and remove boredom and depression” (the Introduction to Aboth Tractate, Talmud, Fifth Chapter). That is, if a person feels depressed, s/he can take a break from his or her studies and listen to music, take a stroll in the garden or go to a museum and look at the works of arts.

Being a doctor, Maimonides knew that the beauty of nature and art have a calming effect on the person’s mind and therefore recommended it, not as having value in its own right, but for its curative powers. He also gave permission to hold conversations, to tell stories and sing songs, on condition that they teach good virtues, and on condition that they are included among the five types of speech defined as “speech that is removed and serious”, intended to “encourage the soul with speeches and songs”.

Clarifying the different aspects of leisure shows that work and leisure are not necessarily two contrasting phenomena. The aim is to view leisure as a rehabilitative means and as a cure for a low mental state, the answer to which is to be willing to do things and to be constantly curious, not accepting things at face value, but looking for new angles of vision. People can live in different ways and express themselves creatively, such as, for example, through music, art, movement and drama, and reach quality of life and self-fulfillment.

The words of several elderly people who participated in workshops at the Elderly Center in Kiryat Tivon can clarify the meaning of creativity and pleasure:

It gives me a sense of accomplishment. It's very relaxing. It helps me to recognize beauty. I am able to transfer onto paper and canvas the things I see that are beautiful. To be able to express myself at this point in life is very rewarding.

It means educational and creative growth. It means new friends, new ideas and ways of thinking. It opened up my spiritual side more than ever before. Even on days when I don't feel like painting… this was the place I wanted to be and I felt comfortable and part of the group.

The goals of the third age activities are to help people fill their time, helping them to realize the potential inherent in them, while considering their needs and aspirations. The role of the coordinators dealing with developing programs for leisure time and work as consultants is to help members of the third age consolidate patterns of time spending, choosing activities and structuring a suitable mixture of activities for each individual (Ronen, 1999). The goal is to achieve a quality of life at an optimal level, which is the core of the rehabilitative perception in modern life.

Leisure activities

The attitude towards leisure in the third age has to be based on the assumption that it is never too late and that a person develops throughout his or her life. There are many examples of this. Kato, the Roman elder began learning Greek at the age of 80 and Rabbi Akiva began to learn how to read and write at the age of 40 (Ronen, 1999).

A study conducted in 1997 found that aging people aged 67-78 prefer non-isolated activities. Women, contrary to men, prefer activities that involve direct interaction with others. The better educated the elder is and the more financially independent, the higher is the level of his or her activity, the more varied are his or her activities and the more his or her preferences concentrate on the area of outdoor social activities (School-Bacon, 1997).

The Prussian Chancellor, Otto Bismarck, set the age of retirement, 110 years ago, at 65 years. The increase in life expectancy

has pushed back the old age period, and as a result, the life period following the formal age of retirement is longer than before. This fact has serious actuary implications on pension funds, on the labor force, on the pensioners' position and on leisure.

When the trade unions won the right of retirement for male workers at age 65 and for female workers at age 60, the average life expectancy was 67 years, and it was believed that people deserve to rest in the last two-three years of their life. In the last century, life expectancy has risen in the developed countries by ten years. At the same time, due to the high standard of living, the elderly have managed to retain their physical and mental stamina (their psychological and biological age is less than their chronological age).

In many cases, retirement is perceived no longer as a right but as a punishment. For many, retirement signals the beginning of deterioration and the feeling that they are no longer needed. Society finds it difficult to cope with the problems of the aged. Geriatric experts maintain that the problem is only that of the society. The older population is swelling, demanding more resources, while the average age of the world population is increasing.

The Importance of Creativity

The following story will clarify the importance of productivity for the individual and for society.

The secret of long and happy life

The traditional Jewish blessing "May you live to be a hundred and twenty" (unknown source) is no longer valid these days. Some researchers claim that in certain regions of the world, people live up to a hundred and thirty years, not all of them, of course, but some of them. One of the researches who has investigated the subject thoroughly is Dr. Alexander Leaf, who spent his sabbatical leave in three parts of the world, whose inhabitants excel in their longevity: the republic of Azerbaijan in the Caucus (the Former Soviet Union); the Honza region in Pakistan and the Wilkambra region in the Peruvian Andes. What is common to these three regions is that they are mountainous and are located high above the sea level.

Dr. Leaf interviewed hundreds of old people and their relatives in these regions, examined their birth certificate, the periods in which

they were born and the historical occurrences that took place in these times (in some cases, the old people were born in the 70's and 80's of the 19th century). He claims that his findings are reliable and sound. Other researchers have examined Dr. Leaf's data and his considerations and have fully approved his conclusions. What is the secret of the longevity of the dwellers in these three regions?

Environmental conditions: clean mountain air, not like the city air in the developed world (and in recent years in the developing world as well), which is polluted with gas emissions and car exhaust, machines and all kinds of garbage. Living in these regions is not easy, but it is healthy. They have to exert themselves every day climbing up and down the mountainous slopes. Therefore they continuously exercise all their muscles, including the heart muscle.

The inhabitants cultivate the gardens by their houses, almost everyone having a small vegetable garden, fruit trees and flowers by their homes. Working in the garden has been known for generations to strengthen the body, being both healthy and enjoyable, and a healthy mind, as is well known, adds to the health of the body. Their diet includes lots of natural food, especially fruit and vegetables. On the other hand, it is very low on animal fats and on sugar, in its various forms. The residents are not fat and the calcium level in their body is optimal. Most of them do not smoke and do not consume alcohol.

The elderly spend their time in the bosom of their family, contrary to many elders in the world who are lonely and neglected. They are useful to their families and contribute from their long life experience, from their wisdom and industriousness. Even widows and widowers are not lonely. Last but not least, and this is perhaps the most important factor, the old people of Azerbaijan, in the Honza areas and in the Wilkambra region are respected by their communities, where they serve as advisors and mediators.

Summary

People should be educated throughout their life to accept aging and view it as part of the life cycle. It should not be feared, but on the contrary, people have to keep busy in terms of work, studies, maintaining relations with family members and so on. Thus the possibility of a large vacuum being created in their daily routine that cannot be filled is not actualized. Many claim that retirement has

affected their health. However, studies indicate that there is no evidence supporting the claim that retirement affects health, although it is undoubtedly accompanied by pressures, especially if not entered into willingly. Not all celebrate their retirement from work, although this too is a beginning of something new, of another stage in life. The years of retirement are not necessarily a bad thing, and there are ways of turning them into something that is very positive. However, the help of the aged themselves and of society at large is needed to bring this about.

If the elderly view themselves in a positive light and they feel vital and that they contribute to their community, society will also see them as such. Once a person feels that s/he is no longer needed and that his or her opinion in no longer considered, s/he feels himself rejected and his or her self-esteem is affected. When a person presents him/herself as such in society, this is the impression s/he gives and s/he is treated accordingly.

My assumption is that the busier the person is, the better will be his or her mental state, and as a result, physical state. A bored person sits at home in idleness, immersed in his or her own depression and self-pity. Hence, it seems that willpower assists in physical and mental recuperation. This is the place to present the words of Arthur Schopenhauer, a German philosopher of the 19th century, who said that with the help of willpower it is possible to fight diseases (Sontag, 1977). In this case, while the fact of aging has be accepted, at the same time it must be "fought" and made more pleasant for the individual and for society.

Here, on the one hand, I see our role as a society as being to educate the aged to accept old age and to live their lives to the full, and to improve the image of the old in their own eyes. On the other hand, it is our role to educate the youth to respect the aged through appropriate programs.

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Book Review

Housing for the Elderly : Policy and Practice Issues**,** edited by Philip McCallion. The Haworth Press, Inc. New York, 2007. 260 pages.

The fast changing demographic profile of the societies is throwing up several challenges. One challenge relates to the growing number of the elderly population. With increasing longevity, reduced mortality and better health services, the number of elderly people is increasing, and in the near future their numbers are likely to increase dramatically. With limited living space and changing family patterns in favour of nuclear families, one of the serious emerging problems is that of housing for the elderly. The present volume deals with this problem. Although the book deals with the problem in USA and Canada (with one chapter on Puerto Rican population in USA), the issues discussed are quite relevant for other societies also.

The book emphasizes the interaction of responsibility at the individual and the societal levels. A large number of scholars have contributed significant papers on several aspects of the problem. The volume contains 13 chapters, mainly in two parts. The first part has ten chapters, four defining the context of preparing for the aging society, and the issues of the poor and homeless elders, three focus on the implications of the Olmstead decision of the Supreme Court of USA, and three discuss the evolution and the current status of the phenomenon of Naturally Occurring Retirement Communities (NORCs). The second part discusses two areas: Housing outcomes and historical understanding of the housing issues for the elderly.

The first chapter defines the context in terms of creating “elder-friendly communities” that actively involve, value, and support older adults, both active and frail, with infrastructure and services that effectively accommodate their changing needs. The chapter besides reviewing the available literature reports results of a Delphi study identifying the most important characteristics of an elder-friendly community, accessible and affordable transportation, housing, health care, safety, and community involvement opportunities. The second chapter compares recent older homeless with long-term older homeless adults in Toronto according to their health and wealth, their housing history, and their use of health and social services. Findings indicate that people who become homeless for the first time at older ages have needs that are different from the lifetime elderly homeless and require different approaches of intervention. Another chapter

examines the impact of housing disparities, health status, and cultural patterns of caregiving in relation to older Puerto Ricans on the U.S. mainland, making policy recommendations to advance adequate housing options for this population. Another chapter has made recommendations for social workers and grandparent caregivers to lobby legislators for increases in funding for programmes to ensure that all grandparent families have safe, affordable and accessible housing.

In 1999 the Supreme Court of USA, in a case Olmstead v. LC ex. Rel .Zimring, held that unnecessary institutionalization of people with disabilities is discrimination and violates the Americans with Disabilities Act (ADA). Three chapters are devoted to the implications of the Olmstead decision for the frail older person. One chapter examines how frail older people may be included in the ADA's definition of persons with disabilities with the implications for long-term care as it relates to housing for them. Another chapter reviews the components of the decision and steps being taken by the federal and state governments to address its challenges and mandates, suggesting a number of key areas where social workers can play important roles. Another chapter discusses the national implementation of the Olmstead decision. The states differ tremendously in what they have accomplished in the years since the decision. As of December 2002, 43 states had initiated Olmstead task forces. Twenty-nine states had developed comprehensive Olmstead Plans or Reports as of June 2004. One chapter is mainly focused on the roles social workers can play in both policy implementation and advocacy for persons with disabilities. These include (1) interpreting the Olmstead decision through the political process, (2) attaining true integration of ser- vices, (3) reducing fragmentation of services, (4) transitioning people from institutions into the community, (5) assuring funding for individuals during transitions, (6) creating assessment tools, (7) addressing workforce issues, (8) balancing community and institutions, (9) promoting quality, (10) forging collaboration, (11) securing state-level funding, and (12) engaging in public advocacy. As key players in the service system, social workers can play a pivotal role in informing policy makers about court-imposed time limits, and how best to structure an effective plan.

The second part discusses Naturally Occurring Retirement Communities (NORCs), which provide unique settings for the delivery of a variety of supportive services to the elderly. One chapter discusses New York State's experience with the development of supportive service programmes within NORCs providing valuable information for community planners and practitioners in terms of factors that contribute to the evolution and shaping of service programmes and lessons learned from existing programmes. Another chapter draws on the work of the Housing Plus Services committee of the National Low Income Housing Coalition, constituted in 2000. The Committee is comprised of a diverse group of practitioners, administrators, policy analysts, professors, and researchers who share a commitment to the integration of services in housing settings. The chapter reports their work, including the typology and principles and dissemination of the findings.

Most older adults prefer to live at home as long as possible, requiring supports and services to help them age in place. One chapter examines the relocation concerns of a group of older adults in a suburban naturally-occurring retirement community (NORC). Twenty-six percent of the 324 residents interviewed expressed concern about having to move in the next few years. Residents who were worried differed from those who did not worry on a number of demographic and bio-psychosocial characteristics. Overall, residents present a profile of vulnerability that calls for preemptive action to help them stay in their homes.

Assisted living facilities have become increasingly popular for older adults needing assistance. They are intended to enable privacy and provide support, but the extent to which they do so, and the degree to which these relate to residents' needs, are unknown. One chapter reports a study of 1830 residents in 182 facilities indicating that, during the mid-afternoon, the majority of residents are awake (79%), and one-half (49%) are awake and in public spaces. Residents who are cognitively and functionally impaired are more likely to be in public spaces, but less likely to be engaged. Residents who are awake and alone in private spaces are less likely to be impaired, but more likely to life more positively once moved from a nursing home to an assisted living facility using Medicaid funds. Results of this exploratory study are promising and suggest that having housing options available across

the continuum of care with individualized case management offers older adults the hope for "quality living."

The final chapter of the volume, using an historical approach to document the importance of early housing and self-help initiatives in the African American community, focuses on the important contributions the venerable Harriet Tubman made to the field of housing for older persons and other populations at risk. It lauds Harriet Tubman and other early housers for their good works and acknowledges them as contributors to the rich legacy of community social work practice and its sage principles of empowerment and self-help.

On the whole, the present volume has made useful contributions, stimulating attention to diverse issues, relevant for all societies, as they encounter the emerging problems of housing for the older population.

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Charting a Course for High Quality Care Transitions (edited by) A. Coleman MD, MPH The Haworth Press, 1He 10 Alice Street Bunghamton NY 13904-1580. www Haworth Press Com.

The book is a valuable material for nurses working in hospital set up or home care providers. It is a significant contribution in the field of nursing. The book contains 8 paper written by different authors and introduction is given by Marian Essey, RN, BSN, Director, Home Health Quality Improvement Organization Support Center, Quality Insights of Pennsylvania, Penn Center West, Bldg-2 Suite 220 Pittsburgh, U.S.A.

The book illustrates discharge planning, transitional care, coordinating care and continuity of care. It also clarifies concepts and conceptual model. For example, continuity of care focused by Mc Bryde Foster *et al.*(2005) on continuum of care as a Summative entity whereas the author makes it clear on transitional points. He further makes it clear that the planning is for quality health outcomes and it will be a guide for research.

In the second paper the authors emphasise on development and testing of an analytic model to identify home health care patients at risk for hospitalization within the first 60 days of care.

In this paper Robert J. Rosate Ph.D. Liping Huand, MA explored those factors which place, patients at risk at the start of care and one predictive over the first 60 days of care. Outcome assessment set, plan of care, medication and medical record information from an urban home health agency were used to validate a predective hospitalization model. The results of this study provide insights into the factors that could be used to identify patients who are at risk for hospitalization and this leads to future study scope.

The third paper deals with rehospitalization for patients with complicated transactions in the just 30 days after hospital discharge for acute stroke. Amy J.H. Kind MD *et al.* showed that infections and aspiration pneumonitis were the most common reasons for rehospitalization in stroke patients. The authors further add that prevention efforts specially targeting population at high risk for complications of immobility if skilled nursing given, it many prove extremely valuable in decreasing bounce back in stoke patients, prevention of recurrent stroke provides way to decrease house back

stroke number and this can help prevent death occurring in the first 30 days.

The fourth paper is written by D. Maylor Ph.D., R.M. et al. classifies the need for care co-ordination for cognitively impaired older adults and their care givers. Dementia and deliriums the most common causes of cognitive impairment among hospitalized older adults are associated with mortality high rates. This explains the need for improved transitional care for suth patients.

The fifth paper by Pamela Parson Ph. D. RM and Pater A. Boiling, MD in residential care settings. In this the authors found significant differences between categories and between facilities within categories (P<.001). The marked variation in emergency transport rate within a given facility type suggests that care process or resident characteristics may differ between sites and the size of the differences shows potential issues of care quality. They are of opinion that there is a need for standardization of transfer processes from one setting and another.

The sixth paper by Eric A colemen MD *et al.,* clearly explains the control role of Performance measurement in improvmg the quality of transitional care. These include health plans, hospitals, home health agenesis, Quality improvement organizations government organizations, researchers and policy makers. WHO is sponsoring a hospital Quality improvement project to demonstrate care transition measures (CTM) to identify care deficiency areas. The study was conducted to find out deficiency areas, remedies for deficiencies and to assets the impact of Quality improvement. At the end of the study it was clean that CTM is an important tool for assessing performance, CTM is patient centered and well accepted by the patients.

Seventh paper by Patriera Simuio Boyle RM, MA Ph.D. and Penny Hollander Feldman, Ph.D. discusses about reducing acute care hospital hospitalization (Re ACH). It is a collaborative hearing model for patients in home care settings aiming to reduce hospitalization to 23 per cent. This article reports on the early implementation experience of a sample of 17 of 65 home health agencies participating in Re ACH. They say that only Time will tell how effective is the implemation of the collaborative model. They are of opinion that the complementation of their model will reduce in patient hospitalization,

which is a function of many complicated factors both within and outside the control of home care provides.

The eighth and the last paper deals with the policy agenda for Transitions from Nursing Home to Home by Peter A Boiling MD and Pamela Parsons. Ph.D., RN. This paper reviews pertinent published data and health services research as background information and outlines a research agenda for studying important transitions. Research agenda can make positive steps toward improving quality in health transition for the future generation.

The author has listed in each paper the key words and very rich bibliography alphabetically.

I recommend this book for Medial & Nursing college libraries.

Dr. Vimal Agrawal, Ph.D.
Former Principal
Government Nursing College
JLN Marg, Jaipur 302004

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Books Received for Review :

1. **The Alzheimer's Action Plan** by P. Murali Doraiswamy, M.D. Chief of Biological Psychiatry, Duke University Medical Center, USA
   & Lisa P. Guyther, M.S.W., Duke University Centre for Ageing, U.S.A.
2. **The Abuse of Older Men** by Jordani Kosberg, Ph.D. (Editor), The Haworth Maltreatment & Trauma Press, 10 Alice Street, Birghamton, NY, USA.
3. **A Journey Called Aging : Challenges and Opportunities in Older Adulthood** by James C. Fisher, Ph.D. & Henry C. Simmons, Ph.D., The Haworth Press, Taylor & Francis Group, New York, London.
4. **Gerontological Supervision - A Social Work Perspective in Case Management and Direct Care** by Ann Burack - Weiss & Frances Coyle Brennan, The Haworth Press, New York.
5. **Discourse on Aging and Dying**, Edited by Suhita Chopra Chatterjee, Priyadarshi Patnaik & Vijayaraghavan M. Chariar, www.sagepublications.com.
6. **Aging in Contemporary Canada**, edited by Neena Chappell, Lynn McDonald and Michael Stones, Pearson Prentice Hall, Canada.
7. **Geriatric Psychiatry Basics** by Kenneth Sakauye, M.D., W.W. Nortan & Company, Inc. New York & London, 2008, $ 27.95.

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