Vol XXVIII No. III & IV

ISSN - 0971-8060

Jul - Sep., 2018
Oct - Dec., 2018

AGEING & SOCIETY

THE INDIAN JOURNAL OF GERONTOLOGY

PUBLISHED BY

CALCUTTA METROPOLITAN INSTITUTE
OF GERONTOLOGY

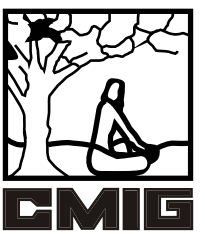
Vol XXVIII No. III & IV

ISSN - 0971-8060

Jul - Sep., 2018
Oct - Dec., 2018

AGEING & SOCIETY

THE INDIAN JOURNAL OF GERONTOLOGY



PUBLISHED BY

CALCUTTA METROPOLITAN INSTITUTE OF GERONTOLOGY

AGEING & SOCIETY
THE INDIAN JOURNAL OF GERONTOLOGY

ISSN - 0971-8060

SUBSCRIPTION RATES

Indian (₹):

Institutional- ₹100.00
Individual- ₹ 80.00

Foreign ($):

Institutional- $ 35.00
Individual- $ 35.00

Subscription should be sent to :

The Secretary
Calcutta Metropolitan Institute of Gerontology
E/1, Sopan Kutir, 53B, Dr. S. C. Banerjee Road, Kolkata - 700 010
Phone : 2370-1437, 23711437
e-mail : cmig@rediffmail.com
Web : www.cmig.in

Printed by	:	Dr. Indrani Chakravarty
Published by	:	Dr. Indrani Chakravarty
Name of Owner	:	Calcutta Metropolitan Institute of Gerontology
Name of Printer	:	Swanris, P-19, Raja Rajkrishna Street, Kolkata-700006
Published at	:	E-1, SOPAN KUTIR, 53B, DR. S. C. Banerjee Road, Kolkata-700 010

ISSN - 0971-8060

AGEING & SOCIETY

THE INDIAN JOURNAL OF GERONTOLOGY

Vol XXVIII No. III & IV

Jul - Sep., 2018
Oct - Dec., 2018

CONTENTS

THIS JOURNAL PUBLISHED REFERRED ARTICLES ONLY

AGEING & SOCIETY : THE INDIAN JOURNAL OF GERONTOLOGY

Editorial Board

This Journal will be devoted to papers on the following aspect of human ageing

- ★ Social Gerontology
- ★ Biology
- ★ Medicine
- ★ Behavioural Science

In addition we welcome Abstracts, Book reviews & Interviews with senior citizens

CRITICAL ISSUES IN GERONTOLOGY THE CASE OF USA

Phoebe S. Liebig *

ABSTRACT

Critical issues in aging in the United States closely resemble those in India. However, despite similar problems, the ways in which these challenges are met are different due to historical, political, economic and cultural differences. The major issues facing both the United States and India as aging societies include income, especially for older women, and supporting family caregiving. Other crucial issues in America include employment of older workers, costs and availability of health care/long-term care, and housing combined with services for low and moderate-income elders. However, due to space constraints, these three other issues will not be examined.

** Ph. D, Associate Professor of Gerontology,*
University of Southern California and Fulbright Senior Scholar (1997-1997) and Senior Specialist (2006) (India)

Retirement Income and Poverty

The structure of the U.S. retirement income system has been described as a “three-legged stool”, composed of the national social security system, employer-provided pensions, and individual savings and assets. The availability of these three sources of income is tied to the employment history of each individual.

U.S. Social Security Program

The U.S. Social Security program is an earned entitlement, based on working a minimum of 10 years. Created in 1935, nearly all workers today, regardless of occupation, are included. This social insurance system is financed by a compulsory tax on labour paid by the employer and the employee. Other aspects include a family benefit for a surviving spouse and minor children of a deceased, long-term disabled or retired individual; income for the severely disabled; and annual cost of living adjustments to partially offset the rate of inflation. The monthly amount paid out is based on salary and wage levels and number of years worked.

Before Social Security was enacted, the elderly had the highest rate of poverty of any wage group. In 1959, 35% of U.S. elders lived below the official poverty line. In 2003, the poverty rate for the American aged had fallen to 10.2%, compared to 10.8% for working age adults (Gonyea, 2005). Declines in poverty among elders have been accompanied by rising real incomes since the 1970s. From 1974 to 2002, the median household income for persons age 65+ rose from nearly $17,000 to slightly over $23,000 (Federal Interagency forum on Aging Related Statistics [FIFARS], 2004).

While income is an important measure of economic well-being, so is net worth – the value of various assets, eg., stocks, bonds and home ownership minus any debt. For many U.S. elders, home ownership is a large portion of their net worth; 80% of older households own

their homes. In the year 2000, the median net worth of older Americans with the lowest income was $46,000, but $42,000 comprised the value of their homes. By contrast, the net worth of the highest income group was nearly $570,000, with $155,000 attributed to home ownership (Gonyea, 2005). Net worth is critical for an older person's ability to weather life crises, such as health problems and widowhood.

However, despite this overall improvement in economic status, approximately 3.6 million U.S. elders fell below the official poverty life in 2003; an additional 2.2 million were classified as near poor (FIFARS, 2004). Additionally, it is predicted that by 2008, 6.7 million persons aged 55 and over will be below the poverty line, a 22 percent increases from the year 2000. The risk of late life poverty varies dramatically by gender, marital status, age and race. Elderly American women, like their Indian counterparts, are more likely than men to become widowed (Quadagno, 1999; Shoba, 2005), putting them at risk for poverty. Because women have longer life expectancies and are more likely to live alone, the numbers of poor older females in the United States are double that of men. Furthermore, older women of color (eg.,Blacks, Hispanics), living alone, are the most economically vulnerable, often described as "triple jeopardy".

Social Security supplies the largest proportion of aggregate information of older Americans; 39%. However, for the poor and near poor elderly, it constitutes 83% of their total income. By contrast, Social Security is 20% of total income for the highest income group among the U.S. aged. Even more startling is the fact that for 44% of older women, Social Security represents 90 to 100% of their retirement income, even though it was never intended to be the only source of retirement income! The costs of the program are easy to track, and actuarial analyses show that if its financing and/or benefit structure is not changed, it will not be able to pay out promised benefits by mid-century, or perhaps even earlier. This problem is shared by most social security programs in Western industrialized nations. Unless changes are made, the first (and primary) leg of the retirement

income stool, Social Security, has a wobbly future. However, proposed privatization in which part or all of employer-employee contributions are invested in the stock and bond market is likely to be less beneficial for women (Gonyea, 2005).

Employer Pensions: All the Americans need pensions and retirement savings to maintain a decent standard of living. These two other "legs" of the stool are primarily financed by tax expenditure or tax subsidies of private sector efforts and activities. These special income tax provisions for individuals and employers are designed to accomplish some social or economic goal, such as ensuring adequate income in retirement or paying for children's college education (Liebig, 2002). Representing forgone tax revenues, the costs of which are hidden in contrast to direct budget expenditures, these indirect payments have been called "fiscal welfare" (Quadagno, 1999).

From the 1930s on, the U.S. income tax code has encouraged businesses, usually large and medium-sized firms, to provide pensions to their employees, on a *voluntary* basis. Two kinds of pensions exist: defined benefit plans that guarantee the monthly dollar amount to be paid out in retirement; and defined contribution plans that set aside savings for retirement, but without any specific amount guaranteed. The amount accumulated depends on how well plan administrators invest those amounts. About half of U.S. workers participate in an employer retirement plan. Lower income workers, such as women, are less likely to work in jobs or for employers that provide such coverage.

Contributions to pension funds by both employers and employees are exempt from income taxation, as are earnings on those savings. The benefits are taxed only when withdrawn by retirees, generally at a lower rate than they would have paid during their working years. This tax relief for pension savings amounts to approximately one-quarter of the outlays for Social Security (Quadagno, 1999). Only one-third of people 65 and older receive any kind of pension from a past job (Social Security Administration [SSA], 2005); the largest tax benefits go to those with the highest incomes.

In the 1980s, a "self-pensioning" scheme, Individual Retirement Accounts (IRAs), was enacted to provide another tax incentive for retirement income savings, but primarily for individuals not covered by an employer pension plan, eg., women who may not work a sufficient number of hours to get pension coverage (Gonyea, 2005). However, fewer than 3% of taxpayers contribute to IRAs, usually those in higher income brackets.

India, among other countries, also encourages personal pensions via similar tax treatment. The Contributory Provident Fund allows tax exemptions for the amounts contributed, and accumulated funds in the General Provident Fund earn interest tax-free. An income tax rebate is also available for holders of the Jeevan Suraksha endowment plan with its savings-linked insurance approach to retirement income for workers in the unorganized sector (Kumar, 2003). However, these schemes primarily benefit higher income workers with "surplus" income that can be put aside for the future.

The second leg of the U.S. retirement income also is becoming less stable. Defined benefit plans are being terminated, frozen or replaced by defined contribution plans, requiring more workers to save even more on their own, due to uncertainties about how to achieve a reasonable level of retirement income security. Today, more than one-third of households headed by someone age 55-59 have no retirement savings in a defined contribution plan or an IRA (Orszag, 2004), and many workers have been badly hurt by investing their retirement savings in their company's stock. Should Social Security benefits be cut in the future, workers will need to accumulate even more, a difficult task for lower income workers, many of whom are women. They also will need to work longer because the eligibility age for full Social Security benefits is being increased to age 67, from age 65 today.

Asset Income

Income from assets, such as rentals, stocks and bonds, can be a source of income in retirement. In aggregate, asset income provides

about 14% of all retirement income. However, for 25% of older Americans, this source is relatively limited, accounting for less than $250 annually. For the highest income elders, however, asset income is nearly 19% of their total retirement income, on average generating $9,600 per year. This is in comparison to the $84 received by the lowest income group of elders (Gonyea, 2005).

Some of this asset income also receives preferential tax treatment. Middle-and upper-income elders benefit from federal income tax policies that exempt income generated by state and local government bonds. Many states also do not tax personal income generated by their own bonds or those sold by local governments within their jurisdiction.

Supplemental Security Income

In recognition of the income needs of very low-income persons, the Supplemental Security Income (SSI) cash assistance program, enacted in 1972, operates as a safety net for 7 million aged, blind, and disabled adults and children with few resources (SSA, 2005). About half (54%) of SSI payees have no other source of income. That figure includes the 850,000 persons aged 65+, primarily older women, who are likely to become SSI recipients when they are widowed. Only 2.5% of older men receive SSI benefits, compared to 4.5% of older women; 24% of elderly Blacks and 22% of older Hispanics are SSI beneficiaries (Gonyea, 2005). Even more telling is the figure that only 60% of elders eligible for SSI currently receive assistance. Even so, the federal benefit rate for individuals in 2005 was $579 monthly, 27% below the official poverty level.

Furthermore, SSI income and asset eligibility requirements have not been updated for several years. Income exclusions have not been increased since 1972, and asset limits have not been updated since 1989. Despite increases in the overall U.S. standard of living and recommended improvements made by an expert panel in 1992, little action has been taken. SSI beneficiaries do not have access to in-kind benefits, such as food stamps (similar to India's Annapurna

program) and moderate or no cost medical care for older persons and for the poor, including elders, but automatic cost of living adjustments in Social Security and SSI do not keep pace with increased costs of U.S. medical care.

Similar beneficiary patters are seen in India's National Old-Age Pension Scheme (NAOPS). The most vulnerable sections of Indian society, such as women (especially widows) and lower caste individuals (similar to U.S. racial minorities), have benefited from this program (Kumar, 2003). For example, the proportion of women beneficiaries increased from 30% to 37% in just one year (Irudaya Rajan, 2001). Still, this program is insufficient to keep older persons out of poverty. The patterns of female poverty in both nations are not likely to recede any time soon. Earlier life situations, eg., educational opportunities, marriage, labor force participation patterns, affect economic well-being over the life course, including old age, a process known as cumulative advantage or disadvantage. Increasingly, it has become clear that women's roles as family caregivers over their life span have major impacts on their economic status in late life.

Family Caregiving

As in India, today more American women – especially middle-class, educated women – are working outside the home, in large part because it requires two earners to maintain a decent standard of living. This higher rate of labor force participation affects younger women with children, as well as middle-aged and older women whose numbers have increased steadily over the past two decades, while their male counterparts have decreased their work force participation. While some American women are earning higher pay, primarily in the professions, equal pay for equal work still does not exist. Despite improvements, the average women's pay is 73 cents for every $1 earned by them.

Additionally, many American women work part-time, due to caregiving responsibilities for their children and older family members. Alternatively, they take time off from full because of the way in which Social Security and pensions are structured, less than fulltime work on a sustained basis results in lower retirement income for women. Indeed, Social Security is skewed towards the traditional nuclear family (male breadwinner, wife and children) with payments benefitting families, even though payroll taxes are paid on an individual basis. Consequently, a woman's Social Security benefits earned in her own right, for which she has made contributions over her working life, are often less than the benefits she receives as the spouse of her retired husband. Additionally, a single or divorced woman with the same work history and wage levels will receive less Social Security than her married counterpart. This is an example of institutions not keeping pace with social changes, called structural lag.

U.S. family structure in the United States changed considerably in the 20th century, a trend likely to continue in this century. Unlike India and other Asian nations, the United States does not have a family tradition of multigenerational co-residence (Liebig, 2001). Today, the nuclear family is fast disappearing and being replaced by non-traditional families. Divorce and remarriage into blended families, a growing number of never-married individuals, co-habitation by unmarried couples, married couples with one child, and greater numbers of single households headed by women with children are all part of the changing structure of American families. Furthermore, the multigenerational family had become a "beanpole", with more generations alive at one time, due to greater longevity, but with fewer individuals in each generation (Bengston, 2001). This beanpole structure is fast evolving in India and other parts of the world, as longevity increases and birth rates come down.

The living arrangements of U.S. elders also have changed. While 25% of older persons lived with other relatives in 1960, today the proportion is 13%. Most Americans aged 65+ live in one-and two-person households: 31%, primarily older women who never

married or are widowed, live alone and 54% live with their spouse. The two-person older household is beginning to be seen more frequently in India as well, but hardly at the same level as in the United States. All these changes raise concerns about the availability of family caregiving for older and younger family members, but family structure is less important than the degree to which families continue to operate as a caring supportive unit (Gokhale, 2003). Research shows that family composition is changing, but cross-generational support remains strong (Bengston and Burton, 1995), even when families do not live under the same roof or next door.

Women of all ages in the United States and elsewhere, including India, are increasingly juggling family and work responsibilities. On average, more American women are engaged in "caregiver careers", spending 18 or more years caring for their children and at least an equal amount of time caring for their parents or parents-in-law, or both. Their ability to earn enough income for retirement is compromised by these responsibilities. In particular, informal caregiving – unpaid help primarily provided by spouses and daughters – has long been the most common form of assistance for the elderly. This elder-care responsibility is likely to occur during the prime earning years, age 25-54; its impact is borne out by a recent study on caregiving trends in the United States.

Between 1994 and 1999, Spillman and Black (2005) found that the number of spouses and children providing care to an older person increased, while the use of formal care declined. Over the same period, the proportion of older persons relying solely on family care increased significantly. Their study also showed that a larger proportion of family caregivers were caring for persons with higher levels of disability, and that both caregivers and recipients were older in 1999 than in 1994. Nearly 13% of caregiving children were themselves 65 or older. Thus, the caregiving family itself is getting older and more likely to have disabilities that make practical and psychosocial care more difficult, unless caregiver support is available.

Two laws have been passed with some potential to help. The first is the Family and Medical Leave Act of 1992, which allows workers to take up to six months time off to care for children, parents or spouses, without risk of losing their jobs. However, it leaves the caregiver in the difficult position of taking time off from work, but with no guarantee that salary will be paid during this absence. Additionally, the worker is also out of pocket to keep employer-provided health-care access. Employers with 20 or fewer employees, a large source of part-time work by women, are exempt from this mandate.

In 2000, the National Family Caregiver Support Program (NFCSP) was passed that explicitly recognizes the services needs of families caring for family members age 60 and older and for persons age 60+ who are caring for their grandchildren on a sustained basis. The NFCSP provides information about available services, individual counseling and caregiver education, and also helps caregivers gain access to supportive services, respite care, and very limited supplemental services, such as assistive devices for mobility. However, without adequate availability of nearby home and community-based programs, such as transportation, home aides and meals on wheels, women may still need to take off substantial periods of time from work to care for older family members.

All governments in aging societies have a financial interest in ensuring that families get some help, but not so much that family ties are weakened (Walker, 1992). The mantra about “no care” families that was commonplace in the United States in the 1960s and is increasingly heard in India has given way to family care as normative and the basis for eldercare policy. Policy makers have committed to the bulk of support being provided by relatives, especially women who are seen as “natural carers”, particularly as research shows that caregivers who get help are more likely to keep dependent family members at home, rather than look to publicly-funded institutional care.

DISCUSSIONS AND CONCLUSIONS

This commodification of eldercare (Walker, 1992) and its impact on women, however, needs to be addressed head on in the United States, as well as other countries. Recent moves toward greater privatization and devolution in U.S. social welfare policy, echoing World Bank pronouncements, has put more responsibility on states and local governments, as well as non-governmental organizations, to provide solutions often without the necessary funding (parallel to India's National Policy on Older Persons).

Similarly, more responsibilities for retirement income and caregiving are being put on individuals and families. For more vulnerable sectors of U.S. society, especially women and members of many racial and ethnic minorities, these actions bode ill for great income equality in old age. Recent tax laws benefitting much higher income individuals in the United States will only exacerbate the gap between rich and poor. Without major changes, similar problems are likely to arise for women, scheduled and backward castes and tribals in India, due to cumulative disadvantages experienced over the life course.

In the future, if the United States and other nations want to have fewer older women in poverty by the time the age tsunami hits full force in 2050, several structural changes in society will be required, such as equal pay for equal work, crediting women's caregiving roles in national social security systems, even making ad hoc adjustment in retirement income for much older persons (primarily women who are likely to outlive their resources), and ensuring more widespread availability of home and community based care and services to support family caregivers, so they can build up adequate income in their retirement years. Without some or all of these changes, the economic well-being of older women in the latter part of the 21st century is not likely to improve substantially.

REFERENCES

Bengston, V.L. (2001). Beyond the nuclear family: The increasing importance of multigenerational bonds. Journal of Marriage and Family, 63, 1-16.

Bengston, V.L., Rosenthal, C., & Burton, L. (1995).Paradoxes of families and aging. In R.H. Binstock& L.K. George (Eds.), Handbook of Aging and Social Sciences (4th ed., pp., 258-282). San Diego, CA: Academic Press.

Federal Interagency Forum on Aging Related Statistics (2004).Older Americans 2004: Key Indicators of Well-being. Washington, DC: U.S., Government Printing Office.

Gokhale, S.D. (2003). Towards a policy for aging in India. Journal Of Aging & Social Policy, 15 (3/4), 213-234.

Gonyea, J.G. (2005). The economic well-being of older Americans and the persistent divide.Public Policy & Aging Report, 15(1), 1, 3-11.

Irudaya Rajan, S. (2001, February 24). Social assistance for poor elderly: How effective? Economic and Political Weekly, 613-617.

Kumar, S.V. (2003). Economic security for the elderly in India. In P.S. Liebig & S.I. Rajan (Eds.), An Aging India: Perspectives, Prospects, and Policies (pp. 45-66). New York: Haworth Press.

Liebig, P.S. (2001). International perspectives on housing frail elders. Journal of Architecture and Planning Research, 18 (3), 208-222.

Liebig, P.S. (2002).Tax policy.In G.L. Maddox (Ed.), Encyclopedia of Aging.Volume II.New York; Springer.

Orszag, P.R. (2004, February 2). Balances in defined contribution plans and IRAs.Tax Notes, p. 655.

Quadagno, J. (1999). Aging and the Life Course. New York: McGraw Hill College.

Shobha, I. (2005). Ageing women in India: Problems and initiatives. Ageing & Society, XV (3 & 4), (15-35).

Social Security Administration (2005).Income of the Population 55 or Older. Washington, DC: Author.

Spillman, B.C., & Black, K.J. (2005).Staying the Course: Trends in Family Caregiving. (Issue Paper # 2005-17). Washington, DC: AARP Public Policy Institute.

Walker, A. (1992). The care of elderly people in industrial society: A conflict between the family and the state. In P. Krishnan & K. Mahadevan (Eds.), The Elderly Population in the Developed and Developing World. Delhi: BR Publishing.

ELDER ABUSE AND MEDICAL CARE

A. M. Khan*
Smita Taneja **

ABSTRACT

Although family ties in India are still strong and an overwhelming majority of the old live with their family members, but now qualitatively they are living is the real issue. In the present scenario they cannot take it for granted that their children will look after them when they need care in their old age. In the recent years, indignity, disgracefulness, embarrassment, dishonor, indifference, injustice, psychological torture and host of negative behaviors & attitudes are reflected in the society towards elderly. Millions of elderly are suffering emotionally from the growing phenomena of gross indifference, profit motive, selfishness & decay in family system. Researchers while trying to study the life condition of elderly, their status in the family and society, health status, participation in work and general treatment meted out to them have projected many of it as elderly abuse. But what elderly consider as abuse is a silent issue and we have not come across empirical studies that delineate what elderly consider as abuse. It is also not clear whether elderly from different social and cultural context hold similar views of elderly abuse? There is a lack of scientific measures or tools to study the elderly abuse. So as a

* *Prof. Dr. A. M. Khan,*
Head of department, Social Science, NIHFW, MUNIRKA
** *S.M.O., Sahastra Suraksha Bal (SSB)*
currently post graduate resident (MD CHA), in NIHFW, MUNIRKA.

requirement of developing a scientific tool, it was decided to collect detail information through in-depth interviews and discussions with elderly across different sections of society in Delhi with a view to delineate on meaning of old age to the elderly, their perception about what abuse is? Where and why does it occur? Their socio demographic profile, their expectations from the family, community & government, existing and required services, how care during sickness and old age care are addressed. This paper discusses the findings of interviews so conducted with elderly residing across different income group colonies in Delhi at length.

INTRODUCTION

We are presently in a state of demographic transition. Salient features of demographic transition are: i) growth rate of elderly (3.09) is higher than general population (1.9), ii) size of female elderly is more than men, iii) life span after retirement is 5 times more than what it was at independence, iv) at 60+, widows figure (54%) is more than widowers (15.5%), at 70+, 21% are widower & 67% are widow, at 80+, 25% are widower & 70% are widow. This demographic transition along with increase in longevity has generated enormous challenges for healthy ageing. So, how to ensure quality of life? How to make longevity meaningful? How to ensure good treatment to the elderly in every society? For healthy ageing, it is important that elderly are not victimized, mistreated or abused in any way in the society. It is a difficult proposition because the main threats to the quality of life of elderly are: i) migration of the care providers, ii) women's work force demanding change in their role from being 'caregiver' to resource earner of family, iii) disintegration of values related to elderly care and iv) structural & functional change of the family. Three out of these four are part of development of modernization, urbanization and industrialization. Because migration and women's participation in work forces are inevitable factors in the existing model of development of the whole world; we simply need to recognize it and strive for

best alternatives. Other two pillars related to disintegration in the values of elderly care and structural and functional change of family as an institution need attention of immediate action. And we need to know empirically how much disintegration of values is actually taking place. Although family ties in India are still strong and an overwhelming majority of the old live with their family members, but how qualitatively they are living is the real issue. In the present scenario, they cannot take for granted that their children will look after them when they need care in their old age (Reddy, 2003). In most countries of the world the older persons do not enjoy a decent status in society. This is all the more so in developing countries such as India which are economically poor and have been subjected to the ravages of demographic transition, migration, modernization, dwindling joint family, market economy, poor public health & hygiene and low social & economic security (Ramamurthy, 2003).

In the recent years, indignity, disgracefulness, embarrassment, dishonor, indifference, injustice, psychological torture and host of negative behaviors & attitudes are reflected in the society towards elderly. Millions of elderly are suffering emotionally from the growing phenomena of gross indifference, profit motive, selfishness & decay in family system (Khan, 2004). Graceful, happy and healthy ageing is therefore a main issue. Abuse is synonym of misuse, mistreatment, ill-treat, and mal treat. It is a noun that refers to improper use/handling, giving physical maltreatment, using unjust practices, insulting and using coarse language. As a verb it means to use wrongly, improperly, to hurt/injure by maltreatment, to force sexual activity on, to assail with contemptuous, coarse or insulting words (Khan, 2004). A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person is defined as abuse by UN (WHO Toronto Declaration of Elderly Abuse). US National Academy of Sciences defines abuse as intentional actions that cause harm/create a serious risk to a vulnerable elder by a caregiver/other person who stands in a trust relationship to the elder/failure by a caregiver to satisfy elder's basic needs or to protect elder from harm.

From the existing review of literature in the Indian context one gets a generic form of elderly abuse varying from indifference to physical assault. It has been shown that elderly abuse cuts across class, gender, caste and religion but transparency is more in the lower strata according to many – Balambal V (2004), Bhoite A (2004) and Chakravarty I (2004). Researchers while trying to study the life condition of elderly, their status in the family and society, health status, participation in work and general treatment meted out to them have projected many of it as elderly abuse. But what elderly consider as abuse is a silent issue and we have not come across empirical studies that delineate what elderly consider as abuse. It is also not clear whether elderly from different social and cultural context hold similar views of elderly abuse? There is a lack of scientific measures to study the elderly abuse. So as a requirement of developing a scientific tool, it was decided to conduct series of focus group discussions with groups of elderly as well as with the care providers and also to collect detail information through in-depth interviews with elderly across three different sections of society in Delhi with a view to delineate on the meaning of old age to the elderly, their perception about what abuse is? where and why does it occur?; Their socio demographic profile, their expectations from the family, community & government, existing and required services and how care during sickness and old age are addressed.

A study of elderly abuse, its aetiology across different socio-cultural and economic groups in Delhi with focus on 'medical care' was undertaken with following objectives:

1. To identify the various facets of elderly abuse across different socio-cultural and economic groups.

2. To find out the cultural, social, psychological & financial aetiology of elderly abuse.

3. To ascertain the status of medical care of elderly during sickness and to find out different levels of elderly abuse across different groups under study.

4. To suggest remedial & preventive measures to curtail the extent & intensity of elderly abuse in the society.

Methodology

The study population of 384 included elderly males & females above the age of 65 years residing in different colonies namely New Rajdhani Enclave, Madhu Vihar and Pandav Nagar. These colonies represent three different strata of society – upper, middle and the lower class respectively. Methods adopted to collect data from the elderly were – 1) Focus group discussion, 2) In depth interview and 3) Case study method.

Five different types of abuses namely – emotional, financial, physical, neglect and indifference and abuse in medical care were studied in detail. After conducting FGDs a 5-point Likert scale with unequal items was devised to measure the occurrence of abuses. Interview schedule was used to collect information on socio-economic and cultural background of the elderly besides measuring if they were suffering from any form of abuse; and if so then to what extent. The schedule so prepared was subjected to pilot testing amongst 45 elderly – 15 from each of three different categories of residential colonies. The 15 elderly residing in each of these colonies were selected on convenient sampling basis.

Advanced analysis was not carried out though it was found that most of the items were working. The few items, which were not working, were dropped from the scale. Also rewording of some of the questions was felt necessary to make them easier and more accurate to understand. It was also decided based on pilot study and FGDs to analyze the physical abuse scores separately because its occurrence in Indian context as expected was very less and its low scores would affect findings inadvertently. Finally, on the basis of pilot study the abuse scale was finalized which included 48 items with 4 items dropped from the scale used to measure neglect and indifference.

Validity and reliability of the five-point abuse scale used (with scores ranging from 0 to 4) was also studied to see whether it was consistently and reliably measuring what it was devised to measure. Abuse scale was tested for reliability using split half method which showed high reliability for all forms of abuse significant at p<.01 – (Table – 1).

Table – 1 Reliability statistics (split half method)

Type of abuse	Reliability	Significance
Neglect and indifference	0.9223	**
Financial	0.8557	**
Emotional	0.9095	**
Abuse in medical care	0.9707	**

*Here ** denotes significance at p<.01*

Each reply was rated on the scale as always/quite often/sometimes/rarely/never. Abuse scoring was done from 0 to 4 with never being scored as 0 and always as 4 for the positive questions (e.g. are you involved in solving family problems) and from 4 to 0 for the negatively oriented questions (e.g. are you left alone).

Probability sampling method (using multi stage random sampling technique) was used to select the elderly for interview from the three colonies. As per sample size (390) equal representation of elderly people from each of these three classes of colonies was taken by systematic random sampling/complete enumeration where no. of elderly residing in selected area was found to be low. 127 elderly were interviewed from New Rajdhani Enclave (high income group) out of which 57 were males and 70 were females, 125 elderly were interviewed from Madhu Vihar colony (middle income group) out of which 57 were males and 68 were females and 132 elderly were interviewed from Pandav Nagar colony (low income group) out of which 73 were males and 59 were females.

Major findings

Out of 384 respondents 262 (68.2%) were Hindus, 92 (24%) were Muslims, 8 (2.1%) were Christian and 22 (5.7%) were Sikh. 297 (77.3%) of respondents belonged to general castes, 71 (18.5%) SC/ST and 16 (4.2%) OBC. 291 were currently married, 88 were widow(ers) and 4 were divorcee and only 1 was separated –

Table – 1: Socio demographic profiles of the respondents (n=384).

Residential Colony	Marital Status	Age Group	Sex		Total
			Male	Female	
	1) Married	65-70	8	23	31
		71-80	24	17	41
		80+	13	11	24
1) High Class	Total		45	51	96
	2) Widow	65-70	10	6	16
		71-80	1	5	6
		80+	1	6	7
	Total		12	17	29
	3) Divorcee	65-70	0	0	0
		71-80	0	2	2
		80+	0	0	0
	Total		0	2	2
Total					127*
2) Middle Class	1) Married	65-70	2	27	29
		71-80	44	9	53
		80+	0	0	0
	Total		46	36	82

Contd….

Residential Colony	Marital Status	Age Group	Sex		Total
			Male	Female	
	2) Widow	65-70	0	26	26
		71-80	9	0	9
		80+	2	6	8
	Total		11	32	43
Total					125*
3) Low Class	1) Married	65-70	28	23	51
		71-80	26	20	46
		80+	11	5	16
	Total		65	48	113
	2)Widow	65-70	0	3	3
		71-80	0	6	6
		80+	6	1	7
	Total		6	10	16
	3)Divorcee	80+	2	0	2
	4) Separated	80+	0	1	1
Total					132*
Grand Total			187	197	384

Out of total 384 respondents 42 (10.9%) were found to be illiterate, 35 (9.1%) were educated till primary level, 137 (35.7%) till middle level and 170 (44.3%) had acquired higher education. Preferred living arrangements across all the classes were definitely with the family. Majority 356 (92.7%) were staying with one or more sons and rest with either married daughter (0.8%), unmarried daughter (0.5%), daughter-in-law (0.5%), with spouse only (2.9%), alone (1.6%) and with other relatives (1%). 90.9% of respondents had just accepted their retiree roles and were not currently engaged in any productive activity. 3/4th of them had some or other source of income even though majority of lower class respondents depended solely on

meager amount of old age pension – Rs.300/- month under the social welfare scheme. Retired government employees were the ones enjoying sufficient amount of pension to meet their requirements. Monetary assistance and interaction pattern of the elderly with their children who were staying away was highly unsatisfactory.

Majority of the respondents had the property in their own names (40.9%) or in the name of their spouses (31%). 16.9% had it in their son's name and 11.2% had it in the name of their daughter-in-laws or other relatives. Thus, about 3/4th of the respondents had kept the property in their own/spouses name showing a trend to keep possession of property till death. In middle class few of the elderly had let out a room or two to tenants to enable them to meet their financial needs.

Analysis of different types of abuses revealed that emotional abuse was the commonest across all the colonies. Though the scores are low in majority of cases; nevertheless it clearly indicates that the elderly are vulnerable to be hurt emotionally. **Pattern of elderly abuse** showed strong interclass difference.

Neglect and indifference – Major brunt was felt by the elderly in the form of not getting due weightage to their opinion; not being involved in important matters and family members not spending enough time with them. The elderly residing in the upper class colony maximally felt social isolation. Score of abuse in form of not getting timely medication was also high compared to other basic needs such as food, shelter and clothing requirements. Ignoring of social and health needs was much more compared to other basic needs across all classes. Arbitrary categorization neglect and indifference depending on range of scores revealed that only 9.2% were scoring high degree of score, 9.5% from moderate and 70.1% from mild degrees of abuse of this type, whereas 11.2% scored nil.

Financial abuse – This form of abuse was also high across all the classes. Irrespective of whether they had independent source of income or not, 66 (17.2%) of the respondents were partially, 95

(24.3%) totally dependent on their family members to spend money to satisfy their monetary needs – such as to make personal purchases, buy gifts, etc. Rest – 223 (58.1%) were not dependent at all as they rather take their own decisions on how to and what to spend as per their wishes. Having property was a curse in disguise and pressurization to part with valuables and property was prevalent across all classes (28.1%) especially in the upper class. 2/3rd of elderly complained that they were forced to bear their own medical expenses as well as forced to spend against family needs. Inadequate financial resources were indicated as one of the major problems in the Indian elderly, higher in females compared to males. Having too much or too less were both seen to be responsible for financial abuse. Only 20.6% reported no financial abuse at all. Rest of them were found to be suffering from some or other form of financial abuse – 39.2% from mild, 31.8% from moderate and 8.4% from severe degree of financial abuse.

Emotional abuse – It was mainly felt by the elderly due to insensitivity and apathy on part of the family members. Relationship with families was rated above average by 86.7% of respondents only. 66.4% felt free to discuss matters with their families whereas 25.5% felt inhibited and 81% felt afraid to openly discuss any matter with their families. So there was lack of good interpersonal communication in 1/3rd of the respondents. 45.3% felt they had to compromise a lot in life to adjust with the present situation. Emotions were hurt mainly due to misbehavior by the family members deliberately/unknowingly, talking aversely about old age and lack of acceptance on their part of this very physiological change in continuum of life cycle as one moves from young to the older age group. Feeling of loneliness, worthlessness and burden were very much prevalent. Only 50% were getting love and affection from their families as per expectations. Such feelings of loneliness and depression are very harmful for healthy social existence and mental peace of the elderly leading to increased incidence of psychological disorders in the elderly age group. 6.3% reported nil, 79.1% reported to be suffering from mild degree, 12.7% from moderate and 1.9% from severe degree of emotional abuse.

Physical abuse – It was found to be the rarest form of elderly abuse. Respondents across all the three classes were sensitive about responding to this form of abuse. 62% scored nil, 31.2% scored to have suffered from mild degree, 5.8% scored moderate and 1% scored to have suffered from severe degree of physical abuse. Though 90% denied having been physically mishandled ever, but 1/4th felt that their physical capacity was disregarded while assigning work to them. But as age increases mean scores of this form of abuse were found to decrease thus showing that Indians carry the value to increasing age of elderly. Physical abuse is found to increase as we move down the social ladder. Scores were lower in the widows and widowers, divorcees and the separated compared to the currently married group and also lower in the females compared to males though difference was not statistically significant. Also literacy level was seen to influence vulnerability of being physically abused with the illiterates being more abused than those having higher education. More sympathy in the mind of family members for the physically dependent elderly was evident across all the respondents. Monetary dependence was an important risk factor for physical abuse in the elderly. Those with complete or partial dependence for money on their family members were found to be suffering from higher scores of physical abuse.

Care During Illness – There were lot of complaints. Except 1/5th of elderly all had some or other complain in the form of delay in seeking treatment, providing aids, purchasing medicines, providing adequate and timely nursing. Impatience towards them during sickness as if they were deliberately posing sick was also complained of by 1/3rd of respondents. Similar to FGDs here also data analysis shows that family members – mainly the spouses and daughter-in-laws, play the caregiver role in majority of cases. It was only in the upper class colony residents that outside help for nursing etc. were resorted to. Preference of care during illness was “by one’s own family” rather than by anyone else. Almost all the respondents confirmed that on calling for sudden assistance their families came to their help immediately and only in 1/4th cases was medical expenditure on the elderly

taken as a burden, rest did it happily or felt that it was their responsibility. 66.1% were in favor of home care. Severe degree of abuse in medical care was evident only in 9.7% cases and as such sheer neglect and total abandonment during sickness was not evident. 24.2% scored nil, 48.9% were found to be suffering from mild degree and 17.2% from moderate degree of this form of abuse. Majority showed faith in laws and legislations to ensure their protection from being abused.

Morbidity study revealed that problem in vision, moving about, hearing and cardiovascular system problems were the most commonly experienced ones as evident from other studies also. But then with increasing age as there is degeneration of living cells and reduced regenerating capacity mild deterioration in overall functioning occurs and it should be regarded as gradual physiological change in the continuum of life cycle rather than pathology labeling elderly as sick/ill/deceased. Only if dysfunction of any organ crosses the threshold it should be regarded as pathological. In this study sample only 20% had one or more severe degree of problem and majority were performing all the daily activities without any aid.

Difficulty in access to health services – cost wise (80%), physical access wise (75.3%) and availability wise (61%) was felt in severe or mild form and more so by the poorer respondents.

Comparative analysis of different forms of abuse across different background variables revealed the following –

Table – 2: Comparison of 4 types of abuses – (Duncan's mean test)

Types of abuse	High income			Middle income			Low income colony			(1) vs (2)	(2) vs (3)	(1) vs (3)	F ratio	Sig
	Colony (1) (n = 127)			Colony (2) (n=125)			(3) (n=132)							
	X	SD	SE	X	SD	SE	X	SD	SE					
Neglect	7.91	5.49	0.49	5.53	4.52	0.4	10.62	7.46	0.65	*	*	*	23.33	**
Financial	5.85	4.09	0.36	3.9	3.74	0.33	7.67	5.33	0.46	*	*		22.98	**
Emotional	11.22	9.22	0.82	13.54	11.02	0.99	16.69	15.45	1.34	-	*	*	6.60	**
Abuse in med. care	7.20	6.78	0.60	3.84	3.81	0.34	8.89	7.16	0.62	*	*	*	22.38	**

*Here * Denotes significance at p. 05 and ** denotes significance at p<.01*

Intercolony/interstrata difference was statistically significant ($p<0.05$) for all the forms of abuse with scores for all forms of abuse being highest in lower class colony and least in middle class colony – (Table – 2). Transparency is more in the lower strata – findings are similar to that of Balambal V (2004), Bhoite A (2004) and Chakravarty I (2004). Thus socio economic status is an important variable in determining incidence of abuse amongst the elderly. It was also clearly observed that as age increased mean scores of all forms of abuse also increased –

Table – 3 Comparison of 4 types of abuses between the different age groups i.e. group (1) 65-70 years of age group, (2) 71-80 years of age group, and (3) 81+ years of age – Duncan's mean test

Types of abuse	Group (1) (n=156)			Group (2) (n=163)			Group (3) (n=65)			(1) vs (2)	(2) vs (3)	(1) vs (3)	F Ratio (3)
	X	SD	SE	X	SD	SE	X	SD	SE				
Neglect	7.071	5.71	0.46	8.17	6.60	0.52	10.18	6.53	0.81	-	*	*	5.72
Financial	5.46	4.43	0.35	6.14	4.97	0.39	6.02	4.68	0.58	-	-	-	0.88
Emotional	12.94	12.93	1.03	14.09	12.02	0.94	15.09	12.2	1.51	-	-	-	0.77
Abuse in med. care	5.51	5.69	0.46	6.96	6.70	0.52	8.84	7.04	0.87	*	*	*	6.56

Specially abuse in medical care increased with age which may be due to the fact that oldest old requires more medical care as well as are least productive, more sentimental, more physically and monetarily dependent on others thus increasing their vulnerability to be abused. This supports the findings of study by Gupta and Sarkar (2003), which pointed to urgent need of extending assistance to elderly especially the older individuals. Martin et al (2001) and Douglas R. L. (1983) had also identified increasing age as an associated risk factor in increasing incidence of elderly abuse of various types. But then, physical abuse scores are less in the oldest old compared to young old thus showing that in Indian context old cultural values of giving respect to elderly predominate.

Monetary dependence/independence of the elderly was also an important risk factor in determining vulnerability to be abused. When irrespective of independent income, dependency on family members to spend money was considered, it was seen that it was the partially dependent who fared better across all the classes as far as abuse was concerned with higher scores both in the completely independent groups of respondents – (Table-4). Incidence of frequent conflict leading to neglect seems to be related to degree of self-assertion which may be possibly more in the completely independent (economically) elderly.

Table – 4: Comparison of 4 different types of abuses versus monetary dependence of the elderly – (Duncan's mean test)

Types of abuse	Group 1 partially dependent (n=66)			Group 2 completely dependent (n=95)			Group 3 not dependent at all (n=223)			(1) vs (2)	(2) vs (3)	(1) vs (3)	F Ratio (3)
	X	SD	SE	X	SD	SE	X	SD	SE				
Neglect	7.36	6.10	0.75	7.96	5.52	0.56	8.32	6.70	0.45	-	-	-	0.60
Financial	3.86	4.66	0.57	5.65	4.33	0.44	6.51	4.71	0.32	*	-	*	8.48
Emotional	11.38	10.69	1.32	12.34	10.46	1.1	15.13	13.49	0.90	-	-	*	3.23
Abuse in med. care	5.04	5.67	0.69	6.05	6.67	0.68	7.45	6.50	0.43	-	-	*	4.20

*Here * Denotes significance at p<.05 and ** denotes significance at p<.01*

This is similar to finding of study conducted by Veedon (2001) in Mumbai.

No statistically significant variation was found in mean scores of the different forms of abuses gender wise – in fact the females scored lower for all forms of abuses (Table – 5). This may be due to the fact that as per the gender roles assigned to them by the society-patience, endurance and silent acceptance of any situation is inbuilt into the very core of their characters which influences them to complain less even though they may be the ones suffering more. Right from childhood it is inculcated into their nature to respond practically and analytically in every situation. Also female respondents were found to be adjusting more easily and feeling more satisfied with life than males. Especially the housewives never retire from work and to some extent due to involvement in household chores and kitchen they retain their authority while men tend to lose it the moment they stop going to work. Childs HW et al (2000) also supported a view of elderly abuse that emphasizes its realistic nature where in perception of elderly abuse depends on both the characteristics of perceiver and the victim & perpetrator variables which was found to be very much true in the present study.

Table – 5: Comparison of 4 types of abuses amongst elderly males and females with Group 1 – Males and Group 2 – Females (t test – independent samples).

Types of abuse	Group 1 – Males (n=187)			Group 2 – Females (n=197)			Pooled Variance estimate		F ratio	
	X	SD	SE	S	SD	SE	t value	2 tail "p"	F value	2 tail "p"
Neglect	8.16	6.33	0.46	7.98	6.32	0.45	0.26	0.79	1.01	0.96
Financial	5.92	4.62	0.34	5.77	4.79	0.34	0.31	0.76	1.08	0.61
Emotional	13.8	11.49	0.84	13.79	13.28	0.95	0.01	0.99	1.34	0.047
Abuse in med. care	6.92	6.63	0.48	6.47	6.31	0.45	0.68	0.49	1.10	0.497

This is in contrast to findings of Dak & Sharma (1987) and Nandal et al (1987). In most of the studies – Reddy (2004), Bendre MT (2004) elderly men were said to be treated differentially to the elderly women

because of societal differential parameters with women suffering abuse more than the men. In western context also prevalence of abuse was more in females than males – Body et al (2005). It is actually the relationship, which matters more than the sex of the elderly as observed by Hazel Morbey (2002).

Marital status – But whether male or female definitely the scores of all forms of abuse were higher in the widowers, widows, divorcees and the separated (Table – 6). Thus spouse still continues to play an important role in life and has a buffering effect on the various stresses faced in the life lessening the feeling of being abused and there is less emotional trauma with provision to share your feelings. As against other forms of abuse financial abuse was more in the currently married group, which may be due to the fact that widows specially had less money to part with than the married ones.

Table – 6: Current marital status wise comparison of distribution of different types of abuses (t test – independent samples)

Types of abuse	Group 1 – Currently married (n=291)			Group 2 – Others (n=93)			Pooled Variance estimate		F ratio	
	X	SD	SE	S	SD	SE	t value	2 tail "p"	F value	2 tail "p"
Neglect	7.54	6.48	0.38	9.71	5.49	0.57	-2.91	0.004**	1.39	0.061
Financial	5.86	4.90	0.29	5.77	4.05	0.42	0.61	0.87	1.46	0.032
Emotional	12.82	11.94	0.70	16.83	13.41	1.39	-2.71	0.006**	1.26	0.155
Abuse in med. care	6.46	6.83	0.40	7.41	5.14	0.53	-1.23	0.219	1.77	0.002

*Here * Denotes significance at p<.05 and ** denotes significance at p<.01*

These findings in respect of marital status of individuals playing an important role in determining degree of abuse of various types is similar to that of Lalitha K et al (2003), Ramamurthi (1989), Chakravarty (2001), Reddy et al (2002), Ramamurthi, Jamuna (2002). **As far as religion and caste of the respondents was concerned** it was observed that elderly abuse cuts across all castes, class and religion and is prevalent to some or other extent across all. Neglect and indifference, financial

abuse and abuse in medical care were found to be higher in other castes whereas emotional abuse was higher amongst the Hindus though only medical care abuse scores were statistically significantly higher (at p<.05) whereas others were not statistically significant. Similarly mean scores of all forms of abuse were higher in SC/ST/OBC category compared to those belonging to general castes. Except emotional abuse all the other abuse scores showed statistically significant difference (at p<.05) in the two groups. Mean scores of all forms of abuse were found to be higher in respondents not physically dependent on their family members but feeling of neglect and indifference was felt less by them compared to the physically dependent respondents. Thus on the whole across all classes family showed more sympathy towards the elderly who were physically dependent on them.

Table – 7: Comparison of distribution of different abuses in relation to state of physical dependency of the respondent (t test – independent samples)

Types of abuse	Group 1 – Dependent (n=42)			Group 2 – Not dependent (n=342)			Pooled Variance estimate		F ratio	
	X	SD	SE	S	SD	SE	t value	2 tail "p"	F value	2 tail "p"
Neglect	8.43	6.59	1.02	8.02	6.29	0.34	0.39	0.69	1.10	0.641
Financial	3.95	4.97	0.77	6.07	4.62	0.25	-2.79	0.006**	1.16	0.489
Emotional	12.90	10.49	1.62	13.9	12.65	0.68	-.49	0.62	1.45	0.145
Abuse in med. care	5.47	6.09	0.94	6.84	6.50	0.35	91.29	0.198	1.14	0.629

These two factors – financial and physical dependence have also been identified as risk factor for abuse by Jamuna D (2004).

Prevalence of elderly abuse though in mild forms was found widespread across all the different groups, classes, castes, religion and sexes of respondents with 70.1% suffering from mild, 9.5% from moderate and 9.2% from severe forms of neglect and indifference, 39.2% from mild, 31.8% from moderate and 8.3% from severe forms of financial abuse, 79.1% from mild, 12.7% from moderate and 1.9% from severe forms of emotional abuse, 48.9% from mild, 17.2% from moderate and 9.7% from severe forms of abuse in medical care.

Perpetrators of abuse included mainly the near and dear ones i.e. sons/daughter-in-laws/spouses. It was their misbehavior that hurt the elderly maximum. Incidentally these very people were playing the care-giver roles in their families. As regards reporting of abuse 56% of the respondents would not resort to reporting of abuse under any circum-stance mainly because they felt it was a family matter, or the belief that it would stop on its own. Reasons given by these respondents for not reporting were apathy of police (3.6%), it is a family matter (24.5%), felt that abuse would stop on its own (14.3%), felt guilty and themselves responsible for behavior meted out to them (3%), accepted it as a part of life (3.6%), felt afraid that it would have dire consequences (1%), felt ashamed to report (8.1%). Out of 169 (44%) respondents who said they would report abuse or misbehavior if any meted out to them – 25 (6.4%) were in favor of approaching their relatives for helping them, 41 (10.7%) were in favor of neighbors, 74 (19.3%) in favor of police and 29 (7.6%) in favor of other help agencies. But their reluctance to report was vividly evident. In the old age group > 49% of respondents said that they would report abuse whereas gender wise it is seen that except in young old percentage of females saying that they would resort to reporting abuse is higher compared to males.

Respondents were not at all sure about where and whom to approach. Police and help lines can thus play an important role in combating elderly abuse by becoming more user-friendly. Adult protective services have been very successful in doing the same in western countries. Clear guidelines and policies in this regard should be available.

Discussion of some major findings – While exploring scenario of neglect and indifference it is seen that although it runs across all social groups, however the incidence of it is more seen in the colonies of lowest income group. Although it reflects about relationships between social class and neglect & indifference but it cannot be explained in terms of deterioration in the values towards care of the older people. It may rather be reflection of their own economic compulsions for which they seem to be struggling for themselves. It gets validated from the finding related to financial abuse, which is found to be relatively low in the posh colony and

higher in the lower income colony. It also gets some support from the findings about emotional abuse, which has also been revealed to be significantly higher in the case of lower income group in comparison to upper income group. This tends to reflect that in the lower income group family member's emotional concern for the older person is relatively poorer in comparison to the family members from upper strata. It looks that material deprivation and mechanical lifestyle centering around self is relatively more in the lower ladder of society in comparison to the upper. The picture of middle income is relatively closer to the upper class. Abuse of all types is lowest in the middle-income colony. It also gives impression that concern for emotional enrichment of the elderly people perhaps seems to be associated with the modern style living which is emerging around the individual more than the group i.e. family and society. However this would require further research to explore the changes in the emotional profile of the people towards older persons resulting out of modernity, competitive and market oriented culture in the recent years.

One general assumption could be a linear relationship between emotional abuse and care during illness and in the study it has emerged as per expectations. One would presume that individual or groups having higher emotional concern for the elderly would provide relatively better quality of care during illness and finding shows a relatively poor care during illness in the lower income colony in comparison to middle and high income colony. It again provides support to the assumption that family members in the lower income colony are perhaps more involved into the routine of daily earning and possibly not available to provide the care to the elderly during illness.

The picture of different types of abuses across three age groups provided conventional finding showing higher rate of abuse, as the age increases. This is a matter of great concern to the planners and interventionists contrary to our noble concept, which has been heritage to our cultural reality. All possible safeguard mechanisms need to be evolved to ensure that elderly do not suffer any kind of abuse by the family members simply out of their vulnerability of age. It would require multipronged

approach to sensitize the youth and children towards the care and concern of older people. The picture emerging on all types of abuse is contrary to our belief system.

Another interesting finding which is unconventional (to be validated in further research) shows relatively higher incidence of financial abuse in group of completely independent elderly as compared to partially and completely dependent. It looks that those who are independent perhaps assert strongly and enter into conflicting situations with family members which we see nowadays in the form of extreme cases of elderly abuse around the issues related to property. It also gives impressions that those who are partially or fully dependent monetarily perhaps accept all the dictates of family members out of their vulnerability and compulsions. This requires further research to get a clear cut picture.

Contrary to general belief regarding gender difference the study did not find significant difference on any type of abuse included in it. Rather relatively low mean was achieved almost on all types of abuse in case of females in comparison to males. It looks that female either out of their cultural realities of tolerance or capability of adjusting with adverse situations are accepting their care as per convenience of the family members or enter into conflicting situations relatively less compared to males.

The incidence of abuse was found relatively lower in currently married group compared to the other group, which includes widows, divorcees and the separated. There seems to be a linear relationship between the deprived condition of elderly failing into the other category and their abuse. Finding is as per expectation.

Those who are physically dependent on their family members suffer a relatively more incidence of abuse in comparison to those who are not dependent although this difference was non-significant which requires further proof.

The finding overall provides some blueprint about different facets of abuse emerging in the recent years. Before any intervention programmes are designed more and more information would be needed

from different sections of society including different cultural groups.

REFERENCE

1) Balambal V (2004) – Senior Fellow, ICHR, New Delhi, Study On Abuse, Neglect, Violence Factors In The Three Strata Of Society-Presented In National Seminar On Elderly Abuse, Thiruvanthrapuram, 2004.

2) Bender MT (2004), Dept. of Sociology, University of Pune – Abuse Of Elderly Women And Strategies For The Care Of Elderly – Presented In NS On Elderly Abuse, Thiruvanthrapuram, 2004.

3) Bhat VN (2004) – Dependency, Abuse Of The Elderly And The Gender Factor In Malanad Region Of Karnataka, Presented In NS On Elderly Abuse, Thiruvanthrapuram, 2004.

4) Bhoite A (2004) – Professor of Sociology, Department of Sociology, Pune, Study on Marginality And Categorization Of Elderly – The Origin Of Abuses – Presented In National Seminar On Elderly Abuse, Thiruvanthrapuram, 2004.

5) Boldy D et al (2005) – Research Addressing Elder Abuse: Western Australia case study – Australian Journal of Ageing, 2005,Vol 24, Issue 1, pp 3-15.

6) Chakravarty I (2001) – Combating Problems Of The Widows, Ageing and Society: The Indian Gerontology, 4, (1 & 2), 53-65.

7) Chakravarty I (2004) – Tackling Elder Abuse – Role Of A Voluntary Organization In The City Of Kolkata, Presented In National Seminar On Elderly Abuse, Thiruvanthrapuram.

8) Childs HW et al (2000) – Young and Middle Aged Elderly's Perception Of Abuse – Gerontologist, 2000, Feb 40(1), 75-85.

9) Dak TM and Sharma ML (1987) – Changing Status Of The Aged In North Indian Villages, in ML Sharma and TM Dak (eds) – again in India, Ajanta Publications, New Delhi, pp 43-45.

10) Douglas RL (1983) – Opportunities of Prevention Of Domestic Neglect And Abuse Of The Elderly – Preventive Human Services, 1983-Fall, 3(1), 135-150.

11) Gupta Indrani & Sarkar Deepa (2003) – Study on Health of Elderly in India: A Multivariate Analysis (Journal of Health & Population in Developing Nations, Uncedu/com).

12) Hazel Morbey (2002) – Older Women's Understanding of Elder Abuse –

Journal of Adult Protection, 2002, Sep, Vol 1, Issue 3, 4-13.

13) Jamuna D (2003) – The Use And Abuse Of Care, What The Caregivers And Care Receivers Say? Presented in International Conference On Ageing in Asia held at Hyderabad, 16-18th February.

14) Khan, (2004) – Decay in Family Dynamics of Interaction, Relation & Communication As Determinants Of Growing Vulnerability Amongst Elderly, Indian Journal of Gerontology, Vol 18 no. 2, 2004.

15) Lalitha K, Jamuna D, Vandana R and Vishnu K (2004) – Elderly Abuse And Marital Status – Presented In NS On Elderly Abuse, Thiruvanthrapuram, 2004.

16) Martin E (2001) – Abuse and Neglect In The Informal Care Of Older People – Paper Presented At Elderly Abuse And Neglect Conference, Victoria, Espania, 2001.

17) Nandal DS, RS Khatri and RS Kadian (1987) – Aging Problems In The Structural Context in Aging in India, Ajanta Publications, New Delhi, pp 10-16.

18) Ramamurthi (2003) – Empowering The Older Persons In India, Indian Research & Development Journal, Vol 9, no. 2, May, pp 5-9, 2003.

19) Ramamurthi PV (1989) – Old Age As A Stress: Strategies For Its Management, Proceedings Of Workshop, ChinmayaSeva Trust, Rewa, October.

20) Ramamurthi PV (1994) – Aging as Stress: Strategies For Coping – paper presented in the International Symposium on Gerontology, AIIMS, New Delhi.

21) Ramamurthi PV and Jamuna D (2002) – Ageing In Developing Countries: the Asian perspective, in SD Gokhale and N Pandit (ed) Ageing in Search Of Its Identity, Pune, AmeyaPrakashan, 277-288.

22) Reddy (2003) – Interactive Session On Active Participation Of Older Persons In Economic, Social & Political Life, Research & Development Journal, vol 8 no. 3, pp 5-21, 2002.

23) Reddy P J (2004) – Dept. of Population Studies, SU Uni., Tirupati – Study on Neglect Of Rural Elderly Female In Chitoor, AP – Presented In NS On Elderly Abuse In Thiruvanthrapuram, 2004.

24) Veedon Rosamma (2001) – Elderly Abuse In Urban Context – Indian Journal of Social Work, 62 (3), 480-91.

PSYCHOLOGICAL HEALTH OF THE ELDERLY-AGE AND GENDER ISSUES

N.K Chandha
Piyusha Majumdar
D.Chao
Ritu Sharma*

ABSTRACT

Old age is the period of decline in all multidimensionality. Psychological health is one such important dimension for the gerontologists to determine so as to understand the reality of the aged people. Social support, loneliness, life satisfaction, state of happiness, and self-rated mental health are the important determinants of the psychological health. Age has strong impact over psychological health for the elderly. Sex of the elderly found to have important implication to determine the psychological health of the elderly. The present research work attempts to determine the psychological health of the elderly with age and sex as the independent factors. The results showed that the age influenced the psychological health of the elderly. Sex, however, does not much influence the psychological health of the elderly.

* *Department of Psychology, Delhi University*

INTRODUCTION

Ageing is a natural biological process of life cycle; it is not a disease, which can be cured. It is a time of decline or degeneration of physical and mental abilities of human being. With the advancement of science and technology, efficient and sophisticated medical support, life expectancy of people has increased tremendously than expected. As the results, the total population is almost double within the last half century. This increasing size of the population of the elderly has changed socio-economic situation. The problems of the disadvantaged groups are increasing leap and bounds. Thus, ageing and old people's problems are becoming so imminent and urgent that any civilized society can no longer ignore the urgency of the conditions. Ageing problem is not an independent problem. And the problems of the ageing cannot be isolated any longer. And it is affecting the overall general at large.

Ageing may be defined as a decline in physiological competency that has inevitably increased the incidence and intensify the effect of accident, disease and other form of environmental stress.

Old age is a period of decline, but all the old people do not form a homogenous group. Some are physically and mentally more active and sensible in spite of their advance age, whereas some are not. For some decaying starts early for some it is late. There are three designations that have been made for the better understanding of elderly people. They can be categorized as (1) Young-Old= Age from 60-69 years, (2). Old = 70-79 years, and (3) Old – Old= 80 years over. As the people grow older the problems increase (Chadha, Bhatia, Rohatgi, & Mir 2004). However, each stage of the aging process has its levels of problems. The main problems of elderly people can be categorized in three different headings. They are: (1) Health and medical problems, (2) Economic problems and economic dependency, and (3) Social and psychological problems. All these problems are interdependent on each other. Geographical location factors plays great role for its elderly along with its prevailing social

system in that given place. For any reasons as to understand the conditions of elderly, each dimension of problems needed separate research so as to understand the entire problems of the elderly. In this research attempt is made to understand the psychological health status of the elderly in Delhi.

1. SOCIAL SUPPORT AND LONELINESS

Older people often feel alienated, neglected and marginalized and helpless. To the extent elderly perceive that others should support them and come to their rescue at the time of their need, they feel secure (Chadha, et al., 1990; Jamuna & Ramamurti 1991). If there are other people around them, to whom they can go to relate, unburden their vows, seek assistance and support, they feel greatly relieved. Social support has a significant role in making the elderly feel wanted and supported (Ramamurti, 1989a). The number of interacting social contacts or persons, whom individual can count upon or approach at the time of need, constitutes the social network. When compared between various age groups, the results show that there were no significant differences in almost all the dimensions of the social support networks structure (Chadha, Chao, Mir & Harpreet,.2005).

In old age, it is not physically being alone, but the feeling of being lonely. Many men and women in their old age “feel lonely” sometimes even in the midst of people. They express that they do not have people 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.

2. LIFE SATISFACTION

A feeling of successful completion of tasks influenced life satisfaction and obligation in one’s lives so far, values and meaning in life, quality of social support and networks, educational level, health status and disability, work status, socioeconomic status and living arrangement. (Chadha, Aggarwal & Mangla, 1990). Life satisfaction in most of the studies has been used as dependent variables. Sometimes it was used synonymous to good adjustment, mental health, psychological

wellbeing. Successful ageing is measured in terms of good life satisfaction found to be related to better social support, greater belief in philosophy of Karma, self-acceptance of ageing changes, flexibility, positive perception of health and economic well-being.

3. STATE OF HAPPINESS

Happiness cannot be objectively measured rather it is feeling that can be felt, and seen in the eyes of people. In our entire life there are specific phase of life in which people are happier. Generally people are happy in their childhood and in their youth. Very few people are found to be happy in their old age. Health, wealth and emotional support are the primary basis of happiness. In addition, level of education, occupational status, marital status, availability of transportation, and housing and social interaction are also related to happiness. Chao, et. al. (2004) found that male and female differ in their rating of happiness and male rated greater state of happiness than their female counterparts.

4. RELIGIOSITY

There are plenty of studies reported in the western literature on religious and spiritual activities of elderly. Ancient texts prescribe prayers, bhajans, and religious meeting as best ways of spending old age to obtain Moksha (spiritual liberation). Prayer and meditation are mentioned as a means for ensuring mental peace and securing salvation (moksha). Religiosity has also been related to the adjustment, mental health and quality of life in older years (Dave, 1999; Dhillon,1996; Ramamurti & Jamuna, 1993c; 1994b; Singh, 1995, 2002; Ushashree & Basha, 2003).

5. SELF-RATED MENTAL HEALTH

Mental disorder in old age is not just due to ageing brain. But they are due to losses associated with ageing, comprised quality of life and socio economic problems. Widowhood and increased dependency increases the vulnerability of women in old age. Depression, Lower life satisfaction and psychological distress are reported in elderly. Positive and successful ageing involves positive self-esteem,

active life style and good interpersonal relationship. There are several mental disorders that are also associated with improper mental health like Depression, Dementia, Alzheimer's disease and problems in adjustment.

METHODOLOGY

1. SAMPLE

The investigation was carried out on a sample of 200 persons ageing 60 years and over. The age range of the present sample was 60-94 years. The sample was taken from the NCR and consisted of 114 males and 86 females. The method employed was random stratified sampling method. The sample was divided into three age groups as: Group A: 60-69 years (Young-Old), Group B : 70-79 years (Old), and Group C :80 years and over (Old-Old).

2. OBJECTIVES OF THE STUDY

The main objectives of study are to make in depth investigation about the psychological health of the elderly mainly in two areas they are as:

I. To compare the male and female elderly in terms of life satisfaction, social support measures, state of happiness, self- rated mental health, optimistic attitude and religious attitude.

II.To differentiate the elderly in three age group categories Young-Old, Old, and Old-Old, and compare them in terms of above said psychological health variables.

3. TOOL USED

The elderly were assessed on different aspects, which may be considered to be the predictors of psychological health. The tools used to study different areas were given in detail below:

I. Self-Rated Mental Health :

This tool was prepared by principal investigator along with the researchers to analyze the mental health of an individual. A list of 32

items included with two categories of response option as “Yes” or “No”. The response of “Yes” means they do not have sound mental health and “No” means that they have sound mental health and able to think in a positive manner. A score of “zero” is given to response of “No”.

II. Assessment of Social Health :
This tool is used to understand the social linking of elderly people with their neighbours, friends and family. A list of 20 items included with two categories of response option as Yes or No. The means elderly is socially active accompanied by friends, relatives and neighbours and No means socially inactive person. A score of 2 is given to response of Yes and 1 is given to response of No.

III. Assessment of Life Satisfaction: This tool was prepared by John van Willigen and N.K. Chadha (1995) to understand the psychological well- being of an individual. It refers to the attitude that individuals have about their past, present and future. A list of 28 items is included with seven categories of response option as “Strongly Disagree”, “Disagree”, “Slightly Disagree”, “Neutral”, “Slightly Agree”, “Agree” and “Strongly Agree”. There are two categories of items, positively worded and negatively worded. Positively worded items scored from 7 to 1 for response categories of agree to strongly disagree. On the other hand for negatively worded items the score would be from 1 to 7 for response category of “Strongly Disagree”.

IV. State of Happiness: In this, a question was asked about the period of happiness. A score of 1 mark is given for childhood; a score of 2 marks is given to youth, a score of 3 points is given to young adulthood, a score of 4 points is given to Middle Age and a score of 5 points is given to later life. Apart from this there are three more questions to determine the position of personal psychological health status. The questions are given below.

1. Where on the ladder do you feel personally stand at present?

2. Where on the ladder you stood 5 years ago?

3. Where on the ladder you stand five years from now?

V. Optimism about Life: In this, it is to measure the personal optimism about the life. When one is young there are reasons to be optimistic but when one is old there is nothing to look forward too? Three alternatives were given in which the subject has to mark any of three alternatives.

VI. Religiosity in Later Life: In this a question was asked from elderly to determine how the elderly turn towards religious activities and spiritual pursuit as they get older.

RESULTS AND INTERPRETATION

The data were treated statistically employing both the Descriptive and Inferential Statistics. The data were subjected to statistical analysis (Descriptive Statistics) by using a software package called SPSS to obtain Mean and Standard Deviation. And then the inferential Statistics was employed to determine the level of difference.

Table 1: The comparison of man and woman on the various indicators of Psychological Health

S. No	Name of variables	Male (114)		Female (86)		t-value
1	Self Rated Mental Health	23.12	6.5	20.6	6.2	2.71**
2	Social Health	37.03	3.6	35.5	5.43	2.29**
3	Life Satisfaction	137.4	27.5	122.3	27.6	3.82**
4	State of Happiness	3.3	1.7	2.7	1.7	2.83**
5	Self rating of Present State of Happiness (in a 10 Pts Scale)	7.8	1.8	6.9	2.0	3.09*
6	Self rating of the State of Happiness five year ago (in a 10 Pts Scale)	8.1	1.7	7.4	2.1	2.31*
7	Self rating of the State of Happiness five year from now (in a 10 Pts Scale)	7.3	2.3	5.9	2.6	3.45**
8	Optimistic About Life	1.5	0.53	1.4	0.58	1.43
9	Religious Attitude	1.3	0.48	1.2	0.44	1.63

**Denotes pair of groups significantly different at 0.01 levels.*

** *Denotes pair of groups significantly different at 0.05 levels.*

Table 1 shows the comparison between male and female elderly on psychological health variables like self-rated mental health, life satisfaction, and of happiness, optimism and believing in religiosity in their twilight years.

The comparison is made between male and female with respect to self-rated mental health of elderly, results indicated significant difference at 0.01 level of significance. The mean scores showed that the male elderly have better mental health status than their female counterparts. Again when the social health is taken into consideration and compared between the male and female elderly, the results indicated significant difference at 0.01 level of the significant difference. The mean scores further states that the male elderly group has better social health than the female counterparts. When the variable of life satisfaction is taken to consider and compared between the male and female elderly, the results indicated significant difference at 0.01 level of the significant difference. The mean scores further indicated that the female elderly have lesser life satisfaction as compared to their male counterparts. Relating to state of happiness, the comparison between the male elderly and the female elderly, the result indicated that the significant difference at 0.01level of the significant difference. The mean scores showed that the male elderly have greater amount of happiness than their female counterparts. And when the stages of happiness in three stages, as at present, past (five years ago), and future (five years from now) based on their ratings, the comparison showed that their ratings found to have significant difference at 0.05 level of significant difference for present state and the past state of happiness, but the difference for the state of happiness in the future (five years from now, expected) is at 0.01 level of significant difference between the male and female elderly. Further from the mean score we can conclude that the male elderly rated their happiness than their female counterparts in all three stages of happiness.

When the elderly males and elderly females are compared on their optimism about life, the results indicated no significant difference

between two groups at any level of the significant difference. From the mean scores, male elderly are more optimistic about their lives than their female counterparts. Similarly, as comparison made between the male elderly and female elderly, their inclination to religious pursuit in their old age, the results indicated no statistical significant difference at any level of the significant significance. Mean scores of the comparison showed that the female elderly are slightly less inclined to religiosity than their male counterparts.

Table 2: The comparison between various age categories of the elderly on the various indicators of Psychological Health.

Name of Variable	Young-Old (a)		Old (b)		Old-Old (c)		t-value		
	Mean	S.D	Mean	S.D	Mean	S.D	ab	bc	ac
S-R Mental Health	22.7	5.6	21.2	7.5	18.2	7.6	1.5	1.7	1.3
Social Health	36.6	4.5	35.8	4.6	36.5	4.3	1.2	0.9	0.46
Life Satisfaction	132.6	27.1	129.2	30.7	119.7	28.8	0.78	1.29	0.92
State of Happiness	3.0	1.7	3.1	1.7	3.8	2.0	0.64	1.24	0.99
Self rating of Present State of Happiness (in a 10 Pts Scale)	7.5	1.8	7.3	2.1	7.3	1.6	0.88	0.40	0.05
Self rating of the State of Happiness five year ago (in a 10 Pts Scale)	7.9	1.8	7.7	2.0	7.6	2.0	0.45	0.35	0.15
Self rating of the State of Happiness five year from now (in a 10 Pts Scale)	7.1	2.3	6.5	2.8	5.6	2.7	1.30	1.49	0.87
Optimistic About Life	1.4	0.53	1.6	0.6	1.4	0.52	1.26	0.28	0.83
Religiosity	1.2	0.44	1.4	0.5	1.2	0.44	2.6	0.30	1.4

Table 2 shows the comparison between Young Old, Old and Old-Old on psychological health variables like self-rated mental health, life satisfaction, state of happiness, optimism about life and religiosity in their old age.

When the various age categories of the elderly are compared on the self-rated mental health, the results indicated no significant difference between any groups i.e., Young-Old and Old, Young-Old and Old-Old and Old and Old-Old groups at any level of the significant difference. However, the mean scores showed that the younger the person the better the rating of their mental health. The oldest old groups found to have rated their mental health worst among the three groups.

Similarly, in the social health status the comparison between the various age categories showed no significant difference between any of the three groups at any level of the significant difference. The mean scores indicated the Young –Old comparatively have better social health and the least among the Old-Old. In term of life satisfaction, the comparison among the various age categories, the results indicated no significant difference between any groups at any level of the significant difference. However, the mean scores showed that the Young-Old group has the most satisfied life and the Old-Old group has the least satisfied life. As we further look to the state of happiness, the comparison between the groups of elderly age categories, the results indicated no significant difference at any level of the significant difference. Interestingly, the mean scores showed that the oldest old group enjoyed the maximum state of happiness and the Young-Old groups enjoyed the least state of happiness.

Similarly, in the present state of happiness, the comparison between various age categories of the elderly, the results indicated no significant difference any groups of the elderly age categories at any level of the significant difference. From the mean scores we Can also see that there are not much difference between the groups scores. When their past (five years ago) experience is compared between the groups of the various age categories, the results indicated significant difference between any groups at any level of the significant difference. Mean scores of each group showed that there are not many differences between the scores of all the groups. Regarding the rating of the future, five years down than line (expectation of the future), and the comparison between the various age categories showed no statistical significant difference between any groups at any level of the significant difference. Mean scores of each group indicated that the Young-Old group has greater expectation than the older groups.

When the comparison based on their optimism of life is made, the results indicated that no statistical significant difference was found between any groups at any level of significant difference. The mean

scores also do not show the relationship with age. Relating to religiosity, the comparison be3tween the various age groups showed no statistically significant difference at any level of the significant difference. The mean scores of the comparison also indicated not much difference in their scorings.

DISCUSSION

Age of the elderly found to have great impact on the psychological health of the elderly. With the age grow older, the physical health also weakened. For the matter their economic and social health is of vital importance to improve the psychological health. This psychological health could be strengthened through better social support network and social acceptability within or outside the core social circle. Perceiving the presence and absence of social support (1) perceived willingness of others (members of the society) to listen when they want to talk, (2) perceived level of caring by the fellow, members provided to them, and (3) perceived reliability of others to provide support in times of sick and trouble all determine the healthiness of the elderly within his or her social environment. Thus, social support has a significant role in making the elderly feel wanted and supported (Ramamurti, 1989 a) within the social world. Physical functional and absence of physical illness along with supportive social network probably would be responsible for elderly to perceive life satisfaction. At the twilight years, a person's positive perception about his her life is of paramount importance for the well-being and successful-ageing. Successful ageing is measured in terms of good life satisfaction found to be related to better social support, greater belief in self, self-acceptance of ageing changes, flexibility, positive perception of health and economic well-being. However, the ageing processes thus inevitably dragging all the negative aspects of life to the fore. In spite of these facts, that those who has positive perception about life and optimism about life compensate many of the disabilities of life. The results of the study do not however, surprise as age has greater impact whereby the psychological health of the elderly is relatively poorer among the oldest old. With positive per-

ception and physical activity (vibrant) in life probably yield to have better psychological health than the frail and negative mindset of life.

However, gender differences among the old people seem to have no significant variations in perceiving their life and it correlates as psychological health. In all the indicators of psychological health, including the self-rated mental health, life satisfaction, state of happiness, self-rated happiness of different points of time, optimism about life, and religious inclination do not yield no difference between different sex to indicate psychological health.

Conclusion: Women as compared to men, mature earlier, exhibit better immunity to ageing changes and certain disease conditions, and also live longer (Jamuna, 1988a). But women were relegated to lower social and professional status in the Indian culture. Its root lies in the lower status enjoyed by the girl child in the family and social settings, the preference for male progeny among couple and the traditional patriarchal lineage in India. All these factors continue to affect women as they grow older. Elderly women perceive more mental problems, more disturbed with life; quality of life is deteriorated as compared to elderly males. Their social circle is reduced because during their entire life they are quite busy in their family affairs as they even ignored their own well-being. So they do not have successful ageing and not at all satisfied with life. Most of them are not happy with their present life and also expect that they will not get any happiness in their future. They are less optimistic as compared to the male elderly. But they are quite religious; attend various spiritual sessions during their entire lifetime to attain “Moksha”, whereas more elderly males are turned out to be religious only after reaching certain age (Dhillon,1996).

When elderly are categorized in three categories depending on their age the young old perceive better mental health as compared to old and old-old because due to increasing mental disorder. Again Young-Old are found to be more socially active as compared to Old-Old. This is due to the reason that increasing age hinders their

physical activity so neither they go outside nor they make friends. Moreover, in today's fast changing world, in urban areas most of the senior citizens are living either in nuclear family alone so their children do not have time for them. So elderly are socially less involved with their family, relatives and neighbours and friends. Again increasing age makes elderly less satisfied with life because this variable is dependent upon socio-economic, educational status and marital status. Elderly, due to their increasing age suffer from various problems like negligence by the children, economic problems, various physical and mental health problems it affect them and make them less happy and contented with life.

REFERENCE

1. Banerjee, M.(1997). Level of isolation and interpersonal relationship of age person in the family. Astudy in Shillong. Ageing & Society: The Indian of Gerontology,7 (3&4), 25-34.

2. Chadha, N.K, Bhatia, H., Chao, D., Rohatgi, M., & Mir, U.A.(2004). "Predictors of the physical functional of the old". Interim Report submitted to the Indian Council of Medical Research (ICMR). New Delhi.

3. Chadha. N.K. Chao, D., Mir, U.A., & Bhatia, H. (2005). Structure of social network of the elderly in Delhi. Indian Jourbal of Gerontology, Vol. 19, (3), 307-326.

4. Chadha. N.K., Aggarwal, V., & Mangla, A.P. (1992) Hopelessness, alienation and life satisfaction among aged. Indian Journal of Gerontology, 6 (3&4), 82-92.

5. Chadha, N.K., & van Willigen, J. (1996). Life Scale: the development of a measure of successful ageing. Indian Journal of Gerontology 10 (3&4) : 83-90.

6. Chadha, N.K., Aggarwal, V. & Mangla, A.P. (1990). Hopelessness, alienation and life satisfaction among aged. Indian Journal of Gerontology, 6(3&4) : 82-92.

7. Chao, D., Chadha, N.K., & Joshi, P.C.(2004). Psycghological well-being of the elderly among the Nagas. In A.K. Kalla and P.C. Joshi. (Eds), Tribal health Medicine, New Delhi: Concept Publications. Pp. 247-275

8. Dave, C. (1999). Psycho-social aspects of Hindu religion and spirituality in the ageing years. Paper presented at 4th Global Conference of the IFA, Montreal, Canada

9. Dhillon, P.K. (1996). Religiosity and death among the aged. Research and Development Journal,2(2), 33-39.

10. Jamuna, D. (1988a). Adjustment among pre and post-menopausal rural women, Journal of Psychological Research,31 (2). 88-92.

11. Jamuna, D; & Ramamurti, P.V. (1991). Social support inventory for the elderly. Journal of Psychological Researches, 35, 133-136.

12. Ramamurti, P.V & Jamuna , D.(1994b). Ageing as stress: Strategies for coiping. Paper presented at the International Symposium on Gerontology and the sixth AGI Conference, AIMS, New Delhi

13. Ramamurti, P.V. & Jamuna, D. (1993c). Are religiosity and external locus of control associated with good adjustment in old-age. Personality Study and Group Behaviors. 13 , 59-63.

14. Ramamurti, P.V. (1989a). Determines of satisfaction with present life among a sample of elderly rural men in India. Abstracts Proceedings of the XIV International Congress of Gerontology, Acapulco Mexico June.

15. Singh, S. (1995). Prepare now for a happy old age. In S. Vijayakumar (Ed.), Challenges before the elderly; An Indian scenario (273-280). New Delhi: M.D. Publications.

16. Singh, S. (2002). Issues of emotional integrations, peace and happiness the vedantic view. Journal Gerontology 17 (1&2), 205-2012.

17. Ushashree, S. & Basha, A. (2003). Religiosity as a contributor to meaning in life. Journal of Gerontology, 17 (1&2), 85-98.

The present Paper is based on the Task force Project “Determinants of the functional status of the older India” funded by the Indian Council of Medical Research (ICMR), New Delhi. We are thankful to the ICMR.

NOTES FOR CONTRIBUTORS

All Contributions and correspondence should be sent to Dr. Indrani Chakravarty, Calcutta Metropolitan Institute of Gerontology, E-1, Sopan Kutir, 53B, Dr. S. C. Banerjee Road, Kolkata-700 010. Contributors are requested to conform to the following norms and those articles that do not conform may not be considered.

Journal articles that deal with the biological, medical, psychosocial, service or other aspects of ageing are welcome.

Articles should be original contributions. Redundancy is discouraged. The articles should be written in English, free of grammatical or spelling errors, repetitions etc.

Articles shall contain: A brief introduction (reflecting the context, the review of relevant work and why the present study was planned) : relevant details of plan methodology, sample, (including standardization properties of tools) etc., the results or findings and their discussion and conclusions arrived at. At the beginning of the article the title and names of authors shall be mentioned. (Their affiliation may be given at the bottom of the page). This shall be followed by a brief abstract of the article (not exceeding 100 words) in single space, bold and set off the margins (inset by two spaces). Two or three key words of the article should be provided at the end of the abstract separately.

Articles may be computer generated. Two hard copies, double spaced in A4 size (one side only) with wide margin may be sent. The articles would be adjudicated by referees and the result would be communicated. When the article is accepted contributors are requested to send 2 corrected versions of the article (hard copies) and the same in an electronic version in CD, press ready.

(a) References as below in international style (e.g. journal of Gerontology) arranged in alphabetical order in the Text : (Altekar, 1973, Birren, 1959, Tyson 1983 ....). End list of references:

Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. *Developmental Psychology*, 23,611-626.

Baltes, P. B. Reese, H. W., & Nesseiroade, J. R. (1988). *Life-span Developmental Psychology*: Introduction to Research Methods. Hillsdale, NJ : Eribaum.

(b) Footnotes should be avoided unless absolutely essential.

(c) Tables and figures should be clearly laid out, typed in standard format, numbered consecutively, and designed to fit on the page of the journal “AGEING & SOCIETY” of CMIG.