CHAPTER-II

REVIEW OF LITERATURE

There are great gaps in our knowledge about age in society. Perhaps in response to the sudden emergence of a large stratum of old people in our society who are quite different from the old people in the past, there has been considerable outpouring of research in recent decades about old age. Scholars have come to grasp an essential point that one cannot understand old people without placing them in a broader framework of all age groupings in society of the previous life histories of older persons and of the situation of old people at other times and places.

Sociological interest in aging reflects the increasing visibility of the old persons in the modern society and also the realization that investigation into the social life of the older people provides an opportunity to test many basic propositions about the causes and consequences of social behaviour generally. Researches in the field of social gerontology in western societies were initially aimed at studying the problems of adjustment in old age. *Social adjustment in old age – A Research Planning Report* by Otto Pallock is the most elaborate earlier work concerning social adjustment of the aged. The Committee on Social Adjustment of the Social Science Research Council (U.S.A.) had already selected in 1941, “adjustment in old age” as an area that requires active attention.

In 1948, Argentina drew the attention of the world to the problems of the aged at the general assembly of U.N. Any country, no matter what its order of priorities may be, is morally committed to protect the rights and provide the basic care to all sections of its population. The studies have been conducted to
know the actual situation of the elderly in all over the world. Some of them are as follows:

Stieglitz (1952) defines aging “as the element of time in living”. According to him “aging is a part of living. Aging begins with conception and terminates with death. It can not be arrested unless we arrest life”. The view of Stieglitz tallies with other that aging involves two simultaneous processes which operate continuously in spite of the fact that they are contradictory of each other.¹

Blau (1956) analysed the changes in the aged people and reported that of the two major changes in social status that occur in old age – retirement and widowhood – only retirement appears to hasten the onset of old age. The difference was justified as retirement implies a social judgement that the person has become old, whereas widowhood because it comes about through a natural event, does not have this implication for the older people.²

Dube and Herlen (1958) reported that respect is known to older people on ritual occasions but in every day life one can ignore these considerations. He further found that parents dominate the family until middle age, but with approaching old age, they gradually recede to the background. With regard to participation in community interests the old people generally stay at home. The middle aged people have in effect the controlling hand in village affairs, the truly aged retire into insignificant and fade away.³

Becker (1959) defined aging in the broadest sense, “as those changes occurring in an individual, as the result of the passage of time.” These may be according to him, anatomical, physiological, psychological and even social and economic. He adds, “Aging consists of two simultaneous components, anabolic building up and catabolic breaking down.”⁴

Riegel’s studies (1955 and 1960) regarding growing rigidity in old age supported the belief that growing old is identical with growing fear of change. This attitude becomes more and more dependent on the variety of factors which
may be defined as need for security and steadiness, more or less suppressed wishes for change and growing awareness as far as the satisfaction from one’s life is concerned.⁵

Donahue, Orbach and Pollak (1960) studied of adjustment in old age were conducted by Folsom and Morgan in 1937 and Landis in 1942. As Morgan and Folsom stated “they have used the present life happiness as the index of adjustment and reported that factors like good health, freedom from liabilities, pleasant social and emotional relations with friends and family members, hobbies, work like activities and independent living in own homes are positively associated with good adjustment of the recipients of old age assistance in New York.”⁶

Aries (1961) argued that youth was the privileged age of 17th century, childhood of the 19th and adolescence of the 20th. Although old age is yet to be a time of privilege in modern society, the aged and aging were discovered as social problems in the second quarter of the 20th century.⁷

Singh (1962) found that status as head of the joint family, with its associated authority and prestige is not automatically retained by old men by reason of age alone, it appears to be determined by several factors, including marital status and the pattern of inter-generational and inter-personal relationship. The family patriarch is reduced in status and becomes a dependent in the household of his eldest son. A majority of fact, subordinates to the control of another person in the household. This study leads to two major conclusions: first, the status of old people was high, but varied with age, physical health, marital condition and inter-personal relationship, and second only a majority of men had continued to enjoy prestige, authority and security beyond the age of 60.⁸

Thomae (1962) revealed that the differentiation and structuration of the life course of the individual as seen by the individual himself is determined by the major events of life. Within these events are to be found from the main
source of adjustment problems of aging. This means that changes in the
socio-psychological situation of individual calls for adjective reactions on the
part of aging person.9

Indra (1963) found that the old man maintains his status if he behaves
well with the other family members of the family and he has some valuable
material in his possession. There are the basic and critical considerations of the
conception that authority, prestige and security automatically accrue to the
aged in village’s society. The old man, particularly those of low socio-
economic position occupy a very poor status in old age, and that their
difficulties are not instigated by outside forces nor are they new in the long
history of Indian family.10

According to Weinberger and Rubingtion (1963) human suffering
among aged persons in the form of capacity, isolation and poverty were
considered to be prevalent enough to warrant social concern and social action.
The way a society defines its own problems and discusses their solutions –
reflects at least implicitly, a perspective. They have suggested five common
perspectives on social problems, which can be usefully applied to both early
and contemporary references to the aging or to the aged as social problem. The
two major perspectives are social pathology and social disorganization. The
three additional perspectives concentrate on various aspects of social power
and its uses-these are value, conflict and labeling.11

Kanaha (1970) reported that the elderly shared society’s worship of
youth. Young people are viewed as hardy, active, independent and involved.
The elderly not surprisingly, are value the least. They are seen as relatively
hopeless, passive, uninvolved and fragile. Young people make little distinction
between old men and old women in their evaluation and young adults tend to
have mere negative view of the aged than others do.12

Jackson (1971) while focusing on the physical and mental health of the
blacks, found that black males having an age of 75 years and above tend to be
in better health than their females or white counterparts. This fact may be attributed to the much earlier deaths of black males who were psychologically, physiologically and socio-culturally less advantaged.13

Sharma (1971) in his survey of happiness and unhappiness in old age, inferred that happiness, to a great extent, depends on busy life, good health, financial stability and having a spouse and social contacts. The range of psychological problems was much wider, and the impact entirely different as compared to that in the ‘unorganised’ sector.14

D’Souza (1971) concluded that the problem of older people in India has arisen because the structure of Indian society is changing fundamentally. As a result of this, position and roles available to the older people have also undergone a change. He found that wherever the older persons are still in occupation of leadership positions it is mainly because of their wealth and higher degree of education rather than their old age.15

Kurian (1972) in his study “Aging in India and Canada,” found that there have been many changes in the traditional position of the old people in India. He also pointed out that emotional security of the old people is not given adequate consideration and that loneliness is one of the sad features of the old age.16

Parthasarthy (1973) found that disruption and division of the joint family system and the family poverty entrusted by the parents to their successors make the matters worse. None comes to their rescue. He further remarked that previously the role of the old in the family was to earn and protect the family members which enhanced their status at home and outside. The problem of money hinders their balance of mind. The mental torture of their habits and addiction afflict them a lot. He suggested that the poor old people who have no one to support can be helped with mobile medical facilities, at least the genuine cases.17
Soodan (1975) found that about half the aged were wholly dependent upon others. One third of the aged were still the chief bread earners of their families. On the whole, the burden of supporting the aged was on their children and to a lesser degree on their relatives. Depending on others was greater among women than the men as the majority of the former had just remained housewives. He further remarked that in some cases the elderly had to live with their relatives because the children had to leave their parents homes to establish their own homes or they failed to support them.18

Shanbag (1977) reported about the opinion of youths towards the elderly. He revealed that among most Hindus staying in joint families, but the young breathe signs of relief when the doddering old senile grand father finally dies. He had served his purpose years ago and there was very little reason for him to live. Another youth says that of course it is his duty to look after his parents when they are old. May be they can’t earn but what about their wisdom and advice.19

Ramamurthi (1978) found that such problems tend to manifest gradually after the age of 50, resulting in poor adjustment and dissatisfaction with life. However, after retirement, people gradually adjust—the index reflecting as positive over a period of time. This continues till the age of 70, after which the negative effects of ageing become pronounced again.20

Anantharman (1979) studied the various problems of aging like perception of the old age by two generations and physical health and adjustment in old age. He found that older people perceive more worries in old age. Younger subject perceived more negative characteristics of old age. Negative perception by elder people was due to retirement, loss of income, more free time, friendship, work environment and loss of spouse or friends etc. While discussing their adjustment and health, he noted that those who were young (below 65) active good in adjustment belonging to professional occupation and under social class rated their health to be good and those who
were old and of lower social class rated their health to be poor. In addition to it, those who rated their health to be good and who do not have any physical problems, were found to have better adjustment.\textsuperscript{21} 

Ramachandran, Menon & Ramamurthy (1981) found that family and living conditions are significant factors affecting the mental health of the elderly. Mental disorders are attributed to abuse, neglect or lack of care for a parent.\textsuperscript{22} 

Sharma (1981) reported that 10% American living alone, in spite of their wisdom, skills, mobility were living virtually in psychospiritualistic deprivation. The problem of aging, at least in American society is one of the belief in the denial of the inevitable i.e. pain, decay, death. Dying at home is non-existent. When aging is fragmented into sexual, economic-psychological, then it becomes difficult to hold it together. Spirituality provides the gestalt, and provides the basis for respect, belonging, work etc.\textsuperscript{23} 

Chandrika and Anantharaman (1982) also found that non-institutionalised older people adjusted better than institutionalised geriatric patients. Factors such as rigidity of attitude, availability of a role to play and the extent of involvement, communication with the spouse, marital satisfaction, approach to retirement, attitude regarding one’s future, physical and mental health (including death) influenced adjustment.\textsuperscript{24} 

Bhatia (1983) pointed out that “age and ageing are equally related to role-taking, value orientations and modes of behaviour of a person the expectation of which varies at different age-stages of members of a society”. It may be mentioned that the process of ageing is not uniform for all individuals in the society. Thus, changes in the life of the old age, which are considered to be the \textit{sanyas ashram} of the Hindu ashram theory, is influenced by the biological as well as the social and cultural systems. However, in recent times, the status and role of the old age population have been diminished due to the technological developments that have colonized the outlook of the youths.
While contemplating on the issue of the ‘aged’, the ideas that haunt our imagination are quite complex as well as intriguing. Some argue that the elderly individuals are in a state of ‘decay’. It implies that their role in society seem to be redundant and obsolescent for our contemporary times. In other words, they rarely have any function/role to contribute to our times. On the other hand, it is also believed that elderly persons are the guardians of our generation, preservers of the joint families, foundation of experience and knowledge, and resource of traditional values, norms and cultural practices. Thus, at this juncture, sociologists should be engaged in this debate in providing sociological perspectives on the transitional state of affairs of the elderly persons and advocate alternative approaches also for their emancipation to mainstream life.\(^{25}\)

Chanana and Talwar (1987) conducted a study dealt with the growth rate of the aged population in India, the dependent population in the non-productive age groups, the old age dependency ratio, sex ratio, marital status, literacy among males and females, and working and nonworking aged. The health status of the aged was also analysed on the basis of the data collected in the 28th Round of the National Sample Survey in 1973. The analysis included measures of the prevalence of temporary illness and chronic diseases, the number of old people requiring medical assistance and the types of physical impairment from which they suffered, cross-classified by place of residence and sex. The study also threw light on the welfare programs for the aged being implemented in different states of India.\(^{26}\)

Mahajan (1987) focused on intergenerational changes and found that most of the elderly population felt that the younger people did not respect them and anticipated tension in bonding and togetherness.\(^{27}\)

Nandal, Khatri and Kadian (1987) found a majority of the elderly suffering from diseases like cough (cough includes tuberculosis of lungs,
bronchitis, asthma, and whooping cough as per the International classification of diseases), poor eyesight, anaemia and dental problems.\(^{28}\)

Punia, Malk and Punia (1987) in their study “Problem of the Aged: A Study of Rural-Urban Differential” found that people in the rural and urban areas of district Hisar in Haryana state, based on sample of 130 urban and 230 rural aged, male and female respondents, aimed at family, daily routine, occupational and economic status, health are participation in decision making and psychological perception about themselves and society. His findings were that there is a difference between rural and urban age in education, awareness about there rights, occupation, income of the household and personal earnings. In both communities, their sons are replacing the status of the aged as the head of the household. The urban aged like his wife most among the adult female members, because both partners are to live alone in the home and have closer affection and develop understanding. Keeping good health is a measure problem of the aged. In urban communities, health services are available but the increasing cost has made it difficult to benefit. On the other hand in rural areas the problem if more grave neither the health facilities nor the financial support is available to them.\(^{29}\)

Bose (1990) pointed out that the old people had a feeling of being neglected by the society because nobody had the time to sit with them. Generation gap increases this gulf and increases the feeling of despondency. Almost the same number of working and non-working aged women had severe social adjustment level. The aged women had feeling of being neglected by the society and the members of the family as their children did not allow them to mix up with others. In old age, they felt they had become less active and due to their poor economic condition, they can’t attend the social gatherings.\(^{30}\)

Joseph (1991) made a comparative study of 411 persons: 207 men and 204 women over 60 living with families; 48 men and 44 women aged 60+ living in homes for the aged; and 257 people, 127 men and 130 women, aged
20-50 years in Kottayam district in Kerala. Joseph (1991) identified stereotypes of the aged, attitudes of the young towards them, their problems, including health problems, and their personality and religiosity.\(^{31}\)

Kohli (1991) in his study “challenge of Ageing” studied the problem of aged in three aspects, firstly the force of modernization, technological changes, mobility and the explosion of human knowledge are making changes in life style’s and values to adjust, secondly the problem of houses accommodation, thirdly increasing an employment of women outside the home and fourthly the adverse effect on the interfamily distribution of income, and finally the breakdown of joint family system resulting in breakdown in common ownership of means of production. He further stated about the constitutional and legislative provisions alongwith the policies and programs launched by the govt. for the aged persons.\(^{32}\)

Dandekar (1993) in his study observed that the elderly citizens are in need of urgent attention. They do not need our pity, but the understanding love and care of their fellow human beings. It is our duty to see that they do not spend the twilight years of their life in isolation, pain and misery. Older persons are, therefore, in need of vital support that will keep important aspects of their lifestyles intact while improving their over-all quality of life.

Shah (1993) in his study of urban elderly in Gujarat found deteriorating physical conditions among two-thirds of the elderly, consisting of poor vision, hearing impairment, arthritis and loss of memory. An interesting observation made in this study relates to the sick elderly’s preference for treatment by private doctors. Besides physical ailments, psychiatric morbidity is also prevalent among a large proportion of elderly.\(^{33}\)

Ramamurti and Jamuna (1993) pointed out that happiness in old age depends to a great extent upon a busy life, good health, access to funds and having a spouse and social contacts. Anxiety is reported to be at higher levels among the elderly in general. A majority turn to religion for overcoming their
feelings of anxiety by reading or reciting religious books and hymns. Studies have found that non-institutionalised older people are better adjusted than institutionalised and geriatric patients. The younger generation, as well as the elderly, themselves view institutionalisation of the elderly unfavourably, which is partly due to a deep rooted tradition in our society that it is the duty of the children and family to look after the elderly. Some of the factors that are found to influence the adjustment of the elderly are rigidity; flexibility; role availability and role involvement; nature and quality of husband-wife communication; marital satisfaction; nature and quality of attitude to retirement; attitude to future and death; and satisfactory physical and mental health.34

Goldman et al (1995) investigated the effect of marital status on health and mortality at older ages using data from the National Health Interview Survey: Longitudinal Study of Aging, 70 years and over. Results suggest that marital status continue to benefit health and survival outcomes at older ages. While being a widow or widower is associated with higher mortality and disability, divorced and single people seem to create a social environment that compensates for the loss or absence of a spouse so that changes in marriage patterns need not have adverse effects.35

Liu, et al. (1995) have examined the effects of social and emotional support, both to and from Chinese elderly, on health status, in urban compared to rural areas. Study was done on 2943 elders aged 60 years and more drawn from the 1991 Survey of Health and Living conditions of the Aged persons in Wuhan. They completed questionnaires on self-health status socio-demographic characteristics, living conditions and health care utilization. A theoretical model was used to explicate the causal linkage between social support and health status. The results that obtained show that enhanced social support to an older was associated with improved health status; and emotional support played a crucial role in this relationship. These effects were stronger in
rural areas. Emotional social support, both received and given, had positive impact on self-rated health; while loneliness, chronic disease and functional disability had stronger negative impacts. Working and socially active subjects reported better health.\textsuperscript{36}

Chowdhury and Nugent (1996) pointed out that it is indeed a severe shortcoming that hardly any of the available social security mechanisms for the elderly cover health care requirements, except some that have emerged in the organized public sector or in private concerns. The question confronting the state is the management of the fluidity of formal schemes along with the tenuousness of informal systems such as the family. It is really a matter of observing the viability of the former with the continuing support of the latter.\textsuperscript{37}

Dandikar (1996) investigated the socio-economic and health conditions of the elderly in India drawing on data from the 1986-87 National Sample Survey of 50,000 households and interviews with 601 elderly people in a rural village of Maharashtra. It was found that a large percentage lived in rural areas and existed in poverty, as they have since their youth. More men than women are likely to reach an elderly age, a fact attributed to the abysmal condition of women in India; thus, the burden of the elderly most often falls on their sons. Though poor, the elderly play a prominent and integrated role of their community, exercising considerable influence in the social and religious matters of Indian society. These conditions for the elderly are found to be uniform across the Indian states, perhaps attributable to the massive amounts of poverty in the country and the dependence on agriculture. It is revealed in a case study of old age homes in Maharashtra that, when circumstances required that the elderly be segregated from their families, these homes offered useful and badly needed services. For the rural elderly, old age tended to work until they could no longer do so. In contrast, the urban elderly stopped working by age of 50 yrs and a vast majority of them did not own their own homes. Based on these findings, it is argued that, because the rural poor are well integrated
into their communities and not disposed to live in old age homes, government policies ought to be directed at providing old-age pension programmes as the cheapest method of providing relief to the Indian elderly.\(^{38}\)

Kumar (1996) compared the living arrangements of the elderly in two Indian states of Kerala and Uttar Pradesh found that an overwhelming majority of the elderly in both states live with their off-spring. The study also showed that the traditional value system of the family and younger generations taking care of the elderly continues to persist through demographic transitions and cultural norms appear to be the same in the two demographically divergent states. At the same time, the study also revealed that the number of surviving children is positively correlated with co-residence after controlling for social and economic variables, while income is found to be significantly reducing the possibility of living with children.\(^{39}\)

Chakrabarti (1997) has tried to give an overview of the old age problems in India and tried to emphasize the preventive measures needed to solve the problem of our senior citizens. He suggested that for integrating the elderly into society an appropriated population policy should be adopted to develop the balanced economic activity, to raise labour productivity and to improve the physical, psychological and culture quality of people in general. To promote the elderly in taking part in a planned and organized way a well planned policy is necessary. He concluded that the solution of the problem of the aged demands integrated measures to tackle the problem of individuals in different phases of life and not only when they reach their senselessness period.\(^{40}\)

Chan (1997) found that in Singapore, about 90 per cent of the elderly above age 60 lived with at least one of their children. This article foresees some of the gaps in the government’s support systems for the elderly and the future challenges that might be faced by this population group and their care-givers. In Thailand, despite major demographic and social changes, an extensive familial system of support and care is maintained.\(^{41}\)
Natividad and Cruz (1997) examined living arrangements among the Filipino elderly in terms of gender, marital status and place or residence. Although it is common for the elderly to live with their children, they are not passive recipients of support.\footnote{42}

Anh et al. (1997) indicated that the proportion of parents living with at least one child in the same dwelling unit is declining. But the article does not consider this an erosion of the support system, since daily contact between older parents and non-co-resident children compensates for this decline. Another study on Vietnam has identified that married sons constitute the most important source of social security in addition to the finding that the family constitutes the most important source of social support and security.\footnote{43}

Achir (1998), in the paper “Strategies to formulate family support system and community based services for the care of the old” showed although, changes are good indicators of development, dilemma for support capacity of the family towards the elderly is inevitable. With many women entering the work force, available support for the elderly has significantly reduced. As a consequence, the International Year of the Family has appealed to the world to maintain, strengthen and protect the family to ensure continuity of its vital role in preserving dignity, status and security of its ageing members.\footnote{44}

Chen (1998) investigated the consequences of the living arrangements on the elderly in Taiwan. The study acquires special importance, as many Asian countries are expected to follow the Taiwan experience. Models were formulated to predict the probability of living in a specific household structure. The study identified migration, resource change and life cycle events as significant factors that decided living structure during old age.\footnote{45}

Vasantha (1998) in a study “Nutrition and health problems” found that the rural aged suffered from nutritional, psychological and other problems, when compare to urban aged. The aged employed privately and those self employed had more of health problems then not gainfully employed person. In
general, the male members were found to be literate, economically independent and had less physiological and nutritional problem when compare to the female counterparts, when literacy level, income level and employment status improve, they seem to have better health. \(^{46}\)

Chadha (1999) emphasized that psychological and environmental problems including feelings of neglect, loneliness, being unwanted, all related to loss of power are usually associated with old age. Imbalance in the reciprocal relationship makes the aged feel unwanted and neglected. With current trends such as encouraging seniors to live longer at home or in the community, a highly mobile society and fewer children per family, the issue of social isolation takes a new importance. \(^{47}\)

Government of India (1999) Report of Expert Committee of Projects, OASIS (1999) pointed out that in a country like India where the majority of the population is suffering from chronic poverty, it is found interesting to study chronic poverty and vulnerability in the aged. Here, poverty is looking into issues of hunger and vulnerability is a larger issue of the socio-economic insecurity among the elderly that act as a determinant of the poverty among the aged. Poverty is addressed in terms of denial of livelihood to the aged where they are denied of adequate flow of food, cash and assets to attain minimum basic needs. \(^{48}\)

Karkal (1999) pointed out that apart from the livelihood inputs to old age social security, which includes food and shelter, the other major component is health or medical and disability care. In a society that has achieved some though not excellent levels of public health standards, with increasing life expectancy, the special health needs of the older populations have not merited attention. A comprehensive review of the health status of older people and the various measures adopted by the state and non-governmental agencies has indicated the enormity of the issue and the need for special attention to this group. \(^{49}\)
Mathiyazhagan (1999) in his research commented that though there is a significant growth in the government infrastructure since our independence, its efficacy has been suspected and this has caused confusion and frustration among the people. In a supply-constrained public health system like ours, the sick have not waited for the government to find a way to provide better health services. They continue to bypass the inadequate government facilities to seek care in the private sector, which is expanding in almost all parts of the country.50

Ngugi (1999) in her study analyzed that the action taken when sick was at two levels: an immediate action after diagnosing the problem called ‘first action’ followed by a second action called ‘follow up action’. Off-the-counter service was popular as an immediate action. Among the adults, non-use of facilities was mainly due to cost implications of visiting the formal facilities. Public facilities were preferred because they were near and cheap, and because services received were perceived as adequate although consumers had to supplement them with services from alternative sources. Private and mission facilities were mainly selected because of the locality and the availability of drugs.51

Kumar (1999) observed that in traditional Indian society, the informal support systems of family, kinship and community are considered strong enough to provide social security to its members, including older people. Urbanisation, industrialisation and the ongoing phenomenon of globalisation have cast their shadow on the traditional values and norms within the society. Gradual nuclearisation of the joint family, erosion of morality in economy, changes in the value system, migration of youth to urban areas for jobs or work and increasing participation of women in the workforce are important factors responsible for the marginalisation of older people in rural India. As a result, the elderly depend on ‘money-order economy’ and their intimacy with their children is only from a distance.52
Bhandari (2000) pointed out that in the last 50 years global life expectancy increased by 20 years to its present level of 66 years. The fall in fertility is dramatized by the Chinese and Indian experience. In China, fertility fell from 5.5 in 1970 to 1.8 in 1998. The corresponding figures for India are 5.0 and 3.1. This segment has social security in the form of provident fund, gratuity and pension. Senior citizens above the age of 65 also have concessions regarding rail and air travel and income tax. The main problem faced by a number of old persons of the middle class is not so much economic security as emotional deprivation because of social ostracism.53

Desai (2000) found that “Ageing” encompasses all the biological changes that occur over a lifetime. “Getting old”, on the other hand, is a social concept and slightly related to the biological processes of ageing. The social context of ageing, according to the Dharmashastra, is when wrinkles and grey hair appear in a person and a grandson has also appeared in the house. Then it is considered time for the householder to retire. Thus, the Brahminic concept of old age emphasizes conclusion of and, therefore, is engagement from family life cycle responsibilities.54

Devi and Premakumar (2000) observed that elderly members are confronted with various nutritional, physiological and other general problems. The rural elderly are mostly illiterate with low income. They suffer from more nutritional, physiological and other problems. The men are more literate, economically independent and face less physiological and nutritional problems as compared to their female counterparts. When the literacy level, income level and employment status improve, they seem to be more comfortable with their health conditions and living status.55

McAuley et al. (2000) examined social relations, physical activity and well-being in 174 formerly sedentary adults (age 60-75 years). Such people were found to have close friends and their contacts with friends increased with
Thus, good health was associated with greater supportive contacts and enhanced satisfaction among the older adults.\textsuperscript{56}

Sun (2000) reported that physical health and well-being was affected by the number of children the elderly had during their old age. The children provided informal social support which may have enhanced their health and have a positive impact on the daily activities of the old aged people. Humans are social beings, they live in social set-ups and the kind of support and supporting relations one has with others matters and influence the well-being. Not only this, how the person perceives the available support i.e. whether the person is satisfied with available support or not has implications for the subjective well-being.\textsuperscript{57}

Cohen (2001) discussed the development and effects of loneliness in the elderly. The need for mental health specialists to identify what factors predispose an individual to the phenomenon as well as those that precipitate it is noted. The image of social interventions and psychological counseling either alone and in combination is promoted as an effective form of treatment. It is concluded that, given the prevalence of loneliness and the frequency of adverse effects on health in later life, the topic should be considered a more prominent mental health matter in the future.\textsuperscript{58}

Visaria (2001) presents a summary of two large surveys conducted by the National Sample Survey Organization during 1987-88 and 1995-96. The surveys pointed out that only about 6 to 8 percent of the aged were without any surviving child. A large majority of the aged had one or more surviving children, who might potentially at least after some support to their parents. With the rising volume of mobility and migration form rural to urban areas, the surviving children may not be around to support the aged persons. According to both surveys, about 80 percent of the aged, who were partly or fully economically dependent on others, received support from their children or grand children. To conclude the characteristics of the aged presented here
highlight the enhanced needs of the aged for health care as well as the mechanisms available to them to meet those needs.\textsuperscript{59}

Baarsen (2002) indicated that elderly who had lost a partner experienced lower self-esteem, resulting in higher emotional and social loneliness, which was the perception of inadequate support.\textsuperscript{60}

Jun (2002) has constructed a health index by taking into account physical, mental and social well-being variables. The study has shown that aged people who live alone have the poorest health status compared to others.\textsuperscript{61}

Mba (2002) addresses the demographic and socio-economic correlates of the living arrangements of elderly women. The study identifies several of these variables and draws major policy conclusions. It strongly suggests that there is evidence of some convergence of Lesotho to the Western family system.\textsuperscript{62}

Knodel and Auh (2002) gave a broad profile of Vietnam’s older population including age distribution, marital status, education, economic activity and household work, religious adherence, quality of house and living arrangements. However, the study identifies the remarkable stability in the living arrangement of Brunei elders with respect to co-residence of children, and thereby keeps away the common fear of desertion of elderly parents socially. The article adds, “the result makes clear that many older Vietnamese men and women are not simply dependent, but in turn, are likely to contribute to stability in living arrangement”.\textsuperscript{63}

Rajan et al. (2002) examined 5,000 elderly in India to study the socio-economic profile, secondly an aging survey was conducted in 5 Indian states study issue was living support, social security, health and nutrition. Survey based on interviews with 2,253 persons aged 60 years and above involving 4 other South East Asian countries. More specifically the articles explore immobility, vision and hearing problems, tobacco use and use of health services. Results show that 44 to 47 males and 67 to 68 females per thousand
seniors in the all India ample report physical immobility. In the 4 states sample, 35% of elderly report perennial health problems, one third experience vision problems and mobility and hearing handicap are 17.6% and 11.1% sample shows 10% of elderly assessed themselves as being unhealthy.  

Raju (2002) found that old age is an age of ailments and physical infirmities is deeply rooted in the Indian mind and many of the sufferings and physical troubles which are curable are accepted as natural and inevitable by the elderly. Regarding the health problems of the elderly of different socioeconomic status, it was found that while the elderly poor largely describe their health problems, on the basis of easily identifiable symptoms, like chest pain, shortness of breath, prolonged cough, breathlessness/asthma, eye problems, difficulty in movements, tiredness and teeth problems, the upper class elderly, in view of their greater knowledge of illnesses, mentioned blood pressure, heart attacks, and diabetes which are largely diagnosed through clinical examination. 

Rajan, Sarma and Mishra (2003) pointed out that India is one of the few countries in the world where males outnumber females. This phenomenon among the elderly is intriguing because female life expectancy at ages 60 and 70 is slightly higher than that of males. However, at any given age, contrary to what we would normally expect, there are more widows than widowers and reasons for this unusual phenomenon need to be identified. Life expectancy at birth among Indian males had been higher than that among females until the first half of the 1990s. Apart from this unusual demographic pattern of excess female mortality during infancy and childhood, the phenomenon of age exaggeration among the aged complicates the analysis. Thus, the above observation of more males in old age does not reveal a true picture of elderly persons.

Irudaya Rajan and Kumar (2003) using National Family Health Survey-I pointed out that living arrangements among the Indian elderly. The study
presents detailed characteristics of living arrangements among the elderly in India in terms of headship, average household size and marital status. The article draws attention to the fact that only 6 percent of the elderly in India live in a household where their immediate relatives are not present. Furthermore, the paper put forward a few policy prescriptions to enhance the well-being of the Indian elderly.  

Legare and Martel (2003) have attempted to highlight the differences and similarities regarding the living arrangements of the elderly in Canada, Switzerland, United Kingdom and Finland, and to investigate the effects of these differences and similarities in demographic trends. The countries studied show great similarities in living arrangements, notwithstanding their cultural differences. Living alone is becoming popular although gender differences do exist.

Patil, Gaonkar & Yadav (2003) noticed lesser depression in a larger proportion of the sample elderly in Dharwad city. Stress events are specifically more evident in females, those with low per capita income and those who perceived crises in the family.

Martel and Carriere (2003) also found that prevalence of widowhood and divorce rates have different impacts on the living arrangements of the elderly. Besides living arrangements, housing conditions of the elderly are a prominent research area, as everyday environment has a direct impact on the well-being of individuals.

Rao, et al. (2003) in a study of health status of the rural aged in Andhra Pradesh, found that health problems tend to increase with advancing age and very often the problems aggravate due to neglect, poor economic status, social deprivation and inappropriate dietary intake. A high proportion of the total respondents stated that they were suffering from illness seriously. Lack of medical facilities in the village and poor economic conditions might be responsible for the low health status of the villagers.
Sudha and Rajan (2003) pointed out that in India, the sex ratio of the aged as well as that of the old-old favours males. Reasons for more males in old age may consist of under-reporting of females, especially widows, age exaggeration, low female life expectancy at birth, and excess female mortality among infants, children and adults.72

Vermani and Darshan (2003) noticed that the majority were involved in less important and non-remunerative roles and felt neglected during important decision making in the family.73

Batra (2004) assumed that working elderly are economically independent and have respect in their family and social life, enjoy positive experiences resulting in better quality of life. In contrast, the elderly who are not engaged in any work are entirely, or in some degree, dependent for their livelihood on their children, experience problems in interpersonal relationship, emotional insecurity and loss of power and lead a low quality of life.74

Chaudhry (2004) in his study observed that a life course perspective on aging recognizes that older people are not one homogeneous group and individual diversity increases with age as the old people do not belong to the same gender, economic class, marital status, family background, religious status, health status, mode of living, professional background, and educational attainment, and they respond to the old age differently, face different needs, hopes, fears and problems according to a given specific situation.75

Majumder (2004) opined that though illness is unexpected occurrence of a random event, it has a fair degree of predictability with respect to demographic factors like age, gender, family size and marital status. For example, the size of a household may work positively or negatively. In a large family, per capita income may be less and therefore the ability to pay for health care will also be less; thus chances of utilizing care from a modern source may reduce. On the contrary, in larger families, interaction among the members or
with the neighbours may be more intense which may increase chances of seeking health care.\textsuperscript{76}

Pitkala et al. (2004) pointed out that positive life orientation, on the other hand, plays an important role in elderly people’s lives. More than half of the participants, of a Finnish study, with positive attitude were alive after ten years comparing with one third of the rest of the sample. Although, it does not protect against mobility and cognitive decline, significantly less people with positive life orientation were in institutional care in five years’ follow up.\textsuperscript{77}

Shaw and Lee (2004) pointed out that various studies across the globe show that economic deprivation of the aged is one of the common phenomena in almost all developing countries, which have achieved their targets in demographic transition.\textsuperscript{78}

Yadav (2004) concluded that socioeconomic status is a significant factor influencing lifestyles and religiosity among the elderly in India; sex significantly affects overall emotional maturity, emotional instability, emotional regression, personality disintegration and lack of independence; the normal coping, exploitative, domineering authoritarian and one-upmanship styles of life; religiosity and locus of control; and the interaction effect is significant only for emotional regression, personality disintegration, lack of independence and the individualistic, pampered, spoiled and domineering-authoritarian lifestyles.\textsuperscript{79}

Chakraborty (2005) conducted a study in Kerala, 90\% of the elderly, irrespective of their gender, consulted doctors for their illness. Recognition of disease by the elderly, his/her response to it and reaching or changing a provider depended on several factors. Geographic location and time convenience were cited by 64.9\% of elderly as reasons for choosing the first contact point. Over 40\% had chosen the first contact point based on cost of care. Other reasons cited were quality of care (13.7\%), faith in the provider (7.2\%), lack of alternative (4.2\%) and emergency (4.0\%).\textsuperscript{80}
Devi (2005) pointed out that the degeneration of the joint family system, dislocation of cultural and familial bonds, has resulted in declining possibilities of family care and greater need for self and formal care. While joint family system is on the decline, co-residence has become difficult and a separate existence is challenging due to issues of access to basic facilities and physical security. 

Ketshukietuo (2005), in the paper “Health problems of aged among the Angaminagas” mentioned that health is not only a biological or medical concern but also a significant personal and social concern. In general with declining health, individuals can lose their independence, lose social roles, become isolated, experience economic hardship, be labeled or stigmatized, change their self perception and some of them may even be institutionalized.

Mao (2005) investigated the family support of the elderly in the modern society. He observed that due to globalization, technological changes and mobility, the traditional care system, i.e., family based caring suffered greatly. In India, the changing family system (from joint to nuclear family) and occupational structure (from agriculture to non-agriculture) had considerably affected the care giving system that prevailed in the country.

Pappathi et al. (2005) in their study, “Psycho-social characteristics and problems of Rural Aged” showed that the psycho-social perspectives and problems and strategies to welfare of the rural female aged found that a majority suffer from joint pain, blood pressure and chest pain. A few complaint of asthma, piles, lose of weight, diabetes and skin diseases. Only 30 per cent among the rural aged where in good health.

Phoebe et al. (2005) pointed out that a society as large and complex as India needs to explore the contemporary society to work out an extensive plan for the care and well-being of the elderly. The plan would vary from those in the more developed countries due to the different stages of urbanisation and differences in the cultural and familial systems in India. The diversity that has
emerged in the ageing process necessitates that research efforts focus on different ageing issues in society. This in turn is expected to promote the development of effective age-related policies and programmes. The heterogeneity among the elderly population cannot and should not be ignored, while framing various models of care for the elderly in our society. For social and familial relations of the elderly, there appears to be a steady change in care-giving from the traditionally secure joint family care of the elderly to extended family care in which care by adult children forms a major part. Scholars cite that if the present trend continues, there will likely be a decrease in elder care by adult children in the future, which will create more demand for old-age homes. India is at a crossroads and has to decide whether to go the family care way or the institutional/community care way. They stated that for a country like India, the State cannot enter as a major player in elder care in view of the high (prohibitive) cost to the exchequer and the low national priority to elder care. The need to develop models of home or family care may be supplemented by suitably adapting them to a variety of respite services while at the same time suitably adapting them to Indian conditions.85

Post (2005) found that people who help others report better physical health, well-being, increased longevity and greater life-satisfaction. It has also been conjectured that giving may be an evolved biological indicator of healthy ageing, whereas receiving support may indicate needs associated with disability or illness.86

Rajan and Sarchandraraj (2005) studied the problems of the aged in Pondicherry, particularly those living in old-age homes. The study highlighted that the main problems faced by the old were: poor health, lack of finances, loneliness and lack of self-esteem because of retirement from job. These factors can be mitigated to some extent if the elderly begin planning for retirement while still in service. The stress induced by social isolation may increase
physical susceptibility to diseases and mental illness and the amelioration of these stressful conditions can improve health as well as quality of life.\textsuperscript{87}

Santana et al. (2005) stated that aging of the population is a phenomenon faced by most nations, such as Mexico, where 7.5\% of the population is older than 60 years, a significant population of who live alone (10\%). This fact is related with the ever-increasing migration of 1 or more of their relatives, mostly to USA. Their aim is to provide a technological solution that eases the isolation of elder people living alone in Mexico while their families are abroad. They suggested an electronic family newspaper, through which elders and their families could share information, personal reminiscessces and cultural stories and occasionally interact with each other. Through its functionality, the electronic newspaper enables elders not only to maintain close social ties, but also ameliorate cognitive decline.\textsuperscript{88}

Schnittkar (2005) showed that the likelihood of severe isolation increases with age because of the changes in demographic factors such as the increased likelihood of living alone. Yet, age is not associated with decline in the number of friends or in the number of confidants. Furthermore, the loneliness declines and evaluations of support become more positive with age. Much of the improvement in loneliness with age appears to be top-down, it occurs irrespective of changes in the environment or how individuals make choices among friends. This top down process is so powerful that loneliness declines even among those who are living alone have no children and report no confidants. Because of this process, loneliness is not at all common among the elderly.\textsuperscript{89}

Jain, Nandan and Misra (2006) conducted a study to assess the health seeking behaviour and perceptions regarding quality of health care services among rural community of District Agra. The findings of a study revealed that trying home remedies or taking medicines on the basis of previous treatment was the most common practice in villages in case somebody fell sick in the
family. When there was no improvement or if the problem aggravated, then majority of the people approached some clinic based practitioner in the village or nearby area, irrespective of provider’s qualification. However, when the health condition was severe or uncommon, most people directly approached a qualified health care provider either in the village itself or in the city.  

Reddy (2006) conducted a study “The health of the aged in India”. In his study he pointed out that because of declining fertility, the proportion of the aged in the Indian population has risen. Although the rise has been modest, as shown by an increase in the population over 60 years of age from 5.5 to 7.0 per cent between 1951 and 1995, by the latter date, India’s experience with 65 million people of this age is unusual. The paper employs data on persons 65+ years of age drawn from the 42nd Round of the National Sample Survey, and for the analysis subdivides them into three age groups, 60-64, 65-69 and 70+. It is shown that, among population over 60 years of age, 10 per cent suffer from impaired physical mobility and 10 per cent are hospitalized at any given time, both proportions rising with increasing age. Of the population over 70 years of age, more than 50 per cent suffer from one or more chronic conditions. The very limited support provided to the old by government is brought out by the fact that even in Karnataka, one of the states with the most generous provision, only 15 per cent of persons over 65 years of age receive any type of pension.  

Alam (2006) indicated that a very large majority of the elderly suffer from curtailed functional abilities in physical (eating, bathing, dressing, walking, climbing stairs, getting-up from a sitting position, etc.) as well as in sensory (hearing and vision) health domains. This forces them to rely on formal or informal help in their day-to-day activities. These problems of incapacitation are found to be particularly acute among the lower income groups. Women are the worst sufferers, with less of filial support.  

Offer (2006) reported that social isolation among low income populations was more prevalent. He found that living below the poverty line,
low level of education and immigrant status were the major factors associated with an increased likelihood of social isolation. He also discussed the implications of inadequate social support for family functioning and well being in the post reform era.\textsuperscript{93}

Teng (2007) observed that scholars and policy makers working in this area view the living arrangements of the elderly as a measure of their wellbeing. It has been a common assumption that co-residence with children and grandchildren in multi-generational households benefit the elderly, and that the elderly who live with at least one adult child are better off and better provided for than those who live alone or with nonrelatives.\textsuperscript{94}

Das and Satsangi (2008) explored the relationship between social support and life satisfaction among elderly people. Generally, older people are seen as losing interest in social interaction, but social support provides a buffer against stress in their lives, including the age related stress of retirement and bereavement. They reported that elderly people, who had more social support, were more satisfied with their lives in comparison with those who had lesser social support. It was suggested that the elderly who could identify several close friends or family members with whom they could share their concerns freely, experienced higher levels of wellbeing.\textsuperscript{95}

Pettigrew and Robert (2008) found that loneliness was thought, by most of elderly Australians, to be a natural part of aging and older age as a result of decreased participation in social activities due to health problems, death of friends and busy life of their children. On the other hand, many of the participants felt that loneliness can be decreased by constructive free-time activities, like reading, gardening or taking part in voluntary work.\textsuperscript{96}

Mutharayappa and Bhat (2008) analysed NFHS-2 data to examine the type of lifestyle adopted by the elderly and its effects on their health conditions. “It was found that lifestyle adversely affects health and increases morbidity conditions among the elderly. Lifestyle habits such as alcohol consumption,
regular smoking and tobacco chewing have adverse effects on one’s ability to control diseases."

Balagopal (2009) examined morbidity among 206 sampled elderly in an urban slum in Chennai showed that 40.5 per cent of ailments of the elderly were not medically treated and the two most important reasons for not seeking care were financial problems and the perception that the ailment was not serious. The author concluded that social policy of developing countries like India underplays the healthcare requirements of the elderly, especially elderly women. Another study wherein two sub-sample surveys were conducted by Ramamurthy and Jamuna shows the utilisation pattern of various available health services and assesses the impact of the geriatric services made available. It indicates that while lessons are to be learnt from the experiences of the west, the policies to be adopted by India need to be geared to existing factors like changes in beliefs and practices, relative responsibility of the kin and the community, values attached to the health and the elderly. Mere availability of services does not ensure its utilisation.

Hauge and Kirkevold (2009) explored elderly people’s understanding of loneliness more deeply. Their findings confirmed that loneliness is highly subjective. Differences of loneliness description were found between “not lonely” and “lonely” group, by lonely people giving more comprehensive description. What more, loneliness was seen negatively and was stigmatized. The group of “not lonely” reported loneliness to be one’s own fault connected to one’s personality and passive attitude to life.

Kotwal and Prabhakar (2009) conducted a study “Physical Needs and Adjustments Made by the Elderly.” They pointed out that old age is generally a closing period in one’s life span. Results of the study revealed that majority of elderly men and women lived in joint families. Majority of the respondents were satisfied regarding their financial position. They had enough money to look after their needs. Majority of both elderly men and women liked to watch
T.V in leisure time. Men liked to read newspapers and women preferred reading religious books. Majority of the respondent were facing the health problems like joint pains, failing vision, high blood pressure and diabetes. The finding revealed that the elderly were looked after by their spouses when they fell ill. It was observed that though most of the elderly were living in joint families still the spouses looked after each other when they fell ill this may be due to the growing generation gap.\textsuperscript{100}

King (2010) found that the older people with the highest support needs often have complex needs and can experience multiple forms of discrimination. By breaking the population of older people with high support needs down into broad sub-groups or equality strands, there is a risk that we overlook the considerable diversity within each category.\textsuperscript{101}

Jariwala et al. (2010) conducted a study of depression among aged in Surat City. The findings of the study shows that the prevalence of depression was moderately high (39.04\%) among the elderly in our study population and it was observed that several important socio-demographic variables had shown a significant association with depression in the elderly. The researchers found that those aged who are severely depressed and who require an institutional treatment are more in old age homes (25.71\%), followed by those living in the affluent areas (22.8\%) and those living in the slums (11.4\%). It was further observed that the prevalence of cases of mental disorders needing institutional treatment is around 67 per 1000 population. The prevalence of depression according to marital status was found to be significantly higher in the elderly who were single (never married), widowed, divorced or separated.\textsuperscript{102}

Khan and Raikwar (2010), in an empirical study of 320 people over 60 years of age in Delhi, selected through multi-stage stratified random sampling, suggest that 89 per cent of the respondents expected that their family members should take care of them but only 37 per cent are actually taken care of by their family members. Ninety- two per cent of the elderly felt that they should be
included in important household matters but only 26 per cent of them were actually involved in family affairs. Though a majority of the younger generation view the elderly as a socioeconomic burden, the advantages of having an elderly person at home such as care in times of sickness, advice in family matters, education and all-round development of the family are also recognised by a few from the younger generation.\textsuperscript{103}

Pandya (2010) in his study pointed out that an increase in the duration of un-utilised time during the post-retirement period as compared to the pre-retirement period is also noticed among the elderly. Religiosity seems to have increase with age. A quantitative study to understand the role of spirituality and ageing process in 906 elderly respondents in Mumbai reveals that the spirituality was perceived to provide support, aid relationship building and maintenance, facilitate coping with stress and ideas, and issues in relation to death and dying.\textsuperscript{104}

Patel (2010) conducted a study based on content analysis of reports published in two leading newspapers between 2004-2008 showed that most of the crimes against the elderly remain unreported. Female victims outnumber male victims and more crimes against the elderly were reported from urban areas as compared to rural areas (78 per cent and 22 per cent respectively). Surprisingly, 60 per cent of the crimes were committed indoors and most of them during the day. It was also found that 25 per cent perpetrators were their own family members.\textsuperscript{105}

Dubey et al. (2011) conducted a study of elderly living in old age home and within family set-up in Jammu. They pointed out that the last century has witnessed a rapid increase in the population of the elderly people in the developed and industrialized countries. Results of the study revealed that most of the elderly felt the attitude of the younger generation is unsatisfactory towards them especially those who were in old age homes in terms of getting respect, love and affection from the family members instead they were
considered as burden for others. Women living in the families had a positive attitude towards old age. The social relationship of the elderly women living in families and those living in old age home also differed. Noticeably, there was a fall in the overall efficiency, sociability, degree of involvement in work and hobbies. On the other hand, better social relations were maintained by the family dwellers because they had regular interaction, expressions of feelings and support from the family.106

Kumar, Sathyanarayana, and Omer (2011) using the 2005-2006 National Family Health Survey in India examined living arrangements by household, which is defined by having separate cooking facilities even if older parents and adult children live in adjacent structures. The survey found that more than four out of five (78 percent) Indians ages 60 and older lived in the same household with their children, while about 14 percent lived with only a spouse and 5 percent lived alone.107

Wason and Jain (2011) in a study of Jodhpur observed that the risk of malnutrition was more among females (42.2 per cent) than among males (32.9 per cent). Today, even if the urban setting provides better scope to earn a living, their status within the family continues to be dependent on their husband and they sometimes have little or no say in the aspect of financial saving for old age. The loss of status at the death of their husband only increases the situation of dependency in old age. This dependency can become more complex as the woman grows older, given the situation that she has no source of income or right to property as seen in traditional families, where her relationship with her son and daughter-in-law decides her fate in old age.108

Balamurugan and Ramathirtham (2012) conducted a study, “Health Problems of Aged People” and pointed out that aging brings about a number of physiological changes. It not only affects a person’s looks, but also becomes a cause of physical deterioration. This study was undertaken to understand the health status of elderly people and to gather some information about their
perceived health needs using the information and over of Puducherry district. The present study is descriptive in nature. Herein, an attempt is made to describe the situation and major health problems faced by the elderly from 213 elderly population of aged 60 and above in three rural communes of Puducherry. Findings reveal that majority of the elderly, both male and female, are unhealthy. The most common health problems aged people face include eye sight, hearing, joint pains, nervous disorders, weakness, heart complaints, asthma, tuberculosis, skin diseases, urinary problems and others. More health problems were reported by women compared to men.\textsuperscript{109}

Bevinamar (2012) in her study pointed out that elderly problem is a major problem across the world, as the elderly population is growing due to increase in health facilities. Among the elderly people, elderly women are most vulnerable group of the society suffering from socio-economic and health problems. The extents of problems of elderly women are more if they are widows. The paper analyzed the statistics of the elderly population and discussed the problems faced by elderly women in India. It is found that there is no particular social welfare scheme available for the betterment of health problems of the elderly women. Hence, the paper concluded with the remarks that there is need for health scheme for the elderly women.\textsuperscript{110}

Alam et al. (2013) conducted a study, “Socio-economic problems of persons with old age in District Dir Lower Khyber Pakhtunkhwa Pakistan.” The purpose of this study is to analyze the increasing adversity of old age which has emerged as a global phenomenon. Number of person with old age worldwide is estimated to be around 605 million today. This aging population is posing insurmountable challenges both for the developed as well as developing countries. Pakistan being a developing country is also among countries that accumulate a plethora of aged persons and which are also speculated to be multiplied in the coming years. Pakistani society, which is traditionally recognized as an aged honoring society, has also undergone
considerable changes in its social structure during the course of the broader modernization process. This change, in one way or the other, has affected the overall status and role of the elderly within the domain of social affairs. In this context, the current study identifies the socio-economic problems as well as factors responsible for the problems of persons with old age. For the present study 45 respondents were selected through convenience sampling because sampling frame of the persons with old age was not available in the universe. Samples were selected from three villages of Union Council Khungi, District Dir (lower). The quantitative approach has been used in order to analyze the data with the help of frequency and percentage. The quantitative analysis illustrate that persons with old age are facing problems in decision making, denial and verbal abuse, separation from spouse as well as married sons. They have low social status in the community as well as in their families. The persons with old age are facing problems in health due to expensive medicines and lack of personal money to spend for their health. It has been suggested that proper role of family members, revival of religious values, media and government intervention will promote the status of persons with old age in Pakhtun society.\textsuperscript{111}

Ageism can be intentional or inadvertent. The society we live in is permeated with ageism in varying degrees. Cultural stereotypes, pop cultures and media reinforce in a youth oriented society, “Young is beautiful”. Further, the constant emphasis on youth, beauty, vitality and strength, indirectly strengthens the negative aspects of ageing. Literature reveals that younger people have negative image of ageing, while the aged have a relatively positive image but at the same time the aged themselves had negative attitudes and perspectives of the other aged. It appears the aged themselves are impervious to negative stereotypes of aging being influenced by the social image. This bears proof to a maxim of social psychology which says, what we think of a person influences how we perceive him, how we perceive him influences how we
behave towards him and how we behave towards him ultimately shapes, who he is? Early research on aging reinforced the negative stereotypes of ageing. There is an urgent need to study the self-image of the aged, the social image and how the social image influences the self-image of the aged. The present study is an endeavour in that direction. It is descriptive and exploratory and attempts to understand the ‘self-image’ of the aged and their ‘image of the social image’.

Hence, it is obvious from the studies carried out by various scholars on this burning issue on aging population which is suffering from various socio-economic, health, and psychological problems. In this context, the scholars, belonging to different streams have highlighted the ‘cause effect relationship’ on this pressing problem of rural and urban societies of India. The problem has varied, dimensions in accordance with various strata of societies, as highlighted by the various authors, scholars, researchers and the social reformers from time to time. This pressing problem requires a judicious social planning, so that the elderly people may feel a social security and love in each and every strata of society in India.
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