CHAPTER II

REVIEW OF LITERATURE
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The size of the world’s elderly population has been growing for centuries. What is new is the rapid place of ageing. The review of literature attempts to highlight a few pertinent points of studies done earlier relating to issues of the elderly. In fact the present problems presents a “Silent Crisis” which affects not only elderly people but also the economic and social development of our entire society.

This chapter deals with the various research studies that have been conducted previously. The following gists were taken from various journals, and research studies.

Research studies and other materials are very less about Alzheimer’s disease. Many studies are focused about the problems of ageing. A few of the studies reviewed here. This reviews are classified studies related to psychiatry, studies related to physical health, studies related to social aspects and studies related to general aspects.

Studies Related to Psychiatry: -

Gupta (1968) has shown that old age presents a number of problems and important among them is the problems, which are purely Social and Psychiatric in nature such as mania, depression senile, Psychosis and Senile dementia. Herman and Barness (1982) in their study says that, already challenged by the management of dementia and depression, mental health practitioners will see increasing number of these disorders will be a function of the growing base rate of the elderly population in this country.
A study on aged persons in Madras conducted by Madras School of Social Work (1972) revealed that only 2 percent suffered from bouts of loneliness. These were mostly widows/widowers living either alone or with a son or daughter.

A study of about 2,000 aged persons was conducted in Delhi by Delhi School of Social Work (1974) indicated that about 57 percent of the aged had impaired vision besides the following other main medical and health problems such as

- Poor dental health
- Insomnia
- Impaired hearing/Deafness
- Giddiness/hypertension
- Forgetfulness/nervous disorders and
- Lack of free movements of limbs.

This indicates that health and medical care is a major problem for the aged.

Krishnamoorthy (1976) holds that old people in an affluent society suffer more from isolation because they cannot look up to their grown up children even for psychological support, various facts of advancement have weakened the psychological bonds between the young and old.

Joseph J.C conducted a study in Kerala in 1988 found that in a majority of cases; social relationship between the young and the old was not very cordial. Many reported that quarrel between themselves and their aged parent was a usual phenomenon. The young generation finds fault with the behavior and the
beliefs of the old. It was seen that certain very old parents are the scapegoat of the difference between brothers as to who should take care of the aged parents. The aged who have lost their spouse are the worst sufferers of loneliness and agony, as they have nobody to understand their misery since the youngsters have their own matters to attend to. Impairment of vision and hearing and various chronic ailments make social interaction difficult, and attitudes of self-pity or centering of interest may alienate family and friends alike.

The National Mental Health Programme in India shows the point prevalence of mental illness in the country to be around 10-20 per thousand populations. That is, about 10 million people at any point of time are supposed to be suffering from some kind of serious mental illness. (Nadkarni and Das 1993).

In a recent study of elderly in rural West Bengal (Nandi, Banerjee, Mukherjee, Nandi and Nandi, 1997), Mental morbidity was as high as 612/1000 populations. 61 percent of those 60 years and above were identified as mentally ill.

Rao (1997) the vulnerability of the elderly to mental disorders resulted from biochemical and morphological changes in the ageing brain, a compromised immunity and none too favourable psychosocial milieu. Rao also stated that elderly form a high-risk group for self-destructive behavior. The suicide rates rise sharply from the ‘young-old’ to the ‘old-old’ group.

Raj and Prasad (1971) conducted a survey of 327 aged people over 50 years of age belonging to 210 families from 3 villages. This study found that 31.3 percent of the respondents depressed because of death of spouse, of children, infirmity, crop failure and indebtedness.
Ramachandran (1980) studied the population of 18,721 in Chennai. In this study ‘geriatric population in India’, he concluded that among the 1863 aged persons, aged above 50 years came out with the findings that there were 318/1000 cases of functional psychiatric illness (Anxiety, Hysteria and Alcoholism). In those aged above 60 years the rates were as follows.

- Organic illness 61/1000
- Functional illness 276/1000
- Depression 93.6/1000 and
- Anxiety 5/1000

National Task Force study on problems of the elderly seeking Psychiatric helps by Rao (1987) for the Indian Council for Medical Research (ICMR). The subjects for the study comprised of 150 consecutive patients aged 60+ who attended the Gero-Psychiatric clinic of the Institute of Psychiatry, Rajaji Hospital, Madurai. This study gives the details of the differentials in the nature and extent of psychiatric disorders among the elderly belonging to 2:1. This study reflects the trend that is commonly seen in older in widowed women.

An another study conducted by Rao (1987) noticed that only two percent of cases came from ‘Completely Joint’ families. Physical composition of the family per se was found to contribute little to the genesis of Psychiatric Morbidity in the elderly. Social integration of the patients had been assessed taking into consideration the work and the social activity level and the status the older persons enjoyed in their family. About 45 percent of the Paraphrenics, 40 percent of the cases of secondary depression and 32 percent of the cases of dementia were described as ‘not integrated’.
‘A study on psychiatric disorders in the elderly’ was conducted by Prasad et al. (1991), at Banglore. Adequate understanding of the mental health problems in population and their characteristics are crucial in organizing the services. This is a retrospective chart based study of the elderly attending the geriatric clinic of NIMHANS during the year 1991. Two hundred and fifty seven patients who were aged 60 years and above had been seen in the year. Out of them, 251 charts could provide us with adequate data for the study. The patients were diagnosed according to ICD-9 criteria. About 91 percent of the patients could be diagnosed as per ICD-9, non-organic psychotic disorder (43%) formed the target group in this population followed closely by the organic psychotic disorder (23%). Among the non-organic psychotic disorder, effective disorders constituted 56.5%, schizophrenia 9.2 percent and other psychosis formed 32.3 percent. The affective disorders were mainly depression 75.4 percent and two thirds of the patients were women, which was significant. Among organic psychosis which comprised dementia and arteriosclerosis dementia constituted a small proportion of about 14 percent.

A study carried out at the All India Institute of Medical Sciences (AIIMS) by Khetrapal, Soneja and Kumar (1996) reports geriatric functional assessment of 612 ambulatory elderly subjects. Depression was seen in 23 percent of the cases and 5.3 percent of the persons were cognitively impaired. Low socio-economic status was closely related to both depression and cognitive impairment. Both Social and Health morbidity were reported to be higher in the low socio-economic category, more so in case of female geriatric patients.

In a study of depression and family Jointedness by (Bhogle an Reddy, 1996), depression was found to be less in the urban community than in the rural group. Family Jointedness was low among urban upper social class and migrants
but high among rural. Depressions in family jointedness were found to be highly
a positively correlated in the rural community. Unfixed residents (as in the case
of migrants), restriction on mobility bereavement and lack of social contact had
definite effect on feelings of depression.

Nandi et al. (1997) found depression to be common in old age, the rate
being 522/1000 people. Women had a higher rate of depression (704/1000).
Rate of dementia was 16 per 1000. In India affective disorders, particularly
depression, late paraphrenia and dementia (Psycho-organic syndrome) form the
bulk of total mental morbidity in the elderly.

Nandi et al. (1997) study found that higher rate of morbidity in widowed
persons (63.4%) when compared to married elderly (36.6%). Stressful factors
like isolation and socio-economic status were found to be closely associated
with widowhood in their sample.

Studies Related to Life Satisfaction: -

With regard to the life satisfaction of the elderly, Havighurst (1968)
studied the personality as a pivotal dimension in describing patterns of ageing
and in predicting relationship between level of activity and life satisfaction. He
studied 159 men and women, aged 50-90, from the upper working to upper
middle class. Although engagement in common social roles was negatively
related to age; generally those more active at the later ages had higher life
satisfaction score, but there were many expectations.

Intensive investigation has been conducted for more than a decade
concerning the biological, psychological and sociological correlates of
individual well being, of which life satisfaction cores is one component. It has
been demonstrated that life satisfaction scores correlates significantly with many variables including age, health, socio-economic status, work status and size of the community. Edward and Klemmack (1973) made an attempt to find out which of the variable is significantly related to the life satisfaction and found that socio-economic status especially income perceived health is also an important predictor, as the non-familial participation variables, particularly the combination of extend and intensity of neighbouring.

Medley (1976) underscored the importance of family life satisfaction as a whole. The study points out the value of examining inter relationship among variables using a path-analytic model.

Larson (1978) has reviewed the last 30 years of research on life satisfaction, morale and related constructs. He reveals consistent body of findings: subjective well-being is most strongly related to health, socio-economic factors and the degree of social interaction in older population.

Markides and Martin (1979) applied path analysis to data from interviewing 141 persons, 60 years and older, with predictor variables, self reported health, income, education and activity index. The results indicated that for both sexes activity was strongly related to life satisfaction. Income was found to be only indirectly significant via activity. Education was found to be least significant variable.

Conners et al. (1979) studied the role of social interaction in affecting life satisfaction. This results show that “the number of person interacted with” and “frequency” of interaction in and of themselves have little importance controlling for the effects of income, health and status produced significant relationship between life satisfaction and 1) the number of siblings and other
relatives seen: 2) exclusively in scope of interaction with immediate family members and: 3) exclusively in scope of interaction with siblings and other relatives. These results prompted the authors to suggest that it is the quality of interaction rather than the quantity that is the important determinants of life satisfaction.

**Manchini (1979)** stressed the role of family interaction in influencing well being and results of this study indicated that qualitative variables, such as “perceptions concerning marital satisfaction and effectiveness and involvement as a spouse of parent” are strongly related to morale rather than the quantitative variables.

The value of social behaviors in the later years may be best understood by considering relationship of various forms of socialization and participation as possible determinants of morale and life satisfaction of the aged (**Kahana, 1982**).

**Sayee Kumar (1987)** studied the life satisfaction among the institutionalized and non-institutionalized aged in relation to the health and leisure time activities. The non-institutionalized group has got positive life satisfaction and the institutional group shows the absence of leisure time activities. The absence of physical activities among the institutional respondents could be due to institutional norms, poor stimulation and lack of initiative. It is evident from the study that the institutional and non-institutional respondents with physical and intellectual activities have got high life satisfaction.

**Nayar (2000)** studied the processes and problems of population ageing in Kerala. He found out that 10 percent of the respondents were fully satisfied with their life, 76 percent were somewhat satisfied and rest, 14 percent were
dissatisfied. About 36 percent of the respondents were optimistic towards life and only 18 percent were pessimistic, however, a large group of 46 percent were indifferent towards life.

**Studies Related to Social Interaction:**

Social interaction occurring within the context of family and friends is of particular importance to elderly. These relationships are often characterized by mutual assistance, exchange and support involving both material and socio-emotional forms of aid (Taylor and Chartters; 1986). The results indicated that over 80 percent of respondents received support from either a best or close friend. The types of support were advice and encouragement, companionship, goods and services, financial assistance, transportation, help during sickness and prayer. Assisted by family members for goods and services were 26.5 percent. Thirty two percent were church members who supported elderly during sickness.

Paranjeet Kaur Dhillon and Sheila D’souza (1992) studied the effect of age and sex on level of frustration experienced, modes of frustration, social adjustment and the need patterns. They selected 240 subjects comprised of three age groups: 30-40 years, 45-55 years and 60 and above years. The results of the study were: age significantly effects resignation and aggression modes of coping with frustration, social maturity, emotional adjustment and need for affiliation. People above 60 years of age use resignation more as a way of coping with frustration than people of younger age groups.

Krause and Borawski – Clark (1998) investigated social class differences in social support among older adults. Data on a comprehensive range of social support measures provided by a nationwide sample of elderly people
suggests that social class differences emerge when measures of contact with friends, support provided to others, and satisfaction with support are examined. However, significant differences fail to emerge with indicators of contact with family, support received from others, and negative interaction.

A four-year longitudinal study on losing and gaining in old age; changes in personal network size and social support by Van Tilburg (1998). This study models that individuals variability of the changes affecting multiple personal network characteristics. A stable network size was observed, with an increasing number of friends. Contact frequently decreased in relationships and the instrumental support received and emotional support given increased. The widely varying patterns of losses and gains among the respondents squares with the focus on the heterogeneity of developments among ageing people. The instability of the network composition might reflect the natural circulation in the membership of networks.

Kelly Everard et al, (1999) carried out a cross – sectional study on relationship of activity and social support to the functional health of older adults. The results showed that maintenance of instrumental, social and high demand leisure activities was associated with higher physical health and higher mental health.

Nayar (2000) attempted to find out the processes and problems of population ageing in Kerala and selected 1600 subjects as four sample groups. He found out that 69 percent of the older persons had friends outside the family with whom they frequently interacted. About 12 percent of the respondents received old age pension and of those 29 percent reported that it was inadequate. In total sample, 20 percent stressed the fact that they were in need of financial
help, 35 percent needed medical assistance and another 13 percent need personal help.

The reasons by those who reported negative attitude towards them by their kin were: they were considered a burden financially and health-wise, they were unadjustable, and there was nobody to look after them in the family. 44 percent of the respondents suffered from lack of attention / love from their near and dear ones, 52 percent were dependent on others for money, 73 percent of decline health and 49 percent had other problems of old age. The old perceived the positive aspects of being old as: being looked after by kin (41%), and having plenty of leisure time (21%). The study revealed that by and large a sizeable proportion of the old people were happy in their families.

Howard Litwin (2001) studied the relationship of social network type and morale in old age. He found out that respondents in diverse or friends networks reported the highest morale; those in exclusively family or restricted networks had the lowest.

Studies Related to Physical Health: -

Joshi (1971) through his clinical study of the elderly opined that the differential agency phenomena, both physical and mental, appear to depend on environmental and social factors such as, diet, type of education, adjustment to family and professional life, and consumption of tobacco and alcohol.

Purohit and Sharma (1972), in their clinical study, observed that males were reported to have more ailments (Average: 4.07) than females (Average: 3.85). Further, they also found that the elderly patients had under-reported the
incidents of diseases during the survey and that some of the serious and significant ailments were revealed only on closer examination.

Singh and de Souza (1980), from their study on slum and pavement dwellers, noted that since medicine and consultations are very expensive, they take medicines only until the symptoms go away, and as a result most of the leading ailments become chronic in nature.

Gore (1980), analyzing the social factors affecting the health of the elderly, concluded that, while there are no data showing direct relationship between income level and health of elderly individuals, one would assume that nutritional and chemical care needs of the elderly are better met with adequate income than without it. It is stated that, the poor countries and the poorer segments of the elderly population within each country would experience greater problem of health well-being.

Pathak J.D (1982) conducted a study about “Health problems of the aged in India” found that 62.6 percent of the elderly patients had cardiovascular ailments. 42.4 percent had gastrointestinal problems, 32.5 percent had urogenital problems, 19.8 percent had nervous breakdowns, 19.2 percent had respiratory problems, 11.6 percent had lymphatic problems, 7 percent had high or low blood pressure, 11.2 percent had ear and eye problems, 4.8 percent had orthopaedic problems, 5.7 percent had surgical problems, while 37.3 percent of the elderly had problems with all their systems.

Darshan et al. (1987) carried out a study of the elderly in various slums scattered in and around city of Hisar. Among the 85 subjects interviewed by them, 67.1 percent were sick at the time of Survey. Out of these, 73.7 percent of the sick subjects were suffering from chronic illness.
Sharma (1987), from his study of elderly woman in Haryana found a significant association between their age and the prevalence of some illness among them.

A field survey was conducted in chamber (Mumbai) 1993 found that one fourth (25%) of the total respondents health condition was poor and a very high (70.5%) of elderly where rated as the sufferer of chronic ailments. In the study Middle Income Group (M.I.G) who were mostly retrieves, suffered from various health problems. The reason for difference in the health status between the M.I.G. and the poor may be result of the fact that where as the M.I.G. males experience a sudden change in the social and economic status after retirement, The poor continue in the employment market even after attaining the age 60 In the study the female elderly where rated to have a better health status when compared to male status. For instance, among the total elderly, while a relatively higher proportion (29.%) of the female elderly where concentrated as ‘good’ in their health condition, their corresponding proportion among the males was found to be only 19.5 percent. Among the female besides the fact that they had greater longevity, factors like the addiction –free life and continuity in the fixed and regular domestic activities, contributed to their maintaining a higher level of health.

The association between age and perception of health status was found to be highly significant (at 1% level) among the total elderly. Regarding the influence of marital status on the actual health status of the elderly. It is observed among the total elderly that those who are currently married Maintained good health status relatively at a higher level (35.2%) when compared to those who are widowed (25.5%).

The Educational background of the elderly was found to have significant (at 5% level) influence on their perception of their health status.

The elderly who felt that they were living in their own homes and their children lived with them perceived themselves in good health (44.8%).

Sex wise data showed that the status in the family and the perception of health status were significantly associated among the females, but not among the males. Those males elderly who perceived that their children are living with them are relatively at a higher level of health (28.8%) as compared to those among the females (20.6%)

Studies Related to Social Aspects

Arnhoff et al. (1964) has reported that ageing is accompanied by many stereo typed beliefs, which make the old people predominantly negative in outlook, regardless of country involved. The role and needs of the old people are not same as that of younger people. Older adults are generally more conservative than younger people. They cling to older ideas and are slow to adopt new ones. Studies have shown that socio-economic status accounts for considerable variations in ageing effects of individuals. Participation of elderly in community activities is closely related to socio-economic status at all stages of the life cycle.

Backman (1973) has reported that older man and women suffer from rolelessness, powerlessness and depression. With ageing there is decline in many function which lead to feelings of inadequacy and in security.

Edward and Klemmack (1973) made a attempt to find out which of the variables is significantly related to the life satisfaction and found that socio
economic especially income, perceived health is also an important predictor, as those are the non-familiar variables particularly the combination of extent and intensively of neighboring.

De Carlo (1974) Made a study on analysis of the relationship between the frequency of activity and successful ageing suggested that individuals who engage in a high recreation pattern are more successful than whose engagement is of low degree and sporadic.

Mooney (1978) found that at present, psychological problems of old age seem to be consequences of the democratizing effects of personal poverty, social alienation and cultural deprivation.

Larson (1978) has reviewed the last 30 years of research of life satisfaction, Morale and related constructed. He reveals that consistent body of findings; subjective well-being is most strongly related to health, socio-economic factors and the degree of social interaction in older population.

Markides and Martin (1979) conducted a research study by applying path analysis data to interview 141 persons 60 years and older, with predictor variables like self-reported health, income education and activity index. The results indicated that for both sexes activity was strongly related to life satisfaction. Income was found to be only indirectly significant through activity. Education was found to be the last significant variable.

Conners, Powers and Bultona (1979) studied the role of social interaction affecting life satisfaction was found out that the number of persons interacted with an frequency of interaction in and of themselves have little importance. Controlling for the effects of income, health and status produced significant relationship with life satisfaction.
According to **Kahan (1982)** in his research study came out with the conclusion that the value of social behavior in later years may be best understood considering relationships of various forms of socialization and participation as possible determinants of morals and life satisfaction of the aged.

In the year **1987**, **MISS. M. Sathiyavathy** conducted a study on the psychosocial problems of the institutionalized aged in the Madurai City by using descriptive design had found out following.

- 48 percent of the respondents are happy in the institution because individual care is given to them. 24% of the respondents are enjoying more facilities in the institution 20 percent of them get more love and affection from the inmates.
- 32% of the respondents have disturbed sleep, which is at times by diseases and other time by mental worries.
- 20% of the respondents feel isolated.
- 78% of them have the feeling of negligence.
- 34% of them have the feeling of worthlessness to others.
- 84% of them have cordial relationship with the inmates and authority, the rest 16% of them do no have the habit of moving freely with others.
- 28% of the respondents are not going to church because, they have physical problems due to loss of eyesight and having lack of strength to walk which is hindrances for them.
- Since of them (56%) have no means of income during their old age, they are dependent on their children, foreign aids and local people etc.
T.R. Lakshmi Narayanan and G. Malathi (1991) studied lonely aged and aged couples in a rural setting. Sixty respondents (25 lonely aged and 35 aged couples) were administered with a life Satisfaction index-2 scale. After statistical analysis using mean, standard deviation and ‘t’ test. It was found that the aged couples had better mental health than the lonely aged rural subjects.

Gopal and Chadha (1991) suggests that social network size of institutionalized elderly and the non-institutionalized elderly have a high life satisfaction than the institutionalized elderly.

Studies Related to General Aspects

H.M. Marulasiddaiah (1969) conducted a case study in Dharwar District - Karnataka of 120 household revealed that 78 percent of the sons in the village had established separate household within ‘5’ years of their marriage. The parents dominated the family till their middle age. When they approached old age they gradually receded to the background. The control of the household as well as village affairs had passed on to Middle-aged persons. This was despite the relatively better position in which the aged were placed in the rural setting as compared to the urban.

A survey of the aged conducted in Madras city by the Madras School of Social Work (1972) showed that 68 percent of old persons reported poverty as their main problems as they found it difficult to make both ends meet. About 25 percent reported that they were financially well to do, while the remaining just managed to else out their livelihood.

Sinha (1972) brought out a comprehensive study on the dimensions like perception of people and events, motivation, concept of happy life, values,
attitudes and reaction to frustrations. The result indicated the inter-generational gap in a good in many dimensions.

A study conducted by the Indian council of Social Welfare in (1980) has come out with the findings that dependency of the aged is higher in urban areas than in rural areas probably because in rural areas probably because in rural areas self-employment is more in formal sectors where retiring age is fixed.

The Indian Council of Social welfare, Madhyapradesh Branch conducted a socio-economic survey of elderly of Bhopal city in (1982) concluded the research findings as the majority of the aged people depended upon their children.

Ramamoorthy and Jamuna (1987) in their studies on the inmates of some old age homes in two major cities in India concluded that the elderly had been institutionalized mainly because they were poor and destitute or were disabled with no one to care for them or were disowned and ill-treated by their offspring.

Nandal, Khatri and Kadian (1987) found that loss of the decision-making was experienced more by those who had surrendered their property in favour of young members and had thus no control over the source of income.

Sati (1988) has reviewed a research study related to ageing in India. Reveals that like the majority of the western studies, research attempts in India seem to have neglected the problems of the institutionalized elderly. When compared to other subjects in India. Studies of the aged are scanty and sporadic and are still in a rudimentary stage.
Linesay et al (1989) in his research study about institutionalized aged found out that due to cognitive impairment, depression, and anxiety which are relatively common in old age, family members experience a high level of practical and emotional burdens, which in turn leads to institutionalization.

Pinto and Prakash (1991) in their study found that home bound elderly have more advantages than the institutionalized elderly in respect to daily activities, level of satisfaction, social contact and source of financial support thus enjoying a better quality of life than their institutionalized counterparts.

According to the ESCAP Report (1991), although family support and case of the elderly are unlikely to disappear in the near future, family care of the elderly seems likely to decrease as the countries of Asia develop economically and modernize in other supports.

A WHO epidemiological study conducted at Chennai in urban and rural areas, in 1993, reports prevalence of Alzheimer’s disease in three percent of the elderly above the age of 65 years. In population above 80 years, the prevalence of Alzheimer’s disease is 15-25 percent. Alzheimer’s disease is likely to become a major health concern in estimated that there will be 75 million elderly in India and increasing longevity.

A study conducted by P. Ilango and D. Padma Sheela in 1996 in the institutionalized aged persons. The study indicated that a great majority of the institutionalized aged suffers from physical ailments. Females have more physical ailments than males and the duration of illness is also longer among the females. Females have been found to have a longer duration of institutionalization also.
Problems such as sadness and hopelessness are more prevalent among the females. On the other hand loneliness, lack of appetite, worthlessness and fear of death are the emotional problems, which are more prevalent among the males. Elderly males in the age group of 60-69 years and 70-79 years have been found to have a greater level of dependency than the females in the same age groups. On the other hand 80-89 years old females have a significantly higher level of dependency than the males.

An eleven-year study, the National Institute of Mental Health identified two major Socio psychological barriers to good mental health in the later years: (1) The inability to bounce back from Psychosocial losses, and (2) failure to maintain ‘meaningful’ life goals.

ARDSI (2000) conducted a study in Kerala. A study was undertaken in “An Epidemiological study of Dementia in a Rural Community”. Prevalence of dementia was ascertained to be 3.4 percent in those above 60 years.

ARDSI (2002) conducted a survey in urban area in the city of Cochin, Kerala. The survey has covered nearly 2000 elderly population; aged at 60 years and above a high prevalence of dementia is indicated from the available data.

**Dementia Care**

Leung (1999) studied the family care giving functions for elderly persons receiving the portable comprehensive social security assistance in Hong Kong. The author remarked and concluded that even for those recipients requiring more intensive care, primary carers have not expresses a feeling of perceiving their elderly parents as a burden. There is no obvious evidence of elderly abuse and neglect. The economic independency of the elderly recipients has relieved
the financial responsibility of the family members. Even for recipients facing high hospitalization charges, their families have shows to be able and willing to share the cost.

*Tsein and Cheng (1999)* studied about the care giving impacts and needs of Chinese demented elderly families in Hong Kong. This exploratory study aims to investigate the care giving impacts on the family caregivers of the demented elderly and their needs or it explores the utilization and satisfaction level on informal and formal services of the caregivers. The data for this study arises from two inter-related methods. The first part adopted a structured qualitative questionnaire from data collected from the qualitative method. The results reveal that majority of the elderly lived with the caregivers, caregivers complained of sacrificing their leisure and personal time and perceived care giving as a burden. Mentally, they experienced more stress, more sense of burden and more depression. Physically, caregivers suffered most from insomnia, tiredness and muscle ache. Three quarters of caregivers agreed that there was an increase in financial expenditure due to the care, especially in medical expenses.

A study conducted on dimensions of care for Dementia sufferers in Long-term care institutions. This study empirically examined whether dimensions of care cluster in special care units (SCU’s) compared with non-SCU’s. The relationship between SCU status plus separate measures of the dimensions of care and outcomes for dementia sufferers was then investigated. Data were drawn from the intermediate care facility protect. The sample included residents with dementia, aged 65 and older, in intermediate care facilities throughout the province of British Columbia, Canada Longitudinal data included 6 outcomes: cognitive function behavioral problems of agitation and social skills, physical
functioning, and quality of life measured through affect and expressive language skills. Separate multiple linear regression equations were estimated relating each of these outcomes to 5 dimensions of car pre-admission and admission procedures, staff training and education, non use of physical and chemical restraints, flexible care routines and resident relevant activities and the environments. The results showed that there is virtually no clustering of dimensions along SCU/non-SCU lines. Moreover, it raises questions about the benefits of “best practice” dimensions of care, regardless of SCU status. (Chappella and Reida, 2000).

Social support for spouse caregivers of persons with Dementia study analyzes the value of simultaneously taking helpers and caregivers characteristics into account when examining social support received by spouse caregivers of persons with dementia. This study questions whether sources and types of received support vary by the gender and relationship of the helper and/or by the caregiver’s race and gender. Drawing a sample of 210 spouse caregivers of persons with dementia, the Generalized Estimating Equation (GEE) method was used to estimate a population – average logistic regression model to address cross-level helper and care giver interactions. Results indicate that helper and caregiver characteristics interact in complex ways. White male caregivers are more likely to receive emotional support from adult children and to receive practical assistance from formal sources compared with other types of support and to other race-gender caregiver groups. Description of social status characteristics of caregiver as determinants of their social network may be less fruitful in understanding the benefits of social support than a focus on which helpers assist with what kinds of task for which groups of caregivers. (Millera and Guoa, 2002).
The purpose of the study about social support in the context of care giving and husband's provision of support to wives involved in parent care. The purpose of this study was to identify ways in which social support is related to the care giving stress and well-being experienced by adult daughter care givers. The study focused on a specific source of support, caregivers husbands, and included reports from 126 caregivers and their husbands. Main and buffering effects of four types of support (emotional and instrumental support provided to the caregiver and to her parent) were tested, and caregiver's level of optimism was controlled. Results were similar for caregivers’ and husbands’ accounts of support. Buffering effects found only for physical health, whereas effects opposite those predicted by the buffering hypothesis were detected for positive affect. A main effect was found in nearly all analyzes of marital satisfaction. No main or buffering effects of support were detected for depression. Findings highlight the complexity of supportive exchanges by illustrating the simultaneous operation of different types of support and their distinctive impact on the care giving stress and well-being relationship. (Franks and Stephens, 2001).

A study on caregivers at risk for mortality done by Schulz and Beach (1991). It is widely believed that providing care for an elderly family member with a disability is very stressful and may contribute to psychiatric complications. The prolonged psychological and physical distress associated with extended care giving has been posited as a possible risk factor for physical health problems leading to increased risk of mortality, in particular for caregivers who are themselves older adults. In order to examine the risk more closely, researchers conducted a study of the relationship between care giving
demands among older spouses caregivers and mortality participants in this four-
year investigation consisted of 392 caregivers and 427 non caregivers, all aged
66 to 96 years and living with their spouses. Groups were controlled at baseline
for socio-demographic factors and preexisting clinical or subclinical disease.
Each subject was evaluated at baseline and placed into one to four groups
depending upon their level of care giving (1) Spouse not disabled (2) Spouse
disabled and disabled and helping with no strain reported; and (4) Spouse
disabled and helping with mental or emotional strain reported. The researchers
than determined subject mortality over the next four years. At the end of this
period, 103 (12.6%) participants had died. Participants providing care and
experiencing caregiver strain were 63% more likely to die than non-caregivers.
Participants in groups 2 and 3 (i.e., subjects with disabled spouses who either
did not provide care or provided care without strain) had no elevated risk of
mortality. The data suggest that mental and emotional strain brought about by
caring for a disabled elderly spouse is an independent risk factor for four-year
mortality among elderly caregivers.

Studies Relating to Elder Care in India

The study conducted by Jamuna (1987) on self and caregivers
perceptions of needs and problems of elderly women. The status of the elderly,
primarily depends on how the family members perceive their problems and
needs and how they regard the elderly . This study tries to assess how old
women and their caregivers (Head or chief earning member of the family)
perceive the needs and problems of these older people. A multistage random
sample of 150 families where aged women stayed with their caregivers (75 rural
and 75 urban) were selected from the urban and rural areas of Tirupati and
Chandragiri taluks. The individuals were interviewed personally and their needs
and problems were assessed by using appropriate inventories. The perceptions of the aged women and the perception of their caregivers with regards to needs and problems were different. The results reveal that some caregivers viewed that generally the elderly cannot have better health and therefore should not complain as much as they do. Similarly, there were views expressed by caregivers that in as much as food and clothing was completely taken care of what is there for these elderly by way of needs. They added that there was no need for the elderly to feel lonely as they had enough to do their homes and could relate themselves meaningfully to others in the family. Appropriate counselling and interventions are suggested to mitigate their economic and other psychosocial problems and needs, as well as to reduce the gap in the perceptions of the elderly and their caregivers.

**Jamuna (1990)** caring for elderly women aims to understand the attitudes of caregivers towards are giving at present and in future, to assess the perception of social supports among elderly women and their caregivers at present and in the future. The study consists of 200 elderly women who were residing with their children. A multistage random sample was used to select the samples. The results indicate that caregivers attributed greater social supports to the elderly in both rural and urban areas. But care-receivers perceived comparatively less social supports. Consequently, there is the feeling of lack of enough social supports by the care receivers.

**Jamuna (1996)** conducted a study on the psychological dimensions of caregivers stress. A sample of 120 primary caregivers, who were attending to frail elderly (with paralysis, fracture, arthritis, etc.), at least for 6 months were selected from the surrounding areas of Tirupathi through a purposive sampling. The inventory on care giving burden (CBI) was administered to these 120
caregivers. From the total samples, those who reported high care giving burden (top-half) 60 caregivers were identified and a five-point care giving stress intensity scale was administered. The results indicate that care giving stress was found to be high when the elder person was cognitively impaired, emotionally disturbed, immobile and had multiple functional impairments. This study assessed the nature, intensity and sources of caregivers stress, the perception of care giving burden and its impact on the care givers behaviour.