Chapter – II

Review of Literature
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REVIEW OF LITERATURE

2.1 INTRODUCTION

Review of literature is an in–depth analysis of relevant material published in the past. The function of such a review is two–fold. By shedding sufficient light on the problems related to the subject, it enlightens the researcher with a clear idea on the subject on hand and also steers the researcher in the proper direction by enabling her to formulate the research hypothesis and methodology. Thus, it becomes an important and integral component of the research process. A systematic analysis of the related material pertaining to the research problems journals, books, reports etc., is properly documented in this chapter, which helps the researcher to find out the gap in the knowledge. Based on the analysis of the available literature and the gap in the knowledge, the researcher framed research questions for her study, which is also documented in this chapter after each head.

2.2 THE STUDIES RELATED TO THE PROBLEMS OF OLD AGE ARE CLASSIFIED INTO THE FOLLOWING HEADS

a. Problems due to physical health.
b. Problems due to psychological stress.
c. Problems due to economic depravity.
e. Problems of maladjustment.
f. Problems of socialization.
g. Religious attitude
h. Reasons for institutionalization
i. Problems of the elders due to institutionalization.
2.3 PROBLEMS DUE TO FAILING PHYSICAL HEALTH

Most of the studies pay importance to the failing physical health of the senior citizens of which a few are taken up for discussion here. Environmental and social factors play a vital role in influencing the health of a person. It is but natural that growth of age has an adverse effect on human body and health. The type of food, addiction to toxic items like tobacco, alcohol, drugs and the nature of work or business are some of the major factors that have a say upon the health of a human being. Joshi’s study (1997) concludes that the aged fall an easy prey to infections such as parasitic diseases, diseases of respiratory systems, arthritis, rheumatoid, hypertension, cognition impairment, heart ailment and diabetes mellitus. Misra in his study (1992) points out that the highest percentage (82 per cent) of the senior citizens are affected by visual problems while 78.8 per cent are the victims of psychomotor problems. The other problems that attack old age are bone–joint problems (78 per cent), memory problems (5 per cent) and sleeplessness or somnambulism (58 per cent).

Poverty is the chief cause that influences the health of the person, particularly the aged. Economic backwardness of the family naturally deprives the members of the family, the chances to have sufficient food for survival.

A survey of 327 aged persons over 50 years of age belonging to 219 families from three villages in Lucknow District (Uttar Pradesh) with respect to family organization, occupation, mental and socio-economic states, diseases and attitude towards life shows that 66.9 per cent of the cases were hailing from poor to very poor economic background; 52.2 per cent were still respected as the head of the family; 88 per cent were suffering from various diseases such as blindness, deafness, paralysis of lower limbs and 31.1 per cent were found to be depressed because of death of or separation from spouse or children, crop failures and unpaid debt. (Ravi and Prasad, 1971)

A striking feature pointed out by the researchers is that elderly women are more prone to physical ailment rather than males the and the duration of
illness is also longer. (Illango P.R. and Padma D. Sheela, 1996). They attributed the reason as to that the octogenarians do not take extra care to keep themselves fit and healthy unlike men of the same age group who regularly practice physical exercises more intensively. It is interesting to note that it is a global phenomenon. The study also shows that in three Nordic countries (Finland, Sweden, Denmark) men enjoyed a better health condition than women because they regularly practice physical exercise like walking and jogging.

Most of the aged grow nervous easily because of their limitations, insecurity, dependence and fear of death. They suffer from cardiac problems, breathlessness, fatigue, aches and pains, shivering, sleeplessness. Sometimes they develop illness like polio and hypochondriasis (Chandra Shekar C.R., 1997).

In elderly persons, physical illness is swiftly followed by psychological tension or stress. In other words they are complementary and it is difficult to determine which disorder is dominant. In a more recent study it is established that functional bowel disorder including constipation, fecal impaction and fecal incontinence are common gastrointestinal diseases among the aged. (Lillo R.Anthony and Rose Suzanne 2000).

An extensive and exhaustive study on the health of the older women with a sample of 100 Maharashtrian Brahmin Women of Pune, reveals the fact that 51 percents suffered from cardiovascular problems and an equal number from diabetes; 50 percent from arthritis, 55 per cent from gastric disorders and 44 per cent from urinary incontinence and 66 per cent from hearing problems. In India, the old, especially the women tend to philosophize even the deteriorating health as an inevitable consequence of their age and ignore even treatable and curable illness. (Bagga and Sakurakar, 2000).

The age related decline in the cardiovascular system is considered to be the major determinant of decreased tolerance for exercise and loss of conditioning and the overall decline in energy reserve. This results in diminished blood flow to the brain, kidneys, liver and muscles. Above all, the
The rate of heart beat is also lessened. (Murry and Zentner, 2001; Sadock, 2003). The decreased level of thyroid hormones in endocrine system causes a lowered basal metabolic rate. Impairments in glucose tolerance are evident in ageing individuals (Pietraniec – Shannan, 2003). The ripening age increases the risk of autoimmune disorders (Beers & Jones, 2004). Some of the age related changes within the nervous system may be due to alternation in neurotransmitter release, catabolism or receptor functions (ibid).

Cessation of growth marks the beginning of ageing. Hence some of the researchers focus on age–related changes that occur at different rates for different individuals. The ageing process naturally ushers in normal biological changes. Fat redistribution results in a loss of the sub–coetaneous cushion of adipose tissue. Old people lose “insulation” and are more sensitive to extremes of ambient temperature than the younger people. (Stanley, Blair & Beare, 2005)

It is the physical abuses that torment the elders more than physical illness. But many are reluctant to make a free and frank complaint about personal abuse. They either minimize the abuse or hide it totally. Despite their unwillingness to disclose information either because of fear of retaliation or embarrassment, the signs of physical abuses like striking, hitting, beating, bruising, cutting are found on them which clearly brings to the fore the irrefundable and undeniable truth about the existence of such abuse. (Sadock & Sadock, 2003 and Murray & Zentner, 2001). Some more indicators of physical abuse may include bruises, lacerations, burns, punctures, evidence of hair pulling and skeletal dislocations and fractures (Murray & Zentner, 2001; Stanley, Blair & Beare, 2005).

The review of the above literature on the aspect of physical health of aged people indicates the different health problems and major diseases the aged people are subjected to. There are limited studies to elucidate the physical health status of the older women. Further, there is hardly any study to understand the physical health condition of the aged people under institutional care. Hence, the researcher in her study brought the forth research question on
the aspect of ‘physical health’ and restricted her study with women under institutional care.

- What is the nature of physical illness and the intensity of illness faced by the aged women in institutional care?

2.4 PROBLEMS DUE TO FAILING PSYCHOLOGICAL HEALTH

So far, the researcher has discussed somatic complaints. A few studies prove that somatic complaints lead to psychotic complaints, symptoms including apathy, anorexia, insomnia, decreased energy and lipids, and somatic complaints are all manifestations of depression. Depressive symptoms can accompany endocrine disorders, lung infection, brain tumors and Parkinson’s disease etc. (Salynmen and Shader, 1979).

Yet another study shows that old age poses a number of problems. Important among them are the problems which are purely social and psychiatric in nature such as mania, depression, senility, psychosis and senile dementia. (Gupta, 1968).

A study concludes that there is a short-term prevalence rate of 2 to 3 per cent suffering from severe depression and up to 3 per cent to 4 per cent mild depression. Regardless of its exact prevalence, depression is a serious mental health problem in the elderly males (75 per cent). (Gurland, 1976). A study conducted near Chennai recorded the prevalence of mental disorder in those aged 60 and above. (Ramachandran and Menon Sarada, 1980)

Loneliness is yet another major psychological problem. In a study, two samples of patients aged over 70 years were selected. One sample was from a large Urban General Practice. Patients were interviewed in order to assess their mental, physical and social well-being. Included in the interview were questions on subjective feelings of loneliness. The interview brought to the limelight two important facts. One is the inseparable association between the feelings of loneliness and disability. The second and more significant fact is that the fearful feeling of loneliness is found deeper in women than men; and
even among women the worst affected are the new widows. (Dee. A. Jones, Christina R. Victor, and Vetter J. Norman, 1985)

Not only depression, but also other psychological disturbances such as feelings of loneliness, fear of loss of general ability - either fake or real, feelings of insecurity due to dependence on others play a havoc in the life of elders in general and that of institutionalized elders in particular. Though depression is common among both institutionalized and non-institutionalized elders, the degree is higher in the former. (Godkari, 1989)

It is estimated that 50 – 70 per cent of the elders under institutional care have behavioral, emotional and mental disorders. (Trimbath of Brestensky, 1990). In the opinion of a few researchers, the depression or distorted cognition in the elders affect the life-satisfaction. The authors compared the level of life-satisfaction in 100 depressed and 100 non-depressed elders. The results revealed that the life satisfaction scores of depressed aged were significantly less than that of non-depressed group. Distorted cognitions and activities were significantly correlated to life-satisfaction. The overall study indicated that positive thinking and higher level of activities leads to positive mental health. (Bhadwaj, Sen and Mathur, 1991).

Most of the elderly persons do feel that even their children do not look upon them with the degree of respect, to which they were rightfully entitled. Hence, they feel neglected and humiliated. This ultimately leads them to shun themselves from the company of others. Loneliness, in turn, may rise to depression and may eventually lead to worsening of sickness. (Chowdry, 1992).

A few psychiatrists investigated the offensive disorder particularly depression and organic psychiatric syndrome and found that they constitute the bulk of total mental morbidity in the elders. (Venkoba Rao, 1993). There are some studies, which have highlighted the factors of loneliness and depression felt by the residents of old age homes. These studies have looked at the structure of old age homes, life of the inmates, their level of satisfaction or dissatisfaction, loneliness, depression and family linkage of the inmates.
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(Mishra, 1993; Bagga, 1997; Dandekar, 1996; Nalini, 1997; Chadha and Kanwar, 1998; Rajan et al. 1999). Depression is a universal disorder which preys upon most of the elders. Especially the depression level of institutionalized elders is reported high. (Meera, 1997).

In order to find out the condition of the non-institutional elderly people, a comparative study on institutional and non-institutional elderly people was carried out. The problems of insecurity, hopelessness and depression among elders investigated. The inventory was administered to 60 elders and the findings show that a majority of the elders suffer from depression, loss of hope, insecurity, either moderate or high in both the institutionalised and non-institutionalised people (Meera, 1997).

Yet another study was conducted at the old age homes for women only and it showed that younger among the old felt more depressed than their senior counterparts. Further, the residents felt more lonely and depressed in old age homes, where they remained as paying guests without any work including preparation of food. (Bagga, 1997)

In West Bengal a team of psychiatrists conducted a study with the aim of assessing the mental morbidity among the elderly population in the rural community. A door to door field survey was made in two villages. The total sample comprised of 183 persons, and it was identified that sixty one percent of the population were mentally ill. Women had a higher rate of psychological morbidity than men. (Nandi, P.S., Banerjal, G., Mukherjie, S.P., Nadhi. S and Nandhi, D.N. 1997).

Another study report shows that age is an important determinant of mental disorders. High prevalence of disorder is detected in old age and the magnitude of some mental and behaviour disorder increase with age. Predominant among the disorders is depression, which is common among elderly people. Yet another study on the community samples of people over 65 years of age found the prevalence of depression among 11.22 per cent of this group. (Newman et. Al, 1998). The findings of some studies showed that there was a high association among stress level, depressive symptoms and mood
status. (Wang, J.J., Synder, M. and Kaas, M., 1998). Though shocking and bitter it is a fact that people of all ages of elders nourish a deep longing to commit suicide for different reasons.

This research study was carried out among the elderly in a long-term institutional care. The authors identify the most “at risk” group and highlight the major factors contributing to suicide in older adults in institutions. Results of the survey of over 1,000 inmates of long-term care confirmed that suicide behavior occurred in approximately 20 per cent of the survey population. (Nancy J. Osgood, Barbara A., Brant, Aaren Lipman, 2002) The psychological problems experienced by the respondents is so acute that, at times it implants in the patients a keen desire for death. Suicide is common among the people with advanced age. Persons above 65 who commit suicide comprise 12 per cent of the population (Charbonneau, 2003). The Whites outnumber others in attempting to commit suicide. Predisposing factors include loneliness, financial problems, physical illness, loss of friends and relatives, and depression (Sadock & Sadock, 2003).

It is clear that there are many studies, as shown above, to understand the psychological health of the aged people. The review of the various studies clearly portrays that depression, loneliness, stress, emotional and mental disorder, distorted cognition, dementia, sleeplessness, suicidal behaviour are the major problems that affect the psychological health of the aged people and there is a high correlation between life satisfaction and psychological health. The studies also reveal that depression is higher among the institutionalized elders and loneliness affects women very much. Thus the literature available analysed the psychological health of the aged people in relation to the variable ‘institutional care’ and ‘sex’.

After reviewing the literature on the psychological health of aged people, the researcher brought forth the following research questions to understand the psychological health of the aged women under institutional care. In addition to enumerating the various psychological illnesses and
symptoms experienced and exhibited by the respondents, the researcher used a ‘scale’ to measure the ‘Geriatric Depression level’.

**The research questions are as follows:**

- Is there any association between various socio, demographic variables and geriatric depression?
- Is there any association between geriatric depression and life-satisfaction?
- Is there any association between geriatric depression and religious attitude?
- Is there any association between geriatric depression and adjustment?
- Is there any association between geriatric depression and social behaviour?
- Is there any association between geriatric depression and self-esteem?

**2.5 PROBLEMS OF ADJUSTMENT**

The psychological changes eventually result in a decline in higher mental functions like intelligence, abstract thinking, and memory, decision-making, orientation and reduction in motor and sensory performance. This leads to poor comprehension, slow reaction and shrinking ability to learn new skills and to adapt to a new environment. Instead, the individuals stick to their traditional beliefs and views. They grow more and more rigid and display utter dislike and aversion to any change. The old people find it difficult to accept or adjust with the changing environment.

A study reported the relationship between psychological variables, a behavioral rating scale and the subsequent adjustment of a group of elderly people newly admitted to a home for the elderly. It shows that in the sample, three groups can be identified, a fairly independent group of people that exhibits no apparent deterioration in functioning during the first year of admission, a nondependent group that shows loss of functioning during the same period and a third group which shows an immediate negative effect from admission, and which has a poor outcome. (Pattie AH and Gilleard C.J., 1986).
Another study reported that mental health determines the adjustment level of individuals to the environment and with each other with maximum effectiveness, and happiness. (Menninger, 1945).

A study was conducted on the assumption that the problems of the aged relating to adjustment will have their relation to the five personality variables – extrovert, neuroticism, dependence, proneness, and authoritarianism. The sample was 100 elderly male respondents of Patna. The study revealed a negative correlation of these personality variables with adjustment. (Hussain and Priyadarshini, 1996). A study explained the relationship between time structure and wellbeing of retired persons with a sample of 40 males and 80 females. Respondents who had more of a sense of purpose in their use of time showed better adjustment and wellbeing. (Sinha and Singh, 1997)

One more study analysed the aged women’s problems. It is found that there is a wide gap exists between the expectations of older women and their care givers. The results bring out the fact that the old women’s emotional problems begin in the very household itself. Their problems do not generally attract the attention of the family members and as a result of which the gravity of their problems is not at all understood in the proper perspective. It has to be noted that the growing number of old women will have to face a triple jeopardy of being old, being female, and being poor. A majority of them live with children and the quality of their life will solely depend on the sentiments, resources and inclinations of the care givers. (Saha K.B. Shaha V., 1998)

Thus, there are few studies that show the adjustment level of the aged people. The studies reveal that there is a correlation between psychological variable, cognitive measure and the subsequent adjustment of the aged people and correlation exists between the period of stay and adjustment. The studies explain that physical and psychological health influences the orientation, intelligence, abstract thinking, comprehensive skills and to adapt oneself to the situation and the environment. The value towards life and lifestyle too influences their adjustment levels. Elderly women have more adjustment
problems than elderly men. There is no significant difference between the aged people from the rural and urban region in the areas of social adjustment.

The level of adjustment is also analysed in relation to the factors such as dependency status, emotional, social and family conditions, and personality variables.

From the above studies, the researcher has taken the relevant aspects and tested the same in her study. The researcher adopted a 'Bell Adjustment Scale' to measure the individual’s adjustment on the dimensions of home, health, emotional and social. The researcher brought forth the following research questions:

- How are the elders adjusting themselves in the institution?
- Is there any association between various socio-demographic variables and adjustment?
- Is there any association between adjustment and life-satisfaction and its contribution in determining life-satisfaction?
- Is there any association between adjustment and self-esteem?
- Is there any association between adjustment and social behaviour?
- Is there any association between adjustment and religious attitude?
- Is there any association between adjustment and depression?

2.6 ECONOMIC PROBLEMS OF THE AGED

In the Indian context, besides the physical and psychological factors, economic condition is yet another major issue the aged have to contend with. Studies related to the economic condition have been numerous.

A majority of the respondents, both men and women experience financial and socio-psychological problems during old age. (Dasai and Naik, 1970)

A study was conducted in a village called (Makunti, 1979), with a population of 1.630 persons of which 145 were aged. The purpose of the study was to make a preliminary assessment of the role played by financial constraints and other problems encountered by the older people of the rural
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community in India. The results of the study showed that those who were above 65 years of age were generally passive members of the family and the community. The position of the aged persons in the family was to a great extent determined by their economic status. (Marulasiddiah, 1980) Another study commented that successful and better adjustment in old age is associated with economic status of the individuals. The inference is that the economic status and adjustment are in direct proportion. (Mathew and Sen, 1989) Another study established the fact that the reduction in income eventually results in inevitable loss of status and meaningful social relationship. (Bhetia, 1983).

A study was conducted by the Madurai School of Social Work on the Psycho Social Problems of the aged in Madurai City. 4.8 per cent of the respondents unhesitatingly expressed their willingness to work in order to up keep their economic status. (M.R. Machakallai, 1978).

Aged people invariably feel that self-support is the only right and proper means of decent and dignified survival. Consequently, aged people who cannot work and do not have enough savings to support themselves generally feel unhappy to accept help from their children. A major problem of growing old is the feeling of being rejected by the society to which they belong. A unique problem of aged women is the loss of their life – partner which forces them to face life single handedly. (Having Hurst and Albrecht 1953).

A few opined even their independent income does not rescue them from indifference and family rejection and even in joint families the old feel insecure. The belief that children will take care of their parents in old age is slowly but certainly vanishing. (Desai, 1985).

2.7 RESEARCH QUESTIONS

A Review of the existing literature on economic problems faced by the aged as shown as above highlights contradictory views on the aspect of economic independence of the aged and their status and being respected in the family. One study shows that there is a positive correlation between economic status and respect in the family. Another study exhibits a negative correlation
between economic status and their position in the family. Studies also show that there is high correlation between economic status and adjustment; and negative correlation between economic status and psycho social problems. There is no study to elucidate the economic problems being faced by the aged under institutional care and its implications on their adjustment, life satisfaction and psychological health. Researchers evolved her research question in such a way to fill this gap.

- How does the economic condition of the respondents contribute for determining the various components of life satisfaction such as Self-Esteem, Religious- Attitude, Social-Behaviour, Geriatric-Depression and Social-Adjustment?

2.7 PROBLEMS OF SOCIALIZATION

An interesting study has been conducted comparing the experience of loneliness between residents living in nursing homes and those in the community. Though no difference could be detected in the level of the feeling of loneliness between two groups, the residents in nursing homes with frequent contacts with family and friends felt the pangs of loneliness less than those without such contacts. The residents in old age homes did not experience loneliness because of their frequent contacts with family and friends (Bondevik nad Skogstad, 1996). Another study investigated the association between social support practices and life-satisfaction among 23 men and 41 women aged between 60 to 75 years. Analysis showed that the subjects who were satisfied with interpersonal relationship and those engaged in more meaningful activities had more satisfaction than subjects without them (Hawley and Klaukave, 1988).

A majority of the retired persons are engaged in various leisure time activities, like reading newspapers, household activities, morning and evening walk, listening to radio, sitting and talking with children, especially grand children, chatting and gossiping with friends, talking with the wife, participating keertan and bhajans, inviting and entertaining friends home, or
sleeping during day time. The study shows that the individuals having better pass time activities have better social behaviour (Sharma, 1996.) Social support can be provided spontaneously through the natural helping network of family and friends or can be mobilized through professional intervention. Social support that is provided through an informal helping network is typically characterized by mutuality, reciprocity, and informality not often evident in professional-helping relationship (Wood, 1984). Social support refers to the different ways in which people render assistance to one another, emotional encouragement, advice, information, guidance, tangible aid, or concrete assistance (Bawera and Ainley, 1983, Gotheib, 1983, House and Kahn, 1985, Wood, 1984). A study proved that the number of the support relationship is not related to life-satisfaction but it is related to inter-personal effect and that the staunch support of friends and frequent contact with them are more important than the support and contact with relatives. They reiterated that the role of friendship expectancies is the key factor in both life-satisfaction and interpersonal relationship (Burgio, Maria Rose, 1987). Another study investigated the association between social support practices and life-satisfaction among 23 men and 41 women aged between 60 and 75 years. Analysis showed that the subjects were well satisfied with interpersonal relationship and those engaged in more reality activities had more satisfaction than subjects without them. (Hawley and Klaukave, 1998)

Most of the studies emphasized that older people have very similar mortality risks associated with social isolation when compared to the middle aged, although their risk of exposure may be greater. (Herkman, et.al., 1992)

A study to examine the effects of social networks and social support on the mortality of a national probability was made with a sample of 2,200 elderly Japanese and it concluded that social participation had a strong negative impact on mortality. (Sugisava, Liang and LW, 1994). A research on “Social situation of the Aged in India” attempts a comprehensive study on the elderly in India under various topics – status, health and social adjustment in old age. It concludes that there is mutual help between the elderly and their families.
Isolation and loneliness appears to be a problem prevalent in middle class and upper class families while it is almost absent in lower classes. It suggests that more social security schemes for the elderly are to be adopted and recreational activities are to be promoted. (Kohli, 1996).

A very important and striking study impressed the researcher. It was an empirical research, and it showed that three types of functions occupied the center stage of social support. The first is emotional support - the availability or presence of someone to talk about personal matters and express solid comfort and concern for one's well being. The second is often called instrumental or tangible support. Here someone is available to help with tasks, provide transportation, and help with groceries, and so on. The third is informal or guidance oriented help with offering information, getting on right path or suggesting action. Aspects of support that are important to measure availability under hypothetical conditions and sources i.e, who provides support, in brief, social support contributes to the individual’s feeling about themselves and the world around them (Berkman, et. al., 1992, 1999).

Review of the existing literature and studies show that there is a positive correlation between the cordial and frequent relationship with the family members and other relatives and their feeling of loneliness of the inmates under institutional care. The review also reveals that the aged having well satisfied interpersonal relationship and participating in family events have high life satisfaction. The studies also exhibited positive correlation between leisure time activities, effective time management and life-satisfaction and meaningful engagement and time management have better life-satisfaction. Further, the inmates of the institution who have good social network with other inmates and extending social support have better life satisfaction and better adjustment. Contradictory result also emerged from one of the study's, which show that there is no significant relationship that exists between the supportive relationship and the level of life satisfaction and supportive relationship from friends is highly correlated than the supportive relationship from family members and relatives.
As there is no specific study available to elucidate the problems of socialization that prevail among the women under institutional care, the researcher framed her research questions in such a way to fill this gap. The researcher used SBAS Scale to assess the level of social-behaviour of the respondents in the dimensions of 1) Institutional Activities, 2) Supportive Role, 3) Spare Time Activities and 4) Relationship.

The research questions included:

- What is the level of social behaviour in different dimensions?
- What is the linkage between various socio-demographic variables and social behaviour?
- Is there any association between social-behaviour and life- satisfaction?
- Is there any association between social-behaviour and depression?
- Is there any association between social-behaviour and adjustment?
- Is there any association between social-behaviour and religious attitude?
- Is there any association between social-behaviour and self-esteem?

2.9 RELIGIOUS ATTITUDE

A study on the problems of adjustment, life-satisfaction and religious attitude of 50 elderly people revealed that life-satisfaction and emotional characteristics are inter-related and the age of respondents has an influence on religious attitude. Further it stated that there is a significant relationship between family size and emotional problem. (Poongulahahli, 1992)

Another study indicated that the elderly people are moderately satisfied in their life and a majority of the respondents have a indifferent attitude towards religion. It has thrown light on the close relationship between life-satisfaction and religious attitude (Sivakumaran, 1992). One out of every five patients admitted in the hospital have strong religious convictions, treading on the path of the divinely with active participation in the religious chanting and activities and this has largely relieved them of physical ill-health and remained an unfailing source of mental peace. The variables that were associated with
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religious coping included black race, older age, being retired, religious affinity, high level of social support, infrequent alcoholism, a prior history or psychiatric problems, and higher cognitive functioning. The reassessment of 202 men were re-evaluated during their subsequent hospital admissions approximately after 6 months, that guaranteed lower depression scores during follow-up. These findings suggested that religious coping is a common behavior that is inversely related to depression in hospitalized elderly men. (Koening HG, Cohen HJ, Blazer D.G. Piper C. Meador KG, Shelp F, Gobi V, Di Pasquale B., 1992).

A study conducted on centenarians with a sample of 36 cases from Rayalaseema showed that most of the centenarians were women and that too from rural areas. Many of them had unique psycho-social characteristics of flexibility, coping, tolerance of stress, religiosity and good social support. (Ramamurthy, Jamuna and Sudharani, 1996). An investigation was made to study “Religiosity and Mitigation of loneliness among elderly”. The sample consisted of 30 Christians and 320 Hindu respondents from Karnataka. The study revealed that Christian respondents were more religious than Hindus. Unshakeable faith with strong religious commitment and involvement offered them comfort and connotation in the otherwise pointy and painful loneliness. (Jayashree, 1996)

Another study describes the level of religious well-being and selected characteristics of religiosity in a sample of 114 non-institutionalized, largely rural elderly women. The study identifies the relationship between selected factors and the level of religious well-being. Descriptive research revealed a high correlation between the level of religious well-being and the variables of social support and hope. Through stepwise multiple regressions, “hope” has emerged as the single significant predictor of religious well-being, explaining 31 per cent of the various in the dependent variable. The majority of the respondents reported that regularly participating in religious activities, highly influence their religious beliefs and identified that religious faith grew increasingly with age. Conducting a comprehensive assessment and
implementing focused interventions associated with religious well-being will strengthen the scope of health care practice for elderly women. (Zorn CR, Johnson MT., 1997)

A study was reported of the religious beliefs, attitudes, and practices of old people in the west of Scotland, based on a questionnaire given to 501 people of 65 years and above, randomly selected from those living at home. Almost all had a full range of religious instruction, and regarded their parents as religious. Weekly church attendance was more common among Catholics (70 per cent) than Protestants (40 per cent) among women than men; among those whose beliefs were those of organized religion, and among those with unrestricted mobility. The pattern of participation in Church organizations and social activities was similar. A firm belief in the ‘life after’ was expressed by 80 per cent of Catholics and 60 per cent of Protestants and higher proportions of the sample population derived comfort from religion, especially in bereavement. Over 70 per cent expressed no fear of their own death. (Reid, W.S. Anne J.J. Gilmore, G.R. Andrews, 1996)

A study on “CLINICIANS’ ATTITUDE TO SPIRITUALLY IN OLD AGE PSYCHOLOGY” was carried out in U.K. The registered members of the faculty of the Psychiatry of old Age in the United Kingdom were the respondents. The majority of respondents (92 per cent) recognize the importance of spiritual dimensions of care for older people with mental health needs and about 25 per cent respondents appear to consider referring patients to the chaplaincy service. (Lawrence R.M., 1998)

Hundreds of studies have documented a positive association between health or well-being and religious participation. These studies examine religious experiences of economically backward women in the United States. Results underscore the deep seated religious commitment of this group. The dominant theme, mentioned time and again was gratitude. Respondents view the LORD as the perennial source of all that is good. Hence, they are determined to be grateful for all boons like life, good fortune, and help in times of hardship, and material prosperity. One third of the respondents who
mentioned regular church attendance shared that their physical ability is a factor encouraging them to go to church regularly. So, while religion promotes one's health as well being, good health does facilitate participation in church-related activities. In other words good health and religious activities, apparently seems independent are in fact inter-dependent. Elders thought the world would turn to religious organization and rely on religious beliefs to cope with both the routine challenges of daily life and the hardships brought on by severe adversity. (Barusch. A.S., 1999)

In a study on "Loneliness and Death Anxiety Among the Elderly – The Role of Family set up and Religious Belief” with a sample of 60 (30 males and 30 females) from Coimbatore District, indicated that gender difference plays no significant role in the experience of loneliness and death anxiety. Similarly there is no difference between the systems of joint family and nuclear family. But religion does play a vital role in changing the magnitude of loneliness. The religious elderly feel less lonely than the non-religious elderly. But in the experience of death-anxiety no such difference exists between the religious and the non-religious. (Asgarali and Broota, 2000)

The peculiar and unique nature of the old age home with emphasis on engagement in various activities and stress on partial disengagement from family responsibilities is instrumental in facilitating a satisfactory stay of the residents of the old age home. (Anendya Jayantha Mishra, 2004). The researcher authentically expresses his views in a different manner. His arguments establish that being away from home does in no way affect the mindset of the aged. They felt neither lonely nor depressed. On the contrary they are quite satisfied and happier with their life in the old age home and the residents do not experience either social isolation or desolation.

In the old age home, the residents are targeted through sermons about the way and means of overcoming the feeling of loneliness. The divine discourses encourage them to live alone, without craving for family and friends, and their alteration in shift to religious activities and any other work that interest them. (Misra, 2004)
There are many studies regarding the religious attitude of the aged people. The review of the existing literature on religious attitude of the aged reveals that it correlates with life satisfaction, adjustment, physical and psychological health, loneliness, happiness, social-behaviour and demographic variables such as age and religion. Some of the research findings are that Christians are more religious than Hindus and gender is not a significant with religious attitude. Studies also establish a contradictory view related to the variables religious attitude and death anxiety. There is no study to assess the religious attitude of women under institutional care and its association with social-behaviour.

On reviewing the existing studies, the researcher framed her research questions to study the field reality in the area chosen and to find the association between religious attitude and its association with social behaviour, adjustment, depression level, self-esteem, and life-satisfaction. The researcher uses religious attitude inventory to assess the level of religious attitude of the respondents and focused on finding out answers for the following questions:

- What is the level of religious-attitude of the respondents?
- Is there any association between religious-attitude and various socio, demographic variables?
- Is there any association between religious-attitude and depression level?
- Is there any association between religious-attitude and adjustment?
- Is there any association between religious-attitude and life satisfaction?
- Is there any association between religious-attitude and social behaviour?
- Is there any association between religious-attitude and self-esteem?

2.11 LIFE – SATISFACTION

Certain research studies examined the relationship between life-satisfaction and variables such as age, health status, job status, region, home ownership, religiosity, emotional well being, social support etc. One of such studies lays emphasis on different factors such as income, health status
sociological factors and family setting that accentuate life-satisfaction of the aged. Results indicated that the lower life-satisfaction resulted primarily from the loss of income and not from the loss of worker / producer role. (Chat Field, Walter F, 1977)

Life-satisfaction is also determined yet by other factors. There is an inseparable relationship between life-satisfaction and physical health, emotional stability, balanced social support and focus of control in the frail elderly. A random sample of 99 low incomes, frail elderly living in the community was interviewed. Almost 40 per cent of the participants reported high levels of life satisfaction. Multiple regression analysis identified four significant predictors of life-satisfaction: perceived physical health, social support, emotional balance, and focus of control (Gray and Calsyn, 1989). Physical health emerged as the most significant predictor of life-satisfaction accounting for 14 per cent of the variance. Social support, emotional balance and focus of control each accounted each for an additional 6 per cent of the variance in life-satisfaction (Soleman, H. Abu Bader, Anissa Rogers, Amanda S. Barusch, 1990). A study was made about the lonely aged and aged couples in rural settings. Sixty respondents (25 lonely aged and 35 aged couples) were chosen for a life-satisfaction 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. (Lakshmi Narayananam T.R. and Malathi G., 1991). Research studies suggest that the social network range of institutionalized elderly is significantly smaller than the non–institutionalized elderly and the latter have a high life-satisfaction than the former (Gopal and Chandna, 1991). There is an investigation to analyze the problems of adjustment, life satisfaction, insecurity and religious attitude. The subjects were 2008 Headmasters. The findings showed that the majority of Headmasters have less adjustment problems in all areas of adjustment studies. They have less fear of insecurity and they are well satisfied in life. (Rajan D., 1991)

The aged having sailed across major life events successfully and can only be the best advocates of life-satisfaction. A study listed the significant
determinants of successful ageing as self-acceptance of aging changes, self-perception of health, perceived functional ability, perception of social support, inter-generational anxiety level, belief in Karma and after life, flexibility, range of interests, activity level, marital satisfaction, religiosity, certain value orientation and economic well-being (Ramamurthi and Jamuna, 1992). A study on “Wisdom and Life – Satisfaction in Old Age” was conducted with a sample of 120 elderly men and women. It concluded that wisdom has a profoundly positive influence on life – satisfaction independent of objective circumstances.

While one research finds that life-satisfaction does not guarantee the presence of good mental health (Vasanthy, 1989), another researcher had a totally opposite result. According to him the life – satisfaction is the indicator of Mental Health. (Khadi, 1993 and Goanlcas, 1993)

Another study also strengthened the previous one. The study found that social support was significantly related to life-satisfaction (Aquins, Russell, Cutrona, and Altmaier, 1996). Yet another factor that determined life satisfaction is age. One study revealed that the higher the age of the respondents is the Life-Satisfaction less. Age at marriage was also found to have a significant positive correlation to life-satisfaction. Those who got married at a later age after achieving at least some of their goals in life do have better life-satisfaction than those who had to forgo many of their personal wishes, because of early marriage (Suseela Mathew, 1997). Other findings were that healthy persons, who were not cognitively impaired have high life-satisfaction (Premilla K., Hiller. S, Anthony F, Jorm, Agenta Herlity, Bengt, and Winblad, 2001). It has also been noted by different researchers that different factors contribute to life-satisfaction for old people. They are: 1) Physical health and functional status 2) Self-Resources 3) Material Security 4) Social support resources and 5) Life-Activity (Dieter Fering, Christian Balducci, Varessa Burholt, Clare Wenger, F. Thissen, Germain Weher and Ingalill Hallberg, 2004)
Women in married households and single women with children were found to be more satisfied than single women in households without children and single women living with others. (Kim J., Kim E., and Lee J., 2005)

Thus, there are many studies to understand the life-satisfaction of the aged and these studies analysed the life satisfaction with variables such as age, physical and psychological health, emotional stability, job status, social support, institutionalization vs non-institutionalisation, range of interests, marital satisfaction, religious attitude. Here too, the studies brought out contradictory views regarding life-satisfaction related to mental health. One study says that life-satisfaction does not guarantee the presence of good mental health and another study reveals that life-satisfaction is an indicator of mental health. Further, there are limited studies to analyse the life-satisfaction factor in the dimension of gender. There is no study to compare the life-satisfaction with components such as self-esteem and adjustment.

With the above review, the researcher framed her research questions to test the already established association and to study the pointed gaps in the studies.

- What is the relevance of various socio-demographic variables in determining the life-satisfaction?
- What are the significant factors attributed to Life-Satisfaction?

2.12 REASONS FOR INSTITUTIONALIZATION

Institutional care is offered to individuals in settings outside home. Thus the institution become a second home – a home away from home for the aged. Here all the needs of the individual, physical, health, psychological health, educational, spiritual, recreational are met in the institution itself. It is also known as residential care. The own home is always the best provider of care; certain individuals have to seek shelter in homes because of their handicap, like blindness, deafness, physical and mental disabilities. They cannot properly be looked after and rehabilitated in their own homes. These individuals have special needs and so require special facilities. Institutions for such individuals are equipped with trained staff, good infra structure, facilities and amenities to
keeps them comfortable as satisfied. Some even prefer to go to old age homes than to stay in the unwanted atmosphere of this home. Yet it cannot be denied that institutionalization of the aged is the new concept which is growing day by day.

In India, the position and the status of the elderly and the care and protection they traditionally enjoyed have been undermined by several factors. Urbanization, migration, breakup of the joint family system, growing individualism, change in the role of women from being full time home–maker to bread–winners, and increased dependence status of the elderly are some of them. There is also a generation gap in terms of education, aspirations and values and the allocation of resources to different members of the family. Often the family is unable to meet the financial, social, psychological, medical and welfare needs of the elderly and seeks help from supporting services.

Another study found that institutionalized females came from poor socio-economic families and often from families with serious social problems like domestic disharmony (30 per cent), marital disharmony (20 per cent), poverty (10 per cent), unwed motherhood (8 per cent), broken homes (51.1 per cent), etc. 90 per cent inmates had one or more morbid conditions. (Kale K.M., Jogdand, G.S., Aswar N.R., 1990). In some countries the perceptions of the aged differ. For example a comparative study was carried out on the attitude of the Turkish and Swedish towards institutionalization. It was found that the Swedish had a favourable attitude towards institutionalization while the Turkish rejected the idea totally. (Imamoglu and Imameglu, 1992)

One study established that prolongation of the life–span and the emergence of the ‘old’ and ‘the oldest old’ have resulted in mushrooming of old age homes (Nayar, 1996). There are innumerable reasons for seeking these institutions for their stay. A study examined the sample consisting of 50 aged persons (25 males and 25 females) from Salem. The Study revealed that the most common forms of abuse which drive the aged out of their homes to the institution are neglect, denial of freedom, lack of alternation, failure to provide personnel care, health care, proper food etc., Pensioners and male elders were
Factors influencing Life-Satisfaction of the Institutionalized Aged Women

subjected less to abuse (Rethi Devi, 1996). Institutional care for the old is extended mostly by non-government, private, voluntary, non-profit and particularly religious based charitable organizations. The Government played almost a negligible role in this regard till the last decade. There are too few in the country and approximately 28,000 stay in them (Help Age India, 1998).

Old age homes are of two types – free and paid. In the beginning, all old age homes rendered meritorious service free of cost as they were established and run for the sake of the elderly destitute. Commercialization of a Home is a recent trend and there is a phenomenal growth of paid homes, which clearly shows that poverty is not the only reason for the spread of old age homes.

There was an important component that the elderly persons are opting to stay in old age homes to avoid conflict and domestic quarrels at home (Mishra, 1993; Nalini, 1997 and Rajan et.al., 1999). An interesting and challenging study provoked the researcher to analyze in depth, the reason for institutionalization. The study indicates that the majority of the residents are ‘Overwhelmingly’ happy. But the study did not investigate what makes them feel so satisfied in the old age homes. (Rajan et. al., 1999).

There has been a marked change in the treatment of the elderly compared to earlier periods. Many of the recent studies emphasize the transition in the role and status of the elderly Indian from pre-industrial society to the existing industrial social order. Their main argument is that the elderly enjoyed a much higher status in pre-industrial society marked by group oriented social interaction, agricultural mode of production, extended family system, kinship and patriarchal authority. They compare this with low position of the aged in the new industrial social order of India, affected by the process of change such as modernization, industrialization, urbanization, secularization and changes in women’s position. (Souza D.,1982, Gangrade 1999, Khan 1999, Singh 1999).

There is a comparative study of social status of elders staying with their family’s vis-à-vis those living in institutions. The sample consisted of 114 elders of both sexes in Madras city. The study revealed that widows
outnumbered widowers. Poor economic status is the major reason for institutionalization. A majority in the institutions were octogenarians. 74 percent of those in families preferred to remain in families. 90 percent of those in institutions preferred to remain in institutions. A greater number of elders in institutions expressed greater satisfaction with the quality of life, compared to those in families. However, those staying for longer periods expressed dissatisfaction with the monotony of institutions. 80 percent of the elders in institutions claimed that children were not supportive. This feeling was greater in males than in females. (Jebasingh, Natarajan, Muthukrishnan, and Prathiba, 1996)

A study was conducted to assess the kind of support required by the aged, living in families. The sample comprised 1,000 households from Delhi. A majority felt that their being in the family was decided by their economic independence and non-interference in family affairs. The disrespect shown in the family renders them to be psychologically upset. Old Age Homes were not preferred by the majority except by the lower class. More than half of the poor preferred old age homes. The support they needed was more towards health assistance and pre-retirement counselling. (Suba and Tyagi, 1999)

A survey was conducted (Irudhayarajan, 1999) in Kerala and Tamil Nadu covering 7 old age homes and 126 elderly. It showed that 58 percent of the inmates were females and 42 per cent males. Among the inmates, a majority were below 70 years of age (50 per cent); 33.3 per cent were in the age group of 70 – 79 and the remaining 16.7 per cent were above 80 years. 47 percent were currently married and 26 per cent never married. 27 per cent were widowed and 46 percent of inmates did not have a living son or daughter. Among those who had children, 74 per cent did not feel lonely to live away from children. This is an indication of their bitter experiences with children. 56 per cent reported that the old age home was the best suited place for the aged to live in. The other preferred arrangements were: with the son (12 per cent), with the daughter (10 per cent) and to live alone (11 per cent). 91 percent of the inmates were overwhelmingly happy about their stay in old age homes. Only 4
percent of the inmates were supported by others in old age. (Irudhayarajan, 1999)

Another survey report expressed that the present value system which considers money as the 'be – all and end – all' of life regards. Old people are considered as a liability and hence they are simply abused. People's attitude towards the old is changing. They are considered as unwanted because of their thin contribution to the economic well being of their families (Lawrence, 2000). A study on well-being among the institutionalized and non-institutionalized elderly with a sample of 60 institutionalized and 60 non-institutionalized elderly revealed that the institutionalized are less depressed than the non-institutionalized. Institutionalized have better life-satisfaction. However, the findings are based on the study of only one institution. (Sharmen and Sharmen, 2000).

Another study identified that a vast majority of the respondents from India preferred to spend their old age in their own homes, whereas in Japan only 27 percentage of the respondents preferred to stay in their own homes. It was also found that 51 percentage of the respondents from Japan preferred to spend their old age in nursing homes or care houses, whereas no respondent from India preferred this option. (Rathi, Rama Chandran and Rathika R, 2001)

The existing studies enumerated various reasons for institutionalization, whether the choice is their own or the decisions of others. The researcher in her study also included this component to study whether any new reasons emerge for institutionalization, in this fast changing socio, economic world.

2.13 PROBLEMS DUE TO INSTITUTIONALISATION

A review of studies on the institutionalized elderly suggests that the institutionalized elderly people share the following characteristics namely, poor adjustment, depression and unhappiness, intellectual ineffectiveness etc., because of increased rigidity and low – energy, negative self – image, feelings of personal insignificance, a view of self as old. Residents tend to be submissive and show a low range of interests and activities and tend to live in
the past than future. They are withdrawn and unresponsive in relation to others (Tobin et al., 1976). A number of studies indicate that institutionalized older people share certain negative characteristics, including low morale, negative self-image, pre-occupied with the past, feelings of personal insignificance, intellectual, ineffectiveness, withdrawal, anxiety and fear of death. (Ward, 1979.)

Substantiating the above study, some more studies pointed out that the inmates of old age homes suffer from the damaging effects of "Total institution". Total institution refers to a place, which is cut off from the surrounding world and impose regimental schedules on inmates. In such a situation, the inmates lose control of many seemingly trivial things which define their individuality such as uniforms, furniture, hair cuts, and so on and they lose their autonomy and spontaneity, in regimentation of eating, sleeping, play and work. Suspicion, hostility and derogation are limiting their meaningful interaction. (Goffman Ward, 1979.)

The study makes us understand that long term care is becoming more common, especially for those patients with chronic illness and those elderly who do not have family members to function as care givers (Stumph, 1987).

Another study indicated that the old age home has many advantages. If offers the aged a safe alternative, the company of peer group, etc. But today such homes are like a dumping ground where the youngsters can get rid of their old people. They refuse to visit them in the homes and cut off all contacts, which in turn result in aggravating the feeling of loneliness and grief for the old folk (Madhaan Nagar, 1996). Numerous studies report that institutional care has many problems. One of them is that old people are being forced to live with older people. As one women said, "We are fed up of hearing of each other's aches, pains, and death news". The separation from people of different generations is emotionally stultifying (Maitregi, 1999).

All the above studies enumerated the problems of institutionalization and listed poor adjustment, unhappiness, intellectual effectiveness, withdrawn, unresponsive, low morale, negative self-image, preoccupied with past, feeling
of personal insignificance, withdrawal, anxiety, declining intellectual capacity, suspicious attitude, hostility, limiting meaningful interaction, frustration etc., as major problems. One study specifically assessed the problems of aged in 'total institution'.

While reviewing, the researcher found that all the study limited itself with enumeration. None of the study specifically focuses the problems of the aged women. The researcher apart from enumerating the various problems of the elderly women due to institutionalization, also pinpoints the factors influencing Life Satisfaction.

Thus, the researcher in her study focuses to find the answer for the following questions:

1. What are the physical health problems faced by the elders in the institutions?
2. What are the psychological health problems faced by the elders in the institutions?
3. What is the relevance of various socio-demographic variables in factors such as social-adjustment, social-behaviour, self-esteem, geriatric-depression, religious attitude and life-satisfaction?
4. Are there associations amongst different factors such as social-adjustment, social-behaviour, self-esteem, geriatric-depression, religious attitude and life-satisfaction?
5. What are the significant factors attributed to Life-Satisfaction?