Chapter 2

Review of Related Studies
As behavioural scientists concerned with the psychosocial concomitants of aging than with the process of aging itself. Demographers have pointed out that as a result of demographic transition it is the turn of developing countries to follow suit of developed countries to experience the growth of an aging population. China and India, the most population growth till recently, are likely to be saddled with a large aged population in the coming decades. It is predicted that for India, the present 6.80 percent of the elderly may cross the 10 percent mark by the turn of the century. The average life expectation at birth would move into the 70s by 2025 AD from its present position at 61.50 (United Nations Report, 1992).

With the burgeoning of the elderly population becoming a global phenomenon, the United Nations declared 1982 as the year of the elderly. It convened the World Assembly on Aging at Geneva in the same year and came out strongly in favour of the welfare of the elderly as contained in the slogan “Add life to years”. International research, particularly in the social sciences, was quick to follow suit by laying emphasis on social and behavioural science research to identify ways and means of making old age the best period of life. This trend is continuing (Ramamurti and Jamuna, 1992, 1995).

The Geriatric Society of India was founded in 1979 and the
multidisciplinary Association of Gerontology India (AGI), with headquarters at Banaras, came into being as an affiliate of the International Association of Gerontology (IAG) in 1982. A series of seminars and conferences were organised in the area of aging by many institutions to mark the International Year of the Elderly. A centre for Research on Aging was established at the Department of Psychology, S.V. University, it was probably the first centre to be wholly devoted to scientific research on the psychosocial aspects of aging with “Livelier Longevity” as its motto. Specialisation in the psychology of aging at the Master’s level (from 1976) and PG Diploma in Aging (since 1994) are being offered by this department. A multidisciplinary study group on aging has also been set up.

From the early 1980s onwards the volume of research on aging in India swelled considerably. Several funding agencies- the DST, the ICMR, the UGC, the ICSSR, and the Department of Welfare, Government of India- considered “Gerontology” (Aging) as a thrust area. The UGC recognised the Department of Psychology, S.V. University, under the Special Assistance Programme for study on aging. Soon, gerontology in India came of age. A multitude of welfare organisations (more than 500 at present) were established to care for the elderly both in the government and nongovernment sectors (Khandpur, 1992). Residential homes and day care centres for the
elderly were set up in most towns, cities, and village (Khandpur, 1992; Nair, 1982). More than a score of books entirely devoted to the subject of aging have been published (Ramamurti and Jamuna, 1984, 1993, 1993). The International Federation on Aging (IFA) held its first Global Conference on Aging at Bombay and Pune in 1992. The Indian Council of Medical Research organised an Indo-UK workshop on public health implications of aging in 1993 which discussed several psychosocial problems of the elderly. (Ramachandran and Belashah, 1994).

One of the earliest trends in research is the study of the problems of the elderly and how they adjusted to these problems. Nearly 100 of such studies have appeared in the past (Bali, 1995; Ramamurti and Jamuna, 1984, 1987, 1993). These myriad studies have several common findings. Most of them highlight problems related to health, finance, fraility, interaction with adult children, social relationships, personal adjustment, personal care, leisure, future anticipation, and unfinished tasks. Several studies investigated the factors associated with adjustment in old age in a comprehensive manner.

**Problems of Adjustment in Old Age**


**Mental Health and Disability**

Closely related to the problems of the elderly is their mental health which is affected by the unwelcome changes in old age-
1991; Verma, Kohli, Banerjee, and Nehra, 1992; Vinodh Kumar, 1994; Warty, 1988). Or particular interest is the report of the task force on aging of the ICMR lead by Dr. Venkoba Rao (Venkoba Rao, 1986, 1986, 1989, 1990, 1994). It was a good study of health care needs in rural areas (Venkoda Rao, 1990, 1994). Geriatric services are being provided to the elderly for more than a decade at the Geriatric Unit, Madras Medical College (MMC) under the associates at Bombay Hospital have carried out a series of studies on the medical problems of the elderly (Natrajan, 1987, 1990; Pathak, 1975, 1975, 1976, 1985). More recently a Geriatric out-patient counselling centre was established at the All India Institute of Medical Sciences (AIIMS), New Delhi, under the guidance of Dr. K. Vinodh Kumar and Dr. Khetarpal attached to the Department of Medicine.

A growing malady among the elderly (old-old) is the incidence of senile dementia. Recently, the National Association of Alzheimer’s and Related Disorders Society of India (ARDSI), an affiliate of Alzheimer’s Disease International, Chicago, with its headquarters at Kunnamkulam, Kerala, was formed and several branches of the organisation are providing services to dementia victims. The World Health Organisation has also undertaken a survey on Alzheimer’s and Related Disorders (ARD) in India as part of a multinational study under the guidance of Dr Copeland of the Institute of Human Aging,
University of Liverpool.

Nearly 2 to 4 per cent of the elderly population is afflicted by psychogeriatric disorders. It was reported that the prevalence rate of symptoms of dementia of varying degrees was 27 per 1000 in urban and 35 per 1000 in the rural population (Rajkumar, 1995). More geriatric services are needed, as the existing services are wholly inadequate (Biswas, 1988; Gore, 1981; Mehta, 1987; Venkoba Rao, 1990). As a preventive measure, considerable community education is required for ensuring the mental health of the middle aged and the elderly (Bansal and Sanjay, 1993; Rajkumar, 1994; Ramamurti, 1991, 1992, 1993, 1995; Venkoba Rao, 1994).

Medical facilities in rural areas need to be improved. At present there is no mental health programme for the elderly worth its name anywhere in India. The National Institutes of Mental Health (NIMH) should focus on this lacuna and take appropriate preventive measures to provide better mental health services for the elderly.

A major problem of aging is physical health. As age advances body immunity is lowered. Also wear and tear causes dysfunctions in organ systems. These poor health conditions threaten the individual with disability. Therefore, it is of prime importance that individuals take adequate care from the middle years to ensure good health in old age. Much of this depends upon a working knowledge of disease
conditions and hygienic practices that promote health. A study of knowledge, attitudes, and practices (KAP) with regard to health in old age revealed poor knowledge and practices though there was a desire to maintain good health (Attitude). Further, it was observed, that many elderly as well as individuals in other age groups were of the opinion that poor health is common in old age (L.K. Reddy, 1994, 1995), therefore it does not deserve special attention. The value of life in the elderly is not accorded the same importance as it is at the younger age levels. All these vitiate proper health care for the elderly. An ICMR study of these aspects has been undertaken (Ramamurti, 1995). Some studies also examined the correlates of physical health (Anantharaman, 1990; Guha Roy, 1994; Jamuna, 1992; Ramamurti, 1989; Ramamurti and Jamuna, 1992, R.R. Singh, 1994; Vinodh kumar, 1994).

For many people, old age is synonymous with disease and disability. Weakness and disability which are concomitants of old age need to be handled both at the physical and psychological levels. A balanced diet that takes care of bodily requirements in terms of Recommended Daily Allowances (RDA) in old age coupled with optimal and judicious exercise could partly alleviate the general weakness and malaise and lend to a feeling of general well-being (Ramamurti, 1989; Ramamurti and Jamuna, 1990, 1990; Ramamurti, Jamuna, and Reddy, 1992).
According to an English adage, *so you think, so you are!* Despite the actual physical condition, how a person feels or perceives his condition is important, in this sense, the self-perception of one's health status is a determinant of well-being (Anantharaman, 1980; Jamuna, 1994; Ramamurti, 1989, 1989, 1991, 1992; Ramamurti and Jamuna 1990, 1992, 1993; Ramamurti, Jamuna, and Reddy, 1993, 1994). In the same manner, even if a person is disabled more than the disability itself how an individual perceives his disability is critical and a positive disposition towards one's condition greatly reduces the misery that may accrue from one's disability (Ramamurti, 1995; Ramamurti, Jamuna, and Reddy, 1993, 1994).

**Life Satisfaction and its correlates**

Closely related to mental health and influencing it, is now an individual perceives his own life and the degree of satisfaction with regard to both the past and the present. Early studies on life satisfaction appeared in the late 1960s and the early 1970s (Ramamurti, 1968, 1970, 1972). In recent years life satisfaction has not only been studied as a significant aspect of the well-being of the elderly, but also in terms of the factors determining it (Anuradha and Prakash, 1991; Bhardwaj, Sen, and Mathur, 1991; Chadha, 1991; Chadha, Aggarwal, and Mangla, 1992; Godhavari, Madhumathi and Sunil Kumar, 1991; Jamuna and Ramamurti, 1988; Jayasree, 1987; Nagpal and

Life satisfaction gives meaning to one’s life and combined with a life review (Dave, 1994; Pinto, 1995; Ramamurti, Jamuna, and Reddy, 1994), it can be a source of a feeling of self-worth. In the Indian context most of the elderly review their past life in terms of completion of their personal, familial, and social obligations and those who believe that they have done justice to their obligations experience a sense of fulfilment in consonance with the self-fulfilment theory of Butler (1968). Life satisfaction promotes mental health. The variables of creativity, ego-Integrity, autonomy, and altruistic behaviour contribute to life satisfaction (Ramamurti, 1991, 1992, 1995; Ramamurti and Jamuna, 1992, 1993, 1993; Ramamurti et al., 1993, 1994).

**Retirement and its effect**

In a developing country like India, where an occupation or job provides the wherewithal to eke out a livelihood, it becomes a significant aspect of the person’s self. The job gives an identity to an

Many people in India as well as in the west are fully fit to continue to work beyond the age of mandatory retirement (Baltes, 1989; Baltes and Lindenberger, 1988; Birren, 1985; Ramamurti, 1978, 1989, 1995). It may be unjust to forcefully retire them at a predetermined age without considering their functional capabilities (Ramamurti, 1982, 1989, 1991, 1992, 1995, 1995; Ramamurti, Jamuna, and Reddy, 1993).
Index of Aging and work Efficiency

Considerable work has been done in the west on how to index aging changes which can be used to assess the work efficiency of an individual at a given time (Birren, 1964). There is, however, no consensus on a universal concept of a simple index of aging. No doubt there is a decline in abilities with age but most old people compensate for this loss by certain skills which they have acquired through their long years of experience (Baltes, 1989; Birren, 1985; Ramamurti, 1990). The time and money spent on years of human resource training age not fully utilised when there is mandatory retirement (Das, 1991; Imam, 1970; Mohankumar, 1991; Ramamurti, 1982, 1989, 1991; Ramamurti et al., 1992, 1992; Srivastava and Aswathappa, 1994).

Recently there has been a debate on productive aging and the utilisation of the experienced elderly manpower for national development. There can be no two views on the utility of using the dormant manpower of the elderly to the benefit of the community and raise the GNP of the country (Ramamurti, 1982, 1991). However, little has been done in this regard. There is a need for well planned studies on assessment of decline in abilities with age and factors that contribute to it in the Indian context (Ramamurti, 1989, 1990, 1994). This is a grey area which needs to be researched (Ramamurti, 1994; Ramamurti and Jamuna, 1993, 1993, 1995).
An index of aging of abilities can only be with reference to one's own peak of capability attained in the early years. The decline can be expressed as a proportion of this maximum performance then and performance now (Ramamurti, 1989; Ramamurti et al., 1993). The index of aging with regard to the ability in question can be calculated thus:

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\text{Index of Aging (A) = } \frac{\text{Present Performance Score (PPS)}}{\text{Maximum Past Performance Score (MPPS)}} - 1
\]

Cognitive Aspects

There is a paucity of cognitive studies of aging in India (Ramamurti and Jamuna, 1984, 1993, 1993, 1995). However, in the past a few tests of memory and cognitive functioning have been adapted (Pershad and Wig, 1977; Prabha, 1975; Ramamurti and Jamuna, 1984, 1993). Using these tests, some studies have reported a general decline in cognitive functioning in later years (Anuradha, Anita, and Verma, 1991; Dube, 1994; Kohli et al., 1992; Persahd, 1979; Pershad and Wig, 1977; Ramamurti, 1978a; Sharma, Bansal, and Bhatt, 1992). Tests of intelligence largely standardised on younger populations have been found to be unsuitable for use with the elderly (Ramamurti, 1990). A cross-sequential study of cognitive changes in the older years was undertaken at the Department of Psychology, SV University but the results are yet to be reported (Ramamurti and Jamuna, 1994).
Roles, Activity, And Disengagement

Consequent on a number of changes in the physical, occupational, behavioural, and social spheres that old age brings, several roles (parenting, worker, etc.) are lost or restricted and new roles (grandparenting) have to be learnt. The extent to which an individual adjusts to the loss of old roles and learns to play new roles determines his satisfaction and mental health (Avinash and Aswathappa, 1991; Prakash, 1987; Ramamurti, 1972, 1976). A person’s psychological well-being also depends on the amount of role utilisation and role satisfaction (Anantharaman, 1979; Ramamurti, 1972; Subramanian, 1989). Role activity and role involvement were found to be related to good adjustment (Jamuna, 1984, 1988, 1989, 1994; Paintal, 1976; Usha, 1991).

Speaking of roles Manu in his “Ashrama Dharma” (Manu, 1932) suggested Vanaprasthashrama and Sanyasashrama as suitable for the older years. Upon completion of Grihastha Dharma an individual enters into Vanaprastha in early old age. During this period though he is with his family and friends, he cultivates emotional detachment and reduces ego involvement. It is a sort of gradual disengagement and a preparation for Sanyasa or total detachment and renunciation that is to follow (Ramamurti, 1978). Cumming and Henry (1961) proposed a theory of disengagement wherein the individual and society mutually
disengage from each other. This sort of disengagement is normative and occurs in most people. Contrasted to this is the activity view that suggests an active old age as a way of keeping mentally fit (Anantharaman, 1970, 1979; Jamuna, 1988; 1994; Paintal, 1976; Ramamurti, 1972, 1976). Much can be said in support of both views but finally it is the individuals’ lifestyle that may actually determine his choice and make him happy (Anantharaman, 1979; Jamuna, 1984; Pal and Sharma, 1985; Paintal, 1979, 1991; Ramamurti, 1972, 1976, 1991, 1992; Vatuk, 1980). There are several patterns of successful aging (Havighurst, 1963; Maddox, 1968; Paintal, 1976, 1991; Ramamurti, 1978).

**Personality**

An important factor that determines an individual’s adjustment in old age is his personality characteristics. Personality can be viewed as an aggregate of an individual’s dispositions, habits, and styles of functioning. Whether personality characteristics are stable over the later part of the life span is a much debated issue. Longitudinal studies tracking an individual’s personality characteristics over the later years need to be undertaken to answer this question. A few such studies have been carried out in the west; these studies do not report any significant change over the later years in many aspects of personality (Conley, 1984; Costa and McCrae, 1988; Moss and Susman, 1980;
Neugarten, 1972; Neugarten, Crolty, and Tobin, 1964; Schaie and Parham, 1976; Schmitz-Scherzer and Thomae, 1983; Siegler, George, and Okun, 1978; Woodruff and Birren, 1972). There are no Indian studies, especially of a longitudinal or sequential type, to corroborate these findings (Ramamurti and Jamuna, 1984, 1987, 1993, 1995).

Self-concept, considered as a dimension of personality, may show some changes during the later years. It has been well documented that the onset of old age brings about several changes that are not acceptable to the individual which affects his self-perception (Anantharaman, 1981; Chadha, 1991; Dhillon, 1992; Jamuna, 1984, 1985, 1989; Jamuna and Reddy, 1993; Paintal, 1992; Ramamurti, 1989c; Shanmugam, 1970). Aspects of self-perception include self-perception (acceptance) of aging changes and self-perception of health and disability (Jamuna, 1994; Ramamurti, 1989, 1990; Ramamurti and Jamuna, 1990, 1992, 1993; Ramamurti et al., 1994). Self-acceptance as an aspect of the self-concept has been investigated in the Indian context. Findings indicate that many individuals do not accept aging changes (Jamuna, 1989; Ramamurti, 1989, 1990). To the extent an individual accepts these changes as normal it contributes to satisfaction (Jamuna, 1989, 1994; Ramamurti, 1989, 1989, 1989, 1991, 1992; Ramamurti and Jamuna, 1992; Sunanda, 1990) and is regarded as a sign of well-being in old age (Ramamurti and Jamuna, 1992).
Another aspect of an individual’s personality which has significance for old age is locus of control. Many western studies indicate that those with internal locus of control do better than those with external locus of control (Baltes and Baltes, 1986; Felton and Kahana, 1974; Wolk, 1970). The Indian studies have reported inconsistent findings (Jamuna, 1989; Jamuna and Ramamurti, 1988; Ramamurti, 1989, 1992, 1992; Ramamurti and Jamuna, 1992, 1993, 1993; Ushasree, 1991). One view argues that belief in fate is the ultimate determiner of events which enables the elderly to accept things that they are unable to change. Thus, belief in Karma as a variant of external locus of control appears to be an important determiner of adjustment in old age (Jamuna, 1994; Ramamurti, 1989; Ramammurti and Jamuna, 1992, 1993, 1993, 1994).

**Rigidity**

One of the characteristics of an individual’s personality is his position on the rigidity-flexibility dimension. Rigidity is considered as an aspect of personality (Schaie, 1955). Most persons obtain higher rigidity scores with the onset of middle age and this affects their adjustment in old age (Ramamurti, 1968, 1970, 1970, 1975, 1976, 1982; Ramamurti and Gnanakannan, 1972). In a study on markers of successful aging it was observed that rigidity is one of the psychological markers of aging (Jamuna, 1994; Ramamurti, 1982,

The period of adulthood and middle age that precedes old age is a long one compared to childhood, adolescence, and youth. During this period of adulthood and middle age, the individual appears to be somewhat settled, having secured a job, got married, reared children, managing his family, etc. Life is more or less a routine affair with little change. This state of affairs continues until retirement and old age set in demanding several changes in habits. The more the individual settles down and gets set in his routine during adulthood, the more difficult it becomes to change his habits consequent on retirement and aging. Often feelings of insecurity, being unsure of how and what to do, and hesitancy in risk taking may add to the rigid behaviour of the elderly (Ramamurti, 1978; Ramamurti and Jamuna, 1984, 1992).

**Frustration, Stress, and Coping**

Frustration is a part of life. Old age too has its share of frustration. In the older years there are many things an individual cannot do which he could do with ease in his youth. This growing incapacity results in frustration. Added to this, there are normal day-to-day frustrations which are a part of life. An ICSSR funded study of sources of frustration and resources of frustrations were economic, health, family and social aspects. Persons who reacted to frustration
exhibited a predominance of extragression of the obstacle dominance type among the old-old than among the young-old (Sunanda, 1990; Ushasree, 1992, 1994).

In another study it was observed that the person's locus of control and personality make-up determined his reactions to frustration (Ushasree, 1991). Dhillon (1992) reported that the use of aggression as a strategy of coping with frustration decreased with age, particularly among people above 60 years of age. Elderly women resorted to resignation and aggression as modes of coping with frustration less than men.

The awareness that a person is aging can be a source of unhappiness. The onset of old age heralds life's last stage and is viewed as an indication that the end of life is drawing near. This perception of threat can be a major source of anxiety and stress. In other words, the perception of the process of aging itself can cause stress (Ramamurti, 1989, 1994). Added to this, there is increasing incapacity, weakness, and consequent depression. Indian studies on aging viewed old age as stress. These studies revealed that many individuals experienced stress with the onset of old age (Ramamurti, 1989, 1994). Stress may not only be due to aging itself but may also be due to various conditions associated with aging (Ramamurti, 1989, 1994; B.K.K. Reddy, 1989; Reddy and Ramamurti, 1990, 1992) Such
as loss of a job, reduced income, declining health, and stresses and strains in interaction with family members.

In the case of employees, including executives, stress could be both on the job and off the job (Avinash and Aswathappa, 1991; Reddy, 1990, V.S. Reddy and Ramamurti, 1987, 1989, 1991, 1992). As these conditions are attendant on aging and are unique to the aging individual they should be perceived as stress caused by aging (Ramamurti, 1989, 1994; Srivastava and Gupta, 1994). These stress effects sometimes manifest themselves in the form of psychosomatic conditions and contribute to ischemic heart disease (Jamuna and Sujatha, 1984; Ramamurti, Jamuna, and Sujatha, 1984).

People adopt different methods of coping which are termed as styles of coping. Some of the frequently used coping styles in the case of the Indian elderly are problem-focused and cognitive appraisal-focused coping strategies. Emotion focused coping strategies are less frequently used and are more common among less successful individuals. The main sources of stress among the rural elderly are financial, health, and family relationships. The methods of coping used by the rural elderly are cognitive appraisal-focused coping strategies (Reddy and Ramamurti, 1990, 1992). In view of the large number of problems faced by the elderly, it would be worthwhile to design

Many elderly may not appear to be sufficiently motivated to develop new coping strategies. Motivating the elderly to improve their own resources should be part of every training programme or intervention directed at the elderly. If the elderly are sufficiently motivated, they would be able to successfully utilise effective coping strategies (Jamuna and Ramamurti, 1989; Srivastava and Aswathappa. 1994).

An important aspect of coping with old age is an individual’s perception of the process of aging in terms of its acceptance or rejection and his perception of other’s appraisal of his aging. Research has consistently shown that self-perception of aging and the level of acceptance of aging changes determine an individual’s approach to coping with old age. Individuals who view aging as a normal developmental process find it easier to accept it themselves and thus cope better than those who do not accept aging and fight against it.

The acceptance of aging changes as normal does not imply that an individual should not be concerned about his appearance and should be uncouth and shabbily dressed. A certain amount of grooming is essential since perception plays a significant role in interactions. Therefore, good personal grooming and observance of hygiene within the limits made possible by the aging process enhance one’s self-confidence which in turn leads to a positive appraisal by others. Providing education to the elderly is important as it enables them to develop efficient coping strategies. Such interventions pay rich dividends (Ramamurti, 1995, 1995; Ramamurti and Jamuna, 1992; Ramamurti et al., 1992).

**Caring Issues**

In old age and particularly among the old-old there is a feeling of loss of gusto and energy, and a dwindling of financial assets and incomes. Such a situation leads to insecurity and dependency. The elderly tend to lean on another person to care for them. As there are cultural sanctions favouring older persons’ dependency on their

Industrialisation, modernisation, urbanisation, and consequent migration are rapidly changing the family structure and interpersonal attitudes of the family members. Investigations have revealed a host of factors in the family set-up that militate against the traditional care of the elderly by their adult children. Migration of children in search of higher education and jobs is a growing phenomenon. This, coupled with the reluctance of the elders to leave their familiar habitats and cope with the restraints of living with their migrant children in urban areas where accommodation is scarce, have made it difficult for children to keep their parents with them.

The need for additional income in the family and vocational aspirations of women have brought in compulsions of a dual career resulting in the absence of continuous caring facilities at home for the elderly. These sociopsychological realities seem to set at nought the

Psychologically caregiving is a delicate dyadic interpersonal relationship between the caregiver and the care receiver. The quality of any dyadic interpersonal relationship would depend, among other things, on the interperceptions between them and a balance between the perceptions of needs of the two individuals which are sought to be satisfied through the interaction. Since most of the caregivers of the elderly in Indian families are spouses (if living) or daughters-in-law much would depend upon the interperceptions of the mother-in-law and the daughter-in-law. To the extent they accept each other’s role and perceive each other favourably, the quality of the caregiver-care receiver relationship will be good. As there is a negative cultural stereotype of the relationship between the daughter-in-law and the mother-in-law, it is bound to influence their interperceptions and vitiate the interrelationship (Jamuna, 1990, 1992, 1994, 1995, 1995; Jamuna and Ramamurti, 1994; Jamuna and Reddy, 1992; Medha and Munothekar, 1989; Ramamurti and Jamuna, 1986; Ramamurti and Suryanarayana, 1981; Reddy and Usharani, 1995, 1995; Sivasankar,
Caring for the old-old or the disabled elderly is a difficult task demanding energy, patience, and a service (altruistic) disposition towards the care receiver. If caring is strenuous and round-the-clock it could be stressful, a situation that is aggravated by a poor in-law relationship. There is no dearth of instances where the stress of caring could lead to a burnout feeling (Jamuna, 1992, 1994, 1995). This is more so in the case of caregivers of the elderly with Alzheimer’s disease (Rajkumar, 1994, 1994). In order to reduce the caregiver’s stress, group counselling sessions have been organised. Such counselling sessions have enhanced the caregivers’ time management, motivation for caring and have provided them with troubleshooting strategies (Jamuna, 1995, 1995; Jamuna and Ramamurti, 1993).

Social Supports

When an individual is burdened with problems, disability or helplessness he feels a great need for psychological as well as emotional support from others. He feels greatly relieved and secure if he can get some social support. Such social support from significant others goes a long way in providing emotional security to the individual. A number of studies have investigated such social support networks of the elderly in India (Chadha, Aggarwal, and Mangla, 1990; Dhillon, 1992; (Gangrade, 1988; Jamuna, 1987, 1989, 1992, 1994;

**Gender Issues in aging**

That there are gender differences in behavior is a well established fact. The scientific assessment of gender differences with regard to various facets of behaviour is a concern of psycholgists and is well documented in psychological treatises. In as much as the lifestyles, role expectations are different for man and women in Indian culture, the patterns of aging are likely to show gender differences (Desouza, 1974; Jamuna, 1989, 1992, 1995; Prakash, 1993, 1995). The average life expectation of women is more than that of men and most women marry men elder to them. There is thus the possibility of women outliving their spouses leading to a long period of widowhood and dependency.
Normally, age 60 is used as the criterion to define old age. However, researchers make finer distinctions to categorise women as menopausal women or mid-adults, old, old-old, and very old (Prakash, 1992). Menopause is viewed as the onset of the aging process when a vital physiological function of the body ceases and by the age of 50 women consider themselves old (Prakash, 1989). Although, no profound personality changes are observed in women due to menopause, several psychological changes are reported like fatigue, irritability, and nervousness (Indira & Murthy, 1981; Prakash, 1991). Psychiatric morbidity is likely to be high during this period with symptoms like depression (Prakash, 1991) and affective psychosis (Indira & Murthy, 1980). There is some evidence that the adjustment pattern of women is affected during menopause (Jamuna, 1987) but this study which was conducted among lower income rural women needs to be substantiated by further research. Western literature on the subject points to role and identity crisis among menopausal women a they experience the “empty nest” syndrome and loss of youth and sex appeal. Unlike their western counterparts, Indian women do not perceive menopause as a threat or loss of femininity and nor do they face the “empty nest” syndrome (Prakash, 1991). In fact, Indian women in this age group may gain status in family and society. However, for want of information and facts, there are widespread misconceptions about menopause with
important implications for women's physical and mental health. Prakash (1991) cautioned against the indiscriminate dismissal of all symptoms of middle aged women as menopausal symptoms and against the unwarranted "psychologising", on the part of women, of a purely physiological change. The meagre evidence that is available in this area does not explicate the psychological behaviour pattern of menopausal women. Clearly, this is an area requiring collaborative work between psychologists, psychiatrists, and medical professionals.

As women age, they experience change in their lifestyle, pace of work, nature of activities, health, financial position, family roles and relationships, social network, and their overall attitude towards life. Also, every third woman above the age of 50 is likely to face the trauma of widowhood. Examining a group of rural based, middle and old age women, Prakash (1990) found that the major stressors were financial problems, family worries, and health care needs. Similar problems, especially of a financial and familial nature, were identified by Easwaramoorthy (1991) among rural aged women. Problems of aging women cannot be isolated from those of women in general in Indian society. Economic dependence and neglect of their physical and emotional health are problems faced by women across all ages but research shows that these become aggravated as women grow older.

When women are actively involved in home management and child
rearing tasks they tend to have at least some access to financial resources and their preoccupation with familial responsibilities helps them to cope with their daily problems. As roles diminish and their active contribution to the family ceases, their financial position deteriorates and their sense of worth declines. During this later stage in their life, their psychological well-being and overall satisfaction depend to a large extent on a supportive family and an accommodative and understanding social network (Prakash, 1991).

While physical health declines progressively with advancing age, mental health is found to be correlated, nor with age per se, but with the subjective feeling of well-being among middle and old age women. Respondents who were satisfied with their life and with the available support system experienced less negative moods and obtained lower scores on the Self Report Questionnaire (SRQ) measuring subjective well-being (Prakash, 1992). Support networks were crucial for the positive mental health of older women. However, it was the quality of support and not the number of support which was associated with emotional well-being (Prakash, 1990).

Physical health was a good predictor of life satisfaction (Anuradha & Prakash, 1991). Good physical health enabled aged women to enjoy the company of others, to lead an active outdoor life, to pursue interests, and to maintain social and friendly relationships.
Women who reported having a confidant and a friendship circle expressed less feelings of loneliness and greater satisfaction in life. Higher role activity of aged women was associated with better general adjustment (Jamuna, 1988; Jamuna & Ramamurti, 1984). This points to the need to promote greater role activity among the elderly to make them feel useful and involved in family life.

Gender, marital status, and place of residence were significant determinants of life satisfaction and psychological well-being among the elderly. Older women in India have a poorer social network than older men because they have fewer sources of intimacy and friendship, more so as a majority of the women are widowed by the age of 50. Societal norms and values discourage widows from seeking intimacy elsewhere and consequently they experience more loneliness and less satisfaction in life (Anuradha & Prakash, 1991). Predictably, married older women feel more satisfied than widowed or single older women. In the Indian context, widowhood lowers not only the financial status but also the social status of women inducing loneliness and psychological distress (Prakash & Anuradha, 1988).

In the Indian context, loss of role status and diminishing authority of aging women within the family need to be considered as significant factors contributing to their mental health status. Bambawale (1991) observed that women who enjoyed authority within their homes
were reluctant to give it up with increasing age, until they grew very
old (above 70 years) when physical health did not permit them to
remain active. Bambawale suggested that relinquishing authority in the
case of Indian women may be treated at par with retirement in the case
of men.

Finally, attitude towards aging and stereotypes about old age are
significant in explaining the problems and social position of the aged
in contemporary Indian society. Reddy and Ramamurti (1988) found
that older men and women who held negative attitudes towards old age
were more maladjusted as they could not accept changes due to aging
as nature. There are no studies that examine the existing social
setereotypes for aged women. Sabita and Prakash’s (1991) study
revealed that in comparison to American students, Indian students gave
less negative stereotypes for older males. An old man was judged to be
less attractive, less pleasant, less calm and less wealthy than younger
looking men by Indian students. American students, on the other hand
evaluated older men negatively on as many as 12 traits.

The needs, problems, and considerations for elderly women who
represent a sizeable proportion of the total population should be
specially recognised in any policy or programme for the aged in India.
Because of differences in social situation and biography the intensity
of needs and problems very from one life course to another and from
one group to another. A major study on the needs and problems of elderly women of forward and backward classes (Jamuna, 1992) noted that higher order needs like esteem and self-actualisation were least reported, the respondents reported more problems in meeting certain basic needs. Majority of the respondents showed greater intensity in survival, security, and belongingness needs. Women of the scheduled caste (SC) group, the old-old, and low income groups had higher intensities of survival, security, and belongingness needs as compared to women of the forward castes (FCs) and middle income groups (Jamuna, 1991, 1992).

In gender aging special attention needs to be paid to elder widows. Elder widows constitute a special concern group as recognised by the World Health Organisation. Elder widows face a double jeopardy, that is, of aging effects as well as from the ill-effects of widowhood in a compounded fashion (Jamuna, 1995; Jamuna and Ramamurti, 1988; Jamuna and Reddy, 1993; Jamuna, Reddy, and Ramamurti, 1991; Jamuna, Ramamurti, and Sudha Rani, 1994; Ramamurti, 1989; Ramamurti and Jamuna, 1986). These women have been found to be subjected to widowhood observances which place them at a severe social disadvantage. Elder widows have been observed to suffer from both physical and mental distresses compared to nonwidows (Jamuna, 1989, 1992, 1995; Prakash, 1991, 1993, 1994, 1995). The forward
caste elder widows were subjected to stringent widowhood observances than those belonging to the Scheduled Castes (Jamuna, 1992; Jamuna and Reddy, 1993; Jamuna, Reddy, and Ramamurti 1991; Jamuna, Ramamurti, and Shudha Rani, 1994; Ramamurthi 1989; Reddy, Jamuna, and Ramamurti, 1992).

In view of these problems, elder women and in particular elder widows find themselves in a helpless situation. These conditions can be improved only if there is some sort of empowerment in social and economic spheres, an aspect that has been more talked about than practised. Such empowerment would increase their status and bargaining power vis-a-vis other members. In this regard specific suggestions have been made in several studies on elder women (Girimaji, 1991; Jamuna, 1992, 1995; Nair and Tracy, 1989; Prakash, 1995).

Saxena (1996) examined the influence of family structure (joint and nuclear) and employment status (working and non-working) on life satisfaction and perceived happiness among 80 women and found that non-working women experienced greater life-satisfaction compared to working women and attributed their happiness to the home environment. Perceived happiness was higher among women from nuclear families compared to those from joint families. Kanwar & Chadha (1997) presented a profile of leisure activities and common health problems of pre-retirement, retirement and post-retirement groups of
elderly. Findings revealed a significant difference between the pre retirement and retirement groups in the present of leisure activities and between the post-retirement groups in their physical health.

Mathew (1997) compared the life satisfaction of institutionalised and non-institutionalised elderly. A results revealed that life satisfaction was higher among the non-institutionalised group compared to the institutionalised group. Further life satisfaction was found to have a significant positive correlation with education, age at marriage, number of living children and number of friends. A negative correlation was noted between age and life satisfaction.

Malik (1997) studied psychological well-being and life satisfaction among retired persons. The results revealed that the duration of retirement did not effect psychological well-being and life satisfaction of the subjects.

Husain, Arya & Imran (1998) compared retired and pre-retirement elderly people with respect to their attitude towards life. A group of 63 retired teachers (age 63-70 years) and another group of 82 preretirement teachers (age 56-60 years) were administered. The life attitude profile (Recker and Peacock, 1981). Results revealed significant difference between the groups on all the factors of the life attitude profile. The pre retirement groups positive and purposeful attitude towards life was discussed in terms of their unique experience.
of self, family atmosphere and socio-cultural milieu. Dwivedi, Srivastava & Srivastava (1998) examined the impact of biological factors on the life satisfaction of 100 elderly persons (age 60-75 years) from middle class families. Results indicated that the marital status of aged females affected their life satisfaction. Age, family network and education of the elderly had no significant effect on their life-satisfaction.

Chadha and Easwaramorthy (2001) discussed issues related to leisure time activities (LTAs) and quality of life of the elderly. The conception of leisure and coping with leisure are described as important contributors to life satisfaction. An increasing number of retired people today have drawn attention to the issue of leisure. LTAs are strongly and positively related to the general well-being of elderly. Cherian (2003) explored the impact of living arrangement, gender and family life satisfaction on adjustment of the elderly. Ching factorial design data has been collected through an adjustment inventory and family life satisfaction inventory (Cherian) for the elderly from 300 subjects aged between 60 and 79 years from Kuttayam and Kozhenchery taluks in Kerala. An analysis of variance done on the data revealed that there is a significant effect of (a) living arrangement on emotional arrangement (b) gender on general adjustment and (c) family life satisfaction on emotional and general adjustment.

Adeyemo (2004) studied on 200 retirees randomly selected
from four pay points in Ibadan. The results showed that health, finance, children, religion, leisure and social support as a block, contributed positively and significantly to the prediction of life satisfaction among the subjects. Chadha and Gregory (2004) attempted to understand the motives underlying participation in physical activity by older adults and describe its relationship to intergenerational issues. The study involved 123 older Asian Indian adults (76 males and 47 females) who were taking part in regular physical activity or exercise at least once a week. Participants completed the Participation motivation Questionnaire for older Adults to assess the motives for their participation in physical activity. Nine motives were identified which contained loadings on the family and social (outdoor) front. The results showed that the motives for physical activity could be used as intervention strategies to strengthen intergenerational relationships.