CHAPTER – II

REVIEW OF LITERATURE

Over the past three decades, a great deal of survey data has accumulated on living arrangements and support of the elderly in third world countries. Some of the most important demographic and structural sources of information have been provided by projects such as the Collaborative Study on Social and Health Aspects of Ageing in the Western Pacific Region (Andrews and other, 1986); the Comparative Study in Four Asian Countries: Rapid Demographic Change and the Welfare of the Elderly, in East Asia (Ofstedal, Knodel and Chayovan, 1999); the seven-country study, Social Support Systems in Transition, within Asia, Africa and the Middle East (Hashimoto, 1991; Kendig, Hashimoto and Coppart, 1992); and the United Nations Fertility Survey among Six Latin American Countries(De Vos, 1990). This survey work has been complimented by more focused sociological research in Asia and Africa, which has begun to detail how these family structures are adapting to dramatic global changes(Apt,1996, Okharedia, 1999), in Asia and Africa(Hermalin,1995; Knodel and Saengtienchai, 1999) and Latin America (de Lehr, 1992; Ramos, 1992; Lloyd-Sherlock,1997).

On a more local level, a voluminous body of anthropological work now exists on the cultural dynamics of ageing within family networks for most
regions of the world (Foner, 1984; Albert and Cattell, 1994; Keith and other, 1994; Rhoads and Holmes, 1995; Sokolovsky, 1997a; Aguilar, 1998; Putnam-Dickerson and Brown, 1998; ikels and Beall, forthcoming). Scuah community-based and culturally focused studies are crucial for helping us to understand the dynamic context that is now testing the capacity of families in developing countries to sustain the elderly. Throughout this chapter, an attempt is made to integrate this largely qualitative research with the quantitative data sources mentioned above and try to develop the conceptual framework to do the in depth analysis in order to understand the present research concept in a more detail way.

**Patterns of living arrangements and support for Elders:** Leo Simmons, in his classic examination of the role of the aged in 71 non-industrial societies, observed that throughout human history the family has been the safest haven for the aged. Its ties have been the most intimate and long-lasting, and on them the aged have relied for greatest security (Simmons, 1945, p.176). If the survey data collected over the past two decades is any judge, Simmons simplistic axiom about the aged and family living still holds in much of the third world, even in urban areas where a majority of older adults still reside with younger relatives and must rely exclusively on familial resources for survival (Hashimoto, 1991). In the Western Pacific survey, for example, it was
found that in Fiji, the Republic of Korea, Malaysia and the Philippines, between 75 and 85 per cent of the elderly reside in extended family settings. Importantly, within each country, variables such as gender, age of elder or marital status had little impact on the likelihood of co-residence.

As Albert and Cattell (1994, p.99) suggest, there seems to be a strong cultural prescription at work in this region. Similar findings from surveys carried out in the mid-1990s show a continuing pattern of high co-residence in the Philippines, Singapore, Taiwan Province of China and Thailand.

More variation was seen in the United Nations University study of seven countries, although in all sampled countries, except Brazil and Egypt, a majority of elders lived in multi-generational setting, with the highest percentages occurring in India, Zimbabwe and Thailand (Hashimoto, 1991). One of the significant differences is seen in both Zimbabwe and Thailand, which had the highest percentages of skipped-generation households, where elders resided with their grandchildren or other young relatives. In the Zimbabwean rural community of Manguwende, the study found that the grandparent / grand child household was the most frequent living arrangement of older adults. The especially high figures of skipped-generation households, for Zimbabwe reflect not only heavy migration patterns but also a cultural pattern.
whereby married sons often reside in another house compound or area of the locality.

Additionally, in Zimbabwe, economic dislocation and one of the world’s highest rates of HIV infection (United Nations, 1999b) have conspired to force reformulation of local support systems. One result of the AIDS pandemic is the loss of young and middle-aged adult caregivers, compelling the elderly to work much harder to support themselves and their grand children. The Government has asked local headmen to set aside a plot of land to help support stressed grand parents. Non-Governmental Organizations such as Help Age International are trying to establish small businesses and collective farms to bolster the economic efforts of destitute seniors. More subtle but equally profound changes can be seen in the indigenous belief system. One noted example is the loss of traditional ancestor worship associated with conversion to Christianity. Previously, there was a widespread ritual of ancestor pleasing Kupir Mudzimuz. It was believed that if people did not care for their parents, the ancestors would curse them. This seems now to have lost its effectiveness in an era when cross generational interdependence is seldom a mainstay of gaining economic maturity for young adults.

The limited survey research on living arrangements in Asia and Africa, such as that carried out by Peil (1985) during the 1980s, shows consistently
high levels of co-residence and family-based support in both rural and urban areas. She reported that about 80 per cent of her respondents over age 60 were receiving help from children, grandchildren or siblings. However, it is important to note that there is an enormous variation in family and descent systems in Asia and Africa, as well as some basic and important differences in informal support systems compared with other regions of the world. Typically, one finds that family based systems of support tend to encompass a broader definition of kin support than is usually found in any regions of Asia or Latin America (Cattell, 1997a). Especially in West Africa, widespread matrilineal descent systems, coupled with the traditional importance of women in local market economies, appear to provide older women with a more secure late life support network. Support in old age from siblings is also more a part of care giving than it is in Asia and cultural traditions of child fostering and adoption potentially expand the number of persons one can claim as his or her child (Apt, 1996; Cattell, 1993). In some matrilineal systems, where marriage pulled women to the homesteads of their spouses, after menopause they will be reintegrated in their natal households, where they will be supported for the remainder of their lives.

Among the important research indicators emerging from the recent work on living arrangements and ageing in Asia is the need for attention to regional
variation, even within relatively small countries. For example, research in Vietnam (*Anh and others, 1997*) shows a variation between the Red River Delta area with an extreme preference for residing with married sons – and Ho Chi Minh City and its surrounding regions, where this preference was much less pronounced. In looking at these types of variation, one should always expect both context and culture to shape the reality of household formation. For example, data from the senior sample of the Second Malaysian Family Life Survey show that more than two thirds of Malaysians aged 60 or older co-reside with an adult child.

Analysis by *Chan and Davanzo (1994)* indicates that co-residence is influenced by the opportunities and costs of co-residence versus separate living arrangements. Married seniors were found to be more likely to co-reside with adult children when housing costs were greater in their area or when an elderly spouse was in poor health. This work suggests that married parents and children live together to economize on living costs or to receive help with household services.

In an another study by *Chan and DaVanzo (1996)* found that ethnic and cultural factors strongly influenced co-residence. Chinese and Indian seniors with at least a son and a daughter were more likely than were Malay age peers to live with adult children. Chinese elders, however, were more likely to reside
with a son than with a daughter, whereas Malay and Indian elders were about equally likely to live with a child of either sex. This diversity points to two distinct family systems at work in the region.

In East Asia and the northern sector of South Asia, (Mason, 1992) cultures based on either Confucian, Hindu or Muslim philosophies and an authoritarian, patrilineal system stress co-residence and care by sons and their spouses. In South-east Asia and the southern zone of South Asia, Buddhist spiritual orders within a less rigid, bilateral kin system push adult daughters to play equal and sometimes more important support roles in elder care than sons.

In another part of the world, the analysis by Solis (1999) of national census data from Mexico for the period from 1976 to 1994 shows strong consistency in the moderately high percentage of elders residing in complex multigenerational households and a low percentage of seniors living alone.

A factor in understanding how the situation in this region differs from that in much of Asia and Africa is that in a majority of Latin American countries, seniors are now primarily city dwellers, and within two decades it is projected that in all but a few countries, two thirds or more will live in such settings. In Mexico, both limited ethnographic information (Velez 1978) strongly indicate that, while there may not be a significant drop in the percentage of urban multigenerational households, there are likely to be high
numbers of fluid and amalgamated family formations. This is reflected in the statistics Solis analyzed for the 1990 Mexican census, which showed that of the complex households, the largest subcategory was other complex, in which, with wide variety of younger kin other than children, in-laws or grand children were incorporated into the home.

What can one make of this kind of stability in the face of the rapid change going on in places like India and Mexico. Martin argues that, while a shifting away from massive joint extended families can be seen, the transition from a high to a low mortality and fertility demographic picture can actually maintain a high level of multigenerational system families (Martin, 1990).

Tradition unbound of Aged in Urbanized Family. The dramatic upsurge in the longevity of older citizens in third world countries is a legacy of the past two decades. This demographic change has been inter-twined with powerful modernizing events. These include alterations in economic production and wealth distribution, an explosion of super-sized cities and the often violent devolution of large states into smaller successor nations. The primary model for considering the impact of major worldwide changes on the elderly has been the modernization theory. Third world countries are said to develop or progress as they adopt, through cultural diffusion, the modernized model of rational and efficient societal organization. While such a transformation is often viewed as
an overall advance for such countries, a strong inverse relationship is suggested between the elements of modernization as an independent variable and the status of the aged as a dependent variable. Validation of this paradigm has been uneven and has spurred a small industry of gerontological writings that debate the proposed articulation of modernization and ageing (see Rhoads and Holmes, 1995). Historians in particular have sharply questioned the model, saying it is not only a historical but that by idealizing the past, an inappropriate world we lost syndrome has been created (Laslett, 1976; Kertzer and Laslett, 1994). For example, summing up research on the elderly living in Western Europe several hundred years ago, historian Andrejs Plakans states there is something like a consensus that the treatment of the old was harsh and decidedly pragmatic dislike and suspicion, it is said, characterized the attitudes of both sides (Plakans, 1989).

Goldstein and Beall (1981) argue that the concept of status of the aged must be constructed as a multidimensional variable with not necessary assumption of covariance between the different dimensions of status. The ethnographic evidence shows that the impact of change on the elderly is quite varied and depends on such factors as gender, class, social organization of the local community and how the nation-state’s political economy transfers modernizing changes into the local region.
A good example of the complexity of this issue is seen in a study of three untouchable communities in the South Tamil Nadu area of India (Vincentnathan and vincentnathan, 1994). The authors show how in the poorest communities, the assumption of respect and high status as a prior condition does not hold. Here, the elders had no resources to pass on. Modernization programmes that included providing material resources for the elders became a new basis for binding together the young and the old. However, increased education of the young led many children and young adults to feel superior to their parents. This fostered a distinct negative change in generational relations – sometimes involving high levels of abuse and even gericide – closer to the predictions of the modernization theory.

In India, increasingly since the 1980s, there has been much public discussion of the problem of ageing, evoked in emerging protective legislation, new gerontological societies, popular magazines, and other forms of popular culture. In the Indian State of Himachal Pradesh, the Maintenance of Parents and Dependants Bill was passed in 1997 making it mandatory to provide for ageing parents. In the preface to the bill, a Himachal Pradesh minister proclaims ‘Aged and infirm parents are now left beggared and destitute on the scrap heap of society. It has become necessary to provide compassionate and speedy remedy to alleviate their sufferings (Lamb, forthcoming). Sarah Lamb notes
that in some sectors of Indian society (especially urban areas and more prosperous rural zones) a bad old age is viewed as a paradigmatic sign of the evils brought by modernization, urbanization and the changing attitudes and behaviour of young women. In the West Bengal community, people constantly talking about how these modern changes provoked families to break up, old people to be left alone and society in general to be undergoing a general deterioration. Working elsewhere in India during the early 1990s, a lower-caste Nagwa slum of Varanasi, Lawrence Cohen found that the problems of the elderly were discussed in quite different terms. Old-age afflictions set in the context of family conflict were perceived as neither new nor unusual (Cohen, 1998). They were blamed on the caste order, impoverishment and the debilities of old age itself and the splitting of joint families through conflict between co-resident brothers.

Significant changes in village life have not altered the fact that the lives of the aged remain thoroughly embedded in the social matrix of surrounding households, headed by adult children, siblings and cousins. Elders are in constant contact with children, if not with a resident grand child then with a wide range of very young kin and god children living within a few hundred yards. As has been noted in other parts of the developing world, the child-
minding aspect of grand parenting has, in fact, increased over the past decade, as in many households at least one parent is working in the city during the day.

Most marriages (about 75 per cent) take place within the village, imparting a particularly intense geographic density to the social networks of the aged, especially for males. While a woman’s kind group is more physically dispersed from her abode than is a male’s, this does not imply that females are more isolated in old age. In fact, owing to their greater role continuity, women past age 65 will typically maintain reciprocal support networks with more personnel and have greater frequency of exchange than their male age peers.

Older People’s Mental Health, Old age psychiatry (also called geriatric psychiatry, psycho geriatrics, psychiatry of the elderly, and older people’s mental health) is a relatively young speciality which concerns mental health services across the range of mental health problems in later life. It has developed over the past 40 years, with specialty status being achieved in the United Kingdom in 1989 (Pitt et al, 2006). Thus, the speciality has been developing over the period when the user movement has been developing.

Patients of old age psychiatry services may be disadvantaged by several factors including co-morbid physical illness, sensory impairments, multiple medication use, frailty associated with advanced age, social circumstances, co-morbid cognitive impairment along with other mental illness, limited finances,
and the assumptions people make about advanced age and cognitive impairment. These factors are relevant to the relative absence of older patients with the user movement. Carers are more visible and carer support has been described as a fundamental component of all aspects of service provision (Benhow and Jolley, 2006). Although the role of the family in the care of children is clear and accepted, for older adults the case has had to be made (perhaps another example of ageist assumptions) (Benhow and Marriott, 1997).

With regard to older people’s mental health (OPMH) policy the National Service Framework (NSF) for Older People emphasized person-centered care (Standard 2) and the issue of choice, and the National Service Framework Mental Health included a Standard on career support. Unfortunately old age psychiatry fell between the two NSFs. when the NSF for Mental Health was published it did not apply to older adults and the NSF for Older People highlighted other priorities. Everybody’s Business (2005) was later produced as a document focused on older people’s mental health and described involvement of patients and careers in services as central to quality improvement arguing that it should be embedded in the way staff and organizations operate. Everybody’s Business appears to have had little influence, probably for several reasons: it brought no money into services, was a we-based document and was
followed by a period of financial stringency and considerable upheaval in services. More recently the National Dementia Strategy (2009) identifies engaging with public and patients as one of the World Class Commissioning competencies which fits with many of the strategy’s objectives, describing people with dementia and their careers as being fully engaged in the design and delivery of services. New Horizons: a shared vision for mental health, published in 2009, makes the point that older people (should be) equally involved in the planning of their own individual care, service planning, foundation trust membership etc. and includes older people and their care firmly within the sphere of mental health.

**Demographic Dynamics of Old Age:** The proportion of women in each birth cohort who have remained childless has fluctuated widely since 1900. For female cohorts aged 50 to 90 in 1990, the proportion childless ranged from a high of nearly 22% among women who reached child bearing age during the Great Depression to a low of 8.8% among women born in the mid-1930s. Increased childlessness has resulted from delays or marriage or child bearing, as well as from an increase in voluntary childlessness (*Poston, 1976; Poston and Gotard, 1977; Jacobson, Heaton, and Taylor, 1988*), a trend which has escalated among cohorts born after 1940.
Himes (1992) estimated that among persons over age 65 in 1990, childlessness characterized over one-fifth of the population. Among the very old, it has been estimated that up to the year 2015, “about one-quarter of women aged 85 to 89 will be childless and another one-quarter will have only one surviving child (Preston, 1992). The aging of cohorts born after 1940 will lead to a substantial increase in the proportion of elders without children.

The social and familial resources with which current and future cohorts enter middle and old age reflect the dramatic social changes of this century. These cohorts are characterized by a much greater diversity of family forms and personal histories than the cohorts that preceded them, a result of lower mortality, lower fertility, and higher divorce rates as well as societal acceptance of a wider range of available life paths for men and women (Bengston and Silverstein, 1993; Uhlenber, 1974). Specifically, low fertility in this century has resulted in a high proportion of people entering old age with few or no children and with fewer siblings within their families (Bengston, Rosenthal, and Burton, 1990).

Gerontological research has documented the importance of familial resources, especially adult children, in providing social support for the aged (see Horowitz, 1985; Cantor, 1979; Brody, 1990), and childless elders have been generally identified as a potentially vulnerable sub-group among the
elderly people. Childlessness has been associated with higher risks of loneliness, social isolation, depression. Much of the literature on the childless elderly is nearly fifteen years old and, therefore, does not reflect the changes in the composition and experiences of the current and emerging cohorts of elderly persons (Preston 1989; Goldsheider 1990).

For these reasons it is important to update our understanding of the effects of childlessness on the experience of middle and old age. Three key questions need to be addressed. First, does childlessness influence comparative psychosocial status, specifically loneliness and depression, in middle and old age? Second, how are these patterns different for men and women? Finally, to what extent are the differences between the childless and their peers with children a consequence of other, related social circumstances such as marital status and living arrangements? The data collected in the National Survey of Families and Households (NSFH) provide the basis for an updated portrait of the relative effects of parental status and family history (Goldscheider 1990).

Childlessness in Old age And Societal Attitudes: The meaning of childlessness for emerging cohorts of older adults will depend in part on the changing normative context and how it has defined the salience of childlessness over the life course. Strong pro-natalist norms have been pervasive in the United States (Blake, 1972; Gerson, 1985; Veroff, Douvan, and Kulka,
1981), and although acceptance of childlessness has increased, most Americans associate childlessness with greater loneliness in old age (Blake, 1979).

When asked directly about the advantages and disadvantages of childlessness, older women’s reports have varied according to whether or not they were themselves mothers (Houser, Berkman, and Beckman, 1982). Currently married and widowed mothers expressed negative views of childlessness in old age. The most frequently mentioned disadvantage of childlessness was loneliness, named by 60% of the mothers but only one third of childless women. Childless women reported significantly more advantages and fewer disadvantages of childlessness.

Empirical studies of childless elders’ isolation and loneliness compared to parents have yielded mixed results. Using U.S. data from 1974, Bachrach (1980) found that childless elders were more likely to live alone, and that among all elders living alone, the childless about twice as likely to be isolated (having few or no face-to-face social contacts in the last week) than those with children (24.8% compared to 10.7%). She also found a significant interaction between childlessness and health, with childless elders in poor health experiencing the greatest isolation.
Glenn and McLanahan (1981), using data from the U.S. General Social Survey (1973-78) found no significant effects of childlessness on global happiness or well-being among persons over age 50.

A similar national study in Canada (Rempel, 1979) found no significant differences by parental status in either happiness or loneliness. Dating back to the mid-1970s, none of these three analysis of rural elderly in North Carolina found no differences in loneliness. Keith’s (1983) studies in the Midwestern U.S. found no difference in loneliness between parents and the childless, but reported significant interactions by marital status and sex, with married men less lonely than married women and unmarried men more lonely than unmarried women.

However, two studies of purposive samples found important effects of childlessness as well as interactions between childlessness and marital status. Beckman and Houser (1982), comparing married and recently widowed women aged 60-75, found that parental status was more salient for widows than for married women in influencing social isolation and depression. Widowed mothers were significantly less depressed, less lonely, and less socially isolated than childless widows, but no such differences were found among married women.
Connidis and McMullin’s (1993) study of people 55 and older in Ontario, Canada, suggested that the consequences of childlessness in later life were conditioned by the process through which childlessness occurred in the life course. Focusing on subjective well-being and depression, the authors compared four groups of elders – childless by choice, childless by circumstance, close parents, and distant parents. They found that women who were childless by circumstance were significantly more depressed than mothers who were close with their children, but there were not differences between the close parents and the women who were childless by choice. There were no effects of parental status for men, but their depression was linked to marital status, with greater disadvantage observed among divorced men. However, the authors did not compare the overall groups of parents and childless, and their distinction among the childless between choice and circumstance is problematic. Retrospective assessments of choice vs. circumstance are subject to personal re-evaluations over the life course (See Alexander, et al., 1992), suggesting that contemporaneous reports of circumstantial childlessness and high depression may both be related to other and these are underlying sources of unhappiness.

By focusing on aged parents i.e., men and women separately, this study try to explores the constellations of social influences that shape the life course
in gender-specific ways. Namely, social norms which emphasize pro-natalism and associate childlessness with loneliness and depression in old age are empirically and substantively dominant in the lives of older parents in general but in particular on whom it has more influence whether, on men or women (father or mother) need to be study, and researcher thought of it as below.

This study is based on a literature review, discussions with experts from the multi centre network on Burden of Disease in Old Age (http://www.jyu.fi/BURDIS), the EU sponsored activity, and the results of the longitudinal and comparative studies at the Finnish Centre for Interdisciplinary Gerontology. Published randomized controlled trials, meta-analyses and reviews as well as other relevant literature were sought from Medline, Pub Med and Sociological abstracts, and bibliographic searches using the reference lists of relevant articles were also undertaken. Bibliographic searches related to the population aged 65 and over. Various terms were combined for different searches (for example, disability, disablement process, risk factors, interventions, comprehensive geriatric assessment, physical activity, depression, and elderly). Due to the complex nature of the old age disability and limited space available for this review, only a few risk factors were considered in more detail, namely: chronic illnesses, depression and physical inactivity, and related functional decline. However, it can be assumed that successful
interventions targeted to any of the above-mentioned risk factors for disability will eventually prevent and reduce old age disability.

Findings of the study are as follows:

Much research has been done to identify risk factors for the onset of disability by applying the disablement model (3) (Annex 1) originally developed by Nagi (2). The main pathway of the model consists of four components: pathology, functional impairments, functional limitations, and disability. These personal characteristics are modified by behavioural factors such as physical exercise, smoking, alcohol consumption, nutrition, social activities, or influenced by permanent characteristics such as age, gender and genetic factors (3, 4). It is also clear from several studies that the prevalence of disability is lower in relatively privileged socioeconomic groups (5, 6, 7, 8). The development of disability is further conceptualized on the assumption that environmental factors such as social support, services, and physical characteristics of the living area in concert with an older person’s personal capabilities influence the likelihood of becoming more or less disabled. Changes in bodily structures and functions with advancing age also modify the disablement process and increase the risk for disability (9). This is particularly important in the oldest age groups, in which ageing processes contribute to
decline in sensory and motor performance and in the cardio-respiratory, musculoskeletal and nervous systems, for example.

Given that there seem to be three main underlying causes of disability - diseases, injuries and processes of ageing - it would be logical to examine the risk factors separately in relation to these causes. The borderlines between the processes of ageing and diseases of old age and consequent functional decline are in many cases poorly understood. In the studies of old age disability it is, therefore, for the time being difficult to define separate risks for accelerated ageing and diseases. In a systematic literature review Stuck et al. (10) listed various behavioural and health factors that at an individual level contribute to the development of disability in old age. The highest strength of evidence for an increased risk in functional status decline (defined as disability or physical function limitation) was found for (in alphabetical order):

- Cognitive impairment

What are the main risk factors for disability in old age and how can disability be prevented? WHO Regional Office for Europe’s Health Evidence Network (HEN) September 2003.

- depression
- disease burden
- increased and decreased body mass index
- lower extremity functional limitation
- low frequency of social contacts
- low level of physical activity
- no alcohol use compared to moderate use
- poor self-perceived health
- smoking
- vision impairment.

Other risk factors, usually related to different chronic diseases, include hypertension, elevated blood lipids and glucose, low bone density, alcohol and drug misuse (11, 12, 13, 14). A recent synthesis by Miller et al. (15) of 78 journal articles identified 22 risk factors as predictors of adverse outcomes including reduced physical performance. Certain risk factors (for example, nutrition and physical environment) have been largely neglected in earlier research. Research has also shown that certain psychological and psychosocial characteristics, such as poor self-efficacy, coping strategies, depression and social integration predict the development of disability (16, 17).

INTERVENTIONS TO PREVENT DISABILITY:

The basic premise for any larger scale application of interventions aimed at preventing disability in old age is that the targeted factor is significantly implicated in a certain disability outcome. In addition, the prevalence of this factor in the population concerned should be taken into account and there should also be evidence that interventions aimed at this factor are effective.
Table 1 gives estimates about the reliability of associations between certain risk factors and disability in old age, the importance of the risk factors at population level and the current evidence regarding the possibility of improving the situation through interventions.

Several important risk factors for disability have already been established, as indicated by the review of Stuck et al. (10). Additional research is, however, needed for the development of effective interventions, and there are obviously many other individual and environmental risk factors that have not yet been identified and properly investigated from an intervention point of view. Obesity, for example, is a major public health concern but only a few prevention programmes have been developed or implemented, and the success rates have been low (13). Randomized controlled trials are still rare in this field of research, and there seems to be considerable variation in the target populations and the intervention duration, strategies and designs. Outcome measures have included different domains of functional status, admission to hospital and institutional care, use of community services and visits to physicians, home nursing care, health status and self-rated health, quality of life and mortality.
Very few studies on Old Age Persons in Karnataka, especially in the Hyderabad Karnataka region consisting of Gulbarga, Bidar and Raichur districts have been undertaken.

**Marulasiddaiah, H.M.** made a study of old age people in Mukunti Village in Karnataka. The report was published in 1975. The study made significant contributions towards understanding the problems of the aged. It is evident from the study that old age persons are facing lot of problems.

A study sponsored by the Ministry of Welfare was conducted by **Gurumurthy, K.G. (1998)** in rural Karnataka in 1991. The title of the project was “A Study of the Problems of the Aged and Need for Social Intervention”.

**Patil, Prema B (2000)** conducted a study of the “Psycho-Social Problems of the Retired”. The study was conducted in Dharwad and Belgaum cities of Karnataka. The study revealed that relatively the more aged ones with a low income were mentally distressed. The life of the old age persons will be a curse. Unfortunately these people are not getting proper care and mental support from the younger generation.

**Sonar, Gangadhar B (2004)** conducted a survey of “Old Age Pensioners: A Socio-Psychological Study” in Shahabad town and surrounding villages in Gulbarga district of Karnataka State during the year 1997-2001. The
study concluded that the socio-psychological and economic conditions of old age pensioners were more vulnerable than those of others.

**Jayashree (2000)** conducted a study on “Work After Retirement” in Mangalore urban area in South Canara District of Karnataka State. The study tried to understand the various factors and issues involved in work after retirement.

**Sati, P.N. (1988)** studied the problems of retired people. But the problems of non-retired elders above 60 years need to be studied. To be specific, it is pertinent to ask whether pensioners and non-pensioners differ in their approach in solving familial, economic and health problems.

**Mohanty, S. (1989)** in an article “Retired Government Servants and their Problems of Socio-psychological Adjustment” describes the problems of retired government servants. He points out that the increase in the aged population has brought several problems to the surface.

**Ramamurthi, P.V. (1997)** in an article “The Psychological Scenario of the Elderly: Problems, Priorities and Perspectives” dealt with the significance of the study of aged people. He has pointed out that the senior citizens would become a “power minority”, who constitute vote banks and can wield power. He is of the opinion that the young old (60-75) can be a great resource to the country and their trained modifiable manpower should not be wasted. Suitable
plans for the appropriate use of this human resource is urgently needed. He also suggests that priority regarding research on aged should be given. He highlights the role of the state and NGOs in providing adequate security to the aged.

Srivastava and Sanjaya Kumar (2001) in their study “Attitudinal and Life Style Changes in Old Age” have concluded that, contrary to the traditional belief that life becomes static in old age, it is a period which is characterized by considerable change in life style and attitudes. The study has shown that most of the aged persons spent their time in walking, gardening or reading newspapers. The study further showed that the traditional image of old age persons, who have retreated from the world of brisk activity and movement and have become devoted to socio-religious activities, was no more true. The aged in the changed socio-cultural milieu of contemporary society are adopting new ways of life. The mass media have generated a new sense of participation among the aged and contemporary old aged persons are more socially involved and consciously participate in the modern social whirling.