CHAPTER-VII
SUMMARY AND CONCLUSION

Ageing is universal and inevitable. The process of ageing varies from individual to individual. The way in which we grow old and experience this process, our health and functional ability all depend not only on our genetic makeup, but also (and importantly) on what we have done during our lives; on what sort of things we have encountered in the course of our lifetime; on how and where we have lived our lives. Ageing is highly complex and variable phenomenon. It is chronological, biological, psychological, social and developmental in nature.

As defined by Gothelf (2008), ageing is a constant and predictable process that involves growth and development of living organisms. It cannot be avoided, but how fast we age varies from individual to individual. The concept of ageing can be understood by the explanation of three broad as well as inter-linked dimensions namely, physiological ageing, psychological ageing and social ageing.

Looking into the history of ageing, Manu, in his Dharmashastra divided the life span into four ashramas (stages)- brahmacharya, grihastha ashram, vanaprastha and sanyasa. This classification was incomplete as it did not explain anything about the women’s life. Wife’s role was pre-assumed to be following her husband.

Geriatric population includes the persons who are 60 years and above. They are categorized into young old (60-75yrs), old-old (76-85yrs) and very old (>85yrs). In 2009, 12 per cent of the world’s population- approximately 740 million people- were aged sixty and above. The Indian aged population is currently the second largest in the world. The 2001 census has shown that the elderly population of India consisting of 28 states and 7 Union Territories accounted for 77 million which accounts for 7 per cent of the total population. It has been projected that the elderly population will rise to 9% by the year 2016. By 2020, 177 million people will be in this age group.
According to the report submitted by Bhattacharya (2005), Indian population has approximately tripled during the last 50 years, but the number of elderly Indians has increased more than fourfold.

The above given trends clearly highlight the need for focusing on the health needs and welfare of the aged—who are going to be a sizable proportion of the population. This demographic trend of a rapidly increased elderly population is likely to have serious medical, psychological, socio-economic and socio-political implications for the development of our country. On one hand, we have a rapidly increasing population of elderly people and on the other hand, our society is experiencing many social changes under the influence of rapid urbanization and industrialization, which are likely to further compound the magnitude of this demographic transition. Common by-products of increased modernization are ‘individualism’ and the need to be self-dependent (Pati and Jena, 1989). Another change is the disintegration of the joint families into nuclear families. There is a transition of families from being multigenerational to two-generational, particularly in urban areas. Thus, the care of the elderly, which was inbuilt in the social structure of our age-old joint family system, has been adversely affected. These changes have rather led to the concept of institutionalization of the elderly.

The present study is significant as it moved a step beyond description to understanding of psychological correlates of differences. It is also significant because it highlighted a need for an integrated approach for understanding the social, psychological, economic and other aspects of the life of elderly people. This study provided a comparison between institutionalized and non-institutionalized elderly on the indices of healthy ageing. Realizing the importance of healthy ageing, the present study focused on the indices of healthy ageing viz. happiness, optimism, social support, emotional intelligence and spiritual intelligence and their effect on stress and coping among elderly.

A review of related literature has been made on the concept of healthy ageing, ageing and stress; ageing and coping; ageing and happiness; ageing
and optimism; ageing and social support; ageing and emotional intelligence; and ageing and spiritual intelligence. Studies in a time frame of 1960s to 2011 have been selected up for the purpose. The perusal of the related literature reveals some significant aspects of the ageing- social ageing, psychological ageing, role of social support in ageing, change in social roles and expectations, to name a few.

The conceptual and theoretical framework involving three approaches of stress are discussed in the third chapter. The concepts of health, ageing, stress, coping, happiness, optimism, social support, emotional intelligence, spiritual intelligence and socio-economic status have been explained. In addition to the above mentioned concepts, the transactional model of stress and coping, as applied by the researcher, has been discussed in detail.

Health is an age-old as well as culture-specific concept. To a layperson, health would mean a sound physical body. It is more so, a condition of a body that helps a person to perform his day-to-day activities to the expectation of others. For older persons, health determines their ability to perform the task that facilitates their participation in society. World Health Organization (WHO) defined health in its constitution as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Stress is an inevitable part of our lives. Stress is a universal phenomenon that often results in intense distressful experiences that can have a tremendous influence on one’s behaviour and is usually associated with a negative feeling (i.e. feeling tense, worried and under strain).

Lazarus and Folkman (1984) described a two phase process when individuals experience a stressor. The first, namely appraisal, can be subdivided into primary and secondary appraisal. Primary appraisal is the initial evaluation the individual makes of whether an event is irrelevant, relevant but not threatening, or stressful. When the individual sees an event as stressful, he/she is likely to make a secondary appraisal, which implies an
evaluation of coping resources and options for dealing with the stressful situation (Lazarus and Monat, 1991). The second phase, namely the coping appraisal, is conceptualised not as what the individual should, would or could do, but rather what the individual in fact does as he/she reacts to a specific stressful condition (Lazarus and Folkman, 1984). Researchers have systematically examined coping strategies among different people. Usually coping strategies have been divided into two types i.e. problem-focused where focus is to decrease stress by changing person-environment relationship and emotion-focused where focus lies on the way one interprets the stress. Others add a third style: appraised-focused coping based on cognitive analysis, redefinition and avoidance.

Webster’s Encyclopaedic Unabridged Dictionary of the English Language (1994) defines happiness as the quality or state of being happy; an agreeable feeling or condition of the soul arising from good fortune or pleasure of any kind; the state of contentment, felicity and aptness.

Optimism is an inclination to put the most favourable construction upon actions and events or to anticipate the best possible outcome (Merriam-Webster’s Online Dictionary, 2007).

Social support is a companionship from others that conveys emotional concern, material assistance, or honest feedback about a situation. In stressful situations, people who perceive a high level of social support may experience less stress and may cope more effectively (Straub, 2007).

Emotional intelligence (EI) states that to be successful requires effective awareness, control and management of one’s own emotions and those of other people.

Spiritual intelligence refers to a capacity for a deep understanding of existential questions and insight into multiple levels of consciousness. It can be defined as pure consciousness or awareness of one’s inner self (Wild, 2004). The four core abilities or capacities of spiritual intelligence include
critical existential thinking, personal meaning production, transcendental awareness and conscious state expansion.

Socio-economic status means the ranking of the family in the milieu to which the family belongs, in respect of defined variables viz., physical assets, economic status, education, occupation, social position, social participation, caste, muscle power, political influence, etc. Research indicates that income is perhaps the strongest and most robust predictor of health.

Chapter 4 gave a description of area and people selected for the present study. Chandigarh is known for its health infrastructure. There are two referral/tertiary hospitals, one secondary hospital. In addition, there are two community health centres, one polyclinic and a number of dispensaries in all parts of the Union Territory. The crude birth rate (CBR) and Infant Mortality Rate (IMR) of Chandigarh is 15.6 and 22, respectively (SRS, December, 2011) and maternal mortality ratio (MMR) is 40 per 100,000 live births (Jaiswal, 2011). The sex ratio is 777 as compared to 933 of India (Census, 2001). Most of the required infrastructure for health is in place in Chandigarh.

As per Census (2001), the population of Chandigarh is 900,635 comprising of 506,938 males and 393,697 females. Age structure of the population reveals that the elderly population (60 years and above) accounts for 5 per cent (44,912) of the total population, consisting of 52.9 per cent of males and 47.1 per cent of females. There is no geriatrics unit at the secondary level hospital to tackle the problems of the aged.

Life expectancy is steadily increasing, but cities are no longer safe nor do friendly neighbors a certainty. Children either settle abroad or in some other states, for better career opportunities. The sense of insecurity, loneliness and lack of companionship have force elderly to walk out of their own home in search of a journey that promises peace, joy and celebration of life with a group of people who share the same boat of life (the wrecked one).

The fifth chapter essentially deals with the research methodology used for conducting the present research work. The fieldwork to collect data and
information was conducted Chandigarh. The respondents comprised of the elderly living in their homes as well as the elderly residing in the old age homes of Chandigarh. For the present study, 6 old age homes of Chandigarh were covered, namely, Home for old and destitute people, Sector-15-D, Chandigarh; Vaidik Sadhna Dham, Sector-7, Chandigarh; Sri Satya Sai Old Age Home, Sector-30; Chandigarh, Senior Citizens Home, Sector-43-A, Chandigarh; All India Pingalwara Charitable Society (AIPCS), Palsora, Sector-55, Chandigarh; and Akal old age home, Mullanpur.

Both primary as well as secondary data were collected for the present study by using various tools of data collection like schedule, and questionnaires. Seven standard scales for measuring various variables were used to collect the quantitative data relating to the respondents, namely Presumptive Stressful Life Events Scale, Ways of Coping Questionnaire, Happiness Measure, Life Orientation Test, Social Support Scale, Emotional Intelligence Questionnaire and Socio-economic Scale. Information related to the population of elderly, list of old age homes and number of residents residing in each old home were collected from secondary sources of information like Census, reports generated by Social Welfare Department, Chandigarh Administration; and Directory of Help Age India. Relevant literature on ageing was collected from various libraries and reviewed.

The actual fieldwork for data collection was conducted in the time period from April, 2009 to May, 2010 in the Union Territory of Chandigarh. The information generated through different modes of data collection was analyzed with appropriate statistical tests like the measure of percentage, and presented in the form of tables, graphs, bar-diagrams, pie-charts, etc. To observe the significant level and association of different variables, chi-square test was applied. The qualitative data obtained has been mentioned in the form of the narratives.

Out of 337 respondents covered in the present study, 200 (59.3%) respondents were non-institutionalized and 137 (40.7%) respondents were
institutionalized. Majority of the respondents were males (122 males and 78 females among non-institutionalized respondents and 73 males and 64 females among the institutionalized respondents) as compared to females. The age of the respondents was divided five categories including 60 years, 61-65 years, 66-70 years, 71-75 years and 75-80 years. Among the non-institutionalized respondents, 89 (44.5%) were from the age group of 61-65 years, while 55 (27.5%) and 30 (15.0%) respondents in the age group of 66-70 years and 71-75 years formed the second largest and third largest groups, respectively. In case of the institutionalized respondents, 54 (39.4%) respondents belonged to the age group of 61-65 years. The second largest group comprised of 43 (31.4%) respondents in the age-group of 66-70 years. All the 200 non-institutionalized respondents were married whereas only 34 respondents among the institutionalized were married. Maximum respondents were widows and widowers. 81.5 per cent of the non-institutionalized respondents and 60.6 per cent of the institutionalized respondents belonged to the upper caste group. None of the 337 respondents was from scheduled tribe caste. The association of socio-economic status with the type of residence (home or old age home) of the respondents was found to be statistically significant at .0001 level. Positive correlation was found ($r= .21$).

When the stress level of the respondents was studied, the mean stress scores of the non-institutionalized and institutionalized elderly were found to be 329.76±246.72 and 835.07±295.69, respectively and the difference was found to be statistically significant ($p<.001$). The two groups differed in stressful events occurred in lifetime in a way that non-institutionalized respondents reported significantly lesser number of desirable events (mean±sd:0.85±0.97 vs 1.36±1.52, $p<0.05$), undesirable events (mean±sd:1.54±2.13 vs 2.48±2.31, $p<0.05$) and total events (mean±sd:4.87±3.67 vs 7.64±5.91, $p<0.01$) than the institutionalized respondents. In terms of stressful life events occurred in the past one year, non-institutionalized respondents reported 0.80±0.93 number of desirable events as compared to 1.22±1.40 events.
The study of coping strategies used by the respondents revealed that non-institutionalized respondents were using problem-focused or approach coping such as positive reappraisal, planful problem solving, etc. more often while dealing with a stressful situation. Contrary to this finding, the institutionalized respondents were largely found resorting to emotion-focused coping strategies such as escape avoidance, distancing and self-controlling, etc. This difference was found to be significant among the non-institutionalized elderly but not among the institutionalized ones. No significant gender differences were found. The nine ways of coping namely confrontive coping, planful problem solving, positive reappraisal, escape-avoidance, distancing, seeking social support, accepting responsibility, self-controlling and shifting the burden to God/Religion were explained with illustrations of case reports. The cases reported were the real cases observed and analysed by the researcher in the course of her interactions with the respondents.

Happiness is an important component of quality of life. The important elements of happiness include life happiness, happiness in living in the family and happiness in living with others in the society. None of the non-institutionalized and institutionalized respondents was feeling very unhappy and extremely unhappy. The number of institutionalized respondents (29.2%) was found to be five times more ‘slightly unhappy’ as compared to non-institutionalized respondents (5.0%). Where 30 per cent of the non-institutionalized respondents were found to be feeling pretty happy, none of the institutionalized respondents felt the same. The dependency of happiness on sex was found to be highly significant statistically (p<.001). Males were found to be happier than females. The association of social support with happiness among the non-institutionalized respondents was found to be significant (p<.001). The same association was non-significant in case of the institutionalized respondents. Socio-economic status had an effect on the
level of happiness among the non-institutionalized respondents but no such
effect was found among the institutionalized ones. The respondents were also
asked to comment on the source of happiness in their life. Among the non-
institutionalized respondents, the responses given by the males were
consolidated into three main themes: ambitious, recreational, and altruistic
(pro-social) and the responses received from females were based on the
happiness and success of families, supporting others and attending religious
ceremonies. The institutionalized respondents replied that they get happiness
by meeting new people, attending social and religious ceremonies, sharing
their experiences, thoughts and ideas with others.

The optimism level of the respondents was studied to find out if they still have
much hope for living and whether this hope will make them happy. It was
found that 57.5 per cent of the non-institutionalized respondents as compared
to 50.4 per cent of the institutionalized respondents were high on the optimism
level where as 49.6 per cent of the institutionalized respondents were found to
be low on the optimism level as compared to 42.5 per cent of the non-
institutionalized ones. The association of optimism with sex was found to
highly significant statistically (p<.001) but its dependency on social support
was not found to be significant statistically. It was important to observe that as
compared to the non-institutionalized respondents, 13.1 per cent of the
institutionalized respondents with high level of optimism and 5.9 per cent of
them with low optimism level felt mildly unhappy. And also 14.5 per cent with
high optimism and 17.6 per cent with low optimism felt mildly happy. This
finding expressed a negative correlation between optimism and happiness.
The present study indicated that there is a strong relation between optimism
and problem-focused coping. Regarding the association of optimism with
socio-economic status (SES), it was found that majority of the respondents
(NI and I) with high level of optimism belonged to upper middle SES whereas
ones with low level of optimism mostly belonged to high SES.

Majority of the respondents were found to be low on perceived social support
level. Data showed that among the non-institutionalized respondents, 53 per
and 47 per cent (N=200) of the respondents had low and high perceived social support, respectively. In case of the institutionalized respondents (N=137), 59 per cent of the respondents were having low perceived social support against 41 per cent of the respondents having high perceived social support. In case of non-institutionalized respondents, the association of social support with education and socio-economic status showed highly significant results (p<.001). Significant association was found between social support and ways of coping (p<.01). But in case of the institutionalized respondents, no significant associations were found between social support and education, SES and ways of coping.

On asking the respondents about the type of social support they enjoy, support provided by a spouse was found to be the most important predictor of social support. Many respondents from the non-institutionalized category, especially males were found to be the members of the senior citizens’ club or any other religious clubs. Some of them were working even after their retirement. Majority of the institutionalized respondents responded that they have found very good and supporting friends in the institutions where they were residing. It was found that if one resident of the old age home cried, then others always consoled and supported him/her. The management team of the old age homes took care of all the basic needs (hunger, thirst, shelter) of the residents. Financial assistance was also provided in those old age homes which are being run by the public sectors.

Emotional Intelligence refers to the competence to identify and express, understand and assimilate emotions in thought, and regulate both positive and negative emotions in one self and others (Matthew et al., 2002). 63.5 per cent of the non-institutionalized respondents and 55.5 per cent of the institutionalized respondents were found to be having moderate emotional intelligence. 31.4 per cent of the institutionalized respondents were found to be low on emotional intelligence as compared to 25.0 per cent of the non-institutionalized respondents. Data shows that 13.1 per cent of the
institutionalized respondents were high on emotional intelligence whereas it was 11.5 per cent for the non-institutionalized respondents. None of the males and females was found to have ‘very low’ level of emotional intelligence.

The association of emotional intelligence with social support depicted that the non-institutionalized respondents with high social support were found to be low on all the three levels of emotional intelligence, i.e. high, moderate and low than the respondents with the low social support. In case of institutionalized respondents, majority of the respondents with high perceived social support, i.e. 38 (67.9%) were moderate in emotional intelligence whereas this number in case of respondents with low perceived social support stood at 47 (58.0%).

The non-institutionalized respondents at all the three levels of emotional intelligence were found to be using positive appraisal and planful problem solving as the ways of coping. Whereas the institutionalized respondents with low and moderate emotional intelligence used escape avoidance the most whereas same percentage of respondents (18.8%) with high EI used confrontive coping, self-controlling and accepting responsibility as a ways of coping.

There are various dimensions of spiritual intelligence such as God and religiosity, Soul, Self-awareness, Spiritual practices, Life style values, Gender and caste equality, religious beliefs (Karma), Interpersonal relations, Divinity in love, spirituality in leadership, helping behaviour, flexibility, Ability to use and overcome suffering, Ability to transcend pain and being spiritually intelligent about death (Daftaur and Daftaur, 2003). In the present study, the researcher had selected only two dimensions of spiritual intelligence, namely ‘God and religiosity’ and ‘religious beliefs’. It was found that 100 per cent of the non-institutionalized females, institutionalized males and females each and 64.75 per cent of the non-institutionalized males offer prayers at home. Regarding visiting the temple for offering prayers, 83.3 per cent of the non-institutionalized females and 51.56 per cent of the institutionalized females
formed the first and second largest group. The percentage of males (non-institutionalized and institutionalized) was found to be similar, i.e. 100%. It was found that majority of non-institutionalized females, i.e. 58.97 per cent are involved in giving financial aids to the religious institutions for building infrastructure, etc. But the institutionalized females were found to be least interested in doing such activity.