CHAPTER-I
INTRODUCTION

1.1 AGEING
   1.1.1 Defining Ageing
   1.1.2 Dimensions of Ageing
   1.1.3 History of Ageing In India

1.2 OLD AGE DOWN THE AGES

1.3 ELDERLY
   1.3.1 Psychosocial factors related to elderly
      1.3.1.1 Physical health
      1.3.1.2 Mental health
      1.3.1.3 Culture
      1.3.1.4 Living arrangements
      1.3.1.5 Retirement
      1.3.1.6 Interpersonal relationships
         1.3.1.6.1 Interaction with members of social network
         1.3.1.6.2 Interaction with family
      1.3.1.7 Widowhood
      1.3.1.8 Facing death in late adulthood

   1.3.2 Profile of the Elderly
      1.3.2.1 Global Scenario
      1.3.2.2 Indian Scenario

   1.3.3 Promoting the well-being of elderly
      1.3.3.1 Existing programmes
      1.3.3.2 Future responses to population ageing

1.4 SIGNIFICANCE OF THE STUDY
“Old age”, the very word brings to mind white hair, stooped shoulders, an uncertain gait, and certain isolation. The whole life cycle of human existence has been divided into four distinctive but successive stages. They are juvenile age, young age, middle age and old age. These four main stages in human life have been compared with four main seasons of the year, i.e. spring, summer, autumn and winter. Spring and summer represent the energetic and joyful childhood and warm and vigorous youth respectively. Autumn denotes the middle age of maturity and ripeness. After this, comes the winter of human life which is the old age when one’s physical strength begins to leave him and youthful vitality starts yielding to a sense of despair. The teeth start falling, the hair turn grey, skin becomes wrinkled, vision becomes poorer, ears need hearing aid and there is a decrease in muscle strength. This is the time when many a man becomes three legged (the third leg being the stick). It is from here that the problems of old people start arising (Sinha, 1989).

Categorical definitions of the old, elderly, aged and ageing are neither straightforward nor universally applicable. Old is an individual-, culture-, country- and gender-specific term. Elderly consists of people who near or surpass the average life span of human beings. Old age consists of ages nearing or surpassing the average life span of human beings, and thus the end of the human life cycle. The terms used for old people include seniors (American usage), senior citizens (British and American usage) and the elderly.

1.1 AGEING

Ageing is universal and inevitable. The process of ageing varies from individual to individual. It begins the day one is born and continues with the passage of time. A child envies the grownups for their ability to perform and the power that they wield, and is keen on ageing to grow into an adult. The youth gradually and imperceptibly passes the middle age and then is called an old person after attaining a certain age. Although the process of ageing is a biological phenomenon, it is very much conditional to or associated with
various social factors, cultural values, norms and regulations to a great extent. In this context, Neugarten (1980) said “In all societies, age is one of the bases for the ascription of status and one of the underlying dimensions by which social interaction is regulated”. In the words of Seneca; “Old age is an incurable disease”, but more recently, Sir James Sterling Ross commented: “You do not heal old age. You protect it; you promote it; you extend it” (cf. Vijaya and Kiran, 2004).

It is important to distinguish the ageing process from the process of ageing. The ageing process (‘normal ageing’) represents the universal biological changes that occur with age and are unaffected by disease and environmental influences. Not all of these age-related changes have adverse clinical impacts. By contrast, the process of ageing is strongly influenced by the effects of environmental, lifestyle and disease states that, in turn, are related to or change with ageing but is not due to ageing itself (Kirkwood, 1996).

The way, in which we grow old and experience the ageing process, our health and functional ability all depend not only on our genetic makeup, but also 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. Lifespan is defined as the maximum survival potential for a particular species. In human beings, the lifespan is thought to be about 110 to 115 years (Matteson, 1997). Life expectancy, then, is defined as the average observed years of life from birth or any stated age.

Most of the people anticipate old age with trepidation. Will it be the “golden years” or “statuary senility”? There is a special and not unrealistic fear, by young and old, that many of the last years of life will be spent in ill health, with some chronic diseases that will limit activity and possibly even impair reasoning abilities. The elderly are a precious asset for any country. With rich experience and wisdom, they contribute their might for the sustenance and progress of the nation.

1.1.1 Defining Ageing
Conceptualizing a definition regarding old age is complex as age can be considered from different aspects. According to Gerdes et al. (1988) and
Lowy (1985), several aspects of ageing need to be taken into account when defining old age; these are chronological, biological, psychological, social and developmental aspects.

Chronological age is the most common criterion used to depict an individual's age (Stokes, 1992). This can be further divided into different age-spans e.g., young-old-age (55-65 years of age), middle-old-age (65-75 years of age), and old-old age (over 75 years of age) (Brown, 1982; Duvall and Miller, 1985).

The second aspect to consider when defining old age is the biological or physical element which refers to the physical signs of ageing such as the deterioration of the senses and the changes in the structure and functioning of cells and organ tissue (Kleinke, 1998). Ageing refers to normal, progressive and irreversible biological changes that occur over an individual's life span. It is a constant, predictable process that involves growth and development of living organisms. Ageing can also be defined as a state of mind, which does not always keep pace with our chronological age. Attitude and coping with the normal changes, challenges and opportunities of later life may best define our age (Mehta et al., 2009). Dutt (1986) signified ageing as the progression of changes in biochemical processes which determines structural and functional alterations with age in the cells and non-cellular tissues and hence in the whole organism. He also endorsed the view that chronological age is a poor predictor of functional ability.

From the social point of view, ageing refers to a change in the role of the elderly within the society. In other words, certain roles are associated with certain ages (Gerdes et al., 1988). The psychological age, on the other hand, refers to the individuals’ adjustment to growing older (Stokes, 1992). An anthropological study conducted by Glascock and Feinman (1980) provides a basis for a definition of old age in developing countries. Definition of old age fell into three main categories: i) chronology; ii) change in social role; and iii) change in capabilities. Results from this cultural analysis of old age suggested that change in social role is the predominant means of defining old age.

According to Louw et al. (1998), the psychological age refers to an individual’s actual feeling regarding his/her age and the perception of how old
he/she really is. In other words, an individual might feel younger or older than his/her chronological age. Birren and Schaie (1977) elaborated and suggested that the psychological element refers to the individual's capacities in response to his/her changing environment. They indicated that the level of functioning of the brain contributes to the functioning of memory, to the learning process of new skills, and to the individual's motivation and emotions.

Ageing is a highly complex and variable phenomenon. Not only do organisms of the same species age at different rates, but the rate of ageing varies within the single organism of any given species. The process of ageing is slow but dynamic which involves many internal and external influences, including genetic programming and physical and social environments (Matteson, 1997). Ageing is a constant, predictable process that involves growth and development of living organisms. Ageing cannot be avoided, but how fast we age varies from one person to another. How we age depends upon our genes, environmental influences, and life style (Gothelf, 2008).

Ageing can be defined as a progressive, generalized impairment of function resulting in a loss of adaptive response to stress and in a growing risk of age-associated disease (World Health Organization, 2002).

From the above-mentioned information, it can be determined that ageing is a complex process beginning with conception and ending with death. Birren and Schaie (1977) offered a multi-dimensional approach that considered the biological, social, chronological, psychological and developmental changes in functioning that occur over the lifespan; they refer ageing as the regular charges that occur in mature genetically representative organisms living under representative environmental conditions as they advance in chronological age.

1.1.2 Dimensions of Ageing

Generally speaking, ‘ageing’ has three broad dimensions and each one is associated with another. These are physiological ageing, psychological ageing, and social ageing.
a) **Physiological ageing**: It is the product of biological process. It is a process by which physical and mental changes occur through growth and decline. In the early years of life ‘growth’ predominates and in the later years ‘decline’ predominates (cf. Bhatia, 1983). The changes which occur in physiological ageing are by and large visual as in old age skin is wrinkled, head and body hair becomes gray, tooth falls, etc. Some of the changes are also not visual such as the immunological system, cardiovascular system, digestive system, nervous system, endocrine system, reproductive system, skeletal system, respiratory system and function of kidney deteriorates in old age (Rao, 1994).

b) **Psychological ageing**: It is a process by which a person loses his/her mental ability. Most often psychological pressure or disturbances bring young people to look aged and it is reflected in body as an unnatural process. Poplin (1978) opined that one of the major problems of ageing persons is the shock of growing old. This ‘shock’ of course hardens the remaining life course and the persons get older much faster than the natural process because of this psychological trauma attached to the person. Wechsler (1995) pointed out that psychological capacities may show decline with age, but traits like interpretation and imagination may decline very little over the years.

c) **Social ageing**: Social ageing is a process by which a person acquires the superior knowledge and takes up responsible roles depending upon his/her age-status in the society. Every society has its own conception of ageing and age groupings. Through the process of socialization, the society ensures the transmission of social and cultural values from one generation to the next and enables its members to acquire necessary skills, values, norms, etc. As the individual moves from one age grade to the next, he acquires new roles in accordance with the prevailing practices. Bhatia (1983) defined social ageing as a stage in the life span of the individuals that is regarded as old age by the group. Muttagi (1997) professed that social ageing is administratively determined for purposes of social security, retirement from job in the organized sector, or for demographic classification, its consequences on the individuals and community.
1.1.3 History of Ageing in India

In ancient India, life span of one hundred years was divided into four stages: life of a student, householder, forest dweller and ascetic. There was a gradual move from personal, social to spiritual preoccupations with age. Manu, the ancient law giver, in his Dharmashastra divided this span of life into four ashramas (life stages). The first, Brahmacharya (life of a student) was to be spent at the teacher’s (guru) house. This is the life of a celibate, to be spent in education and training. Once education was complete, the boy (grown into adulthood by now) would be ready to enter the grihastha ashram. This was the life of a householder. A man was to marry, have children, and shoulder the responsibilities of an average citizen in the society. He was to discharge the debts which he owed to the parents (pitta rin) by begetting sons and to the gods (deva rin) by performing Yajnas (rituals). This was the stage when a man would fulfill his basic desires, for love, marriage, for parenthood, for status, wealth, prestige and other such physical and social needs. When a man’s head ‘turned grey’ and wrinkles appeared, he was required to give up this life of householder and turn to vanaprastha which literally means ‘moving to the forest’. A mature and ageing man would gradually give up his worldly pursuits, move away from the mundane routine of householder and turn inward in search of spiritual growth. Finally, when he was spiritually ready, he would renounce the world completely and enter the stage of sanyasa (asceticism).

Though this scheme of a man’s life did not comment about a woman’s life, it was assumed that a wife would follow her husband faithfully in his move through different stages. In ordinary social intercourse, a person would be considered old when his children were married and he had grandchildren, regardless of his chronological age. Marriage of a son and arrival of a daughter-in-law into the joint family often marked a major transition in the life of a woman. She would usually hand over the responsibilities of the household and relinquish her own position as ‘mistress’ of the house. In some parts of India, married women usually would have the keys of the house tied to the end of their pallu (part of the sari that is drawn up over the upper part of the body or head). When the bride arrived, these keys would be handed over.
to her symbolizing a transition in the status of the older woman. Menopause and arrival of grandchildren usually marked old age for women. There is a trend for women to consider themselves old at a younger age than men.

Indian culture, like many other Asian cultures, emphasized filial piety. Parents were honoured as gods. It was considered the duty of a son to respect and care for his parents. Even today, in India, old parents live with son/s and their families. Living with the eldest son and his family is the most common living arrangement. Indian society is patriarchal and after marriage sons bring their wives to the parental household to live. This tradition assured that old people would have younger in-laws and grandchildren to care for them. Also, caste and kin group exerted pressure on younger members to obey and respect elders (Prakash, 1997).

1.2 OLD AGE DOWN THE AGES

The mystery about old age persists. It is strange that Gods in India like Rama and always remain young. Prince Sidhartha, on encountering an old man for the first time, was so intrigued by human existence that he renounced the world of human affairs. Eventually, he did resolve his problem philosophically but the mystery about old age persists till this day.

When does one become old, why and how? These are questions that have been asked often. Each age has tried to explain the phenomenon of ageing in its own way – depending on its temper, its world-view, as well as on the level on its knowledge in respect of physiology, sociology, psychology, theology, etc. Needless to add, since the world has been changing with time, and since time is known to move cyclically, attitudes towards ageing and old age have not been making a linear progress, upward or downward.

If we go by myths, there were perhaps times when a man lived for hundreds of years. In India, if Gandhari mothered 100 sons, and was going strong at the time of the Mahabharata war, one’s guess about her life span may be as good as anyone else’s. On the other hand, although Manu’s ashrams assumed 100 years as the average age of a man, his fixing the third stage of withdrawal from worldly affairs in the middle point of 50 sounds rather queer.
Did people start ageing so fast? Of course, in India, even in the 20th century, there was a time when people were declared superannuated at 50; but that was because the mortality rate then was high, and the average age was below 60. Interestingly enough, in India, where parents are supposed to be worshipped like Gods, the Gods are even young, active, prankish, fond of music, dances, drinks and love-making. After all, having a monopoly of amrit, they enjoy the privilege of being immortal. In fact, when they assume mortal frame, and descend on the earth as avatars, they retain their power to keep old age at bay. Who, indeed, ever thinks of Rama and Krishna as old men? For reasons, unknown, only Brahma, the creator, is projected as an ancient being. In the collective consciousness of India, Vishnu, the preserver, and Mahesh, the destroyer, are ever young (Prakash, 1999).

On the other hand, rishis always had long, shaggy beards – the symbol of their stigmatic status as mortals until they would undergo unending penance to attain parity with the gods. Of course, these were myths, and myths are there to be believed implicitly, and not to be questioned or dissected analytically. In any case, encapsulating the world-view of an age, myths are the only source of information about pre-historic times. The problem in India is that Hindu thinkers, rarely beyond primordial myths to brood over the phenomenon of old age, and how one may overcome or transcend its problems.

In some other parts of the world, starting with myths, people went on to modify or reshape their perspectives on old age. For example, as a corollary of the myths that sanctified ancestor worship, old men came to be revered. They were supposed to have mastered the holy art of not dying; and having gained through experience such knowledge as enabled them to treat some ailments, they were credited with magic powers of healing. Even otherwise, on the verge of joining the hallowed group of ancestors, they were supposed to have a measure of super-natural power. Thus, it came to be believed that the greater the physical infirmity, the more was their spiritual strength.

In this condition, youngsters were even duty-bound to help them transcend their physical handicaps by carrying the old up to hill-tops where they might join the spirits of the ancestors. In this context, one might recall that in India,
too, filial duty has always included taking old parents on pilgrimage to holy places where, if they die, they may earn moksha (Prakash, 1999).

Of course, in most civilizations, the practice did not have spiritual motivation. The old were led to mountains or jungles only to be abandoned—just to save them from the misery of pitiable existence. Some cultural anthropologists have even suggested rationale of such traditions of mercy killing. For example, according to one theory, the tradition of ancestor worship could lose sanctity if grandchildren carried the memory of repulsive looks, ridiculous conduct, and perverse sexual tendencies of the senile grandparents. Again, since a king or feudal chief was expected to protect his country or tribe, and since his becoming weak in old age implied threat to the security of the community, he must be replaced by a youthful son who was supposed to have inherited the aged ruler’s divinity. Hence, the practice of the king killing himself, or being killed ceremoniously—a practice that extended to heads of families and even other old people. The fact of the matter is that ambivalence has always marked man’s attitude towards old age because an old man was, on the one hand, a repository of experience and tradition and, on the other, just an extra mouth to feed when totally unproductive.

Even in the history of biology, explanations of the phenomenon of old age have the touch of myths. According to Hippocrates, the father of medicine, life comprised four seasons, old age is its winter. Aristotle compared old age to the “loss of heat” and, therefore, recommended hot bath, wine, diet, etc. Claudius Galen, a Roman physician, in his treatise on old age title Gerocomica, declared old age as a stage between illness and death. Eleventh century doctors likened life to a lamp, and just as a lamp needs a periodic supply of oil to keep it going, the flame of life needs regulated diet. While the 13th century sought to transcend the limitations of old age through the magnifying glass, false teeth (from the bodies of animals), etc, 16th century looked upon man as a chemical compound in which old age got caused by auto-intoxication (Prakash, 1999).

The 18th century treated old age as an incurable disease, but for the 19th century, body was a machine, which got worn out in old age. Later the vitalists modified the concept by declaring that every organism is endowed with
energy, which is exhausted in due course. That was the time that sowed the seeds of geriatrics. In the 20th century, old age came to be attributed to the lowering of metabolism and thus, the interest shifted from pathology to the process of ageing.

1.3 ELDERLY

Elderly or old age consists of ages nearing or surpassing the average life span of human beings. The boundary of old age cannot be defined exactly because it does not have the same meaning in all societies (Ministry of Statistics and Programme Implementation, 2011). Conventionally, elderly are defined as those people who have crossed a given life span, 65 years in developed countries (while those from 65 through 74 years old are referred to as "early elderly" and those over 75 years old as "late elderly") (Orimo et al., 2006) and 60 years in developing countries like India. Government of India adopted ‘National Policy on Older Persons’ in January, 1999. The policy defines ‘senior citizen’ or ‘elderly’ as a person who is of age 60 years or above (Ministry of Statistics and Programme Implementation, 2011).

1.3.1 Psychosocial Factors Related To Elderly

According to Erik Erikson’s "Eight Stages of Life" theory, the human personality is developed in a series of eight stages that take place from the time of birth and continue on throughout an individual’s complete life. He characterizes old age as a period of “Integrity vs. Despair”, during which a person focuses on reflecting back on their life (Erikson, 1963, 1968). Those who are unsuccessful during this phase will feel that their life has been wasted and will experience many regrets. The individual will be left with feelings of bitterness and despair. Those who feel proud of their accomplishments will feel a sense of integrity. Successfully completing this phase means looking back with few regrets and a general feeling of satisfaction. These individuals will attain wisdom, even when confronting death (Carver & Scheier, 2000). Coping is a very important skill needed in the aging process to move forward with life and not be ‘stuck’ in the past. The way a person adapts and copes, reflects their aging process on a psychosocial level.
Psychosocial factors are those factors which affect a person either psychologically or socially. Each individual is different, and not all men have the same experience, thoughts, or feelings. However, some common feelings, concerns and challenges may be present in the elderly, including the following:

1.3.1.1 Physical Health: Beaver (1983) pointed out that none of the available theories describing the process of ageing is adequate to explain how and why the body ages. Santrock (1997) stated that the reason for the deaths of approximately 75 per cent of elderly people is due to different illnesses such as heart diseases; strokes; and different types of cancer. Fry et al. (1997) described the impact of physical health on the functioning of the elderly, saying that one of the best ways to have a difficult old age is to have bad health. Humans do not die of old age; they die of diseases (Beaver, 1983). Kleinke (1998) stated that the physical challenges people face in old age is generally in the form of the following common medical problems:

- Arthritis refers to a common illness with no medical cure;
- Detrimental mobility and increased difficulty in walking;
- Ageing bones that are weak and, as a result, break more easily;
- Changes in bowel functioning (i.e. constipation and changes in regularity);
- Prostrate problems experienced by elderly men;
- Eye problems, with cataracts being quite common amongst the elderly;
- Heart problems, with arteriosclerosis, heart attacks, heart failure and other related problems;
- The occurrence of strokes increase, with strokes being the most common reason for the elderly to be placed in nursing homes

While some researchers in the field of gerontologists continue to search for indicators to predict the biological aspects of human ageing, others investigate the relationship between biological and psychological well-being,
as these two aspects are closely related. The psychophysical reality is so enormous that emotions, thinking, learning and belief systems get entangled with body functions to such an extent that serious attempts are being made by physicians and psychologists to pool their resources, skills and strategies to understand the complex disease like Coronary Heart Disease (CHD) and Essential Hypertension (EHT) or their proneness in terms of behavioural correlates (Mohan, 1999).

The medical and psychological research, throughout the world indicates the role of several non-traditional factors in cardiovascular disease. The researcher highlighted personality, anger, stress hostility, Type A behavior, depression and social support as important psychological correlates of Coronary Artery Disease (CAD). Probably, for the first time, a major research project was launched to study the patients and healthy groups in a premier heart care and research center in Jalandhar, Punjab, India. The underlying objective was to analyze the basic psychological, lifestyle, social and medical parameters of these people so that one could draw inferences with regard to the role being played by the typical Punjabi temperament and stress of immigration to newer countries or an interaction of both to then disadvantage of the progressive group (Mohan and Sehgal, 2006).

1.3.1.2 Mental Health: Kimmel (1990) stated that although illness and pathology are not evident in all ageing individuals, there appears to be a correlation between mental illness and advancing age. In research conducted by Louw et al. (1998), it was found that approximately 10 per cent to 20 per cent of the elderly suffer from a mental disorder that warrants professional help.

Beaver (1983) distinguished between two types of mental disorders associated with old age namely, organic disorders and functional disorders. Organic disorders have a physical cause; they include disorders such as organic brain syndromes (related to the impaired functioning of brain tissue), senile dementia (generalized intellectual and cognitive impairment), and arteriosclerotic brain disease (due to the death of brain tissue). Functional disorders, on the other hand, appear to be rooted in emotional stress such as depression which is often accompanied by suicidal ideation.
Depression is the most common mental illness among the elderly and often manifests in both physical and psychological ways (Kaplan & Sadock, 1998). Psychological symptoms include sadness, withdrawal, lack of interest, pessimism and disorientation toward the future. Physical symptoms usually manifest in disturbed eating and sleeping, early morning fatigue and insomnia (American Psychiatric Association, 2000).

National research conducted by Gilles (1992) has revealed that for all ages, stress resulting from poor socio-economic conditions could lead to depression. This researcher suggested that urgent attention should be given to the high prevalence of depression in the elderly, especially in our South African townships, where the Black female elderly group reported the highest incidence of depression. Another cause of concern is that the occurrence of suicide amongst the aged is high (i.e. 40 per 100,000), and it is commonly found to be highest among males (Kaplan and Sadock, 1998). Depression, resulting from helplessness, is the most important underlying cause of suicide among the elderly. Other predisposing factors include diagnosed or suspected physical disease (e.g. organic, cerebro-vascular or cancer), the loss of a spouse, social isolation and retirement (Hattingh et al., 1996).

Much of the psychoneuroimmunology's popularity with both the public and the psychological community derives from its promise to explore and explain the common belief that our personalities and emotions influence our health (Mohan, 1995b, 1995c, 1997, 1999; Sehgal, 1999).

1.3.1.3 Culture: Ageing is not only a physical condition; it is also a social and cultural concept (Beaver, 1983). He stated that in many societies, not enough attention has been given to the needs of the adult members resulting in the inability of this population to remain integrated in society. In extensive cultural research conducted by Fry (2000), it was found that culturally related activities of daily living played a determining role in the functionality of the elderly. Popenoe (1980) indicated that many countries still ascribe high status to the elderly individual. He mentioned that during the nineteenth century, the status of the elderly was displaced with the dominant social value of the time, namely equality, which tended to be correlated with the young.
According to Cavanaugh (1997), individuals’ behaviour and feelings towards themselves are consequences of their living arrangements and their interaction with others. Thus, in order to provide for their needs, the elderly become increasingly dependent on others and on their environment.

1.3.1.4 Living Arrangements: Choosing living conditions plays a crucial role in the general life satisfaction, general state of health and financial position of the elderly person (Duvall and Miller, 1985). Ferreira et al. (1992) stated that living with one’s children is less acceptable amongst White South Africans as opposed to the norm of three-generational living arrangements amongst black, coloured and Indian groups. In this country, retirement villages have became popular especially for the more affluent elderly. Eckley (1996) stated that South Africa has 801 old-age homes, which assist more than 53 000 elderly people. However, Duvall and Miller (1985) have stated that choosing a retirement village is often associated with a form of traumatic experience due to the discomfort of the many related changes. Louw et al. (1998) indicated that some of the associated changes include the break of their established routines, giving up a certain degree of their independence, disengageing themselves from familiar surroundings, being physically separated from their neighbourhood and community support systems, and leaving their possessions behind while moving into smaller accommodation. One of the major features has been the migration of populations from under developed to developed countries, from rural to urban sites and from open to crowded places. These changes brought with them social, psychological and cultural consequences (Mohan and Sehgal, 2006).

However, there appears to be several advantages to living in retirement villages. These include remaining relatively independent, the preservation of privacy, the availability of certain services such as medical services and meals, and the sustaining of social contact and security (cf. Louw et al., 1998).

1.3.1.5 Retirement: Retirement is a relatively new concept associated with the industrial development in the last two decades, and is one of the
outstanding aspects of ageing (Gerdes et al., 1988). The association of retirement with a time of vacation or rest prior to death has changed and today the average individual will spend 20 per cent to 25 per cent of his/her life in retirement (Hattingh et al., 1996).

Retirement is likely to be perceived in different ways by different individuals. Some individuals look forward to retirement and to the opportunity of doing the things they never had the time to do. According to Bell (1979), some individuals (especially males) perceive their occupational role as very dominant in adulthood. Thus, exiting the occupational role might result in a sense of loss of status, self-esteem, self-worth and economic benefits. This perception makes it extremely difficult to adjust to the changes and to the different style of living resulting from retirement.

Santrock (1985) stated that retirement is an ongoing process. Several stages have been identified as related to retirement (cf. Gerdes et al., 1988):

- Pre-retirement – The phase of planning for retirement in which the individual begins to orientate him/herself to the event of retirement.
- Retirement as an event – This event marks the end of employment. In this phase, the individual may experience ambivalent feelings about retirement namely joy and uncertainty regarding the future; the later may result in anxiety.
- The honeymoon phase – During this phase, a sense of euphoria and freedom is experienced by the individual
- The disenchantment phase – Individuals without hobbies and interests struggle to occupy their time and might experience the failure of the fantasy that took place in the previous phase.
- The reorientation phase – The individual explores new avenues of involvement and establishes a structure for daily living.
- The stability phase – The individual’s new lifestyle becomes stabilized.

It is important to note that not all individuals will experience all the aforementioned phases and some may pass directly from the event of retirement to the stability phase (Santrock, 1985).
1.3.1.6 Interpersonal Relationships: Bearing in mind that social relationships have been found to be extremely important to the elderly, Duvall & Miller (1985) has focused specifically on their interaction with members of their social networks and their family members.

1.3.1.6.1 Interaction with members of social network: Rice (1998) pointed out that ageing results in many changes related to the social relationships of the elderly. Successful adaptation to ageing is highly dependent on the support of the social network that provides assistance with daily living, assistance with crisis intervention, a sense of validation and companionship (Stokes, 1992).

A study by McDaniel & McKinnon (1993) showed that elderly females preferred more intimate and frequent contacts with friends when they are ill. Older males were found to rely mostly on the spouse for emotional support and had fewer social contacts when not feeling well. In general, the elderly tend to socialize with other elderly who lived close to them, are of the same gender, same age and socio-economic status. Louw et al. (1998) opined that many elderly engage in various leisure, social and compulsory household activities (e.g. shopping) as a source of social contact with others.

Findings from research conducted by Moller (1992) indicated that most elderly are socially well-integrated. They tend to engage in relatively passive leisure time activities such as watching television, listening to the radio, reading and visiting friends and social clubs. The quality of their social relationships is of the utmost importance, with little emphasis being placed on the quantity. The presence of a confidant with whom an elderly person is able to share their problems is crucial. Elderly people who experience close, stable relationships, in which they can share their deepest feelings, appear to cope better with the changes and crises of ageing.

The above-mentioned research indicates that the value of friendships cannot be underestimated when growing older and these contribute to the growth potential of the elderly individual; however, it is interesting to note that elderly individuals tend to regard their relationships with their children and family as more important than their social relationships (Atchley, 1977).
1.3.1.6.2 Interaction with family: The family is the most basic social construct in which the values of society are transmitted, basic needs are met and roles and behaviour are regulated. A family plays an important role in supporting the emotional and social needs of the elderly (Berger, 1994).

Common myths regarding elderly are that most elders either have no families, or at best have infrequent, obligatory, and conflicting contact; adult children do not care about their aged parents and dump them in institutions; and families in later life are too set in their ways to change long-standing interaction patterns (cf. Carter & McGoldrick, 1988). Another study on elderly stated that 75 per cent of old people tend to live with their families. It was concurred that four out of five elderly individuals in the United States are members of a multi-generational family (Duvall and Miller, 1985). Similar patterns were found amongst the South African population in which approximately 79 percent of the urban elderly and 66 per cent of the rural elderly were supported by their families (Ferreira et al., 1992).

Louw et al. (1998) found diversity of preference amongst elderly individuals when it comes to their interaction with their families. While some individuals prefer to live with their children, others prefer to live in the same environment as their children but not in the same house as them. Some of the reasons for this are the association of the loss of independence and the need to live under their children's supervision. The authors refer to this stage as intimacy with distance.

Janzen and Harris (1986) studied the type of relationship that the elderly individual shares with his/her children and grandchildren and found that older adults place less emphasis on the significance of practical exchanges with their family members and place more value on the emotional closeness and warmth of their family life.

1.3.1.7 Widowhood: The most difficult task in one's life is to prepare for one's spouse’s death by learning to accept it emotionally. The death of one's spouse naturally symbolizes the end of the marital relationship. The remaining spouse has to face a new task of adjusting to the new social status of widowhood (Lowy, 1985). Hattingh et al. (1996) stated that men have a
higher mortality rate than women, which means that the number of women older than 65 years is higher than that of men of the same age. According to Louw et al. (1998), the ratio is approximately 4:3. Thus, women are often the ones who have to deal with the loss of a partner. Adjusting to widowhood is an ongoing process starting with grief and following with the adaptation of new roles, hobbies or interests (Stinnett et al., 1984). Widows and widowers tend to experience more psychological disorders (e.g., depression) than those who are married (Balkwell, 1985). The normal bereavement process tends to be prolonged or delayed when dealing with an elderly individual (Hattingh et al., 1996). The death of a spouse has been found to bring about the following changes for the remaining spouse:

- The individual has to accept a new social status and role;
- Some of the deceased's roles need to be learnt;
- A decrease in the financial income;
- Loss of support and possible social isolation;
- Having to move home and becoming more dependent on others;
- Increased loneliness;
- A general deterioration of physical health (i.e., psycho-physiological conditions may develop) and psychological well-being.

Atchley (1977) conveyed that the experience of widowhood might affect men and women differently as women are less likely than men to remarry in the later stages of their lives. In the traditional type of marriage relationship, the female may lose a certain degree of her basic self-identity caused by the loss of the wife role, while males are as apt as females to encounter an identity crisis due to the loss of the husband role. Stokes (1992) supported the above mentioned point of view and indicated that over the age of 75, two-thirds of men are married while two thirds of women are widowed.

1.3.1.8 Facing death in late adulthood: The most difficult task of late adulthood is facing the inevitability and immediacy of death. Lefrancois (1998) concluded that older people are less apprehensive about dying than
younger individuals. In a study conducted by Jeffers and Verwoerdt (1997), 10 per cent of the elderly participants reported that they were fearful of dying. This could be linked to Erikson's last life phase of ego-integrity versus despair, where those who experience ego-integrity and who feel that their lives have been meaningful, tend to accept their mortality (cf. Louw et al., 1998).

Schultz and Ewen (1993) identified various reasons for fear of death. These include the fear of physical pain associated with different illnesses; the fear of isolation and loneliness; the fear of not existing; the fear of being weak in the actual event of dying; the fear of not being able to achieve important goals before dying; the fear of the impact of one's death on his/her remaining significant others; the fear of punishment (religious) or the fear of the unknown, and the fear of the death of a loved one, together with the physical and psychological suffering that they may have to endure.

Religion also plays an important role in accepting the reality of death (Wass, 1989). Moberg stated that religion plays an important role in the later years of life and that there is a tendency towards both disengagement and re-engagement with religion when growing older (cf. Barry and Wingrove, 1977). Disengagement occurs when an individual's tendency to involve him/herself with sacraments outside of the home decrease, as he/she grows older due to the physical and mental deterioration of the body. Re-engagement refers to the fact that the spiritual aspects of the elderly individual become more intense despite the effects of ageing on body and mind (Barry and Wingrove, 1977).

1.3.2 Profile of the Elderly

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) (Park, 2007).

1.3.2.1 Global Scenario: According to an estimate, the elderly will constitute one third of total population of the world by 2050 AD (SunderLal et al., 2007). Life expectancy in India has increased from 37 years (1951) to 62 years (2000) due to overall socioeconomic developments and developments in medical science. In 2009, 12 per cent of the world’s population- approximately
740 million people were aged sixty and above. By 2050, this number is expected to be almost three times as large—nearly two billion persons, making up 22 per cent of the total population. Additions to the older population are projected to account for half of all population increase between 2009 and 2050.

In all regions, and in the large majority of countries, the population is growing older. In more developed regions, 21 per cent of the population is currently aged sixty or over, and this is projected to increase to 27 per cent in 2025 and 33 per cent by 2050 (Table 1.1). In the developing world, the proportion averages only 8 per cent in 2009, but by 2050 this is projected to rise to 20 per cent, the same as in the more developed regions today.

Table 1.1: Number of persons aged sixty or over and their percentage of the total population, World and Major Areas, 1950-2050

<table>
<thead>
<tr>
<th>Region</th>
<th>Population aged 60 years or over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (millions)</td>
</tr>
<tr>
<td>World</td>
<td>205</td>
</tr>
<tr>
<td>More developed</td>
<td>95</td>
</tr>
<tr>
<td>Less developed</td>
<td>110</td>
</tr>
<tr>
<td>Africa</td>
<td>12</td>
</tr>
<tr>
<td>Asia</td>
<td>94</td>
</tr>
<tr>
<td>Europe</td>
<td>66</td>
</tr>
<tr>
<td>Latin America</td>
<td>10</td>
</tr>
<tr>
<td>Northern America</td>
<td>21</td>
</tr>
<tr>
<td>Oceania</td>
<td>1</td>
</tr>
</tbody>
</table>

**Note:** More developed regions include Australia/New Zealand, Europe, Japan and Northern America. Less developed regions include all other areas. Latin America includes the Carribean.

**Source:** United Nations Population Division, 2009.
1.3.2.2 Indian Scenario: 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 per cent by the year 2016. By 2020, 177 million people will be in this age group. In 1961, the elderly population was only 24 million; it increased to 43 million in 1981 and to 57 million in 1991. Table 1.2 shows that the proportion of the elderly persons in India has risen from 5.63 per cent in 1961 to 6.58 per cent in 1991 (Irudaya Rajan et al., 1999) and to 7.5 per cent in 2001 (Irudaya Rajan, 2006). This scenario is also true of other older age groups. The elderly population aged 70 years and above which had counted just 8 million in 1961 rose to 21 million in 1991 and to 29 million in 2001. The proportion of the elderly above 70 to total population has increased from just 2.0 per cent in 1961 to 2.9 in 2001. In short, India is dooming towards a graying future (Irudaya Rajan, 2006).

In India, 52 million older people live on less than a dollar a day. 80 per cent of the older people have no regular income, live in the rural areas while 90 per cent belonged to the unorganized sector and have no social security, no pension, no provident fund or gratuity, and no medical coverage. Of India’s ageing population, 55 per cent are women, and staggering 20 million elderly women are widows. The vast majority of older women are housewives who depend completely on their family for survival. 70 per cent of the older women work as agriculture laborers in the rural areas (Gokhale, 2007).

India is one of the few countries in the world where males outnumber females. This phenomenon among the elderly is intriguing because female life expectancy at ages 60 and 70 is slightly higher than that of males. However, at any given age, contrary to what we would normally expect, there are more widows than widowers and reasons for this unusual phenomenon need to be identified. Life expectancy at birth among Indian males had been higher than that among females until the first half of the 1990s. Apart from this unusual demographic pattern of excess female mortality during infancy and childhood, the phenomenon of age exaggeration among the aged complicates the analysis. Thus, the above observation of more males in old age does not reveal a true picture of elderly persons (Irudaya Rajan et al., 2003).
### Table 1.2: Demographic profile of aged in India

<table>
<thead>
<tr>
<th>States/union territories</th>
<th>Number in 000</th>
<th>Per cent to total population</th>
<th>Population in 000</th>
<th>Percentage of the elderly</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>76622</td>
<td>7.44</td>
<td>55606</td>
<td>6.58</td>
</tr>
<tr>
<td>A &amp; N Islands</td>
<td>17</td>
<td>4.87</td>
<td>10</td>
<td>3.55</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>5788</td>
<td>7.64</td>
<td>4306</td>
<td>6.47</td>
</tr>
<tr>
<td>Arur achal Pradesh</td>
<td>50</td>
<td>4.57</td>
<td>37</td>
<td>4.33</td>
</tr>
<tr>
<td>Assam</td>
<td>1580</td>
<td>5.86</td>
<td>1186</td>
<td>4.25</td>
</tr>
<tr>
<td>Bihar</td>
<td>5501</td>
<td>6.64</td>
<td>5227</td>
<td>6.05</td>
</tr>
<tr>
<td>Chandigarh</td>
<td>45</td>
<td>4.99</td>
<td>29</td>
<td>4.52</td>
</tr>
<tr>
<td>Chhatisgarh</td>
<td>1504</td>
<td>7.23</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>D. &amp; N. Haveli</td>
<td>9</td>
<td>4.00</td>
<td>6</td>
<td>4.40</td>
</tr>
<tr>
<td>Daman &amp; Diu</td>
<td>8</td>
<td>5.09</td>
<td>6</td>
<td>6.32</td>
</tr>
<tr>
<td>Delhi</td>
<td>720</td>
<td>5.22</td>
<td>444</td>
<td>4.72</td>
</tr>
<tr>
<td>Goa</td>
<td>112</td>
<td>8.35</td>
<td>74</td>
<td>6.34</td>
</tr>
<tr>
<td>Gujarat</td>
<td>3499</td>
<td>6.92</td>
<td>2540</td>
<td>6.15</td>
</tr>
<tr>
<td>Haryana</td>
<td>1584</td>
<td>7.51</td>
<td>1230</td>
<td>7.42</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>548</td>
<td>9.01</td>
<td>402</td>
<td>7.79</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>675</td>
<td>6.71</td>
<td>432</td>
<td>5.78</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>1579</td>
<td>5.87</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Karnataka</td>
<td>4062</td>
<td>7.70</td>
<td>3041</td>
<td>6.78</td>
</tr>
<tr>
<td>Kerala</td>
<td>3336</td>
<td>10.48</td>
<td>2549</td>
<td>8.77</td>
</tr>
<tr>
<td>Lakshadweep</td>
<td>4</td>
<td>6.15</td>
<td>3</td>
<td>5.22</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>4281</td>
<td>7.09</td>
<td>4254</td>
<td>6.43</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>8455</td>
<td>8.74</td>
<td>5453</td>
<td>6.91</td>
</tr>
<tr>
<td>Manipur</td>
<td>145</td>
<td>6.09</td>
<td>109</td>
<td>5.94</td>
</tr>
<tr>
<td>Meghalaya</td>
<td>106</td>
<td>4.58</td>
<td>82</td>
<td>4.62</td>
</tr>
<tr>
<td>Mizo‘am</td>
<td>49</td>
<td>5.50</td>
<td>34</td>
<td>4.93</td>
</tr>
<tr>
<td>Nagaland</td>
<td>90</td>
<td>4.54</td>
<td>65</td>
<td>5.40</td>
</tr>
<tr>
<td>Orissa</td>
<td>3039</td>
<td>8.28</td>
<td>2217</td>
<td>6.98</td>
</tr>
<tr>
<td>Poncherry</td>
<td>81</td>
<td>8.32</td>
<td>56</td>
<td>6.90</td>
</tr>
<tr>
<td>Punjab</td>
<td>2192</td>
<td>9.02</td>
<td>1532</td>
<td>7.56</td>
</tr>
</tbody>
</table>
In India, the sex ratio of even the elderly favours males. Reasons for more males in old age may consist of under-reporting of females, especially widows, age exaggeration, low female life expectancy at birth, and excess female mortality among infants, children and adults (Sudha and Irudaya Rajan 2003; Mari Bhat, 2002).

The twentieth century has seen remarkable increases in the growth of the old population throughout the world. This growth has occurred in developing as well as developed countries. In addition, the old population is itself becoming older, i.e. the number of people over 80 years of age, often referred to as the "oldest old", is growing rapidly in many countries. Projections by Singh (2001) indicated that increase in the size of the world’s elderly population have considerable effects on social structures, economics and health care systems throughout the world.

Bhattacharya (2005) reported that Indian population has approximately tripled during the last 50 years, but the number of elderly Indians has increased more than fourfold.

Changes in population structure would have several implications for health, economic security, family life and well-being of people. Demographers have worked out the dependency ratio, which basically takes into account the working versus non working sections in the population and find it rising steadily. This means the burden of a larger group of older people will have to
be borne by a relatively smaller younger adult working group. Table 1.3 give
details of changes that have taken place in the last few decades in the age
structure of the population.

Table 1.3: Dependency ratios and indices of ageing, India 1951-2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Child (a)</th>
<th>Elderly (b)</th>
<th>Total (c)</th>
<th>Index of ageing (d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>68.49</td>
<td>9.80</td>
<td>78.29</td>
<td>14.31</td>
</tr>
<tr>
<td>1961</td>
<td>76.97</td>
<td>10.56</td>
<td>87.53</td>
<td>13.72</td>
</tr>
<tr>
<td>1971</td>
<td>80.82</td>
<td>11.47</td>
<td>92.29</td>
<td>14.20</td>
</tr>
<tr>
<td>1981</td>
<td>73.64</td>
<td>11.92</td>
<td>85.56</td>
<td>16.18</td>
</tr>
<tr>
<td>1991</td>
<td>61.43</td>
<td>11.31</td>
<td>72.75</td>
<td>18.42</td>
</tr>
<tr>
<td>2001*</td>
<td>50.94</td>
<td>12.59</td>
<td>63.53</td>
<td>24.72</td>
</tr>
</tbody>
</table>

* Census, 2001

The above given trends clearly highlight a need to focus on the health needs
and welfare of the aged- 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. We have a rapidly increasing
population of elderly on one hand and on the other hand, our society is
experiencing many social changes under the influence of rapid urbanization
and industrialization, likely to further compound the magnitude of this

Source: Sharma, S.P. & Peter Xenos. 'Ageing in India: Demographic
background and analysis based on census materials' Occasional
paper No. 2 of 1992, Office of the Registrar General and Census
Commissioner, India, New Delhi, 1992 (4).

a) No. of persons aged 0-14 per 100 aged 15-59
b) No. of persons aged 60+ per 100 aged 15-59
c) No. of persons aged 0-14 and 60+ per 100 aged 15-59
d) No. of persons aged 60+ per 100 persons aged 0-14

* Census, 2001
demographic transition. Common by-products of increased modernization are ‘individualism’ and the need to be self-dependent (Pati and Jena, 1989). Another change is a 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, care of the elderly, as was available in our age-old joint family system, is adversely affected. These changes have rather led to the concept of institutionalization of the elderly.

Institutionalization of the elderly may not blend with our background and culture but matter of the fact is that there is good number of elders who are utilizing institutional care. Modernization, urbanization, career-oriented couples, shift towards market economy and consumerist outlook have resulted in the weakening of the very foundation of our traditional families (Chakravarthy, 1997; Kumar, 1996). Consequently, the family care of the elderly has suffered and the ties of kinship have become slender and many elderly now seek institutional care to escape the ills of family conflict (Ramamurthy, 2001). Majority of the institutions which take care of the aged, such as the ‘Old Age Homes’, are urban based and these provide a range of services such as residential care, day care, recreation, counseling, etc.

An investigation of the aged living in these institutions, managed by either government or private sector, in comparison to those living with their families can provide useful insight into the various problems and issues related to the aged people of our society. The worldwide increase in population of the elderly necessitates the study of factors which facilitate or inhibit healthy ageing. The present investigation studied stress and coping among elderly in relation to happiness, optimism, social support, emotional intelligence and spiritual intelligence in Chandigarh.

1.3.3 Promoting the Well-Being of Elderly

Much progress has been made in the quality and quantity of health care services in India in the last fifty years. However, improvements have been uneven with urban areas getting the best advantage of modern technological advances in medicare. Much of the emphasis of health care delivery system was on mother and child programmes with special emphasis on controlling
population. Older people were largely excluded.

While elderly people in India may have reasonable access to family care, they are inadequately covered by economic and health security. The Government, which is already grappling with a number of pressing problems, does not have enough resources. For more than a decade, several individuals and organizations working with older people have been pressing the Government to introduce a National Policy for their welfare. Several draft proposals have already been submitted to the Government.

Health promotion programs provide planned, organized, and structured activities and events over time that focus on helping individuals make informed decisions about their health. In addition, health promotion programs promote, policy, environmental, regulatory, organizational and legislative changes at various levels of government and organizations. These two complimentary types of interventions are designed to achieve specific objectives that will improve the health of individuals as well as, potentially, all individuals at a site. Health promotion programs are now designed to take advantage of the pivotal position of their setting within schools, workplaces, health care organizations, or communities to reach children, adults, elderly and families by combining interventions in an integrated, and systematic manner (Fertman and Allensworth, 2010).

1.3.3.1 Existing Programmes: The Constitution of India encourages the State to shield older people from undeserved want in their old age. An Old Age Pension (OAP) scheme has been introduced to meet the needs of people who have no means to support themselves. But many states accord OAP low priority and the amount given is as low as Rs 50 per month (roughly US$1). The Ministry of Welfare makes financial assistance available to voluntary agencies to run day care centres. Often called ‘activity centre’, ‘hobby club’ or ‘golden age centres’, these centres are managed by voluntary agencies. In 1995, there were 73 such centres in seven states supported by the Ministry of Welfare (Kahn, 1995).

There is a need for these centers to expand both quantitatively and qualitatively in order for their impact to be felt. Even in urban areas many
older people do not have any idea of the relevance of such centres.

The Constitution of India contains some provisions for the welfare of older people. In 1992 the schemes of giving rebate on the income tax paid by senior citizens were introduced. The Law also helps retired citizens in evicting tenants who occupy their houses and refuse to vacate them. Voluntary organizations are given grant-in-aid to start old age homes, day care centres, day centres and mobile medical units. Although concessions in train and air fares for senior citizens are made by some states, the environment is not as "elder friendly" as in European countries. There is as yet no serious effort to redesign public transport, public buildings, governmental offices to make their use easier for older people.

1.3.3.2 Future Responses to Population Ageing: The implications of the population ageing for India are far-reaching. The numbers are increasing; the resources are limited and perceived social priorities lie elsewhere. Hence, the response to such demands has to be well orchestrated, multi-sectoral and based on systematic planning (Kalache and Sen, 1998). The first step is advocacy, to raise policy makers' awareness of the multiple issues related to ageing in the country. Professionals, politicians, voluntary workers, NGOs and the general public need to be targeted by these awareness-building exercises.

Since economic security is of prime importance, the State is being requested to introduce an Old Age Pension scheme for all needy, especially the rural aged, widows and people in urban slums. The existing pensions need to be enhanced, and steps taken to assure, it's appropriate disbursement. How soon and effectively this can be achieved is still a question, for the problem of caring for a vast elderly population is complex and there are no immediate and easy answers. The Government is still grappling with controlling life-threatening diseases and preventable maternal and child mortality. Even schemes like the National Social Assistance programme launched in 1995 that cost over ₹4,000 million, and the Governments monthly financial assistance for those who are destitute do not cover the entire section of people requiring such help. Hence, the emphasis is now on enlisting the cooperation of the NGOs as well as the community. Providing necessary care
and support to elderly people within the community setting is recommended instead of opening more old age homes.

Schemes to keep elderly people economically active have also been mooted. NGOs have been encouraged to provide income generating activities so that people feel economically independent and experience an increase in self esteem. Though some suggest that the retirement age in the private and the public sectors should be raised; there are counter arguments that in a country with a vast unemployed young population, this may not be a popular measure.

Tax incentives for families providing long-term care to elderly family members’ are also recommended. Making payments to carers and providing respite care will help strengthen the family’s willingness to provide care. Since large segment of elderly require care, efforts are being made to train a large number of paraprofessionals, voluntary workers, community workers and family members. Apart from health professionals, a large number of multipurpose carers are needed at grass-root levels to give comprehensive coverage for older persons in the community. It is increasingly felt that solutions to the problems of the elderly people should be sought outside the health care system and the state (Satyanarayana and Medappa, 1997).

Geriatric medicine has not yet developed strong roots within Indian medical schools — in only two of them are there academic departments for this specialty. Advocacy, research, involvement of voluntary agencies, training different levels of gerontological workers, catalyzing the community, awareness building, organizing older persons themselves and networking with international agencies are all essential to empower older Indians.

Good planning, policy making and action should be based on accurate information. Hence quality research in ageing issues is urgently needed. At present, nation-wide community-based studies that provide baseline data on health, morbidity, psychological status, socio-economic conditions and living arrangements of the total population are not available. In the early part of 1998, HelpAge India took the initiative of conducting a series of seminars in the four regions — north, south, east, west of the country. From each region, existing regional data were compiled and eventually presented at a National
Conference held in New Delhi. This was one of the most serious efforts to document and compile existing nation-wide data. This Conference recommended that a National Institute on Ageing be established in order to undertake, promote and supervise cross regional multidisciplinary research on all basic issues related to ageing; issue guidelines for training different levels of gerontological workers; evaluate such training programmes; monitor the work of old age homes and NGOs involved in gerontological work; initiate and maintain networking among institutions and individuals involved in gerontological work; and act as a documentation and dissemination centre.

An examination of culturally relevant strategies for improving the well-being of elderly people is strongly recommended. Indian culture has inherently several elder friendly values and practices which need to be reinforced. Importing a western model of care for elderly people is likely to be costly in a country that can ill afford such initiatives. Working in close collaboration with international agencies is one way of learning from models that have been used in other countries and adapting those best suited to the socio-cultural milieu of India.

1.4 SIGNIFICANCE OF THE STUDY

The present study is significant because it moved a step beyond description to understanding of psychological correlates of differences. It points out to the need for an integrated approach to an understanding of the social, psychological, and anthropological aspects of the life of elderly people. The present study is an interdisciplinary research work in which the researcher has tried to integrate the information, data, techniques, tools, perspectives, and concepts from two disciplines namely psychology and anthropology. The researcher could find psychological as well as anthropological studies on ageing and elderly, in particular. But interdisciplinary work on elderly could rarely be found which makes this study imperative.

The disciplines of psychology and anthropology are closely related to each other. Psychology is the science of human behavior. Even anthropology encompasses in its scope the understanding and analysis of human behavior. Psychology studies man’s behavior in relation to the environment. Anthropology is also a comparative and analytic study of human behavior and
experiences. Both try to understand man in the context of social behavior. Whereas on one side psychological knowledge helps an anthropologist in understanding the root causes of human behavior in different cultures, on the other side anthropological studies help the psychologist in calculating the influence of cultural environment on human behavior. Karl Popper (1963) quoted “We are not students of some subject matter, but students of problems. And problems may cut right across the borders of any subject matter of discipline”.

The study is unique in its integration of two research methodologies: quantitative research and qualitative-phenomenological research, which together facilitate the examination of a theoretical model and comprehension of the experiences of elderly people – the significance and explanations that these people attribute to their situation.

The studies on the elderly people have been largely descriptive, documenting the socio-economic differences but not providing the reasons for the differences in the socio-economic conditions, attitudes and problems of the elderly. Stress among elderly has been widely studied and but not much emphasis has been given to coping and coping styles. The research work done on the social support among elderly is quite extensive both at the national and international level. But the number of studies on emotional and spiritual aspects of elderly is quite small. The problems and adjustment of the institutionalized elderly have rarely been studied. Researchers in the area of gerontology rarely view the elderly people as human resources and active participants in society. The present study aimed to fulfill these gaps.

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, spiritual intelligence and emotional intelligence and their effect on stress and coping among elderly. A look at the indices of healthy ageing may have many implications for policymakers as well as the aged population to promote healthy living among them.