CHAPTER THREE

UNDERSTANDING OF RESEARCH CONCEPTS
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The researcher puts forth the following explanations, in an attempt to clearly understand and define the concepts used in respect to this research. The researcher has attempted to describe the origin of the concept, and the different meanings that they may hold, the importance these concepts generate in later life.

3.1 Living Arrangements.

Living arrangement refers to where and with whom, one resides. The joint family structure as well as the values and respect attached to the aged in our culture for long, provided emotional strength, security and adjustment to them. Anantharaman (1980) has found that the breaking of joint families and changing social values are responsible for the devalued status of older people. In Indian society, children have usually been considered as a source of security and economic support to their parents, particularly, in times of distress, sickness and in old age. Old people still receive respect and regard. The prevalent social norm stands for protection and care to the old persons. However, the traditional support base of elderly persons has slackened due to rising inflation and increasing pauperization. It is estimated that about 11% of elderly live alone (Datta, 2007).
Industrialisation has brought in unprecedented pressure in urban centers. The storage or housing accommodation in the cities and their rentals act as a severe constraint, on the aged for staying in common residence with their children, particularly for migrant families. The migration of younger people increases the vulnerability of the old who stay behind, particularly for families who do not have independent assets and are dependent on their labour. There is a greater investment by the family on the education and upbringing of children. The high cost of living and changing priorities affect the family distribution of income in favour of the younger generation.

The ageing effects resulting from industrialization and its accompaniments are of two kinds: intrinsic and reactive. Intrinsic effects are due to biological changes with ageing. Reactive effects arise from social structures including the family structure, which itself is the result of industrialization and other changes. Most old age behaviour is shaped by social experience.

The developmental evolution has taken the female folk out of home and transformed the family structure to be nuclear which results in deprivation of care for the needy at home. Also increasing employment of women outside the home, in offices and in factories, due to economic compulsions of modern day implies that the family can spend less time for
taking care of the elder members specially those who require constant care
(Khan, 1997).

This brings to attention the living arrangements among the elderly. The status of the aged in the changing social structure has been investigated by social scientists from different perspectives. Two types of living arrangements are considered in this study, one wherein the elderly live in their own residences, popularly called as community living/dwelling, and the second living arrangement is the 'home for the aged' or any other similar institution or asylum wherein the elderly who are alone or who have no one to care for them, are housed.

3.2 Marital Status

Marital Status refers to whether one is single or has entered the institution of marriage. The institution of marriage is significant and sacred in one’s life, more so in the Indian context. Though there is a slow and steady increase in marriages breaking or women choosing to remain single, due to the economic independence she now enjoys, there is still a large section of women, who find the presence of a spouse most fulfilling in life. The presence of this constant companionship becomes more important in the later years of life, when one’s children are away and
settled. A spouse becomes an anchor in one's uncertain and often insecure journey of ageing. Thus the loss of a spouse has an overbearing effect on all aspects of one's life.

The marital status of Indian women is all encompassing, perhaps even overtaking her personal identity. The presence of a husband defines the status, the woman enjoys, and the way she will be treated. Loss of a spouse has far fetching effects that are usually negative, and has a profound and detrimental effect on the woman’s adjustment in later life. Widowhood brings sudden change in the status of an individual. (Vijaya Kumar, 1991). Overall status means living conditions, authority, responsibility, role in a family and respectability of the individual by other members of the family.

Bambawale (1993) reported that the loss of companion is a very important factor in India, where widows or single women are still considered inauspicious. The identity of a woman is still solely dependent on her marital status. The best adjusted are married old couples as their degree of happiness in marriage was related to general satisfaction with what they had achieved all these years. Even though they were aware of one spouse departing from this world, before the other, the women hoped that it would be they who would precede their husband. Not only was this a Hindu value, but also because a widower is much better off financially and is an object of sympathy and compassion from society.
The role that family members play in the lives of the elderly is a crucial component of the socio-economic and emotional support systems of the elderly. Most of the roles which women performed in their younger days in the family shift into the hands of daughter-in-law, after their entry into the family. The death of the aged husband brings about serious consequences for the aged women. As long as he is alive, the aged woman is looked after well, in family and society. After the death of her husband the woman is left alone to suffer the pains and agonies of widowhood. An estimated 50 percent of elderly widows live alone in India (Datta, 2007).

In this study, marital status as a variable has two levels, one wherein the elderly women is married with spouse living, and another level, wherein the elderly women is widowed.

3.3 Social support

Social support became a heated term when a branch of learning of psycho-social epidemiology achieved its phenomenal existence in the late 1970s or early 1980s. The roots of interest are traced to early sociologist Emile Durkheim’s classic work. There was a belief that morale and well-being are sustained through primary group ties, the absence of which may result in psychological disorder and social problem.

Social support is a broad term that includes the quantity and interconnectedness or web of social relationships in which a person is embedded, the strength of those ties, the frequency of contact, and the
extent to which the support system is perceived as helpful and caring (Bergeman et al., 1990). There are many definitions of social support, though most of them carry the same underlying meaning.

Social support can be defined as a mutual network of caring, interested others, who help one cope with stressful situations that one may experience. The psychological well being very much depends on how a person is valued by those around oneself. Maintaining an adequate social support network has been linked to better mental health and quality of life. Social support is also defined as the number of social contacts maintained by a person or the extensiveness of a social network.

A social support system is a pattern of continuous and/or interdependent ties and interchanges of mutual assistance that plays a significant role in maintaining the physical, social and psychological integration of the individual over time. Social support system may also be known as social support networks, which is defined as that set of personal contacts through which the individual maintains his social identity and receives emotional support, material aid and services, information and new social contacts.

Social support is often used interchangeably with social care. It can be divided into two subsystems, informal and formal. The formal sector is made up of agencies consisting of a range of incorporated/public bodies, government and voluntary organizations and private market-based services. In the Indian and Goan contexts, this would include the new
mushrooming private homes for the aged that are financed by the elderly residents themselves or those who sponsor the elderly resident. Most of these homes are run by private trusts or similar organisations. It also would include the government run homes for the aged, that were at one time called asylums, as well as, homes that are run by charitable Christian orders. The informal sector consists of an array of non professionals who provide assistance and support to individuals in times of crisis. It is also referred to as a natural support system which includes family members, both physically close and extended families, which are available to respond to a need for care. It also includes friends, neighbours, and a widely diverse group of people whose primary relationship to the person in need is not as a helper with personal problems. Any person, who has established a relationship over time that provides reciprocal support, would be a part of the informal system.

Usually, social support is often exclusively used to imply the informal sector, defined as support accessible to an individual through social ties to other individuals, groups and the larger community. Community care/support means the provision of help, support and protection to others by lay members of societies acting in every day domestic and occupational settings. The term social support may also be used synonymously with community care/support systems, particularly in the informal sense.
Social support has gained significance, because it acts as a mechanism by which interpersonal relationships presumably protect people from deleterious effects of stress. Observations in a variety of settings have highlighted the positive role played by social support in psychological adjustment and quality of health (Cassel, 1976; Unger & Powell, 1980). In the context of this research, social support can be interpreted as the support assessed and received by the elderly women from sources of family, friends, close relatives and neighbours and society at large. Also the aspects of social support received those of financial, social and emotional support

3.4 Adjustment

The most widely accepted meaning of 'adjustment', comes perhaps from 'The Dictionary of Psychology', that defines 'adjustment', as a general term that refers to an individual' ability to meet the demands of society and satisfy his or her own needs (Basavanna, 2000).

The Encyclopedia of Psychology (Eysenck & Meilli, 1972) defines 'adjustment' in two ways, keeping in view, the environmental factor, which is crucial to being adjusted. 'Adjustment', here refers to:

a) A state in which the needs of the individual on the one hand and the claims of the environment on the other hand, are fully satisfied and

b) The process by which this harmonious relationship can be attained.
It implies harmony between the individual and the objective or social environment; is, of course expressible only in theoretical terms, since in practice no more than a relative adjustment is reached in the sense of optimal satisfaction of individual needs and untroubled relation to the environment.

It is interesting to note that the idea of 'adjustment' was biological and originally it was termed 'adaptation'. Hussain (1985) has outlined how the concept of adjustment, as how one knows it now, came about. The first concept of adaptation can be traced to Darwin (1959) and his own work, entitled, 'The Origin of Species', wherein he maintained that only the organisms which are most fitted to adapt to the hazards of the physical world could survive, and this was called as survival of the fittest. Such type of adjustment with which biologists were concerned about, was nothing but physical adaptation.

The term adaptation has come to be replaced gradually by the term 'adjustment', which now stands for psychological survival in which psychologists are more interested. One will agree that human personalities and environments are very complex and the concept of adjustment cannot be understood within the limitations of biological adaptation only. It should encompass the individual's adjustment to social or interpersonal pressure also (Lazarus, 1961). Besides there are differences between adaptation and adjustment. Biologists tend to think of adjustment in terms of adaptation to the physical world. Psychologists
consider adjustment to be the need for a person's adjusting to oneself, understanding one's strength and limitations, facing reality and achieving a harmony within oneself. Thus adjustment is tension reducing which has to be immediate.

Among the different psychological explanations, there are some varying views about the concept of adjustment. For instance, while clinical psychologists consider an organized behaviour to be adjusted behaviour and therefore freedom from fears, obsessions, phobias and other pathological symptoms, are the criteria against which adjustment can be evaluated, while the counseling psychologists see adjustment as consistency between real self and ideal self. These different and somewhat conflicting views on adjustment exist because no two psychologists agree on a common definition. Shamshad Hussain (1985), however, finds that most psychologists do agree to define adjustment, in terms of achieving a balance between internal demands and the requirements of the environment, or between internal psychological forces and external conditions. Adjustment, here, is to be understood as a process and not as a condition or state.

There maybe a tendency to mistake good adjustment, as a passive conformity to the demands of the environment. This is not correct. While conformity is only one form of adjustment, to a psychologist, adjustment implies not mere conformity but a harmonious relationship between the individual and his present environment. A person can achieve adjustment
either by adapting his behaviour to the requirements of a situation or by changing the situation to meet his personality needs.

Whatever definition of adjustment, one adopts, when applied to a person; it becomes impossible to classify individuals simply as adjusted and maladjusted. Adjustment is a continuous variable. Psychologists do not provide scientific and objective criteria of healthy adjustments or unhealthy adjustments. An individual may be adjusted at one time but be maladjusted at another time in the same social context. He maybe adjusted to one aspect of life and not to another. Thus, it is better to judge adjustment in terms, of a person’s ability to meet problems appropriate to his level of development.

Havinghurst (1972) put forth that adjustment is an achievement and process, and is an essential task for the quality of life of persons at each life stage, including the old age. In fact, Havinghurst lists adjustment to the death of a spouse as one of the major developmental tasks in the life of older married persons. A developmental task is a task which arises at or about a certain period in the life of the individual.

Theorists have put in their own viewpoints of what is considered to be successful adjustment where ageing and old age is concerned. ‘Adjustment’ is good when it leads to general satisfaction of the whole person rather than the satisfaction of an intense drive at the expense of others. The Disengagement theorists believe that as an individual grows older, one enters the phase of mutual disengagement between oneself and
the society. This is a characteristic of successful adjustment. On the other hand, the Activity theorists emphasis that activity contributes to better adjustment in old age. Their engagement in work makes the older people better adjusted and happier.

Bromley (1966) has given comprehensive description of good and poor adjustment. According to him, a well adjusted person is likely to be physically fit, active and mentally alert for his age. His morale is high and he will be fairly confident in social relationships. He will be content and effective in overcoming frustrations, resolving conflicts and achieving socially acceptable satisfactions and achievements. In addition, Bromley has mentioned that personality factors like anxiety, rigidity, depression and dependence are related to poor adjustment of the aged.

A general picture of research is that old age is fraught with negative changes in the psycho-physical and socio-economic status of the individual. Field (1977) has reported that adjustment is rather difficult during old age on account of economic insecurity, health problems, fewer relations and friends, loss of significant roles and loss of status.

Part of the reason for difficult adjustment during old age, could be due to rigidity usually displayed by older persons. Ramamurti (1978) has indicated a substantial negative relationship between rigidity and adjustment of old people. Anxiety and apprehension of death increases poor adjustment among the aged people (Cumming 1963).
While a comprehensive definition of adjustment is yet to be put down to paper, the very term of adjustment has now come to be replaced and has become synonymous with other terms in the research literature of gerontology. The terms ‘quality of life’, ‘well being’ and ‘life satisfaction’ are often used to denote adjustment (Ramamurti, 2004). Quality of life indicates well being. Indicators of a good quality of life are health, sufficient funds, absence of psychological distress and availability of supportive family and friends (Chadha, 1993).

Life satisfaction or ‘level of satisfaction’ is a yardstick of the ‘psychological well-being’ of the aged individual. It reflects their psychological, physical, social and financial adjustments (Chadha & Willigen, 1995, Chadha et al 1992).

Within the context of this research, the term ‘adjustment’ has being retained. However, one is to note that in the chapter of review of literature, other terminology has been quoted. Adjustment here is viewed, as the assessment of one’s emotional, health, social, family and personal aspects of life, and one’s satisfaction on these dimensions.

3.5 Mental Efficiency

Mental efficiency is also referred to as one’s ‘cognitive ability/function’. It is a broad term that encompasses such varied abilities as vocabulary, problem solving, and short term memory. It is possible that the pattern of change in abilities with age depends on which ones are
tested. Some abilities are frequently used and have been developed to a high level of efficiency. Also important are the level of abstraction and the relevance of the tasks used to measure adult cognitive functioning. Most intelligence tests refer to capacities that are predictive of school-related success. The criteria for assessing adult intelligence are necessarily more varied than the ability to succeed in a school curriculum. Motivational factors come into play in the measurement of intelligence. If a test is perceived as irrelevant or unimportant, an adult may not give much effort to performance.

Signs of decline in physical and mental functioning associated with ageing, start from the early 20s. By the time, one reaches 80 years, the brain weighs about 8% less than it did at the peak of adulthood. As one enters the 60s and 70s, the cumulative effects of age begin to show and the process seems to accelerate. Inside the body, brain cells die at a faster rate and reflexes continue to slow down. Muscles continue to lose strength, bones become brittle and the immune system weakens. There is a reduced sense of taste and smell, noticeable loss of hearing and steady loss of visual acuity.

With improved understanding of aging and the importance of health care and supportive environments, it is found that older people can function better at the same age than their parents or grandparents did (Eastwood, 1995). Geary and Lin (1996) have distinguished primary and secondary cognitive processes. The primary cognition refers to
biologically based, hardwired cognitive functions that emerge in children and unschooled populations. Secondary cognitive processes are culture based cognitive processes that result from training and education. The biologically based hardware of basic cognitive function appear to be more susceptible to the effects of ageing, whereas the culturally based cognition is less susceptible to ageing due to the buffering effects of experience, learning and culture.

Mental efficiency studied here is the general reflection of various functions, which are crucial and affected the most in old age. They include motivation, alertness, general orientation to time and place, memory, concentration, depth perception, muscular coordination and depressive symptoms and mood associated with old age.

3.6 Memory

Memory maybe linked to efficient mental functioning. The loss of some of the ability to hold items in working memory may limit older adult’s overall cognitive functioning. This idea is based on the extremely important role working memory is believed to play in information processing. Working memory is where all the action is during processing. It is where information obtains meaning and is transformed for longer storage. As a result, age differences here would have profound implications for almost all aspects of memory. If information becomes degraded or is only partially integrated into one’s knowledge base, it is
very difficult to remember it. Studies show differential magnitude of decline in different domains of working memory. This suggests that there may not be an overall general decline but a much more specific decline in certain areas.

One way to determine the degree to which memory is impaired by ageing is to merely ask older individuals to rate the quality of their memory, to estimate the frequency to which they suffer from memory failures. Such self appraisal or self monitoring of memory is referred to as meta-memory. Self reports of memory complaints, maybe also due to people’s naive ideas about the structure, function and organization of human memory, that maybe inaccurate.

3.6 Depression

Depression is a negative emotion frequently characterized by sadness, feelings of helplessness, and a sense of loss. The causes of depression can be grouped into two main categories: biological and psychosocial theories. Biological theories focus most on genetic predisposition and changes in neurotransmitters. The genetic evidence is based on several studies that show higher rates of depression in relatives of depressed people than would be expected given base rates in the population. Though this genetic link is stronger in early-onset depression, than in depression that has its onset in late life (Kasl-Godley et al, 1999).
Severe depression is linked to the ineffective use of neurotransmitters such as norepinephrine and serotonin (Smyer & Qualls, 1999). These links are the basis for the medications developed to treat depression. The levels of these neurotransmitters change with age. This would mean that the rates of depression should increase with age. But because the rate of clinical depression actually declines, this theory link does not explain the data very well. Other physiological theories of depression cite abnormal brain function and physical illness.

Alexopoulos et al (1997), propose the ‘vascular depression hypothesis’, which suggests that cerebrovascular disease can predispose, precipitate, or perpetuate a depressive syndrome in many elderly patients with underlying neurologic brain disorders. The vascular depression hypothesis is supported by the high frequency of depression in patients with hypertension, diabetes, coronary artery disease, and stroke; the frequency occurrence of silent stroke and white matter hyperintensities in geriatric depression, and the association of depression with lesions impairing the integrity or regulation of the circuits linking basal ganglia and frontal cortex.

The most common theme of psychosocial theories of depression is loss (Cohler 1993; Gaylord & Zung, 1987). Bereavement is the type of loss that has received most attention, but the loss of anything considered personally important could also be a trigger. Moreover, these losses may be real and irrevocable, threatened and potential, or imaginary and
fantasized. The likelihood that these losses will occur varies with age. Older adults are more likely to experience the loss of a loved one. In old age, depression may often be induced by the loss of a significant person or object (Holmes & Rahe, 1967). Though the death of spouse carries the highest rating, other experiences likely to life events on a scale ranging from 100 (death of a spouse), to minor traffic violations be encountered by an older person, all have high average stress ratings, for example, the death of a close family member (63), personal injury/illness (53), retirement (45), change in financial status (38), death of a close friend (37), and a change in living conditions (25). Adaptation to such loss, along with associated problems and crises, is a major task for the elderly.

An alternative psychosocial explanation argues that whether a person experiences depression depends on a balance among biological dispositions, stress and protective factors (Gatz, 2000). Developmentally, biological factors become more important with age, whereas stress factors diminish. Protective factors, such as psychological coping skills, also improve, which may account in part for the decreased incidence of depression in later life.

The behavioral approach argues that people with depression engage in fewer pleasant activities and receive less pleasure from them than do non-depressed people (Smyer & Qualls, 1999). The cognitive-behavioural approach emphasizes, internal belief systems, which focuses on how people interpret uncontrollable events (Becks, 1967). The idea
underlying this approach is that experiencing unpredictable and uncontrollable events instills a feeling of helplessness, which results in depression. Additionally, perceiving the cause of negative events as some inherent aspect of the self that is permanent and pervasive also plays an important role in causing feelings of helplessness and hopelessness.

After dipping to be low in the 60s, rates of depressive symptoms rise again in advanced old age. Actually the most striking fact about depression is its relationship to gender, not age. In every culture, women are about twice as prone to this problem as men. To understand this difference, experts look to hormonal factors, life stresses, temperament or other forces (McGrath et al, 1990)

Depression in later life is usually diagnosed on the basis of two clusters of symptoms that must be present for at least two weeks: feelings and physical changes.

The most prominent symptom of depression in older adults is feeling sad or down, termed ‘dysphoria’. The second cluster of symptoms includes physical changes such as loss of appetite, insomnia, and trouble breathing. But in older adults, they may simply reflect normal, age-related changes. Thus in older adults physical symptoms of depression must be evaluated very carefully (Smyer & Qualls, 1999). An important criterion to be established is that the symptoms must interfere with daily life as clinical depression involves significant impairment of daily living.
In addition, the researcher has also investigated some other factors that are inherent in the way they interact with the chosen variables for this research. These factors include age and education.

3.7 Age.

Age very simply implies chronological age, that is, the number of years that have elapsed since a person’s birth. It is based on calendar time. Such a simple definition of chronological age has often been criticized on the ground that it poorly represents biological, social and psychological dimensions.

The concept of ‘biological age’ puts forth that ‘age’ is an estimate of the individual’s present position with respect to his or her potential life span. It is assessed by measuring the functioning of the various vital or life limiting organ systems.

‘Psychological age’ refers to the individual’s functional level of psychological ability to adapt to changing environmental demands as compared with the adaptability of other individuals of identical chronological age. These abilities include memory, intelligence, feelings, motivation, and other skills that foster and maintain self esteem and personal control. Tibbits (1960) sees ‘psychological age’ in terms of the individual’s adaptive capacities.

‘Social age’ refers to the social roles and expectations that people have for themselves as well as those imposed by other members of the
Taking culture into consideration, socio-cultural age refers to the specific set of roles individuals adopt in relation to other members of the society and culture to which they belong. Tibbits (1960) believed that social age can be assessed in terms of social habits and roles.

Some view ‘age’ as a state of mind and hence ‘old age’ is a relative state of one’s mind. There are many people who show the mental and physical characteristic of old age long before they are 60 years. Partha Mukherji (1972), in this regard, distinguishes between biological and psychological age. According to Mukherji, biologically a person maybe old, but if one possesses a youthful temperament psychologically speaking, one should be included in the younger generation. There are many who live into their eighties without significant impairment. In fact, the newest and perhaps most creative euphemism for old people is the term, ‘chronologically gifted’.

The definition of old age may vary in different contexts, societies and cross-culturally. Everyone attains old-hood at a particular age. There is no uniformity to it. Some may argue it is 55, 60 or 62 years, keeping in mind the age of retirement from the labour market. Mahadevan (1986) states, in India traditionally, old age begins at 60. The age of 60 has been adopted by the Census of India for the purposes of classifying a person as old.

One must also keep in mind that one’s attitudes and perceptions about ageing itself are important. Perceived age refers to the age one
Levy et al (2002), used information from 660 participants, aged 50 years and older from the Ohio Longitudinal Study of Aging and Retirement. They compared the mortality rates to responses made 23 years earlier by the participants (338 men and 322 women). They found that older people with more positive self-perceptions of ageing, measured up to 23 years earlier, lived 7.5 years longer than those with less positive self-perceptions of aging. Therefore, perceived age also has its own influence on the age structure.

3.8 Education

Education, according to a standard dictionary, can refer to systematic instruction, number of academic years or experience. Education and literacy are almost synonymous in usage as far as everyday conversation is concerned. Generally, both refer to the number of schooled years. A person is considered literate if the criteria of having passed the 10th standard are met. While the definitions of education in present times are changing to include parameters that were at one time, totally different from education, it has become now a growing fashion to include the same. Creativity, value based education are now counted as what should make up an ‘educated’ person, and not just mere years of instructions received from the teacher. In the context of the research, however, the number of schooled years is taken as the dimension for education.