Chapter - II

Review of Literature
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The various problems of the aged population are increasing with increase in life expectancy and loosening social fabrics of the society. It is not surprising that even the WHO had chosen "Active Ageing Makes the Difference" as a theme for world health day 1999. In this chapter an attempt has been made to review the research findings on Psychosocial and Health Problems of the elderly. The present review is by no means exhaustive; it is an attempt to indicate the main trends in research and theory, which have a direct or indirect impact on the present study.

The research studies have been reviewed under the following main headings:

1. Problems and implications of ageing
2. Status of the elderly
3. Sex wise distribution
4. Marital status
5. Literacy
6. Religion and elderly
7. Economic status of the elderly
8. Habits
9. Leisure time activities
10. Psychosocial aspects of ageing
11. Maltreatment of the elderly
12. Living arrangements
13. Nutrition
14. Health problems of the aged
Problems and implications of aging

When the elderly were few, there was a place for them in the social structure of the community. Past values and traditions called for support of the older persons in the family and the community. As a result of urbanization, a large number of persons are moving away from the villages, leaving elderly persons behind. Those who want to take them along to the cities find it difficult to do so because of limited accommodation. Moreover, moving to a new environment means adaptation to the new unfamiliar physical conditions, which is difficult for the elderly.

The problems of the aged have not received due attention all over the world due to the different existing cultural patterns. Problem/issue is a relative terms, to be confronted at all walks of life, but is specific for every age group including the elderly people. The old people have many problems different from the younger or middle ages. Joshi (1971) noted in his study that ageing in human beings creates a number of bodily dysfunctions as well as psychological disorders. Seal (1979) has highlighted various problems of the aged and their genesis. He has divided their problems into national, special (community and family) and personal (physical, psychological and socio-economic).

The problems amongst the elderly would too differ in different cultural settings and in India, our senior citizens face problems peculiar to our socio cultural system. Venkoba Rao (1979) has mentioned that while improved health has increased longevity in India, its typical socio-economic conditions like poverty, breaking up of the joint family system and poor service for the aged pose a psychiatric threat to them. He has indicated as to how the prevalent cultural conditions are affecting or contributing to the
problems of the aged. Ghosal (1982) has reported that the problems of old age tend to be multiple rather than single. The problems of the old age are different chiefly because they are so often multiple and because of the importance of social factors in determining management. Seventh decade and the period thereafter is marked by growing consciousness on the part of the social scientists in India to deal with problems of aging (Sharma and Jain 1969; Sharma and Bhadure 1970; Shanmugam, 1970; Ramamurti, 1970; Sharma, 1971; Krishna, 1971; Satyavati and Murthy, 1976). Older persons are often seen as generally undesirable and unappealing persons. Their needs and conditions differ significantly from those of the young. There is lack of investment in such persons and the attitude is that the older person is no longer useful in society. The perceived psychosocial changes in the older individual's lifespace are loneliness, isolation, existential sadness, and so forth. With increased longevity there is related increase in the chronic illness and long term disability requiring new approaches to medical care and delivery of health and social service. Special efforts will have to be made for health and social manpower requirement and training for meeting the health and social needs of the aging population. Finally, there are special implications with regard to the economic security, housing, health services, transportation and facilities for recreation (Barkat Narain 1979).

The old man, if he outlives his use, becomes an unwanted person. In the bigger cities, with the increase in the cost of living, limited accommodation and the absence of domestic help, an aged man means one more mouth to feed and to look after. Wohlwill (1970) has suggested that social age should be examined as a dependent variable and not only as a variable to examine behavioural correlates of differences in chronological age.
Labouvie, et al. (1976) have reported that lack of environmental stimulation among the aged affects adversely their motor learning. Kasechan and Bengtson (1976) have shown that solutions to problematic aspects of ageing differ in society having different structures and norms. Crimmins, et al. (1997) show no trend in the prevalence of needing help with personal care but show declines in the prevalence of needing help with routine care and declines in the incidence of both personal and routine care needs. Manton, et al. (1997) had put forth even stronger evidence for a decline in prevalence and incidence of old age disability.

**Status of the elderly**

The old is seldom gold for the young. The problems faced by old people have grown throughout the whole world. Neglect of the aged, earlier considered a western aberration has now spread to Asian countries with the break of the joint family system, especially among the urban middle class (Probe India 1982). Yet the situation in many developing countries is quite different from that in countries where industrialization and urbanization took place many years ago. Today, in many developing countries there are still customs, which incorporate the elderly into the life of the community. Infact in these countries wisdom is still equated with age and the elderly are often considered to be natural statesmen of the community (Mahar, 1982). Sahayam (1988) reported that status of the males was not related to their land holding. For married males the percentage of head of the households (HHH) to total persons was 70.6% in the case of landless households, 50% for households with less than one acre of land, 90% for households with 1 to 2.5 acres of land, which again declined to 33.5% for households having more than five acres of operational holdings. No married female among the aged had HHH status in
spite of the land holding position of the households. Singh, et al (1994) reported in the rural area of Meerut that 38.8% were the head of the family, and 30.4% were the wives of the heads. Niranjan, et al (1996) also observed that the majority of the elderly expressed that their family members did not regard them as a burden to the family. Kishore, et al. (1997) observed in the rural area of Wardha District that 40.6% elderly were still the head of the family and rest were related to the head of the family. Elango (1998) reported from the rural area of TamilNadu that 62% of the elderly felt that their position in the family had not deteriorated and 46% were totally satisfied.

In India, the elderly have always been given respect and esteem. Our culture demands that the aged should be respected. In fact the order of precedence in India is mother, father, teacher and God. Since times immemorial most of the traditional families in India believe that since it is the duty of the parents to look after their children, it is equally incumbent upon children to look after their dependent parents. One repays one’s debts to the parents also and paves one’s way to salvation. The traditional joint family system in India provided security to the aged. However, industrialization and urbanization have started changing all that. There is gradual shift from joint family norms to nuclear families. The aged feel neglected in their own house where they once wielded power in not too distant past (Garg & Gupta, 1982). The housing problem, especially in urban areas is a major headache for the old. Not only in the bastis but also in lower middle class house, space is a problem. There are today overcrowd nuclear families in which the old parents are passed from one unwilling son’s house to another. Things become worse in India when families put pressure on old people to transfer their property to the sons/daughters. Once this is done old people are neglected all the more (Probe
India 1982). King Lear syndrome is on the increase in both urban and rural areas of India (Chari, 1977).

In affluent countries of the west, there are clubs, special programs, and other facilities for the old provided by official agencies, church organizations and the community. In West Germany, for instance, old age passes permit the holders to travel on trains and buses by paying half of the fair. Even in the state of Punjab free bus facility has been provided to the elderly. In the West elderly can attend musical concerts or visit museum on a fifty percent concession. There are not very many such facilities for the elderly in the developing countries. Some of the facilities are available in India but a survey conducted by Neerja, Vasudeva and Verma (1990) shows that many elderly people are not aware of such facilities/concessions.

A corrective pessimism about later life and prejudice against the elderly still persist in many areas of the society, including the health care field. Many elderly persons and their families find scant comfort in the administration of health care organization. The image of nursing homes is scarred by scandal, abuse, ignorance, and fear—an image, similar to that of the ancient hospital untouched by science (Butler 1981).

Sex Wise Distribution

In most developed countries, there are about 65 men for every 100 women in the age 65 years and above. There is generally a higher proportion of men in developing countries, and in a few countries, including Bangladesh, Egypt and India; there are more old men than old women. Further, the sex ratio is projected to increase in most developed countries, as a result of a narrowing gap between male and female mortality rates.
However, the sex ratio will probably fall in many developing countries, where female life expectancy is projected to increase faster than male life expectancy (WHO 1995).

Garg (1982) in a study of urban aged (50 years and above) from Merrut reported that 55.8% were males and 44.2% females. Sahayam (1988) reported 50.9% males and 49.9% females in Tamil Nadu. De-Andino, et al. (1989) observed 51% females and 49% males in their study. Chacklo, et al. (1990) reported 47.7% males and 52.3% females in the rural area of Tamil Nadu. Wonderlein (1991) reported the sex wise ratio of elderly women to men was 2:1 at Frauenklink, University Ulm. Singh, et al. (1994) reported 47.2% males and 52.8% females in a survey of rural area of Meerut. Niranjan, et al. (1996) observed 54.5% males and 45.5% females in the slum area of Bangalore. Jordi, et al. (1997) reported 38.5% males and 61.5% females in Barcelona. Maredce, et al. (1997) reported the sex ratio of elderly women to men above the age of 70 years to be 1.8:1 in USA. Kishore, et al. (1997) found 45% to be males and 55% females. Padda, et al. (1998) conducted a study in Amritsar and reported there to be 60.6% males and 39.4% females. Elango (1998) reported the sex wise distribution of the elderly in the rural area of Tamil Nadu as 51.55% males and 48.5% females.

Marital Status

In both developed and developing countries, more women than men are widowed. In most countries, more than 50% of women aged 65 years and older are widowed and in some countries, more than 75% of women aged 75 and older are widowed. In contrast, there are no countries in which more than 40% of men aged 75 years and older are widowed (WHO 1995).
Marital status is a simple, obvious criterion for distinguishing older people who are in families from those who are not. According to US Bureau of the census (1984), the marital distribution of men differs sharply from that of women in three age groups. In 1984, four out of five men aged sixty five to seventy four years were married and living with their wives; only about one out of eleven (9%) were widowed. Women sixty-five years and over are much more likely to be widowed than living with the husband. Forty nine percent of women aged sixty-five to seventy four years and 23 percent of women aged seventy five and over were married and living with their husbands; over one half of all elderly women were widowed (67% among those aged seventy five and over). The changes in marital status since the end of World War II have been quite substantial, especially for men. The proportion of elderly men who are married has increased, and the proportions of single and widowed have fallen significantly.

Bose and Suman (1964) found that 0.9% of the males aged 55 years and above were unmarried, while all the women were married in a rural area of Rajasthan. Wonderlein (1991) found that 1/7 of the 70-75 men were widowed as compared to 50% of the women of the same age. De-Aandino, et al. (1989) reported in the community of Gurabo that of the elderly of sixty years and above, 60 percent were married and 25 percent widowed. Chacko, et al. (1990) reported that 22.7% men and 80.4% of women were widowed in the age group of 60+ years and there was no single or divorced persons in the study. Niranjan, et al. (1996) observed that 49.1% were widows and widowers and only 0.7% were unmarried. Kishore, et al. (1997) found that 31.6% were widows and widowers Gurumurthy (1998) conducted a study on the elderly in the rural area of Karnataka and reported that widowhood was more (79%) in females than males (26%).
Further it was observed that there were 0.67% unmarried, 44% married 0.17% divorced, 0.50% separated, 52.5% widowed, 1.0% deserted and 0.16% remarried. Elango (1998) reported that 70.5% women were widows as compared to 12.8% widowers among elderly 60 years and above.

**Literacy**

Spending or passing time in villages as well as in towns by the aged is one of the major problems. If the elderly are immobilized owing to ill health and/or blindness, it becomes all the more difficult. If the elderly are illiterate or have not cultivated the habit of keeping themselves engaged in some kind of activity, their life becomes all the more miserable.

Mitra, et al. (1971) found that among the aged persons in Lucknow 5.6% of men and 37.7% women were illiterate. Ray (1975) in a study at Delhi observed that 29.8% aged persons were illiterate, the rate was three times more in women (44.3%) as compared to men (13.6%). Mehrotra, et al. (1979) reported literacy in 54.7% males and 20.9% females in a geriatric survey at Agra. Illiteracy amongst aged as reported by Garg, et al. (1982) was 5.4% in males and 55.9% in females from an urban field practice area of Meerut. A study by Charan (1990) had reported illiteracy rate of 80.2% in a rural area of Meerut, out of which 64.8% were males and 93.9% females. Singh, et al. (1994) reported 20% literacy in their study. Literacy was higher in males (35.2%) than females (6.1%).

Niranjan, et al. (1996) observed only 26% to be literate. Kishore, et al. (1997) reported that only 33.4% were literate (63.3% males and 10% females). Gurumurthy (1998) reported 46.3% males and 8.7% females to be literate. Elango (1998) reported that only
22% geriatric population was literate. Female literacy rate was 10.6% and 52.6% for males. Padda, et al. (1998) reported 61.3% literacy in their study at Amritsar.

Religion and Elderly

Elders are constantly portrayed as both more superstitious and more religious than younger people and the assumption is that the role of older people in religious activities remains strong and enduring (Hess and Markson 1980). As a social institution, religion fulfills several basic functions within human societies. According to Marx (1844/1963) religion produces an otherworldly focus that diverts attention from the circumstances and reality of life in this world. Marx portrayed religion as a painkiller for the suffering experienced by all oppressed people. The general respect and favourable position of the elderly in ancient Hebraic culture was a function of three vital roles they played (Achenbaun1985). First, the aged were often instruments of the Lord's will. The second function fulfilled by the elderly was that of wielder of political influence and power. Finally, the elderly were viewed as custodian of the collective wisdom of the years.

A religious institution brings together people of all ages and helps to reduce the isolation of the elderly. For many elderly, especially those in smaller communities, religious pursuits help instigate and provide nurturance for social relationship (Twente 1970). Greater religiousness has been associated with lower levels of functional disability and symptoms of depression (Idler 1987). A rural community survey at New York revealed that religion was the most important thing to their lives (Moberg, 1965).

Religion can be a powerful integrative force for older people in a society. Old people can be the caretakers of rituals and tradition. Not only can they teach the details of
ceremonies but they also represent a liaison between the affairs of earth and the realm of the supernatural (Holmes 1983).

As a social function, religion fulfills several basic functions within human societies. For example, religion defines the spiritual world and provides explanation for events and occurrences that seem difficult to understand. According to the French sociologist Emile Durkheim (1912/1965), ideas about the ultimate meaning of life and ritual ceremonies that express these ideas arise out of the collective experience of individuals (Kart, 1995).

Religion has an important place in the life of the old. Mittra, et al. (1971) reported that in Lucknow 63.4% aged persons spent time in prayers. Ray (1975) found that 80.1% of the aged performed Puja and prayers during their leisure time. Harold, et al. (1999) conducted a study in North Carolina on the elderly and reported that the relationship between religious attendance and survival tended to be greater for women than for men. Women who attended religious services once a week or more were about one half as likely to die as women attending services less often; this effect was weaker in men. Further it was observed that persons attending religious services once a week or more were physically and mentally healthier, had larger social support, had more confidant and lived healthier life styles. Analysis revealed that the risk of dying for frequent attendees was 46 % lower than for those attending services less often. This risk lessened (28%) but remained significant after adjusting demographic factors. The association was stronger in women than in men (35%Vs 17%) but was present in both sexes.
Economic Status of the Elderly

The importance of economic status in the old age cannot be exaggerated. The presence (or absence) of financial resources will have considerable impact on individual's capacity to adjust to ageing. Income will affect whether or not a retiree's values and preferences can be realized (Irela and Band 1976). The older person with adequate financial resources can maintain some degree of control over his or her life, including making decisions on which leisure activities to pursue, how much to travel, what kind of diet to maintain, and the amount of preventive medical care to seek. Older people without money can do none of these things.

Gurumurthy (1998) observed in a study of the rural area of Karnataka that 66% of the aged owned some or the other property. Out of them 40.2% owned a house, 59.8% owned both house and agriculture land. Only 2.2% owned all the three types of property such as a house, agriculture land and also a plot of land. About 2% owned only a plot of land. Property also brings status to a person in the society. It was further reported that the monthly income of the aged from all sources ranged between Rs. 100 to Rs. 1000. Only 1.3 percent aged had income, which was over Rs. 1000.

Habits

Zimberg (1974) in a New York study found the extent of the problem of alcoholism considerably high. In the 50-69 years of age group, 63% men and 35% women were alcoholics and in the age group of 70 years and above 56% men (no women) were alcoholics. Ray (1975) found that 12.9% of the aged were addicted to alcohol in Delhi. 36% of these persons had the habit of drinking more than thrice a week and took
alcohol only on occasions. Chen, et al. (1987) reported in Malaysia that 20% elderly men
smoke 15 or more cigarettes a day while 44% smoke at least one cigarette a day, and 40%
elderly men were alcoholic. Niranjan, et al. (1996) reported that 90.4% elderly had one or
more addictions. 42.6 % males were smokers while 68.3% females chewed tobacco, 27%
respondents had multiple addictions (alcohol & tobacco etc.). Garg, et al. (1982),
reported similar findings. Singh, et al. (1994) conducted a study in the rural area of
Meerut and reported that 49.4% of the elderly were addicted. 41.4% were smokers, 2.4%
were alcoholic and 5.6% had other addictions (Bhang, Betel, etc).

**Leisure Time Activities**

Mitra, et al. (1971) found in a study that the usual leisure activities of elderly
were prayers (63.4%), reading (31.16%), indoor games (3.6%) and social activities
(1.09%). In a Delhi study, Ray (1975) observed that all the aged had more than one
leisure time activity, 99.2% of them were passing some of their leisure time in the
company of relatives, friends, and neighbours. 94.5% were engaged in recreational
activities like music, radio, and TV and 80.1% in religious activities. Gurumurthy (1998)
observed that 42.2% spent leisure time in reading news papers/magazines among those
who were educated, 19.3% listening to radio, 33.0% watching TV, 5.3% playing indoor
games and 11.6% were the members of some social organization

**Psychosocial Aspects of Ageing.**

Psychosocial problems including loneliness, maltreatment and living arrangement
have been reviewed by various studies available in India and abroad.

Generation gap in human adjustment has invited world- wide attention of social
scientists. Findings have shown as to how in every society the old generation differs from
the younger generation on cognition, attitudes, values, personality, and total mental makeup. Sinha (1972) did a comprehensive work on intergenerational gap in Indian society in respect of psychological manifestations. He compared university teachers of older generation (45 years and above) with college students and young teachers on dimensions like, perception of people and events, motivation, concept of happy life, values, attitudes and reactions to frustration. The results indicated intergenerational gap in good many dimensions but it was not as wide and tensional as generally expected. Nevertheless a few psychologists have provided enough data on impairment and decline of mental abilities during old age.

Systematic study of the psychological manifestations and factors of aging started relatively late. Cowdry’s effort (1919) to study psychological problems of aging may be taken as the first major study in the area. Serious research on psychological and social aspects of aging started with the constitution of the Chicago Committees on Human Development of the Social Research Council in United States of America in 1949. This committee published its important bulletin “Social adjustment in Old Age-A Research Planning Report” in 1948 (Pollak, 1948). This was followed by an investigation into the process of growing old with regard to city dwellers. By the year 1960 a good number of well-programmed work was carried out in Chicago. Similar programmes were taken in other countries and also under the supervision of UNO. As a result, aging today has become a subject of specialized scientific enquiry of interdisciplinary nature in which the social scientists, particularly the psychologists have started taking keen interest. Birren (1959) and Bromley (1974) bear evidence to the multidisciplinary approach to aging phenomenon.
In the old age, the physical problems and deterioration in biological capabilities are coupled with a number of psychological problems and complications. In fact, to a certain extent they reinforce each other, because most of the diseases and problems are psychosomatic in nature. Psychologists on the basis of their research finding have confirmed the popular belief that during advanced age with the trend towards decline in other areas, there is natural and automatic decline in mental abilities as well (cf. Hurlock, 1981, p. 400). According to Chen (1987) the health of the elderly was intimately tied up with both biophysical as well as psychosocial factors which include status loss, loneliness, fear of illness and death, poverty, harmful life-styles and deterioration of the quality of life. The effects of these psychosocial factors can manifest as sleep difficulties, worry and anxiety, depression, loss of interest, and a feeling of tiredness. In extreme cases, there may be auditory or visual hallucinations or paranoia. Chen (1987) conducted a study of 1001 elderly Malaysians, and noted that 36% of the elderly had sleep difficulties, 47% "felt tired", 31% had a "loss of interest" and 22% were "worried or tense". However 71% of the elderly were able to correctly perform at least 12 of 15 cognitive tests. Twenty percent of elderly men smoked 15 or more cigarettes a day while 44% smoked at least one cigarette a day. 40% of elderly men indicated that their families complained about the amount of alcohol they drank.

Cheriboga (1982) found that older subjects exhibited more psychosocial distress than did younger subjects and sex differences suggested that males and females had different vulnerabilities. Goldstein, et al. (1989) conducted a study to assess the relationship of psychosocial distress and perceived health status among 1,034 older (65+)
members of an HMO. Distress was measured by recent life events, four types of social strain, and the CES-D, a measure of depression/demoralization. The distributions of these measures and perceived health status indicated that this sample was relatively healthy and undistressed. The strength of the associations within each group of variables was significant but generally modest. Using hierarchical multiple regression analysis with demographic variables, social support, and religiosity as controls, the strongest associations were found between health status and the CES-D, life events, financial strain, and the strain of being single (unmarried respondents only).

Arnhoff, et al. (1964) reported that ageing is accompanied by much stereotyped belief, which makes the old people predominantly negative in outlook regardless of the country involved. Post (1966) has stated that the development of withdrawal of social interest, suspiciousness and antipathy towards others can be viewed as a paranoid process in old age. Social isolation in old age is also caused by several factors, some of which may be viewed as the nominal process of ageing and some other as pathological. Advancing age brings with it death of companions and loss of social attractiveness. Gupta (1968) has shown that old age presents a number of problems and important among them are the problems which are purely social and psychiatric in nature such as mania, depression, senile, psychosis, and senile dementia. Boverley (1975) and Gonda (1976) have reported that lack of environmental stimulation among the aged affects adversely their mental and motor learning. Nair (1976) has also reported that physical and intellectual isolation of the old age gives rise to human problems, which are intense and pathetic. Sanchez-Ibanez, et al. (1990) evaluated the influence of sociocultural and economic factors in 135 elderly individuals distributed in four groups depending on their
personal relation setting: 39 were inmates of a closed institution, 40 lived by themselves, 43 lived with their families and 13 were displaced. The evaluation was carried out with a social questionnaire and the General Health Questionnaire (GHQ--28 items). The overall prevalence of psychological distress (positive GHQ) in the study sample was 51.1%, with a significant relation between distress and the following variables: personal relation setting, rural or urban origin, and satisfaction with personal relations and degree of personal autonomy. No significant relation was found between psychological distress and age, sex, marital status, amount of the pension or educational level. It was concluded that there is a high prevalence of psychological distress in the population over 65 years. There is a remarkable influence of the personal relation setting and family milieu on the preservation of psychological well being in the elderly and the prevention of feelings of misery and loneliness. There is increasing somatic preoccupation due to which grief and depression are easily precipitated.

Rook, et al. (1990) conducted interviews with 162 community-residing older adults, and assessed social control (direct attempts by other to influence participants' health practices and the existence of significant role obligations to others), health risk taking (medication misuse, alcohol consumption, cigarette smoking, and the overall level of unsound health practices), psychological functioning (depression, loneliness, and self-esteem), and interpersonal satisfaction (satisfaction with friends and family members). Analyses revealed that social control was only weakly related to participants' health practices and, contrary to expectation was generally related to less psychological distress and too greater interpersonal satisfaction.
Backman (1973) has reported that older men and women suffer from rolelessness, powerlessness and depression. With ageing there is decline in many functions which lead to feelings of inadequacy and insecurity. Kocken (1993) conducted a study to examine the prevalence of psycho-social problems among the elderly in order to plan prevention-programs. A questionnaire was sent in 1990 to a sample of 1989 inhabitants of the city of Rotterdam aged 65-79 years living on their own, drawn at random from the municipal registrar's office (response 58%). The results show that one third of the respondent's experienced psychosocial problems. Groups at risk were: women, men who live alone, those with a low socio-economic status, people who live on their own but receive limited support from institutions. These socio-demographic variables explained only 5% of the variance in psychosocial well being. Risk-indicators for psychosocial problems were problems in the performance of activities of daily living (ADL) and household-activities (HHA) as well as decreased social support. Elderly experiencing both psychosocial and ADL/HHA-problems most frequently visited their GP (General Practitioner). More elderly in Rotterdam compared to elderly in some other Dutch cities and to norm scores seemed to have psychosocial problems. Pacovsky (1993) showed that the most important characteristic of old age is quality of life. With the latter various forms of activities (psychosocial and physical) are associated. Activities in elderly and old people are influenced by many factors, the most important ones being the social atmosphere (social perception of old age), the personality of the old person, his health status and economic security. To a considerable extent everybody is responsible for his/her own programme of active old age. Support of the individual efforts is, however, essential.
Prevalence of depression varies between studies more widely than for dementia. This is probably partly due to differences in the screening instruments used giving different threshold for caseness. Myers, et al (1984) conducted a study in USA among the aged of 65 years and above and found that around 20% had symptoms of depression. Copeland, et al. (1987) found that 10.7% of their sample were subcases of depression in addition to the 11.3% who were cases. Key, et al (1964) found that 10% of their Newcastle sample had moderate to severe depression on and a further 16.2% had mild depression. The incidence of depression in the elderly has been estimated to be between 15 and 30 cases per 1000 per years (Copeland, et al. 1992, Blanchard, et al. 1994). Levels of depression have been found not to vary with age, but studies have demonstrated a consistent sex differences with approximately above the prevalence in women compared to men. Iliffe, et al. (1991a) found prevalence of 25.3% in women and 13.4% in men. Dewey, et al. (1993) found prevalence in Liverpool and Zaragoza of 14.2% and 14.8% respectively for women and 7.2% and 6.2% respectively for men. Callahn, et al. (1994) conducted a study on 1633 elderly aged above 60 years and reported that 15% patients with significant symptoms of depression. These were more in females as compared to males.

Murphy (1982) found that the onset of depression in elderly was associated with major life events including bereavement, physical illness and financial problems. Vulnerability was increased by major social difficulties and incidence of depression was higher in working class subjects. Livingston, et al. (1990) found that being single and living alone increased the likelihood of depression, but by contrast. Iliffe, et al. (1991b) found no association with a lack of conflicting relationships. Green, et al. (1992) found
that depression was associated with bereavement within the previous of six months and with feeling of loneliness, but not with marital status, living alone, poor housing, size of social network or physical illness.

Krause, et al. (1992) conducted a study to estimate the prevalence of depression symptoms among older adults in four culturally diverse groups (White Americans, black Americans, Japanese, Taiwanese). It was found that lowest levels of depressive symptoms were found among Japanese, followed by Taiwanese, White Americans, and Black Americans respectively. Muller, et al. (1994) reported that depressive symptoms and dementia were the most frequent psychiatric disorders in the elderly. Reactive depressive symptoms can be associated with the restrictions of social competence due to increasing multi morbidity, loneliness, social isolation, consequence of retirement, interpersonal conflicts, and the loss of partners or close relatives. Furthermore, depressive symptoms can be caused by somatic illness, degenerative disorders and other organic diseases. Forsell, et al. (1994) conducted a study on a sample of 1304 persons aged 75 years and older registered in a parish of Stockholm were examined by physicians. Factor analysis showed factors of mood and motivation symptoms, and these were related differently to the associated variables. When the other associated variables were controlled for, age was unrelated to both types of symptoms. Women had more mood disturbance. As cognitive function declined, mood disturbance first increased then decreased. Motivation symptoms increased sharply with decreasing cognitive function. A relationship was also found between increasing disability and both the mood and motivation symptoms.
Carpiniello, et al. (1989) conducted a study on 317 elderly subjects randomly selected from people living in the community in 1 urban and 2 rural areas. Data were collected by means of a semistructured clinical interview, the Social Adjustment Scale, and the Beck Depression Inventory. An emerging trend was demonstrated towards a higher rate of prevalence of depression among females and urban residents. Widowhood, absence of a confidant, poor education and financial difficulties (only among urban elderly people) were significantly correlated with rates of depression. Physical impairments and diseases were also associated with depression, independently of whether subjects lived alone. Wenderelein (1991) showed that elderly women suffer from depression that lasts for weeks about three times as often as men did. Ahmed, et al. (1993) conducted a study to determine the health problems of the elderly and family care presented to them. The study was carried out in four MCH centers in Zagazig. The sample comprised 275 women, having elderly members in their families; who were interviewed individually at the MCH center. The results showed that the main physical problems of the elderly were decline in daily activities, impairment of vision, & digestive and urinary disorders. Psychological problems as mentioned by their families were agitation, loneliness, depression and low body image. The main identified socio-economic problem was the limited income. Regarding the family care presented to the elderly, the results showed that the low social class families had poor consideration as regards nutrition of elderly, regular physician visit and personal hygiene.

Klofer (1946) in an early study reported intellectual impairment, loosening of intellectual ties to reality, inability to make full use of inner resources, difficulty in forming social relationships and reduction in responsiveness to finer emotional stimuli in
older people. A few findings indicate that the older individual experience reduced drive, stereotype thinking, reduced judgement, and loss of emotional control (Light and Amiek, 1956; Pradus and Fried, 1947). Kay (1959) and Post (1965) have shown that depression in old age is associated with continually increasing losses such as loss of close relatives, intimate friends, status of job. Fremont (1971) has reported that in old age recent memories are usually adversely affected whereas the remote memory usually remains unaffected. Poon (1980) has found that advancing age results in loss of intellectual and cognitive functioning and adjustment difficulties. Savage, et al. (1973) found that a group of elderly people who were free from physical and mental health problems and free from adjustment and social difficulties had higher score on tests of cognitive functioning than others who were not free. In the over 75 years, it is likely that increasing evidence of cognitive decline can be accounted for by disease process. Bozzetti (1977) has reported that the aged are susceptible to loss of independence, employ simple and primitive defense strategies and frequently exhibit affective disorders. The malaise of the elderly may assume a vide variety of psycho-pathological expression. Cutman (1978) has reported that elderly persons suffer from depression on account of their loss in competence. However, they have marked tendencies to minimize family conflict in their expression (Tcaud, 1978). A few other findings have indicated that people in the older age group are more conservative and display more rigidity in their viewpoint (Kublen, 1945; Schait, 1958).

Anxiety is frequently encountered in general practice, although elderly people are vulnerable to having certain complaints dismissed as preoccupations natural for an older person. Older people living by themselves are more fearful of death than older people
living within institutions (Swenson 1962). An important focus for normal anxiety in later life concerns loss and threat of loss, particularly of physical ability, health, opportunities for valued action and significant others (Verwoerdt 1981). Anxiety in normal elderly people tends to be practical in nature, governed by judgements about the consequences of aversive events as much as by reactions to the event itself. (Fattah & Sacco 1989). In this regard, Sato (1983) found that older people were more anxious about economic hardship than about criticism or failure of friendship. Prevalence estimates of anxiety depend on the classification system used and the location of anxiety within hierarchical diagnostic system means that prevalence estimates may be underestimates of the true rate of anxiety disorders (Lindesay 1991a).

In a survey of approximately 9000 general practice patients, anxiety disorders were identified in 10% of patients aged 65 and older, in contrast to 21% for all ages (Watts, et al. 1964). Population based studies provide the most accurate and unbiased estimates of prevalence. Copeland, et al. (1987) assessed 1070 people aged 65 and older randomly drawn from 360 GP patient lists. These authors reported a prevalence rate of 2.4% for all neurosis, with 1.1% for non-phobic anxiety and 0.7% for phobias. These prevalence estimates are clearly lower than those reported by the ECA studies. Lideasay, et al. (1989) also suggested that the GMS utilises more severe diagnostic criteria than DSM-III. These authors randomly sampled 890 older people within the Lewisham and North Southwark Health District of South East London, using the electoral register. Anxiety was measured by a schedule that incorporated items from several scales, including the GMS. They reported that 3.7% of their total sample had general anxiety and 10% had a phobic disorder.
Christensen, et al. (1994) conducted a study in a sample of 708 community dwelling elderly people aged 70 years and above. It was found that cognitive performance declined significantly across the age groups 70-74, 75-79, 80-84, and 85-89 years on the Mini-Mental State Examination. Prince, et al. (1996) conducted a study in a sample of 2584 aged 65-74 years, who were followed up for 54 months in the Medical Research Council Elderly Hypertension Trial (1982-1989). The subjects completed a cognitive test, the Paired Associate Learning Test (PALT) five times over this period. Decline on PALT was associated with advanced age, male sex, rural residence, depression and low intelligence. Advanced age, rural residence, and number of cigarettes smoked daily were only associated with PALT decline among women of below median intelligence. The association between depression and PALT decline was only apparent in women of below median intelligence and men of above median intelligence.

Enzell (1983) conducted a follow-up health control of 69-year-old persons in Stockholm; 589 were examined psychiatrically. Of these, 462 persons had responded affirmatively to symptoms indicating a depressive syndrome. Neurotic disorders were judged to be present in 258 persons, sleeping disturbances in 81, other types of psychiatric disorders in 10 whereas 113 persons were judged to be without psychiatric symptoms. In addition, 127 persons constituting a control group were examined. Of these 89 were judged to be without psychiatric symptoms while 38 had some form of psychiatric disturbance. The 258 persons in the group 'neurotic disorders' and the 81 in the group 'sleeping disturbances' were compared with the 89 persons in the control group judged to be without psychiatric symptoms. The comparisons included a number of variables of medical and social interest. Significantly more persons in the groups with
neurotic disorders and sleeping disturbances than in the group without psychiatric symptoms reported impaired mobility and high blood pressure, worries about their health, in take of pain-killing pills daily and financial worries. Median income was lower for the group with financial worries than for the groups without. Women in the group 'early onset neurosis' claimed significantly more often than women in the group without psychiatric symptoms that a member of their immediate family had suffered from some mental disorder. The group 'late onset neurosis' did not differ in this respect from the group without psychiatric symptoms. Bereavement was significantly more often claimed by women in the group 'late onset neurosis' versus women in the group 'early onset neurosis'. Information on social group and level of education indicated that it was the better situated and better educated who took part in the health check-up.

Welford (1958) presented a detailed account of deterioration of human skills on account of ageing effect. He found in another study (1965) that the decline in speed of performance is one of the most outstanding behavioural characteristics of ageing. Bromley (1974) has shown that motivation in general appears to decrease in old age because of decreased energy and poorer arousal mechanism. Some motivations, including secularity, fall off fairly steadily. Old people have less intense enthusiasm and need strong incentives and support to embark on a new course of action.

Kivela, et al. (1988) used the symptoms and signs of depression in the elderly in a population study for rating, and the symptoms and signs of persons diagnosed as depressed were compared to those who were not depressed. The commonest symptoms of depression both in men and women were sleep disturbances, fatigability, loss of interest, depressed mood, loss of activity, pains, pessimism and sense of uselessness. In addition,
worry was a common symptom in women. Hallucinations and delusions other than those about unforgivable behaviour were very uncommon. Sex differences in the commonest symptoms of depression were evident: worry, crying spells, helplessness, loneliness, suicidal ideas and pains were more common in depressed women than in depressed men. Some age differences in symptoms were also found both in men and in women. Sad expression was a common sign of depression in both sexes. In addition, slow movements, scarcity of gestures and slow speech were quite common signs in depressed men and stooping posture was quite common in depressed women.

Cameron (1945) noticed certain clinico-psycho-pathological trends in geriatric population and has described that as strength and endurance decline in the aged there may be attempts at energetic over compensation and an emulation of the individual with heightened feelings of inadequacy. In an early study, Foulds and Raven (1948) held that the capacity for abstract reasoning and for efficient behaviour in novel situations is impaired in old age. Rao (1975) has reported that emotionally disturbing influences affect the aged more frequently than the young. The former suffer from such psychological traumas as death of a near and dear one, fear of death, conflicts with the younger generation, disappointments at the son's or daughter's failure to live up to their expectations and the like. An old man suffering from a fatal illness, such as cancer, goes through a series of emotional reactions like shock, anger, dependency, depression and dejection which spread over weeks or months before the inevitable is finally accepted. Certain mental disorders are not uncommon in the aged. These include loss of memory, loss of confidence, mental deficiency, depressive states, suicidal tendencies, and madness.
Muller-Spahn, et al. (1994) observed that depressive syndromes and dementia are the most frequent psychiatric disorders in the elderly. Reactive depressive syndromes can be associated with the restriction of social competence due to increasing multi-morbidity, loneliness, social isolation, the consequences of retirement, interpersonal conflicts, and the loss of partner or close relatives. Endogenous depressive syndromes in the elderly are frequently combined with diffuse and changing somatic complaints, psychomotor restlessness and agitation. Furthermore, depressive syndromes can be caused by somatic illness, degenerative disorders, other organic diseases or certain drugs. The presence of simultaneously occurring somatic illness, positive family history, certain personality traits, and severity of disease could exert an adverse influence on clinical outcome.

Being old, weak, hard of hearing, partially blind and immobile, the aged seldom move out or are approached by others for help and consultation. So they feel very lonely. The adult and active members of the family such as sons and grandchildren are much too busy to give company to them. So it becomes difficult for the aged to pass their time. If the aged are illiterate and there is no such facility as electricity, TV, Radio, Clubs and associations, it becomes all the more difficult for them to spend time.

Loneliness is not a new phenomenon. Many authors have offered passing insights and also provided illuminating descriptions of loneliness feelings and the agony associated with loneliness.

Baldoni (1983) found that the most frequent causes of the feeling of "being a burden" in elderly people dependent on others due to chronic disabling pathologies are described. Often this feeling is the main, and sometimes the only reason for their isolation from the community. Perloff, et al. (1987) compared the relative impact of social,
structural, and psychosocial variables on the television uses of elderly viewers. The results of a survey of 113 older respondents indicated that psychosocial factors accounted for variance above and beyond that of demographic and situational factors in viewing of television entertainment programs, parasocial programs (e.g., soap operas), as well as in watching of television for companionship purposes. Emotional loneliness and locus of control proved particularly significant predictors of television behavior. Morris (1987) conducted a pilot survey among the elderly white and black people in East London. The results revealed some fundamental differences; 90% of whites Vs. 58% of blacks experienced problems with ageing. Loneliness was not a major feature in either group, but about 80% of both white and black single subjects were lonely. Three quarters of the whites but less than one-third of the blacks had a hobby and considered that they were fully occupied. Eighty-one per cent of whites and 40% of blacks saw a doctor regularly, and 88% and 47% respectively took medicine regularly. The white population was not abusing the medical services, but the reasons for the low figures for blacks are not clear. Both groups had a significant demand for spiritual help, emphasizing the important role of the clergy in geriatric care. Accommodation was acceptable to 93% of whites but only 25% of blacks. Both groups resisted going to an old-age home, yet 93% of those in a home were happy. This pilot study has confirmed that the services rendered for the white population in East London are adequate. Cairella, et al. (1989) carried out a study in the population sample of 1250 elderly subjects living at home, from five Italian regions (Budrio in Emilia-Romagna, Ponte S. Nicolo in Veneto, Bernareggio in Lombardy, Sezze in Latiumm, Melito in Campania). The results obtained lead to the following conclusions:

1. The condition of loneliness appears to have a detrimental influence on health in both
sexes. Among other consequences, loneliness leads to progressive spontaneous reduction of daily milieu and social requirements, as well as to an impression of dependence that cannot be easily overcome. 2. The study of the relationship between the presence or absence of chronic pathologies and legal title of domicile has shown that if the home is their own by legal property, this has a favorable influence, especially in males. Property also satisfies emotional needs, through the profound ties between personal history and certain places. 3. Positive changes in life style may have beneficial effects on the interaction between socio-economic variables and the onset of chronic pathologies, especially in old age. Rodgers (1989) conducted a study on the elderly and observed that loneliness may contribute to deterioration in physical and mental health. Some factors that may contribute to loneliness in the older persons include the death of a spouse, loss of a pet, lack of visitors, physical incapacity, role changes, and relocation. In general, loneliness may be the result of events that typically occur as a part of the aging process. Singh, et al. (1994) reported loneliness in 20.3% of the elderly (19.2% males and 21.2% females) in Meerut. Kishore, et al. (1997) reported 24.3% loneliness and 31.5% neglect of the elderly in the rural area.

Schmidt, et al. (1985) examined age and gender differences and personality correlates of loneliness in different relationships. Loneliness was measured in three groups of subjects (college men, college women, and elderly women) with the Differential Loneliness Scale which assesses dissatisfaction with four types of relationships (Family, Larger Groups, Friendships, and Romantic). Age and gender differences were significant. Compared to elderly women, college women expressed more dissatisfaction with their Family and Large Group relationships. Compared to
college women, elderly women expressed more dissatisfaction with their Friendships and Romantic relationships. With regard to gender differences, college men expressed more dissatisfaction with Family, Large group, and friendship relationships than college women. For each subject group, dissatisfaction scores were correlated with health status, locus of control, social support, depression, and self-consciousness. Correlations varied with type of relationship as well as with age and gender.

Creecy, et al. (1985) indicated that marital status, self-perceived health status, income, social activity levels, and a sense of social fulfillment directly predicts feelings of loneliness. The social fulfillment variable, however, was the most important predictor. An interesting finding was that age had no notable direct or indirect effect on feelings of loneliness. Linnemann, et al. (1990) conducted a study in Amsterdam in 1987. An inventory was drawn up of factors that practitioners (n = 39) and volunteers (n = 22) associated with loneliness among the elderly. Three groups of non-institutionalized old elderly (80 years and older) served as respondents (total n = 100). Some of the factors that the helpers mentioned, such as reported health problems, not having children and dissatisfaction with housing conditions are actually found to be related to loneliness. Other factors such as gender, marital status and the presence of children, relatives and friends in the neighbourhood had no association with loneliness. Although not all the factors mentioned were related to loneliness, when practitioners assumed an older person to be lonely, their assessment was rather correct.

Mullins, et al. (1990) examined the impact of various social relationships on levels of loneliness reported by 208 elderly residents of 10 senior housing apartments. Because the literature demonstrates a clear relationship between depression and

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loneliness, this study, controlled for depression, provides a more concise look at the condition of loneliness. Those who were less satisfied with the quality of their relationships and had less contact with close friends were more lonely. Whether one had children, grandchildren, siblings, or neighbours had no significant effect on reported loneliness?

Andersson (1990) who observed the results from a study of elderly women in Stockholm, Sweden, indicated that loneliness in old age is greater among an intruded group in comparison to those whose parental influence was not intrusive. The feelings of loneliness were even more severe if the mother was a housewife. There was also a relationship between social position and loneliness, but only for those women whose family orientation was not intrusive and whose mothers were housewives. Olsen, et al. (1991) found that loneliness was found to be associated with cardiovascular mortality, especially for males. For the aged, social isolation and loneliness are among the most frequent causes of hospitalization or placement in homes.

Martin-du-Pan, et al. (1991) conducted a survey of 730 people over 65 years and reported that cohabitation becomes rarer with advancing age, a phenomenon that has grown increasingly important during the twentieth century. Social isolation, characterized by extremely infrequent contacts with other people, affects approximately one out of ten elderly people. Most at risk are those who retired from lower positions in employment, divorced people and widowers. The main causes are the absence of children and relatives in the immediate area, the fact of being divorced, the lack of professional apprenticeship and, above all, a psychological disposition to introversion.
Hegge (1991) observed the findings of a qualitative retrospective study of coping strategies of newly widowed elderly. The focus was on the effects of anticipatory grieving on the caregiver before the spouse's death as reported by the widowed partner following the death. Most frequent and troubling problems were reported as loneliness, social isolation, and disruption in eating and sleeping patterns and independent decision making. Changes in health status following the death were not as detrimental as expected. Caregivers' health actually improved when those responsibilities were over.

Mikhailova (1991) analysed the syndrome-nosological spectrum of subclinical mental disorders in lonely outpatients (198) in comparison with a group of lonely old subject's (112) identified in the course of epidemiological study of elderly population. It was established that mild depressive disorders occur more frequently in connection with a lonely-dweller situation that old people find themselves in. The expediency is recognized of setting-up district services of medico-psychological aid for the aged to prevent mental disorders and perform psychological correction for social dysadaptation of the elderly persons experiencing stressful life events common for this age group.

Holmen, et al. (1993) conducted a study to investigate, in relation to subjective loneliness, the ADL (Activities of Daily Living) dependence of elderly persons with and without impaired cognitive capacity. Two hundred and sixty four persons were interviewed. The Mini-Mental State Examination was used as a screening instrument for obtaining a cognitively impaired and a normal group of elderly. Persons with impaired cognitive capacity who experienced loneliness had the greatest ADL dependence.
Andersson, et al. (1993) conducted an interview survey with a representative sample of 267 elderly community residents in the age group 65-74. Standard measures for health, self-esteem, anxiety, depression, and loneliness were included as dependent variables. Quality of parenting was measured by means of a retrospective questionnaire focused on the care dimension of parental behavior. The foremost conclusion of this study was that early experiences with parents have an impact on the well being of elderly persons. The effect was stronger among those older persons who lacked a current attachment figure in the form of an affectionate partner; also, it was stronger for unattached older men than for unattached older women.

Grimby (1993) made the ratings of grief reactions, post-bereavement hallucinations and illusions and quality of life during the first year after the death of a spouse among 14 men and 36 women in their early seventies. In both sexes, the reactions were generally moderate or mild and characterized by loneliness, low mood, fatigue, anxiety and cognitive dysfunctioning. Feeling lonely was the most persistent problem during the year. Post-bereavement hallucinations or illusions were very frequent and considered helpful. Half of the subjects felt the presence of the deceased (illusions), about one third reported seeing, hearing and talking to the deceased (hallucinations). Former marital harmony was found to make a person more prone to loneliness, crying and hallucinations or illusions. The quality of life was significantly lower among the bereaved than among married people and those who never married, but equaled that among divorcees. Muller-Spahn, et al. (1994) found that the depressive syndromes and dementia were the most frequent psychiatric disorders in the elderly. Reactive depressive syndromes can be associated with the restriction of social competence due to increasing
multi-morbidity, loneliness, social isolation, the consequences of retirement, interpersonal conflicts, and the loss of partners or close relatives. Endogenous depressive syndromes in the elderly were frequently combined with diffuse and changing somatic complaints, psychomotor restlessness and agitation. Furthermore, depressive syndromes can be caused by somatic illness, degenerative disorders, other organic diseases or certain drugs. The presence of simultaneously occurring somatic illness, positive family history, certain personality traits, and severity of disease could exert an adverse influence on clinical outcome.

Chen (1994) observed that the prevalence of hearing impairment increases with age. Hearing handicap resulting from hearing loss may lead to psychosocial problems in elders. Previous studies have shown relations among hearing handicap, loneliness and low self-esteem, but those studies focused on populations other than elders. Early detection of hearing handicap and appropriate interventions promotes increased independence and preserve the ability of elders to interact with their environment.

Ferrari, et al. (1994) observed that medical, psychological and social problems are typical of the old age. Usually growing old means organic impairment, loneliness and a lower social role; moreover, spatial behavior is completely reduced. The period could be lived and considered in a different way, although aging is unavoidable. The cyclic, biological time can be replaced by a time, which considers and gives expression to everybody's needs and activities.

Barron, et al. (1994) conducted a study to investigate relationships between marital status, social support, and loneliness in visually impaired elderly people. The sample was derived from a larger study designed to examine loneliness in low-vision
adults. Subjects were 87 visually impaired elderly people, who were at least 65 years of age, had a visual acuity less in the better eye, had been visually impaired for at least 1 year, and were not totally blind. Data were collected by interview using the Revised UCLA Loneliness Scale, the Social Support Questionnaire, and a demographic and health information form. Results indicated that marital status was not directly related to loneliness but may be indirectly related through social support. Loneliness was associated with greater network dissatisfaction related to caring and relaxation. Findings provide direction for nursing assessment of and intervention into loneliness with visually impaired elderly people.

Heikkinen, et al. (1995) conducted a study with the primary objectives to examine recent stressful life events and to explore possible social interaction factors across age groups in a population for suicides. Life events during the last 3 months preceding suicide (32 items) and factors related to social interaction (6 items) among 219 suicide victims aged 60 years and older were compared with those of 803 victims aged 20 to 59 years. The study population comprised all adult suicides that had life events interview data assessed as reliable by the interviewers in a nationwide total suicide population (1,397) of 1 year in Finland. Differences in life events were found across age groups: Family discord, loss (separation, death), financial trouble, job problems, unemployment, and residence change were more common among younger victims, and somatic illness was more common among elderly victims. Age groups were similar with regard to proportions of persons living alone, availability of confidants and friends with common interests, and reports of loneliness. Similarly, few differences were found among persons aged 60-74 years compared to age 75+ years with regard to rates of life events, living
alone, opportunities for social interaction, and complaints of loneliness. Loneliness was reported for persons who experienced loss among both younger and older suicides. In terms of age differences, younger men were more likely to have experienced job-related events, whereas older men were more likely to have had a somatic illness. Somatic illness appeared to be the most important stressor in elderly suicides, particularly for men. Living alone and diminished opportunity for social interaction were not common factors in late-life suicides.

The above review of literature shows that the needs and the problems of the elderly are peculiar to this age group. There is a gross need to understand and recognize their physical as well as mental states because significant improvements in the life conditions of the elderly will depend on wide public understanding of their vital human needs.

Maltreatment of the Elderly

Maltreatment of the older adults is not a new problem. Like other forms of family abuse, however, it has only recently been recognized as a social problem. The maltreatment of older adults includes several types of abuse. Physical abuse includes direct physical assaults, from slapping to homicide. This also includes sexual assaults, which some authorities place in a separate category. Physical neglect is the failure to provide a dependent older adult with necessities of life, such as food, clothing, medicines, a safe living environment, and assistive devices. Psychological abuse and neglect include verbal abuse, isolating the person from social contact and threats, common being the threat to place the elder in a nursing home. Exploitation includes actions taken against the older person's property or other items and forcing an older person to make decisions
against his or her will, such as forcing a change in residence or a will or preventing marriage or divorce. These categories are often inter-related. Most cases of victimization involve more than one type, and the less severe types, such as psychological abuse or neglect and exploitation, are often precursors of the more life-threatening physical abuse and neglect (Senstock 1993).

Most laws focus on maltreatment at the hands of others, but some also focus on self-neglect, which is being reported with increasing frequency. It is difficult to obtain accurate data on the prevalence of elder maltreatment, since victims and their families are prone to hide such behavior. Official statistics fail to include large number of cases, and studies tend to employ small, biased samples. The most frequently quoted study, using a community sample of households of persons over 65, found a rate of 32 per thousand or approximately 3 percent (Pilemer 1988). Since the study excluded some types of elder maltreatment, this figure should be considered to be a minimum.

Maltreatment can occur in the older adult's own home, the homes of relatives and in an institution. Not all-elder maltreatment is deliberate action taken to injure the victim. Families often face serious dilemmas in caring for an aged member. For example, older persons often fail to recognize their failing capacity and may insist on living alone when they no longer are capable of caring for themselves. Their children must either violate their rights by forcing them to move or worry that they may later be charged with neglect if the older person should fall or otherwise be injured.

Living Arrangement

Marital status has the greatest impact on living arrangements in the elderly population, although a number of other factors play an important role. In developed
countries, the proportion of persons aged 65 and older who live alone ranges from 10% in Japan to 40% in Sweden; in many countries it is around 30%. Large increase in the number of people living alone in developed countries over the past three decades have been mainly due to increase in the number of women living alone. Women are also more likely than men to be in long-term care institutions. The proportion of old people living alone is smaller in most developing countries, where there is a tradition of multigenerational households and both married and widowed older persons commonly live with their children and grandchildren. This pattern is being disturbed as younger family members migrate to join the urban workforce, and it is likely that in future more elderly people in developing countries too will live alone (WHO 1995).

Indian culture and values give high respect to the elderly and familial ties are quite strong. Consequently, we may find many of them living with their sons and daughters without undergoing the pangs of loneliness.

Social isolation of the aged is also on of the increase, especially in the western countries. Mayrick and Cox (1969) found in southeast London survey that 22 percent of the aged person's 65 years and above were living alone. This figure was 14 percent in a similar survey in 1960-61. In Varanasi, Gupta, et al. (1973) observed that 61.9% of the aged people were living in unitary families while the percentage of old persons living in joint families was 38.1%. A study in Gothenburg (Sweden) revealed that only seven percent of the 70 years olds lived in extended families. More than one third of the respondents felt that personal contact had become less common after retirement. (Swanborg 1977). Mehrotra, et al. (1979) found 72% of the elderly population in Agra living in joint families. Somers (1980) reported that 17 percent of the aged males and 41
percent females were living alone or with non-relatives. Singh, et al. (1994) observed in the rural area of Meerut that of the total aged, 59.1% were living with their spouse, 28.5% with their children and 6.3% each were living either with some relative or alone.

In one survey of elderly persons in Rajasthan villages, Bose and Suman (1964) observed 1.3% of the aged persons living alone, 1.7% living with mates only and 5.15 living with relatives other than wife and children. Mittra, et al. (1971) in Lucknow, found that 4.7% of the old were living alone, 9.2% with spouse only, 5% with relatives and 81.9% were living with grown up children. However, in UK (1971) only 42% of the elderly were living with their relatives (spouse, children or any other). Ray (1975) found 1.5% of the elderly living alone in his Delhi study. Sahayam (1988) conducted a study in TamilNadu and reported that the living arrangement of the old dependents differentiated by sex and marital status. Eighty five percent of the married males lived with their sons, while 37.5% of the older married females lived with them. Half of them, however, lived with their spouses. The living arrangements among the old dependents, not in their currently marital status showed the following trend. Among males, 62.5% lived with their sons, 25% with their daughters and 12.5% lived with persons other than their spouses and children. Among females, 57% lived with their sons, 21.4% with their daughters and another 21.4% lived with other persons. There was a striking difference in the living arrangements between the sexes that a greater proportion of male dependents without their spouses lived with their sons and daughters; while a smaller proportion of female (widowed) dependents lived with their children.

Elango (1998) reported that only 15% elderly were living in the family. Niranjan, et al. (1996) conducted a study in the urban slum area of Banglore and reported that
95.2% males and 80.6% females were staying with their family members and only 9.1% of the aged persons were living alone. Kishore, et al. (1997) observed that 20% were staying with their children whereas 5.27% with their relatives and 6.5% alone. Marader, et al. (1997) conducted a study in the USA and observed on the living arrangement of dwelling older adults and found 29.9% males and 73.2% females living with spouse; 48.3% males and 17.7% females living alone, and 21.9% males and 9.1% females living with others. Jordi, et al. (1997) conducted a study in Spain and found that 8.3% males, and 26% females living alone and 91.5% males and 73.9% females not living alone. De-Andino, et al. (1989) reported that the 82 percent of the elderly lived within their family setting and only 17 percent live alone. Padda, et al. (1998) reported that 73.7% elderly were living in joint families in Amritsar, Panjab.

According to US Bureau (1980) approximately two thirds of the elderly were living with family in the USA, with great majority of these married and residing with spouse and only 5% in the institutions. The household composition of elderly men and women was strikingly different and reflects the differences in marital status between the sexes. Elderly women were about 2.5 times as likely to live alone as men (36.9% versus 14.1%), whereas almost three quarters (71.8%) of all aged men were married and living with their wives. Gurumurthy (1998) found in the rural area of Karnataka, 81.3% of the elderly living with their family, 5.5% with relatives and 13.2% independently.

This shows the magnitude of the problem of isolation of the elderly in developed countries where majority of the aged do not live with their relatives. Now when most of the industrialized countries have started rediscovering the human worth of the aged and are trying to allow them to live within the community and outside the institutions
whenever possible, it would be tragically ironical if developing nations were to discard their own traditions which accord a place of honour to the aged (Mechler, 1982).

The aged can contribute in many ways. Perhaps the main contribution of the aged is a human one; they can add something to those around them by their presence and life experiences. Education is not something dispensed only in schools and based on books, it is the distillation of life’s experience. In most Indian families, the elderly bear the main responsibility towards the children who are denied formal schooling. From grandparents, children receive the kind of education called learning through doing. This brings children and adults together (Adiseshiah, 1982).

**Nutrition**

Nutrition, health, and ageing are related and recent decades’ choices of food and drink have made helpful eating easier. Exton-Smith (1977) observed that individual dietary patterns in most of the people remain similar to those that have been acquired by habits established at a younger age.

Fries, et al. (1980) speculated that the goal of long and vigorous life might be attainable as a result of the compression of morbidity from chronic diseases in to very late life. However, it appears that increasing longevity is usually accompanied by only fair or poor health and limited activity especially in the ninth and tenth decades of life (United States 1984-85). There was evidence in North America that mortality from “lifestyle diseases,” such as heart diseases and stroke is declining (Garraway 1979).

Ageing brings progressive loss of tissue function along with possible accumulation of diseases. With ageing physiology changes may effect ingestion and enjoyment of food. The sense of taste changes with aging. Digestion tends to be slower with ageing and may
be modified through attention to nutrition. Morlay (1994) reviewed nutritional modulation of behavior and immune competence suggesting that these are parallels with ageing changes and protein energy malnutrition.

Decrease in muscle mass and strength with increasing age have been linked to frailty, falls, functional decline, and impaired mobility. Evans (1996) examined a population of healthy men, one group with protein calorie supplement and one without. The ones with supplement had greater gains in muscle mass. He also applied the programs to persons over age 90 in an institution and showed increase in muscle strength by 174% and muscle size by 9%. Persons who received the supplement and did not exercise decreased their ad-lib intake. In those who exercised their weight and ad-lib intake increased. Encouraging older persons to remain active, be it in the community or even performing basic activities of daily living in an institutional setting, leads to improved self-esteem, muscle tone, and interest in and intake of nutrients.

Mobarhan, et al. (1991) assessed that malnutrition is common in elderly persons living in institutions and in the community. In many cases, the problem arises from a highly individual constellation of interacting physiologic, economic, and psychosocial causes that have the common effect of reducing nutrient intake. Protein-calorie and micronutrient undernutrition added to the normal effects of aging can undermine functional independence and diminish the quality of life of the elderly.

Mahajan, et al. (1993) conducted a study to see if gender, marital status, and congregate meal participation influenced dietary intake in the non-institutionalized elderly. The randomly selected 290 elderly men and women were interviewed using food frequency and diet history methods. Men had a better nutrient intake than women did for
selected nutrients. Single elderly of both sexes had a better nutrient intake than the married elderly. Congregate meal participants had a poorer nutrient intake than the non-participants.

Volkert, et al. (1991) reported that one of the nutritional problems in elderly people is undernutrition, which is multifactorial in origin: The causes cannot only be seen in poor nutrition. Physical handicaps such as problems with chewing and swallowing, difficulties to cut food, immobility and mental restrictions are responsible for reduced food intake and malnutrition. Psychic and socio-economic problems such as depression, life events and loneliness may reduce appetite; poverty also contributes to the risk of undernutrition. The authors further observed that immobility or chewing problems were found in nearly 50% of all cases, and undernutrition was observed in 22% of the patient group. In a group of 50 apparently healthy women aged 75 or older, the frequency of risk factors as well as the frequency of malnutrition was remarkably lower. He concluded that, in most of the cases, undernutrition was related to medical problems and to the simultaneous presence of several of the above-mentioned risk factors. Therefore, situation has to be considered in the treatment and prevention of malnutrition. Present risk factors have to be removed, if possible; even better would be to avoid them.

Walker, et al. (1991) evaluated the dietary adequacy of elderly individuals to determine whether factors such as loneliness, social isolation, or physical health were related to nutrient intake. The participants (n = 61) were independently living individuals aged 60 to 94 years recruited through senior citizen centers, residential housing areas, and social agencies in Rutherford County, Tennessee. Three-day food records were used to collect dietary data, and nutrient intakes were compared with the 1989 Recommended
Dietary Allowances. Three-day social contact diaries were used to measure frequency of interaction with others. The Physical Health Questionnaire was used to evaluate subjectively the number and severity of disease states, and the loneliness index was computed using the revised UCLA Loneliness Scale. Energy and calcium were most likely to be underconsumed, and poor physical health was related to decreased intakes of vitamin A and ascorbic acid. Loneliness was related to dietary inadequacies.

Health Problems of the Aged

Human organs gradually diminish in function over time, although not at the same rate in every individual. By itself, this gradual diminution of function is not a real threat to older people but diseases are that matter. Diseases represent the chief barriers to extended health and longevity. According to Freedman, et al. (1978) health is as much subjective as an objective phenomenon. Individuals assess their health on the basis of various factors, including their expectations about how people like themselves should feel. People experiencing changes in usual body functioning try to make sense of their experiences, often by hypothesizing, about the possible cause of symptoms. According to Janis, et al. (1979) the elderly themselves seem overly ready to make attributions to internal physical processes rather than to the environment. Their perceptions often include grossly exaggerated notions of what happens during normal ageing. Too many associate pain and discomfort, debilitation, or decline in intellectual function with ageing occur in itself. Kahn, et al. (1975) found that only a small amount of memory loss was evident in an elderly sample, yet patients perceived a high degree of loss. These perceptions were highly correlated with depression. They attribute all negative changes in health and mood to ageing per se.
Many studies have been conducted in India to assess the health and social conditions of the general population and children but those particularly designed to survey the problems of the aged persons appear to be very few. The most common complaints of the elderly observed were poor appetite, constipation, ankle swelling, hearing loss, dizziness, uncomfortable feet, incontinence, insomnia, instability, low back pain, memory loss, dry mouth, chronic pain and impaired vision.

Brocklehurst and Hanley (1981) reported three chronic illnesses that cause a great deal of morbidity, activity limitation, and mortality among the elderly are heart disease, cancer, and cerebrovascular disease. Heart disease accounts for a great deal of morbidity, disablement, and inactivity in older people. The dominant cause or form of heart disease is ischemia, closely followed by hypertension; in third place are mixed cases where both these diseases are present. According to Kart (1985) there is a relationship between family income and the prevalence of chronic conditions. For some specific conditions, arthritis, for example, there does appear to be linear relationship between income and prevalence; the higher the family income, the lower the prevalence rate of arthritis. For other conditions, the pattern is not so clear-cut. Still, for most chronic conditions, those elderly with low family income (less than $5,000) show a prevalence rate is higher than that for the total sixty-five years and over population, whereas those elderly with higher family income ($15,000 or more) show a prevalence rate below that for the total elderly population (Kart 1985).

The morbidity pattern in general and pertaining to various body systems, as observed by the various workers, in the aged people is as follows:
Lindemann (1944) indicated that the physical reactions to grief experienced by older people included stomach distress, shortness of breath, lack of strength, and "subjective distress". According Clayton (1973) several more studies also show increases in physician visits during the first year of bereavement, especially for psychological symptoms. Kraus and Lilienfield (1959) showed that the effects of widowhood (grief and accompanying environmental changes) are the most likely causes of the increased mortality. It is well established that the mortality rate is much higher among widows and widowers than among married persons of the same age (Parkes, 1964).

Raj and Prasad (1970) in a rural study of UP found that the brunt of illness fell on the persons who were 80-89 years of age or above. The prevalence rate of illness was significantly higher in lower middle, poor and very poor social classes as compared to upper middle and rich social classes. The illness rate was 16.6% in bachelors, 52.5% in married persons, 56.6% in widows and widowers and 25% in separated persons. The overall sickness rate was observed to be higher in the illiterate group (55%) as compared to the literate group (31.6%). McDonnell, et al. (1979) observed in Leeds Metropolitan district study that over 50% of all respondents (65 years and above) were having some form of long term illness.

According to U.S. Bureau of the Census (1985) there has been a reduction in the incidence of infectious diseases in the United States and increase in the importance of chronic conditions. Chronic conditions represent the key health problems affecting middle aged and older adults. In fact, when compared with younger age groups, middle-aged and older adults show lower rates of acute conditions, including infective and parasitic conditions, respiratory conditions, conditions of digestive system, and injuries.
Gupta, et al. (1973) in a study of aged persons (55 years and over) in Varanasi city reported that the morbidity was higher in females (58.7%) as compared to males (51.4%). Kulkarni and Niyogi (1974) observed that 4.9% males and 2.8% females were suffering from acute illness in a study of aged persons (60 years and above) in Baroda municipal area. Mehrotra, et al. (1979) in a study in Agra found approximately 43% of aged population (55 years and over) showing some illness during the period of survey. Amongst the sick persons, females suffered more (73.7%) than males (26.3%). Kishore, et al. (1997) observed the morbidity pattern in the rural area of Wardha and found that the causes of illness in elderly were chronic diseases. Morbidity rates increased with the advancing age being maximum about 65 years of age. All the aged persons studied had one or the other illness.

Raj and Prasad (1970) found that 52.2% of the persons aged 50 years and over were ill. The illness rate was higher in men (59.6%) in comparison to women (42.4%). The variable pattern was not found to be associated with social class, religion, type of family, and literacy status. Most common diseases were arthritis, cataract or visual impairment, hypertension, chronic bronchitis, bronchial asthma, diabetes mellitus, and disability. Sengupta, et al. (1982) reported 2.5 illnesses per person; Garg (1982) found it to be 2.5 among urban aged while 3.0 illnesses per aged person was reported by Ray (1975). Niranjan, et al. (1996) reported almost equal morbidity rates among males and females. Padda, et al. (1998) conducted a study to compare the health problems of the elderly (60 years and above) in the urban and rural areas of Amritsar. It was observed that the total numbers of illnesses among 698 old persons were 1833, i.e., average number of illnesses per person was 2.62. In other words one person was suffering from

\[ T = 126.53 \]

\[ S = 2525 \]
multiple illnesses at the same time. Average number of illnesses increased with advancing age. According to Leibowitz, et al. (1980) and NAECVR (1987) the prevalence of cataract in Americans between ages 65 and 74 was about 50%. The prevalence increases to 70% over age 75.

Ray (1975) observed cataract in 23.4% of the aged 60 years and above in Delhi. The prevalence rate of cataract was higher in females (28.3%) than males (17.8%). Purohit, et al. (1973) reported this to be 37.2%. Mishra and Srivastva (1980) reported cataract in 25.9% of the aged 55 years and above. The rate was more than double in females than males. Garg (1982) found cataract in 24.3% aged population (50+ years) from Meerut. Sengupta, et al. (1982) reported cataract among 17.7% of people (55 + years) from slums of Calcutta. Sommer (1986) reported that 80 million Americans had a medical or surgical disease of the eye and visual system. According to American Academy of Ophthalmology (1987) more than 1 million Americans were legally blind, Americans over age 65 constitute 50% of the U.S blind population. Further more, 13% of Americans over age 85 years were blind according to Tielsch, et al. (1990) and Klein, et al. (1991). The prevalence of cataract in Americans between ages 65 and 74 is about 50%. The prevalence increases to 70% over age 75 years. (Brown, et al. 1989; Beck, et al.1990). Morbidity pattern of aged from rural health center Faridabad by Kapil, et al. (1989) has reported cataract in only 2.15% of the aged. Chakco, et al. (1990) reported the prevalence of cataract to be significantly higher in women (61.2%) as compared to men (48.9%). A rising trend with age was seen. Singh (1996) reported 54% of the aged persons to be suffering from cataract or visual impairment. Singh, et al. (1996) found visual problems in 37.3 % of aged persons. Niranajan, et al. (1996) reported that the
cataract was the commonest (46%) among various diseases from urban slums of Bangalore. Elango (1998) observed cataract in 30.1% elderly in the rural area of Tamilnadu. Kishore, et al. (1997) observed cataract (30%) in the rural area of Wardha.

Prevalence estimates of hypertension vary widely with the number of blood pressure measurements taken. Burt, et al. (1995) reported in the National Health and Nutrition Examination Survey, the prevalence of hypertension varies by age, ethnicity, and gender. Men had higher age specific rates of hypertension than women until 60 years of age. Raj and Parsad (1970) found that 6.1% of the aged (55 years and above) were hypertensive. The prevalence of hypertension was more in widows and widowers (10.9%) as compared to bachelors (8.2%) and married persons (3%). Widows and widowers are more prone to develop high blood pressure, as perhaps, they feel more insecure, neglected and dejected. Purohit, et al. (1976) from Naila reported hypertension in 12.6% of the elderly. Lee, et al. (1977) in a nation wide survey at Singapore found 40% of the population in 60-69 years age group having hypertension while Gupta, et al. (1978) found 21.6% males and 25% females (60-69 years group) suffering from hypertension in Rohtak City. Barrot Conner et al. (1981) reported 29% of elderly persons (50-79 years) in California, suffering from high blood pressure. Garg (1982) found it to be 16.5%. Sengupta, et al. (1982) reported the prevalence of hypertension to be 9.2% in the slums of Calcutta. McGrother, et al. (1986) reported the prevalence of hypertension to be 11% in men and women aged 65 years and above in England. The prevalence of systolic hypertension was more in males (22.2%) than females (19.8%). The prevalence of diastolic hypertension was more in females (16.7%) than males (14.4%). Burt, et al. (1995) showed that the prevalence of hypertension varies by age, ethnicity, and gender.
The Systolic Hypertension in the Elderly Programme (SHEP) in USA, estimated a 5% prevalence of hypertension in the aged 60-69 years and approximately 10% in those more than 70 years of age and 20% in those more than 80 years of age. Singh, et al. (1996) found that 14.6% of the rural elderly in Varanasi were hypertensive. Niranjan, et al. (1996) reported hypertension to be prevalent in 10.3% of the aged (60 years and above) in the slums of Bangalore. More females (14.5%) had hypertension as compared to males (6.7%).

Diabetes is common in older persons and is associated with considerable economic and personal costs. William, et al. (1972) in a Lancashire industrial town study reported that 1.6% of elderly (75 years and above) were suffering from diabetes. Hay (1976) found diabetes mellitus in 4.5% aged in a Notinghamshire geriatric study. Medalic, et al. (1978) reported that 5% of Israeli men aged 40 years and above suffered from diabetes. Garg (1982) observed diabetes mellitus in 4.2%. Sengupta, et al. (1982) reported it in 2% of the aged (50+). Diabetes mellitus increases in prevalence with age. In the United States, it is estimated that 3.6 million people aged 65 or older are afflicted with this disease, the majority of whom have type 2 disease (Robin, et al 1994). According to Weinberger, et al. (1990) almost half of diabetics are aged 65 years or older with an approximately even split between men and women. The absolute number of older persons with diabetes will continue to rise in the foreseeable future. The rate of diagnosed diabetes in persons 65 to 74 years of age and more than 75 years has increased about 2.5 times in the past 30 years. According to Harris(1990), about half of the cases in older persons are undiagnosed, if method of detection improve, the numbers of clinically recognised cases may rise even further. Singh, et al. (1996) reported a higher rate
(26.1%) of diabetes among the aged. Niranjan, et al. (1996) in Bangalore observed the prevalence of diabetes to be 4.9% in the aged 60 years and above.

Pulmonary disease is a common cause of morbidity and mortality in the elderly. Raj and Prasad (1970) observed chronic bronchitis in 13.3% aged persons. Garg (1982) reported this to be 9.0% while Sengupta, et al. (1982) found it in 10.2%. Niranjan, et al. (1996) reported that 12.2% of the aged persons suffered from chronic bronchitis and bronchial asthma was found in 12.6% cases. Chronic bronchitis was 3.5 times more in men (10.6) than women (2.9%). Elango (1998) observed the chronic bronchitis to be 15.4% in the rural area. Chacko, et al. (1990) conducted the study in the rural area of TamilNadu and reported chronic bronchitis to be 3.5 times more in men (10.65) than women (2.9%). Kishore, et al. (1997) observed chronic bronchitis (7.3%) in the rural area of Wardha. by Kapil, et al. (1989) reported chronic bronchitis in 14.5% in a study on morbidity pattern of the aged from rural health center Faridabad. Braman (1993) reported the 7-8% prevalence of Asthma in U.S.A. Mortality older asthmatic populations is eightfold higher than that of younger populations. The overall mortality for asthmatic is 0.6 per 100,000 population, but in those over 65 with asthma the mortality is 4.9 per 100,000 population.

Sengupta, et al. (1982) reported the prevalence of ulcer in 1.7% of old people. Garg (1982) found chronic gastritis in 6.6% of the aged. Singh, et al. (1996) reported chronic gastritis in 19.6% of the rural elderly from Varanasi. Niranjan, et al. (1996) reported chronic gastritis in 5.8% of the elderly. It was more prevalent in males (7.3%) as compared to females (3.6%).
Raj and Prasad (1970) in their study found 8.8% disabled among the aged 50 years and above (5.4% males, 3.4% females). The causes of disability were deafness (7.2%), blindness (0.9%) and paraplegia of acute onset (0.6%). Kulkarni and Niyogi (1974) found in Baroda municipal area that 20.4% of the aged (60 years and above) had disability of movements for walking or having bath. Ray (1975) observed in his Delhi study that 13.6% of the aged persons were disabled on account of chronic illnesses. Sengupta, et al. (1982) observed disability in 10.7% aged persons. The aged were disabled either due to deafness or blindness. Blindness was the commonest type of disability. Niranjan, et al. (1996) showed that disability was found in 38.1% of the elderly, 60 years and above. Common causes of disability were partial blindness (12%), difficulty in walking and standing (10.5%) and partial deafness (5.4%). Singh, et al. (1996) reported that complete deafness and blindness were found among 3.6% and 2.6% of the aged persons, respectively.

Musculoskeletal pain and discomfort are common complaints for older adults (Bagge, et al.1992). Lawrence, et al. (1989) reported that arthritis was the leading chronic disease in the United States and that it increases in prevalence and incidence with age. Arthritis frequently results in painful symptoms that can result in compromised function, loss of mobility, and disability (Verbuge, et al.1991). Ricitelli (1965) mentioned that, of the numerous causes of low back pain in the elderly, arthritis, degenerative diseases and osteoporosis are so common that they are considered a part of the ageing process. Raj and Parsad (1970) reported arthritis in 17.7% of elderly population in a rural area of UP. Kulkarni and Niyogi (1974) found 37% of the people suffering from bone and joint diseases in Baroda. Females were affected more (46%) than males (29.4%). Chacko, et
al. (1990) conducted the study in the rural area of Tamil Nadu and reported that the backache and arthralgia had a higher prevalence in women (44.7% and 42.7%) than men (25.5% and 34%). Singh (1996) reported incidence of arthritis to be 57.4% among elderly (60+ years) in rural area of Banaras. Elango (1998) observed 30.5% arthritis in the rural area.

Chacko, et al. (1990) conducted a study in the rural area of Tamil Nadu and reported that the prevalence of urinary incontinence was 5.4% in men and 8.1% in women aged 65 years and above. Elango (1998) observed some causes of illness in the rural area were dental problems (12.9%), Skin diseases (1.5%), and 17.5% were found to have no apparent illness. McGrother, et al. (1986) reported that functional disability increases with age. The majority of the elderly required assistance in toilet, bathing, dressing, walking and eating. However it was seen that among those needing assistance in the performance of ADL, widows constituted 65%. Besides, prevalence of functional disability was 2.4 times more in widows than the rest of the population. Similar results were obtained by Moore (1978), Mc Donnel (1979), Jagger, et al. (1986).

Approximately 50 million deaths occur throughout the world each year, with almost 80% of these (39 million) occurring in developing countries. It has been estimated that approximately one-quarter of all deaths in developing countries and almost half of all deaths in developed countries are attributable to cardiovascular diseases (WHO, 1995). William, et al. (1964) reported that 18.5% persons aged 65 years and above had heart problems in Edinburgh. Ray (1975) found 32.8% of elderly persons suffering from cardiovascular diseases in Delhi. Rao and Anwikar (1976) reported that cardiovascular diseases were responsible for 25% of total deaths among the aged (55 years and above) in
Nagpur City. Polliack and Bialik (1975) found 63% of the elderly (65 years and above) having cardiovascular diseases, in one general practice area in Israel. Niranjan, et al. (1996) reported 11.9% of circulatory diseases of the aged 60 years and above in Bangalore.

According to William, et al. (1992) living to an old age can be a mixed blessing. Although age itself is not a disease, with ageing there is an increase in the incidence of chronic diseases and related disability. Today, 4 out of 10 individuals over age 65 have one or the other chronic disorder that may result in some functional limitation; common disorders associated with ageing include sensory acuity losses, cardiovascular disease, cancer, osteoporosis and related fractures, and cognitive disorders. Despite these limitations, the majority of the elderly remain active, vigorous, and productive for at least a decade after reaching the age of 65 years.

Rao (1975) has stated that some of the common somatic diseases of the aged found in India are high blood pressure, heart disease, accidental injuries, strokes, cancer, diabetes, lung diseases, kidney infection and diseases of joints and bones. Decline in vision, hearing and sensitivity of taste are the other common deficiencies of the old age. Parohit and Sharma (1975) reported the nutritional status of persons of 60 years and above in India. According to them, 71.9% persons showed manifestations of anemia, vitaminsosis and other deficiency. Mehrotra, et al. (1979) have reported on the basis of door to door survey of 178 aged persons (55 years and above), that 43% of them had some morbidity, predominantly respiratory illness, skin-infection, bowel disorders and dysentery.
In this review the various psychosocial and health problems among the elderly have been reviewed extensively from the existing literature available from India and abroad. Most of the studies on the elderly are available from the Western countries because of higher proportion of such population in this age group. But with the increase of life expectancy and declining trend of communicable diseases, the focus is also shifting towards the problem of elderly in developing countries, which is evident from pouring in of many studies undertaken in the recent times. The problems of the elderly are multiple and multifactorial. However, the main problems of elderly had been identified as psychosocial and health. The present study was undertaken with this background to assess the psychosocial and health problems among the elderly in Chandigarh. This review is an attempt to explore the above problems from the existing literature.