A Study on
The Factors Influencing Life Satisfaction Among the Aged Women Under Institutional Care in Madurai District.

Thesis submitted to

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In fullfilment of the requirements for the award of
the Degree of Doctor of Philosophy in Social Work

By

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CERTIFICATE

This is to certify that the thesis entitled **"A Study on the Factors Influencing Life Satisfaction Among the Aged Women Under Institutional Care in Madurai District"** submitted by **Mrs.D.Janet Vasantha Kumari** is a record of bonafide research work carried out by her for the Degree of Doctor of Philosophy, under my guidance.

This thesis is an original work of the candidate and to the best of my knowledge, this has not been submitted in part or in full for any Diploma, Degree, Associateship, Fellowship or other similar titles in this or any other university. No portion of this thesis is a reproduction from any other source, published or unpublished with out acknowledgement.

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DECLARATION

I declare that the thesis entitled **"A Study on the Factors Influencing Life Satisfaction Among the Aged Women Under Institutional Care in Madurai District"** is the result of a study originally carried out by me, under the guidance and supervision of **Dr.P.N.Narayana Raja,** Research Guide and Principal, Madurai Institute of Social Sciences, Madurai, affiliated to Madurai Kamaraj University. This work has not been submitted earlier in full or in part as Diploma, Degree, Associateship, Fellowship or other similar titles in this or any other university.

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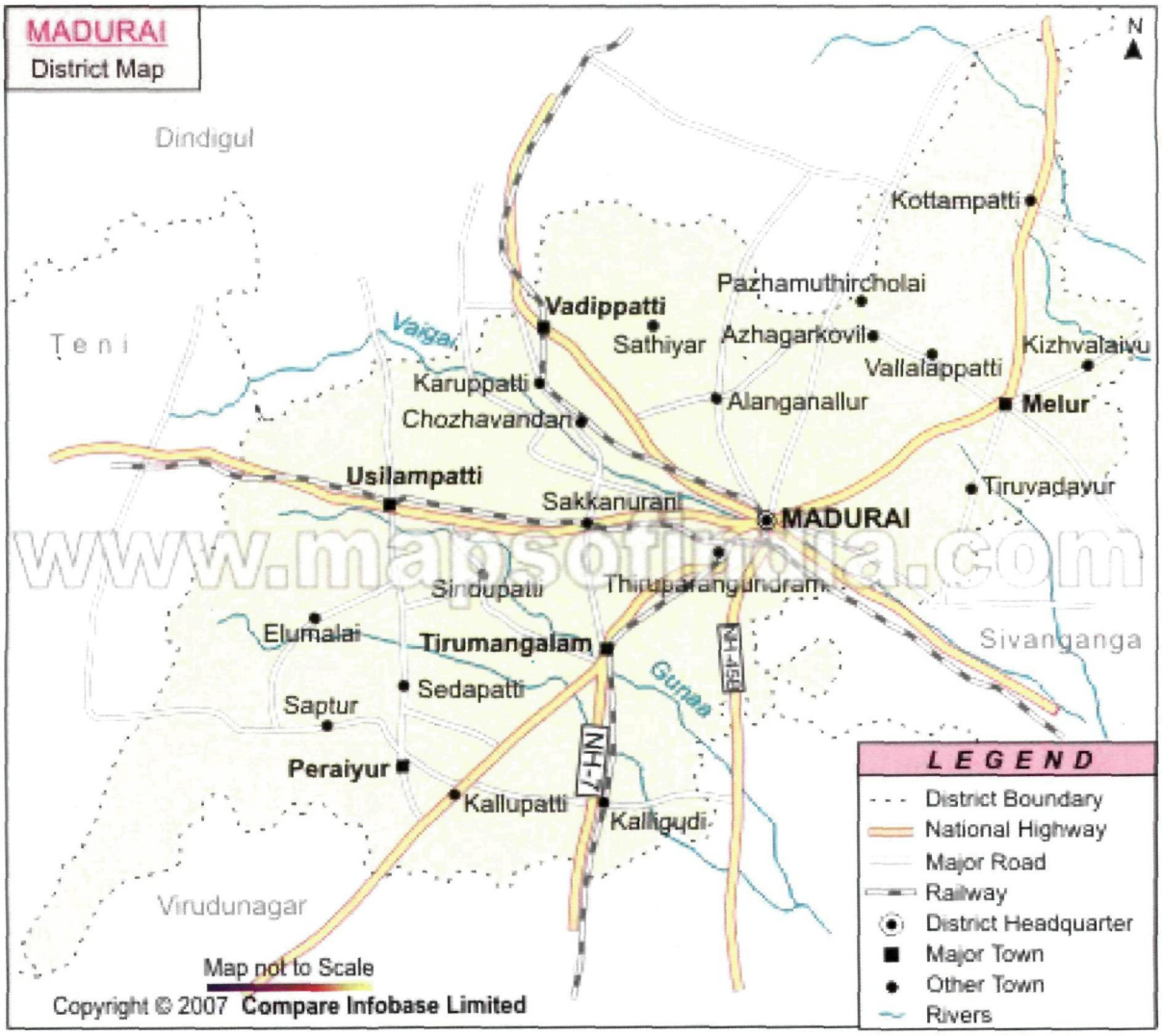
MADURAI DISTRICT MAP



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Introduction to background of the Research Study

CHAPTER-I
INTRODUCTION AND BACKGROUND OF THE RESEARCH STUDY

1.1 INTRODUCTION

Everything in this world undergoes periodical changes and passes through varied and various phases before it ceases to be. A day, for example, born as dawn develops into morn, noon, afternoon, eve and dusk before it becomes night. So does a human life too. In between cradle and grave it walks across different avenues of infancy, childhood, adolescence, adulthood, mid-age, old age and ripe old age which Shakespeare poetically describes as the "Seven ages of man". As this study is concerned with old age, the focus is on the last phase of human life which Shakespeare calls "the second childhood sans teeth, sans eyes sans everything".

Decline in the power of functioning of physical and mental faculties marks the beginning of old age in a human being. Generally the sixtieth year in a human being is considered as the starting point of old age. Though the unprecedented development of medical science has played a pivotal role in lengthening the longevity of human life, the deteriorating conditions of physical, mental and psychological abilities in old age yet remain to be overcome. Changes in external appearance, internal systems like digestive and metabolism system, sensory changes including sexual desire or appetite are the clear indications of the gateway of old age. Added to these changes in the physique-both external and internal-are changes in the motor and mental faculties too. These changes vary in magnitude and time of occurrence from person to person. Therefore no two persons of the same age cannot be considered the same to be.. Such variations are caused by hereditary qualities, socio-economic-educational background, environmental conditions and life-style. And these changes are more obvious and apparent in women as they are supposed to enter into the realm of old age earlier than men. The central

Government of India itself, taking into consideration this aspect, defines man and woman at sixty plus as senior citizens. Above all, these changes do play a major role in the individual's capacity to adjust with self, family and society.

1.2 DEFINITION

Ageing in a living organism usually refers to the adverse effects of the passage of time, though occasionally the term refers to the describable process of motivation or acquiring a desirable quality (Busse, 1989). The term 'elderly' is synonymous for age. The definition of elderly changes according to the mindset and the demographic distribution of the population changes. For a youth of 20 years, a person at 60 seems old, while a 60 year old individual in good health probably considers someone in the 80's and 90's as old.

New categories have been created in scientific literature to reflect these changes as more people pass the century mark (Medalie, 1989). Ageing is generally associated with a decline in physical and mental ability (Kapoor and Kapoor, 2000). "Biologically" ageing begins at least as early as puberty and is a continuous process throughout adult life. "Socially" the characteristics of members of a society who are perceived as being old, vary with the cultural setting and from generation to generation. "Economically", the elderly are sometimes defined in terms of retirement from the work force. "Chronologically" age has long been used as an indicator of the expected residual life span.

According to Elizabeth, B. Hurlock (1976) the last age (elderly) in the life span is frequently subdivided into early old age, which falls between 60-70 years and advanced old age, which begins at 70 years and extends to the end of life. Hence, people, during the sixties are usually referred to as elderly and old after seventy.

1.3 HISTORICAL PERSPECTIVE

Prior to the Industrial Revolution, in the primitive hunting and gathering societies, where production was carried out by domestic groups, the oldest

member was considered a source of knowledge about rituals and survival skills. In a society where social differentiation was largely on age, authority was linked to age of elders held influential positions in the social, political and religious spheres of life (Goody, 1976). Based on an analysis of seventy-one privative societies (Simon 1945, 1952) found that states and treatment of the aged was governed by tradition and rituals unique to each culture.

Long life was viewed by the ancient Hebrews as more of a blessing than a burden. The aged in most of the pre-industrial societies held meaningful roles, as long as they were physically and mentally able to contribute to the family and community. They had considerable power over the social, religious and economic life of the society. This gave them influence, security and status. When the elderly were no longer able to contribute, they "retired" and transferred control over family resources, usually to the eldest son. They were then cared for by the family and the community because of part contributions. The residual components of prestige, and also because they were the major source of knowledge about culture.

The status of the aged probably varied within societies, depending on locale and period. There were a few instances, where the old were forced to die by self-killing or at the hands of others, once they were deemed a burden to society. The aged and aging were also highly respected in conservative outlying districts of Ancient Greece (Koller, 1968). But in cities like Athens attitudes towards the elderly were generally negative and condescending.

Old age was viewed by Aristotle in a more negative vein. In Rome, old men were generally portrayed as vicious, miserly, treacherous, thoughtless and tyrannical (Beaver, 1983). However, not all elderly men were perceived in this light. Some had the good fortune of being revered as moral guardians to young boys from wealthy families. They trusted elderly women servants, who were held in high regard, as they accompanied the young boys to school, stayed with them during school hours and brought them home safely (Kollar, 1968). Old age was seen by Plato as a time of peace and liberation. Under platonic philosophy, the role of the aged was to command and of the young to obey. In

his Republic many of the important functions of State were given to men aged between 50 to 70 (Victor, 1987). Nevertheless, the majority of Ancient Roman authors consistently portrayed the elderly in a negative and highly uncomplimentary way. The Egyptians saw old age as a burden both for the individual and society. Considerable effort was expanded in the search for a method of controlling the decline in physical prowess which characterised old age. One such method advocated by the Egyptians was the use of the glands of young animals to rejuvenate the aged.

With the onset of the Industrial Revolution, first in Great Britain and Western Europe and then in North America, societies experienced dramatic social changes. New social structures, cultural values political and social systems and social processes began to evolve. At societal level, the Industrial Revolution led to many changes in the social and economic system (Burges, 1960; Cowgil, 1974).

Cowgill and Holmes (1972) argued that improvements in health care lead to aging of the population. The decrease in the mortality rate resulted in aging of the working population and a decrease in job opportunities for the young. Thus inter generational tensions are created by the competition for jobs. Additionally, economic and technological developments devalued the employment skills of the old. Urbanisation attracted young people from the rural areas resulting in a break–up of the extended family. Finally, the development of mass education reduced the hold the older people had over knowledge. These factors contributed to a decrease in the status of the elderly in modern society. Thus, despite improvement in the quality of life, the role and the status of the aged declined after the Industrial Revolution. The old became socially and physically abandoned living a marginal existence on the fringes of society.

Colton Mather (1965-1728) was one of the first –Americans to write about Ageing. But he treated it as illness, Benjamin Rush (1746-1813) was one of the pioneers to describe the changes in body and mind that accompany old age. He refuted the idea that old age was a disease.

In 1930, the problems commonly associated with growing old were being described frequently as a "problem group". (Maddox and Wiley, 1974). The growing number of older people in the population, their increasing life expectancy and their inability to maintain themselves economically and the social implications these factors would have for the rest of the population is alarming. According to (Maddox and Wiley, 1976), "human suffering among aged persons in the form of incapacity, isolation and poverty were considered to be prevalent enough to warrant social concern and social action".

Historical evidence clearly indicates that probably there was no time in the past when the old were venerated for themselves. Rather, where the elderly did seem to be in an exalted position, it was essentially a result of their control of power and wealth. Consequently, in trying to look to the role of elderly in history it should be accepted that aging was, for most people, a time of pauperism and degradation.

1.4 THEORIES OF AGING

A number of theories related to the aging process have been described. These theories are grouped into two broad categories : biological and psychosocial.

1.4.1 Biological Theories

Biological theories explain the physical process of aging, including changes in the major organ systems and the body's ability to function adequately and resist disease. They also explain why people are differents and what factors affect longevity.

1.4.2 Genetic Theory

According to genetic theory, again it is an involuntarily inherited process that operates over time to alter cellular or tissue structures. This theory suggests that life span and longevity changes are predetermined. (Stanley, Blair, and Beare 2005) state, The development of free radicals, collagen, and

lipofuscin in the aging body, and of an increased frequency in the occurrence of cancer and autoimmune disorders, provide some evidence for this theory and the proposition that error or mutation occurs at the molecular and cellular level.

1.4.3 Wear-and –Tear Theory

Proponents of this theory believe that the body wears out on a scheduled basis. Free radicals, which are the waste products of metabolism, accumulate and cause damage to important biological structures. Free radicals are molecules with unpaired electrons that exist normally in the body; they also are produced by ionizing radiation, ozone, and chemical toxins. According to this theory, these free radicals cause DNA damage, cross-linkage of collagen, and the accumulation of age pigments.

1.4.4 Environmental Theory

According to this theory, factors in the environment (e.g., industrial carcinogens, sunlight, trauma, and infection) bring about changes in the aging process. Although these factors are known to accelerate aging, the impact of the environment is a secondary rather than a primary factor in aging. Science is only beginning to uncover the many environmental factors that affect aging.

1.4.5 Immunity Theory

The immunity theory describes an age-related decline in the immune system. As people age, their ability to defend against foreign organisms decreases, resulting in susceptibility to diseases such as cancer and infection. Along with the diminished immune function, a rise in the body's autoimmune response occurs, leading to the development of autoimmune diseases such as rheumatoid arthritis and allergies to food and environmental agents.

1.4.6 Psychosocial Theories

Psychosocial theories focus on social and psychological changes that accompany advancing age, as opposed to the biological implications of

anatomic deterioration. Several theories have attempted to describe how attitudes and behaviour in the early phases of life affect people's reactions during the late phase. This work is called the process of "successful aging".

1.4.7 Personality Theory

"Evidence supports the general hypothesis that personality characteristics in old age are highly correlated with early life characteristics". (Murray and Zentner, (2001).

The personalities of older men were classified into five major categories according to their patterns of adjustment to aging. According to this study:

- **Mature men** are considered well-balanced persons who maintain close personal relationships. They accept both the strength and weakness of their age, finding little to regret about retirement and approaching most problems in a relaxed or convivial manner without continually having to assess blam.
- **"Rocking chair"** personalities are found in passive dependent individuals who are content to lean on others for support, to disengage, and to let most of life's activities pass them by.
- **Armored men** have well-integrated defense mechanisms, which serve as adequate protection. Rigid and stable, they present a strong silent front and often rely on activity as an expression of their continuing independence.
- **Angry men** are bitter about life, themselves, and other people. Aggressiveness is common, as is suspicion of others, especially of minorities or women. With little tolerance for ambiguity or frustration, they have always shown some instability in work and their personal lives, and now feel extremely threatened by old age.
- **Self-baters** are similar to angry men, except that most of their animosity is turned inward on themselves. Seeing themselves as dismal failures, being old only depresses them all the more.(Richard, Livision, and Peterson, 1962).

1.4.8 Developmental Task Theory

Development tasks are the activities and challenges that one must accomplish at Specific stages in life to achieve successful aging. (Erikson, 1963) described the primary task of old age as being able to see one's life as having been lived with integrity. In the absence of achieving that sense of having lived well, the older adult is at risk for becoming preoccupied with feelings of regret or despair.

1.4.9 Disengagement Theory

Disengagement theory describes the process of withdrawal by older adults from societal roles and responsibilities. According to the theory, this withdrawal process is predictable, systematic, inevitable, and necessary for the proper functioning of a growing society. Older adults were said to be happy when social contacts diminished and responsibilities were assumed by a younger generation. The benefit to the older adult is thought to be in providing time for reflecting on life's accomplishments and for coming to terms with unfulfilled expectations. The benefit to society is thought to be an orderly transfer of power from old to young.

There have been many critics of this theory, and the postulates have been challenged. For many healthy and productive older individuals, the prospect of a slower pace and fewer responsibilities is undesirable.

1.4.10 Activity Theory

In direct opposition to the disengagement theory is the activity theory of aging, which holds that the way to age successfully is to stay active. Multiple studies have validated the positive relationship between maintaining meaningful interaction with others and physical and mental well-being.

Sadook and Sadook (2003) suggest that Social integration is the prime factor in determining psychosocial adaptation in later life. Social integration refers to how the aging individual is included and takes part in the life and activities of his or her society (Sadook and Sadook, 2003). This theory to most

people is a basis for deriving and sustaining satisfaction, self-esteem, and health.

1.4.11 Continuity Theory

This theory, also known as the development theory, is a follow-up to the disengagement and activity theories. It emphasizes the individual's character traits as a basis for predicting how the person will adjust to the changes of aging. Basic lifestyle characteristics are likely to remain stable in old age, barring physical or other types of complications that necessitate change. A person who has enjoyed the company of others and an active social life will continue to enjoy this lifestyle into old age. One who has preferred solitude and a limited number of activities will probably find satisfaction in a continuation of this lifestyle.

Maintenance of internal continuity is motivated by the need for preservation of self-esteem, ego, integrity, cognitive function, and social support. As they age, individuals maintain their self-concept by reinterpreting their current life style in keeping with present circumstances. Internal self-concepts and beliefs are not readily vulnerable to environmental change; and external continuity in skills, activities, roles, and relationships can remain remarkably stable into the 70s. Physical illness or death of fringes and loved ones may preclude continued social interaction (Sadock & Sadock, 2003).

1.5 EVOLUTION AND FUTURE PROSPECTS

1.5.1 Longevity

Old scriptures, most religions mention that the length of human life had steadily declined. Longevity in earlier periods was attributed to health promoting life style. Actually, however, the length of human life has increased most dramatically only in the last century. The twentieth century has been a century of longevity with an unprecented increase in the population of older persons, the centenarians alone numbering 1,35,000 globally. Their number is expected to rise to 2, 2 millions by 2050. Here are some instances of

centenarians; Jeane Calment, French superstar of longevity, who died on August -4, 1997, at the age of 122 years 5 months and 14 days. She said the secret of / longevity was wine, olive oil and a sense of humour,. Another example is that of a centenarian couple in Haryana, Chand Raw and his wife, who celebrated their 100th birth day in April 2001 (Hindustan Times, April 7, 2001). The ascribed their good health and long life to milk consumption, and hard work in the field.

1.6 LONGEVITY–WORLD SCENARIO

The elongated life expectancy is one of the remarkable achievements of the 20th of century which can be attributed to the various scientific and medical advancements, and which, in turn, has multiplied the population of people aged 60 plus in the world level and is expected to accelerate in the next 50 years. In 1950, there were 205 million people above 60; in 2000,the number trebled to 606 million and by 2050, it is expected to cross two billion worldwide.

The impact of rapid industrialization and urbanization the world over in the 20th century is strongly felt in the development of major changes in the social structure in India. The materialistite advancement in life naturally killed the human values and it rang the knell of the centuries–old joint family system in India. The first casualty of the disintegration of the Joint family system and rise of nuclear family was the safety of the aged parents and grand parents. The unsympathetic attitude of the governments adds fuel to fire and virtually orphanages the aged Since the welfare of the elderly is a low priority with the State tantamounting to total neglect, they have no benefactor and they become refugees in their own land and hence they rightly feel disillusioned, shattered, isolated and rejected.

If achieving the longevity was the triumph of the 20th century, protection and care of the elderly will be the challenge of the 21st century. While research on aging is well developed and documented in developed countries, it happens once in a while in developing countries such as India.

According to Dhar Chakraborti, The graying of India, (Sage Put, 2004,) this is primarily because of the belief that the family support system is and will continue to be an adequate insurance against all problems related to old age.

1.7 LONGEVITY- INDIAN SCENARIO

Though developed countries have a relatively high proportion of the elderly, the older population in the developing world is growing at a much faster rate. Two-thirds of the elderly live in developing countries. A "large majority" of elderly people will soon be living in the developing world with their number rising in geographical progression in the next 25 years. A UN agency says citing India and China as notable examples of a new trend. Although the proportion of the elderly seems to be relatively small in a developing country like India, it has more elderly persons in absolute terms because of its large population base.

The population of the senior citizens in India saw a steep rise from 19 million in 1947 to 84.6 million in 2005, an increase of 445 percent in the last six decades. It is expected to further double in the next 25 years. As of 2001, India accounted for 77 million elderly people of 60 plus a figure second only to the number of elderly in China. Similarly 29 million of India's elderly are above 70 years and 8 million above 80. One in every 10 in China is an elderly population aged 60 and above is expected to increase to 179 million in 2031 and further to 301 million in 2051. With a comparatively young population, India is still poised to become home to the second largest number of older persons in the world.

The special features associated with the elderly population in India listed below

a) A majority (80%) of them are in the rural areas
b) Feminization of the elderly population (51% of the elderly population would be women by the year 2016)
c) Increase in the number of the older-old (persons above 80 years) and
d) A large percentage (30%) of the elderly are below poverty line.

In India in terms of size, Uttar Pradesh state tops with the highest number of 11 million elderly followed by Maharashtra (8.5 million), West Bengal (5.7 million and Tamil Nadu (5.5 million)

1.8 Various Aspects of Ageing

There are several perceptions about the aged and ageing in society; Demographic, Biological, psychological and social. The starting point of discussion among these perceptions is the demographic criterion.

Conventional usage of the term "Old Age" in demographic literature refers to the populations aged 60 years and above. In the developing countries, the demographic conception of old age is still taken to be 60 years and above. It is useful to examine the biological, psychological and social concepts of age for describing "Man as a whole system" (Beaver, 1983).

The concept "Biological Aging" generally considers physical changes in the organism which has been found, in general, to be associated with ageing in the from of incapacity, isolation and poverty, were considered to be prevalent enough to warrant social concern and social action".

Historical evidence clearly by indicates that probably this was at a time in the past when the old were venarated for themselves. Rather, where the elderly did seen to be in an exalted position, it was essentially a result of their control of power and wealth. Consequently, in trying to look to the role of elderly in history it should be accepted that aging was, for most people, a time of pauperism and degradation. These changes many gell in structure, organ systems or their functioning (Beaver, 1983). It is well known that there are marked individual differences in the onset and rate of physical changes with age. All individuals do not age at the same rate. However, psychological capacities decrease linearly and death rates rise exponentially with increasing chronological age (Jarvik & Cohen, 1974).

Psychologists explain ageing in terms of changes in the central nervous system, in sensory and perceptual capabilities and in ability to organize and

utilize information (Andason, 1956). They are also concerned with changes in personality and external behaviour of the ageing persons. In short, psychological aging consists of general decline in the mental abilities that accompany old age. A number of changes appear to occur in the psychological area as an individual grows old. Generally the changes are associated with some kind of loss, which may interfere with and delimit competence and skill, affect well being and ultimately diminish the older person's self-Esteem.

The social aspect of ageing refers to what happens to people of society as they grow old. As individual ages, he begins to withdraw from society by surrendering or giving up some of his social roles. Many of the relations between a person and other members of society are several and those that remain are altered in quality.

The above discussion on various aspects of ageing clearly indicates that in gerontological literature, ageing is a broad concept which does not refer to only one process but to many processes such as physical changes in human body, psychological changes in human mind and social changes in relationship with others.

Thus, each of the broad perspective of ageing-biological, psychological and sociological separately does not explain adequately the total process of aging. Whereas the biological aspect examines the processes of ageing the internal to the individual's environment, the psychological and sociological aspects take into consideration the external environment. Moreover, there is a mutual interaction between the internal and external environment. When the psychological causes of ageing process is accelerated by speeding up the rate of decline in various sensory and motor activities (Hurlock, 1950). However, this acceleration in the ageing process may further gain momentum or slow down when the sociological dimension is added to both physical and psychological contributors of aging. The social structural conditions may boost the morale of an individual within a congenial set of social relationship and lead to slacking down of ageing syndromes, whereas the absence of social support systems may accelerate the process of ageing.

It is difficult to define old age precisely because the term "old" is used to describe persons of different ages depending on the circumstances and on the area of operation.

1.9 LONGEVITY OF TRIBAL PEOPLE

According to an extensive anthropological study of Kurichias conducted for the past three decades and published recently the elderly Kurichias generally live longer than many other tribals and non-tribals in south India. (Aiyappan & Mahadevan, 1990)

1.10 Origin / Furthering Geriatrics

The constitution of India directs that the state shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age and sickness and disablement".

The term "Geriatrics" was introduced in the United States and it was developed into a specialty in Britain. Geriatrics as a specialty is still in its infancy in India having just crossed to toddler's stage. In the late 1960s the Government of India, on the recommendations of the ICMR, decided against the establishment of a gerontological institute in the country on the plea that the situation did not warrant it.

During the last two decades the discipline of geriatries in India has taken important steps towards research and care and for starting professional organizations. Many centres of developmental studies and centres for research on ageing have been established, many of them within university campuses- Research has centred not only on basis neurosciences, biochemistry, genetics, anthropology, psychology and sociology but also on clinical and behavioural sciences. The Department of geriatrics has been started in many teaching medical institutions, Chairs have been created in geriatric medicine and geriatric surgery in some institutions; eg. Madras Medical college, Chennai. Post graduate courses in geriatrics have also been started in some universities,

Nevertheless, the undergraduate syllabus is yet to include the study of geriatrics. Among the professional organizations in geriatrics in the country, the important ones are: the Association of Gerontology (India), the Geriatrics Society of India, the Indian Gerontological. Association of Gerntology (India), the Geriatric society of India, the Indian Gerontological Association, the Association for Alzheimer's and Related Disorders of India, and India Academy of Geriatrics. Besides in the Indian Psychiatric Society has an active section on geropsychiatry. Continuing medical education programmes are organized periodically by these organizations. Voluntary bodies have been offering care and research facility in geriatrics, and Help Age India is an important on among them. (Rao Venkoba. 2006, P 311-312).

The ICMR prioritized geriatrics as an area for research and the Task Force project was initiated, which resulted in the publications of "The problems of the Aged seeking psychiatric help" and Total health care of the rural aged.

1.11 Entering "Old Age"

Entering the world of the elderly needs a preparation. It has been observed that the more healthier one is in his /her 60th year, shorter will be the period of morbidity preceding death: called "Compression of Morbidity" in the aged (Fries, 1996). It has been reported that a quarter of the remaining years of life in likely to be spent with some disability, disease or handicap. (Murrag & Lopery, 1997). The concept of successful ageing is to improve health of the entrants to enable them to pass through the find "eugeria" the term coined by Aristotle to indicate the state of freedom diseases, the disability, dependence and without being a burden to others. The essence of preventive geriatrics is enabling the elderlies to remain in such an optimal state of health.

1.12 AGED IN INDIA

In traditional Indian society, the aged enjoyed a high position. They were the head of the family and had complete control over the property and other resources, Durkheim's terminology, the social life in Ancient India was

based on "Mechanical solidarity". It was believed that with age men acquired knowledge. It was during the sutra periods that the individual life, as well as the social structure was crystallized. Society was divided into four varnas and individual life was divided into four stages what is called as Varna Ashrma Dharma scheme". From the societal point of view Gri-hasta Ashram was considered most important because it was only during this state of one's life that one could not only raise the family and satisfy one's physical needs but also have an opportunity to get rid of different loans, one of the important obligation was to look after the aged person and pay them due respect. The "Grihya" sutra ordained filial piety. Such religious dictates gave the old persons in the Indian society authority, security and honour and enjoyed upon the son to look after his old parents failure on the part of sons was considered a serious demerit and earned social opprobrium (D' Souza , 1982). Such a system provided economic, social and emotional security to the aged (Radhakrishnan.S. 1960, P-65).

The Institution of joint family, caste and village community, which formed the building block of traditional structure in India assured economic security and high social status to the aged. With the introduction of the formal education system the Britishers and new judiciary system, the traditional network of relationships underwent drastic changes. With the advent of Industrialization and education, formal institutions came into being, through which knowledge could be acquired.

Further, large scale migration from the rural areas to industrial units by the surplices population on the look out for new job opportunities gave a big jolt to the traditional family composition and network of relationships . Those who were employed in far-off places could not afford to take their aged parents and other members of their kin group with them. Hence, the younger generation prepared mobile nuclear family to the traditional complex family set up. The negation of large family structure by the compact nuclear family, where young members were given more care, attention and importance devalued the aged (Barron, 1953).

In the beginning migrant warhorse maintained their links with their parental families either by regularly remitting money and keeping their wives and children in the village and by regularly visiting them. However, slowly but steadily, traditional family ties began to break down due to emergencies of work and new represent groups. Thus, the frequency of interaction diminished, gradual growth of conjugal families emerged and the gap between the old and the young widened. According to Parsons (1953), the young generation have least importance to their obligations to the aged in the hierarchy of obligations.

In the near future because of increased dependency ratio, it was felt that the population of the older people social economic condition would deteriorate (Ranade, 1984). It was being contended that the states of the aged would decline with technological and economic development because the status in the industrial set up was based on the individual's acquired formal skills and education. As the industrial society was oriented towards the individual rather than a group, the aged were bound to be rendered useless, generating a feeling of meaninglessness in them (Mahajan, 1987). In short, problems of the aged in developed countries are mostly confined to isolation, whereas India being a poor country, problems are associated with struggle for survival.

1.13 AGEING IN RELIGIOUS CONTEXT

In most geronotological literature, people above 60 are considered as old and as constituting the 'elderly' segment of the population. Even in the Indian context, people who have attained 60 are considered aged, whereas in developed countries old age begins at 65.

In the traditional Indian culture, a human life span is one hundred years, Manu the ancient lawgiver, in his Dharmashastra divided the life span into four Ashrams of life stages.

A) *Bhramacharya* – Student: The celibate students time of youth is for learning the foundation of lifestyle. The focus is on health, positive training and discipline, learning about spiritual, community and family life.

B) *Grashasta* - Householder: The householder phase of life is the period of life with spouse and children, fulfilling wordly interests and duties. It is a time of giving, living, and loving in family community. Religious or spiritual practices are undertaken or performed in the context of worldly life and service to others.

C) *Vanaprastha-Hermitage*: Now the focus is transferred to spiritual practices of meditation, contemplation, and prayer. Relationships with grown children and community are more in the role of a matured mentor. Lifestyle is more simplified and the couple may retreat to a quieter place for deeper and divine practices .

D) *Sanyasa–Renunciation*: The elder person now retreats from active involvement in all worldly activities and seeks only spiritual goals in this final phase. With no political, professional or social engagements, he ultimately turns towards being an elder teacher of spiritual knowledge. (Murti Rao,D.L, 1980, P-22:19-31 & Rao Venkoba.A, 1980).

In the above mentioned four stages of life, the last two pertain to old age. These two stages of life cycle are marked by dissociation from worldly activities and retirement to forest where spiritual orientation is cultivated in pursuit of salvation after death (Kapadia 1966). Though these stages of life are not strictly adhered to, they play a significant role in influencing the life pattern of the aged. As the concept of setting off for spiritual pursuit to the forest does not fit into contemporary society, certain religious organizations build homes, for the old people to stay and spend their time in prayer and meditation to attain *Mukthi.* (Salvation) Here they are trained to minimize their contacts with family and friends.

Many verses and renderings in the Qur' an clearly instruct how one should deal with ageing parents. In chapter 17 *(Al-Asara)*, the duty of the son is exhorted as: "and your Lord has decreed that you worship none but Him and you be dutiful to your parents. If one of them or both of them attain old age in

your life, say not to them a would of disrespect nor shout at them, but address them in terms of honour" (Irfan, 2001)

In the *Holy Bible* health and longevity is linked to living according to God's words and strictly adhering to His commands or commandments. *Psalms* 92:12 says ," the religious shall flouring like a palm tree, he shall grow like a cedar in Lebanon"/ Old age hence is not considered a curse, but a blessing and long life is a mercy from God.

The way of living in a joint family system with due respect not only to the aged parents but also to the advance of aged grand parents underwent a lot of changes in the flow of time because of the sudden and rapid growth of nuclear families. The role and status of the elderly also underwent a drastic change. Many of the recent studies show the transition in the role and status of the elderly Indians from pre-industrial society to the existing industrial social order (D'Souza 1982, Gangrade 1999, Khan 1999, Singh 1999). The elderly enjoyed a much higher status in pre-industrial society marked by group oriented social interaction, agricultural mode of production, extended family system, kinship and patriarchal authority, in sharp contrast to the degraded and humiliation in the new industrial social order of India, affected by the process of changes such as modernization, industrialization, urbanization, secularization and changes in women's position.

1.14 OLDER WOMEN IN INDIA: PERCEPTION AND REALITY

1.14.1 Gender Perspective

India is one of the few countries in the world where males outnumber females. However, among the elderly, female life expectancy is higher. Moreover, according to the 2001 census, the sex ratio among the Indian elderly of 60 years and above was 1028 females to 1000 males. Women comprised a greater number and proportion of the elderly in almost all societies. This disparity rose as people grew older-women comprised 55 per cent of the 60 plus population; in the 80 plus set, they were 65 per cent and in the 100 plus 77 per cent. According to the UN estimates there are 208 million aged women

in the world and about half of them live in rural areas in developing countries (UN 1990). It has been further estimated that elderly women in India would constitute 14 per cent of the total population of India by 2025 (Ibid),

The general perception of elderly women is that of an over-assertive member of the family where the main occupation is to ensure that the life of the daughter-in –law becomes miserable. The subtle message is that they are the wielder of patriarchal authority in the family and is most often an instrument of exploitation of younger woman. This image no doubt has basis on reality but is that all that is there to the elderly women in our society?

Are these woman not the ones who have faced all the disadvantages piled upon females in our society right from infanticide to ill-treatment to malnutrition, and inaccessibility to resources? Life might not have been a bed of roses for many of them when they were young; but, if that has been the case then how came they turned out to be manipulative aggressors? Probably there is an urgent need to look beyond this stereotyped image and find out the real status of elderly women in India particularly those living in urban areas. Research on the quality of life of the elderly in India is dominated by social studies. Studies are being conducted to find out how the elderly individuals, both males and females, live and interact with their children and their spouses in urban and Rural areas.

Since elderly woman far outnumber elderly men due to their longer life expectancy and because their husbands are much older than their wives, social conditions of in-laws constitute a major area of such research. Widows, by and large, are economically dependent, socially isolated and have several physical and mental disorders which make them, in source cases, immobile and bedridden.

In such cases, their contribution to the family and to the community is almost nil. Social science has been by passing elderly women earlier. It is only now that some research is done regarding their plight.

1.15 COMPARISON BETWEEN URBAN AND RURAL ELDERLY

There are significant socio-economic differences between the urban and rural elderly. More than 80 per cent of those over 60 years in our country live in the rural areas. The rural elderly are older than the urban elderly, but have little access to tertiary care. In rural areas over 6 per cent of the women are elderly, while in urban areas it is 5.1 per cent .While over 78 per cent of the elderly men enjoy the support of their spouses, 64 per cent of elderly women are widowed, and dependent on someone else for their livelihood. A large workforce among the elderly exists in the rural informal sector. Over 70 per cent of the rural elderly men continue to work, as against 48 per cent of their urban counterparts. Health care services also differ significantly in rural and urban areas with emphasis on primary health care in the rural areas and tertiary care in the urban areas. As India is strongly believed to live in villages, it is but natural to expect most of its elderly population to live in rural areas. Poverty, lack of education and malnutrition, play a dominating role in the life–style, health-both physical and mental-and other characteristics associated with aging. Malnutrition, an offshoot of poverty is detrimental to the health and physical growth of an individual, but the rustics are able to overcome this obstacle by compensating it with their strong will-power and industry. In the same way lack of education does not darken their minds, dampen their spirits for they are worldly-wise and that knowledge comes through their rich experience and ancestry.

1.16 FACTORS RELATED TO AGEING

The striking differences in personalities, varied social support networks and contrasting cultural background makes the process, time and experience of ageing individualistic and unique. Similarly as the social and cultural background, adequacy or inadequacy of resources, emotional motivation and political factors are the deciding factors of a society in its response and support to the aged, there is a sharp difference in its attitude towards the aged from society to society.

The worst affected are women. The early aging and longer life-span make their old age a horrendous experience. Still worse are widows of this category as the curse of widowhood adds insult to injury. If they happen to belong to the lower middle class they are doomed further. Older women had a higher poverty rate than older men. Poor people who have worked all their lives can be expected to become poorer in old age and others become poor only after becoming old. The traditional customs in the family not only prevents them from enjoying the love, care, affection and support of other family members and society but also forces them to work strenuously for others, despite old age (Nayar, 1996). The women of yester generations were generally uneducated and they were unemployed. Even if they were employed it was in the non-organizational sectors and so they do not come under the purview of any social security scheme as a result of which it aggravated their suffering. Hence, the economic, health nutrition and 'psychological problems of women in this age group is comparatively deeper and more intense than those of men.

The inevitable decline in the function and performance of various organs naturally makes the old age a bundle of diseases. As the fall in stamina and resistance is the alter ego of growing age, the old are more prone to ill-health than the young.

1.17 PROBLEMS OF ELDERLY WOMEN

1.17.1 Physical problems

Exhaustion, pains, poor mobility, failing vision, heart and breathing problems, and cardiovascular diseases combined with diseases of the musculoskeletal system are the most frequent, hazardous health problems faced by the aged. Besides physical illnesses, the aged are more likely to be affected by poor mental health, caused by senility, neurosis etc.

Assumption of the symptoms as part of the aging process makes the aged ignorant of the actual ailment which, in turn, makes the early diagnosis of the disease difficult. As a result, it is often too late when a disease is diagnosed.

In some cases they suffer in silence and in some others the family does not pay heed to their complaints. Youngsters are hesitant to spend money and time for the aged. Lack of interaction between the aged parents and young children magnifies the problem. The medical problems of the elderly are generally chronic. Coronary heart disease is known to be fatal in the elderly. Visual impairment and locomotive disabilities are widely reported. In a recent rural survey by the ICMR, only 20 per cent of those interviewed said they had major medical problems. It is reported that about 60 per cent of the elderly in India live a disability free life. The remaining 40 per cent are invariably the victims of one or the other disability. The incidence is slightly higher among females. More than one symptom generally in the elderly may at times lead to the diagnosis of more than one disease. The problems often and generally are related to vision (65 per cent), movement (36 per cent), respiration (10 per cent), skin (8.5 per cent), the central nervous system (7.4 per cent), cardiovascular ailments (6.3 per cent), and hearing (5.8 per cent).

According to HL.Dhar, Director of Medical Research Center, Mumbai, there are three most common problems or ailments from which the elderly suffer 'namely' hypertension, arthritis and diabetes. Primary osteoarthritis is almost a disease of the elderly population. Diabetes mellitus is a common metabolic disorder in aging population and a vast majority of elderly are type 2 diabetics. Elderly patients with diabetes may suffer from some specific syndrome like diabetic neuropathy, malignant otitis and the like .

According to Osdfeld, Kelle and Klawans, (1986), 50 per cent of the elderly population in the west suffer from hypertension, while 55 per cent of males and 45 per cent of females of the 50-60 age group are preyed upon by hypertension in Chandigarh. The study of Taiwan shows that the Taiwanese elders are least affected by hypertension. In the age group of 65-75, only 28.3 per cent and 35.8 per cent of men and women respectively have symptoms of hypertension, while in the advanced age group of above 75, the percentage is still lower in males (25 per cent), but higher in women (45.9 per cent). (Wen Ping T.Serg, 1977).

Some of the common health related problems to the elderly are listed below:

- Arthritis
- Cancer
- Cardiovascular (Blood Pressure and Heart Disease)
- Cerebrovascular (Strokes)
- Dementia
- Depression
- Diabetes
- Falls and Injuries
- Gastrointestnal Disorders
- Hearing impairment
- Memory
- Nutrition
- Osteoporosis
- Parkinson's Disease
- Respiratory Disease
- Pressure ulcers
- Sleep problems
- Thyroid diseases
- Urinary disorders
- Visual impairment

(Source: Health Action: Vol.12)

1.18 NUMBER OF ELDERLY (IN MILLIONS), BY TYPE OF PHYSICAL IMPAIRMENT, PLACE OF RESIDENCE AND SEX

Type of Impairment	*1991*			*2001*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
Visual disability						
Rural	1.00	1.48	2.48	1.29	1.93	3.22
Urban	0.20	0.31	0.51	0.34	0.53	0.87
Hearing Disability						
Rural	0.51	0.54	1.05	0.74	0.70	1.44
Urban	0.15	0.10	0.25	0.25	0.25	0.50
Speech Disability						
Rural	0.70	0.05	0.75	0.10	0.06	0.16
Urban	0.02	0.01	0.03	0.04	0.02	0.06
Locomotors Disability						
Rural	0.67	0.44	1.11	0.80	0.58	1.38
Urban	0.15	0.13	0.28	0.25	0.22	0.47

(Source: NSS, 36th Round)

Advancement of medical science has lowered the mortality rate. In other words, longevity is extended behind the rising proportion of the aged. From 34 per cent in 1950,the proportion of children below 15 declined to 30 per cent in 2000 and is projected to fall to 21 per cent by 2020. Around this time the proportion of the elderly population will equal the population of below 15 years. The dependency ratio (the number of over 65 dependent on every person in the 15-64 age group) would zoom to 23; it had risen from eight in 1950 to 10 in 2000. This indicates that every parent would be left with fewer children to take care of them during old age. With the cost of parent care rising per child, and in the face of continuing financial crisis, most children, even if they are willing, do not have adequate resources to take care of their elderly parents. Where resources are not scarce, other problems like psychological ones emerge. Caught in the inescapable web of unemployment and job insecurity,

the youth are forced to seek brighter and greener pastures on foreign soil. Such migration further affects the aged as they remain in their native soil uncared, unloved and even unnoticed. Housing problems leading to the dwindling living space makes it difficult, if not impossible, for the allotment of sufficient space for the elders to breathe in, leave alone privacy. The elderly are the first casualty of the break up of the joint family system. According to NSS 42nd round, there were 654 widows and 238 widowers per 1000 old persons in rural areas and 687 and 200 respectively in urban areas. More than 65 per cent of Indian women and 29 per cent of old men lead a single life in old age. There is nobody to look after them and financial constraints and lack of security worsen their plight.

Socializing is poor in old age. Every third aged person visits nobody, while every fifth aged person is visited by nobody. In the first half of the 21st century, the major socio economic problems is going to be the maintenance of health and nutrition of the elderly through social security, social assistance and other social support mechanisms. It is a pity that a comprehensive social security systems is not functioning in our country as it does in western countries.

1.17.3 FINANCIAL PROBLEMS

Lack of support to rely upon, clubbed with pressing financial stress, leave the aged in rural areas with no alternative than earning their bread by the sweat of their brow even in the advanced age. Compared to the urbanites the rural people are less employed in regular wages and salaried sectors. Hence they do not enjoy the retirement benefits that the urbanites are entitled to. This is yet another reason for their continuing to work till they are physically and mentally capable of doing so. Once again it is men that work, thus while women, either because of lack of opportunity or of personal inability, do not engage themselves in such works (Gulati, Rajan and Ramalingam 1997).

The financial crisis, as the inevitable consequence of less or lack of guaranteed monthly income, is so acute that the aged find it difficult to meet

with the essential expenses of medical treatment as a result of which they suffer in silence. Added to this physical ailment is the mental ill-health caused due to the humiliating and contemptuous treatment meted out to them by those who are expected to extend respect, love and care at the most needed hour.

1.17.4 PSYCHOLOGICAL PROBLEMS

As already pointed out, the hurt and humiliation caused by the loved ones has its own repercussions. It results first into social isolation which enters into a vicious cycle of social isolation leading to total neglect of people. Secondly, natural and unavoidable changes like wrinkles in the skin, gray hair and poor hygiene make them alienated into isolation. Thirdly cortical changes in the brain resulting in confusion, dementia and the like put them into behavioural isolation. Fourthly, social changes like urban crime and separation from grown up children result in mental isolation too. In fine, all these bio-psychological changes sow the seeds of poor socialization resulting in diminished self-esteem with passivity, self-disgust, self-pity, sense of guilt and anger. These are the very obstacles of human development that ultimately affect their mind-set towards self actualization. Advancement in age increases the number of ailments afflicting the people and aggravate their agony. Primary dementia, and the physical problems of strokes, heart disease and other illnesses which affect reasoning, mood and psychological health, prey upon these weak victims.

Some of the psychological problems of the elderly include depression, isolation and anxiety disorders, together with an increased risk of suicide. Loss of ability, loss of spouse, loss of sense of purpose and declining competency are the contributing factors. For many elders, there has never been a focus on feelings or emotional difficulty. Lack of ability to explicitly or coherently express their inner feelings deprives them of any necessary assistance. Their inability to identify the very problem adds to the cup of their woes.

1.17.5 GERIATRIC DEPRESSION

Geriatric depression is one of the major problems suffered by the elderly. Tension or stress that saps away the already weak old people is the ultimate result of the suppressed emotion over the loss of their loved ones, particularly the life partner and lack of resources to treat the persisting health problems eventually leading to depression. 'Depression' ruins the lives of the old people and kills a few either through suicide or possibly through 'turning the faces to the wall' (Pitt, 1980)

Many elderly come across significant life changes and stressors that make the risk of depression higher and deeper. Those with a personal or family history of depression, failing health, substance abuse problems or inadequate social support, are very close to such risk.

1.17.6 Cause and risk factors that contribute to depression in the elderly include

- 5.6.1 **Loneliness and isolation** – living alone, a dwindling social circle due to death or privileges.
- 5.6.2 **Reduced sense of purpose** – feeling of purposelessness or less identity due to retirement or physical limitation on activities.
- 5.6.3 **Health problems** – illness and disability; chronic or severe pain; cognitive declines; damage to external appearance due to surgery or disease.
- 5.6.4 **Recent bereavement** – the death of friends, family members and pets; the loss of a spouse or partner
- 5.6.5 **Fears** – fear of death or dying ; anxiety over financial problems or health issues

The elderly under the protective care of their own family are certainly free from the risk of depression while those living all alone or those institutionalized fall an easy prey to depression, which like a canker in the rose eats away their life in the long run.

1.18 FACTORS CONTRIBUTING TO THE LIFE SATISFACTION IN THE ELDERLY

Factors that influence life satisfaction include environmental characteristics, such as the availability of social support; personal traits, such as self esteem, physical health, financial resources, a sense of connectedness and focus of control. Studies indicate a positive relationship between social support and life satisfaction. Aquino et al. found that demographic variables such as financial year status, educational level and work patterns affect life satisfaction in the aged. Elders who were working or volunteering tend to show higher life satisfaction than those who were idle due to various factors. Lack or less education and socio economic levels, deteriorating health and negligible social support result in low life satisfaction on the aged. Those with physical difficulties also perceive their social support to be poor which might have affected their level of satisfaction. Indeed, (Kahana et al. 1995), it was found that short term problems such as those caused by financial difficulties and changes in relationship through retirement from service or death may have a significant impact on life satisfaction. Low levels of personal autonomy and high level of dependency tend to be more negatively affected by poor health and show a need for social support in the form of lose in more autonomous and independent individuals.

1.19 FACTORS AFFECTING LIFE – SATISFACTION

Ageing naturally ushers in many physiological changes, physical functional decline, specific health problems, psychological and social changes. The chronic illness that rings the knell of physical and mental ability of an individual attacks the elders more easily and more often. The psychological changes in the elderly is the outcome of many types of deprivation, such as the loss of a beloved person by separation or death and loss of social and economic status. These changes adversely affect the mentality of the elderly, as they are aggrieved over the fear of loss of power and self esteem. Social

and economic changes too play a vital role in creating and perpetuating problems to the aged. The changes in cultural tradition towards westernization could affect the elderly with changes in social conditions, abandonment, lack or total loss of respect and a feeling of lower self worth. The eventuality of such physical, psychological, social and economic changes is the mental instability in the elderly. The loneliness of self ultimately intensifies their feeling of depression and fear of loss of self esteem. Self esteem is an important factor in individuals for coping with problems in daily life and for sustaining appropriate behaviour that would be a guide to their worldly life and community. The unfailing sense of high self esteem in the elders is the passport to good health and peace of mind. But the elderly with low self esteem, often suffer from inferiority complex, anxiety, worry, isolation and are anxious about declining or failing health which eventually leads to depression. Therefore, self esteem is a very important factor that ensures the well being of the elderly and decides the level of life satisfaction. Coppersmith states that two factors influencing the development of self-esteem, are the personal factors such as gender, age, marital status, educational level, occupation, monthly income, personality and activities of daily living; environmental factors, such as family activity participation, social activity participation and social support.

1.20 RELIGION AND ELDERS

Religiousness among elders is high, especially in a country like India where religion is the invisible but unbreakable thread of Indian culture. The practice of daily worship, offering prayers in the places of worship is the second nature of a vast majority of Indians irrespective of region, religion, caste, language, sex and age. For elders, religion is an important means of not only salvation in the hereafter but also coping with the demands of worldly life at an advanced age. With advancing years, active participation in religious activities begins to decline, and hence the elderly continue to practice religion in a more informal manner (Mindel & Vaughan, 1978).

1.21 SPECIFIC PROBLEMS OF AGED WOMEN

Aged women are called wet leaves in Japan, 'Kankeri' (second childhood) in China and 'Shastiathpurthi' in Sanskrit (Gowry, 2003). In India older women are seldom part of the development agenda. Their contributions are slighted and discussions of their situations are usually after thoughts. Their work is not considered economically productive and their contribution is not quantified or valued (Karkal, 2000). In Indian culture women were not allowed freedom or equality with men, (*Manusmrithi–Pitharakshathi Kaumare, Bharatharakshathi Yauvane: Rekhshanthi Sthavireputhra, Na Sthree Swathanthriyamarhathe'*). Female security largely depends on the willingness or readiness of male members of the family fathers, husbands or sons-whereas male security depends on the ownership and control of family property.

According to the 2001 census, 33.1 per cent of the elderly in India live without their spouses. The widowers among older men form 14.9 per cent as against 50.1 per cent of their female counterpart. Among the oldest-old (80 years and above) 71.1 per cent of women were widows while widowers formed only 28.9 per cent . (census, 2001).

According to the National Sample Survey data 58 per cent of females 45 per cent of males in rural areas are fully dependent, whereas in urban areas, the ratio was 64 and 46 per cent respectively. The most vulnerable group consists of elderly females in urban areas, 64 per cent of them being dependent on others for food, clothing and health care. Among the elderly, the widows constitute a vulnerable group health wise. The experience of single life on loss of life partner varies from men to women due to the structural disadvantages associated with gender and marital status. This results in a much greater risk factor for the aged women as compared to men. Recent Indian Council of Medical Research (ICMR) studies conducted in Chennai, Lucknow, Delhi and Mumbai have revealed that out of the surveyed older population, 52 per cent did not have any source of income. The studies show that it is the women that suffer more and in greater numbers as they live longer than men. Widows formed a large number of the elderly, particularly among Indian women who

were married to men 10-15 years older than they were and who therefore, have to endure longer periods of widowhood. Their conditions are worse as they, more often than not, cannot fend for themselves after the death of their husbands. Studies also show that they are abused severely–verbally, psychologically and physically. (National Sample Survey, 46th Round).

As women live longer than men, the problem of the elderly is more particularly the problem of the elderly women. Elderly women, widows or spinsters, have always been among the poorest and most disadvantaged in a society. In developed countries they are considered a burden because of dwindling financial support and growing expenses on health care. Analysis of the National Sample Survey shows that a striking gender differential exists in the ownership of property and assets and in the participation of their management. In India's aged women suffer more from deprivation of ownership of property and financial assets and participation in their management compared to aged men in both urban and rural areas. Individual property right is certainly an important aspect of social security for aged people as it increasingly generates resources and hence ownership of property and assets could ensure the security of aged, particularly of women.

In most of the developed and developing countries women's biological, psychological and social development across their life span is compromised by cultural, political and economic factors. The remarkable thing about older women in our culture is that they are able to survive against all odds against them. Long and bitter experiences of discrimination, deprivation and neglect reflect in their later years. There is no rest or retirement for elderly women, particularly in India until death or dementia or disability, which proves but a blessing in disguise comes to their recent. Poverty, malnutrition, poor health care and depression are the major problems affecting the elderly women. In Indian culture, women do not enjoy freedom from or equality with men. Female security always rests with the men folk in the family, fathers, husbands or sons, whereas male security is ensured by the ownership and control of family property. Various factors such as food sharing practices,

eating the left overs, poor medical facilities, poor sanitation as well as low levels of education may be responsible for poorer nutritional and health status of the elderly women of the lower income group. Added to this, incidence of widowhood is much higher among the female aged than among the males. This is a global phenomenon India is no exception. In 1991 in our country, the economic security, social fulfillment and personal dignity was not well assured as in western countries due to economic imbalance. The position of the elderly woman in the family depends upon her economic position, support systems available, marital and health status. "The great longevity of women would mean that there would be more widows than widowers, the more so as grooms were usually older than their brides. In addition there was a higher remarriage rate among widowers than among widows".

1.22 VANISHING JOINT FAMILY SYSTEMS

Family has so far been the most effective protector of old age in India. India is a country as the family itself was acting as the unfailing means of old age there was no recessing for the raise of institution to extend support to the aged. with a fine, rich and long tradition of respecting, loving and caring for the aged. The extended families for several generations under the same were the basic unit of protection and livelihood in traditional agricultural society in ancient India. As a result of unprecedented economic development and westernization, the healthy system of joint families slowly began to collapse and there came into being nuclear families. The change from love -oriented to money-oriented outlook has adversely affected the security offered by the family. This type of transformation has further deepened the difficulties of supporting and taking care of the aged. Though the aged and the dependent are taken care of by family members even now, there is a change in the emotional climate of the family. This affects the emotional and psychological security they need. (Devanandan and Thomas, 1996).

1.23 OLD AGE HOMES

The changing social scenario sows the seeds of conflict and problems in adjustment. Substitution of joint families by nuclear families has aggravated the problem and as a result, maladjustment with and withdrawal of support for the aged have become a normal and regular feature of the Indian families. Many of the elderly parents are abandoned by their children and forced to stay in old age homes. The phenomenal growth of old age homes, which were once a rarity, is a sure indicator of the ever widening and unbridgeable gap between the generations. It is a social expectation in India that the adult sons will take care of their aged parents and the daughters take charge of the parents in case the parents do not have sons (Vatuk 1980;1981; 1990). In case the sons stay separately from each other, the parents have to be under the care of one of the sons (Vatuk 1981). It is sometimes asserted that the absence of any such care will cause adjustment problems, loneliness and depression in the milieu of old age homes as the elderly persons are habituated to staying with their family members. The residents of the old age homes would find it difficult to adapt to the setting of the old age homes, where the warmth and security of the family environment is totally absent. There are some studies, which have indicated this factor of loneliness and depression felt by the residents of old age homes. Research studies (Mishra 1993; Bagga 1997: Dandekar 1996: Nalini 1997; Chadha and Kanwar 1998; Rajan et al 1999) have looked into the structure of old age homes, life of the inmates, their level of satisfaction or dissatisfaction, loneliness, depression and family linkage of the inmates.

1.24 EMERGENCE OF OLD AGE HOMES

On the whole, in India the position and the status of the elderly and the care and protection they traditionally enjoyed have been undermined by several factors – urbanization, migration, break up of the joint family system, growing individualism, change in the role of women from being full time home makers to bread winners, and increased dependency status of the elderly. There is also a generation gap in terms of education, aspirations and values and the

budgetary allocation of resources to different members of the family. Often the family is unable or unwilling to meet the financial, social, psychological, medical and welfare needs of the elderly and seeks help from supporting services.

Pursuance of education or the hunt for employment by the junior members of the family at times, adversely affect their household duties and responsibility and they are not in a position to take care of their elders. An old person's personality, personal relationship and reproductive success are other important factors in the kind of care they receive, with the childless and the sonless, especially women at a definite disadvantage, (P.Krishnan & K.Mahadevan 1992).

1.24.1 Many factors have contributed for the growing number of old age homes:

- Migration of young couples from the rural areas to cities in search of better employment opportunities to fend for themselces.
- Elders who have been in control of the household for a long time are unwilling or reluctant to hand over the responsibility to their children. Youngsters on their part are resentful of this attitude of their parents.
- Many youngsters have moved to places far away from their native homes and in the recent past to many countries abroad. So even if they want to, they cannot extend the love and care to their parents in their own homes.
- Elders are sometimes too incapacitated or unwell to look after themselves or get medical care especially in an emergency.

All these have made the old age homes seem more relevant in the Indian context than ever before. There are two types of old age homes in India. One is the "Free" type which cares for the destitute old people who have no one else to care for them. They are given shelter, food, clothing and medical care completely free of cost. The second type is the "Paid" home where care is provided on a fee. Now a days, such "Retirement" homes are growing very

popular in India and they render worthy service to those who can afford to pay. Old age homes are meant for senior citizens who are deprived of the shelter in their families or in other words destitutes. States in India such as Delhi, Kerala, Maharashhtra and West Bengal have developed good quality old age homes. These old age homes offer special medical facilities for senior citizens such as mobile health care systems, ambulances, nurses and provision of well balanced meals.

There are more than a thousand old age homes in India, most of which offer free accommodation, while some homes function on a payment basis depending on the type and quality of service offered. Apart from food, shelter and medical amenities, old age homes also conduct yoga classes to senior citizens. Old age homes are facilitated with telephones and other forms of communication so as to enable residents to keep in touch with their loved ones. Some old age homes have day care centers for taking care of senior citizens during the stay.

1.24.2 RISE OF OLD AGE HOMES

Vicissitudes of life are the factors behind the origin and perpetuation of the misery of elders. With none to depend on, no means of income and no emotional security they become destitutes with a question as to how to lead their remaining life. The growing intolerance among youth, coupled with their inability to adjust with the elderly is one of the prime reasons for the rise in the number of old age homes in India. The fading joint family system in India and other innumerable factors have given rise to west inspired phenomena of old age homes. The shocking cost of living and scanty return on savings have almost pushed these senior citizens on road. For older people who have nowhere to go and no one to support, old age homes provide a safe haven. These homes create a family like atmosphere for the residents. Senior citizens experience a sense of security and friendship when they share their joys and sorrows with one another.

1.25 ADJUSTMENT IN OLD AGE

There are certain problems that are unique to old age as given below:

- Physical helplessness
- Economic insecurity
- Shifting to living conditions favoring economic status.

Owing to this certain adjustmental problems develop in old age. The following are some of the factors which influence adjustment to old age.

1) Preparation for old age
2) Earlier experiences
3) Satisfaction of needs
4) Retention of old friends
5) Grownup children
6) Social attitudes
7) Personal attitudes
8) Method of adjustment
9) Health conditions
10) Living conditions
11) Economic conditions

Sooner or later most old people have to adjust to the death of spouse. This is far more likely to be a problem for women than men. The death of a spouse is not an isolated problem for it is always accompanied by partial or complete closure of financial resources, disrespect and rejection by family members and society and other hazards of living a solitary life. Hence it is implied that the widow has to quickly get to the new and strange environment.

The unfavorable social attitudes towards the elderly are reflected in the way the society treats them; it is not surprising that many elderly people develop unfavorable self concepts. These tend to be expressed in maladjustive behaviour of different degrees of severity.

Many elders have adjustment problems in the old age homes. Adjustment in old age homes depends on the following factors:

- voluntary option
- Contentment and happiness in direct proportion to their readiness or willingness to quick adjustability
- Proximity to their early living place
- Lingering feeling of oneness with the family

1.26 PROBLEMS OF INSTITUTIONAL CARE OF THE AGED

A study reveals that majority of the respondents from India (77%) preferred to stay in their own homes, whereas in Japan only 27% of the respondents preferred to stay in their own homes. It is also found that 51% of the respondents from Japan preferred to spend their old age in nursing homes or care houses, whereas no respondent from India preferred this option. In general, inmates feel dissatisfied at residing in old age homes as they develop a sense of segregation from the family and wider community. All of them nurture a desire to go back to their families to spend the rest of their life with their near and dear ones. Similarly in her study of all female old age homes reveal that younger entrants to the old age homes feel more depressed than their senior counterparts. Denial of opportunity to work or even prepare their food themselves gives them an uneasy feeling of being treated like mere guests which in turn aggravates their pain and intensifies the feelings of loneliness, depression and frustration, (Bagga, 1997).

Institutionalized aged feel more lonely and depressed as they lack social network support and do not feel " the level of kinship" felt by non-institutionalized aged. (Chadah and Kanwar, 1998).

At present managing the problems of the aged is not upto the expected or required standard. Lack of planning and inefficient execution makes it unsatisfactory and inadequate as of common humanity demands the formulation of some program of care that permits the elderly to maintain dignity, self respect and a sense of worth as well as providing physical needs. This can be accomplished by state institutions designed to prove a program of activities and care suited to the needs and abilities of an aged resident

population. In the long run, the total cost of such care will never exceed the present wasteful and haphazard types of custodial management. In addition, it will permit this larger group to spend their last phase of life in a setting that ensures a sense of personal dignity and offers encouragement for the proper and perfect utilization of their interest and skills.

1.27 Government support for the Aged

Article 41 of the Directive Principles of State Policy in the Indian Constitution specifies that the State shall, within the limits of economic capacity, provide for assistance to the elderly. The National Policy on older persons, announced by the Government of India (Government of India, 1999) mandates State support for the elderly with regard to health care, shelter and welfare. Social security has been made the concurrent responsibility of the central and state governments. The policy recognizes that older persons could render useful services to the family and to the society. Section 125 of the Criminal Procedure Code, 1973, specifies the rights of parents without any means for maintenance to be supported by their children having sufficient means. If any person refuses or neglects to maintain his parents a magistrate may order such a person to make a monthly allowance for the maintenance of his/her mother or father at a monthly rate not exceeding Rs.500 (Natarajan, 2000). Government pension schemes have become the most sought after income security schemes. The policy seeks to ensure the immediate and prompt settlement of pension, provident fund, gratuity and other retirement benefits. It is also proposed to setup a welfare fund for the old age persons. Regarding health care for the elderly, the goal of the policy is to provide good and affordable health services. In this process it envisages to have the cooperative and coordinating efforts of the public health services and of the private health services and of the private medical care. Development of health insurance is also being given high priority. Mobile health services, special camps and ambulance services are thought of for easy reachability and accessibility of the health care facilities to the elderly. For solving the problem of providing

housing for the elderly group, housing is proposed which will have common service for meals, laundry common room and rest rooms. They should have easy access to community services, medicare, parks, recreation and cultural centers. The Government proposes to encourage construction and maintenance of old age homes. However, family is recognized as the main provider of old age support not only in the area of housing which is merely physical but also in other areas, which are psychological and hence crucial to old age persons. The policy also proposes to develop educational and informative material relevant to the loves of older people such as the creative use of leisure, appreciation of art, culture and social heritage, skills in community work and welfare activities. Further it will provide information about the process of aging and the changing roles, responsibilities and relationship at different stages of the life cycle.

The Government of India honours the senior citizens by giving fare concessions to sum modes of travels, concessions in entrance fees, preference in reservation of seats, priority in telephone and gas connections. The Government declared the year 2000 as the National year for the old age people. It was also proposed to have a National Older Person's Day every year. The National policy recognizes the need for making use of the huge untapped resource of the old age population by providing training appropriate to the person's experience and capabilities. However, the individuals are absolutely free to make their own decisions regarding the continuance of work or peaceful retirement. The policy seeks the cooperation and active involvement of media for creating and spreading a better understanding of the aging process and also enlightens the authorities on the issues and the areas for action, connected with the aged.

In order to implement the National Policy on Older Persons, the National Council for Older Persons (NCOP) was constituted in May 1999 by the Ministry of Social Justice and Empowerment, Government of India with the Minister for Social Justice and Empowerment as the Chairperson, and the Secretary of that Ministry as the Vice chairperson.

1.28 Non Governmental efforts provide care for the aged

The government instead of resolving the problems of the elderly by itself, is introducing the schemes to assist voluntary organizations to help senior citizens. These organizations are provided financial assistance-grant upto 90 percent of the project expenditure – to set up day-care centers, old-age homes and mobile medical units for the elderly.

Increase in the number of appropriate policies and lack of resources to execute those policies make it difficult, if not impossible, for the Government to extend the necessary and timely assistance to the aged. It is here that the private sector consisting of the voluntary agencies play an important role in this regard in bridging the gap of services available. The Non-Governmental Organizations (NGO) sector constitutes a very important institutional mechanism to provide user friendly, affordable services to take care of the elderly. However, this sector in India is playing only a minor role catering to a rather small segment of the old age population, which is capable of paying for the service rendered. NGOs run Old Age Homes and Day Care Centers where old age persons are admitted on a specified fee per month.

The paying guest type of homes ignites the other financially weak elderly to look up to places where services are provided at a much cheaper cost. But cheaper cost or free service in homes is synonymous with lack of facilities, ill– treatment, humiliation which the elderly have to bear without a murmur. Such is the case of the institutional care in Indian settings.

As aging itself opens up the portals of innumerable and inescapable problems, men and women undergo more hazardous experiences. The institutionalized find themselves caged in an odd atmosphere as a lot of adjustment and other adaptive issues await them there. The factors that would ensure life satisfaction are an important factor to note under these circumstances.

In this chapter, the researcher has discussed in detail the present scenario of the aged, theories of aging, problems of the aged in various dimensions, factors contributing for life satisfaction of the elderly, institutional care of the

aged, the efforts of the government and non-government in providing services to the aged and the like. In the following chapter, the researcher intends to present various literature related to problems of aged women under institutional care and the factors influencing the life satisfaction among the aged women with the singular aim of pinpointing the gap in the knowledge such as the causes, consequences and remedial measure of the factors influencing Life-Satisfaction among institutionalized aged women.

Chapter – II

Review of Literature

CHAPTER - II
REVIEW OF LITERATURE

2.1 INTRODUCTION

Review of literature is an in–depth analysis of relevant material published in the past. The function of such a review is two–fold. By shedding sufficient light on the problems related to the subject, it enlightens the researcher with a clear idea on the subject on hand and also steers the researcher in the proper direction by enabling her to formulate the research hypothesis and methodology. Thus, it becomes an important and integral component of the research process. A systematic analysis of the related material pertaining to the research problems journals, books, reports etc., is properly documented in this chapter, which helps the researcher to find out the gap in the knowledge. Based on the analysis of the available literature and the gap in the knowledge, the researcher framed research questions for her study, which is also documented in this chapter after each head.

2.2 THE STUDIES RELATED TO THE PROBLEMS OF OLD AGE ARE CLASSIFIED INTO THE FOLLOWING HEADS

a. Problems due to physical health.
b. Problems due to psychological stress.
c. Problems due to economic depravity.
d. Problems related to life–satisfaction.
e. Problems of maladjustment.
f. Problems of socialization.
g. Religious attitude
h. Reasons for institutionalization
i. Problems of the elders due to institutionalization.

2.3 PROBLEMS DUE TO FAILING PHYSICAL HEALTH

Most of the studies pay importance to the failing physical health of the senior citizens of which a few are taken up for discussion here. Environmental and social factors play a vital role in influencing the health of a person. It is but natural that growth of age has an adverse effect on human body and health. The type of food, addiction to toxic items like tobacco, alcohol, drugs and the nature of work or business are some of the major factors that have a say upon the health of a human being. Joshi's study (1997) concludes that the aged fall an easy prey to infections such as parasitic diseases, diseases of respiratory systems, arthritis, rheumatoid, hypertension, cognition impairment, heart ailment and diabetes mellitus. Misra in his study (1992) points out that the highest percentage (82 per cent) of the senior citizens are affected by visual problems while 78.8 per cent are the victims of psychomotor problems. The other problems that attack old age are bone–joint problems (78 per cent), memory problems (5 per cent) and sleeplessness or somnambulism (58 per cent)

Poverty is the chief cause that influences the health of the person, particularly the aged. Economic backwardness of the family naturally deprives the members of the family, the chances to have sufficient food for survival.

A survey of 327 aged persons over 50 years of age belonging to 219 families from three villages in Lucknow District (Uttar Pradesh) with respect to family organization, occupation, mental and socio–economic states, diseases and attitude towards life shows that 66.9 per cent of the cases were hailing from poor to very poor economic background; 52.2 per cent were still respected as the head of the family; 88 per cent were suffering from various diseases such as blindness, deafness, paralysis of lower limbs and 31.1 per cent were found to be depressed because of death of or separation from spouse or children, crop failures and unpaid debt. (Ravi and Prasad, 1971)

A striking feature pointed out by the researchers is that elderly women are more prone to physical ailment rather than males the and the duration of

illness is also longer. (Illango P.R. and Padma D. Sheela, 1996). They attributed the reason as to that the octogenarians do not take extra care to keep themselves fit and healthy unlike men of the same age group who regularly practice physical exercises more intensively. It is interesting to note that it is a global phenomenon. The study also shows that in three Nordic countries (Finland, Sweden, Denmark) men enjoyed a better health condition than women because they regularly practice physical exercise like walking and jogging.

Most of the aged grow nervous easily because of their limitations, insecurity, dependence and fear of death. They suffer from cardiac problems, breathlessness, fatigue, aches and pains, shivering, sleeplessness. Sometimes they develop illness like polio and hypochondriasis (Chandra Shekar C.R., 1997).

In elderly persons, physical illness is swiftly followed by psychological tension or stress. In other words they are complementary and it is difficult to determine which disorder is dominant. In a more recent study it is established that functional bowel disorder including constipation, fecal impaction and fecal incontinence are common gastrointestinal diseases among the aged. (Lillo R.Anthony and Rose Suzanne 2000).

An extensive and exhaustive study on the health of the older women with a sample of 100 Maharashtrian Brahmin Women of Pune, reveals the fact that 51 percents suffered from cardiovascular problems and an equal number from diabetes; 50 percent from arthritis, 55 per centt from gastric disorders and 44 per cent from urinary incontinence and 66 per cent from hearing problems. In India, the old, especially the women tend to philosophize even the deteriorating health as an inevitable consequence of their age and ignore even treatable and curable illness. (Bagga and Sakurakar, 2000).

The age related decline in the cardiovascular system is considered to be the major determinant of decreased tolerance for exercise and loss of conditioning and the overall decline in energy reserve. This results in diminished blood flow to the brain, kidneys, liver and muscles. Above all, the

rate of heart beat is also lessened. (Murry and Zentner, 2001; Sadock, 2003). The decreased level of thyroid hormones in endocrine system causes a lowered basal metabolic rate. Impairments in glucose tolerance are evident in ageing individuals (Pietraniec – Shannan, 2003). The ripening age increases the risk of autoimmune disorders (Beers & Jones, 2004). Some of the age related changes within the nervous system may be due to alternation in neurotransmitter release, catabolism or receptor functions (ibid).

Cessation of growth marks the beginning of ageing. Hence some of the researchers focus on age–related changes that occur at different rates for different individuals. The ageing process naturally ushers in normal biological changes. Fat redistribution results in a loss of the sub– coetaneous cushion of adipose tissue. Old people lose "insulation" and are more sensitive to extremes of ambient temperature than the younger people. (Stanley, Blair & Beare, 2005)

It is the physical abuses that torment the elders more than physical illness. But many are reluctant to make a free and frank complaint about personal abuse. They either minimize the abuse or hide it totally. Despite their unwillingness to disclose information either because of fear of retaliation or embarrassment, the signs of physical abuses like striking, hitting, beating, bruising, cutting are found on them which clearly brings to the fore the irrefundable and undeniable truth about the existence of such abuse. (Sadock & Sadock, 2003 and Murray & Zentner, 2001). Some more indicators of physical abuse may include bruises, lacerations, burns, punctures, evidence of hair pulling and skeletal dislocations and fractures (Murray & Zentner, 2001; Stanley, Blair & Beare, 2005).

The review of the above literature on the aspect of physical health of aged people indicates the different health problems and major diseases the aged people are subjected to. There are limited studies to elucidate the physical health status of the older women. Further, there is hardly any study to understand the physical health condition of the aged people under institutional care. Hence, the researcher in her study brought the forth research question on

the aspect of 'physical health' and restricted her study with women under institutional care.

- What is the nature of physical illness and the intensity of illness faced by the aged women in institutional care?

2.4 PROBLEMS DUE TO FAILING PSYCHOLOGICAL HEALTH

So far, the researcher has discussed somatic complaints. A few studies prove that somatic complaints lead to psychotic complaints, symptoms including apathy, anorexia, insomnia, decreased energy and lipids, and somatic complaints are all manifestations of depression. Depressive symptoms can accompany endocrine disorders, lung infection, brain tumors and Parkinson's disease etc. (Salynmen and Shader, 1979).

Yet another study shows that old age poses a number of problems. Important among them are the problems which are purely social and psychiatric in nature such as mania, depression, senility, psychosis and senile dementia. (Gupta, 1968).

A study concludes that there is a short–term prevalence rate of 2 to 3 per cent suffering from severe depression and up to 3 per cent to 4 per cent mild depression. Regardless of its exact prevalence, depression is a serious mental health problem in the elderly males (75 per cent). (Gurland, 1976). A study conducted near Chennai recorded the prevalence of mental disorder in those aged 60 and above. (Ramachandran and Menon Sarada, 1980)

Loneliness is yet another major psychological problem. In a study, two samples of patients aged over 70 years were selected. One sample was from a large Urban General Practice. Patients were interviewed in order to assess their mental, physical and social well–being. Included in the interview were questions on subjective feelings of loneliness. The interview brought to the limelight two important facts. One is the inseparable association between the feelings of loneliness and disability. The second and more significant fact is that the fearful feeling of loneliness is found deeper in women than men; and

even among women the worst affected are the new widows. (Dee. A. Jones, Christina R. Victor, and Vetter J. Norman, 1985)

Not only depression, but also other psychological disturbances such as feelings of loneliness, fear of loss of general ability - either fake or real, feelings of insecurity due to dependence on others play a havoc in the life of elders in general and that of institutionalized elders in particular. Though depression is common among both institutionalized and non–institutionalized elders, the degree is higher in the former. (Godkari, 1989)

It is estimated that 50 – 70 per cent of the elders under institutional care have behavioral, emotional and mental disorders. (Trimbath of Brestensky, 1990). In the opinion of a few researchers, the depression or distorted cognition in the elders affect the life–satisfaction. The authors compared the level of life–satisfaction in 100 depressed and 100 non–depressed elders. The results revealed that the life satisfaction scores of depressed aged were significantly less than that of non–depressed group. Distorted cognitions and activities were significantly correlated to life–satisfaction. The overall study indicated that positive thinking and higher level of activities leads to positive mental health. (Bhadwaj, Sen and Mathur, 1991).

Most of the elderly persons do feel that even their children do not look upon them with the degree of respect, to which they were rightfully entitled. Hence, they feel neglected and humiliated. This ultimately leads them to shun themselves from the company of others. Loneliness, in turn, may rise to depression and may eventually lead to worsening of sickness. (Chowdry, 1992).

A few psychiatrists investigated the offensive disorder particularly depression and organic psychiatric syndrome and found that they constitute the bulk of total mental morbidity in the elders. (Venkoba Rao, 1993). There are some studies, which have highlighted the factors of loneliness and depression felt by the residents of old age homes. These studies have looked at the structure of old age homes, life of the inmates, their level of satisfaction or dissatisfaction, loneliness, depression and family linkage of the inmates.

(Mishra, 1993; Bagga, 1997; Dandekar, 1996; Nalini, 1997; Chadha and Kanwar, 1998; Rajan et al. 1999). Depression is a universal disorder which preys upon most of the elders. Especially the depression level of institutionalized elders is reported high. (Meera, 1997).

In order to find out the condition of the non–institutional elderly people, a comparative study on institutional and non–institutional elderly people was carried out. The problems of insecurity, hopelessness and depression among elders investigated. The inventory was administered to 60 elders and the findings show that a majority of the elders suffer from depression, loss of hope, insecurity, either moderate or high in both the institutionalised and non–institutionalised people (Meera, 1997).

Yet another study was conducted at the old age homes for women only and it showed that younger among the old felt more depressed than their senior counterparts. Further, the residents felt more lonely and depressed in old age homes, where they remained as paying guests without any work including preparation of food. (Bagga, 1997)

In West Bengal a team of psychiatrists conducted a study with the aim of assessing the mental morbidity among the elderly population in the rural community. A door to door field survey was made in two villages. The total sample comprised of 183 persons, and it was identified that sixty one percent of the population were mentally ill. Women had a higher rate of psychological morbidity than men. (Nandi, P.S., Banerjal, G., Mukherjie, S.P., Nadhi. S and Nandhi, D.N. 1997).

Another study report shows that age is an important determinant of mental disorders. High prevalence of disorder is detected in old age and the magnitude of some mental and behaviour disorder increase with age. Predominant among the disorders is depression, which is common among elderly people. Yet another study on the community samples of people over 65 years of age found the prevalence of depression among 11.22 per cent of this group. (Newman et. Al, 1998). The findings of some studies showed that there was a high association among stress level, depressive symptoms and mood

status. (Wang, J.J., Synder, M. and Kaas, M., 1998). Though shocking and bitter it is a fact that people of all ages of elders nourish a deep longing to commit suicide for different reasons.

This research study was carried out among the elderly in a long–term institutional care. The authors identify the most "at risk" group and highlight the major factors contributing to suicide in older adults in institutions. Results of the survey of over 1,000 inmates of long-term care confirmed that suicide behavior occurred in approximately 20 per cent of the survey population. (Nancy J. Osgood, Barbara A., Brant, Aaren Lipman, 2002) The psychological problems experienced by the respondents is so acute that, at times it implants in the patients a keen desire for death. Suicide is common among the people with advanced age. Persons above 65 who commit suicide comprise 12 per cent of the population (Charbonneau, 2003). The Whites outnumber others in attempting to commit suicide. Predisposing factors include loneliness, financial problems, physical illness, loss of friends and relatives, and depression (Sadock & Sadock, 2003).

It is clear that there are many studies, as shown above, to understand the psychological health of the aged people. The review of the various studies clearly portrays that depression, loneliness, stress, emotional and mental disorder, distorted cognition, dementia, sleeplessness, suicidal behaviour are the major problems that affect the psychological health of the aged people and there is a high correlation between life satisfaction and psychological health. The studies also reveal that depression is higher among the institutionalized elders and loneliness affects women very much. Thus the literature available analysed the psychological health of the aged people in relation to the variable 'institutional care' and 'sex'.

After reviewing the literature on the psychological health of aged people, the researcher brought forth the following research questions to understand the psychological health of the aged women under institutional care. In addition to enumerating the various psychological illnesses and

symptoms experienced and exhibited by the respondents, the researcher used a 'scale' to measure the 'Geriatric Depression level'.

The research questions are as follows:

- Is there any association between various socio, demographic variables and geriatric depression?
- Is there any association between geriatric depression and life-satisfaction?
- Is there any association between geriatric depression and religious attitude?
- Is there any association between geriatric depression and adjustment?
- Is there any association between geriatric depression and social behaviour?
- Is there any association between geriatric depression and self-esteem?

2.5 PROBLEMS OF ADJUSTMENT

The psychological changes eventually result in a decline in higher mental functions like intelligence, abstract thinking, and memory, decision–making, orientation and reduction in motor and sensory performance. This leads to poor comprehension, slow reaction and shrinking ability to learn new skills and to adapt to a new environment. Instead, the individuals stick to their traditional beliefs and views. They grow more and more rigid and display utter dislike and aversion to any change. The old people find in difficult to accept or adjust with the changing environment.

A study reported the relationship between psychological variables, a behavioral rating scale and the subsequent adjustment of a group of elderly people newly admitted to a home for the elderly. It shows that in the sample, three groups can be identified, a fairly independent group of people that exhibits no apparent deterioration in functioning during the first year of admission, a nondependent group that shows loss of functioning during the same period and a third group which shows an immediate negative effect from admission, and which has a poor outcome. (Pattie AH and Gilleard C.J., 1986).

Another study reported that mental health determines the adjustment level of individuals to the environment and with each other with maximum effectiveness, and happiness. (Menninger, 1945).

A study was conducted on the assumption that the problems of the aged relating to adjustment will have their relation to the five personality variables – extrovert, neuroticism, dependence, proneness, and authoritarianism. The sample was 100 elderly male respondents of Patna. The study revealed a negative correlation of these personality variables with adjustment. (Hussain and Priyadarshini, 1996). A study explained the relationship between time structure and wellbeing of retired persons with a sample of 40 males and 80 females. Respondents who had more of a sense of purpose in their use of time showed better adjustment and wellbeing. (Sinha and Singh, 1997)

One more study analysed the aged women's problems. It is found that there is a wide gap exists between the expectations of older women and their care givers. The results bring out the fact that the old women's emotional problems begin in the very household itself. Their problems do not generally attract the attention of the family members and as a result of which the gravity of their problems is not at all understood in the proper perspective. It has to be noted that the growing number of old women will have to face a triple jeopardy of being old, being female, and being poor. A majority of them live with children and the quality of their life will solely depend on the sentiments, resources and inclinations of the care givers. (Saha K.B. Shaha V., 1998)

Thus, there are few studies that show the adjustment level of the aged people. The studies reveal that there is a correlation between psychological variable, cognitive measure and the subsequent adjustment of the aged people and correlation exists between the period of stay and adjustment. The studies explain that physical and psychological health influences the orientation, intelligence, abstract thinking, comprehensive skills and to adapt oneself to the situation and the environment. The value towards life and lifestyle too influences their adjustment levels. Elderly women have more adjustment

problems than elderly men. There is no significant difference between the aged people from the rural and urban region in the areas of social adjustment.

The level of adjustment is also analysed in relation to the factors such as dependency status, emotional, social and family conditions, and personality variables.

From the above studies, the researcher has taken the relevant aspects and tested the same in her study. The researcher adopted a 'Bell Adjustment Scale' to measure the individual's adjustment on the dimensions of home, health, emotional and social. The researcher brought forth the following research questions:

- How are the elders adjusting themselves in the institution?
- Is there any association between various socio-demographic variables and adjustment?
- Is there any association between adjustment and life-satisfaction and its contribution in determining life-satisfaction?
- Is there any association between adjustment and self-esteem?
- Is there any association between adjustment and social behaviour?
- Is there any association between adjustment and religious attitude?
- Is there any association between adjustment and depression?

2.6 ECONOMIC PROBLEMS OF THE AGED

In the Indian context, besides the physical and psychological factors, economic condition is yet another major issue the aged have to contend with. Studies related to the economic condition have been numerous.

A majority of the respondents, both men and women experience financial and socio- psychological problems during old age. (Dasai and Naik (1970)

A study was conducted in a village called (Makunti, 1979), with a population of 1.630 persons of which 145 were aged. The purpose of the study was to make a preliminary assessment of the role played by financial constraints and other problems encountered by the older people of the rural

community in India. The results of the study showed that those who were above 65 years of age were generally passive members of the family and the community. The position of the aged persons in the family was to a great extent determined by their economic status. (Marulasiddiah,1980) Another study commented that successful and better adjustment in old age is associated with economic status of the individuals. The inference is that the economic status and adjustment are in direct proportion. (Mathew and Sen, 1989) Another study established the fact that the reduction in income eventually results in inevitable loss of status and meaningful social relationship. (Bhetia,1983).

A study was conducted by the Madurai School of Social Work on the Psycho Social Problems of the aged in Madurai City. 4.8 per cent of the respondents unhesitatingly expressed their willingness to work in order to up keep their economic status. (M.R. Machakallai, 1978).

Aged people invariably feel that self-support is the only right and proper means of decent and dignified survival. Consequently, aged people who cannot work and do not have enough savings to support themselves generally feel unhappy to accept help from their children. A major problem of growing old is the feeling of being rejected by the society to which they belong. A unique problem of aged women is the loss of their life – partner which forces them to face life single handedly. (Having Hurst and Albrecht 1953).

A few opined even their independent income does not rescue them from indifference and family rejection and even in joint families the old feel insecure. The belief that children will take care of their parents in old age is slowly but certainly vanishing. (Desai , 1985)).

2.7 RESEARCH QUESTIONS

A Review of the existing literature on economic problems faced by the aged as shown as above highlights contradictory views on the aspect of economic independence of the aged and their status and being respected in the family. One study shows that there is a positive correlation between economic status and respect in the family. Another study exhibits a negative correlation

between economic status and their position in the family. Studies also show that there is high correlation between economic status and adjustment; and negative correlation between economic status and psycho social problems. There is no study to elucidate the economic problems being faced by the aged under institutional care and its implications on their adjustment, life satisfaction and psychological health. Researchers evolved her research question in such a way to fill this gap.

- How does the economic condition of the respondents contribute for determining the various components of life satisfaction such as Self-Esteem, Religious- Attitude, Social-Behaviour, Geriatric-Depression and Social-Adjustment?

2.7 PROBLEMS OF SOCIALIZATION

An interesting study has been conducted comparing the experience of loneliness between residents living in nursing homes and those in the community. Though no difference could be detected in the level of the feeling of loneliness between two groups, the residents in nursing homes with frequent contacts with family and friends felt the pangs of loneliness less than those without such contacts. The residents in old age homes did not experience loneliness because of their frequent contacts with family and friends (Bondevik nad Skogstad, 1996). Another study investigated the association between social support practices and life–satisfaction among 23 men and 41 women aged between 60 to 75 years. Analysis showed that the subjects who were satisfied with interpersonal relationship and those engaged in more meaningful activities had more satisfaction than subjects without them (Hawley and Klaukave, 1988).

A majority of the retired persons are engaged in various leisure time activities, like reading newspapers, household activities, morning and evening walk, listening to radio, sitting and talking with children, especially grand children, chatting and gossiping with friends, talking with the wife, participating keertan and bhajans, inviting and entertaining friends home, or

sleeping during day time. The study shows that the individuals having better pass time activities have better social behaviour (Sharma, 1996.) Social support can be provided spontaneously through the natural helping network of family and friends or can be mobilized through professional intervention. Social support that is provided through an informal helping network is typically characterized by mutuality, reciprocity, and informality not often evident in professional-helping relationship (Wood, 1984). Social support refers to the different ways in which people render assistance to one another, emotional encouragement, advice, information, guidance, tangible aid, or concrete assistance (Bawera and Ainley, 1983, Gotheib, 1983, House and Kahn, 1985, Wood, 1984). A study proved that the number of the support relationship is not related to life–satisfaction but it is related to inter-personal effect and that the stunch support of friends and frequent contact with them are more important than the support and contact with relatives. They reiterated that the role of friendship expectancies is the key factor in both life–satisfaction and interpersonal relationship (Burgio, Maria Rose, 1987). Another study investigated the association between social support practices and life–satisfaction among 23 men and 41 women aged between 60 and 75 years. Analysis showed that the subjects were well satisfied with interpersonal relationship and those engaged in more reality activities had more satisfaction than subjects without them. (Hawley and Klaukave, 1998)

Most of the studies emphasized that older people have very similar mortality risks associated with social isolation when compared to the middle aged, although their risk of exposure may be greater. (Herkman, et.al., 1992)

A study to examine the effects of social networks and social support on the mortality of a national probability was made with a sample of 2,200 elderly Japanese and it concluded that social participation had a strong negative impact on mortality. (Sugisava, Liang and LW, 1994). A research on "Social situation of the Aged in India" attempts a comprehensive study on the elderly in India under various topics – status, health and social adjustment in old age. It concludes that there is mutual help between the elderly and their families.

Isolation and loneliness appears to be a problem prevalent in middle class and upper class families while it is almost absent in lower classes. It suggests that more social security schemes for the elderly are to be adopted and recreational activities are to be promoted. (Kohli,1996).

A very important and striking study impressed the researcher. It was an empirical research, and it showed that three types of functions occupied the center stage of social support. The first is emotional support - the availability or presence of someone to talk about personal matters and express solid comfort and concern for one's well being. The second is often called instrumental or tangible support. Here some one is available to help with tasks, provide transportation, and help with groceries, and so on. The third is informal or guidance oriented help with offering information, gettting on right path or suggesting action. Aspects of support that are important to measure availability under hypothetical conditions and sources ie, who provides support, in brief, social support contributes to the individual's feeling about themselves and the world around them (Berkman, et. al., 1992, 1999)

Review of the existing literature and studies show that there is a positive correlation between the cordial and frequent relationship with the family members and other relatives and their feeling of loneliness of the inmates under institutional care. The review also reveals that the aged having well satisfied interpersonal relationship and participating in family events have high life satisfaction. The studies also exhibited positive correlation between leisure time activities, effective time management and life-satisfaction and meaningful engagement and time management have better life-satisfaction. Further, the inmates of the institution who have good social network with other inmates and extending social support have better life satisfaction and better adjustment. Contradictory result also emerged from one of the study's, which show that there is no significant relationship that exists between the supportive relationship and the level of life satisfaction and supportive relationship from friends is highly correlated than the supportive relationship from family members and relatives.

As there is no specific study available to elucidate the problems of socialization that prevail among the women under institutional care, the researcher framed her research questions in such a way to fill this gap. The researcher used SBAS Scale to assess the level of social-behaviour of the respondents in the dimensions of 1) Institutional Activities, 2) Supportive Role, 3) Spare Time Activities and 4) Relationship.

The research questions included:

- What is the level of social behaviour in different dimensions?
- What is the linkage between various socio-demographic variables and social behaviour?
- Is there any association between social-behaviour and life- satisfaction?
- Is there any association between social-behaviour and depression?
- Is there any association between social-behaviour and adjustment?
- Is there any association between social-behaviour and religious attitude?
- Is there any association between social-behaviour and self-esteem?

2.9 RELIGIOUS ATTITUDE

A study on the problems of adjustment, life–satisfaction and religious attitude of 50 elderly people revealed that life–satisfaction and emotional characteristics are inter–related and the age of respondents has an influence on religious attitude. Further it stated that there is a significant relationship between family size and emotional problem. (Poongulahahli, 1992)

Another study indicated that the elderly people are moderately satisfied in their life and a majority of the respondents have a indifferent attitude towards religion. It has thrown light on the close relationship between life–satisfaction and religious attitude (Sivakumaran, 1992). One out of every five patients admitted in the hospital have strong religious convictions, treading on the path of the divinely with active participation in the religious chanting and activities and this has largely relieved them of physical ill–health and remained an unfailing source of mental peace. The variables that were associated with

religious coping included black race, older age, being retired, religious affinity, high level of social support, infrequent alcoholism, a prior history or psychiatric problems, and higher cognitive functioning. The reassessment of 202 men were re-evaluated during their subsequent hospital admissions approximately after 6 months, that guaranteed lower depression scores during follow–up. These findings suggested that religious coping is a common behavior that is inversely related to depression in hospitalized elderly men. (Koening HG, Cohen HJ, Blazer D.G. Piper C. Meador KG, Shelp F, Gobi V, Di Pasquale B., 1992).

A study conducted on centenarians with a sample of 36 cases from Rayalaseema showed that most of the centenarians were women and that too from rural areas. Many of them had unique psycho–social characteristics of flexibility, coping, tolerance of stress, religiosity and good social support. (Ramamurthy, Jamuna and Sudharani, 1996). An investigation was made to study "Religiosity and Mitigation of loneliness among elderly". The sample consisted of 30 Christians and 320 Hindu respondents from Karnataka. The study revealed that Christian respondents were more religious than Hindus. Unshakeable faith with strong religious commitment and involvement offered them comfort and connotation in the otherwise pointy and painful loneliness. (Jayashree, 1996)

Another study describes the level of religious well–being and selected characteristics of religiosity in a sample of 114 non–institutionalized, largely rural elderly women. The study identifies the relationship between selected factors and the level of religious well– being. Descriptive research revealed a high correlation between the level of religious well-being and the variables of social support and hope. Through stepwise multiple regressions, "hope" has emerged as the single significant predictor of religious well-being, explaining 31 per cent of the various in the dependent variable. The majority of the respondents reported that regularly participating in religious activities, highly influence their religious beliefs and identified that religious faith grew increasingly with age. Conducting a comprehensive assessment and

implementing focused interventions associated with religious well–being will strengthen the scope of health care practice for elderly women. (Zorn CR, Johnson MT., 1997)

A study was reported of the religious beliefs, attitudes, and practices of old people in the west of Scotland, based on a questionnaire given to 501 people of 65 years and above, randomly selected from those living at home. Almost all had a full range of religious instruction, and regarded their parents as religious. Weekly church attendance was more common among Catholics (70 per cent) than Protestants (40 per cent) among women than men; among those whose beliefs were those of organized religion, and among those with unrestricted mobility. The pattern of participation in Church organizations and social activities was similar. A firm belief in the 'life after' was expressed by 80 per cent of Catholics and 60 per cent of Protestants and higher proportions of the sample population derived comfort from religion, especially in bereavement. Over 70 per cent expressed no fear of their own death.
(Reid, W.S. Anne J.J. Gilmore, G.R. Andrews, 1996)

A study on "CLINICIANS' ATTITUDE TO SPIRITUALLY IN OLD AGE PSYCHOLOGY" was carried out in U.K. The registered members of the faculty of the Psychiatry of old Age in the United Kingdom were the respondents. The majority of respondents (92 per cent) recognize the importance of spiritual dimensions of care for older people with mental health needs and about 25 per cent respondents appear to consider referring patients to the chaplaincy service. (Lawrence R.M., 1998)

Hundreds of studies have documented a positive association between health or well being and religious participation. These studies examine religious experiences of economically backward women in the United States. Results underscore the deep seated religious commitent of this group. The dominant theme, mentioned time and again was gratitude. Respondents view the LORD as the perennial source of all that is good. Hence, they are determined to be grateful for all boons like life, good fortune, and help in times of hardship, and material prosperity. One third of the respondents who

mentioned regular church attendance shared that their physical ability is a factor encouraging them to go to church regularly. So, while religion promotes one's health as well being, good health does facilitate participation in church–related activities. In other words good health and religious activities, apparently seems independent are in fact inter-dependent. Elders thought the world would turn to religious organization and rely on religious beliefs to cope with both the routine challenges of daily life and the hardships brought on by severe adversity. (Barusch. A.S., 1999)

In a study on "Loneliness and Death Anxiety Among the Elderly – The Role of Family set up and Religious Belief" with a sample of 60 (30 males and 30 females) from Coimbatore District, indicated that gender difference plays no significant role in the experience of loneliness and death anxiety. Similarly there is no difference between the systems of joint family and nuclear family. But religion does play a vital role in changing the magnitude of loneliness. The religious elderly feel less lonely than the non–religious elderly. But in the experience of death–anxiety no such difference exists between the religious and the non– religious. (Asgarali and Broota, 2000)

The peculiar and unique nature of the old age home with emphasis on engagement in various activities and stress on partial disengagement from family responsibilities is instrumental in facilitating a satisfactory stay of the residents of the old age home. (Anendya Jayantha Mishra, 2004). The researcher authentically expresses his views in a different manner. His arguments establish that being away from home does in no way affect the mindset of the aged. They felt neither lonely nor depressed. On the contrary they are quite satisfied and happier with their life in the old age home and the residents do not experience either social isolation or desolation.

In the old age home, the residents are targeted through sermons about the way and means of overcoming the feeling of loneliness. The divine discourses encourage them to live alone, without craving for family and friends, and their alteration in shift to religious activities and any other work that interest them. (Misra, 2004)

There are many studies regarding the religious attitude of the aged people. The review of the existing literature on religious attitude of the aged reveals that it correlates with life satisfaction, adjustment, physical and psychological health, loneliness, happiness, social-behaviour and demographic variables such as age and religion. Some of the research findings are that Christians are more religious than Hindus and gender is not a significant with religious attitude. Studies also establish a contradictory view related to the variables religious attitude and death anxiety. There is no study to assess the religious attitude of women under institutional care and its association with social-behaviour.

On reviewing the existing studies, the researcher framed her research questions to study the field reality in the area chosen and to find the association between religious attitude and its association with social behaviour, adjustment, depression level, self-esteem, and life-satisfaction.

The researcher uses religious attitude inventory to assess the level of religious attitude of the respondents and focused on finding out answers for the following questions:

- What is the level of religious-attitude of the respondents?
- Is there any association between religious-attitude and various socio, demographic variables?
- Is there any association between religious-attitude and depression level?
- Is there any association between religious-attitude and adjustment?
- Is there any association between religious-attitude and life satisfaction?
- Is there any association between religious-attitude and social behaviour?
- Is there any association between religious-attitude and self-esteem?

2.11 LIFE – SATISFACTION

Certain research studies examined the relationship between life–satisfaction and variables such as age, health status, job status, region, home ownership, religiosity, emotional well being, social support etc. One of such studies lays emphasis on different factors such as income, health status

sociological factors and family setting that accentuate life–satisfaction of the aged. Results indicated that the lower life–satisfaction resulted primarily from the loss of income and not from the loss of worker / producer role. (Chat Field, Walter F, 1977)

Life-satisfaction is also determined yet by other factors. There is an inseparable relationship between life–satisfaction and physical health, emotional stability, balanced social support and focus of control in the frail elderly. A random sample of 99 low incomes, frail elderly living in the community was interviewed. Almost 40 per cent of the participants reported high levels of life satisfaction. Multiple regression analysis identified four significant predictors of life–satisfaction: perceived physical health, social support, emotional balance, and focus of control (Gray and Calsyn, 1989). Physical health emerged as the most significant predictor of life – satisfaction accounting for 14 per cent of the variance. Social support, emotional balance and focus of control each accounted each for an additional 6 per cent of the variance in life – satisfaction (Soleman, H. Abu Bader, Anissa Rogers, Amanda S. Barusch, 1990). A study was made about the lonely aged and aged couples in rural settings. Sixty respondents (25 lonely aged and 35 aged couples) were chosen for a life – satisfaction analysis using mean, standard deviation and 't' test. It was found that the aged couples had better mental health than the lonely aged rural subjects. (Lakshmi Narayanam T.R. and Malathi G., 1991). Research studies suggest that the social network range of institutionalized elderly is significantly smaller than the non– institutionalized elderly and the latter have a high life–satisfaction than the former (Gopal and Chandna, 1991). There is an investigation to analyze the problems of adjustment, life satisfaction, insecurity and religious attitude. The subjects were 2008 Headmasters. The findings showed that the majority of Headmasters have less adjustment problems in all areas of adjustment studies. They have less fear of insecurity and they are well satisfied in life. (Rajan D., 1991)

The aged having sailed across major life events successfully and can only be the best advocates of life–satisfaction. A study listed the significant

determinants of successful ageing as self–acceptance of aging changes, self–perception of health, perceived functional ability, perception of social support, inter–generational anxiety level, belief in Karma and after life, flexibility, range of interests, activity level, marital satisfaction, religiosity, certain value orientation and economic well–being (Ramamurthi and Jamuna, 1992). A study on "Wisdom and Life – Satisfaction in Old Age" was conducted with a sample of 120 elderly men and women. It concluded that wisdom has a profoundly positive influence on life – satisfaction independent of objective circumstances.

While one research finds that life–satisfaction does not guarantee the presence of good mental health (Vasanthy, 1989), another researcher had a totally opposite result. According to him the life – satisfaction is the indicator of Mental Health. (Khadi, 1993 and Goanlcas, 1993)

Another study also strengthened the previous one. The study found that social support was significantly related to life-satisfaction (Aquins, Russell, Cutrona, and Altmaier, 1996). Yet another factor that determined life satisfaction is age. One study revealed that the higher the age of the respondents is the Life–Satisfaction less. Age at marriage was also found to have a significant positive correlation to life–satisfaction. Those who got married at a later age after achieving at least some of their goals in life do have better life-satisfaction than those who had to forgo many of their personal wishes, because of early marriage (Suseela Mathew, 1997). Other findings were that healthy persons, who were not cognitively impaired have high life–satisfaction (Premilla K., Hiller. S, Anthony F, Jorm, Agenta Herlity, Bengt, and Winblad, 2001). It has also been noted by different researchers that different factors contribute to life–satisfaction for old people. They are: 1) Physical health and functional status 2) Self–Resources 3) Material Security 4) Social support resources and 5) Life–Activity (Dieter Fering, Christian Balducci, Varessa Burholt, Clare Wenger, F. Thissen, Germain Weher and Ingalill Hallbarg, 2004)

Women in married households and single women with children were found to be more satisfied than single women in households without children and single women living with others. (Kim J., Kim E., and Lee J., 2005)

Thus, there are many studies to understand the life-satisfaction of the aged and these studies analysed the life satisfaction with variables such as age, physical and psychological health, emotional stability, job status, social support, institutionalization vs non-institutionalisation, range of interests, marital satisfaction, religious attitude. Here too, the studies brought out contradictory views regarding life-satisfaction related to mental health. One study says that life-satisfaction does not guarantee the presence of good mental health and another study reveals that life-satisfaction is an indicator of mental health. Further, there are limited studies to analyse the life-satisfaction factor in the dimension of gender. There is no study to compare the life-satisfaction with components such as self-esteem and adjustment.

With the above review, the researcher framed her research questions to test the already established association and to study the pointed gaps in the studies.

- What is the relevance of various socio-demographic variables in determining the life-satisfaction?
- What are the significant factors attributed to Life-Satisfaction?

2.12 REASONS FOR INSTITUTIONALIZATION

Institutional care is offered to individuals in settings outside home. Thus the institution become a second home – a home away from home for the aged. Here all the needs of the individual, physical, health, psychological health, educational, spiritual, recreational are met in the institution itself. It is also known as residential care. The own home is always the best provider of care; certain individuals have to seek shelter in homes because of their handicap, like blindness, deafness, physical and mental disabilities. They cannot properly be looked after and rehabilitated in their own homes. These individuals have special needs and so require special facilities. Institutions for such individuals are equipped with trained staff, good infra structure, facilities and amenities to

keeps them comfortable as satisfied. Some even prefer to go to old age homes than to stay in the unwanted atmosphere of this home. Yet it cannot be denied that institutionalization of the aged is the new concept which is growing day by day.

In India, the position and the status of the elderly and the care and protection they traditionally enjoyed have been undermined by several factors. Urbanization, migration, breakup of the joint family system, growing individualism, change in the role of women from being full time home–maker to bread–winners, and increased dependence status of the elderly are some of them. There is also a generation gap in terms of education, aspirations and values and the allocation of resources to different members of the family. Often the family is unable to meet the financial, social, psychological, medical and welfare needs of the elderly and seeks help from supporting services.

Another study found that institutionalized females came from poor socio – economic families and often from families with serious social problems like domestic disharmony (30 per cent), marital disharmony (20 per cent), poverty (10 per cent), unwed motherhood (8 per cent), broken homes (51.1 per cent), etc. 90 per cent inmates had one or more morbid conditions. (Kale K.M., Jogdand, G.S., Aswar N.R., 1990). In some countries the perceptions of the aged differ. For example a comparative study was carried out on the attitude of the Turkish and Swedish towards institutionalization. It was found that the Swedish had a favourable attitude towards institutionalization while the Turkish rejected the idea totally. (Imamoglu and Imameglu,1992)

One study established that prolongation of the life–span and the emergence of the 'old' and 'the oldest old' have resulted in mushrooming of old age homes (Nayar, 1996). There are innumerable reasons for seeking these institutions for their stay. A study examined the sample consisting of 50 aged persons (25 males and 25 females) from Salem. The Study revealed that the most common forms of abuse which drive the aged out of their homes to the institution are neglect, denial of freedom, lack of alternation, failure to provide personnel care, health care, proper food etc., Pensioners and male elders were

subjected less to abuse (Rethi Devi, 1996). Institutional care for the old is extended mostly by non–government, private, voluntary, non–profit and particularly religious based charitable organizations. The Government played almost a negligible role in this regard till the last decade. There are too few in the country and approximately 28,000 stay in them (Help Age India, 1998). Old age homes are of two types – free and paid. In the beginning, all old age homes rendered meritorious service free of cost as they were established and run for the sake of the elderly destitute. Commercialization of a Home is a recent trend and there is a phenomenal growth of paid homes, which clearly shows that poverty is not the only reason for the spread of old age homes.

There was an important component that the elderly persons are opting to stay in old age homes to avoid conflict and domestic quarrels at home (Mishra, 1993; Nalini, 1997 and Rajan et.al., 1999). An interesting and challenging study provoked the researcher to analyze in depth, the reason for institutionalization. The study indicates that the majority of the residents are 'Overwhelmingly' happy. But the study did not investigate what makes them feel so satisfied in the old age homes. (Rajan et. al., 1999).

There has been a marked change in the treatment of the elderly compared to earlier periods. Many of the recent studies emphasize the transition in the role and status of the elderly Indian from pre–industrial society to the existing industrial social order. Their main argument is that the elderly enjoyed a much higher status in pre–industrial society marked by group oriented social interaction, agricultural mode of production, extended family system, kinship and patriarchal authority. They compare this with low position of the aged in the new industrial social order of India, affected by the process of change such as modernization, industrialization, urbanization, secularization and changes in women's position. (Souza D.,1982, Gangrade 1999, Khan 1999, Singh 1999).

There is a comparative study of social status of elders staying with their family's vis-à-vis those living in institutions. The sample consisted of 114 elders of both sexes in Madras city. The study revealed that widows

outnumbered widowers. Poor economic status is the major reason for institutionalization. A majority in the institutions were octogenarians. 74 percent of those in families preferred to remain in families. 90 percent of those in institutions preferred to remain in institutions. A greater number of elders in institutions expressed greater satisfaction with the quality of life, compared to those in families. However, those staying for longer periods expressed dissatisfaction with the monotony of institutions. 80 percent of the elders in institutions claimed that children were not supportive. This feeling was greater in males than in females. (Jebasingh, Natarajan, Muthukrishnan, and Prathiba, 1996)

A study was conducted to assess the kind of support required by the aged, living in families. The sample comprised 1,000 households from Delhi. A majority felt that their being in the family was decided by their economic independence and non–interference in family affairs. The disrespect shown in the family renders them to be psychologically upset. Old Age Homes were not preferred by the majority except by the lower class. More than half of the poor preferred old age homes. The support they needed was more towards health assistance and pre–retirement counselling. (Suba and Tyagi, 1999)

A survey was conducted (Irudhayarajan, 1999) in Kerala and Tamil Nadu covering 7 old age homes and 126 elderly. It showed that 58 percent of the inmates were females and 42 per cent males. Among the inmates, a majority were below 70 years of age (50 per cent); 33.3 per cent were in the age group of 70 – 79 and the remaining 16.7 per cent were above 80 years. 47 percent were currently married and 26 per cent never married. 27 per cent were widowed and 46 percent of inmates did not have a living son or daughter. Among those who had children, 74 per cent did not feel lonely to live away from children. This is an indication of their bitter experiences with children. 56 per cent reported that the old age home was the best suited place for the aged to live in. The other preferred arrangements were: with the son (12 per cent), with the daughter (10 per cent) and to live alone (11 per cent). 91 percent of the inmates were over whelmingly happy about their stay in old age homes. Only 4

percent of the inmates were supported by others in old age. (Irudhayarajan, 1999)

Another survey report expressed that the present value system which considers money as the 'be – all and end – all' of life regards. Old people are considered as a liability and hence they are simply abused. People's attitude towards the old is changing. They are considered as unwanted because of their thin contribution to the economic well being of their families (Lawrence, 2000). A study on well-being among the institutionalized and non-institutionalized elderly with a sample of 60 institutionalized and 60 non-institutionalized elderly revealed that the institutionalized are less depressed than the non–institutionalized. Institutionalized have better life–satisfaction. However, the findings are based on the study of only one institution. (Sharmen and Sharmen, 2000).

Another study identified that a vast majority of the respondents from India preferred to spend their old age in their own homes, whereas in Japan only 27 percentage of the respondents preferred to stay in their own homes. It was also found that 51 percentage of the respondents from Japan preferred to spend their old age in nursing homes or care houses, whereas no respondent from India preferred this option. (Rathi, Rama Chandran and Rathika R, 2001)

The existing studies enumerated various reasons for institutionalization, whether the choice is their own or the decisions of others. The researcher in her study also included this component to study whether any new reasons emerge for institutionalization, in this fast changing socio, economic world.

2.13 PROBLEMS DUE TO INSTITUTIONALISATION

A review of studies on the institutionalized elderly suggests that the institutionalized elderly people share the following characteristics namely, poor adjustment, depression and unhappiness, intellectual ineffectiveness etc., because of increased rigidity and low – energy, negative self – image, feelings of personal insignificance, a view of self as old. Residents tend to be submissive and show a low range of interests and activities and tend to live in

the past than future. They are withdrawn and unresponsive in relation to others (Tobin et.al., 1976,). A number of studies indicate that institutionalized older people share certain negative characteristics, including low morale, negative self–image, pre–occupied with the past, feelings of personal insignificance, intellectual, ineffectiveness, withdrawal, anxiety and fear of death. (Ward, 1979,)

Substantiating the above study, some more studies pointed out that the inmates of old age homes suffer from the damaging effects of "Total institution". Total institution refers to a place, which is cut off from the surrounding world and impose regimental schedules on inmates. In such a situation, the inmates lose control of many seemingly trivial things which define their individuality such as uniforms, furniture, hair cuts, and so on and they lose their autonomy and spontaneity, in regimentation of eating, sleeping, play and work. Suspicion, hostility and derogation are limiting their meaningful interaction. (Goffman Ward, 1979,)

The study makes us understand that long term care is becoming more common, especially for those patients with chromic illness and those elderly who do not have family members to function as care givers (Stumph, 1987).

Another study indicated that the old age home has many advantages. If offers the aged a safe alternative, the company of peer group, etc. But today such homes are like a dumping ground where the youngsters can get rid of their old people. They refuse to visit them in the homes and cut off all contacts, which in turn result in aggravating the feeling of loneliness and grief for the old folk (Madhaan Nagar, 1996). Numerous studies report that institutional care has many problems. One of them is that old people are being forced to live with older people. As one women said, "We are fed up of hearing of each other's aches, pains, and death news". The separation from people of different generations is emotionally stultifying (Maitregi, 1999).

All the above studies enumerated the problems of institutionalization and listed poor adjustment, unhappiness, intellectual effectiveness, withdrawn, unresponsive, low morale, negative self-image, preoccupied with past, feeling

of personal insignificance, withdrawal, anxiety, declining intellectual capacity, suspicious attitude, hostility, limiting meaningful interaction, frustration etc., as major problems, One study specifically assessed the problems of aged in 'total institution'.

While reviewing, the researcher found that all the study limited itself with enumeration. None of the study specifically focuses the problems of the aged women. The researcher apart from enumerating the various problems of the elderly women due to institutionalization, also pinpoints the factors influencing Life Satisfaction.

Thus, the researcher in her study focuses to find the answer for the following questions:

1. What are the physical health problems faced by the elders in the institutions?
2. What are the psychological health problems faced by the elders in the institutions?
3. What is the relevance of various socio-demographic variables in factors such as social-adjustment, social-behaviour, self-esteem, geriatric-depression, religious attitude and life-satisfaction?
4. Are there associations amongst different factors such as social-adjustment, social-behaviour, self-esteem, geriatric-depression, religious attitude and life-satisfaction?
5. What are the significant factors attributed to Life-Satisfaction?

Chapter – III

Research Methodology

CHAPTER III
METHODOLOGY

3.1 INTRODUCTION

India is a country of too many paradoxes. It enjoys the twin glory of entering into the Forbes Book for having the richest in the world as well as, housing the highest number of people struggling for existence below the poverty line. Same is the case with Indian attitude towards and treatment of women. It is a country where deification of womanhood and female foeticide take place side by side. Women deities in this country equal the number of men deities. Women are glorified here by naming the river after her like Ganga, Kaveri, by calling the land of living as motherland and language spoken as mother tongue. But in reality women present a different and dismal picture. Born free she is found in chains everywhere. In childhood she is under the protective care of her father, then her brother - elder or younger becomes the guardian, and under the pretext of marriage she is enslaved by her husband; in her old age her very survival solely depends on the mercy of her sons. She is honoured as the home maker or creator of the family. But the irrefutable and bitter truth is that she is treated as the unpaid servant both in her mother's house and in her in – law's house. In short, she is almost a bonded slave from cradle to grave.

In most of the developing countries women are worse off than men with regard to a number of important dimensions of human existence. Problems of ageing women are not due to age but due to psycho social environment, diminishing support and changes in life situation. The remarkable thing about older women in our culture is that they still survive despite all the odds. They continue to work till functional disabilities cripple them.

Even frail old women act as caregivers to their older spouses. Most dual career families in urban areas depend on old women for child care. In rural areas, home based farm work is still managed by women. In fact there is no

retirement for an elderly women till either death, dementia or disability chains her.

Depressed elderly women are more likely to be widowed, living lonely and experience greater financial and environmental stress.

It is nothing less than a miracle that despite such humiliation and neglect they could rise like the stars of great magnitude like Indira Gandhi and Kiran Bedi. But the likes of Indra and Kiran are few and far between.

The close association with and active participation in the social activities of Help Age India, an International Organization supporting the institutions working for the aged, for about a decade in the Nineteen Eighties enabled this researcher to gain a thorough knowledge of the pitiable plight of women, in general and the aged in particular. Deeply shocked by the stark reality of the pathetic plight of the almost orphaned old women and greatly influenced and inspired by the relevant literature on this topic the researcher decided to continue the investigation further with a view to finding solutions for the redressal of grievances. The researcher further decided to focus on the problems of aged women, an area which hitherto remained in the dark without proper recognition. The result is this thesis.

Women treat everyone with kindness. But the irony is that she is never paid back in her own life. On the contrary, she receives only brick – bats. The "*unkindest cut of all*" comes from her own ungrateful son. She nurtures a fond hope that her sons would offer her shelter in her old age. But the ingratitude of her son drives the last nail into her coffin. Her hope of a comfortable and peaceful life at home in old age is shattered her to pieces when she is forcibly thrown out of her own home. Though she deserves a better deal, she is considered as an unwanted burden. Hence the house which has sufficient space for the immovable and inanimate objects like refrigerator, television, washing machine has no space to accommodate this living person. As a result, she becomes a refuge and seeks the support of outsiders for her survival.

Of course, many have lost their life partners by this time, as longevity of women is larger than that of men. In the early stage, they managed the house,

reared children, maintained interpersonal relationships and remained the invisible root of domestic harmony. Even if widowed in a young age, women, particularly women with children have no inclination for a second marriage even though no religion is against widow marriage. They shoulder the family responsibility, almost single handedly by entering into the work force. In their old age chances for economic independence begin to vanish. Physical ill health and growing weakness due to ageing adds fuel to fire. In short, women performing the roles of selfless daughter, sister, wife and mother become the very symbol of sacrifice and servitude.

Actually, she is mercilessly denied love and care when she most expects and needs it. On the contrary she is brutally thrown out or forced to leave the family and take refuge in an old age home. Poverty also drives some families to this unwelcome situation.

It cannot be denied that family is the only right and appropriate place for all the aged to live in. The changing concept of family institutions does not allow their dreams to be translated into reality. Desire for a safer home at the most needed hour remains but a mirage. There is no change in her condition for the past quarter of a century. Instead, the condition has worsened resulting in the phenomenal growth of institutions. In due course, the situation has so worsened that organization, which rendered exclusively free social service has begun to commercialize the services. As a result, today, the paid institutions outnumber the free homes. The pathetic plight of the women, summarily rejected by their own kith and kin haunted the researcher aggressively as to force her to pursue this matter further and deeply. The study of their problems has naturally paved the way for an in-depth analysis of the functioning of the organizations – both free and paid homes working for the welfare of the aged in general and women in particular.

For many, familial reunion is no more a matter of thought. For many, own home or in institution does not make any difference. All these women have a totally different way of living in the institution. They are free from being exploited by others and their basic needs are being met in the homes.

But, there is an imbalance of Psychological status of these women, when they are uprooted from their own family environment.

3.2 NEED FOR THE STUDY

As the psychological problems of these unfortunate women,whether self admitted or forced – have not so far been given due recognition, the researcher decided to focus on the emotional status of these women, who were brutally removed from their familiar places. However, a careful study of the surveys on the problems of old aged women in the old age homes revealed that only a few studies have been conducted on limited areas. Further, no study has been conducted to the researcher's knowledge, to find out the 'Life-Satisfaction' of the old aged, particularly the women in the old age homes and what are the factors contributing for the life-satisfaction of these deprived and unfortunate women.

Considering the deficiencies in the knowledge pertaining to this issue , as individuals in the previous chapters, the various problems faced by the old aged women in the institutions and the factors contributing for their life satisfaction, it was decided to take up this study. The researcher also felt discomfort in understanding the gap in the knowledge, which compelled her to select the topic for the study, and it is important to find suitable answers to the following research questions that the researcher has identified after reviewing the existing literature on the topic.

1. How far do aged women adapt and adjust in the institution?
2. What sort of psychological problems do they face in the institution?
3. Do they socialize with their fellow inmates in the institution?
4. Is there any relationship between the religious attitude and satisfaction in life?
5. What levels of self esteem do they have?
6. What are the factors contributing for life satisfaction?
7. Is there any association between the socio-demographic variables and the factors that contribute for their life satisfaction?

8. Is there any association among the various factors that determine life satisfaction?

This chapter on Research Methodology explains the methods, techniques and procedure followed in this research study. According to Fred.N.Kerlinger, Research Design is a planned structure and the strategy of investigation conceived is prior hand with an aim of obtaining answers to research questions. The research questions were described in the previous chapter based on their review of literature and the gap in the knowledge found by the researcher. The researcher has followed the steps in proper direction to reach the goal and this chapter describes the steps taken by the researcher.

In this chapter, the researcher discusses the methodology for carrying out the present study and expresses scope of the study, objectives of the study, research hypothesis, research design, universe and sample design, tools of data collection, methods of data collection, operational definitions, statistical tests, limitation of the study and the problems encountered by the researcher.

3.3 TITLE OF THE STUDY

"A Study on the Factors influencing Life Satisfaction among the Aged Women under Institutional care in Madurai district".

3.4 AIM

To find out the Factors influencing Life - Satisfaction of the Aged Woman in Institutional care services in Madurai District.

3.5 OBJECTIVES

1. To study the socio demographic characteristics of the Aged Women.
2. To assess the psychological faculty of the aged women in terms of a) adjustment, b) self – esteem and c) depression of the Aged Woman
3. To assess the social dimensions of the aged women namely a) socialization, b) attitude towards religion of the Aged Women.

4. To assess the factors that contribute for the life satisfaction of the aged women.
5. To find out the association between the socio, demographic variables and the factors that could contribute for life satisfaction.
6. To find out the relationship among the various subject dimensions such as adjustment, socialization, self – esteem, depression and religious attitude and its contribution for life satisfaction.

3.6 DEFINITION OF THE TERMS:

3.6.1 Old Age

According to Elizabeth B.Hurlook (1976) the last age (elderly) in the life span is divided into early old age, which extends from the age of 60-70 years and advanced old age which begins at 70 years and above. In this study also, the researcher defined the old age as senior citizen who has completed sixty and above.

Adjustment: Adjustment is defined as the process of making or becoming suitable or adjusting to the circumstances such as Home, Health, Emotional and Social Factors in the study **Bell Adjustment Scale (Bas) (Bell, 1978)** is used to measure the Adjustment.

The inventory consists of 128 items which assesses the individual's adjustment on the following four dimensions of adjustment.

- **Home:** Individuals scoring high tend to be unsatisfactorily adjusted to their home environment.
- **Health:** High Score indicates unsatisfactory health adjustment. Low score indicates satisfactory adjustment.
- **Emotional:** Individuals scoring high tend to be unstable emotionally. Individuals with low score are emotionally stable.
- **Social adjustment:** Individuals scoring high tend to be submissive and retiring in their social contacts. Individuals with low score are aggressive in their social contacts.

The scoring in the inventory is 1 for 'yes' and 0 for 'no'. The description of the total score on the inventory is as mentioned in the above paragraph.

The coefficient of the reliability of each dimension of the Bell Adjustment Scale is as follows: Home: 0.91, Health: 0.81, Social: 0.88, Emotional: 0.91 and Total Score: 0.94: Bell Level of Adjustment Scale is interpreted as (-) Higher the score, higher the unsatisfactory adjustment i.e high score means high maladjustment.

3.6.2 Self Esteem

It is an automatic and inevitable consequences of sum of individuals choices in using their consciousness in following areas of self evaluation including overall self –worth, social – competence, problem solving activity, intellectual calibere, self –competence and worth relative to other people. In this study Self Esteem Rating Scale (SERS) (NUGENTW.R., et al., 1993) is used to measure Self Esteem.

The SERS is a 40 item instrument that was developed to provide the measure of self esteem with a clinical accuracy that can indicate not only problems in self esteem but also positive and non problematic levels. The items were written to tap into a range of areas of self evaluation including overall self worth, social competence, problem solving ability, intellectual calibere, self competence and worth relative to other people. The SERS is a very useful instrument for measuring both positive and negative aspects of self esteem in clinical practice.

The SERS is scored by scoring the items 3, 4, 6, 7, 8, 9, 10, 14, 15, 18, 19, 21, 24, 26, 28, 29, 32, 35, 36, 37 positively and the remaining items negatively by placing a minus sign before the item score. The items are summed to produce a total score ranging from -120 to +120. Positive scores indicate more positive levels of self esteem and negative scores indicate more negative levels of self esteem.

SERS has excellent internal consistency with an alpha of 0.97. The standard error of measurement is 5.67. Data on stability was not reported. The SERS is reported as having good content and factorial validity. The SERS has good constructive validity, with significant correlations with the index of self esteem and the generalized contentment scale. The score of this scale in interpreted as Self Esteem (+) : Higher the score higher will be Self Esteem

3.6.3 Social Behaviour

It has process that begins at infancy and continues in one's life by which a person acquires values, behaviours skills and performs different roles such as institutional activities, supportive roles, spare time activities and relationship. In this study Social Behaviour is measured is using the Social Behaviour by Assessment Schedule (SBAS) (PLATT et al., 1980).

SBAS was used to assess the level of social behaviouramong the inmates of the home for the aged. This schedule was prepared on the basis of SBAS developed and discussed by Platt et al in 1980. The modified tool used for this study has 40 items totally with 4 dimensions such as: 1) Institutional Activities, 2) Supportive Role, 3) Spare time Activities, 4) Relationship.

3.6.3.1 Role Performance Of The Inmates To Maintain The Four Dimensions

3.6.3 1. a) Institutional Activities:

It has 10 items assessing the frequency of subjects participation in the institutional activities related to religion, fund raising, household work, cultural activities, shopping, maintenance of cleanliness, informant to visitors etc.

3.6.3.2 b) Supportive role:

It also has 10 items to elicit the information regarding the situations, incidental problems, health problems, interpersonal problems, unmet religious needs, motivation and expressing the concern at the time of loneliness.

3.6.3.3 c) Spare time activities

This dimension has 10 items to explore the pattern of activities that involved the subjects to spend the spare time. They are activities related to gardening, listening to radio, watching movies and T.V, writing letters, attending organized lectures, participating in social gathering, playing games, reading books and spending time in groups.

3.6.3.4 d) Relationship

This dimension has 10 items, on information related to subjects' views about their connectedness with one another in the old age home and their initiation in and response to developing relationships.

Each item in the scale is scored on 3 point scales,namely never, sometimes and often. The score value of 1 is awarded to 'never', 2 to 'sometimes' and 3 to 'often'. Total score of each subject is consolidated to assess their level of socialization. The interpretation is that the high score on SBAS indicates the high level of social behaviourand the low score indicates the low level of socialization. The score is interpreted as Social Behaviour (+) : Higher the score, higher will be the level of socialization.

3.6.3.5 e) Religious Attitude

Religious Attitude among the respondents is measured using Religious Attitude Inventory (Ausubal And Schoort, 1957)

This is a 50 item Likert type scale developed by Ausubal and Schoort in 1957. It measures attitude towards the following religious referents: religious doctrine, immortality, God and the place of worship. Most of the respondents belonged to the Hindu religion. Hence the researcher referred to the term "temple" instead of church, to those respondents, who belongs to Hindu religion and referred to the term "mosque" to those respondents who belong to the religion Muslim. The researcher referred the term temple, mosque and

church accordingly, as the statements were related to belief system which is common to all the religions.

Five – point scale: strongly agree (pro-religious) to 1 (strongly disagree). It was developed to study the accuracy of the perception of persons holding extreme versus neutral views on a relevant topic. In the composition of the scale, 159 statements were collected and administered to subjects, and the mean item rating was determined. The final scale was constructed by choosing the 25 items as each extreme of the distribution of item values.

The response alternatives for positive (pro religious) item were weighed from 5 (Strongly agree) to 1 (strongly disagree). Weights for alternatives of the negative (anti religious) items had to be reversed. The persons score is the sum of the weighted alternative endorsed by him. High scores indicate acceptance and following of religion and religious doctrine.

The split half reliability coefficient of 0.97 was reported by the authors. Items were chosen for their ability to discriminate extreme scores. Further the authors tested the significance of the difference between mean scores of the high, middle and low groups of subjects and found that it was significant at the 0.01 level. The scale apparently possessed content validity. Religious attitude (+) : Higher the score higher the acceptance of religion.

3.6.5 Geriatric Depression

Depression is defined as fluctuation in mood that may deepen and persist when equilibrium cannot be restored because of poor internal regulation or external stress and the range of depressive, phenomena, including loss, cognitive complaints, somatic complaints and self image among older adults. The Geriatric Depression is measured using Geriatric Depression Scale (GDS) (BRINK T.L., 1983).

The GDS is a 30 item instrument to assess the depression in the elderly. The GDS is written in simple language and can be administered in an oral or written format. The main purpose of the development of GDS was to provide a screening test for the depression in the elderly population that would be simple

to administer and no special training necessary for the interviewer. The GDS has been used successfully with both physically healthy and ill samples of the elderly.

Of the 30 items, positive answers of 20 indicate the presence of depression while negatives 10 (items – 1, 5, 7, 9, 15, 19, 21, 27, 29, 30) indicate depression. The GDS scored by totalling one point counted for each depressive answer and zero for a non - depressive answer.

The GDS has excellent internal consistency with an alpha of 94 and split half reliability of 94. It also has excellent stability with a one week test-retest correlation of 85. Besides it has excellent concurrent validity, with correlations of 83 between the GDS and Zung's self rating depression scale and 84 with the Hamilton Rating Scale for depression. It has well known group validity in distinguishing significantly among respondents classified as normal, mildly depressed and severely depressed.

The GDS also has distinguished between depressed and non-depressed physically ill elderly and between depressed and non-depressed elderly undergoing cognitive treatment for senile dementia. Geriatric Depression (-) : Higher the score higher the depression.

3.6.6 Life satisfaction

Life Satisfaction is a reality enduring cognitive assessment of attainment of one's desired goals or overall conditions of life and measure the psychological well being of the elderly. The Life Satisfaction among the respondents is measured using Life Satisfaction Index Z (LSIZ) (NEUGARTEN. B., 1961).

LSIZ is an 18 item instrument designed to measure the life satisfaction of older people. The LSIZ was developed from a rating scale that was designed to be used by interviewers rating respondents and it may be administered as a self report instrument orally or in writing. Items were selected on the basis of their correlations with original rating scale and their ability to discriminate between high and low scores on the rating scale. Based on research, on this

instrument it is recommended that LSIZ be used mainly with individuals over 65 years.

The LSIZ is easily scored by assigning one point to each item that is 'correctly' checked and summing those scored. The correct score is 'agree' on items 1, 2, 4, 6, 8, 9, 11, 12, 13, 14, 17; other items are correct if the respondents answers\ 'disagree'. No data was reported on reliability but the rating scale from which the LSIZ was developed had excellent inter observer agreement. The LSIZ showed moderate correlation with the instrument from which it was developed, the Life Satisfaction Rating Scale indicating some degree of concurrent validity. The LSIZ also demonstrated the form of known group's validity by successfully discriminating high and low scores on the Life Satisfaction Rating Scale. Life Satisfaction (+) : Higher the score higher will be the life satisfaction or well being.

3.7 PILOT STUDY

'Pilot study' is the process of knowing the feasibility of conducting a research study in the field chosen. The researcher did a pilot study in the selected homes for the aged at Madurai, to know the possibility and feasibility of conducting the study by discussing the same with the aged women at the old age home and was satisfied to find out that the study could be conducted. The researcher met the Presidents and the Secretaries of the aged homes and explained the purpose of the study and obtained permission. Simultaneously, the researcher collected the secondary data (Books, Annual Reports, Attendance Register to know the number of inmates, Fees studies, Admission procedures etc.). The researcher met few inmates and explained the purpose of the study. The researcher also observed the living and working conditions of the inmates.

3.8 RESEARCH DESIGN

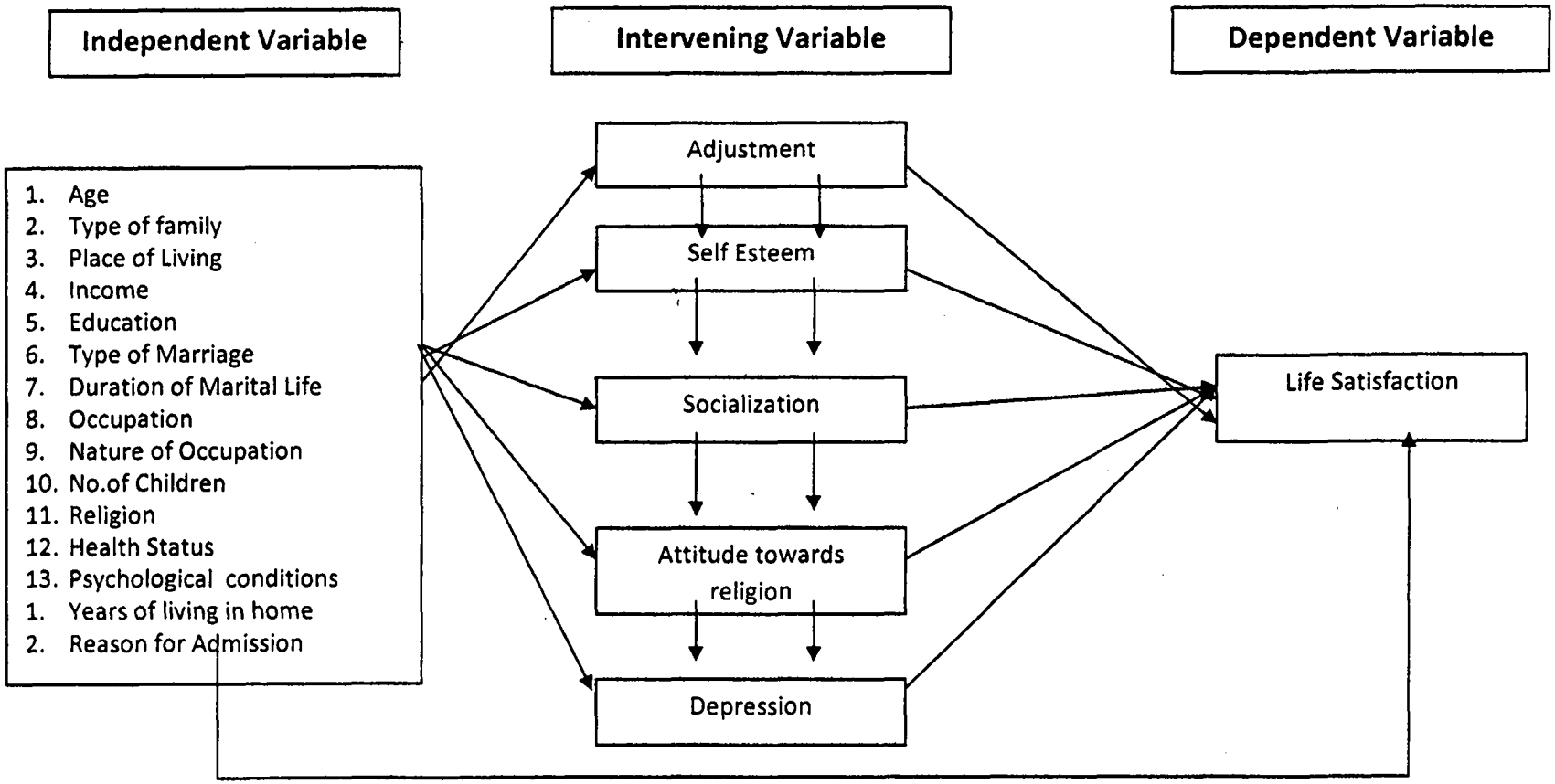
Research design is a plan or a scheme used to carryout a research in a systematic manner to achieve some specific goal. Diagnostic design is used in

this study. Diagnostic design is a design that diagnoses the nature of variables and explains the relationship and its degree between two variables in the given study. The study is focused on the solution of a specific problem by the discovery of the relevant variables that are associated with it in varying degrees. In this study, analysis has been made to find the inter-relationship between the level of adjustment, self-esteem, social behaviour, religious attitudes and depression visavis Life Satisfaction. Existing studies were scanned in order to validate the findings. Thus Diagnostic Research Design is the suitable design for this study.

3.9 HYPOTHESES

1. Higher the adjustment, higher will be the life satisfaction
2. Higher the self esteem, higher will be the life satisfaction.
3. Higher the level of socialization, higher will be the life satisfaction.
4. Higher the religious attitude better will be the life satisfaction.
5. Higher the depression, lesser will be the life-satisfaction.
6. Aged women from different socio demographic background do not differ with regard to their level of adjustment, self-esteem, socialization, religious attitude and depression.

VARIABLE MAP



3.10 SELECTION OF RESPONDENTS

All the registered homes for the aged situated in Madurai District in Tamil Nadu is the universe for the study. The list of Homes as on 1st January 2006 was obtained from the 'Help Age India is an international funding organization that promotes the welfare of the aged. The researcher also got the list of registered homes from the District Social Welfare Office, which is the authority for registration of old age homes. Both the lists were verified and all the registered homes shortlisted for preparation of unit for study. All the organizations were visited by the researcher and the details of the inmates were collected before setting the population frame.

3.11 OLD AGE HOME DETAILS

- **Total No.of Home for the Aged = 53**

  Not functioning = 8

  Only for men = 1

- **Homes taken for the Study = 44 (53-9)**

Total No. of inmates:

Men	= 507
Women	= 586
No. of aged women not able to answer due to illness	= 21
Not available at the time of interview	= 8
Not willing to participate	= 4

Total No.of Aged Women Interviewed = 586 - 33 = 553

3.12.1The following are the inclusions and exclusion criteria

3.12.2 Inclusion Criteria

- Women aged 60 years and above.
- Women those who are willing to participate in the study.
- Women from registered homes.

3.12.3 Exclusion Criteria

- Women who are not able to communicate.
- Women with terminal or severe mental illness.
- Women who are not willing to participate
- Women who are not in registered homes.

The researcher visited all the 53 homes for the aged in the target area. Using the inclusion and exclusion criteria, a list of inmates was prepared for each home. Thus, census method using inclusion and exclusion conditions was adapted for this study. All the shortlisted inmates were interviewed for this study.

3.13 PRE-TEST

Pre-test is a process of verification of the tool selected for the study. In the study, the researcher used an Interview Schedule and Scales to collect data. With the help of pre-test, the researcher could find repetition of some of the questions, inappropriate variables on which the respondents were confused and some variables that did not show any variance. Based on the experiences, the researcher made necessary corrections and sharpened the tool for data collection. During the pre test for following observations were made by the researcher.

It took 1 hour 30 minutes on an average to administer all the instruments to each of the Institutionalized Aged Women. This included a detailed orientation of the study and each of its instruments and an assurance that the process of data collection was a very confidential one and the data provided by the respondents will not be shared with the authorities concerned or in-charge, in order to alleviate their fears. Some of the respondents at times felt tired due to advancing age. The researcher had to offer refreshments at times so that they could overcome fatigue and continue the interview with necessary vigour. However, many showed interest by their participation as all the questions were relevant to their life and their present condition. Further, they hardly have

someone to talk with them and were eagerly longing for someone to share their inner mind.

None of the items in instruments were identified as the incompatible culturally or unsuitable to the psycho – socio – cultural contexts of the respondents. All the items were found relevant and appropriate to their life contexts.

When the instruments were applied to the respondents, a majority of them expressed their concern regarding the contents of the items. Referring to their psychological status, they displayed a lot of emotions with tearful eyes. They showed aversion and dejection explicitly towards their family members. It appeared that they feared a probable identification of something psychologically abnormal in them. This type of emotional reaction also warranted attention while gathering data from such concerned or apprehensive subjects. Empathetic understanding and universalizing their experience as normal human response during abnormal times weas found to be remedial in majority of the cases. However many of them were generally experiencing pain, distress and emptiness but were provided with certain psychosocial care and support.

3.14.1Based on the observations and experiences gained during the pre-test, the following changes were adopted to collect the data:

1. The respondents were oriented about the study and were provided with sufficient information before the session was initiated. At the same time, the researcher also addressed the specific doubts of the respondents. This had resulted in saving time and reducing the unnecessary disturbances and distractions at the time of interview. The process of gathering the data was brought down to a time span of about one hour on an average.

2. Specific appointments were fixed with the respondents to identify an appropriate time suitable for them, so that they would be entirely free to focus on the topic on hand with as less distractions and interruptions as

possible. Mostly, data collections were arranged before lunch and after tea, as a result of which there was betterment in the quality of data gathered.

In short, all the instruments and the items therein were retained. The modes of collection of data were modified to make it simple to understand and to respond. Whenever self doubts, psychological concerns and related subjective apprehensions were noted, the respondents were provided with necessary clarification or assurances or psychosocial care and support as per indications. These efforts paid rich dividends in making the phase of actual data collection, a productive outcome.

3.15 TOOLS FOR DATA COLLECTION

- A semi structured interview schedule was prepared by the researcher to assess the socio - economic conditions of the respondents.
- Bell Adjustment Scale (BAS) (Bell, 1978) to assess the level of adjustment of the respondents.
- Self Esteem Rating Scale (SERS) (Nugent W.R., et al., 1993) to assess the self esteem of the respondents
- Social Behaviour Assessment Schedule (SBAS) (Platt et al., 1980) to assess the social behaviour of the respondents.
- Religious Attitude Inventory (RAI) (Ausubal and Schoort, 1957) to assess the religious attitude of the respondents.
- Geriatric Depression Scale (GDS) (Brink T.L., 1983) to assess the level of depression among the respondents.
- Life Satisfaction Index Z (LSIZ) (Neugarten. B., 1961) to assess the life satisfaction of the respondents.

3.16 DESCRIPTION OF TOOLS

3.16.1 SEMI STRUCTURED INTERVIEW SCHEDULE:

A Semi structured interview schedule was prepared by the researcher to understand the socio - demographic details of the respondents that includes personal profile, family profile, institutional profile, health status, hobbies,

dietary pattern and the likes. It consisted of 44 items. The details of other tools are given in the previous pages.

3.17 TRANSLATION OF THE SCALES:

Respondents who were selected for the study were institutionalised aged women in Madurai District. Most of them could speak, some of them could read and write Tamil. Hence, all the tools were translated into Tamil. The initial Tamil translations of the instruments for data collection was done by experts in Tamil. Later, that was translated into English by another set of language experts, fluent in both Tamil and English. The original and the back translated versions were compared to ensure that the translated version intended to measure what was expected. For this purpose, the help of experts from mental health field, who are familiar with both the languages and the field of gerontology were elicited. Thus translation validity was done using experts views and content validity.

3.18 DATA COLLECTION

The researcher, after pre-test did the finalization of the instruments for the data collection. The researcher did the pre-testing at Inba-Illam. She obtained an informal consent from the respondents explaining the purpose of the study and administered the tools, which took approximately one hour and thirty minutes for the researcher to interact with a respondent and complete the data. After the completion of the pre-test, the researcher was able to complete the interview in 60 minutes. This time schedule was followed in collecting the data from all the respondents. It took nearly 18 months from March 2007 to August 2008 to gather the data.

Data Collection consumed much time. Though the researcher fixed appointments in prior to the interview, it was postponed sometimes due to some or other urgent and unforeseen circumstances. These factors were not in the control of the investigator because most of these delays were attributable to

the health and mental conditions of the Institutionalized Aged Women. Thus the data collection took a considerable period.

3.19 DATA ANALYSIS

The data collected on the six instruments were coded for the purpose of computer data entry. Coding was done on the assessment sheet itself. Statistical Package for Social Sciences SPSS version 16.0 was used to analyze the data.

The following statistical analysis was used to analyze the data. The descriptive statistics were used to measure the frequency distribution and percentage was calculated for the socio demographic profile and each item of the instruments used for the study. Simple frequency tabulsis adapted by the researcher to make it more explanatory and present the actual distribution of the respondents thought the length of he reports exceeds than its originally planned the researches also feels the simple frequency data analysis will help the interest group to gain better information about the detailed description of the respondents on socio demographic factors to plan their strategic interventions. The central tendencies like Mean and Standard Deviation were calculated for the calculated frequencies and percentage. Pearson's correlation was calculated to find out the association among the different variables which included Socio Demographic Profile, Adjustment, Self Esteem, Socialization, Religious Attitude and Level of Depression

Step-wise Regression analysis was done to find out the significance of the predictors of the dependent variables.

3.20 ETHICAL ISSUES

- The aged women who were taken for the study were duly informed of the purpose of the study. The objectives of the study were made clear to the respondents before the data collection, and it was also made clear that it will not raise any hope or expectation of help.
- Informal consent was obtained from the respondents considered for the study.

- It was ensured that the confidentiality of the given information will be maintained.
- The researcher herself handled the psychological care and support during the data collection.

3.21 LIMITATION OF THE STUDY

- The researcher restricted her study with the institutionalized aged women and left out aged men, which is a limitation and the opportunity for future study.
- Further, the study area was restricted to Madurai District. Thus, the study provides less chance for the researcher to compare the plight of the aged person in metropolitan cities.
- To have a better understanding about the plight of the institutionalized aged women, the administrators of the old aged homes, and the family members could be included as study groups, which the researcher did not consider to accommodate in her study. But these are the areas to consider for future study.
- However, the researcher satisfied herself, as she focused specifically to study the plight of the aged women, the most underprivileged, uncared and unnoticed members of the society.

3.22 CHAPTERIZATION

The present research study is divided into five chapters. The back ground of the study is given in the Chapter I. The review of literature in the concerned subject is given in the Chapter II. The chapter III is deals with the research methodology, where the methods and techniques used to carry out this research were presented. The empirical data collected from the field were analyzed, interpreted and presented in the form of tables in Chapter IV. The findings of the present study are given in Chapter V. The suggestions and recommendations and scope for future research are given in chapter VI. The

copy of the questionnaire, the case studies old age home list and the bibliography are given in the annexure I, II and III.

Chapter – IV

Factors Influencing Life Satisfaction (Empirical Data)

CHAPTER IV

FACTORS INFLUENCING LIFE SATISFACTION

Table: 1

Distribution of Respondents based on Type of Institution

S. No.	Type of Institution	No. of Institutions	No. of Respondents	%
1.	For Women alone	3	142	25.7
2.	For both Women and Men	41	411	74.3
Total		44	553	100.0

It is observed from Table.1 that 74.3 per cent of the respondents are from 41 institutions, providing care for both women and men, whereas 25.7 per cent of the respondents are from 3 institutions providing services exclusively for women. The number of homes for women alone are negligible in number. Though the number of institutions for both women and men are more, these institutions have separate wings for women and men and there is little interaction between them, except at the times of dining and prayer. The data also shows that the number of women in each 'institution for women alone' is approximately 40, whereas the strength of women in 'institutions for both women and men' is in the range of 10-15.

Table: 2

Distribution of Respondents Based on Nature of Payment

S. No.	Nature of Payment	N	%
1.	Paid	323	58.4
2.	Unpaid (Free)	230	41.6
Total		553	100.0

Table 2 shows that 58.4 per cent of the respondents are from 'Paid Homes' and 41.6 percent from 'Unpaid Homes'.

Unlike a general perception that old age services are primarily for the destitute elderly, man of the elderly come to old age homes from families that possess resources in terms of family and economic security. The data of this study also proves the veracity of this statement. The inference is that though many families have resources to make them meet the expenses of the respondents in the institution, yet they are shunning themselves from the duty and responsibility of taking care of the elders by not retaining them in their own families.

This table also reveals the fact that the problem arises not out of financial constraints, but psychological factors. The growing dislike of the youngsters is the outcome of the generation–gap that leads to misunderstanding between the aged and youth.

DIAGRAM -2A

DIAGRAM SHOWING THE DATA ON RESPONDENTS NATURE OF PAYMENT AT OLD AGE HOMES

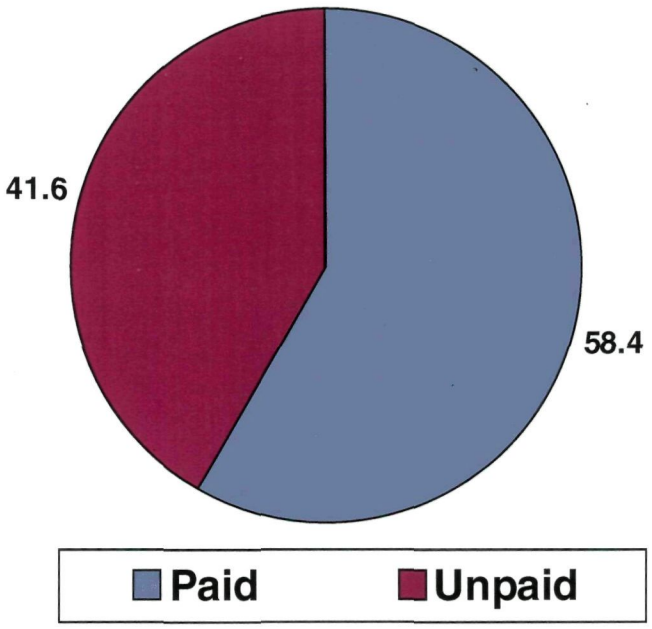


Table: 3

Distribution of the Respondents based on their Age

S. No.	Age in years	N	%
1.	Below 70 years	215	38.9
2.	71 years and above	338	61.1
Total		553	100.0

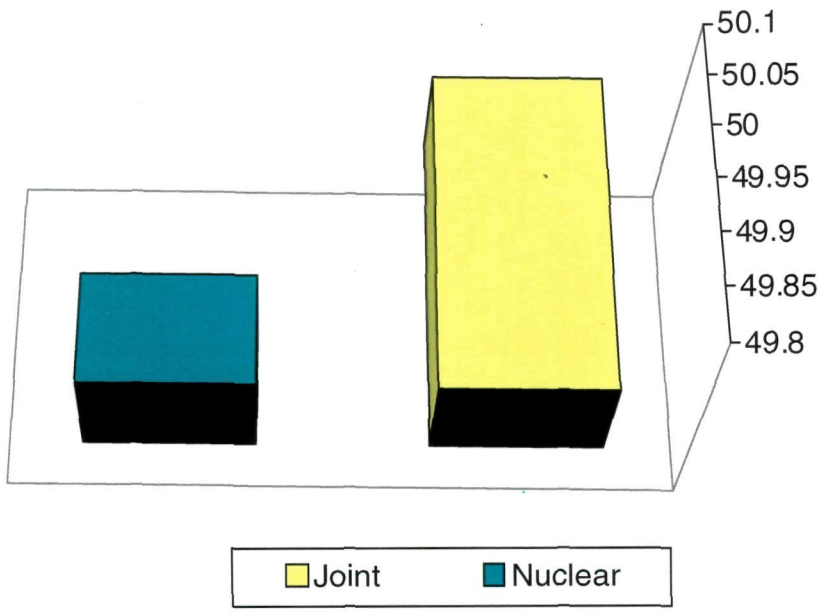
Regarding the age of the respondents, it is observed from Table 3, that 38.9 percent of the respondents are in the age group of 60 to 70, while 61.1 percent of the respondents are 70 plus. Thus a majority of the respondents are in the category of 'old-old'.

All the individuals above 60 are categorized as elders. However, all aged individuals cannot be put in one homogenous group. They can be categorized into "young-old", between the age of 60 and 75 years, "old-old", between 75 and 85 years and "very-old", after 86. The first age group mentioned are physically active and mentally alert, and in most cases they are not dependent on others. While the third category needs all types of support, particularly for maintaining them which is a major concern.

In this study, the researcher classified the aged into two categories in the age group of 61-70 and above 70 years. Thus, the categories of elders in the age group of below 70 years are mostly able bodied elders. Thus, of 38.9 per cent of the respondents in the category of 'below 70 years', most of them must have been physically active and mentally alert. This data has to be corroborated with the data of the Table.16, which shows that 42.7 percent of the respondents were employed before being admitted in institutions. The data shows that the able bodied and mentally alert persons are being admitted in the institutions and all their productive energies are not being utilized fully and they lose their economic value for their productiveness.

DIAGRAM – 3A

DIAGRAM SHOWING THE DATA ON RESPONDENTS AGE



The elderly seeking institutional care in old age homes is a phenomenon found not only in India, but all over the world (Ward, 1979, P.388, Wells and Frer, 1988, P.217; Tobin and Lieherman, 1976, P.3). A study conducted by Nayar in Kerala gives the statistics, "100 elderly persons staying in old age homes were interviewed. The ages of inmates in these institutions showed that 47 percent were in the age group of 60 to 70 years, 38 percent in the age group of 71 to 80 years and 15 percent were above 80 years" (Nayar, 2000 pp. 9). The glaring difference in the percentage of the aged over 70 between Kerala and Tamil Nadu is mainly due to longevity decided by various factors including environment.

Table: 4

Distribution of the Respondents based on Religion

S. No.	Religion	N	%
1.	Hindu	387	70.0
2.	Non – Hindu	166	30.0
Total		553	100.0

From Table No.4, it is clear that 70 per cent of the respondents are Hindus and the remaining 30 per cent belong to other religions. The other religions include Christians and very few Muslims.

All religion codes stress that it is the duty of the youngsters to take care of the elders and the sons should take care of their parents in their old age when they grow frail or chronically disabled.

In the Hindu scriptures, the aged were ascribed to in the last two stages of old age as 'Vanaprastha' and 'Sanyasa'. These 'Varnashramas' involved growing old gracefully, casting off family ties, indulging in social service and a retreat to a quiet life. The scriptures recommended right conduct 'Sadachar' to get one's longevity enhanced with peace and happiness. Hinduism insists that parents are to be venerated as Gods.

In Islam, respect for the parents is a basic religious duty. Many verses and renderings in the Quran clearly instruct how one should deal with ageing parents. In Chapter 17 (Al-Asra), it exhorts, "and your Lord had decreed that you worship none but Him and that you be dutiful to your parents. If one of them or both of them attain old age in your life, say not to them a word of disrespect nor shout at them, but address them in terms of honour: (Irfan, 2001).

Christianity emphasizes care for parents as a God given commandment, fulfillment of which ensures abundant blessing. In the Holy Bible, health and longevity are linked to living according to God's words and being obedient to his commands. Psalms 92:12 says, "The righteous shall flourish like the palm tree, he shall grow like a cedar in Lebanon. Old age is not considered a curse, but a blessing and long life comes from God".

So it is pretty clear that all the religions, culture and society instruct to give due respect for the elderly and emphasize the need for the younger generation to take care of the elderly and to provide them with whatever services and facilities they need. In the modern society, religion is relegated to the background and religious values do not control people's behaviour any more.

The data of this study proves that such religious values are being eroded from the minds of the youngsters. The data further proves the apparent neglect or rejection of elders by their wards and relatives. Further, the observation shows that the Muslim respondents are very few in this study. Generally, the Muslim elders are being taken care of in families and if being neglected, they are admitted in the vicinity of the place of worship i.e mosque / dhargha, which accommodates the elders, orphaned and disabled Muslim elders and protects them. These elders are not covered in this study, as these are not registered homes.

Table: 5

Distribution of the Respondents based on their type of Family

S. No.	Type of Family	N	%
1.	Joint Family	277	50.1
2.	Nuclear Family	276	49.9
Total		553	100.0

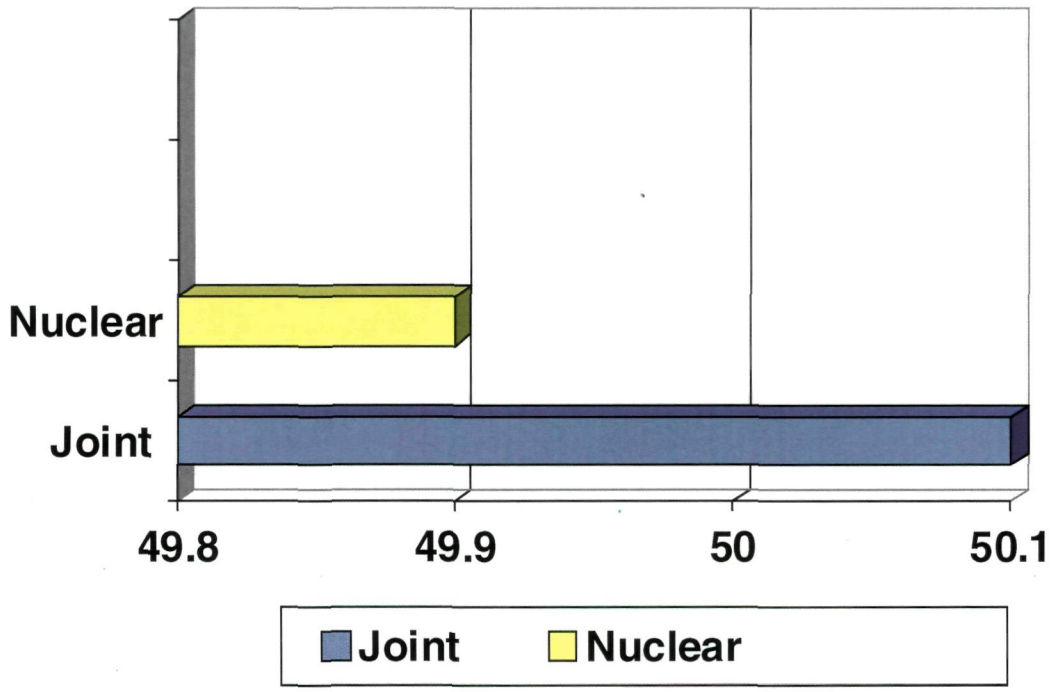
It is evident from Table 5 that 50.1 per cent of the respondents are from joint families and the remaining 49.9 per cent hail from nuclear families. That is almost equal number of elders from both the joint families and nuclear families that are seeking the services of old age homes.

The data of this study proves the disruption of the customary family and community bonds, dismantling of the joint family living. Further, it points out the erosion of responsibilities of accommodating the elders. The joint family system was the traditional way of living in India until recently and is still prevalent in rural areas. The senior-most member by age automatically assumed the family headship and carried out the responsibilities. With socio-cultural and economic changes taking place all round, the status of the elders has become devalued. The accumulated experience of the elderly is being obliterated by the push and dynamism of the youth. Older people are looked upon as those who did not have a legitimate claim over family support.

An analysis of the family by the Task Force Project on older people, funded by the Indian Council of Medical Research (ICMR), in Madurai City, Tamil Nadu, revealed that only 38 per cent of them lived in joint families while 52 per cent resided in extended families and 10 per cent in nuclear families. The attitude of family members towards older people varied from being neutral (10%); rejected, unwanted and just tolerated (38%); and loved and respected but having no control over other family members (52%). (Rao,Venkoba A., 44).

DIAGRAM - 5A

DIAGRAM SHOWING THE DATA ON RESPONDENTS FAMILY TYPES



Aged women are more often dissatisfied in nuclear families. Nevertheless, aged people staying in families are far better in terms of well being and life satisfaction than those in institutions. All interventions should be directed towards empowering the family to care for their elderly relatives. Enhancing their adjustment in families would be a step towards realizing the WHO goal: "care for the elderly is home-bound" (Archana, Kaushik, Panda 2005).

In urban areas, dependence on servants, degree of helplessness and insecurity, physical distance due to increasing mobility and deterioration of law and order situation in general makes the life of the elders in the nuclear family more difficult and painful. At the same time, the problems in rural areas is altogether different. Migration of kin to industrial and urban centres, acute shortage of accommodation leave little money for the additional responsibility of caring for the aged and leaves older persons generally under neighbourhood shelter. Social networks at the local level are only in the case if the young migrates of the family fail to provide regular economic support.

72 per cent of the old people felt their sons are less willing to live with them after marriage and 76 per cent felt their sons were less useful to them (Usha Rani, 1989). Elders in nuclear families prefer to live in a joint family for both emotional and economic reasons.

Table: 6

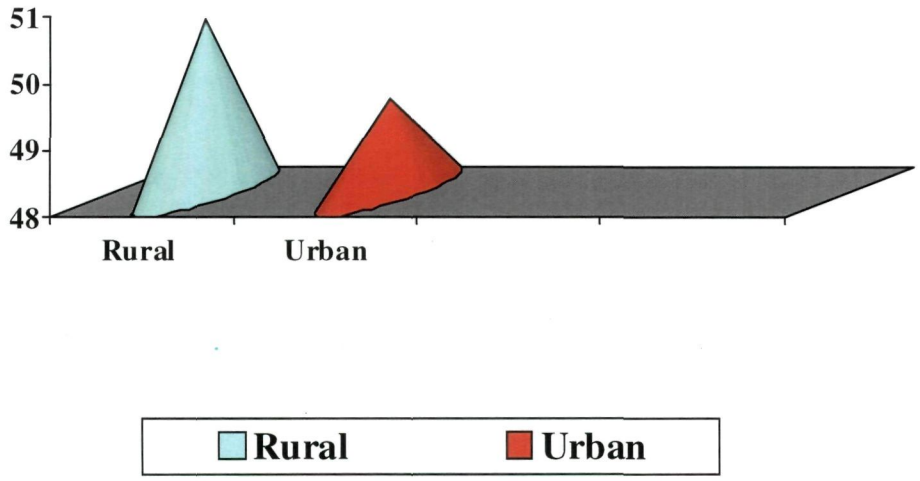
Distribution of the Respondents based on their Native Place

S. No.	Native Place	N	%
1.	Rural	280	50.6
2.	Urban	273	49.4
Total		553	100.0

Table 6 reveals that 50.6 per cent of the respondents hail from rural regions whereas 49.4 per cent are from the urban region. The data shows that

DIAGRAM – 6A

DIAGRAM SHOWING THE DATA ON RESPONDENTS PLACE OF LIVING



institutional seeking behavior is equally prevalent in both urban and rural regions.

Older people in rural areas complain of poorer quality of life than those in the cities and towns. They are disadvantaged by economic hardship, unresolved chronic health problems, functional impairment and illiteracy. The elderly in rural areas are largely landless labourers, surviving on day-to-day earnings, without any long-term savings. They are no longer physically strong because of their age, and hence their capacity for work is proportionately reduced. In an unorganized sector, there is no retirement age, and though the government recognizes old-age poverty, all are not covered under the pension scheme for the elderly destitute. (Health Action, 2000,)

Rural women in India who face poverty, discrimination and environmental stress have higher scores of psychological distress than urban women living in more comfortable conditions (Jaiprakash, April 99). In general, the living conditions of the aged are almost similar in both regions. The attitude of the youngsters towards the aged is almost the same.

Most of the aged in the rural areas belong to the low income groups and they continue to work for their livelihood and they are mostly illiterate and unorganized. (Sunil. Goyal, Oct 1999).

Rural elders are disadvantaged in terms of economic, physical, psychological and social indications, indicating that they are having comparatively poor quality of life than their urban counterparts (Easwaramoorthy and Chanda, 1997).

Table: 7

Distribution of the Respondents based on their Marital Status

S. No.	Marital Status	N	%
1.	Single	57	10.3
2.	Married	184	33.3
3.	Widow	280	50.6
4	Separated	32	5.8
Total		553	100.0

Marital status decides the way of life. This study reveals that 50.6 per cent, almost half of the respondents are widows. 33.3 per cent of the respondents have their spouses alive. 10.3 per cent are unmarried and remain single. 5.8 per cent of the respondents are separated from their husbands for various reasons. The researcher observed that except a few, many of the marital partners, the husbands of these married elders are either living in other homes or in the families with their children. Separating the marital partners in their old age is a human rights violation.

Eminent psychologists assert that in their old age, the elders find the company of their marital partners more comfortable and soothing. The spouse acts as both partner and close friend. The spouse – shares their inner feeling of life, like joys and sorrows; they preferred and considered their spouse as their close and intimate person in the family. (Eizabeth B.Hurlock, V Edition).

It is often seen that widows are abandoned, deprived of their property and driven out of their homes by sons or relatives. Being shelterless, they are forced to migrate to the holy cities where they wait for death. In Varanasi and Vrindavan, hundreds of ashrams house only aged persons. Sometimes, stories of widows, harassment and torture at the hands of temple sadhus are reported.

The rising rate of divorce, the emergence of single parent families and the trend towards smaller families will also affect the possibility of home care

DIAGRAM – 7A

DIAGRAM SHOWING THE DATA ON RESPONDENTS MARITAL STATUS

for the aged. They have few or no relatives to take care of them or they may have weak family ties.

As a consequence of higher life expectancy and other cultural reasons, more women tend to be widowed than men. This could have repercussions on their quality of life.

Elderly widows prefer to live in the family mainly because of the feeling of emotional insecurity, emotional bond with children, and because she may still be useful to daughter-in-law in rearing children and doing household chores. (Sandhu P. and Bakshi R., Oct 2004)

Elderly widows experience severe physical and psychological problems (ICMR, 1999).

Table: 8

Distribution of the Respondents based on Their Age at Marriage

S. No.	Age at Marriage	N	%
1.	Below 18 yrs	265	48.0
2.	19 to 22 yrs	202	36.5
3.	23 to 26 yrs	29	5.2
4	Not married	57	10.3
Total		553	100.0

From the above Table No. 8, it is derived that 48.0 per cent of the respondents got married while still in their teens, while 36.5 per cent got married when they were between 19 and 22 years and 5.2 per cent of the respondents were married between 23 and 26 years of age. 10.3 per cent of the respondents remain unmarried. Thus, the data proves that 84 per cent of respondents got married before the age of 22, which means that the 'empty-nest period' starts for them in their middle of middle-age, though it starts for many at the end of middle-age. Thus, they have longer empty-nest period and longer old age period. Children leave the family at an early age, which contributes for their physical, social and psychological well-being.

Women married during adolescence, the stage where the body is still developing, have multiple pregnancies that deprives the body of its nutrients. Their food is not always balanced and thus the age-related problems are accepted as inevitable. (Dr Indir Jair Prakash, Oct 2004).

Age at marriage is positively correlated to life satisfaction. Those who got married at a later age might have achieved at least some of their goals in life than others who had taken up responsibilities at a very early age (Mathew Susheela, 1997).

Table: 9

Distribution of the Respondents based on type of marriage partners

S. No.	Marriage Partners	N	%
1.	Blood Relation	196	35.5
2.	Not Related	300	54.2
3.	Unmarried	57	10.3
Total		553	100.0

It is evident from Table 9 that 35.5 per cent of the respondents married within blood relations, whereas 54.2 per cent of the respondents have married men outside. The remaining 10.3 per cent of the respondents remained unmarried.

Generally, it is perceived that if the marriage is between blood relations, it provides a kind of security within the family when they become older. It is perceived that marriage within blood relation provides better support system. But the data shows that even respondents who married within their blood relations are admitted in the institutions.

Table: 10

Distribution of the Respondents based on Type of Marriage

S. No.	Type of Marriage	N	%
1.	Love	36	6.5
2.	Arranged	460	83.2
3.	Unmarried	57	10.3
Total		553	100.0

Table .10 sheds light on the type of marriage of the respondents. 83.2 per cent of the respondents were united in wedlock through their parental arrangements whereas 6.5 per cent of the respondents married the partners of their own choice and the remaining 10.3 per cent remained unmarried through out their life.

Table: 11

Distribution of respondents based on duration of marital life

S. No.	Duration of Marital Life	N	%
1.	Below 20 yrs	67	12.1
2.	21 to 30 yrs	77	13.3
3.	31 to 40 yrs	146	26.4
4.	41 to 50	150	27.1
5.	51 and above	56	10.1
6.	Unmarried	57	10.3
Total		553	100.0

Table .11 shows the length of marital life of the respondents. 12.1 per cent of the respondents had marital life for the period less than 20 years, while 13.3 per cent spent their life together for about 30 years. It is observed that 26.4 per cent of the respondents had their marital life for about 40 years and 27.1 per cent of the respondents had their marital life for about 50 years. A minimal of 10.1 per cent of the respondents had their marital life for more than 50 years. The remaining 10.3 per cent remain unmarried.

Only 12.1 percent of the respondents have less than 20 years of marital life and almost 77 percent of them have a marital life for more than 20 years. Thus, 12 percent of the respondents have brought up their children on their own without their spouse, sacrificing their life for their children is well being, with the hope that they would care for them in their twilight period. In the same way, 77 percent having more than 20 years of marital life have derived mutual support from their spouses in bringing up their children. The faith they reposed on their spouses and children was shattered, by the abandonment of their children, which would affect their healthy ageing.

Table: 12

Distribution of the Respondents Based on their Living Sons

S. No.	No. of Sons Alive	N	%
1.	No son	119	21.5
2.	One or Two	217	39.3
3.	Three or Four	160	28.9
4.	Unmarried	57	10.3
Total		553	100.0

Generally, sons are preferred in our society as it is hoped that they to extend support and look after the parents in their old age. However, it is evident from Table 12 that no such support is extended, though 39.3 per cent of the respondents have one or two sons alive and 28.9 per cent of the respondents have three or four sons alive. 21.5 per cent of the respondents do not have either a living son or no son at all. Thus, more than two thirds of the respondents have one or more sons alive. The remaining 10.3 per cent of the respondents remain unmarried.

It is a common belief that children are the security for the old aged. Contrary to this belief, 377 persons (67.12%) though blessed with children are found in old age homes. It is because the present generation considers old

people as a burden and their presence in the family irks most of the members. (Irudayarajan, 1999).

As our's is a patriarchal society there is a culture of parents wanting to live with their married sons and not married daughters (Jayashree, 2000; Indira Jaiprakash, 1999). However, our study shows that 39.3 percent with one or two sons are forced to seek asylum in an old age home.

While the poor cannot afford to keep their parents, the better placed do not keep them either, because they have been isolated due to migration or because there is no time to spend or live with the aged due to the clash of value systems. This is about sons. Why daughters? The increasing participation of women in the work force has made it much harder for the daughter to take care of parents and so they are despatched to asylum.

Table: 13

Distribution of Respondents based on their Living Daughters

S. No.	Living Daughters	N	%
1.	No living daughter	69	12.5
2.	One or Two	214	43.6
3.	Three or Four	135	24.4
4.	More than Four	51	9.2
5.	Unmarried	57	10.3
Total		526	100.0

From Table 13, it is noticed that 12.5 per cent of the respondents do not have daughters because they were dead or not born at all, whereas 43.6 per cent of the respondents have one or two daughters alive; 24.4 per cent of the respondents have three or four daughters and 9.2 per cent have more than four daughters alive. Thus, 77.2 per cent of the respondents have one or more living daughters. 10.3 per cent of the respondents remain unmarried.

As observed in table 12, when the respondents have been ignored by sons who are morally bound to look after their parents, the role of daughters is not obligatory but optional. The factors which make the daughters helpless

would be a) lack of economic independence, b) no role in decision making in the family of in-laws.

From continuing Table 12 and 13, one can infer that 67.12 percent of the respondents have one or more than one boy and 76.1 percent of them have daughters. Having boy children in our culture would boost them and make them proud of giving birth to a child who would care for them even after their spouse's demise. However, when these dreams shatter them, the inability of the daughters also shakes them.

Having failed in their prime years, 54.1 percent of them are left at the mercy of the old age homes, while 30.6 percent have their family paying for the home 40 percent of them have old age pension. It is revealed in table: 26 that 86.6 percent of them have been forced into the homes due to unwillingness on the part of the children and family members. Only 20.3 percent have quoted poverty as reason. Thus, we see that the number of children is immaterial. The question is how many are willing to accommodate and take care of them. In other words, the quality of children is more important than the quantity.

This realization is a great blow to the parent (respondent) which could psychologically isolate them and would take a long time to trust new found relationships and fill up the vacuum created by their children. Those who had earlier been religious and pious could become bitter and blame themselves. The inevitable outcome of this complex interplay of factors is depression

Most of the respondents are not willing to stay with the married daughters. (Jayashree, Jun-Sep 2000).

Table: 14

Distribution of the Respondents based on their Educational Qualification

S. No.	Respondents	N	%
1.	Illiterate	219	39.6
2.	Elementary	139	21.1
3.	Middle	73	13.2
4.	High School	84	15.2
5.	College	38	6.9
Total		553	96

Table No.14 reveals that 39.6 per cent of the respondents had not been to school and remain illiterate, whereas 21.1 per cent of the respondents have their education upto Elementary Level; 13.2 per cent of the respondents have their education upto Middle Level. 15.2 per cent had reached upto High school Level. A minimal of 6.9 per cent had entered the college and completed either their graduation or post-graduation.

Unfortunately, the educational status of the elderly in our country, gives a gloomy picture. More than two thirds of the aged males and almost 90 percent of aged females are illiterate. (Bose 1998).

The majority of the illiterate elderly were engaged either in agriculture pursuits in their rural areas or as unskilled or semi-skilled workers in urban areas, many of whom were living below or just above the poverty line.

DIAGRAM – 14A

DIAGRAM SHOWING THE DATA ON RESPONDENTS EDUCATIONAL QUALIFICATION

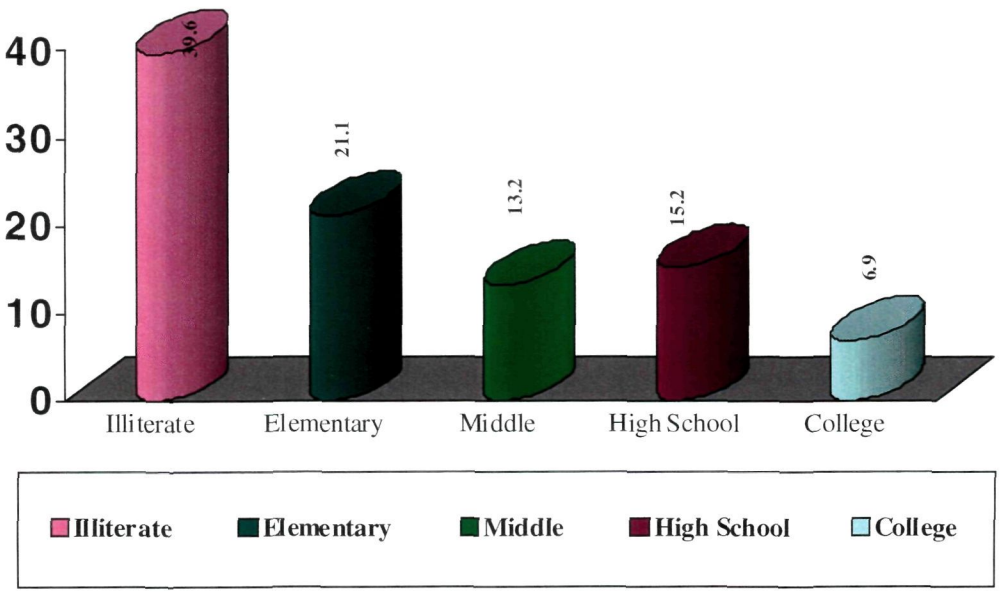


Table: 15

Distribution of the Respondents Based on their Spouses' Educational Qualification

S. No.	Spouse	N	%
1.	Upto High School (10^{th} Std.)	338	61.2
2.	Above High School	158	28.5
3.	Not Applicable	57	10.3
Total		553	100.0

Table.15 reveals that 61.2 per cent of the respondents' spouses had their education upto High School Level, whereas 28.5 per cent of the respondents' spouses had their education above High School Level. The data is not applicable to 10.3 per cent of the respondents as they remain unmarried.

Table: 16

Distributions of Respondents based on their Occupation Before Admission in the Home

S. No.	Occupation	N	%
1.	Retired	57	10.3
2.	Employed	236	42.7
3.	Unemployed	260	47.0
Total		553	100.0

The occupation of the respondents is an important variable that reveals whether the respondents were physically, economically independent during their productive years. It is evident from Table16 that 10.3 per cent of the respondents had retired from their work at the time of admission, whereas 42.7 per cent of the respondents employed themselves in the labour market. 47 per cent of the respondents were unemployed before admission. Aged women who continue to maintain their preferred active life style by involving themselves in household chores generally have higher Life Satisfaction. (Dhillan, 1992).

Table: 17

Distribution of Respondents based on their period of Occupational Experiences

S. No.	Years of Experience	N	%
1.	Below 10 Years	82	14.8
2.	Upto 20 years	134	24.2
3.	Above 20 years	77	14.0
4.	Not employed	260	47.0
Total		553	100

Table 17 shows that 14.8 of the respondents have worked for a period less than 10 years; 24.2 per cent were in the labour force for about 20 years and 14.0 per cent have laboured themselves for more than 20 years. 47.0 per cent of them were not employed. Thus, 53 per cent of the respondents were in the labour market for different length of periods.

Table: 18

Distribution of Respondents based on their Nature of Occupation

S. No.	Nature of Occupation	N	%
1.	Unorganised Sector	95	17.2
2.	Professional	26	4.7
3.	Government	32	5.8
4.	Private Sector	87	15.7
5.	Seasonal work	53	9.6
6.	Not employed	260	47.0
Total		553	100.0

According to Table 18, 17.2 per cent of the respondents were working in the unorganized sector as labourers and 9.6 per cent of the respondents were engaging themselves in seasonal work. Only 4.7 per cent of the respondents were professionals and 5.8 per cent were in the Government sector. Among the

respondents few had guaranteed employment, assured regular income, retirement benefits and covered by social security measures. 15.7 per cent of the respondents were working in private sectors. The remaining 47 per cent of the respondents were not employed.

There are a large number of people who have no life and nothing to offer outside their place of employment. Retirement is fine for the professional classes because they can continue to work if they wish to, but the poor do not have the same privilege. What really makes are boil is that the rich can afford to retire but the poor cannot. (Asim Bardhan, Oct 1999).

Most of the elders who worked in the unorganized sectors are not covered by social insurance schemes or regular pension and consequently they fall dependent on others and more so on the government.

A closer look at tables 16,17 and 18 brings out some striking points i.e the major one being that 47 percent of the respondents were never employed and among those employed, except for 5.8 percent who were in Government jobs are not eligible for retirement benefits

Economic factors could have made them vulnerable and adaptable to people and situations which could continue even after joining the home

Table: 19

Distribution of Respondents based on their Monthly Income

S. No.	Monthly income in Rs.	N	%
1.	Below 1000	107	19.3
2.	1001 to 2000	129	23.3
3.	2001 to 3000	35	6.3
4.	3001 and above	22	4.0
5.	Not applicable	260	47.1
Total		553	100.0

From Table .19, it is inferred that 19.3 per cent of the respondents had a monthly income of less than Rs.1000 per month. 23.3 percent in the range of Rs.1001 to Rs.2000; 6.3 percent had income in the range of Rs.2001 to Rs.3000 and only 4.0 percent earned more than Rs.3000. That means, about 10 per cent had fair income.

"Despite the belief that children are the security of the aged, institutions for the aged are mushrooming since the late 1990's. The major reasons for institutionalization are low economic status, widowhood, destitute, conditions abused by family members and lack of support from social networks" (Jamuna 1998, P.8). A study conducted at Karnataka shows that a sizeable proportion of elderly women do not have any independent source of income. Even in the agriculture sector, as women age, they are less preferred as labourers and land owners hire younger persons for farming practices and push older women out of work (Nair, 1998) Economic independence helps to maintain self esteem in old age. (Lakshmi Rani Kulshretha).

The issue of economic dependency is more relevant to elderly females. It is reportedly high among elderly females (86%). (Prakash, 1996). Reports reveal that only 17% women receive a share in their spouse's property and that 90% do not have any independent income or property. Economic independency seems to be linked with status and respect in the family. Dak and Sharma (1998) reported that elderly widows face loss of status in the family and problem in financial security (Social welfare No.46 pp: 36-37).

Elderly people in low socio-economic groups are among those living alone who are at higher risk of poor dietary intake (Wadhwa et al. 1997). Institutionalized females largely come from poor socio-economic families and often from families with serious social problems, like family disharmony (Kale K.M., Jogdand G.S., Aswar N.R., 1990).

Table: 20

Details of Respondents Based On Their

Sources of Revenue, While Residing In the Old Age Home

S. No.	Sources of income	Yes		No	
		N	%	N	%
1.	Pension (includes old age pension)	222	40.0	331	60.0
2.	Charity	166	30.0	387	70.0
3.	Home for the Aged	298	54.0	255	46.0
4.	Family Members	169	30.6	384	69.4
5.	Relatives	92	16.6	461	83.4
6.	Friends	4	0.7	549	99.3
7.	Others	96	17.4	457	82.6

Table 20, lists the various sources of revenue for the respondents, in the old age homes. It is obvious that 40.0 per cent of the respondents are receiving old age pension either as a retirement benefit or as a welfare scheme of the government for senior citizens. 30.6 per cent of the respondents are receiving financial assistance from their own family members; 16.6 per cent received help from their relatives and only 0.7 per cent is receiving assistance from friends. 30.0 per cent of the respondents rely on charity, 54.0 of the respondents rely on the old age homes in which they reside. 17.4 per cent of the respondents also derive assistance from sources other than those mentioned here. The data also reveals that many respondents have more than one source of revenue.

Table: 21

Distribution of Respondents based on their Hobbies

S. No.	Hobbies	Yes		No	
		N	%	N	%
1.	Reading	193	34.9	360	65.1
2.	Gardening	198	35.8	355	64.2
3.	Writing	123	22.2	430	77.8
4.	Hand Work	124	22.4	429	77.6
5.	Painting	27	4.9	526	95.1
6.	Domestic Work	442	79.9	111	20.1

Table 21 throws light on how the respondents are utilizing their leisure time in a healthy way. Reading is the leisure time activity of 34.9 per cent of the respondents. 35.8 per cent of the respondents pursue gardening. 22.2 per cent engage themselves in writing. Doing handwork is a hobby of 22.4 per cent of the respondents. Painting is a hobby of a minimal of 4.9 per cent respondents. 79.9 per cent of the respondents derive happiness and relaxation by engaging themselves in the domestic work of the old age home.

Poor leisure participation is associated with poor health adjustment contributing to poor life-satisfaction (Griffin and McKenna, 1998).

Table: 22

Distribution of Respondents based on their Daily Physical Activities

S. No.	Physical activities	Yes		No	
		N	%	N	%
1.	Sweeping	261	47.2	292	52.8
2.	Fetching Water	176	31.8	377	68.2
3.	Gardening	203	36.7	350	63.3
4.	Kitchen Work	482	87.2	71	12.8
5.	Hand Work	105	19.0	448	81.0

Physical activities signify the physical well-being and physical fitness of the respondents. To be happy in old age, they must try to keep themselves active by getting involved in any activity of their interest. Physical activities in one's older age have been shown to increase physical strength, balance, joint suppleness and overall physical co-ordination. Appropriate physical activity enhances relaxation, reduces stress anxiety and depression and increasing mental agility. Physical activities foster well-being and contact with other people and are also the best guarantee for independent living and increasing the ability to cope until late in life.

From Table No.22, it is inferred that 47.2 per cent of the respondents do sweeping; 31.8 per cent fetch water; 36.7 per cent of the respondents do gardening; 87.2 per cent do kitchen work and 19.0 per cent do hand work. The data clearly gives a picture that the respondents are interested in doing their traditional role of preparing food and kitchen management.

There is a positive relationship between activity and life-satisfaction, that the greater the role loss, the lower is the life satisfaction. (Bali, 1999 and Singh 1999)

The various social components which pave the way to active and healthy ageing are adequate financial status, good physical and mental health, active participation in leisure time activities, continuation of persuasion of hobbies, maintenance of daily schedule, retaining social network, relationship

and assumption of social roles. (Sushma Batra, Jan 2004,) Walking is a safe and natural exercise. Other physical activities include gardening, cycling, swimming, gymnastics, dancing or house work or simply climbing the stairs. (Health Action, 2004). Under-engaged and idle residents of old age homes feel more depressed and restless (Bagga, 1997)

Table: 23

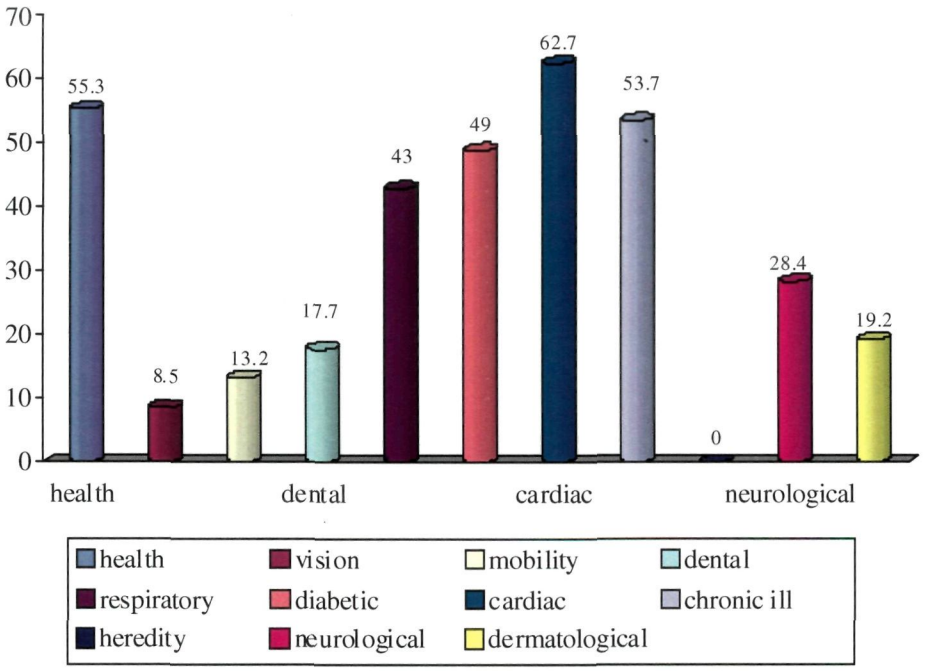
Distribution of Respondents based on their Health Conditions

S. No.	Health Conditions	To a Large extent		To Some Extent		Not at all	
		N	%	N	%	N	%
1.	Health Problem	306	55.3	182	32.9	65	11.8
2.	Problem in Vision	47	8.5	132	23.9	374	67.6
3.	Difficulty in Mobility	73	13.2	178	32.2	302	54.6
4.	Dental Problem	98	17.7	212	38.3	243	43.9
5.	Respiratory Problem	238	43.0	157	28.4	158	28.6
6.	Diabetic Problem	271	49.0	92	16.6	190	34.4
7.	Cardiac Problem	347	62.7	78	14.1	128	23.1
8.	Any Chronic Illness	297	53.7	56	10.1	200	36.2
9.	Heredity Disease	292	52.8	67	12.1	194	35.1
10.	Neurological Complications	157	28.4	122	22.1	274	49.5
11.	Any Dermatological complication	105	19.2	115	20.8	333	60.2

The health conditions of the respondents can be determined by analyzing the various health problems being faced by them. From Table 23, it is clear that cardiac problem is the major illness prevalent among the respondents. 62.7 per cent of the respondents have cardiac problem and the intensity is too severe. 55.3 per cent have severe health problems and 32.9 per cent have health problems with less severity. Thus, only 11.8 per cent of the respondents are free of any health problems. In the same way, 53.7 per cent of the respondents are suffering from chronic illness and the severity of the illness is higher. 67.6 per cent and 60.2 per cent of the respondents do not have

DIAGRAM – 23A

DIAGRAM SHOWING THE DATA ON RESPONDENTS HEALTH *CONDITIONS*



problems in vision generally problem in vision and dermatological complication. Generally, a problem in vision is the major disability being faced by elders and many studies also supported the view. From the table it is interesting to note that only 8.5 percent have problems in vision to a large extent and 2.9 percent have problems to some extent. Interviews with the respondents and home in charges realized that eye camps are being periodically conducted to detect problems in vision, and necessary interventions are being made to correct the problem that could be the reason for less number of respondents having problems with vision. Similarly, during the general health checkup which is mandatory for every institution, special focus is being given to skin care. Hence only 19.2 percent have dermatological complication to a large extent and 20.8 percent have problems to some extent. Further, 54.6 per cent of the respondents have no difficulty in their physical movement. Diabetic, respiratory problems are other major health issues and 49 per cent are suffering from severe diabetic condition and 43.0 per cent have severe respiratory problems. Thus, it is clear that the health status of the respondents is not appreciable.

Healthy aged women are more satisfied with life than those who are weak and frail. The elderly women who rarely feel lonely, have fewer worries and tensions and are optimistic and often have greater satisfaction with life (Help age India, Jan 2005).

Increased blood pressure is very often regarded as a manifestation of old age. Old age is not a disease. But the natural process of ageing makes individuals susceptible to multiple diseases and disabilities. Though diseases in old age are preventable or treatable, people attribute the diseases in later years of life to old age and neglect to take proper care of their health" (Natarajan, 2000,Chandra 1996). Many factors contributed to good health conditions. The main quality of life of the outcome for inmates is the possibility of taking care of peers, feeling of bearing part of a group, self respect feeling of reciprocity within relationships, emotional support with physical assistance, competence,

open minded and flexible organization, well adapted services and activities to the needs of physical and mental health and well adapted environment to the needs of care and self realization" (Robichand 2001). An important variable contributing to happiness is not so much health itself but self perception of health" (Ramamurthi and Jamuna 1993). The health related disorders common in older people are obesity, osteoporosis, arthritis, mental disorder, life depression, anxiety, Alzheimer, hypertension, constipation, diabetes" (Athar 2001).

Cancer of Cervix is more common amongst Indian women. Most of the genital tumors among women who are 60+ are malignant. They are often not detected because they do not interfere with physical and sexual activity (Gupta and Pal, 1998). Worldwide statistics show that the breast to be the commonest site for cancer in women, but in India, cancer of uterine cervix is more common (Bhargava, 1998).

In a rural survey carried out by the ICMR, only 20 per cent of interviewed elders said they had no major medical problems. Many reported five or six symptoms. The problems reported related to vision (65%), movement (36%), respiration (10%), skin (8.5%), the central nervous system (7.4%), cardiovascular ailments (6.3%) and hearing (5.8%) (ICMR, 1999). The aged persons suffer from ineffective and parasitic diseases, disease of respiratory systems, arthritis, rheumatism, hypertension, constipation, heart failure and diabetes mellitus (Joshi, 1971). For the elderly, the problem of vision is foremost (82%) followed by psychomotor problems (78.8%), bone joint problems (78%), memory problems (58.8%) and sleeplessness (58%) (Misra, 1992). Women had more pain, emotional, sleep and mobility problems than men (Agneta Grimby, 1995).

Elderly living in nuclear families and those living alone were more prone to physical and psychological disorders (Ramachandran, 1980).

Table: 24

Distribution of Psychological Conditions of the Respondents

S. No.	Psychological conditions	Yes		No	
		N	%	N	%
1.	Neurotic Problems	296	53.5	257	46.5
2.	Anxiety	145	26.8	408	73.8
3.	Phobia	54	9.8	499	90.2
4.	Hypochondriasis	57	10.3	496	89.9
5.	Other psychological problem	67	12.1	486	87.9

Table No. 24 explains the psychological well being of the respondents. It shows that 26.8 per cent have anxiety syndrome; 9.8 per cent exhibit symptoms of phobia, 10.3 per cent have symptoms of hypochondriasis and 12.1 per cent of the respondents have other symptoms pertaining to psychological illness. From the data, it can be inferred that the psychological well being of the respondents is not appreciable.

The disturbing trend is revealed in table: 24 where some form of psychological disturbance is prevalent among the inmates. Age along with psychological health is bound to have an impact, but the predominant factors like lack of care, emotional disturbances, worry, fatigue, loss of relationships, feeling of not being wanted, fear of a new future atmosphere, change of life style and isolation have a large role to play in the psychological health of the person. The matter of time to come to terms with the reality could vary from person to person. Many of them who would internalize their feelings show signs of neurosis, whereas others exhibit anxiety or fear. How their end would come is what they fear most. Alienated in their mind, passive adjustment is possible, but as anxiety rules high existing in their own frame of mind in isolation.

Leaning to religion as a last anchor would force some to piously chant prayers while others could go away from it. Belief in the faith that has provided

shelter is strongly felt. This could usher in hope and peace in their mind. Absence of faith either in fellow beings and or religion hastens the path of depression.

Loneliness, poor health and family conflicts were found to be the major reasons for institutionalization (Reznikou, et al.1991). "Frequent conflicts with family members lack of proper care by the younger generation, isolation, loneliness, lack of own house are prominent reasons for institutionalization (Saraswathi, 1993,).

A study reviewed the concepts of loneliness with particular reference to old age and suggested that successful treatment of loneliness in life reduces the risk of more serious complications, self contacts, self esteem and trust (weeks, 1994). One more study proved that loneliness at any age level can be reduced. Distancing from loneliness and the attempt to ignore it were the least effective and on temporary basis only (Rokach 1996).

Family conflicts, retirement, bereavement, and isolation often precipitated emotional and physical decomposition in the elderly. Such stresses could cause a precipitous regression and as the ego tried to master the intense anxiety; massive denial, hypochondriasis, projection, introjections and helplessness could take over. (Straker, 1976)

Depression was the commonest illness (236/1000). The other illnesses were anxiety (20/1000), hysteria (5/1000). In those aged over 60 years, the rates were as follows: Organic illness 61/1000, functional illness 276/1000, depression 94/1000 and anxiety 5/1000. (Kay et al, 1964)

Old people become anxious easily because of their limitations, insecurity, dependency and fear of death. Any physical illness adds to the fear. They suffer from vague fear, increased heart beat, breathlessness, fatigue, aches and pains, shivering and sleeplessness. Sometimes, they develop illness like phobia, hypochrondriosis (undue concern over health) and compulsion. (Chandrasekar.C.R., 1997)

Numerous studies indicate that the effect of industrialization, urbanization has weakened the traditional joint family set-up whereby older persons are least or not wanted in the social setup of a family or the society at large resulting in loneliness and death anxiety. (Sureender, 1997; Gupta, 1976; Laxminarayan, 1982; Mullins et.al, 1996; Roth, 1978)

Psychological distress is reported higher among older women especially among rural women (Shirlokar & Prakash, 1995)

Women are more depressed than men across all stages of life. (Indira Jai Prakash, Oct 2004)

Depression level of the institutionalized elderly people was found to be high. A Majority of elders have depression, hopelessness, insecurity, either moderate or high in both institutional and non-institutional care (Meera, 1997).

Depressed elderly women are more likely to be widowed, lonely and they experience greater financial and environmental stress. (Health Action, April 99).

Table: 25

Distribution of Respondents based on their Dietary Pattern

S. No.	Dietary pattern	N	%
1.	Vegetarian	238	43.0
2.	Non – Vegetarian	315	57.0
Total		553	100.0

From Table 25, it is observed that 43.0 per cent of the respondents are vegetarian and 57.0 per cent of the respondents are non-vegetarian. Thus, a majority of the respondents are non-vegetarian. Observation reveals that almost all the homes provide vegetarian and non vegetarian but with no separate kitchen or vessels for cooking non vegetarian food. Though religious values and dogmas related to religious belief create adjustment and adaptation

problems for vegetarians, homes continue to prepare food for both the vegetarian and non vegetarians

Table: 26

Distribution of Respondents based on Reasons for Admission

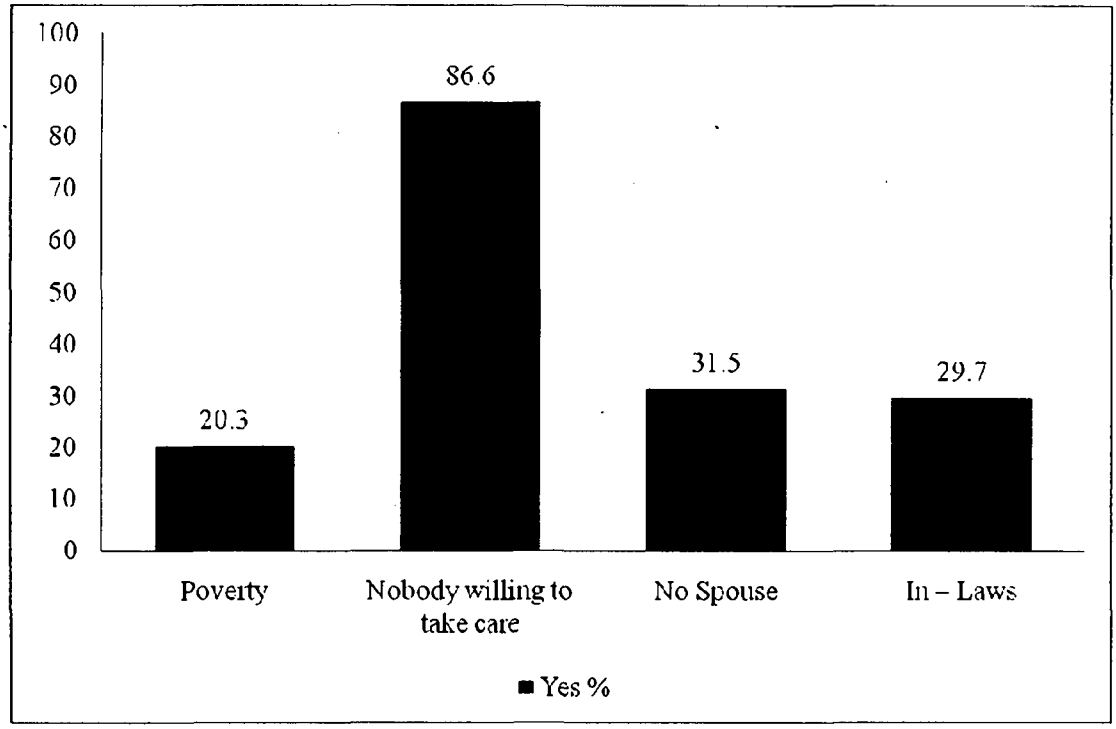
S. No.	Reasons for admission	Yes		No	
		N	%	N	%
1.	Poverty	112	20.3	441	79.7
2.	Nobody willing to take care	479	86.6	74	13.4
3.	No Spouse	174	31.5	379	68.5
4.	In – Laws	164	29.7	389	70.3

Table .26 discusses the various reasons behind the admission of the respondents in the old age homes. It is shocking to know that 86.6 per cent of the respondents were admitted in the home as no family members of the respondents were willing to take care of them. This data has to be corroborated with Table 12 and 13, which shows more than 70 per cent of the respondents have their living son or daughter. Thus, it can be concluded that the respondents have living daughters / sons, who are not willing to take care of their parents in their old age. Further, the Table shows that 'poverty' is not a major cause for their admission in the Home.

Factors cited as reasons for the institutionalization of the aged are economic, social, psychological and cultural. The elderly are retired, most of them from the unorganized sector, with no claim for pension. So they are looked upon as liabilities by families, which are struggling hard to give a better future for their children, with shrinking resources and expanding desires and expenses on children. The sacrificed lot is the elderly. In a study of 100 institutionalized elderly persons in Kerala, Nayar states that in 60 percent of cases, poverty was the major reason for institutionalization, (Nayar 200). Similarly in a study, of 351 inmates of old age homes in Maharashtra it was

DIAGRAM – 26A

DIAGRAM SHOWING THE DATA ON RESPONDENTS REASONS FOR ADMISSION IN OLD AGE HOMES



found that 64 percent had 11nobody to take care of them and among these, 45 percent had no money either (Dandekar, 1996 P.146).

Old age is equivalent to poverty. Most of the inmates of the free old age homes have lived a life of poverty. They have worked in the organized sector, have earned very low income, with great difficulty have risen up their children and have not had any possibility of saving for their old age. They worked as long as they could, and finally, could not earn anything due to their ailing health and deteriorating physical activities and considered themselves as lucky and silently moved into these homes for the aged. In India, 50 percent of the people live below the poverty line and the level of poverty increases with increase in age.

Loneliness, poor health and family conflicts were found to be the major reason for institutionalization. (Reznikov etal 1991, pp 71-73), "Frequent conflicts with family members, lack of proper care by younger generation, isolation, loneliness, lack of own house are prominent reasons for institutionalization. (Saraswathi, 1993 PP 107).

A major factor for institutionalization, accepted by many is lack of cordiality in in-law relationship. In many households, there is persistent conflict between daughter-in- law and mother-in-law or father-in-law. Wherever the mother-in-law had been kind to the daughter-in-law and treated her well, the daughter in law had expressed sympathy towards her and the caring was better. But in some cases where the daughters-in- law felt they were treated badly by their mother in law the quality of care decreased.

Table: 27
Association between various Socio Demographic Conditions and Adjustment

S. No	Factors	Adjustment					Total (553)	Result
		Excellent (13)	Good (53)	Average (124)	Un-satisfactory (57)	Very un-Satisfactory (306)		
1	TYPE OF INSTITTUION							
	Women alone	6 (46.2)	24 (45.3)	25 (20.2)	13 (22.8)	74 (24.2)	142 (25.7)	X^2=16.112 df=4
	Women and men	7 (53.8)	29 (54.7)	99 (79.8)	44 (77.2)	232 (75.8)	411 (74.3)	p<0.05 Sig
2	NATURE OF INSTITUTION							
	Paid	9 (69.2)	40 (75.5)	67 (54.0)	28 (49.1)	179 (58.5)	323 (58.5)	X^2=9.981 df=4
	Unpaid	4 (30.8)	13 (24.5)	57 (46.0)	29 (50.9)	127 (41.5)	127 (41.3)	p<0.05 Sig
3	AGE							
	Below 70	3 (23.1)	16 (30.2)	61 (49.2)	25 (43.9)	110 (35.9)	215 (38.9)	X^2=10.304 df=4
	71 and above	10 (76.9)	37 (69.8)	63 (50.8)	32 (56.1)	196 (64.1)	338 (61.1)	p<0.05 Sig
4	RELIGION							
	Hindu	11 (84.6)	34 (64.2)	97 (78.2)	42 (73.7)	203 (66.3)	387 (70.0)	X^2=8.499 df=4
	Non-Hindu	2 (15.4)	19 (35.8)	27 (21.8)	15 (26.3)	103 (37.7)	166 (30.0)	p>0.05 NS
5	TYPE OF FAMILY							
	Joint	5 (38.5)	23 (43.4)	60 (48.4)	32 (56.1)	157 (51.3)	277 (50.1)	X^2=2.813 df=4
	Nuclear	8 (61.5)	30 (56.6)	64 (51.6)	25 (43.9)	149 (48.7)	276 (49.9)	p>0.05 NS
6	PLACE OF LIVING							
	Rural	5 (38.5)	21 (39.6)	74 (59.7)	80 (31.6)	162 (52.9)	280 (50.6)	X^2=16.330 df=4
	Urban	8 (61.5)	32 (60.4)	50 (40.2)	39 (68.4)	144 (47.1)	273 (49.2)	p<0.05 Sig

7	EDUCATIONAL QUALIFICATION							
	Illiterate	3 (23.1)	10 (18.9)	51 (41.1)	20 (35.1)	135 (44.1)	219 (39.6)	
	Middle	3 (23.1)	11 (20.8)	19 (15.3)	6 (10.5)	34 (11.1)	73 (13.2)	X^2=33.427 df=16 p<0.05 Sig
	High School	3 (23.1)	10 (18.9)	16 (12.9)	6 (10.5)	49 (16.0)	84 (15.2)	
	College	0 (0)	6 (11.3)	5 (4.0)	1 (1.8)	26 (8.5)	38 6.9	
8	OCCUAPTION							
	Retired	1 (7.7)	7 (13.2)	8 (6.5)	4 (7.0)	37 (12.1)	57 (10.3)	
	Employed	6 (46.2)	23 (43.4)	64 (51.6)	30 (52.6)	113 (36.9)	236 (42.7)	X^2=12.299 df=8 p<0.05 Sig
	Unemployed	6 (46.2)	23 (43.4)	52 (41.9)	23 (40.4)	156 (51.0)	260 (47.0)	
9	MONTHLY INCOME							
	Below 1000	2 (5.4)	13 (24.5)	29 (23.4)	12 (21.1)	51 (16.7)	107 (19.3)	
	1000 -2000	3 (21.1)	11 (20.8)	36 (29.0)	15 (26.3)	64 (20.9)	129 (23.3)	
	2001 – 3000	2 (15.4)	4 (7.5)	3 (2.4)	2 (3.6)	24 (7.8)	35 (6.3)	X^2=19.096 df=16 p>0.05 NS
	3001 & above	0 (0)	2 (3.8)	4 (3.2)	5 (8.8)	11 (3.6)	22 (4.0)	
	Not applicable	6 (46.2)	23 (43.4)	52 (41.9)	23 (40.4)	156 (51.0)	260 (47.0)	
10	EXPERIENCE							
	Below 10yrs	0 (0)	6 (11.3)	24 (19.4)	13 (23.8)	39 (29.7)	82 (14.8)	
	11 – 15yrs	2 (15.4)	14 (26.4)	16 (12.9)	9 (15.8)	43 (14.1)	84 (15.2)	X^2=24.887 df=20 p<0.05 Sig
	16 – 20 yrs	2 (15.4)	6 (11.3)	14 (11.3)	1 (1.8)	27 (8.6)	50 (9.0)	
	21 – 25 yrs	2 (15.4)	2 (3.8)	8 (6.5)	4 (7.0)	18 (5.9)	34 (6.1)	
	26 yrs & above	1 (7.7)	2 (3.8)	10 (8.1)	7 (12.3)	23 (7.5)	43 (7.8)	
	Not applicable	6 (46.2)	23 (43.4)	252 (41.9)	23 (40.4)	156 (51.0)	260 (47.0)	

11	EDUCATION OF THE HUSBAND							
	Primary	1 (7.7)	9 (17.0)	28 (22.6)	11 (19.3)	42 (13.7)	91 (16.5)	
	Middle	3 (23.1)	19 (35.8)	51 (41.1)	32 (56.1)	142 (46.4)	247 (44.7)	
	High School	3 (23.1)	9 (17.0)	23 (18.5)	9 (15.8)	33 (10.8)	77 (13.9)	X^2=39.683 df=16 p<0.05 Sig
	College	1 (7.7)	12 (22.6)	15 (12.1)	2 (3.5)	51 (16.7)	8 (14.6)	
	Not applicable	5 (38.5)	4 (7.5)	7 (5.6)	3 (5.3)	38 (12.4)	57 (10.3)	
12	MARITAL STATUS							
	Unmarried	5 (38.5)	4 (7.5)	7 (5.6)	3 (5.3)	38 (12.4)	57 (10.3)	
	Married	4 (30.8)	20 (37.7)	45 (36.3)	31 (54.4)	84 (27.5)	184 (33.3)	X^2=33.139 df=12 p<0.05 Sig
	Widow	4 (30.8)	26 (49.1)	64 (51.6)	22 (38.6)	164 (53.6)	280 (50.6)	
	Separate	0 (0)	3 (5.7)	8 (8.2)	1 (1.8)	20 (6.5)	32 (5.8)	
13.	DURATION OF MARITAL LIFE							
	Below 20 years	0 (0)	7 (13.2)	17 (13.7)	12 (21.1)	31 (10.1)	67 (12.1)	
	21 to 30 years	1 (7.7)	12 (22.6)	18 (14.5)	10 (17.5)	36 (11.8)	77 (13.9)	
	31 t0 40 years	3 (23.1)	15 (28.3)	37 (29.8)	14 (24.6)	77 (25.2)	146 26.4)	X^2=40.227 Df=20 p<0.05 Sig
	41 to 50 years	4 (30.8)	10 (18.9)	26 (21.0)	12 (21.1)	98 (32.0)	150 (27.1)	
	51& above	0 (0.0)	5 (9.4)	19 (15.3)	6 (10.5)	26 (8.5)	56 (10.1)	
	Not Applicable	5 (38.5)	4 (7.5)	7 (5.6)	3 (5.3)	38 (12.4)	57 (10.3)	
14.	TYPE OF MARRIAGE							
	Love	0 (0.0)	4 (7.5)	7 (5.6)	4 (7.0)	21 (6.9)	36 (6.5)	
	Arranged	8 (61.5)	45 (84.9)	110 (88.7)	50 (87.7)	247 (80.7)	460 (83.2)	X^2=18.462 Df=8 p<0.05 Sig
	Unmarried	5 (38.5)	4 (7.5)	7 (5.6)	3 (5.3)	38 (12.4)	57 (10.3)	

15.	PATTERN OF MARRIAGE							
	Blood Relation	3 (23.1)	13 (24.5)	46 (37.1)	24 (42.1)	110 (35.9)	196 (35.4)	X^2=21.952 Df=8 p<0.05 Sig
	Others	5 (38.5)	36 (67.9)	71 (57.3)	30 (52.6)	158 (51.6)	300 (54.2)	
	Unmarried	5 (38.5)	4 (7.5	7 (5.6)	3 (5.3)	38 (12.4)	57 (10.3)	

Old age, which begins approximately at 60 years, is characterised by certain physical and psychological change that are far more likely to lead to poor adjustment and unhappiness than to good adjustment (Hurlock B.Elizabeth, 1981., pp 416-417). Adjustment in old age is the outcome of physical conditions of their living environment, activity level, relationships with family and friends, physical and psychological health conditions, emotional well being, economic status, self-acceptance, freedom, personality traits, outlook towards life, religious attitude etc. The institutionalized elders have to adjust themselves to their present atmosphere and conditions with all their limitations such as deterioration in physical well being, economic insecurity, loss of spouse and friends, unfavorable attitude of family members and society, restricted social circle, disengagement from family and community etc.

Table 27 presents the results of Chi-Square analysis carried out to see whether there is a statistically significant association between various socio-demographic conditions and level of adjustment. It is observed that respondents in institutions for both men and women have very unsatisfactory adjustment than the respondents in institutions for women only. Similarly, respondents of paid homes, respondents of age 71 and above, respondents from rural background, illiterate, respondents who were unemployed before their admission in homes, widows, respondents having long married life ranging from 41 to 50 years, respondents who had arranged marriages and respondents whose marital partners are not blood related have unsatisfactory adjustment.

This observed difference is satisfactorily significant, since the Chi-Square value is significant at 0.05 level.

Elders of rural background had successful living in their own community, with a feeling of closeness with members and such a living condition is absent for the rural respondents in the institutions. Their segregation from their community could be the reason for their very satisfactory adjustment. The elders of the paid homes have less social interaction with co-inmates, as they have limited group activities. Emotionally cut off from family members, relatives, friends, leads to boredom and loneliness, contributing for poor adjustment. Many remain idle for most part of the time. The respondents in the category of 71 and above have deteriorated physical well being and cannot remain active which contributes for their poor adjustment, since physical health is much related to the physical and psychological well-being of the individuals and their adjustment.

The outcome of this research is supported by theory on the psychology of elders. The elderly people develop unfavorable self-concept. They tend to be expressed in maladjustive behaviour of different degrees of severity. (Slater, P.E., and Scarr, P.A., 1964,). Elderly people, as a group are more subject to maladjustment than those who are younger. (Dennis, W.1973,). Successful and better adjustment in old age is associated with economic status of the individual. Lower income is the cause for decreased adjustment with advance in age (Mathew and Sen, 1989). Rural women do not differ significantly from urban women in homes, health, and emotional, self and general adjustment but differ significantly in social adjustment. (Asha C.B. and Subarmanian K.A., 1991).

Elders who have to depend upon their offspring are less well adjusted than those who are economically independent or autonomous (Desai, 1970). Social-adjustment is better around sixties and poor after sixty. Education, personal problems, deprivation and happiness affect adjustment among the elders.

It is seen from the tables 14 and 27 that women with minimum and no educational qualification form 60.7 percent of the respondents and 52.6 percent have negative Self Esteem. Greater the educational level, greater would be the capability to analyze one's own necessities and accept situations and people better. Therefore, education influences self and the acceptance of others i.e better self esteem and adjustment to social situations. When one is able to accept him and others, expectation of the others are balanced and therefore one is aware of what one can give and receive. Therefore, when adjustments are made the ability to get along with others increases and treating other inmates as extended family became easier. Education broadens the prospective and helps interacting with people with varied interests. It helps people look further away from the smaller confines of home and family and looks at improving lives qualitatively. The active process of Self Esteem leading to Adjustment and social behaviour results in a greater level of leading worthy lives.

Table 28

Association between various

Socio Demographic Conditions and Self- Esteem

S. No	Factors	Total Self Esteem			Result
		Negative (393)	Positive (160)	Total (553)	
1	TYPE OF INSTITTUION				
	Women alone	91 (23.2)	51 (31.9)	142 (25.7)	X^2=4.530 df=1 P>0.5 NS
	Women and men	302 (76.8)	109 (68.1)	411 (74.3)	
2	NATURE OF INSTITUTION				
	Paid	222 (56.5)	101 (63.1)	323 (58.4)	X^2=2.061 df=1 P<0.5 significant
	Unpaid	171 (43.5)	59 (36.9)	230 (41.6)	
3	AGE				
	Below 70	147 (37.4)	68 (42.5)	215 (38.9)	X^2=1.242 df=1 P<0.5 significant
	71 and above	246 (62.6)	92 (57.5)	338 (61.2)	
4	RELIGION				
	Hindu	273 (69.5)	114 (71.3)	387 (70.0)	X^2=1.172 df=1 P<0.5 significant
	Non-Hindu	120 (30.5)	46 (28.8)	166 (30.0)	
5	TYPE OF FAMILY				
	Joint	201 (51.1)	76 (47.5)	277 (50.1)	X^2=0.604 df=1 P<0.5 significant
	Nuclear	192 (48.9)	84 (52.5)	276 (49.9)	
6	PLACE OF LIVING				
	Rural	209 (53.2)	71 (44.4)	280 (50.6)	X^2=3.527 df=1 P<0.5 significant
	Urban	184 (46.8)	89 (55.6)	273 (49.4)	

7	EDUCATIONAL QUALIFICATION				
	Illiterate	177 (45.0)	42 (26.3)	219 (39.6)	
	Primary	86 (21.9)	53 (33.1)	139 (25.1)	
	Middle	43 (10.9)	30 (18.8)	73 (13.2)	X^2=21.110 df=4 P>0.5 NS
	High School	60 (15.3)	24 (15.0)	84 (15.2)	
	College	27 (6.9)	11 (6.9)	38 (6.9)	
8	OCCUAPTION				
	Retired	41 (10.4)	16 (10.0)	57 (10.3)	
	Employed	162 (41.2)	74 (46.3)	236 (42.7)	X^2=1.205 df=1 P<0.5 significant
	Unemployed	190 (48.3)	70 (43.8)	260 (47.0)	
9	MONTHLY INCOME				
	Below 1000	74 (18.8)	33 (20.6)	107 (19.3)	
	1000 -2000	87 (22.1)	42 (26.3)	129 (23.3)	
	2000 – 3000	28 (7.1)	7 (4.4)	35 (6.3)	X^2=3.474 df=4 P<0.5 significant
	3001 & above	14 (3.6)	8 (5.0)	22 (4.0)	
	Not appilcable	190 (48.3)	70 (43.8)	260 (47.0)	
10	EXPERIENCE				
	Below 10yrs	61 (15.5)	21 (13.1)	82 (14.8)	
	11 – 15yrs	53 (13.5)	31 (19.4)	84 (15.2)	
	16 – 20 yrs	35 (8.9)	15 (9.4)	50 (9.0)	X^2=4.479 df=5 P<0.5 significant
	21 – 25 yrs	22 (5.6)	12 (7.5)	34 (6.1)	
	26 yrs & above	32 (8.1)	11 (6.9)	43 (7.8)	
	Not applicable	190 (48.3)	70 (43.8)	260 (47.0)	

11	EDUCATION OF THE HUSBAND				
	Primary	62 (15.8)	29 (18.1)	91 (16.5)	
	Middle	181 (46.1)	66 (41.3)	247 (44.7)	
	High School	52 (13.2)	25 (15.6)	77 (13.9)	X^2=1.477 df=4 P<0.5 significant
	College	57 (14.5)	24 (15.0)	81 (14.6)	
	Not applicable	41 (10.4)	16 (10.0)	57 (10.3)	
12	MARITAL STATUS				
	Unmarried	41 (10.4)	16 (10.0)	57 (10.3)	
	Married	131 (33.3)	53 (33.1)	184 (33.3)	X^2=0.049 df=3 P<0.5 significant
	Widow	198 (50.4)	82 (51.3)	280 (50.6)	
	Separate	23 (5.9)	9 (5.6)	32 (5.8)	
13	DURATION OF MARITAL LIFE				
	Below 20 yrs	51 (13.0)	16 (10.0)	67 (12.1)	
	21 – 30 yrs	49 (12.5)	28 (17.5)	77 (13.9)	
	31 – 40 yrs	97 (24.7)	49 (30.6)	146 (26.4)	X^2=9.334 df=5 P<0.5 significant
	41 – 50 yrs	118 (30.0)	32 (20.0)	150 (27.1)	
	51 yrs & above	37 (9.4)	19 (11.9)	56 (10.1)	
	Not applicable	41 (10.4)	16 (10.0)	57 (10.3)	
14	TYPE OF MARRIAGE				
	Love	28 (7.1)	8 (5.0)	36 (6.5)	
	Arranged	324 (82.4)	136 (85.0)	460 (83.2)	X^2=0.899 df=2 P<0.5 significant
	unnamed	41 (10.4)	16 (10.0)	57 (10.3)	

15	PATTERN OF MARRIAGE				
	Blood related	137 (34.9)	59 (36.9)	196 (35.4)	X^2=0.203 df=2 P<0.5 significant
	Others	215 (54.7)	85 (53.1)	300 (54.2)	
	Unnamed	41 (10.4)	16 (10.0)	57 (10.3)	

Self-Esteem is an individual's sense of self-worth, an evaluation that an individual makes and maintains about oneself. The newer environment may or may not strengthen the feeling of self-worth, characterized by feelings of achievements, adequacy, self-confidence and usefulness. Similarly, the environment may or may not be ideal to attain aspiration, goals, values that an elderly person considers as an ideal and wants to attain it. It leads to lowering of self-esteem.

Retirement, change of life style, leaving friends and work environment and social roles that one enjoyed and lack of adjustability to these changes lead to stress. 'Loneliness' and awareness that one's own death is imminent are stressful. But maintaining high self-esteem will help to achieve inner peace and ego-integrity.

The elderly, who are put up in a strange situation to live till the unpredictable time, have to develop a relationship with others. In other words, those elderly are more concerned about their relationship with the other elderly people, with whom they are put up with in the old age homes. The success of relationship among them contributes to the elderly a sense of well-being or Self-Esteem. Persons with high Self-Esteem are generally happier and more able to cope with demands and stresses than persons with low self-esteem. Persons with low Self-Esteem tend to feel unloved and often experience depression and anxiety.

Table 28 shows the results of Chi-Square analysis carried out to see whether there is a statistically significant association between various socio-demographic conditions and the level of Self-Esteem. It is inferred that respondents in paid homes have negative self-esteem. For the majority of the

respondents, the fee is being paid by the family members. This economic dependency could be the reason for the negative Self-Esteem. Similarly, the respondents of the age above 71 years have negative Self-Esteem; respondents belonging to Hindu religion; respondents from joint family, illiterate respondents, unemployed, low monthly income, employed for less than 10 years, widows, having marital life for a period of 41-50 years, respondents of arranged marriage, respondents who married non-relatives have negative Self-Esteem.

The observed difference in these cases is satisfactorily significant, since the Chi-Square values are statistically significant at 0.05 level.

This finding is supported by the findings of other studies. When a person is no longer in an occupation, his or her status and power and Self-Esteem may be lost. (Health Action, 2000,). Generally, elders of paid homes might have been self-employed, economically independent or self-sufficient, or from family of better economic background. For those employed and economically independent, the sudden loss of one's occupational identity and the associated feeling of inadequacy leads to low morale, decreased level of satisfaction, embarrassment, feeling of inferiority and low Self-Esteem (Miller, 1965). Women who had worked throughout their life, face the traumatic experience because of retirement and develop negative self-concept. Even the home-makers who spent their valuable time in household activities, occupied themselves in productive work, contributed for the family well-being and felt a sense of self-worth. These home-makers, who so far felt productive, when pushed into institutions, felt that their productive roles had been nullified. The shift makes them feel unwanted and unworthy and they develop a negative self-concept. This could be reason for their low Self-Esteem.

Studies have pointed to the feminization of poverty as well as the feminization of aging. Studies have also pointed to the risk of becoming increasingly marginalized that rural aged women face. Their illiteracy combined with economic backwardness creates serious problems for the rural

aged, leading to poor Self-Esteem. They enjoy the benefits of better physical infrastructure, if their presence was respected and they had a feeling of self-worth.

Based on the table presented, significant correlations and conclusions have been drawn. The role of economic strata determining the Self-Esteem and Level of Adjustment of the respondents does not seem to contribute significantly as seen in Table No.2 and Table No.19. Although 58.4 percent are affordable enough to be in paid homes, 52.6 percent have negative Self-Esteem and unsatisfactory adjustment. Certain questions like "why am I not wanted" although they can afford them make them loose their trust in primary relationships and that reflects in their present living situations. Hence, emotional well-being determines the way one looks at oneself and others.

A study at Patna revealed a negative correlation of the personality variables such as extravention, neuroticism, dependence proneness authoritarianism with adjustment. (Hussain and Priyadharshini, 1996). "Successful personal adjustment among the ages is more closely related to primary attachment with family and friends" (Rose from Binstock, 1976, p.324).

Table 29

Association between various Socio Demographic and Social Behaviour

S. No	Factors	Social behavior				
		Low (170)	Moderate (237)	High (146)	Total (553)	Result
1	TYPE OF INSTITTUION					
	Women alone	45 (26.5)	47 (19.8)	50 (34.2)	142 (25.7)	X^2=9.918 df=2
	Women and men	125 (73.5)	190 (80.2)	96 (65.8)	414 (74.3)	p<0.05 Sig
2	NATURE OF INSTITUTION					
	Paid	108 (63.5)	72 (48.3)	91 (62.3)	323 (58.4)	X^2=6.374 df=2
	Unpaid	62 (36.5)	113 (47.7)	55 (37.7)	230 (41.6)	p<0.05 Sig
3	AGE					
	Below 70	59 (34.7)	98 (41.4)	58 (39.7)	215 (38.9)	X^2=1.899 df=2
	71 and above	111 (65.3)	139 (58.6)	88 (60.3)	338 (61.1)	p>0.05 NS
4	RELIGION					
	Hindu	116 (68.2)	170 (71.7)	101 (69.2)	387 (70.0)	X^2=0.637 df=2
	Non-Hindu	54 (31.8)	67 (28.2)	45 (30.8)	166 (30.0)	p>0.05 NS
5	TYPE OF FAMILY					
	Joint	81 (47.6)	121 (51.1)	75 (51.4)	277 (50.1)	X^2=0.590 df=2
	Nuclear	89 (52.4)	116 (48.9)	71 (48.6)	276 (50.1)	p>0.05 NS
6.	PLACE OF LIVING					
	Rural	95 (55.9)	125 (57.7)	60 (41.1)	280 (50.6)	X^2=7.609 df=2
	Urban	75 (44.1)	112 (47.0)	86 (58.9)	273 (49.4)	p<0.05 Sig

7	EDUCATIONAL QUALIFICATION					
	Illiterate	91 (53.5)	95 (40.1)	33 (22.6)	219 (39.6)	
	Primary	30 (17.6)	65 (27.4)	44 (30.1)	139 (25.1)	
	Middle	16 (9.4)	27 (11.4)	30 (20.5)	73 (13.2)	X^2=35.604 df=8 p<0.05 Sig
	High School	22 (12.9)	36 (15.2)	26 (17.8)	84 (15.2)	
	College	11 (6.5)	14 (5.9)	13 (8.4)	38 (6.9)	
8	OCCUAPTION					
	Retired	23 (13.5)	19 (8.0)	15 (10.3)	57 (10.3)	
	Employed	61 (31.9)	103 (43.5)	72 (49.3)	236 (42.7)	X^2=8.230 df=4 p>0.05 NS
	Unemployed	86 (50.6)	115 (48.5)	59 (40.4)	260 (47.2)	
9	MONTHLY INCOME					
	Below 1000	33 (19.4)	44 (18.6)	30 (20.5)	107 (19.3)	
	1000 -2000	35 (20.6)	50 (21.1)	44 (30.1)	129 (23.3)	
	2000 – 3000	10 (5.9)	18 (7.6)	7 (4.8)	35 (6.3)	X^2=7.393 df=8 p>0.05 NS
	3001 & above	6 (3.5)	0 (4.2)	6 (4.1)	22 (4.0)	
	Not appilcable	86 (50.6)	115 (48.5)	59 (40.4)	260 (47.0)	
10	EXPERIENCE					
	Below 10yrs	19 (11.2)	39 (16.5)	24 (16.4)	82 (14.8)	
	11 – 15yrs	27 (15.9)	33 (13.9)	34 (16.4)	84 (15.2)	
	16 – 20 yrs	21 (12.4)	13 (5.5)	16 (11.0)	15 (9.0)	X^2=14.226 df=10 p>0.05 NS
	21 – 25 yrs	7 (4.1)	15 (6.3)	12 (8.2)	34 (6.1)	
	26 yrs & above	10 (5.9)	22 (9.3)	11 (7.5)	43 (7.8)	
	Not applicable	86 (50.6)	115 (48.5)	59 (40.4)	260 (47.4)	

11	EDUCATION OF THE HUSBAND					
	Primary	29 (17.1)	41 (17.3)	21 (14.4)	91 (16.5)	
	Middle	74 (43.5)	113 (47.7)	60 (41.1)	247 (44.4)	
	High School	21 (12.4)	33 (13.9)	23 (15.8)	77 (13.9)	X^2=6.062 df=8 p>0.05 NS
	College	29 (17.1)	26 (11.6)	26 (17.8)	81 (14.6)	
	Not applicable	17 (10.0)	24 (10.1)	16 (11.0)	57 (10.3)	
12	MARITAL STATUS					
	Unmarried	17 (10.0)	24 (10.1)	16 (11.0)	57 (10.3)	
	Married	51 (30.0)	84 (35.4)	49 (33.6)	184 (33.3)	X^2=2.054 df=6 p>0.05 NS
	Widow	93 (54.7)	114 (48.1)	73 (50.0)	280 (50.6)	
	Separate	9 (5.3)	15 (6.3)	8 (5.5)	32 (5.8)	
13	DURATION OF MARITAL LIFE					
	Below 20 yrs	19 (11.2)	36 (15.2)	12 (8.2)	67 (12.1)	
	21 – 30 yrs	11 (6.5)	36 (15.2)	30 (20.5)	77 (13.9)	
	31 – 40 yrs	39 (22.9)	69 (29.1)	38 (26.0)	146 (26.4)	X^2=28.600 df=10 p<0.05 Sig
	41 – 50 yrs	62 (36.5)	55 (23.2)	23 (22.6)	150 (27.1)	
	51 yrs & above	22 (12.9)	17 (7.2)	71 (11.6)	56 (10.1)	
	Not applicable	17 (10.0)	24 (10.1)	16 (11.0)	57 (10.3)	
14	TYPE OF MARRIAGE					
	Love	12 (7.1)	14 (5.9)	10 (6.8)	36 (6.5)	
	Arranged	141 (82.9)	111 (84.0)	120 (82.2)	460 (83.2)	X^2=0.356 df=4 p>0.05 NS
	unnamed	17 (10.0)	24 (10.1)	16 (11.0)	57 (10.3)	

15	PATTERN OF MARRIAGE					
	Blood related	57 (33.5)	84 (35.4)	55 (37.7)	196 (35.4)	X^2=0.843 df=4 p>0.05 NS
	Others	99 (56.5)	129 (54.4)	75 (4.4)	300 (54.2)	
	Unnamed	17 (10.0)	24 (10.0)	16 (11.0)	57 (10.3)	

Social Behaviour is an important component that shapes the social interaction of the inmates of old age homes. They have to have satisfactory interaction with the co-inmates to make their life meaningful. Healthy social behaviour is essential to maintain one's psychological and emotional well-being. The absence of interaction will lead to loneliness, isolation and less life-satisfaction. Various socio-demographic variables and personality of the individuals influences the social behaviour of the individual.

Table 29 explains the results of Chi-Square analysis carried out to see whether there is a statistically significant association between various socio-demographic conditions and level of Social Behaviour. It is inferred that respondents in institutions for both men and women have moderate and high level of Social Behaviour than the respondents in institutions for women only. Similarly, respondents of unpaid homes, respondents from urban background, illiterate and respondents who had marital life for more than 30 years have moderate and high-level Social Behaviour than those of paid homes, rural background, literate and have less years of marital life.

Observed differences are satisfactorily significant, since the Chi-Square values are statistically significant at 0.05 level in all the areas.

The findings of this study are supported by findings of other studies. The profile of interaction and relations in the unpaid home was a little different from the paid home. There was homogeneity amongst residents; interpersonal interaction was smooth and normal. But, in paid homes, most of the inmates preferred to live a lonely life, they did not like to become close friends. (Helpage India, Oct 2005).

Reduced income lead to loss of status and affect meaningful social relationship (Bhatia, 1983).

Table 30

ASSOCIATION BETWEEN VARIOUS SOCIO DEMOGRAPHIC CONDITIONS AND RELIGIOUS BEHAVIOUR

S.No	Factors	Religious behaviour				
		Low (149)	Moderate (252)	High (152)	Total (553)	Result
1	TYPE OF INSTITTUION					
	Women alone	43 (28.9)	61 (24.2)	38 (25.0)	142 (25.7)	X^2=1..13 Df=2 p>0.05 NS
	Women and men	106 (71.1)	191 (75,8)	114 (75.0)	411 (74.3)	
2	NATURE OF INSTITUTION					
	Paid	90 (60.4)	142 (56.3)	91 (59.9)	323 (58.4)	X^2=.817 Df-=2 p>0.05 NS
	Unpaid	59 (39.6)	110 (43.7)	61 (40.1)	230 (41.6)	
3	AGE					
	Below 70	54 (36.2)	106 (42.1)	55 (36.2)	215 (38.9)	X^2=1.976 Df=2 p>0.05 NS
	71 and above	95 (63.8)	146 (57.9)	97 (63,8)	338 (61,1)	
4	RELIGION					
	Hindu	110 (73,8)	176 (69.8)	101 (66.4)	387 (70.0)	X^2=1.954 Df=2 p>0.05 NS
	Non-Hindu	39 (26.2)	76 (30.2)	51 (33.6)	166 (30.0_	
5	TYPE OF FAMILY					
	Joint	78 (52,3)	129 (51,2)	70 (46.1)	277 (50,1)	X^2=1.417 Df=2 p>0.05 NS
	Nuclear	71 (47.7)	123 (48,8)	82 (53,9)	276 (49,9	
6.	PLACE OF LIVING					
	Rural	55 (36.9)	132 (52,4)	93 (61,2)	280 (50,6)	X^2=18,299 Df=2 p<0.05 Sig
	Urban	94 (63,1)	120 (47.6)	59 (38.8)	273 (49.4)	

7	EDUCATIONAL QUALIFICATION					
	Illiterate	55 (36.9)	92 (36.5)	72 (47.4)	219 (39.6)	X^2=8.039 Df=8 p>0.05 NS
	Primary	36 (24.2)	71 (28.2)	32 (21.1)	139 (25.1)	
	Middle	25 (16.8)	30 (11.9)	18 (11.8)	73 (13.2)	
	High School	22 (14.8)	42 (16.7)	20 (13.2)	84 (15.2)	
	College	11 (7.4)	17 (6.7)	10 (6.6)	38 (6.9)	
8	OCCUAPTION					
	Retired	15 (10.1)	23 (9.1)	19 (12.5)	57 (13.3)	X^2=2.780 Df=4 p>0.05 NS
	Employed	70 (47.0)	105 (41.7)	61 (40.1	236 (42.7)	
	Unemployed	64 (43.06)	124 (49.2)	72 (47.4)	260 (47.0)	
9	MONTHLY INCOME					
	Below 1000	27 (18.1)	44 (17.5)	36 (23.7)	107 (19.3	X^2=7.901 Df=8 p>0.05 NS
	1000 -2000	38 (25.5)	63 (25.0)	28 (18.4)	129 (23.3)	
	2001 – 3000	12 (8.1)	12 (4.8)	11 (7.2)	35 (6.3)	
	3001 & above	8 (5.4)	9 (3.6)	5 (3.3)	22 (4.0)	
	Not appilcable	64 (43.0)	124 (49.2)	72 (47.4)	260 (47.0)	
10	EXPERIENCE					
	Below 10yrs	23 (15.4)	43 (17.1)	16 (10.5)	82 (14.8)	X^2=8.798 Df=10 p>0.05 NS
	11 – 15yrs	24 (16.1)	34 (13.5)	26 (17.1)	84 (15.2)	
	16 – 20 yrs	``14 (9.4)	20 (7.9)	16 (10.5)	50 (9.0)	
	21 – 25 yrs	13 (8.7)	14 (5.6)	7 (4.6)	34 (6,1)	
	26 yrs & above	11 (7.4)	17 (6.7)	15 (9.9)	43 (7.8)	
	Not applicable	64 (43.0)	124 (49.2)	72 (47.4)	260 (47.0)	

11	EDUCATION OF THE HUSBAND					
	Primary	25 (16.8)	39 (15.5)	27 (17.8)	91 (16.5)	X^2=7.238 Df=8 p>0.05 NS
	Middle	59 (39.6)	122 (48,4)	66 (43.4)	247 (4.7)	
	High School	26 (17.4)	32 (12.7)	19 (12.5)	77 (13.9)	
	College	19 (12.8)	39 (15.5)	23 (15.1)	81 (14.6)	
	Not applicable	20 (13.4)	20 (7.9)	17 (11.2)	57 (10.3)	
12	MARITAL STATUS					
	Unmarried	20 (13.4)	20 (7.9)	17 (11.2)	57 (10.3)	X^2=10.790 Df=6 p>0.05 NS
	Married	60 (40.3)	76 (30.2)	48 (31.6)	184 (33.3)	
	Widow	64 (43.0)	139 (55.2)	77 (50,7)	280 (50.6)	
	Separate	5 (3.4)	17 (6.7)	10 (6.6)	32 (5.8)	
13	DURATION OF MARITAL LIFE					
	Below 20 yrs	22 (14.8)	29 (11.5)	16 (10.5)	67 (12.1)	X^2=15.750 Df=10 p>0.05 NS
	21 – 30 yrs	17 (11.4)	46 (18.3)	14 (9.2)	77 (13.9)	
	31 – 40 yrs	34 (22.8)	70 (27.8)	42 (27.6)	146 (26.4)	
	41 – 50 yrs	44 (29.5)	58 (23.0)	48 (31.6)	150 (27.1)	
	51 yrs & above	12 (8.1)	29 (11.5)	15 (9.9)	56 (10.1)	
	Not applicable	20 (13.4)	20 (7.9)	17 (11.2)	57 (10.3)	
14	TYPE OF MARRIAGE					
	Love	3 (2.0)	22 (8.7)	11 (7.2)	36 (6.5)	X^2=9.632 Df=4 p<0.05 Sig
	Arranged	126 (84.6)	210 (83.3)	124 (81.6)	460 (83.2)	
	unnamed	20 (13.4)	20 (7.9)	17 (11.2)	57 (10.3)	
15	PATTERN OF MARRIAGE					
	Blood related	47 (31.5)	89 (35.3)	60 (39.5)	196 (35.4)	X^2=5.209 Df=4 p>0.05 NS
	Others	82 (59.0)	143 (56.7)	75 (49.3)	300 (54.2)	
	Unnamed	20 (13.4)	20 (7.9)	17 (11.2)	57 (10.3)	

Religious interest plays an important role in the individual's lifes. Religious concepts are blindly accepted from childhood, though it was reinvestigated by many in their adolescent period. During the adulthood period, the individuals have formulated a philosophy of a life based on religious belief that is satisfactory to them, based on their exposure and experiences. When the responsibilities of parenthood are assumed, the religious faith is stabilized and all the rituals related to religion are practiced. Particularly, the married women are expected to observe the religious faith and rituals though they have a negative attitude towards religion. A Religious awakening takes place and it continues in their later life.

Table 30 illustrates the results of Chi-Square analysis carried out to see whether there is a statistically significant association between various socio-demographic conditions and the level of religious attitude. It is inferred that respondents from a rural background have a moderate and high level of religious attitude than respondents of urban background. Similarly, respondents of arranged marriages have moderate and high level of religious attitude than respondents of love marriages and unmarried respondents. All the other socio-economic variables are not significantly associated with the religious attitude of the respondents.

This observed difference is satisfactorily significant, since the Chi-Square value is significant at 0.05 level.

Faith in God grew firmer with age though the visits to places of worship decreased over the years (Gaur Rajan, 1999).

Table 31

ASSOCIATION BETWEEN VARIOUS SOCIO DEMOGRAPHIC CONDITIONS AND GERIATRIC DEPRESSION

S.no	Factors	depression				
		Normal (119)	**Moderate (78)**	**Severe (356)**	**Total (553)**	**Result**
1	TYPE OF INSTITTUION					
	Women alone	43 (36.1)	11 (14.1)	88 (24.7)	142 (25.7)	X^2=12.466 df=2 p<0.05 Sig
	Women and men	76 (63.9)	67 (85.9)	269 (75.3)	414 (74.3)	
2	NATURE OF INSTITUTION					
	Paid	72 (60.5)	39 (50.0)	212 (59.6)	323 (58.4)	X^2=2.676 df=2 p>0.05 NS
	Unpaid	47 (39.5)	39 (50.0)	114 (40.4)	230 (41.6)	
3	AGE					
	Below 70	45 (31.8)	43 (55.1)	127 (35.7)	215 (38.9)	X^2=10.262 df=2 p<0.05 Sig
	71 and above	74 (62.2)	35 (44.9)	229 (64.3)	338 (61.1)	
4	RELIGION					
	Hindu	77 (64.7)	60 (76.9)	250 (70.2)	387 (70.0)	X^2=3.376 df=2 p>0.05 NS
	Non-Hindu	42 (35.3)	18 (23.1)	106 (29.8)	166 (30.0)	
5	TYPE OF FAMILY					
	Joint	56 (47.1)	39 (50.0)	182 (51.1)	277 (50.1)	X^2=0.590 df=2 p>0.05 NS
	Nuclear	63 (52.9)	39 (50.0)	174 (51.1)	276 (50.1)	
6.	PLACE OF LIVING					
	Rural	51 (42.9)	32 (41.0)	197 (55.3)	280 (50.6)	X^2=8.910 df=2 p<0.05 Sig
	Urban	68 (57.1)	46 (59.0)	159 (44.7)	273 (49.4)	

7	EDUCATIONAL QUALIFICATION					
	Illiterate	31 (26.1)	28 (35.9)	160 (44.9)	219 (39.6)	
	Primary	32 (26.9)	28 (35.9)	79 (22.2)	139 (25.1)	
	Middle	26 (21.8)	6 (7.7)	41 (11.5)	73 (13.2)	X^2=24.99 df=8 p<0.05 Sig
	High School	19 (16.0)	12 (5.4)	53 (14.9)	84 (15.2)	
	College	11 (9.2)	4 (5.1)	23 (6.5)	38 (6.9)	
8	OCCUAPTION					
	Retired	13 (10.9)	7 (9.0)	37 (10.4)	57 (10.3)	
	Employed	50 (42.0)	41 (52.6)	145 (40.7)	236 (42.7)	X^2=3.772 df=4 p>0.05 NS
	Unemployed	56 (47.1)	30 (38.5)	174 (48.9)	260 (47.0)	
9	MONTHLY INCOME					
	Below 1000	22 (18.5)	20 (25.6)	65 (18.3)	107 (19.3)	
	1000 -2000	30 (25.2)	12 (15.4)	87 (24.4)	129 (23.3)	
	2000 – 3000	6 (5.0)	9 (11.5)	20 (5.6)	35 (6.3)	X^2=15.888 df=8 p<0.05 Sig
	3001 & above	5 (4.2)	7 (9.0)	10 (2.8)	22 (4.0)	
	Not appilcable	56 (47.1)	30 (38.5)	174 (48.9)	260 (47.0)	
10	EXPERIENCE					
	Below 10yrs	13 (10.9)	22 (28.2)	47 (13.2)	82 (14.8)	
	11 – 15yrs	23 (19.3)	12 (15.4)	49 (13.8)	84 (15.2)	
	16 – 20 yrs	12 (10.1)	3 (3.8)	35 (9.8)	15 (9.0)	X^2=24.593 df=10 p<0.05 Sig
	21 – 25 yrs	9 (7.6)	1 (1.3)	24 (6.7)	34 (6.1)	
	26 yrs & above	6 (5.0)	10 (12.8)	27 (7.6)	43 (7.8)	
	Not applicable	56 (47.1)	30 (38.5)	174 (48.9)	260 (47.0)	

11	EDUCATION OF THE HUSBAND					
	Primary	16 (13.4)	15 (19.2)	60 (16.9)	91 (16.5)	X^2=10.457 df=8 p>0.05 NS
	Middle	50 (42.0)	44 (56.4)	153 (43.0)	247 (44.7)	
	High School	17 (14.3)	9 (11.5)	51 (14.3)	77 (13.9)	
	College	22 (18.5)	6 (7.7)	53 (14.9)	81 (14.6)	
	Not applicable	14 (11.8)	4 (5.1)	39 (11.O)	57 (10.3)	
12	MARITAL STATUS					
	Unmarried	14 (14.8)	4 (5.1)	39 (11.0)	57 (10.3)	X^2=5.828 df=6 p>0.05 NS
	Married	43 (36.1)	31 (39.7)	110 (30.9)	184 (33.3)	
	Widow	57 (47.9)	37 (47.4)	186 (52.2)	280 (50.6)	
	Separate	5 (4.2)	6 (7.7)	21 (5.9)	32 (5.8)	
13	DURATION OF MARITAL LIFE					
	Below 20 yrs	12 (10.1)	16 (20.5)	39 (11.0)	67 (12.1)	X^2=14.753 df=10 p>0.05 NS
	21 – 30 yrs	19 (16.0)	14 (17.9)	44 (12.4)	77 (13.9)	
	31 – 40 yrs	31 (26.1)	22 (28.2)	93 (26.1)	146 (26.4)	
	41 – 50 yrs	27 (22.7)	17 (21.8)	106 (28.8)	150 (27.1)	
	51 yrs & above	16 (13.4)	5 (6.4)	35 (9.8)	56 (10.1)	
	Not applicable	14 (11.8)	4 (5.1)	39 (11.0)	57 (10.3)	
14	TYPE OF MARRIAGE					
	Love	7 (5.9)	6 (7.1)	23 (6.5)	36 (6.5)	X^2=2.836 df=4 p>0.05 NS
	Arranged	98 (82.4)	68 (87.2)	294 (82.6)	460 (83.2)	
	unnamed	14 (11.8)	4 (5.1)	39 (11.0)	57 (10.3)	

15	PATTERN OF MARRIAGE					
	Blood related	41 (34.5)	37 (47.4)	118 (33.1)	196 (35.4)	X^2=6.999 df=4 p>0.05 NS
	Others	64 (53.8)	37 (47.4)	119 (55.9)	300 (54.2)	
	Unnamed	14 (11.8)	4 (5.1)	39 (11.0)	57 (10.3)	

Table 31 illustrates the results of Chi-Square analysis carried out to see whether there is a statistically significant association between various socio-demographic conditions and the level of depression.

It is observed that respondents in institutions for both men and women have severe depression rather than the respondents in institutions for women only. Similarly, respondents of paid homes, respondents of age 71 and above, respondents from rural background, illiterate, respondents who were from a low economic background having a monthly income of less than Rs.2000 per month, women who were unemployed before their admission have a severe level of geriatric depression than others. These observed differences are statistically significant, since the Chi-Square values are statistically significant at 0.05 level.

Studies conducted on the aged in the old age homes revealed that most aged people are not happy at being separated from their kin; they are more pessimistic about the future and feel more lonely and depressed. (Health Action, 2000,)

Depressed elderly women are more likely to be widowed, lonely and they experience greater financial and environmental stress.

Studies have shown that rural women in India who face poverty, discrimination, and environmental stress have higher scores on psychological distress than urban women living in a more comfortable condition. (Health Action, 1999,)

A study conducted in rural Karnataka shows that a sizeable proportion of elderly women do not have any independent savings inspite of their continued labour force in the field of agriculture.

Economic conditions significantly influence the depression level of the aged (Patel et al., 1998).

Table 32

ASSOCIATION BETWEEN VARIOUS SOCIO DEMOGRAPHIC CONDITIONS AND LEVEL OF LIFE-SATISFACTION

S.no	Factors	Level of life-satisfaction				
		Low (276)	Moderate (149)	High (120)	Total (553)	Result
1	TYPE OF INSTITTUION					
	Women alone	70 (35.4)	30 (20.1)	42 (32.8)	142 (25.7)	X^2=5.828 df=2 p<0.05 Sig
	Women and men	206 (74.6)	119 (79.9)	86 (67.2)	411 (74.3)	
2	NATURE OF INSTITUTION					
	Paid	173 (62.7)	72 (48.3)	78 (60.9)	323 (58.4)	X^2=8.651df= p<0.05 Sig
	Unpaid	103 (37.3)	77 (51.7)	50 (39.1)	230 (41.6)	
3	AGE					
	Below 70	98 (35.5)	62 (41.6)	55 (43.0)	215 (38.9)	X^2=2.689 df=2 p>0.05 NS
	71 and above	178 (64.5)	87 (58.4)	73 (57.0)	338 (61.1)	
4	RELIGION					
	Hindu	194 (70.3)	109 (73.2)	84 (65.6)	387 (70.0)	X^2=1.883 df= p>0.05 NS
	Non-Hindu	82 (29.7)	40 (26.8)	44 (34.4)	166 (30.0)	
5	TYPE OF FAMILY					
	Joint	136 (49.3)	78 (52.3)	63 (49.2)	277 (50.1)	X^2=0.416 df=2 p>0.05 NS
	Nuclear	140 (50.7)	71 (47.7)	65 (58.8)	276 (50.1)	
6.	PLACE OF LIVING					
	Rural	143 (51.8)	85 (57.0)	52 (40.6)	280 (50.6)	X^2=7.735 df=2 p<0.05 Sig
	Urban	133 (48.2)	64 (43.0)	76 (59.4)	273 (49.4)	

7	EDUCATIONAL QUALIFICATION					
	illiterate	120 (43.5)	66 (44.3)	33 (25.8)	219 (39.6)	X^2=30.459 df=8 p<0.05 Sig
	Primary	58 (21.0)	48 (32.2)	33 (25.8)	139 (25.1)	
	Middle	35 (12.7)	9 (6.0)	29 (22.7)	73 (13.2)	
	High School	45 (16.3)	16 (10.7)	23 (18.0)	84 (15.0)	
	College	18 (6.5)	10 (6.7)	10 (7.8)	38 (6.9)	
8	OCCUAPTION					
	Retired	33 (25.0)	11 (7.4)	13 (10.2)	57 (10.3)	X^2=2.591 df=4 p>0.05 NS
	Employed	116 (42.0)	63 (42.3)	57 (44.5)	236 (42.7)	
	Unemployed	127 (46.0)	75 (50.3)	58 (43.5)	260 (47.0)	
9	MONTHLY INCOME					
	Below 1000	52 (18.8)	30 (25.1)	25 (19.5)	107 (19.3)	X^2=13.466 df=8 p>0.05 NS
	1000 -2000	72 (26.1)	28 (18.8)	29 (22.5)	129 (23.3)	
	2000 – 3000	20 (7.2)	5 (3.4)	10 (7.8)	35 (6.3)	
	3001 & above	5 (12.8)	11 (7.4)	6 (4.7)	22 (4.06)	
	Not appilcable	127 (46.0)	75 (53.3)	58 (45.3)	260 (47.0)	
10	EXPERIENCE					
	Below 10yrs	39 (14.1)	8 (18.8)	50 (11.7)	82 (14.8)	X^2=13.984 df=10 p>0.05 NS
	11 – 15yrs	42 (15.6)	18 (12.1)	23 (18.0)	84 (15.2)	
	16 – 20 yrs	32 (11.6)	5 (3.4)	13 (10.2)	50 (9.0)	
	21 – 25 yrs	17 (6.2)	8 (5.4)	9 (7.0)	34 (6.1)	
	26 yrs & above	18 (6.5)	15 (10.1)	10 (7.8)	43 (7.8)	
	Not applicable	127 (46.0)	75 (50.3)	58 (45.3)	216 (47.0)	

11	EDUCATION OF THE HUSBAND					
	Primary	47 (17.0)	30 (20.1)	14 (10.9)	91 (16.5)	X^2=10.413 df=8 p>0.05 NS
	Secondary	117 (42.4)	69 (46.3)	61 (47.7)	247 (44.7)	
	Hr.sec	36 (13.3)	24 (16.1)	17 (13.3)	77 (13.9)	
	College	46 (16.7)	13 (8.7)	22 (17.2)	81 (14.6)	
	Not applicable	30 (10.9)	13 (8.7)	14 (10.9)	57 (10.3)	
12	MARITAL STATUS					
	Unmarried	30 (10.9)	13 (8.7)	14 (10.9)	57 (10.3)	X^2=1.808 df=6 p>0.05 NS
	Married	86 (31.2)	52 (34.9)	6 (35.9)	184 (33.4)	
	Widow	143 (51.8)	75 (50.3)	62 (48.4)	280 (50.6)	
	Separate	17 (6.2)	9 (6.0)	6 (4.7)	32 (5.8)	
13	DURATION OF MARITAL LIFE					
	Below 20 yrs	36 (13.0)	16 (10.7)	15 (11.7)	67 (12.1)	X^2=13.953 df=10 p>0.05 NS
	21 – 30 yrs	30 (10.9)	26 (17.4)	21 (16.4)	77 (13.9)	
	31 – 40 yrs	67 (24.3)	48 (32.2)	31 (24.2)	146 (26.4)	
	41 – 50 yrs	87 (31.5)	34 (22.8)	29 (22.7)	150 (27.1)	
	51 yrs & above	26 (9.4)	12 (8.1)	18 (14.1)	56 (10.1)	
	Not applicable	30 (10.9)	13 (8.7)	14 (10.3)	57 (10.3)	
14	TYPE OF MARRIAGE					
	Love	17 (6.2)	12 (8.1)	7 (5.5)	36 (6.5)	X^2=1.311 df=4 p>0.05 NS
	Arranged	229 (83.0)	124 (83.2)	107 (83.6)	460 (83.2)	
	unnamed	30 (10.9)	13 (8.7)	14 (10.3)	57 (10.3)	
15	PATTERN OF MARRIAGE					
	Blood related	91 (33.0)	62 (41.6)	43 (33.6)	196 (35.4)	X^2=3.493 df=4 p>0.05 NS
	Others	155 (56.2)	74 (49.7)	71 (55.5)	300 (54.2)	
	Unnamed	30 (10.9)	13 (8.7)	14 (10.9)	57 (10.3)	

Table 32 shows the results of Chi-Square analysis carried out to see whether there is a statistically significant association between various socio-demographic conditions and the level of Life-Satisfaction. It is inferred that respondents in institutions for both men and women have low Life-Satisfaction than the respondents in institutions for women only. Similarly, respondents of paid homes, respondents from rural background and illiterate have low Life-Satisfaction than respondents of unpaid homes, urban background and literates.

This observed difference is satisfactorily significant, since the Chi-Square values is significant at 0.05 level.

The findings of other related studies that discuss the association of socio-demographic variables and Life-Satisfaction say that: Non-institutionalized elderly have a high Life-Satisfaction than the institutionalized elderly (Gopal and Chandha, 1991). Financial security is closely connected with Life-Satisfaction (Kahana et al., 1995). Elders who have less education, low socio-economic levels, poor physical health have low life-satisfaction. (Auino, Russell, Cutrona and Altmairer, 1996). Family based aged have proved to be the most psychologically and socially satisfied as their Life-Satisfaction is significantly higher than those of others (Vijayashree, 1988). Loss of income leads to lower Life-Satisfaction (Ghat Field, Water F., 1977). Those who got married at a later stage have better Life-Satisfaction. (Suseela Mathew, 1971).

Thus, this study reiterates the significant association between socio-demographic variables such as geographical region – whether the elders are from rural or urban background, their economic status and their literacy level and level of Life-Satisfaction. The study also established an association between the type of institution (whether the institution is for unisex or bisex) and level of Life-Satisfaction.

The institutions, specifically for women have approximately 40 elderly women. Thus, such institutions have a comparatively large size of inmates and a group of homogenous nature. That could be the reason for the establishment

of this new association with Life-Satisfaction. The study established this new association with Life-Satisfaction, which is statistically significant.

Married people are found to be low on hopelessness and high on Life-Satisfaction as compared to their widow or widower counterparts (Chadhan et al 1992). The female more often scores low on Life-Satisfaction and the variable is strongly associated with relational variables, say marital happiness, rather than socio economic factors like income level (Kart and Sharma 1996).

Table: 33

Distribution of Respondents based on Self - Esteem and Adjustment

S. No	Self - Esteem	Adjustment					Total
		Very Unsatis factory	Unsatisfactory	Average	Good	Excellent	
1	Negative	291 (52.6)	39 (7.1)	58 (10.5)	2 (4.0)	3 (5.0)	393 (71.1)
2	Positive	15 (2.7)	18 (33.0)	66 (11.9)	51 (9.2)	10 (1.8)	160 (28.9)
	Total	306 (55.3)	57 (10.3)	124 (22.4)	53 (9.6)	13 (2.4)	553 (100.0)

Figures in Paranthesis are percentage to Total (553)

Chi-Square: 253.00 df = 4 P< 0.05 Significant, "r" value =0.706 (P<0.05)

Life from beginning to end is a continuous series of adjustments and changes. Unless these adjustments are made by individuals in a satisfactory way, these individuals cannot adequately respond to society. Some of the adjustments associated with ageing are the maintenance of Self Esteem in the face of physical and mental decline coping with grief and depression associated with personal losses, remaining a contributing mentor of the society and retaining some sense of identify in the ever-changing environment.

The level of Self Esteem and the level of Adjustment are cross tabulated in Table.33. It has been found that 52.6 percent of the respondents with negative Self-Esteem have very unsatisfactory adjustment. But 1.8 percent of the respondents with high Self Esteem have an excellent adjustment. This

observed difference is statistically significant, since Chi-square value is significant at 0.05 level.

Further the Karl Pearson's "r" value for the above two variables are found to be 0.706 ($P<0.05$) which indicates that the two variables under investigation are negatively, and also significantly associated. Hence, it can be stated that by and large those who have negative Self Esteem have unsatisfactory adjustment and those who have positive Self Esteem have an excellent and good adjustment.

Elderly women have more adjustment problems than elderly men (Nair 1989, Subramaniayan 1990). Further, another study shows the factors of emotional, social and home which aggravate the problems of adjustment faced by elders (Coli, 1983).

A study on emotional and Social Adjustment to ageing brought out the result that well adjusted men on the whole had good health, happy family relations, were economically secure, socially active, satisfied with their achievements, happily disposed, highly hopeful and hold themselves with regard and confidence, whereas the health worsened among poorly adjusted man. Munjal (1969). Another research attempted to investigate the self concept among the elderly, and was found that the elderly had negative self concept. The self concept of an individual deeply affects not only his relationship to himself, but his relation to other people and the world at large.

Further, it is stated that a realistic self-evaluation and a full measure of self acceptance and Self-Esteem were regarded as foundation stones of healthy adjustment (Rogers 1951). Elderly women have more problems of adjustment than elderly men (Asha C.B and Subramanian, K.A 1991).

Further, a study revealed that adjustment problems of older widows and older non-widows in the rural areas found the indication of poor adjustment among widows than in non-widows (Jamuna J. and Ramamurthi. P.V.1998).

Table No: 34

Distribution of Respondents based on Social Behaviour and Adjustment

S. No.	Social Behaviour	Adjustment					Total
		Very Unsatisfactory	Unsatisfactory	Average	Good	Excellent	
1	Low	148 (26.8%)	4 (0.7 %)	17 (3.1 %)	1 (0.2 %)	0 (.0 %)	170 (30.7 %)
2	Moderate	137 (24.8 %)	41 (7.4 %)	53 (9.6 %)	2 (0.4 %)	4 (0.7 %)	237 (42.9 %)
3	High	21 (3.8 %)	12 (2.2 %)	54 (9.8 %)	50 (9.0 %)	9 (1.6 %)	146 (26.4 %)
	Total	306 (55.3 %)	57 (10.3 %)	124 (22.4 %)	53 (9.6 %)	13 (2.4 %)	553 (100.0 %)

Figures in paranthesis are percentage to Total: 553

Chi-Square: 262.607 df = 8 P< 0.05 Significant, "r" = - 0.651

Social Behaviour is behavior that is particularly social and is oriented towards other 'selves'. Such behaviour includes components such as perceiving, thinking, moral, intentional and a behaving person considers the intentional or rational meaning of the other's feeling of expression, involves expectations about the others' act and actions and manifests and orients to invoke in another self, certain experiences and interactions.

Social Behaviour is adaptability to changed situations, positive communication pattern, optimism, healthy outlook towards life, initiatives to take up roles, realistic expectation and the ability to adjust harmoniously. It seems that social adjustment has a direct and strong bearing on Life Satisfaction.

It may be noted that qualities like adaptability to changed situations, positive communication pattern, optimism, healthy outlook towards life, initiatives to take up roles, realistic expectation are among other essential components of the ability to adjust harmoniously. It seems that social adjustment has a direct and strong bearing on the life satisfaction. Social adjustment is the adaptability of the persons to the social environment.

In Table 34, the researcher finds out the association between Adjustment and Social Behaviour. It has been found that 26.8 percent of the respondents who are having very unsatisfactory adjustment have a low level of social behavior, whereas 1.6 percent of the respondents who are having a high Social Behaviour have excellent adjustment. This observed difference is statistically significant at 0.05 level.

Further the Karl Pearson's "r" value is found to be -0.651 (P<0.05 Significant), which indicates that the two variables under investigation are negatively and significantly associated. Hence, it can be stated the lower the level of Social Behaviour the higher will be the maladjustment.

Table: 35

Distribution of Respondents based on Religious Attitude and Adjustment

S. No.	Religious Attitude	Adjustment					Total
		Excellent	Good	Average	Unsatisfactory	Very Unsatisfactory	
1	Low	8 (1.4)	30 (5.4)	41 (7.4)	18 (3.3)	52 (9.4)	149 (26.9)
2	Moderate	5 (0.9)	23 (4.2)	73 (13.2)	28 (5.1)	123 (22.2)	252 (46.6)
3	High	0 (0.0)	0 (0.0)	10 (1.8)	11 (2.0)	131 (23.7)	152 (27.5)
	Total	13 (2.4)	53 (9.6)	124 (22.4)	57 (10.3)	306 (55.3)	553 (100.0)

Figures in Paranthesis are percentage to Total (553)

Chi-Square: 106.30 df = 8 P< 0.05 Significant, "r" value = -0.401

The level of Religious Attitude and the level of adjustment are cross tabulated in the above table to derive the association between these two factors.

It has been found that 9.4 percent of the respondents who are having a low Religious Attitude have a high have level of unsatisfactory Adjustment, but 23.7 percent of the respondents having high religious attitude have high level of Adjustment. 14.2 percent of the respondents having average and above

average level of Adjustment have low level of religious attitude. That shows Religious Attitude and adjustment are directly associated to each other.

Further the Karl Pearson's "r" value is found to be -0.401 which indicates the two variables under investigations are negatively and significantly associated. Hence, it can be stated the lower the level of Religious Attitude the higher will be the unsatisfactory maladjustment.

The result of this table has to be discussed by corroborating the data of table: 14.

Lack of education amounts to lack of exposure to concepts and wider knowledge. Dogmatic religious attitudes are formed due to lack of education and exposure to other religious rituals from the core of religion, while deeper aspects of religion are not known. The ability to develop tolerance, discipline, forgiveness, inner strength and love for fellow human beings is lost when one rigidly practices. Their own religion. An educated person would be willing to relate whatever religion teaches and live with fellow beings in harmony and accept the misgivings and failures of their kith and kin and go through the remaining years with forgiveness and peace.

However this logic is explained in table:35, where religious attitude and adjustment are in direct proportion to each other. This could be because of an understanding of the inevitability of life situations.

There exists a positive relationship between religious belief and Depression and spirituality and well being. Spirituality need not be necessarily associated with belief in God or religion. Though spirituality is difficult to define, its practices are easy. It implies an affiliation to a higher power of seeing all in one and one in all and the individual in the divided. (ReJchel, 2000). The lines from Bhagvad Gita on the similarity between changing the old body to the new for the spirit and changing the old clothes to the new offers a new perspective to one's own mortality (Raman 1997). Sigmund Freud, though an atheist, recognized the need for and the usefulness of religion in the resolution of the conflicts in his patients and attributed the modern man's under

spread mental anguish to his increasing inability to believe in God. Freud expressed that religion could assuage guilt feelings, especially of the aggressive type and helps one to come to terms with the problem of inevitable dissolution death (Rao Venkoba A, Gita and Mental Sciences, 1980).

Table No: 36

Distribution of Respondents based on Geriatric Depression and Adjustment

S. No.	Geriatric Depression	Adjustment					Total
		Excellent	Good	Average	Unsatisfactory	Very Unsatisfactory	
1	Normal	11 (2.0)	41 (7.4)	41 (7.4)	9 (1.6)	17 (3.1)	119 (21.5)
2	Moderate	0 (.0)	10 (1.8)	25 (4.5)	22 (4.0)	21 (3.8)	78 (14.1)
3	Severe	2 (0.4)	2 (0.4)	58 (10.5)	26 (4.7)	268 (48.5)	356 (64.4)
	Total	13 (2.4)	53 (9.6)	124 (22.4)	57 (10.3)	306 (55.3)	553 (100.0)

Figures in Paranthesis are percentage to Total (553)

Chi-Square: 256.92 df = 8 P< 0.05 Significant, "r" = +0.636

The level of Geriatric Depression and level of Adjustment are cross tabulated in the Table : 36 which shows the association between two factors.

It has been found that out of 48.5 percent of the respondents having severe Geriatric Depression, have very unsatisfactory adjustment. 10.5 percent of the respondents with severe depression have average level of Adjustment whereas 2.0 percent at normal level of Geriatric Depression have excellent Adjustments and less than 1 percent of the respondents having severe Geriatric Depression have an excellent level of adjustment.

64.4 percent of the respondents have severe geriatric depression. 14.1 percent have moderate geriatric depression and 21.5 percent have normal level of geriatric depression. Only 1.8 percent of the respondents having moderate

level of depression have a good level of adjustment and 4.5 respondents have an average level of adjustment. 16.8 percent of respondents who have a normal level of geriatric depression have an average and above average level of adjustment. Depression in the elderly is a wide spread problem. Most people suffer from depression show dwindling awareness of their surroundings and loss in interest in news and happenings.

This observed difference is statistically significant since the Chi-square value is significant at <0.05 level.

Further the Karl Pearson's "r" value is found to be +0.636 which indicates that the two variables under investigation are positively and statistically associated. Hence, it can be stated that the degree of depression goes higher among the respondents who are having a higher level of unsatisfactory adjustment.

Table: 37

Distribution of Respondents based on Life-Satisfaction and Adjustment

S. No.	Adjustment	Life-Satisfaction			
		Low	Moderate	High	Total
1	Very Unsatisfactory	220 (39.8)	66 (11.9)	20 (3.6)	306 (55.3
2	Unsatisfactory	14 (2.5)	33 (6.0)	10 (1.8)	57 (10.3)
3	Average	37 (6.7)	43 (7.8)	44 (8.0)	124 (22.4)
4	Good	3 (0.5)	5 (0.9)	45 (8.1)	53 (9.6)
5	Excellent	2 (0.4)	2 (0.4)	9 (1.6)	13 (2.4)
	Total	276 (49.9)	149 (27)	128 (23.1)	553 (100.0)

Figures in Paranthesis are percentage to Total (553)
Chi-Square: 248.52, df = 8, P< 0.05 Significant, "r" value is = - 0.608

The level of Life-satisfaction and the level of Adjustment are cross tabulated in the above table to find the association between these two factors. It has been found that 39.8 percent of the respondents with low level of Life-Satisfaction have an unsatisfactory adjustment. 1.6 percent of the respondents

with an excellent level of Life-Satisfaction have a high level of adjustment. That shows Life-Satisfaction and adjustment are in direct association with each other.

This observed difference is statistically significant since the Chi-square value is significant <0.05 level.

Further the Karl Pearson's "r" value is found to be -0.608 which indicates that the two variables under investigation are negatively and statistically associated. Hence, it can be inferred that people having a higher unsatisfactory adjustment will have low life-satisfaction, and the degree of life-satisfaction goes higher and they have better adjustment.

Table: 38

Distribution of Respondents based on Social Behaviour and Self Esteem.

S.No	Social Behaviour	Self – Esteem		
		Negative	Positive	Total
1.	Low	162 (29.3%)	8 (1.4%)	170 (30.7%)
2.	Moderate	212 (38.3%)	25 (4.5%)	237 (42.9%)
3.	High	19 (3.4%)	127 (23.0%)	146 (26.4%)
Total		393 (71.1%)	160 (28.9%)	553 (100.0%)

Figures in paranthesis are percentage to Total (553)
Chi-square : 326.78, df=2, P<0.05 significant, "r" value is = +0.806

Self Esteem is the feeling of being happy with one's own character and abilities. It is manifested in a feeling of inner balance grounded on Self Acceptance and a healthy comforting self respect towards oneself. High Self Esteem is knowing who we are and living in harmony with ourselves without the necessity to have the approval of others. It is a life of happiness, of sound mind and health. Social Behaviour is behaviour directed towards the members of environment. In Table:338, the level of Social Behaviour and level of Self Esteem are cross tabulated to find the association between these two factors.

It has been found from the above table that 29.3 percent of the respondents having low Social Behaviour suffer from negative Self- Esteem,

whereas 23.0 percent of the respondents wtih high Social Behaviour enjoy positive Self –Esteem.

The observed differences is statistically significant since the chi-square value is significant at <0.0.5 level.

Further the Karl Pearson's "r" value is found to be +0.806 which indicates that the two variables under investigation are positively and significantly associated. The data also shows that as the level of Social Behaviour moves up from low to high, the respondents move from negative self esteem to positive self esteem.

Table: 39

Distribution of Respondents based on Religious Attitude and Self-Esteem

S. No.	Religious Attitude	Self - Esteem		
		Negative	Positive	Total
1.	Low	65 (11.8)	84 (15.2)	149 (26.9)
2.	Moderate	178 (32.2)	74 (13.4)	252 (45.6)
3.	High	150 (27.1)	2 (0.4)	152 (27.5)
Total		393 (71.1)	160 (28.9)	553 (100.0)

Figures in paranthesis are percentage to Total (553)

Chi-Square: 110.98 df = 2 P< 0.05 Significant, "r" value is = +0.546

The level of Religious Attitude and the level of Self-Esteem are cross tabulated in Table. 39 to find out the association between these two factors.

It has been found that 15.2 percent of the respondents with low Religious Attitude have positive Self-Esteem, whereas 27.1 percent of the respondents with high religious attitude have negative Self-Esteem. 13.4 percent of the respondents having moderate have 13.4 percent have positive Self-Esteem.

The findings are a new revolution against the normal thinking that a positive religious attitude commands a higher self esteem. But this study establishes a negative relationship between religious attitude and Self Esteem.

In table:39 which discuses the association between Religious Attitude and Geriatric Depression supported this finding.

Respondents having high Religious Attitude experience high depression are established in table:45. It is inferred that dealt anxiety is highly prevalent among the elders.

From the researcher thereby observation and personal discussion with the respondents it was understood that many of them are engrossed by the feeling of loneliness, worthless and pessimistic. They blame the whole world, for their abundant state. Their grief for their loss of emotional bond with the family poor physical health also aggravated their negative attitude towards their existence. All these factors could have lead to poor Self-Esteem. Thus, the interesting findings of the studies that people having high Religious Attitude have negative Self-Esteem.

It can be stated that people having negative Self Esteem such as self-put down, self-abuse, self-denial, self-centeredness, self–deceit, self-doubt took refuge in religious belief. This leads them to have a higher Religious Attitude in order to protect them from ill-effects.

Further the Karl Pearson's "r" value is found to be +0.546, which indicates that the respondents having negative Self Esteem will have a high level of Religious Attitude. This association is statistically significant.

Table: 40
Distribution of Respondents based on Geriatric Depression and Self-Esteem

S. No.	Geriatric Depression	Self – Esteem		
		Negative	Positive	Total
1.	Normal	11 (2.0)	108 (19.5)	119 (21.5)
2.	Moderate	41 (7.4)	37 (6.7)	78 (14.1)
3.	Severe	341 (61.7)	15 (2.7)	356 (64.4)
Total		393 (71.1)	160 (28.9)	553 (100.0)

Figures in paranthesis are percentage to Total (553)

Chi-Square: 339.98 df = 2 P< 0.05 Significant, "r" value is = - 0.829,

The level of Geriatric Depression and the level of Self-Esteem are cross tabulated in Table No: 40 to find out the association between these two factors.

It has been found from the above table that 61.66 percent of the respondents with severe Geriatric Depression have negative Self-Esteem, whereas 19.57 percent of the respondents with depression level have positive Self-Esteem.

This observed difference is statistically significant since the Chi-square value is significant at 0.05 level. Further, the Karl Pearson's "r" value is found to be -0.829, which indicates that the two variables under investigations are negatively associated. Hence, it can be stated that the higher the Geriatric level of Depression the Self-Esteem is negative and lower the level of depression, the Self Esteem is positive. This association is statistically significant.

A study revealed that Depression is a universal disorder which preys upon most of the elders. Especially, the depression level of institutionalized elders is reported high (Meera, 1997). Another study also expressed that 50-70 percent of the elderly receiving home care have emotional behavioural and mental disorders (Trimbath & Brestenskey 1990) A study mentions that the emotional depression either causes or aggravates the problems of Adjustment by elders (Coli.1983).

A major dent in their physical wellbeing due to old age when they have exhausted their energy in a rising their families would be a great blow. A cynical attitude due to lack of support from their children sets in and is projected either against themselves or at others. Irritability, lack of concern for themselves, Ignoring, personal hygiene and care, self-denial as expressed in the form of anger or withdrawal affects their adjustment pattern. The existence of major problems like cardiac and diabetes erodes their Self Esteem. Fear and apprehension about how to handle their health issues either make them

submissive or sometimes withdrawn. Table:40 correlates the association between Social Behaviour and Self Esteem. Table31,32 and 34 should be read together which brings out the fact that in the absence of healthy adjustment and low Self-Esteem Life-Satisfaction is at stake. Though mobility is not restricted, the burden of illness casts a shadow that restricts their Social Behaviour togetherness and leads to inner introspection. This helplessness pushes them to submit themselves to a higher power, seeking refuge in religion. Powerlessness over their lives brings an self–pity and fear. Thus, efforts to build up physical health would give a boost to the morale of the elders and make their days less stressful and acceptable.

Table: 41

Distribution of Respondents based on Life satisfaction and Self-Esteem

S. No.	Self - Esteem	Life - Satisfaction			
		Low	Moderate	High	Total
1	Negative	269 (48.6)	106 (19.2)	18 (3.3)	393 (71.1)
2	Positive	7 (1.3)	43 (7.8)	110 (19.9)	160 (28.9)
	Total	276 (50)	149 (26.9)	128 (23.1)	553 (100.0)

Figures in paranthesis are percentage to Total (553)

Chi-Square: 298.82 df = 2 P< 0.05 Significant, "r" value is = 0.803

The level of Life-Satisfaction and the level of Self-Esteem are cross tabulated in the above table to find out the association between these two factors.

It has been found that 48.6 percent of the respondents with a low level of Life-Satisfaction have negative Self-Esteem, whereas 3.3 percent of the respondents with high Life-Satisfaction have negative Self Esteem, whereas 19.9 percent of the respondents with high level of satisfaction have positive Self-Esteem.

This observed difference is statistically significant at 0.05 level. It can be inferred that a person having low Life-Satisfaction has negative Self-Esteem. Whereas, a person having high Life-Satisfaction has positive Self-Esteem.

Further, the Karl Pearson's "r" value is found to be 0.803, which indicates the positive association. Hence, it can be informed that a lower level of Life-Satisfaction leads to negative Self-Esteem. Self-esteem is an important factor associated with Life-Satisfaction of the elderly (Rogers, 1999).

Table: 42

Distribution of Respondents based on Religious Attitude and Social Behaviour

S. No.	Religious Attitude	Social Behaviour			
		Low	Moderate	High	Total
1.	Low	27 (4.9)	49 (8.9)	73 (13.2)	149 (26.9)
2.	Moderate	58 (10.5)	122 (22.1)	72 (13.0)	252 (45.6)
3.	High	85 (15.4)	66 (11.9)	1 (0.2)	152 (27.5)
Total		170 (30.7)	237 (42.9)	146 (26.4)	553 (100.0)

Figures in paranthesis are percentage to Total (553)

Chi-Square: 110.97 df = 2 P< 0.05 Significant r = 0.512

The level of Religious Attitude and the level of Social Behaviour are cross tabulated in Table :42 to find the association between these two factors.

It has been found that 22.1 and 13.0 percent of the respondents who are having moderate and high Religious Attitude to some extent have moderate and high level of Social Behaviour. Whereas, 11.9 percent of the respondents who are having moderate Social Behavior have high level of Religious Attitude. But a very megare (0.2% percent) having high Religious Attitude have an excellent Social Behaviour.

This observed difference is statistically significant since the Chi-square value is statistically significant at 0.05 level.

Further the Karl Pearson's "r" value is found to be +0.512, which indicates that the two variables under investigation are positively and statistically associated. Hence, it can be stated that a positive attitude towards religion will encourage high Social Behaviour. .

Table: 43

Distribution of Respondents based on Geriatric Depression and Social Behaviour

S. No.	Geriatric Depression	Social Behaviour			
		Low	Moderate	High	Total
1.	Normal	8 (1.4)	16 (2.9)	95 (17.2)	119 (21.5)
2.	Moderate	1 (0.2)	52 (9.4)	25 (4.5)	78 (14.1)
3.	Severe	161 (29.1)	169 (30.6)	26 (4.7)	356 (64.4)
Total		170 (30.7)	237 (42.9)	146 (26.4)	553 (100.0)

Figures in paranthesis are percentage to Total (553)

Chi-Square: 283.55 df = 4 P < 0.05 Significant, "r" value is = - 0.718

The level of Geriatric Depression and level of Social Behaviour are cross tabulated in this table to find the association between these two factors.

It has been found from Table:43, that 29.1 percent of the respondents with severe Geriatric Depression have low Social Behaviour, whereas 17.2 percent of the respondents who are normal in depression level have high Social Behaviour.

This observed difference is statistically significant since the Chi-square value is significant <0.05 level.

Further, the Karl Pearson's "r" value is found to be -0.718, indicates that the two variables under investigation are negatively associated. Hence it can be stated that higher the level of depression, lower will be the Social Behaviour among the respondents. This association is statistically significant.

Table: 44

Distribution of Respondents based on

Life – Satisfaction and Social Behaviour

S. No.	Life - Satisfaction	Social Behaviour			
		Low	Moderate	High	Total
1.	Low	147 (26.6)	116 (21.0)	13 (2.4)	276 (49.9)
2.	Moderate	17 (3.1)	104 (18.8)	28 (5.1)	149 (26.9)
3.	High	6 (1.1)	17 (3.1)	105 (19.0)	128 (23.1)
Total		170 (30.7)	237 (42.9)	146 (26.4)	553 (100.0)

Figures in paranthesis are percentage to Total (553)

Chi-Square: 345.80 df = 4 P< 0.05 Significant, "r" value is = 0.734

The level of Life-Satisfaction and the level of Social Behaviour are cross tabulated in the above table to find the association between these two factors.

It has been found that 26.6 percent of the respondents with low Life-Satisfaction have low Social Behaviour, whereas 19.0 percent of the respondents with high level of Social Behaviour have high level Life–Satisfaction.

This observed difference is statistically significant since the Chi-square value is significant at < 0.05 level.

Further the Karl Pearson's "r" value is found to be 0.734, which indicates that the two variables under investigation are positively associated. Hence it can be stated that higher the level of Life – Satisfaction higher will be the Social Behaviour.

A study has examined a strong positive correlation between Life Satisfaction and the level of activity among the elderly. (Pamore and Luikar 1972).

A strong positive correlation between Life Satisfaction and the level of activity among the elderly (Palmore and Luikart 1972). On the other hand (Abrams, 1991) records that ageing brings negative changes in self-concept and Life-Satisfaction increase in emotionally and rise in frustration, tolerance, (Kant and Sharma, 1996) observe that females more often score low on Life Satisfaction and the variable is strongly associated with relational variables, say, marital happiness, rather than socio-economic factors like income level.

Table: 45

Distribution of Respondents based on

Geriatric Depression and Religious Attitude

S. No.	Geriatric Depression	Religious Attitude			
		Low	Moderate	High	Total
1.	Normal	62 (11.2)	55 (9.9)	2 (0.4)	119 (21.5)
2.	Moderate	34 (6.1)	35 (6.3)	9 (1.6)	78 (14.1)
3.	Severe	53 (9.6)	162 (29.3)	141 (25.5)	356 (64.4)
Total		149 (26.9)	252 (45.6)	152 (27.5)	553 (100.0)

Figures in paranthesis are percentage to Total (553)

Chi-Square: 110.27 df = 4 P< 0.05 Significant, "r" value is = - 0.478

The level of Geriatric Depression and the level of Religious Attitude are cross tabulated in Table No. 45 to find the association between these two variables.

It has been found that 2.4 percent of the respondents with normal depression level have religious attitude. Whereas 9.6 percent of the respondents with severe depression have a low level religious attitude. 25.5 percent of the respondents having high religious attitude have severe level of Geriatric Depression and 29.3 percent of the respondents have a moderate level of Religious Attitude have severe level of Depression. Thus, it is clear that even if

the respondents have moderate and high level of Religious Attitude, they have severe level of Geriatric Depression.

This observed difference is statistically significant since the Chi-square value is significant at < 0.05 level.

Further the Karl Pearson's "r" value is found to be -0.478, which indicates that the two variables under investigations are negatively associated. Hence, it can be stated that the higher the level of Depression the lower will be the Religious Attitude.

Normally the elderly living in institution feel more anxious about death than those in families (Baum, 1983). Generally the fear of death and irrational ideas are widespread features of psychopathology of ageing, those who seemed fearless sometimes are revealed as most terrified when death anxiety is pulsed (Handal et al 1984). Religion is the response of human beings to constant threats to their safety, security and future existence (Galloway 1925). Based on evidence it is indicated that the elderly who experienced less death fear and threat were more likely to express a stronger belief in an after life (Rigdon and Epting 1985). Participating in religious activities is one of the highly rated leisure time activity in old age. Religious activities are very conducive to good adjustment in later life. (Sharma 1969). Religion is a powerful cultural force in the lives of the older in promoting medical and physical health (Koeing 1990) Religious values acted as the natural social security for the elders (D'Souza, 1982).

In this study the data clearly reveals that respondents having high religious attitude (25.5%) and respondents having moderate level of Religious Attitude (29.3%) have severe Geriatric Depression. This is supported by the findings (Thorson and Pauell, 1988), that the elderly are confronted daily with the fear of death. The elders have accumulated enough of unpleasant events in life over the years and to relieve themselves from that trauma, they greatly involve in religion. Thus, people having high depression also have a high Religious Attitude.

Table: 46

Distribution of Respondents based on

Life – Satisfaction and Religious Attitude

S. No.	Religious Attitude	Life - Satisfaction			
		Low	Moderate	High	Total
1.	Low	35 (6.3)	123 (22.2)	118 (21.3)	276 (49.9)
2.	Moderate	45 (8.1)	72 (13.0)	32 (5.8)	149 (26.9)
3.	High	69 (12.5)	57 (10.3)	2 (0.4)	128 (23.1)
Total		149 (26.9)	252 (45.6)	152 (27.5)	553 (100.0)

Figures in Paranthesis are percentage to Total (553)

Chi-Square: 112.95 df = 4 P< 0.05 Significant, "r" value is = + 0.470

The level of Life-Satisfaction and the level of Religious Attitude are cross tabulated in Table No:46 to find out the association between these two factors.

It has been found that 21.3 percent of the respondents with a high level of Religious Attitude and 22.2 percent with moderate level of Religious Attitude have low Life Satisfaction, whereas 10.3 percent of the respondents with a moderate level of Religious Attitude and 12.5 percent of the respondent with low level of Religious Attitude have high level of satisfaction. Only 0.4 percent of the respondents having high level of Religious Attitude have high level of Life Satisfaction.

This observed difference is statistically significant since the Chi-square value is significant level.

Further, the Karl Pearson's "r" value is found to be +0.470 which indicates that the two variables under investigation are positively associated. Hence it can be stated that a higher level of religious attitude leads to high level of Life-Satisfaction.

However, there are studies which have shown that as old people are often victims of mental disorders on account of their fear about death and feelings of dependency, anxiety, boredom, loneliness, frustration, depression, low self esteem, fanatics about religion, helplessness and as a last ten resist they surrender themselves to God.

Hence, the overall view is that the higher the religious attitude the higher the level of Life-Satisfaction.

Elderly females are less satisfied from life than their male counterparts. (Chadha, 1991). Old people review their past life and if they feel that goals of their life have been fulfilled, they feel satisfied (ego-integration). Conversely, a feeling that not much has been achieved, brings a sense of despair among the aged, because it may be too late to make amends which affects a higher level of Life Satisfaction. (Erichson, 1982), Life satisfaction and religious attitude are interrelated (Sivakumaran, 1992).

Engaging the elders in various activities, frequent spiritual discourse and emphasising to follow the spiritual duties contribute for their life-satisfaction positively (Anindya Jayanta Mishra, 2004).

Table: 47

Distribution of Respondents based on

Life – Satisfaction and Geriatric Depression

S. No.	Geriatric Depression	Life - Satisfaction			
		Low	Moderate	High	Total
1.	Low	2 (0.4)	5 (0.9)	269 (48.6)	276 (49.9)
2.	Moderate	9 (1.6)	54 (9.8)	86 (15.6)	149 (26.9)
3.	High	108 (19.5)	19 (3.4)	1 (0.2)	128 (23.1)
Total		119 (21.5)	78 (14.1)	356 (64.4)	553 (100.0)

Figures in Paranthesis are percentage to Total (553)

Chi-Square: 516.82 df = 4 P< 0.05 Significant, "r" value is = - 0.904

The level of Life-Satisfaction and the level of Geriatric Depression are cross tabulated in Table No.47 to find out the association between these two factors.

It has been found that 48.6 percent of the respondents with high level of depression have low level of Life-Satisfaction, whereas 19.5 percent of the respondents with low Depression level have high level of Life–Satisfaction. Only 0.2 percent of the respondents having high level of depression have high level of Life Satisfaction.

This observed difference is statistically significant since the Chi-square value is significant at < 0.05 level.

Further the Karl Pearson's "r" value is found to be -0.904 which indicates that the two variables under investigation are negatively associated. Hence it can be stated that higher the depression, lower the life – satisfaction. This association is statistically significant.

Ageing brings negative changes in self concept and life satisfaction increases in emotionality and rises in frustration tolerance (Alrams, 1991). There is a strong positive association between multiple roles and psychological well being among aged people. Multiple roles (like, spouses, parent, homemaker, grand parent, caregiver, employee, volunteer, etc.) are associated with higher Life Satisfaction and positive influence on Life Satisfaction, particularly among aged women (Ardelt 1997) Life Satisfaction is the indicator of mental health (Khadi 1993 Goanlcas 1993).

Emotionally stable personality, independent of other factors, is the most important factor for life-satisfaction among the very old. (Pernilla K.Hiller, 2001)

CORRELATION TABLE

Table No: 48

Correlation Matrix showing the Factors influencing Life –Satisfaction

	Life satisfaction	Adjustment	Self - Esteem	Social behaviour	Religious attitude	Geriatric Depression
Life satisfaction	1.000					
Adjustment	- 0.608	1.000				
Self esteem	0.803	- 0.706	1.000			
Social behaviour	0.734	- 0.651	- 0.806	1.000		
Religious attitude	-0.470	0.401	- 0.546	- 0.512	1.000	
Geriatric depression	- 0.904	0.636	- 0.829	- 0.718	0.478	1.000

The level of unsatisfactory adjustment is negatively correlated with Self Esteem (r=-0.76) Social Behaviour (r=-0.651) and Life-Satisfaction (r= -0.608) and positively associated with Geriatric Depression (r = - 0.636).

The variable Self Esteem for the aged women is positively associated with Social Behaviour (r= + 0.806) and Life Satisfaction (r=+0.734). The Social Behaviour is positively associated with Life Satisfaction (r=+0.734) and negatively associated with Geriatric Depression (r = - 0.718).

Geriatric depression is negatively associated with Life-Satisfaction (r=-0.904).

The above mentioned positive and negative associations are statistically significant at 0.05 level, since the t-values for the correlation values are significant at this level of significance.

Multiple Regression Analysis:

Table No: 49

Multiple Regression Results Dependent Variable Life Satisfaction

S.No	Factors	R	Multiple R	R^2	R^2 Change	B Coeff	t Value	Significance
1	Geriatric Depression	-0.904	0.904	0.817	0.817	-0.421	23.463	P<0.05 Sig
2	Social Behaviour	+0.734	0.912	0.832	0.015	0.037	4.807	P<0.05 Sig
3	Self Esteem	+0.803	0.913	0.833	0.001	0.006	2.002	P<0.05 Sig

Constant: 18.31 F - ratio = 914.942 $p<0.05$ Significant

The researcher has applied Karl Pearson's coefficient of correlation tests to find out the type, degree and direction of relationship between various selected subject variables. The results had been shown in the previous analysis.

An attempt has been made here, to find out which are the most important predictor variables for the dependent variable. For this purpose Multiple Regression (Step wise method) was used. The required Multiple Regression equation is

$Y= a+b_1X_1+b_2X_2+b_3X_3+.....+b_nX_n$ (Equation.1)

Where Y denotes the dependent variable and X1, X2, X3.... etc are the independent variables, b1, b2, b3... etc are the B coefficients for the corresponding Independent variables and 'a' is the constant. The researcher has considered the following five variables as the independent variables:

- Adjustment
- Self Esteem
- Social Behaviour
- Religious Attitude and
- Geriatric Depression

Further the variable Life-Satisfaction was considered as the Dependent Variable or the outcome variable.

The required multiple regression equation is

Life Satisfaction = 18.331+(-0.421) Geriatric Depression +(0.037) Social Behaviour +(0.006) Self Esteem).

Step wise Multiple Linear Regression was used and it was found that among the five independent variables, three variables were very important. The independent variables namely Geriatric Depression, Social Behaviour and Self Esteem were the important ones for the dependent variable. These three variables could collectively contribute 83.3 percent of the variance (R^2= 0.833).

Further it can be noted that Geriatric Depression alone could contribute 81.7% (R^2=0.817). The table has explained the Correlation value, Multiple R values. R^2 values, B-coefficient values, t-values for the B coefficient values and the significance level. Using the values the required multiple regression equation could be formulated.

(Life Satisfaction = 18.331+ (-0.421) Geriatric Depression + (0.037) Social Behaviour +(0.006) Self Esteem).

This equation is the most appropriate one since the F-ratio for the selected independent factors is significant at 0.05 level.

It can be noted that if one wants to manipulate or increase the Life-Satisfaction of Aged women in future they need to focus on Geriatric Depression, Social Behaviour, and Self Esteem of the Aged Women. Further by using the above equation the Life-Satisfaction of the Aged women could be predicted.

In the following chapter, the researcher enumerates the major findings suggestions and recommendations based on the analysis of the data from tables 1 to 49.

Chapter –V

Findings of the Present study

CHAPTER -V
MAJOR FINDINGS

This chapter brings out the major findings of the study based on the research analysis. The results are derived from different tables presented in the previous chapter.

- The majority of the respondents 74.3 percent are from institutions providing shelter and care for the aged of both the sexes, while 25.7 percent of them are from Institutions offering protection exclusively for women. It shows that the number of homes for women only is negligibly few.
- 58.4 percent of the respondents have sufficient resources to avail themselves of services of 'Paid Homes', while 41.6 percent are unable to afford and so they are left in "Unpaid Homes". The families of elders that possess resources and economic security are also admitting their elders in the institutions.
- It is evident that a majority of the respondents (61.1%) have crossed 70 years of age and the remaining are below 70 years. 42.7 per cent of the respondents were employed before being admitted in the institutions. Thus the finding is that the able bodied and mentally alert persons are also admitted in the institutions.
- The study establishes the fact that a vast majority of the respondents (70%) are Hindus while the remaining (30%) belong to other religions such as Christianity and Islam.
- 50.6 percent of the inmates are from the rural sector, whereas 49.4 percent are urbanites. Thus, the study shows that the institutional seeking behavior is equally prevalent in both urban and rural regions.
- Almost half of the respondents (50.6%) are widows: one third of the respondents (33.3%) have their spouses alive. A very small number of

respondents (5.8%) are separated from their husbands. 10.3 percent are unmarried and remain single. Many elders have their spouses alive and are either living in other institutions or in families with their children.

- It is interesting to note that 48.0 percent of the respondents got married in their teens and 36.5 percent got married when there were between 19 and 22 years and 5.2 percent of the respondents were married later, i.e. 23-25 years. Thus, the data shows that 84 percent of respondents got married before the age of 22, which means that the "empty- nest period "starts for them in their middle of middle age or end of middle age.
- It is learnt that the matrimonial relationship between blood relatives is found in 35.5 percent of the respondents while 50.2 percent of them got married with non relatives. The remaining 10.3 percent were unmarried.
- 83.2 percent of the respondents were united in wedlock through their parental arrangements, whereas 6.5 percent of the respondents married partners of their own choice and the remaining 10.3 percent remained unmarried.
- The study reveals that 12.1 percent of the respondents have less than 20 years of marital life and almost 77 percent have marital life for more than 20 years. These 12.1 percent of the respondents must have brought up their children on their own without their spouses, sacrificing their life for the children's wellbeing, with the hope that they would care for them in their last stage.
- It is evident that 39.3 percent of the respondents have one or two sons alive, 28.9 percent have three or four sons alive and only 21.5 percent do not have either a living son or no son at all. Thus, more than two–thirds of the respondents have one or more sons alive.
- It is also noticed that 12.5 percent of the respondents do not have daughters alive whereas 43.6 percent have one or two living daughters, 24.4 percent have three or four living daughters and 9.2 percent have more than four daughters alive. Thus, of the 89.7 percent of the

respondents who got married 77.2 percent have one or more living daughters.

- It is noted that 39.6 percent of the respondents were illiterate and only 7 percent of them are graduates or post graduates and the remaining 49.5 percent have education either up to elementary, middle or high school level.
- It is inferred that 42.7 percent of the respondents were employed in the labor market just before being admitted in the institution. 10.3 percent retired from their work in the organized sector, 47 per cent were unemployed before admission.
- The study indicated that 17.2 percent of the respondents were working in the unorganized sector as laborers and 9.6 percent of the respondents engaged themselves in seasonal work. Only 4.7 per cent of the respondents were professionals and 5.8 percent were in the Government sector. 15.7 percent of the respondents were working in private sectors. The remaining 47 percent of the respondents were not employed. Thus, only a small per cent of the respondents are assured of regular income, retirement benefits and social security measures.
- It is inferred that 19.3 percent of the respondents had a monthly income of less than Rs.1000 per month. 23.3 percent in the range of Rs.1001 to Rs.2000; 6.3 percent had income in the range of Rs.2001 to Rs.3000 and only 4.0 percent earned more than Rs.3000. That means, about 10 per cent had fair income.
- The study reveals that 40.0 percent of the respondents are receiving old age pension either as a retirement benefit or as a welfare scheme of the government for senior citizens. 30.6 percent of the respondents are receiving financial assistance from their own family members; 16.6 per cent received help from their relatives and only 0.7 percent is receiving assistance from friends. 30.0 percent of the respondents rely on charity, 54.0 of the respondents rely on the old age homes in which they reside.

17.4 percent of the respondents also derive assistance from sources other than those mentioned here. The data also reveals that many respondents have more than one source of revenue.

- It is interesting to note that reading is the leisure time activity for 34.9 percent of the respondents. 35.8 per cent of the respondents pursue gardening. 22.2 percent engage themselves in writing. Doing handwork is a hobby for 22.4 percent of the respondents. Painting is a hobby for a minimal of 4.9 percent respondents. 79.9 percent of the respondents derive happiness and relaxation by engaging themselves in the domestic work of the old age homes.
- It is inferred that 47.2 percent of the respondents do sweeping; 31.8 percent fetch water; 36.7 percent of the respondents do gardening; 87.2 percent do kitchen work and 19.0 percent do hand work. The data clearly gives a picture that the respondents are interested in doing their traditional role of preparing food and involving is kitchen management.
- It is clear that cardiac problem is the major illness prevalent among the respondents. 62.7 percent of the respondents have cardiac problems and the intensity is too severe. 55.3 percent have severe health problems and 32.9 percent have health problems with less severity. Thus, only 11.8 percent of the respondents are free of any health problems. In the same way, 53.7 percent of the respondents are suffering from chronic illness and the severity of the illness is higher. It is interesting to note that only 8.5 percent have problems in vision to large extent, and 2.9 percent have problems to some extent because eye camps are being periodically conducted to detect problems in vision. 54.6 per cent of the respondents have no difficulty in their physical movement. Diabetic, respiratory problems are other major health issues and 49 percent are suffering from severe diabetic condition and 43.0 percent have severe respiratory problem. Thus the major illnesses are cardiac problem followed by general health problems, diabetic and respiratory.

- The data explains that neurotic problem is the major illness that affects the psychological well being of the respondents. 53.5 percent of the respondents have neurotic problems, 26.8 percent have anxiety syndrome; 9.8 percent exhibit symptoms of phobia, 10.3 per cent have symptoms of hypochondriasis and 12.1 percent of the respondents have other symptoms pertaining to psychological illness.
- It is observed that 43.0 per cent of the respondents are vegetarian and 57.0 per cent of the respondents are non-vegetarian. Thus, the majority of the respondents are non vegetarian.
- It is shocking to know that 86.6 percent of the respondents were admitted in the home as no family members of the respondents were willing to take care of them. 'Poverty' is not a major cause for their admission in the Home.
- There is a statistically significant association between socio-demographic conditions such as type of institution, nature of institutions (paid homes and unpaid homes), age of the respondents, native place, literacy, occupation before admission, marital status, period of marital life and pattern of marriage and Adjustments. It is observed that respondents in institutions for both men and women have very unsatisfactory adjustment than the respondents in institutions for women only. Similarly, respondents of paid homes, respondents of age 71 and above, respondents from rural background, illiterate, respondents who were unemployed before their admission in homes, widows, respondents having long married life ranging from 41 to 50 years, respondents who had arranged marriages and respondents whose marital partners are not blood related have unsatisfactory adjustment.
- The study establishes the statistically significant association between socio-demographic conditions such as nature of institutions (paid homes and unpaid homes), age of the respondents, religion, type of family, education qualification, occupation, income, period of labor, marital

status, period of marital life, type of marriage and pattern of marriage and Self Esteem. It is inferred that respondents in paid homes have negative self-esteem. Similarly the respondents of age above 71 years have negative self-esteem; respondents belonging to Hindu religion; respondents from joint family, illiterate respondents, unemployed, low monthly income, employed for less than 10 years, widows, having marital life for a period of 41-50 years, respondents of arranged marriage, respondents who married non-relatives have negative self-esteem.

- The study establishes a statistically significant association between socio-demographic conditions such as type of institution, nature of institution (paid or unpaid), place of living, educational background, period of marital life and Social Behaviour. It is inferred that respondents in institutions for both men and women have moderate and high level of Social Behaviour than the respondents in institutions for women only. Similarly, respondents of unpaid homes, respondents from urban background, illiterate and respondents who had marital life for more than 30 years have moderate and high-level Social Behaviour than those of paid homes, rural background, literate and have less years of marital life.
- A statistically significant association between socio-demographic conditions such as place of origin, type of marriage with a level of Religious Attitude is established. It is inferred that respondents from a rural background have moderate and high level of religious attitude than respondents of urban background. Similarly, respondents of arranged marriages have moderate and high level of Religious Attitude than respondents of love marriages and unmarried respondents. All the other socio-economic variables are not significantly associated with the Religious Attitude of the respondents.
- The study establishes a statistically significant association between socio-demographic conditions such as type of institution, nature of institution, age of respondents, place of living, educational background, monthly

income, occupation and Geriatric Depression. It is observed that respondents in institutions for both men and women have severe depression than the respondents in institutions for women only. Similarly, respondents of paid homes, respondents of age 71 and above, respondents from rural background, illiterate, respondents who were from low economic background having a monthly income of less than Rs.2000 per month, women who were unemployed before their admission have severe level of Geriatric Depression than others.

- A statistically significant association between socio-demographic conditions such as type of institution, nature of institution, place of living, educational background and Life-Satisfaction. It is inferred that respondents in institutions for both men and women have low Life-Satisfaction than the respondents in institutions for women only. Similarly, respondents of paid homes, respondents from rural background and illiterate have low Life-Satisfaction than respondents of unpaid homes, urban background and literate
- Respondents having negative Self-Esteem have unsatisfactory adjustment and respondents having positive Self-Esteem have an excellent and good Adjustment.
- The variables Social Behaviour and Adjustment are negatively and statistically significantly associated which means that the lower the level of Social Behaviour higher will be the maladjustment.
- The study shows the direct association between Religious Attitude and Adjustment. The inference is that the lower the level of Religious Attitude the higher will be the unsatisfactory adjustment.
- Two variables Geriatric Depression and Adjustment are positively and statistically associated. It can be stated that the degree of depression goes higher among the respondents who are having higher level of unsatisfactory Adjustment.

- The two variables Life-Satisfaction and the level of Adjustment are negatively and statistically associated. It is inferred that people having higher the unsatisfactory Adjustment will have low Life-Satisfaction, and the degree of Life-Satisfaction goes higher they have better adjustment.
- The two variables Social Behaviour and Self Esteem are positively and significantly associated which means that as the level of social behaviour moves up from low to high, the respondents move from negative Self Esteem to positive Self Esteem.
- The study establishes the negative relationship between Religious Attitude and Self Esteem. The interesting finding is that respondents having higher Religious Attitude have negative Self Esteem. It can be stated that people having negative Self Esteem such as self-put down, self-abuse, self-denial, self-centeredness, self–deceit, and self-doubt took refuge in religious belief. This leads them to have higher Religious Attitude in order to protect them from ill-effects.
- The two variables Geriatric Depression and Self-Esteem are negatively and statistically associated. The study establishes a fact that higher the Geriatric level of Depression, the Self-Esteem is negative and lower the level of depression, the Self-Esteem is positive.
- The study reveals a fact that the respondents having low Life-Satisfaction have negative Self-Esteem. Whereas persons having high Life-Satisfaction have positive Self-Esteem.
- The variables Religious Attitude and Social Behaviour are positively and statistically associated. It can be inferred that respondents having positive attitude towards religion have high Social Behaviour.
- The variables Geriatric Depression and Social Behaviour are negatively associated. This means that higher the level of depression lower will be the Social Behaviour among the respondents.

- The variables Life–Satisfaction and Social Behaviour are positively associated. The inference is that higher the level of Life–Satisfaction higher will be the Social Behaviour.
- The variables Geriatric Depression and Religious Attitude are negatively associated. It can be stated that higher level of Depression lower will the Religious Attitude.
- The variables Religious Attitude and Life-Satisfaction are positively associated, which means that higher level of Religious Attitude leads to high level of Life-Satisfaction.
- The variables Geriatric Depression and Life-Satisfaction are negatively associated, which mean the higher the depression lowers the Life–Satisfaction. This association is statistically significant.
- Level of unsatisfactory adjustment is negatively correlated with Self Esteem, Social Behaviour, Life-Satisfaction and positively associated with Geriatric Depression. Self Esteem is positively associated with Social Behaviour and Life Satisfaction. The Social Behaviour is positively associated with the Life Satisfaction and negatively associated with the Geriatric Depression. The Geriatric Depression is negatively associated with Life-Satisfaction.
- An attempt is made to find out which are the most important predictor variables amongst the independent variables such as Adjustment, Self-Esteem, Social Behaviour, Religious Attitude, Geriatric Depression for the dependent variable 'Life Satisfaction'. The revealing outcome of the study is that among the five independent variables, three variables namely Geriatric Depression, Social Behaviour and Self- Esteem were found to be important for the dependent variable Life Satisfaction. The explanation is that to manipulate or increase the Life Satisfaction of aged women in institution focus should be made on variables such as Geriatric Depression, Social Behaviour and Self- Esteem.

Chapter –VI

Suggestions, Recommendations and Scope for Future Study

CHAPTER - VI
SUGGESTIONS AND RECOMMENDATIONS

The revealing outcome of the study is that among the five independent variables, three intervening variables namely Geriatric Depression, Social Behaviour and Self-Esteem are found to be important factors that influence Life-Satisfaction of the elderly women. Further, the linkage between various socio-demographic conditions with the intervening variables and the enumerated predictor variables were discussed in detail in the previous chapter. Based on the emerging findings, the researcher put-forth the following suggestions to enhance the life-satisfaction of the elders in the old age homes, under different headings.

The researcher also offers suggestions and recommendations to different interest groups associating with the elders, particularly the role of State in promoting the Life-Satisfaction of the women elders. As many studies establish the findings that the elder people in families and community have better satisfaction than the elders in old age homes, suggestions are also made to improve preventive services to promote healthy ageing process.

SUGGESTIONS TO PREVENT ILLNESS AND PROMOTE PHYSCIAL WELL-BEING

- Health problem is the major issue of the aged. Cardiac problem, diabetes, respiratory, arthritis are the major physical ailments experienced by the aged in homes. The home should organize periodical medical camps to diagnose such illness at an early stage and curative and preventive services should be ensured. Health education should be given to the inmates.
- Health promotional activities such as therapeutic diet, recreational activities, use of humor, yoga, outing, meditation, participation in community activities etc need to be encouraged.

- In addition to organizing general health changes and eye camps for the beneficiary of the old age homes, they should organize dental camps to maintain oral hygiene and tooth care.
- Basic hygiene is essential for the happy living for the aged. Hence it is imperative that cleanliness is maintained in the home with care.
- The care-takers of elders of the old age home should be capacitated on the theme such as geriatric counseling and psychological, geriatric illness, geriatric diet, geriatric leisure time activities, importance of social networking etc.
- Degenerative diseases such as Dementia, Alzheimer, Parkinson paralysis etc. can be diagnosed at an early stage and can be prevented by timely intervention.
- Integrated care, linking and coordinating the various aspects of care delivered by different care systems, such as general health practitioners, primary and specialty care, preventive and curative services, and acute and long-term care, as well as physical and mental health services and social care, to meet the multiple needs and problems of individuals should be delivered.

SUGGESTIONS TO PROMOTE EMOTIONAL WELL-BEING

Old age homes, in addition to providing general physical health care, should focus more on enhancing their emotional and psychical well being.

- Geriatric depression is identified as an important variable that influences Life-Satisfaction. The elders are longing for recognition, affection and attention. Counseling and psychotherapy works just as well as medication in relieving mild and moderate depression. The elders should have access to counseling services whenever they need. The underlying causes of the depression should be identified and addressed.

- Therapeutic programmes should be organised periodically to stimulate the memory of the elders by means of old films, pictures, objects, music etc., to allow them to remember their positive achievements, contribution in life and thereby enhance their self-esteem.
- Supportive counseling including religious and peer counseling should be extended to the elders. It can help to ease loneliness and hopelessness, which are main for the causes for depression.
- Cognitive Behavioural Therapy help people to change negative thinking patterns, deal with problems in healthy ways, and develop better coping skills.
- Potential individuals can be indentified from the inmates of the old age home and can be trained on counseling skills to provide peer counseling for those in need.
- Permission should be given to the elders to possess certain personal belongings of their choices.
- Secretarial assistance needs to be provided in order to maintain correspondence with family members, relatives and friends. Family interactions programme should be organized periodically.
- Old ages homes should explore the possibility of interaction of elderly with other social groups in the community and with the school children to satisfy the social and emotional needs of the elder.
- It is important to evaluate the effectiveness of counselling services for strengthening self esteem and improving social behaviour of the elderly by mental health professionals. Such studies could be undertaken at the old age home to understand the impact of geriatric counselling programme.

SUGGESTIONS TO PROMOTE SOCIAL BEAHVIOUR AND ADJUSTMENT

- Family interaction programmes should be organized periodically to strengthen the network with family and friends.
- Suitable recreational and leisure time activities should be organized by the management to old age homes, to combat loneliness, which is a main cause for depression. To enhance their physical activities, different categories of work should be allotted to the old people like young old, educated, illiterate, depending upon the mobility.
- To make the aged feel at home, and to enable the inmates to adopt themselves to the entirely new and strange atmosphere. The homes may organize groups activities as often as possible to promote social interaction, to overcome the fatigue of loneliness, to develop the virtue of mutual help, mutual understanding, tolerance and mutual adjustment. Such activities will create opportunities to share their past experiences, both sweet and bitter, which will in turn strengthen the ties between them.

PROGRAMMES TO ENHANCE THE SPIRITUAL WELL-BEING:

The results of this study indicate that the respondents have high religious attitude. Yet, their depression level is high and self-esteem is negative. Ensuring such a trend one can infer their spiritual well-being is low. To enhance the spiritual well-being of the elders, the homes should focus on the following:

- Frequent visits to religious places and of religious personnel, and religious discourse should be organised to broaden the perspectives of the elders on spiritual health and instill a value that spirituality is a framework for leading a satisfactory and peaceful life. Values such as self-care, kindness to others, supporting friendship and forgiveness should be promoted. They should be encouraged to

listen to music and enjoy nature. Nature walk should be organised. They should be encouraged to participate in diverse spiritual activities and spiritual readings.

- The institutions should periodically assess the spiritually needs of their residents and manage the same at a high priority level to promote life-satisfaction of their inmates.

PROGRAMMES TO IMPROVE THE SELF-ESTEEM AND LIFE-SATISFACTION OF THE WOMEN ELDERS

- Group activities such as games and discussions involving the participation of many members that would promote healthy interaction should be organised in the old age homes.
- Elders should be encouraged to critically analyse and review the latest news and current social issues.
- The traditional knowledge and expertise of the aged should be documented and recognised, and efforts should be taken to make use of the same available to the public. Such initiatives will help them to develop positive self-concept and self-worth among the elders.
- Healthy competitions and talent exhibiting events can be organised periodically in the old age homes. It is suggested to organize events such as cooking, rangoli, hand-work, folk arts, dancing, singing, solving the riddles etc., which will provide a platform for them to exhibit their skills and talents, instill competitive spirit and thereby enhance better interaction and boost their self-esteem. They may be encouraged to participate in public competitions taking place in the city.
- Income generating programmes like pickle making can be organised, making the able-bodied elders, to engage themselves in productive and meaningful way.

- 'Laughter Club' may be organised in each home for lightening the mood of the elders. Performers may also be invited from the community.
- Events like 'talk show' can be organised on topics of general interest to the aged, by involving the inmates as participants.
- The elders should be provided with the facility to re-train themselves in the areas of their interest, and thus continue to contribute to their well being

GENERAL RECOMMENDATIONS TO THE INSTITUTIONS

- Infrastructure facilities to be planned to suit the needs of the elderly to ensure independent living in the homes.
- To customize the living environment to suit their developmental needs, infrastructure like commode, supportive bars in the bathroom, walking stick, wheel chair, torch, spittoons, working bar, woolen coat, mosquito net, socks, two way switch near the bed, preset reminders etc. to be provided.
- All old age homes should take an effort to ensure that the beneficiaries of their respective homes avail the old age pension scheme of the government.
- The institution should provide free legal aid and support for the needy inmates.
- Extra care has to be taken by the homes that offer both types of vegetarian and non vegetarian food to the inmates. If separate kitchen for the preparation of non-vegetarian food is not available, at least separate utensils should be arranged.

GENERAL RECOMMENDATIONS FOR DIFFERENT INTEREST GROUPS

- Community based old age homes are preferred by the rural and urban senior citizens, which can promote better social interaction and involvement among its members. Day care centre, recreational and holiday homes, "home away home" are welcome assets to the welfare of the aged.
- Awareness about preventive health care of the elders should be organized either by the State or through NGO's to different interest groups such as family members, paramedical, NGO, community workers, primary health doctors, social workers, members of social defence, police and private doctors under the guidance of psychiatrists.

RECOMMENDATIONS TO STATE

- Rights of the senior citizens should be included in the school curriculum to insist positive value in the minds of the adolescent towards elder.
- Awareness about the **THE MAINTENANCE AND WELFARE OF PARENTS AND SENIOR CITIZENS ACT, 2007** should be broadly published by the government and the senior citizen should be educated about their legal rights and constitutional rights.
- In the same way, budgeting allocation for the benefits of senior citizens should be widely published through print and visual media and state should ascertain that the allocated funds properly reach the beneficiaries.
- The government should bring every year, detailing the budget allocation for different beneficiaries under each scheme.

- Pre-menopause counseling should be given to the women and the family members to strengthen the family ties, to educate about the diet and nutrition requirement.
- While sanctioning to open new old age homes, the following points could be considered by the State.

1. Children's home and home for the aged should be located together.
2. Ages of both sexes should be housed in the same compound to promote healthy social Behaviour. This home should be in the community and not away from them, so that the aged can keep in contact with their family members, relatives and friends.

- The government needs to crystallize the concept of institutionalized care and set standards and appropriate guidelines to safeguard the social, economical, medical and psychological well being of the elderly and make it mandatory for the old age homes.
- Curriculum for geriatrics and gerontology for medical/ paramedical/ community workers/and support service faculties, should be developed, considering the health and nutrition concern of older women. Medical fraternity should be educated to address the specific health concerns of older women.
- Women in the age group of 60 -70, who are willing to work, should be encouraged to form a co-operative and earn for their living. NGO's can assist such women to develop those skills and get credit from micro-credit schemes. Those who are incapacitated, more than 70 years must be consideed for outright help and are given pension so that the family does not treat them as a burden.
- A nutrition education programme should be organized to raise awareness among the families and care givers about the importance of a good varied diet for elder people.

- Counseling for both the young and the old to adjust to each other's needs should be imparted and new methods of conflict management and better interpersonal relationship should be taught to the people.

SCALES

A STUDY ON THE FACTORS INFLUENCING LIFE SATISFACTION AMONG THE AGED WOMEN UNDER INSTITUTIONAL CARE – MADURAI DISTRICT

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RESEARCH GUIDE

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Socio-economic Check List

1. Name of the Institution	:	
2. Name of the Interviewee	:	
3. Type of the Institution	:	1. Unisex 2. Bisex
4. Age	:	
5. Religion	:	1. Hindu 2. Christian 3. Muslim 4. Others
6. Type of Family	:	1. Joint 2. Nuclear
7. Place of Living	:	1. Rural 2. Urban
8. Educational Qualification	:	1. Illiterate 2. Primary School 3. Middle School 4. High School 5. Under Graduate 6. Post Graduate 7. Professional
9. Occupation	:	1. Rtd from Govt. Services 2. Rtd from Non-Govt. Services 3. Employed 4. Unemployed
10. Monthly Income	:	1) <500 2) 500-1000 3) 1000-2000 4) >2000
11. Experience	:	(Yrs)
12. No. of Switches in the Career	:	
13. Reason for Switching	:	
14. Education of Husband	:	
15. Occupation of Husband	:	
16. Marital Status	:	1) Single 2) Married 3) Widow 4) Separator 5) Others

17. Age at Marriage : Self : Husband :

18. Duration of Marital Life :

19. Type of Marriage : 1. Love 2. Arranged

20. Pattern of Marriage : 1. Blood Relation 2. Others

21. Status of the Spouse Aged : 1) Expired 2) Home of the

3) Living Along 4) Living with Son
5) Divorce 6) Unmarried
7) Living with daughter 8) Others

22. Monthly Income of the Spouse : Rs.

23. How many Children do you have : Male : Female :

24. No. of dependent in the family : Male : Female:

25. Sources of income after admitted in the home: 1) Pension 2) Charity
3) Home for the aged 4) Family members

5) Relatives 6) Friend 7) Others

26. Daily Hobbies : Yes / No

1. Reading
2. Gardening
3. Writing
4. Hand work
5. Painting
6. Domestic work
7. Any other

27. Physical Activities : Yes / No

1. Gardening
2. Sweeping
3. Fetching Water
4. Kitchen Work
5. Hand Work
6. Any other

28. Duration of the Stay in this home : Yrs Months

29. Previous Occupation :

1. Domestic work
2. Professional
3. Government
4. Non-Government
5. Others

30. Health Status : To a larger Extent To some Extent Not at All

31. Problem in Vision :

32. Difficult in Mobility :

33. Dental Problem :

34. Problem id digestion :

35. Respiratory Problem :

36. Diabetic Patient :

37. Cardiac Problem :

38. Any Chronic Illness :

39. Heredity Disease :

40. Any dermatological complication :

41. Neurological Problem :

42. Mental Illness :

Neurotic problems :
Anxiety :
Phobia :
Hypochondriacs :

43. Dietary Pattern

Type of meal you take : 1) Vegetarian 2) Non-Vegetarian
3) Ovo Vegetarian

44. Reasons for getting admitted in home for aged :

1) Poverty
2) Nobody Takes Care
3) No Spouse
4) In – Laws Aarrasment
5) Others

Title: A STUDY ON THE FACTORS INFLUENCING LIFE SATISFACTION AMONG THE AGED WOMEN UNDER INSTITUTIONAL CARE – MADURAI DISTRICT

Researcher : **Mrs. Janet Vasantha Kumari** Guide : **Dr.P.N. Narayanaraja**

SOCIAL DEMOGRA						BELLS ADJUST SCALE																	
V1		V16		V31		A1		A16		A31		A46		A61		A76		A91		A106		A121	
V2		V17		V32		A2		A17		A32		A47		A62		A77		A92		A107		A122	
V3		V18		V33		A3		A18		A33		A48		A63		A78		A93		A108		A123	
V4		V19		V34		A4		A19		A34		A49		A64		A79		A94		A109		A124	
V5		V20		V35		A5		A20		A35		A50		A65		A80		A95		A110		A125	
V6		V21				A6		A21		A36		A51		A66		A81		A96		A111		A126	
V7		V22				A7		A22		A37		A52		A67		A82		A97		A112		A127	
V8		V23				A8		A23		A38		A53		A68		A83		A98		A113		A128	
V9		V24				A9		A24		A39		A54		A69		A84		A99		A114			
V10		V25				A10		A25		A40		A55		A70		A85		A100		A115			
V11		V26				A11		A26		A41		A56		A71		A86		A101		A116			
V12		V27				A12		A27		A42		A57		A72		A87		A102		A117			
V13		V28				A13		A28		A43		A58		A73		A88		A103		A118			
V14		V29				A14		A29		A44		A59		A74		A89		A104		A119			
V15		V30				A15		A30		A45		A60		A75		A90		A105		A120			

SELF ESTEEM				SOCIALIZATION				RELIGIOUS ATTITUDE				DEPRESSION				LIFE - SATISFACTION			
B1		B21		C1		C21		D1		D21		E1		E21		F1			
B2		B22		C2		C22		D2		D22		E2		E22		F2			
B3		B23		C3		C23		D3		D23		E3		E23		F3			
B4		B24		C4		C24		D4		D24		E4		E24		F4			
B5		B25		C5		C25		D5		D25		E5		E25		F5			
B6		B26		C6		C26		D6		D26		E6		E26		F6			
B7		B27		C7		C27		D7		D27		E7		E27		F7			
B8		B28		C8		C28		D8		D28		E8		E28		F8			
B9		B29		C9		C29		D9		D29		E9		E29		F9			
B10		B30		C10		C30		D10		D30		E10		E30		F10			
B11		B31		C11		C31		D11		D31		E11				F11			
B12		B32		C12		C32		D12		D32		E12				F12			
B13		B33		C13		C33		D13		D33		E13				F13			
B14		B34		C14		C34		D14		D34		E14				F14			
B15		B35		C15		C35		D15		D35		E15				F15			
B16		B36		C16		C36		D16		D36		E16				F16			
B17		B37		C17		C37		D17		D37		E17				F17			
B18		B38		C18		C38		D18		D38		E18				F18			
B19		B39		C19		C39		D19		D39		E19							
B20		B40		C20		C40		D20		D40		E20							

BELL'S ADJUSTMENT SCALE

Code	Statement	Yes	No
A1	Does the place in which you live now in anyway interfere with your obtaining the social life which you would like to enjoy?		
A2	Do you have ups and downs in mood without apparent cause?		
A3	Are you troubled occasionally by a skin diseases or skin eruption such as athlete's foot, earbuncles or boils?		
A4	Do you feel self-conscious when you have to ask an employer for work?		
A5	Have you had any troubled with you heart or kidneys or lungs?		
A6	Do you that your present home environment allows you enough opportunity to develop your own personality?		
A7	Do you like to participate in festival gathering and levelly parties?		
A8	Have you ever been extremely afraid of something which you know could do you no harm?		
A9	Is any member of your home very nervous?		
A10	Have you ever been anemic (lacking in red blood corpuscles)?		
A11	Do you worry too long over humiliating expenses?		
A12	Do you find it difficult to start a conversion with strangers?		
A13	Did you disagree with your parents about the type of occupation you should enter?		
A14	Does it upset you Considerably to have no time to prepare you talk?		
A15	Does some particular unless thoughts keep coming into your mind to bother you?		
A16	Do you take cold rather easily from other people?		
A17	Do you keep in the background on social occasions?		
A18	Have you had unpleasant disagreements over such matters such as religious politics or sex with the persons with whom you live?		
A19	Do you get upset easily?		
A20	Do you find it necessary to watch you health carefully?		
A21	Has there ever been divorce among any members of your immediate family?		
A22	Do you frequently come to your meals without really being hungry?		

A23	Are you often in a State of excitement?		
A24	Do you feel embarrassed if you if you have to ask permission to leave a group of people?		
A25	Have any of the members of your present home made you unhappy by critic sing your personal appearances?		
A26	Do you find that you tend to have a few close friends rather than many casual acquaintances?		
A27	Have you had an illness from which you feel that you have not completely recovered?		
A28	Does criticison disturb you greatly?		
A29	Are you happy and contented in your present home environment?		
A30	Are you often the center of favourable attention at a party?		
A31	Do you frequently have shooting pains in the head?		
A32	Are you trouble a with the ideas the people are watching you on the street?		
A33	Do you feel a lack of affection and love in your present home?		
A34	Do you suffer from sinusitis or any obstruction in your breathing?		
A35	Are you bothered by the feeling that people are reading your thoughts?		
A36	Do you make friends readily?		
A37	Do the person or persons with whom you now live understand you and sympathize with you?		
A38	Do you day-dream frequently?		
A39	Has any illness you had resulted in a permanent injury to your health?		
A40	Do you hesitate to entire a room by yourself when a group of people are sitting around taking together?		
A41	Do you feel that your friends have happier home environment from you?		
A42	Do you often hesitate to speak out in a group lest you say and do the wrong things?		
A43	Do you have difficult in getting rid of a cold?		
A44	Do ideas often run through your head so that you cannot sleep?		
A45	Does any person with whom you live how become angry at you very easily?		
A46	Are you trouble a with too high or too low blood pressure?		

A47	Do you worry over possible misfortunes?		
A48	If you come late to meeting would you rather stand or leave than take a front seat?		
A49	Are you subject to have fever or asthma?		
A50	Are the members of your resent home congenial and well united to each other?		
A51	At present or a tea do you seek to meet the important person present?		
A52	Are you feelings easily heart?		
A53	Are you trouble a much wit constipation?		
A54	D you dislike intensely certain people with whom you live now?		
A55	Are you sometimes the leader at a social affair?		
A56	Are you bothered by the feeling that things are not real?		
A57	Do you occasionally have conflicting moods of love and hate for members of your immediate family?		
A58	Do you feel self-conscious in the presence of people whom you greatly admire but with whom you are not well acquainted?		
A59	Do you frequently experience nausea or vomiting or diarrhea?		
A60	Do you blush easily?		
A61	Have the actions of any person with whom you now live frequently caused you to feel blue and depressed?		
A62	Do you ever cross the street toward meeting somebody?		
A63	Are you subject to tonsillitis or other threat ailments?		
A64	Do you often feel-conscious because of your personal appearance?		
A65	Is the home where you live now often in a state of turmoil and dissension?		
A66	Do you consider yourself rather a nervous person?		
A67	Are you subject to attacks of indigestions?		
A68	Do you greatly enjoy socializing.		
A69	Did either of your parents frequently find fault with your conduct when you lived with them?		
A70	Do you find it very difficult to speak in public?		
A71	Do you feel tried most of the time?		
A72	Are you troubled with feelings of inferiority?		

A73	Do you troubled with feelings of inferiority?		
A74	Do the personal habits of some of the people with whom you now live imitate you?		
A75	Do you often feel just miserable?		
A76	How it been necessary for you to have frequent medical attention?		
A77	Have you had a number of experiences in appearing before public gatherings?		
A78	Does any member of your present home try to dominate you?		
A79	Do you often feel fatigued when you get up in the morning?		
A80	When you are a guest at an important dinner do you do without something rather thank ask to have it passed to you?		
A81	Does if frighten you to be alone in the dark?		
A82	Did your parents tend to supervise you too closely when you lived with tham?		
A83	Are you considerably under weight?		
A84	Have you ever, when you were on a high place, been afraid that you might jump off?		
A85	Do you find it easy to get along with the person or person with whom you live now?		
A86	Do you have difficulty in starting conversation with a person to whom you have just been introduced?		
A87	Do you frequently have spells of dizziness?		
A88	Are you often sorry for the things you do?		
A89	Do you have frequent disagreements with the individual or individuals where you live now concurring the way things are to be done about?		
A90	Do you get discouraged easily?		
A91	Have you had considerable illness during the last ten years?		
A92	Have you had experience in making plans for and directing the action of other people such as committee chairman leader of a group etc?		
A93	Does any person in the place you now live frequently object of the companions and friends with whom you like to associate?		
A94	Are up subject to attacks of influenza?		

A95	Would you feel very self – conscious of you had volunteer an idea to start a discussion among a group of people?		
A96	Have you frequently been depressed because of the unkind things other have said about you?		
A97	Are any of the members of your persent house hold very easily unitated?		
A98	Do you have many colds?		
A99	Are you easily frightened by lightening?		
A100	Are you troubled with shyness?		
A101	Have you every had a major surgical operation?		
A102	At home did your parents frequently object to the kind of companions you went around with?		
A103	Do you find it easy too ask other s for help?		
A104	Do things often go wrong for no fault of your own.		
A105	Would you like very much to move from the place where you now lives so that you might have more personal independence?		
A106	When you want something from a person with you are not very well acquainted would you prefer to write a note or letter to the individual rather than go and ask him or he personality.		
A107	Have you ever been seriously injured in any kin of an accident.		
A108	Do you dread the sight of a shake?		
A109	Have you lost condiderable weight recently?		
A110	Does the lack of money tend to make your present home – life unhappy?		
A111	Would it be difficult for you to give an oral report before a group of people?		
A112	Are you easily moved to tears?		
A113	Do you frequently feel very tired towards the and of the day?		
A114	When you lived with your parents did either of them frequently criticize		
A115	Does the thought of an earth – quake or a fire frighten you?		

A116	Do you feel embarrassed when you have to enter a public assembly by yourself after everyone else has been seated?		
A117	Do you sometimes have difficulty getting to sleep even when there are no noises to disturb you?		
A118	Is there any one at the place where you live now who insists on your obeying him or her regardless of whether or not the request is reasonable?		
A119	Did you ever take the lead to enliven a dull party?		
A120	Do you often feel lonely – some even when you are with people?		
A121	As a youth did you ever have a strong desire to run away from home?		
A122	Do you have marry headaches?		
A123	Have you ever felt that some one was hypnotizing you and making you act against your will?		
A124	Do you often have much difficulty in thinking of an appropriate remark to make in group conversation?		
A125	Have you ever had sear let fever or diphitheria?		
A126	Do you sometimes feel that you have been a disappointment to your parents?		
A127	Do you take responsibility for introducing people at a party?		
A128	Do you frequently have spells of the blues?		

BILLS' ADJUSTMENT SCALE (1978)

The inventory consists of 160 items, divided equally among five areas of adjustment. Since the dimensions of occupation found in this inventory were not relevant to the objective of this study the item pertaining to it have been removed. So 128 question were administered, which assess the individuals' adjustment on the following four dimensions of adjustment.

- Home: Individuals scoring high tend to be unsatisfactorily adjustment to their home environment.
- Health: High score indicates unsatisfactory health adjustment. Low score indicates satisfactory adjustment.

- Emotional: Individuals scoring high tend to be unstable emotionally. Individuals with low score emotionally stable.
- Social Adjustment: Individuals scoring high tend to be submissive and retiring in their social contacts. Individual with low score are aggressive in their social contacts.

The scoring involves awarding one mark for each question. The response be "yes" or "no" scored according to the key provided along with the scale. As the score increase, greater will be the adjustment problem in these four areas. The norms for grading the respondents on each of the four areas are given in the appendix.

RELIABILITY

The co-efficient of reliability for the author reports each of the four sections of the inventory and total score is given below.

BELL'S ADJUSTMENT SCALE

NORMS FOR ADJUSTMENT KEY

Norms for Grading:

S. No.	Adjustment	Description	Men	Women
01	Home Adjustment	Excellent	0-1	0-1
		Good	2-3	2-3
		Average	4-11	4-12
		Unsatisfactory	12-16	13-17
		Very Unsatisfactory	Above 16	Above 17

S. No.	Adjustment	Description	Men	Women
02	Health Adjustment	Excellent	0-1	0-1
		Good	2-3	2-4
		Average	4-8	5-9
		Unsatisfactory	9-13	10-14
		Very Unsatisfactory	Above 13	Above 14

S. No.	Adjustment	Description	Men	Women
03	Emotional Adjustment	Excellent	0-1	0-1
		Good	2-4	2-6
		Average	5-11	7-15
		Unsatisfactory	12-15	16-20
		Very Unsatisfactory	Above 15	Above 20

S. No.	Adjustment	Description	Men	Women
04	Social Adjustment	Very Aggressive	0-1	0-4
		Aggressive	2-6	5-8
		Average	7-15	9-19
		Retiring	16-20	20-24
		Very Poor	Above 20	Above 24

S. No.	Adjustment	Description	Men	Women
05	Total Adjustment	Excellent	0-8	0-16
		Good	9-21	17-30
		Average	22-47	31-58
		Unsatisfactory	48-60	59-71
		Very Unsatisfactory	Above 60	Above 71

KEYS FOR THE ADJUSTMENT SCALE

S. No.	Home Adjustment	Answer	Health Adjustment	Answer	Emotional Adjustment	Answer	Social Adjustment	Answer
1.	1	Yes	3	Yes	2	Yes	4	Yes
2.	9	Yes	5	Yes	8	Yes	7	No
3.	13	Yes	10	Yes	11	Yes	12	Yes
4.	18	Yes	16	Yes	15	Yes	14	Yes
5.	25	Yes	20	Yes	19	Yes	24	Yes
6.	21	Yes	22	Yes	23	Yes	17	Yes
7.	33	Yes	27	Yes	28	Yes	26	Yes
8.	41	Yes	31	Yes	32	Yes	30	No
9.	6	No	34	Yes	35	Yes	36	No
10.	29	No	39	Yes	38	Yes	40	Yes
11.	37	No	43	Yes	44	Yes	42	Yes
12.	45	Yes	46	Yes	47	Yes	48	Yes
13.	50	Yes	49	Yes	52	Yes	51	No
14.	54	Yes	53	Yes	56	Yes	55	No
15.	57	Yes	59	Yes	60	Yes	58	Yes
16.	61	Yes	63	Yes	64	Yes	62	Yes
17.	65	Yes	68	No	66	Yes	67	No
18.	69	Yes	71	Yes	72	Yes	70	Yes
19.	73	Yes	75	Yes	74	Yes	76	Yes
20.	77	Yes	78	Yes	80	Yes	79	Yes
21.	81	Yes	83	Yes	84	Yes	82	No
22.	85	No	87	Yes	88	Yes	86	Yes
23.	89	yes	91	Yes	90	Yes	92	Yes
24.	93	Yes	94	Yes	96	Yes	95	Yes
25.	97	Yes	98	Yes	99	Yes	100	Yes
26.	102	Yes	101	Yes	104	Yes	103	No
27.	105	Yes	107	Yes	108	Yes	106	Yes
28.	110	Yes	109	Yes	112	Yes	111	Yes
29.	114	Yes	113	Yes	115	Yes	116	Yes
30.	118	Yes	117	Yes	120	Yes	119	Yes
31.	121	Yes	122	Yes	123	Yes	125	Yes
32.	124	Yes	126	Yes	128	Yes	127	No

பெல்ப்ஸ் ஒத்துப்போதல் அளவீடு

கீழ்க்கண்ட வினாக்களுக்கு உங்களிடம் கேட்கப்படும்பொழுது நீங்கள் ஆம்.இல்லை என்ற ஏதாவது ஒரு பதிலை மட்டும் கூறுமாறு கேட்டுக்கொள்கிறோம். தாங்கள் கொடுக்கும் ஒத்துழைப்புக்கு நன்றி.

எண்	வாக்கியங்கள்	ஆம்	இல்லை
1	நிங்கள் இப்போது இருக்கும் முதியோர் இல்லம் எவ்வகையிலேனும் உங்களது மகிழ்ச்சியான சமூக வாழ்க்கையினை பாதிப்பதாக உள்ளதா?		
2	காரணமில்லாமல் உங்களது மனநிலையில் ஏற்றத்தாழ்வு உள்ளதா?		
3	நீங்கள் தோல் வியாதியினால் சருமத்தில் உண்டாகும் கட்டிகளால் பாதங்கள் வலியினால், கொப்பளங்களால் சிரமப்படுகிறீர்களா?		
4	நீங்கள் வேலை கேட்கும் பொழுது மனதிற்குள் கஷ்டப்படுவதில்லை.		
5	உங்களுக்கு இதயம் சிறுநீரகம் மற்றும் நுரையீரலில் ஏதேனும் பிரச்சினைகள் உள்ளதா?		
6	நீங்கள் இப்பொழுது இருக்கும் முதியோர் இல்லத்தில் உங்களது ஆளுமையை மேம்படுத்த சரியான சூழ்நிலை உள்ளதா?		
7	நீங்கள் பண்டிகைகள் மற்றும் விழாக்கள் விருந்துகளில் பங்குபெற விரும்புவீர்களா,		
8	உங்களுக்கு துன்பம் விளைவிப்பவர்களை பார்த்து அதிகம் பயப்படுகிறீர்களா?		
9	உங்கள் குடும்பத்தினர் யாரேனும் அதிகம் உணர்ச்சிவசப்படுபவரா?		
10	உங்களுக்கு இரத்த சோகை உள்ளதா?		
11	நீங்கள் பிரச்சினைகளை அதிகம் நினைத்து அதிகம் கவலைப்படுவீர்களா?		
12	உங்களுக்கு அறிமுகமில்லாத நபர்களிடம் பேசுவதற்கு சிரமப்படுவீர்களா?		
13	நீங்கள் உங்கள் பணிக்கு செல்வதற்கு முன்னதாக உங்கள் பெற்றோருடன் கருத்து வேறுபாடு இருந்ததா?		
14	உங்களை பேச அழைக்கும் பொழுது அதற்கு சரிவர தயார் செய்யாத நிலையில் அது குறித்து அதிகம் கவலைப்படுவீர்களா?		
15	உங்களுக்கு ஏதேனும் குறிப்பிட்ட தேவையற்ற எண்ணங்கள் அடிக்கடி		
16	மற்றவர்களிடம் இருந்து விலகி இருக்கிறீர்களா?		
17	நீங்கள் பொது நிகழ்ச்சிகளில் அதிகம் கலந்து கொள்ளாமல் இருப்பவரா?		
18	நீங்கள் எப்பொழுதேனும் மதம், அரசியல் மற்றும் பாலியல் சம்பந்தமான மாறுபட்ட கருத்துகள் நீங்கள் இருக்கும் இடத்தில்ஏற்பட்டதுண்டா?		
19	நீங்கள் எளிதாக மனவேதனைப்படுபவரா?		
20	நீங்கள் உங்கள் உடல்நலத்தில் அக்கறை காட்டுவதை மிக முக்கியமானதாக கருதுகிறீர்கள்?		
21	உங்கள் குடும்பத்தில் யாரேனும் விவாகரத்து பெற்றவர் உள்ளனரா?		
22	நீங்கள் அடிக்கடி பசி இல்லாமலே சாப்பிடுகிறிர்கள்?		
23	நீங்கள் அடிக்கடி உணர்ச்சி வசப்படுபவரா?		
24	நீங்கள் ஒரு குழுவில் இருக்கும் சமயம் அங்கே இருந்து வெளியேற அனுமதி வாங்குவதற்கு மிகவும் தயங்குவீர்களா?		
25	உங்கள் வீட்டில் உங்களுக்கு நெருங்கியவாகள்		

	எப்பொழுதேனும் உங்களது உருவத்தை பார்த்து குறை சொல்வார்களா?		
26	நீங்கள் உங்களுக்கென்று வெகு சில நண்பர்களை மட்டும் வைத்துள்ளீர்களா? அல்லது பொதுவாக எல்லோரையும் மேலோட்டமாக நண்பர்களாக வைத்துக்கொள்வீர்களா?		
27	உங்களுக்கு ஏதேனும் வியாதி தாக்கி அதிலிருந்து முழுவதுமாக குணமடையவில்லை என்று எண்ணுகிறீர்களா?		
28	உங்களுக்கு குறை கூறுவது அதிக தொந்தரவு தருகிறதா?		
29	நீங்கள் இப்பொழுது உங்கள் முதியோர் இல்லம் பற்றி மகிழ்ச்சியும். திருப்தியும் அடைகிறீர்களா?		
30	நீங்கள் எந்த விருந்து நிகழ்ச்சிகளுக்கு சென்றாலும் அதிக முக்கியத்துவம் பெறுபவரா?		
31	உங்களுக்கு அடிக்கடி அதிகமாக தலையை துளைத்தெடுக்கும் தலைவலி வருவதுண்டா?		
32	தெருவில் உள்ளவர்கள் உங்களை கண்காணிப்பதாக உணர்கிறீர்களா?		
33	உங்களுக்கு அதிகமான அன்பு பரிவு இப்பொழுது இருக்கும் இந்த முதியோர் இல்லத்தில் கிடைக்கவில்லை என எண்ணுகிறீர்களா?		
34	நீங்கள் ஏதேனும் ஒற்றை தலைவலி அல்லத மூச்சு விடுதலில் ஏதேனும் சிரமங்கள் இருப்பதாக உணர்கிறீர்களா?		
35	நீங்கள் மற்றவர்கள் உங்களது மனதில் இருப்பதை கண்டுபிடித்து விடுவார்களோ? ஏன கவலைப்படுகிறீர்களா?		
36	நீங்கள் எளிதில் நண்பராகி விடுபவரா?		
37	நீங்கள் தற்சமயம் சேர்ந்து வாழும் நபர் அல்லது நபர்கள் உங்களை நன்கு புரிந்து கொண்டு உங்களிடம் அனுதாபம் காட்டுபவரா?		
38	நீங்கள் அதிகம் பகல் கனவு காட்டுபவரா?		
39	உங்களுக்கு இதுவரையில் ஏதேனும் உடல்நலகுறைவு நிரந்தரமான காயத்தை உங்கள் உடல்நலத்தில் ஏற்படுத்தியுள்ளதா?		
40	நீங்கள் கூட்டமாக சிலர் பேசிக்கொண்டு இருக்கும்பொழுது அந்த அறைக்குள் செல்லத்தயங்குபவரா?		
41	உங்கள் நண்பர்கள் உங்களை காட்டிலும் மிகவும் மகிழ்ச்சியான சூழ்நிலை இருக்கும் இல்லத்தில் வசித்து வருகின்றனர் என எண்ணியதுண்டா?		
42	நீங்கள் அதிகமாக குழுக்களில் பேசும்பொழுது ஏதேனும் தவறான விளைவுகள் வந்து விடுமோ என தயங்குபவரா?		
43	நீங்கள் உங்கள் வேதனையில் இருந்து வெளிவரத் தயங்குகிறீர்களா?		
44	அடிக்கடி ஏதேனும் சிந்தனைகள் உங்கள் மூளையில் ஒடிக்கொண்டு இருப்பதால் உங்களுக்கு தூக்கம் வர சிரமமாக உள்ளதா?		
45	யாரேனும் ஒருவர் உங்களோடு இல்லத்தில் வசித்து வருபவர் அதிகம் உங்களிடம் கோபப்படுபவரா?		
46	நீங்கள் அதிகமான இரத்த அழுத்தத்தாலும் குறைவான இரத்த அழுத்தத்தாலும் சிரமப்படகிறீர்களா?		
47	நீங்கள் காலதாமதமாக ஒரு கூட்டத்திற்கு வரும்பொழுது தயக்கத்துடன் வெளியே நிற்பீர்களா? அல்லது உள்ளே சென்று முன் இருக்கையில் சென்று அமர்வீர்களா?		
48	உங்களுக்கு ஆஸ்துமா அல்லது காய்ச்சல் வருவதுண்டா?		
49	உங்கள் இல்லத்தில் உள்ள அனைவரும் ஒருமித்து நல்ல இதமான சூழ்நிலையில் ஒருவரோடு ஒருவர் ஒற்றுமையாக உள்ளனரா?		
50	நீங்கள் வரவேற்பின் போது அல்லது தேநீர் பருகும்பொழுது அங்குள்ள மிகவும் முக்கியமான நபரை பார்க்க எண்ணுவீர்களா?		

51	நீங்கள் விரைவில் மனம் புண்படக்கூடியவரா?		
52	நீங்கள் மலச்சிக்கலில் அவதிப்படுபவரா?		
53	நீங்கள் இப்பொழுது வசிக்கும் இல்லத்தில் உள்ள யாரேனும் ஒரு நபரை அடியோடு வெறுக்கிறீர்களா?		
54	நீங்கள் எப்பொழுதாவது சமுதாய காரியங்களுக்கு ஏணியாக இருந்துள்ளீர்களா?		
55	நீங்கள் அடிக்கடி உங்கள் உணர்வுகள் நிஜமல்ல என கவலைப்பட்டதுண்டா?		
56	நீங்கள் எப்பொழுதாவது உங்கள் இல்லத்தில் இருப்பவரிடம் அன்பு காட்டவோ அல்லது வெறுக்கவோ எண்ணுகிறீர்களா?		
57	உங்களை பற்றிய சுயமதிப்பீடு உங்களுடன் நெருக்கமாக பழகுபவர்களுடன் உங்களை மதிப்பவர்கள் முன்னிலையில் அதிகமாகுமா? அல்லது உங்களுடன் அதிகம் வித்தியாசப்படுபவர்கள் முன்னிலையில் அதிகம் வெளிப்படுமா?		
58	நீங்கள் அடிக்கடி வாந்தி அல்லது குமட்டல் அல்லது பேதியால் பாதிக்கப்படபவரா?		
59	நீங்கள் அடிக்கடி வெட்கப்படுபவரா? முகம் சிவக்குமா?		
60	நீங்கள் தற்பொழுது தங்களுடன் வசிப்பவர்களின் நடவடிக்கையால் அடிக்கடி வருத்தமும் மனச்சங்கடமும் அடைபவரா?		
61	நீங்கள் யாருடைய முகத்தையும் பார்த்து பேச பிடிக்காமல் விலகிச்செல்பவரா?		
62	நீங்கள் தொண்டை சதை வளர்ச்சி அல்லது ஏனைய தொண்டை சம்பந்தமான பிரச்சினையால் பாதிக்கப்படுபவரா?		
63	உங்கள் உருவத்தினால் உங்கள் சுயமதிப்பீடு அதிகமாகிறது என்று எண்ணுகிறீர்களா?		
64	நீங்கள் வசிக்கும் இல்லம் அதிக குழப்பம் அல்லது எவருடனும் ஒத்துப்போகாத தன்மையுடன் உள்ளதா?		
65	நீங்கள் அடிக்கடி பதறுபவர்களாக உணர்கிறீர்களா?		
66	அடிக்கடி அஜாக்கிரதையால் பாதிக்கப்படுகிறீர்களா?		
67	சமூகமயமாதலை நீங்கள் விரும்புகிறீர்களா?		
68	நீங்கள் உங்கள் பெற்றோருடன் வசிக்கும் போது அவர்களில் ஒருவர் உங்களை எப்போதும் குற்றம் சொல்லிக்கொண்டிருப்பாரா?		
69	பொதுமக்களுடன் பேசுவதில் உங்களுக்கு சிரமம் உண்டா?		
70	எப்போதும் அதிக களைப்புடன் இருப்பதாக உணருகிறீர்களா?		
71	தாழ்வு மனப்பான்மையால் பாதிக்கப்படுகின்றீர்களா?		
72	தாழ்வு உணர்ச்சியில் வேதனைக்குள்ளாகின்றீர்களா?		
73	உங்களுடன் வசிப்பவரில் எவரது பழக்கவழக்கங்கள் உங்களை எரிச்சலுக்கு உள்ளாக்குகிறது?		
74	நீங்கள் அடிக்கடி கஷ்டப்படுவதாக உணருகிறீர்களா?		
75	உங்களுக்கு அடிக்கடி மருத்துவக்கண்காணிப்பு தேவைப்படுகின்றதா?		
76	பொதுக்கூட்டங்களில் உங்கள் பங்கீடு அதிக எண்ணிக்கையில் உள்ளதா?		
77	தற்போது உங்களுடன் வசித்து வரும் எவராவது உங்களை அதிகாரம் செய்கின்றனரா? அடக்கி ஆளுகின்றனரா?		
78	அதிகாலையில் எழும்போது அடிக்கடி மனச்சோர்வு அடைகிறீர்களா?		
79	நீங்கள் விருந்தினராக இருக்கும் பொழுது வேலை செய்கிறீர்களா?		
80	தனியாக இருட்டில் இருப்பதற்கு பயப்படுவீர்களா?		
81	உங்கள் பெற்றோருடன் வசிக்கும்பொழுது அவர்கள் உங்களை மிகவும் கூர்ந்து கவனிப்பதாக உணருகின்றீர்களா?		
82	உடல் எடை குறைவு உள்ளவரா?		
83	மிக உயரத்தில் இருக்கும்போது கீழே குதித்து விடுவோம் என்று பயப்படுவீர்களா?		

84	உங்களுடன் தற்போத வசிப்பவர் / வசிப்பவர்களுடன் தொடர்ந்து வசிக்க முடியும் என்று நம்புகிறீர்களா?		
85	சமீபத்தில் உங்களுக்கு அறிமுகமானவர்களுடன் பேசிப்பழக தயங்குகின்றீர்களா?		
86	அடிக்கடி தலைசுற்றுவதாக உணருகிறீர்களா?		
87	நீங்கள் செய்த காரியத்தை நினைத்து அடிக்கடி வருந்துவீர்களா?		
88	உங்களுடன் தற்போத வசிப்பவர் / வசிப்பவர்களின் காரியங்களுடன் நிங்கள் கருத்து வித்தியாசப்படுவீர்களா?		
89	நீங்கள் சுலபமாக தன்னம்பிக்கையால் தளர்ந்து விடுவீர்களா?		
90	சொல்லிக்கொள்ளும் அளவிற்கான பெரிய வியாதியினால் கடந்த பத்து ஆண்டுகளுக்கும் பாதிக்கப்பட்டுள்ளீர்களா?		
91	ஒரு குழுவின் தலைவராக. முதல்வராக இருந்து திட்டமிடுதல், மற்றவர்களை வழிநடத்துதல் போன்ற செயல்களில் ஈடுபட்டுள்ளீர்களா?		
92	உங்கள் நண்பர்கள் மற்றும் உடனிருப்பவர்களின் பழக்கத்தை உன்னுடன் வசிப்பவர்கள் எதிர்க்கின்றனரா?		
93	இன்புளுயன்ஸா காய்ச்சலில் பாதிக்கப்பட்டுள்ளீர்களா?		
94	ஒரு குழு விவாதத்தில் ஆரம்பத்தினை நன்முறையில் துவக்கி வைக்கும் போது தன்னம்பிக்கை கொள்வீர்களா?		
95	அடுத்தவர்கள் உங்களைப்பற்றி சொல்லும் கருத்துகளுக்கு அடிக்கடி மனத்தளர்ச்சி அடைகின்றீர்களா?		
96	இப்போது நீங்கள் வசிக்கும் இல்லத்தில் யாரேனும் வெகுசுலபமாக எரிச்சல் அடைவார்களா?		
97	அடிக்கடி ஜலதோஷம் / சளி தொல்லை உண்டாகுமா?		
98	மின்னலுக்கு பயப்படுவீர்களா?		
99	வெட்கப்படுவது உங்கள் இயல்பா?		
100	பெரிய அறுவை சிகிச்சை ஏதேனும் உங்களுக்கு நடந்ததுண்டா?		
101	நீங்கள் சிறுவர்களாக இருக்கும்பொழுது உங்கள் சக நண்பர்களுடன் வெளியில் பழகுவதை உங்கள் பெற்றோர் அடிக்கடி சுட்டிக்காட்டி தவிர்க்க சொல்வார்களா?		
102	அடுத்தவர்களை உங்கள் உதவிக்கு எளிதில் அழைப்பீர்களா?		
103	உங்களிடம் தவறு இல்லாதபோதும் உங்கள் மேல் பழிவருவதை எவ்விதம் தாங்கிக்கொள்வீர்கள்?		
104	உங்கள் தனிசுதந்திரத்திற்காக உங்கள் இருப்பிடத்தை மாற்றி அமைத்துக்கொள்வீர்களா?		
105	உங்களுடன் சகஜமாக இல்லாதவரிடமும் எப்போதும் உதவி நாடுவீர்கள், ஏதேனும் ஒரு தயவை எதிர்பார்க்கும் தருணத்தில் நேரில் கேட்டதை விட கடிதம் மூலம் உங்களை வெளிப்படுத்திக்கொள்வீர்களா?		
106	ஏதேனும் விபத்தில் பலமான காயப்பட்டிருக்கின்றீர்களா?		
107	பாம்பினை கண்டால் பெரிதும் பயப்படுவீர்களா?		
108	சமீபத்தில் சொல்லும் அளவிற்பு உடல் எடை குறைந்துள்ளதா?		
109	பணமில்லாத நிலை உங்களின் தற்போதைய குடும்பத்தை மகிழ்ச்சியற்ற நிலைக்கு தள்ளியள்ளதா?		
110	ஒரு சிறிய கூட்டத்தில் ஏதேனும் ஒரு குறிப்பு வழங்குவதில் உங்களுக்கு சிரமம் உள்ளதா?		
111	உடனடியாக கண்ணீர் விடுபவரா?		
112	ஒரு நாளின் முடிவில் அடிக்கடி அதிகம் களைப்படைவதாக உணர்கின்றீர்களா?		
113	உங்கள் பெற்றோருடன் நீங்கள் வசித்து வரும்போது உங்களை இருவரும் அடிக்கடி தவறாக விமர்சிப்பவர்களா?		
114	நிலநடுக்கம் (அல்லது) நெருப்பு பற்றிய எண்ணம் உங்களை பயமுறுத்துகின்றதா?		
115	ஒரு சபை கூட்டத்தில் அனைவரும் அமர்ந்த பிறகு உள்ளே		

	நுழைந்து அமர்வதற்கு உங்களுக்குத்தயக்கமாக இருந்திருக்கின்றதா?		
116	எவ்வித சப்தமும் இல்லாதபோதும் உங்கள் தூக்கத்திற்கு இடையூறு வருவதாக நினைக்கின்றீர்களா?		
117	எவ்வித காரணமும் இல்லாதபோதும் உங்களுடன் வசிப்பவர்கள் உங்களை அடிமைப்படுத்துவதாக எண்ணுகின்றீர்களா?		
118	ஏதேனும் ஒரு முறையேனும் விருந்தினை புத்தாக்கம் செய்கின்றீர்களா		
119	மற்றவர்களுடன் உள்ள போதே தனிமையை உணர்கிறீர்களா?		
120	இளமையில் நீங்கள் எப்போதேனும் வீட்டை விட்டு வெளியேற உறுதியான முடிவை எடுத்துள்ளீர்களா?		
121	உங்களுக்கு அதிகமாக தொல்லைகள் / தலைவலி உள்ளதா?		
122	யாரேனும் உங்களை மனவசியப்படுத்தி உங்கள் விருப்பத்திற்கு எதிரே செயல்பட வைப்பதாக உணர்கின்றீர்களா?		
123	குழுவிவாதத்தில் பங்கு கொள்ளும்போது தனித்தன்மையான கருத்துகள் தீர்ப்புகளை சொல்வதற்கு சிரமப்படுவீர்களா?		
124	உங்களுக்கு எப்போதேனும் அம்மைக்காய்ச்சல், டிப்திரியா, காய்ச்சல் வந்திருக்கின்றதா?		
125	உங்கள் பெற்றோருக்கு நீங்கள் எப்போதேனும் ஏமாற்றத்தை கற்றதாக உணர்கிறீர்களா?		
126	ஏதேனும் விருந்து விசேஷங்களில் உங்களுடன் இருப்பவர்களை அறிமுகப்படுத்துவதில் உங்களுக்கு பொறுப்பு உள்ளதாக உணர்கிறீர்களா?		

SELF — ESTEEM RATING SCALE (SERS)

Please answer each item as carefully and accurately as you by placing a number by each one as follows.

1 — Never, 2 — Rarely, 3 — A little of the time, 4 — Some of the time, 5 — A good part of the time, 6 — Most of the time, 7 — Always

Code	Statements	1	2	3	4	5	6	7
B1	I feel that people would NOT like me if they really knew me well.							
B2	I feel that others do things much better than I do							
B3	I feel that I am an attractive person.							
B4	I feel confident in my ability to deal with other people.							
B5	I feel that I am likely to fail at things to do.							
B6	I feel that people really like to talk with me.							
B7	I feel that I am a very competent person.							
B8	When I am with other people I feel that they are glad I am with them.							
B9	I feel that I make a good impression on others.							
B10	I feel confident that I can begin new relationship if I want to.							
B11	I feel that I am ugly.							
B12	I feel that I am a boring person.							
B13	I feel very ---------- when I am with strangers.							
B14	I feel confident in my ability to learn new things.							
B15	I feel good about myself.							
B16	I feel ashamed about myself							
B17	I feel inferior to other people.							
B18	I feel that my friends find me interesting.							
B19	I feel that I have a good sense of Humor.							
B20	I got angry at myself over the way I am.							
B21	I feel relaxed meeting new people.							
B22	I feel that other people are smarter than I am.							
B23	I do not like myself							
B24	I feel confident in my ability to cope with difficult situation.							
B25	I feel that I am Not very likeable.							
B26	My friends value me a lot.							
B27	I am afraid I will appear stupid to other.							
B28	I feel that I am an OK person.							
B29	I feel that I can count on myself to manage things well.							
B30	I wish I could just disappear when I am around other people.							
B31	I feel embarrassed to let others hear my ideas.							
B32	I feel that I am a nice person.							
B33	I feel that if I could be more like other people than I would feel better about myself							
B34	I feel that I get pushed around more than others.							
B35	I feel that people like me.							
B36	I feel that people have a good time when they are with me.							
B37	I feel confident that I can do well in whatever I do.							
B38	I trust the competence of others more than I trust any own abilities.							
B39	I feel that I mess things tip.							
B40	I wish that I were someone else.							

AUTHORS

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PURPOSE

The SERS is a 40 – item instrument that was developed to provide a clinical measure of self – esteem that can indicate not only problems in self – esteem but – also positive or non problematic levels. The items were written to tap into a range of areas of self – evaluation including 1. overall self – work. 2. Social competences 3. Problem – solving ability, 4. Intellect cal ability, 5. Self – competence, and worth relative to other people. The SERS is a very useful instrument for measuring both positive and negative aspects of self – esteem in clinical practice.

NORMS

The SERS was studied initially with two samples. Samples 1 contained 246 people, of whom 91 were male and 155 female, with an average age of 32.5 years and an average of 15.7 years of formal education. Thirty-one percent were white. 11.8% black, 4.5% Hispanic, 7.7% Asian, and the rest were mixed or other groups. Sample 2 involved 107 people including 23 males and 84 females, with an average of 15.3 years of education 95.5% were white, 4.7% black and the rest in other groups. Actual norms were not available.

SCORING

The SERS is scored by scoring the items shown at the bottom of the measure as p / + positively, and scoring the remaining items (N / -) negatively by placing a minus sign in front of the item score. The items are summed to produce a total score ringing from – 120 to +120. Positive scores indicate more positive self – esteem and negative scores indicate more negative levels of self-esteem.

RELIABILITY

The SERS has excellent internal consistency, with an alpha of 97. The standard error of measurement was 5, 6, 7 date on stability were not reported.

VALIDITY

The SERS was reported as having good content and factorial validity. The SERS has good constructive validity, with significant correlations with the index of self – esteem and the generalized contentment scale (a measure of depression) as predicted, and generally low correlation with a vanity of demographic variables, also predicted.

PRIMARY REFERENCE

Nugent W.R. and Thomas J.W. (1993). Validation of Self – Esteem Rating Scale, Research on Social Work Practice 3, 191 – 207.

AVAILABILITY

Journal article.

தன் மதிப்பீடு அளவுகோல்

கீழே கொடுக்கப்பட்ட வாக்கியங்களுக்கு பதில் 1-7 வரை கொடுக்கப்பட்டுள்ளது. உங்களுக்கு சரியென்றுபட்ட பதிலை குறிப்பிட்டு ( ) குறிப்பிடவும்.

1) இல்லை 2) எப்பொழுதாவது 3) சில நேரங்களில் 4) அவ்வப்பொழுது 5) ஒரு சில நேரம்
6) எப்பொழும் 7) முழுவதும்.

எண்	வாக்கியங்கள்	1	2	3	4	5	6	7
1	எனக்கு தெரியும் என்னைப்பற்றி நன்கு புரிந்து கொண்டவர்கள் என்னை விரும்பமாட்டார்கள்							
2	மற்றவர்கள் என்னைக்காட்டிலும் நன்கு செய்கிறார்கள்							
3	நான் ஒரு கவர்ச்சியானவன்/வள் என நினைக்கிறேன்							
4	நான் மற்றவர்களை கையாளும்பொழுது மிகவும் தைரியமாகக்காணப்படுகிறேன்							
5	நான் அநேகமாக நான் செய்யும் காரியங்களில் தோல்வியடைவேன் என எண்ணுகிறேன்.							
6	என்னிடம் அனைவரும் பேசவிரும்புகிறார்கள் என எண்ணுகிறேன்							
7	என்னைப்பொறுத்தவரை நான் அனைத்தையும் தெரிந்தவன் என எண்ணுகிறேன்							
8	நான் மற்றவர்களோடு இருக்கும் பொழுது மற்றவர்கள் மகிழ்ச்சியடைகிறார்கள் என எண்ணுகிறேன்							
9	நான் மற்றவர்கள் முன்னிலையில் என்னைப்பற்றிய நல்லெண்ணம் கொண்டுவர எண்ணுகிறேன்							
10	நான் புது உறவுகளை எனக்கு தேவையானால் வளர்த்துக்கொள்ள முடியும்							
11	நான் மிகவும் அசிங்கமாக உள்ளேன் என்று எனக்குள்ளே எண்ணிக்கொள்கிறேன்							
12	நான் மிகவும் அறுவையானவன் என எண்ணுகிறேன்							
13	நான் எனக்கு அறிமுகம் இல்லாதவர்களுடன் இருக்கும்பொழுத மிகவும் நடுக்கமாக உணருகிறேன்.							
14	ஏனக்கு எனது திறமையில் நம்பிக்கை உள்ளது ஆகவே நான் புதிய விஷயங்களை கற்றுக்கொள்கிறேன்.							
15	நான் என்னைப்பற்றி நல்ல அபிப்ராயம் வைத்துள்ளேன்							
16	எனக்கு என்னைப்பற்றி ஒரு வெட்கம் உள்ளது							
17	நான் மற்றவர்களோடு ஒப்பிடும்பொழுது மிகவும் தாழ்வு மனப்பான்மையோடு காணப்படுகிறேன்							
18	எனது நண்பர்கள் என்னிடம் இருப்பதை மிகவும் விருப்பமுடன் ஏற்றுக்கொண்டு ரசிக்கிறார்கள்							
19	எனக்கு நல்ல நகைச்சுவை ஆற்றல் உள்ளதாக எண்ணுகிறேன்							
20	என் மேலேயே எனக்கு கோபம் வரும் ஏனெனில் நான் நடந்து கொள்ளும் விதம் அவ்வாறு உள்ளது							
21	நான் புதிய மனிதர்களை பார்க்கும்பொழுது பழகும்போதும் மிகவும் லேசாக உணர்கிறேன்							
22	நான் என்னைக்காட்டிலும் மற்றவர்கள் மிகவும் திறமைவாய்ந்தவர்கள் என எண்ணுகிறேன்							
23	என்னை எனக்கு பிடிக்கவில்லை							

24	எனக்கு நல்ல மனதைரியம் எனது திறமை மேல் நம்பிக்கை உள்ளதால் எத்தகைய இக்கட்டான சூழ்நிலையிலும் நன்கு ஒத்துப்போக முடியும்.							
25	நான் அதிகமாக மற்றவர்களால் விரும்பப்படவில்லை என நினைக்கிறேன்							
26	எனது நண்பர்கள் என்னை நன்கு எடைபோட்டு உள்ளார்கள்							
27	நான் மிகவும் பயந்தவன், நான் மற்றவர்கள் பார்வைக்கு மிகவும் முட்டாளாக தெரிகிறேன்.							
28	நான் மிகவும் சரியானவர் என எண்ணுகிறேன்							
29	நான் நானாகவே அனைத்து காரியங்களையும் செய்து முடிக்க முடியும் என எண்ணுகிறேன்							
30	நான் என்னை மற்றவர்கள் சூழ்ந்து இருக்கும்பொழுது நான் மறைந்து விட வேண்டும் என எண்ணுகிறேன்							
31	மற்றவர்கள் எனது கருத்தை கேட்கும்பொழுது எனக்கு மிகவும் சங்கோஜமாக இருக்கும்							
32	நான் மிகவும் நல்ல மனிதன்							
33	நான் மற்றவர்களைப்போல் இருந்து விட்டால் எனக்கு மிகவும் நல்லது							
34	நான் மற்றவர்களை விட அதிகம் தள்ளப்படுவதாக உணர்கிறேன்							
35	நான் மற்றவர்கள் என்னை விரும்புகிறார்கள் என எண்ணுகிறேன்							
36	மற்றவர்கள் என்னோடு இருப்பதில் அவர்கள் மிகவும் மகிழ்ச்சியடைவார்கள் என எண்ணுகிறேன்							
37	என்மேல் எனக்கு நம்பிக்கை உள்ளது நான் எதைசெய்தாலும் அதை நன்கு செய்வேன் என எண்ணுகிறேன்							
38	நான் என்னிடம் உள்ள எனது திறமையைக்காட்டிலும் மற்றவர்களது திறமைகளை நம்புகிறேன்							
39	நான் சில சமயங்களில் எல்லா விஷயங்களையும் நன்கு குழப்பிவிடுவேன்							
40	நான் மற்றவர்களாக இருந்திருக்கலாம் என்று எண்ணுவேன்							

SOCIAL BEHAVIOUR ASSESSMENT SCHEDULE (SBAS)

OF HOME FOR THE AGED

1. Never 2. Some Times 3. Often

Code	Statements	1	2	3
C1	I like the various activities of this — home			
C2	I am involved in many of the activities of the home			
C3	I like the religious activities of this home.			
C4	I feel fairly contented with my daily pattern of activities			
C5	I actually participate in fund raising activities.			
C6	I take up certain household responsibilities.			
C7	I help sisters ¡n organizing cultural activities.			
C8	I help the sisters in doing their shopping.			
C9	I give required information to the visitors.			
C10	When certain inmates come to me with their problems or needs. I acknowledge their problems and render support.			
C11	I extend my emotional support to inmates during their grief			
C12	I make enquires about the well being of others.			
C13	I extend my support in case others develop any health problem			
C14	I help others in fulfilling their responsibilities.			
C15	I motivate others to take part in institutional activities.			
C16	I encourage others to maintain harmonious relationship.			
C17	I extend my help in enabling others to attend religious activities.			
C18	1 help others to get involved in some leisure tune activities.			
C19	I help others to understand day to day events of the world.			
C20	I spend my time working ¡n the garden along with others.			
C21	I have some hobbies to do with other inmates.			
C22	Listening to the radio and discussing in one of my activities.			
C23	Watching movies and Television in a group is my pleasure.			
C24	I write letters.			
C25	I attend lectures organized by the institution.			
C26	I play music or sing in social gathering.			
C27	I play cards and other table games.			
C28	I share what I read from books, magazines and news papers.			
C29	I prefer to sit with company.			
C30	People around me enjoy hearing about what I speak.			
C31	I really on the sisters here for my emotional support			
C32	The inmates here and I are very open about what we think about things.			
C33	Inmates of this home are good at helping me in solving the problems.			
C34	I have a deep sharing relationship with a number of inmates here.			
C35	My relatives express their happiness in visiting me.			
C36	My friends visit me.			
C37	I am able to make new friends when opportunity arises.			
C38	I visit my relatives			
C39	I visit nay friends.			
C40	My relatives visit me.			

I was used to assess the level of socialization among the inmates of home for the Aged. This schedule was prepared based on the **SBAS** developed and discussed by Platt et.al. in 1980 and also based on KAT2 adjustment scales (Katy and Lyerly, 1963). The modified tool used for this study has 40 items totally with 4 dimensions.

1. Role performance of the inmates to maintain the institutional activities. 2. Supportive role. 3. Spare time activities. 4. Relationship

I. ROLE PERFORMANCE OF THE INMATES TO MAINTAIN THE INSTITUTIONAL ACTIVITIES

It has 10 items assessing the frequency of subjects participation in the institutional activities related to religion, fund raising, household work, cultural acuities, shopping, maintenance of cleanliness, informant to visitors, etc.,

II. SUPPORTIVE ROLE

It also has 10 items to elicit the information regarding the situations, incidental problems, health problems, interpersonal problem, unmet religions needs, motivation and expressing the concern when the inmates felt lonely.

III. SPARE TIME ACTIVITIES

This had 10 items to explore the pattern of activities that involved the subjects to spend the spare time. They are activities related to gardening, engaged in hobbies, listening to radio, watching movies and T.V. writing letters, attending organized lectures, participating in social gathering, playing games, reading books and spending time in groups.

IV RELATIONSHIP

This dimensions had 10 items, brought out the information related to subjects view about his connectedness with one another in the old Age. Home and his initiation and response in developing relationship.

The constructed part of the tool was given to 5 mental health experts to give their opinion.

Their suggestions were incorporated to modify the tool. The content validity of the tool was established by retaining only those items which had 100% consensus by all the exports. The tool was tested for its reliability thought split half method. Each item in the scale is scored on, 3 point scale namely never, sometimes and often. The score value of one is given to "Never", two is given to "Some – time" and there is given to "Often". Total score of each subject is found to assess their level of socialization. The interpretation is higher the scores indicate higher the level of socialization, and the low indicate low level of socialization.

முதியோர் இல்லங்களில் வசிக்கும் முதியோரிடம் காணப்படும் சமூக உறவுகள்

1) இல்லை 2) எப்பொழுதாவது 3) அடிக்கடி

எண்	வாக்கியங்கள்	1	2	3
1	இந்த இல்லத்தில் நடைபெறும் பல்வேறு நிகழ்ச்சிகள் எனக்கு பிடிக்கும்			
2	நான் பல்வேறு நிகழ்ச்சிகள் இல்லத்தில் நடைபெறும்பொழுது பங்கெடுப்பேன்			
3	இந்த இல்லத்தில் நடைபெறும் இதை வணக்கமுறைகள் எனக்கு பிடிக்கும்			
4	எனது அன்றாட வேலைகள் நடைபெறும் முறைகள் எனக்கு போதுமானதாக உள்ளது.			
5	நான் நிதி வசூல் செய்யும் அனைத்து நிகழ்ச்சிகளிலும் உற்சாகமாக பங்கெடுப்பேன்			
6	நான் வீட்டு வேலைகள் சிலவற்றிலும் பங்கெடுப்பேன்			
7	நான் இல்லத்தில் உள்ள சகோதரிகளோடு கலைநிகழ்ச்சிகளை நடத்துவதில் பங்கெடுப்பேன்.			
8	நான் சகோதரிகளுடன் கடைவீதிக்கு சென்று தேவையானவற்றை வாங்கி வருவேன்			
9	நான் பார்வையாளர்கள் வரும்பொழுது மிகவும் சரியான தேவையான தகவல்களை தருவேன்			
10	எப்பொழுதாவது இல்லத்தில் இருக்கும் முதியவர்கள் அவர்களது பிரச்சினைகள் அல்லது தேவைகளுக்காக என்னை நாடி வரும்பொழுது என்னால் முடிந்த அளவு அவர்களது பிரச்சினைகளுக்கும் தேவைகளுக்கும் உதவி செய்வேன்.			
11	நான் இல்லத்தில் வசிப்பவர்களுக்கு அவர்கள் துக்கத்தில் இருக்கும்பொழுது சரியான முறையில் ஆறுதல் அளிப்பேன்			
12	நான் பிறர் வாழ பல வகைகள் உதவிசெய்வேன்			
13	நான் மற்றவர்கள் இறைப்பணி செய்ய நன்கு ஊக்குவிப்பேன்.			
14	நான் மற்றவர்கள் தங்களது பொறுப்பினை நன்கு நிறைவேற்றுவதற்கு உதவி செய்வேன்			
15	நான் மற்றவர்களை இல்லத்தின் செயல்பாடுகளில் பங்கெடுக்க நன்கு உற்சாகப்படுத்துவேன்.			
16	நான் இல்லத்தில் இருப்பவர்கள் பிறரிடம் நல்ல சுமூகமான உறவினை வளர்க்க ஊக்குவிப்பேன்			
17	நான் மற்றவர்கள் இறைப்பணி செய்ய நன்கு ஊக்குவிப்பேன்			
18	நான் மற்றவர்கள் தங்களது ஓய்வு நேரங்களை நன்கு பயனுள்ள			

	வழிமுறைகளில் செலவிட உதவிடுவேன்			
19	நான் மற்றவர்கள் அன்றாடம் நடைபெறும் உலக நடவடிக்கைகளை புரிந்து கொள்ள ஏதுவான உதவிகளை செய்வேன்			
20	நான் எனது நேரத்தை தோட்ட வேலைகள் செய்வதில் செலவழிப்பேன்			
21	நான் மற்ற இல்லத்து முதியோர்களுடன் இணைந்து எனக்கு விருப்பமான வேலைகளில் ஈடுபடுவேன்.			
22	நான் வானொலி கேட்பது மற்றும் கலந்துரையாடுவது போன்றவை எனது முக்கிய நிகழ்வாகும்			
23	நான் திரைப்படம் பார்ப்பது சின்னத்திரை நிகழ்ச்சிகளை பார்ப்பது எனது முக்கிய பொழுதுபோக்காகும்.			
24	நான் கடிதங்கள் எழுதுவேன்			
25	நான் இல்லம் நடத்தும் அனைத்து விரிவுரை நிகழ்விலும் பங்குபெறுவேன்			
26	எனக்கு பொது நிகழ்ச்சிகளில் பாடுவது மற்றும் இசைக்கருவிகளை மீட்டுவது மிகவும் பிடிக்கும்			
27	நான் சீட்டு விளையாடுவது மற்றும் சில மேசை விளையாட்டுகள் விளையாடுவேன்			
28	நான் படிக்கும் புத்தகங்கள், மாத இதழ்கள் மற்றும் நாளிதழ்களில் உள்ள விஷயங்களை பிறருடன் பகிர்ந்து கொள்வேன்			
29	நான் எப்பொழுதும் நண்பர்களோடு இருப்பதை விரும்புவேன்			
30	என்னைச்சுற்றி உள்ளவர்கள் நான் பேசுவதை மிகவும் விரும்புவார்கள்			
31	நான் இங்கு உள்ள சகோதரிகள் எனக்கு மன ரீதியான ஆதரவு அளிப்பார்பள் என நம்புகிறேன்.			
32	இங்கு உள்ள அனைவரும் மிகவும் திறந்த மனதுடன் அவர் அவர்கள் எண்ணுவதை பகிர்ந்து கொள்வார்கள்			
33	இங்கு உள்ள அனைவரும் எனது பிரச்சினைகளை தீர்க்க எனக்கு நன்கு உதவுவார்கள்			
34	இங்கு உள்ள அனைத்து இல்லவாசிகளுக்கு நன்கு மனம் விட்டு உறவினைப்பகிர்ந்து கொள்வேன்			
35	எனது உறவினர்கள் என்னை வந்து பார்த்துவிட்டு செல்வதில் மிகவும் மகிழ்ச்சியடைகிறார்கள்			
36	ஏனது நண்பர்கள் என்னை காண வருகிறார்கள்			
37	நான் சந்தர்ப்பம் கிடைக்கும் பொழுது புது நண்பர்களை நண்பர்களாக்கி கொள்வேன்			
38	நான் எனது உறவினர்களை காணச்செல்வேன்			
39	நான் எனது நண்பர்களை சென்று பார்த்து வருவேன்			
40	எனது உறவினர்கள் என்னை காண வருகிறார்கள்.			

THE RELIGIOUS ATTITUDE INVENTORY

RESPOND TO EACH OF THESE ITEMS ON A 1 TO 5 SCALE

1. Means that you strongly agree with a given statement.
2. Means that you tend to agree more than disagree with a given statement.
3. Means that you neither agree nor disagree with a given statement.
4. Means that you tend to disagree more than agree with a given statement.
5. Means that you strongly disagree with a given statement.

1. God made everything, the stars, the animals, and the flowers.
2. The gift of immortality has been revealed by prophets and religious teachers.
3. The church has acted as an obstruction to the development of social justice.
4. There are many events which cannot be explained except on the basis of divine or supernatural intervention.
5. The church is a monument to human ignorance.
6. The idea of God is useless.
7. God hears and answers one's prayers.
8. The soul is mere supposition, having no better standing than a myth.
9. The belief in immortality follows from the fact that the human soul partakes of the divine.
10. Specialists in religions tend to accept the doctrine of immortality and we should rely upon their authority.
11. Human values cannot perish with the death of our physical existence.
12. Religious beliefs may furnish solace to some people vexed by troubles, but these beliefs do not furnish truthful answers to individual problems.
13. There must be life after death since otherwise man would be no more than an animal.
14. Religion with its fear – inspiring supernaturalism is responsible for a large amount of mental suffering.
15. The modern rejection of the God concept is an intellectual one.
16. The notion of immortality is unintelligible and creates more mysteries than it solves.
17. The affirmation of the belief in an after life is no proof of its existence.

18. The idea of creation out of nothing is incomprehensible.

DESCRIPTION

This is a 50 item, Likert – type scale developed by Ausubel and Schpoont (1957). It measures attitudes toward the following religious referents: religious doctrine, immortality, God, and the church. It was developed to study accuracy of perception of persons holding extreme versus neutral views on a relevant topic. In the composition of the scale, 159 statements were collected and administered to subjects, and the mean item rating was determined. The final scale was constructed by choosing the 25 items at each extreme of the distribution of item values.

SUBJECTS

The sample included 38 graduate students in education, at the University of Illinois; 95 freshmen and sophomores (82 of whom were women) in the College of Education and in the Liberal Arts College at the University of Illinois. The mean age of the latter group of subjects was 20.5 years.

RESPONSE MODE

Subjects respond to a modified set of Likert alternatives, on a five – point scale, strongly agree, tend to agree more than disagree, neither agree nor disagree, tend to disagree more than agree, and strongly disagree.

SCORING

The response alternative for positive (pro-religious) items are weighted from 5 (strongly agree) to 1 (strongly disagree). Weights for alternatives of the negative (antireligious) items must be reversed. The person's score is the sum of the weighted alternatives endorsed by him. High scores indicates acceptance of religion and religious doctrine.

RELIABILITY

The authors report a split – half reliability coefficient (corrected) of 97, based on an N of 95.

VALIDITY

Items were chosen for their ability to discriminate extreme scorers. Further, on the responses of the 95 undergraduates, the authors tested the

significance of the difference between mean scores of the high, middle, and low groups of subjects and found them significant at the .01 level. The scale apparently possesses content validity.

COMMENTS

This seems to be a reliable scale for measurement of attitude toward religion and its teaching, but evidence of validity is limited. Test – retest reliability estimated would be a valuable addition to the sup portive information on the scale.

இறைநம்பிக்கை பற்றிய நடத்தை (அல்லது) கருத்துகள்

கீழே கொடுக்கப்பட்டுள்ள ஐந்து வினாவிடையில் சரியான விடை என நினைக்கிறீர்களோ அதில் ( ) குறியிடவும்

1) கொடுக்கப்பட்ட விடை மிகச்சரியானது 2) சரியானது
3) ஒத்துக்கொள்ள இயலவில்லை மறுக்கவும் இல்லை 4) ஒரு வேலை மறுக்கலாம்
5) திடடவட்டமாக மறுக்கிறேன்.

எண்	வாக்கியங்கள்	1	2	3	4	5
1	கடவுள் அனைத்தையும் உருவாக்கினார் அவை வானத்து நட்சத்திரங்கள், மிருகங்கள் மற்றும் மலர்கள்					
2	அழியாத பரிசுகளை மதப்போதகர்கள் மற்றும் தீர்க்கதரிசிகளும் வெளிப்படுத்தியுள்ளனர்					
3	ஆலயங்கள் சமுதாய வளர்ச்சிக்கு சமூக நீதிக்கு தடையாக உள்ளது					
4	நிறைய காரியங்கள் விளக்க முடியாது. ஏனெனில் இறைவனின் இயற்கையை மீறிய சக்தி செயல்படுவதில்லை					
5	ஆலயம் ஒரு நினைவுச்சின்னமாக மாறுவதற்கு மனிதகுலத்தின் அறியாமையே					
6	கடவுள் பற்றி நினைவுகள் ஒரு பயனற்ற செயல்					
7	கடவுள் மனிதன் செய்யும் ஜெபத்தை கேட்டு ஆசிர்வாதம் தருகிறார்					
8	நமது ஆத்மானானத					
9	அகில உலகம் என்பது ஒரு இயந்திரம் மனிதன் மற்றும் இயற்கை படைப்புகளில் காரணம் மற்றும் விளைவும் ஆகும். இவ்வுலகம் முழுவதையும் அறிவு சார்ந்த அழகு மற்றும் இறையாண்மை போன்றவை மாற்ற ஜெபம் அனைத்தும் வெறும் மாயையே					
10	ஆலயங்களில் இறைவனின் வார்த்தைகள் மூலம் சமாதானம் மற்றும் நல்லெண்ணங்கள், வெறுப்பு தீய செயல்களை அகற்றி அவைகள் நல்ல இடத்தை பெற வேண்டும்					
11	கடவுள் மனிதனை தனியாக மிருகங்களிடம் இருந்து வேறுபடுத்தி படைத்துள்ளார்					
12	ஆலயம் என்பது ஒரு தீமை விளைவிக்கும் நிறுவனம் அங்கு குறுகிய மனப்பான்மை மதவெறி மற்றும் கலவரங்களை பிறப்பிக்கும் இடமாக உள்ளது					
13	கிறிஸ்து உலகின் நற்செய்தி. அவர் கடவுளின் வடிவமாக மனித உருவில் இவ்வுலகிற்கு வந்தார்.					

14	விஞ்ஞான உலகில் எவ்வித தடயமும் இயற்கைக்கு முரணாக இல்லை					
15	வாழ்க்கையின் எதிர்காலம் நம் நல்லெண்ணங்களை பொருத்து உள்ளது.					
16	ஆலயங்களில் செய்யும் நல்ல காரியங்கள் மற்ற பணம் மற்றும் அடுத்த காரியங்கள் ஒன்றாக முடியாது.					
17	உலகம் முழுவதும் கடவுளின் அணுகிரகத்தால் அனைத்தும் சரிவர நடந்த வருகிறது.					
18	ஆலயங்கள் மற்றும் இறை நம்பிக்கை மனித குலத்தின் நன்மைக்காக ஏற்படுத்தப்பட்டுள்ளது. ஆகவே தான் பல இக்கட்டுகள், சகிப்பு தன்மை இல்லாமை மற்றும் அறியாமை போன்றவைகளில் இருந்து காக்கப்பட்டு வருகிறது					
19	இன்று இவ்வுலகில் கடவுள் உள்ளார் என நிருபிக்கப்பட்டள்ளது. ஏனெனில் அவர் உள்ள தீர்க்கதரிசிகளுக்கு காண்பித்து உள்ளார் என வேதம் சொல்கிறது.					
20	ஆலயங்கள் ஒரு நல்ல அரசு உருவாகுவதற்கும் சரியான வாழ்க்கை வாழ்வதற்கும் அவை முக்கிய பங்கு வகுக்கின்றன					
21	கடவுள் என்பது மனிதனின் கற்பனை உருவம்					
22	மனிதன் நம்பிக்கையின் படைப்பு நம்பிக்கையற்ற வாழ்க்கை நமது ஆத்மாவை ஒரு மிகப்பெரிய சக்தியை இழக்க வைக்கும்.					
23	கடவுள் நம் இவ்வுலகில் எவ்விதம் நடந்துகொள்கிறோம். ஏத்தகைய பாராட்டை பெறுகிறோம் அல்லது தண்டனையை அடைகிறோம் என்பதை காணவே இவ்வுலகில் வந்தார்.					
24	ஓய்வு நாளான ஞாயிற்று கிழமையை நன்கு மிகவும் கட்டாயமாக அனுசரிப்பவர்கள் மதவெறியர்கள் ஆவர்.					
25	எந்த கடவுளும் அகில உலகை தனது கட்டுப்பாட்டுக்குள் வைத்துள்ளார் என்பது மிகவும் தெளிவாக தெரிந்த உண்மை					
26	ஆலயம் என்பது உலகத்தாரின் மேம்பாடான வாழ்க்கைக்கு மிகவும் முக்கியமான ஒன்றாகும்					
27	கடவுள் பற்றிய கருத்துகள் அனைத்தும் ஒரு பொய்யான நம்பிக்கை ஆகும்					
28	இவ்வுலகானது ஆறு நாட்களில் உருவாக்கப்பட்ட ஒன்றாகும்					
29	இன்றைய நவீன நாகரிக உலகில் கடவுள் நம்பிக்கை என்பது தேவையற்ற ஒன்றாகும்					
30	கடவுள் நமக்கு நடக்கும் காரியம் ஒவ்வொன்றிற்கும் ஒரு காரணம் வைத்திருப்பார் ஆனால் அது நமக்கு அது உடனே தெரியாது					
31	நமது ஆத்மாவானது நாம் இறந்த பின்பும் வாழ்ந்து கொண்டிருக்கும்					
32	நமது பிரார்த்தனைகள் மூலம் கடவுளை நாம் நினைக்கும் பொழுது அவர் நமக்கு நல்ல பலன்களை தருவதன் மூலம் இறைவன் இருக்கிறார் என்பதை நாம் உணர முடிகிறது					
33	இந்த நாடு எப்பொழுது வளம் பெறும் என்றால் அனைத்து ஆலயங்களும் மூடப்பட்டு அங்குள்ள அனைத்து ஊழியர்களும் பயனுள்ள வேலைகளுக்கு அனுப்பபடும்பொழுது					
34	ஆவிக்குரிய வாழ்க்கையின் அனுபவமானது மனிதன் மனதளவிலும் உணர்விலும் பிரித்து பார்க்க முடியாத அளவிற்கு வெளிப்படையாக இருப்பதுவே மனநல வாழ்க்கையே ஆவிக்குரிய வாழ்க்கையாகும்					
35	முதலில் வேதமான கடவுளது வழிநடத்தலின்படி அவரால் எழுதப்பட்டது					
36	ஆலயம் என்பது நூறு ஆண்டுகளுக்கு பின்னால் உள்ளவைகளை கடைபிடித்துக்கொண்டு இருப்பது அது இக்கால நவீன உலகுக்கு ஒத்து வராது					

37	கடவுள் நம்பிக்கையானது இம்மண்ணுலக வாழ்க்கையினை நம்பிக்கையுடையதாக பயனுள்ளதாக மாற்றும்					
38	கடவுள் நாம் மனம் திருந்தினாலும் திருந்தாவிட்டாலும் நம்மைப்பாதுகாத்து பராமரிப்பார்					
39	மனிதன் தனது எண்ணங்களில் உண்மையுள்ளவனாக இருக்க முடியாது அதே போன்ற ஆலயம் சொல்லிக்கொடுகும்படி நடக்க இயலாது					
40	மனிதன் இறந்தவுடன் அவனுக்கு வாழ்க்கையில்லை					
41	இறைவன் இம்மண்ணுலக வாழ்வை வெறுத்து நித்திய வாழ்வை நம்பிக்கை உள்ளவர்களுக்கு அளிக்கிறார்					
42	ஆலயம் என்பது நிச்சயமற்ற மாயமலமான மற்றும் அகங்காரம் நிறைந்த ஒரு ஒட்டு மொத்த உருவமாகும்					
43	ஒரு கண்ணுக்கு புலப்படாத எங்கும் வியாபித்து இருக்கிற அகில உலகத்தை உருவாக்கி பலத்த பாதுகாப்பு கொடுத்து இறைவனை வழிபடுதல் மூலம் பிரார்த்தனைகள் மூலம் சக்தி நடத்தி வருகிறது					
44	ஆலயத்தின் வழிமுறைகள் கண்மூடித்தனமாக நடத்தைகள் அனைத்தும் பக்குவப்பட்ட மனிதர்களுக்கு மிகவும் வேதனையான விஷயமாக இருக்கும்					
45	ஆலயம் பொதுவாக மேலோட்டமாக அனைத்து விஷியங்களையும் கவனிக்கும் ஆற்றலும் சட்டம் மற்றும் உண்மைகள் ஏற்றுக்கொள்ளத்தயங்கும்					
46	கடவுள் அவரை உண்மையாக நேசிப்பவர்கள், நம்புகிறவர்களை எப்பொழுதும் பாதுகாப்பார்					
47	சாவாமை என்பது நிச்சயம். ஏனெனில் கடவுள் மனிதகுலத்துக்காக தன்னையே ஈவாக கொடுத்தார்.					
48	கடவுளைப்பற்றிய எத்தகைய அனுமானமும் இல்லாமல் இவ்வுலகிற்காக உழைப்பது சாலச்சிறந்தது.					
49	மனிதன் ஆலயத்தின் மேல் அதிக அக்கறை காட்டுகிறான் என நினைப்பது முற்றிலும் தவறான ஒன்றாகும்.					
50	நமது அழகான இவ்வுலகில் இறைவனை பற்றிய எண்ணம் மிகவும் நல்ல ஒரு எண்ணமாகும்.					

Geriatric Depression Scale

Choose the best answer for how you felt over the past week.

Code	Statements	Yes (1)	No
E1	Are you basically satisfied with your life.		
E2	Have you dropped many of your activities and		
E3	Do you feel that you life is empty?		
E4	Do you often get bored?		
E5	Are you hopeful about the future?		
E6	Are you bothered by thoughts you can't get out of your		
E7	Are you in good spirits most of the time?		
ES	Are you afraid that something bad is going to happen		
E9	Do you feel happy most of the time?		
E10	Do you often feel helpless?		
E11	Do you often get restless and fidgety?		
E12	Do you prefer to stay at home, rather than going out and doing		
E13	Do you frequently worry about the future?		
E14	Do you feel you have more problems with memory		
E15	Do you think it is wonderful to alive now?		
E16	Do you often feel downhearted and blue?		
E17	Do you feel pretty worthless the way you are now?		
EIS	Do you worry a lot about the past?		
E19	Do you find life very exciting?		
E20	Is it hard for you to get started on new projects?		
E21	Do you feel full of energy?		
E22	Do you feel that your situation is hopeless?		
E23	Do you think that most people are better off than you		
E24	Do you frequently get upset over little things?		
E25	Do you frequently feel like crying?		
E26	Do you have trouble concentrating?		
E27	Do you enjoy getting up in the morning?		
E28	Do you prefer to avoid social gatherings?		
E29	Is it easy for you to make decisions?		
E30	Is your mind as clear as it used to be?		

The geriatric depression scale (GDS) is a widely used instrument development in the early 1980s as a measure of geriatric depressive symptomatology. It is a measure well suited for use as a screening and / or monitoring instrument in primary care settings where qualities such as brevity,

sensitivity and specificity are valued. A relatively extensive literature on the GDS is reviewed in this chapter, accompanied by suggestions for its use. Our opinion is that use of the (GDS) in primary care settings would improve the detection of depression among older adults. This is an important and worthwhile goal for at least a couple of reasons. 1. Depression has been reliability associated with increase health care use (Callahan, Hui, Nieaher Musick & Tierney, 1994) Second, geriatric depression is a treatable disorder. (Friedhoff, 1994).

OVERVIEW

The development of the (GDS) was motivated by the perception, that existing self – report measure of depression were lacking when used with older adults (Eg. Jarvik, 1976, Kane & Kane, 1981, Salzman & Sheeler, 1978). The most frequently expressed concerns were with somatic symptoms or depression, including energy, sex, sleep, and gastrointestinal difficulties, as these tended to be unreliable indicants of depression when evaluated in elders. Other concerns included the confusion often engenereed by the multiple response format of extant instruments, especially with older adults, experiencing mild to moderate cognitive impairment. The lack of norms for older adults was frequently expressed as a short – coming as well. These concerns coincided with the maturation of the field of geriatric mental health to the point that investigators were ready to develop a self – report depression instrument specifically gear eel for older adults.

DEVELOPMENT

The results of initial development efforts of the GDS were detailed in articles published in the early 1980s. A group of investigators at Stanford University and the Palo Alto. Vesteran's Administration Medical Center. The first (Brink et al., 1982) reported in rather, truncated fashion the development of the scale.

The second (Yesavage et al, 1983) is a much more detailed version of the same initial development and validation and is reviewed for the purpose of this chapter.

The development of the (GDS) began with the generation of 100 questions that experts in geriatric psychiatry believed might be useful in detecting depression among older adults. An effort was made to include items that covered the range of depressive phenomena, including loss, cognitive complaints, somatic complaints and self – image. A yes / no response format were chosen based on the experiences of the authors with multiple – response formats. They observed that multiple – response formats often confused elderly patients. The 100 items were administered to 47 persons 55 years of age or older who either were community dwelling with no complaints of depressive or wee hospitalized for depression. The authors used a bootstrapping strategy to select items whereby those items evidencing the best correlation to the total score were retained for further validation. The rationale provided for the strategy was that the 100 items generated would provide the best measure of the geriatric depression construct. A decision to select 30 items was made presumably to minimize effects. The item – to – total correlations for these items were not in the top 30.

The next step in the development of the GDS involved cross – validation with a new set of participants. Forty Community dwelling non depressed elders and 60 older adults in treatment for depression comprised the sample. The depressed sample was divided into mild (n=26) and severe (n=34) cases based on the number of depressive symptoms evidenced participants were administered the Hamiltan Rating Scale for Depression (HRSD), Hamilton, (1967) the Zung Self – Rating Scale for Depression (SDS), Zung, 1965, and the GDS in random order.

Consistency and reliability estimates for the (GDS) were impressive. The alpha co-efficient was 94. split half reliability was also 94, and test – retest – reliability over a 1-week interval was 85. Validity was examined by using the classifications for non-depressed, mildly depressed, and severely depressed as

between subjects variables and the comparisons of the scores obtained on the GDS, HRSD, and SDS were made. Scores on each of the measures reliability distinguished the three grades of severity suggesting, discriminate validity, concurrent validity for the GDS was explored by correlating total scorer from the three instruments. The GDS correlated at 84 with the SDS and at 83 with the HRSD. These correlations were suggestive of concurrent validity.

Yes wage and colleagues also suggested a cut off score of 11 for identifying depression (ie. 0-10 non – depressed) Zn depressed. This cut score fielded sensitivity (the ability to correctly classify depressed patients) and specificity (the ability to correctly classify "normal" patients) rates of 84% and 95% respectively.

The results of this initial validation study were encouraging. The GDS demonstrated adequate reliability and validity, although the methods of this study did not permit the demonstration of superiority to other measures of depression. This article serves as the cornerstone of GDS literature and is the most frequently referenced study pertaining to the scale.

GERIATRIC DEPRESSION SCALE – (GDS)

AUTHORS

T.L. Brink, J.A. Yesavage, O. Lam, P. Hearsema, V. Huang – T.L. Rose, M. Adey and V.O. Leirer.

PURPOSE

To measure depression in the elderly.

DESCRIPTION

The GDS is a 30 items instrument to rate depression in the elderly. The GDS is written is simple language and can be administered in an oral or written format. If administered orally, the practitioner may have to repeat the question in order to get a response that is clearly yes (or) no. Translations are available

in Spanish, Helrew, omanian, Russian, and French, the main purpose for development of the GDS was to provide a screening test for depression in elderly population that would be simple to ad mister and not require special training for the interviewer. The GDS has be used successfully with both physically healthy and ill samples of the elderly.

NORMS

The initial data for the GDS came from two groups of elderly people. The first (n=40) were individuals recruited from Senior--- centers and housing projects who were functioning well with no History of mental problems.

The second group (n=60) comprised elderly under treatment – inpatient and out patient for depression.

SCORING

Scoring of the 30 items, 20 indicate the presence of depression when answered positively while 10 (items 1, 5, 7, 9, 15, 19, 21, 27, 29, 30) indicate depression when answered negatively. The GDS is seared by totaling one point counted for each depressive answer and zero points counted for a non – depressed answer.

RELIABLITY

The GDS has excellent internal Consistency with an alpha of 94 and spilt – half reliability of 94. The GDS also has excellent stability, with a one – week test – retest conflation of 85.

VALILDITY

The GDS has excellent Concurrent Validity, with Correlations of 83 between the GDS and Zungs self _Rating depression scale and 84 With the Hamilton Rating Scale for Depression. The GDS also has good known group's

validity in distinguishing significantly among respondents. Classified as normal mildly depressed and severely depressed.

The GDS also has distinguished between depressed and non – depressed physically – ill elderly and between depressed and non – depressed elderly, undergoing cognitive treatment for senile dementia.

PRIMARY REFERENCE

Yesagge, J.A. Brink, T.L. Rose, T.L. and Letter. V.O. (1983). Development and validation of a geriatric, depression scale. A preliminary report, Journal of Psychiatric Research, 17, 37-49. Instrument reproduced with permission of T.L. Brink and Jerone Yesagge.

AVAILABILITY

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முதியோர்கள் மனஅழுத்த அளவீடு

சரியான விடைகளை கடந்த ஒரு வாரத்தில் எப்படி இருந்தீர்களோ அதன்படி தேர்வு செய்யலாம்

எண்	வாக்கியங்கள்	ஆம்	இல்லை
1	நீங்கள் அடிப்படையில் உங்களது வாழ்க்கையைப்பற்றிய திருப்தியுடன் உள்ளீர்களா?		
2	நீங்கள் உள்ளது பல செய்பாடுகளையும் விருப்புகளையும் விட்டு விட்டீர்களா?		
3	நீங்கள் உங்கள் வாழ்க்கை ஒன்றுமில்லாதது என எண்ணுகிறீர்களா?		
4	நீங்கள் அடிக்கடி சோர்வடைந்து விடுவீர்களா		
5	நீங்கள் உங்கள் எதிர்காலம் பற்றிய நம் நம்பிக்கையுடன் இருக்கிறீர்களா?		
6	நீங்கள் உங்களிடம் இருந்து விடுபடாத பல எண்ணங்களை எண்ணிக்கவலைப்படுகிறீர்களா?		
7	நீங்கள் எப்பொழுதும் நல்ல உற்சாகமான மனநிலையில் உள்ளீர்களா?		
8	நீங்கள் உங்களுக்கு ஏதேனும் தீமை நடக்கும் என அஞ்சுகிறீர்களா?		
9	நீங்கள் அதிகமான நேரம் மகிழ்ச்சியுடன் இருக்கிறீர்களா?		
10	நீங்கள் அடிக்கடி அமைதியற்ற நிலை மற்றும் மரத்துப்போன நிலைக்கு தள்ளப்படுகிறார்களா?		
11	நீங்கள் அடிக்கடி அமைதியற்ற நிலை மற்றும் மரத்துப்போன நிலைக்கு தள்ளப்படுகிறீர்களா?		
	நீங்கள் பொதுவாக வெளியில் சென்று புதுப்புது விஷயங்கள்		

12	செய்வதை காட்டிலும் இல்லத்திலேயே இருக்க விரும்புகிறீர்களா?		
13	நீங்கள் அடிக்கடி உங்கள் எதிர்காலம் பற்றி கவலைப்படுவீர்களா?		
14	நீங்கள் உங்களுக்கு அதிகமான பிரச்சினைகள் உங்கள் நினைவுகளை பொருத்து உள்ளது என எண்ணுகிறீர்களா?		
15	நீங்கள் இப்பொழுது உயிரோடு இருப்பத ஒரு பெரிய முக்கியமான நிகழ்வாகும்		
16	நீங்கள் அடிக்கடி மனம் உடைந்த நிலையில் மிகவும் கவலையாக காணப்படுகிறார்கள்		
17	நீங்கள் இப்பொழுது இருக்கும் நிலையில் மிகவும் மதிப்பற்ற நிலையில் இருப்பதாக உணர்கிறீர்களா?		
18	நீங்கள் உங்களது எதிர்காலம் பற்றி அதிகம் பயப்படுகிறீர்களா?		
19	நீங்கள் வாழ்க்கை மிகவும் பரப்பானது என எண்ணுகிறீர்களா?		
20	நீங்கள் தற்சமயம் ஒரு புது திட்டம் வகுப்பதில் சிரமப்படுகிறீர்களா?		
21	நீங்கள் அதிகமான பலத்துடன் இருப்பதாக உணருகிறீர்களா?		
22	நீங்கள் தற்போதைய உங்கள் நிலை எவ்விதப்பிடிப்பும் இல்லாமல் உள்ளது என எண்ணுகிறீர்களா?		
23	நீங்கள் உங்களை காட்டிலும் மற்றவர்கள் நல்ல நிலையில் உள்ளார்கள் என எண்ணுகிறீர்களா?		
24	நீங்கள் மனதை ஒழுங்குபடுத்தி இருப்பதற்கு சிரமப்படுகிறீர்களா?		
25	நீங்கள் அடிக்கடி அழவேண்டும் என எண்ணுகிறீர்களா?		
26	நீங்கள் மனதை ஒழுங்குபடுத்தி இருப்பதற்கு சிரமப்படுகிறீர்களா?		
27	நீங்கள் காலையில் எழும்போது மிகவும் சந்தோஷமாக இருக்கிறீர்களா?		
28	நீங்கள் பொது நிகழ்ச்சிகளில் கலந்து கொள்வதை தவிர்க்கிறீர்களா?		
29	நீங்கள் நீங்களாகவே முடிவு எடுப்பது எளிதாக உள்ளதா?		
30	உங்கள் மனம் தெளிவான நிலையில் பக்குவமாக உள்ளதா?		

Life Satisfaction Index Z (LSIZ)

Read each statement on the list and indicate at left the number that best describes how you feel about the statement.

1. Agree 2. Disagree 3. Unsure

Code	Statements	1	2	3
F1	As I grow older, things seem better than I thought they would be.			
F2	I have gotten more of the breaks in life than most of the people I know.			
F3	This is the dreariest time of my life.			
F4	I am just as happy as when I was younger.			
F5	My life could be happier than it is now.			
F6	These are the best years of my life.			
F7	Most of the things I do are boring or monotonous			
F8	I expect some interesting and pleasant things to happen to me the future.			
F9	The things I do are as interesting to me as they ever were.			
F10	I feel old and some what tired.			
F11	As I look beck on my life, I am fairly well satisfied.			
F12	I would not changed my past life even if I could.			
F13	Compared to other people my age. I make a good appearance.			
F14	I have made plans for things I'll be doing in a month or a year from now.			
F15	When I think back over my life, I didn't get most of the important things I wanted.			
F16	Compared to other people, I get down in the dumps too often.			
F17	I've gotten pretty much what I expected out of life.			
F18	In spite of what some people say, the lot of the average man is getting worse not better.			

AUTHOR'S: Bernice Neugarten, Robert J, Havighurst, and Sheldon S. Tobin.

PURPOSE: To measure the psychological well – being of the elderly.

DESCRIPTION: The LSIZ is an 18 – item instrument designed to measure the life – satisfaction of older people. The LSIZ was developed from a rating scale that was designed to be used by interviewers rating respondents and it may be administered as a self-report instrument orally or in writing. Items for the LSIZ were selected on the basis of their correlations with the original rating

scale and their ability to discriminate between high and low scorers on the rating scale.

Based on research on this instrument it is recommended that the LSIZ be used mainly with individuals over 65.

NORMS: Initial study of the LSIZ was conducted with a sample of 60 people reported to represent a wide range of age from 65 years both sexes, and all social classes. The mean score on the original instrument was 12.4; however, the instrument included two more items than the current LSIZ.

SCORING: The LSIZ is easily scored by assigning one point to each item that is **"Correctly"** checked and seeming these scores. A correct score is **"Agree"** on items 1, 2, 4, 6, 7, 8, 9, 11, 12, 13, 14, 17 other items are correct if the respondent answers **"Disagree"**.

RELIABILITY: No data were reported but the rating scales from which the LSIZ was developed had excellent inter-observer agreement.

VALIDITY: The LSIZ showed a moderate correlation with the instrument from which it was developed, the Life – Satisfaction Rating Scale, indicating some degree of concurrent validity. The LSIZ also demonstrated a form of known groups validity by successfully discriminating between high and low scorers on the Life – Satisfaction Rating Scale.

PRIMARY REFERENCE: Neugarten, B.L. Havinghurst, R.J. and Tobin.C S.S. (1961). The measurement of Life – Satisfaction. Journal of Geronlobogy, 16, 134-143. Instrument reproduced with permission of Bernice Neugarten and Robert J. Hawinghurst.

AVAILABILITY: Journal article

திருப்திகரமான வாழ்க்கை

கீழ்க்கண்ட வினாக்களுக்கு தாங்கள் கீழே கொடுக்கப்பட்டுள்ள விடைகளில் ஏதேனும் ஒன்றைக்குறிக்கவும் விடைகள் ஏற்றுக்கொள்கிறேன் (Agree)/ ஏற்றுக்கொள்ளவில்லை (Disagree) புரியவில்லை (Uncertain) என்பது

எண்	வாக்கியங்கள்	ஏற்றுக் கொள்கிறேன்	ஏற்றுக் கொள்ளவில்லை	புரியவில்லை
1	எனக்கு அதிகவயதாகும் பொழுது நான் நினைத்ததற்கு மேல் எனக்கு அனைத்து காரியங்களும் நன்றாக நடக்கின்றன			
2	மற்றவர்களை காட்டிலும் எனக்கு என் வாழ்க்கையில் அதிகமான நன்மைகள் நடந்துள்ளன			
3	இன்றைய நிலை என்வாழ்வில் எனக்கு கிடைத்த மிக மோசமான நிலை.			
4	நான் எனது இளமைக்காலத்தில் எவ்வளவு மகிழ்ச்சியாக இருந்தேனோ அதே மகிழ்ச்சியுடன் இப்பொழுதும் காணப்படுகிறேன்			
5	நான் தற்பொழுதை விட முன்பு மகிழ்ச்சியாக இருந்தேன்			
6	எனது இன்றைய வாழ்க்கை மிகவும் மகிழ்ச்சியாக அமைதியாக உள்ளது			
7	நான் செய்யும் அதிக காரியங்கள் எனக்கு மிகவும் சோர்வாகவும் உற்சாகமற்றதாகவும் உள்ளது			
8	நான் இன்னும் சுவாரசியமான இதமான மகிழ்ச்சியான நிகழ்ச்சிகள் இனிமேல் நடக்கும் என எதிர்பார்க்கிறேன்			
9	நான் செய்யும் செயல்கள் எனக்கு மிகவும் சுவாரசியமான முன்னாள் இருந்தது போன்றே இப்பொழுதும் உள்ளது.			
10	நான் மிகவும் பலவீனமாகவும் வயதானவனாகவும் தற்பொழுது உணர்கிறேன்			
11	நான் எனது முந்தைய வாழ்க்கையை இப்பொழுது எண்ணிப்பார்க்கும் பொழுது எனக்கு நல்ல திருப்தியாக உள்ளது			
12	நான் எனது கடந்த கால வாழ்க்கையை என்னால் மாற்றிக்கொள்ள முடிந்தாலும் நான் மாற்றிக்கொள்ள விரும்பவில்லை			
13	நான் என்னை ஒத்த மற்ற முதியோர்களை பார்க்கும்பொழுது எனக்கு நல்ல தோற்றம் உள்ளது என பெருமைப்பட்டுக்கொள்கிறேன்			

14	நான் அனைத்து காரியங்களுக்கு மாதம் அல்லது வருடத்திற்கு தேவையான காரியங்களுக்கு திட்டமிடுவேன்			
15	நான் எனத கடந்த கால வாழ்க்கையை நினைத்துப்பார்க்கும் பொழுது எனக்கு தேவையான முக்கியமான காரியங்கள் எனக்கு கிடைக்கவில்லை			
16	மற்ற வயோதிகர்களை ஒப்பிட்டு பார்க்கும்பொழுது நான் அடிக்கடி மனச்சோர்வு அடைந்து விடுகிறேன்			
17	நான் எனக்கு மிகவும் அழகான வாழ்க்கை நான் எதிர்பார்த்ததற்கு மேல் கிடைத்துள்ளது			
18	மற்றவர்கள் சொல்லத்தக்க வகையில் வாழ்ந்துள்ளேன் என கருதுகிறேன்			

CASE STUDY

REAL LOVE ...

It was a busy morning, about 8:30, when an elderly gentleman in his 80's arrived to have stitches removed from his thumb.

He said he was in a hurry as he had an appointment at 9:00 am. I took his vital signs and had him take a seat, knowing it would be over an hour before someone would to able to see him.

I saw him looking at his watch and decided, since I was not busy with another patient, I would evaluate his wound. On exam, it was well healed, so I talked to one of the doctors, got the needed supplies to remove his sutures and redress his wound.

While taking care of his wound, I asked him if he had another doctor's appointment this morning, as he was in such a hurry.

The gentleman told me no, that he needed to go to the nursing home to eat breakfast with his wife. I inquired as to her health. He told me that she had been there for a while and that she was a victim of Alzheimer's Disease.

As we talked, I asked if she would be upset if he was a bit late. He replied that she no longer knew who he was, that she had not recognized him in five years now. I was surprised, and asked him, 'And you still go every morning, even though she doesn't know who you are?'

He smiled as he patted my hand and said, 'She doesn't know me, but I still know who she is.'

I had to hold back tears as he left, I had goose bumps on my arm, and thought, 'That is the kind of love I want in my life.' True love is neither physical, nor romantic.

True love is an acceptance of all that is, has been, will be, and will not be.

The happiest people don't necessarily have the best of everything; they just make the best of everything they have.

'Life isn't about how to survive the storm, but how to dance in the rain.'

I hope you share this with someone you care about.

I just did...

CASE-I

TRIBULATIONS, THE ONLY COMPANY

21-Oct-09 THE HINDU

All she wants is a decent funeral

"I can see death fast approaching me and there is no hope of living anymore"

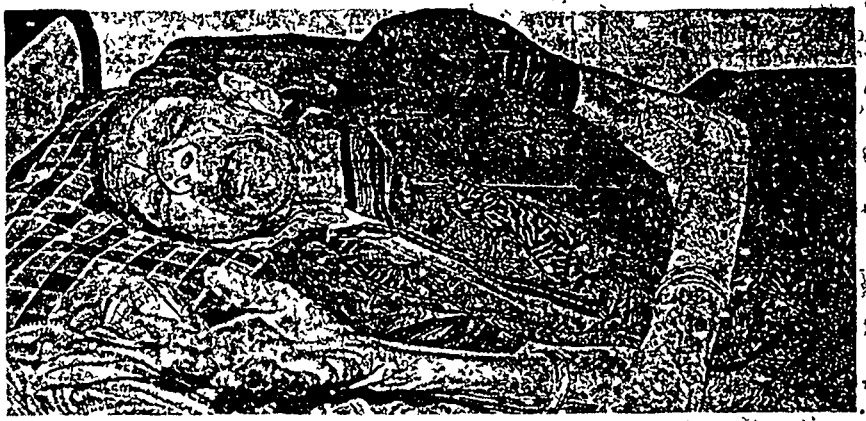
Mohamed Imranullah S

MADURAI: "My end is nearing and I am counting my last days. For nearly a century, I have stood witness to both pleasant as well as harsh realities of life. Now, my only desire is to meet Allah in peace," said 90-year-old K. Ayeesha Beevi with tears waiting to roll down her cheeks.

Born in a poor but loving family of farm labourers at Thamaraikulam near Periyakulam in Theni district, she was brought up with care and affection before getting married at an early age to a cook from Salem. Her husband, Muthalif, lived with her only until he eloped with another woman.

Shaken by the tragedy, she migrated to Madurai without informing any of her relatives, worked as a domestic help and ran errands for many to educate her only son M. Abdul Khader.

But to her bad luck, he refused to study beyond 10th standard and took up a job in a textile shop in Chennai.



FORSAKEN: *K. Ayeesha Beevi at an old age home in Madurai.* – PHOTO: G. MOORTHY

As if all this was not enough, the hapless woman was crestfallen when she heard that her son married his employer's daughter and settled down in Chennai.

He never returned and she stood deserted.

There was no one around to support and she was at the mercy of a local politician who engaged her as a servant.

Even that did not last long and a two-wheeler hit her on the roadside six years back. She was admitted to the Government Rajaji Hospital here and declared an "orphan", leading to her entry into her present residence, an old age home managed by the Women's Voluntary Services here.

"I can see death fast approaching me and there is no hope of living anymore. All that I want is a decent funeral with at least four people around me to lift my janazah (coffin) and recite the funeral prayers," she completed the narration with teardrops still waiting for her to blink.

CASE I

Mrs. A Wife of an Agriculturate hail from down south. She sat before me mute like a repentant criminal with her head lowed. She wept like a child. She was nearly 70 years. She has come to me for a psychological analysis and counseling after an unsuccessful suicide attempt she brought all her children well and they were all in good positions. After her husband died five years ago, she was living with her youngest son. Despite feeling an emptiness. She managed to hold on. She tried to fill up the emptiness with her children and grand children.

But her grand children who had been caught up by the TV and home work could not find time to listen to or enjoy her caressing words. And her children were busy with their day to day problems. How long can one sit at a corner fondling one's memories?

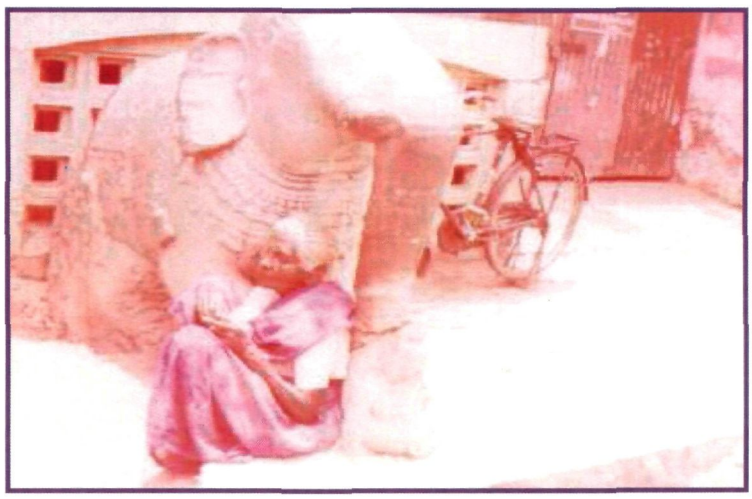
In her decollation, her thoughts started going wild; she began to suspect her children and always looked for such hints in their words and deeds. The feeling that she had become useless. Later, she become sick. She had paralytic attack.

Moving without help became almost impossible. She lost her peace of mind, sleep and appetite. Picking quarrels with everyone even for trivial matters became a daily occurrence. Their resistance worsened the situation making her more and more melancholic. Even small dissatisfactions upset her. She asked her family members to put her in old age home where she expected more comfortable and secured. After some time slowly she developed loneliness, she started missing her home and family members. Now even she liked her room corner. She realized there she found some sort of security and moral support what she missed her in old age home. Though among in the group she realized "Social Isolation". In due course one day she took sleeping tablets. In such a bout of depression, she tried to kill herself.

PLIGHT OF ELDERLY WOMEN

Where can I Go?

Can you give as something kind or cash?



Atlast i left alone

Atlast i left alone

SKY IS THE LIMIT . . . .

CASE II

71 years old widow with 6 years of experience in unpaid home

Mrs.Athilakshmi (Dummy Name) is a 71 years old widow, living in an unpaid home for the aged. This old age home is taking care of 25 inmates and is run by a private organization. This is a heterogeneous home. She lost her husband when she was 67 years old. She was a house wife. Her husband was a farmer. She has two married sons. They too were working in the firm and doing agricultural work.

After her husband's death, she has been leading such a miserable life. She has undergone unmanageable ill treatment at the hands of both her daughter-in-law. She got no regular meals, no oil to apply on the head and no water to bathe. She was a victim of all sorts of hardships and constant abuse. Her sons were silent witness to their ill treatment and were utterly holistic. There were continuous quarrels between her son and daughter in law on account of her. She had spent sleepless nights thinking how the situation could be changed. She says with tears rolling her cheeks, with a husky voice "only God knows how much I have suffered".

Taking pity on her plight, her friends and neighbors got her admitted in the old age home. Now for the past five years she has been in the old age home. Whenever she is alone, she used to recollect her bitter memories with heavy heart. At part she tries to be friendly with fellow inmates and thankful God that atleast she has found a place to spend her last days peacefully. Her only regret is that, she did much for her children but there is no gratitude with a deep breath she concluded.....

Is she satisfied with her life fully?

CASE III

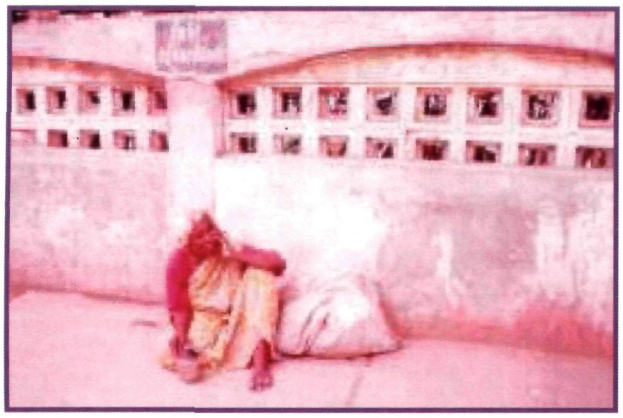
Childless old Lady

Mrs.Parvathi (Name has been changed) is a 68 years old widow staying in a free home for the Aged. She is from a lower middle income groups. Her husband died of road accident, five years back. She has no child. She used to go for daily wages. When she was around 55 years. She suffered from back pain. She was with her brother's house. Slowly she developed a lot of physical complications such as giddiness, low pressure and leg pain.

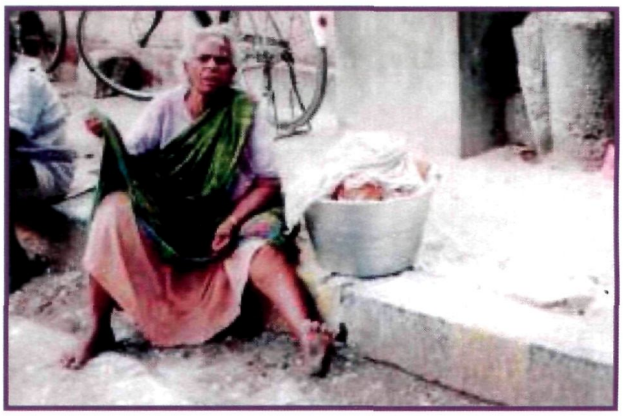
She has to take care of such needs by herself. She needs at least Rs.100/- per month to meet these needs. She has tried for old age pension several times, but has not succeeded till date. She did not have any savings. She found penniless. Ill treatment started slowly. Her brother family neglected her did not gave her proper food. Sometimes they just left her alone and left for their relatives. Then she realized her presence was not wanted by her brother's family. She approached one field project coordinator from a NGO. They referred her to an old age home. The home conditions were not congenial for developing friendship and companionship. Some of the inmates were very much dominating and they suppress others. Inspite of all struggles she wanted to stay at old age home rather to stay with her brother's place. She cursed God saying that "God punished her very badly; she was not having neither husband nor child". Some what she is leading her life....

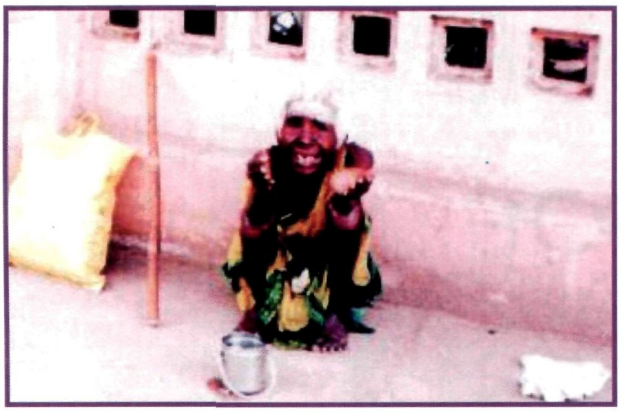
Though she has faith, due to present problem she did not have any confidence on God. Out of depression, helplessness, she expressed her feelings and showed anger towards God.

Looking Sad.....



Tired.....





Lonely.....

Respective The Centenarian

by

Commissioner of Police

Madurai

CASE IV

Old Spinster 69 years old.

Miss.Samuel (name has been changed) is a spinster living in paid old age home run by a Christian organization. She was a teacher and gets her pension Rs.2000/- . She is 69 years old. She has stayed in this home for about 37 years. She remained unnamed for the sake of her brothers and sisters. Now they are all well settled. But she does not know where to go and so she has joined in an old age home. On the eve of her retirement she started worrying where she would go after retirement and this mental anxiety also resulted in some physical illness. Economically she is well off, could have opted for staying alone with her privacy and comforts fully retained. But living alone brought her loneliness and fear. She had thoughts that when she retired, she would be wanted by her people, if not for anything at least for the sake of money. But this did not actually workout as they are all well off. Actually her brothers and sisters invite her to their homes. But so they do not insist on her staying with them, she does not feel that they really want her there and she does not want to force herself in an unwanted situation.

Inmates have freedom to have their own individual, TVs and tape recorders. She finds the house very much comfortable. Though she had some misunderstandings with some inmates, now and then she does not allow such petty matters to upset her. She is quite adjustable and makes herself happy. She knows that she can be happier in this home than in her brother's or sister's house.

However she is full of anxiety about the later years of her life, when she may became sick and bedridden and at such a time, she has to say good-bye to the home and return to her people. She is on the lookout for a home that will look after her till the end, but unfortunately, she has not yet found such a home, only the long term and free homes run by catholic nun and priest's core for the

old till the end and such homes will not admit economic well off individuals. Overall she was happy now, she has hidden her worry and anxiety about her later years of old age. Though economically well off, psycho logically she was depressed and helpless.

CASE V

Mrs.C.

The couples were in the old age home, well educated, economically higher the level. They had two boys and one girl and they do have grand children. When the researcher noted Mrs.C the reason for her stay in this old age home, she did not answer immediately. Then slowly she started to share all the information. Their children were very much particular about their property and relatives were also keen about the property, they shared all the property. But none of them are ready to keep them at their home. But they came forward to take their mother to their homes for household work and look after their children. But she refused and she came along with her husband. Now happly managint their life only with their pension.

Here, socio economic condition, high status, education everything was them but still they were did not received love and affection. Where do they get?

Empty nest?

It's time to enjoy each other then

TARA PARKER-POPE

The empty nest may not be such an unhappy place after all.

Since the 1970s, relationship experts have popularised the notion of "empty nest syndrome", a time of depression and loss of purpose that plagues parents, especially mothers, when their children leave home. Dozens of Web sites and books have been created to help parents weather the transition. The publisher Simon & Schuster has even introduced a "Chicken Soup for the Soul" book dedicated to empty nesters.

But a growing body of research suggests that the phenomenon has been misunderstood.

While most parents clearly miss children who have left home for college, jobs or marriage, they also enjoy the greater freedom and relaxed responsibility.

And despite the common worry that long-married couples will find themselves with nothing in common, the new research, published in November in the journal *Psychological Science*, shows that marital satisfaction actually improves when the children finally take their exits.

"It's not like their lives were miserable," said Sara Melissa Gorchoff, a specialist in adult relationships at the University of California, Berkeley. "Parents were happy with their kids. It's just that their marriages got better when they left home."

NEGATIVE EFFECT OF CHILDREN

While that may not be surprising to many parents, understanding *why* empty nesters have better relationships can offer important lessons on marital happiness for parents who are still years away from having a child-free house.

Indeed, one of the more uncomfortable findings of the scientific study of marriage is the negative effect children can have on previously happy relationships. Despite the popular notion that children bring couples closer, several studies have shown that marital satisfaction and happiness typically plummet with the arrival of the first baby.

In June, *The Journal of Advanced Nursing* reported on a study from the University of Nebraska College of Nursing that looked at marital happiness in 185 men and women. Scores declined starting in pregnancy, and remained lower as the children reached five months and 24 months.

Other studies show that couples with two children score even lower than couples with one child.

While having a child clearly makes parents happy, the financial and time constraints can add stress to a relationship. After the birth of a child, couples have only about one-third the time alone together as they had when they were childless, according to researchers from Ohio State.

The arrival of children also puts a disproportionate burden of household duties on women, a common source of marital conflict. After children, housework increases three times as much for women as for men, according to studies from the Center on Population, Gender and Social Equality at the University of Maryland.

But much of the research on children and marital happiness focuses on the early years. To understand the effects over time, researchers at Berkeley tracked marital happiness among 72 women in the Mills Longitudinal Study, which has followed a group of Mills College alumnae for 50 years.

QUALITY TIME IMPROVES

The study is important because it tracks the first generation of women to juggle traditional family responsibilities with jobs in the workforce. In the empty-nest study, researchers compared the women's marital happiness in their 40s, when many still had children at home; in their early 50s, when some had older children who had left home; and in their 60s, when virtually all had empty nests. At every point, the empty nesters scored higher on marital happiness than women with children still at home. The finding mirrors that of a report presented last year at the American Psychological Association, tracking a dozen parents who were interviewed at the time of a child's high school graduation and 10 years later. That small study also showed that a majority of parents scored higher on marital satisfaction after children had left home.

While the Berkeley researchers had hypothesised that the improvement in marital happiness came from couples' spending more time together, the women in the same study reported spending just as much time with their partners whether the children were living at home or had moved out. But they said the quality of that time was better.

"There are fewer interruptions and less stress when kids are out of the house," said Sara, at Berkeley. "It wasn't that they spent more time with each other after the children moved out. It's the quality of time they spent with each other that improved."

She notes that the lesson from the empty nest may be that parents need to work to carve out more stress-free time together. In the sample studied, it was only relationship satisfaction that improved when children left home. Overall, parents were just as happy with children at home as in the empty nest. "Kids aren't ruining parents' lives," Sara said. "It's just that they're making it more difficult to have enjoyable interactions together."

New York Times News Service

▶While most parents clearly miss children who have left home for college, jobs or marriage, they also enjoy the greater freedom.

Lost Resort.....

OLD AGE HOMES IN MADURAI DISTRICT

S.No	Name of the Home and Address
Home For both Men and Women	
1	Anitha Solai, 22, Kennett Road, Ellis Nagar, Madurai-10
2	Akash Age Care Home, Sasthri Nagar, Kadachanenthal, Othakkadai Road, Near Baba Nagar, Madurai-07
3	Aravind Old Age Home, Sundarrajanpatti, Alagarkoil Road, Madurai
4	Inba Illam (Home for the Aged), 42, GST, Road, Pasumalai, Madurai-04
5	Missionaries of Charity, Opp: Fatima College, Madurai-18
6	Bishop Gnandham Home for the Aged, Behind CSI Church, Thirunagar, Madurai-06
7	Sneha Illam, St.Charless Convent, Thiruvalluvar Nagar, Thanakkan Kulam, Thirunagar, Madurai-06.
8	Valanar Home for the old, 1 /2, Visuvasapuri 2nd street, Gnanolivupuram, Madurai-16
9	Basli Mooligai Thottam, Vedarpuliyankulam, Thanakkankulam, Thirunagar, Madurai-06
10	Claretian Mercy Home , Azhagusirai, Ponnamangalam, P.O, Thirumangalam, T.K.Road, Madurai-06
11	Jeyaraj Annapackiam, Peace Home for the Elders, Ammaya Naickanur, Kodai Road, Madurai
12	Alagai Rajam Ramanathan Home for the Aged, Madurai Sevashram, Old Natham Road, Viswanathapuram, Madurai-14
13	Athma Amaidhi old age home, Behind E.B.office, Thiruppalai, Madurai-17
14	Sri Narayanatruva Destitute Home, 2, E.B. Main Road, Pykara, Madurai-04
15	Ayra Vaisya Vellar Home for the Old, 1st stop, Thirunagar, Madurai-06
16	Sahaya Illam, 7th Poriyalar Nagar, Thirupalai, Madurai
17	Poonkudil, Sivagangai Road, Poovanthi, Madurai
18	M.M.Home for the Aged , 356, TPK Road, Post office Stop, Pasumalai, Madurai -04.
19	Christian Seva Sangam, 6/6, Kennet Gardens, Alagappa Nagar, Madurai
20	St, Annis Home for the Aged, Backside of PRC Bus Depot, Byepass Road, Ponmeni, Madurai-14
21	Women Social Service Organization, Home for the Aged, Near Shuttle Coach Ground, DRO Colony, Natham Road, Madurai

22	Meenakshi Sundaram (Home for the Aged) , A-31, Kumarasamy Street, Thirunagar, Madurai-06
23	J.J.Seva Foundation, Achamuthaman Koil Street, (Income Tax Office) Madurai
24	Home for the Aged Sivakasi Nadar Uravin Murai, Thirupparankundram, Madurai
25	Lingam Welfare Trust, Home for the Aged , 1st stop, Thirunagar, Madurai
26	Sri.Mahalingam Kamakodi Home for the Aged (Hindu Mission Hospital), 58, Anumar Koil, Padithurai Road, Simmakkal, Madurai
27	Anantha Muthiyor Illam, 1 /361, Airlines Colony, Near EMG Yadava Womens' College, Thirunalpuram, Madurai-14.
28	District Red Cross Office, Collectorate Office, Madurai
29	Home for the Aged , Aruppukottai Main Road, Villapuram, Madurai-12.
30	Genatic Care , Grace Kennet Hospital, Ellis Nagar, Periyar Bus Stand, Madurai
31	Anitha Garden Illam, .28, Kennet Road, Ellis Nagar, Madurai-10
32	Home for Elderly, Christian Mission Hospital, Keelavasal, Madurai
33	Mahatma Gandhi Nagar Muthior Illam, Meenakshi Nagar, Opp: Madhu Theatre, Villapuram, Madurai
34	Meenachi Achi Trust, 2/69, Surya Gandhi Street, Komathipuram, Anna Nagar, Madurai-20.
35	Sardar Vallabai Patel Home for the Aged, Thiruppalai Ayyar Bungalow, Madurai-14.
36	Home for the Aged, Narayanapuram, Reserve Line, Madurai-14.
37	Thendral Old Age Home, Mahatma Gandhi Nagar, Madurai
38	Home for the Aged , Alamaram Bus stop, Ayyar Bungalow, Madurai-14
39	Sri Hari Old Age Home , Kali Nagar, Madurai
40	Home for the Aged, Thirunagar, Madurai- 06
Home For Women	
41	Sharanya Old Age Home (only for women), 19th Cross Street, Bharathipuram, Seman Nagar, Madurai-20
42	Arulmigu Subramaniya Swamy Thirukoil (only women), Thirupparankundram, Madurai-05.
43	Philas Saptha Jyothi, C-176, Govindasamy street, Thirunagar Madurai – 06.
44	CSI Jubilee Home for the old women, CSI cathed campus, Narimedu, Madurai-02.

Home For Men	
45	Rajaji Home for the old, (only Men) . Old Natham Road, Viswanathapuram, Madurai-14
Home Not Functioned	
46	Amirtha Old Age Home Standard Fire Works, Srivilliputhur Road, Madurai
47	Muthiyor Illam, Opp: Kalaiselvi Hospital, Keelakuilkudi Road, Nagamalai Pudukottai Road, Madurai-19
48	Anbu Illam C/o.Mr.Moses, A-31, Thenpalanji, Thiru Nagar, Madurai-06.
49	Karunai Illam, Vedar Puliankulam, Thanakkankulam, Thirunagar, Madurai-06
50	Elite Elderly Complex, SNP Avenue Kelakuilkudi, Thiruvalluvar Nagar, Thanakkankulam, Madurai-06
51	Anbalayam (Home for the Old), 7/372, Kambar Street, NGO Colony, Nagamalaipudukottai, Madurai-19
52	Mithra Nikethan Home for the Aged, Plot.65, Anna Nagar, Madurai-20
53	Kanchi Kamatchi Old Age Home, Padithurai Simmakkal, Madurai

(Source: Helpage India, Social Welfare Office, Madurai)

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BIBLIOGRAPHY

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Anantharaman, R.N. 1979	"*Perception of oldage by two generations*" Journal of Psychological Researches, 23(3),198-199
Abrams, Robert, C, 1991	"*The Ageing personality*", International Journal of Geriatric Psychiatry, Vol.1, Jan, PP: 1-3
Adelmann, Pamele. K. 1994.	*"Multiple Roles and Physical Health among Older Adults: Gender and Ethnic Comparisons"*, Research on Aging, Vol.16 (2), PP: 142-166.
Allam, Rafique & Hussain M.G. 1997:	"*Psycho – social Problems of Ageing. Indian Perspective"* in M.G. Hussain (Ed): Changing Indian Society of Aged New Delhi; Manak Publications Pvt. Ltd; Pp. 99-100.
Allport.G.S.Rosss, J.M, 1967	"*Personal Religious Orientation and Prejudice*", Journal of Personality and Social Psychology, 5. PP: 432-443.
Anantharaman, R.N, 1981.	*"Physical Health and adjustment in old age"*. Journal of psychological researchers; 34(2).
Anderson J.E., 1956.	"Summary and Interpretation" quoted by Marion L.Beaven, Human Service practice with Elderly, New Jersey, Englewood, Cliffs, Prentice-Hall, Inc., 1983.
ANDERSON R.J. Freed land. K.E. Clous RE, Et. Al, 2001	The Prevalance if Comorbid depression in adults with diahetes: a Meta analysis in Disasters Care: 24: 1069 – 1078.
Anderson, R.J Clous K.E etal. 2001	The prevalence of co-morbid depression in adults with diabetes: A Meta analysis in diabetics care: 24: 1069-1078.
Ara, Shebeen, 1995.	Old Age Home: the Last resort, Research and Development Journal; 2(1); PP: 3-10.
Arbar, S.& Ginn, J, 1991	"Invisibility of Age, Gender and Class in Late Life" (Sociological Review, Vol39(2), PP : 260-291

Arling.G, 1976	Resistance of Isolation among elderly widows " International Journal of Aging and Human Development ;PP: 67-87
Arora, P,N and Saxena, Shalini, 1997.	A study of pattern of Adjustment, Retired working and Non-working women in M.G Hussain (ed); changing Indian Society and Status of Aged, New Delhi; Manak Publications, Pvt, Ltd, PP: 171-177.
Avdelt, Monika, 1997.	"Wisdom and Life Satisfaction in Old Age" Journal of Gerontology – Psychological Sciences, Vol 52 B, No.1 PP: 15-27.
Bagchi Kalyan, April 1999	Health Action, 1999, Vol.12, No.3
Bagga, Amrita and AnuradhaSakurakar: 2000	"Twlight years and Health of older women" India health action. Vol. Journal of Gerontology, Vol.14 No.3&4.
Bagga, Amrita. 1994:	Health Status of Women in Old Age Homes. Ageing & Society. The Indian Journal of Gerontology; 4 (364): Pp.11 -21.
Bali, Arun P. 1995:	Role of the family in Elderly Care. Research and Development Journal; 2(1), Oct; Pp. 30 – 40.
Bambavale, Usha 1997:	Ageing women and Media Habits. Ageing & Society, The Indian Journal of Gerontology, 7 (3 & 4) : Pp.1-15
Bambawale, Usha 1997:	The Abused Elderly. Indian Journal of Medical Research: 106; Oct' Pp – 389 -395.
Banarjee, Mrimagi, 1997:	Level of Isolation and Interpersonal Relationship of Aged person in the Family. A study in shillong. Ageing of Society; The Indian Journal of Gerontology 7 (3& 4); Pp. 25 -34
Barrett, A, 1999.	Social support and Life Satisfaction among the never married, Research on Aging, Vol, 21(1).

Barron, Milton, 1953.	"Minority Group Characteristics of the Aged in American Society" Quoted by C.J.Joseph, "Pattern of Interaction between the Old and the Young in a Developing Country" paper presented in XI World Congress of Sociology held at New Delhi from August 18-22, 1986.
Baum, S.K.1983	Life Satisfaction and death anxiety in aged women. International journal of ageing and Human Development. Vol15(4) PP:299-306
Beaver, L.Marion, 1983.	Human Service practiced with the Elderly, New Jersey, Englewood, Cliffs, Prentice- Hall. Inc.
Bhargava, V.L, 1998.	Cancers in women: An overview in P.C, Bhatila (Ed). Aged women coping with life, New Delhi; National Institute of Primary Health Care: PP: 28-29.
Bhatia H.S. 1983	Aging and society: A sociological study of Retired public servants, New Delhi; Arya Book centre.
Biswas, S.K, 1985.	Dependency and Family are the Aged in village India: A Case Study, Journal of the Indian Anthropoligical Society, 20 (3), PP: 238-57.
Blamer, D. 2003	Geriatric psychiatric. In R.E Hales & S.C Yundo sky (Eds) Text Book of Clinical Psychiatry 4, ed Washington, D.C: American Psychiatric
Blanger Dan.G, 1982	Social support and Mortality in an Elderly Community Population" American Journal of Epidemiology 115:PP: 684-694.
Blenker Margaret, 1969.	The Normal dependencies of Aging in the dependencies of old people (Occasional in gerontology, University of Michigan, August).
Bootyin R.R and Acocella, J, R. 1988:	Abnormal Psychology (Shet) New York Random House.

Bowling, A, 1994.	"Social Networks and Social Support among elder people and Implications for Emotional well being and Psychiatric Morbidity, International Review of Psychiatry, Vol 6(1). PP: 41-58.
Bradely, J. and Fisher,M, 1995.	Successful Aging , Life Satisfaction and Generating in Later Life" International Journal of Aging and Human Development 41(3), PP: 239-250.
Branch L.G and Jette, A.M, 1981.	"Elders use of informal long term care assistance" presented at the annual meeting of gerontology society of America Toronto.
Bultena G.L. 1969 :	Rural – Urban difference in the familial interaction of the aged" Rural Sociology 34 ; 5-15
Burgess, E, 1960.	"Aging in Western Societies, Chicago" University of Chicago Press.
Busse, E.W 1989	The Myth, history and Science of aging, in genetic psychiatry, Bussa, E.W. and Blager, D.G. (eds), Washington, American Psychiatric Press Inc.
Busse, E.W, 1983.	"Biological and Psychosocial Bases of Behavioural Changes in Aging. In American Psychiatric Association Annual Review (vol.2). Psychiatric Unit, Washington D.C, American Psychiatric Press.
Butena G.L, 1969.	Rural –Urban difference in the familial interaction of the aged" Rural Sociology 34: PP: 5-15
Cantor, 1974.	Neighbours and friends overlook resource in the support system: Research of Aging 1: PP: 343-463
Caplan. I.H.Sadock, J.B and Grebb, A.J, 1994.	Synapsis of Psychiatry, Behavioural Sciences Clinical Psychiatry 7th Edition, New Delhi, B.I, Waverly, Pvt, Ltd.
Caplan.G, 1974.	Support Systems and Community Mental Health: Lectures on Concept Development, Newyork; behvavioural publications.

Cavien, R.S, 1949.	Personal Adjustment in Old Age" Chicago; Science Research Associate, PP: 127-127.
Census of India, 2001.	Govt.of India. NewDelhi,
Chadha, N.K Aggarwal, V and Mangal, A.P. 1992,	Hopelessness, Alienation and Life – Satisfaction among old aged, 6 (3&4) 82-92.
Chandra Shekar, C.R 1997	"Mental Disorders of old age" vol.13 (7) PP 18-20.
Chandrika, Pand Anantharaman, R.N. 1982,	Life Changes and Adjustment in old age. Journal of Psychological researches. 26(3). 137 – 141
Channana, H.B and P.P.Talwar, 1987.	"Aging in India, it Socio Economic and Health Implications, Asia Pacific Population Journal 2 (3).
Chappel.N, 1983.	"Informal support networks among the elderly" Research on Aging 5: PP: 77-100
Chowdry, D.Paul. 1992	Aging and Aged, New Delhi; Inter India Publications
Clark M 1972:	Cultural Values and dependency in later life' in D.O Cowgill. L. Holemes (eds): Ageing and Modernization, New York: Appleton Country Crafts.
Cohen, Lawrence. 2002	No Aging in India, NewDelhi; Oxford university press.
Coming E and William, E.H. Growing, O.H. (1961).	The Process of deingagement, New York Basic Books,
Coming Eard William, E.H, Growing, O.H, 1961.	Christian Perspective on Aging , Prakask, IJ. (Ed). Aging the Indian Experience: Report of the Workshop organized on 9th -10th August Bangalore University.

Comner K. Powers, E and Bultna G. (1979)	Social Interaction and Life Satisfaction an Empirical Assessment of Later life patterns. Journal of Gerontology, 34, 116 -121.
Cowgill D.O and L.D.Holmes, 1972.	"Aging and Modernization" New York: Appleton-century – Crafts.
Cowgill, D, 1974.	"Aging and Modernization: A Revision of the Theory" in J.Gubruim (ed), Later Life; Communities and Environmental Policy, Springfield III, Charless C.Thomas.
D'Souza, Alfered, 1982.	"Aging in South Asia: Arma Printers, New Delhi.
Daivid, R 2001	Christian perspective on Aging. In Prakash, IJ. (Ed). Ageing the Indian Experience: Report of the workshop organized on 9^{th}-10^{th} August 2001, Bangalore, and Bangalore University.
Davidson, 1981.	"Social support and Postburn adjustment" Archivers of physical medicine and Rehabilitation 62, PP: 274-278
Denton and Spencer Chisholm et al, 1982.	"The cost of the Institutionalized care and the rate of confusion and depression among the institutionalized elderly".
Desai K.G Naik, R.D. 1970.	"Problems of Retired people in Greater Bombay" Bombay, Tata Institute of Social Sciences, Publications.
Deva Sahayam M. 1988	Aged females. The most depressed among the deprived. Indian journal of social work, 49(3), PP 261-269.
Devi, Prasad 1997:	Elder Abuse and Neglect; A Review of Research and Programmes. Paper presented at National Seminar on Globalisation of the Ageing Imlications for Gerontological Society Work; Pp. 217.

Dhillion, Paramjeet Kaur, 1992	Psychosocial aspects of Ageing in India, New Delhi. Concept publishing Company.
Dhillon P.R 1992	Psychological aspects of Ageing in India, NewDelhi, concept publishing company.
Diener, E. Such, E.M, Lucas, R.E and Smith H.L, 1999.	Subjective well being: Three Decades of Progress, Psychological Bulleting. PP: 125, 276-302.
Do noetal 1975	Primary groups in old age Structure and Function Research on old age 1, 4: 403 – 433.
Venkoba rao A. & Madhavan 1982	"Depression and Psychiatric Illness.
Chandra Shekar, C.R. 1997.	"Menta; disorders of old age" Vol. 13 (7) : 18-20.
Pankajam, G. 2004.	Are we aged Friendly? Social welfare – Pp7 – 10
Durk heim. E. 1915	"The elementary forms of religious life", New York: Free Press
Eswara Moorthy, M, 1993.	Some Factors related to Adjustment among the rural aged. Indian Journal of Gerontology 7(1&2), PP: 37-42.
Everrard, K.M., Lach, H.W., Fisher, E.V and Baun, M. 2000	Relationship of Activity and Social support to the functional Health of older Adults Journal of Gerontology Series B; Psychological Sciences and Social Sciences, Vol, 55 B (4), S208 – S212,
Fengler, A.P., Denigelis, N.L. and Grams A 1983	Marital Status and Life Satisfaction among the elderly. Ageing and Society (3) 356 -375.

Gallegeos – Camillo. K., Duran – Avenas, J.L., Lopng – Carrillo, l., Lopny , Cerrvantes.M (2003).	Rev. Factors associated with Quality of life Parameters in older adults in Morelos Invest clinic. Aging and Society. 55 (3); Pp : 260–269
Ganguli M, Ratecliff G.Chandra V, Sharma S.Gilby, JE, Pandav R, et.al, 1995.	A Hindi version of the MMSE. The development of a Cognitive Screening Instrument for a largely Illiterate Rural Population in India, International Journal of Geriatric Psychiatry, 10: PP: 367-77.
Gates, A.S. & Jersid, A,	7: Educational Psychology New York McMillan and Company.
God Kavi (1989):	"Study on Personality and Mental Health of institutionalized and non – institutionalized elderly"
Good Man. R. 2006.	Family and Social Policy in Japan: Anthropoligical Approaches, Melborne Combridge University Press.
Goody.J., 1976.	"Aging in Non-Industrial Societies" in R.Binstock and E.Shanas (Eds), Handbook of Aging and the Social Sciences, New York, Van Nostrand, Reinhold.
Gore M.S, 1992.	"Aging and the future if the Human being" in the Indian journal of Social work, Vol III, 2, PP 210-219.
Gowry. R. 2003	"Elderly Women" A study of the unorganized sector, Delhi : Discovery Publishing House.
Gulati, L. Rajan, I and Ramalingam, A. 1997	Women and Work in Kerala: A comparison of the 1981 and 1991 Indian Journal of Gender studies, 4 (2). 222 – 231
Gupta, S.P 2003	Statistical Methods, NewDelhi, Sultain and Chand.
Gurmmeet Singh, Dalbi Kaur, 1984.	"Presumptive stressful life events scale for use in India, "Indian Journal of Psychiatry. 262. PP: 107-114.

Handal, P.J, Peal, R.L, Napoli, J.G, Autism, H.R, 1984	The relationship between direct and indirect measures of death anxiety, Omega, 15 PP: 245-262
Hango P. and Padma Sheela 1996:	Psychological problems of Institutionalized aged person.
Havighrust, R.J. Williams, R.H Tibbitts, C Donahue, W(eds) 1963	Successful aging in process of aging Volume I. Atherton, Newyork, PP 229-320.
Havigurst R.J, 1950.	Developmental Tasks and Education, NewYork; Longmans.
Havigurst R.J. 1953.	Older people in Ling Irren, E.J (ed) 1959.
Hawighurst, R.J. 1963,	Successful aging in process of aging, Volume I.A therton, New York, Pp. 229 – 320.
HelpAge India, Jan 2005	Research & Development Journal, Vol11, No.1, 2005
HelpAge India, Jan 2009	Wellness of elderly PP: 3,19.
Henry P. Brehm, Rodney M.Coe. 1980.	Medical Care for the aged from Social Problem to Federal Program. USA: Preeger Publisher Inc.
Henry P.Brehm, Rodney M.Coe, 1980	Medical care for the aged from social problem to federal program, USA" Preeger publisher Inc.
Hurlock, E.B, 1950.	"Biological Foundation of Health Education" Quoted by Marian, L.Beaver, Human Service Practice with the Elderly, New Jersey, Englewood, Cliffs; Prentice-Hall, Inc, 1983.

Hussain, M.G (ed) 1997.	Changing Indian Society of Status of Aged, New Delhi: Manak Publications Pvt Ltd; Pp – 217.
India: office of the Registrar General, 2002.	Census of India 2001, NewDelhi
Irudayarajan, S. Mishra, U. and Sharma, P 1999	; India's Elderly; Burden or challenge? New Delhi; Sage Publications.
Irudayarajon, S. 2002,	Indian's Elderly. New Delhi: Sage Publications
Irudhayarajan, S, Mishura, V and Sharma, P. 1999.	India's Elderly; burden or challenge?, New Delhi; Sage Publications.
Jacoby's 1999:	Great Sex: What's age got do with it? modern Maturity, 42 W (5), 40 – 45
James E. Birre novarnes, Schaie 1977:	Hand book of the Psychology of Aging" Vanno Strnt Rein hold Company, New York.
James H. Woods. 1935,	Helping older people enjoy life. New York: Harper and Brothers Publishers.
Jarvik, L.F and D.A Cohen, 1974.	"Bio-behavioural Approach to Intellectual Changes with Aging" Quoted by Marion, L.Beaver, Human Service Practice with the Elderly, New Jersey, Englewood cliffs; Presentice- Hal, Inc., 1983.
John Seward. P, 1999.	Depression: living with and treating the disorder, Bombay; partner publishing.
Johnson et al (1986)	Studied the Life – Satisfaction of the elderly.Life – satisfaction
Kumar (1987)	

Kapoor S and Kapoor.A, 2000.	Let us care for our older women, Research and Development Journal, 6(1), PP 19-21.
Keiko,T.Junko, T.Tokaro, M. 1997.	Patterns of Social Relationship and Psychological well being among the Elderly. International Journal of Behavioral Development 21, PP: 417-430.
Khan MZ, Archana Kaushik 1999:.	"Where do the Elderly Stand in the changing Economic Sciences?" in Social Welfare, Vol. 46. No. 1. New Delhi: Central Social Welfare Board
Khan, M, Z, 1997.	Elderly in Metropolis, New Delhi, Inter- India Publications.
Koeing, H.G, 1990	Research on Religion and Mental Health: A Review and comnantary, Journal of clinical Geranatics psychiatry, 23 PP: 23-53
Kohli.S 1996	"Social situation of the Aged in India, New Delhi; Anomol Publications,
Koller, M.R, 1968.	"Social Gerontology" New York, Random House.
Kothari, C.R, 2000	Research Methodology, New Delhi, Vishwaprakashan.
Kurian, Rao, B.S, 1975.	"Old age can be made happy in social welfare, 21(2) ;910
L.D.Souza, 1982.	"The Aged in India" a paper presented at the "World Assembly on Aging' Vienna, 26 July- 6 August 1982.
Lakshmi Narayanan, T.R, 1997.	Comparison of Institutionalized Aged in their Health and Emotional Problems. Aging & Society: The Indian Journal of Gerontology 7 (1+2) PP:1-8.
Laslett, P. 1976.	"Social Development and Aging" in R.Binstock and E, Shanas (Eds) Handbook of Aging and the Social Sciences, Newyork; Van Nostrand, Reihold, 1976.
Leffy, S, 1953	Social Medicine, London : Routledge and Kegan Paul Ltd.

Lemon Buree, W, Vern L.Bengston, James A.Peterson, 1972	"An exploration of the activity theory of aging. Activity types and life satisfaction among immovers to a retirement community" in J.Gerotal, 27: 511-23.
Sharma M.L. & Dak T.M. 1987:	Aging in India, Challenge for South New Delhi: Ajantha Publications.
M.S. Gore. 1992.	"Aging and the future if the Human Being" in the Indian Journal of Social Work. Vol.L III, # 2, Pp, 210-219.
Maddox, G.L and J.Wiley, 1979.	"Scope Concepts and Methods in the Study of Ageing" in R.H.Binstock and E.Shanas (ed). Handbook of Aging and the Social Science, New York, Van Nostrand Reinhold, 1976.
Mahadevan, K , Audinarayanan, N., Jayashree, R, and Ramalingam S, 1992.	Demographic and social implications of the elderly in India. In Krishnan.P .and Mahadevan. K (Ed). The elderly population and perspectives, New Delhi; B.R publishing corporation PP: 261-264.
Mahajan, 1987.	Problems of the Aged in unorganized sector, NewDelhi, Mittal Publications, Health Action: Vol: 12 No.4 April 1999.
Mangal SK 1984:	Abnormal Psychology, New Delhi; Sterling Publisher Private Limited.
Marle – Francose: (1997).	Aging and Humanlengivity, Bickausor Boston Schulmj – Allen Birkuser
Matilda Gold bong Ann Mortimer Brain.T William 1970	Helping the aged. A field experiment in social work, London, George Allen and Unwin Ltd.

Melstosh, D.N, Silver R.C, and Wortman, C.B, 1993.	"Religious role in adjustment to a negative life event: coping with the loss of a child, journal of personality and social psychology, 65, 812-821
Merriam – Webstar Dictionary: (1974)	Webster's New Collegiate Dictionary. Toronoto (1974) Thomas Allen and Son.
Moberg, D.O, and Taves M.J 1965.	"Church Participation and Adjustment in Old Age. Older People and their Social World, PP:113-124.
Modi, Ishwar, 2001	Ageing Human Development, New Delhi, Ravert Publications
Moses. C., Dec 2004.	A Study on Psycho –social problems of elderly: P.G Dept pf Social Work, Sri Ramakrishna Mission, Vidyalaya Arts and Science College Coimbotore – 20,
Muali Desai and Siva Raju, 2000.	Gerontological Social Work in 2000 India (Some Issues and Perspectives) Delhi. .R Publishing Corporation.
Murali Desai & Siva Raju 1999, 2001.	Gerontological social work in India, some isues and perspectives, 26-56, 250-257, New Delhi V.R Publications,
Nagatomo I, Nomaguchi M, Matsumoto K. 1993.	"Depression and quality of life in the elderly in a special nursing home" in Journal Psychiatry Neurology, Sep: 47(3): 525 -9
Nager, S, 1987.	Status and care of the Aged in India and Japan Sharma M.L and Dak T.M (Eds), Ageing in India, Challenge for the Society, New Delhi, Ajanta Publications, PP:187-189.
Nair Krishnan, T, 1980	Old People in Rural TamilNadu, Social Work, Madras School of Madras.

Narayana Raja, P.N, 2007	"Knowing and Doing Research" Madurai Institute of Social Sciences, Madurai
Nayar, P.K.B, 2000.	"The aging scenario in Kerala. A Holistic Perspective" Helpage India Research and Developmental Journal, Vol; 6 No.2, Feb 2000 to May 2000.
Neugarton B, Havighurst R.J. Fobin SS. 1961.	"The measurement of Life – satisfaction" in J. Gerontol, 16: 134 -43.
P.J. Pancar 1989.	"Study on elderly widow's (Self –esteem) her role in transistion" Journal of Psycho – social Nursing Vol 27 – No.2.
Palmore, E.B and Luikart, C, 1972.	Health and Social factors related to Life-Satisfaction, Journal of Health and Social Behaviour, vol 13(1), PP: 68-80
Pancar, P.J, 1989.	"Study on Elderly widow's Self esteem her role in transition" Journal of Psycho Social Nursing Vol 27.
Pankajam, G. 2004	Are we aged friendly? Social welfare, PP 7-10.
Pappathi.K, 1997	Research Asst in the Rural extension and evaluate cell, Gandhigram, University, Gandhigram.
Parasuraman, Shalini Bhogle. 1979	Developmental psychology. Light and life publishers.
Parmalee P.A, Livton, M.P, Katny, I.R, 1998.	"The structure of depression among elderly institution resident affective and somatic correlates of physical frailly" in J.Gerontol A.Biological Science Medical Sciences, Mar; 53(2); M 155-62
Patel, A and Broota, A 2000.	Loneliness and Death anxiety among the elderly: the role of family set us and Religious Belief, Research and Development Journal 6(3), PP: 28-33.

Patel, Hitesh N. 1998:	Mental Health Problems of Aged women and Care of them by the family in P.C. Bhatta (Ed): Aged women; Coping with life New Delhi: National Institute of Primary Health Care; Pp. 58 – 60.
Patel, Minal & Kamala, R. 1995.	Situation of Institutionalized Ageing Women. India Journal of Gerontology 9 (1& 2); Pp, 28 – 31.
Patricia A, Bomer and Morries A Okun, 1983.	Stability in Life Satisfaction in late life in the Gerontological, Vol. 23, No.3, PP 261-265
Paul.D 1992.	Ageing and the aged, New Delhi, Inter-India publications.
Persons, Talcott, 1953.	"Revised analytical approach to the theory of social stratification", quoted by C.J.Joseph "Pattern of interaction between the old and the young in a developing country. "Paper presented in XI world congress of sociology held New Delhi from August 18-22, 1986.
Pillai A.K.B, 1988.	"The Asian Indian Model of the Elderly – A Study in Anthropological Gerontology" in aging in Contemporary Society (Ed). Auth.Society of India, Calcutta.
Pollner, M, 1989.	"Divine Relations, Social Relations and wellbeing" Journal of Health and Social Behaviour, 30, PP: 92-104.
Pradeep.P, 2004.	"Depression and Life Satisfaction among Diabetes and Non-Diabetic Elderly. P.S.G.College of Arts and Sciences, Coimbatore.
Pradheep. P. 2003	R 436: Depression and Life – Satisfaction among Diabetic and Non –Diabetic Elderly. P.S.G. College of Arts and Science – Combitore, Dec – 2004.

Prakash, Indira Jai, 1994.	Aging Indian women in Ramachandran, C.R, and Shah, Bela (Eds): Public Health Implications of Aging in India, New Delhi: Indian Council of Medical Research, PP: 187-191
Pratap Joshi 2000.	Old age care and Welfare administration planning, policy imperative and projection. Kamishka publication, New Delhi.
Preethi, Peter and Majeen, Kris, G, 1991.	Behaviour Variables Affecting Emotional Abuse among the Elderly. Indian Journal of Gerontology 7 (3&4); PP:75-79.
Raj Singh, 2004	Aging: A social concern social welfare Pp. 4-6
Rajamaickam M. 1976	A Psychological Study of religious and related attitudes of student and professional groups in South India, Chinambaram, Srininagara.
Raju. S. 2002:	Health of the elderly in India; Issues and Implications, Research and Development Journal, 8 (1) – 25-28.
Ramachandran, India, 1974-1980.	Psychiatric illness among the Aged, depression, anxiety, organic illness and functional illness.
Ramamurthi.P.V, 1970.	Life Satisfaction in the older years, Indian Journal of Gerontology, vol.2 (3-4) PP: 68-70.
Ramamurthy, P.V, Jamuna.D and Sudharani, N.N, 1996	"Profile of centenarians of Rayalaseema - The Tirupati Centenarian Study" (abstracts). International Congress o Ageing, Tiruvandram, 1996.
RamMohan Vijayalakshmi Sobha.I, Reddy, M.S.N, June Sep- 2000	HelpAge India- Research of Development Journal, Vol.6, NO.3, 2000

Ranade, S.N, 1984.	"Special Aspects of Aging in India" a background paper submitted at institutional federation on agin consultation on "Aging" Problems, Priorities, Progrmmes of Services and Research" New Delhi, 16-17, November, 1984.
Ranganth 2002.	Prospects of Health Insurance in India with reference to older persons, research and development Journal 8 (1), 15 – 24.
Venkoba Rao, A, 1987	Problems of the Aged seeking psychiatric helps, National task force profeit, Indian Council of Medical Research, New Delhi, 1987
Rao Venkoba, A, 1990	Health Care of the Rural Aged, New Delhi, Indian Council of Medical Research, New Delhi
Rao, M.K.et.al, 2003.	"Health Status of the Rural Aged in Andhra Pradesh" A Sociological Perspective" Help Age India –Research and Development Journal, Vol 9 No.2 May 2003.
Rath, B Weg , 1975	"Changing Psychology of Aging Scientific perspective and social issues" New york D.Van Nostrand Co.
Rathi. Ramachandran and Radhia,R, 2006	"Socio-Economic status of elderly women in India and Japan"
Rathore, Saroj, 1992	"Subjective well being in old Age" Indian Journal of Gerontology, Vol.3 Nos, 344, PP 99-103.
Revati, S. Hosmath, Gaon Khar.V, Khadi P.D, 1993.	"Life satisfaction during later years" Man in India 73 (3) : PP 229-232.
Rigdon, M.A & Epding, F.R, 1985	Reduction in death threat as a basis for optional functioning. Death studies, 9, PP: 427-448.

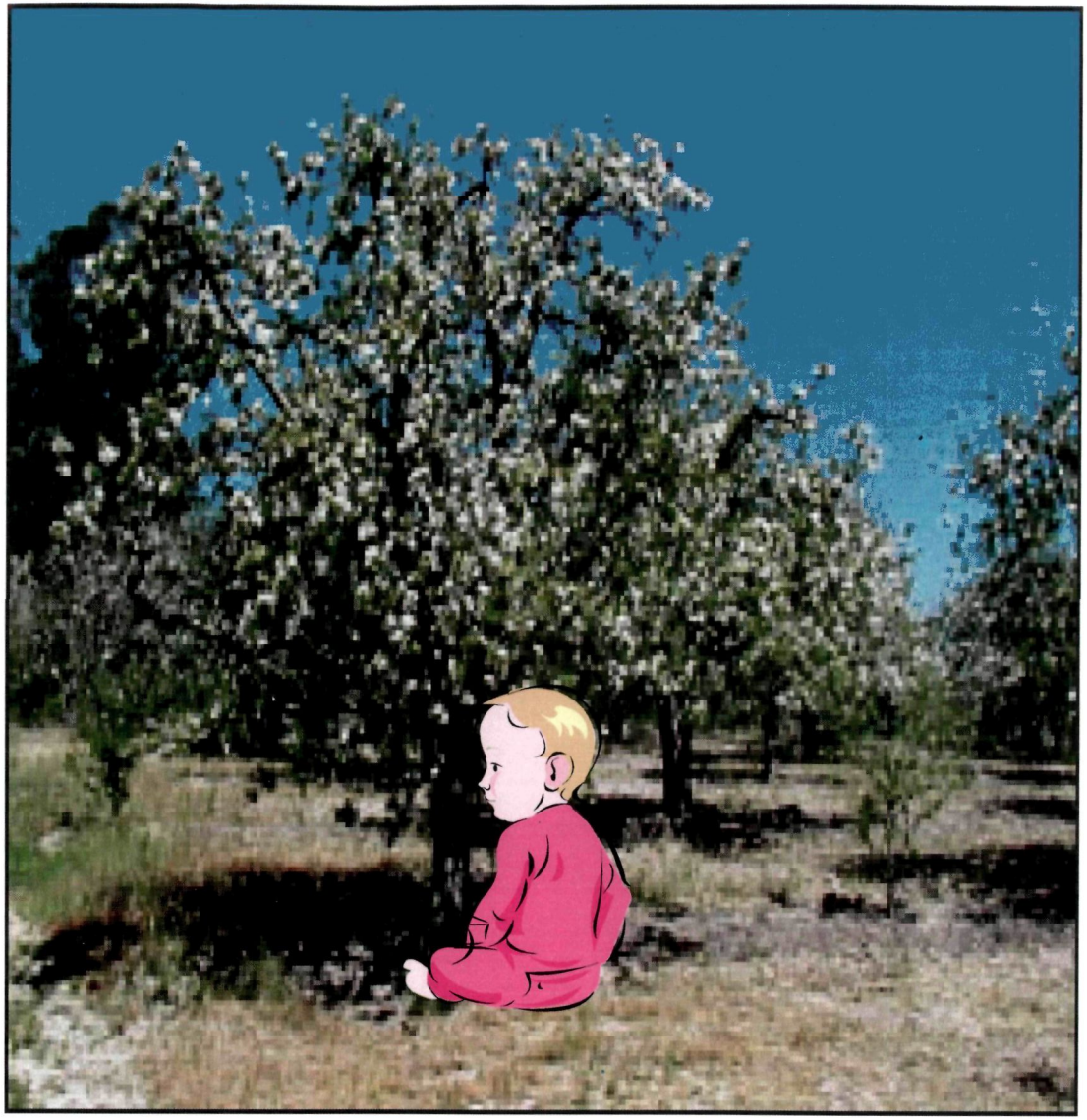
Robert.N. Bulter, Myuna I Lewis. 1982.	"Aging and Mental Health, Positive Psychosocial and Biomedical Approaches". St. Louis C.V Mosby, Co.
Safer L.H. 1936:	Psychology of Adjustment Babtron : Moustons Miffin Company effectiveness in (S.B. Sells Ed.,) 1968.
Samuel. H, 1975	Mental Health contemporary, Topics and Health Service, Lowa WMC, Brown company.
Saswathy Mishra 1987.	Social adjustment in old age "B.R. Publishing Corporation. Delhi.
Sati. P.N. 1998 :	Retired And Aging people, Delhi, Mittal Publications
Shanas, 1968.	"Old age in three industrial societies" Newyork, Artherton, London, Poutedgeard Kogan Paul.
Sharma K.L, 1999.	Elder Women of Kachchi Basti : A Socio Psychological Profile. Indian Journal of Gerontology 13(1&2) PP: 40-57.
Sharma M.L & Dak T.M (Eds), 1987.	Aging in India challenge for south New Delhi;Ajantha Publications.
Sharma S.J & Agarwal S. 1996	Aging: The Indian Perspective
Sharma, K.L.& Jain, V.C, 1969	Religiocity and Fear of death in young and retired persons. Indian Journal of Gerontology, (14), PP: 110-114
Sharma.A, 2002.	"Personality co-Relates of Wellbeing". Doctoral Dissertation, M.D University Rohtak.
Shastry, K. 2001.	"Old age in the Hindu scriptures". In Prakash I.J (Ed). Aging the Indian experience: Report of the workshop organized on 9-10th August 2001, Bangalroe University.

Shinn, Lehmanan and wong, 1984.	Social interaction and social support
Simmons, L., 1945.	"The Role of the Aged in Primitive Society" quoted by C.Tibbitts, Handbook of Social Gerontology, Chicago, University Press, 1960.
Simmons, L., 1945.	"Social Participation of the Aged in Different Cultures" Quoted by C.Tibbitts, Handbook of Social Gerontology, Chicago, University Press, 1960.
Social Welfare Oct, 2008	Vol.55, No:7, Blessing of Autumn, B1.
Srinivatsava, Ram Chandra. 1994.	"The Problem of the old age". New Delhi; Classical Publishing Company; pp 75-254.
Stanley, M. Blair, K.A, & Beare, P.G (2005):	Gerontological nursing Promoting successful ageing with older adults (3rd ed) Philadelphia; F.A Davis.
Strumph, 1987.	"Study intends to understand the need for Self-esteem and Socialization among the Elderly stating at home for the Aged".
Susheela Mathew, 1997:	"Life Satisfaction and some of its correlates among Institutionalized and Non – Institutionalized elderly', NIMHANS Journal. 15 (3) Pp. 219 – 223
Tara Parker Pope 2009	"*Empty nest*" The Hindu- business line, Friday,January 30,.P: 3
Taylor, R.J and Chatters L.C, 1988.	"Church Members as a Source of Informal Social Support. Review of Religious Research, PP: 30,193.
Toronoto; Thomas Allen & Son, 1974.	Merrium, Webstar Dictionary webstar, New Collegials Dictionary.

Venkoba Rao.A Madhavan, 1982.	"Depression and Psychiatric Illness".
Venkoba Rao.A, 1990.	"Health Care of the Rural Aged, New Delhi, Indian Council of Medical Research".
Victor, 1987.	"Old Age in Modern Society"; A Text Book of Social Gerontology, London, Croom Helm Ltd.
Vijayakumar. S. 1991:	Family Life and Social – Economic problems of the Aged New Delhi: ASISH Publishing House.
Vijayarani.M, 1997	"The graying population in India 1991 censes results: Results and Development Journal, Help Age India".
Vinod Kumar, E.D , 1998.	"Aging: Indian perspective and global scenario", NewDelhi 12-19, All India Institute of Medical Sciences.
Wag.N.G, 1987	"Welfare services for the Aged encyclopedia of social work in India", New Delhi; publication of Dwism,Government of India, 1987
Ward 1984.	"The Aging Experience An Introduction of Social Gerentology", New York, Harpen and Rew
WHO: SEARO 3: 1999	Fifty year of WHO in South – East Asia, New Delhi,. P.99.
Yoshida, S 2003:	Social participation among the elderly, Tokeyo: Japan Ageing Research Centre.
Zeo-D, 1998	Reasons for living and the pandox of suicide in Old Age Crisis. The journal of crisis intervention and suicide prevention, Vol.19: PP: 147-151
Zorn, C.R and Johnson, M.T 1997.	Religious Wellbeing in Non-Institutionalized Elderly Women Health Care for Women International, PP: 118, 209-219.

Long Back ago…
There was a huge Apple tree..


A Little boy loved to play with it..



He Love to climb the tree, love to eat apples…love to take the nap under its shadow

Times went on…

The boy grew up…

And he no longer play around the tree

..

..

..

One day the boy came….

The Tree asked him.. "Hi.. Come and Play with me.."

The Boy replied.. "I am not a kid. I don't play around tree"

"I play with toys. I need money to buy toys."

The Tree said… “I don’t have money but you can take all my apples and sell it. You will get the money.”

The boy picked all the apples of the tree and went..
He sold the apples and got money… he bought lots of toys…

But he didn't turn back…

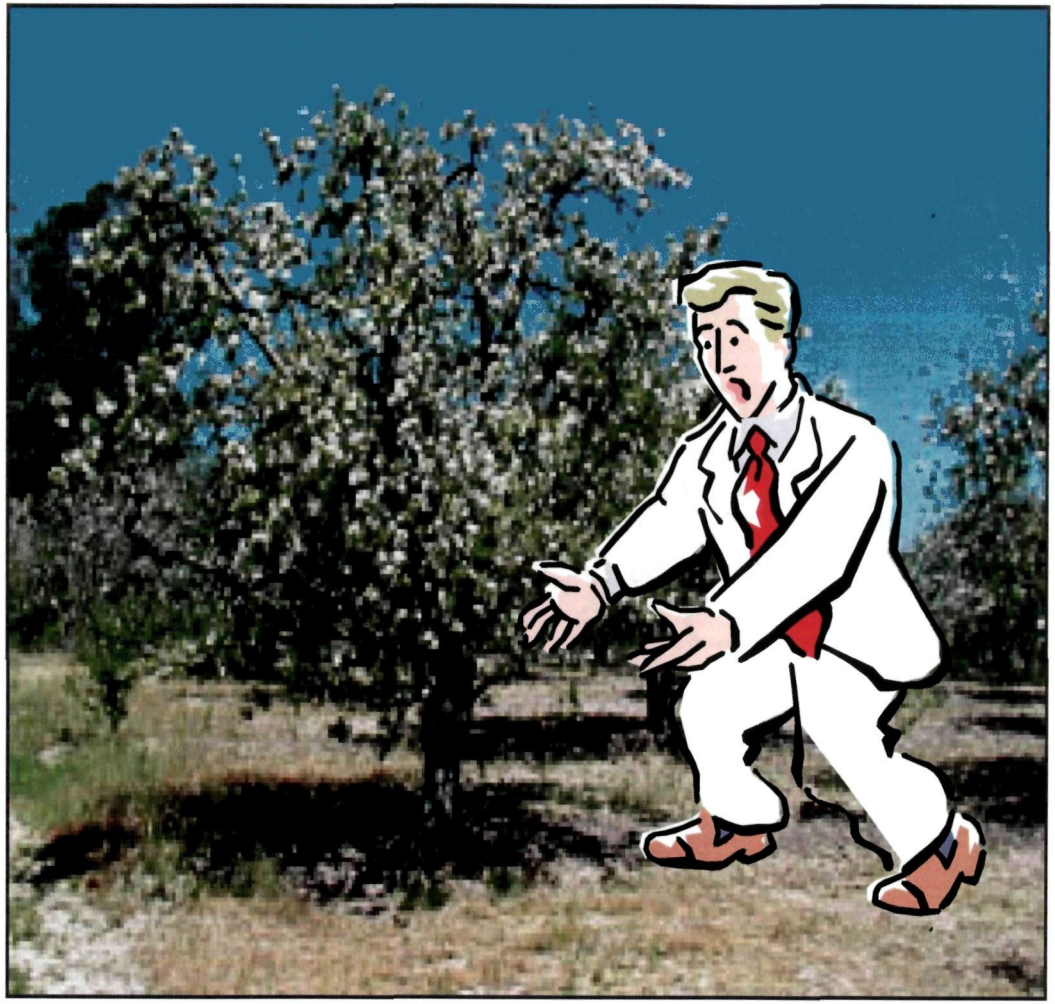
..

The Tree was again sad…

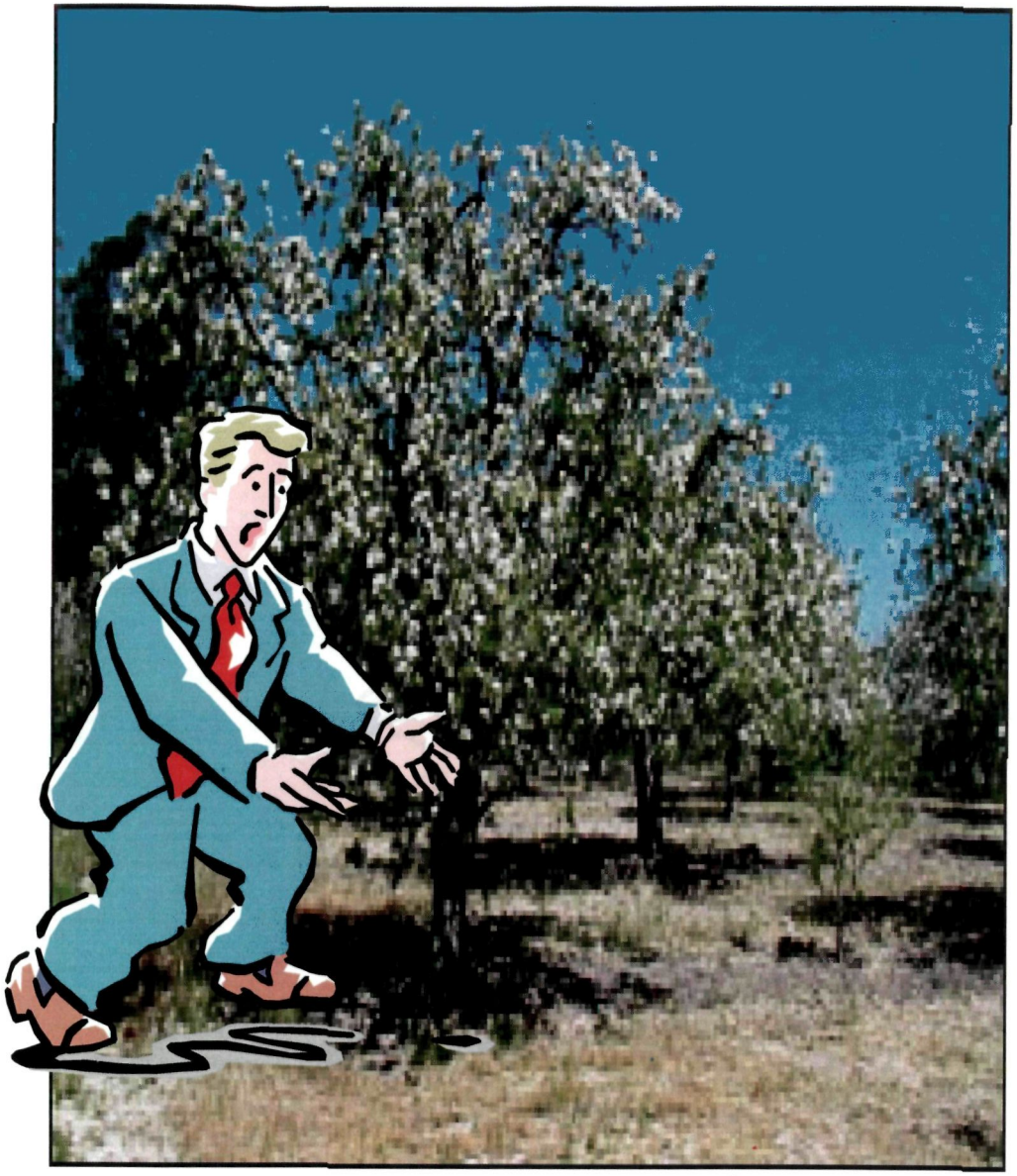
..

..

One day again the boy came, he became a young man now…….



The Tree said… “HI… Why are you Sad? Come and Sit under my shadow… I am feeling very lonely without you...”



The boy said…
“I don’t have time…
I work for my family…
I want to build Home for them…
I Need money…”

The Tree said.. "I don't have money… You can take my Branches and Trunk… and build your home…"

The Boy Became Happy…

He cut all the branches and trunk of the tree...

And built a home for him….

Again the tree became alone..

..

The boy didn't turned back..

...

Time passes on ..

After Long time the boy came back..

..

He was so old…

Looking sad…

Tired…

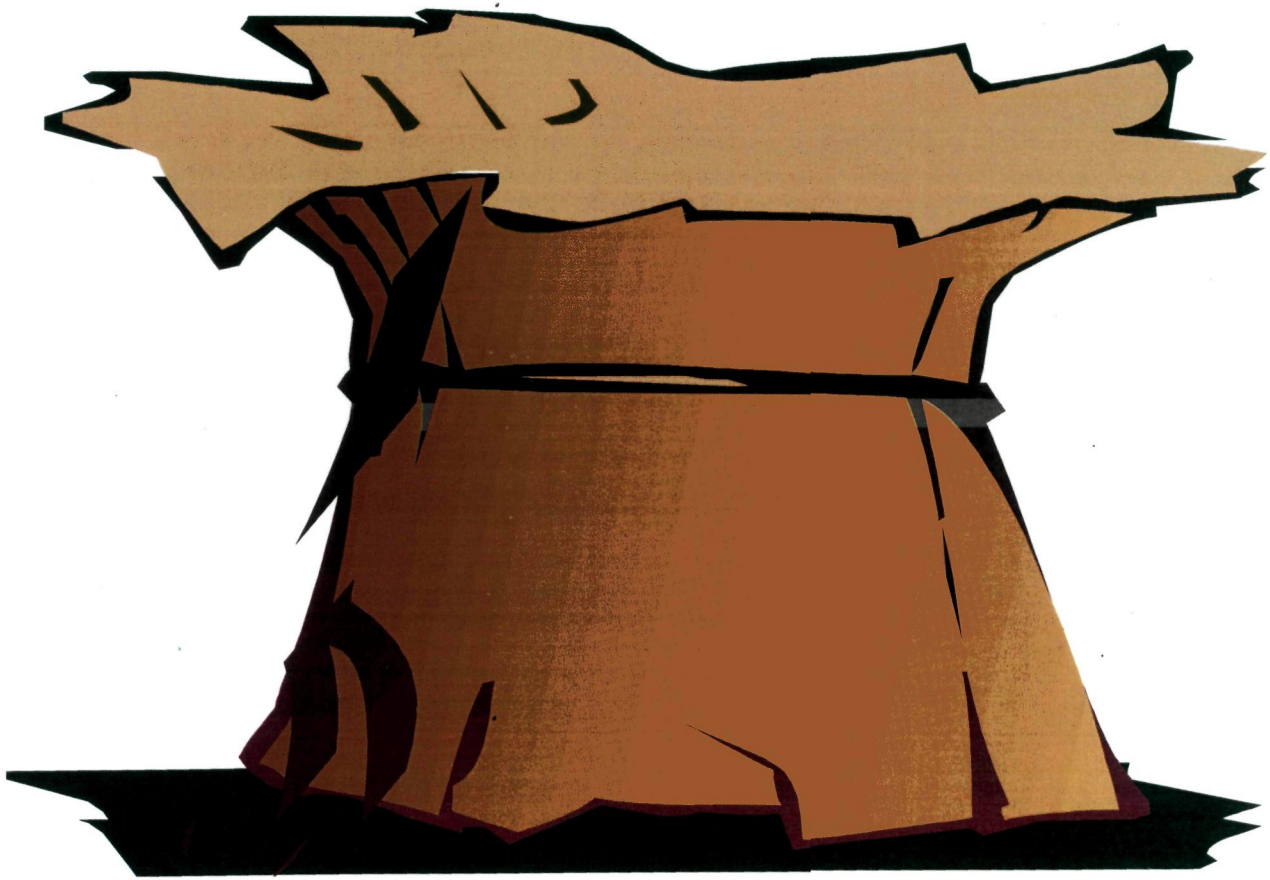
And lonely..

The Tree asked him.. “Why are you Sad.. I Wish.. I Can help you…

… but I Don't have Apples.. I don't have branches…. Even I don't have Shadow…

Nothing to Offer you…

The Boy (old man) replied…
"I am tired of my life…
I am alone…"



…"I just need you… Can I sit down at your roots."

…

…

…

The Boy (Old man) sit down .. Both were happy & weeping ...

Is the boy really cruel and selfish??

??

??

??

??

??

No…

We all are like him…
And treating our parent
like that….

The tree is like our parent

We love to play them when we were kids…

We leave them alone…and come only when…

We are in need or in trouble

We don't have Time for our Parent…

No matter what, parent will always give everything….

To make us happy and solve our problems…

And in return what they want….

Just our company!

Please love to your parent…

Don't forget them…

Give them Time…

Give them your company…

They will be happy by seeing you happy.....