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AGEING & SOCIETY

THE INDIAN JOURNAL OF GERONTOLOGY

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AGEING & SOCIETY : THE INDIAN JOURNAL OF GERONTOLOGY

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This Journal will be devoted to papers on the following aspect of human ageing

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- ★ Biology
- ★ Medicine
- ★ Behavioural Science

In addition we welcome Abstracts, Book reviews & Interviews with senior citizens

NOTES FOR CONTRIBUTORS

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Journal articles that deal with the biological medical, psychosocial, service or other aspects of ageing are welcome.

Articles should be original contributions. Redundancy is discouraged. The articles should be written in English are free of grammatical, spelling, errors, repetitions etc.

Articles shall contain: A brief introduction (reflecting the context, the review of relevant work and why the present study was planned) : relevant details of plan methodology, sample, (including standardization properties of tools) etc., the results or findings and their discussion and conclusions arrived at. At the beginning of the article the title and names of authors shall be mentioned. (Their affiliation may be given at the bottom of the page). This shall be followed by a brief abstract of the article (not exceeding 100 words) in single space, bold and set off the margins (inset by two spaces). Two or three key words of the article should also be provided at the end of the abstract separately.

Articles may be computer generated. Two hard copies, double spaced in A4 size (one side only) with wide margin may be sent. The articles would be adjudicated by referees and the result would be communicated. When the article is accepted contributors are requested to send 2 corrected versions of the article (hard copies) and the same in an electronic version in CD, press ready.

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A COMPARATIVE PSYCHOSOCIAL PROFILE OF MARRIED MALE AND FEMALE ELDERLY WITH RESPECT TO THEIR ANGER EXPRESSION AND DEPRESSIVE TONE

Sraboni Chatterjee*

ABSTRACT

A sample of 60 aged individuals (30 males and 30 females) were selected to determine their psychosocial profiles. The variables selected for this study were depression and anger expression.

Results revealed that the two groups differed significantly with respect to anger expression but not in case of depression.

* Contractual lecturer, Muralidhar Girls' College

INTRODUCTION :

The current world scenario is embracing a significant population of aged individual within its fold. Such a population is spreading its impact on several socio-cultural as well as psychological dimensions of our social life. The focus of medical science is not to mend the health when it is broken but to initiate health condition much earlier so that diseases can be prevented and overall sense of well-being prevails. Not only do we have our concern towards people of this age group owing to their inabilities of various kind, we do have our concern regarding their positive effect of generatively that leaves its mark on the younger members of the society. The basic intentions of gerontologist is to open the vistas of different dimensions of aged life with the intention of bringing out alterations in its several aspects to make them more happy and adjusted in advanced years of life so that we also enjoy the presence of them in our life situations. Having lived longest these people can act as the most assured carrier of techniques and beliefs which may be passed on virtually from one generation to the next. But life is not that colourful and positive all the time. Life shows lack of tolerance, regarding so many things including considering the aged as burdens on us because the negative conditions and situations that the population creates. To erase the odd effects from the situation the current scientific attitude is directed at the fulfillment of a need to unravel the psychological profiles of aged people so those strategies can be adopted to make their presence more fruitful in life for them as well as for others.

Aging is the closing period of life-span. It can be socially defined as a time of fulfillment or a time of marginalization. It is a period when people shift away from previous life processes. It is a period of decline. The phenomenon of old age is conceived in terms of chronological

measurement mainly. The aging of population is an obvious consequence of the process of demographic transition.

In a globalizing world, the meaning of old age is changing across culture and within countries and families. The position of elderly person in a society is a measuring rod of civilization. With advancing age, most people suffer from increasing social loss or social disengagement (Chen 1998). 'The Aging' or period of old age can be subdivided into another two ways [Armstrong 1978].

Old age has different implications for men and women. For male, his role as a major earner in the family is critical, is likely to suffer in self-esteem if he sees himself as dependent**.** A man who is dependent on her son experience a sense of inadequacy in the non-traditional, urban setting (Muttagi 1997). On the other hand, most women perceive themselves as 'old' by the time they are 50 years old. This perception of self as old age is based on the presence of grandchildren widowhood, shrinkage of social roles and post menopausal status (Prakash, 1997). Marriage of a son and arrival of a daughter – in -law into the joint family often marked as a major transition in the life of a woman. Effect of the family cycle is more traumatic for women than for men because deeper involvement of female role in the domestic spheres (Butler et. Al 1976).

Marriage, in some form, is now widely recognized as almost universal (Betzig, 1989). Couples who are still together in old age are less likely than younger ones to say that their marriages have a lot of problems. One major reason is that because divorces have been easier to obtain over the past couple of decades, those marriages that have lasted over the years are self-selected. The spouses in them deliberately chose to stay together. The decision to divorce usually comes in early years of marriage, and couples who stay together despite difficulties

are often able to work out their differences and eventually arrive at mutually satisfying relationships.

Aging is related to many variables. Popular stereotypes suggest that people become less emotional as they age. Studies also suggest that there are decreases in the frequency and intensity of self reported emotional experience with increasing age. Literature survey on the other pole indicates that depression is common in the elderly population, it is associated with higher risk if death from suicide than for any other age group. Elderly people may tend to be reluctant or unable to report depressive symptoms; thus depression is often not recognized. Considering the contradictory findings **anger expression** and **depression** are selected as the interacting psychosocial variables for the present study.

Selected psychosocial variables :

Anger expression:

Anger is more frequent emotional response. State anger is defined as an emotional state marked by subjective feelings that vary in intensity from mild annoyance or irritation to intense fury or rage. Trait anger is defined as the dispositions to receive wide range of situations with frequent elevations of state anger (Speilberger, 1996).

Depression:

One of the most equivocally discussed mental disorder among elderly adult is depression with the old age and there is less opportunity than before, hope for future, so that value defense against depression is no longer effective. Loss of friends, loved ones will bring depression. Researchers suggest that traditional socialization practices may be responsible for creating more depression in women (NIM consensus Development Conference, 1991).

Objectives :

To locate the difference if there is any between married aged males and females

i) In terms of anger-expression.

ii) Pattern of depressive tone.

METHOD :

Sample:

Description of the subjects:

A total of 60 aged individuals are selected. The subjects are selected on the basis of certain criteria. Detailed information about the subjects are as follows:

Criteria for the selection:

Sex	Male and Female
Age	60-65 years
Educational level	higher secondary to graduation
Occupation	Female – house wife, Male – Retired
Religion	Hinduism
Mother tongue	Bengali
Socio-economic status	Middle class

Exclusion criteria:

Marital status	Widow/widower, divorced, bachelor and spinsters are excluded.

Occupational status	Candidates who are still working are excluded.
Psychopathology	Candidates who possess psychiatric morbidity are excluded.

Selected tools:

In the present study data was collected by administering the following questionnaires:

1. Information Bank.

2. General Health Questionnaire (GHQ) is used for eliciting psychopathology within individuals.

3. State Trait Anger Expression Inventory (Speilberger 1996)

4. Beck Depression Inventory was developed by Beck, Ward, Mendelson and Erbaugh (1961).

Data collection procedure:

The individuals were selected according to the inclusion criteria, already mentioned. Rapport was established with subjects and they were told that their information would be kept absolutely confidential. Data were collected according to the following predetermined sequence of the presentation of tools:

1) Information Bank.

2) General Health Questionnaire (GHQ).

3) State-Trait Anger Expression Inventory (STAI).

4) Beck Depression Inventory (BDI).

Treatment of the data:

1) Mean and standard deviations were computed for all the variables.

2) Significant difference between the variables were verified with appropriate statistical tests (t-test).

RESULTS AND DISCUSSIONS :

The aim of present investigation is to locate a comparative psychological profile of married aged male and female individuals.

Obtained data have been analyzed using parametric test. In parametric test, t-test is used. For interpretation 0.05 and 0.01 levels of significance are accepted.

The sample consisted of 60 aged individuals (30 male and 30 female).

TABLE-I: Mean, standard deviations and t-values of selected variable- Anger Expression (state and trait Anger) of married male and female elderly.

	State Anger		Trait Anger	
	Mean	S.D	Mean	S.D
Males (N=30)	24.1	.69	25.23	5.
Females (N=30)	14.8	3.93	18.5	3.68
	t-values 12.74**		t-values 5.85**	

* Significant at 0.05 level,

** Significant at 0.01 level

Aged men were found to possess high score or both the state and trait anger dimensions. It indicates that they are experiencing relatively intense situational determined angry feelings. Their independent life styles, lack of satisfaction in dual role context prompt them to express mild annoyance or irritation to intense fury or rage. As a result of this such persons are likely to experience great deal of frustration which makes them less adaptive in behavior pattern at times (Speilberger, 1996).

Elderly females, due to their low aspiration point emotional lucidity possess softer bend of mind, that makes them more adaptive and hence carrier of less anger than their counterparts (Zube, 1982).

TABLE- II: Mean, standard deviations and t-values of selected variables- Anger Expression (Angry temperament and Angry reaction) of married male and female elderly.

	Angry temperament		Angry reaction	
	Mean	S.D	Mean	S.D
Males (N=30)	10.83	.53	10.3	1.75
Females (N=30)	7.23	.92	7.73	2.69
	t-values		t-values	

* Significant at 0.05 level

** Significant at 0.01 level

Male elderly seem to possess high score or angry-temperament and angry reaction dimensions. This may be due to the fact that coming to them greater hassles in life they are short tempered and readily express their angry feelings in slightest provocation. As a result, they are highly sensitive to criticism, perceived affronts and negative evaluation by others and experience intense feelings of anger under such circumstances (Speilberger, 1996).

Females on the other hand, owing to their lower anxiety and anger disposition, seem to be more balanced in their anger expression. Due to their satisfactory conjugal life, it is expected that they are usually able to control their angry reaction.

TABLE- III: Mean, standard deviations and t-values of selected variable- Anger Expression (Anger in and Anger out) of married male and female elderly.

	Anger In		Anger Out	
	Mean	S.D	Mean	S.D
Males (N=30)	24.7	4.19	23.16	2.44
Females (N=30)	16.83	4.61	17.5	4.29
	t-values 6.90**		t-values 6.29**	

* Significant at 0.05 level

** Significant at 0.01 level

Research findings suggest that those who possess high anger in score may possess high anger out, but they may expires anger in some situations and anger-out in some situations (Speilberger, 1996). Most probably on account of such logic the male sample was found to have greater in aggression as well as out-aggression. The expression of anger is not always open as they are marked by education and adaptive behavior pattern.

On the other hand, females owing to their comparatively smoother life flow needed manipulative approach in behavior pattern possess lower score in these two dimensions.

TABLE-IV: Means, Standard deviations and t-values of selected variable- Anger Expression (Anger Control and Anger Expression) of married male and female elderly.

	Anger Control		Anger Expression	
	Mean	S.D	Mean	S.D
Males (N=30)	13	3.65	48.63	12.69
Females (N=30)	23.77	3.25	24.93	6.56
	t-values 12.10**		t-values 9.08**	

* Significant at 0.05 level, ** Significant at 0.01 level

Married male have lower score in anger control and score in anger-expression dimensions. This is because continuous demand of external work life together with personal aspiration towards achievement, lowers down their tolerance limit and hence in this outbreak of aggressive behavior at times in interpersonal relations (Speilberger, 1996).

On the other hand, females tend to invest a great deal of energy in maintaining and preventing the experience or expression of anger. Since, they do not have the scope of being achiever in outer-world, they try to have cozy interpersonal bond to earn blissful state in inner world of home.

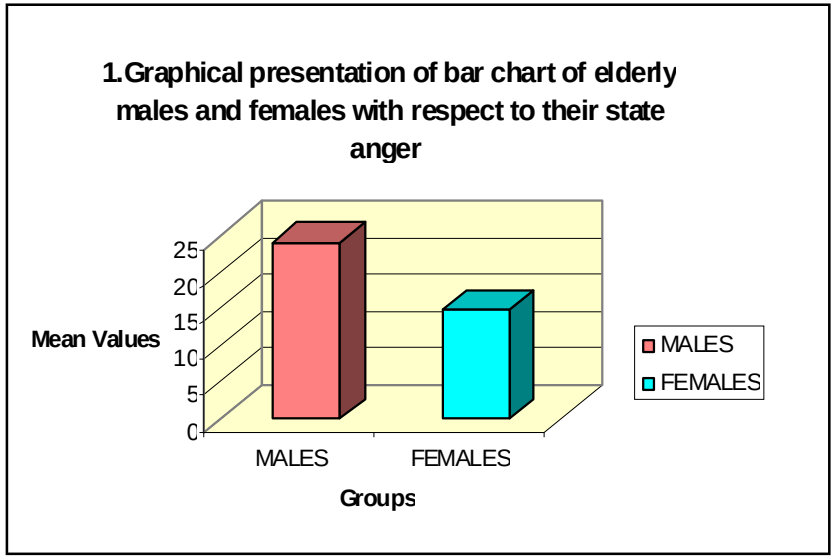
TABLE-V: Means, Standard deviations and t-values of selected variable- Depression of married male and female elderly.

	Mean	S.D
Males (N=30)	5.73	14.03
Females (N=30)	11.10	1.77
t-values	.74	

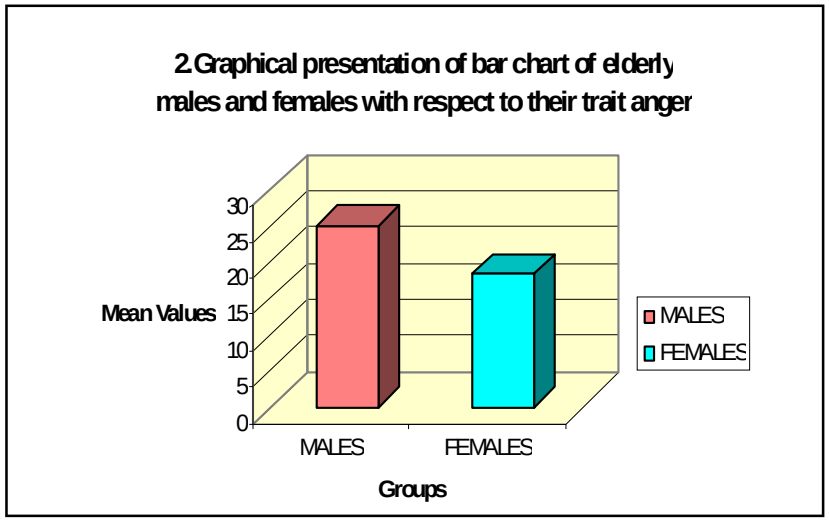
*Significant at 0.05 level, ** Significant at 0.01 level

Research findings suggest that our traditional socialization practices for women may also be responsible factor for depression (Gurland et. al., 1980). Males tended to have comparatively lower score in this respect. But inter sample comparison yielded no statistically significant difference, most probably indicating the arrow towards lower social-emotional status of women in general in our society and consequent frustration, deprivation and depression in them.

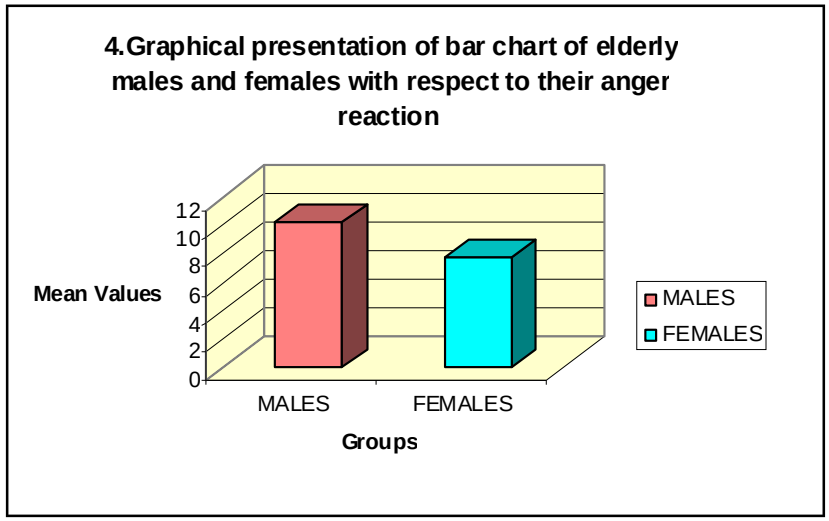
Graphical presentations of the bar diagrams with respect to the selected variables are as follows :



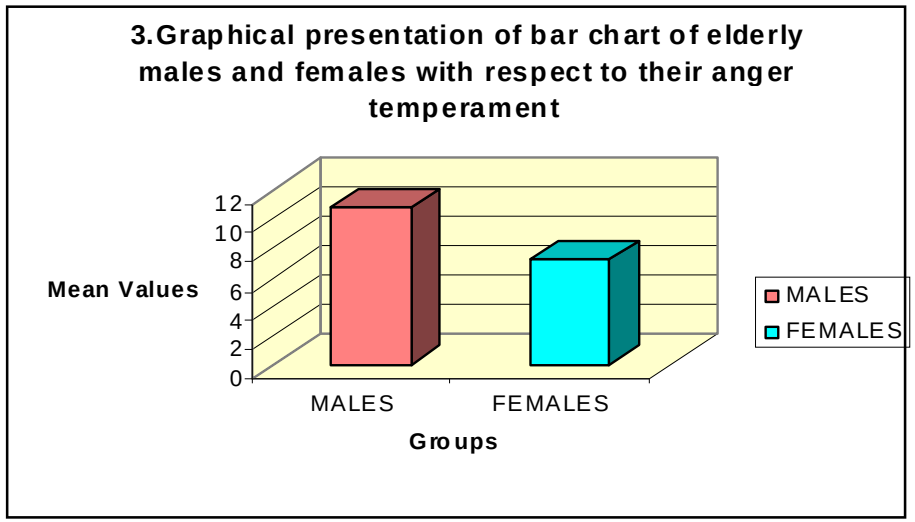
It is seen that the male aged groups possess higher state anger than female elderly groups.



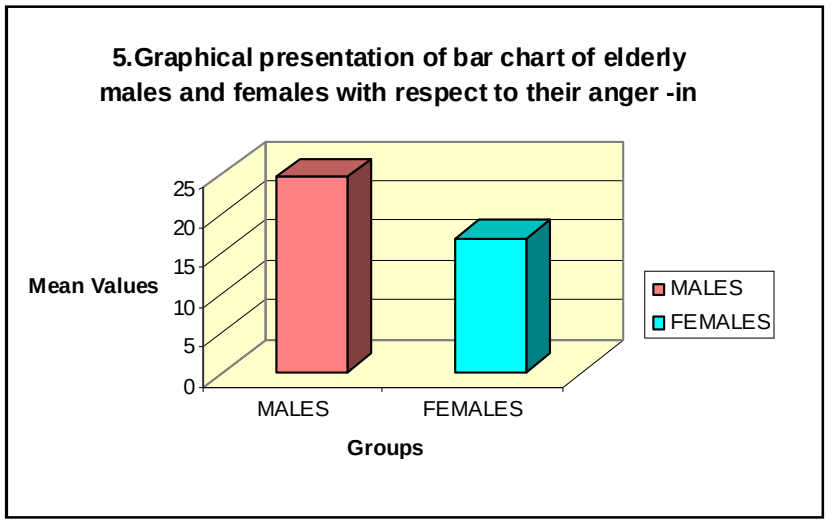
It is seen that the male aged groups possess higher trait anger than female elderly groups.



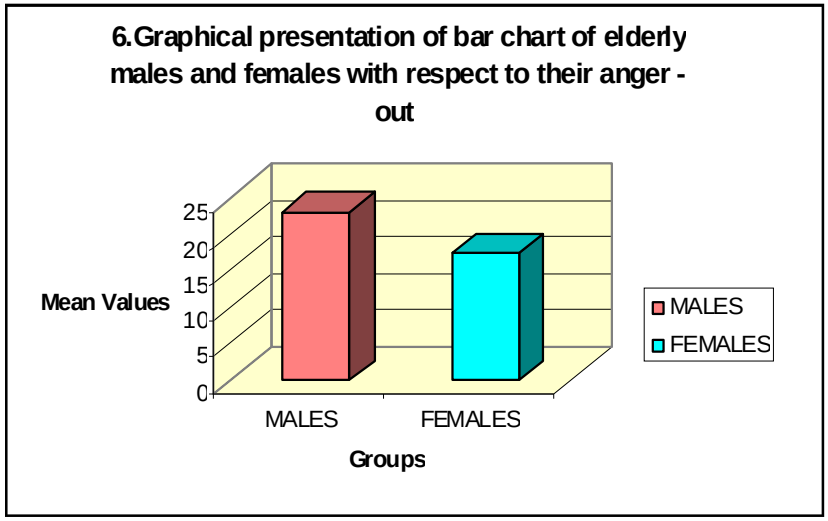
It is seen that the male aged groups possess higher anger-reaction than female elderly groups.



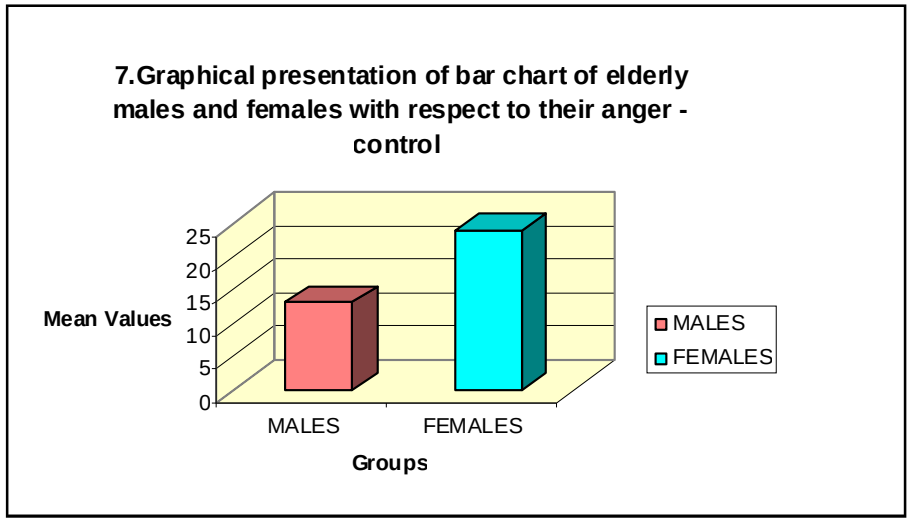
It is seen that the male aged groups possess higher anger-temperament than female elderly groups.



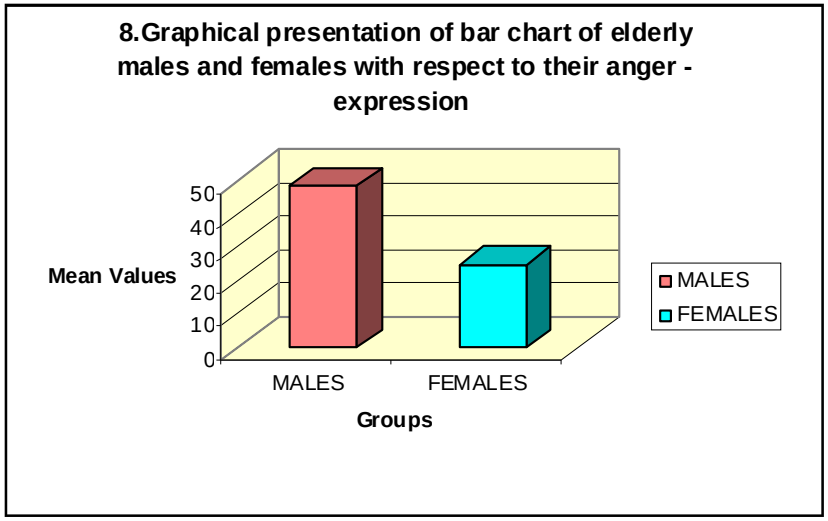
It is seen that the male aged groups possess higher anger –in than female elderly groups.



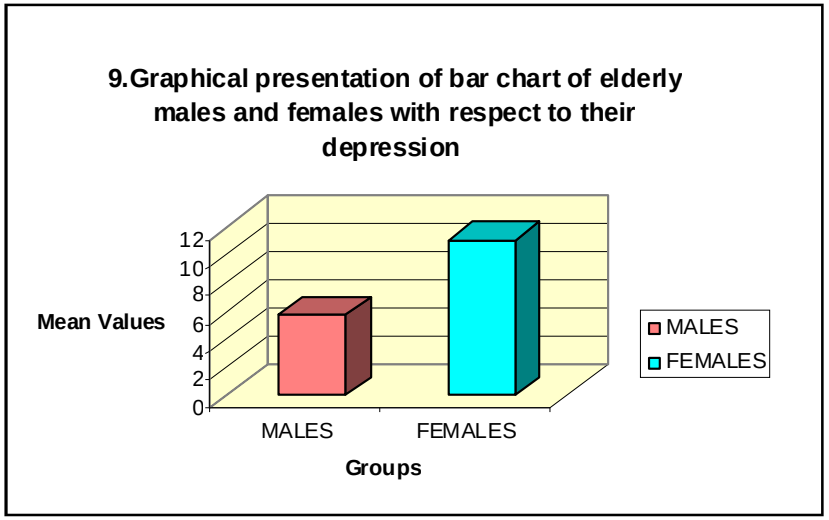
It is seen that the male aged groups possess higher anger –out than female elderly groups.



It is seen that the male aged groups possess lower anger control than female elderly groups.



It is seen that the male aged groups possess higher anger expression than female elderly groups



It is seen that the male aged groups possess lower depressive tone than female elderly groups.

CONCLUDING COMMENTS :

Highlighting points of study:

Married male aged have;

* Less anger control but more anger expression.

* Less depressive tone in character pattern.

Married female aged have;

* More anger control but less anger expression.

* More depressive tone in character pattern.

IMPLICATIONS OF THE PRESENT STUDY :

* The present findings are of immense value in the mental profile of two groups.

* The findings are also helpful in counseling purposes.

LIMITATIONS OF THE PRESENT STUDY:

No research is free from limitations, this study also is not an exception to this. The limitations are as follows;

* The sample size is very small.

* If working segment of female population are included then the specific findings will bear more socio-emotional relevance in our culture specific situations.

SUGGESTIONS FOR FURTHER RESEARCH:

Further research in this area may highlight on other aspects like adjustment, loneliness, self-concept etc. It is also to improve the quality of life of the elderly.

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ADJUSTMENT OF OLDEST OLD

H. Venkat Lakshmi*
K.N. Krishna Murthy**

ABSTRACT

Aging is unequivocally universal and irreversible process. This process varies considerably within and between the genders. Aging is the part of biological, social, psychological and ecological factors. Old age is the last phase of the human life cycle.

Adjustment of the oldest old with the changing scenario and rising platform of globalization, modernization and industrialization is very challenging and of utmost importance.

The purpose of the study was to understand the adjustment pattern of the 40 elderly men and women in the age group of 80 to 90+. Adjustment of the aged was assessed by using the Shamshad – Jasbir Old Age Adjustment Inventory (SJOAI) 1995.

Analysis of the data obtained revealed that there is a non significant difference within the adjustment pattern of elderly men and women with respect to the independent variables such as Age, Educational qualification, Occupation, Income of the Family, Retired/in service and status of Partner.

Further, the study also indicates that there is significant difference in the adjustment pattern between elderly men and women. A very low level of mean scores of adjustment was observed among elderly women when compared to the elderly men. The study highlighted the fact that elderly women are emotionally unstable, and is unable

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to cope up with the pressures of financial, social, marital and home environment due to their age factor. The finding emphasizes the need to sensitize the younger generation to be more sensitive to the needs, problems and adjustment of the oldest old.

Introduction

Ageing is a universal phenomenon and a natural biological process of life span development. Age 60 and above is the traditional entrance point for late adulthood / aged, the last phase of life span. This life period, like any other, is of continuing change and adjustment both in the physical and the psychosocial realms.

John Glenn epitomizes a new view of aging, challenging the formerly pervasive picture of old age as a time of inevitable physical and mental decline. Like people of all ages in life span, the oldest old are individuals with different needs, desires, abilities, lifestyles, and cultural background.

A shift in the family paradigm has brought about a tremendous change in outlook, life style and the adjustment that the aged should make. Many factors such as marital status, finances, health, and family size influence the adjustment of the oldest old. Decisions about where and with whom to live also are affected by broader societal influences: cultural traditions and values, availability of social services and the types of housing available (Kinsella and Velkoff, 2001). Adjustment does not necessarily imply the living arrangements, family cohesion and support; instead it is the older person's good health, economic self sufficiency, and desire for sense of belongingness. Despite these concerns, the success of adjustment of the oldest old largely depends on the quality of relationship being shared by both the generations effectively and emphatically. Parents and children need to respect each other's dignity and autonomy and accept their differences (Shapiro, 1994). Adjustment of the Oldest Old is of vital importance in the age of industrial advancement, globalization and era of modernization of the changing norms. Hence an attempt has been made in the present study to know the level of adjustment made by the Oldest Old.

Objective:

To study the adjustment of the Oldest Old with reference to independent variables such as age, income, type of family, educational qualification and the marital status.

Methodology:

Sample Size and Sampling Procedure:

The sample for the study consisted of 28 elderly men and 12 elderly women, thus comprising of 40 samples in the age bracket of 80 to 90+. The study was conducted in Bangalore city. The sample was drawn from family, religious, academic and social organizations. Purposive sampling technique was used to select the sample. Personal rapport was established with the respondents in the first session of half-hour duration. The main idea of this session was to establish comfort level and to elicit accurate information.

Tool Used

The Shamshad Jasbir Old Age Adjustment Inventory developed by Shamshad Hussian and Jasbir Kaur (1995) was used to find out level of Adjustment of the Oldest Old in different areas Viz. Health, Home, Social, Financial, Emotional, and Marital. The Inventory consists of 125 statements. Each of the above mentioned areas of adjustment contains 26, 25, 21, 15, 21 and 17 items respectively, totaling to 125 statements. Specific scoring key is available in which a score of 'one' is given for each correct response. Higher score indicates better adjustment.

Result and Discussion

Table 1 Level of Adjustment among the Elderly Men

Characteristics		Level of Adjustment			Significance of Chi-square value
		Low	Average	High	
Age	80 – 85	4	6	2	5.6190 NS
	85 – 90	0	5	4	
	90 +	3	3	1	
Educational Qualification	Post Graduate	3	8	3	0.5710 NS
	Professional	4	6	4	
Occupation	Public Sector	4	1	6	7.4000 NS
	Private	0	3	1	
	Business	3	1	0	
Income	6000 - 8000	2	2	1	3.9000 NS
	8000 – 10000	5	9	6	
	10000 - 12000	0	3	0	
Type of Family	Joint	2	3	1	2.4440 NS
	Nuclear	0	2	2	
	Extended	5	9	4	
Service	Service	4	5	4	1.2910 NS
	Retired	3	9	3	
Status of Partner	Alive	5	8	4	0.4490 NS
	Deceased	2	6	3	

NS Not Significant

Table 1 indicates that there is a non significant difference in the levels of adjustment among the male respondents in association with the basic profile.

The non significance could be attributed to factors that majority of the respondents educational background which keeps them occupied, even after years of their retirement, income helps the elderly to be more independent financially and sustain life at their age, which otherwise is the core of adjustment problem, family interaction and involvement in other (recreational) activities that keeps them physically, mentally and emotionally fit. Further the study indicates that majority of the respondents have their spouses as companion and they also look forward spending quality time together.

Table 2 Level of Adjustment among the Elderly Women

		Level of Adjustment			Significance of Chi-square
		Low	Average	High	
Age	80 – 85	1	3	2	1.6670 NS
	85 – 90	1	1	4	
Educational Qualification	Post Graduate	1	3	2	1.6670 NS
	Professional	1	1	4	
Occupation	Public Sector	1	4	5	2.4000 NS
	Private	1	0	1	
Income	6000 - 8000	1	3	2	1.6670 NS
	8000 – 10000	1	1	4	
Type of Family	Joint	1	3	2	1.6670 NS
	Nuclear	1	1	0	
	Extended	0	0	4	
Service	Service	1	4	5	2.4000 NS
	Retired	1	0	1	
Status of Partner	Alive	1	3	2	1.6670 NS
	Deceased	1	1	4	

NS Not Significant

Table 2 clearly indicates that no differences have been observed among level of adjustment among the elderly women. Further the results indicate that respondents have fairly good level of adjustment amongst themselves as a homogenous group. The respondents expressed that they let go of their leisure time in order to maintain harmony within the family. Studies indicates that the role of the women in Indian scenario projects women as an individual with qualities such as tolerance, determination , potential, empathy, and greater concern for family.

Table - 3 Adjustment between Elderly Men and Women

Area of Adjustment	Men (Mean ± SD)	Women (Mean ± SD)	Significance of t value
Health	22.10 ± 2.85	11.25 ± 1.13	12.6930 **
Home	23.71 ± 1.73	10.41 ± 1.67	32.5080 **
Social	19.32 ± 0.90	7.25 ± 1.21	34.9957 **
Marital	15.82 ± 2.05	8.91 ± 0.66	11.3539 **
Emotional	16.32 ± 1.36	4.50 ± 1.00	27.0604 **
Financial	14.57 ± 0.74	6.50 ± 0.90	29.6256 **

** Significant at 1 % level

Table 3 and Fig 1 indicate the level of adjustment of both elderly men and women. The mean scores of elderly women are far below when compared to that of the elderly men. Irrespective of economic, marital or educational status, elderly women face an emotional void in their life. A common explanation for their emotional void is ‘empty nest syndrome’ and stereo – typed life style wherein they are unable to

cope with the pressure and to keep up with the demands of their day's routine. They further expressed that lack of socialization and financial constraints due to family commitment causes frustration and boredom in them. Loneliness and ill health is further making adjustment difficult for them. Surendar et al (2003) in their study indicated that elderly face health and economic problems, which affect their mental health and well being. Jamuna and Lalitha (2004) reviewed and found that most of the elderly were suffering from loneliness. These considerations are evident of the fact that health and financial problems along with loneliness are common among the elderly and have to be given due consideration.

In comparison the elderly men have a good adjustment in all the above mentioned aspects. This could be attributed to the factors such as spacing of time, being more concerned about their health by following a regime like good diet, exercise, hold on their savings which gives a boost to their confidence and self esteem.

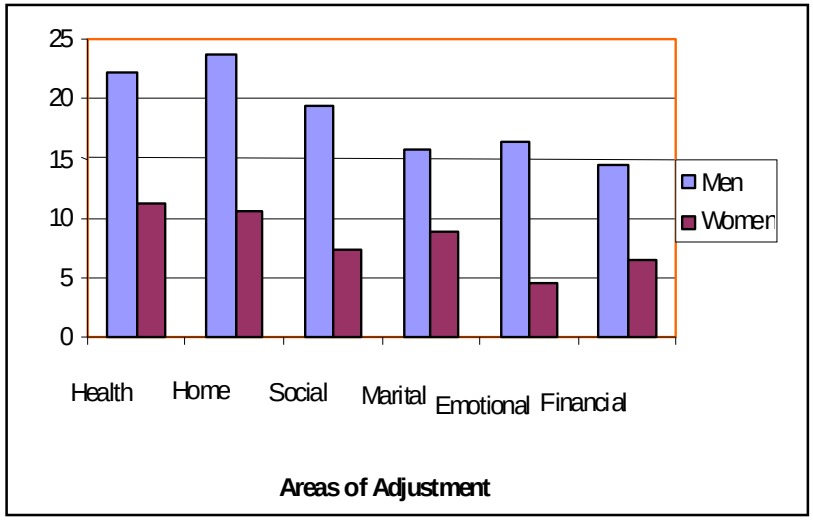

Figure1. Comparison of areas adjustment among the elderly men and women

Conclusion

Oldest Old is a time of relinquishing and adapting oneself by making adjustment, changing their ideas and schedules. Adjustment of the aged is affected by health status, financial stability, sense of personal control over life events, including the retirement, decision, nature of the work they did, satisfaction derived from work, social support and marital happiness.

The present study also indicates that there is significant difference in the areas of adjustment between elderly men and women. A very low level of mean scores of adjustment was observed among elderly women when compared to the elderly men. The study highlighted the fact that elderly women are emotionally unstable, and unable to cope up with the pressures of financial, social, marital and home environment due to their age factor. Their responsibilities and expectations from the family is even greater than what it was before. The present study underlines that successful aging occurs when elderly develop many ways to minimize their weakness and maximize their strength.

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A COMPARATIVE CLINICAL EVALUATION OF SARASWATA CHURNA AND SATVAVAJAYA CHIKITSA (AYURVEDIC PSYCHOTHERAPY) IN THE MANAGEMENT OF GERIATRIC DEPRESSION

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ABSTRACT

Depression is an extremely common problem, and it can be an extremely painful one, regardless of the individual's age or life circumstances but Geriatric Depression is often undiagnosed because of the overlapping of symptoms due to associated pathoplastic effect of aging and physical ill health. Conventional anti depressant treatment has failed to tackle the problem; hence a need of multidisciplinary approach for managing the patients of Geriatric Depression arises. At this juncture, Ayurvedic Medhya Rasayana therapy probably the best option for treating the mental disorders of elderly, especially depression. The present study has been conducted in eighty patients of Geriatric Depression dividing them into four groups A, B, C & D using Saraswata Churna (1.5 gram twice a day with Ghrita and honey) and Satvavajaya Chikitsa. The DSM-IV-TR diagnostic criteria of Depression along with Geriatric

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Depression Scale (GDS-30) have been used for selection of cases. Hamilton depression Rating Scale (HDRS) has been used to evaluate the response of the treatments. Based on the findings it can be concluded that the combination of the Saraswata Churna & Satvavajaya Chikitsa are the most effective therapy for the management of the Geriatric Depression.

Key words: Saraswata Churna, Satvavajaya, Depression, Stress, Geriatrics.

Introduction

The demographic changes during last 50 years have led to the increased importance to the geriatric care all over the world. The control of the infectious diseases because of discovery of newer antibiotics, the improved emergency care & coming up of ICUs & CCUs have led to the increased mean life span leading to the growth in the elderly population & at the same time decrease into the children's and young population because of improved birth control and family welfare measures. Thus the phenomenon of population reversal is clearly obvious in western and developed countries while it is slowly happening into the Indian scenario.

In addition to physical changes, the social and psychological changes are more disabling to the elderly population. Biologically speaking, there is no perceptible change in an individual immediately after the retirement from a job but the consequent social and psychological changes are drastic and traumatic. Most of the time elderly are disengaging from social activities and are lonely neglected and become depressed. Further due to industrialization, children move to far away places leaving old parents alone, or uprooting them to newer environment, both causing significant psychological distress. Financial dependence also adds to the distress in elderly. These persons are unable to cope-up with these varieties of changes & become the victim of many psychological & chronic diseases, the most significant of which is depression.

The Study of *Ayurvedic* literature reveals that, ancient Ayurvedists have described the conditions resembling to depression in the form of *Vishada*, *Awasada*, etc. *Shoka* is also a similar term to depression which describes the state of *Manodainyata* (Cha. Vi. 4/8). *Vishada* has also been included under the categeory of *Manas Vyadhis* during

the classification of diseases by *Sushruta* (Su. Su. 1/33). The term *Chittawasada* has been used for the depressive disorder & term *Kaphaja Unmada* signifies psychotic depression and Major Depressive Disorder.

The clinical presentation of *Geriatric Depression* deviates considerably from depression in young making it an independent clinical entity. Most of these changes are resultant of predominance of *Vata Dosha* in *Jarawastha (charak vi.8/122)*, which can explain the majority of symptomatic deviation. The *Restlessness* and Psychomotor *Agitation* (M. G. Gelder,2006) in cases of *Geriatric Depression* in contrast to classical sign of Psychomotor *Retardation* in adults is one such change. The conventional treatment of *Depression* includes a variety of antidepressant medications, including *Tricyclic Antidepressant, Selective Serotonin Reuptake Inhibitors, Monoamino Oxidase Inhibitors* and newer Atypical Antidepressants, but these treatments are not devoid of side effects. Further, the associated cognitive deterioration is continued and not taken care of.

In this scenario there has been need of such medications which are helpful in elevating the mood of these patients producing symptomatic relief and simultaneously improving cognitive abilities. Looking into the overall requirements one is naturally tempted towards *Ayurvedic Medhya Rasayana* drugs which are not only promote the Intellect (*Dhi*), Retention power (*Dhriti*), Memory (*Smriti*) and also produce *Neuronutrient* effect by improving Cerebral metabolism thereby helpful in reverting the Mental dysfunction and relieving the symptoms. These effects have also been substantiated by many scientific studies (Singh R.H. et.al.2008)

Selected trial drug

The Saraswata Churna is selected for the management of Geriatric Depression In present study.

It is a unique combination of *Ayurvedic* herbal drugs, containing mainly *Medhya Rasayana* drugs, mentioned in *Bhavprakash Unmadadhikar.* Later Bhaisajya Ratnawali also mentioned about Saraswata Churna (Bhaisajya Ratnawali 24/26-29). This is a unique combination of medhya drugs have high content of *Vacha,* which is the drug of choice for central nervous system stimulation in Ayurveda. It containing mainly three category of drugs namely (a) Medhya Rasayana, viz. *Vacha*, *Shankhpushpi*, *Aswagandha*, *Bramhi*, (b) Rasayana that acts at the level of Agni viz, *Pipali*, *Ajmoda*, *Jiraka*, *Mahabhaishajya*, *Maricha*, and (c) drugs that spread the active principles of all other drugs all over the body viz. *Saindhava lavana* along with *Raktshodhak* dravyas viz, *Kushtha* & *Patha*. Here the *Bramhi* is used as decoction for trituration in order to mix the powder of all other drugs.

Aims and objective

1. To screen and diagnose depression in the patients of geriatric age group attending the OPD/ IPD of S. S. Hospital IMS, BHU, Varanasi.

2. To study demographic and constitutional profile in the patients of geriatric depression.

3. Clinical evaluation of the therapeutic efficacy of Ayurvedic drug (Saraswata Churna) & Satvawajaya Chikitsa (Ayurvedic Psychotherapy) for their anti-depressant effect and also compare their antidepressant activity clinically with the established modern antidepressant citalopram.

Material and methods

Selection of cases

This was a randomized, control clinical trial approved by institutional ethics committee of Institute Of Medical Sciences, Banaras Hindu University, Varanasi. In the present investigation the patients of Geriatric Depression were recruited from Kayachikitsa and Psychiatry O.P.D./I.P.D., S. S. Hospital, I. M. S. Varanasi. The case selection was random regardless of sex, education, socioeconomic status, and habitat. A written informed consent was taken from each patient.

Inclusion criteria

The elderly patients (e¬ 60 yrs.) who have Geriatric Depression Scale (GDS -30, First Developed In 1982 By J.A. Yesavage And Others) score >11 were included in this study. Patients who fulfilled the DSM-IV-TR diagnostic criteria for depressive disorder were also included in this study.

Exclusion criteria

Patients with following symptoms or having the history of following clinical conditions were excluded

1. Mood incongruent delusions or hallucinations, incoherence or marked loosening of associations.

2. Patients superimposed with schizophrenia, schizophreniform disorders, mania or bipolar disorders or psychotic disorder not otherwise specified.

3. Generalized anxiety disorders, obsessive compulsive disorders.

4. Chronic Drug abuse, e.g.-barbiturates, etc.

5. Toxic abuse like alcohol ingestion and withdrawal.

6. Organic diseases like some diseases of gastrointestinal system (irritable bowel syndrome, colitis), myocardial infarction, neurodegenerative CNS diseases (e.g. Alzheimer's disease), Hypothyroidism & hyperthyroidism and systemic diseases like Rheumatoid arthritis and other connective tissue disorders etc.

The study groups

A total no. of 108 patients were selected for the study, after carefully examining their clinical presentation and fulfilling the inclusion criteria who were registered for this study were randomly allocated into four groups. Among these eighty patients who turned up for complete follow-ups from different groups are as follows -

1. A. The group A (Stv.) consisted of 10 patients who were given Satvavajaya therapy.

2. B. The group B (S.C.) comprised of 30 patients who were put on the trial drug Saraswata churna.

3. C. The group C (Mix) consisted of 20 patients who were put on Saraswata churna along with Satvavajaya therapy.

4. D. The group D (Cit.) consisted of 20 patients who were put on Citalopram *20mg* once a day.

The dose of *Saraswata Churna* used for patients of different groups is 1.5 gm twice daily along with one tea spoon full (5 ml) ghrita & half tea spoon full(2.5 ml) honey, after meals for a total duration of three months. For Satvavajaya therapy the causative problems of the patient were discussed, evaluated and the possible solutions were suggested, with a view to improve their coping and adjustment ability.

The assurance and suggestions related to change into their perceptions and thinking were given. Total therapy was given for 45 min. in each case. The therapy was given to every patient in the beginning of the study and on each follow ups for 45 minutes.

Follow up study

After the initial registration and basal study, all the patients were recruited in respective trial groups. They were advised to come at 15 days interval for the assessment of progress but the follow ups were recorded at one month interval each for three consecutive months. During each visit, patients were interviewed regarding their progress in symptomatology, physical examination, mental status examination, if any or other associated features besides information about compliance of the therapy given.

Parameters for assessment of the drug response

1. Clinical assessment
2. Psychological assessment

Clinical assessment

The symptomatic relief produced by the trial treatment was assessed on initial visit and on successive follow ups at 1month intervals for entire period of therapeutic trial i.e. for three months.

Psychological assessment

Hamilton Depression Rating Scale (HDRS)(Hamilton M ,A 1960) has been used to quantify the psychological parameters. Hamilton depression rating scale is an objective method for clinical assessment of depressive states in patients of depression. Being one of the most reliable scale for measuring level of depression comprising the rating of diverse clinical signs and symptoms of disease, it was used for the

objective assessment of clinical condition in patients of depression in present study. This scale consists of 17 items, each of which is rated 0 to 2 or 0 to 4 with total scoring ranging from 0-50. Score of 7 or less may be considered normal, 8 to 13 mild, 14-18 moderate, 19-22 severe and 23 and above very serious. Rating was done over this scale before treatment and at each follow up and total score was calculated. At the end of the study, the difference was obtained between initial and final score.

Certain basic biochemical and hematological investigations, like total leukocyte count, heamoglobin, serum urea & creatinine, SGPT, SGOT, and fasting blood sugar were measured before and after the trial.

Statistical Analysis

The data collected were transferred on master chart showing various items/variables in columns and subjects in rows. The analysis of data was done using statistical software SPSS version 16.0.To test the significance of mean of difference of paired observations (BT versus AT) paired t test was applied. For intergroup comparison One-way ANOVA (Analysis of Variance) was applied and value of F test was determined. Wherever F test resulted statistically significant, post–hoc test was applied for multiple comparisons, identifying significant pairs of groups.

Observation and results

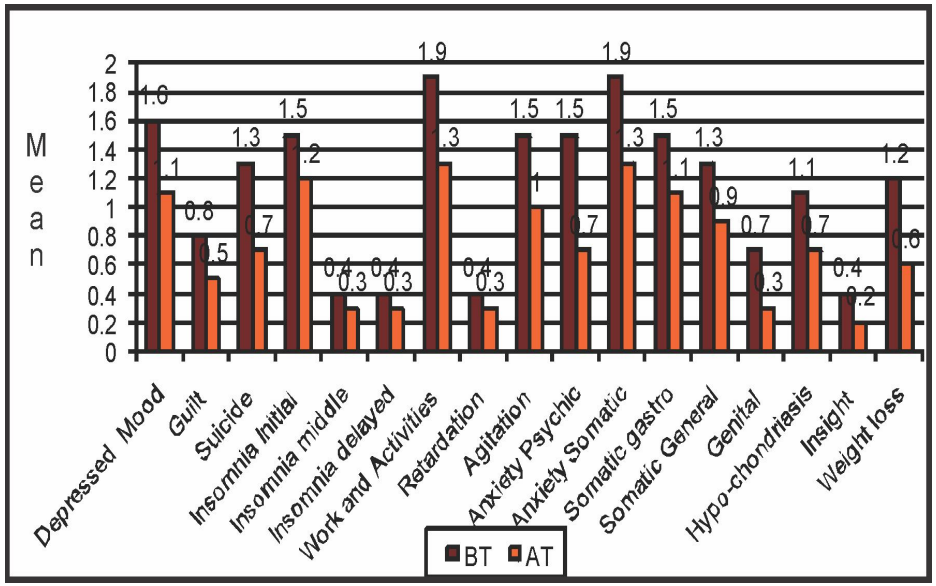
Observations regarding the **Demographic and constitutional profile (age, sex, occupational status, family type, and prakriti) of the 80 patients of geriatric depression are shown in table 1.**

Table.1 Showing Demographic and Constitutional Profile

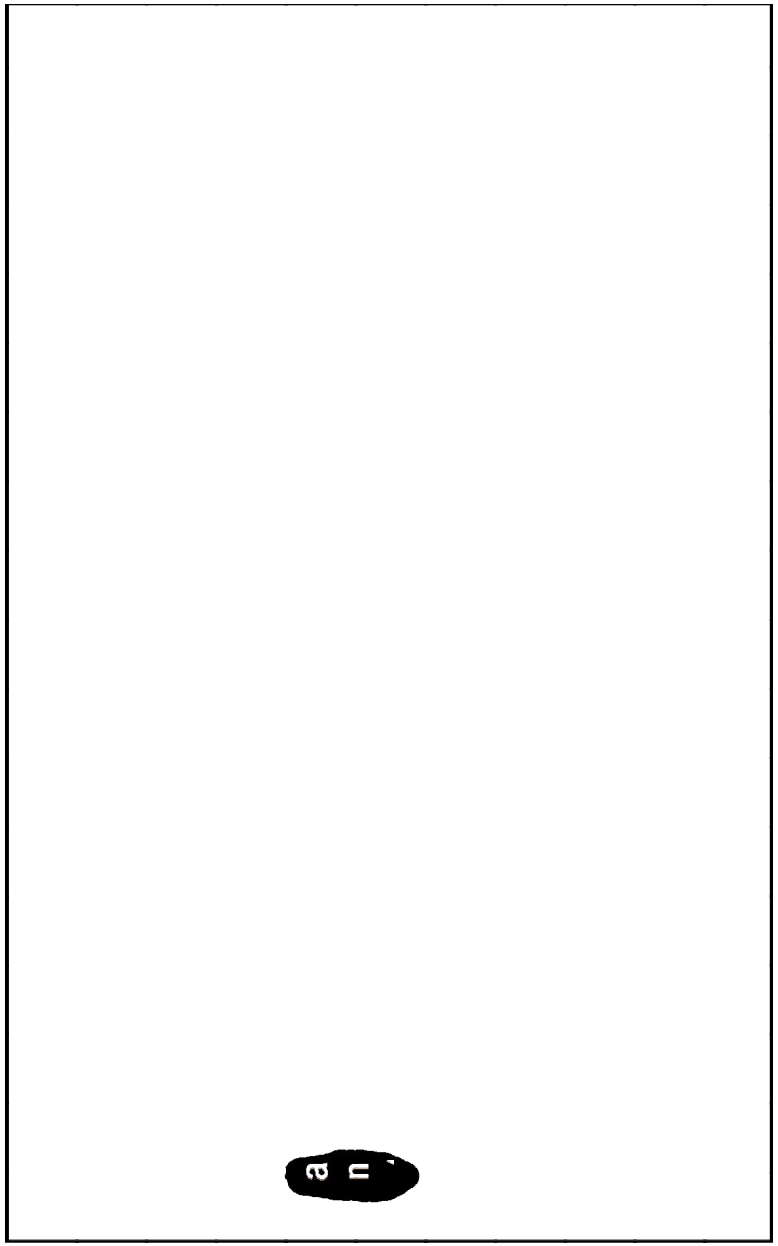
Items	No. of cases	Percentage
1. Age groups (years)		
60-65	**18**	22.50%
66-70	**30**	37.50%
71 – 75	**18**	22.50%
>75	**14**	17.50%
2. Sex		
Male	**59**	**73.75%**
Female	**21**	**26.25%**
3. Occupational status		
House wife	14	17.50%
Farmer	13	16.25%
Business man	16	20.00 %
Retired Service class	37	46.25%
4. Family type		
Joint	33	41.20%
Nuclear	47	58.80%
5. Deha prakriti		
Vata –Kaphaja	28	35.00%
Pitta –Vataja	4	5.00%
Kapha –Vataja	20	25.00%
Pitta –Kaphaja	18	22.50%
Kapha –Paittika	10	12.50%
6. Manas prakriti		
Satvika	0	0.00%
Rajas	38	47.50%
Tamasika	42	52.50%

The response of the therapeutic trial in various trial groups are shown in the graphs 1, 2, 3, and 4 respectively. On intergroup comparison, considering decrease in **total HDRS score**, in different groups there was no significant difference was found in response of treatment between groups B & C (p=.287), B & D (p=.554), and C & D (p=.132) but highly significant difference was found between groups A & B (p<.001), groups A & C(p<.001) and groups A & D (p<.001). On comparing means of these groups before and after treatment, it was found that there was comparatively more decrease in **total HDRS score**, in group C (t=17.098 p= .000, mean difference=13.75) compared to all the other groups (group A-t=12.176 p= <.01, mean difference=6.900; group B- t=17.059 p= <.001, mean difference=12.27; group D- t=15.245 p= <.001, mean difference=11.85).

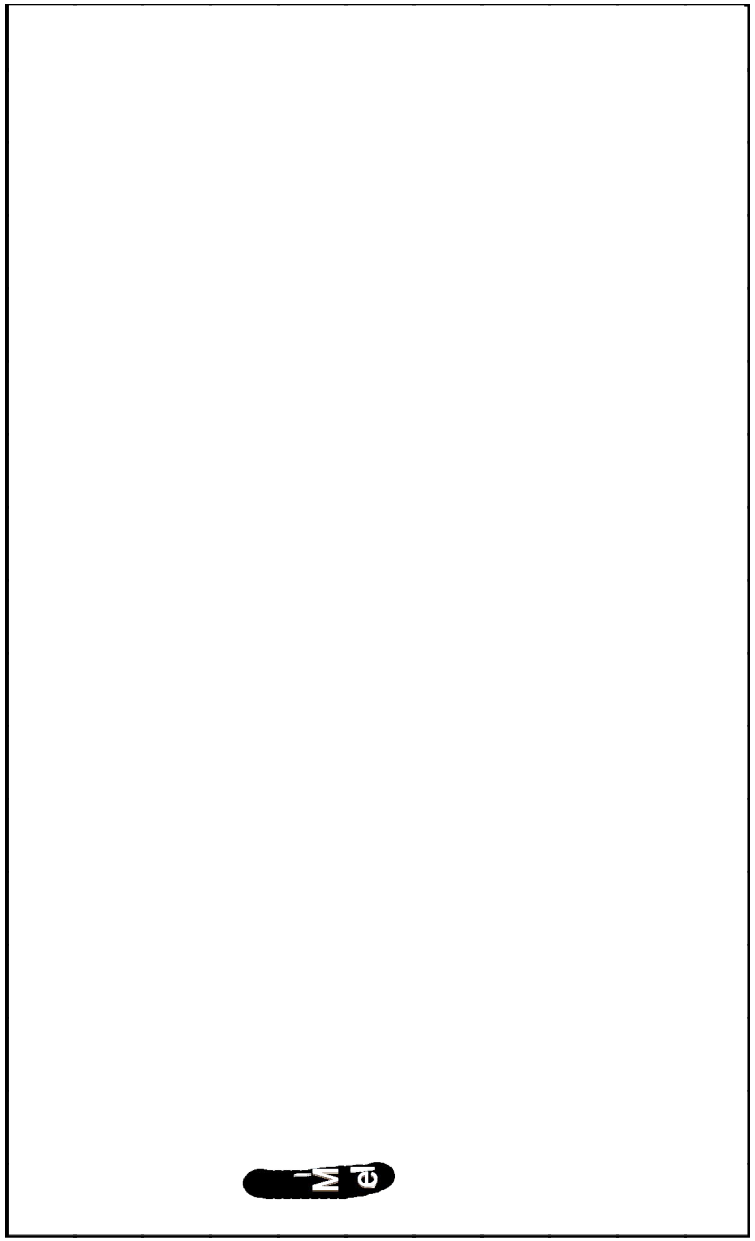
Graph 1: Graph showing effect of therapeutic trial over HDRS score in the patients of Group A



Graph 2 : Graph showing effect of therapeutic trial over HDRS score in the patients of Group B



Graph 3. showing effect of treatment over HDRS score in the patients of Group C



Graph 4. Showing effect of treatment over HDRS score in the patients of Group D

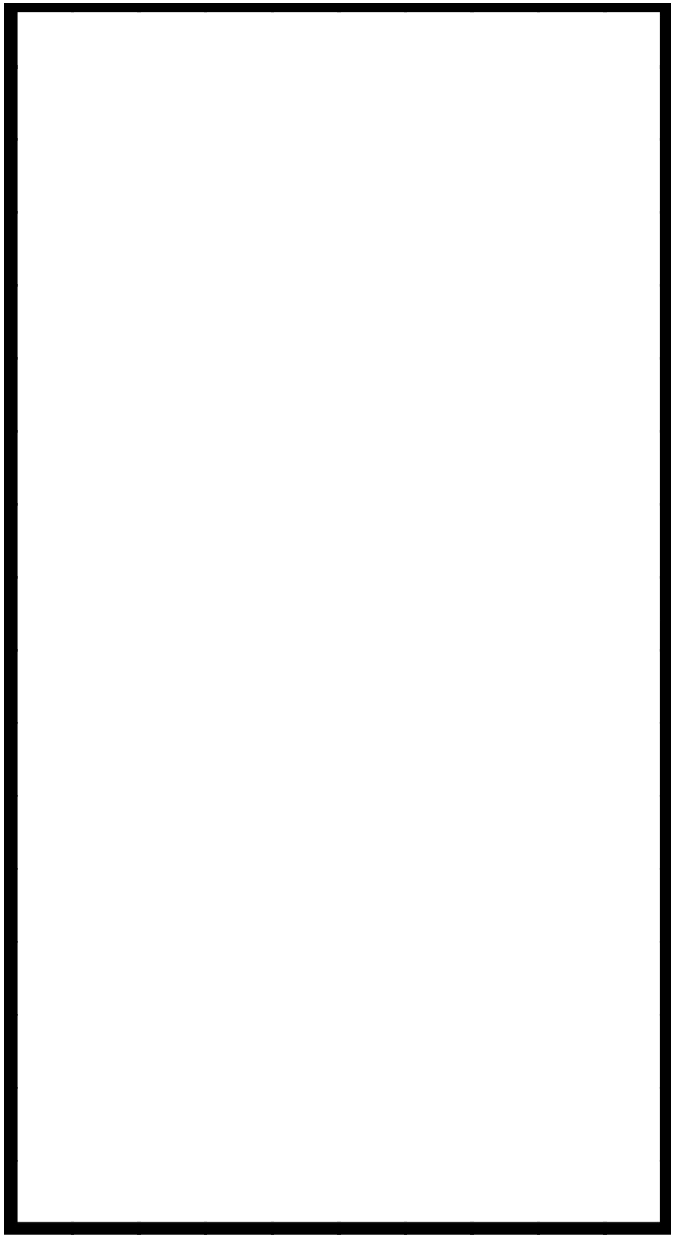


Table 3 : Response of therapeutic trial in terms of changes in total HDRS scores in the 80 cases of *Geriatric Depression*

Item	Groups	Mean±SD BT	Mean ±SD AT	Paired t- valuc	p- valuc	Post HOC Test
HDRS score	A (n – 10)	19.400±2.547	12.500±2.505	12.176	< 0.001	Between groups A&B, A&C and A&C P < 0.01
	B (n = 30)	19.933±6.280	7.666±3.251	17.059	< 0.001	
	C (n = 20)	22.350±5.806	8.600±2.760	17.098	< 0.001	Between B, C, & D - P > 0.05
	D (n = 20)	18.900±6.129	7.150±3.099	15.245	< 0.001	
F/p = (ANOVA)		1.335/.269	7.933/.000(h.s.)			

Certain basic biochemical and hematological investigations, like total leukocyte count, heamoglobin, serum urea & creatinine, SGPT, SGOT, and fasting blood sugar were measured before and after the trial. The observations reveal that there is no any statistically significant change in any of the above parameters (table 4).

Table 4 : Table showing mean changes in the biochemica and heamatological parameters in various trial groups

Parameters	Group A(n=4) Mean		Group B(n=12) Mean		Group C(n=10) Mean		Group D(n=8) Mean	
	BT	AT	BT	AT	BT	AT	BT	AT
TLC(cumm)	7800.50	8000.50	7500.00	7450.00	8400.00	7900.00	7940.00	8000.00
Hb (gm%)	11.50	12.00	11.20	11.40	12.60	13.00	10.90	12.00
E.S.R. (in mm in 1st hour)	10.50	11.00	21.00	18.00	9.00	11.00	13.00	16.00
Sr. urea (mg/dl)	17.60	15.60	23.40	21.00	14.40	15.00	21.40	16.00
Sr. creatinine (mg/dl)	0.60	0.67	0.80	0.80	0.70	0.65	0.85	0.90
SGPT (IU/L)	19.00	18.00	23.00	24.50	21.00	16.00	18.00	26.00
SGOT (IU/L)	14.00	16.00	12.00	12.00	19.00	21.60	16.60	30.00
Blood sugar(f) (mg/dl in non dm patients)	90.50	91.50	104.00	96.00	89.00	86.00	84.00	96.00

Discussion

The study related with incidence of **age and sex** revealed that maximum number of patients were found to be between age group of 65-70 yrs. The sex incidence of the patients showed the predominance of male (73.75%) over females (26.25 %) (59 -males, 21-females). This may be due to the fact that the males have got the dominant social position particularly in this part of the country, so any illness pertaining to them is usually given more priority and the family members bring them to the hospital while the problems related to females are generally avoided and ignored. However Depression is diagnosed about two times more often in women than in men in general population (Sadock et.al 2005). Findings of the present study also reveal that Geriatric Depression is more common in **retired service class** (46.25%). This may be due to loss of employment and other facilities, consequent loss of reputation in society, and the financial crisis. Out of 80 patients 47 (58.8%) are from **nuclear family** i.e. disease is more common in the nuclear type of family. In general, loss of spouse, divorce, poor socioeconomic support & loneliness have been found to be the major risk factors of geriatric depression (Sadock et.al 2005)

The study of the incidence of the ***Deha Prakriti*** revealed that the incidence of geriatric depression was found to be highest in persons with vata- *Kaphaja Prakriti* (35%) followed by *Kapha- Vataja* (25%). Although *Kapha prakriti persons* have *uttam bala (Cha. vi. 8/96) but* in the geriatric age group there is predominance of Vata and kapha is hina (physiologically least) so ultimately the bala of the persons of the kapha prakriti also gets decreased in the elderly stage.

Therapeutic response was objectively assessed with the help of rating on Hamilton Depression Rating Scale (HDRS). In the patients of group A, based on scores of HDRS statistically highly significant

results were found in items of suicide (t=3.674, p< .01), work and activities (t=3.674, p< .01), anxiety psychic(t=4.000, p< .01),, & anxiety somatic(t=3.674, p< .01), while significant changes were noted in, depressed mood(t=3.000, p< .05), agitation (t=3.000, p< .05), somatic gastrointestinal (t=2.449, p< .05), somatic general (t=2.449, p< .05), genital (t=2.449, p< .05) and Hypochondriasis (t=2.449, p< .05).

The patients of this group were given Satvavajaya therapy only which is the best procedure to decrease the level of the *Raja* & *Tama*, & also improve coping and adjustment ability. The assurance and suggestions related to change into their perceptions and thinking helps in the improvement of the emotional symptoms.

Patients of group B demonstrated statistically highly significant changes over HDRS scores in case of depressed mood (t=12.042, p< .01), guilt (t=4.264, p< .01), suicide (t=6.496, p< .01), insomnia initial (t=9.327, p< .01), insomnia middle (t=3.525, p< .01), work interest (t=13.310, p< .01), retardation, (t=3.071, p< .01), agitation (t=6.227, p< .01), anxiety psychic (t=7.761, p< .01), anxiety somatic (t=9.633, p< .01), somatic gastrointestinal (t=7.712, p< .01), somatic general (t=4.785, p< .01), genital (t=4.000, p< .01), and Hypochondriasis (t=4.474, p< .01).

Trial drug, *Saraswata churna with ghrita and honey,* used in this group of patients specially works at four different levels viz, at the level of *Agni*, at the level of *Doshas*, at the level of *Manas* (psyche), & at the level of *Manovaha* srotas (tracts of the Brain) which finally are able to degrade the samprapti (pathogenesis) of *Vriddhawasada* (Geriatric Depression) and responsible for effect obtained. **In the patients of group C** statistically highly significant changes were found in depressed mood (t=10.466, p< .01), guilt (t=4.677, p< .01), suicide

(t=7.255, p< .01), insomnia initial (t=8.718, p< .01), insomnia middle (t=3.199, p< .01), work interest (t=12.568, p< .01), agitation (t=6.850, p< .01), anxiety psychic (t=12.568, p< .01),, anxiety somatic (t=8.718, p< .01), somatic gastrointestinal(t=3.943, p< .01), somatic gastrointestinal (t=4.951, p<.01), somatic general (t=3.684, p< .01), genital (t=3.327, p< .01), weight loss (t=6.658, p=<.01) and Hypochondriasis (t=3.327, p< .01), while significant change was noted in insight(t=2.179, p< .05), over HDRS scores. Here the synergistic effect of *Satvavajaya* therepy and *Saraswata churna* might be responsible for good response,and proving the fact that the *dravyabhoot* (pharmacological) and *adravyabhoot* (nonpharmacological e.g. psychotherapy) both type of therapeutic techniques are necessary to be incorporate for obtaining good result in psychiatric disorders.

In the patients of group D, statistically highly significant changes were found in the areas of depressed mood (t=12.337, p< .01), guilt (t=3.943, p< .01), suicide (t=6.164, p< .01), insomnia initial (t=6.474, p< .01), work interest (t=8.718, p< .01), retardation (t=2.939, p< .01), agitation (t=5.107, p< .01), anxiety (psychic) (t=8.718, p< .01), anxiety (somatic) (t=7.025, p< .01), somatic gastrointestinal (t=5.480, p< .01), somatic general (t=5.339, p< .01) weight loss (t=3.199, p< .01), while significant change was noted in insomnia delayed (t=2.517, p< .05).

For intergroup comparison of results One-way ANOVA (Analysis of Variance) was applied and value of F test was determined. In whatever symptoms/objective item, F test result was found statistically significant, post–hoc test was applied for multiple comparisons among various groups, identifying significant pairs of groups.

On intergroup comparison, considering decrease in **total HDRS score**, in different groups there was no significant difference was

found in response of treatment between groups B & C (p=.287), B & D (p=.554), and C & D (p=.132) but highly significant difference was found between groups A & B (p<.001) , groups A & C(p<.001) and groups A & D (p<.001). On comparing means of these groups before and after treatment, it was found that there was comparatively more decrease in **total HDRS score**, in group C (t=17.098 p= .000, mean difference=13.75) compared to all the other groups (group A-t=12.176 p= .000, mean difference=6.900; group B- t=17.059 p= .000, mean difference=12.27; group D- t=15.245 p= .000, mean difference=11.85).

Saraswata Churna is a unique combination of ayurvedic herbal drugs, containing mainly three category of drugs namely (a) Medhya Rasayana, viz. *Vacha*, *Shankhpushpi*, *Aswagandha*, *Bramhi*, (b) Rasayana that acts at the level of Agni viz, *Pipali*, *Ajmoda*, *Jiraka*, *Mahabhaishajya*, *Maricha*, and (c) drugs that spread the active principles of all other drugs all over the body viz. *Saindhava lavana* along with *Raktshodhak* dravyas viz, *Kushtha* & *Patha*. Here the *Bramhi* is used as decoction for trituration in order to mix the powder of all other drugs. As it is *shita* in *virya, madhura* in *vipaka* and *medhya* in *prabhava,* it potentiates the effect of drug and reduces the *tikshna* property of *Vacha.* Further the anupana ghrita itself have medhya property, also it detoxify the toxic effect of Vacha. Based upon above description the mechanism of action on Geriatric Depression can be proposed as-

1. *Vacha*- it elevate the mood, increase the cognitive ability (Tripathi A.K. et. al. 2011)

2. *Aswagandha* – reduces the stress and anxiety, decreases the neurodegeneration & promotes regeneration (Kuboyama T et al (2005)).

3. *Shankhpushpi* & *Bramhi* – These are best among *Medhya* drugs, so it potentiates the effect of *Vacha*, and *Aswagandha* and ensure the better nourishment of brain tissues. They may also be responsible for promotion of good sleep and decrease in the forgetfulness.

4. *Pippali*, *Ajmoda*, *Jiraka*, *Mahabhaishajya*, & *Maricha* are agnivardhaka dravya,they might be promotes the metabolism by increasing the biofire thereby effecting the improvement in the gastrological symptoms in particular and overall nourishment of body tissues including the *Mastulunga* (Brain) & Hridaya (Heart) etc.

5. Kushtha, and Patha, purify the blood (Rakta shodhan) and pacify tridoshas, thereby improving the other vegetative functions.

Summary and Conclusion:

Based on our findings it may concluded that the combination of Saraswata Churna & Satvavajaya Therapy (group-C) is more effective in the management of Geriatric Depression than either of the two (group A Satvavajaya & group B Saraswata Churna) alone. The combination therapy is slightly more effective than Citalopram alone.

Though several studies have been conducted on the role of *Medhya* drugs in the management of *Chittawasada* (Depressive Disorder) (at various centers of the country but the present study is probably the pioneering work, evaluating the role of the potent medhya drug *Saraswata Churna* specifically in the *Vriddhawasada (Geriatric Depression).* The patients have been selected and evaluated using standard parameters like Geriatric Depression Scale (GDS-30), and Hamilton Depression Rating Scale (HDRS). The role of the *Satvavajaya Chikitsa* in the resolution of psychological, social, and precipitating factors of depression can't be overestimated, especially in the elderly population. Based on the findings, it can be concluded

that the combination of the *Saraswata Churna & Satvavajaya Chikitsa* are the most effective therapy for the management of the geriatric depression without any side effects, instead promoting a greater degree of relief in the symptoms. Thus, the present study has shown potential of its wide application in the management of geriatric depression.

Being a pioneering but preliminary work in this area, it has got certain limitations with regards to number of sample population included. Thus there is a need of more elaborate and extensive studies in this important area of *Psycho Geriatrics*. Nevertheless it can be concluded that, it has provided the strong platform for the further studies in this area and has definitely opened newer avenues in the field of *Ayurvedic* psycho-geriatrics.

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NATIONAL CONSULTATION ON EMPOWERMENT OF OLDER WOMEN

WITH FOCUS ON HEALTH AND WELLBEING

(Held at Thiruvananthapuram on March 21 – 23, 2011)

P.K.B. Nayar*

CONCLUSIONS AND RECOMMENDATIONS

The Context

Ever since population aging became an issue to be concerned with, UN has been impressing upon member countries that though stemming from the same base, the issues faced by older men and older women are different and have to be approached from different perspectives instead of viewing aging as a common phenomenon among both sexes and attempting at a common approach towards it. UN further held that in formulating aging policies, women's issues and concerns should receive priority. Thus, at the First World Assembly on Aging (1982) itself, UN declared "The situation of older women everywhere must be a priority for policy action. Recognizing the differential impact of ageing on women and men is integral to ensuring full equality between women and men and to the development of effective and efficient measures to address the issue. It is therefore crucial to ensure the integration of a gender perspective into all policies, programmes and legislation." This appeal for gender perspective on aging problems was continued by UN in all it later meetings.

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The Convention for Eradication of Discrimination Against Women (CEDAW) in 2002 endorsed this recommendation of the UN and further declared that "Both men and women face discrimination due to old age but women experience ageing differently. Gender relations structure the entire life cycle from birth to old age, influencing access to resources and opportunities and shaping life choices at every stage. Good health, economic security and adequate housing are essential requirements of aging with dignity. But older women in both developed and developing countries face difficulties in accessing these on a basis of equality with men." The GOI even though a member of the CEDAW Convention as well as the earlier UN Declarations on Aging has not been able do much to conform to the UN or CEDAW resolutions. This is clear from India's Country Report on CEDAW (2002) and also the 2nd NGO Shadow Report on CEDAW (2006). To be sure, India's National Policy on Older Persons (NPOP 1999) has failed to appreciate this reality fully.

Taking these points into account, the Centre for Gerontological Studies (CGS), organized in Thiruvananthapuram on March 21-23, 2011, a National Consultation on Empowerment of Older Women with Focus on Health and Wellbeing (two major areas identified by both UN and CEDAW for ageing with dignity). The Consultation was partly funded by the United Nations Population Fund (UNFPA), National Human Rights Commission (NHRC) and Indian Council of Medical Research (ICMR). It was attended by over a hundred delegates from all over India and included, *inter alia*, 3 out of 5 members of the Review Committee on the National Policy on Older Persons (NPOP), 8 out of 13 members of the Core Group on Protection and Welfare of the Elderly Persons of the National Human Rights Commission (NHRC), leading gerontologists and geriatricians, academicians, administrators, women activists and office bearers of India's largest

federation of older persons. There were one Symposium, one Panel Discussion, one Round Table, and one Brainstorming Session, besides 4 Technical Sessions, 3 Group Meetings and the Inaugural and Concluding Sessions. The Consultation was organized and coordinated by Prof. (Dr.) P.K.B. Nayar, Chairman of CGS.

The following conclusions and recommendations emerged from these meetings. Though a large number of suggestions came from the delegates, many of them were either for both sexes or not so basic to the problems of older women. Only suggestions that are of critical importance to the independence, participation, care, self-fulfillment and dignity of older women (vide UN Principles of Older Persons 1991) are listed below as the theme of the Consultation was "Empowerment of Older Women" which connotes all these five UN Principles.

CONCLUSIONS AND RECOMMENDATIONS

(1) Government of India should recognize that

Older women's issues should not be treated on a par with those of older men or as issues impacting on both sexes alike. There should be adequate and appropriate appreciation that older women's problems, needs, contexts and concerns are considerably different from those of their male counterparts and as such they require special attention. There should be gender sensitive programmes in aging policies and if necessary a ***Sub Plan for Older Women*** may be formulated and integrated into the national policy on senior citizens

The Unique Role of the Family

The family should be considered as the best and basic support for older women. In fact the UN advocacy for *aging in place* goes more appropriately for women than for men. An older woman spends most of her time within the four walls of the family not only because of

reasons of health and mobility but also because of cultural reasons. In fact an older woman has no culturally defined functional role to play in society except taking care of children and/or helping in household chores. But these are possible only when she is minimally healthy. However, most old women lose their functional capacities and consequently lose their productivity especially in advanced years. The 60th Round of the National Sample Survey (Statement 51) found that while only 67 out of 1000 old men were immobilized at home ("persons who cannot move or are confined to bed or home") 94 women out 1000 were so immobilized and the difference was several times more at 80 and above age. Since women live longer than men, they carry this burden of morbidity for longer periods. Also, while only 320 men out of 1000 persons were fully dependent on the family for their living, the number of women was 720. (NSS 60th Round Statement 48). Again, the agony of this total dependence is longer for women than for men. Economic dependence and a prolonged period of life in morbidity and inability to contribute due to ill health, without commensurate contribution to the family would take away an old woman's self-respect and feeling of self-worth and would make her unwelcome and unacceptable to even the most considerate and loving family. In turn, this would result in at best toleration or indifference towards a necessary evil and at worst abuse and violence on them and possible abandonment. Any solution to this plight should aim at giving old women a feeling of self worth and dignity and making them acceptable to the family.

This could be achieved, *inter alia,* by lessening the financial burden to the family on her account (economic security) and minimizing the burden of health-care on her by appropriate health service intervention (Health security).

Economic security

(2) All old women irrespective of their economic status should be given a minimum pension and the amount of this pension should be 20% more than that for men and staggered according to age, i.e., 20% increase after 70 years, 50% increase after 80 years and double after 100 years. (The increase is warranted by the increased expenses for the old woman on account of extra physical and medical needs). The minimum pension thus given should be adequate for meeting the reasonable expenses of the old woman, including health care expenses. This pension should be uniform in all states and the burden of payment should be shared between the Centre and the States on agreed upon proportions. Necessary provision may be made through the Statutory Finance Commission or otherwise for raising the required funds. States are free to provide more than the minimum pension.

(3) The procedure prevailing in some States (e.g. Kerala), of giving Old Age Pension to only one member in the family (usually the male member) should be stopped and all members of a family who are 60 plus should be made eligible to receive OAP.

(4) A woman should have right to 50% of the family income/property earned by the husband and wife together after marriage and on separation/divorce or death of husband the wife should be additionally eligible for 50% of the personal wealth of the husband irrespective of any will that he would have made to the contrary. A Uniform civil code may be enacted for this purpose.

(5) A family that has to hire the services of a home nurse for the old kin either for reasons of proven invalidity or dementia should be given a supplementary allowance.

(6) All old BPL women and all old widows and those old staying alone or with spouse only should be given free ration from the PDS system.

(7) A BPL family maintaining an old (or olds) should be given appropriate quantity of free ration from the Public Distribution System (PDS). Similarly placed APL families should be given ration at heavily subsidized rates.

(8) All old women from BPL families should be given one full and balanced meal a day through the ICDS system or a system created for this purpose. This is not only to alleviate their hunger but also to assure minimal nutritive food for them.

(9) All 80 plus women irrespective of their income status should be exempted from income tax payment.

(10) Irrespective of income status, all 80 plus women should be given free passes in the Railways and public transport system. Where warranted, an attendant on such women also should be given free pass when visiting hospitals and other service providing agencies

(11) A scheme similar (or parallel to) the prevailing Women's Self Help Groups may be started for those old women who need/are willing to work . This will achieve 3 purposes: (1) a feeling of self worth and productive ageing, (2) power and dignity, and (3) freedom from monotony of being secluded at home. Govt. should not only sponsor and supervise the system but should also provide necessary financial support and/or bank guarantee towards capital. Neighborhood Club (see below) could do a lot to promote the scheme.

(12) A website may be created from where details of jobs available to older women could be collected and may be available to the old women who have access to internet facility. Such jobs that could be done at home or that are convenient to them could be taken up by

those who so desire, This will keep some of the APL women to be employed in meaningful and productive jobs.

(13) For those who are confined to their homes either due to immobility, morbidity or other reasons, and are in bad shape, there should be some monitoring mechanism to ensure their wellbeing. The ***neighborhood club*** (mentioned below) will be a good agency to do this. Members of the club could visit them, ensure their welfare and help mitigate their sufferings. If the lady is abused or neglected, these members could use their influence on the kin to behave properly. Their visits will be a threat and warning to the delinquent kin to correct themselves. These visits will also provide a social bond and give a feeling of companionship with age-mates to the immobile women who would be otherwise isolated.

(14) There should be ***Neighborhood Clubs/Elders' Forums*** (different from the conventional Senior Citizens' Associations or Forums/Pensioners' Associations and the like) consisting of all senior citizens (Men and women) in a ward or convenient geographical space. This Club/Forum will address the problems and concerns of old women residing in that area on a priority basis and will act vigil on all matters concerning older persons with focus on older women. These include cases of abuse, complaints relating to pension, issues under the MWPSC Act and all disputes or issues involving older persons, especially older women. It will screen the applications for old age pension and all other applications and complaints from the old women on a priority basis and ensure that they get redress promptly. It will also check for abuses and neglect suffered by women in the four walls of the house and provides prompt remedy by way of counseling the parties concerned and seeking redress and by invoking the law where necessary. Members of the Club/Forum will routinely and periodically visit the homes of the immobile.

Members and help them and their family members in keeping the invalid old woman in as good a condition as possible. The Club/Forum could liaise with the Gram Panchayat and Social Welfare and Health Departments in facilitating its work to promote the interests of elderly women.

Shelter for the abandoned

(15) In many cities in India, destitute women and those with mental problem are left to wander in the streets begging for food and being in utter neglect and abandonment. These women should be identified and placed in shelter homes or old age homes. The role of old age homes is quite relevant to them as they cannot get care from any other place. Some of them may not be acceptable in an old age home because of some mental problem and they should be accommodated in a neighborhood geriatric home.

Health Security

One of the major reasons that make the presence of the old in the family unwelcome is his/her health condition. If the old kin is immobilized for life, requires a bystander all the time and huge expenditure on medicine the family in most cases would not be comfortable with him/her. This will be more so if the kin happens to be an old woman who, as mentioned earlier, suffers heavy marginalization, especially in health care. Hence great attention has to be devoted to the health of the old woman to make her acceptable in the family.

(16) There should be free universal health insurance for all the old and the coverage for health should be comprehensive. This coverage should be 50% more for women because they additionally suffer from many gender-related illnesses All financial transactions relating to health care claims by hospitals should be settled between the

concerned hospital and the government/insurance company and the patient should not be burdened with any financial aspect. The health insurance programme should be flexible. There should be minimum but comprehensive health coverage for all sections of the old. Those who can afford to have additional/wider coverage in terms of money could pay a premium accordingly. In such cases, the amount should be very much lower than that charged by commercial insurance companies.

(17) Geriatric Mobile Medicare Units should be attached to all Taluk Hospitals and the staff in them should visit the homes of immobile women on a continuing basis and check the progress of their morbidity condition. They should also provide referral facility to these patients and help them and their kin to get prompt, affordable services from the referred health care Unit.

(18) In hospitals with geriatric wards, a certain number of beds should be ear-marked for old women.

(19) Under the auspices of the Neighborhood Club or Multi Service Community Age Care Centre (MSCACC, please see below) every 80+ ambulatory woman should be assessed by a family member or a health worker in her own home twice a year to detect any physical, mental or socio-psychological morbidity concerning her mobility, vision, hearing, memory, depression, nutrition, social support, home environment and activities of daily living by using a simple and quick to perform screening procedure. Where applicable, help from the geriatric mobile medical care (GMMU) can be taken. They may then be classified into those who are quite healthy, those who are frail and suffer from chronic disease, those who are in terminal stage of illness and those who are bedridden and need special home care. Any impairment detected is to be reported to authorities concerned for timely intervention and medical referral if required.

(20) All old women who are immobile or have other handicaps that limit their activity and that could be corrected by appliances should be supplied with free traditional devices such as walkers, wheel chairs, hearing aids etc and the more recent devices like for urinary incontinence, dementia, immobility etc. The MSCACC could negotiate with the Department of Science and Technology, Government of India for supply of this equipment at competitive rates for free distribution.

The recently introduced National Programme for the Health Care of the Elderly (NPHCE) is a good beginning in the health care of older persons but in terms of both structure and personnel, it is weak and gives out signs that many of its promises would not be fulfilled in the planned manner or in targeted time. It offers very little to the geriatrics-hungry medical profession. It does not seem to offer immediately deliverable geriatric services. Its grassroots level operation is marred by several factors, (a) it is being introduced in only 100 districts to begin with and as such will remain remote to the vast majority of the old for quite some time, (b) Even in the selected areas, it provides only very small amounts of funds for PHCs and Sub Centres and that too for capacity building. (c) Work relating to geriatric care is entrusted to ANMs and ASHAs who are already overburdened with heavy loads. (d) Each of the 8 Regional Geriatric Centres (RGCs) has to take care of a large area which extends to other states as well and at least in the beginning, RGCs could work only as model centres with limited scope in terms of attending on geriatric patients. As such this programme does not promise any large-scale solution to the rapidly increasing number of geriatric patients.

In spite of all these, it is welcome because the MH&FW has been seized with the geriatric problem of the country and hopefully will widen its net in the years to come. Hence

(21) The NPHCE should be expanded in terms of scope, structure and personnel and extended to other districts in a speedy and time-bound manner. Nutrition of the elderly is a much ignored and neglected field. World Bank calculates that 20% of the whole Indian population is under-nourished. Old women, especially widows are the worst sufferers among this lot both because of poverty and culture.

(22) Education through Mass media, Neighborhood Clubs and Primary Health Centres for all categories and free nutritious noon meal for the BPL women with special focus on widows (already mentioned, Sec. 8) are some of the suggestions made in this respect.

Old Age Homes

Currently most of the old age homes are not inmates-friendly. This affects women inmates more than men as men could fight with the management for their requirements whereas women will meekly submit to all privations.

To begin with, most old age homes do not cater to the special needs and requirements of their women inmates, notwithstanding the fact that most of the care givers are women. In destitute homes there is no geriatric care and women inmates, because they live longer and are victims of chronic disease, have to suffer all their sick conditions stoically and be satisfied with whatever marginal care they can get from the OAH. It may not be feasible to provide facilities for full geriatric care in each old age home, even in “women only” homes. The only solution to this phenomenon for the old women, especially in advanced ages, whose sickness will be chronic, and prolonged and treatment costly, is to have more geriatric homes in future instead of general old age homes. Because of the huge cost of opening and running them, charitable agencies may not come out in a big way and only government, including local self governments, could open and operate them.

(23) There should be a Geriatric Home in every district with a progressive policy of a Geriatric Home in every Taluk or Block. In all categories of such homes, 50% of the beds should be earmarked for women.

(24) There should be long term care institutions for old women with chronic or terminal illnesses, those without family support and those requiring lifelong hospitalization for chronic illnesses.

(25) Old age homes should concentrate also on nursing care to inmates, especially to women inmates and this should be supplemented by basic medicines for chronic diseases.

(26) There should be periodical (once in 6 months) health checkup of inmates of OAHs and those found in need of medical attention should be so provided.

The Legal System and older women

Even though there are a number of laws for the protecting of the rights of older persons, these laws are not women-friendly and when it comes to the case of older women, this is more so. Most old women are ignorant of the laws protecting their rights and even those who know them seldom go to the court of law to get relief. Reasons are many. Patriarchic bias of those handling the law, old woman's hesitation to haul an earring son or daughter to the court or the Police Station at the fag end of her life, with no certainty about the outcome and the long-drawn-out procedure involved in litigation – these and many others are minus factors in women going for legal remedies. The poor response to the MWPSC Act, where it has been implemented, is a case in point.

(27) The Neighborhood Club will be able to help needy old women to get the better part of the law without having recourse to legal

procedures through counseling and other means. Wherever needed, the Neighborhood Club can call for the assistance of the Community Police or the Multi Service Community Age Care Centre for assistance.

Panchayat System

The Gram Panchayat has to play a crucial role in the care of older women. It can sponsor Seniors' (Neighborhood) Clubs, Geriatric Care Homes, Geriatric Multi Service Centres and a host of other programmes giving focus to older women in their area. The Ward Member of the Panchayat can activate the community of senior citizens as part of his/her "meet the electorate" programme and in that process identify the problems of older women, especially those in the 80 Plus age who are mostly invisible, non vocal, secluded and deprived on all accounts – care, health care, family and social integration and other basic elements that contribute to dignity and feeling

of self-worth. He/she could associate with agencies and individuals engaged in care of the elderly in the area. Here, since the programme is more general rather than women- oriented, no specific suggestion is made except to have some gender focus in all activities.

Community support

Community level support is required in changing the mindset of people on:

(1) Ageism, especially about old women, widows, especially old widows,

(2) In reacting to abuse and crime against women, especially old women,

(3) In matters involving women's rights, especially on husband's property when diseased or separated,

(4) On matters relating to dignity of old woman,

(5) On attitude about old woman's ailments as natural and due to aging, not requiring serious medical attention.

To a great extent, these could be addressed by a Community-Centered Elder-Care Service Agency which can take up all issues – individual and collective - involving the old, especially old women. Many problems and

needs of old women are concealed under social taboos which do not allow them to be brought out to public attention. E.g., wife's claim for fair share of husband's property at the time of divorce or death, kin's obligation to maintain a chronically ill mother, subtle but agonizing domestic abuses on the older kin, especially property-based etc. As a result, in many cases, they are denied a fair enjoyment of justice as patriarchal agencies handling the law do not give adequate and appropriate weight to their side of the law.

The public attitude on most such issues is still patriarchal and consequently their reaction to such issues when relating to women is at best mild if not indifferent and at worst neutral if not hostile. A positive social attitude coupled with a favorable mindset could not only minimize their severity but, in the long run, eradicate such evils from society.

(28) It was suggested that a Multi Service Community Age Care Centre (MSCACC) at the Gram Panchayat level with lower and higher level offices forming vertical as well as horizontal chains would go a long way to overcome many handicaps that are special to older women. While such agency will work across gender, its capacity to focus on and take up older women's issues will be paramount. It can act vigil on most issues of exploitation of older women whether at the domestic or at the community level, it can visit old age homes, it can

oversee pension allottees, it can support and supplement mobile medical vans and help the staff there in better serving the needy client. Finally, it can sponsor and assist neighborhood clubs which will supplement its work at the grassroots level.

(29) The vast potential of the youth of the country especially the adolescents have to be tapped in the service of elderly women. In fact, their services are available to these women if they (the youth) are on the one hand given proper counsel and on the other a forum to serve the old. The methodology used by *Helpage India* in mobilizing school children could be adopted *mutatis mutandis* for this purpose. Bringing the adolescents into the cause of older women will effect at least two things – a good bond between generations and a dedicated core of volunteers. Perhaps the Neighborhood Club and the Multi Service Age Care Centre may evolve a common strategy to this end.

Oldest Old Women (80+)

Perhaps no single major group among the old suffers so much and for so long as the 80 plus women. As per NSS 80th Round (Statement 51), 325 out of 1000 eighty-plus women are totally immobile (those who cannot move and are confined to bed or home) and all of them are totally dependent on their kin for their survival. Even those who have property/wealth are at the mercy of the kin care givers. A large number are paralyzed and some are no better than vegetables, most do not have any caregiver worth the name. Their lot is not known to most people outside of their homes. For them and

for their relatives, there is only one thing to look forward to and that is death – agonizing, undignified and unmourned death. They are the most despised and deprived segment of the old and their misery is prolonged by their expanded life span and extended period of widowhood with all that it implies in a patriarchal society. None of the

much applauded “UN Principles of Older Persons” - independence, participation, care, self fulfillment and dignity - is applicable to them.

The delegates discussed their lot at length but could not arrive at any feasible solution. However, they felt that

(30) In addition to the several measures such as Increased rate of pension, free ration under PDS, tax relief and other measures mentioned under the different sections earlier, home services by the mobile geriatric medical unit was suggested as a partial relief, visits by the members of the neighborhood club and help and counseling to the concerned families by them was another. A full-fledged terminal care/palliative care/geriatric care centre in every Block Panchayat seems to be another satisfactory solution. *The crux of the problem is how to make the oldest old women — possibly with some impairment or handicap – acceptable to the family and what measures are warranted to relieve the family of a major part of its burden in looking after the old.* In view of the fact that the number of such old women will be increasing over the years it is necessary that government and NGOs think and act in such terms in a serious manner.

Data on older women

(31) The NSSO should conduct surveys on *Morbidity, Health Care and Health of the Aged* every five years. Currently this is being done every 10 years and heath of the aged forms only a small part of the exercise. In view of the fact that aging is going to occupy the centre stage in vital statistics, the statistics on health of the aged should contain more information like type of morbidity, pattern of treatment behavior, expenditure on treatment, agency approached for treatment, amount spent (also as a proportion of the annual family income) etc. This should be done age wise and gender wise.

General

(32) When the **National and States Commissions on Ageing**/ Senior Citizens are constituted, 50% of their Members should be older Women.

(33) When the **National Council on Senior Citizens** is constituted, 50% of the members should be older women.

(34) In the **National Institute on Aging** (as also State Institutes on Aging), there should be a major wing to study older women’s issues.

(35) In **all sub-committees on aging issues**, starting from the level of Parliament to the level of Gram Panchayat, **33% members should be women.**

(36) It will be desirable to have 50% of the **Tribunal officials** appointed in a State under the Maintenance and Welfare of Parents and Senior Citizens (MWPSC) Act 2007 to be women. Where there are two members in a Tribunal, one of them **should be a woman**.

(37) When a **Ministry/**full-fledged Department of Senior Citizens is set up at the Centre, one of the **top positions should be held by a woman.**

(38) There should be a mechanism for monitoring and evaluation of schemes intended for the wellbeing of older women. This could be located as a cell/unit within the National/State Commission for Older Persons. It could also act as watchdogs on all issues that are faced by older women. In view of the fact that women outnumber men among the old and their problems are different from those of old men, the functioning of this cell within the Commission is quite relevant.