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Social Integration and Psychological Well-being of Elderly Women in India: A Comparative Study of Elder Women at Homes and in Elder Care Facilities

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Abstract

In the present study, we examined the critical role of institutionalization of elder women on the social relationships, social integration and psychological well-being. A total of 194 elderly women were selected from Kannur district (Kerala) using multistage cluster sampling. Hundred and one participants were from homes and ninety three participants were from institutional care facilities. The data analyses were performed by using descriptive statistics, chi-square test for association, t' test for independent samples and stepwise logistic regression analysis. The results revealed that the unmarried, widowed and separated elder women were more likely to be institutionalized than married elder women. Former employment, being economically active, religion and place of residence were significantly associated with institutionalization of the elder women. Objective social integration was higher among the institutionalized elderly women while subjective social integration was higher among elderly women living at homes. The elder women at homes enjoyed better family group support, better social support and more social contacts than those who were institutionalized. But the primary group concern, perceived ill health and inadequate mental mastery were higher among elder women at homes than the institutionalized. The step wise logistic regression analysis revealed that; age, marital status and perceived ill health significantly explained 58% (R^2=0.581) of the variance on social integration. The caste affiliation and conflicts in social relationships accounted for 62.7% (R^2=0.627) of the variance on psychological well-being. The study concluded that the socio-demographic variables, especially elder women's residence have significant influence on social integration and psychological well-being.

Keywords: Elder women, social relationships, social integration, psychological well-being

India accommodates about 76 million elderly persons above 60 years as per the Census 2001. It was a three times increase within four decades since 1961 (Rajan, 2006). The proportion of elder population growth among general population increased from 5.6% in 1961 to 7.5% in 2001. The current growth rate of elderly in India was higher than 2% of the growth rate of general population. Kerala had the highest proportion of elderly (i.e., 10.5%) to general population among the other states and union territories in India. About 75% of the elders above the age of 60 years were living in rural areas. The statistical projections showed an increase in the elderly population aged 60 years and above from 76 million in 2006 to 176 million in 2031. Moreover, the oldest people (80 years and above) in India was expected to grow from 8 million in 2001 to 32 million in 2051, which would be a faster growth than any other age group (Rajan, 2006).

Aging was associated with disabilities and social vulnerabilities on an alarming rate, including increasing institutionalization of elderly individuals. This scenario raised serious concerns and challenges to ensure quality of life and well-being of elder citizens. Evidence suggested that the critical components of successful ageing were social engagement, social connectedness, social networks and social integration (Cornwell *et al.,* 2008). Though many of these construct were likely to interact closely and overlapped each other, they had critical predictor properties on psychological, emotional, social well-being and better cognitive functioning (Moen, *et al.,* 1989; Cornwell, *et al.,* 2008; and Krueger *et al.,* 2009).

From the role enhancement perspective, the present study conceptualized that the elderly individuals improved their physical and emotional health and well-being as they were engaged in complex social roles. It also created multifaceted identities that people could relay for psychological and social support (Barnett and Hyde 2001; Chrouser and Ryff 2006; Moen *et al.,* 1989; and Wethington et al. 2000). This in turn positively influenced psychological well-being. Tanaka and Johnson (2010) reviewed the studies from the United States which lend more evidence to the role enhancement perspective of social integration. They detailed that earlier measurement of social integration was guided by six possible social roles that a woman occupied such as worker, Church member, friends, neighbors, relative and club or organization member outside the family. The measurement assumed that larger the count in social roles, higher the chance of participants' survival till the second wave of the study (see Moen *et al.,* 1989). However, the analysis revealed that having membership in club/organization was the only social role that increased odds of survival to wave two. The study inferred that other five social roles might create stress that reduced the enhancement of physical health, thus concluded that membership in organization increased likelihood of survival (Moen *et al.,* 1989; cited by Tanaka and Johnson, 2010). In addition, Tanaka and Johnson (2010) studied

the role of gender and rural residence on social integration of Japanese elderly individuals by analyzing two waves (1999 and 2001) of the Nihon University Japanese longitudinal study of aging (NUJLSOA). The study found that older Japanese men had lower risk to depressive symptoms than older women. Further, rural elderly had higher risk on disability in the areas of activities of daily living and instrumental activities of daily living than their urban counterpart.

In India, deficits or problems accumulation in socioeconomic and familial aspects of elderly life reduced life satisfaction and increased life alienation, especially for those who were in institutional care (Rao, 2010; and Mehrotra and Batish, 2009; Vaswani, 2001; and Prakesh, 2001). The critical concern of elderly was the lack of sustained financial support that restricted them to meet their basic needs, which often forced them to work even after 70 years of age. Elders from lower socio-economic status were faced with severe economic problems that often deprived from accessing medical services even during health emergencies (Vaswani, 2001; and Prakesh, 2001). Further, the elderly men of middle income background were faced with critical financial concerns (Soneja, 2001) while elders from higher economic background were found to be faced with severe economic exploitation by family members, relatives and others, by using fraudulent and sometimes physical and emotional means to acquire elders' wealth (Veedon, 2001). Elderly women who live alone become the subjects of exploitation by plumbers, painters and small contractors who intimidate them and extract money through unjustified means (Veedon, 2001). Further, studies revealed that 30-31 percent of men aged in both rural and urban areas of India were dependent on others (Rao, 1995; and Mehrotra and Batish, 2009).

Childlessness, strained intergenerational relationships and inadequate financial support were critical in determining institutionalization of elderly individuals. They reported inadequate social support, restricted social networks, increased social isolation and reduced life satisfaction (Kalavar, and Duvvuru, 2008; Shanmuganandan, 1997; and Thomas and Nagaraju, 2012). Besides, in Indian socio-cultural context, institutionalization was viewed as a mark of shame on family due to its vulnerability or apathy to deliver the required care to its elder members (Thomas and Nagaraju, 2012; and Kalavar, and Duvvuru, 2008). The socio-cultural values and practices further defamed institutionalizing elderly individuals. The Indian society at large viewed that default by families to render the socially suggested and expected care to its ageing members as the critical moral decay of the respective families (Thomas and Nagaraju, 2012; and Kalavar, and Duvvuru, 2008). Thus, institutionalization of the aged created a feeling of alienation from their family members, friends and society. It also affected elderly inmates' lives' satisfaction both positively and negatively (Thomas and Nagaraju, 2012).

However, there was a paucity of comparative evidence on how institutionalization of elderly influences social integration and the resultant psychological well-being. Thus, it was imperative to examine the role of institutionalization on social integration and consequent psychological well-being in the world aging demographic context, especially in developing countries including India where the state funded welfare services and schemes were extremely restricted (Thomas and Nagaraju, 2012; and Kalavar and Duvvuru, 2008).

In the context of elders' socio-economic and psychological aspects of elders' marginalization in social institutions including families, it was important to understand how later life experience influenced elders' sense of social integration, social relationships and psychological well-being. It was also important to understand how the elders' own views and societal views on institutionalization in later life influenced the elder persons' social integration, social relationships and psychological well-being.

There was a paucity of evidence on how institutionalization of elderly influences social integration and resultant psychological well-being. Thus, it was imperative to examine the role of institutionalization on social integration and the consequent psychological well-being in the world aging demographic context, especially in India, where the state funded welfare services and schemes were limited. Further, though elders in India continues to enjoy better social capital regulated by familial and socio-cultural values and ties, the pressing social forces such as migration, urbanization, changes in family structure, changes in the traditional roles of women as caregiver family members including elderly pose newer challenges to the care of elderly persons (Thomas and Nagaraju, 2012; Vaswani, 2001; and Prakesh, 2003).

In addition, developing a systematic evidence base on these areas was expected to help in deconstructing the negativist images and stereotypes about institutionalization in the context of changing familial and societal structure of Indian society. Systematic evidence base was further expected to assist helping professionals to arrive at evidence based decisions on psychosocial interventions aiming at improving psychological and social well-being of institutionalized elderly. The present study therefore hypothesized that, 'there was a significant difference on the level of social integration between elderly women living at homes and in institutional care facilities'. Further, it was hypothesized that 'there was a significant difference on psychological well-being experienced by elder women living at homes and institutional care facilities'. Finally, the study examined the socio-demographic predictors of social integration and psychological well-being.

Methods

A cross sectional study was conducted to examine the difference of social integration, social relationships and psychological well-being experienced by the elder women at homes and in elder care facilities in Kannur district of Kerala (South India). Peravoor was a developmental administrative block that consisted of seven local self-governing bodies (i.e., Panchayats). Since the Centre for Social Work Research and Practice Organization (a professional social work organization) works in this geographic area, we selected this development block as the universe of the study. There were three registered social care homes for elderly people from where all elder women who met our inclusion criteria were selected. It constituted a sample size of 93 institutionalized elderly women.

Whereas multi-stage sampling procedure was used to select home dwelling elderly women following a sampling procedure as detailed. Firstly, three village Panchayats (local self-governing bodies) were randomly selected from the list of local self-governing bodies (Panchayats) in Peravoor block. Secondly, thirty wards (lowest administrative divisions of village Panchayat) were listed out from each Panchayat. Thirdly, four wards from each Panchayat were randomly selected. A sampling frame was developed with the help of local volunteers, which listed out all elder women above 60 years of age from the selected wards. Finally, 8-10 elder women were selected by using systematic random sampling (every 10th households with an elder women above the age of 60 years), ensuring about 30% of representation of the population. Thus, the final sample size of the women living at homes was 101.

Eligibility criteria for participation: Firstly, the women participants who completed 60 years of age at the time of the interview were included in the study. Secondly, women of all marital statuses such as unmarried, separated or divorced and widowed were included. Finally, the participants who resided in Peravoor block who either with their own families or in any registered elder care facilities were selected. Elder women who had restricted mobility or bedridden, those who were suffering from major physical or mental illnesses and finally those who were not ready to give informed consent for the participation, were excluded from the study.

Measurements

The variables measured in this study were social integration and psychological well-being which were operationalized in terms of objective and subjective social integrations, conflicts in elder women's social relationships and psychological well-being (O' Boren, 1993; and Nagpal and Sell, 1995). Firstly, the social relationship was operationalized as "the frequency of elder women's feeling of being loved and

concerned, irritated, respected, felt tensed due to argument or disagreement, felt resentful, misunderstood and engaged in distressing social interaction with people in their personal life such as spouse, children and other family members. Secondly, objective social integration was operationalized and measured on two items that taped number of social organization where the participants had memberships and level of participation in terms of its frequency in meetings and other programmes. Thirdly, subjective social integration was measured in terms of the frequency of the subjective feelings and experience of elder women over the last one month at the time of interview. It specifically examined "whether elder women felt loved and wanted, felt isolated from others, felt no one knows them well, felt the part of groups or friends, wished for more friends, restrict self from interacting with others, no of significant people from whom elder women could get critical support and concerns". Finally, we examined the influence of psychological well-being on eleven domains as constructed by Nagapal and Sell (1992).

Social Relationship Scale by O' Brien *et al.* (1993) was a 26 item scale designed to measure social support and social relationships in five domains viz., perceived social support, validity, conflict, objective social integration and subjective social integration. Support and conflict items were drawn from surveys conducted at the University of Michigan's Institute for Social Research at the time of scale development, including the work of Antonucci, Cobb, French, House, Kahn, Kessler, and Vinokur; and from Norbeck and colleagues (Norbeck, Lindsey and Carrieri, 1981; cited in O' Brien *et al.*, 1993). The established alpha coefficient for social support was 0.873; conflict alpha coefficient was 0.775, for conflict alpha coefficient was 0.820, objective social integration with an alpha coefficient of 0.886 and for subjective social integration with an alpha coefficient of 0.820 showing uni-dimension of factors. But for the present study, we selected three dimensions viz., conflicts in social relations, objective social integration and subjective social integration.

The psychological well-being was measured on eleven domains as constructed by Nagapal and Sell (1992) and how psychological well-being domains were influenced by institutionalization. This was a 40-item scale that consisted of eleven subscales. General well-being- positive affect consisted of 3 items reflecting the feeling of well-being arising out of an overall perception of life as functioning smoothly and joyfully. Expectation-achievement congruence consisted of 3 items that referred to a feeling of well-being generalized by achieving success and a standard of living as per one's expectation, or what may be called satisfaction. Confidence in coping consisted of 3 items related to perceived personality strength and the ability to master critical or unexpected situations. Transcendence consisted of 3 items relating to life experiences that were beyond the ordinary day-to-day material and rational existence.

They reflected subjective well-being derived from values of spiritual quality. Family group support consisted of 3 items reflecting positive feelings derived from the perception of the wider family as supportive, cohesive, and emotionally attached.

Social Support consisted of social environment beyond the family as supportive in general and in times of crisis. Primary group concerns consisted of 3 items wherein positive and negative items were correlated and form one cluster. It was conceptualized that feelings about the primary family would perhaps form a part of overall well-being. Inadequate mental mastery consisted of 7 items with significant loading that imply an insufficient control over, or inability to deal efficiently with, certain aspects of everyday life that were capable of disturbing mental equilibrium. Perceived ill health consisted of 6 items which was a one dimensional factor since happiness and worries over health and physical fitness were highly correlated to depression. Deficiency on social contacts consisted of 3 items that refer to worries about being disliked and feeling of missing friends. General well-being-negative affect consisted of 3 items that reflected a generally depressed outlook of life.

Statistical analysis: Descriptive analyses was performed using frequency, percentage, mean and standard deviation was followed by chi-square test for association, independent sample t' test and step wise logistic regression analyses which examined the socio-demographic characteristics, tested major hypotheses and examined significant socio-demographic predictors of social integration and psychological well-being.

Ethical considerations: The study proposal was approved by the institutional review board of the Centre for Social Work Research and Practice-India. Further, informed consent was obtained from each study participant in writing before her participation in the study while confidentiality was assured and maintained.

Results

Table 1 shows the socio-demographic characteristics of elder women who live at homes and in institutional care facilities. There was a significant difference in mean age of elder women who live at homes and in institutional care facilities ($t = –4.268$; df: 192; $p < .001$). The mean age difference implied that women with higher age were more likely to be in institutional care facilities (Mean= 72.34 years; SD = 7.1) than those who were with relatively less age (Mean = 68.1yrs; SD = SD of 6.7 yrs). No significant difference was observed on the number of years completed in schools for formal education between both groups ($t = –.245$; df: 192; $p < .807$). For elder women who live at homes, the mean number of years spent in schools was 4.7 years with a SD of 2.9 years. Similarly, elderly women who lived in institutional care

Table 1: Socio-demographic profile of elder women living at homes and in elder care facilities

Socio-demographic variables	*Elder women at home*			*Elder women at Institutions*			*t' test*	*df*	*Sig.*
	Number	*Mean*	*SD*	*Number*	*Mean*	*SD*			
Age	101	68.1	6.7	93	72.34	7.1	-4.268	192	p<.001
Education	101	4.7	2.9	93	4.77	3.9	-.245	192	p<.807
Duration of stay in old age home	000			93	5.71	4.8	—	—	—
Hours of work per day	16	3.6	2.6	08	5.38	.5	-1.946	22	p<.065
No of working days in a week	16	4.7	1.9	08	7.00	.0	-3.427	22	p<.002
Daily earning	15	74.8	63.2	08	50.00	.0	1.099	21	p<.284
Personal income per month	38	1156.3	1855.3	28	1.57E4	23256.8	-3.861	64	p<.001
Family income per month	98	5580.6	3525.8	42	1.60E4	22254.9	-4.510	138	p<.001

facilities, mean years spent for education was 4.77 years (SD= 3.9). The mean duration of stay in institutional care facilities was 5.71 years with an SD of 4.8 years. There was a significant difference on the hours of work the elder women engaged in based on their residence (t= -.1.946; df:192; p<.05). The mean hours of work per day for elder women at homes was 3.6 hours (SD=2.6 hrs) while mean working hours per day was high for those who were in institutions (Mean = 5.38 hrs; SD=0.5 hrs).

Table 2 shows the socio-demographic characteristics of elder women in home and institutional care facilities and their association with current residential status. Among the elder women at homes, 37.6% (n=38) were married, three women were unmarried, 58.4% (n=59) women were widows and one woman was separated. Among the elderly women in institutional care facilities, three women were married, unmarried elder women were 26.9% (n=25) and widows were about 65.6% (n= 61) and four women were separated. It was evident from this distribution that widows were majority in both groups, while most married women were likely to be at homes and unmarried elder women were more likely to be institutionalized along with separated women. The chi-square test for association further reiterated this differences with a statistically significant association between elder women's marital status and current residence (X^2= 48.750; df: 3; p < .001).

Among elder women at homes and care facilities, majority had primary school education (76.2% and 59.1% respectively) whereas the second largest group was illiterates, i.e., 10.9% and 16.1% respectively. Only five participants reported that they had graduate level of education. Chi-square test for association showed no significant difference on the educational profile of the elder women at homes and in institutions (X^2=7.251; df 4; and p> .123). Among the elder women at homes, 47.3% belonged to the age group of 60 to 65 years, 29% belonged to the age group of 66-70 years while 71 to 75 years of age group constituted the third group, i.e., 18.3%. Elder women who were living in elder care facilities, only 16.1% were at the age group of 60-65 years, 33.3% of them belonged to the age group of 66-70 years, and 24.7% of them belonged to the age group of 71 to 75 years. It was evident from this pattern that increase in age was associated with increase in the likelihood of institutionalization. Chi-square association also showed a significant association between age groups and type of residence (X^2= 18.405; df: 4; and p<.001). Categorical analysis showed that 78.2% (n=79) of the elder women at homes were living with their sons and 10.9% (n=11) of them were living with their daughters while 5.9% (n=6) were living alone.

Table 2: Socio-demographic profile of elder women in homes and in elder care facilities

Variables	*Living status*				
	Home [%]	*Institution [%]*	*Total [%]*	X^2	*df*
What is your marital status?					
Married	[37.6] 38	[3.2] 3	[21.1] 41		
Unmarried	[3] 3	26.9] 25	[14.4] 28		
Widow	[58.4] 59	[65.6] 61	[61.9] 120	48.750**	3
Separated	[1] 1	[4.3] 4	[2.6] 5		
Total	[100]101	[100] 94	[100] 194		
Educational qualifications					
Illiterate	[10.9] 11	[16.1] 15	[13.4] 26		
Primary	[76.2] 77	[59.1] 55	[68] 132		
Secondary	[8.9] 9	[15.1]14	[11.9] 23	7.251	4
Intermediate	[2.0] 2	[6.5] 6	[4.1] 8		
UG & above	[2.0] 2	[3.2] 3	[2.6] 5		
Total	100] 101	[100] 93	[100]194		
Age groups					
60-65 yrs	[47.3] 44	[16.1]	[30.4] 59		
66-70 yrs	[29] 27	[33.3] 31	[29.9] 58		
71-75 yrs	[18.3] 17	[24.7] 23	[20.6] 40	18.405**	4
76-80 yrs	[5.4] 5	[9.7] 9	[7.2] 14		
>80 yrs	[7.9] 8	[16.1] 15	[11.9]		
Total	[100]101	[100]93	[100]104		
With whom are you currently living?					
Son	[78.2] 79	—	—	—	—
Daughter	[10.9] 11	—	—	—	—
Relatives	[1] 1	—	—	—	—
Daughter in law	[3] 3	—	—	—	—
Husband	[1] 1	—	—	—	—
Living alone	[5.9] 6	—	—	—	—

(Cont...)

What is the nature of services availing in old age homes?					
Paid service	—	[17.2] 16	—	—	—
Free service	—	[78.5] 73	—	—	—
Partially free service/ paid	—	[4.3] 4	—	—	—
What was your former occupation?					
Govt. employee	[2] 2	[7.5] 7	[4.6] 9		
Private employee	[1] 1	[8.6] 8	[4.6] 9		
Self-employee	[5.9] 6	[7.5] 7	[6.7] 13	18.058**	6
Daily wage earner	[29.7] 30	[37.6] 35	[33.5] 65		
House wife	[60.4] 61	[35.5] 33	[48.5] 94		
No job	[1]1	[2.2] 2	1.5] 3		
Are you economically active at present?					
Yes	[19.2] 19	[8.7] 8	[14.1] 27	4.328*	1
No	[80.8] 80	[91.3] 84	[85.9] 164		
Religion					
Hindus	[29.7] 30	[21.5] 20	[25.8] 50		
Muslim	[0] 0	[5.4] 05	[5.4] 05	6.746*	2
Christians	[70.3] 71	[73.1] 68	[71.6] 139		
Place of residence					
Urban areas	[1] 1	[31.2] 29	[15.5] 30		
Rural areas	[79.2] 80	[47.3] 44	[63.9] 124	36.317**	2
Semi-urban area	[19.8] 20	[21.5] 20	[20.6] 40		

Elder women who live in institutional care facilities, 78.5% received free service and 17.2% (n=16) were availing paid services while only 4 participants were using partially paid services.

During the economically active age, most of the elder women at homes were housewives (60.4%; n=61) and 29.7% (n=30) were daily wage earners, two of them were government employees, one person was in private sector employment and so on. Among those who were in institutional care facilities, 35.5% (n=33) were housewives, 37.6% (n=35) were daily wage earners, seven persons were in government service, eight persons were in private sector employment and seven

women were engaged in self-employment. In total, 48.5% (n=94) elder women were housewives and 33.5% (n=65) were daily wage earners. This distribution evidenced that most of the elder women were housewives during their economically active age while many others were wage earners. The chi-square test for association revealed a significant statistical association between former employment and current residence (X^2=18.058; df: 6; p < .001).

About 19.2% (n=19) of the elder women who live at homes with family members reported that they were currently economically active while 8.7% (n=8) from institutional care facilities also reported that they were currently earning. Otherwise, majority in both groups were currently economically inactive with an association significant at 05 level (X^2=4.328; p < .05). The cross tabulation of religious groups across homes and institutional care groups showed that Christians were majority in both institutional and residential groups (73.1 and 70.3% respectively). The second largest religious group was Hindus both at institutional and residential cares (21.5% and 29.7% respectively). The chi-square test revealed a significant association between religious groups and type of residence (X^2 = 6.746; df: 2; p < .05). In both groups (residential and institutional), majority of the participants were from rural areas (79.2% and 47.3% respectively). But a noticeable difference of women's residence was that only one woman from rural area was institutionalized while 21.5% (n=20) who were from urban areas were institutionalized. This difference was significant at 0.001 level (X^2 =36.317; df: 2; p< .001). Overall results showed the critical influence of socio-demographic characteristics in later institutionalization of elder women.

Table 3 shows the descriptive analysis and test results of social integration and psychological well-being of elder women at homes and in institutional care facilities. First sub-domain was on conflictual social relationships of elder women with people in their personal life. This construct was measured in terms of the frequency of elder women's feeling of being loved and concerned, irritated, respected, felt tensed due to argument or disagreement, felt resentful, misunderstood and engaged in distressing social interaction with people in their personal life such as spouse, children and other family members (O'Brien et al., 1993). Among elder women at homes, the mean score on this sub-domain was 20.99 (SD=3.6) while elder women in institutional care facilities reported a mean of 21.1 (SD=2.6). Independent sample t' test revealed a non-significant mean difference in conflictual social relationships (t =-.233; df: 192; p = NS).

Objective social integration was measured on two items that taped the number of social organization where the participants had memberships and level of participation in terms of its frequency in meetings and other programmes. Among

Table 3: Social integration and psychological wellbeing of elderly women in homes and in elder care facilities

Sub-domains	Home *Number*	*Mean*	*SD*	Institutions *Number*	*Mean*	*SD*	*t' test*	*df*	*Sig.*
Sub-domains of social integration									
Conflictual social relationships	101	20.99	3.6	93	21.1	2.6	-.233	192	
Objective social integration	101	4.7	.94	93	5.1	1.1	-2.725	192	p<.001
Sub-domains of psychological well-being									
General wellbeing (positive affect)	101	4.4	1.8	93	4.0	.94	1.772	192	p<.078
Expectation achievement congruence	101	4.9	1.98	93	4.5	1.0	1.538	192	p=NS
Confidence in coping	101	5.2	1.5	93	5.4	1.1	-1.381	192	p=NS
Transcendence	101	5.4	1.7	93	5.5	1.0	-.282	192	p=NS
Family group support	101	5.3	2.0	93	4.6	1.5	2.604	192	p<.010
Social support	101	5.7	1.7	93	5.2	1.1	2.418	192	p<.017
Primary group concern	101	7.3	1.4	93	9.9	2.1	-10.370	192	p<.001
Inadequate mental mastery	101	13.1	3.4	93	11.6	2.3	3.600	192	p<.001
Perceived ill health	101	9.5	3.3	93	8.3	2.1	3.031	192	p<.003
Social contact	101	6.2	1.9	93	5.4	1.3	3.388	192	p<.001
General wellbeing (negative affect)	101	5.1	2.1	93	4.5	1.2	2.156	192	p<.032

those who live at homes, the mean score on this sub-domain was 4.7 (SD= .94) while those who were in institutional care facilities obtained a mean of 5.1 (SD=1.1). This mean difference was statistically significant at .001 level ($t = -2.725$; df: 192; $p < .001$). The result revealed that institutionalized women were more likely to enjoy better objective social integration than women who were at homes.

Subjective social integration was measured in terms the frequency of the subjective feelings and experience of elder women over the last one month at the time of interview that "whether they felt loved and wanted, felt isolated from others, felt no one knew them well, felt the part of groups or friends, wished for more friends, restricted self from interacting with others, no of significant people from whom elder women could get critical support and concerns" (O'Brien et al., 1993). There was a significant difference on the level of subjective integration between elder women at homes and in institutional care facilities ($t = 2.582$; df: 192; $p < .05$). The mean difference showed that elder women at homes reported higher mean score of 18.9 (SD=2.8) while elder women in institutional care facilities reported a mean of 17.98 (SD=2.2). The result revealed that elder women who lived with their own families better enjoyed higher level of subjective social integration than those who lived at institutional care facilities.

General well-being arises out of overall perceptions of life as functioning smoothly and being joyful (Nagpal and Sell, 1985; 1992). In the present study, there was a significant difference of general well-being (positive affect) between elder women at homes and in institutional care facilities ($t = .1.772$; df: 192; $p < .05$). The mean difference showed that elder women at homes enjoyed relatively better general well-being (Mean=4.4; SD=1.8) than women in institutional care facilities (Mean=4.0; SD= .94). Expectation-achievement congruence referred to feelings of well-being generated by achieving success and the standard of living as per one's own expectation or satisfaction (Nagpal and Sell, 1992). In the present study, no significant statistical difference was found on expectation-achievement congruence between elder women at homes and in institutions ($t = 1.538$; df: 192; p =NS).

Confidence in coping referred to perceived personality strength, the ability to master critical or unexpected situations or a positive mental health in an ecological sense (Nagpal and Sell, 1992). In the sub-domain of confidence in coping, the elder women at homes reported a mean of 5.2 (SD=1.5) while the elder women at institutions reported a mean of 5.4 (SD=1.1). But no significant difference was found on confidence in coping between the elder women at homes and in institutions ($t = -1.381$; df: 192; p=NS). The transcendence related to life experiences that were beyond the day-to-day material and rational existence (Nagpal and Sell, 1992). The

elder women at homes reported a mean of 5.4 (SD=1.7) while for those who were in institutions reported a mean of 5.5 (SD=1.0). No significant statistical difference on transcendence was found between the elder women who lived at homes and in institutions (t = -.282; df: 192; p=NS).

Family group support reflected the positive feelings derived from the perception of the wider family (beyond the primary group of spouse and children) as supportive, cohesive, and emotionally attached (Nagpal and Sell, 1992). There was a significant difference on family group support between the elder women at homes and in institutions (t = 2.604; df: 192; p < .001). The mean difference showed that the elder women at homes reported a higher mean of 5.3 (SD=2.0) than those who were at institutions (Mean=4.6; SD=1.5). This means that better level of perceived family support, cohesiveness, and emotional attachment were enjoyed by elder women at homes than those who were in institutions.

Social support emerged out of two theoretical constructs. The first construct included the feeling of security and density of social networks. The second construct related to the social environment and the traditional support provided beyond the family in time of crises (Nagpal and Sell, 1992). Independent sample t' test revealed that there was a significant difference on social support between elder women at homes and in institutions (t = 2.418; df: 192; p< .017). The mean difference showed that the elder women at homes enjoyed better social support (Mean=5.7; SD=1.7) than those who were in institutions (Mean=5.2; SD=1.1).

There was a significant difference on primary group concern between the elder women at homes and in institutions (t =.-10.370; df: 192; p <.001). The mean difference showed that women in institutions had more primary group concerns (Mean=9.9; SD=2.1) than those who were at homes (Mean=7.3; SD = 1.4). Inadequate mental mastery contains a sense of insufficient control over, or inability to deal efficiently with, certain aspects of everyday life that were capable of disturbing the mental equilibrium. This inadequacy was perceived as disturbing or reducing subjective well-being. This factor was based on the theoretical construct of mental mastery over self and environment (Nagpal and Sell, 1992). Inadequate mental mastery was also significantly differed between the elder women at homes and in institutions (t = 3.031; df: 192; p<.003). The result revealed that the elder women at homes had better mental mastery (Mean= 13.1; SD=3.4) than those who lived in institutions (Mean=11.6; SD=2.3).

Perceived ill health was significantly differed between the elder women at homes and in institutions (t= 3.031; df: 192; p <.003). The result indicated that perceived ill health was more among those who live at homes (Mean=9.5; SD=3.3) than in

institutions (Mean=5.4; SD=1.3). Deficiency in social contact contains worries about being disliked and about missing friends (Nagpal and Sell, 1992). Deficiency in social contact was differed between women at homes and in institutions (t= .3.388; df: 192; p<.001). The result showed that elder women at homes had deficiency in social contact (Mean=6.2; SD=1.9) than those women who lived in institutions (Mean=5.4; SD=1.3). General well-being (negative affect) gave an overall depressed outlook about life (Nagpal and Sell, 1992). There was a significant difference on general well-being (negative affect) between the elder women at homes (t=2.156; df: 192; P <.032) with a direction that women at homes had more negative affect (general well-being) (Mean=5.1; SD=2.1) than those who lived in institutions (Mean=4.5; SD=1.2).

Table 4: Socio-demographic predictors of social integration of elderly women

	Unstandardized Coefficients			*Standardized Coefficients*		
Model-1:	***B***	***Std. error***	***Beta***	***t' value***	***F' test***	R^2
Constant	11.595	5.412	—	2.142*		
Age	.180	.069	.398	2.605*		
Marital status	1.598	.493	.484	3.240**	8.797**	.581
Perceived ill health	-.446	.168	-.409	-2.657*		

NB: * Significant at 0.05 level and ** significance at 0.001 level

Constant: 11.595 elder social integration = .180* age + 1.598** marital status

+ -.446* perceived ill health

Table 4 shows the socio-demographic predictors of social integration of elder women after excluding non-significant variables entered into this model. Age increased social integration (beta = .398) followed by marital status (beta= .484) while perceived ill health had a decreasing effect on social integration (beta= -.409). The table presents the corresponding t value and P values for each significantly contributing variable. The linearity was tested by using the ANOVA. The F statistic showed a significant liner relationship between social integration and the predictor variables (F=16.818; and p<.001). R square value was 0.581 which indicated that 58% of the variance was explained by the variables such as age, marital status and perceived ill health.

Table 5 shows the socio-demographic predictors of psychological well-being of elderly women. Excluding the non-significant variables, it was found that the caste (beta= .521) had an increasing effect on psychological well-being while conflicts in social relationships had a decreasing effect on psychological well-being (beta = –.480). The table presents the corresponding t value and p values for each significantly

contributing variable. The linearity was tested by using the ANOVA. The F statistic showed a significant liner relationship between psychological well-being and predictor variables. R square value was 0.627 implying that 62.7% of the variance on psychological variance was explained by caste affiliation and conflicts in social relationships.

Table 5: Socio-demographic predictors of psychological well-being of elderly women

	Unstandardized Coefficients			*Standardized Coefficients*		
Model-2:	***B***	***Std. error***	***Beta***	***t' value***	***F' test***	***R^2***
(Constant)	56.902	7. 240	—	7.859***		
Caste	.657	.178	.521	3.695**	16.818***	.627
Social relationships	-1.048	.308	-.480	-3.407**		

NB: * Significant at 0.05 level; ** significance at 0.001 level; and

*** Significant at .000 level

Constant: 56.902 psychological wellbeing = .657*** caste affiliation + -1.048 **

+ nature of social relationships

Discussion

We investigated the nature of social relationships, social integration of and psychological well-being of elder women who lived at homes and in elder care facilities in a semi-rural community setting in southern India. The findings of the study were summarized as follows. Firstly, results revealed that institutionalized elder women were more likely to be older than those who were living at homes. They engaged in more hours of work every day and more number of working days in a week. The unmarried, widowed and separated elder women were more likely to be institutionalized than married elder women. Former employment, being economically active, religion and place of residence were significantly associated with institutionalization of elder women. Second, the objective and subjective social integration significantly differed between elder women living at homes and in care facilities. Third, the sub-domains of psychological well-being such as general well-being (positive affect), family group support, social support, primary group concern, inadequate mental mastery, perceived ill health, social contact and general well-being (negative affect) were significantly differed between elder women living at homes and in institutions. Finally, age, marital status and perceived ill health significantly predicted 58% (R^2= 0.581) of the variance on social integration whereas caste affiliation and conflicts in social relationships accounted for 62.7% (R^2= 0.627) of the variance on psychological well-being.

Comparison of Socio-demographic Characteristics

The study revealed that older women were more likely to be institutionalized than younger age groups of elderly. The disability and functional limitations were significantly increased with advancing age that necessitated more intensive care for the elder wherein families looked for alternative care facilities which resulted institutionalization of the elderly women (Berlau et al., 2009; and Hairi et al., 2010). We found that women in institutional care facilities worked more number of hours a day than those who lived at homes. Consistently, women in institutional care facilities worked more number of days in a week than those who lived at homes. Plausible explanation may be that activities in elder care facilities were highly structured and the inmates were made to assist the functioning of the institutions in a scheduled manner and on a regular basis. In addition, most of the elder women were unpaid inmates who accessed free service wherein care home managements were likely to use available human resource from the elderly in order to keep the cost of everyday functioning at a minimal level. On the other hand, the elder women who lived at homes, especially in rural areas, often did not have structured activities of daily living wherein they need not spent a prescheduled time on activities, assisting household chores and other activities.

In the current study, nearly 80% of the elder women in institutional care facilities availed services at free of cost. It indicated that these women were from economically poor households. In care facilities, though women were engaged in assisting activities of the day to day function of the institution, they were not paid for it. In turn they receive total care that covered food, accommodation, health care and so on. But the elder women at homes were economically active and were likely to earn and control their earnings. It was evident that widows were more at homes and in institutions as well. This was in agreement with the current demographic and mortality trends that women outlived men (UN, 2011; Prakash, 2003; and Rajan, 2006).

Consistently, the current study revealed that most married women were likely to live at homes with their sons and other family members while unmarried elder women were more likely to be institutionalized along with separated women. This was because; the marital status affected the socio-economic situation, living arrangements and overall health and well-being of oldest women (UN, 2011; and Kinsella and He, 2008). In addition, elder women's economic security was often significantly influenced by their marital status than of men's economic status (UN, 2011). Further, the present study revealed that most of the elder women were housewives during their economically active age while many others were wage earners. Otherwise, majority in both groups were economically inactive at present.

Traditionally, multigenerational families provided the main social context for sharing family resources and the provision of mutual support as and when needs arose over the life course (UN, 2011). The life course included old age when the elder family members were taken care of by younger family members, especially by sons in patriarchical family systems. In developing country like India, where family ties were still stronger, nearly one percent of the older persons were institutionalized (Prakash, 2003). It indicated that even today, most elders co-reside with their own children in families, especially in rural areas though elder care facilities were available in our society. Overall results showed the critical influence of socio-demographic characteristics in later institutionalization of elder women.

Social Integration of Elder Women

It was interesting to note that objective social integration of elder women was higher among those who lived in institutional care facilities whereas subjective well-being was found to be higher among those who lived at homes. These directions needed to be viewed in the context of measurement of these constructs. The objective social integration was measured in terms of memberships in clubs and associations (prayer groups, religions association and so on) and frequency of elders' participation (O' Brian et al., 1993; and Moen et al., 1989). Elder inmates in care facilities had structured activities of daily living which often included provision to participate in elders' clubs and associations where all inmates regularly participated. On the other hand, elder women at homes were likely to have unstructured and less formal activities of daily living wherein family members might not take active role to engage the elder persons. Therefore, social engagement was likely to depend on individuals' interest and other situational factors. Thus, elder women at institutional care facilities were at better social context where they interacted more frequently with their peers even within the care facilities and in outside, resulting better objective social integration (Moen et al., 1989; and Thomas and Nagaraju, 2012).

In Indian socio-cultural milieu, institutionalization of elderly persons was viewed against socio-cultural values and morale. Thus, it induces a sense of abandonment and of being orphans. This view was supported while 84.30% of the elderly population showed their dislike to live in old age homes, though the objective social isolation was relatively less for those who lived at homes when compared to the institutionalized elder women (Dept. of Economics and Statistics, Govt. of Kerala, 2006). In this context, elder women in institutional care facilities were more likely to negatively perceive their stay in institution along with a sense of abandonment. As a result, they were unlikely to feel and experience to be loved and wanted. Though they experienced less level of objectively measured social isolation (see Dept. of Economics and

Statistics, Govt. of Kerala, 2006), they were less likely to subjectively appraise high level of social integration, experienced high life alienation and decreased life satisfaction (Thomas and Nagaraju, 2012). On the other side, the elder women at homes were relatively free from these negative perceptions of abandonment and sense of being orphaned even when they experienced isolation from other family members which enabled them to appraise better subjective social integration.

Psychological Well-being of Elder Women

There was a little research conducted on well-being in developing countries though well-being studies had obtained worldwide acceptance and importance as a means to assess and evaluate the dimensions of health care programmes (Abas et al., 2009). Studies on well-being was conceptually supported by the positive mental health which allows individual to realize their abilities, cope and contribute to their communities (WHO, 2004) and capacity to sustain social relationships (WHO, 2001). The measurement of well-being was multidimensional that often measured autonomy, self-acceptance and relationships with others (Tennant et al., 2007; Ryff and Keyes, 1995; cited in Abas et al., 2009).

The present study examined how institutionalization of elderly in Kerala influenced their psychological well-being. The psychological well-being was measured on eleven sub-domains. All domains except expectation achievement congruence, confidence in coping and transcendence, were significantly differed between elder women at homes and in residential care facilities. The directions of the relationships showed that elder women at homes enjoyed better family group support, better social support and more social contact than those who were institutionalized. But primary group concern, perceived ill health and inadequate mental mastery were higher among elder women at homes than the institutionalized women. Previous studies have revealed that institutionalization invoked the sense of abandonment, felt being orphaned, increased life isolation and alienation, decreased life satisfaction (see Dept. of Economics and Statistics, Govt. of Kerala, 2006; and Thomas and Nagaraju, 2012).

Thus, we made an effort to discuss the current study findings within this socio-cultural context where institutionalization was negatively perceived and valued. The elder women who lived with their own children in families enjoyed better social support including more frequent social contacts. The evidence suggested that social support, social network, frequent contact with a child along with other socio-demographic variables significantly predicted high level of psychological well-being and less level of disability among elderly women (Abas et al, 2009). On the other hand, elder women living with own children at homes were likely to have less active

social roles, often face passive neglect from family members, generalization of elders' health related concerns, reduced functionality and disabilities to old age and restricted physical movement outside homes. This would in turn lead to deficits in the forms of perceived ill health and inadequate mental mastery.

Logistic regression models implied that the significant socio-demographic predictors of psychological well-being. Caste and social relationships significantly predicted psychological well-being of elderly women. Consistently, Abas et al. (2009) found that age, household wealth, currently working, family network size close by, receiving support from children, significant others, perception of adequate support from children, perceiving giving support to children and less impairment due to disability predicted psychological well-being. Better social support was found to buffer the severe disabling effect of disabilities and ensure better psychological well-being to elderly women. In the present study, age, marital status and reduced perceived ill health of elder women significantly predicted social integration.

The cultural sanctions of elderly care by family members at homes often overlooked by well-being researchers, practitioners and policy makers in India. Though elder women at homes were found to be enjoying many advantages over the institutionalized elder women such as better subjective social integration and positive well-being experiences, they were vulnerable to social isolation, reduced social engagement and participation. Thus, the role enhancement perspective of social integration guides social work researchers and practitioners in elder care towards improving psychological and social well-being of elderly at homes and in institutions. This may be achieved by greater social integration through accelerated social participation and engagement and frequent quality social interactions with family members. For this, it was imperative to design appropriate psychosocial interventions which enhance the elderly, their family members and elder care home managers and staff to improve subjective well-being experience of elderly individuals both at homes and in institutions.

Conclusion

Overall results showed that institutionalized elder women were more likely to be older than those who were living at homes. The institutionalized women engaged in more hours of work on every day basis and also they worked more number of days in a week. The unmarried, widowed and separated elder women were more likely to be institutionalized than the married elder women who were more likely to live with their children, especially son. Other socio-demographic factors such a former employment, being economically active, religion and place of residence were

significantly associated with institutionalization of elder women. The objective and subjective social integration significantly differed between elder women living at homes and in care facilities. The objective social integration was better reported by institutionalized elderly while subjective social integration was better reported by elderly women living at homes with their own children. The sub-domains of psychological well-being such as general well-being (positive affect), family group support, social support, primary group concern, inadequate mental mastery, perceived ill health, social contact and general well-being (negative affect) were significantly differed between elder women living at homes and in institutions. Finally, the age, marital status and perceived ill health significantly contributed to social integration whereas caste affiliation and conflicts in social relationships accounted for psychological well-being. The study concluded that socio-demographic variables, especially elder women's residence had significant influence on social integration and psychological well-being whereas institutionalization was determined by deficits in socio-economic background of the elderly women.

Reference

Abas, M.A., Punpuing, S., Jirapramupitak, T., Tangchonlatip, K., and Leese, M. (2009).

Psychological Well-being, Physical Impairments and Rural Aging in a Developing Country Setting. *Health and Quality of Life Outcomes, 7,* 1186-1477.

Barnett, R.C., and Hyde, J. S. (2001). Women, Men, Work, and Family. *American Psychologist, 56,* 781–796.

Berlau, D. J., Corrada, M. M., and Kawas, C. (2009). The Prevalence of Disability in the Oldest-Old is High and Continues to Increase with Age: Findings from The 90+ Study, *International Journal of Geriatric Psychiatry, 24,* 1217–1225.

Chrouser, C. J., Ryff, A.C.D. (2006). Multiple Roles and Well-being: Socio-demographic and Psychological Moderators. *Sex Roles, 55,* 801–815.

Cornwell, B., Laumann, E. O., and Schumm, L. P. (2008). The Social Connectedness of Older Adults: A National Profile. *American Sociological Review, 73,* 185–203.

Hairi et al. (2010). Prevalence and Correlates of Physical Disability and Functional Limitation among Community Dwelling Older People in Rural Malaysia: A Middle Income Country. *BMC Public Health, 10,* 492-.

Kinsella, K., and He, W. (2009). An Aging World: 2008, U.S. Census Bureau, *International Population Reports,* P95/09-1 (Washington, D.C.: U.S. Government Printing Office, June 2009). Available at http://www.census.gov/prod/2009pubs/p95-09-1.pdf.

Krueger, K. R., Wilson, R.S., Kamenetsky, J.M., Barnes, L. L., Bienias, J.L., and Bennett, D.A. (2009). Social Engagement and Cognitive Function in Old Age. *Exp Aging Res, 35,* 45–60.

Moen, P., Chermack, K. (2005). Gender Disparities in Health: Strategic Selection, Careers, and Cycles of Control. *Journals of Gerontology Series, 60*: 99–108.

Moen, P., Dempster-McClain, D., and Williams, R.M. (1989). Social Integration and Longevity: An Event History Analysis of Women's Roles and Resilience. *American Sociological Review, 54*: 636–647.

Nagpal, R. and Sell, H. (1985). *Subjective Well-being*, SEARO Regional Health Paper, No. 7, World Health Organization: New Delhi.

Nagpal, R. and Sell, H. (1992). *Assessment of Subjective Well-Being Inventory (SUBI) Regional Health Paper, SEARO*, No.24, New Delhi: World Health Organization.

O'Brien, K., Wortman, C.B., Kessler, R.C., and Joseph, J.G. (1993). Social Relationships of Men at Risk for AIDS. *Social Science and Medicine, 36*: 1161-1167.

Prakash, I.J. (2001). Elder Abuse: Global Response and Indian Initiatives. *Indian Journal of Social Work, 62*: 446-463.

Rajan I.S. (2006). Kerala Aging Survey Among Old Age Homes. Centre For Development Studies, Jawaharlal Nehru National University: Trivandrum. Studies, Jawaharlal Nehru National University: Trivandrum.

Ryff, C.D., Keyes, C.L.M. (1995). The Structure of Psychological Well-being Revisited. *Journal of Personality and Social Psychology, 69*:719-727.

Tanaka, K., and Johnson, N. E. (2010). Social Integration and Healthy in Japan: How Gender and Rurality Matter. *Journal of Cross Cultural Gerontology,* 25, Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., *et al.* (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): Development and UK Validation. *Health Quality of Life Outcomes, 5*, 63.

Thomas, T., and Nagaraju, K. (2012). Socio-demographic Predictors of Experience of Alienation and Life Satisfaction among Institutionalized Elders in Kerala. In Jose J, P., and Sultana, A. S. (Eds.), Building Psychosocial Perspective on Disability Experience: Children, Elderly, Mentally Ill Persons and Caregivers. *Lambert Academic Publishing*, 230-267.

United Nations. (2011). Current Status of the Social situation, Well-being, Participation in Development and Rights of older Persons Worldwide. Department of Economic and Social Affairs, United Nations: New York.

Wethington, E., Moen, P., Glasgow, N., and Pillemer, K. (2000). Multiple Roles, Social Integration, and Health. In: Pillemer, K., Moen, P., Wethington, E., and Glasgow, N. (Eds.), Social Integration in the Second Half of Life. *The Johns Hopkins University Press*: Baltimore, pp. 48-71.

World Health Organization. (2001). Strengthening Mental Health Promotion: Geneva. World Health Organization. (2004). Promoting Mental Health: Concepts, Emerging Evidence and Practice, Summary report: Geneva.

———(2006). Report on Elders in Institutions. Department of Economics and Statistics, Government of Kerala: Trivandrum.