

Coping strategies adopted by the institutionalised and non-institutionalised elderly in Kathmandu, Nepal: A comparative correlational study

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ABSTRACT

Introduction: With an increasing population ageing and by the changing context of the world, elderly has been pushed into various psychosocial problems but lack sufficient policies and programmes to deal with the problems. The study aimed to compare the coping strategies adopted by the institutionalised and home living elderly of Kathmandu, Nepal, determine its relationship with their selected socio-demographic variables, and determine the correlation between coping strategies and psychosocial problems.

Materials and Methods: The correlational comparative study was carried out in 2013 among 132 old aged people of 60 years and/above living in old age homes and home settings in Kathmandu by using pre-tested structured interview schedule. Data were analysed by using both descriptive and inferential statistics using SPSS version 19.

Results: The coping strategies were found to be effective among non-institutionalised elderly and there was significant difference between coping strategies of the elderly living in institutional and non-institutional settings. The psychosocial problems were dependent on educational status, monthly income and inter personal relations in institutionalised elderly and with present job status, monthly income and type of family in non-institutionalised elderly.

Conclusions: The elderly living in their own homes were able to cope with the psychosocial problems in an effective way. The study suggests the need of encouragement towards joint family norms in this changing context of the world. Besides, older adults should be trained for active ageing and old people should be involved in the family activities and useful works rather than keeping them away.

Key words: Coping, elderly, institutional, non-institutional settings

Introduction

Longevity is an achievement of the present century derived from tremendous advancement of science and medicine. The increase in life expectancy, decreased birth and death rate has resulted in the increased proportion of the elderly population. With an increasing proportion of our population living for longer years, we are now confronted with the problem of not knowing how to deal with growing problems of our elderly population. Simultaneously, our senior citizens too are challenged by how creatively and usefully occupy themselves in the society.

Everyone wants to live long but no one wants to grow old because it is age which is viewed as avoidable,

undesirable, problem ridden phase of life. In Nepali society when life was simpler and values counted for more those who reached a ripe old age takes prestigious place in society where they could really relax and enjoy the life, actually perceiving old age with fear and an age of problems is a recent phenomenon which results of the moral harassment, lack of sensitivity and the world becomes more complex and less comprehensible. The old man face the problem of isolation, loneliness, neglect, illness, helpless, lack of self-confidence, lack of ability to concentrate, forgetfulness, depression, intergenerational wars etc. like every phase in life old age does have its problems.

Population ageing is expanding worldwide including developing countries like Nepal. The percentage of

elderly population has increased from 4.6% in 2001 to 8.13% in 2011 [1]. If such growth trend continues, the Government of Nepal has to make many wide-reaching changes in areas of health, finance, employment, education, social relations, physical, environmental, legal and sociological conditions because an aged nation touches on all aspects of society. But due to the changing societal norms and for the sake of family business for their livelihood, young generation is living away from their parental home. It is difficult for elderly to change their homes and get adjusted to new place. Apart from this because of more and more working women, their traditional role of care giver of the elderly is abandoned. Bhattarai and Bhattarai (2012) said that recent trends show that many women are looking for career goals, hence ending up with fewer children [2]. Besides, our social culture is also being broken by the changing context of the world, desire for a small family, poverty and urbanization process. In such circumstances, the society seems to have empathized the problems and needs of the elderly and hence have attempted, though not sufficient, to ease their life. In developing countries like Nepal number of old age homes and presence of aged patients in hospital is on rise. Elderly homes, religious sites are the only destination for senior citizens out of their family during the old age. Different activities from the side of government, NGOs and individuals are being done for the senior citizens. However, many of them are still deprived of proper care and support and basic need for comfortable survival [3]. Present day society has pushed down the elderly population into a state of loneliness, helplessness, frustration, and meaningless, leading them to various psychosocial problems. Having ample scope, there is a relative paucity of researches done on psychosocial problems and coping strategies adopted by elderly in Nepal.

The present study the first of its nature in the proposed study setting had the objectives of comparing the coping strategies adopted by elderly living in institutional and home settings, to determine the correlation between psychosocial problems and coping strategies of elderly and to seek the relationship of coping strategies adopted by the elderly with gender, educational status,

marital status, type of family, monthly income, present job status and interpersonal relations.

Materials and Methods

The comparative correlational study was carried out among 132 elderly aged 60 years and/above living in old age homes and home settings in Kathmandu, Nepal. The sample size was determined on the basis of prevalence of nervous system disorders among the elderly in an urban area of Udaipur Rajasthan, India [4]. At first ward number 14 was selected by simple random sampling for home setting. Then 66 elderly respondents were selected by systematic random sampling from ward number 14 of Kathmandu. Similarly, 66 elderly from five old age homes (Social Welfare Center Pashupati Bridhashram, Divine Service Home, Center of Services for Helpless, Old Age Management/Social Welfare Trust-Soalteemod and Gurjudhara) were selected by proportionate random sampling. A total of sixty-six elderly from both the settings were interviewed from 24th December 2012 to 25th February 2013 by using structured interview schedule. Content validity of the structured interview schedule was established by submitting the schedule to five experts in the respective field along with the criteria rating scale. The experts were chosen on the basis of their clinical expertise, experience, qualification and interest in problem area. Criteria rating scale consisted of items with three response columns for rating against each criterion, like "fully met", "mostly met" and "to some extent" and remarks column. Criteria rating scale included areas like selection of items: based on objectives, relevancy, and adequacy of content, organisation of items, language and feasibility. Then prior to final administration of the tool pre-testing of the structured interview schedule was done among the elderly in Kathmandu by the principal investigator himself to check whether the tool was appropriate or not and to make any changes if required. The schedule consisted of three parts- personal data, psychosocial problems (comprised of items related to psychosocial problems of elderly like depression, loneliness, social isolation, anxiety, neglect by family members and lack of self confidence) and coping strategies adopted (comprised of items related to coping

strategies adopted by elderly in response to the psychosocial problems which had sub scales of cognitive and behavioural coping strategies). Reliability of the schedule was worked out by using Cronbach Alpha Coefficient for Part II and Part III separately. For Part II: Cronbach's alpha was 0.968 for home setting and 0.960 for institutional setting. For Part III: Cronbach's alpha was 0.773 for home setting and 0.820 for institutional setting. Prior to administering the structured interview schedule informed verbal consent was taken from the concerned authorities of the old age homes, ward office and all the participants. The data were compiled and analysed by using SPSS version 19 and appropriate statistical tests were performed to draw the inference.

Ethical approval was obtained from International Ethical Committee for Biomedical Research on Human Participants, Sam Higginbottom Institute of Agriculture Technology & Sciences (Deemed to be University). Permission was sought from all the concerned authorities of the old age homes and oral informed consent (via informed consent forms) was obtained individually from all participants following a detailed description of the study protocol along with purpose of the study, potential benefits and risks, confidentiality, and right to participate and leave the study. No personal identifiers were recorded to ensure confidentiality. Participants were not given any compensation for participating in the study.

Results

Socio-demographic findings

The findings of the study showed that around 70% of the elderly in the home settings were in the age group 60- 69 followed by 24% and 3% each in the age group 70-79, 80-89 and 90 and/above years respectively. Similarly, in the institutional setting 41% of the elderly were in the age group 70-79 followed by 30%, 24% and 5% in the age group 80-89, 60-69 and above 90 and/above years. In both the settings, male and female were in equal proportion. Only 9% of the elderly from institutional setting were literate. While more than the halves of the elderly (55%) in the home

settings were literate. Most of the respondents (59%) were married and living together in home settings where as in institutional settings around 64% of the elderly were widow/ widower or unmarried.

The result also showed that around 27% of the elderly in the home settings were employed whereas 97% of the institutionalised elderly were retired and not employed. More than the halves of the elderly in institutional settings (54.5%) had minimum income up to NRs 2000 per month. But in home settings, around 35% of the elderly had income more than NRs 10000 per month. The elderly who lived in joint family constituted 71% of the elderly in the home setting whereas 58% of the elderly were from nuclear family in the institutional setting.

Findings related to physical health status

The elderly with long term illness or other chronic illnesses were greater in institutional setting (83 per cent) than in home settings (44 per cent). In both the settings respiratory disease and arthritis were found to be the major problems in the elderly. Around 29 per cent of the elderly in institutional setting and 12 per cent of the elderly in home setting were suffering from illness for more than five years. Majority of the elderly in home setting (around 58 per cent) were at good health while most of the respondents (79 per cent) in institutional setting were at moderate health with 4.5 per cent at poor health.

Reasons for institutionalisation

Half of the cases were brought to old age homes because of no one to take care followed by conflicting relationship with family (33 per cent), lack of care by family members (21 per cent), economic insecurity and mental or physical illness (each 15 per cent).

Coping Strategies and its relationship

The findings related to cognitive strategies adopted by the elderly depicted that majority of the respondents (more than 95 %) from both the settings tried to cope with their problems by trying to find comfort in their religion and spiritual beliefs. Also it showed that high proportion of elderly i.e. 3/4th of the

elderly in institutional settings adopted negative coping strategy of avoiding social contacts with others while only 24 per cent of the respondents did so in home settings. Similarly, it was also found that in both the settings most of the elderly had adopted behavioural coping strategies like praying to god and reading religious books (more than 98%), visiting religious places (more than 86%), and participating in religious or social welfare activities (more than 90%). While there was difference among the elderly in home settings and institutional setting in behavioural strategies like yoga (84% and 42% respectively), spend time with grand children (91% and 21% respectively), take alcohol (27% and 16% respectively), take drug to calm down (7% and 22% respectively), and enjoy in taking care of pets (54% and 13% respectively).

The findings also revealed that highly effective overall coping strategies were adopted by 26 per cent of the home living elderly whereas only 4.5 per cent of the institutionalised elderly had highly effective overall coping strategies. Majority of the elderly (56 per cent) in institutional setting and 68 per cent in home setting

had moderately effective overall coping strategies. Only 6 per cent of the elderly from home setting had less effective overall coping strategies compared to 39.4 per cent from institutional setting. It can be interpreted that the elderly in home settings were able to cope more effectively with psychosocial problems than institutionalised elderly.

The difference in coping strategies adopted by the institutionalised and home living elderly is presented in Table 1. It clearly depicts that there was significant difference in mean scores of the elderly living in institutional and home settings for coping strategies as the 't' value obtained (7.39) is more than tabulated value ($t=2.62$) at 0.01 level for 130 degree of freedom. Thus, it can be inferred that the obtained mean difference of 8.318 was not by chance, but was a true difference indicating that the non-institutionalised elderly were able to cope with their problems in a more effective way as compared to that of the institutionalised elderly. This clearly showed that elderly living in their homes were more able to face their problems in a better way.

“Table: 1. Comparison of coping strategies adopted by the institutionalised and home living elderly.”

S. N.	Variables	Elderly in Institutional Setting n = 66		Elderly in Home Setting n = 66		Mean D	SE D	't' value	Sig. (2-tailed)
		Mean	SD	Mean	SD				
1	Overall Coping Strategies	37.82	6.90	46.14	5.98	8.31	1.12	7.394*	0.000

*t value significant at 0.05 level of significance.

$t_{(130), .01} = 2.62$ and $t_{(130), 0.05} = 1.98$

Chi-square values are presented in Table 2 which shows the association between coping strategies and selected socio-demographic characteristics of the elderly. The table depicts that the coping strategies of the elderly in institutional setting had significant association with inter-personal relations ($p < 0.01$), educational status ($p < 0.01$), and monthly income ($p < 0.05$) and no association with marital status,

present job status, type of family belonged, health status and gender ($p > 0.05$). It also indicated that the coping strategies of the elderly living in home setting had significant association with present job status, monthly income and type of family ($p < 0.01$) and no association with educational status, marital status, interpersonal relations, health status and gender ($p > 0.05$).

“Table: 2. Association between coping strategies and selected socio-demographic characteristics of the elderly.”

S. N.	Respondent Characteristics	Elderly in Institutional Setting n = 66			Elderly in Home Setting n = 66		
		Chi-Square Value	df	Asymp. Sig. (2-sided)	Chi-Square Value	df	Asymp. Sig. (2-sided)
1	Educational status	24.822**	10	0.006	14.934	12	0.245
2	Marital Status	7.108	8	0.525	4.770	4	0.312
3	Present Job Status	2.327	4	0.676	20.273**	8	0.009
4	Monthly Income	12.726*	6	0.048	27.537**	8	0.001
5	Type of family belong/belonged	2.875	2	0.237	10.844**	2	0.004
6	Interpersonal Relations	22.232**	4	0.000	7.266	4	0.122
7	Health Status	4.480	4	0.345	0.523	2	0.770
8	Gender	0.360	2	0.835	1.081	2	0.582

*Significant at 0.05 level and **significant at 0.01 level of significance

Correlation between psychosocial problems and coping strategies

The data presented in Table 3 portrays that there was a significant negative relationship between psychosocial problems and coping strategies of the elderly living in both the settings ($p < 0.01$). It can be

interpreted that with the adoption of effective coping strategies, severity of psychosocial problems decreased and vice versa. Alternatively, as the psychosocial problems increase, the coping strategies become less effective and vice versa.

“Table: 3. Correlation between psychosocial problems and coping strategies adopted by the elderly.”

Settings	Variables	Mean Score	S.D.	'r'	Sig. (2-tailed)
Institutional	Psychosocial Problems and Overall Coping Strategies	40.12	14.791	-0.7338**	0.000
		37.82	6.904		
Home	Psychosocial Problems and Overall Coping Strategies	18.83	14.722	-0.625**	0.000
		46.14	5.989		

** Correlation is significant at 0.01 level (2-tailed)

$$r_{(64), 0.05} = 0.2423 \text{ and } r_{(64), 0.01} = 0.3150$$

Discussion

A comparison of the personal data of the institutionalised and non-institutionalised elderly (home living elderly) revealed that almost 41% of the elderly in institutional settings had no income whereas in home settings, 76% of the elderly had income of their own. Also, majority of the elderly (59%) were married and living together in home settings whereas in institutional settings, 64% of the elderly were widow/ widower or unmarried. The findings of the study are in consistence with the study conducted by Nagpal and Chadha (1991) who found that the incidence of widowed persons was relatively higher in institutional group (48.3 per cent), compared with that of family group (25%). Also it was found that the number of subjects with no income was significantly higher (16.6%) in the institutional group as compared with that of the family group (1.6%) [5].

The present study exposed that the respiratory disease and arthritis held the greatest percentage in institutional (24 per cent and 23 per cent respectively) and in home settings (21 per cent and 31 per cent respectively) followed by eye problem (18 per cent in institution) and diabetes (15.4 per cent). A study conducted by Lena et al., (2009) also showed that a majority of aged had health problems such as hypertension (59.1 per cent) followed by arthritis (41.3 per cent), diabetes (10.3 per cent), asthma (10.7 per cent) and cataract [6].

An exploration into the reasons for institutionalisation of elderly revealed that 50 per cent of the elderly left home because of no one to take care, followed by reasons like conflicting relationship with the family (33 per cent), lack of care by family members (21 per cent) and 15 per cent of the samples had economic reasons. The findings of the present study are in line with Rani (2001) who found that most of the residents came to stay in old age home because there was nobody to take care of them or could not afford to sustain themselves [7]. The findings are also in conformity with the findings of study conducted by Ramamurti (2001), Bansod & Paswan (2006) and Devi & Murugesan (2006) [8-10].

The study showed that coping strategies were higher in home settings (46.14) than in institutional settings (37.82). These findings are in consistence with the study findings of Minal & Kamala (1995) according to which institutionalised elderly are having poor adjustments as compared to the non-institutionalised elderly [11]. It is clearly evident from the above findings that the coping strategies of institutionalised elderly are significantly less than their home living counterparts.

Also coping strategies of the elderly in institutional setting were dependent on inter-personal relations, educational status, and monthly income and independent of marital status, present job status, type of family belonged, health status and gender. Similarly, the coping strategies of the elderly living in

home setting were dependent on present job status, monthly income and type of family and independent of educational status, marital status, interpersonal relations, health status and gender.

It was also found that there was negative relationship between psychosocial problems and coping strategies of the elderly in both the settings indicating that as psychosocial problems increase the coping strategies become less effective and vice versa.

The results indicated that the elderly people need special attention as a special concern group. There is much scope to reduce the physical and psychosocial problems and improve the quality of life of the elderly by providing health care services based on the needs of the elderly. There is also a need for organising counselling programmes for the caretakers and the elderly living in family and staying in the geriatric homes. Much of the psychosocial problems can be prevented or minimised with communication and having people to share the problem.

Conclusion(s)

The coping strategies adopted by the elderly living in institutional settings were less effective as compared to that of home living elderly. There was significant difference in mean scores of coping strategies in institutional and home setting. This shows that the institutionalized elderly were facing more psychosocial problems and they were not able to cope with those problems in an effective manner as the elderly in home settings do. This may be due to neglect from the family members. It also indicated that effective coping strategies should be developed at all levels in order to fight with the growing problems of the elderly.

the children and can supervise household work. Elderly should not be detached from the children. The planning for old age should be started while the parents are at adulthood with respect to finances, type of work, involvement in decision making, taking benefit of their lifelong experiences. Older adults should be trained for active ageing so that they can participate in the development of nation. Institutionalized elderly as per

their capability should be involved in useful works that they know and we can make use of their experiences.

It is the time to understand that if we do not plan now, our future can be same as theirs and if our children do not see us caring for our elderly, one day we can also be in the same situation.

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