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Life Satisfaction Among Urban Elderly

Implications For Social Work Practice

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India is witnessing a revolution in population ageing. An increased effort is required to understand the social and economic impact of this demographic transformation. In the Indian society, old age is often seen as a stage of weakening health, loneliness due to death of loved ones and separation from children. These changes subsequently impact life satisfaction among the older adults. This study was done to assess the level of life satisfaction among the elderly and to identify its determinants and conceptualise the implications for social work practice with the elderly in urban settings. Life satisfaction of the elderly – an effect variable- was studied in relation to a set of cause variables using the property-disposition approach of social research. Standardised scales were used to measure the key variables. Overall, about 40 % of the variance in life satisfaction was explained by the four predictor variables, and this was statistically significant ($F(4, 280) = 54.866$, $p < 0005$). Considering the incredibly large number of variables that could affect an individual's level of life satisfaction, the ability to explain such a large amount of variance with only four variables is impressive. It is imperative for professional social workers to equip themselves with special intervention strategies and techniques and play a constructive role in enabling the elderly to live the last phase of their life in a contented manner.

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INTRODUCTION

According to the projections made by the United Nations (2001), the world population of the elderly in 2000 was 608 million and is expected to reach 754 million by the end of 2009. India contributes to about 12 % of the global elderly and this figure is expected to reach 15 % by 2020. According to the 2001 Census of India, since 1961 the sharp decline in mortality levels in the older age groups initiated a process of population ageing and the population of elderly reached a staggering 81 million. These figures are expected to escalate to 107 million by the end of 2010. The elderly population in India grew from 6.5 % of the total population in the year 1981 to 7.9 % in 2009.

Earlier, ageing, as a social problem did not preoccupy societies. Life expectancy was low, only a few survived for long years. It was easier to respect the elders as wise and as people safe-guarding tradition. Social mechanisms were created which encouraged the aged to step away from the management of everyday concerns. Today, demographically the numbers of old people in the population are increasing. With improvement in medical sciences the old are living longer. Definition of old age, categorising the old and roles of the ol, are being revised and redefined. They are tending to be very much a part of family and society and are making their presence felt.

Late adulthood is associated with a number of predictable life transitions including loss of spouse, children, relatives and friends, changes in health, income, career status and connection with one's social network. Decline in income may not be as severe as disruptions in established social roles that have been maintained across the life span. When these transitions occur simultaneously with the ageing process their individual effects worsen a person's life and his existence. In old age often the only salvation or deliverance unique to our society in India is resignation to fate or seeking solace in a spiritual way of life. These changes subsequently impact life satisfaction among the elderly.

REVIEW OF LITERATURE

In India, Ramamurti and Jamuna have done noteworthy studies on Life Satisfaction, Successful Ageing and on many other aspects related to the aged. They also have to their credit many measurement scales, which they have developed. In a study on life satisfaction by Ramamurti (1970) on older individuals between 50–70 years of age, results indicated decline of life satisfaction around the 55th year and also beyond the 61st year and improvement in between these. He argued that the first decline may be due to retirement effects and the later decline due to psychological and physical effects of old age.

In a study on markers of successful ageing, Ramamurti (1996), found that good-mental health, life satisfaction, including satisfaction with present life and adjustment were important to ensure a happy old age. The results for women indicated that self-accepdtance of ageing changes were related to the belief in the philosophy of *karma* and after-life. For men, the results showed that self acceptance, good interfamilial and spousal interaction, self perception of health, flexibility of behaviour, perception of social

supports, external loci and positive acceptance of ageing were found to be positively related to happiness in old age.

Rudinger and Thomas (1990) reiterated that the measure of successful ageing was life satisfaction and a sense of well-being in the face of declining health. While successful ageing and life satisfaction remain to be defined, the authors agree that these are the ultimate goals that human beings strive to achieve in their entire lives.

Health

Joshi and Sengupta (2000) state that the psychophysical problems that the elderly experience due to ageing and associated socio-cultural, nutritional and environmental factors demand that the health of the elderly be perceived within a holistic perspective. An analysis of data in the study done by Anantharaman (1980) revealed that among the elderly, those who were younger, active, able to adjust to different situations and environments, still associated with their profession and belonged to the upper social class rated their health to be good. Those who were old, less active, unable to adjust to changing situations and environments, associated with an unskilled occupation and belonged to lower social classes rated their health to be poor.

Siva Raju (2002) has reported that the notion of old age as an age of ailments and physical infirmities is deeply rooted in the Indian mind. He has further mentioned that the mental health of the elderly, is also deteriorating, as they are not free from mental worries owing to unfinished familial tasks. Rowe and Kahn (1997), Forsyth, Roberts and Robin (1992) found health was moderately correlated with life satisfaction. Ramamurti (1995) stated in his study that good mental health, psychological adjustment and life satisfaction were the three criteria for successful ageing. According to him, these three criteria are positively correlated. He further stated that, it is not illness, but its perception that is of consequence and the significant factor.

Loneliness

Peters (2004) addresses one of the wide spread issues of ageing in contemporary society, which is isolation and loneliness. According to him, social isolation and loneliness increases as people age and as family and friend networks become smaller. Social isolation can occur without the presence of loneliness, while loneliness can occur even with many social contacts.

He also found that lack of intimate relationships, increased dependency and loss (i.e., friends, home, previous lifestyle, independence and self-identity) were all found to increase loneliness.

According to Jai Prakash (2004), loneliness and concerns about progressive health-decline caused anxiety. The aged could not perceive any advantage in living alone but had adjusted to the reality. Jamuna and Lalitha (2004) found that feelings of loneliness were high among the widowed. They inferred that the amount of loneliness, health, happy period in life, and life satisfaction may be crucial factors in the successful ageing of the elderly.

Social Support

A study by Kaur and Kaur (1987) revealed that the social supports network of the aged was a major contribution to their general sense of well-being in spite of the age related problems. Gangrade (1988) concluded that the family supports to the aged existed in the form of financial and social help while the elderly continue to feel isolated and emotionally deprived. Chadha and Nagpal (1991) in their study found that social supports and life satisfaction were significantly related to each other and the factors were found to be higher among non-institutionalised males than among females compared to institutionalised elderly. Nathawat and Rathore (1996), Chadha and Aggarwal (1990) found that elders with high social supports generally appeared to be more satisfied with life and entertained higher positive effect and lesser hopelessness than the aged who had low social supports.

Conner (1979) found that both number and frequency of social ties were unrelated to life satisfaction, although kin, children play a central role in the supports network of elderly; family availability and interaction exhibit little relation to subjective well-being. Hawley and Klaukave (1988) investigated associations between social supports, health practices and life satisfaction among elderly and found that subjects satisfied with interpersonal relations were more satisfied and engaged in more healthful practices than subjects who were not satisfied.

On a study of 100 randomly selected elderly above the age group of 60 years, Das and Satsangi (2008) indicated that there was significant positive correlation between social support and life satisfaction among the elderly people who identified members with whom they could share their concerns freely.

Spiritual Well-being

Neill and Kahn (1999) studied the role of personal spirituality and religious social activity on life satisfaction of older widowed women. They found that social religious activity like attendance at church meetings and services, volunteer activities associated with religion and other religious activities involving two or more people, appeared to be associated with life satisfaction rather than spirituality.

Moberg (1995), states that research on personal adjustment in old age began in the late 1940s. Several studies have shown relationships between life satisfaction, morale, successful ageing, or related conceptualisations of total wellness and various aspects of religion and spirituality. Higher religious commitment and involvement are associated with higher life satisfaction or subjective well-being. He summarises in his book (Moberg 2001, p. 67) that high levels of religiousness and spirituality are correlated positively with life satisfaction.

Ushashree and Basha (2003) did an interesting study to find out how satisfied were the aged persons living in ashrams (religious retreats) and devoting their time to religious practices. Do they cope better and was there any difference in their motivational styles and meaning in life? There were no differences found in religiosity and meaning in life scores. Jain and Sharma (2004) in their study of 100 older adults aged 60–75 years used the religiosity scale of Bhushan (1990) and the Comprehensive Quality of Life Scale–Adult, of Cummins (1996). Engagement in activities was assessed by asking about involvement in various activities. It was found in the study, that, religiosity as well as productive engagement in work does play a pivotal role in individual's quality of life. Ramamurti (2004) has posited by stating that gerontological research is multidisciplinary and an integrated understanding of the multifaceted status of the elderly is necessary for getting a holistic picture of the Indian elderly.

Although several research studies have brought into sharp focus the need to understand the importance of life satisfaction as an important indicator of successful ageing, hardly any effort has been attempted to determine the contributing factors. The review also shows that no effort has been made so far to analyse cause-effect relationship among variables related with life satisfaction among older adults using trivariate analysis (Nachmias and Nachmias 2000).

This study was contemplated to assess the level of life satisfaction among the elderly and identify its determinants to conceptualise social work interventions with urban elderly.

METHODOLOGY

In this study, life satisfaction of elderly — an effect variable — was studied in relation to a set of cause variables using the property-disposition approach of social research, Nachmias and Nachmias (2000). The 'property' in this study is the age of the older adults. By virtue of being older adults the respondents possessed certain characteristics, which determined their life satisfaction. The key variables identified were physical and psychological health, loneliness, social supports and spiritual well-being. These variables were considered as cause variables for this study. The unit for the study comprised the twin cities of Hyderabad and Secunderabad (Andhra Pradesh).

Sampling

The 1999 electoral roll was taken as the base to know the population of the elderly in the twin cities of Hyderabad and Secunderabad. The data was procured from the Election Commission of India, Andhra Pradesh, on a compact disk, and was analysed with the aid of the Microsoft Excel Software Package. The elderly between the age group of 60–75 years were selected for the study. It was found that about 2, 00,000 elderly were registered as voters in the rolls. This data was checked and sifted to eliminate erratic and irrelevant data. The data was mixed up to cancel out the stratification existing in electoral data as they are arranged by location.

Based on the assumptions of probability sampling, Krejcie and Morgan's (1970) table was used to determine the size of the sample. As per the table, a sample of 385 was calculated for a population ranging from 75,000 to 10, 00,000. Out of the selected sample, the researcher could locate 285 elderly who conveyed their consent to participate in the study. It was found that while a large number of the elderly were not registered in the electoral rolls, some had shifted residence, some had addresses that could not be located, or were sick and bed ridden.

Attrition rate was high also because of the comparatively higher death rate. As per the data available in the 2001 census, it was found that of the total death rate among the 65 years and above population in AP, the death rate in urban areas was reported to be 34.90 %.

Being aware of the consequences of higher attrition rate, the researcher calculated the standard error of mean as well. The study was conducted with a sample of 285 respondents. While analysing personal data like age along with arithmetic mean, standard deviation and standard error of mean were calculated to see if the sample represents the population. It was found that the standard error of mean (0.324) was negligible. This justifies the representativeness of the sample size.

Tools of Data Collection and Data Analysis

Relevant questions were included in the questionnaire to collect demographic information of the sample. Rating scales were used to measure the dependent and independent variable. The questionnaire was translated into Telugu. It was pre-tested by administering both the English and the Telugu version to seven individuals who were experts in both the languages. A comparison showed that the responses were more or less the same for both. Split half reliability test was applied to assess the reliability of the instrument and it was found that all the scales included were reliable as seen in Table 1. SPSS package was used to perform the statistical analysis of the data.

TABLE 1: Reliability Indices

Scale	***Description***	***Indices***
Life satisfaction	Inventory -A (LSI-A) by Neugarten Havighurst and Tobin (1961)	0.8780
Physical and Psychological Health	Inventory by Ramamurti and Jamuna updated in 1989, 1992	0.7000
Loneliness	UCLA Loneliness Scale (version-3) by Russell (1996)	0.8574
Social supports	Inventory for the Elderly by Ramamurti and Jamuna (1991)	0.5256
Spiritual well-being scale	Ellison and Smith (1991)	0.7111

To measure Physical and Psychological Health a scale developed and standardised by Ramamurti and Jamuna (1989) was used. The test-retest reliability was found to be 0.93 for Part A and 0.91 for Part B.

The revised University of California at Los Angeles (UCLA) Loneliness Scale revised by Russell (1996) was used to evaluate the extent of loneliness. The revised scale has a high internal consistency with a coefficient of alpha of 0.96.

Perception of social supports was measured by using the Social Supports Inventory for the Elderly developed and standardised by Ramamurti and Jamuna (1991). The social supports inventory discriminated significantly at 0.01 level, (t=9.40).

The Spiritual Well-Being Scale developed and standardised by Paloutzian and Ellison (1979) was used to measure the level of spiritual well-being of the elderly. The Test Re-Test Reliability Coefficients was found to be 0.93.

After ascertaining the level of reliability of the scales, the questionnaire was administered to the respondents (N=285). The scores obtained by the respondents were summed up and analysed. Results are presented in Table 2.

Data in Table 2 shows the statistical results of score analyses of each instrument. These results reflect the level of (High, Medium and Low) physical and psychological health, loneliness, social supports, spiritual well-being and the dependent variable - life satisfaction.

As per the norms prescribed by the author of the scale, low score on physical and psychological health indicates good health. Analysis of the scores shows that on an average the respondents have obtained low score of 7.12 (33.90 % of the total score of 21). This indicates that, by and large, the older adults selected for the present study perceived good health. However, the higher order of variance (C.V. = 54.63 %) suggests that overall scores obtained by the respondents varied extensively.

With regard to the variable loneliness, statistical analysis shows that on an average the respondents have obtained high score of 37.82 (63.03 % of the total score of 60). This shows that the older adults, in general, perceived higher level of loneliness. The variance (C.V. = 22.55 %) in overall scores obtained by the respondents suggests that loneliness was more or less uniform among them.

Data analysis shows that on an average the respondents have obtained high score of 53.64 (57.06 % of the total score of 94) on the Social Supports Scale. This shows that the older adults, in general, perceived higher level of social supports. The low variance (C.V. = 19.43 %) in overall scores suggests that the level of social supports was more or less uniform among respondents.

TABLE 2: Score Analyses

Variable	*Mean*	*S.D.*	*C.V.*	*Range*	*Minimum Score*	*Maximum Score*	Q_1	Q_3
Physical and Psychological Health	7.12	3.89	54.63	20.00	1.00	21.00	5.00	9.00
Loneliness	37.82	8.53	22.55	38.00	22.00	60.00	32.00	43.00
Social Supports	53.64	10.42	19.43	83.00	11.00	94.00	48.00	59.00
Spiritual Well-Being	88.05	9.56	10.86	56.00	54.00	110.00	83.00	95.00
Life Satisfaction	9.23	5.26	56.99	18.00	0.00	18.00	5.00	14.00

Notes: S.D. = Standard Deviation, C.V. = Coefficient of Variance, Q1 = First Quartile, Q3 = Third Quartile.

Analysis of the scores shows that on an average the respondents have obtained a high score of 88.05 (80.04 % of the total score of 110) on the Spiritual Well-being Scale. This indicates that, by and large, the older adults selected for the present study perceived higher level of spiritual well-being. The variance (C.V. =10.86 %) in overall scores obtained by the respondents suggests that spiritual well-being was more or less uniform among them.

With regard to the dependent variable-life satisfaction, statistical analysis shows that on an average the respondents have obtained a high score of 9.23 (51.28 % of the total score of 18). This shows that the older adults, in general, perceived higher level of satisfaction. However, the higher order of variance (C.V. = 56.99 %) suggests that overall scores obtained by the respondents varied extensively.

FINDINGS AND DISCUSSION

Demographic Characteristics

The demographic characteristics of the sample are shown in Table 3.

TABLE 3: Demographic Characteristics of the Respondents

Variable	*Frequencies*	*Percentage*
Age (in years)		
60–65	70	24.60
66–70	95	33.30
71–75	77	27.00
76–80	33	11.60
81–85	9	3.20
86–90	1	0.30
Total	285	100.00*
Gender		
Male	170	59.60
Female	115	40.40
Total	285	100.00

Variable	*Frequencies*	*Percentage*
Religion		
Hindu	231	81.00
Muslim	43	15.10
Christian	11	3.90
Total	285	100.00
Marital Status		
Married	200	70.20
Widowed	82	28.80
Divorced/Separated	3	1.00
Total	285	100.00
Level of Education		
Secondary School Certificate and Below	178	62.50
Undergraduate	91	31.90
Postgraduate and above	16	5.60
Total	285	100.00
Earlier Occupation		
Government Organisation	127	44.60
Private Organisation	98	34.40
Self-employed	34	11.90
Housewife	26	9.10
Total	285	100.00

Note: *mean $\chi 2=70$, SD=5.47.

The respondents in this study were young-old in the age group of 66 to 70 years. Majority of the respondents were male Hindus. Most of them continued to be married while nearly one third of them were widowed. Majority had studied till the Secondary School Certificate level and most had worked in government organisations.

Key Variables and Life Satisfaction

An analysis of bivariate association between independent key variables, namely, physical and psychological health, loneliness, social supports, and spiritual well-being and the dependent variable — life satisfaction — showed statistically significant association between the independent and the dependent variable. To know whether the bivariate association is non-spurious or there is a third variable which is effecting the relationship (spurious) the bivariate relationships were re-examined by controlling the effects of the third or independent variables. This was done by preparing trivariate tables (partial crosstables) (Nachmias and Nachmias, 2000: 387).

Physical and Psychological Health and Life Satisfaction

Bivariate analysis of data revealed that, respondents with good physical and psychological health were more likely to have a high level of life satisfaction. Lher, (1982) Fernandez-Ballesteros, Zamarron and Ruiz, (2001), also found that elders with poor health, chronic problems or pain scored lower on life satisfaction than healthy people and subjective health according to them was found to be the best predictor of life satisfaction. The results of this study also corroborate the findings of Srinivasan (1988), Bose (1993), Anil and Pradhan (1996), Jai Prakash and Sreenivas (1997), and George (1999). However, in the trivariate analysis (Nachmias and Nachmias, 2000: 387) this association did not exist for individuals with a high degree of loneliness or for individuals with a high degree of social supports. The association seemed to remain regardless of the levels of spiritual well-being.

Loneliness and Life Satisfaction

It was found in this study that respondents with a high level of loneliness were less likely to have a high level of life satisfaction. The finding is similar to the findings of Peters (2004) who states that social isolation and loneliness increased as people age and as family and friend networks become smaller. Jamuna and Lalitha (2004) infer that the amount of loneliness, health, happy period in life, and life satisfaction may be crucial factors in the successful ageing of the elderly. However, in the trivariate analysis (Nachmias and Nachmias, 2000: 387) this association did not seem to exist for respondents with poor physical and psychological health; low level of social supports and with a low level of spiritual well-being. Moberg (2001: 78), appropriately states that old age necessarily entails a unique aloneness that is proper to this time in life. The challenge is not to runaway from loneliness and aloneness, for it can be “the key to spiritual life”.

Social Supports and Life Satisfaction

Analysis of data in this study revealed that levels of social supports seemed to be positively associated with levels of life satisfaction. The findings in this study are similar to the findings of Chadha and Nagpal (1991), Nathawat and Rathore (1996), Chadha and Aggarwal (1990), Das and Satsangi (2008), who found that elders with high social supports generally appeared to be more satisfied with life. Similarly, Hawley and Klaukave (1988) found that subjects satisfied with interpersonal relations were more satisfied with life and engaged in more healthful practices. In the trivariate analysis (Nachmias and Nachmias, 2000: 387), it is interesting to note that the association between the variables remained, regardless of the level of spiritual well-being. However, this association did not seem to be present for respondents with good physical and psychological health or with a high level of loneliness.

Spiritual Well-being and Life Satisfaction

In the bivaraite analysis, it was found that elders with a low level of spiritual well-being, seemed to have a low level of life satisfaction. The findings were not similar to the findings of Neill and Kahn (1999), who found that social religious activity like attendance at church meetings and services, volunteer activities associated with religion and other religious activities involving two or more people, appeared to be associated with life satisfaction rather than spirituality. Moberg (2001) summarises that there is overwhelming evidence from research, that high levels of religiousness and spirituality are correlated positively with life satisfaction, health, healing, and well being.

However, the bivariate association did not seem to remain for levels of physical and psychological health and spiritual well-being. It was also revealed in the trivariate analysis (Nachmias and Nachmias, 2000: 387) that spiritual well-being was associated with life satisfaction, regardless of the degree of loneliness. In addition, spiritual-well being was not related to life satisfaction only for respondents with a high level of social supports. A summary of analysis is presented in Table 4.

Contribution of Factors Determining Life Satisfaction of Elderly

Further analysis was done to find out the contribution of these factors. Overall, about 40 % of the variance in life satisfaction was explained by the

four predictor variables, and this was statistically significant (F (4, 280) = 54.866, p < 0005).Original bivariate association is spurious.

All four predictor variables had statistically significant relationships with life satisfaction. First, physical and psychological health was negatively related to life satisfaction (â = -. 395, t = -7.189, p < .0005). That means older adults with low scores on physical and psychological health (meaning 'Good Health') had higher levels of life satisfaction. Second, loneliness was inversely related to life satisfaction (â = -.206, t = -4.221, p < .0005), indicating that respondents who were more lonely had lower levels of life satisfaction. Third, social supports were positively related to life satisfaction (â = .209, t = 4.258, p < .0005), indicating that individuals with higher levels of social supports tended to have higher levels of life satisfaction. Fourth, spiritual well-being was positively related to life satisfaction (â = .125, t = 2.506, p = .013), indicating that respondents with higher levels of spiritual well-being tended to have higher levels of life satisfaction.

Considering the incredibly large number of variables that could affect an individual's level of life satisfaction, the ability to explain such a large amount of variance with only four variables is impressive.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Given the steady growth in the population of the elderly, there will be a need for a significant growth in the population of social workers who are trained specifically to respond to the needs of this population. They will need to be capable of responding to evolution of new and different ways of tackling the problems of the elderly. This is a very important requirement because over the next few decades, the body of knowledge relating to the problems of the elderly and methods of intervention will expand and evolve rapidly.

The study conducted by the author points at certain factors that play a role in influencing life satisfaction. It is apparent that the first requirement for the social work community is to study these and other parameters more extensively and design intervention strategies. At the conclusion of this study, we can suggest, that, the existing infrastructure of old-age homes and day-care centres be used to study the veracity of intervention strategies and the consequential benefits, so that approaches may be routed firmly on such work.

TABLE 4: SUMMARY OF FACTORS DETERMINING LIFE SATISFACTION

Original bivariate association between	**Controlling for**	**Original bivariate association effected in case of**	**Inference**
Physical and Psychological Health And Life Satisfaction	Loneliness	High-Loneliness	Conditional Association. Loneliness emerged as intervening variable
Physical and Psychological Health and Life Satisfaction	Social Supports	High-Social Support	Conditional Association Antecedent
Physical and Psychological Health and Life Satisfaction	**Spiritual well-being**	**Original bivariate association not affected.**	**Original bivariate association is non-spurious.**
Loneliness and Life Satisfaction	Physical and Psychological Health	High (Bad)-Physical and Psychological Health	Conditional Association Intervening
Loneliness and Life Satisfaction	Social Supports	Low-Social Supports	Conditional Association Antecedent
Loneliness and Life Satisfaction	Spiritual Well-Being	Low-Spiritual Well-Being	Conditional Association Intervening
Social Supports and Life Satisfaction	Physical and Psychological Health	Low(Good) Physical and Psychological Health	Conditional Association Intervening
Social Supports and Life Satisfaction	Loneliness	High-Loneliness	Conditional Association Intervening
Social Supports and Life Satisfaction	**Spiritual Well-Being**	**Original bivariate association not affected**.	**Original bivariate association is non-spurious.**
Spiritual Well-Being and Life Satisfaction	Physical and Psychological Health	Original bivariate association disappeared	Original bivariate association is spurious
Spiritual Well-Being and Life Satisfaction	**Loneliness**	**Original bivariate association not affected**.	**Original bivariate association is non-spurious**.
Spiritual Well-Being and Life Satisfaction	Social Supports	High-Social Supports	Conditional Association. Intervening

Health, Loneliness and Social Supports

Health is a variable, which cannot be controlled either by the elders or by the social workers using interventions. Planning of awareness and education programmes about the importance and maintainenance of good health into old age is an area of work for social workers. Social workers could help the elderly not to see ageing as merely a number count or as a dreadful stage in life full of problems. Instead, positive emotions, maintaining a social circle, and remaining active and fit would actually contribute to happiness.

Empty nest syndrome can be positively perceived by elders as having accomplished and completed responsibilities and enjoying one's independence. Social workers should encourage the elderly to engage in activities they have always wanted to do such as writing, travelling, pursuing education and volunteering, if health permits. Travelling in groups with peers is healing. Loneliness and lack of social supports can be overcome to some extent. Multiservice centres as suggested by Desai and Siva Raju (2000: 401) are ideal institutions for the elderly to spend time carrying out various activities during the day, while keeping in touch with their families when they go home in the evening. Companionship and help can also be extended to the elderly who are frail, lonely, need help and cannot come out of their houses. Volunteers from the centre can go and visit them as "friendly visitors" and help them in whatever way possible.

Spirituality and Social Work

Spiritual intervention in gerontological practice could include helping elderly to reflect on losses, gathering spiritual information and enabling them to associate with helpful spiritual support systems. Having knowledge of different faiths is important as spirituality is a fundamental dimension of human living. Moberg (2001) reminds us that social work was found in the context of the spiritual-religious domains of societies in Europe and America. In India, religion and spirituality are important aspects of the everyday lives of older persons. If this fact is lost to social workers, they miss an opportunity to link older clients to a major source of strength for coping and for support systems that serve to enhance the quality of their lives.

Thus, the social workers can play a constructive role in enabling the elderly to live a fulfilling, enlightened, satisfied, and productive final phase of life.

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In urban areas, the elderly who preferred family eldercare reported significantly higher scores for subjective support (t=4.788, p<0.001), objective support (t=7.961, p<0.001) and overall social support (t=5.667, p<0.001).Â . Analysis of differences and changes of life satisfaction of the elderly in urban and rural areas-Based on CLHLS project survey data[J]. Academia Bimestris 2015;1:101â€“10. OpenUrl. 30.â†µ. Preference of the urban elderly for caring facilities: Variation across different communities. China Soft Science, 1, 103â€“114. (In Chinese).Google Scholar. Gao, X. L., Yan, B. Q., & Ji, J. (2012). Urban eldersâ€™ desirable caring patterns and its rationality. Progress in Geography, 31(10), 1274â€“1281. (In Chinese).Google Scholar.Â Residential satisfaction, sense of belonging and loneliness among older adults living in the community and in care facility. Health & Place, 17(6), 1183â€“1190.CrossRefGoogle Scholar. Rosenberg, M. W. (1998). Factors Affecting Life Satisfaction Among the Elderly. You probably wonâ€™t find this surprising, but one of the most influential factors affecting life satisfaction for elderly people is wisdomâ€”defined as having â€œexpert knowledge in the fundamental pragmatics of life,â€ the tendency towards reflection on oneâ€™s own behavior and that of others, and kindness and empathy instead of egotism (Ardelt, 1997). While physical health, socioeconomic status, and social involvement can play a significant role in life satisfaction for elderly people (and for all people), wisdom was found to be almost twice as The role that psychological variables play in depression among elderly urban residents has received little research attention. Therefore, the purpose of this study was to examine the relationships between social capital, social capital satisfaction, self-esteem, and depression among elderly urban residents. We used the responses provided by 701 elderly persons to scales assessing social capital (i.e., network, trust), social capital satisfaction, self-esteem, and depression, as part of the Korea Welfare Panel Study (KOWEPS).Â Relationships between Social Capital, Social Capital Satisfaction, Self-Esteem, and Depression among Elderly Urban Residents: Analysis of Secondary Survey Data. by Hyun Jin Lee 1 , Dong Kun Lee 2,* and Wonkyong Song 3. 1. Self-reported life satisfaction differs widely between people and between countries. What explains these differences?Â Life satisfaction and happiness vary widely both within and among countries. It only takes a glimpse at the data to see that people are distributed along a wide spectrum of happiness levels. Richer people tend to say they are happier than poorer people; richer countries tend to have higher average happiness levels; and across time, most countries that have experienced sustained economic growth have seen increasing happiness levels.