



**6th INTERNATIONAL SOCIAL & APPLIED
GERONTOLOGY SYMPOSIUM**

“Knowing is not enough, we must apply. Willing is not enough, we must do”
Goethe (1749-1832)

Host: Akdeniz University Department of Gerontology
October 15-17, 2014, Antalya, TURKEY

Edited by **Özgür Arun**

PROCEEDINGS BOOK

6th INTERNATIONAL SOCIAL & APPLIED GERONTOLOGY
SYMPOSIUM



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PROCEEDINGS BOOK
6th INTERNATIONAL SOCIAL & APPLIED GERONTOLOGY
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Sponsored by / *Ana Sponsor:* allioglu Holding
Gerontoloji B6lümü



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PREFACE:

The coming of population aging is one of the most challenging issues confronting contemporary Turkey. Declining fertility rates along with improvements in life expectancy is positioning Turkey to witness increasing numbers of its younger citizens reaching “old age.” Turkey is undeniably part of global aging and cannot hide behind The Peter Pan Syndrome, thinking that somehow its population, like that of the fabled Neverland, will cease to age. Given its present population, with about 27% less than 15 years of age, some may suggest that demographic aging is not a real issue for Turkey. Others, however, recognize the impending reality and the need for innovative social policies that support both the young and older population groups rather than promote intergenerational conflict.

In Turkey today, there is much rhetoric and little visible evidence of positive actions to improve the care and well-being of older people. The government currently considers that the establishment of care facilities for older people is sufficient for their well-being. The care of the older population is not considered a high priority item on the political agenda. Therefore, gerontologists are calling for a strong response through research, education, and policy initiatives to dispel the belief that support for the aged is solely an individual and family responsibility without governmental support.

Within this framework, The Organizing Committee from the Department of Gerontology at Akdeniz University decided that the theme for the 2014 Symposium “Aging and Caregiving” needs to be:

- Inclusive of diverse groups and interests,
- Reflective of a range of issues and priorities relating to aged care, and
- Committed to addressing “human rights” in ways that are tangible and relevant for both caregivers and aged care recipients.

In the face of current and projected demographic trends there will be enormous challenges across the world to meet unprecedented demands and challenges in respect to a myriad of ageing related issues. Of primary concern will be the need to provide a better future for the coming cohorts of older people. In particular, caregiving is now a multidimensional reality in need of clarification that will allow for new interpretations and understandings that recognize the diversity within and between older population groups.

This 6th International Social and Applied Gerontology Symposium (ISAGS) aims to place the notion of caregiving in a wider framework that allows for the value added impact of research, policy, education and programming that either directly or indirectly supports both informal and formal caregivers who are engaged in caregiving of dependent older people. In a very important way it is now becoming quite clear that more attention and focus is needed to promote a wider recognition and value attachment to unpaid informal care throughout the world, including Turkey.

Topics and themes considered important for providing a valuable stimulus for collegial discussion and improved understandings of caregiving in the 21st century include but are not limited to:

- Culture, ethnicity and caregiving.
- Legal, policy and financial issues.
- The role of migrant care workers in ageing societies.
- Promoting self-care strategies for carers and helpers.
- Contemporary practices in palliative home care of older adults.
- Hospice a key component of end of life caregiving.
- Changing roles of family and community in an ageing society.
- The impact of migration on the level of intergenerational care and support .
- Modernization and the impact on caregiving.
- Aged care management programs in higher education.
- Education and training of health care professionals and allied support.
- The challenge of translating research into practice.
- Caregiving for persons with developmental disabilities, Alzheimer's Disease.
- The place of health promotion within a caregiving framework.
- Caregiving (informal & formal) as a public health priority.
- Future directions in practice, theory and research.
- Global trends in caregiver demand.
- Exploring creative solutions to support caregivers.
- Placing volunteerism in a caregiving framework.
- Understanding older people's loss, grief and quality of life.

It is time for Turkey to understand and act on the long-term economic, demographic, and social trends occurring at a rapid pace. Old age and social justice is a good starting point for examining equity imbalances to understand the disadvantages associated with gender, partnership status, migration, education, social class, health, religion, and ethnicity. Holding onto the myth that Turkey has a considerable young population is no longer realistic or sustainable in light of the impending pace of population aging that will dramatically increase the proportion of people aged 60 and older during the next 40 years.

The Peter Pan syndrome raises some serious questions surrounding the nature of citizenship in Turkey when consideration is given to both gender inequality and old age. The inequalities reported and discussed by colleagues attending the 6th ISAGS lend strong support to the opinion that citizenship rights are being violated.

Citizenship implies among other things that older people, like all people in a society, are entitled to a range of services that are relevant to their physical, social, economic, mental, and spiritual needs, which collectively contribute to their general well-being and quality of life.

Between 2000 and 2025, employed adults will represent the largest population group in cumulative population in the history of the country. This segment of the population can be considered as a demographic gift. Turkey should decide in what direction it needs to go both politically and economically provided by way of this gift. Otherwise, it may turn into a curse.

Özgür Arun

Chair of The Organizing Committee of 6th ISAGS & Head of the Dept. of Gerontology

A message from the 6th ISAGS main Sponsor, İbrahim Şencan, owner and CEO of Çalioğlu Holdings

Honorable Deans,

Distinguished guests representing 10 countries and highly esteemed scientists of Akdeniz University,

Valuable representatives of the press,

Ladies and gentlemen,

I welcome each of you to the site of the 6th International Social and Applied Gerontology Symposium on the theme of Active Ageing and Caregiving, with my sincerest respect.

I would like to begin by introducing myself. My name is İbrahim ŞENCAN. I am the owner and CEO of Çalioğlu Holdings. I graduated from Istanbul Technical University in 1953. Since that time, over the past 60 years, I've worked as an engineer and a contractor. I continue to have an active role in my company today.

The Department of Gerontology began scientific work 8 years ago for the first time in Antalya. Construction of our Gerontology building started shortly after that time. And the meaning of gerontology, the study of ageing, is a very important issue for everyone.

As one of our poets has said:

‘Inevitably, death eventually visits all of us. One day, you will sleep, and never wake up. God knows when, where, how and up until which age you will live only to depart from this earth.’

Another poet said:

‘Dying is the hardest thing, and living is even harder.’

There is no escape from death, for living creatures. A series of kings, sultans, emperors have passed through life on earth for centuries. Some of them even called themselves a god or goddess and still vanished forever.

People often say these words of good will to one another, ‘May God give you a healthy and peaceful long life.’

Ageing is a huge issue in the journey of life, inevitably leading to death for all living creatures. Especially for people 80 years of age and over, like myself, the issue is even

more imminent. Within this perspective, it is the aim of gerontology to make living, which the poet has declared harder than death, easier.

The central idea of our symposium is to emphasize the importance of gerontology.

We gladly welcomed the establishment of the Department of Gerontology 8 years ago, for the first time under the roof of the Faculty of Arts at Akdeniz University.

I offer gratitude, on behalf of humanity, to our rector İsrail Kurtcephe and all partners for their precious efforts.

We, Çalliođlu Holdings, wanted to contribute to the Department of Gerontology in a way which would provide a great service to humanity, atleast by constructing its building. Our building stands completed today and facilitates the university education of gerontology students.

I thank God for allowing our company to perform such a charity.

I sincerely wish each one of you a healthy and long life,

İbrahim ŐENCAN

Owner and CEO of Çalliođlu Holdings

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Symposium Program

October 15, WEDNESDAY

OPENING - Day-1:

15:00 – 16:00	Opening Ceremony	
16:00 – 16:45	İsmail Tufan	Keynote Speech A
16:45 – 17:45	Music Recital	

October 16, THURSDAY

Day-2

09:15 – 10:00	Neena Chappell	Keynote Speech B
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SESSION I

10:00 – 10:20	Terence Seedsman	Opening the mind's eye of the body politic to the everyday life of informal caregivers: A first-step for valuing unpaid caring of community-dwelling older adults
10:20 – 10:40	Karen A. Roberto	Changes in family structures and the care of older adults across the globe
10:40 – 11:00	M. J. Penning & Z. Wu	Spousal caregiving, stress and mental health: A Canadian study of caregivers in middle and later life
11:00 – 11:20	Discussion	
11:20 – 11:40	Coffee Break	

SESSION II

11:40 – 12:00	Nina M. Silverstein	Promoting healthy aging in your community: The Massachusetts model
12:00 – 12:20	Gentaro Mizugaki	<i>Raku-Raku Nouhou</i>: A multidisciplinary approach for aged farming communities to be sustained
12:20 – 12:40	Rachel Pruchno	Writing for publication in GSA journals: Increasing the odds
12:40 – 13:00	Discussion	
13:00 – 14:00	Lunch Break	

SESSION III

14:00 – 14:20	Ö. Arun & J. Holdsworth	Empowering older adults in Turkish society: Innovative social and health care service strategies
14:20 – 14:40	Tinie Kardol	Competence care: A new care concept aiming to achieve quality of life in residential settings for the elderly
14:40 – 15:00	Türkan Yılmaz	Health and care challenges facing international migrants: German – Turkish case study (Uluslararası emekli göçünde sağlık ve bakım: Türkiye Almanya örneğinde)
15:00 – 15:20	Bernd Gasch	Psychological first aid in emergency situations for older adults
15:20 – 15:40	Discussion	

SESSION IV

16:00 – 16:20	R. G. Heinze & J. Hilbert	MOPACT Project: Introduction
16:20 – 16:40	G. Naegele & K. Linnenschmidt	Promoting individual mobility in an ageing society
16:40 – 17:00	Rolf G. Heinze	ICT-based products and services supporting independent living in old age
17:00 – 17:20	G. Naegele, S. Schulze & M. Reichert	Potentials of social support and long-term care
17:20 – 17:40	Discussion	

October 17, FRIDAY

Day-3

SESSION V

09:40 – 10:00	James Collins	Where are older persons in the united nations post-2015 development agenda?
10:00 – 10:20	Patricia Brownell	Neglect, abuse and violence of older women: A human rights perspective
10:20 – 10:40	Susan Somers	Older women count: Addressing the harm of a lifetime of systemic neglect, abuse and violence against older women
10:40 – 11:00	Discussion	
11:00 – 11:20	Coffee Break	

SESSION VI

11:20 – 11:40	Ikuko Murakami	Personal communication networks among single older women: Ankara case study (Yaşlı kadınların toplumsal iletişim ağı: Ankara’da yaşayan kadın örnekleri)
11:40 – 12:00	A. Canatan & S. Oğlak	Building age-friendly environments in Turkey: Hospital example (Türkiye’de yaş dostu ortamların oluşturulması: Hastane örneği)
12:00 – 12:20	Melihat Kızıl	Relationship between depression and diet in older persons living in nursing homes (Huzurevinde yaşayan yaşlılarda depresyon ve beslenme ilişkisi)
12:20 – 12:40	Hamza Kurtkapan	Retirees’ associations and senior citizens’ participation to social life: The case of Istanbul (Emekli Dernekleri ve Yaşlıların Toplumsal Hayata Katılımları: İstanbul Örneği)
12:40 – 13:00	Discussion	
13:00 – 14:00	Lunch Break	

SESSION VII

14:00 – 14:20	Dena Shenk	Journey of a caregiver: Empathy and engagement
14:20 – 14:40	Anne L. Blaakilde	A Danish nursing home with a multi-ethnic profile: Challenges, negotiations, experiences
14:40 – 15:00	B. Seeberger, R. Akif Aktuğ, B. Schmidt	Evaluation of retired -people friendly Antalya project study
15:00 – 15:20	Discussion	
15:20 – 15:40	Coffee Break	

SESSION VIII

15:40 – 16:00	Jocelyn Angus	Innovative leadership in postgraduate curriculum: The key for effective leadership and management in aged care services
16:00 – 16:20	Yvonne Schikhof	A gerontechnology experience
16:20 – 16:40	B. Özdemir & V. Duyan	Long-term care (LTC) services in the UK and Turkey: A comparative perspective
16:40 – 17:20	Discussion	
17:20 – 18:00	Emer. Prof. Dr. Terence Seedsman	Closing Remarks



KEYNOTE SPEECH

October 16, 2014



Intersecting Inequalities, Implications for Caregivers

Neena L. Chappell¹

Abstract

Background: The concept of intersectionality has gained in popularity as a way to explore the co-occupancy of two or more statuses, typically disadvantaged statuses, without assuming additive effects. Among caregivers to older adults, much research suggests that being female, poor and older are disadvantageous social locations with undesirable consequences for the quality of life and well-being of caregivers.

Objectives: This paper examines what we know about the relation between gender, social class and age among spouse and adult child caregivers to older adults then presents preliminary analyses to explore their intersectionality in terms of their self-esteem, anxiety, depression and.

Methods: Review of existing knowledge then secondary analyses of a province-wide data set of caregivers to older adults in British Columbia, Canada. T-tests compare single and co-occupancy of the three statuses. The intersection of gender and relation between caregiver and care recipient is explored demonstrating the utility of the intersectionality concept beyond disadvantaged statuses.

Conclusions: The analyses indicate the usefulness of the concept of intersectionality not only for the co-occupancy of disadvantaged statuses but for any statuses. Among caregivers to older adults, they suggest that, in terms of depression, being male can be disadvantageous but in terms of anxiety and burden, being female can be. For the three negative well-being outcomes, being younger (<75), not older, is disadvantageous. They also point to the differences between negative well-being and positive well-being, the importance of measuring several outcomes, and the importance of not generalizing from one outcome to others not measured.

Key Words: self-esteem; anxiety; depression; burden; well-being

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Introduction

The history of caregiving research in gerontology is sympathetic to the demands of this role especially for those who are more disadvantaged. Research documents the greater toll of the demands of caregiving for women compared with men (Pinqart & Sørensen, 2005) and of the poor compared with those better off (Thoits, 2010). In the past, interest in the combined effects of occupying more than one disadvantaged status has been studied in terms of double, triple, and multiple jeopardy. The 'jeopardies' have been criticized as implying co-occupancy of two or more disadvantaged positions is additive (Acker, 2006; Denis, 2008), a criticism no doubt fuelled by the popularity of statistical techniques that measure linear relationships. More recently, the notion of intersectionality has gained in popularity in recognition of the fact that the intersection of two or more disadvantaged statuses can result in non-additive effects, that each can weaken, strengthen, or neutralize the influence of the other, compete with or supplement the other (Krekula, 2007). That is, the intersection of the roles we occupy is complex; this applies whether those statuses are considered ones of disadvantage or not.

Within the broader literature on the social determinants of health, i.e., not restricted to caregiving, disadvantage is often discussed in terms of social class, gender and race, with many other lower status positions added more recently (such as sexual orientation and persons with obesity). Age is also considered a disadvantaged status although less so in the broader literature than in gerontology where there is more interest, not only because of deteriorations in health but also because of persistent ageist attitudes within society (Calasanti, 2006). The concept of intersectionality or intersecting statuses, although typically discussed in terms of low status positions, need not be restricted to disadvantages only. We all occupy numerous positions, with varying degrees and types of status associated with each. And these multiple positions intersect within our lives, impacting our well-being and quality of life in complex ways. The notion of intersectionality facilitates thinking beyond examining one positional status either singly or linearly with another status and asks about the complex interactions of occupying several/multiple roles simultaneously.

Here, discussion begins with the notion of inequalities and their relation to health and quality of life generally before turning to caregivers to older adults in particular. The focus here is on three potentially disadvantageous statuses: lower social class, being female and being of older age, and their intersections, reviewing what we know and exploring some

original analyses that relate disadvantaged position to four caregiver outcomes. The paper ends with a brief discussion examining intersecting statuses that may not necessarily be disadvantageous. The discussion points to the complexity of the caregiving experience and the theoretical value of the notion of intersectionality.

Positional Disadvantages

The social determinants of health, “the economic and social conditions that influence the health of individuals, communities and jurisdictions as a whole” (Raphael, 2004:1) refer to social class, education, income, occupation, social exclusion, food security, transport, gender, race, disability, housing stress, social environments, among others (Raphael, 2009; World Health Organization, 2003). The social determinants of health, also studied in terms of population health, health promotion, and public health, garner widespread interest because of their foundational relationship to social inequality and inequity. Age is often not included in these lists, presumably because of the tendency to equate age with biology. However, within gerontology, old age is a commonly accepted dimension of inequality and inequity (McMullin & Cairney, 2004), related to many other social determinants of health such as education, income, social exclusion, etc. Here, interest is focussed on three social determinants of health: gender, social class, and age.

The adage ‘women are sicker but men die quicker’ summarizes the many findings pointing to women’s greater longevity but more acute illnesses, more chronic health conditions and more serious functional disabilities than men (Thoits, 2010). Interestingly, both genders suffer similar rates of mental health problems but women have higher levels of psychological distress and of mood and anxiety disorders; men have more alcohol and drug problems, substance use-disorders, aggressive behaviours and anti-social personality disorders (Kessler, Chiu, Demler, Merikangas, & Walters, 2005) suggesting in this area, women may not be worse off but rather may manifest their issues differently.

Much of the literature on women’s disadvantage concentrates on labour force and socio-economic differentials between women and men. Lower socio-economic status, whether measured in terms of lower education, income, occupational prestige, wealth, or a combined measure is related to higher rates of morbidity, disability, mortality, psychological distress, and mental disorder compared with those of higher socio-economic status or class position (House, 2002, House, Lantz, & Herd, 2005). The social gradient of health literature abounds with documentation of the disadvantage of lower social class for health, especially physical health. It is one of the most well-established relationships in the social sciences. Not only poverty per se but lower social status is bad for one’s health.

Old age is undeniably associated with declines in physical health although its association with various mental health measures is not clear. A review of Canadian research from 2000 to 2010 (Penning & Chappell, 2010) concludes that the prevalence of chronic illnesses and conditions and of resulting functional disability, increases from middle-age to later life. Other than cognitive impairment, the evidence does not suggest this is the case for mental *illness* including depression. Mental *health*, in terms of happiness and well-being, does not appear related to age and if anything, the relationship is opposite to that of physical health with older adults as happy as those in mid-life and happier than teens and young adults.

Chappell and Penning's (2012) review of the Canadian research within old age, finds that the older one is, the more likely s/he will have more chronic conditions and functional disability and it is worse still for women and those of lower socio-economic status, although not for all chronic conditions or disabilities. It is not at all conclusive that the same holds for mental health and well-being (life satisfaction, happiness, depression). Well-being appears to be high among seniors, without clear evidence of a decline but some suggestion of one in later old age. Even in terms of caregiver burden, it is not clear that burden increases among caregivers within old age; findings vary depending on the measures used. And caregiving per se is not a negative outcome; in Canada only 5% of caregivers to older adults say they are not doing well (Cranswick & Dosman, 2008). At the same time, 70% say caregiving is stressful, close to 80% say they have emotional stress and 70% that they need a break. According to Canadian research, caregiver stress decreases with age; among caregivers less than age 45, 81% report some stress; among those age 45 – 64, the figure is 68%, among those age 65+, the figure is 60% (Decima Research Inc., 2002).

One of the arguments as to why these statuses effect their incumbents negatively is due to differential exposure to stressful experiences. One factor is the discrimination (unfair or unjust treatment by others on the basis of gender, race-ethnicity, age, social class, sexual orientation, body weight, or other status characteristics) suffered by these individuals (Thoits, 2010). Other factors include less healthy living environments, hazardous working conditions, inability to buy healthy foods, inability to access proper health care when needed, and lack of autonomy and control over many spheres of their lives. Furthermore, both acute and chronic stressors tend to be concentrated in those groups that are also more deficient in stress-buffering assets such as mastery and self-esteem, compounding stress proliferation – a process by which an initial stressor gives rise to additional stressors such

as caregiving interfering with work performance or causing job loss or conflict with other family members.

Caregiving

Caregiving to older adults is itself a chronic or ongoing stressor (Pinquart & Sörensen, 2005; Thoits, 2010), characterized as devalued due to its association with women and with old age which is associated with decline, and weakness (Calasanti, 2006). It has been studied in numerous ways, often in terms of its physical and psychological/emotional demands on those providing care. Health, especially physical health, is often examined as a predictor of quality of life and well-being. Quality of life can refer to the person's perception of their position in life while well-being can refer to a person's valuation regarding their life. As Camfield and Skevington (2008) conclude from their review of history on subjective well-being and subjective quality of life, the two terms they are virtually synonymous with each other.

Quality of life and well-being are very broad terms used in multiple ways in the gerontological literature. Hansen, Sladsvold, and Ingebretsen (2013), Deaton (2008) and Knight and Rose (2011) distinguish between cognitive well-being (examples include life satisfaction and self-esteem) and affective well-being, sometimes referred to as subjective well-being (Pinquart & Sörensen, 2004) (examples include happiness and depression). It is often accepted that well-being is not unidimensional, that positive and negative aspects are related but different phenomenon that co-exist. That is, negative and positive affectivity are considered two separate dimensions, not opposite ends of one continuum. How they are related to one another, however, has not been resolved.

Not surprisingly, a great variety of outcomes is apparent in the literature. Selecting only four caregiver outcomes: self-esteem, burden, depression and anxiety, the lack of clarity within the literature in terms of consequences for the caregiver and in terms of how the concepts relate to one another is obvious. Self-esteem is a positive concept referring to one's sense of overall worthiness (Mruk, 2006; Pearlin, Mullan, Semple, & Skaff, 1990). Burden is arguably one of, if not the most studied caregiver outcome in gerontology. It is role specific and refers to the negative consequences of caregiving whether they be physical, psychological, emotional social and/or financial. It can be objective (such as tasks and/or hours of caregiving) or subjective. Some, such as Black and Almedia (2004) argue the concept of burden is not as clinically relevant as depression.

Depression refers to “both a mood state or symptom and to a syndrome (‘disorder’) comprising a collection of symptoms that often occur together in a recognisable pattern” (Dow, Lin, Tinney, Haralambous, & Ames, 2011). Anxiety can also refer to a disorder and clinically significant symptoms including excessive worries, obsessive thinking, compulsive behaviour, and panic attacks (Dow et al., 2011; American Psychiatric Association, 2013). Depression and anxiety often co-occur; Cooper, Balamurali, and Livingston (2007) conclude from their systematic review that most depressed caregivers are also anxious but that those who are anxious are not necessarily depressed, that caregivers are more anxious than non-caregivers and caregivers to those with dementia are more anxious than caregivers to those without dementia. Studying those 90+, Van der Wee, Gussekloo, De Waal, De Craen, and Van der Mast (2009) argue that anxiety is likely part of depression in old age, finding that among those who are depressed, those with and without anxiety do not especially differ.

It would appear that the four concepts are related to one another. For example, Badr, Acitelli, and Taylor (2007) report that negative role stressors such as burden and depression mediate the effects of self-esteem on caregiver mental health. Costa-Requera, Cristófol, and Cañete (2012) and Crespo, López, and Zarit (2005) find that self-esteem and burden are related to anxiety and depression; Cho and colleagues (2009), Denno and colleagues (2013), Garcia-Alberca and colleagues (2012) and Park and colleagues (2013) all report that burden is related to anxiety and depression. Conceptualizing the direction of influence differently, Ho, Chan, Woo, Chong, and Sham (2009) as well as Mekala and colleagues (2013) find both anxiety and depression related to burden, Grov, Fosså, Sørebo, and Dahl (2006) find that depression is related to burden, Cooper, Katona, Orrell, and Livingston (2006) find depression related to anxiety and Cooper and colleagues (2007) find burden related to anxiety. However, these studies are cross-sectional. Taken together, they tell us that the concepts are related to one another but do not tell us about causal direction.

Conducting a literature review including adults of all ages and including both cross-sectional and longitudinal research, Sowislo and Orth (2013) conclude that, in terms of self-esteem and depression, the vulnerability model is strongly supported. That is, low self-esteem leads to depression whereas the scar model is not supported, i.e., depression is much less likely to affect self-esteem. In terms of anxiety and self-esteem, the effect is reciprocal. This supports Orth, Robins, Trzesniewski, Maes, and Schmitt (2009) analyses

of two longitudinal data sets wherein they find that low self-esteem predicts depression but depression does not predict self-esteem.

Gender, Poverty, Age and Caregiving

There is much research on well-being and gender among caregivers. Most of it reports that caregiving takes a greater toll on women than on men (McGuire, Anderson, Talley, and Crews, 2007). Kim, Baker, and Spillers (2007) find, among caregivers to cancer survivors, men are more likely to report the experience has boosted their self-esteem than are women and that sons say the experience is less stressful than do daughters. When gender differences are reported for burden, females are more burdened than males (Beeson, Horton-Deutsch, Farran, & Neundorfer, 2000; Hooker, Manoogian-O'Dell, Monahan, Frazier, & Shifren, 2000; Kim et al., 2012). Among caregivers in Brazil (Carod-Artal, Ferreira, & Trizotto, 2009), in Spain (del Rio-Lozano, Garcia-Calvente, Marcos-Marcos, Entrena-Durán, & Maroto-Navarro, 2013) and in Hong Kong (Ho et al., 2009) women experience worse depression and more anxiety than men. In the U.S., Mahoney, Regan, Regan, and Livingston (2005) report that women experience more anxiety than male caregivers but not more depression. While Grov, Dahl, Moum, and Fosså (2005) find no difference in the level of depression between men and women, they report that caseness of HADS-defined depression is more prevalent in women. BurrIDGE, Barnett, and Clavarino (2009) find females experience greater anxiety and depression than males. Nordtug, Korkstad, and Holen (2011) find higher anxiety scores among female caregivers than males as do Wilz and Kalytta (2008) among caregiving spouses.

Pinquart and Sörensen's (2006) meta-analysis concludes that, while many of the gender differences in stressors, social resources and health are small, women have higher levels of burden, depression and lower levels of subjective well-being than do male caregivers. They note that caregiving experiences of the genders seem to have become more similar recently and that many of the gender differences are accounted for by the needs of the care recipient and the availability of other helpers, supporting the stress coping model of caregiving. This model postulates that gender differences in caregiving outcomes result from the fact that women have higher levels of caregiving stressors, fewer social resources and lower levels of psychological and physical health (Pearlin et al, 1990; Yee & Schultz, 2000).

Alternatively, Vitaliano, Zhang, and Scanlan (2003) have suggested that observed gender differences in caregiver health could simply reflect gender differences in general well-being and not caregiving-specific factors. Much has been written about the cultural

assumption that women are the nurturers and should assume the caregiving; they are less likely to adopt a flexible attitude toward the role or to seek external support (del Rio-Lozano et al., 2013). The positioning of women as the 'natural' carers tends to be all-encompassing whereby they are expected to do everything: the decision-making, the physical care, the emotional care, to do so in silence and at great self-sacrifice. Men on the other hand are positioned as task oriented wherein they must learn to be competent at providing the tasks of caregiving (Ussher & Sandoval, 2008).

Poverty is another major disadvantage. Low socio-economic status, low social class and its component indicators (income, education, and occupation) are typically related to lower quality of life. Several studies report that caregivers with fewer economic resources experience more burden (Robinson, Fortinsky, Kleppinger, Shugrue, & Porter, 2009; Sun Hilgeman, Durkin, & Allen, 2009) as do those with less education (Navaie-Waliser et al, 2002). Among caregiving daughters, Bachner, Karus, and Raveis (2009) report household income positively correlated with self-worth and negatively correlated with depression. Lower education has been related to higher levels of depression among uneducated daughters (Hansen et al., 2013) as well as a population sample of caregivers to persons with dementia (Piercy et al., 2013) and to higher anxiety and depression scores among caregivers to those with Alzheimer's (Garcia-Alberca, Pablo Lara, & Berthier, 2011; Green & Benzeval, 2013; Sansoni, Vellone, & Piras, 2004); economic hardship is related to lower self-esteem and higher levels of depression among spouses (Wickrama, Surjadi, Lorenz, Conger, & O'Neal, 2012); low income is related to depression (Ferrara et al., 2009); those with more financial concerns report increased anxiety (Park et al., 2013). Sun and colleagues (2009) find that perceived income inadequacy rather than household income predicts more depressive symptoms and more anxiety.

Age, particularly old-old age is another commonly understood disadvantage. As Thoits (2010) notes, stressors accumulate over the life course, resulting in a widening of health and well-being gaps between the advantaged and disadvantaged. Advancing age is associated with an increased risk of adverse outcomes (McCullagh, Brigstocke, Donaldson, & Kalra, 2005). This view is depicted in the cumulative advantage/disadvantage theory, common in gerontology, which posits that resources and deficits experienced early in life compile and compound over the life course, resulting in increasing disparities in wealth, health, and well-being over the life course resulting in even greater negative consequences in old age (Lynch, 2006; Link & Phelan, 1995). However, Beutel, Glaesmer, Wiltink, Marian, and Brähler (2010) do not find clear age-related change in depression among German males across the life span, but do report anxiety highest around midlife (51-60

years) together with reduced self-esteem at this time. McBride, Bebbington, and Cooper (2013) report that older respondents (65+) are less likely to experience irritability and worry than those younger. Similarly, Park and colleagues (2013) find that younger caregivers have a lower quality of life. Pachana, McLaughlin, Leung, Byrne, and Dobson (2012), studying those aged 82-87, also report that women's predominance of distress diminishes with advancing age. Andren and Elmstahl (2007) find it is younger caregivers who experience more burden. That is, when it comes to caregivers, it is not clear that older age is a disadvantage in terms of subjective well-being.

Intersectionality directs us to examine how being of a particular gender, socio-economic status and/or age (or any other status) is relevant for caregiver outcomes. According to Hankivsky and colleagues (2010), an intersectionality perspective assumes different social categories such as gender and class are not discrete and any one category is not necessarily more important than another but are co-constructed, shifting over time. Their co-existence is not additive but multidimensional and relational to one another as well as other social locations. As Arun and Çakiroğlu-Çevik (2013) note, worldwide, older women are more likely to have experienced disadvantage and limited life choices throughout their lives and when elderly, to experience triple jeopardy, i.e., being female, old and poor. These characteristics are true of many caregivers to older adults, especially those who are themselves elderly.

To examine this issue we interrogated a data set consisting of caregivers to older adults, province-wide, in British Columbia, Canada. Very briefly (more complete details on the sample and sampling methods can be found at Chappell, Smith and Dujela (2014b), a sample of 906 caregivers at T₁ and 760 at T₂ were interviewed face-to-face for on average 97.26 minutes at T₁ and 85 minutes one year later. They were interviewed for the Caregiver Appraisal Study (CAS), part of a larger study (the Alzheimer's Drug Therapy Initiative). Caregivers for CAS were recruited if they were providing care to someone diagnosed by a physician as having dementia and prescribed a cholinesterase inhibitor (ChEI) (Aricept, Reminyl, Exelon) and covered in the provincial PharmaCare program. The sample is non-random, obtained through referral and, primarily, from calls made by PharmaCare to inform individuals their medications were approved for coverage for the care recipient. At this time they were informed of the study and asked whether they would like to be linked by phone immediately to study personnel, sent information regarding the study or not interested. Caregivers were interviewed six months after the care recipient had been taking the medication (the time when the physician determines whether the patient

should continue on the medication, switch medications or stop altogether). This timing arose from the original purpose of the study – an examination of caregiver perceptions of the effectiveness or lack thereof of ChEI for the care recipient.

The data set includes four caregiver outcomes; self-esteem (measured using the Rosenberg Scale of Self-Esteem), anxiety and depression (both measured using the Hospital Anxiety and Depression Scale) and burden (the short Zarit Burden Interview). In all cases, the higher the score, the worse the outcome, i.e., the lower the self-esteem, the higher the anxiety, depression and burden. Table 1 shows the bivariate relationships between gender, age, and poverty with each of the four outcomes at T₁, T₂ and change from T₁ to T₂. It shows that, where there are significant relationships, they are in the expected direction for self-esteem. At T₁, those who are older caregivers (defined here as 75+) and those living below the poverty line (using official cut-offs from Statistics Canada) and at T₂, those who are older, have lower self-esteem. There is no significant gender difference. For all three negative outcomes, the results are not always as expected. At T₁ and T₂, females have more anxiety than males. However, at both T₁ and T₂, younger caregivers have worse anxiety than older caregivers. Similar results are evident for burden. At T₁, females have worse burden than males but at both T₁ and T₂, younger caregivers have worse burden than older caregivers. And for depression, the results are entirely unexpected. At T₂, males and those younger have worse depression and overtime from T₁ to T₂, both males and those who are younger, worsen in their depression to a greater extent than do females and those who are older.

Table 1 : Gender, Age and Poverty (pearson's r) s r)

	Low self-esteem	Anxiety	Depression	Burden
T₁				
Male/female	ns	4.39/5.73 ^{****}	ns	10.01/12.25 ^{**}
<75/75+	6.75/7.34 [*]	5.70/4.69 ^{****}	ns	13.09/9.09 ^{****}
Poverty/not	7.89/6.76 ^{**}	ns	ns	ns
T₂				

Male/female	ns	3.76/4.51***	7.11/6.64**	ns
<75/75+	6.91/8.10****	4.56/3.80****	6.94/6.52**	12.05/8.81****
Poverty/not	ns	ns	ns	ns
Change (T₂- T₁)				
Male/female	ns	ns	2.98/2.27**	ns
<75/75+	ns	ns	2.69/2.15*	ns
Poverty/not	ns	ns	ns	ns

*p<.05; **p<.01; ***p<.001; ****p,.000

Table 2 shows what happens when two of the traditionally disadvantaged statuses are co-occupied. Being female and old, female and poor, old and poor, were each compared with all others at T₁, T₂, and in terms of change from T₁ to T₂. Those who are female and poor have significantly lower self-esteem than others at T₁ even though gender is not significant in Table 1. Being female and old shows significantly lower self-esteem at T₂ with worse self-esteem than either being female singly or being old singly. That is, although gender per se is not significant, being a poor female or an old female caregiver is.

Occupying two of these statuses is not significantly different at any point for anxiety, possibly because the relationship with age is in the opposite direction than expected and the relationship with poverty is not significant (this is elaborated below).

For burden, recall females and those younger are more disadvantaged in Table 1. It is not surprising then that those who are female and old experience less burden at T₁ and both less burden and less depression at T₂. Being female and old is related to less of an increase in depression over time while being female and poor and being old and poor are both related to less depression than otherwise at T₂. Given that it is males and those younger who show greater depression in Table 1, this is not surprising.

Table 2 : Two Disadvantaged Positions

	Low self-esteem	Anxiety	Depression	Burden
T₁				
Female & old/ other	ns	Ns	ns	9.43/12.21****
Female & poor/ other	7.79/6.84*	Ns	ns	ns
Old & poor/ otherf	ns	Ns	ns	ns
T₂				
Female & old/ other	8.20/7.11***	ns	6.26/6.93***	8.64/11.47***
Female & poor/ other	ns	ns	6.13/8.87**	ns
Old & poor/ other	ns	ns	6.03/6.82*	ns
Change (T₂-T₁)				
Female & old/ other	ns	ns	1.77/2.69**	ns
Female & poor/ other	ns	ns	ns	ns
Old & poor/ other	ns	ns	ns	ns

*p<.05; **p<.01; ***p<.001; ****p<.000

Because some of the bivariate relationships are opposite to that expected, the statuses from Table 1 that represent the disadvantaged groups in these data were combined (i.e., younger females for anxiety, younger males for depression, and younger females for burden) and compared with all others. Table 3 shows that younger female caregivers have more anxiety at T₁ and T₂; younger male caregivers experience more depression at T₂ and become significantly more depressed over time than do others; younger female caregivers are significantly more burdened than others at both T₁ and T₂.

Table 3 : Age & Gender

A) Anxiety

T ₁ Female, <75/ other	5.95/4.76****
T ₂ Female, <75/ other	4.69/3.91****
Change T ₂ – T ₁	ns

B) Depression

T ₁ Male, <75/ other	ns
T ₂ Male, <75/ other	7.30/6.69**
Change T ₂ – T ₁	3.30/2.35**

C) Burden

T ₁ Female, <75/ other	13.66/9.74****
T ₂ Female, <75/ other	12.29/9.56****
Change T ₂ – T ₁	ns

T ₁ Male, <75/ other	ns
T ₂ Male, <75/ other	ns
Change T ₂ – T ₁	ns

p<.01; **p<.000

What happens when the three statuses are combined? There are too few to pursue (for example, n = 22 for male, young and poor caregivers in the sample.

The point of this very preliminary analysis is to simply illustrate the value of combining statuses and analyzing them in ways other than separately or using linear statistics. They also demonstrate that, when examining outcomes for caregivers, it is important to take more than one outcome into account, while related, they are different and often reflect differences in relation to caregiving stressors. These analyses confirm that positive outcomes are different from negative outcomes.. Importantly, disadvantaged statuses as conceived within the general social determinants of health literature may not be

disadvantageous for all aspects of life, in this instance for caregivers. Gender and age are two cases in point. Given that more caregivers are women and, for many, especially spouses, it can be an expected stage of life, it may not be surprising that outcomes are more negative for men. Women, especially in today's generation of spouses to older adults, have had a life time providing care, a role with which they have much experience. With more women both among older adults and among caregivers to older adults, they also have more individuals in similar circumstances with whom they can share these experiences.

Nevertheless, being male is especially related to depression, while being female is related to anxiety and burden, indicating that the genders experience negative outcomes of caregiving differently. It is also understandable than younger caregivers would find caregiving more stressful than older caregivers, the latter of whom are more likely to be spouses. Younger caregivers, more likely to be adult children, would not see this as normative but rather as an added demand to their busy lives. Of note, being younger and male as well as being younger and female seem to have consequences for caregivers, but different ones for each gender. And it is the negative outcomes (all three examined here, anxiety, depression and burden) that are experienced by younger caregivers, not the positive outcome of self-esteem. Taking both the negative and positive outcomes into account, female caregivers still emerge as especially vulnerable.

We turn now to a brief discussion of the intersection of two other statuses, gender and relation between care giver and care recipient, where relation is not typically considered a disadvantaged status.

Intersections of Gender and Relation

While the research on gender differences in caregiving often shows that women provide more care, more personal care and more tasks of caregiving (Calasanti & Bowen, 2006; Chappell & Hollander, 2013) and they tend to report more burden than men (Beeson et al., 2000; Kim et al., 2012), some studies report no gender difference (Rosdinom, Zarina, Marhani, & Suzaily, 2013). In terms of relation, the research is inconsistent. Pinquart and Sörensen's (2011) review concludes there is no difference in overall burden but that spouses experience higher physical, financial and relationship burden than do adult child caregivers. Yet, spouse caregivers do not have more emotional burden or social or job strain. Research since that review reveals that spouses are more satisfied with their relationship with the care recipient (Williams, 2011), that spouses are more burdened (Kim

et al., 2012) and there is no difference in the burden experienced by spouse and adult child caregivers (Rosdinom et al., 2013).

Intersecting gender and relation, restricting relation only to spouse and adult child caregivers results in four groups: wives, husbands, daughters and sons. Conde-Sala, Garre-Olmo, Turró-Garriga, Vilalta-Franch, and Lopez-Pousa (2010) find that there is an ordering from better mental health and least burden to worst mental health and most burden as follows: husbands, wives, daughters, and lastly sons. The two male groups fall at either extreme and the two female groups are in the middle. However, Chappell, Dujela, and Smith (2014a) find that adult children experience more burden than spouses, with most burden experienced by daughters, then sons, wives and husbands. Burden for adult children decreases over a one year period but the difference remains. Spouses' burden remains constant over a one year period. The differences suggest the different life stages of spouses and children. Adult children tend to be involved in multiple demands including home and work interests (Leggett, Zarit, Taylor, & Galvin, 2011; Williams, Skirton, Barnette, & Paulsen, 2012) so that caregiving may be experienced as an extra demand and also as role reversal (children caring for their parents). Spouses may view caregiving as an extension of their marriage vows (in sickness and in health) and as normative (Bastawrous, 2013; Lee & Smith, 2012).

However, other research reports no relation-gender interaction (Raschick & Ingersoll-Dayton, 2004) in the personal costs of caregiving (exhausted at the end of the day; more to do than they can handle; no time for self; no progress despite the effort as a caregiver) and rewards (felt good about themselves for caregiving; appreciated life more). They do report that women perceive greater costs than men with no gender difference in rewards and adult children report greater rewards than spouses with no difference in costs. Chappell, Dujela, and colleagues (2014) examined this intersection for both burden and self-esteem using the same sample reported above using OLS regression statistics for the sample as a whole and for spouse and adult child caregivers separately but this time examined the four groups depicting the intersection, i.e., wives, husbands, sons, and daughters.

While the analyses reveal that burden is highest among daughters, then sons, then wives, then husbands, the lowest self-esteem is experienced by wives, then husbands, then sons, then daughters with large differences only between wives and daughters. Wives, a particular intersection of relation and gender, are the most vulnerable in terms of role specific burden (a negative dimension) *and* more generalized self-esteem (a positive dimension), more so than other women (in this instance daughters). Daughters, despite

having the highest burden, do not generalize this to how they feel about themselves, suggesting caregiving is not as salient for their self identity. The multivariate analyses suggest that more education can have a protective effect, for self-esteem but not for burden (they are related in opposite directions).

That is, the concept of intersectionality has relevance far beyond the co-occupancy of two or more disadvantaged statuses. It is equally appropriate for studying the co-occupancy of disadvantaged and advantaged statuses and two or more advantaged statuses.

Conclusions

This paper has sought to explore the relevance of intersectionality for caregivers to older adults with a particular focus on co-occupancy of different statuses as related to well-being. Beginning first with a discussion of disadvantaged status found within the more general social determinants of health literature, social class and gender were identified. Both lower social class and being female are associated with poorer physical health and subjective measures of well-being. To this we added age, of much interest within gerontology where older age is associated with declines in physical health although associations with mental health and well-being are not well-established and may be opposite to that often assumed. Of note, the research on gender, social class and age related to self-esteem, anxiety, depression, and burden among caregivers to older adults only partially replicates the findings from the more general health literature. More specifically, caregiving seems to effect women caregivers and those with fewer economic resources more adversely than men caregivers and those with more economic resources, but it is not clear that being old-old is a disadvantage in this context.

In order to explore the utility of studying the intersection of two or more of these statuses, secondary analyses of a province-wide data set of caregivers to older adults in B.C., Canada were presented. Several important findings emerge:

- The findings differ dramatically depending on whether one is looking at positive well-being or negative well-being. Being an older caregiver and living below the poverty line are both related to lower self-esteem, as expected. However, negative well-being is higher among younger caregivers for both anxiety and burden and is higher for depression among male caregivers and those who are younger. These findings support the notion that positive and negative dimensions of well-being are not opposite ends of one continuum but rather represent different concepts. They

also point to the importance of including different measures of well-being in research and not generalizing from one outcome to others.

- The findings also suggest that, for negative outcomes, younger caregivers are more at risk of anxiety, depression and burden than are older caregivers. This makes sense within the context of caregiving where younger caregivers tend to be adult children whereas older caregivers tend to be spouses.
- In addition, males are more at risk of depression whereas females are more at risk of the less severe adverse reactions, namely anxiety and burden. This also makes sense given women are socialized into the caring role and have much more experience with it. That is, the importance of gender and age statuses for caregivers to older adults cannot be assumed but needs to be studied in relation to particular outcomes.
- Intersectionality, or co-occupancy, of more than one disadvantaged statuses can and sometimes does result in outcomes that occupancy of only one of those statuses does not. For example, being female is unrelated to self-esteem but being a poor female caregiver or an old female caregiver is related to lower self-esteem.
- Intersectionality has relevance not only for the co-occupancy of disadvantaged statuses but also for any statuses that we co-occupy. We need to explore novel ways to analyse and understand how different statuses intersect for various subgroups within society.

The intent of this paper has been a discussion of the concept of intersectionality and its potential value in the study of caregivers to older adults. The new analyses that have been presented are not intended to be conclusive or exhaustive but rather to intrigue and stimulate further research. They draw on a non-random sample of caregivers in one part of North America and include only caregivers to those with dementia and furthermore, taking ChEI. Whether this results in a unique sample is unknown. However, there are many randomized control trials of these medications and they reveal that their effectiveness is inconclusive, indicating any benefit is small and applicable to only some. Yet, prescriptions are given on the basis of dementia because the characteristics of any subsample that may benefit from them is at present unknown. In other words, this sample may not be particularly unique.

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SESSION I

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Opening the Mind's Eye of the Body Politic to the Everyday Life of Informal Caregivers: A First Step for Valuing Unpaid Care of Community-Dwelling Older Adults

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Abstract

Background: With the ageing of world population on the increase coupled with a rise in life expectancy there exists an urgent need for governments worldwide to acquire improved awareness, understandings, and policy orientation surrounding contemporary issues impacting informal caregivers of older adults.

Objectives: To undertake a selected literature search on families and elder care with the intention of a) influencing the development of policies that support informal carers b) raising awareness that in every case the informal caregiver situation is a unique and incomparable role that requires due recognition of caregiver circumstances, family dynamics, and cultural diversity.

Methods: A literature search focusing on selected themes was undertaken and involved review, summary and evaluation of collected material for the purpose of creating a coherent case for policy actions by governmental health and social services agencies.

Findings: The health care system is shown to be heavily dependent upon family caregivers who represent a '*shadow workforce*' whereby there exists a moral imperative to make the invisible visible. For many informal caregivers there is the clash of traditional expectations, beliefs and values surrounding caregiving and neo-liberal thinking that fosters individualism and autonomy. With life expectancy on the increase a significant minority of carers are themselves older persons.

Conclusion: Accepting the reality of population ageing and that families will continue to provide a significant level of home care for older adults means that family assistance and support will remain enduring concerns for governments and policy makers worldwide.

Keywords: Shadow workforce, migrant carer, intergenerational solidarity, care transitions.

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Introduction

Major changes in demographic patterns worldwide have signaled that during the 21st century there will be an unprecedented increase in the numbers of older people requiring acute and long-term care. More importantly, long-term aged care systems will never be in a position to completely meet the diverse and complex needs of vulnerable older people without the invaluable services and support provided by family and other lay caregivers. Despite a plethora of research literature on informal family caregiving Walker, Pratt and Eddy (1995) emphasize the need to understand that “Within the family caregiving literature there is great ambiguity around three significant questions: a) What is caregiving? b) What are the negative and positive outcomes of caregiving for caregivers? and c) What is the relation between family or informal caregiving and paid and formal caregiving” (p.402). This ambiguity only serves to divert attention away from mobilizing resources and innovative policies to support informal caregivers and their care recipients. If we are to witness cooperative and collaborative undertakings between researchers, health professionals, policy makers and informal caregivers then it will be necessary to uniformly address the three preceding questions.

An examination of human history shows that “adult children have taken on the primary responsibility of caring for older parents with acute needs” (Silverstein & Gans, 2006, p. 1068). Earlier work undertaken by Himes (1994) and Sorenson and Zarit (1996) indicates quite clearly that informal family caregiving of older dependent parents has been accepted as a normative component of the life course responsibilities, especially for female members of the family. Glenn (2010) in a scathing critique of the social organisation of caring in the United States identifies four aspects that warrant attention “reliance on the private household, feminization and racialization, of care, devaluation of care-work and care workers, and abnegation of community and state responsibility”(p.6). Scanlon (2003) provides an initial starting point for understanding the business of informal caregivers by way of the following definition “ Informal caregivers are caregivers who are not financially compensated for their services. They are usually relatives or friends who provide assistance to persons who are having difficulties with daily activities because of physical, cognitive, or emotional impairments” (p.946). The preceding explanation of ‘informal caregiver’ while useful as an initial starting point is nevertheless incomplete, in

so far, that it fails to recognize the existential dimension, gender inequity issues, levels of care, and social-cultural context impacting each respective informal caregiver. Wiener (2003) highlights that an examination of informal caregivers reveals that it is mainly spouses, adult children especially daughters rather than sons and daughters-in-law who represent the majority of informal caregivers of older dependent people. Recognition must also be given to the fact that at the present time a significant minority of informal caregivers are themselves elderly.

Any genuine effort to explore or know the nature and characteristics of informal family care of older adults should first and foremost put us on guard to respect the importance of the situation and circumstances impacting each caregiver. At the same time, each caregiver is first and foremost a unique person with a dynamic psychological space capable of producing a range of emotions, moods, feelings and passions often resulting in an ebb and flow of positive and negative regard for the caregiving role. Soden (as cited by the Canadian Hospice Palliative Care Association, 2004, p. 5) makes a telling prediction “Compassion, demographics and declining resources will dictate that each one of us has been or will be an informal caregiver at some time in our lives”. Notwithstanding the diverse social and cultural meanings and perceptions associated with care responsibilities there exists the reality that informal caregivers will experience differential levels of engagement with one or more social agents within the wider community. For example, out of home contacts may include work-based settings, community based agencies, hospitals, rehabilitation centres, out-patient clinics, hospice settings and residential care facilities. What is needed is a genuine respect for the work of informal caregivers, in particular, changing the “undervalued and under compensated labor of frontline caregivers” (Dannefer et al; 2008, p.104). Woodward (2012) validates the need for mobilizing the preceding action with the following pertinent statement:

Frail elderly and their caregivers are virtually invisible in representational circuits (film, the novel, photography, television, the web, newspapers) with the elderly habitually dismissed as non-citizens and their caregivers often literally not citizens of the nation-states in which they work (p.17).

Aged Care: Impacts on Informal Caregivers

From the outset it must be acknowledged that many informal caregivers of older people report genuine satisfaction and positive feelings relating to caregiving (Girgis et al; 2006). The point is made by Hooyman and Kiyak (2002) that satisfaction in the caregiving role is known to increase when mutuality and reciprocity exists between caregiver and care

recipient. At the same time there are, however, carers who report feelings of anger, anxiety, guilt, resentment, sadness and grief (Gladsdam et al; 1996; Briggs & Fisher, 2000). Areas of care that can produce unique and challenging issues for family carers involve dementia, cancer and palliative care related responsibilities (Aberdeen, 2007; Kristjanson, Walton & Toye; 2007; Raveis, 2007). A systematic review of grief reactions in dementia carers by Chan et al. (2013) reveals that it is not uncommon for family carers to “experience anticipatory grief as multiple losses for themselves (companionship, personal freedom and control)” (p.1). While feelings of guilt may be part of the caregiving experience Shaheem (2013) speaks of resentment being the emotional cousin of guilt with the main difference being “that resentment is directed outwards while the other is directed inwards” (p.35). Dempsey and Baago (1998) introduce the issue of ‘*latent grief*’ and when examined in the context of their study refers to the unique and invisible grief experienced by carers of loved ones suffering from dementia. The preceding researchers argue that latent grief is “a major factor in caregiver stress and burnout” (p.84) and results from the daily and ongoing mix of losses experienced during their caregiving role. In a more recent study Piiparinen and Whitlatch (2011) offer a conceptual model for dementia caregiving in which they propose “that a caregiver’s confrontation with existential loss plays a determining role in the well-being of the dementia care dyad”(p.185). The reality for dementia carers is the existential challenge of dealing with the progressive loss “where a loved one is *physically present but psychologically absent*” (Boss, 2004 cited in Chan et al; 2013, p.4)). Aberdeen (2007) provides a telling account of the journey often traveled by family dementia caregivers “the pathway of care is a series of letting-goes: letting go of the person they know as they progress from diagnosis to death, letting go of their *own* identity as friend, wife, husband, child, or sibling and taking on the role of carer” (p.99).

With the expected worldwide increase in dementia the need for support for informal dementia carers will be an urgent challenge for health care systems (Ferri et al; 2005). Savage and Bailey (2004) in a brief review of the literature on the impact of caring on informal caregivers in the areas of aged care, disability and mental health found that “Information on the experience of caregiving and the factors associated with the impact of caregiving provides a context within which to examine what type of interventions are appropriate in various situations” (p.107). The provision of support services for informal carers of older people needs to take into account what Pickard (2004) refers to as the ‘*dual focus on caring*’ (Twigg, 1996; Parker & Clarke, 2002). According to Pickard “ It is required as good practice in research on informal care to explore the effect of interventions not just on the carer but on the cared-for-person” (p. 7). While it is becoming increasingly

common to refer to the informal carer and the care recipient as a 'dyad' the point is made by Zarit and Leitsch (2001) that:

While most programs are targeted for one member of the dyad, both are impacted. Failure to examine the possible ramifications of the program on both members of the dyad and indeed, on the larger social context, can lead to unanticipated outcomes as well as impeding the realization of benefits (p. S84).

Damron-Rodriguez and Lubben (2007) draw attention to how time demands on carers represents an important "element in the differentiation of informal and formal support. Informal caregivers are not 'on the clock' as formal caregivers are. Time commitment of informal caregivers requires that they respond to unpredictable demands at all hours of the day and night, such as incontinence" (p.83). Goodhead and McDonald (2012) reporting on the level of informal caregiving tasks show that "Resident caregiving commonly involves a heavier caregiving commitment than those caregivers who live separately from the recipient of care "(p.2). While medical advances have helped to extend life expectancy there is now the trend towards delayed fertility which has increased the likelihood of dual caregiving responsibilities for many families (Himes, 1994; Schumacher, 2010). In more recent years we find an increasing number of policy makers recognizing the need to address the emerging dynamics of population ageing and caregiver vulnerabilities associated with the care of older people with chronic diseases, physical disabilities including the challenges associated with dementia caregiving (Schultz, 2000). A two volume series on "Lessons On Aging From Three Nations" edited by Carmel, Morse and Torres-Gil (2007) involving Australia, Israel and the United States demonstrates that family caregiving of disabled older people is, and will continue to be an area of great concern for both welfare policy makers and social service providers. Raveis (2007) in an examination of the challenges to family caregivers of cancer patients highlights the prevalence of 'cancer-caregiving burden' made more so when cancer diagnosis is combined with other co-morbid conditions of the older care recipient. The case of caregivers supporting a terminally ill older family member warrants a combination of multidisciplinary and interdisciplinary research that leads to evidence-based policies, strategies and applied approaches that support the complex demands of home based hospice and palliative care (Aoun, 2004). According to Raveis "The cumulative effect of all these stresses and burdens over time may diminish caregivers' ability or willingness to continue this role" (p.91). In many instances caregivers can be 'hidden patients' themselves in that they can neglect their own health and health care due to their demanding work as caregivers (Reinhard et al; 2008). Proot et al. (2003) highlight the vulnerability of

informal caregivers of terminal palliative care recipients “Caring for a terminally ill person at home requires continuous balancing between care burden and capacity to cope” (p. 113).

In trying to understand aspects of contemporary family caregiving within specific cultural contexts it is perhaps important to appreciate that while “The intergenerational solidarity paradigm has firm roots in role theory, emphasizing the relatively static role structures and behavioral expectations of role incumbents; however, it has evolved to include interpretive theories that emphasize the latent and probabilistic nature of family relationships” (Silverstein & Gans, 2006, p.1071). It would therefore be unrealistic to assume that intergenerational solidarity is not the source of multiple tensions given the evidence demonstrating the presence of ‘*burden of care*’ arising from the role of caregiver for older family members (George, 1986; Krzywowski, 2011). For example, Schiamberg and Gans (2000) postulate that with increasing growth of the older population along with the increasing demand for family caregiving may also be accompanied by increasing rates of elder abuse. Talley, Chwalisz and Buckwalter (2011) identify a probable source of intergenerational tension when they question the notion of ‘rural cohesiveness’ when they describe rural caregiving “as a patchwork of often uncoordinated and scarce resources... delivered through an amalgamation of de facto systems” (p.233). Perhaps it is more realistic than ever to look at intergenerational solidarity in a more balanced manner that allows recognition of a mix of tensions that can arise from “social expectations, declarations and individual practices” (Krzywowski, 2011,p. 5).

Silverstern and Gans (2000) are adamant that improved understandings are necessary to gain an appreciation of the respective social forces that “enhance or inhibit the assumption of caregiving duties by adult children ” (p.1082). Based on a recent study of Canadian baby boomers facing the need to care for older parents Guberman et al. (2012) found that in general interviewees indicated that they were endeavouring to juggle work, caregiving, family and social life along with high expectations for support from the existing health care system. The preceding researchers refer to this juggling approach to care as a form of ‘*de-naturalization*’ of care which can be taken to mean a lessening of the traditional family responsibility for elder caregiving. In other words, for some families the mix of life circumstances and lifestyle aspirations may weaken the normative expectation of providing informal family care for dependent older parents. As pointed out previously, family caregiving can be usefully examined in the context of intergenerational solidarity which comprises multiple socio-cultural practices, attitudes and emotions which go beyond the phenomenon described as ‘the old taking care of the youngest and the young taking care of

the old' (Silverstein & Bengtson, 1997, cited in Krzyzowski, 2011, p. 56). Undoubtedly, new issues surrounding intergenerational solidarity will continue to evolve, not the least of which will concern future approaches to family caregiving of older family members.

The Social and Financial Worth of Informal Caregivers

Elder care can be considered as operating on a continuum involving short-term, intermittent and long-term care responsibilities with families displaying marked variation in terms of the availability, access to, and affordability of health services and resources in order to meet their respective care goals (Bookman & Kimbrel, 2011). Gibson and Houser (2007) illustrate that estimating the economic value of unpaid caregiving is fraught with difficulties as it requires complex audit undertakings to determine what the real financial costs would be to replace the services provided by informal caregivers. The same researchers offer the viewpoint that even by resorting to conservative assumptions surrounding the replacement of the services of unpaid caregivers the costs would still be astronomical. The variation in approaches and allied difficulties associated with the preceding cost-estimate tasks of informal caregiving are provided by White-Means and Zhiyong (2012) in a valuable literature review of efforts to estimate the financial worth of informal caregiving in the United States. In terms of the overall services and contributions provided by informal caregivers it is easy to see that they are part of the non-money economy and in a very real sense they represent an unpaid '*shadow workforce*' for the aged health care system (Bookman & Harrington, 2007). It is therefore essential that appropriate communication pathways are created that provide meaningful opportunities for health care professionals and policy makers to understand the diversity of experiences and challenges impacting informal caregivers of older adults. Awakening the level of political consciousness or mind's eye of political systems around the world to the complex support needs of informal caregivers represents an urgent agenda issue for human rights advocates.

Healy (2008) provides an important reminder to those in charge of health care systems that informal caregivers need to be seen "as economic subjects, with their desires, motivations, hopes and anxieties" (p.267). By gaining insights from evidenced-based research the many roads travelled by informal caregivers can be made more visible, and as a consequence, can help to facilitate a real change of thinking and commitment from governments, policy makers, health professionals, employers and unions. Glenn (2010) argues that caring must be "recognized as 'real work' and as a social contribution on a par with other activities that

are valued” (p.188). Clearly the needs of informal caregivers and their care recipients represent a growing concern for society, and in particular, health care providers and policy makers (Hooyman & Kiyak, 2002). The Australian Human rights Commission (2013, p. 6) provides the following list of evolving mechanisms based upon what happens in Australia and internationally that highlights developmental approaches aimed at placing a value on the work of informal caregivers:

- legislative mechanisms;
- flexible work arrangements;
- carer support payments;
- leave arrangements;
- services for carers;
- workplace initiatives; and
- mechanisms within the retirement income and saving system (i.e. taxation, superannuation and income support).

Given that informal caregivers provide a major service that would otherwise cost health and social services a vast amount of financial capital, it is imperative that evidenced-based policies be developed with ongoing evaluation to ensure that they receive appropriate support to continue their respective care roles without damaging their own health and well-being. Perhaps the following words of an older woman, a care recipient herself, may suffice to sharpen the focus of professionals in the fields of welfare policy making, labour relations and health care to re-examine their assumptions about the demanding work roles of informal caregivers:

*We never look enough, never exactly enough, never passionately enough
(Colette, aged seventy-nine cited in Jacoby, 2012, p.282.).*

Transitional Care and the Challenge of Quality Assurance

With longer life expectancy there is now increasing numbers of community dwelling older adults displaying chronic illness and deteriorating health status that often require the attention of health professionals across a range of medical, and allied support settings. The decline in the health status of an older community-dwelling care recipient can often lead to their engagement in a transitional care process that also impacts an informal caregiver, usually a family member. Coleman (2003) drawing upon the American Geriatrics Society shows that transitional care is “defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations

or different levels of care within the same location” (p.549). Other descriptions of care transition generally agree that it involves the movement of a patient between a mix of health care professionals and settings as a consequence of acute or chronic illness (Toscan et al; 2012). For example, transitional care can involve a range of movement possibilities that impacts both the caregiver and the older care recipient such as 1) entering hospital for short term medical reasons and then returning back to the community 2) receiving palliative hospice care within the confines of in-home family care 3) receiving palliative care as a part-time or full-time patient within a formal hospice care centre and 4) entering or waiting to be transferred to a long- term residential care facility.

According to Treiger and Lattimer (2011) “Poor communication across care settings and siloed approaches to care often fail to meet the needs of providers, patients and family caregivers” (p.189). Atkins et al. (2010) draw attention to the disturbing fact that informal caregivers are frequently lacking in ability or willingness to manage the complex needs of an elderly care recipient. Coleman (2008) draws attention to the dangers arising when informal caregivers are not well prepared to deal with patients at home, causing in turn, increased risks for multiple errors, and failure in some instances to adhere to core components of a care plan. Atkins et al. (2010) argue that “It is, therefore important that home care nurses assess an informal caregiver’s preparedness to render care to an older patient in the home” (p.1). The situation with respect to transitional care is well illustrated by the following commentary “ Care transitions is a team sport, and yet all too often we don’t know who our teammates are, and how they can help us” (Coleman cited in Treiger & Lattimer, 2011, p.190). Avlund et al. (2002) and Naylor (2006) provide supporting evidence that shows when informal caregivers receive appropriate preparation for the in-home care of an older adult that patient outcomes generally improve and that the likelihood of hospital admission or readmission decrease. Coleman (2003) points out that despite the importance and increasing frequency of transitional care for older people there is an unfortunate lag in terms of research, health policy and development of coordinated clinical health practice.

Dannefer et al. (2008) make reference to the difficulties associated with culture change by way of the following commentary “Change efforts have found themselves caught between constraints imposed by the continuing hegemony of the medical model culture, regulations, cost constraints, the professional self-interest of the nursing profession, union rules, and the inertia of hyper-habituated practices and expectations” (p.104). Toscan et al. (2012) in an examination of perspectives on care transitions for older persons with hip fracture found

that the collective experiences of older care recipients, informal caregivers and health service providers indicated four major problem factors involving 1) poor communication across the circle of care resulting in informal caregivers receiving little or no information 2) unclear roles and responsibilities for informal caregivers and health providers 3) ill-defined ownership of care among health providers and 4) role strain for informal caregivers and health providers resulting from health service constraints. Levine et al. (2010) posit the view that “The care transition process offers a critical opportunity to treat family caregivers as important care partners” (p.116). Unfortunately, it appears that in many situations the call for the development and maintenance of coordinated integrated care for older persons including improved information systems that connect health care providers, patients and their informal caregivers has to a large extent fallen on deaf ears (Freeth, 2001; Fuji, Abbott & Norris, 2012; Gagliardi, Dobrow, & Wright, 2011; Hudson, 2007).

Translating Research Into Evidenced-Based Action

The informal or family related care of the frail and dependent older population is now a major research focus, with a growing list of “ published studies carried out by researchers from all of the social-science and many of the health-science disciplines” (Schultz & Martire, 2004, p. 241). The challenge for both policy makers and health care systems, however, is to not only acquire research knowledge and findings on informal caregiving but then to move to the point whereby they can assess, adapt and apply evidence based research to particular socio-cultural contexts. Despite calls to hasten the dissemination of research into practice (Zerhouni, 2005) there exists the constant challenge of overcoming the protracted time lag between development and application of research findings (Berwick, 2003; Glasgow, Lichtenstein, & Marcus, 2003). At the same time, the development and implementation of ‘*evidenced-based practice*’ will require efforts to identify the barriers to knowledge translation in the policy making environment. Indeed genuine efforts to uncover the story behind research data can assist communities to engage in a ‘*results driven process*’. This approach will help to build situation based policies and programs in combination with authentic integrated health service partnerships to support informal caregivers and their older care recipients. Tally and Crews (2005) recognize, however, that while there exists an urgent need to understand the ways and means of moving caregiver support interventions into practice there is also the reality of facing the challenges of translating research into policy based programs. Pawson (2006) argues that

policy formation needs to be built upon solid systematic review of evidence-based research that is in turn properly targeted to operate in a rapidly changing social landscape. The same author offers the view that evidenced-based policy making should also take into account how a new policy formulation is likely to impact on existing interventions that are currently operating.

Domestic Migrant Care Attendants

The ageing of world societies is generating an increasing demand for the care of older people, and foreign-born female workers are now seen as an important part of the supply chain in helping informal caregivers to meet that demand (Badkar, Callister & Didham, 2009; Di Santo & Ceruzzi, 2010; Martin et al; 2009; Rodrigues, Huber, & Lamura, 2012). This preceding trend would seem to be a departure from the traditional practice whereby families are bound together by strong social norms and kinship ties that ensure a commitment to informal family caregiving to a frail and dependent older family member (George, 1986; Davis, Gillis & Harper, 2011). Van Hooren (2011) speaks of the concept of the “migrant in the family model of employment” while Di Santo and Ceruzzi (2010) describe how informal family caregivers of older family members in Italy are hiring female migrants as carers. It would seem reasonable to suggest that there appears to be a legitimate case for encouraging inter-disciplinary research to examine the impact on intergenerational solidarity arising from the practice of contracting female migrant workers as part of informal caregiving of dependent older people in family settings. The concept of ‘*de-familization*’ is introduced by Fitzpatrick et al. (2006) which is “seen in the sense of allocating duties and responsibilities to actors other than family members which may occur in *different* ways and duration” (p.448). It must be recognized, however, that the practice of ‘de-familization’ will produce many variations and decisions that are specific to each family. On the other hand Leitner and Lessenich (2007) point out that ‘de-familization’ is “strictly defined in the sense of financial independence, basically ignoring the social and emotional aspects of the caregiver’s ‘liberation’ from his or her care responsibilities” (p.252). The preceding researchers indicate that engagement of families in practices involving ‘de-familization’ are often undertaken with little or no regard for the flow-on consequences that impact the older care recipient. The overall effectiveness or otherwise of ‘*transnational caregiving programs*’ presents many challenges for immigration authorities, health professionals and families, not the least of which is the operation of such programs across a social- cultural divide (Koehn, 2004). Perhaps we should be mindful of the

following viewpoint offered by Walsh and O’Shea (2009) that “ It is impossible to separate the fate of migrant care workers from that of older people” (p.128).

Conclusion

It is important to understand that informal family caregivers represent an integral component of an older person’s overall support system. The psycho-social challenges facing family caregivers are complex and demand support programs and policies to enable carers to perform their ongoing care responsibilities (Aberdeen, 2007; Raveis, 2007). It is also necessary to recognize that the diversity of the human condition is such that we should expect to witness a range of behavioural responses, value orientations and emotional experiences amongst informal caregivers irrespective of gender and socio-cultural background. Indeed the existential nature of informal caregiving necessarily reflects a private and somewhat lonely journey for family carers, particularly for the primary caregiver. There is no better way to understand the impact of informal caregiving than to hear the voice of each respective carer. As a consequence there exists an urgent need for governments worldwide to create opportunities that create a deeper and more informed dialogue between the diverse and ever changing experiences of informal caregivers and their older care recipients with key aged health care professionals and policy makers. The following voice of a carer provides a sobering and illuminating perspective:

Telling our stories is a political act. Without stories, there is no articulation of experience. Without stories, we don’t learn the value of our struggles or comprehend our pain. Without stories we cannot understand ourselves or dance in the rain. We are closed in our own silence (Christ cited in Aoun, 2004, p. 40).

Packard et al. (2000) provide a timely warning to the National Health Service in England which no doubt holds much credence for societies elsewhere “The extent to which elderly people continue to rely on informal care could have substantial influence on demand for formal care” (p.746). With population ageing now a well established fact it is imperative that societies fully understand the dynamics and value added contributions provided by informal family caregivers. Bergeron and Healy (2013) argue a case for society to imagine economic development in new and innovative ways by “ seeing the value added contribution of those issues once viewed as ‘outside’ of development—such as non-capitalist production and unpaid non-market transactions—are now foregrounded as resources for fostering economic and social progress” (p.3). The same researchers also challenge the myopic thinking that sees activities that foster care, cooperation and interdependence as

essentially non-economic. Unfortunately, the traditional emphasis on Gross Domestic Product (GDP) as a measure of a country's economic success has fostered the situation whereby monetary compensation is more highly valued than is the case with unpaid labour. Gibson and Houser (2007) in support of assisting informal caregivers argue that "For economic and ethical reasons, it is essential to protect family caregivers from being overwhelmed by the demands placed upon them" (p.7).

Informal caregivers of older people are without question key partners with professionals in providing health related care, and as such, "it makes no sense to overlook their contributions and needs for support" (Gibson, Kelly & Kaplan, 2012, p.48). Without question, the complex and demanding experiences of family caregivers must be taken seriously and given a central focus in the creation of new policies that embrace support within a more coordinated transitional health care system (Bookman & Harrington, 2007). In a time of competing demands for a slice of government revenue it will take a measured sense of political courage to ensure that policy capacity is available to ensure that informal caregiving is "recognized as a community and collective (public) responsibility rather than as a purely family (private) responsibility" (Glenn, 2010, p.177). More than ever the mind's eye of social health care systems worldwide needs to be opened to the significance and consequent call for action arising from the following perspective offered by Schultz and Martire (2004):

Addressing the challenges of caregiving in American society now and in the future will require not only innovative research and clinical applications but also macro-level social experiments to support and motivate caregivers, as well as changes to healthcare policy that fully recognize the caregiver as a healthcare resource (p.248).

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SESSION II

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Promoting Healthy Aging in Your Community: The Massachusetts Model

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Abstract

Background: Population aging is a phenomenon occurring across the globe. In the United States, 10,000 adults turn age 65 each day and this trend will continue through 2031. This study shares how one state in the U.S. is preparing for healthy aging.

Objectives: Our goal is to activate communities to form new partnerships to promote positive changes to enhance health, social engagement, and independence of older adults.

Methodology: With support from the Tufts Health Plan Foundation whose mission is to promote healthy life styles and the delivery of quality care in our communities, the Massachusetts Healthy Aging Data Report: Community Profiles was created. The Report includes data on over 100 indicators for each of the 351 cities and towns in Massachusetts as well as the 16 neighborhoods of Boston. Three primary data sources were used to develop the Community Profiles: Census, Behavioral Risk Factor Surveillance Survey, and Centers for Medicare and Medicaid Services.

Findings: Highlights show disparities across the state related to chronic disease, depression, falls and life style behaviors including eating sufficient daily servings of fruits and vegetables, engaging in physical activity, and getting regular screenings and immunizations.

Conclusion: The profiles can serve as benchmarks for planning and assessing healthy aging interventions. A key component of this initiative is an interactive website consisting of community profiles, an interactive map of chronic conditions, statewide maps of healthy

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aging indicators, and evidenced-based programs addressing challenges to healthy aging. This approach can serve as a model for communities worldwide who are committed to optimal planning for healthy aging.

See: www.mahealthyagingcollaborative.org⁵

Key words: healthy aging, community profiles, health promotion

⁵ Adapted from:

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Introduction

The Massachusetts Healthy Aging Data Report: Community Profiles consists of custom profiles of nearly 100 healthy aging indicators for every city and town in Massachusetts including the 16 neighborhoods of Boston (367 Community Profiles). Each Community Profile is designed to help community residents, agencies, providers, and governments understand the older adults who live in their cities and towns – their ages, living arrangements, health status, strengths and vulnerabilities. Never before has Massachusetts had such a comprehensive view of healthy aging indicators reported at this local geographic level.

Background

Healthy Aging

Every day 10,000 adults turn age 65 in the United States and this trend will continue until 2031. As baby boomers (cohort born between 1946-1964) age, the older adult population in Massachusetts is expected to grow from 14 percent in 2010 to 21 percent of the state population by the year 2030. Healthy aging includes physical and mental health as well as staying involved with friends, family and community, having purpose in life, feeling safe, eating well, drinking responsibly, staying physically active, and being proactive about managing one's health. The potential benefits to families, communities, and the state are enormous if every adult had the opportunity to age well, to reach his or her own potential, virtually every sphere of daily life would be enhanced by their contributions. Employers, organizations dependent on volunteers, faith communities, health care and education systems, transportation, travel and leisure companies, and families could all benefit from healthier older adults.

While states are often ranked on various health attributes, this is the first time in Massachusetts that we are able to compare communities within the state on several indicators of healthy aging. This report provides an overview of the research findings noting our strengths, challenges, and gaps. The Community Profiles can serve as benchmarks for planning and assessing healthy aging interventions, large and small. A sample of the Community Profile is provided in Appendix A. To view all the Community Profiles and maps, please visit the Massachusetts Healthy Aging Collaborative website: <http://www.mahealthyagingcollaborative.org>

Our goal is to activate providers, consumers, communities, policy makers and legislators to form new partnerships and coalitions that will promote positive changes to enhance the health, social engagement and independence of older adults. Our focus is on actionable areas reduction of multiple chronic diseases, including diabetes, obesity and hypertension – as well as reduction of depression and falls, and increasing opportunities for older adults to get life-saving screenings and immunizations.

An Aging Population

We are living in remarkable times. In a little more than a century, the average American has gained an additional 30 years of life. A person in 1900 could expect on average to live to age 47. Those born today can expect to live past 80. Due to increased longevity and the aging of the baby boom generation there will be a dramatic increase in the older population. The Centers for Disease Control and Prevention (2013) estimates that by 2030, more than 72 million Americans will reach age 65 or older, an astonishing 20 percent of the population.

We are not just living longer, but we are living healthier thanks to advances in public health and medicine. The leading causes of death have shifted from infection or acute illnesses to chronic and degenerative diseases. A century ago few people lived with chronic disease, whereas today most of us may live 20, 30 or more years with one or more chronic diseases.

Aging in Massachusetts

The Massachusetts population is slightly older than the U.S. population. For the nation, 13 percent of the population is age 65 or older while in Massachusetts the rate is about 14 percent (891,303 older adults; using 2010 data). Figure 1 illustrates the distribution of persons 65 and older across Massachusetts. Today 59 percent of older adults age 65 or older in Massachusetts are female, 50 percent are married, and 32 percent live alone. However, when you look at the very old (e.g., adults age 85 or older), this is a population that is more likely to be female, to live alone, to be very frail, and to have limited financial resources. Nearly 16 percent of Massachusetts older residents are age 85 or older. Currently, the over 65 population is primarily Caucasian (92 percent). Approximately 4 percent are African American, 3 percent Asian, 3 percent Hispanic/Latino, and 2 percent other races. However, in future years, projections suggest that the aged population will become increasingly diverse in terms of racial and ethnic background. According to a 2013 report by the University of Massachusetts Donahue Institute, the Commonwealth will also

steadily get older in the future. The percentage of the state population age 65 or older will increase from 14 percent in 2010, to 15 percent in 2015, to 17 percent in 2020, to 19 percent in 2025, to a remarkable 21 percent in 2030. Thus, one out of every five people in the state will be an older adult by 2030. This may seem like a large increase, but the populations in Japan and several European countries are already more than 20 percent over age 65.

Ingredients of Healthy Aging

The healthy aging model developed by the Massachusetts Healthy Aging Collaborative shows that it is possible to experience healthy aging while living with disease or disability. The key is to maximize what is possible (See “Ingredients of Healthy Aging,” Figure 2).

Healthy aging is influenced by our genetics, lifestyle, health behaviors, and health practices. All these factors are influenced by our community, our culture, and our differential access to opportunities. From birth to death we are constantly adding to or subtracting from our capacity to age well. It is a complicated, dynamic lifelong process. Although screening, early detection and management of chronic diseases at the individual level are essential to maximizing both quality of life and longevity, changes in policies and systems that affect healthy aging are also needed, including the development of supportive social systems and physical environments. Over the next 30 years the population in the United States will become older and more racially and ethnically diverse. As a result, the programs and services we offer will need to address the health and social disparities that may be more common among certain populations as they age. This clearly will have an impact on healthy aging. Knowing the current status of healthy aging in Massachusetts and making a commitment to act on that knowledge will help us prepare for a better tomorrow.

Methodology

Three primary data sources were used to develop the Community Profiles: Census data, Behavioral Risk Factor Surveillance Survey (BRFSS) data, and Centers for Medicare and Medicaid Services (CMS) data. While the Behavioral Risk Factor Surveillance System represents community-residing respondents, the Medicare Master Beneficiary Summary File contains both community-residing and older adults that are institutionalized. About 5 percent of aged Medicare beneficiaries in the state are institutionalized.

The lack of available data did not permit all indicators to be reported for individual cities and towns. Whereas Medicare claims data were available for all Massachusetts Medicare

beneficiaries receiving care from fee-for-service medical providers, fewer than 9,000 respondents age 60 years or older are surveyed by the BRFSS in Massachusetts each year. These data limitations led us to stratify indicators into three geographic tiers related hierarchically. At the lowest tier, 100 percent CMS data were used to compute some indicators for 310 communities, the great majority of which were individual cities or towns. The second tier of indicators derived from Massachusetts BRFSS data are reported for 33 larger areas defined by aggregating communities served by Massachusetts Area Agencies on Aging, called Aging Service Access Points (ASAPs). The same BRFSS indicator values are reported for each city and town within these aggregated service areas. The third tier is comprised of a few healthy aging indicators where data were only available for counties. The same county-level indicator values are reported for all cities and towns within the same county. While these geographic tiers help to partially address small sample size problems, this limitation cannot be overcome with existing data sources. A large-scale primary survey data collection effort would be needed to compute reliable estimates for all healthy aging indicators for all individual cities and towns.

We are not aware of any other public source where healthy aging indicators are reported for geographic areas smaller than counties as they are here. We believe that our pragmatic approach achieved a balance between competing goals of geographic specificity, timeliness, and the breadth of healthy aging indicators. Information about data sources and the definitions of the healthy aging indicators is compiled in the full technical report found at: www.mahealthyagingcollaborative.org

Beyond the three data sources noted, we also included several community variables. For each Community Profile we report a wide range of variables including cost of living, safety, walkability, and resources that contribute to healthy aging. The community's "walkability score" is derived from a measure of access to restaurants, shops, grocery stores, parks, and other community locations (see www.walkscore.com). Each Community Profile also includes some preliminary data on older adults' access to transportation options. According to the National Highway Traffic Safety Administration (2013), adults age 65 or older comprise 16 percent of all licensed drivers in the U.S. today. An increasing number of older adults will face retirement from driving due to medical conditions that impact critical driving skills. It is likely that the impairments that cause an individual to cease driving are the same impairments that may make it difficult to navigate public transportation. Rather than a "curb-to-curb" alternative, many will need "door-through-door" transportation. Communities in Massachusetts are beginning to recognize the need

for supplemental transportation programs and some strategies are emerging utilizing both paid and volunteer drivers as well as public and private transit. We need to build on these strategies to assure that older adults in Massachusetts can get to where they need or want to go, when they want to go there. We also include county-level data from the Elder Economic Security Index on income needed for older individuals or couples in good health who own or rent to be able to maintain a modest standard of living. (see www.basiceconomicsecurity.org/) Finally, we note if the community has a Senior Center or other opportunities for lifelong learning.

Results

How Massachusetts Compares Nationally

Massachusetts is advantaged in several important ways compared to other states and these benefits translate directly into better healthy aging outcomes. Education, income, and access to health insurance are all above national averages. In a United Health Foundation report (2013) of senior health indicators across U.S. states, Massachusetts was ranked the fourth healthiest state. Strengths noted were: high prevalence of dental visits, high community support expenditures, and high percentage of health screenings.

Despite high national rankings as a state, we could do much better. The vast majority of older adults in Massachusetts have multiple chronic diseases and a staggering 59 percent have four or more chronic conditions. While the average education and income levels in Massachusetts are above national averages, there are deep pockets of poverty. In fact, more than 28 percent of households with an older adult have an annual income of less than \$20,000. And, as seen in the data, poverty can be dangerous to your health. Poorer communities with fewer resources tend to have greater challenges on the indicators measured than those communities with more affluence and resources.

There is no acceptable percentage of adults that should be denied the opportunity to age well. Therefore, this report looks within Massachusetts to determine how communities are doing on a broad range of healthy aging indicators. To get the most clinically useful picture we have taken the long view and used data of those ever diagnosed with a condition instead of the more narrow current diagnosis. Please note that while we include a vast number of indicators, our list is not exhaustive.

Summary of Key Findings

The healthy aging indicators in this report represent a broad range of issues: Population composition, physical and mental health, chronic disease, nutrition/diet, access to care, service utilization, wellness and prevention, and community variables (walkability, access to resources, safety and economic factors). By reporting data at the community-level along with state averages we aim to help communities focus on both local and statewide problems.

Some key findings of the report include:

Chronic disease is high among older adults. In Massachusetts, the state average for persons age 65 or older having four or more chronic conditions is 59 percent.

Rates of depression, hypertension, and Alzheimer's disease or related dementias among older adults are higher in Massachusetts compared to national averages shown in CMS data.

When longer histories of Medicare claims (e.g., since 1999) are examined, we find that 32 percent of Massachusetts older adults were ever diagnosed with diabetes.

At 15 percent, the prevalence rate of prostate cancer among men in the state is higher than the prevalence rates for all other cancers included in this report.

In Massachusetts, 23 percent of adults age 60 and older are considered obese (Body Mass Index of 30 or higher). Only a quarter of older adults in Massachusetts eat the recommended five servings daily of fruits and vegetables.

While about two out of three adults in Massachusetts age 60 or older are getting annual flu shots and have taken the pneumonia vaccine, there is still room for improvement and the state average for getting the shingles vaccine is only 15 percent. Solutions may involve individual, system, or community changes.

Healthy Aging: By Indicator

While increased chronic conditions are associated with age, on average 8 percent of residents of Massachusetts age 65 or older do not report any chronic conditions. In fact, there are 23 communities where 13 to 16 percent of the residents age 65 or older are chronic disease free. These communities tend to be smaller rural areas within the central

and western regions of the state. Following is a summary of how communities fare on a number of chronic conditions:

Obesity. Obesity is defined as a body mass index of 30 or greater. A key to healthy aging is maintaining a healthy weight, however in Massachusetts 23 percent of adults age 60 and older are obese.

Chronic Disease. The State of Aging and Health in America 2013 report from the Centers for Disease Control and Prevention shows that two out of three older Americans have two or more chronic conditions such as obesity, diabetes, hypertension, heart disease, lung disease, stroke and cancer. Multiple chronic conditions place older adults at greater risk for premature death, poor functional status, unnecessary hospitalizations, greater use of physician, emergency room and home health visits, adverse drug events, and nursing home placement. Chronic conditions also impact health care costs: 93 percent of Medicare expenditures are for beneficiaries with multiple chronic conditions. In Massachusetts, the state average for persons age 65 or older having four or more chronic conditions is 59 percent.

Diabetes. Diabetes is a chronic disease which can be effectively managed with lifestyle changes especially losing weight through exercising and eating healthier foods. The state average prevalence rate for ever having been diagnosed with diabetes is 32 percent for persons age 65 or older. Higher rates of diabetes are generally found in urban communities and many of the same communities also had higher than average rates of obesity, which is a critical risk factor for diabetes.

Hypertension. Hypertension is a risk factor for heart disease and stroke, and is one of the most common chronic diseases among older adults. The state average prevalence rate for ever having been diagnosed with hypertension is 78 percent for persons age 65 or older. Towns with the lowest prevalence rates for hypertension were often in smaller towns in western Massachusetts.

Lung Disease. Chronic Obstructive Pulmonary Disease (COPD) impacts on average 23 percent of Massachusetts older adults age 65 or older, ranging from 11 percent to 34 percent.

Heart Disease. The prevalence of diagnosed congestive heart failure (CHF) is slightly higher than COPD with a state average of 25 percent for persons age 65 or older, ranging from 9 percent to 36 percent.

Stroke. The state average for diagnosed stroke in persons age 65 or older is 13 percent and ranges from 8 percent to 17 percent, both in the central region area of Worcester county.

Alzheimer's disease. The state average prevalence rate for Alzheimer's disease and related dementias in persons age 65 or older is 14 percent. The lowest prevalence rates tend to be found among smaller towns in western Massachusetts.

Glaucoma. The state average for glaucoma in persons age 65 or older in Massachusetts is 25 percent. Along with macular degeneration, glaucoma may impact critical driving skills and challenge community mobility for older adults in addition to presenting other challenges to healthy aging.

Cancer. At 15 percent, the prevalence rate of prostate cancer among men in the state is higher than the prevalence rates for all other cancers included in the Community Profiles. The level of diagnosed prostate cancer in men age 65 or older ranged from 6 percent to 21 percent.

Depression. The state average prevalence rate for ever having a diagnosis of depression among persons age 65 or older is 29 percent. There are several communities with rates higher than the state average and these are in scattered locations across the Commonwealth). The rates of poor mental health days among persons age 60 or older are higher than the state average of 7 percent in the Roxbury, Mattapan, North Dorchester, and South Dorchester areas within Boston (13 percent). The lowest rates of poor mental health days were found in towns outside of Worcester (4 percent).

Falls. Falls are typically more serious for older adults than for younger people due to the fragility of the older body. According to the Behavioral Risk Factor Surveillance Survey (BRFSS) data, the average state rate of persons age 60 years or older reporting to have fallen at least once in the past three months resulting in injury (defined as causing one to limit regular activities for at least a day or to go see a doctor) is 5 percent. Hip fracture can be a result of falls. From the CMS data, we learn that the state average for hip fracture in persons age 65 or older in Massachusetts is 4 percent and ranges from 2 percent in New Marlborough to 6 percent in Williamstown. Experts observe that this is a transformative time for falls prevention in Massachusetts in that (1) evidence-based low-cost low tech interventions are coming on line; (2) fall-risk assessment tools for use by healthcare providers are newly available; and (3) changes in the structure of healthcare financing should encourage deployment of these innovations.

Healthy Aging Behaviors

Diet. The Centers for Disease Control and Prevention identifies the area of nutrition, physical activity, obesity, and food safety as a public health priority that is a “winnable battle” where with the cooperation of public health partners, significant progress can be made in improving health outcomes in a relatively short time frame – generally within one to four years. We agree and believe we can make a difference in Massachusetts. According to the BRFSS data, currently only a quarter of the residents in Massachusetts age 60 or older eat the recommended five or more servings of fruits and vegetables per day. The highest rates (about 33 percent) are found in west suburban towns outside of Boston. Many factors go into maintaining a healthy diet and

clearly access to affordable and nutritious choices is paramount. Other less visible factors include the act of meal preparation that may become more difficult as we age and the lack of socialization and support that may motivate when we have our meals and what choices we make.

Physical Activity. Our lifestyle decisions and behaviors influence our health. Physical activity is essential to healthy aging. For older adults with Type 2 diabetes, physical activity reduces the risk of heart disease and stroke and helps to manage blood sugar levels. In addition, exercise can decrease depression and may even help to prevent it. In general, adults age 65 years or older are advised to get 150 minutes of physical activity a week and according to the Centers for Disease Control and Prevention, only about one-third of older adults achieve the recommended level. The data presented in this report are based on the BRFSS where persons age 60 years or older were asked the question, “During the past month, (other than your regular job) did you participate in any physical activities such as running, calisthenics, golf, gardening or walking for exercise?” It is difficult to know whether the respondents to that question achieved the equivalent of 600 minutes of physical activity per month and thus, the measure reported in the Community Profiles is one of “participation in physical activity” rather than “adequacy of physical activity.” Given that, we can state that residents on Cape Cod and the Islands were the greatest participants in any physical activity (72 percent) while the least likely to participate in physical activity were older adults in Fall River (52 percent).

Drinking and Tobacco Use. Older adults on average have lower rates on high risk behaviors like excessive drinking or smoking tobacco than other age groups. The state average rate of smoking among persons age 60 or older in Massachusetts is 9 percent. The state average rate for excessive drinking among persons age 60 or older is also about 9 percent, with only modest variations throughout the Commonwealth.

Annual Check-ups, Screenings and Immunizations

Oral Health. The state average for complete tooth loss in persons age 65 or older is 36 percent and ranges from 24 percent to 54 percent. The state average for the number of dentists per 100,000 persons is 85. The state average rate for annual dental exams among persons age 60 or older is 76 percent, ranging from 53 percent in urban communities to 86 percent in the western suburbs of Boston.

Physical Exams and Screenings. Over 90 percent of Massachusetts residents age 60 or older report that they get annual physical exams. In fact, 88 percent see a doctor one or more times per year in physician office visits for an average of 8.65 office visits per year. The great majority (96 percent) of Massachusetts residents age 60 or older are screened for high cholesterol. The state average rate for women age 60 or older who have had mammograms in the past two years is 85 percent. A lower percentage, however, of older adults age 60 or older are screened for colorectal cancer. The state average for colorectal cancer screening is 66 percent and ranges from 56 percent to 74 percent.

Immunizations. By preventing the flu and its complications, older adults can also reduce the risk of having a heart attack or stroke, particularly for those who already have cardiovascular disease. The state average for persons age 60 or older who get annual flu shots is about 68 percent and ranges from about 59 percent to 77 percent. The state average rate for people age 60 or older who are immunized for pneumonia is slightly less at 61 percent. A challenge is found in the low percentage of older adults age 60 or older who are immunized for shingles. The state average for taking the shingles vaccine is only 15 percent and ranges from a low of 5 percent to a high of only 26 percent. Shingles is a painful, debilitating condition and studies have shown that having shingles may increase the risk of heart attacks.

Conclusion

The Massachusetts Healthy Aging Data Report: Community Profiles provides local data on nearly 100 indicators to 367 cities and towns within Massachusetts including all of the neighborhoods of Boston. Each Community Profile provides a summary narrative and descriptive data on healthy aging indicators to help community residents, agencies, providers, and governments understand the older adults who live in their cities and towns – their ages, living arrangements, health status, strengths and vulnerabilities. Every community is different and the data, available on the new Massachusetts Healthy Aging

Collaborative website, will help each community to develop responses with more confidence, better targeting and coordination, and the capacity to track results over time.

There are several areas – family caregiving, disability, asthma and social issues like housing and volunteerism– that we did not address in this first Massachusetts

Healthy Aging Data Report, which we plan to consider for future iterations of this report.

For example, the Department of Public Health (DPH) has developed a report on asthma among older adults that indicates that this population had the second highest asthma hospitalization rate and the highest mortality rate of any age group in the Commonwealth. DPH recently convened a Task Force to make recommendations to address this important public health problem. Also available on the Massachusetts Healthy Aging Collaborative website is a directory of more than 150 evidence-based and other healthy aging programs in Massachusetts, which can be searched by community or topic area. We hope that these reports will help Communities become aware of challenges and develop strategies to address them with the goal of promoting healthy aging in the Commonwealth.

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Figure 1: Aging in Massachusetts

Percentage of Population Age 65+ Years By Town / City / Community

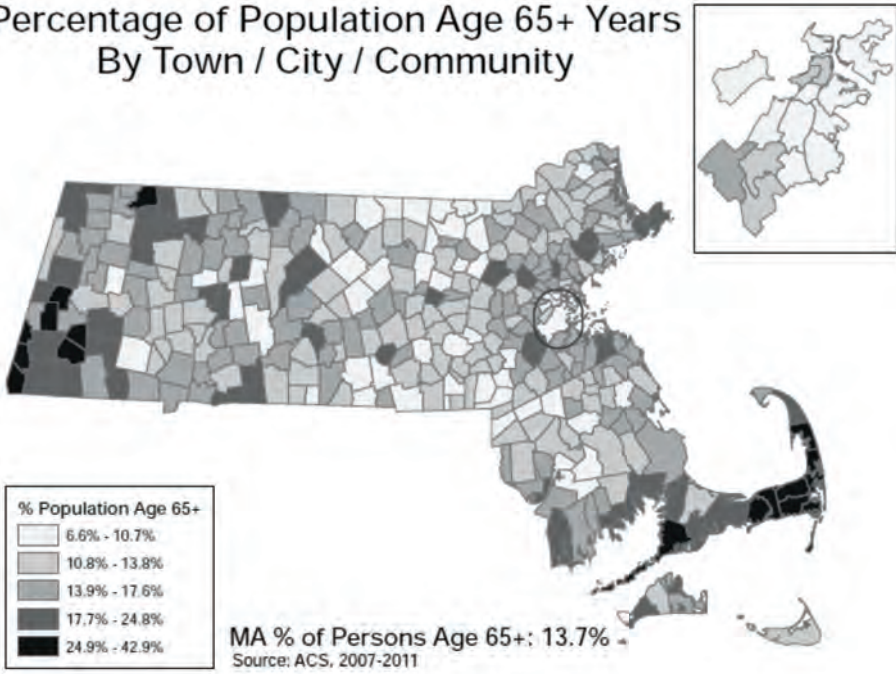
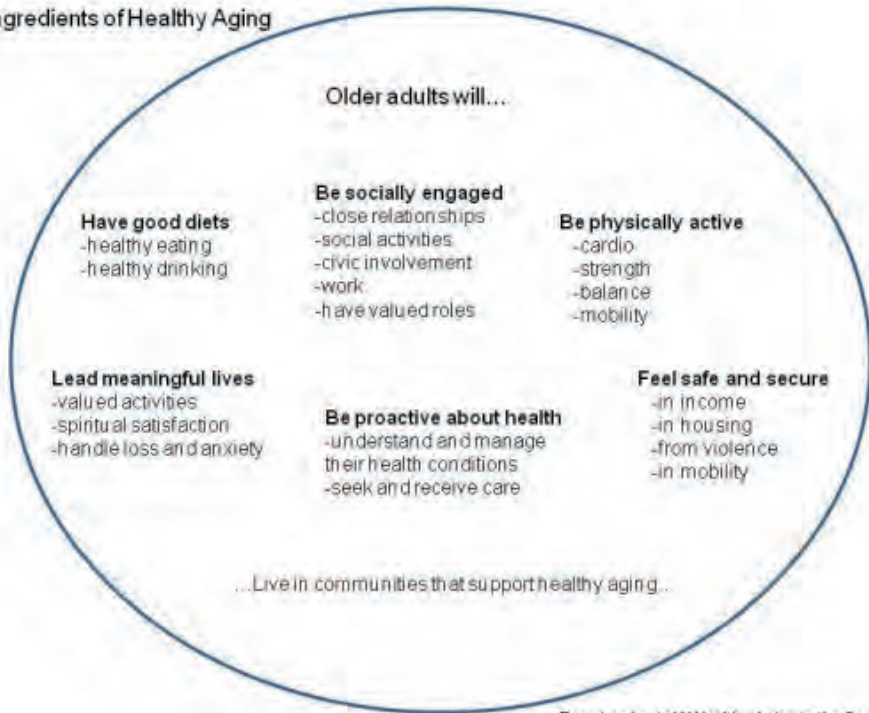


Figure 2

Ingredients of Healthy Aging



Based on Leutz W Healthy Aging in the Commonwealth: Pathways to Lifelong Wellness, Issue Brief 37

APPENDIX-I

MASSACHUSETTS HEALTHY AGING COMMUNITY DATA PROFILE

Boston (Suffolk)

This is a summary profile for the city of Boston. Please see the individual neighborhood reports (East Boston, Charlestown, South Boston, Central Boston, Back Bay-Beacon Hill, South End, Fenway/Kenmore, Allston-Brighton, Jamaica Plain, Roxbury, North Dorchester, South Dorchester, Mattapan, Roslindale, West Roxbury and Hyde Park).



POPULATION COMPOSITION ¹	COMMUNITY	STATE
	ESTIMATE	ESTIMATE
Total population all ages	617,594	6,547,629
Population 65 years or older as % of total population	10.1%	13.7%
Total population 65 years or older	61,351	891,303
% 65-74 years	51.3%	49.8%
% 75-84 years	33.1%	34.3%
% 85 years or older	15.6%	15.8%
<i>Living Situation (65+ population)</i>		
% living alone	41.3%	32.0%
<i>Gender (65+ population)</i>		
% female	60.0%	58.5%
<i>Race/Ethnicity (65+ population)</i>		
% White	61.4%	91.5%
% African American	23.8%	3.8%
% Asian	9.0%	2.7%
% Other	5.9%	2.1%
% Hispanic/Latino	8.5%	2.9%
<i>Marital Status (65+ population)</i>		
% married	38.9%	50.9%
% divorced/separated	16.3%	11.7%
% widowed	29.2%	30.2%
% never married	15.6%	7.3%

Education (65+ population)

% with less than high school education	30.7%	20.4%
% with high school or some college	46.4%	54.5%
% with college degree	22.9%	25.1%

Medicare (65+ population)

% Medicare managed care enrollees	18.6%	21.2%
% dually eligible for Medicare and Medicaid	37.0%	15.9%

HEALTHY AGING INDICATORS

BETTER / WORSE

STATE RATE

COMMUNITY ESTIMATE

STATE ESTIMATE

PHYSICAL/MENTAL HEALTH²

% with self-reported fair or poor health status	W	28.0%	20.7%
% injured with a fall in last 3 months		4.4%	5.1%
% with 15+ physically unhealthy days last month	W	17.7%	14.0%
% disabled for a year or more		31.7%	31.0%
Age-sex adjusted 1-year mortality rate	B	4.3%	4.7%
% with 15+ days poor mental health last month		8.2%	6.7%
% satisfied with life	W	94.0%	95.8%
% receiving adequate emotional support	W	73.4%	80.7%
% ever diagnosed with depression	W	31.9%	28.6%

CHRONIC DISEASE³

% with Alzheimer's disease or related dementias	W	16.5%	14.4%
% with diabetes	W	39.1%	32.1%

% with stroke	B	11.7%	12.6%
% with chronic obstructive pulmonary disease (COPD)	B	21.5%	23.3%
% with hypertension	W	79.2%	77.5%
% ever had a heart attack	B	4.5%	5.0%
% with ischemic heart disease	W	45.1%	44.1%
% with congestive heart failure	W	27.6%	24.8%
% with osteoarthritis/rheumatoid arthritis	B	47.8%	50.2%
% ever had hip fracture		3.9%	3.9%
% with glaucoma	W	27.4%	25.1%
% women with breast cancer	B	9.6%	10.3%
% with colon cancer		3.5%	3.3%
% men with prostate cancer		14.4%	14.6%
% with lung cancer		2.2%	2.1%
% with osteoporosis	B	19.8%	21.7%
% with 4+ chronic conditions (of 14)		59.0%	58.6%
% with no chronic conditions (of 14)	B	9.0%	8.2%
% with complete tooth loss	W	41.7%	35.9%
NUTRITION/DIET⁴			
% with 5 or more servings of fruit or vegetables per day	W	18.8%	24.9%
% obese		23.0%	22.6%
% current smokers		11.5%	9.1%
% excessive drinking		7.3%	9.2%

HEALTHY AGING INDICATORS	BETTER / WORSE	STATE RATE	COMMUNITY ESTIMATE	STATE ESTIMATE
ACCESS TO CARE⁵				
% with a regular doctor			94.7%	96.2%
% did not see doctor when needed due to cost			4.0%	3.7%
# dentists per 100,000 persons (all ages)			153	85
SERVICE UTILIZATION⁶				
Inpatient hospital stays/1000 persons 65+ years per year	*		384	354
Inpatient hospital readmissions (as % of admissions)	*		19.6%	17.8%
Skilled nursing facility stays/1000 persons 65+ years per year			121	117
Home health visits per year	*		7.1	4.2
Physician visits per year	*		6.7	7.6
Durable medical equipment claims per year	*		2.4	2.1
Emergency room visits/1000 persons 65+ years per year	*		736	646
Part D monthly prescription fills per person per year	*		56.8	52.7
WELLNESS and PREVENTION⁷				
% any physical activity last month			68.6%	72.4%
% mammogram within last 2 years (women)			86.9%	85.4%
% colorectal cancer screening			65.6%	65.6%

% cholesterol screening		93.9%	95.8%
% flu shot past year		65.8%	67.8%
% pneumonia vaccine	W	56.4%	60.8%
% shingles vaccine	W	11.6%	14.9%
% with physical exam in past year		90.5%	90.2%
% with annual dental exam	W	68.8%	76.1%
COMMUNITY VARIABLES⁸		COMMUNITY ESTIMATE	STATE ESTIMATE
<i>Walkability of Community</i>			
Walkability score (0-100)	Walker's Paradise	98.0	52.6
Access to groceries (0-20)		20.0	12.0
Access to restaurants (0-20)		20.0	11.3
Access to shopping (0-15)		15.0	6.1
Access to coffee shops (0-15)		15.0	6.7
Access to schools (0-6)		6.0	4.2
Access to parks (0-6)		6.0	4.8
Access to bookstores (0-6)		6.0	1.6
Access to entertainment (0-6)		6.0	2.3
Access to banking (0-6)		6.0	3.5
Average block length in feet (good, fair, poor)	Good	236	643
# of intersections per square mile (good, fair, poor)	Good	453	105
HEALTHY AGING INDICATORS		COMMUNITY ESTIMATE	STATE ESTIMATE
SAFETY⁹			
Violent crime rate /		845	428

100,000 persons		
Property crime rate / 100,000 persons	3,129	2,259

ECONOMIC VARIABLES¹⁰

Household income (65+ householder)

% households with annual income < \$20,000	44.1%	28.4%
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	\$ COUNTY ESTIMATE	\$ STATE ESTIMATE	RATIO OF COUNTY TO STATE
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Elder Economic Security Standard Index

Single, homeowner without mortgage, good health	\$24,564	\$23,808	1.03
Single, renter, good health	\$30,048	\$27,924	1.08
Couple, homeowner without mortgage, good health	\$36,516	\$35,532	1.03
Couple, renter, good health	\$42,000	\$39,648	1.06

See our technical report for information on data sources, methodology, and margin of errors. For most indicators the reported community and state values are both estimates derived from sample data. Hence some of the differences between state and community estimates may be due to chance associated with population sampling. We use the terms “better” and “worse” to highlight differences between community and state estimates that we are confident are not due to chance. “Better” is used where a higher/lower value should have positive implications for the health of older residents. “Worse” is used where a higher/lower score should have negative implications for the health of older residents. When the implication for healthy aging is unclear we use an *.

Explanatory Notes:

¹ Total population estimates are from the 2010 Census and are reported for individual cities/towns and subareas within Boston. Medicare managed care and dual eligible estimates are for beneficiaries 65 years or older in 2011 from the 2011 Centers for Medicare and Medicaid Services (CMS) Master Beneficiary Summary File (MBSF). For these estimates some towns with smaller populations were aggregated together resulting in 311 geographic areas in the state. The same estimate is reported for all cities/towns within the same aggregated geographic area. All other estimates are from the 2007-2011 American Community Survey (ACS) and are reported for individual cities/towns and subareas within Boston. Percentages may not add up to 100% due to rounding error.

² Mortality and depression rates were estimated from 2010-2011 CMS MBSF data for 311 geographic areas (see note 1). The 2007-2011 Behavioral Risk Factor Surveillance System (BRFSS) is the source for all other estimates. BRFSS indicators were estimated for persons 60 years or older for 33 geographic areas based on Aging Services Access Point (ASAP) geographic service areas. The same rate is reported for all cities/towns within the same ASAP service area.

³ The tooth loss rate was estimated for 33 areas from BRFSS data (see note 2). All other rates were estimated for 311 areas from CMS MBSF data (see note 1)

⁴ All rates were estimated for 33 areas from BRFSS data (see note 2).

⁵ Rates for access to doctors were estimated for 33 areas from BRFSS data (see note 2). Dentist supply estimates for 2010 were from the Area Resource File for 14 counties. The same rate is reported for all cities/towns within the same county.

⁶ All rates were estimated for 311 areas from CMS MBSF data (see note 2).

⁷ All rates were estimated for 33 areas from BRFSS data (see note 2).

⁸ Estimates were downloaded from <http://www.walkscore.com/> in July-August, 2013 using the finder term “city/town name, Massachusetts.” Estimates are reported for individual cities/towns and subareas within Boston. “NA” is reported for towns where data on block length and intersection density were not posted. The state estimates are simple unweighted averages of the values reported for all towns with posted data and the 16 subareas within Boston.

⁹ Estimates are from 2007-2011 FBI Uniform Crime Reports (<http://www.fbi.gov/stats-services/crimestats>). Some towns with smaller populations were aggregated together resulting in 310 geographic areas in the state. The same rate is reported for all cities/towns within these aggregated geographic areas and for subareas within Boston.

¹⁰ The household income < \$20,000 estimates are from the 2007-2011 ACS and are reported for individual cities/towns. The city of Boston rate is reported for all subareas within Boston. The 2010 Elder Economic Security Standard Index estimates were downloaded from <http://www.basiceconomicsecurity.org/EI/> for 14 counties for persons 65 years or older. The same rate is reported for all cities/towns within the same county.

Raku-Raku Nouhou: A Multidisciplinary Approach for Aged Farming Communities to Be Sustained The "Farming Easy and Pleasant" (Raku-Raku Nouhou) Project

Gentaro Mizugaki¹, Shingo Teraoka², Sadahiro Hamasaki³, Hiroaki Obitani

Abstract

Objectives: The aim of this paper is to introduce a joint project called “Farming Easy and Pleasant” (Raku-Raku Nouhou) into multiple disciplinary sectors to increase the sustainability of elderly farming communities.

Background: Rural communities in Japan are facing the problem of a lack of successors to the aging farmers. Most farming communities still consist main of elderly people who sometimes have difficulty farming due to its physically challenging nature.

Method: Our project is implemented in a hilly, mountainous area located in the Kansai region, where some elderly farmers have been forced to give up farming because of its hard work in the steep fields. Our solution to make farming easier for the elderly is supported by the following four sectors:

a) Mechanical engineering: Development of an electric transport vehicle that the elderly farmers can handle easily.

b) Agricultural engineering: Including a shift from the cultivation of persimmon fruits to the cultivation of persimmon leaves that require less physical work.

c) Health sciences: Measurement of the physical load of farm work and devices to reduce that load.

d) Sociology: Investigation of farmers' motivational system and social support network where they are embedded.

Findings And Conclusion: In this paper, first we introduce the outline and process of this project. Next, we show how cooperation among the four sectors enables analysis and

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improvement to the community's current situation. Finally, we consider the prosperity of the farmers and challenges ahead in this project.

Keywords: Raku-raku, agriculture, rural community, participation, action research

Background and Objective

Most of the rural communities in Japan, especially in the hilly, mountainous area, are facing difficulty surviving because of aging and depopulation with a shortage of successors to the aging farmers.

Since the high economic growth in 1960s, farmhouses and farmhouse population has decreased because of occupational mobility and out-migration to the urban areas (Figure 1, 2). This not only has brought to the rural communities the devastation of houses, farmland and forests, but also the deterioration of the transportation and social networks. Schools which served as the central institution of the community life have been consolidated into those in other areas because of decrease of the children. Traditional events or festivals phased out. These diminish the willingness of younger generation, female population in particular to stay in their homeland. Through the negative spiral, there has been a threat to the community life of the residents left and linked to failure to inherit farming techniques and reason for living or subjective sense of well-being.

The current rural communities are maintained by elderly people who are engaged mainly in farming. Although there has been more migration into farming communities from urban areas, most farming communities still consist main of elderly people who sometimes have difficulty farming due to its physically challenging nature. While the people who live in rural communities and do farming are aging, even if the people who are originally from the rural communities and who are now working at other areas return to the community and do farming after retirement, they will also be elderly farmers.

Indeed, the elderly people are a valuable work force for agriculture. Moreover, agriculture is the very purpose in the life for them by which they play an active role in the rural communities.

However, farming work fundamentally requires tough work and healthy physical strength as preconditions because farmers go to their fields as workplaces, take care of crops, and harvest and transport the crops. The agricultural instruments that are used are often made without consideration of elderly people's physical limitations. In addition, in the case of orchards, tree shapes are designed exclusively from the viewpoint of adult male's work efficiency, which is not fit for the actual situation of a rural community where the elderly people are playing a central role in farming work.

The aim of this paper is to introduce a joint project called "Farming Easy and Pleasant" (Raku-Raku Nouhou) into multiple disciplinary sectors to increase the sustainability of

elderly farming communities, and next to discuss the significance, prospect and challenge of the project¹.

Method

1) The target field of study

The target field of the project is Tochiyama district of Shimoichi Town, Nara Prefecture in Japan (Figure 3) (Teraoka, 2013; Teraoka, Hamasaki, Mizugaki & Obitani, 2014). It adjoins the Keihanshin Major Metropolitan Area (MMA), while it is located at approximately 300 meters above sea level in the northern part of Yoshino Mountains with a steep terrain where the fruit such as persimmon and plum flourishes (Mizugaki, Obitani, Teraoka & Hamasaki, 2014). Farming there is hard work, particularly at the time of the fruit harvest in the steep fields, where some elderly farmers have been forced to give up farming because of its hard work. The population of the district is 270 with the households of 82 (Census 2010; Mizugaki et al., 2014). The district consists of six communities and full time farmer households account for about 40%. Fruit cultivation such as persimmons and plums are common across the area and most of the fruit farms are on a steep slope. Because of the aging population (about 33% of the district and about 37% of Shimoichi), the district's agricultural management has been facing a harsh reality.

2) Outline of the project

Our solution to make farming easier and more pleasant for the elderly is supported by the following four aspects of the project (Figure 4).

The first aspect is development of machinery and apparatus used for work. In agriculture, various tools have been developed to increase productivity and save labor. Recently, agricultural machinery has been developed to promote large-scale agriculture. When rural communities are experiencing rapid aging, it is even more important to develop agricultural instruments for elderly farmers. In this project, mechanical engineers of a private enterprise developed an electric transport vehicle that the elderly farmers can handle easily.

The second aspect is agriculture as regular occupation. To make a living, people must have some regular occupation to earn money. Willingness to work will increase if a farming method for elderly farmers to gain income is realized. Moreover, even if their income is

increased only slightly, it is importance in terms of their purposes of life. Although urban employees are supposed to retire at their retirement age regardless of irrespective of their willingness and strength, if farmers are able to make a living all their life, farming in a rural community can be more attractive to them. This project proposed conversion of a cultivation system, including a shift from the cultivation of persimmon fruits to the cultivation of persimmon leaves that require less physical work.

The third aspect is physical health. This project conducted measurement of the physical load of farm work to ascertain the reality of strength and body of elderly farmers.

The fourth is network and community. This project collected data on farmland, farmers' kin support network where they are embedded and community resources by several check methods.

The four aspects will be explained in the next section.

Findings

1) Attempts, Check and feedback in each of the four groups

a) Mechanical engineering by private enterprise

As mechanical engineering team, Sanko Seiki Inc., as a local business, manufactured the trucks equipped with lithium cells, but with no gasoline engine. Carrying persimmon fruit on a steep slope is not only difficult task, but also a dangerous labor for the farmers. They developed a compact truck for elderly people to operate (60 cm wide, 120 cm long, and 80 cm high) with sufficient load capacity of more than 100 kg.

For safety, this truck is applied four devices: 1) it stops as soon as the operator loses a grip of the switch. 2) It can stop without slipping off even on a steep slope inclined at over 20 degree. 3) It provides remote-controlled handling. A user can move it forward and backward and turn it with a simple controller like a gaming console. The remote-controlled handling can reduce the risk that the operator might get caught under the truck body if it should fall down because the operator stands far away from the truck. 4) The newest type is equipped with a camera in front so that the operator can confirm the front field of view from the driver's seat on the remote control monitor.

Furthermore, this truck has been improved through farmers' check and feedback. To meet the request of the farmers that they should drive it easily on rough and broken field and

they should operate in narrower spaces, they changed the truck's propulsion to a crawler type and apart from the truck they also developed another electric-powered wheelbarrow.

For convenience, the electric-powered truck and wheelbarrow can also be used as a big battery. For example, the battery makes it possible to use an electric heating pot to provide hot tea or coffee and meal. Users can use a battery charger of a cell phone or smart phone, and PCs in the field. The truck can be also equipped with a communicator to tell others the positional information in an emergency until its battery runs down. Electrical power will inspire the user to discover new ideas and utilization.

These devices can provide the "easy and pleasant" aspects of future farming work.

b) Agricultural engineering by a public-funded agricultural experimental station

As agricultural engineering team, the agricultural general center of Nara Prefecture is in charge of the research into cultivation technology including a shift from the traditional cultivation system which needs hard work to that which requires less physical work and meets the market needs at the same time.

Persimmon fruit has been a main agricultural product as the local industry around the field of study, while there is a traditional recipe of sushi that demands numerous persimmon leaves to wrap the sushi. Sushi businesses have long used leaves produced in other regions or overseas. With a recent growing concern to local products, however, an increasing number of sushi businesses have also needed more leaves for the sushi. Our project aims to produce persimmon leaves as the derivative of the main product on a commercial basis.

Although farmers used to carry three containers full of 20 kg persimmon fruits per container when they are young, they have become old and unable to carry even a single container by themselves. It is easier for elderly farmers to take and transport persimmon leaves because they are lighter than fruit in weight. They can earn from them in an enjoyable way.

A pilot research with the several farmers founds that cultivation of leaves brought revenues of 200 thousand yen per 10 a. Then, our project is attempting to develop processed products using fruit, leaves, and soybeans and to plant persimmon trees for leaves in idle farmland. It is easier, more pleasant and desirable to develop local food culture and improve local traditional products in accordance with contemporary tastes than to conduct unexperienced work on strange products.

Through the farmers' check and feedback, our project has aroused the farmers, and women in particular, around the field of study to advance the production facilities, and to discover and restore actively forgotten local foods so that they can serve them at local festivals and events. To support and further develop their spontaneous activities, the project must develop of new items which elderly farmers can culture easily and longer, and which allow effective land use.

c) Sports sciences in the university

The sports scientist team conducts the "Framing Work Check" to measure body movements included in farming work and its physical load and the "Get-Together Body Check" (Yoriai Karada Tenken) for the farmers and residents in the field of study to ascertain their strength.

The research showed that because the farmers carry a basket in one side of the body on which the weight of persimmon fruits is concentrated while harvesting, they have a sense of fatigue in the shoulder or neck. While the farmers require balance ability because they must harvest persimmon fruit on a stepladder for a long time, none of them has high physical performance and their strength and flexibility vary among them.

On these results, our project developed an easy exercise "Easy and Pleasant Exercise" (Raku-raku Taiso) for them to recover from exhaustion and offered it with the results at community briefing. These are being well received especially by women.

d) Sociology in the university

To help the farmers manage their agricultural management and maintain their community, first of all, it is important for the farmers themselves to comprehend the actual state of farming and successors of their community (Tokuno, 2011), and that the farmers and members of the project mutually discuss the future of the community. Our project conducted three kinds of check in terms of farmland, family, and community's cultural resources all at once. The farmers are asked to gather in a small group (about ten households) at the community hall. Those who consent to participate in our research are asked to join the following three checks.

One of the three checks the "Farmland Check" (Nouchi Tenken). The farmers are asked to mark each of their fields in an enlarged map. They are also asked about the ownership, area, inclination and intensity of solar radiation of each field, the kind of crops, age of trees, transportation used, accessibility to the field, difficulty in farming work, the

possibility to maintain each field ten years later, and so forth. The last question of the possibility to maintain each field ten years later has three alternative responses: "I will maintain it," "I will give it up," "I do not know." According these responses, each of their fields is painted on the map respectively as blue, red and yellow. On this color-coded map the prediction of maintained or deserted fields 10 years later is clear at a glance.

Another check is the "Family Check" (Kazoku Tenken). The participants are asked to draw their own family tree on a large sheet of paper spread on a table, including their spouse, parents, children and grandchildren. Added to the graph is information about all members referred such as their age, sex, place of residence, occupation, frequency to return to their hometown, participation in farming work.

The result reported at community briefing is that the population of 54 years old or less is remarkably small in the demographic structure (Figure 5), that the majority of the residents' children (the second generation) and the grandchildren (the third generation) live within 80 km distance from their parent's house (Figure 6, 7), and that approximately one third of them return to their hometown and keep face-to-face communication with their parents every month (Table 1). The robustness of the community is based on such family and social networks. For an elderly farmer to continue farming work, the community and network in which he or she is embedded are important.

The other check is the "Community Resource Check" (Mura Tenken). It is a kind of group interview in such a way that the residents talk about annual events, festivals, old crops, and traditional recipes on it together and the researcher recorded them on a large sheet of paper spread on a table. By sharing a time to talk, it is possible for them to ascertain the solidarity of their community and its actual state of communication. From the old crops and traditional recipes, new products are sometimes developed.

Further improvement of this method is our important challenge, referring to previous workshop-style researches conducted nationwide on a sporadic basis.

Conclusion

Finally, we discuss the significance of multidisciplinary cooperation, community participation and empowerment, and consider the prosperity and challenges ahead in this project.

1) Multidisciplinary approach

The first trait of this project is a multidisciplinary implementation. Our project pays attention to the following three points when to organize; many conventional tools or devices for agriculture are designed for a strong and experienced adult male, but not for an elderly person, a woman or a beginner with little experience of farming. Maintenance of elderly farmers' health should be considered not only in terms of farming work load but also from a point of view of their daily life. Elderly farmers are likely to make decisions whether they should continue farming or not, taking into account support network of their family, relatives and successors.

Our project constitutes the implementation organization from four fields of agricultural and mechanical engineering, sports science and sociology. Development of assistive tools or devices for agriculture by mechanical engineering field and cultivation and marketing by agricultural engineering aims to design "barrier-free field" in the farmland. Sports science attempts to grasp the multi-faceted health of farmers. Sociology operates to measure and evaluate social environment around farmers and visualize the current status and prospective status of farmland.

It is notable that for technological development in this project, the social situation is important.

Taking the development of electric-powered trucks as an example, this project does not aim only to develop a high-powered and durable truck, but also to produce tools to provide elderly farmers with a motivation for working. It is important for a machine not only to help elderly people but also to encourage them to undertake physical activity and be healthy.

In addition, it must be a technological development to upgrade elderly farmers' regular vocation (agricultural income) and their community. It is necessary to collect and offer local information to help research and development. By addressing the development of

sociological research methods with a view to such purposes, this project has realized the active collaboration.

2) Community participatory research

The second feature is community participatory research or action research. By this term, we refer to the research in collaboration with experts / researchers and community towards resolution of social issues. In other word, the results of the research are available to the people of the community (Stoecker, 2012).

This project took on the character of community participant research from the beginning of preliminary research. The purpose of this project, empowerment of the aged community ten years later, was raised by some farmers in the target field of study. The Agricultural center has long kept in contact with them and accumulated information of the target field of study. Collaboration with the farmers in terms of persimmon leaf cultivation has result in a productive cooperation system set up in the community. It is desirable that any individuals and organization will spontaneously inherit the achievement of this project.

3) Multidisciplinary approach and community participant research

Two features described above are closely related to each other. First of all, a multidisciplinary approach in a community participate research facilitates the construction of a system of cooperation with the community. Action research has been conducted for a long time in the field of agricultural technique guidance. However generally it is farmers that manifest interest in an agricultural project, although even a small community has diverse interests. By the multidisciplinary approach consisting of engineering, agriculture, sports science and sociology, it is possible to draw attention of different people, including non-farmers and young people, and to obtain a broad involvement and participation in the project.

4) Future challenges of this project

This project, which started in October 2012, has been producing good results in four aspects. However, currently it is one of the most important issues for the project to find successors within the community in terms of the other three aspects besides agricultural engineering.

Another important issue is to establish the method of evaluating the effects of such kind of project as ours. Although similar projects have been conducted as "action research" targeting communities across the country in recent years, the method of evaluating them is

not always established in an academic manner (Stoecker, 2012). For such attempts of social technological development to become more active, it might be important to formulate an axis of evaluation.

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Footnotes

1. This project is funded and currently in progress as the R &D Project 2011-2014, "Innovations in age-friendly farming (Development of the "Farming Easy and Pleasant" method for elderly Farmers)," by the Research Institute of Science and Technology for Society (RISTEX) of the Japan Science and Technology Agency (JST).
The details of this project are as follows:

http://www.ristex.jp/korei/en/02project/prj_h23_08.html

<http://www.nara-wu.ac.jp/scc/tochihara/english.html>

"Column 2-2 Working for life by cultivating persimmons - efforts made by the Tochihara District in Shimoichi Town, Nara Prefecture," in: Ministry of Education, Culture, Sports, Science and Technology, White Paper on Science and Technology 2013: Science and Technology as a Foundation for Innovation, 94.

http://www.mext.go.jp/component/english/_icsFiles/afieldfile/2013/10/30/1340804_05.pdf

Table 1

Frequency in which family members living outside the target community return to their parents' house

More than once a week	12	9.4%
A few times a month	36	28.3%
Several times a year	35	27.6%
One or two times a year	36	28.3%
Less than once a year	8	6.3%
Total	127	100.0%

Figure Captions

Figure 1. Total farmhouses, farmhouse population in Japan (Census of Agriculture and Forestry 2010)

Figure 2. Total farmhouses, ratio of population aged 65 or over of farmhouse population(Census of Agriculture and Forestry 2010)

Figure 3. The location of the target field, the Keihanshin Major Metropolitan Area and the place of residence of the second and third generation

Figure 4. Four Aspects of the project

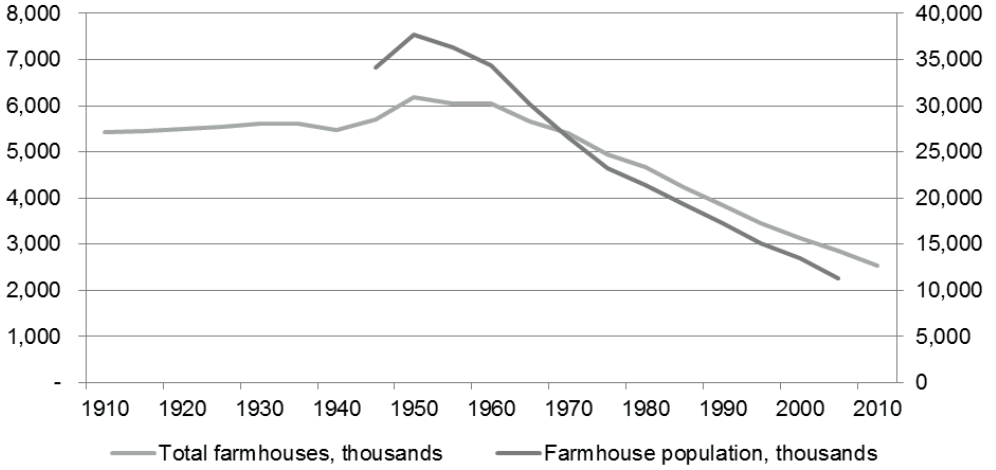
Figure 5. Population (Census 2010) in the target field of study Tochiyama District

Figure 6. Age of the respondents' sibling, children, children's spouse, and grandchildren living outside Tochiyama: Male

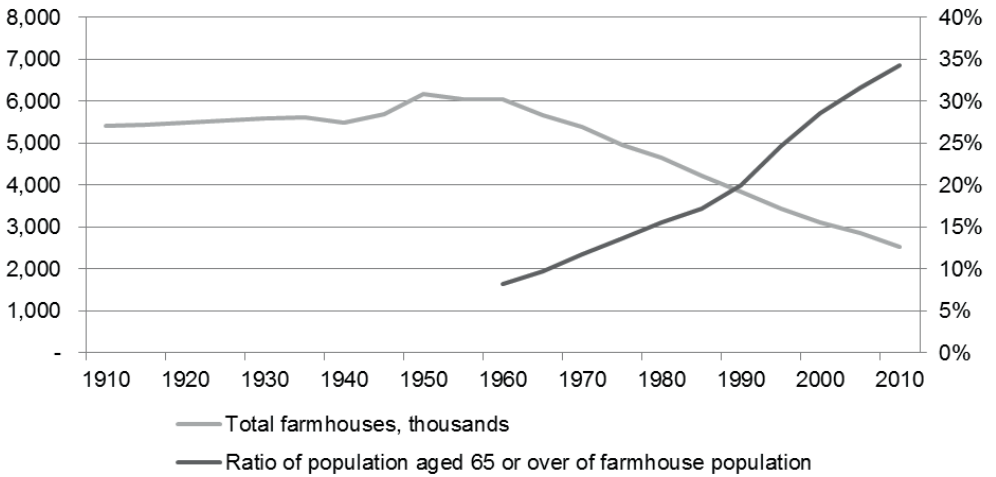
Figure 7. Age of the respondents' sibling, children, children's spouse, and grandchildren living outside Tochiyama: Female

[Figures]

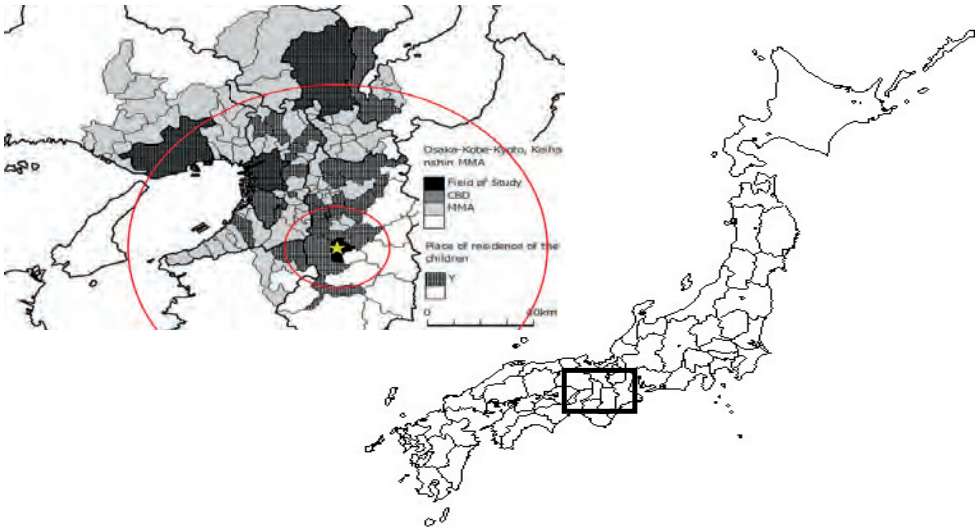
(Figure 1)



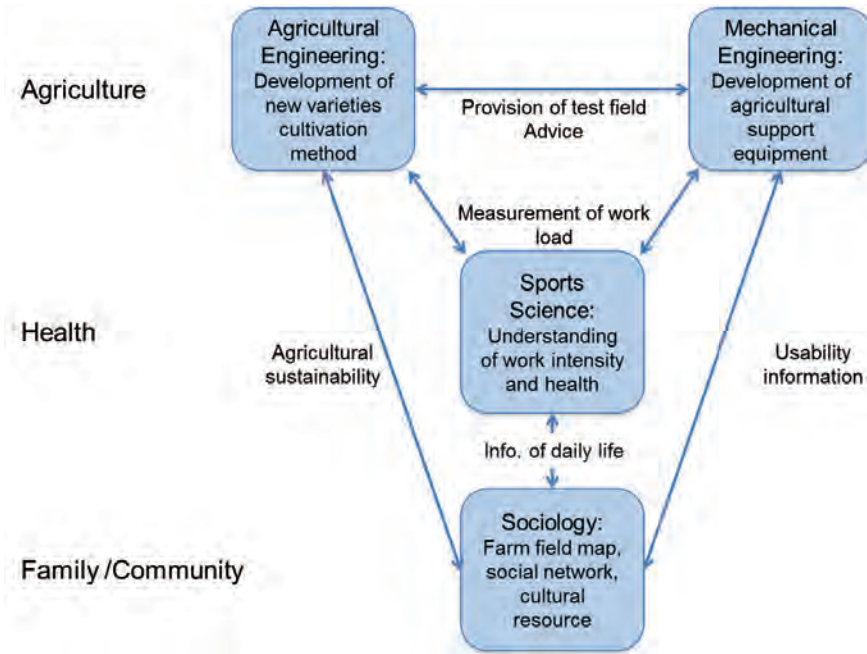
(Figure 2)



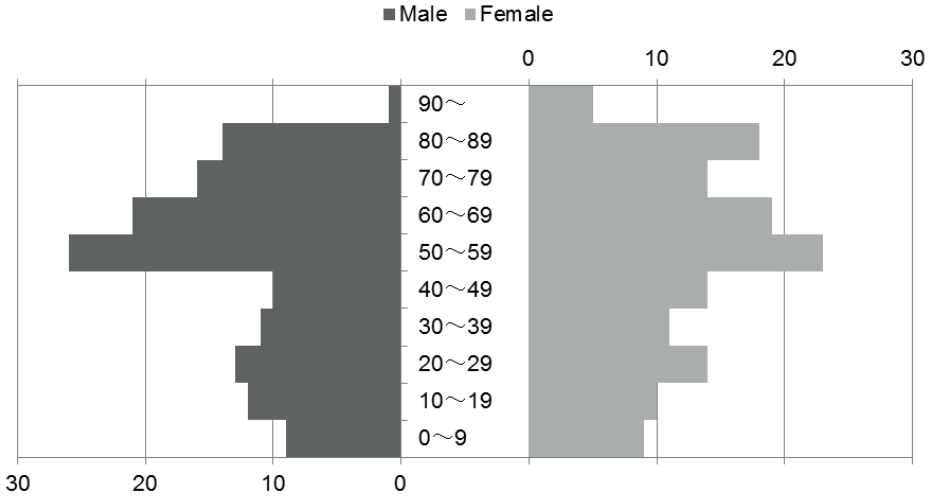
(Figure 3)



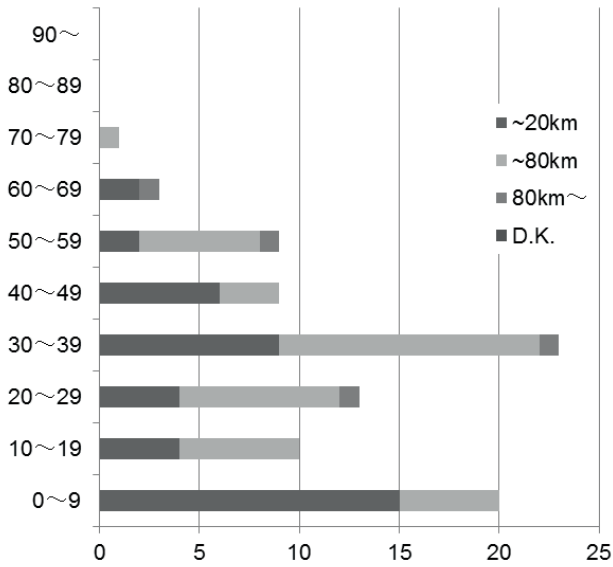
(Figure 4)



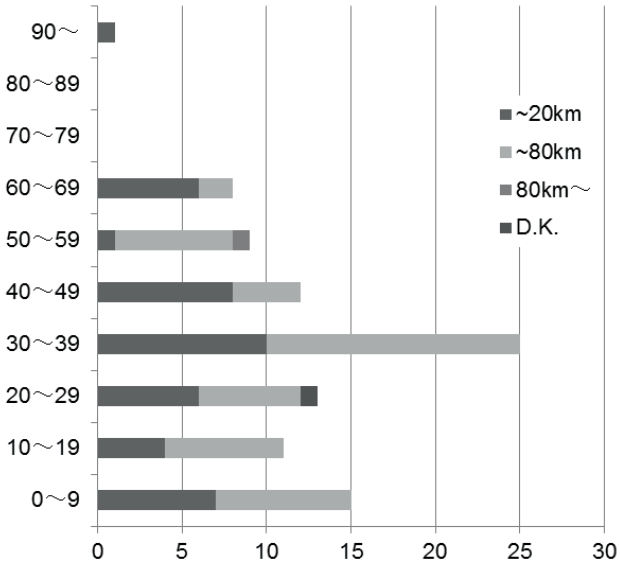
(Figure 5)



(Figure 6)



(Figure 7)





SESSION III

October 16, 2014



Empowering Older Adults in Turkish Society: Innovative Social and Health Care Service Strategies

Özgür Arun¹, Jason Holdsworth²

Abstract

Background: For centuries and millennia, there had been relatively static or negligent increases among older adult populations. By 2045, the number of older adults aged 60+ worldwide is expected to exceed the number of children aged 14 and under for the first time in history.

Objectives: This paper explores the challenges requiring informed action related to issues of gender and age-related disparities with respect to education, marital status, income, health status and health problems such as chronic illnesses.

Method: Secondary analyses of national representative raw data from TurkStat's Health Survey Of Turkey will be conducted.

Results: Younger generations have both higher education and income compared to older generations, revealing structural lag. Numerous personal care difficulties are most prevalent in the oldest old age group. Difficulties with ADLs and IADLs are also an issue for the 75+ age group. On the other hand, among the most important issues for 45-74 age groups is prevalence of chronic disease and subsequent utilization of chronic disease follow-ups within the primary care services system.

Conclusion: Because difficulties arise in ADLs and personal care due to increased frailty among adults aged 75+, social care services comprise the most urgent of needs among older adults. On the other hand, preventive health services and nutrition programs should be planned and implemented for 55-74 age groups. Additionally, educational levels in the 45-54 age group are low while incidence of chronic disease will rise with age. As a result, while working with these age groups, education, gender and social classes must be addressed and the scope of social support broadened in a diverse society like Turkey.

Keywords: Social and health care, Gender, Education, Social class, Turkey, Correspondence analysis

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Global Demographic Transitions

For centuries and millennia, there had been relatively static or negligent increases among older adult populations. As of the later half of the twentieth century, increases in aging populations as a proportion of the total population have increased at unprecedented rates, getting the attention of governments and policy makers around the world. Exponential growth of persons reaching old age in primarily developed countries and, in more recent years, developing countries make population aging a global phenomenon.

The fastest growing population in the world as a share of total population is centenarians, followed by populations aged 80 years and over and 60 years and over (UNFRA, 2012, p.19). Thus, older cohorts are aging more rapidly and comprising an increasingly larger share of the global population than any of the respective younger populations. By 2045, the number of older adults aged 60 and over worldwide is expected to exceed the number of children aged 14 and under for the first time in history (UN, 2010, p.xxiv; as cited in Holdsworth, 2013, p.3).

Due in large part to medical and technological advancements stemming from global transition from agrarian to industrial societies, the world's population is growing older. More specifically, population aging is the result of decreases in fertility and mortality rates and increases in life expectancy. Accordingly, median ages are on the increase. Population aging is a reality in progress in *virtually all countries* in the world (Bloom, et al., 2011, p.3; as cited in Holdsworth, 2013, p.4).

In 1950, some 205 million older adults aged 60 and over were in the world. By 2012 the numbers of older persons had increased to 810 million. By 2050, projections put the number of older adults at 2 billion, almost a ten-fold increase since 1950 (UNFRA, 2012, p.13)!

Demographic Transitions in Turkey

The aging of societies reflects a global trend that is inevitable (UNFRA, 2012, p.16), of which Turkey is no exception. In fact, compared to its global neighbors, Turkey is on a particularly fast population-aging trajectory. Pointed decreases in fertility (marked by decreased proportions of the 0-14 age group in *Figure 1* below) and mortality rates combined with rapid increases in life expectancy (visually represented by increased

proportions of 65+ age group in *Figure 1*) over the past decades detail the prevailing reasons for the swift and steady demographic transition period that Turkey is experiencing.

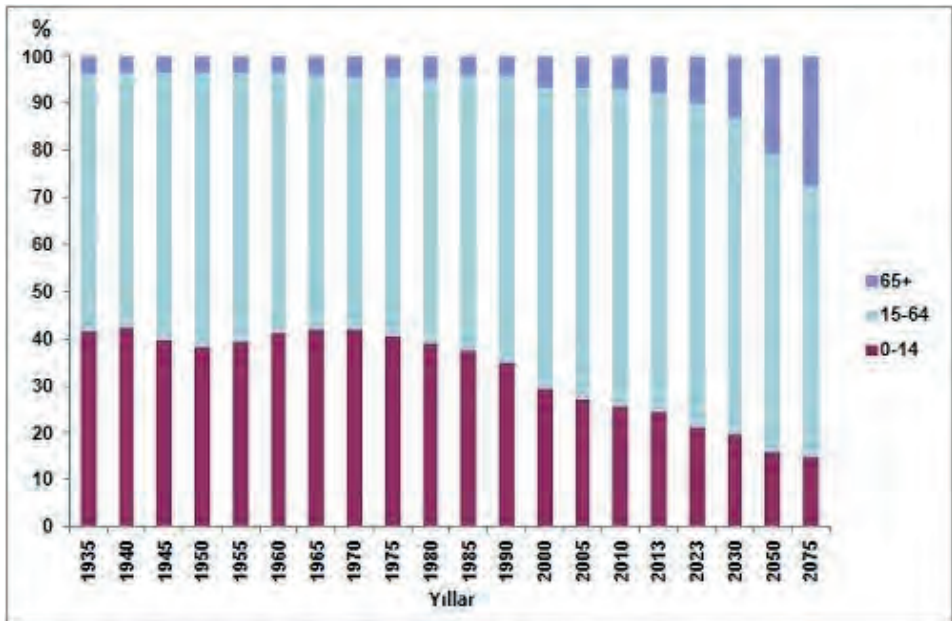


Figure 1. Proportion of young, working age and older persons in Turkey, 1935-2075; TurkStat, 2013

In fact, according to OECD records (2011), Turkey is the second fastest aging country in the world (Arun & Arun, 2011). Of the 76 million 667 thousand 864 people living in Turkey (Turkstat, 2013) today, some 5 891 694 million or 7,7% are 65 years of age and over. This percentage of older adults aged 65 and over is projected to reach 10,2% by 2023 and 20,8% by 2050.

For most older people in Turkey, being old is associated with living in poverty (Tufan, 2009, p.384). Not unlike most other nations, females make up a majority of older persons in Turkey. Additionally, women are more prone than men to be widowed in their older years, especially as they reach the old old cohort. Some 21.0% of women aged 60-64 were widowed compared to just 1.8% of men from the same cohort. Nearly three quarters (74.8%) of women between the ages of 80-84 were widowed compared to less than one third (31.4%) of men, respectively (Arun, 2013b, p. 306). The overrepresentation of older widowed women compared to older widowed men naturally lends to cumulative disadvantage for many older women. This disadvantage is further accentuated in that, compared to men, Turkey's older women are faced with a history of disadvantages such as access to education, employment, and life opportunities (Arun, 2013b, p. 304).

Social & Health Care Services in Turkey

While a variety of services available in Turkey today might be described in greater detail, the following *figure* will suffice to present the major social and health services provided by one or more of the following: central or municipal government, private and/or non-profit organizations.

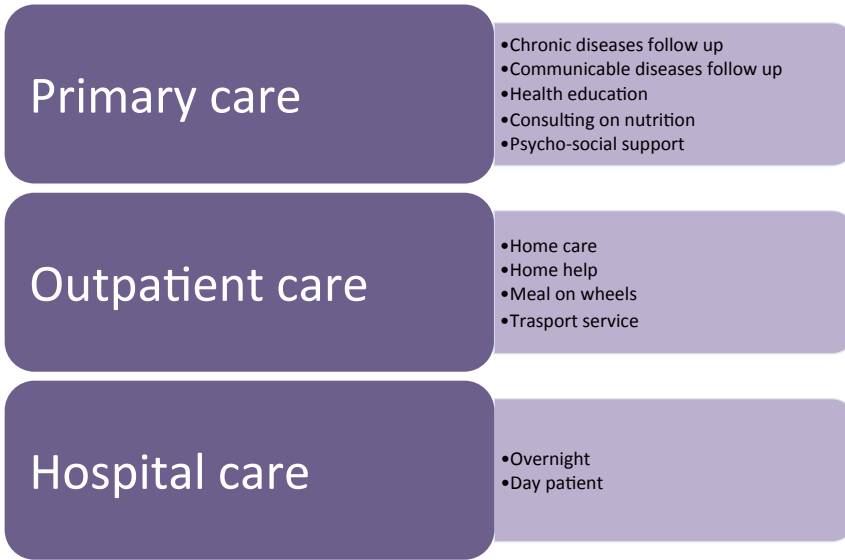


Figure 2. Social and Health Care Services Available in Turkey, 2012

Figure 2 highlights the major social and health services available today in Turkey. Services are grouped under three main headings namely, primary care, outpatient care and hospital care. Primary care refers to services such as chronic disease follow-up, communicable disease follow-up, health education, nutrition consultation, and psychosocial support. Outpatient care includes home care, home help, meals on wheels programs and transportation services. Lastly, hospital care refers to overnight and day patient care services.

Methodology

Background and Purpose

The Turkish Statistical Institute (TurkStat) conducts national surveys annually on a range of issues such as employment, income, education, housing, family, health, work-life

balance, life satisfaction, and perceived quality of society.

The aim of the Health Survey of Turkey (HST) is to get information about health indicators including health conditions, the utilization of health services, satisfaction levels from these services and difficulties faced by adults carrying out daily activities. HST is important in that it's the first study that reflects the health conditions of adults in Turkey, allowing international and national needs comparisons. HST is representative of all individuals living in Turkey. Institutional populations (soldiers, individuals living in dormitories, prisons, long-term hospital and nursing home facilities, etc.) and small settlements, not to exceed 1% of the proportion of the total population, with adequate number of households (defined as populations of more than 132 persons) are thought to be reached and included in the sample.

Sample Size and Sampling Method

HST is designed to produce estimates for all of Turkey, including urban and rural communities. Thus, the total sample size was 14,400 households, 10,656 households for urban and 3,744 for rural areas. According to TurkStat, strata and a two-phase cluster sampling method was used. The first stage of sampling units comprised blocks selected from clusters containing an average of 100 household addresses and the second stage comprised sampling units of households derived systematically from each of the selected clusters. Weighting procedures were carried out to obtain parameters from the data set resulting from sampling so as to acquire universal representation (TurkStat, 2012).

Basic Characteristics of Adults in Turkey

The basic personality characteristics of persons who participated in the HST will be given in this section, followed by information on care and welfare services in Turkey. Lastly, utilization levels of available care and health services will be discussed.

Gender distribution of participants of the HST study is presented in the following table:

Table 1: *15+ population in Turkey*

Gender	Frequency	%
Male	26910252	49.2
Female	27731831	50.8
Total	54642083	100.0

Source: Estimates computed by authors of HST-2012, (TurkStat, 2012).

According to the table, 49.2% of the population over the age of 15 are male, and the remaining 50.8% are female.

A Turkish population profile, in the context of age and gender, is presented in Table 2, below:

Table 2: *Socio-demographic profile of persons aged 15+ in Turkey, 2012*

	Variable	Age groups						
		15-24	25-34	35-44	45-54	55-64	65-74	75+
Marital Status	Married-M	4.8%	61.9%	90.5%	94.7%	94.3%	87.9%	73.1%
	Married-F	25.0%	83.7%	91.0%	88.4%	77.5%	55.6%	30.0%
	Widowed-M	0.0%	0.1%	0.2%	0.7%	2.4%	9.4%	24.7%
	Widowed-F	0.1%	0.4%	1.7%	5.8%	17.9%	42.2%	68.1%
Financial Independence /	Working-M	33.5%	86.0%	89.1%	68.6%	35.9%	16.3%	7.0%
	Working-F	13.7%	27.6%	26.8%	19.0%	9.2%	5.6%	1.6%
	Less than 500\$ -M	29.4%	27.2%	30.9%	28.7%	31.9%	46.4%	59.7%
	Less than 500\$ -F	31.9%	31.4%	31.3%	29.7%	37.0%	57.8%	63.1%
Health (subjective)	Health-very good-M	30.9%	20.7%	13.7%	9.9%	6.4%	3.0%	1.4%
	Health-very good-F	26.6%	14.5%	8.5%	4.0%	2.5%	0.7%	0.4%
	Health-very bad-M	0.2%	0.3%	0.2%	0.5%	1.4%	2.5%	3.5%
	Health-very bad-F	0.4%	0.2%	0.5%	0.8%	2.3%	3.1%	7.1%
Education / Literacy	Illiterate-M	1.3%	1.1%	1.5%	1.8%	5.9%	12.4%	25.4%
	Illiterate-F	3.7%	6.1%	9.4%	18.0%	33.8%	53.9%	70.0%
	Secondary-M	59.5%	18.7%	12.0%	11.9%	11.1%	6.2%	4.0%
	Secondary-F	57.4%	13.2%	7.1%	6.1%	3.4%	2.0%	1.5%
	University-M	5.2%	22.3%	17.0%	10.2%	10.7%	7.9%	5.0%
	University-F	5.9%	17.9%	9.8%	4.5%	3.9%	1.8%	0.5%

M: male / F: female

Source: Estimates computed by authors of HST-2012, (TurkStat, 2012).

In Table 2 above, a socio-demographic profile of the Turkish population is given on the basis of gender and age distribution. When marital status is investigated, advancing age is associated with decreased proportions of both men and women remaining married. Additionally, there is a direct relationship between advancing age and widowhood. However, when males and females are considered separately in terms of marital status, it can be observed that females are in a more disadvantaged position compared with males.

When the working status of the Turkish population is investigated, analysis shows that advancing age causes cessation from active participation in the work force. To illustrate, about 90% of young males take part in the work force, compared to just 7% of males aged

75 and over. For females, research results for work participation are more striking. In Turkey, less than one in three young females are employed. This is a considerably lower proportion when compared with young males. One of the most striking problems in Turkey is that women cannot be incorporated into the labor force as easily as men. Indeed, this gender-based inequality continues even into advanced age, opening the way to further disadvantages for women, especially in terms of social benefits. As a result, older widows are the most vulnerable group in terms of poverty. When assessed in terms of income, differences between the young and old are remarkable. Young persons obtain more income compared with older populations. Income differences between young males and females are not significant. However, in advanced age, the proportion of older females in poverty increases dramatically.

Health status is one of the crucial indicators of wellbeing. Younger persons subjectively assessing their health status in Turkey have reported that they are healthier. However, categorically speaking, it cannot be said that, always and in all conditions, all older adults are unhealthy. In fact, 3.5% of men and 7.1% of women in Turkey, aged 75 and over, reported that their health is in very bad condition. The rate of young people who declared that they are unhealthy is three per thousand.

In Turkey, educational level is an infallible classifier that separates social classes (Arun, 2012). Only 1 of every 100 young males is illiterate, while 1 in 4 older males aged 75+ is illiterate. Illiteracy figures are even more striking among women. Three percent of young females reported that they are illiterate. The rate of illiteracy among older females is 20 times and 60 times that of young females and young males, respectively. In Turkey, 70% of females aged 75 and over are illiterate.

Social & Health Care Services in Turkey

In Table 3 below, the socio-demographic situation of Turkish citizens are analyzed in terms of gender and age. In this section, the profile of beneficiaries of social and health care services will be analyzed.

Table 3: Social & Health Care Services

Services	Gender	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total Rate
Primary Care									
Chronic diseases follow-up	M	2.7%	4.1%	6.4%	10.1%	16.9%	22.4%	25.7%	8.2%
	F	3.4%	4.9%	10.2%	17.3%	23.9%	31.8%	27.4%	12.3%
Communicable diseases follow-up	M	0.4%	0.7%	0.9%	0.6%	0.6%	0.1%	0.4%	0.6%
	F	1.0%	0.6%	0.5%	0.8%	0.8%	0.0%	0.4%	0.7%
Health Education	M	0.5%	0.9%	0.8%	0.4%	0.5%	0.2%	0.6%	0.6%
	F	1.5%	0.8%	0.4%	0.6%	0.7%	0.1%	0.2%	0.8%
Consulting on Nutrition	M	0.5%	0.6%	0.6%	0.4%	0.2%	0.1%	0.5%	0.5%
	F	1.3%	0.9%	0.5%	0.8%	0.8%	0.3%	0.1%	0.8%
Psychosocial Support	M	1.2%	0.9%	1.0%	0.9%	0.7%	0.8%	0.7%	1.0%
	F	1.4%	1.5%	1.8%	2.2%	1.6%	0.8%	0.5%	1.6%
Outpatient Care									
Home care	M	0.6%	0.8%	0.5%	0.7%	1.0%	1.9%	4.2%	0.9%
	F	1.2%	1.8%	1.0%	1.4%	1.5%	2.4%	6.1%	1.6%
Home help	M	0.9%	0.7%	0.8%	0.5%	0.7%	1.1%	2.6%	0.8%
	F	0.8%	1.0%	0.9%	1.0%	1.8%	1.6%	3.7%	1.2%
Meals on wheels	M	0.9%	0.4%	0.9%	0.9%	0.6%	0.7%	0.9%	0.7%
	F	0.4%	1.0%	0.6%	0.5%	1.2%	0.7%	0.9%	0.7%
Transport services	M	0.5%	0.5%	0.9%	0.6%	0.8%	1.6%	2.0%	0.8%
	F	0.5%	0.8%	0.6%	0.8%	1.6%	2.3%	2.0%	1.0%
Hospital Care									
Inpatient overnight	M	4.3%	4.1%	6.1%	6.7%	11.1%	17.6%	22.3%	7.0%
	F	7.4%	12.6%	8.3%	8.9%	11.6%	18.0%	21.4%	10.7%
Day patient	M	25.5%	29.1%	30.7%	31.2%	36.9%	38.1%	43.4%	30.7%
	F	31.2%	39.0%	37.5%	43.0%	44.3%	46.6%	47.5%	39.1%

Source: Estimates computed by authors of HST-2012, (TurkStat, 2012).

In Table 3 above, levels of benefit from the services offered are provided in terms of gender and age. In Turkey, the services offered can be grouped under three headings: primary care, outpatient care and hospital care (see Figure 2). The level of services utilized is also differentiated on the basis of gender and age. In Turkey, the most heavily utilized social and health care services are located under the heading of hospital care. Among all services, day patient care is the most frequently used service for all age groups. The other two service headings constitute the least used service groups. The most heavily utilized service in the scope of primary care is the follow-up of chronic illnesses. With advanced age, the frequency of beneficiaries of chronic illness follow-ups increase.

The challenges awaiting gerontologists in providing social services in Turkey

The social map represents a two-dimensional field, constructed through *correspondence analysis* (By this technique, it is aimed to describe the associations among variables. Basically, this analysis matches the associations in a frequency table between the rows and columns with each other in a two-dimensional field. Firstly, the profile of the categories (relative frequencies) and masses (marginal proportions) are computed. Then, distances between all these points representing such parameters are calculated and placed in the most appropriate locations inside the two-dimensional field. This analysis is an attempt to present the underlying structure of the data set by following the inductive method (Clausen, 1998; as cited in Arun, 2014). Findings obtained are presented visually to generate the chart below.

On the social map above, individuals are located on the horizontal axis according to age and education. With movement towards the right of the horizontal axis, age increases and the level of education decreases. On the vertical axis, categories are placed according to income. All categories on the two dimensional area are positioned according to the horizontal and vertical axis that represent age, gender, education and income. Marital status, personal care difficulties, activity difficulties, and use of social and health care services are also located on this two dimensional area.

The social field above also provides the answer to the question of what challenges await gerontologists in providing social and health care services in Turkey. According to the social map, younger generations have both higher education and income. At that point, structural lag is revealed. Investigation of marital status reveals that widowhood is particularly a status characterizing older generations. In addition to widowhood, feminization of aging, especially among the 75 and over age group becomes visible.

Numerous personal care difficulties are seen to be most prevalent in the oldest old age group. Advancing age is associated with difficulties in carrying out activities of daily living (ADL) such as feeding oneself, toilet usage, bathing or showering, getting in and out of bed or a chair and medicine management. Additionally, older adults aged 75 and over also face difficulties in carrying out instrumental activities of daily living (IADL) like preparing meals, shopping, finances and everyday administrative tasks.

Difficulties with ADLs and IADLs are not an issue for the other age groups. Notably three age groups, namely 45-54, 55-64 and 65-74, suffer from chronic diseases like hypertension, diabetes, heart disease, kidney disease, etc. Therefore, one of the most important issues for these age groups is prevalence of chronic disease and subsequent utilization of chronic disease follow-ups within the primary care services system. In addition older adults, especially in the 65-74 age group, may require provision of home care services by a nurse or nurses assistant within outpatient care services. Depending on the severity of their health condition, they may have been required to stay in a hospital as an inpatient overnight or longer. In other situations, individuals have been admitted as a day patient, but not required to remain overnight. As a result, unlike the younger age groups, these older adult groups, especially the 65 years and over groups, more frequently utilize hospital care services. On the other hand, as the risk of poverty increases across these age groups, the necessity for transportation services and meals on wheels are also increasing, particularly for persons with low incomes (i.e. under \$200/month). As a result,

the level of those most vulnerable across these age groups may be described as follows; illiterate or having no formal education, income under \$200, being female and widowed.

On the other hand, levels of education and income are higher among younger generations, namely person's aged 44 and below. These age groups are mainly composed of males, since they more actively contribute to the labor force. They primarily live in cities and benefit from primary care services and psychosocial support. Those generations also receive communicable disease follow-up services because of seasonal health problems.

The age group 15-24 forms the youngest generation and they receive health education services along with consultation on nutrition. These age groups participate in formal education and are thus able to receive such services while they are at school.

Conclusions

Phrases such as “demographic gift” (Arun, 2013a) and “window of opportunity” (Gürlelel, 2004) have been coined to describe Turkey's present situation. This demographic transition, spanning a period of some 15 to 20 years (Behar, 2006), marks the time allotted in the proverbial sands of time or hourglass that Turkey has to devise and implement strategies to successfully meet the challenges of its aging society. Failure to act will inevitably lead to aggravated societal and economic upheaval that might otherwise be curtailed by informed research, planning, preparation and implementation.

Within this framework, it has been concluded that because difficulties arise in ADLs and personal care due to increased frailty among adults aged 75 and over, social care services are, therefore, among the most urgent needs of such older adults. Challenges awaiting professionals who intend to plan and implement services to this target population need bear in mind the risks of low education levels (including illiteracy) and poverty observed in this study. While planning services, further sensitivity and attention need be shown to the most vulnerable sub-group among the older age groups – widowed women. While working with this sub-group, poverty must be addressed and the scope of social support must be widened.

Three age groups, those between 45-74, reveal distinct problems and special needs. The most evident of the needs arise from the observed decrease in their probability to remain married as they age. The youngest group in this population, age group 45-54, includes

married and primary school graduates. Also, educational levels in this group are low while incidence of chronic disease will rise with age.

Thus, they receive primary care and hospital care services – mainly chronic disease follow-up and overnight patient services. In this case, gerontologists that work in health institutions with family physicians should pay special attention to socio-economic status of patients while providing services to populations having a middle-level income and below. Additionally, suggestions should be made to prevent age-related increases in frailty of these generations. Preventive health services and nutrition programs should be planned and implemented for this age group. Furthermore, mild level physical activity programs should be planned to foster habits of regular physical activity.

Two groups under the age of 45 are drawing attention. The first is the 25-44 age groups. These represent individuals at middle, upper-middle and high income levels who form up the engine of the labor force of Turkey. Males compose a major percentage in this group and the major challenge for this generation is the need to create employment opportunities for women that they might take their place in the labor force. It should be noted that one of the important criteria for Turkey's pending membership in European Union is to create employment opportunities for women. In order to do that, care services need be developed, diversified and applied effectively. Women provide care for their children and older family members and that's why many cannot participate in employment industry. Planning and implementing care programs for older adults and children will address an important obstacle to women engaging in the labor force. As a result, gerontologists working in the field of policy planning and application of care services will do well to consider gender equality as a high priority for this generation.

With regard to the 15-24 age group, high levels of unemployment is chief among concerns. According to TurkStat, the current unemployment rate for younger generations (15-24 age groups) is %17 in Turkey (TurkStat, 2014). Unemployment related issues in this group should be a special focus of inquiry.

In conclusion, Arun (2013a) identified key principles to address these challenges under four titles;

1. Identify levels of vulnerability between older age cohorts by means of a national survey investigating: a) accessibility to services and programs, b) availability of community health agencies supported by inadequate resources, c) adequacy of health education and training and welfare professionals in providing services to heterogeneous older adults in diverse of

community settings.

2. Initiatives are required to rectify existing gender gaps in social contexts such as education, training, labor market participation, and social welfare and social security benefits. Formulation of gender sensitive policies with respect to health and social security benefits will be critical to impede *triple jeopardy – being female, old, and poor*.

3. Ethnic customs and practices need be recognized (and protected) so as not to elicit disadvantage and inequality with respect to human rights, which might inadvertently lead to diminished participation in society. All people will benefit from the development and implementation of social policies committed to: a) maximizing economic, social, and political participation, and the b) inclusion of persons regardless of ethnic, cultural, or religious affiliation.

4. Aging in Turkey need not be viewed as a problem or negative experience, rather Turkey need embrace the *opportunity* afforded it's *demographic gift* and “adjust its social and political functions and structures to meet the needs and capabilities of all ages; thereby realizing the potential of all, for the benefit of all” (Parliament of Victoria, 1997, p. 67).

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Psychological First Aid in Emergency Situations: for Older Adults

Bernd Gasch¹

Abstract

Background: The author has been involved in research in the field of emergency psychology for the past 20 years. The main thesis is that a victim (e.g. of an accident) is not only physically hurt but also psychologically harmed and therefore needs first aid in both aspects.

Objectives: To develop rules in psychological first aid for laymen and professional helpers in acute emergency situations to assist the victim in an appropriate manner.

Methods: The rules were developed from theoretical sources, interviews with victims and helpers, role-play situations and personal self experience of the author as a victim in simulated accident-situations.

Findings: While some principles of a psychological ‘first aid’ approach to emergency situations for older adults (as well as other age groups) are based mainly on common sense, the paper presents empirically based rules for laymen and professionals helpers.

Conclusions: These rules should be transferred into the public for laymen and taught in the education of medical and other professional helpers.

Key words: Psychological help, accidents

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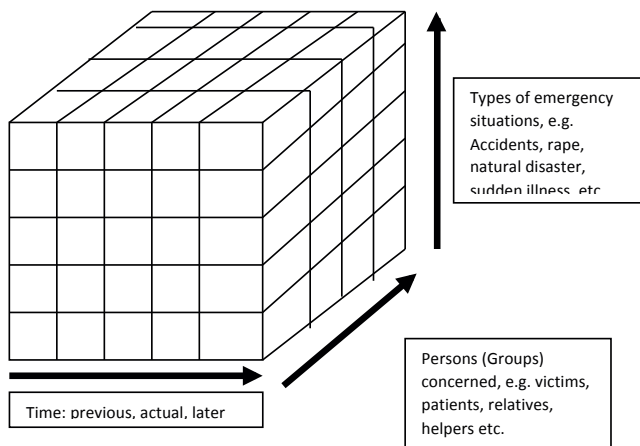
Preface:

This paper is based on empirical research in Germany. As helping behavior is influenced by cultural attitudes the transfer to other countries should be examined, though the author reckons that applying the rules presented in the paper don't cause any harm in other civilized countries. The paper concentrates mainly on accidents in traffic, household and workplace. An application in cases of severe internal medical problems, like heart attacks or epilepsy, needs some adjustment (See: Gasch & Lasogga 1999 and 2011).

Background:

Medical first aid has reached a fairly high level in Western Countries. However, appropriate first aid in emergency situations should not only be focused on medical measures. Every victim is not only physically hurt but also psychologically, and needs support in both aspects which are strictly connected (“psycho-somatic”). Since 1990, Lasogga and Gasch (last publication 2014) are concerned with the topic of psychological aspects in “emergency situations”. At least three dimensions are of relevance: a) Type of situation, b) people concerned and c) the time-dimension; this model can be structured in the form of a cuboid (see figure 1).

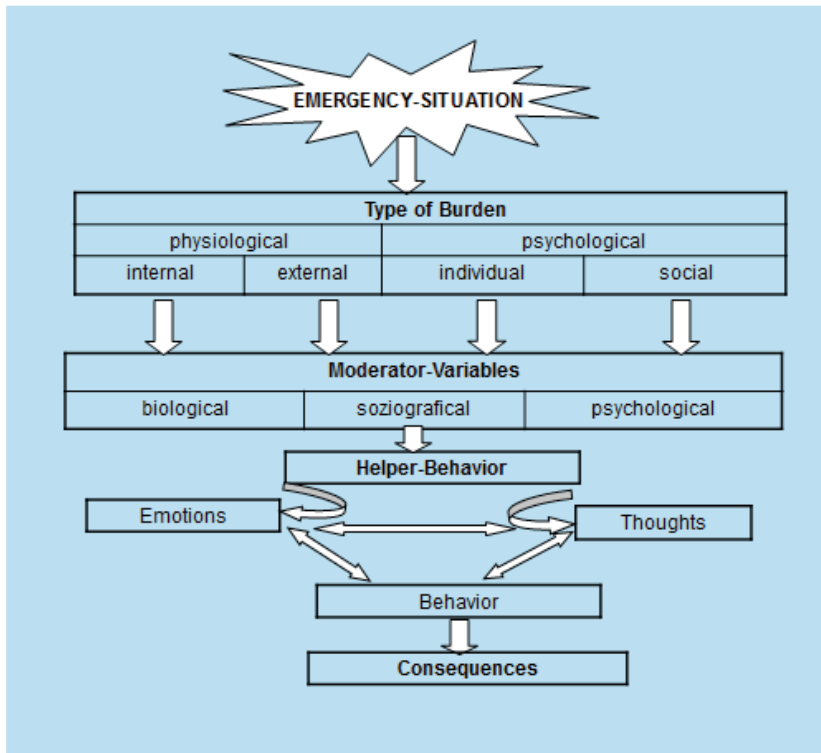
Figure 1: Dimensions of emergency-psychology



The following text concentrates on the sub-cuboid Situation “Accident” – Person affected “Victim” – Time: “Actual”.

How a human being handles an emergency situation is shown in the following figure

Figure 2: Scheme of Reactions in an Emergency-Situation



The burden he/she suffers from can be external (e.g. heat, coldness) and internal. The internal pressure stems from physiological sources (e.g. pain, shortness of breath), but also from psychological ones (e.g. confusion, anxieties), social-psychological ones (e.g. worries for family, profession, etc.). But: everybody has developed different “coping strategies” which help to overcome these misfortunes, which he/she applies now. Examples are pessimistic or optimistic attitudes, different forms of accusations (to himself or to others), attributions etc. These strategies are influenced by biological factors (e.g. male/female, age), sociographical factors (cultural background) and psychological factors (life-experience, social standing, etc.). In addition to these complicated interaction comes another factors namely the behavior of the helper. The results are individual emotions (anxieties, guilt, etc.) and thoughts (way of further kind of living) and relates in a specific individual behavior. Emergency doctors report about common reactions like crying, moaning, complaining, but sometimes even strange ones like laughter, accusations, strict instructions to the helpers or discussions about the costs of the event. In the time after the

accident the victims can develop negative consequences “post traumatic disorders”. It is likely that an appropriate psychological first aid can prevent or at least soften these reactions. But one shouldn’t overlook positive consequences too (a victim in an interview: “I’ll never drink alcohol anymore when driving!”).

Objectives:

The following text shows general aspects of psychological help for adults and puts a special attention to elderly people. The main objective is to show rules for “psychological first aid” both for laymen, but also for professional helpers like “emergency doctors”, “first aid attendants”, “paramedics for the target group “elderly people”. (A modified set of rules is necessary for children).

Methods:

The results of the study are based on a multidimensional methodological concept:

Analysis of literatur

Systematical check of psychological theories (psychoanalytic, behavioral, action-theory, etc.) about their contribution to the topic

Interviews of 60 surviving (adult) victims of accidents in hospitals about their feelings in the accidental situation (“What kind of helper-behavior was psychologically helpful in this situation?” “What kind of behavior caused anger?” etc.)

Interviews of 150 experienced helpers (N=150) “What kind of helper-behavior do you think is psychologically helpful helps for a victim?” “What is harmful?”

Results of various role-play-situations

Experience of the author (partly introspective), being treated by approximately 800 prospective emergency doctors in 6 simulated mass-accidents

Findings:

The results of the different sources didn’t match completely - depending on the method used. To summarize them in simple and easily understandable sentences was a difficult task. The authors have to confess that in this procedure sometimes their individual interpretations could not be avoided.

At last the authors developed two sets of rules to provide “psychological first aid” for victims in accidents; one for laymen and one more articulated one for professional helpers.

RULES FOR LAYMEN

(See English version in: Bourauel, R., Friedel, B., Gasch, B., Lasogga, F. 1993):

(1) Say clearly that you are here and help has been called!

Being alone in an accidental situation seems to be one of the greatest anxieties of a victim. The injured person has the desire that at least “somebody” should be with him/her, even if this person cannot provide any actual specific help.

“Word for word”- instruction for the layman-helper: Do not stand around! Go to the victim! And say the simple sentence like "Good evening, my name is Peter Miller, I just came and saw this accident. I shall stay with you until the ambulance arrives”.

You should take special care on the sound of your voice which should be soothing and not excited.

Special modification for elderly victims: As elderly people are often handicapped in hearing, there might be a special problem to speak loudly on one side, but nevertheless calm on the other. This can be trained.

(2) Shield the injured person against onlookers!

The curious glances of onlookers are unpleasant for an injured person. Ask onlookers politely but firmly to leave the scene.

If onlookers don't follow, use a trick: asking two of them to do this job:

I think the ambulance car needs some space when it arrives; please ask the other people here to step back for 5 meters!” (See: Gasch 2005).

Special modification for elderly victims: This rule is especially important for the elderly, because they are often more irritated than younger people by onlookers, especially when their clothing is not in order or they feel ashamed of their groaning or crying.

(3) Search for body contact!

Body-contact is an old medical and psychological tool providing help. Besides this it is additional information for the victim except seeing or hearing that he/she is not alone. But not every touch is useful in the case of an accident: First it should not cause any physical pain; secondly: not every part of the body is suitable; so one should not touch the face or head or other sensitive parts of the body! If you exercise helpful touch in a role-play one might find, that touching the hand on its back or holding the shoulder provides best relief.

And secondly: “Firm steady touch” is better than moving or stroking. In a simulation one would also find that the helper often touches too soft. In such an exercise-situation the helper should be instructed like: “Touch the hand of the victim in a way that you show trust and competence” and the receiver should answer “firmer or softer”.

Special modification for elderly victims: In contrast to young people, where one should act more carefully and sensible with body contact, body contact is more welcome by the elderly people and nearly always is perceived as a distinct relief.

(4) Speak and listen!

If the victim is conscious, talking is always a good tool. Nearly all of the psychotherapeutic theories are based on the fact that the patient talks about his/her problems. This can be easily transferred to the situation of an accident. If the victim speaks, than the helper should practice what psychologists call “active listening”. This means that you show that you concentrate on your partner, especially by keeping eye contact and by confirming the flow of the speech by remarks like “ah”, “”Yes”, “I understand” and so on. It is not necessary to discuss or comment the facts or stories or to solve the problems mentioned – listening is enough. If the person don’t want to talk, you should assure him/her that this is not necessary, but then talk yourself, e.g. keeping the injured person informed about the measures taken, for instance “I see, the ambulance is now on its way”.

Special modification for elderly victims:

Especially in Germany the helpers tend to the habit, to belittle elderly people by addressing them as “Opa” (Grandpa) or “Oma” (granny, grandma). This should be avoided because we are in a serious situation where dignity of everybody should be respected.

RULES FOR PROFESSIONAL HELPERS:

Surprisingly the results of Lasogga & Gasch (2013) didn’t support the prejudice what victims may suspect as primarily psychological help: consolation, compassion, directive calming (?) etc. This aspect of helping-behavior is only of secondary relevance. Quote of a patient: “This man wanted to give me only some consolation!” The most important word is “only”. What else does a victim need instead? General answer:

INFORMATION, STRUCTURE and COMPETENCE.

Here are the rules for the target group “Professional Helpers” (Emergency doctors, Paramedics, nurses, etc.) for a psychological first aid in emergency situations. These rules are relevant for all adults, including old ones. Only for children there are some modification necessary (See. Karutz, 2008)

Before helping: Try to assess the whole situation!

Don't act immediately! Try first to assess the whole situation! Use at least 20-30 seconds to assess the situation and the planning how you will help.

Especially in traffic accidents it is necessary first to check the whole situation: How many cars are involved? Is there any smoke? Is there any other traffic? Are other people present? Etc.

Introduce yourself and your profession and tell the victim that you will help him/her!

It is very likely that the victim feels helpless, anxious and at a loss. He/she is also overwhelmed by confusing information and probably unsuitable helping attempts he/she got from many different people before. Therefore, he/she needs clear and definite statements about who you are. Tell the victim your name and your professional role! This introduction calms the victims because they know that now an expert takes care for him, which is a great relief. In a second sense this “normalizes” the situation.

Example: "Good evening, my name is Peter Smith. I am an emergency doctor from the Red Cross. I shall help you now! What are your complaints?"

This introduction and the following verbal interaction should be expressed in a soft, calm voice, because the intonation and not primarily the contents expresses and creates positive or negative emotions.

Shield the victim from curious bystanders!

(See also above: Rules for laymen). An injured person dislikes being exposed to bystanders' inquisitive looks. Ask them politely but firmly to leave the scene! But not generally: "Please stay away, there is nothing to look on!" But: "Please move ten meters back! We need the space for the rescue equipment!"

Or: “Give them something to do!” There are psychological theories which proof that “high arousal” disposes for action, but not for which kind of action. So will get a good response by asking for help: But not in a version like: “Can anyone help” but better

“Can you please hold this infusion tool!”. To prevent the victim from onlookers it might be a good measurement to ask two of them directly and personally: "Excuse me - you at the front and you in the blue jacket! Would you mind getting those people here at least ten meters further away? We need space for our equipment!" Not useful might be: “Go home, here is nothing to watch!” – Which is simply a lie? (See: Gasch 2005).

Give INFORMATION about the medical procedures!

Information decreases anxiety. Tell the victims what you are doing and why! This prevents internal panic or defensive over-reactions because the patient knows what is going to happen. It also gives structure to a situation in which the victim is confused in various aspects. Tell him/her how long a procedure will probably last, because the patient then knows e.g. how long he/she will have to stand the pain. Verbal examples: "I am going to give you an injection which will relieve you." "We will reach the hospital in about 10 minutes!"

Very emotionally helpful is it for the patient when the helper can mention one or more positive information after the medical check. Example: “Your left leg is injured, but the right one is completely in order”! Imagine what the victim tells his spouse later on about this scene: “Thanks god, the doctor told me the other leg is quite in order!”

Vera difficult might be the question how to answer to patients’ questions that are heavily injured. On one side the patient has the right to get correct information; on the other he should not be incriminated. This requires for the helper to keep a difficult balance. But everybody (and even the patient too) might understand, that an exact information in an emergency situation it not always possible. Try a formulation like "You are heavily injured, we move you to a special hospital; there you surely will get specific help!”

Medical COMPETENCE stabilizes the psychological situation!

Your medical competence will reassure the victim. But not by global remarks as: "Don't worry! No problem at all!" Carry out the medical procedures and demonstrate that you know the effects of the measures. Express this verbally too – especially to avoid

misunderstandings: Examples: "After this injection you will feel your arm getting warm! That isn't dangerous; you shouldn't be worried about it." Or: "I can fix your leg easily. But your abdomen problems should be better checked by a specialist in the clinic". The last sentence is a quote of a patient! He obviously perceived it in a positive sign of competence that the doctor was aware of his limitations in the current situation!

Encourage the “self-competence” of the victim!

Undoubtedly an emergency patient is in a status of high arousal, but also suffers of a “loss of control”. In a normal situation everybody feels responsible for oneself and tries to reduce the arousal by “action”. In an emergency situation the victim usually feels dependent of others and does not know what kind of action is appropriate for him. Therefore any hint of the helper is welcome. Therefore: If possible, give the victim a useful and manageable task, like “Put your finger on this plaster!” or “Try to keep your right leg in a steady state!” or “Try to breathe deeply especially in breathing out”. In this case the victim doesn't feel to be completely dependent to another person and feels that he can help himself to improve his situation.

Establish psychologically based PHYSICAL CONTACT with the victim!

(See above: rules for laymen). Moderate physical contact calms and gives relief. Get down to the victim's level. Hold his/her hand or touch the shoulder! But: Not everybody likes this kind of help. So the helper should be sensible towards the reaction of the victim and ease or give up in the case of a negative reaction. But usually especially older people feel very relaxed.

SPEAK to the victim - even when he/she is unconscious!

(See above: rules for laymen). If the victim speaks to you – let him speak and react by “active listening”. Quote of one patient, obviously surprised: “The doctor really talked to me!” If the victim cannot or will not talk, speak yourself and use an everyday topic, e.g. “Where do you come from?” or “What is your profession?” or “Have you ever known about something like this?” If he/she is not able to answer; then make it clear that he/she doesn't need to: "You don't have to talk if you don't want to". If there is no answer then nevertheless talk yourself, e.g. giving some information about the situation; “There are sufficient helpers here” - “The hospital is informed” etc.

Even talk to unconscious patients! There are some studies which prove that a special percentage of patients, even in unconscious state or in anesthesia or coma will perceive at least some (hopefully positive) information from the persons who speak to him/her – at least they feel the intention which is connected with their message (Merikle1998).

Tell the victim when you have to leave, and provide a (psychologically competent) SUBSTITUTE!

The victim becomes anxious again when get some help but then is left alone! If important reasons force you to leave (for instance to help other victims), tell him/her why you are leaving and make sure that a psychologically competent substitute will take your place.

Verbal examples: "I've finished treating your injuries so far and have to move on to another patient. But this person (for instance a paramedic or a member of the fire patrol or police or even a bystander) will stay with you until the ambulance car arrives". To a bystander: "Excuse me! You can help! Please stay here with this man, hold his hand and talk to him until the ambulance arrives!"

If necessary: Organize special “psycho-social helpers”

In most of the Central European countries the emergency centers have contact to special persons or groups to deal with “psycho-social” problems in emergency situations (e.g. Emergency Psychologists, Crisis-Intervention-Helpers, special educated priests, etc.). They should be alarmed especially when children are involved, or excited relatives are left, or in cases of suicide, cancellation of reanimation, etc.

Finally:

Good wishes for every victim!

AND: See Eckerd, 2012: “Practicing Psychological First Aid” as a professional helper is a psychological help for him/her him/herself!



SESSION V

October 17, 2014



Neglect, Abuse and Violence of Older Women: A Human Rights Perspective

Patrica Brownell¹

Abstract

Background: Neglect, abuse and violence against older women have been largely overlooked as a focus of research; this is in spite of the fact that inequality and discrimination experienced by women intensifies with old age. Discrimination against older women on the basis of age and gender can result in situations where they experience neglect, abuse and violence. Because of this gap in knowledge and remedies, little is known about neglect, abuse and violence against older women.

Objectives: Address the gap in knowledge and remedies to address neglect, abuse and violence against older women from an international perspective. Understand the different definitions and frameworks used, and findings, of research on neglect, abuse and violence against older women from an international perspective. Recommend research needed to address gaps in knowledge about neglect, abuse and violence against older women and remedies to end it.

Methodology: To begin to address this gap, a literature review was conducted of the state of knowledge, gaps and next steps to address this area of human rights violations against older women. The literature review was funded through a consultant contract with the United Nations Department of Economic and Social Affairs.

Findings: Three dominant definitions and frameworks are used to understand neglect, abuse and violence against older women: active ageing, dependency; and domestic violence across the lifespan. A fourth, human rights, shows promise for developing a holistic understanding about this social problem; however, it has not yet been fully developed as a way of studying abuse of older women.

Key Words: Neglect, abuse, older women, human rights, elder abuse

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Neglect, Abuse and Violence of Older Women: A Human Rights Perspective

Population aging is a global trend that is changing economics and societies around the world. In 2012 people age 60 years and older represented almost 11.5 percent of the global population and by 2050 is expected to double to 22 percent. Older women outnumber older men: in 2012 for every 100 age 60 and above there were 84 men. For every 100 older women age 80 and above there were only 61 men (United Nations Population Fund & HelpAge International, 2012). The feminization of aging, representing the intersection of age and gender, has important implications for policy as the world continues to age. It is time for neglect, abuse and violence against older women to become visible and to end.

Neglect, abuse and violence have been identified as important issues impacting the well-being of older persons in the International Plan of Action on Ageing, promulgated at the Second World Assembly on Ageing in Madrid, Spain, in 2002 (United Nations, 2003). Older women in particular were identified as facing “greater risk of physical and psychological abuse due to discriminatory societal attitudes and the non-realization of the human rights of women” (p. 43). Living a life of dignity, free of abuse, is an important human right for everyone, including older people and specifically older women.

The Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) affirms that violence against women is rooted in historical and structural inequity in power relations between men and women. Gender-based violence is understood as a form of discrimination that serves as a barrier to the realization of all human rights and fundamental freedoms by women. CEDAW General Recommendation No. 27 specifically addresses implications for older women (United Nations, 2010).

Lack of data on neglect, abuse and violence against older women confounds efforts to identify the scope of this problem world-wide, including prevalence, risk factors, health consequences and cultural differences. Available data are contradictory and confusing, based on differing definitions, measures, and forms of abuse used by researchers, policy makers and practitioners. In a recent literature review, three distinct theoretical frames were identified as utilized by researchers to understand neglect, abuse and violence against older women: intimate partner violence; social gerontology; and adult protection.

Intimate partner abuse (IPV) refers to physical, sexual and psychological abuse (defined as threat of physical or sexual abuse) and violence against women and girls that is perpetrated

by intimate partners (including dating partners) and strangers and acquaintances in the case of sexual abuse (Saltzman et al., 2002). Using this theoretical frame to examine abuse of girls and women across the life course, researchers have found that older women experience significantly less abuse than younger women, suggesting that abuse of older women is not a significant problem compared to that of younger women and girls. Prevalence data for abuse of older women in the IPV frame typically ranges from 1-2% (Fisher et al., 2011).

A different picture of abuse and violence against older women emerges when examined from an active aging frame. Perpetrator categories expand from intimate partners and strangers in the case of sexual abuse to include in addition adult children and grandchildren, other relatives, neighbors and friends, and caregivers. Like the intimate partner abuse perspective, victims are assumed to live in the community, but may not currently have an intimate partner relationship. Forms of abuse are also expanded in the frame to include, in addition to physical, sexual and psychological abuse, also financial or material exploitation, and neglect (World Health Organization & International Network for the Prevention of Elder Abuse, 2002). Measures of psychological abuse may be expanded beyond threats of physical or sexual violence to include denigrating verbal abuse as well as non-verbal abuse in the form of social control behaviors like isolating, ignoring and treating the older woman as a child. Where available, prevalence data for abuse of older women has been found to be as high as 38% (Luoma et al., 2011).

A third perspective on abuse and violence against older women assumes frailty and cognitive impairment leading to high levels of care dependency, necessitating protection to avoid victimization. The older adult dependency frame assumes that older women are vulnerable based on inability to self-care or even supervise care (National Research Council, 2003). Perpetrator categories are expanded to include not only family members and neighbors but also formal caregivers and other residents of care facilities as well. Neglect as a form of abuse is highlighted in this frame, although sexual abuse by formal caregivers or other care facility residents is also of concern. Sometimes self-neglect and hoarding are included in this definitional set. This frame assumes the victim may not be able to report abuse or even recognize risk because of cognitive or other impairments, so third party reports of abuse are utilized, creating some difficulty with data quality and access. Gender-based prevalence data are largely unavailable to date for older women in protective settings such as care homes and hospitals.

Research on prevalence of abuse and neglect of older people is also beginning to be conducted in developing countries. A prevalence study of elder abuse was conducted in The People's Republic of China among community dwelling older adults living in a rural community age 60 years and older. Subjects included both older men and older women (Wu et al., 2012). The study found that over 6 percent of the sample of older women reported experiencing physical abuse, almost 29 percent reported experiencing psychological abuse, almost 14 percent reported neglect, and almost 2 percent reported financial abuse. A pilot study on prevalence of elder abuse conducted by the School of Medicine, University of Malaya, found a prevalence rate of 10 percent (Personal Communication, Claire Choo Wan Yuen, University of Malaya, February 9, 2014), equivalent to the finding of a major national prevalence study conducted in the USA (Acierno et al., 2010).

Sadly, some research guides for conducting research on violence against women include ageist directives. In a technical guide on producing statistics on violence against women promulgated by the United Nations Department of Economics and Social Affairs in 2013, readers are advised that "some countries have opted to set an upper age limit for respondents, the reasons being that older people are more prone to memory recall problems and tend to have a general reluctance to discuss sensitive subjects ... It is also likely than an older age category will be too small to allow for separate analysis" (United Nations, 2013, p.15). Misguided and misinformed statements like this discourage researchers from including older women in studies on violence against women, and seemingly encourage nations to exclude data on older women from domestic violence reports that inform national and international policy making.

While identified forms of elder abuse are well established in developed country research, including physical, sexual and psychological abuse, financial exploitation, and neglect, other forms of abuse of older women are less commonly identified in research and have not been well studied. These include harmful traditional practices, particularly those that might be harmful to widows, accusations of witchcraft that are sometimes used as justification to harm or kill older women, and extreme poverty (Manjoo, 2012).

To address this gap, the Global Age Watch Index was launched by HelpAge International in October 2013 (see <http://www.helpage.org/global-agewatch>). It is the first global index to rank countries according to the social and economic well-being of older people. The Index provides a measure of 13 different indicators across the four key domains of income security, health status, education and employment, as well as aspects of the enabling

environment identified in the Madrid International Plan of Action on Ageing (MIPAA). This includes neglect, abuse and violence against older people especially older women (Centre for Analysis of Social Exclusion & HelpAge International, 2013).

Interviews with older women victims of abuse reveal reasons why they are not well represented in domestic violence programs and in police reports (Hightower et al., 2006). Older women report feeling unwelcome in domestic violence shelters, with programs for younger women with children, and older women do not feel that they are considered as entitled to services as women of reproductive age. They also feel that adult protective services are not appropriate for them because they do not identify themselves as frail and cognitively impaired. Aging service systems where they exist may not offer crisis intervention services or trauma counseling. Older immigrant women cite language and cultural barriers as well (Guruge et al., 2010).

Older women also express concerns about leaving older and ill batterers, as well as reluctance to prosecute adult children and grandchildren who may suffer from mental illness or substance abuse problems. Police may not regard abuse of older women by aging spouses or adult children as a matter for law enforcement. Psychological abuse, when experienced by older women, has been found to result in physical health problems like heart disease and joint pain, as well as mental health problems like depression and anxiety (Montminy, 2008). However, psychological abuse that does not rise to the level of a crime, such as menacing or stalking, may be trivialized by domestic violence programs or law enforcement, and even by the victims themselves.

Prevention of domestic violence is an important public policy goal and strategies range from public education to sanctions through the criminal justice system. Elder abuse prevention has lagged behind domestic violence and where it exists has been conducted largely through aging service systems and non-governmental organizations. Criminal justice strategies have largely focused on those who place vulnerable adults at risk. However, several trends are changing this. First, the world is aging, and men are outlived by women, who age with more chronic health conditions that generate long term care needs. Increasingly frail older adults are living at home in the community. Elder abuse has been given a higher profile through media attention. Concerns about the fiscal viability of older adults living longer on pensions and social security, or depending on strained extended family resources, has sensitized the public on the impact the lives of older adults, especially older women (Nerenberg, 2008).

There are no nationally uniform response systems to address, abuse and violence against older women. However, nations, state, localities professional organizations, agencies and local groups have developed innovative preventive programs and initiatives to prevent abuse of older women within different service sectors such as health and mental health, social service, criminal justice and housing. Programs and initiatives may target older women as part of a broader campaign to prevent intimate partner violence of girls and women of all ages, campaign against ageism or for protection of widows, or promote community health. It may also mandate training of workers in health, institutional or care settings to promote understanding of neglect and abuse of care dependent older women and how to prevent it.

Interventions that address neglect or abuse of older women include support groups that are structured specifically for older women participants, domestic violence shelters for the disabled and older adults that are accessible to the mobility impaired, have medication management units and programming for disabled and older victims. Specialized court programs include multi-disciplinary units with expedited access for older victims and specialized elder abuse units. Others include specialized legal services for older women abuse victims, training and education for professionals in working with victims of abuse in later life, and programs for perpetrators. Treatment programs for mentally ill and substance abusing perpetrators are offered with the added advantage of garnering support for older women victims to agree to persecute adult children who want help, and not punishment for their abusive loved ones.

National legislative initiatives, when they exist, have largely been bifurcated between domestic violence and aging or protective service approaches. Older women often fail to fit into either approach. When the problem is intimate partner abuse, older women may be referred to aging service programs that lack capacity to address domestic violence among elder spouse/partners. Older women may not meet the eligibility requirements for protective services for the elderly, such as guardianships, if they are not physically or cognitively frail. Consequently, older women victims of abuse are likely to fall between the cracks of a bifurcated legislative and legal system. In addition, laws related to abuse and neglect of older women by family members or formal caregivers may be legislated but not funded.

A study by the Office of the United Nations Secretary General in 2006 recommended that states should carry out the systemic collection and analysis of data on violence against women, ensuring that data are disaggregated by age and gender, as well as race and

disability. While violence against older women was not referenced by the UN General Assembly Human rights Council in its Directive (Accelerating efforts to eliminate all forms of violence against women: remedies for women who have been subjected to violence, July 2, 2013), the final Outcome Documents of the 57th Commission on the Status of Women includes elimination of violence against older women as a recommendation.

An expert group met at the UN in New York City in November 2013 to begin to address definitional and measurement issues to order to obtain a clearer understanding of prevalence of neglect, abuse and violence against older women across developing and developed countries, and in traditional and modern societies. This meeting was convened by the UN Department of Economic and Social Affairs Ageing Focal Point to identify normative gaps in protections for older people that might suggest a need for a stronger human rights instrument, including a Convention (international treaty) for the Human Rights of Older Persons. Among other issues discussed was the need to know more about evidence based practices for prevention and intervention of abuse of older women and how they can be strengthened. Finally, the expert group recommended that a review of laws related to abuse of older women needs to be undertaken, including an analysis of their implementation and impact of reduction and elimination of abuse of older women (United Nations Department of Economic and Social Affairs, 2013).

This discussion of prevalence of neglect, abuse and violence against older women based on different and sometimes competing conceptual frameworks demonstrates the difficulties in using these data to understand and promote older women's right to live free of abuse. In order to address the current fragmentation in research on older women and neglect, abuse and violence, the international research community must come together to formulate guidelines that standardize measures, eliminate ageist stereotypes, and reflect a more holistic view of older women in society.

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SESSION VI

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Personal Communication Networks Among Single Older Women: Ankara Case Study

Ikuko Murakami¹

Abstract

Purpose: The actual condition and role of older Turkish single women's personal networks are investigated. Additionally, how their personal networks relate to the acquisition of quality of life and life satisfaction is also investigated.

Background: As population aging in Turkey progresses, the proportion of older women living alone and single-person households are increasing, especially in big cities such as Istanbul, Ankara, Izmir. In the capital city Ankara, there are many employment opportunities for women. So it would reason that women might have increased opportunities to establish relations.

Method: This is a qualitative study utilizing semi-structured questionnaires carried out in face-to-face interviews to determine where and how women's communication networks were formed. Candidate requirements for this investigation were women aged 50 and over who live alone in Ankara.

Results: This investigation incorporated both women who are/were employed outside of the home and those who had been homemakers. Of the two groups, women employed outside of the home were observed to have alternative choices in with whom they established communication networks. In line with generational/cohort influences, educational levels of all of the children of the women participants in the study were found to be higher than that of their mothers.

Keywords: Older women, Personal communication networks, Life satisfaction

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Tek Başına Yaşayan Yaşlı Kadınların Kişisel İletişim Ağı: Ankara Örneği

Ikuko Murakami¹

Amaç: Yaşlı kadınların kaliteli yaşam için kişisel iletişim ağından nasıl faydalandıkları, ondan beklentileri ve bu ağının onların yaşam memnuniyetini nasıl etkilediğinin ortaya konulması amaçlanmaktadır.

Arka Plan: Türk toplumunda yaşlılıkla birlikte özellikle İstanbul, Ankara gibi büyük şehirlerde ve Ege Bölgesi'nde tek başına yaşayan yaşlı kadın sayısı artmaktadır. Ankara'nın başkent olması kamu kurumlarında çalışanların ve ayrıca diğer sektörlerde çalışanların sayısının fazla olmasını sağlamıştır. Bu kapsamda yaşlı kişilerin kişisel ilişki kurma şansı da fazla ve geniş olması beklenmektedir.

Yöntem: Bu araştırma nitel araştırmadır. Araştırmada yüz yüze görüşmeler yapılmıştır. Görüşmelerde yarı yapılandırılmış soru formu kullanılarak kadınların iletişim ağının nelerden olduğu ve nasıl kurgulandığı saptanmıştır. Görüşülen kişiler, Ankara'da tek başına evlerinde yaşayan 50 yaş üzeri kadınlardan oluşmaktadır.

Sonuç: Araştırmada hem ev dışında ücretli iş ile çalışmış kadınlar hem de ev hanımı olarak ev içinde çalışmış kadınlar ile görüşülmüştür. Ev dışında çalışmış kadınların kişisel iletişim ağında daha çok seçmeli ilişki görülmüştür. Görüşülmüş bütün kadınlarda onların çocuklarının eğitim seviyesinin daha yüksek olduğu görülmüştür ve kohort etkisi belirlenmiştir.

Anahtar Kelime: Yaşlı Kadınlar, Kişisel İletişim Ağı, Yaşam Memnuniyeti

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Giriş

Türkiye’de kadınların tek kişilik yaşama olumlu bakmadıkları gözlemlenmiştir. “Tek kişilik yaşama nasıl bakıyorsunuz?” sorusuna, Türkiye’de araştırmaya katılan kadınların seçmeli cevaplarında “yalnızlık” veya “benlik” gibi olumsuz cevapların, Japonya’da uygulanan aynı soruların cevabına göre daha fazla seçtikleri görülmüştür¹. Buna karşın Japonya’da daha çok “kendi ayaklarının üzerinde durmak” ve “serbest (özgür)” gibi olumlu cevapların verildiği görülmüştür.

Tek başına yaşayan kişilerin, bu yaşamlarını sürdürebilmeleri için hem fiziksel açıdan sağlıklı olması hem de psikolojik açıdan güçlenmesi² ile birlikte, ekonomik bir güce sahip olması³ ve toplumsal değer yargısı ile desteklenmesi beklenmektedir. Her ne kadar tek başına yaşam mümkünse de insanın toplumsal bir varlık olması, bu kişilerin çevresi ile ilişki içinde yaşamalarını kaçınılmaz kılmaktadır. Bu doğrultuda yaşlı toplum konusunda dünyaca bir numara olan ve tek başına yaşayan yaşlı kadınların oranı oldukça artmakta olan⁴ günümüz Japon toplumunda yaşlıların kişisel iletişim ağı ile ilgili araştırmalar⁵ oldukça fazla görülmektedir.

Türkiye’de de yaşlanma durumu ilerledikçe, özellikle İstanbul, Ankara gibi büyük şehirlerde veya Ege Bölgesi’nde tek başına yaşayan yaşlı kadınların sayısı artmaktadır⁶. Kadınların tek kişilik yaşamına, Türkiye’de olumsuz bakıldığı görülmektedir, ancak gerçekten tek başına yaşayan yaşlı kadınların, bu duruma nasıl baktıkları ve bu durumu nasıl değerlendikleri önemli bir konudur. Bununla ilgili olarak eski ev sahibim (Tablo.1’de Kadın17) sık sık şunu söylerd: Kendi evinin kapısını, kendin aşmalısın. Bu söz ile insanın kendi sorumluluğunu üstlenmesi gerektiğini öğrenmiş oldum ve yabancı bir ülkede yaşayabileceğimi anladım.

Böyle kişisel bir deneyimden yola çıkarak, tek kişilik yaşam sürdüren yaşlı kadınların, toplum tarafından tahmin edildiğinden daha rahat yaşamakta oldukları varsayılmaktadır. Öyle ise onlar, hangi sebeple tek başına yaşamaya başlamış, ne tür sevinç veya endişe ile karşı karşıya kalmışlar ve onlardan ayrı yaşayan ailesi, akrabası, arkadaşları ve komşuları

1. İkuko, MURAKAMI, **Değişim Kültürü ve Aile: Türk ve Japon Aile Yapıları Üzerinde Bir Karşılaştırma**, Ankara Üniversitesi Eğitim Bilimleri Enstitüsü, 2009.

2. Forth World Conference on Women in Beijing, **Beijing Declaration 7**, Beijing, China, September 1995.

3. World Health Organization, **Active Ageing A policy Framework**, A contribution of the World Health Organization to the Second United Nations World Assembly on Ageing, Madrid, Spain, April 2002.

4. Japonya Başbakanlığı, **Ulusal İstatistik Raporu**, Tokyo, 2010. Japonya’da 65 yaşı üzeri insanlardan tek başına yaşayanların oranı, 1980 yılında erkeklerde %4.3, kadınlarda %11.2 idi, ancak 2010 yılında erkeklerde %11.1, kadınlarda %20.3 olmuştur. Japonya Ulusal Nüfus ve Sosyal Güvenlik Araştırma Enstitüsü’nün tahminine göre gittikçe artışı göstermektedir ve 2045 yılında erkeklerde %16.3, kadınlarda %23.4 olacaktır.

5. Masao NOBE and Tsubasa OSUKA, **Some Research Trends Concerning Friendship Relationships of Elderly People in Japan**, Bulletin of Graduate School of Education, Okayama University, NO 145, p.53-58., 2010.

6. İsmail Tufan, **Birinci Türkiye Yaşlılık Raporu**, Gero Yay, Antalya, 2007.

ile ilişkilerini nasıl sürdürmekte olduklarının araştırılması planlanmaktadır. Söz konusu bu kişilerin kendi kişisel iletişim ağlarından nasıl faydalandıkları araştırılacaktır.

Günümüz Japonyası'nda, "sayın yalnız insan" anlamına gelen "o-hitorisama" kelimesi çok modadır. Tek kişilik yaşam tarzı, Japon toplumunda oldukça kabul edilmiş olmasına karşın, "Kodoku-shi (tek başına ölüm)" veya "Koritsu-shi (yalnızlaşmış ölüm)"⁷ ile ilgili haberler sıkça duyulmaktadır ve insanların endişe kaynağı olduğu anlaşılmaktadır⁸. Türkiye'deki yaşlıların da aynı sorunu yaşayıp yaşamadıkları veya ileride nasıl olacakları, kişisel iletişim ağlarının özelliklerinin tartışılması amaçlanmaktadır.

Amaç ve Önemi

Türkiye'de de yaşlanma durumunun ilerleyeceği ve tek başına yaşayan yaşlıların sayısının da artacağı tahmin edilmektedir. Yaşlıların kaliteli yaşamını sağlamak, değerlendirmek ve yaşamından memnun kalmak için Türk toplumunda var olan iletişim ağlarından faydalanmaları beklenmektedir. Bu yüzden toplumunda tek başına yaşayan yaşlı kadınların kişisel iletişim ağları araştırılmıştır.

Öncelikle Türkiye'de tek kişilik yaşamı sürdüren yaşlı kadınların kişisel iletişim ağı durumlarının, onların yaşam tarzı ve memnuniyeti ile nasıl ilişkilendiği araştırılacaktır. Ayrıca serbest şekilde konuşulurken Türkiye Cumhuriyeti tarihinde yarı asır yıldan daha fazla yaşamış kadınların hayat hikayesini kaydetmek de amaçlanmaktadır.

Bu araştırmanın, yaşlılığa karşı var olan "yalnızlık" ve "zavallılık" gibi ön yargılara, hatta yaşlı ayrımcılığına (agisme) karşı bir antitez olarak ortaya koyulması beklenebilir.

Yöntem

Bu araştırma, yaşam seyri yaklaşımına sahip bir kalitatif araştırmadır. Yaşam seyri yaklaşımında kohort kavramı temele alınır ve araştırma hedefi, bireydir. İnsanın yaşadığı toplumda, zaman dilimi ve bireyin çevresindeki değer yargısı vb. bireyin deneyimlerini ve düşüncelerini oluşturmaktadır. Araştırmada bunların ortaya çıkarılması amaçlandığı için yorumlayıcı bir araştırma yöntemi ile kalitatif veri toplama tekniğinden yararlanılmıştır.

7. Tokyo Büyük Belediyesi Adli Tıp Enstitüsü, **Tokyo'da 23 Belediyede Tek Başına Ölümü Durumları**, 09 Aralık, Tokyo, 2010. Japonya Tokyo merkezinde bulunan 23

belediyede evinde tek başına ölmüş 65 yaş üzeri insan sayısı, gittikçe artmaktadır. 2002 yılında 1,364 kişi iken 2010 yılında 2,913 kişi görülmektedir.

8. Japonya Başbakanlığı, **Yaşlıların Toplumdaki Yaşam Tarzı ile İlgili Araştırma**, Tokyo, 02 Nisan 2010. 60 yaş üzeri 3,484 kişiye uygulanmış ulusal anketin sonucuna göre,

"tek başına ölümü" konusunu kendi sorunu olarak görenlerin oranı, %42.9 idi. Hane yapısına göre bakıldığında tek kişilik hanede %64.7, karı-koca hanede %44.3 idi.

Araştırmada yüz yüze görüşmeler yapılmıştır. Görüşmelerde yarı yapılandırılmış soru formu ile kişisel bilgiler başta olmak üzere ekonomik durum, sağlık durumu, hobi, spor ve boş zaman değerlendirme konusu, günlük yaşam aktiviteleri vb. sorular sorulmuştur. Ondan sonra “açık-uçlu” sorular ile kadınların iletişim ağının ne durumda olduğu öğrenilmeye çalışılmıştır. Kişisel iletişim ağı olarak, arkadaş, komşu ve çocuklar ile ilişkileri, sıkıntı çektiğinde kimden destek aldıkları ve toplumsal desteklerden faydalanma durumu vb. araştırılmıştır.

Görüşülen kişiler, başkent Ankara’da tek kişilik yaşam sürdüren 50 yaş üzeri kadınlardan oluşmaktadır. Gerekçe olarak; öncelikle Ankara’nın başkent olmasından ötürü eskiden beri memuriyet gibi kadınların iş imkanlarını daha fazla barındırıyor olmasıdır. Ondan sonra Ankara, Cumhuriyet Dönemi’nin başlaması ile politika merkezi olduğu için, o havasını gündeme taşıyan bir şehir olmasıdır. Bunlara ek olarak, araştırmacının eskiden yaşadığı şehir olması nedeniyle araştırmaya destekçisi bulma konusunda kolaylığının sağlanmasıdır.

Veriler, 2014 yılı Temmuz ile Eylül ayı arasında toplanmıştır. Görüşmelerde genel olarak kişi başı 2 defa olmak üzere ortalama 1 saat konuşulmuştur ve görüşülen kişinin izni ile görüşmeler kayıt altına alınmıştır. Kağıda dökülmüş temel bilgiler Tablo 1.’de görülmektedir. Araştırmaya katılan kadınlar, temel olarak araştırmacının tanıdığı insanlardan, kartopu tekniği aracılığıyla belirlenmiştir ve araştırma kapsamına uygun olan 18 kadın ile görüşülmüştür.

Bulgu ve Yorumlar

1. Araştırmaya Katılan Kadınların ait oldukları Gruba Göre Özellikleri

Araştırmada Ankara’da tek kişilik yaşam sürdürmekte olan 18 kadın ile görüşülmüştür. Bu kişiler üç grupta kategorileştirilmiştir.

Grup1: Kadın 1 (emekli devlet memuru) ve kart oyun arkadaşlar

Grup2: Kadın 10 (eczane dükkanı sahibi) ve komşular, müşteriler

Grup3: Diğer (araştırmacının arkadaşlarından)

Bu gruplardan Grup1. ve Grup2.'de 'anahtar kişi' nitelikli iki kadın sayesinde bir yerde onlara yakın kadınlar ile görüşme fırsatı yakalanmıştır. Grubun ve kadınların özellikleri şunlardır:

Grup (kişi)	Anahtar Kişi	Anahtar Kişinin Özellikleri	Grubun Özellikleri
1 (4)	Kadın 1	Emekli memur. Çocukları büyüttükten sonra kendine daha fazla vakit ayırmak istemiştir. Boşandıktan sonra tek başına oturmaya başlamıştır.	Hobi (oyun) arkadaş grubudur. A Hanım uzun zaman Ankara'da çalıştığı için iş arkadaşları fazla ve eskiden tanıdığı arkadaşları ile ilişkisi devam ediyor. Oyun dışında arada sırada birlikte sinema ve tiyatroya vb. giderler. A Hanım organize ve hazırlık yapmaktan hoşlandığı için genelde A Hanımın evinde haftada bir kaç gün toplanılıyor.
2 (6)	Kadın 10	Eczacı. Kendi dükkanını işletiyor. Komşular ilaç almaya gelmişken sohbet ederler. İş türü nedeniyle müşterilerinin sağlık bilgilerine sahiptir, sanki muhtar gibi mahallede tanınmış bir simadır. Boşandıktan sonra tek başına oturmaya başlamıştır.	Mahallede T Hanımın dükkanına gelen müşteri veya dükkanın bulunduğu apartmanın komşularından, yani bu grup birbirlerine yakın bir yerde oturanlardan oluşuyor. Uzun zamandır tanıdıkları insanlar olduğu için birbirlerine yabancı olmayan insanlardır.
3 (8)			Araştırmacının tanıdığı insanlar ve onun çevresi. Kar topu tekniği ile araştırmaya katıldılar.

2. Katılımcı Kadınların Kişisel Bilgileri

Araştırmaya katılan kadınlar ile yapılmış görüşme sonucu ortaya çıkan özellikler, Tablo 2.'de gösterilmektedir. Ondan sonra konuya göre açıklanmaktadır.

2.1. Katılımcı Kadınların Memleketi ve Ankara'ya Geldikleri Yılı

Katılımcı kadınların çoğu, aslında Ankara dışında doğmuştur. Evlenmek veya okumak için Ankara'ya taşınmış, ondan sonra yerleşip on yıllarca oturmuşlardır (uzun oturma örneği, 60 yıldan daha fazladır). Başka örnek olarak, eşinin tayini yüzünden defalarca birlikte başka yerlere taşınmışlar, sonuçta Ankara'da kalmıştır. Nitecesinde öğrenciyken tanışmış arkadaşlar, aynı iş yerinde tanışmış iş arkadaşları veya mahallede tanışmış komşular gibi, zamanla yoğunlaşmış kişisel iletişim ağları vardır. Tablo 1.'de Grup1 ve Grup2, bu insan ilişkilerinden iki örnek olarak görülmektedir.

NO	Doğum Tarihi (Yaş)	Neresinde Oturuyor?	Nereden Ankara'ya Geldiniz?	Ne zaman Ankara'ya geldiniz?	Ne iş yaptınız?	Geyim Kaynağı	Mevcut Durum
1	1943 (71)	Emek	Zincirli (Bursa doğumlu)	1960 yıllarında okumak için	Memur (Hükümet)	Kendi emekli maaşı /kendi evi	Kızlar evlendikten sonra boşanmış
2	1943 (71)	Ömek	Zonguldak	1962 yılında üniversiteye okumak için	Memur (teftiş şubası)	Kendi emekli maaşı /kendi evi	5 yıl önce eş vefat etmiş
3	1946 (68)	Ömek	Zonguldak	1989 yılında Hanay'dan (işinin işi için)	Ev hanım	Babası ve eşinin emekli maaşı /kendi evi	2007 yılında mühendis olan eş vefat etmiş.
4	1946 (67)	Anıttepe	Ankara	Hep Ankara'da 67 yıldır oturmuş	Devlet memuru	Kendi emekli maaşı/kendi evi	Belkar
5	1933 (81)	Esat	Sivas	1951 yılında teyzesine balamak için	Ev hanım	Eşinin emekli maaşı / oğlunun evi	41 yıl önce eş vefat etmiş
6	1938 (77)	Esat	İstanbul	35-40 yıldır burada. Kendi işi için	Devlet memuru (sanatçı)	Kendi emekli maaşı /kendi evi	3 defa boşanmış
7	1940 (74)	Esat	Ankara	Eskişehir, İzmir ve Konya, sonra Ankara'ya	Ev hanım / Dikiş işi	Eşinin emekli maaşı /kendi evi	25 yıl önce Asuhbay olan eş vefat etmiş
8	1935 (79)	Esat	Alın	1965 yılında eşinin işi için	Ev hanım / Dikiş işi	Eşinin emekli maaşı /kendi evi	24 yıl önce Banka müdürü olan eş vefat etmiş
9	1929 (85)	Esat	Çorum	1949 yılında eşinin işi için	Ev hanım	Eşinin emekli maaşı / kira evi	22 yıl önce işçi memuru olan eş vefat etmiş
10	1950 (64)	Esat	Bursa	1970 yılında okumak için	37 yıldır Ezacı olarak çalışmaktadır	Ezacı /kendi evi	2012 yılında boşanmış. 40 yıllık evliydi
11	1919 (95)	Esat	Bursa	1944 yılında eşin işi için	Ev hanım	Eşinin emekli maaşı /kendi evi	20 yıl önce Doktor olan eş vefat etmiş
12	1961 (53)	Barıkent	Çorum	1983 yılında evlenmek için	Kuraförük / Ev hanım	Eşinin emekli maaşı /kendi evi	2002 yılında İnşaat teknikeri olan eş vefat etmiş
13	1960 (55)	Aydınlık Evler	Kayseri	10 yaşında babasının işi (inşaat işi) için	Muhasebe şirketine çalışmaktadır	Eşinin emekli maaşı ve kendi maaşı /kendi evi	1995 yılında Mobilyacı olan eş vefat etmiş
14	1942 (72)	Mamak	Ankara Köyde	1951 yılında merkeze taşınmış	Ev hanım	Eşinin emekli maaşı/kendi evi	6 ay önce eş vefat etmiş
15	1963 (51)	Cebeci	Ankara	Hep Ankara'da 51 yıldır	Devlet memuru	Kendi maaşı /kendi evi	Belkar
16	1937 (77)	Yaşamkent	Ankara	1927 yılında ailesi ile Selanik'ten göç	Ev hanım	Babasının emekli maaşı /kendi evi	Subay olan eş ile boşanmış
17	1932 (82)	Umitköy	Düzce	1955 yılında evlenmek için	Sekreterlik / Dikiş vb.	Kendi emekli maaşı / kira evi	Kızlar evlendikten sonra boşanmış
18	1955 (60)	Merzifon	Samsun	1997 yılında aynın ile	Ev hanım / Dikiş / Devlet memuru (sanatçı)	Kendi maaşı /kendi evi	1997 yılında boşanmış

2.2. Eğitim Durumu

Katılımcı kadınların eğitim seviyesi, onların mesleklerine tam olarak yansıtılmıştır. Üniversiteden mezun olan kadınlar, almış oldukları eğitime göre, hukukuçu veya hemşirelik gibi uzmanlık gerektiren işlerde çalışmıştır. Ancak eğitim fırsatına erişememiş kadınlar, genellikle ev hanımı olarak yaşamına devam etmiştir. Bu kişilerden iki kadın, evlendikten sonra “Akşam Sanat Okulu” adlı eğitim kursuna katılmış ve terzilik gibi el işlerini öğrenip evinde para karşılığı olarak elbezleri dikmiştir. Eğitim alamamış olmalarının sebebi olarak, en fazla “babasının karşı çıkması”nı sunmuşlardır. Kadınlar isteseler de isteklerini yerine getirememişlerdir. Örneğin K9’un babası şöyle demiştir.

Okula gidip Yozgat Valisi mi olacaksınız? Onlar, eğitim fırsatını kaçırpı belli yaşa gelince evlenmişlerdir. Ancak onların çocukları, annesinden daha yüksek seviyede eğitim almış oldukları için kohort etkisi görülmektedir. Örneğin şuan 72 yaşında bir kadın (K14), Ankara’nın kırsal kesiminde doğmuş, kendisi okula gidememiş ve eşi ilkokul mezunluymuş da onların çocukları, lise mezunlu ve çocuklardan biri üniversiteden mezunmuş. Katılımcı kadınların ve onların çocuklarının eğitim durumları aşağıdaki tabloda görülmektedir.

Tablo 3. Katılımcı Kadınlar, Onların Eş ve Çocuklarının Eğitim Durumu

NO	Kendisi	Eşi	Çocuk 1	Çocuk 2	Çocuk 3	Çocuk 4	Çocuk 5	Not.
1	Üniversite	Üniversite	Üniversite	Üniversite	---	---	---	
2	Üniversite	Üniversite	MYO	---	---	---	---	
3	Ortaokul	Üniversite	Üniversite	Üniversite	---	---	---	
4	Lise	---	---	---	---	---	---	Bekar
5	İlkokul (3 yıl)	İlkokul	Üniv.(2 yıl)	Üniversite	Üniversite	Lise	Lise	
6	Öğretmen okulu	Üniversite	Lise	Üniversite	---	---	---	
7	Ortaokul	MYO	Lise	---	---	---	---	
8	Ortaokul	Üniversite	Üniv.	Lise	---	---	---	
9	Yok	İlkokul	Ortaokul	Üniversite	ilkokul	Lise	---	
10	Üniversite	Üniversite	Üniversite	Üniversite	---	---	---	
11	Lise	Üniversite	Üniversite	Üniversite	Üniversite	---	---	
12	Lise	MYO	Üniversite	Üniversite	---	---	---	
13	İlkokul	İlkokul	Lise	Üniversite	---	---	---	
14	Yok	İlkokul	Lise	Üniversite	Lise	Üniversite	---	
15	Üniversite	---	---	---	---	---	---	Bekar
16	Lise	MYO	Üniversite	Üniversite	---	---	---	
17	Lise	Üniversite	Üniversite	Üniversite	---	---	---	
18	Lise	Lise	Üniversite	Üniversite	---	---	---	

2.3. Sağlık Durumları

Görüşülen kadınlarda bakıma muhtaçlık durumu henüz görülmemektedir ancak sağlık durumlarında kişilere göre farklılık görülmektedir. Yaşları ilerledikçe ilaçlardan devamlı faydalanan kadın sayısı artmaktadır. Çoğu, yüksek tansyon veya şeker hastalığı için ilaç içmektedir. Onlar, sağlıklarına dikkat ederek beslenmeye ve spor (özellikle yürüyüş) yapmaya özen göstermektedirler ancak bacak veya bel ağrısı yüzünden hareketlerin ve

yürüyüş mesafesi kısıtlanmış olan bir kaç kadın (K6 ve K7) da vardır. 95 yaşında kadın (K11), düşmüş ondan sonra ameliyat olduktan sonra günlük yaşam işlerinde sıkıntı çekmeye başlamıştır ve arada sırada akrabalar tarafından bakılmaktadır yine de hala kendi evinde tek başına oturmaktadır. Doktor tarafından demans hastası olduğuna işaret edilmiş bir kadın (K9) vardı. Ancak K9, günlük yaşamında sıkıntı olmadığını ve şunu söyledi:

Ben, hala tek başına otobüs ile uzakta oturan çocuğumu ve akrabamı ziyaret edebilirim.

2.4. Ekonomik Durum ve Yaşam Tarzı

Görüşülen 50 yaş üzeri kadınların çoğu, eşi vefat ettikten sonra tek başına oturmaya başlamışlardır. Çocuklar büyümüş ve ayrı bir yerde yuva kurmuşlardır. Çocuklar evlendikten sonra boşanan kadınlar da vardı ve hiç evlenmeyen de vardı. Evlenmiş bütün kadınlar, çocuk ve toruna sahiptiler.

Çocuk büyüdükten sonra boşanan her iki kadın (K1 ve K17) her ikisi de ve üç defa boşana bir kadın (K6), sebep olarak şunu söyledi:

Serbest olmak istedim. Kendime vakit ayırmak istedim.

Onlardan biri (K17), ekonomik açıdan sıkıntı çekmesine karşın (emekli maaşı çok az ve kendi evi yok) kendi ayakta durmak istediği için boşandığını söylemiştir. Eşinin aldatmasını sebebi olarak sunan kadın (K10) da vardı, o ancak 2 yıl önce boşanmıştır.

Kadınların çoğu, emekli maaş ile geçiniyor. Rahmetli eşi veya babasının maaşı ile geçinenler fazlaydı, ama gençken çalışıp kendi emekli maaşı ile geçinen kadın da vardı. Emekli maaşı, eşinin veya kendisinin hangi iş ile uğraştığına göre farklılık göstermiştir. Katılımcı kadınlarından sadece iki kadın (K9 ve K17) kiralık evde oturuyor. Kendi evine sahip olan bir kadın (K1), kendi emekli maaşını:

Fazla harcamadan ancak geçinebilirim. Yurt dışına seyahat edemeyiz ama yurt içinde yılda bir kaç hafta tatil yapabilirim.

sözü ile değerlendirmiştir. Emekli maaşın az olduğunu söyleyen bir kadın (K9) ise şunu söyledi:

Aç değilim, tok da değilim.

Kendi evine yeni sahip olan bir kadın (K13) ise:

Kredi ile evimi aldım, ay bitene kadar zor geçiniyorum.

Bu kadın, ayrı oturan çocuğu için ev ekonomisine yardım etmiş ve şunu söyledi:

Eşim vefat ettikten sonra aile reisi olarak her şey ile uğraştım her şey ile ben ilgilendim.

2.5. Kişisel İletişim Ağı

Görüşülen kadınların insan ilişkisi, genel olarak güzel olduğu görülmektedir. Kendi ana-babası çoktan vefat etmiş de çocuklar ve torunlar veya kendi kardeşleri ile samimi ilişki kurmakta oldukları görülmektedir. Sık sık telefon eder ve Ankara içinde oturuyorsa haftasonunda ziyaret eder. Hatta kadınlardan ikisi aynı apartmanda farklı dairede oturuyormuş (K8 ve K9).

Amca ile hala, dayı ile teyze ve yeğeni gibi akrabalar ile iyi ilişkisini kuran kadın fazlaydı:

Telefon ile konuşuyorum. Baylamda gidiş-geliş var.

diyorlar. Ancak kadınlardan biri (K2) şunu söyledi:

Annem vefat ettiğinde akrabam onun hakkını yediler, canım sıkıldı. Ondan sonra mesafeli

şekilde ilgilenmeyi tercih ettim. Bir kadın (K5) ise:

Memleketimde oturan akrabalar çok uzaktadır. Yaşlandıkça onları pek ziyaret edemiyorum. diyor. Ancak kadınlardan biri (K15) şunu söyledi:

Türkiye’de çocuk ve torunlar, asla yaşlıyı tek başına bırakmaz. Bu kadın, hala çalışmaktadır ve annesini tek başına evinde bırakmak zorunda kaldığı için “bakım” konusunda oldukça meraklı idi.

Arkadaş grubundaki kadınlar (Grup1), ortak hobi (sinema veya müzik dinleme vb.) veya eğlence (kart oyunu) ile haftada bir kaç defa birlikte vaktini geçirmektedir, yani onların beğeni ve seçimi birbirlerine benzemektedir

2.6. Sorun Olduğunda Destek

Sorun olduğu taktirde kadınlardan çoğu, kendi çocuğu veya arkadaşları ile paylaşacağını söyledi. İş yerinde veya komşulardan arkadaş edinenler, paylaşabilecek insan, yani güvenilir bir insan olup olmamasına dikkat ederek sorunları paylaştıkları görülmektedir. Kadınlardan biri (K9) şuna işaret etti:

Sorunumu paylaşabileceğim bir kaç arkadaşım var. Ama konuştuğum şeyler komşum

tarafından ortada açıklanınca ondan sonra onunla paylaşmam.

Başka bir kadın (K1):

Komşu ile paylaşamam, tabii komşu ile iyi ilişki kurmaya özen gösteriyorum, komşuma da

aniden bir şey olunca hemen ona koşarım, bu insanlık ile ilgili, ancak güven başka bir şey.

Çünkü komşumuzu seçemeyiz. Arkadaşım ise birbirlerine uyumlu olduğu için onlara

güvenebilirim.

şeklinde, arkadaş ilişkisinin seçmeli ilişki olduğunu vurguladı. Aynı apartmanda oturan komşusu üzerine bir kadın (K2) ise şunu söyledi:

Komşum arasında arkadaşım var. Biz aynı zamanda aynı apartmanda oturmaya başlamıştık,

yıllaca birlikte oturduğumuz için birbirlerine güvenebilir hale gelmiştik.

Psikolojik sorunlarda uzman tarafından destek aldığını açıklayan kadın (K2) vardı, ama onun dışında kadımcı kadınlarda, genelde ailesi veya arkadaşlar ile paylaşarak kendilerini rahatlattıkları görülmektedir.

Ekonomik sorunlarda emekli maaşının az olması sebebiyle geçinme konusunda zorlanan kadınlar (K5, K9 ve K17), kendi çocuğu tarafından para veya malzeme olarak desteklenmektedir.

Günlük aktiviteleri konusunda, fiziksel açıdan dinç ve rahat hareket edebilen kadın dışında, bacak ağrısı vb. yüzünden hareket mesafesinin kısıtlanmış kadınlar vardı. Dışarıya çıkma veya alış-veriş yapma konusunda zorlanmaktadırlar ve yakında oturan kendi çocuğu, akrabası veya komşusu (dükkanda çalışan çırak vb.) tarafından desteklenmektedir. Bazı kadınlar (K6, K7 ve K17) şunu söyledi:

Ameliyat yüzünden geçici olarak bakıma muhtaç durumundayken çocuğum (özellikle kız

çocuğu) bana bakmaya geldi.

Yaşlılara sunulan hizmetler ile ilgili haberler, yaşlı kendisinden daha çok çocuğu, yani genç kuşak insanlar tarafından internet vb. aracılığı ile takip edilmektedir. Araştırmada katılımcıların yaşı, 50 yaş ve üzeri olduğu için onların ana-babaları çoktan vefat etmişlerdir. Ancak yaşlı annesine bakan bir kadın (K15), bakıma muhtaçlık durumuna karşı uygulanan hizmet ve desteğe karşı oldukça bilinçli ve meraklı idi. K15 şunu söyledi:

İnternette takip ediyorum, ne hizmet olduğuna dikkat ediyorum, belediyemizin web sayfasına bakıyorum.

2.7. Yaşam Memnuniyeti ve İleriye Karşı Bakış Açısı

Hayatında en çok neden memnun kaldığı sorulduğunda,

“Torunum ile vaktim geçirmek”, “evlilik hayatım” ve “çocuğumu yetiştirmiş olmam” vb. sözler çok fazla duyulmuştur. Ancak eşi vefat etmiş kadınlar, kaç yaşında olursa olsun ikinci evlilik konusunda “asla” demiştir (K5, K7, K8, K12 ve K13 vb.). Onlardan biri (K5) şunu söyledi:

Türkiye’de ikinci evlilik ayıp gibi. Eğer para varsa geçinebilirse bunu düşünmez.

Memur olarak çalışmış ve emekli olmuş kadınlar (K1 ve K2) mesleği ile ilgili memnuniyetinden fazla bahsedilmemiştir. Emekli olduktan sonra oldukça zamanın geçmiş olması, bir sebep olarak sunulabilir. Şu sözü bir kaç defa tekrarlayan bir kadın (K8) vardı:

Eşim vefat etti de hayatım devam ediyor. O, parasını bana bıraktı, gitti.

Az miktar emekli maaşını alan kadınlardan biri (K5) da şu söz ile şu an ki yaşamını kabul ediyor:

Rahat geçinemiyorum, yine de idare ediyorum. Mümkün olduğu kadar tek başına yaşamaya devam ederim.

Bakıma muhtaçlık durumu ortaya çıktığında nasıl yaşayacağı sorulduğunda, onların tavrında düşünmek istemedikleri görülmektedir. Şu söz, üç kadından (K7, K8 ve K1&)) duyulmuştur:

Bakıma muhtaç olmadan önce ölmek isterim. 3 gün yatarım sonra ölürüm.

Arada sırada bu konudan bahsedilmekte olduğu görülmektedir. K16 ise şunu söyledi.

İleride ne olacağını kimse bilmez. Bu yüzden düşünmem. Düşünsem de ne yaparım? Tanrı beni boş bırakmaz. K17 ve K22 de benzer sözden bahsetmiştir. Tanrı adına huzurlu şekilde yaşamak istedikleri gösterilmektedir. Ayrıca gerçekçi fikri olarak şöyle diyen kadın (K22) vardı. Kendi emekli maaş ile huzurevinde yaşamayı planlayan K22 dedi ki:

Huzurevine girelim. Tek başına için evim büyük, temizlik pişirmek çok zahmet.

Bir kadın (K5) ise şunu söyledi:

Evimde bir bakıcı kadın tutarım. Çocuklarım bakım yükünü paylaşarak bana bakar, çocuklarım para verip bakıcı kadın tutar.

Bunu söyleyen kadın (K5), çocuk sayısı fazla idi. Kadınların çoğu, kendi çocuğun evinde bakılmak istemediler, onlardan biri (K8) şunu söyledi:

Çocuğumun evinde bakılmayı hiç düşünemem, onların kendi hayatı var, onu bozamam.

Görüşme sürecinde bu kadından (K8) ve diğer kadından da şu söz defalarca duyulmuştur.

Kimseye muhtaç olmak istemem.

Sonuç:

Bu araştırmada “anahtar kişi” nitelikli kadının merkezinde bulunduğu iki grup görülmektedir. Arkadaş grubunda liderliğini üstlenen kadın vardır ve öbür grup ise mahallede müşterilerin uğradıkları dükkan sahibi kadındır.

Arkadaş grubunda kadınlar, boş zaman değerlendirme konusunda aynı hobi ile uğraşmakta veya benzer şekilde vakit geçirmektedir. Söz konusu onlar seçici ilişki kurmaktadır. Eğitim seviyesi ve meslek hayatı vb. ortak noktalara ve ekonomik güce sahip olmaları, seçici ilişkisini sürdürmek için önemli etkenler olduğu görülmektedir. Bu gruptaki kadınlar, “anahtar kişi” olan kadının evinde sık sık toplanmaktadır ve uzaktan da gelmektedirler. Ote yandan mahallede aynı dükkana uğrayan kadınlar, ortak sorun (sağlık

sorunu) için görüşmektedirler. Söz konusu seçici ilişkisi olmayan, oturdukları yere bağlı olan komşu ilişkisini kurmaktadır.

Araştırmaya katılımcı kadınlar, farklı sebepler ile tek başına yaşamaktadırlar. Bu yaşam tarzını hem kendi seçimi ile sürdüren kadınlar vardır hem de eşinin vefat etmesi ve çocuklarının farklı yere taşınmaları sebebi ile zorunda kalmış kadınlar vardır. Ancak genel olarak şu an ki yaşam tarzından memnun kalmaktadır ve kendi insan ilişkisine olumlu bakmaktadır. Söz konusu durumunu kabul ederek kendi hayatını yaşamaya devam etmeye çalışmakta oldukları görülmektedir ve onların, kendi ayakları üzerinde durabilen ve kendine bakabilen kadınlar oldukları anlaşılmaktadır.

Tek başına yaşamak için önemli etkenlerden biri olan ekonomik güç konusuna bakılacak olursa, görüşülen kadınlarda, kendilerinin çalışarak biriktirdiği emekli maaşından ziyade eşi veya babasının emekli maaşı ile geçindikleri görülmüştür (Tablo 2.'ye göre görüşülen 18 kadınlardan 8'i, kendi maaşı veya kendi emekli maaşı ile yaşamaktadır). Ekonomik güce sahip olduğunda ikinci evliliğe karşı olumsuz bakıldığına göre, evlenmek psikolojik ihtiyaçtan daha ziyade geçim kaynağı gibi görüldüğü gözlemlenmiştir.

Eşi veya babasının emekli maaşı ile geçinen kadınların çoğu, yeterince eğitim görememiştir, yani onların eğitim fırsatı kısıtlanmıştır. Ancak onların çocukları, anne ve babasından daha yüksek seviyede eğitim görmüşlerdir. Söz konusu zamanla ortaya çıkmış toplumsal gelişimden ve değer yargısı değişiminden etkilenmiş, burada kohort etkisi görülmektedir.

Bakıma muhtaçlık durumu ile ilgili soruna karşı kadınlar, genellikle duygusal tepki göstermişlerdir. Katılımcı kadınların çoğu, kendi çocuklarının kendisini yalnız bırakmayacağını düşünmektedir ancak kendisinin bakma muhtaç olma durumu sebebi ile çocuklarının yaşam temposunun bozulmasını istememektedir. Gerekçelerinden biri, çocuklarına yük olmasından kaçınmak olduğu görülmektedir. Görüşülen kadınlar, çocuklarının evi gibi aynı evde kalıp bakılmak yerine, kendi evinde bakıcı tutup yaşamayı veya bakımevinde kalmayı tercih etmektedirler. Buna ilave olarak kadınlar, çocuklarından ekonomik ve psikolojik açıdan desteklemesini beklemekte oldukları görülmektedir.

Genel olarak kadınlar ile çocukları veya kardeşleri arasında, sık ilişkilerin kurulmuş ve devam etmekte olduğu gözlemlenmektedir. Sık sık telefon ile görüşülmekte ve arada sırada her hangi bir gerekçe ile yüz yüze görüşülmekte olduğu söylenmektedir. Bu yaşam tarzı ile yaşadıkça, eğer tek başına yaşasalar da, sağlık sorunları ortaya çıktığında veya aniden vefat ettiğinde günlerce fark edilmemesi gibi olayların nadiren olabileceği tahmin edilmektedir.

Türkiye’de böyle sık ilişkilerin görülmesi merak edilmektedir. Türk insanların sıcak ilişkileri, toplumunun aslı değer yargısından kaynaklanmıştır, yoksa toplumsal değer yargısı ne olursa olsun, Türk insanların kişiliği olarak sık ilişki türüne ihtiyaç duymalarından kaynaklanmıştır. Bununla karşılaştırılacak olursa, günümüz Japonyası’nda böyle sık ilişkiler fazla görülmemektedir. Bu durum, Japon toplumunun aslı değer yargısından kaynaklanmıştır, yoksa eskiden görülmesine karşın günümüzde artık sık ilişkilere fazla ihtiyaç duyulmamıştır. Eğer Japonlarda, sıcak ilişkilere ihtiyaç duyulmuyorsa ne sebep ile bu hale gelmiş olduğu merak edilmektedir.

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Huzurevinde Yaşayan Yaşlılarda Depresyon ve Beslenme İlişkisi (Relationship Between Depression and Diet in Older Persons Living in Nursing Homes)

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ÖZET

Amaç: Bir huzurevinde yaşayan yaşlılarda depresyonun varlığı ve varsa beslenme ile ilişkisinin araştırılmasıdır.

Yöntem: Çalışmaya İzmir Büyükşehir Belediyesi Gürçeşme Zübeyde Hanım huzurevinde kalan ve kendi temel ihtiyaçlarını karşılayabilen 65 yaş üstü yaşlılar alınmıştır. Kişilere yüz yüze görüşme yöntemiyle; sosyodemografik özellikleri sorgulayan 30 soruluk anket, Geriatrik Depresyon Ölçeği (GDÖ)'nin Türkçe versiyonu ve Mini-Nütrisyonel değerlendirme testi (MNT) uygulanmıştır. İstatistik değerlendirme SPSS 21 paket programı kullanılarak yapılmıştır.

Bulgular: Çalışmaya gönüllü 39 kadın (%52.7) ve 33 erkek (% 44.6) olmak üzere toplam 74 yaşlı katılmıştır. Yaşlıların %45,9'u ilköğretim mezunu ve % 9,5'i evlidir. % 70,3'ünün sosyal güvencesi vardır. % 83,8'i sigara kullanmamaktadır. % 24,3'ü her gün egzersiz yapmaktadır. %36,5'i yakınları tarafından hiç ziyaret edilmemektedir. %44,6'sı boş vakitlerini arkadaşlarıyla sohbet ederek değerlendirmektedir.% 67.6'sının en az bir kronik hastalığı vardır ve en sık görülen kronik hastalıklar yüksek tansiyon, diyabet ve kalp yetmezliğidir.Geriatrik Depresyon Ölçeği kriterlerine göre yaşlıların % 29,8'inde depresyon bulunmazken, % 48,6'sında hafif depresyon ve %21,6'sında ise yoğun depresyon saptanmıştır. Yaşlıların % 68,9'unda malnütrisyon riski yokken, % 23'ünde hafif malnütrisyon riski, %8,1'inde yoğun malnütrisyon riski vardır. Mini-Nütrisyonel değerlendirme testi (MNT) puanları açısından kadınlarla erkekler arasında fark saptanmamıştır. (p>0.05). Depresyon değerleri ile malnütrisyon arasındaki ilişki anlamlı bulunmuştur (p<0.05).

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Sonuç: Malnütrisyon riski yüksek olan yaşlılarda beslenme alışkanlıklarının gözden geçirilmesi, huzurevi çalışanlarının depresyon ve malnütrisyon riskleri konusunda eğitilmesi ve konuyla ilgili gerekli önlemlerin alınması, yaşlıların yaşam kalitelerinin artırılması üzerine önemli bir etkidir.

Anahtar Kelimeler: Depresyon, beslenme, malnütrisyon

Giriş

Bu çalışmada; huzurevinde yaşayan yaşlılarda depresyon ile beslenme arasındaki ilişkinin belirlenmesi amaçlanmıştır. Dünya Sağlık Örgütü'ne (WHO) göre yaşlılık çevresel faktörlere uyum sağlayabilme yeteneğinin azalması şeklinde açıklanmaktadır. Tüm dünyada olduğu gibi Türkiye'de de yaşlı nüfusun oranı artmaktadır. İyi beslenme, sağlıklı olmanın en önemli bileşenlerinden biridir. Her yaşta yaşam kalitesi ile beslenme arasındaki ilişkinin varlığı yapılan birçok bilimsel çalışma ile gösterilmiştir. Ancak her zaman için özellikle toplumdaki duyarlı gruplarda (0-5 yaş grubu çocuklar, okul çağı çocuklar ve gençler, gebe ve emzikli kadınlar, yaşlılar gibi) sağlığın korunması ve geliştirilmesi için dengeli ve yeterli beslenme özel önem taşımaktadır.

Yaşlanma süreci büyük ölçüde insan kontrolü dışında gelişen biyolojik bir gerçektir. Gorman (1999) tarafından genel anlamıyla yaşlılık, fiziksel bozulma nedeniyle aktif katılımın mümkün olmadığı nokta olarak tanımlanmaktadır (1). Dünya Sağlık Örgütü'ne (WHO) göre 65 yaş ve üzeri kişiler yaşlı olarak kabul edilmektedir. Türkiye İstatistik Kurumu'nun verilerine göre Türkiye için 65 yaş ve üzeri nüfus 2000 yılında %5.7 iken, 2012 yılında bu oran %7.2'ye artmıştır (2). Bununla birlikte 65 yaş ve üzeri yaş grubunun nüfusunun toplam nüfus içindeki oranı 2013 yılında %7.7 iken, bu oranın 2075 yılında %27.7 olacağı tahmin edilmektedir (3).

Yaşlılık oranları arttıkça huzurevi ve bakımevinde kalma oranları da artmaktadır. Sosyal Politikalar Bakanlığı'nın Engelli ve Yaşlı Hizmetleri Genel Müdürlüğü'nün verilerine göre, 2000 yılında 13454 kişi huzurevleri ve bakımevlerinde kalmakta iken, bu sayı 2013 yılında 19893 olmuştur.

Yaşlanma sürecinde zamana bağlı olarak vücut yapısında, hücre, doku, organlarda ve organların fonksiyonlarında bir takım geri dönüşsüz değişiklikler meydana gelir. Yaşlanma kişiyi sadece fizyolojik olarak değil, aynı zamanda psikolojik ve sosyolojik yönden de değişikliklere uğratmaktadır. Yaşlılık döneminde görülen biyolojik değişiklikler ve fiziksel aktivite azlığı, kronik beslenme sorunları ve kuvvet kaybına neden olmaktadır (4). Yaşlanmayla birlikte ortaya çıkan fizyolojik değişiklikler, değişik hastalıklar, diş ve ağız sağlığı problemleri, ekonomik sıkıntılar, tek başına alışveriş yapamama, yemek hazırlayamama ve yiyememe gibi etkenler bireyin beslenme durumunu olumsuz etkiler. Bunlarında etkili olduğu herhangi bir nedenle ortaya çıkan kilo kaybının başlangıcını takip eden 1-2,5 yıl içinde, sadece bu sebeple mortalite oranının %9-38 oranında arttığı saptanmıştır (5).

Yaşlı insanlarda depresyon yaygın bir problemdir. Depresyon yaşam kalitesinde önemli derece düşüğe neden olan duygusal dengenin bozulmasıyla ortaya çıkan ruhsal bir bozukluktur. Yapılan değişik araştırmalarda depresyonun yaygınlık oranı; Kore’de % 15.2-44, Japonya’da % 19.8-33.5, Tayvan’da %20.1, A.B.D.’de 65 ve üzeri yaşlılarda % 13-27 olarak tespit edilmiştir (6). Türkiye’de yapılan bir çalışmada; Trabzon’da depresyon sıklığı toplumda yaşayan yaşlılarda % 29, kurumsal bakım gören yaşlılarda % 41, Ankara’da yapılan diğer bir çalışmada da depresyon sıklığı huzurevinde yaşayan yaşlılarda % 48.1, evde yaşayan yaşlılarda % 24.3 bulunmuştur (7, 8). Kadın olmak, düşük sosyoekonomik düzeyde olmak, dul olmak, yalnız yaşamak, bilişsel bozukluğun varlığı, fiziksel hastalık gibi etkenlerin yaşlılarda depresyon oluşumuna zemin hazırladığı belirlenmiştir (9, 10).

Yaşlılardaki depresyonun ortaya çıkışında çok sayıda etken rol oynamakla beraber önemli risk etkenleri; normal yaşlanma süreci, tıbbi hastalıklar, beslenme bozuklukları, ilaçlar, psikososyal etkenler ve genetik etmenler olarak belirlenmiştir (11).

Yaşlılar aynı anda birden çok hastalıktan muzdariptirler. Dengesiz beslenme, akut ve kronik hastalıkları tetiklerken dolaylı olarak yaşlanma sürecini de hızlandırmaktadır (2). Yaşlılık döneminde yeterli ve dengeli beslenme, sağlığın korunması, iyileştirilmesi ve geliştirilmesi, yaşam süresinin ve kalitesinin artırılması açısından önemlidir.

Yöntem

Çalışmaya İzmir Büyükşehir Belediyesi Gürçeşme Zübeyde Hanım Huzurevinde kalan ve kendi temel ihtiyaçlarını karşılayabilen 65 yaş ve üstü yaşlılar alınmıştır. Kişilere yüz yüze görüşme yöntemiyle; sosyo-demografik, sosyo-ekonomik ve bazı özellikleri sorgulayan 30 soruluk anket, Geriatrik Depresyon Ölçeği’nin (GDÖ) Türkçe versiyonu ve Mini-Nütrisyonel Değerlendirme Testi (MNT) uygulanmıştır. İstatistik değerlendirme için SPSS 21 paket programı kullanılmıştır.

Geriatrik Depresyon Ölçeği, Yesavage ve ark. (1983) tarafından yaşlı nüfusu için oluşturulmuş 30 soruluk bir ölçektir (12). Ülkemiz için geçerlilik ve güvenilirliği Ertan ve ark. (1997) tarafından yapılmıştır (13). Toplam puan 0–30 arasında olabilir. Bu çalışmada GDÖ’nde 0–9 puan “normal”, 10–19 puan “minör depresyon”, 20 puan ve üzeri alanlar “majör depresyon” olarak sınıflandırılmıştır.

Mini Nütrisyonel Değerlendirme Testi, Guigoz ve ark. tarafından Fransa’da 1994 yılında yayınlanmıştır (14). Bu değerlendirme testi, yaşlıların nütrisyonel durumunu taramada

kullanılan, geçerliliği ve güvenilirliği kanıtlanmış, malnütrisyon riskini değerlendirmek ve erken müdahaleden fayda görebilecek kişileri tanımlamak için geliştirilmiş bir yöntemdir. MNT; beslenme ile ilgili olarak kişinin beslenme durumunu, en yüksek puan 30 olacak şekilde, 0–16 puan arası “malnütrisyon”, 17–23 puan arası “malnütrisyon riski”, 24 puan ve üzeri “beslenme durumu iyi” olarak tanımlamıştır.

Verilerin analizinde tanımlayıcı istatistiksel uygulamalar olarak ki-kare testi, t testi, korelasyon ve regresyon analiz yöntemleri kullanılmıştır. P değeri için anlamlılık düzeyi 0,05 kabul edilmiştir. Araştırmanın bağımlı değişkeni MNT ve GDÖ, bağımsız değişkenler ise sosyo-demografik ve sosyo-ekonomik özellikler, egzersiz yapma, kronik hastalık varlığı, sakatlık varlığı, hastaneye yatma ve aktivite durumudur. $p < 0.05$ değerleri anlamlı kabul edilmiştir.

Bulgular:

Araştırmada İzmir Büyükşehir Belediyesi Gürçeşme Zübeyde Hanım Huzurevinde kalan ve kendi temel ihtiyaçlarını karşılayabilen 65 yaş ve üstü yaşlılar alınmıştır. Bu araştırmaya, gönüllü olarak 41 kadın (%55.4) ve 33 erkek (%44.6), toplam 74 yaşlı katılmıştır. İncelenenlerin % 28.4’ü 65-74 yaş aralığında, % 63.5’i de 75-84 yaş aralığındadır.

Yaşlıların %27’si okuma yazma bilmemekte, %45.9’u ilköğretim mezunu, %9.5’i evli, %51.4’ü dul, %70.3’ünün de sosyal güvencesi vardır. Çalışmaya katılan yaşlıların % 32.4’ünün hiç çocuğu yok, %33.8’inin de geliri yoktur. Araştırma grubuna ilişkin sosyo-demografik ve sosyo-ekonomik bulgular Tablo 1. de görülmektedir.

Araştırma grubuna ilişkin tanımlayıcı bulgulardan, yaşlıların % 83.8’i sigara kullanmamakta, %16.2’si alkol kullanmaktadır. Yaşlıların %43.2’si 7 yıldan daha uzun süredir huzurevinde kalmaktadır(Tablo 2). %55.4’ünün herhangi bir hobisi yoktur. Yaşlıların %48.6’sı haftada 3 gün egzersiz yapmakta ve bunların % 24.3’ü her gün düzenli egzersiz yapmaktadır.

Yaşlıların %36.5’i yakınları tarafından hiç ziyaret edilmemektedir. %24.3’ü yakınlarıyla telefonla bile görüşmemektedir veya yakını yoktur. Fırsatı olsa yaşamak isteyeceği yeri %37.8’i kendi evi olarak belirtmiştir (Tablo 2). Yaşlıların %44.6’sı boş vakitlerini arkadaşlarıyla sohbet ederek değerlendirmektedir. % 13.5’inde sürekli sakatlık vardır. %

67.6'sının en az bir kronik hastalığı vardır ve en sık görülen kronik hastalıklar yüksek tansiyon, diyabet ve kalp yetmezliğidir. Yaşlıların %63.5'i daha önce herhangi bir nedenle hastaneye yatmıştır. %29.7'si sadece temel bakım aktivitelerini yerine getirmektedirler (Tablo 2).

Tablo 1. Araştırma grubuna ilişkin sosyo-demografik ve sosyo-ekonomik bulgular

Özellikler	Denek sayısı (n)	Oran (%)
Yaş		
65-74	21	28.4
75-84	47	63.5
85-üstü	6	8.1
Cinsiyet		
Erkek	33	44.6
Kadın	41	55.4
Eğitim Durumu		
Okuryazar değil	20	27
Okuryazar	10	13.5
İlköğretim	34	45.9
Lise	8	10.8
Yüksekokul/Üniversite	2	2.7
Meslek		
İşçi	9	12.2
Memur	11	14.9
Serbest meslek	14	18.9
Çiftçi	8	10.8
Ev hanımı	29	39.2
Diğer	3	4.1
Medeni durum		
Evli	7	9.5
Bekar	14	18.9
Dul	38	51.4
Boşanmış	15	20.3
Sağlık Güvencesi		
Var	52	70.3
Yok	22	29.7
Çocuk sayısı		
Yok	24	32.4
1	8	10.8
2	16	21.6
3	21	28.4
4 ve üstü	5	6.8
Gelir		

Var	49	66.2
Yok	25	33.8

Tablo 2. Araştırma grubuna ilişkin tanımlayıcı bulgular.

Özellikler	Denek sayısı (n)	Oran (%)
Sigara		
Var	21	%28.4
Yok	47	%63.5
Alkol		
Var	12	%16.2
Yok	62	%83.8
Kurumda kaç yıldır kalıyor		
6 aydan az	6	%8.1
1-3 yıl	22	%29.7
4-6 yıl	14	%18.9
7 ve daha çok	32	%43.2
Hobi		
Evet	33	%44.6
Hayır	41	%55.4
Egzersiz		
Evet	36	%48.6
Hayır	38	%51.4
Yakın ziyareti		
Evet	47	%63.5
Hayır	27	%36.5
Telefonla görüşme		
Evet	54	%73.0
Hayır	18	%24.3
Yaşamak için seçeceği yer		
Kendi evi	28	%37.8
Çocuklarının yanı	5	%6.8
Huzurevi	39	%52.7
Diğer	1	%1.4
Hastalık var mı?		
Evet	50	%67.6
Hayır	24	%32.4
Sakatlık var mı?		
Evet	10	%13.5
Hayır	62	%83.8
Hastaneye yattınız mı?		
Evet	47	%63.5
Hayır	27	%36.5

Aktiviteler		
Temel bakım	22	%29.7
Destekleyici bakım	52	%70.3

Yaşlıların % 68.9'unda malnütrisyon riski yokken, % 23'ünde hafif malnütrisyon riski, %8.1'inde yoğun malnütrisyon riski vardır. Mini Nütrisyonel Değerlendirme Testi puanları açısından kadınlarla erkekler arasında fark saptanmıştır ($p<0.05$). Mini Nütrisyonel Değerlendirme Testi (MNT) puanı ve depresyon puanı arasında pozitif yönde ($r= 0.508$, $p<0.05$) korelasyon mevcuttur.

Malnutrisyon ve riski, depresyon saptanmayan kişilerde görülmezken, hafif depresyonda ya da depresyonda olan kişilerde saptanmıştır. Depresyon puanları açısından kadınlarla erkekler arasında fark saptanmamıştır ($p>0.05$).

Tablo 3. Tanımlayıcı Özelliklere Göre Çalışma Grubunun Dağılımı

Tanımlayıcı özellikler	Denek sayısı (n)	Oran (%)
Beslenme puanına göre gruplama		
Malnutrisyon	6	8.1
Malnutrisyon riski	17	23.0
Beslenmesi iyi	51	68.9
Depresyon durumu		
Normal	20	27
Minör depresyon	36	48.6
Majör depresyon	16	21.6
Toplam	72	100.0

($r=0.508$, $p<0.05$)

Mini Nutrisyonel Değerlendirme Testi (MNT) puanları açısından kadınlarla erkekler arasında fark saptanmıştır ($p<0.05$). Kadınlarda erkeklere göre malnutrisyon ve malnutrisyon riski daha yüksektir. Bu durumda kadınlar beslenme yetersizliğine daha yatkın görülmektedirler. Depresyon puanları açısından kadınlarla erkekler arasında fark saptanmamıştır ($p>0.05$). Depresyon yönünden de kadınlarda erkeklere göre yoğun depresyon riski daha yüksektir. Malnutrisyon en fazla yaş grubu olarak 75-84 yaş aralığında görülmektedir. Majör ve minör depresyonda yine 75-84 yaş aralığında daha yüksektir.

Tablo 4. Bağımlı değişkenlere göre yaş ve cinsiyet dağılımı

Mini nutrisyonel değerlendirme testi puan (MNT)					Toplam	Geriatrik Depresyon Ölçeği (GDÖ) puan			Toplam
		23-30 puan	17-22 puan	16 ve aşağısı		0-9 Normal	10-19 Minör depresyon	20-30 Yoğun depresyon	
Cinsiyet	Kadın	25	11	5	41	9	21	11	41
	Erkek	26	6	1	33	11	15	5	31
Toplam		51	17	6	74	20	36	16	72
Yaş	65-74	15	6	0	21	8	8	5	21
	75-84	31	10	6	47	9	27	9	45
	85 ve üstü	5	1	0	6	3	1	2	6
Toplam		51	17	6	74	20	36	16	72

Tartışma Ve Sonuç:

Yaşlanmanın getirdiği fizyolojik, psikolojik ve sosyal değişikliklere bağlı olarak pek çok sorun ortaya çıkmaktadır. Bunlardan biri beslenme sorunu iken, bir diğeri de depresyondur. Yaşlılığa bağlı oluşan kronik hastalıklar, fizyolojik kayıplar, diş ve yeme problemleri, depresyon varlığı gibi nedenler yaşlılarda malnütrisyon ve yetersiz beslenmeye yol açmaktadır. Bu çalışmada beslenme puanı ile depresyon puanı arasında ilişki bulunmuştur ($p<0.05$). Depresyon düzeyinin yüksek olması beslenmeyi olumsuz yönde etkilemektedir. Levitsky ve ark. (1995) yaptıkları araştırmada malnütrisyonun mental fonksiyonlar üzerine etkisinin, anksiyete ve depresyon puanlarının yükselmesine neden olduğu görülmüştür (15).

Kadınların malnütrisyon ve depresyon oranları erkeklere göre daha yüksektir. Uçku ve ark. (1992) yaptıkları çalışmada kadın olmak, dul olmak, yalnız yaşamak, kronik hastalığı olmak gibi durumları risk faktörü olarak belirlemiştir (9).

Eşini kaybetme, evinden, arkadaşlarından ayrılma gibi sosyal ve duygusal değişiklikler, depresyon ve beslenme bozukluklarına neden olmaktadır. Bu değişimler günlük yaşam becerilerini etkileyerek (yemek yeme, pişirme gibi) sorunlar yaşanmasına ya da bu psikolojik durumlar (iştah kaybı, yemek yememe gibi) yetersiz beslenmeye yol açmaktadır (16, 17).

Yapılan bu çalışmada kurumda 7 yıl ve üzeri kalanlarda minör depresyon ve majör depresyon oranı daha yüksek (%70) bulunmuştur. Çeşitli çalışmalarda huzur evi ve bakım evinde kalan yaşlılarda malnütrisyon oranı, evde kalan yaşlılara göre daha yüksektir (18). Kaiser ve ark. (2010) yaptığı çalışmada evde yaşayan yaşlılarda malnütrisyon oranı % 5.8, huzurevinde kalanlarda %13.8, hastanede yatanlarda ise %38.7 olarak bulunmuştur (19).

Bu araştırmada huzurevi sakinlerinin %67.6'sında kronik hastalık varlığı tespit edilmiştir. Aynı zamanda malnütrisyonu olan kişilerin tamamında kronik hastalık varlığı, sadece %16.6'sında majör depresyon varlığı saptanmıştır. Depresyon varlığı, besin alınımını olumsuz yönde (fazla ya da az yeme) etkilemektedir. Özellikle yaşlılarda, yaşa bağlı fizyolojik gerileme sonucu (örn. tükürük salgılarında, tat duyusunda, mide enzimlerinde azalma, diş ve ağız yapısında bozulma, duyu kayıpları, susama ve açlık hissini azalması gibi) pek çok akut ve kronik hastalık oluşmakta ve tüm bu durumlar da besin alınımı etkilemektedir. Aynı zamanda yaşlılar hastalıkları için çok sayıda ilaç kullanmakta ve diyet

(diyabet, hipertansiyon, kardiyovasküler hastalıklar diyetleri gibi) yapmakta, bu diyetlerinde tatsız, yağsız ve tuzsuz olması yeme oranlarını azaltmaktadır.

Sosyal faktörlerde beslenme üzerinde etkilidir. Sosyo-ekonomik düzey düşüklüğü, eğitim eksikliği, sosyal güvence eksikliği, sağlıklı beslenmeyi etkilemektedir. Bu araştırmada huzurevi sakinlerinin %27'si okuryazar değilken %13.5'i okuryazardır. Bu oran çok yüksektir. Yaşlıların %29.7'sinin sosyal güvencesi yoktur. Seeman ve ark. (2008) yaptıkları araştırmada, sosyo-ekonomik durum ve eğitim eksikliğinin çeşitli sağlık riskleri oluşturduğunu bulmuşlardır (20).

Depresyon gibi psikolojik faktörler besin alımını olumsuz yönde etkilemektedir. Yaşlılardaki bazı kronik hastalıklarda (parkinson, alzheimer, demans, MS, stroke gibi) depresyon riski yükselmektedir. Yapılan birçok çalışma sonucu da depresyon için kronik hastalığın bir risk faktörü olduğu desteklenmektedir. Butcher ve ark. (2005) yaptıkları araştırmada yaşlılardaki depresyon belirtilerinin, diğer yetişkinlerden farklı olduğunu bulmuşlardır. Yaşlılıktaki depresyon diğer kronik hastalıklara karşı bir reaksiyon gibi görülebilir (21).

Yapılan araştırmada egzersiz yapan yaşlılarda depresyon oranı daha az iken, yapmayanlarda bu oranın daha yüksek olduğu görülmüştür. Biderman ve ark. (2002) yaptıkları araştırmada egzersizle depresyon arasında pozitif ilişki bulmuştur (22). Egzersiz yapmak beslenme ve depresyonu iyi yönde etkilemektedir.

Bu araştırmada huzurevi sakinlerinin % 75.6'sı herhangi bir nedenle daha önce hastaneye yatmıştır. Bu yaşlıların içerisinde malnütrisyon saptanan kişilerin neredeyse tamamı (%83.3) hastaneye yatmış ve %92.3'ünde ağır depresyon saptanmıştır.

Yapılan araştırmada huzurevi sakinlerinin %39.7'si sadece günlük temel yaşam aktivitelerini (yatağa yatmak-kalkmak, giyinmek-soyunmak, yemek yemek, tuvalete gitmek-kullanmak, banyo yapmak) yerine getirirken, %70.3'ü hem günlük temel yaşam aktivitelerini hem de yardımcı günlük yaşam aktivitelerini (telefon kullanma, yemek yapmak, günlük ev işlerini yapmak, alışveriş yapmak, ev dışı diğer işleri yapmak, şehir dışına yolculuk yapmak gibi) yerine getirebilmektedir. Bu aktiviteleri yerine getiremeyen kişilerde beslenme bozukluğu ve depresyon görülme olasılığı daha fazladır. Topbaş ve ark. (2004) yaptıkları araştırmada yaşlıların beslenme, banyo, giyim, hareket gibi her gün yerine getirilmesi gereken günlük temel işlevlerini sürdürmekte yaşadıkları güçlüklerin onları çevresine bağımlı hale getirdiğini ayrıca çeşitli derecelerde yaşanan ölüm kaygısı ile birlikte kişinin yaşama gücü, sevinci ve arzusunun azaldığını belirtmişlerdir (22).

Huzur evi sakinleri rahatlıkla izlenebilir olmaları nedeniyle, oluşabilecek problemleri rahatlıkla elimine edilebilir. Yaşlılara yönelik özel diyetler, beslenme programları ve egzersiz takviyesiyle kronik hastalıklara zemin hazırlayan beslenme yetersizliklerinin önüne geçilebilir. Kadınlar 65 yaşından sonra, erkeklerle 55 yaşından sonra kilo kaybetmeye başlarlar. Bu duruma depresyon ve yetersiz gıda alımı eklenirse sonuçlar geri dönüşsüz olabilir.

Malnütrisyon riski yüksek olan yaşlılarda beslenme alışkanlıklarının gözden geçirilmesi, huzurevi çalışanlarının depresyon ve malnütrisyon riskleri konusunda eğitilmesi ve konuyla ilgili gerekli önlemlerin alınması, yaşlıların yaşam kalitelerinin artırılması üzerine önemli bir etkidir.

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Retirees' Associations and Senior Citizens' Participation to Social Life: The Case of Istanbul

Hamza Kurtkapan ¹

Abstract

Background: Retirees' associations are non-governmental organization those are formed to help aging individuals to overcome the problems after the retirement and to build solidarity among the retirees. These associations have functions for individuals who withdraw active business life to overcome new socio-economic situations and participating social life. Retirees' associations although they have important functions, have not been studied sufficiently in Turkey from a sociological perspective. According to our literature survey, the only graduate thesis about the subject was written in 1999.

Objectives: The topic of this research is the role of retirees' associations which emerge as a pattern of on the participation of senior citizens' to social life. The data which are gathered from selected retirees' associations are studied according to the theories that are used in sociology of aging such as "Activity Theory" and "Continuity Theory".

Methodology: In this research data collected via in-depth interviews and document review, which both are research techniques of the qualitative method, studied by Grounded Theory data analysis technique. The study is held throughout the members or managers of retirees' associations whom are reached by the information from the Directorate of Association of Istanbul Governorship. These associations are classified according to the list of retirees' associations (such as labor, officer, institution, occupation, neighborhood etc.).

Conclusion: The preliminary findings are: there are more retirees' associations at the districts with more senior citizens where are also the older parts of the city; the voluntary work in pension associations help individuals to remain active; trips, conferences, educations, celebrations, concerts and seminars are instruments that build a solidarity between retired individuals. Statue gap which remains during the active business life tends to decrease among the retirees who worked similar institutions. It is also observed that

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physical and economical obstacles are the top problems to participate in the activities of retirees' associations.

Keywords: Sociology of Aging, retirees' Associations, Aging, Activity Theory, Continuity Theory

Emekli Dernekleri ve Yaşlıların Toplumsal Hayata Katılımları: İstanbul Örneği

Hamza Kurtkapan¹

Özet

Arka Plan: Emekli dernekleri, yaşlanan bireylerin emeklilik sonrasına ait problemleriyle baş edebilmek ve emekliler arasında dayanışma oluşturabilmek amacıyla kurulan sivil toplum kuruluşlarıdır. Emekli dernekleri, aktif iş yaşamından çekilen bireylerin sosyo-ekonomik yeni durumlarıyla baş edebilmelerinde ve toplumsal hayata katılımları konusunda çeşitli işlevler üstlenebilmektedir. Ülkemizdeki mevcut sosyoloji literatürüne bakıldığında, emekli derneklerinin, önemli işlevlerine rağmen, sosyolojik açıdan yeterince analiz edilmediği görülmektedir. Türkçe literatürde sadece 1999 yılında yapılmış bir yüksek lisans tezine rastlanılmıştır.

Amaç: Bir dayanışma örüntüsü olarak ortaya çıkan emekli derneklerinin yaşlanan aktörlerin toplumsal yaşama aktif katılmalarındaki rolü bu çalışmanın amacını oluşturmaktadır. Bu çalışmada İstanbul'da bulunan emekli derneklerinden elde edilen nitel veriler, yaşlılık sosyolojisi çalışmalarında kullanılmakta olan "Aktivite (Etkinlik) Kuramı" ve "Süreklilik Kuramı" açısından incelenmektedir.

Yöntem: Bu araştırmada nitel araştırma geleneği içerisinde yer alan derinlemesine görüşme ve doküman inceleme teknikleri kullanılarak elde edilen bulgular, Gömülü (*Grounded*) Veri Analiz Tekniği ile incelenmektedir. Görüşmeler, İstanbul Valiliği İl Dernekler Müdürlüğü'nden alınan bilgiler doğrultusunda ulaşılabilen emekli derneklerinde dernek yöneticisi ve üyesi olan kişilerle gerçekleştirilmektedir. Dernekler, emekli dernekleri listesinden hareketle belirlenen 6 kategori (işçi, memur, kurum, meslek, mahalle/semte ve diğer) çerçevesinde sınıflandırılmıştır.

Sonuç: Ön araştırma kapsamında emekli derneklerinin İstanbul'un eski ve yaşlı oranının yüksek olduğu ilçelerinde yer aldığı; emekli derneklerindeki gönüllü çalışmalara katılımın aktif ve üretken kalmaya olumlu katkısının olduğu; bu doğrultuda gezi, konferans, eğitim, kutlama, konser ve seminerler düzenlendiği görülmüştür. Benzer kurumlarda çalışmış emeklilerde, aktif iş yaşamındaki statü farklılıklarının emeklilikle birlikte azaldığı ve

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emekli derneklerinin faaliyetlerine katılmanın önündeki en önemli problemlerin başında ekonomik ve fiziksel engellerin olduğu belirlenmiştir.

Anahtar Kelimeler: Yaşlılık Sosyolojisi, Emekli Dernekleri, Yaşlanma, Aktivite Kuramı, Süreklilik Kuramı.

Giriş

Kentleşme ve teknolojideki hızlı gelişmelere bağlı olarak bireyselleşme artmış, akrabalık bağları zayıflamış, yaşlılıkta aile ilişkilerinden daha çok arkadaş grupları önem kazanmıştır. İleri yaşlarda aile üyeleri ile her zaman birlikte olunamadığından arkadaşlık ve komşuluk ilişkileri önemli olmaktadır (İlgar, 2008, s. 72). Bu nedenle yaşlı bireylerin ailelerinin dışında kalan toplumsal ilişkileri önem kazanmaktadır.

Emekli olduktan sonra meslekten uzaklaşan bireyler *sosyal alanın dışına itildikleri* ve emeklilerin bu dernekler aracılığıyla toplumsal yaşamda kendilerine *yer edinebildikleri* söylenebilir. Emeklilik döneminde toplumsal yaşamda aktif olabilmek önemli problemlerden biridir. Bu dönem sadece yaşlıların değil eşleri ve çocukları gibi yakınlarının da sosyal ve psikolojik yaşamlarını etkilemektedir. Yaşlıların boş zamanlarını en iyi şekilde değerlendirebilmesi için uygun ortamlar, çeşitli kurum ve kuruluşlar aracılığıyla hazırlanması gerekir. Hobi faaliyetlerini geliştirici etkinlikler düzenlenmesi, sanatla ilgilenenler için araç gereç temini ve ortaya çıkan ürünlerin sergi ve satışında yardım, iletişim, sağlık, beslenme vb. ihtiyaç duyulan konularda bilgi verilmesi boş zamanların kullanımını sağlayabilir (İlgar, 2008, s. 92).

Bu çalışmada arkadaş ilişkilerinin devam ettirildiği kurumsal ortamlardan biri olan emekli derneklerinin sosyal işlevlerine odaklanılmıştır. Bu kapsamda İstanbul'daki emekli derneklerinin faaliyetleri gerek derneğe gidilerek, gerekse de internet üzerinden incelenmiştir. Kavramsal olarak, emekli dernekleri, yaşlanan bireylerin emeklilik sonrasına ait problemleriyle baş edebilmek ve emekliler arasında dayanışma oluşturabilmek amacıyla kurulan, emeklilerin isteğe bağlı olarak katıldıkları dernek çeşidinin adıdır. Emekli derneklerinin büyük ölçüde aynı meslek grubundan emekli olan yaşlıların bir araya gelerek arkadaşlıklarını sürdürdükleri veya yeni arkadaşlıklar kurdukları yerler olduğu görülmüştür. Dernek üyeleri arasında erkeklerin sayısal fazlalığı göze çarpmaktadır. Kadın emekliler evlerinde kendi sosyal alanlarını oluşturabilirken, erkek emeklilerin toplanma mekanına ihtiyaç duymaları onları emekli dernekleri bünyesinde bir araya getirmektedir.

Yaşlılık sosyolojisi Literatüründe emekli dernekleri ile yaşlıların toplumsal aktifliği arasındaki ilişkiyi açıklayan çalışmaların çok az olduğu görülmektedir. Emekli dernekleriyle ilgili bir çalışmada, emekli derneklerine katılım gösteren yaşlıların büyük çoğunluğunun gelir ve öğrenim düzeyinin yüksek olduğu, bu derneklerdeki yaşlıların önemli bir bölümünün “boş vakitleri değerlendirme ve sosyo-kültürel etkinlikleri devam ettirme”, “yalnızlık hissinden kurtulmak, arkadaş edinme”, gibi ihtiyaçları karşılamak için

üye olduklarına üye olduklarını (İncealtın, 1999) belirtmiştir. İncealtın (1999) emeklilik sürecine çok iyi hazırlanılması gerektiğini de çalışmasında vurgulamaktadır. Ayrıca literatürde; meslek sonrası yaşama uyum sağlamaya yardımcı dokunan ilişkilerin teşvik edilmesi gerektiğinin (I. Tufan, 2003, s. 245) ve yaşlıların sosyal sorumluluk projelerinde görev almalarının (İlgar, 2008, s. 81) önemi vurgulanmıştır.

Emekli derneklerinin, yaşlanan bireylerin kendilerini değersiz hissettikleri, ümitsizliğe kapıldıkları, reddedilme korkusu yaşadıkları dönemlerinde meslek sonrası yaşlılıkla baş edebilmelerinde işlevsel olup olmadığı bu çalışmanın temel problemidir. Bu doğrultuda, İstanbul'da 23 emekli derneğinde görüşme ve gözlemler yapılmış, emekli derneklerinin yukarıda bahsedilen işlevleri yerine getirip getirmediikleri ve/veya bunların gerçekleştirilmesine katkı sağlayıp sağlamadıkları incelenmiştir. Bu inceleme yaşlılık sosyolojisinde kullanılan *aktivite* ve *süreklilik* kuramları çerçevesinde gerçekleştirilmiştir. Zira bu kuramlar yaşamdan çekilmeyi ya da devam etmeyi ele alan bir çerçeve sunmaktır. Emeklilik iş hayatından çekilmeyle başlayan ve yaşamdan da uzak kalmayı beraberinde getiren bir süreçtir.

Yaşlılıkla İlgili Aktivite ve Süreklilik Kuramları

Yaşlanma ile ilgili psiko-sosyal/sosyolojik kuramlardan *aktivite* ve *süreklilik* kuramlarına göre yaşlılar toplumsal olarak etkinliklerine devam ederler. *Aktivite* teorisine göre, yaşlıların yaşlılık dönemindeki yaşam memnuniyeti ve emekliliğe uyumu, aktif meslek yaşamında gerçekleştirdikleri aktiviteleri yaşlılıklarında da devam ettirmeleriyle sağlanır. Bunun anlamı, emekli olduktan sonra meydana gelen rol, fonksiyon ve ilişki kayıplarının yerlerinin yeni ilişkiler ve aktif uğraşlarla doldurulması gerekliliğidir (Tufan, 2003, s.254).

Bu kurama göre, bireyin faaliyetleri ve yeni roller üstlenmesi yaşam doyumu üzerinde etkilidir. Faaliyetlerini belirli bir düzeyde tutan ve sosyal dünyalarının kısıtlanmasına izin vermeyen yaşlılar psikolojik olarak daha sağlıklı olmaktadır. Yaşlı bireylerin aktiviteleri literatürde (a) arkadaş, akraba ve komşularla ilişkilerini içeren resmi olmayan aktiviteler (b) kulüpler kapsamında yürütülen resmi aktiviteler ve (c) kendi başlarına yaptıkları hobi aktiviteleri olarak üç gruba ayrılmaktadır. Yaşlılar özellikle resmi aktiviteleri sürdürebildikleri sürece daha fazla doyum elde ederler (Kaygusuz, 2008, s. 235)

Bazı yazarlar tarafından yaşlılık konusunda öne sürülen yaklaşımlar arasında en olumlu yaklaşım süreklilik kuramında olduğunu iddia edilir. Bu kurama göre birey tüm gelişim dönemlerinde sorunlarla nasıl baş ettiyse yaşlılıkta da benzer stratejiler geliştirebilirler (

Davies 1994'den aktaran Ilgar, 2008, s.78). Bu yaklaşıma göre hayat bir dizi bağlardan oluşur ve farklı dönemlerdeki değişik bağların daha önemli oluşu, o bağların gerçekte bir diğerinden daha önemli oldukları anlamına gelmez. Yaşlılık döneminde mesleki bağların yerini ailevi bağların alması yeni duruma uyum sağlamanın bir gereğidir (Kaygusuz, 2008, s.240).

Bu kuramlar çerçevesinde bakıldığında emekli derneklerinin yaşamın belli bir dönemi olan yaşlılıkla baş etmede ciddi bir rol oynadığı söylenebilir. Bu dernekler özellikle yaşlıların önceki sosyal rollerini kaybetmenin baskısıyla yeni alternatif aktivitelerle bu boşluğu kapatmaya çalışmaları bağlamında önemli bir hale gelmektedir.

Amaç

İstanbul'daki emekli derneklerinin faaliyetlerini dernek yönetici ve gönüllülerin görüş ve deneyimlerinden yararlanılarak incelenen bu çalışmada, emekli derneklerinin yaşlanan bireylerin toplumsal hayata aktif katılımlarına katkısı anlaşılmaya çalışılmıştır. Bu araştırmanın amacı sivil toplum kuruluşları olarak emekli derneklerinin yaşlı ve ileri yaşlı üyelere yönelik, yaşlılığın problemleriyle baş etmede, yalnızlaşmalarının önlenmesinde, sosyal etkileşimlerinin devam etmesinde ve yaşlıların üretkenliklerini sürdürülmesindeki etkinliğini ortaya koymaktır. Ayrıca yaşlanan emeklilerin toplumdan dışlanmasının önlenmesine yönelik öneriler ortaya koymak bir diğer amacı oluşturmaktadır.

Metodoloji

Nitel yönelimli bir araştırma kapsamında İstanbul'daki emekli dernekleri altı kategoride (işçi, memur, kurum, meslek, mahalli/semte ve diğer) sınıflandırılmıştır. Ancak çalışmanın ilerleyen safhalarında yapılan gözlem ve görüşmeler sonucunda bu derneklerin; (a) *lokal olarak kullanılan dernekler* (b) *üyelerine hukuki destek sağlayan dernekler* (c) *sosyal ve kültürel faaliyetlerde bulunan dernekler* (d) sadece haftanın belli gün ve saatlerinde açılan ve *toplama mekanı olarak kullanılan dernekler* şeklinde sınıflandırılmasına karar verilmiştir.

Lokal (dernekevi) olarak kullanılan dernekler benzer meslek gruplarından eski arkadaşların bir araya geldikleri, briç, tavla, okey vb. oyunlar oynadıkları, muhabbet/sohbet ettikleri ve böylece sosyal etkileşim ihtiyaçlarını karşıladıkları mekânlardır. *Hukuki destek sağlayan derneklerde* ise üyelerin kanuni hakları gözetilmekte ve ihtiyaç halinde gerekli prosedürler ve yasal işlemlerin yerine getirilmesi hususunda

kendilerine yardım edilmektedir.² *Sosyal ve kültürel faaliyetlerde bulunan derneklerde* başta sağlıkla ilgili olmak üzere çeşitli konularda seminer ve konferanslar verilmekte, üyelerin hobi geliştirmelerine, yeni hobiler edinmelerine ve ürünlerini sergilemelerine imkan sağlanmaktadır. *Toplanma mekanı olarak kullanılan derneklerde* ise önemli günlerde ya da haftanın ve ayın belirli günlerinde bir araya gelmekte ve sohbet edilmektedir.

Çalışma Grubu

Çalışma nitel araştırma olduğundan, amaca uygun olabileceği düşünülen çalışma gurubunun arařtırmacı tarafından seçildiđi *maksatlı örnekleme tekniđi* kullanılmıřtır. Bahsedilen gruplandırmanın ardından arařtırmanın çalışma grubu, İstanbul'daki emekli derneklerinin faaliyetleri hakkında bilgi verici bir grup olarak bu derneklerdeki gönüllü üyeler ve yöneticiler ile sınırlandırılmıřtır. *Maksatlı örnekleme tekniđi* kullanılarak İstanbul'daki emekli derneklerinde sekiz dernek yöneticisi dokuz dernek gönüllüsü ile görüşme yapılmıřtır. Emekli derneklerinin seçimi sırasında İstanbul'daki emekli derneklerinin temsil edilmesi amaçlanmıřtır. Çalışma grubunu ilgili kurumlarda görüşmeyi kabul eden 17 emekli üye oluřturmaktadır. Bu üyelerin ancak dört tanesi kadın üyedir, aslında bu durum bizim gittiđimiz derneklerde gönüllü ve yöneticilerin erkek ađırlıklı olmasından kaynaklanmaktadır.

Veri Toplama Süreci

Çalışma grubunda yer alan emekli derneklerine arařtırmacı bizzat giderek emekli derneđi üyeleriyle görüşme talebinde bulunmuřtur. Yarı-yapılandırılmıř (Punch, 2012, s. 167) soru protokolünün ve ses kayıt cihazının kullanıldıđı derinlemesine mülakatlar dernek binalarında gerçekteřtirilmiřtir. Bu kapsamda 23 emekli derneđine gidilmiřtir. Bu derneklerden 3'ünün faaliyet göstermediđi tespit edilmiř, diđer 3'ünün ise sürekli olarak kapalı olduđu görölmüřtür. Bazı derneklere ulařılamaması bir kısım emekli derneđinin aktif olmadıđını gösteren önemli saha bulgularından biridir. Emeklilik derneklerinin belirli dönemlerde aktif olamamaları gözlenmiř, arařtırma sırasında sorgulanan hususlardan biri olmuřtur. Dolayısıyla toplamda 17 farklı dernek deđiřik zamanlarda birkaç kez ziyaret edilerek mülakatlar gerçekteřtirilmiřtir.

² Örneđin Polis emeklileri derneđinde çalışan Aslı Hanım, derneđin amacını řu řekilde açıklamaktadır: "Maddi manevi destek sađlayıcı dernek olarak özlük haklarının korunmasında, maař sıkıntılarında, yardımcı olan dernek, araçlarda geçmeyen kartların geçmesi için gerekli hukuki müracaatları yapmak gibi görevlerimiz var." (Kamu yararına çalışan Türkiye polis emeklileri sosyal yardım derneđinden gönüllü bir bayan).

Başlangıçta sadece dernek üyeleriyle araştırma hedeflenmiş ancak emekli derneklerine araştırmacı tarafından yapılan ziyaretlerde üyelerle sürekli etkileşimde olan dernek gönüllülerinin ve dernek yöneticilerinin görüşlerinin alınmasının daha uygun olacağı saptanmıştır. Görüşmeler 2014 yılının mart ve nisan aylarında araştırmacı tarafından gerçekleştirilmiştir. Görüşme süreleri en az 20 en çok 60 dakikadır.

Veri Toplama Araçları

Bu araştırmada derinlemesine mülakat tekniği kullanılmıştır. Görüşme sürecinde ortaya çıkarılması planlanan veriler için oluşturulan, soru veya başlıkların bir listesini çıkarılması ile görüşmede kullanılacak rehber form düzenlenmektedir. (Kümbetoğlu, 2012, s.75). Emeklilerin kendi deneyimlerinden hareketle ve kendi bakış açılarıyla emeklilik süreçlerini geçmiş ve bugün içinde yeniden yorumlama ve bunların gelecekteki görünümü üzerine düşünmelerini sağlama amacıyla görüşme formu düzenlenmiş ve uygulanmıştır.

Görüşmecinin kendisi de veri yaratımı sürecinin bir parçası olduğunun bilinciyle hareket edilmiştir (Yıldırım, 2008). Nitel araştırmalardaki bu öznellik 'keyfilik' anlamına gelmemektedir, veri analizi sürecini sistematik biçimde yapabilmek için, veriler analiz edilerek daha sonra kategorilere yerleştirme aşaması gerçekleştirilmiştir. Nitel veri analizinde güvenilirliği arttırmak ve sistematik çalışmayı kolaylaştırmak için nitel veri analizi programı Maxqda11'den analiz sırasında yararlanılmıştır.

Verilerin Analizi

Görüşmelerden elde edilen ses kayıtları çözümlenerek, nitel veri analizi programı Maxqda11'e aktarılmış, verilerin analizinde bu programdan yararlanılmıştır. Görüşmelerde yer alan sorular birer şemsiye kategori olarak kullanılmış, bu sorulara verilen yanıtlardan alt-kategoriler oluşturulmuştur. İlk adım in-vivo ile başlamış, ikinci aşamada sorulara verilen cevaplardan kategoriler düzenlenmiş, son aşamada ise kategori listesi emeklilikte aktif kalma ile ilgili teorik kavramlarca yeniden düzenlenmiştir. Kısaca, veri analiz sürecimiz verilerden kavramlara (somuttan soyuta) doğru bir ilerleme kat etmiştir. Analiz sırasında Maxqda11 programı, kodlama ve geri çağırma işleviyle adımların izlenmesini kolaylaştırdığından kontrol sürecine katkı sağlamıştır. Örneğin, kategorilerin yeniden düzenlenmesi aşamasında program sayesinde gerekli olduğu düşünülen düzenlemeleri yapabilmek mümkün olabilmektedir.

Bulgular: Yaşlılık ve İstanbul’da Emekli Dernekleri

“İnsanları onure eden, onların karamsarlığını dağıtan, benim sözüme itibar edilir, benimle konuşulur diyebilecekleri, kendi değerlerini ortaya çıkartabilecekleri, normal yaşama aktif olarak dâhil olabilecek sistemi getirmek istiyoruz.” (Görüşme, Satır Bey, 2014)

İstanbul’daki 23 emekli derneğinde yapılan gözlem ve görüşmelere dayalı bu çalışmada, emekli derneklerinin yaşlıların toplumsal yaşama aktif olarak katılmalarını destekleyici bir takım görevleri saptanmıştır.

Aktif Bir Yaşam ve Deneyim Paylaşımı için Derneklerde Gönüllü Olmak

Emekli derneklerinde gönüllü olmanın yaşama aktif katılımı sağladığı söylenebilir. Araştırma kapsamında görüşme gerçekleştirilen derneklerdeki gönüllülerin, dernek faaliyetlerinde rol almaları, onların eksilen sosyal ilişkilerinin yerine yenilerini koymalarına, toplumsal yaşamda daha fazla aktif olmalarına yaradığı belirlenmiştir. Emekli derneklerinde üye ya da gönüllü olarak çalışmaya başlayanlar hem bir faaliyet içerisine girmekte hem de manevi bir tatmine erişmektedirler:

“Emekli derneğinde gönüllü olduğumdan beri, akşam eve huzurlu gidiyorum, eskiden akşamları uyuyamazdım, şimdi manevi olarak öyle huzurluyum ki ertesi günkü yapılacakları planlıyorum, Ahmet amcaya gideceğiz, Aysel teyze, Fatma abla acaba nasıl oldu. Müthişte huzurluyum. Burada maddi kazancımız yoktur. Ancak 30 sene devlete hizmet ettik, 30 senede bu büyüklerimize hizmet ederiz manevi olarak ben çok mutluyum.” (Görüşme, Memiş Bey, 2014)

Emeklilik sonrası yaşadığı sıkıntıları anlatan bir başka gönüllü ise emekli olup dernekte gönüllü olarak çalışmaya başladıktan sonra rahatladığını ve artık bir “uğraşı” olduğunu söylemektedir:

“2008 yılında emekli oldum 2009 yılında da bir yıl evdeydim, kahveye gidemem, bir zaman sahilde yürü ama nereye kadar, ne yapayım evde karımın başının etini yiyeceğime karar verdim, dernekte gönüllü çalışırım dedim. Bir şeylerle uğraşmak gerekiyordu bende derneğin işleriyle gönüllü uğraşıyorum.” (Görüşme, Tuncer Bey, 2014)

Uzun yıllardır dernek yöneticisi olan bir katılımcı, emekli ve zihnen dinç olduğundan ve hâlâ yapacağı şeylerin olabildiğinden bahsederek dernekte gönüllü olarak çalışmalar yapmanın bir taraftan tecrübe aktarımını sağladığını diğer bir taraftan ise kendisinde topluma hizmet etmekle beraber bir *işe yararlık doyumunu, tatmini* yaşadığını belirtmektedir:

“Gönüllülük esasına dayalı olarak bu dernekte görev yapıyorum, ben emekliyim bir yerde çalışmıyorum kafamın verdiği imkânları birilerine aktarmalıyım. Tecrübelerimi aktararak onların güzel vakit geçirmelerine yardımcı olabildiğime dolayısıyla burada faydalı bir hizmet verdiğime inanıyorum. Ayrıca arkadaşlarla geçmişten gelen birliklikleri devam ettiriyorum.” (Görüşme, Satır Bey, 2014)

Emekli derneklerinde gönüllü olmak, öncelikle yaşama aktif katılım sağlamanın bir aracı görülmekte, gündelik hayata hareket kazandırmakta, insanların tecrübelerini aktarmalarını, becerilerinden diğer insanlara fayda sağlamlarını ve topluma yararlı bir iş yapmaktan ötürü manevî bir tatmin duyarak kendilerini daha huzurlu hissetmelerini sağladığı söylenebilir. Emeklilik sonrasında ya çok ender ya da hiçbir zaman başka insanlarla bir araya gelmeyen ve sosyal ilişkileri eksilen ve farklılaşan yaşlı bireylerin yeni sosyal ilişkiler arayışında olduğu bilinmektedir (İ. Tufan, 2003, s. 244). Bu anlamda kişi emeklilik sonrası boş zaman etkinliklerine gönüllü olarak toplumsal hayata eklenmeye çalışmaktadır (Akçay, 2011, s. 208). Bu bağlamda emeklilerin gerek derneklerde gerekse diğer sosyal alanlarda aktif olarak roller almaları ve gönüllülük faaliyetlerine katılmalarının desteklenmesi ve emekli derneklerinin sayısının artırılması gerektiği ileri sürülebilir.

“Kafayı Dağıtmak”: Bir “Muhabbet Mekânı” Olarak Emekli Dernekleri

Emekli derneğinde *eski dostlar* bir araya gelerek tecrübelerini paylaşır, sohbet ve muhabbet etmektedirler. Zira insanlarda konuşmak ve paylaşmak isteği, yaş ilerledikçe artmakta ancak dinleyecek kişiler bulunamamakta, bulunsa bile bu kişilerin sabırları ve zamanları söz konusu yaşlıları dinlemeye yetmemektedir. Benzer geçmişleri/yaşantıları olan emekliler dernek bünyesinde bir araya gelerek konuşma ve paylaşma ihtiyaçlarını karşılamakta, “şakalaşmakta”, “oyunlar oynamakta” ve “rahatlamakta” dırlar.

“Genelde emeklinin belli bir yaştan sonra konuşmaya ihtiyacı vardır. Her gün duvarlara bakarak yaşadığından için, bir insanla karşılıklı konuşmaya ihtiyaç duyar. Biz ona dernekte çay ikram ederiz ya da açsa yemek söyleriz burada soluklanır, gider. Kafasını dağıtmış olarak bastonuna dayanarak gider.” (Görüşmecisi, Satır Bey, 2014).

Derneklerde insanların buluşmaları ve paylaşımında ve etkileşimde bulunmaları sosyal roller bağlamında onları aktif hâle getirmektedir. Diğer bir buluşma alanı ise “*emekli parkları*”dır. Emekli derneklerinin emekli parklarından farklı yönlerinin vurgulayan bir katılımcıya göre emekli dernekleri, aynı meslekten gelen insanların bir araya getirmekte ve böylelikle geçmiş sosyal ilişkilerin burada da sürdürülmesine olanak tanımaktadır.

Dolayısıyla insanların, park gibi daha heterojen bir yapıda olan kamusal mekanlar yerine kendilerini ait ve rahat hissettikleri ve sürdürülebilir ilişkiler kurdukları emekli derneklerini tercih ettikleri söylenebilir:

“Burası için ideal hatıraları anlatmak, parkta otur bir saat, iki saat sonra kimi bulacaksınız anlatmak için sonra kendi kendine konuşmaya başlarsın, emekli parkı var bu muhabbeti konuşmayı orada kuramazsın. O parkta kimi bankadan emekli kimi başka yerden emekli, ayrı dilleri konuşuyorlar. Bir bankadan ne anlar şimdi gemici, burada sansür yok, küfürlü konuşmalar olabiliyor ve insanlar birbirlerine anlayış gösterebiliyor.” (Görüşme, Şenkal Bey, 2014)

Katılımcılardan bir kısmı ise sohbetlerinin gençler tarafından ilgi çekici bulunmadığını, dolayısıyla kendilerini uzun süreli ve sabırla dinleyecek birilerini bulmakta güçlük çektiklerini sıklıkla dile getirmişlerdir:

“İnsanlar belli yaşa geldiğinde sevgi saygı beklerler, konuşmaya ihtiyaçları vardır. Gençler yaşlıları dinlemek istemiyor. Tamam amca diyorlar ancak onlar konuşmak istiyor onları sabırla dinleyecek insan lazım, aynı şeyleri tekrar tekrar anlatsalar da kırmadan konuşmak lazım.” (Görüşme, Memiş Bey, 2014)

Kahvehane Yerine Lokal: Toplanma Mekanı Olarak Dernekler

Bir buluşma mekanı olan emekli dernekleri aynı zamanda karşılama, ağırlama ve danışma işlevlerini de üstlenmektedir. Genellikle daha yakından gelen emeklilerden bir kısmı zaman ve finans açısından maliyet gerektirse bile kimi durumlarda kentin uzak bölgelerinden de gelerek vakitlerini dernek mekanında geçirebilmektedir.

“Emekli derneğinin arkadaşlarımızın buluşma yeri, kültür merkezi olmasını arzu ediyoruz. Bir iletişim kurma merkezi olarak kullanırız, örneğin arkadaşımız gelir onu ağırlarız, karşılama mekanı olarak kullanırız.” (Görüşme, Kırıl Bey, 2014)

“Bakırköy’den 85 yaşında bir büyüğüm her gün saat 8 de oradan çıkıp masraf yapıp buraya, arkadaşlarıyla sohbet etmek için her gün buraya, geliyorsa derneğin önemi burada sosyologların, psikologların belediyedekilerin dikkat etmesi gereken şey budur.” (Görüşme, Memiş, 2014)

Emekliler öncelikle genellikle evden başka bir yerde vakit geçirmek istemektedirler. Zira evin bir düzeni olduğunu belirterek “hanımları” tarafından oluşturulan bu *düzeni* bozmak istemediklerini ifade etmektedirler. Bununla birlikte emekliler mahallelerde çokça bulunan kahvehane yerine derneğe gitmeyi tercih etmektedir: *“Derneğin lokalini toplanma mekanı olarak kullanırız, beyler kahveye gidemiyor, eski arkadaşların toplandığı stres attığı yer olarak işlev görüyor.” (Görüşme, Korkmaz Bey, 2014)* Derneğin tercih edilmesinin nedeni olarak, kahvehanede her yaşta insanın olduğu ancak dernekte benzer meslekten emeklilerin ve belli bir yaşın üstündeki kişilerin olduğu belirtilmiştir. Bununla beraber bu

tercihin daha önemli ve asıl nedenlerinden biri de yaşlı kişilerin kahvehane ortamında “alaya alınmaları”, *hakarete maruz kalmaları* ve “*dışlanmaları*” olarak ifade edilmiştir:

“Evde sistem kurulmuş hanımın bir düzeni var belirli bir yaş gurubunda insan mahalledeki kahveye gittiği zaman çeşitli meslekten çeşitli yerlerden gelmiş veya iş sahibi işsiz oradakiler tarafından üç beş gün içerisinde onlar tarafından alaya alınırlar. Bu çok önemli bu kişilerin buraya gelmelerindeki en büyük sebep bence bu buraya geliyor ki insan aynı frekanstan yayın yapıyoruz biz burada yeni emekli ast subayla 92 yaşında emekli aynı şeyleri konuşabiliyor, aynı tabirleri konuşabiliyor, aynı sorunları paylaşabiliyor, ama düşünün şu arkada bir kahvede gidildiğinde birinci gün hoş geldin ikinci gün hoş geldin derler, üçüncü gün ise moruk derler ve dışlarlar.” (Görüşme, Memiş Bey, 2014)

“...evde oturuyordur, canı sıkılır bir insanla konuşmak için çıkar, gidebileceği yer kahve olmaz kimseyi kahvede tanımıyor kimseyi konuşamaz en yakın emekli derneğine gelir buranın üyesi olması şart değil onunla hayırdır, nedir ne değildir şeklinde sohbet ederiz.” (Görüşme, Satır Bey, 2014)

Toplanma mekânı olarak emekli dernekleri, kahve, kafe, park vb. yerlerden farklı olarak yaş, meslek, sosyoekonomik, toplumsal statü düzey homojenliğine olanak sağladığı için tercih edilmektedir. Bununla beraber toplumdaki yaşlı adamın ne işi var kahvehanede otursun evinde algısının da kişilerin kahvehanelerden ziyade emekli derneklerinin lokallerinde bir araya gelmelerine neden olduğu söylenebilir.

Hatıraların Paylaşıldığı Mekânlar

Emekli dernekleri aynı zamanda hatıraların paylaşıldığı bir mekan olarak işlev görmektedir. Emekli derneklerinin belirli bir yaşanmışlığı, deneyimi paylaşabilmek, anıları tazelemek için hareketlilik sağladığı, kamusal alana çıkmaya ve böylece aktif kalmaya olanak sağladığı ileri sürülebilir. Emeklilik sonrası durağan gündelik hayatın getirdiği olumsuz duygu durumunu aşmanın yollarından biri olarak emekliler, kendilerini anlayabilecek ve benzeri yaşantılara sahip kişilerle hatıralarını paylaşmaktadırlar:

“Belirli bir yaştan sonra geride kalan anılar oluyor. Anıları paylaştığımız bir yerdir burası, 80 yaşındaki üyemiz merdiven çıkarak gelir, asansör olmamasına rağmen, birbirimizi görmek hasret gidermek için maddi sebeplerde asansörlü yer olmamasına rağmen yine de geliyorlar. Bir zaman sonra birbirimizi görme isteği oluyor. (Görüşme, Alptekin Bey, 2014)

Emeklilerin üzerinde sıklıkla durdukları ve birbirlerine anlattıkları konuların başında meslek hayatlarına dair *hatıralar* gelmektedir. Çoğu zaman aynı meslekten insanların anlayabilecek ve ortak olabileceği hatıralar anlatılmaktadır:

“Dernekte meslekteki hatıralar canlanır ve saatlerce konuşurlar. Herkes eline bir şey alır börek alır çörek alır gelir burası kendiliğinden bir okul havasına döner.” (Görüşme, Satır Bey, 2014)

“[Emekli derneğine gidiyorum çünkü], eski arkadaşların bir araya gelip, birbirleriyle konuşmak eskileri yâd etmek, eskilerden haber almak, yanımdaki İsmail amcanın anlattıklarını dinlemek, arkadaşımın ya da başkanla konuşmak ondan sonrada çıkıp evime gitmek [güzelidir]” (Görüşme, Özkan Bey, 2014)

Araştırmacı derneklerde resim ve yazı panolarının oluşturulduğunu, internet sayfasında ya da fotoğraf albümlerinde dernek üyelerinin ortak anılarının yaşatıldığını gözlemlemiştir. Emekli dernekleri geçmişle günümüz arasında köprü kurmakta, zorunlu bir biçimde görece azalan aktivitelerini, hatıraları anımsayarak artırmakta ve bir nevi sosyal terapi (Newman, 2003) sağlamaktadır.

Yeni Arkadaşlar Edinmek ve Yalnızlıkla Baş Etmek

Emekli dernekleri yeni arkadaşlarla tanışma fırsatı sunduğu söylenebilir. Derneklerdeki tanıdıklar farklı kişilerle tanışmayı sağlamakta ve emeklilerin yeni arkadaşlıklar edinmesini sağlamaktadır. Burada çapraz tanıdıklar vasıtasıyla yeni bir “sosyal çevre” inşası söz konusu olmaktadır:

“Tanışıklığımız işe, denize dayanıyor, diyelim ben bunu tanıımıyordum da kardeşim tanyordu, onunla birlikte geldi. Olduk arkadaş benim Metin diye kardeşim var onunla çalışmış ve buraya geldiler ve arkadaş olduk.” (Görüşme, Sivri Bey, 2014)

Yeni arkadaşlar yalnızlıkla başa etmeye ve sosyalleşmeye önemli katkılar sunmaktadır. Yaşlılıkta temel sorunlardan olan yalnızlığı giderebilmek, azaltabilmek için aileden olmak gibi belirli ortaklıklara ihtiyaç vardır. Meslek ortaklığı sayesinde emekli derneklerinin bu imkanı sağladığı araştırmada görülmüştür. “O insana ben nasıl yardımcı olurum o insanı evinden çıkarıp ta burada bir çay içmesini nasıl sağlayabilirim.” (Görüşme, Satır Bey, 2014) diyen bir dernek yöneticisi evinde yalnız yaşayan üyelerinin olduğunu ve ilerleyen yaşıyla eve kapanmak zorunda hisseden üyelerin derneğe gelmek, derneğin faaliyetlerine katılmak sayesinde toplumsal yaşamda aktif kalabildiklerini vurgulamıştır.

Yaşlıların yalnızlığını gidermek, onları hatırlamak ve temasa geçmek için çeşitli stratejiler geliştirildiği söylenebilir. Özellikle özel günlerde bir takım etkinlikler yapılmaya çalışıldığı ve yaşlıların bunlara katılımının sağlanmaya çalışıldığı görülmüştür:

“Bilgisayar Sistemimizde doğum günleri var o gün doğanları arayıp, mutlu bir yaşam, sağlıklı bir ömür gibi iyi dileklerimize geri dönüşler iyi oluyor. Karamürsel’den bir kadın üyemizi aradık, ben bile unutmuştum dedi, bu yaşta ne kadar mutlu olmuş, bizde onların geri dönüşlerinden memnun oluyoruz.” (Görüşme, Özcan Bey, 2014)

Diğer taraftan dernekler, gönüllüleri aracılığıyla yalnız yaşamak zorunda olan yaşlıları ziyaret ederek onlarla bir arada olmakta ve eğer varsa ihtiyaçlarını gidermektedir:

“Üyelerin %80’i, 75 yaş ve üstüdür, huzurevinde olan ve evinde yatalak olup ta dışarı çıkamayan en az 70-80 üyemiz var, dernek başkanı olarak belirli bir yaşa gelmiş vatanına milletine hizmet etmiş insanların bu zor günlerinde yanlarında olabilmek isterim. Bu amaçla en büyük ağırlığı, hasta ziyareti, huzurevi ziyareti, bu tip ziyarete ayırdık. ...2 üyemiz var hatta bir tanesi vefat etti onun defin işlerinde tören işlerinde yardımcı olduk. Evinden çıkamayan yatalak halde 60 üyemiz var belirli periyotlarla belirli liste halinde onları ufak tefek hediyelerle ziyaret ediyoruz.” (Görüşme, Memiş Bey, 2014).

Hobiler Geliştirme ve Uygulama İmkanlarının Sunulması

Havinghurst’a göre (a) Meslek yaşamından ayrılıktan sonra kaybolan sosyal ilişkilerin yerine yenilerinin konması gerekmektedir. (b) Yaşlılar için, kendi getirdiği randımandan memnuniyet duymasını sağlayacak yeni aktivitelerin hazırlanması gerekmektedir. (c) Zamanını monoton akışına engel teşkil edecek yeni bir günlük ve haftalık zaman ritminin oluşturulması gerekir. Yaşlı kendisinin belirlediği görevleri belli bir tempoyla yerine getirmeli ve alışkanlıklar edinmelidir. (d) Yaşlıyı motive edici koşullar oluşturulmalıdır (aktaran Tufan, 2003, s.272). Emekli derneklerinin yeni sosyal ilişkilerin dışında kişilerin yeni aktiviteler kazanmasına olanak sağlayacak hobi geliştirme etkinlikleri düzenlediği ve uygulama imkanları sunduğu söylenebilir:

“Emekliliğe önceden hazırlık yapmalısınız, emekli olduktan sonra ben ne yapacağım diye düşünmek boşluğa düşmeye sebep olabilir. Hobi anlamında bir şey yapılacaksa bu ancak parayla olurun arkasına sığıyoruz, böyle bir şey yok, kültürel imkanlar da önemlidir. Erkeklerin çorap ördüklerini duyuyorum bu da bir hobidir.” (Görüşme, Yalvaç Bey, 2014)

Emekli olup belli alanlarda becerileri olan kişilerin mevcut çalışmalarını sürdürmeleri desteklenmekte diğer kişilerinde bu etkinliklerden faydalanması sağlanmaktadır:

“Emekli arkadaşlara yönelik o arkadaşları köreltmek için bakın üyelerimizde Günay arkadaş ressamdır, heykeltıraştır. Bir arkadaş resim yapar sergi sergiler imkan hazırlarız ya da başka alanda mesela edebiyat dalında çalışmak isteyebilir, ona da yardımcı oluruz.” (Görüşme, Satır Bey, 2014)

Üyelerin ya da gönüllülerin hobilerinin geliştirilmesine hem maddi hem de manevi destek sağlanmaktadır. Bunun için gerekli ortam oluşturulmakta, malzeme desteği verilmekte ve gerekli motivasyonlar oluşturulmaktadır:

“Emekli amatör kayıkçılar derneği sayesinde hobilerini devam ettiriyorlar, hobi uygun saatlerde denize çıkmak, balık tutmak, yada yan yana olan teknede çay demlemek, bazen de tekne temizlemektir. Deniz hobisinin dışında teknenin ahşap işini yapmak boyasını yapmak onların hobisidir. Üyemiz kısıtlı imkanlar dahilinde bazen sanatkar olabilir. Mesela tekneye branda malzemesini siz alıp yaparsanız daha az maliyet tutar ve bu da bir hobidir.” (Görüşme, Yalvaç Bey, 2014)

Sosyoekonomik düzeyi yüksek, subay, bankacı vb. gruptan emeklilerin kurduğu emekli derneklerinde, üyelerin hobi geliştirmede ve ortaya çıkan ürünleri sergilemede daha aktif rol aldıkları söylenebilir. Hobilerde emeklilik öncesi alışkanlıkların etkili olduğu ve bu yüzden emekliliğe hazırlığın emeklilik sonrası aktif kalmada önemli olduğu belirlenmiştir. Emekli derneklerinde hobi geliştirmeyi desteklenmesi, özellikle yerel yönetimlerin bu konularda aynı ve nakdi yardımlar da bulunması gerektiği önerilebilir.

Sosyal Kültürel Etkinliklerin ve Eğitimlerin Düzenlenmesi

Emekli derneklerinde gezi, resim sergileri, konser ve tiyatro faaliyetleri yapılmaktadır. Ziyaret edilen 20 emekli derneğinin 12'sinde çeşitli gezi organizasyonları, sergiler, tiyatro faaliyetleri tespit edilmiştir. Sosyoekonomik düzeyi yüksek kategoride yer alan emekli derneklerinde sosyal etkinlikler daha fazla gözlemlenmiştir. Bu bağlamda emeklilik öncesi yaşam pratikleri ileri yaşlarda sürdürebildiği söylenebilir:

“Gezi faaliyetlerimiz daha çok kışın olur, çünkü yazın emekli üyelerimizi burada bulmak çok zordur. 9 Mayıs'ta İskenderun'un tarihi kültürel yerlerini gezeceğimiz bir kültür gezisi düzenliyoruz.” (Görüşme, Ergürbüz Bey, 2014)

Emekli dernekleri tur şirketleriyle irtibat kurup, gerek şehir içi gerekse şehir dışı, az da olsa yurt dışı gezileri organize etmektedirler. Gezilerin katılımındaki düşüklüğün en önemli nedeni olarak, ekonomik sebep sayılırken, geziler konusunda derneklere belediyeler aracılığıyla araç tahsisi yapılarak gezi maliyeti düşürülüp katılımın artırılabilmesi saptanmıştır.

Emekli derneklerinde çeşitli konularda eğitim faaliyetlerinin düzenlendiği, bu faaliyetlerde emekliler, hem eğitim verici, hem de dinleyici olarak yer aldıkları belirlenmiştir:

“Konferanslarda başta prostat olmak üzere çeşitli hastalıklarla ilgili yeni gelişmeler adapte olmasını sağlar. Burada konferansı veren hekimle irtibatını sağlıyoruz ve bu şekilde aktif olmasını sağlıyoruz. Belli bir yaş üstünde unutulmuşluk hissi yaşayanlara yeni gelişmeleri aktarmış oluyoruz.” (Görüşme, Satır Bey, 2014)

“Kentsel dönüşümle ilgili hukuki haklarla ilgili bilgilendirme konuşmaları yapılır. Yaşlılıkla ilgili konferanslar yapılır, alzheimer hastalığı ile ilgili bilgilendirme semineri yapılıyor. Cep telefonuyla mesaj üzerinden program bilgileri üyelere ulaştırılır.” (Görüşme, Ergürebüz Bey, 2014)

Özellikle sağlık alanında üyelere bilgilendirme programları yapılmakta, ayrıca emekli derneği, uzman doktorlarla üyeler arasında irtibatı sağlayarak, aracı kurum özelliği göstermektedir. Aynı zamanda üyeler var olan eğitimlerden haberdar edilmekte ve çeşitli kurslara yönlendirilmektedir:

“Üyelerimizi halk eğitim kurslarına göndeririz. Bir üyemiz 73 yaşında bilgisayar kursunu birincilikle bitirdi. Torununa inat sen ne anlarsın demiş, üyemiz bize teşekkür etti, kursa katılan üye nasıl bitiririm derken birinci oldu. Bu tarz kurslara katılıp sertifika alınıyor, ayrıca resim fotoğrafçılık kursları da açabiliyoruz.” (Görüşme, Tuncer Bey, 2014)

Bu türden eğitim faaliyetleri genellikle dernek üyelerinin birinci derece yakınları ya da tanıdıkları uzman kişiler tarafından verilmektedir. Söz konusu kişilerle irtibata geçilip kendi uzmanlıkları ile ilgili bilgi ve destek alınmaktadır:

“Üyelerimizin çocuklarının, torunlarının bilgileri alınıp; onların doktor olanlarından yaşlılarda şeker, kalp, prostat ve dişle ilgili belirli zamanlarda bilgilendirme yapmalarını istiyoruz ve az da olsa tıbbi olarak yardım alabiliyoruz. Haftanın şu günü şu kişi tarafından prostatla ilgili bilgilendirme yapılacaktır şeklinde üyelere duyuruyoruz.” (Görüşme, Memiş Bey, 2014)

Yapılan eğitim faaliyetleriyle güncel meseleler kentsel dönüşümden çeşitli hastalıklara kadar birçok konudaki tartışmalar üyelerle paylaşılmaktadır. Bu eğitim programları genellikle sağlık alanında olmakta, resim, boyama el işi gibi alanlarda da olabilmekte ve emeklinin bireysel aktifliğine katkı yapmaktadır.

Kutlamaların ve Törenlerin Organizasyonu

Araştırma kapsamında ziyaret edilen 20 emekli derneğinin 17 tanesinde yemek vb. organizasyonlar ve çeşitli törenler yapılmaktadır. Bu tür organizasyonlar üyeleriyle aktif bir biçimde ilişkilerini sürdürmelerine olanak tanımaktadır. Özellikle asker emeklileri milli bayramlara katılım sağlanmakta, yemekli organizasyonlar düzenlenmektedir:

“Devletin kutladığı milli günlerimizde bizde Üsküdar ilçesi anma tören alanında, çelenk koyarız. Törene katılmak isteyen üyelerimizi minibüsle tören alanına götürür ve getiririz. Senede iki defa askeri gazinoda yer ayırttırırız 40-50 kişi eşlerle birlikte yemek yer muhabbetimizi ederiz.” (Görüşme, Satır Bey, 2014)

Emekli derneklerinde kaynaşma ve toplanma organizasyonları düzenlenmekte ancak ekonomik ve ulaşım sorunlarının bu organizasyonların yapılmasında ya da katılımcıların

sayısına olumsuz etki ettiği görülmüştür. Bununla birlikte yaşlanmayla beraber sosyal saygınlık azalmaktadır. Dernek üyelerine çeşitli organizasyonlarla belgeler verilerek yaşlının kendisine olan saygısını sürdürdüğü söylenebilir:

“Derneğe üyelikte 25 yılını doldurmuşlara onur belgesi takdim edildi. Gelirken sanki salon subayı gibi grand tuvalet geldiler, bunun yanında kızını dünürünü getirenler oldu. Bu onlar için onur verici bir durum, bu üyemiz buraya 25 yıldır hizmet ediyor. İsimleriyle birlikte resimlerini web sitemizde yayınlayarak onları onure ettik.” (Görüşme, Satır Bey, 2014)

“Derneğin kuruluş yıl döneminde her dernekte en yaşlı üye şilt verilir 17 Ekimde dünya astsubaylar günü etkinliğiyle kutlanılır.” (Görüşme, Memiş Bey, 2014)

Diğer taraftan üyelerin ya da gönüllülerin vefatları söz konusu olduğunda cenaze merasimleri organize edilmekte ya da taziye için organizasyon düzenlenmektedir:

“İstanbul içi olan cenazelerde taziye yemeği organize ediyoruz, dernek gönüllüleri olarak tanışak ta tanınmasak ta cenazelere katılmaya çalışıyoruz.” (Görüşme, Özcan Bey, 2014)

“Her yıl beş on üyemizi ölüyor, tören v.s. dini işlemlerine yardımcı oluyoruz daha sonra geride kalan mirasçılarına resmi prosedür işlemlerinde de yardımcı oluyoruz.” (Görüşme, Memiş Bey, 2014)

Danışma ve İletişim Merkezi Olarak Emekli Dernekleri

Emekli derneklerinin en önemli özelliklerinden adeta birer danışma merkezleri olmasıdır. Bu kapsamda emekli dernekleri üyelerine ve/veya gönüllerine bilgi vermekte, sorun yaşamaları durumunda yönlendirmelerde bulunmaktadır. Bu kapsamda emekli dernekleirnin yalnız ve yaşlı üyeleri ile yaşlılara hizmet sunan kurumlar arasında “*tampon görevi*” üstlendiği söylenebilir:

“Benim 80 yaş üstü 40-50 üyem var, eşleri ölmüştür evde yalnız başlarındadır. Telefon açarlar bizden yardım ister, bakıcı ister. İlgililerle temasa geçerek bakım hizmeti almalarını sağlarız, çeşitli aktiviteleri onların oralardan almalarını sağlarız.” (Görüşme, Satır Bey, 2014)

Emekli dernekleri aylık ve yıllık olarak yayınladıkları dergi ve bültenlerle üyelerine yapılan faaliyetleri ve üyelerle ilgili önemli bilgileri duyurmakta ve böylece emeklilerin birbirleriyle iletişimde kalmalarını sağlanmaktadır:

“Emekliler genelde pasif insanlardır. Sözü dinlenmez ilgi sahası çok düşüktür. Derdini anlatacağı yer bulamaz üyemiz bir yerde gitmiştir orada haksızlığa uğramıştır. İmkani gücü olmadığı için mahkemeye başvuru yapamayacaktır, gelir dilekçeyle şöyle yaptılar diye bize danışır, biz de ilgili makamlara yazı yazarak üyemizin hakkının aranmasını sağlarız.” (Görüşme, Satır Bey, 2014)

Bir iletişim merkezi gibi çalışan emekli dernekleri sağlık sorunlarının çözülmesinde, emekli maaşlarıyla ilgili problemlerde ve sosyal güvenlik konularında önemli roller üstlendikleri söylenebilir:

“Yaşlı emekliler telefonla emeklilerin irtibatını sağlamış oluyor dernek, sağlık merkezimizin telefonunu istiyor derneğin faksına sevk bilgilerinin gelmesini istiyor. Sağlık merkezi, iç hat onunla uğraşmak istemiyor. İşin kolaylığı nasıl olsa dernek var, o bize doğru bilgiyi verir. Bir keresinde ölen eşinin maaşının bağlanması için, ben üç yeri aradım ölüm servisi maaş orası da kurula bağladı kurula girmiş ay sonunda maaş bağlanacak, yaşlı kendi santral telefonundan arasa ulaşamayacak, bizi aradı onun yerine biz o hizmeti yaptık. Kendisine döndük ay başında maaşının geçeceğini bildirdik.” (Görüşme, Özcan Bey, 2014)

Diğer taraftan emekli derneklerinin bir kısmı sosyal yardım ve dayanışma olanağı da sağlayabilmektedir. Bu kapsamda zikredilen çalışmalardan biri Ramazan ayında kumanya dağıtımdır:

“Ramazan bayramlarında mümkün olduğu kadar ihtiyaç sahibi olan üyelerimize ya da yakın çevredakilere kumanya dağıtımı yapılıyor. 100 e yakın kumanya hazırlıyoruz. Belediyenin belirleyemediği göremediği kişilere 50 tanesine üyeler aracılığıyla gerçekten ihtiyaç sahiplerine ulaştırırken 50 tanesi de muhtarlık kanalıyla ulaşıyor. bu kumanyalara hem dernek bütçesinden hem de üyelerin kendi bütçelerinde katkı yapılıyor.” (Görüşme, Memiş Bey, 2014)

Sonuç ve Tartışma

İstanbul'daki emekli derneklerinden 23 tanesinin incelendiği ve gözlem ve görüşmelere dayanan bu çalışmada emekli derneklerine katılımın sosyo ekonomik düzeyi orta ve yüksek olanlarda daha fazla olduğu belirlenmiştir. İncealtın'ın yaptığı (1999) araştırmada da emekli derneklerine katılım gösteren kişilerin büyük çoğunluğunun gelir ve öğrenim düzeyinin yüksek olduğu sonucuna varılmıştır. Bundan dolayı çalışma bulgularının sosyo ekonomik düzeyi orta ve üstü olan emeklilerle ilişkili değerlendirilmesi gerekmektedir.

Araştırma verilerine göre emekli derneklerinin üyeler arasındaki ilişkilerin devam ettirilmesiyle meslek sonrasına uyumda ve emeklilerin sosyal sorumluluk almalarında etkin oldukları görülmektedir. Bu dernekler aracılığıyla zihinsel üretkenliği devam ettirme isteği ve üyelerin faaliyetlere gönüllü katılmaları, yaşlıların modern yaşamda toplumsal alandan geri çekilmediklerini aksine değişen dozda aktifliklerini devam ettirdiklerini göstermektedir. Emekli dernekleri birikimleri köreltmek istemeyen yaşlıların deneyimlerini açığa çıkartabildikleri yerler olarak bir görünür olma mekanı olabilmektedir. Dolayısıyla emeklilik sonrası yaşama uyum sağlamaya yönelik aktivitelerin desteklenmesi (Tufan, 2003, s. 245) ve bu kişilerin toplumsal sorumluluk üstlenmeleri gerektiği (İlgar, 2008, s.

81) ve bunun sağlanmasında emekli derneklerinin önemli bir işlev üstlenme potansiyeli olduğu söylenebilir.

İncealtın (1999) çalışmasında, emekli derneklerindeki yaşlıların önemli bir bölümünün “boş vakitleri değerlendirme ve sosyo-kültürel etkinlikleri devam ettirme” ihtiyaçlarını karşılamak için üye olduklarını saptamıştır. İstanbul’daki emekli derneklerinin bir kısmının incelendiği bu çalışmada da, yaşlıların var olan yeteneklerini çeşitli platformlar aracılığıyla sürdürdükleri, emekli dernekleri, üyelerin hobilerini devam ettirmelerine olanak sağladığı görülmüştür. Emekli dernekleri geziler, sergiler ve eğitim faaliyetleri düzenleyerek, yalnızlaşan ve itibar kaybı yaşayan emeklilerin, bu dernekler sayesinde itibarlarını sürdürmelerine yardımcı olduğu belirlenmiştir. Emekli derneklerinde aktivite kuramında belirtildiği üzere yaşlıların değişen durumlara adapte olarak aktifliklerini devam ettirdikleri (Canatan, 2008) söylenebilir. Hatıraların paylaşıldığı, arkadaşlıkların sürdürüldüğü, kahvehane yerine dernek lokalinde buluşulup, muhabbet edildiği kurumlar olarak emekliler süreklilik kuramında (Akçay, 2011; Canatan, 2008) belirtilen rol ilişkilerini, emekli derneklerinde arkadaşlarıyla bir araya gelerek devam ettirebilmektedirler.

İncealtın (1999) dernekteki yaşlıların bir kısmı, derneklere “yalnızlık hissinden kurtulmak, arkadaş edinme”, gibi ihtiyaçlar için üye olduklarına ilişkin sonuçlara ulaşmıştır (İncealtın, 1999). Emekli dernekleri, yaşlıların yalnızlık hissinden kurtulmalarına yardımcı olduğu bu çalışmanın da önemli sonuçlarından biridir. Ayrıca dernek sayesinde emekliler yeni arkadaşlıklar edindikleri ve sohbet/muhabbet edebilme ortamı sağlaması sayesinde, emeklilerin psiko sosyal açıdan rahatladıkları göze çarpmaktadır. Ayrıca İncealtın (1999) emeklilik sürecine çok iyi hazırlanılması gerektiğini çalışmasında vurgulamaktadır (İncealtın, 1999). Bu çalışmada da, emeklilik öncesi hazırlık yapmanın, emeklilik döneminde, yaşlılıkla baş etmede önemli bir olgu olduğunu belirlenmiştir.

Yapılan araştırmalarda emekli derneklerinin şu işlevleri yerine getirdiği sonucuna ulaşılmıştır. (a) Emekli dernekleri insanların sosyal ihtiyacı olan ait olma duygularını tatmin etme işlevini yerine getirmektedir. İnsan olarak birçok sosyal gereksinimle doğarız. İnsanoğlu, aileye, derneğe, spor kulübüne, dine, millete ait olmak ister (Cüceloğlu, 2002). (b) Emeklilerin zamanları çoktur. Birbirlerini dinlemeye vakitleri vardır. Sonraki nesillerin onlara bu kadar zaman ayırmaları zordur (İlgar, 2008, s. 66). Bu bağlamda emekli derneği çatısı altında toplanan emekliler birbirleriyle muhabbet ederler. Emekli dernekleri anıların paylaşıldığı yerler olarak işlevseldir. Bu dernekler de hem anı anlatımına hem de anı dinlemeye imkan veren ve ortak dilin konuşulduğu sosyal bir alan görünümündedir. (c) Dernek üyeleri, eski mesai arkadaşlarıyla iletişim içinde olmak suretiyle zihnen dinç

kalabiliyor. Arkadaşlarıyla günün belirli saatlerinde etkin kalmaya yardımcı oluyor. Emekli olan üyeler, gerek günde en az birkaç saat dernekte vakit geçirerek, gerekse ziyaret, gezi, seminer ve toplantı organizasyonlarında bulunarak ileri yaşta bile toplumla etkileşimde kalabiliyorlar. (d) Emekli dernekleri emeklilerin ihtiyaçlarının tespit ve çeşitli platformlarda dile getirilmesinde fonksiyoneldir. (e) Emekli dernekleri aile içi ilişkilerin sürdürülmesinde işlevseldir. Erkeğin çalıştığı dönemde evde sürgit devam eden ilişki düzeni erkeğin emekli olmasıyla birlikte değişir. diğer aile üyelerinin yaşayışına daha fazla müdahil olmaya başlar. Bu da aile üyeleri arasında çatışmaya sebep olabilir. Bu çatışmanın önleyicisi olarak erkeğin emekli derneğine gitmesi ve dernekte zaman geçirmesi aile içerisinde ortaya çıkabilecek gerilimli ilişkiyi ve çatışmayı önlemektedir. (f) Yalnızlık yaşlılıkta temel sorunlardandır. Yalnızlığı paylaşmak aile, arkadaş ya da iş arkadaşlığı gibi belirli ortaklıklar gerektirir. Emekli dernekleri iş ortaklığı ve meslek ortaklığına dayanarak bir çeşit yalnızlığı paylaşma imkânı sunmaktadır. Özellikle yalnız yaşamak zorunda olan yaşlılar günün belli saatlerinde dernekte bulunmakla, yalnızlıktan kurtulmaktadır.

Nitel görüşmelere dayanan bu araştırma kapsamında önemli verilere ulaşılmıştır. Sınırlı bir zamanda gerçekleştirilen bu araştırmanın emekli dernekleri konusunda yapılacak yeni araştırmalarla desteklenmesi yaşlılık çalışmalarına katkı sağlayacaktır. Emekli derneklerindeki üyelerin sosyo ekonomik profillerinin çıkartıldığı ve bu derneklerin sosyal durumlara göre sınıflandırıldığı başka çalışmalara ihtiyaç vardır. Ayrıca bu çalışmanın bulgularının, Türkiye'deki emekli dernekleriyle ilgili yapılacak başka nitel ve nicel çalışma bulgularıyla hem desteklenmesi hem de karşılaştırılması gerekmektedir.

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SESSION VII

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Evaluation of Retired -People Friendly Antalya Project Study

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Abstract

Objectives: The aim of the Retired –People Friendly Antalya Project conducted by Antalya Police Organization make the city safer for elders. The main characteristic of this project which consists of various activities is to ensure participation of citizens to the attempt of fighting against crime. The aim of the project evaluation research is answering empirical the question of, to what degree the police was successful by side of elders.

Methods: Treatment group (participated in the project) with 18 questions and 6 index being designed according to these questions and Control Group (not participated in the project) are compared. Treatment group is of 500 individuals and Control group is of 100 individuals. All individuals in both groups are 60 years old and over.

Findings: On the contrary to the expectations of police calling the elders to participate in the project with the slogan of "Retirement is end of the working life but not living", it's determined by the research that the reason of elders participated in the project was not the fight against crime.

Conclusion: The comparison of these groups revealed that the project was evaluated "positive" by the participants and "negative" by the non-participants. On the other hand, it's determined that the reason why elders participate in the project and the expectations of the police are not overlapped.

Key Words: Crime, Retirement, Security, Police

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Emekli Dostu Antalya Projesi: Değerlendirme Araştırması

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Özet

Amaç: Antalya ili polis teşkilatı tarafından yürütülen Emekli Dostu Antalya projesinin amacı bu ilin yaşlılar açısından da daha güvenli hale getirilmesidir. Çeşitli aktivitelerden meydana gelen bu projenin başlıca özelliği vatandaşın suçla mücadele girişimlerine katılımını sağlamaktır. Projeyi değerlendirme araştırmasının amacı ise polisin ne ölçüde yaşlıların nazarında başarıya ulaşabildiği sorusuna ampirik cevap vermektir.

Metod: 18 soru ve bu sorulardan tasarlanan 6 indeks ile “projeye katılan” (Treatment grubu) ve “projeye katılmamış olan” (Kontrol grubu) karşılaştırılmıştır. Treatment grubu 500 kişiden ve kontrol grubu 100 kişiden meydana gelmektedir. Her iki gruptaki bireyler 60 yaş ve üzerindedir.

Bulgular: “Emeklilik çalışma yaşamının sonu, ama hayatın sonu değil” sloganı ile yaşlıların projeye katılması için çağrı yapan polisin beklentisinin aksine yaşlıların projeye katılım nedenlerinin suçla mücadele olmadığı araştırmada saptanmıştır.

Sonuç: Bu grupların karşılaştırması, projenin katılanlar tarafından olumlu değerlendirildiğini, katılmayanlar tarafından ise olumsuz değerlendirildiğini ortaya koymaktadır. Öte yandan yaşlıların projeye katılım sebepleriyle polisin beklentilerinin birbiriyle örtüşmedikleri de belirlenmiştir.

Anahtar Kelimeler: suç, emeklilik, güvenlik, polis

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Giriş

Yaşam süresinin uzaması ve buna bağlı olarak yaşlıların çoğalması, yaşlılıkta güvenliği de önemli konulardan biri haline getirmiştir. Antalya'nın nüfusu 1,92 milyondur. Yaşı 60 ve üzeri nüfusun sayısı 181.636'dur. Yani il nüfusunun %9,5'ini yaşlılar meydana getirmektedir. Her 10 yaşlıdan 3'ü 70-79 yaşında, %10,7'si 80 yaş ve üzerindedir (TÜİK, 2011).

Bu noktadan hareket ederek Antalya İl Emniyet Müdürlüğü Emekli Dostu Antalya Projesi (EDA) adı altındaki projeyi hayata geçirmiştir. Bu, yaşlılığın rollerinde değişim yaratan proje olarak dikkat çekmektedir. Yaşlılara, toplumun yardımcısı rolü proje yürütücüsü tarafından atfedilmiştir. Polis suçla mücadelede yaşlılara yeni roller vermek üzere yönelirken, bu araştırmada yaşlıların projeye katılmalarının ardında başka sebeplerin yatabileceği varsayımından hareket edilmiştir. Araştırma interdisipliner bir araştırma olarak yürütülmüştür (Gerontolojinin interdisipliner perspektifleri için örn. Bkz. Kruse & Martin, 2004). Gerontoloji yaşlanmanın biyolojik ve psikik süreçlerini ve yaşam dönemi olarak yaşlılığı sosyolojik açıdan incelemektedir (Backes & Clemens, 2000). Ayrıca sosyal politikalar için öneriler de getirmektedir (Schulz - Nieswandt, 2006).

Proje Üzerine Bilgi

EDA projesi yaşlıları kriminaliteye karşı korumak ve güvenliklerini arttırmak hedefini odak noktaya koymuştur. Antalya İl Polis Teşkilatı'nın 2008- 2012 yılları arasında AÜ Gerontoloji Bölümü Kurucusu Prof. Dr. İsmail Tufan'ın tasarladığı ve yürütücülüğünü yaptığı proje, kısmen yaratıcı stratejileriyle dikkat çekmektedir. Burada yaşlılar tarafından nasıl değerlendirildiği sorusuna ampirik cevaplar verilmektedir.

Demografik değişim nedeniyle yaşlıların topluma nasıl katkıda bulunabilecekleri sorusuna çeşitli alanlarda yeni cevaplar aranmaktadır. Çünkü yaşlıların pek çoğu gönüllü hizmetlerle topluma katkı sağlayabilecek yeterliktedir (Schulz-Nieswandt & Köstler, 2011).“Emeklilik çalışma yaşamının sonudur, yaşamın değil” sloganıyla başlayan EDA projesini bu açıdan görmek gerekir. Projenin orumluluğu Toplum Destekli Polis Şube Müdürlüğü'ndedir (TDP).

Yaşlıların topluma katılımı, sunulan olanaklara bağlıdır. Türkiye'de yaşlıların topluma katılım olanakları azdır. Yaşam dönem olarak yaşlılık, sosyal tabaka, cinsiyet ve kuşak faktörlerinin etkileri altında şekillenmektedir (Tufan, 2007). Türkiye'nin doksan yıllık

tarihinde polisin yaşlı vatandaşlardan suçla mücadelede işbirliği teklif etmesi, bir ilktir. Bu bile projeye ilgi duymak için yeterli sebeptir. Ama polis bunu teklif etmekle kalmamış, aynı zamanda kriminalite sorununu “yaşlıların gözüyle” görmek isteğini de dile getirmiştir. Bu, projeye yönelik ilgiyi daha da artırmıştır.

Antalya’yı yaşlılar açısından güvenli bir kent haline getirmek üzere, projenin kapsamında yaşlılara yönelik çeşitli etkinlikler düzenlenmiştir. Projenin tamamlanmasından sonra projeye katılan ve projeye katılmamış yaşlılardan (60 yaş ve üzeri) iki örneklemin karşılaştırılmasına dayanan ve projenin yaşlılar üzerindeki etkilerini (pozitif veya negatif) belirlemek üzere bir araştırma gerçekleştirilmiştir. Yaşlıların perspektifinden projenin nasıl algılandığı sorusuna bu şekilde cevap verilmektedir.

Proje tanıtım çalışmaları proje boyunca devam etmiştir. Yerel medyada projeden sıkça söz edilmiş, polisi mahalle etkinlikleri düzenleyerek projenin tanıtımını yapmıştır. Dolayısıyla projeye katılmayanlar da projeden haberdardır. Bu varsayımdan hareket ederek, araştırmanın “kontrol grubu” projeye katılmamış yaşlılardan oluşturulmuştur. “Treatment grubu” (yani üzerinde işlem uygulanmış grup) projeye katılmış olan yaşlılardan meydana gelmektedir (bu bağlamda “treatment” projenin kendisidir, proje bireyin üzerinde uygulanan işlem olarak kabul edilmiştir).

Kriminalite, Suç ve Yaşlılık

Günümüzden bir asır kadar önce kriminologlar, kriminel davranışların ardında biyolojik sebeplerin yattığına inanıyorlardı. Lambroso (1836-1909), anatomik yapısından kriminel kişiyi tanıyabileceğini söylüyordu. Kafa iskeleti, çene kemiği büyüklüğü ve kol uzunluğundan kriminel kişiyi diğerlerinden ayırt etmenin mümkün olduğunu iddia ediyordu (Giddens et al., 2009).

İklim değişimi kriminalite artışına yol açabilir mi? Arkeloji, Coğrafya, Siyasal Bilimler, Ekonomi ve Psikoloji alanında toplam 61 araştırma bu soruya yanıt aramıştır. Bunların 27’si 1950’den sonra gerçekleştirilmiştir. Bu araştırmaların meta analizi, ısının bir miktar yükselmesi ve yağmur miktarının artmasının bile insanlar arasındaki çatışmaların çoğalmasına yol açtığını göstermiştir. İklim değişimi ve çatışmalar arasında istatistiksel manidar bağlantı bulunduğunu gösteren araştırma eleştirilmektedir. Bu araştırmanın sadece güçlü etkileri dikkate aldığı, sadece dikkat çekici iklim olaylarının, örneğin aşırı sıcaklıkların araştırıldığı vurgulanmaktadır (Amrhein, 2013).

Bazı arařtırmacılar televizyon programlarının kriminalite artışına yol açtığını ileri sürmüřtür. Televizyon programları ve kriminalitenin yaygınlaşması üzerine tasavvurlar arasında bağlantı bulunduđuna işaret eden bulgulara erişen arařtırmacılar da vardır (Lüdemann & Ohlemacher, 2002). Fakat 30 yıl kadar önce yapılan bir arařtırmada, deneklerin %75'i televizyon, radyo ve basılı yayınlarda kriminalite hakkında daha çok şey görmek, işitmek ve okumak istediklerini belirtmişir (Smaus, 1985).

Etiketleme tezi (labeling approach) klasik kriminolojinin, suç olgularını nesnelleřtirmesine karşı çıkar. Eleřtirel Kriminolojinin taraftarlarına göre kriminalitenin, suça yönelen bireyin bir özelliđi olarak kabul edilmesi yanlıřtır. Çünkü kriminalitenin objektif olarak kavranabileceđi ve tarafsızca tarif edilebileceđi düşüncesini doğurmaktadır. Halbuki gerçekte amaç tarif etmek deđil, aksine egemen gubun gücü ve çıkarları doğrultusunda etiket yapıřtırmaktır (Kerner & Weitekamp, 2005).

Hukuksal açıdan kriminalite, cezalandırılması gereken bir eylemdir. Ama cezalandırabilmek için yasallık ilkesinin yerine gelmiş olması gerekir. Yani “yasa yoksa ceza olmaz” ve “yasa yoksa suç olmaz”. Böylece alışkanlıkların egemen olmasının önüne set çekilir, diđer taraftan sonradan suç olarak tarif edilen davranışların da önü kesilmiş olur (Kerner & Weitekamp, 2005).

Suçla mücadele, geleneksel bakış açısından devletin ve toplumun suç olaylarına verdikleri bir cevap olarak kabul edilir. Her ne kadar bu bakış açısında sosyal deđişimlerin etkileri ret edilmese de, amaç daha ziyade egemenliđin güvence altına alınması ve kabul ettirilmesidir (Kerner & Weitekamp, 2005).

Kriminal denilen insan kimdir? Onu bir sosyal figür olarak düşünmek gerekir. Bu tasavvurun kaynađı toplumdur. Bu figürü tasavvur edince kafalarda canlanan resimler genellikle herkese aşıkardır ve en önemli özellikleri normalden farklı olmalarıdır. Normalden sapan kişiler veya gruplar, toplumun kurumsallařtırılmış normallik anlayışları ve tasavvurlarına dayanmaktadır. Bunlara hiç uymayan veya yeterince uymayanlar, farklı olarak algılanmaktadır (Lessenich & Nullmeier, 2006).

Suç da (Delinquenz) davranış smpasının bir türüdür. Kriminalite ve kriminal kavramlarının ardında onaylamama ve ret etme eğilimleri vardır. Suç kavramı kullanıldığında, daha ziyade yasalara karşı gelme eğilimlerinin üstesinden gelinmesi hedef alınmıştır (Plewig, 2005).

Davranış sapmasının tersi uyumlu davranıştır. Yani geçerli normalara uygun veya bunlarla örtüşen davranışlardır. Belli sınırlar içerisinde normlara uymayan davranışlara göz

yumudur. Tolerans sınırı aşıldıktan sonra cezalar devreye sokulmaktadır (Jackson ,1960, alıntı: Lamnek 2007). Normlara dayanan tanım, hukuksal tanımdır (Wiswede, 1973), ama her norm hukuksal nitelik taşımamaktadır. Ceza kanunlarında akla gelebilecek normların sadece bir kısmı şifreli olarak yer alır (Lamnek ,2007). Çevrenin reaksiyonları, kimin sapkın davranış gösterdiğini belirlemektedir. Etiketleme tezinin temeli budur. Örneğin epilepsi bazı toplumlarda engellilik, bazılarında ise sosyal statüyü yükselten bir özellik olarak kabul edilir (Lamnek ,2007)

Kurallara uymayan ve sapkın davranış arasında ayırım yapılır. Hangi tanımın geçerli olacağı, interaksiyon partnerinin reaksiyonuna bağlıdır (Lamnek ,2007). Yani aynı davranış, bazen kuralları zedeleyen, bazen sapkın davranış olarak nitelendirilen bir davranıştır. Normların kabullenilmesi, interaksiyon partnerinin politik ve ekonomik gücüne bağlıdır. Dolayısıyla aynı davranış, politik ve ekonomik açıdan güçlü olan interaksiyon partnerinin kurallarına dokunmuyorsa, normlara uygun kabul edilir. Bunun tersi hallerde sapkın davranış olarak cezalandırılabilir. Fakat bazen bir davranış bir kuralı zedelediği halde, politik ve ekonomik yönden güçlü interaksiyon partneri tarafından sapkın davranış olarak tanımlanabilir (Lamnek, 2007).

Kriminalite yaşlıların günlük hayatında fazla rol oynayan bir kavram değildir. Buna karşın kriminal eylemlerin kurbanı olma ihtimali ve bunun yarattığı sübjektif korku, yaşlılıkta rol oynamaktadır. Yaşlıların kriminalite ve şiddet tehdidi altında oldukları 1970’li yıllardan beri araştırılmaktadır. Başlangıçta kriminologlar yaşlıları “kolay kurban” olarak tanımlamıştır. Böylece daha çok kriminal davranışların kurbanları arasında yer aldıklarını kabul etmiştir. Fakat araştırmalar, yaşlıların gençlerden çok daha az kriminal eylemlerin kurbanları arasında yer aldıklarını göstermiştir (Greve, 2000).

Kriminalite yaşlıları da tehdit etmektedir, ama yaşlılıkta güvenlik ihtiyacının geniş açıdan algılanması gerekir. Örneğin kazalardan korunmak, hırsızlığa karşı önlem gibi ihtiyaçların karşılanması gerekmektedir. Polis, hırsızlıktan korunmaya yönelik bazı davranış biçimlerini önermektedir. Örneğin kapıların yeterince sağlam olmayışı, yabancıların eve alınması veya kimsenin fark edemeyeceği bir yerde kalmak gibi sorunlarla bağlantılıdır (Meyer & Mollenkopf, 2010).

Yaşlıların güvenliğini tehdit eden daha başka sebepler de vardır. Ailede ve bakım kurumlarındaki şiddet (Tufan, 2011) (Petzold & Müller, 2005) bunların arasında yer almaktadır. Fakat bunlar tabulaştırılmaktadır (Backes & Clemens ,2013). Resmi

istatistiklerde yaşlılara yönelik aile ve kurumlardaki şiddet ve kriminal eylemlere çok ender rastlanmaktadır (Greve, 2000).

Kriminalite korkusu ve yaşlılık arasında sıkı ilişki vardır. Yaş ilerledikçe birey açısından dikkatli davranmanın önemi artmaktadır. Çünkü yaşlandıkça kendisindeki güvenlik açığının bilincine varmaktadır. Ufak yaralar bile vahim sonuçlar doğurabilir. Ayrıca iyileşme süreci de daha uzun sürmektedir. Bu yüzden olası tehlikelerden korkuya kapılmaktadırlar (Greve, 2000). Yaşlıların evde güvenlik ihtiyacının bir kısmını teknik önlemlerle sağlamak mümkündür. Örneğin “Smart home” sistemleri ile güvenlik artırılabilir. Fakat bu olanaklar sadece gerçekten bireyin güvenliğini artırıyorsa yaşlılar tarafından kabul edilmektedir (Meyer & Mollenkopf, 2010).

Yaşlılar arasında suç olaylarının kurbanları ve suça bulaşmış yaşlı çok azdır. Yaşlılıkta asıl sorun, suç eylemlerinin kurbanı olmaktan ziyade, “mağduriyet-kurban-paradoksu” olarak tanımlanan ve yaşlılarda sık görülen subjektif korkudur (Greve, 2000). Korku, kompleks bir fenomendir. Tıp, psikoloji, sosyal bilimler, felsefe ve teoloji, bu konuyla ilgilenmektedir (Rattner, 1999). Korku bireyin çevreyle bedensel ve bilişsel ilişkilerini de engelleyebilir (Rattner, 1999) (Bassler, 2000).

Bulgular

Projeye katılan yaşlılar burada “treatment grubu” (TG) ve katılmayanlar “kontrol grubu” (KG) olarak tanımlanacaktır. TG’da 500, KG’da 100 kişi yer almaktadır. Hepsi 60 yaş ve üzerindedir. Tabloda her iki grubun demografik özellikleri karşılaştırılmaktadır. Bu özellikler açısından farklı oldukları da görülmektedir. Örneğin TG’da kadın oranı %70 iken, KG’da %50’dir. Eğitim düzeyi açısından farklılık dikkat çekmektedir. TG’da “eğitim düzeyi düşük” kategorisinde deneklerin %84’ü, KG’da ise %66’ı yer almaktadır.

Tablo 1: Denekler: Treatment ve Kontrol Grupları

Deneklerin demografik özellikleri	Treatment-Grubu		Kontrol Grubu
	Sayı	%	Sayı (=%)*
Kadın	148	29,6	50
Erkek	352	70,4	50
Geliri yok	329	65,8	87
Geliri var	171	34,2	13
Kiracı	84	16,8	15
Kiracı değil	416	83,2	85
60 – 69 yaş	270	54,0	67
70 – 79 yaş	195	39,0	27
80+ yaş	35	7,0	6
Evli	392	78,4	77
Bekar	24	4,8	20
Dul	84	16,8	3
Eğitim düzeyi düşük	420	84,0	66
Eğitim düzeyi orta	57	11,4	30
Eğitim düzeyi yüksek	23	4,6	4
Kırsal alanda ikamet ediyor	45	9,0	15
Şehir merkezi veya yakın çevresinde ikamet ediyor	455	91,0	85

Beklentileri, Hoşa Gidenler ve Memnuniyet

Yaşlıların projeden beklentileri 7 soru ile belirlenmeye çalışılmıştır. En yüksek oranı “anamlı ve faydalı uğraş” ile ilgili soru almıştır. Bunu “daha fazla güvenlik” sorusu takip etmektedir. En düşük oranı “yeni tecrübe edinmek” ile ilgili soru almıştır.

TG’da yer alan yaşlılara EDA projesinde nelerden hoşlandıkları ile ilgili 6 soru yöneltilmiştir. Cevap olarak “evet” ve “hayır” alternatiflerinden birinde karar kılmaları istenmiştir. Tabloda “evet” cevabını verenlerin oran ve sayısı görülmektedir. En yüksek oranı “zorlama olmaması” ve en düşük oranı “yapılandırmaya katılma olanağı” ile ilgili

soru almıştır. Yaşlıların çoğu “birlikte güvenliğin sağlanması” açısından üstlendikleri rolü de projenin hoş giden özellikleri arasında görmektedir.

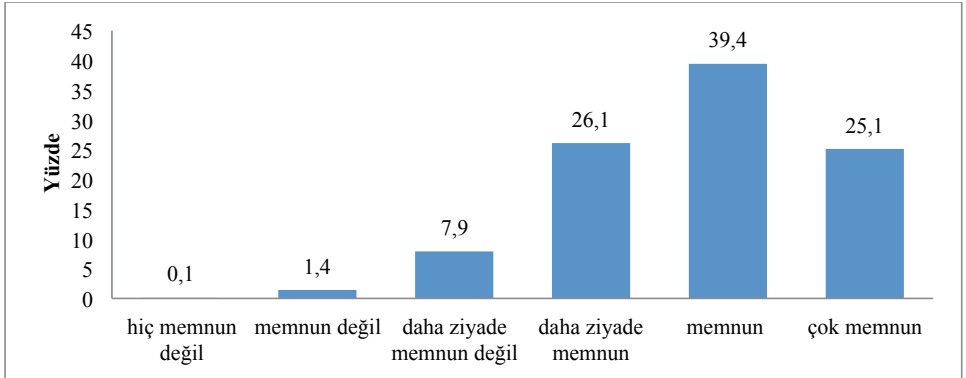
Tablo 1: Yaşlıların projeden beklentileri.

Projeye Katılım Sebepleri	Yüzde	Sayı
Anlamlı ve faydalı bir uğraş	78	391
Daha fazla güvenlik	69	344
Daha fazla kişiyle tanışmak ve sosyal ilişki	58	292
Can sıkıntısından kurtulmak	56	282
Kişisel gelişme imkanı	47	233
Yeni bilgi edinmek	37	183
Yeni tecrübe edinmek	27	137
Hiçbiri	1	5

Tablo 2: Projenin yaşlıların nazarında hoş giden özellikleri.

Projenin hoş giden yönleri	“evet” Yüzde	Sayı
Zorlama olmaması	81	406
Birlikte güvenliğin sağlanması	71	355
Rekabetin olmaması	66	329
Kararlara katılma olanağı	52	262
Yapılandırmaya katılma olanağı	44	219
Hiçbiri	4	20

Genel olarak projeden ne kadar memnun kaldıkları veya memnun kalmadıkları sorusuna çoğu olumlu yanıt vermiştir. Projeye katılan her 10 yaşlıdan 8-9’u projeden en azından “daha ziyade memnun” kaldığını belirtmiştir.



Şekil 1: Projenin yaşlıların genel memnuniyeti

Grupların İndekslerle Karşılaştırması

Yukarıdaki soruların haricinde her iki gruba 18 aynı soru yöneltilmiştir (Bkz. Sunum). Bu sorulardan altı adet indeks tasarlanmıştır. Her indeks için 3 soru kullanılmıştır. İndekslerin adlarından soruların konuları anlaşılabilir. Eğer tek soru yerine, üç soruya verilen cevaplardan elde edilen sonucun, denegin görüşlerini daha iyi yansıttığı görüşü kabul edilirse, indekslerden çıkan sonuçların daha sağlıklı bir yorum yapmaya imkan sağladıkları kabul edilebilir.

İndekslerin ortalama rank ve medyan değerleri her iki grup için hesaplandı. Rakamlar büyüdükçe, cevaplar olumlu yöne kaymaktadır. Tablodan indekslerde “projeye katılan” (TG) yaşlıların hem ortalama rank hem medyan değerlerinin yüksek olduğu görülüyor. Hepsinde istatistiksel manidar farka rastlanmıştır. Bulgular, EDA projesine katılan yaşlılar üzerinde projenin olumlu etkilerine işaret etmektedir.

Tablo 3: Grupların indekslere göre karşılaştırılması.

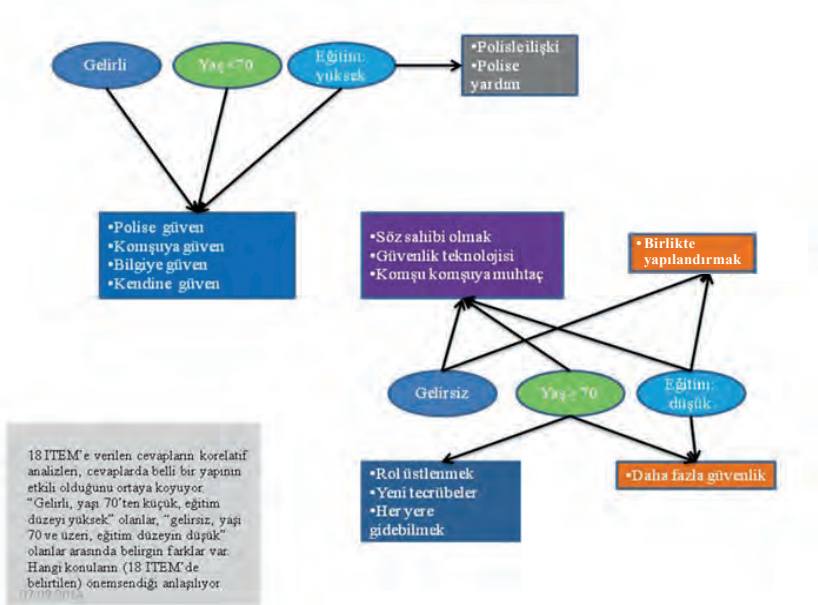
İNDEKS	Ortalama Rank		Medyan		p
	<i>Projeye Katılmayan</i>	<i>Projeye Katılan</i>	<i>Projeye Katılmayan</i>	<i>Projeye Katılan</i>	
GÜVEN	96,6	341,3	2,3	4,3	p<0,001
İNTERAKSİYON	81,8	344,2	2,7	4,7	p<0,001
ÖĞRENME	89,6	342,7	2,7	4,3	p<0,001
SOSYAL OLMAK	92,1	342,2	2,3	4,0	p<0,001
KATILIM	91,6	342,3	2,7	4,0	p<0,001
GÜVENLİK	169,1	326,8	3,3	4,3	p<0,001

Korelatif Bağlantılar

Aşağıdaki grafik gelir, yaş ve eğitim faktörlerine dayanarak TG'daki bireylerin cevap eğilimi hakkında bilgi vermektedir. Gelirli, yaşı 70'ten küçük ve eğitim düzeyi yüksek olanlar, daha ziyade “polise güven”, “komşuya güven”, “bilgiye güven” ve “kendine güven” konularında olumlu cevaplar vermişlerdir. Ayrıca eğitim düzeyi yükseldikçe “polisle ilişki” ve “polise yardım” konularına olumlu bir yaklaşım belirlenmiştir.

Buna karşın gelirsiz, yaşı 70 ve üzeri ve eğitim düzeyi düşük olan denekler, projede başka unsurları ön plana çıkarmaktadır. “Rol üstlenmek”, “yeni tecrübeler” ve “her yere (korkmadan) gidebilmek”, bu grubun projede algıladığı noktalarıdır. Bu grupta gelirsiz ve

eđitim düzeyi azaldıkça “birlikte yapılandırma” isteđine eđilim artmaktadır. Yaş büyüdükçe ve eđitim düzeyi azaldıkça “daha fazla güvenlik” isteđine eđilimin arttığı dikkat çekmektedir.



Şekil 2: Projeye katılan yaşlılarda gelir, yaş ve eğitim durumuna göre cevap eğilimleri.

Sonuç

Araştırmamızın bulguları EDA projesinin yaşlıların bakış açısından ayrı görüldüğüne işaret etmektedir. Projeye katılım ve polisin yaşlılara yönelik sebepleri birbiriyle örtüşmemektedir.

Yaşlılar projede kendileri açısından önemli olan bazı özellikler keşfetmiş, kendilerine anlam çıkarmışlardır, ama kriminalite ile mücadele açısından bunların önemli oldukları söylenemez.

Genel olarak projeye katılanlarda projenin olumlu deđişim yaratabildiđi kabul edilebilir. Buna karşın projeye katılmayan yaşlılara erişilememiştir.

Örneklemlerin reprezentatif olmamaları, sonuçlara dikkatli yaklaşmayı gerekli kılmaktadır. Fakat deđerlendirme araştırmalarında pragmatik özelliklerin öncelikli olduđu dikkate alınırsa, projenin tasarımcısı açısından deđerli kabul edilebilecek bulgulara erişilebildiđi ve yeni projelerde bunların dikkate alınarak, yaşlıların ihtiyacına daha iyi cevap verilebileceđi kabul edilebilir.

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SESSION VIII

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Long-Term Care (Ltc) Services in The UK And Turkey: A Comparative Perspective

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Abstract

Background: The Long-Term Care (LTC) of the elderly has become a contested issue for current welfare states, owing to challenges brought about by demographic ageing and shifts in family relationships. Even though Turkey is identified as a Mediterranean welfare state, recent trends of privatisation and welfare state interventions are giving way for a mixed economy. As a liberal welfare state, LTC services in the United Kingdom are means-tested and highly commodified. For this reason, it is significant to examine the type of LTC services that Turkey can benefit from this Residual Service Model in the UK.

Objectives: The main objective of this study is to determine whether there are some transferable features of the LTC system in the UK for Turkey.

Methodology: In the scope of the project, comparative literature review is employed as a method. The LTC services in both countries will be systematically reviewed from a structural, institutional, financial and cultural point of view.

Findings: The findings show that LTC services in Turkey and the UK are diverse in terms of cultural and institutional aspects; however, there are some similarities in terms of structural and financial aspects.

Conclusion: Even though full commodification of LTC services in Turkey is not feasible from a cultural point of view, there are certain institutional features that Turkey can benefit from the LTC system in the UK.

Keywords: long-term care, elderly services, Turkey, UK

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Introduction

Long-term care (LTC) of the elderly is one of the main challenges that welfare states face as a result of demographic ageing. With increased longevity, change in the family structures and women entering to labour market, care of the elderly has become problematic. Inadequacy of kin sources available for care and the increase in the labour force participation is escalating the pressure on adult children and elderly parents. Inability to combine care duties and work is confronting families economically, socially and psychologically. In this case, welfare state should take on a big role in balancing this conflicting needs and duties as a result of demographic challenge.

Owing to its relatively younger population, ageing is not as intense in Turkey as it is in European Union countries and Far East Asian countries. Having a relatively higher fertility rate and younger population, the percentage of elderly (+65) constitutes 7.7% of the population in Turkey which almost equals to 6 million people (TUIK, 2014). However, considering its relatively larger population, in the long-term, Turkey is more prone to come across severe challenges in terms of population ageing. Even though fertility rate is currently above the replacement rate (2.1), the change in the share of elderly in the whole population will be very dramatic and it will almost threefold (20,8%) by 2050 (TUIK, 2014). In this respect, LTC of the elderly will be a big challenge for Turkey.

On the other hand, UK is a fast ageing country, where the share of elderly in the population and life expectancy are higher than Turkey. Currently, female life expectancy at birth is 82.9 and this number is 79.1 for men. There are 10.8 million people aged 65 or over in the UK. The number of people aged 65+ is projected to rise by nearly 50% in the next 20 years to over 16 million. (Later Life in the UK, 2014). For this reason, UK has long been aware of the challenge and started handling the issue of LTC way before Turkey has.

Turkey has always been identified as a Mediterranean welfare state, where the family is the main point of welfare and provision of welfare services are very limited. However, recent economic developments and privatisation trends has given way for a mixed economy. Turkish welfare state is described as both "residual" and "institutional" by the Ministry of Family and Social Policies (MFSP, 2014). For this reason, expansion of the social services for the needy has become a priority. In order to expand such services, best practices should be transferred from those countries which have been fighting against this challenge and have relatively excelled in provision of these services. For this reason, UK is the most suitable country since it constitutes a liberal, residual welfare model (Esping-Anderson, 1990).

In this respect, this research paper aims to look at the best practices and intervention models in the UK in order to compare and draw lessons for a proper LTC strategy for the elderly in Turkey. However, it is significant to map out country-specific characteristics to be able to identify transferable features. To this end, cultural, structural institutional and financial comparison will be made to find the most transferable LTC services for the elderly in Turkey.

Methodology

‘An age-old idea of philosophers is that knowledge of the self is gained through knowledge of others’ (Dogan & Pelassy, 1990, p. 5.)

Since the purpose of this paper is to draw lessons for Turkey, it is important to look at other practices of LTC for the elderly. In order to assess the applicability and transferability of the LTC systems, it is important to point out the similarities between the countries. Those similarities can only be assessed through comparison. For that reason, as a methodology, comparative literature review will be employed. For comparison, government and international organizations’ documents and existent literature will be used. This systematic review of UK and Turkey will help drawing lessons for Turkey to develop appropriate LTC services for the elderly.

Current LTC Services in the UK and Turkey

In this section, intervention models for LTC of the elderly in the two countries (Turkey, UK) will be presented.. However, it is important to bear in mind that state intervention to provide welfare support to the elderly is a new and growing concept for Turkey. Even if there are some attempts to support long term elderly care (which will be discussed in this section), it is very basic compared to the UK. For that reason, the purpose of this study is to look at the similarities and differences between Turkey and the UK to assess transferability and applicability of the LTC practices, rather than the LTC practices itself.

United Kingdom (UK)

Welfare Typology

According to Esping Anderson’s classification, the United Kingdom is classified as a Liberal Welfare Regime (1990). According to this typology, liberal economy principles prevail over state regulation or interventions. State plays a regulatory role to make sure that market is functioning properly. Welfare of the citizens is believed to be in full

employment, in other words, working and a stable income is regarded the best way to reach welfare. If people fail to be a part of the market system owing to other reasons such as long term-disability and sickness and poverty, state plays a residual role in the provision of social services and that is why these types of regimes are known as “Residual Welfare Models” (Pierson, 2006) However, getting benefits from the social services is highly means-tested. In order to be eligible for the benefits, claimants must prove that they really need the benefit, which requires tedious and rigorous procedure (Walker, 2005). On the other hand, it is important to bear in mind that even though social services are highly commodified in the UK, healthcare is free and universal under the National Health Service (NHS), which actually makes UK a special case for welfare state typology.

Historical Development

Care provision for the elderly has a long history in the UK and even dates back to 1601 when the first Poor Law was enacted. The main principles of LTC for elderly started to evolve during post war era when municipalities started to provide residential support for the frail people. At the time, NHS was also providing care services without means testing and this has started to become financially problematic. A need for reform has escalated and a new model is introduced by the Community Care Reforms which is incorporated in 1990 but started to be implemented in 1993 (Howse, 2007).

With the Community Care Reforms, the role of the local authorities has changed. Before the reform, Local Authorities were providing care services to the needy. With the reform, centralised power was devolved and local authorities gained more power. Their role shifted from a service provider to service purchaser for the elderly. By this way, a quasi-market was aimed to be created in the care sector (Karlsson et. al, 2004).

After the community care reforms, the government has set up a Royal Commission in 1997 and the report presented proposed a free care for the people (Royal Commission, 1999). However, this proposition has never been put into action and the debates still continue. In July 14th 2009, Department of Health has issued a green paper that proposed three different financing systems for LTC. And in 2013, care reform came into place, which changed the eligibility criteria and the financing options for the LTC. This reform will be discussed in the "Financing" section.

Residential Care

In the UK, there are different types of residential care facilities which include nursing homes, residential care homes, retirement homes, assisted living and close-care in tailored housing. However, the main ones are nursing homes and residential homes. The first one generally provides nursing facilities which require more intensive care for the more frail and disabled elderly. On the other hand, the latter provides board and daily care. There are also specialised care-homes such as for elderly with dementia and Alzheimer's disease, which need special attention and care. These facilities are both public and private but since the Local Authorities purchase the services, competition is high and private provision is dominant in the market (Karlsson et al, 2004).

There are approximately 3,836 nursing homes and 10,445 residential homes for people aged 65+ in the UK. The average annual fee in 2012 for a single room in a private residential home was £27,872 (£536 per week). For a nursing home with special care arrangements, it was £38,376 (£738 per week). The most up-to-date statistics show that, as of April 2012 there were approximately 414,000 elderly (65+) people residing both in residential homes and nursing homes (Later Life in the UK, 2014).

Home-based Care

In the UK, home-based care is the dominant type of service provision since the majority of care recipients prefer to stay in their own houses. These services are very flexible and there are different types of home-based care available for the elderly. The needy have an option to choose from care workers or registered nurses as an assistant depending on their need levels. The length and time of the care provided also varies from a couple of hours to 24 hours of assistance. The assessment of need is determined by a care manager employed by the Local Authority (Howse, 2007).

Home-based services are mainly provided by the independent sector with a share of 89% as opposed to a share of 5% in 1993. This can be explained by the discrepancy of unit costs between the two sectors; for instance in 2011-2012, the average unit cost of home-based care provided by the local governments was £35.50 while this cost was £14.70 for the independent sector.

2011-12 statistics show that there were 6,830 home care agencies registered with the Care Quality Commission in England, and they were based in both the private and voluntary sector. The most up-to-date statistics, which are from 2010 show that the size of the

domiciliary care workforce was around 351,470; 267,180 of them working in independent sector, 48,130 of them working in the voluntary sector and 36,160 of them working in local authorities. The workforce is predominantly made of female part time workers and the average age of care worker is estimated at 40.6 (UKCHA, 2013).

As far as the number of service recipients are concerned, 2012 statistics show that 414,780 elderly people received community-based care and support at home. At the same time, 82,285 older people received day care. However, of the 2 million elderly who have care needs, 800,000 of them currently do not receive any formal support (Later Life in the UK, 2014)

On the other hand, the UK government also provides benefits for the caregivers, which is called, "Carer's Allowance". However the take up rate is low since either people are not aware of the benefit or care's allowance leads to other cut-downs in the existing benefits. Moreover, there is a huge number of carers that are above the age of 65. Around 960,000 elderly provide unpaid care for a partner, family, or others, but only 93,000 of them receive any carer-specific support services. IT is also estimated that 58% of all the carers are female. (Later Life in the UK, 2014)

Financing

In the UK, LTC is not universal and public expenditure on social care comes from a mixture of central government grants, council tax revenues, and user charges. However, the majority of the financing (2/3) is provided by the government grants (Howse, 2007). It is up to individual councils to decide how to use that funding and how much of it to spend on social care. 2010 statistics show that public expenditure on social care services for older people and on disability benefits that older people use towards their care costs was around £12 billion. It is projected that this cost will rise to more than double by 2030, namely £25.5 billion (UK Benefits, 2014).

As far as the user charges of residential care is concerned, it is seen that these services is highly means-tested. The elderly, who wish to receive financial support from the local authorities have to prove that they both need it and unable to afford the necessary care. However, this is a very controversial issue in the UK. Examples of income include interest on savings, private and/or State Pension, some benefits like Pension Credit, Attendance Allowance or the care component of Disability Living Allowance and also savings, investments and any property owned (Nidirect, 2014). Since the income threshold for

residential care was £23,250 until 2013, owning a property simply meant ineligibility for long-term care services.

In 2013 the government has announced a reform in the financing of long-term-care services. The new system has brought a cap on costs at £75,000, which did not exist before and rendered service users with huge unaffordable bills. From 2017 and on, LTC costs over £75,000-which encapsulated one-fifth of the users-will be covered by the government. By this way, services users will not have to sell their houses or spend all of their life-time savings to receive LTC services. This cap is expected to benefit especially women, who make up 68% of the service users who are above the age of 65 and who tend to be both carers and care recipients. Moreover, the threshold for the means-tested system has increased from 23,250 to 123,000, which aims to benefit at least 100,000 more people in need of LTC, who were not covered with the previous threshold system (UK Benefits, 2014).

TURKEY

Welfare Typology

Turkey is special case for welfare state typologies owing to its unique and dynamic economic and social structure. Turkish welfare state encompasses Mediterranean welfare state characteristics since provision of welfare relies on the family and state support is minimal, which is the case in Southern European countries such as Italy and Greece (Ferrera, 1996). Long-term care provision in these countries are left to the adult children and benefits for the elderly are highly limited, which is a similar characteristic for Turkey.

On the other hand, Turkey might be considered as a liberal regime, where the state plays a residual role. As a transitional economy, Turkey is going through rapid social and economic changes. Economic growth and privatisation trends lead to idea of full-employment and self-responsibility for the welfare of the citizens where state intervention comes as a last point of resort. As it is stated before, Ministry of Family and Social Policy describes Turkish Welfare State as "institutional" and "residual" (MFSP, 2014). In that respect, Turkey is similar to UK liberal system in terms of its residual welfare state characteristics.

Historical Background

As a traditional country, intergenerational solidarity has operated through extended family relations in Turkey. The responsibility of taking care for the elderly has always been the duty of their children (Canatan, 2008). Children were regarded as a future investment for parents in old age. Turkish society had the roots of intergenerational solidarity deeply embedded within the culture for centuries. Until recently, the cohesion between the generations has been effectual, consensual, functional and practically structural. However, the ongoing demographic change is constituting a challenge for such solidarity and the need for LTC is increasing rapidly. For this reason, state intervention for LTC services is very recent and they will be described in the following sections.

Institutional Care

Institutional care of the elderly in Turkey is provided both by the public sector and the private sector. The public institutions are mainly operated through "Directorate of Disabled and Elderly Services", which is unit that works under the Ministry of Family and Social Policy. There are 109 nursing homes that operate under the directorate, with a capacity of 11.826 people. There are also 20 nursing homes belonging to local authorities (municipalities), 30 belonging to associations and foundations, 7 belonging to ethnic minorities and 2 belonging to other public institution, with a total capacity of 5983 people. There are also 29 life centres for the elderly that operate under the directorate, where elderly people live with their peers in a flat. In these 29 flats currently 118 elderly people are living. On the other hand, there are 139 private nursing homes and there is only one nursing home specialised in Alzheimer's disease, which was opened in 2011 by the Alzheimer's Foundation in Turkey. The overall capacity of these private nursing homes is 6853 and the capacity of the Alzheimer's nursing home is 15 (MFSP 2014).

According to the 2013 statistics, elderly (65+) constitutes 7.7 % of the population with 5,891,694 people (TUIK, 2014). On the other hand, as it was indicated before, the total capacity of the nursing homes is 24.677 (MFSP, 2014). Regarding the gap between the capacity of the nursing homes and population aged over 65, the insufficiency of these institutions is evident. Moreover, since the minimum admittance age to a nursing home is 55, this gap may be even wider. Regarding future projections in aged population, this shortage of institutional care services is more likely to increase.

Home-based care

As stated previously, care of the elderly was being operated by family relations and state intervention in home-based care is a very recent development for Turkey. Formal care services that are provided by the state are very limited. There are only 5 Elderly Service Centres operated by the state, again under the Directorate of Disabled and Elderly Services. Membership is compulsory for service reception, which costs 10 Turkish Liras per year (approximately 3 GBP). These 5 centres have 1066 members in total, 497 of them being males, and 569 being females. These home-based services are provided to the elderly who are not mentally ill or disabled and who do not need medical care.

There are also some home-based services provided by the local governments (metropolitan municipalities and sub-provincial municipalities) for free. Their services include day-care and long-term care, help with activities of daily living (ADL), providing food, combustibles and basic health check-up. However, these services are not being provided systematically and continuously, which makes it hard to track numbers and real benefit.

The state also provides care benefit for the people who take care of their elderly relatives. However, these benefits are extremely means-tested. In order to be eligible for the benefit, the patient or the person in need should have a disability ratio of 70% and not to be able to continue his/her life without the help of a third party. Moreover, eligibility requires a maximum income of 510 Turkish Liras for the first half of 2014 and 540 Turkish Liras for the second half. The amount of money that the care givers receive is around 765 Turkish Liras for the first half of 2014 and around 810 Turkish Liras for the second half (MFSP, 2014). Moreover, the application process itself is also very rigorous. The documents for application include a disability report that includes the level and category of disability, which is going to be issued by the relevant Health Council. Other documents include papers such as consulting covenant and photos. As of February 2011, 27.036 elderly are receiving long-term-care benefit in Turkey (MFSP, 2014).

Financing:

Financing of the residential LTC services depend on the type of the service provider. The state operated nursing homes are subsidized and share the cost with service users. The share of the cost is determined through income assessment and for instance if the client is not able to pay the whole admittance fee, then the state takes 75% of the income and leaves 25% to the client as a pocket money. These percentages may change according to the income level of the client. However, there has been a recent amendment to the Disability

Law (5378) and the extent of pocket money provision is expanded. On the other hand, there are also elderly people who benefit from these services for free. These people mainly have no relatives or income and the financing of this type of placement is provided from tax payers. There is very limited subsidy for private nursing homes.

Findings

Financing of the LTC Services

As it has been put forward before, the financing of the LTC services in both of the countries are maintained through user charges and taxes. The governments provide subsidies but they are highly means-tested. And with the recent law that is passed in Turkey, state will be able to buy services for the elderly, which further supports the similarities in terms of financing. However, it is important to note that the cost of LTC is increasing and putting a lot of pressure to both service providers and service users. For that reason, all the governments has a pressure of cutting down on their expenditures on LTC as a result of globalisation process and increasing service costs. Since home-based care is less costly, there is a shift towards promoting and providing home-based care compared to residential care (Wilson, 2006). According to EU statistics, the unit (per patient) cost of formal care in an institution is relatively higher than the cost of a unit of care provided in the home of the care recipient terms since an additional "hotel costs (board, food, heating, etc.)" is not included in the cost of care (EU Commission, 2009). In that respect, home-based care is a better option for Turkey regarding the budget constraints.

Structural Dimension

When we look at the arrangement and management of LTC services, we see that local governments are the main suppliers of such services in the UK. The local councils have their own autonomy on the determination of need of the care facility, they are partially responsible for financing of the LTC services. In short, municipalities or local governments play a major role in the provision of the care services in these countries. On other hand, municipalities in Turkey are not as empowered as the local governments in the UK. Most of the LTC service provision happens at the state level. The municipalities operate some nursing homes with their own funds and they provide some home-based care in their own power. Admittance to state-led nursing homes and the carer benefits are all organised by the central authorities. Centralised control over such services is assuredly not efficient. Delegation of power to the municipalities may hasten the process and reach out to more

people to provide services. However, expansion of municipal budgets is a must for such delegation of responsibility. In this respect, it can be argued that there are slight similarities in terms of the structural service provision but it should be extended and local government should be further empowered in Turkey.

Institutional Capacity

Looking at the institutional capacity for residential service provision in Turkey, it can be easily seen that Turkey's existing resources are not sufficient to meet the demands for institutional care. As stated before, in Turkey there are only 307 nursing homes that provide care for the elderly as opposed to the 3,836 nursing homes and 10,445 residential homes that exist in the UK. On the other hand, there is only 5 elderly service centres all around Turkey that provide home-based care to the elderly whereas this number is 6830 for the UK. Even though municipalities are providing some home-care services, the extent and content vary in every single province and there is no one uniform model. These services may also be subject to political conditions and personal relations. In that respect, it can be argued that Turkey's institutional capacity is not sufficient for a services-led intervention. For this reason, the services should be expanded both for residential care and home-based care.

Moreover, healthcare services in Turkey are attached to social insurance scheme and those who do not have insurance have access to free health services only a means-tested system, which is a good indicator of the residual model of welfare state. On the other hand, England has a universal free health care system which is provided by the National Health Services. For this reason, it is easier for British Senior Citizens to have access to preventive health care services compared to Turkish Seniors who are at a higher risk of falling out of the social safety network as one of the most disadvantaged groups in Turkey. In this respect, services for the elderly gain more importance in Turkey, which should be increased and expanded all over the country.

Cultural Aspects

As it is stated before filial piety and intergenerational solidarity is a huge motivation for LTC of the elderly. Traditionally, older adults expect their children to take care of them when they are in need and children are seen as future investments and safety network. Institutional care has always been stigmatised and this tradition seem to prevail to this very present day. According to the Family Structure Research (2011), 28,9 % of the participants stated that they would prefer to stay with their sons and 10,3 prefer to stay

with their daughters in old age. 18.4 % stated that they would prefer to receive home care service. Only 9.1 % indicated that they would go to nursing homes or receive institutional care. 2.1 % mentioned other forms of care whereas 34.6 stated that they have no idea about the issue. These statistics show that majority of the people prefer to stay with their children to receive care from their own relatives but also there is a certain extent of confusion and uncertainty about future. And a considerable number (18.4) prefers home-based formal care, which again shows that there is a tendency towards home-based care rather than institutional care.

On the other hand, intergenerational relations and responsibilities in the UK have been diverse throughout history. The poor law of 1601 indicated that it is individual responsibility to maintain personal welfare and there is evidence that during 19th century, there was not much intergenerational exchange happening in the UK (Chan, 2009). Moreover, a woman's responsibility for her parents was terminating with marriage and husband had no responsibility either. It was "unenglish" to expect adult children to take care of the elderly parents and 'making children support parents was alien and offensive to English society' (Chan, 2009). The current research also shows that intergenerational support has decreased over time and community care and support has prevailed (Chan, 2009). In this respect, it can be argued that welfare support and individual responsibility is a much more prevalent idea in the UK rather than familial obligations as it is the case in Turkey.

Conclusion

In conclusion, it can be argued that there are some financial and structural similarities between Turkey and the UK whereas they are totally different in terms of institutional capacities and cultural aspects. The similarities can be seen as an advantage for the transferability of the services. For instance, the similarities in the financing options and structural organisation are important characteristics for the applicability and the extension of services. On the other hand, the differences in the institutional capacity is a sign that the expansion of the services is a must for Turkey and models of home-based care and institutional care can be transferred. However, differences in the cultural aspects is a good indicator for the kind of transferrable models that is unique to the Turkish culture.

Even though the cultural tendency and the residual welfare model that the Turkish government wants to pursue do match, the demographic trends are pushing the boundaries of the families. Both theoretical and empirical evidence show that applicability and

transferability of an informal-led, home-based care model of social services is higher. In this respect, expansion of carer benefits and their insurance is a must for Turkey. Moreover, formal home-based care services by the government should be expanded for those who do not have the social network. However, institutional and financial incapability for a formal services-led model does not mean that Turkey has to abandon improving formal institutional LTC services. Since there is an almost 10 % of the population who would prefer institutional care, expansion of residential care is also essential. Moreover, need-specific care institutions should be expanded to meet the particular needs of the elderly. For future welfare of the elderly, development and improvement of the formal LTC services is essential.

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POST-SESSION

October 20, 2014



Nursing Nasredin Hoca - What Happened to The Positive Images of Aging in Turkey?

Nora Rohstock

Introduction

I want to thank you for giving me the chance to talk to you today. I want to present my research results and my prospect on aging and the living situation of old people in Turkey today. Furthermore, I wish to introduce to you central ideas for a cross-cultural exchange programme in the geriatric care sector between Turkey and Germany.

However, before I start, I want to introduce myself, and my work to you that form the basis for my scientific perspective on and approach to the topic. I have studied Social Anthropology, Political Sciences and Public (International) Law at the Universities of Heidelberg and Tübingen in Germany. During 2010 and 2013 I have worked on my PhD thesis on images of aging and the living situations of older Turkish people in Germany and Turkey. I have done my research from the perspectives of Social Psychology, Gerontology and Cultural Anthropology. Last year I received my PhD in Cultural Anthropology at the University of Freiburg, Germany. My book has been published in April this year and will, hopefully, soon be translated into Turkish. Besides my scientific work, I also work as a Cross-Cultural Trainer and Foreign language trainer. In my presentation I want to show you, how a combination of both, science and trainings can help to improve the living situations of the elderly and the geriatric care sector in particular.

In doing so, I start with my research. In my doctoral thesis I wanted to investigate several aspects:

I wanted to describe and understand the living situations of older people in Turkey, today.

I wanted to find out, what the current images of aging in Turkey are and which factors influence them.

I wanted to compare these with the living situations and images of aging of Turkish people living in Germany asking if the factor migration makes a difference and if so, in how far.

So my research was interdisciplinary ranging between Migration Studies and Geroanthropology, Social Psychology and Cultural Anthropology.

In order to start off with my research I analysed the existing literature on Turkish migrants in Germany. This topic has been an object of research for the last 20 years in the social and cultural sciences, since the so called „guest workers“ from Turkey and other Mediterranean countries have become older. This meant a new major challenge for the German society and its social and health policy. However, in Migrations studies as a whole, the aspect of the non-migrated people has, so far, mainly been neglected. This gap had to be closed. A central initial point for doing so, are the interrelations and perceptions of each other - the migrants and the non-migrants. This leads to my research, focusing on personal identity and collective identity of (older) Turkish people in Germany and Turkey. Today I confine my presentation to the non-migrants in Turkey.

As a cultural anthropologist, I conducted my research in the Rhein-Neckarraum in Germany and Eskisehir in Turkey, using qualitative research methods like ethnography, participant observation and semi-structured, qualitative interviews. In doing this I gained insights into the daily life of my interview partners and their identity. This also counts for the Turkish community in the Rhein-Neckarraum and several groups in Eskisehir.

Moreover, I analysed their self-perception and their perception of other people and collectives constructing them as „the other“. This again was an important basis for the formation of their self-perception and identity. Social Psychological theories on identity building processes and cultural anthropological theories on migration and collective identities, again, formed the basis for my analysis of the existing images of aging in Turkey and the Turkish people in Germany.

I identified several factors with high impact. These are:

the principal of seniority.

sources for normative images of aging like folkloristic traditions, daily rituals or fairy tales.

religion and religiosity.

gender as basis for existing images of aging.

education as role-determining factor.

intergenerational perceptions and expectations.

family.

images of oneself and the other(s).

daily life.

health.

situation of and requirements for care.

review of one's life (course).

Today I want to focus on the development of the images of aging in Turkey and the current images that overweigh in Turkish society, respectively. These images go along with the four types of old people I have identified in my doctoral thesis and lead us to the title of today's lecture: Nursing Nasredin Hoca - What happened to the positive images of aging in Turkey?

Nasredin Hoca is a prominent figure in Turkish folklore and oral and written texts. He is the incarnation of a "wise, educated older man of high moral standard" who leads the „backsliders“ back to the right path and social inclusion. Due to him being so characterful, he deserves to be treated with high respect from everyone. Hence, saygi, the Turkish word for respect and at the same time a principal of treating the elderly is shown in the figure of Nasredin Hoca and the stories about him. The principal of saygi is highly normative and implies a strongly positive image of ageing. If older people, especially men, are regarded the same way as Nasredin Hoca is, they will be treated respectfully and the young will approach the elderly with humbleness.

During my fieldwork I have met several people that fulfilled these characteristics and represent this rather positive image of the elderly. I subsumed it under the

1. type of the elderly: „the wise aged“.

The persons, who fitted into this type, were regarded as wise and helpful by their children and by the people around them. The young asked for their advice and approached to them with high respect like kissing the hand of the aged and caring for them in daily life.

The elderly themselves approached the young with quite tolerance and showed interest in their lives and their future. So this type mainly goes along with a positive self-image and sometimes, but not necessarily, with a positive image of ageing. Not necessarily means, that a few of my interview partners had positive self-images but negative images of ageing. This was shown in them not regarding themselves as old, because being old for them meant, being weak or sick and to depend on others.

2. type: “the demanding aged”

People belonging to this type of the elderly rather have a negative image of ageing and practice the mechanism of *sevgi* and *saygi* in an all-embracing manner. They stick to idea that young people, especially one’s own children, are supposed to show respect towards the elderly and to take care of them when they are old. They do not only have this ideal but also demand to be looked after by their children as a gesture for thankfulness and rightfulness. This type of the elderly exists regardless of the children wanting to take care of their parents or being reluctant to look after their parents. Especially older women, who treated their sons as if they were princes, ever since they were young, tend to belong to this type of the aged. This is due to a sense of guilt that rises in the young men who often feel coerced and forced to take care of their mother who has “sacrificed themselves for their little son”.

3. type: “the frugal aged”

the type I called the “frugal aged” is different to the other types. It is different in so far as they might have a negative image of ageing as it means decline of strength and individuality to them. However, they are eager to cope with their daily life on their own as far as it is possible. They usually reject help of others but realise moments when they depend on others and accept this dependency. For them it is part of the life course, which they cannot change and do not want to change.

4. type: “the suffering aged”

This last type of the elderly is probably the most common among older people with a negative self-image. They focus on the deficiency that goes along with ageing. They suffer from physical decline and physical diseases and they long for help from their children and others. This might even be the case when they, officially, seem to be frugal.

To conclude from these four types of the aged, only those people belonging to the first type, “the wise aged”, usually have a genuine positive image of ageing. This is due to them and their social environment relying on the concept of *sevgi* and *saygi* while, at the same time the old actually offer help and advice to the young. This is a real basis for reciprocity. Similar is the frugal type. However, the frugal aged, do not necessarily have a positive but rather a pragmatic perception of themselves and of ageing and life in general. The other

types of the aged, who form the major part of my interview partners, belong to the other two types. The last one, the suffering aged is the most common type.

Now, what does this mean for an official care system, organised by the state and managed by equivalent educated staff and not by the family? And, how can Turkey and Germany learn from each other in order to provide geriatric care on a higher level than they do now?

In all these mentioned cases, the traditional environment in which the old are cared for, is the family. To comply with this tradition is often not easy or practicable these days. There are several reasons for this difficulty. The most known is the structure of society and the workforce. More and more children move away from their parents in order to find work. More and more women hold down a job and cannot look after their parents, or more commonly, their parents in law (or their husbands).

Another reason lies in the specific family and the interpersonal relations therein, as well as in the personal character of the old and their children. In some families, good intergenerational relations lead to satisfying solutions for everyone. In others, bad relations lead to more and more difficulties with caring for the old. This might even result in physical or psychological violence.

For the last couple of years the Turkish state has realised these changes in society and the need to offer professional institutionalised care for the elderly. However, the knowledge about the organisation of these institutions, the care system and the educational standard of nurses in this care sector is still quite low. The Akdeniz University in Antalya is one major institute in Turkey that, with its international staff, provides the knowledge and experiences also other states have with implementing high standards in geriatric care.

To me as a cross-cultural trainer, this is where my expertise comes into play. My aim is to help organising an exchange between German and Turkish health care professionals and nurses for the elderly both sides benefit from.

I see Cross-Cultural Exchanges within the health care and geriatric care sector as one way to improve the living situations of the elderly in Turkey, Germany (and the EU).

What could a professional exchange look like and what advantages and propable challenges are there? Here we can learn from the existing programmes in several states like China, Germany and Scandinavia. These nations have already started to train new and experienced staff inside the health sector and the geriatric care sector. Hence, we know that the organisation of a professional exchange requires a thoroughly designed multi-level

plan. From the acquisition of suitable institutions and staff, to the funding of the advanced trainings for all people involved up to a training of high level communication skills and many more. Now I wish to draw your attention to the aspect of cross-cultural communication between German and Turkish nurses and medical practitioners and to present some ideas about how to organise a suitable communication training for both sides.

Structure and organisation of a training: Main aspects to be considered

The training should aim at an holistic approach, ranging from organisational and management training over medical and professional knowledge to the training of language skills, communications skills and intercultural, social and emotional competences.

To start with, the knowledge and experiences of the participants should be acknowledged and actively be included into the training programme. The participants should be ensured that their experiences, sorrows and ideas form the basis for the exchange programme. This might include experienced problems with subtle power relations between caretakers and patients, especially when they belong to the majority of the population and the minority of the population, respectively. But it could also mean the recognition and avoidance of misunderstandings in daily working life.

This initial meeting and training forms the basis for further steps, in which the aim is, to actually initiate the international and interregional exchange. Here the participants are trained in general language skills, the country and cultural background of their fosterlings and in professional knowledge about high-level care in both countries. In the field of professional trainings the best-practice-case gets to be the norm that needs to be reached.

From my scientific and practical work experience, I know that cultural norms, values and practices are very important in order to act in favour of the ones cared for. These affect the daily routine and all the aspects that are regarded as being “normal” for either side.

This includes, for example, the food: What is consumed? How has it been cultivated, cooked, served and eaten? Which cultural norms concerning pureness and health are to be considered?

Or it touches the washing: How, when and how often is the washing of the body (or parts of it) included in the daily routine? This is, where concepts of religion, health, medical standard, the body and soul et al. come into play.

Important aspects to be trained are also a reasonable time management that allows the candidates to get slowly accustomed to their new working environment and the

communication channels. At the same time a reasonable time management allows the cared for to feel comfortable and treated respectfully and, last but not least to grow accustomed to the caretakers from abroad and their practices.

During this general pre-sojourn-training, the candidates shall be prepared for their stay abroad. They become accustomed to the way the trainings work and the way profound results and useful output, is generated. They become familiar with interactive and collaborative training methods and can apply these during accompanying trainings included in the whole exchange programme.

To sum up, the need for culture sensitive care and an intercultural exchange has now been accepted in science and the geriatric sector. Currently we are at the point of developing programmes that initiate and advance these exchanges and trainings. During the last twenty minutes I have introduced to you central aspects that need to be considered when developing such an exchange programme between Germany and Turkey.

Alzheimer Hastaları Bakım Vericilerinin Hastaların Beslenmesi Konusundaki Deneyimleri

Emine Aksoydan¹, Merve Susuzlu

Giriş

Alzheimer beyinde bazı bölgelerde nöron kaybı ve metabolik aktivitede azalma ile birlikte hatırlamayı, konuşmayı ve duyguları etkileyen ilerleyici dejeneratif bir hastalıktır. Bellek bozukluğu ile başlayan hastalık mental işlevlerin yerine getirilememesi, kişilik değişiklikleri ile ilerlemekte ve son evrede hastalar sözel ve motor becerilerini kaybetmiş tam bağımlı bireyler haline gelmektedir (1).

Dünya genelinde, 2013 yılında 44.4 milyon Alzheimer hastası olduğu tahmin edilmektedir. Bu rakamın 2030 yılında 75.6 milyon, 2050 yılında 135.5 milyona ulaşacağı ve artışın çoğunun gelişmekte olan ülkelerde olması beklenmektedir. Halen demanslı bireylerin % 62'si gelişmekte olan ülkelerde yaşamaktadır ve bu rakamın 2050'de %71'e yükselmesi beklenmektedir (2).

Kronik bir hastalık olarak Alzheimer hastalığının yıkım süreci 8–10 yıl arası sürmektedir. Bu dönemde hastaların yüksek bir bakım seviyesine ve gözetime gereksinim duymaktadırlar. Klinik gözlemler, hastaların çoğunun birinci derece yakınları (eşi, çocukları) ile beraber kaldığını ve evde bakıldığını göstermektedir (3).

Alzheimer hastalarına verilen bakım, hiçbir getirisi olmaksızın çok zorlayıcı bir süreç olarak algılanmakta olup aileye çoğunlukla gündelik, duygusal, ekonomik ve sosyal yükler getirmektedir (4). Hastalığın erken evrelerinde hastanın ev dışında yürüttüğü aktivitelerin engellenmesine bağlı olarak bakım verenler hem hastanın ev dışında yürüttüğü aktiviteleri, hem de tedaviye ve mali konulara ilişkin işleri yürütürken, bunların yanı sıra hastalığın ilerlemesi ile hastanın öz bakımına yönelik olarak kişisel temizlik, beslenme, giyinme gibi aktiviteleri de üstlenmektedir (1).

Bakım verenlerin bu hastalık konusunda yeterince bilgi sahibi olması hem hastaların bu süreci daha az sorunla geçirmelerini sağlayacak hem de bakım verenlerin bu zorlu süreçte karşı karşıya kalacağı sorunlarla baş etmelerini kolaylaştıracaktır. Bu konuda yapılacak çalışmalar sonucunda elde edilecek veriler evde ve kurumda verilecek bakım

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uygulamalarının geliştirilmesinin yanı sıra hasta ve bakım vericinin yaşam kalitesinin arttırılmasına katkı verecektir.

Bu araştırmanın amacı, alzheimer hastaları bakım vericilerin hastaların beslenmesi konusundaki deneyimlerini belirleyebilmektir.

Gereç ve Yöntem

Çalışmanın veri toplama aşaması Ağustos-Eylül 2014 tarihleri arasında gerçekleştirilmiştir. Bu tarihler arasında Ankara, İstanbul illeri ve Aydın ili Nazilli ilçesinde yaşayan Alzheimer hastalarının bakım vericileri arasından çalışmaya katılmayı kabul eden 23 kişi ile görüşülmüştür. Araştırmada veri toplama aracı olarak literatürden yararlanarak hazırlanan ve 31 sorudan oluşan bir anket formu kullanılmıştır.

Verilerin analizinde SPSS 17 programı kullanılmış ve sıklık, yüzde dağılım, ortalama ve standart sapma değerleri hesaplanmıştır.

Bulgular

Çalışmaya katılan bakım vericilerin 3'ü (%13) erkek, 20'si (%87) kadındır ve ortalama yaşları 51 ± 12.5 'dir. Katılımcıların % 39'u ilkokul mezunu iken %8.7'si yüksekokul/üniversite mezunudur (Tablo 1).

Tablo 1. Bakım vericilerin cinsiyet, yaş grupları ve eğitim düzeylerine göre dağılımı

Cinsiyet	Sayı	%
Kadın	20	87.0
Erkek	3	13.0
Yaş grubu		
39 ve altı	4	17.4
40-49	7	30.4
50 ve üzeri	12	52.2
Yaş ortalaması ($\bar{x} \pm ss$)	51.2±12.5	
Eğitim düzeyi		
İlkokul ve altı	14	60.9
Orta/lise	7	30.4
Yüksek okul/üniversite	2	8.7
TOPLAM	23	100.0

Ortalama bakım verdikleri süre 4.3 yıl ± 3.5 'dur. Bakım süresi 4 ay ile 13 yıl arasında değişmektedir. Bakım verenlerin % 17.4'ü hastanın eşi, %43.5'i çocuğu, % 30.4'ü gündüz bakımevindeki ücretli bakıcıdır. Eş ve çocuk olarak bakım verenlerin hiçbirisinin hasta bakımı konusunda herhangi bir eğitimi yoktur. Gündüz bakımevinde bakım verenlerin

%56'sı Halk Eğitim Merkezleri gibi eğitim kurumlarından en fazla 2 ay olmak üzere yaşlı ve hasta bakımı kursu almışlardır (Tablo 2).

Tablo 2. Bakım vericilerin özellikleri

Alzheimer hastasına yakınlık derecesi	Sayı	%
Eşi	4	17.4
Çocuğu	10	43.5
Akrabası	1	4.3
Bakıcı	8	30.4
Bakım konusunda eğitim alma durumu		4.3
Evet*	5	21.7
Hayır	18	78.3
TOPLAM	23	100.0

*Bakıcı

Hastaların %56.3'ü son evrede (bakım verici ifadesi), %4.3 1. evre, %21.7 ise 2. evrededir. Bakım vericilerin %17.4'ü hastanın kaçınıcı evrede olduğunu bilmemektedir.

Eş ve çocuk olarak bakım verenlerin tümü hastanın yemeklerini kendisi hazırlarken gündüz bakımevine devam edenlerin öğle yemekleri anlaşmalı bir şirket tarafından hazırlanmaktadır ancak bu yemekler Alzheimer hastaları için özel olarak hazırlanan yemekler değildir. Hastaların yaklaşık %70'i için özel yemekler hazırlanmamakta, evde herkesin yediğı yemekleri yemektedirler. Yüzde 21.7'si için ihtiyaçlarına uygun yemekler yapılırken % 8.7'sinin de sevdiği yemekler yapılmaktadır.

Bakım vericiler, hastaların % 95.7'sinin beslenme alışkanlıklarında hastalık nedeni ile değişiklikler olduğunu ifade etmişlerdir. Bu değişikliklerin en önemlisi iştah azlığı ve yiyecek tüketiminin azalması (%49) dır. Ayrıca iştahı ve yiyecek tüketimi artan (%17.2) hastalar da vardır. Bazı hastaların ise ilk dönemlerde iştahının azaldığı hastalık ilerledikçe arttığı ifade edilmiştir. Hastalarda süreç içinde gözlenen diğer değişiklikler ise yiyecek tercihinin değişmesi (%4.3), tüketilen besinlerin çeşidinin azalması(%4.3), tatlıya eğilimin artması, ekmek tüketimini artması ve daha çok çorba türü sıvı yiyecek tüketimidir. Bunların yanısıra yiyecekleri tanımayan, ne yediğini bilmeyen, yemek yemeyi reddeden ve yemek saatinde masaya oturmak istemeyen hastaların olduğu da belirtilmiştir (Tablo 3).

Tablo 3. Alzheimer hastalarının beslenmesi ile ilgili bilgiler

Özel yemek hazırlanma durumu (23)	Sayı	%
Hazırlanmıyor	16	69.6
Gereksinmelerine uygun yemekler yapılıyor	5	21.7
Sevdiği/istediği yemekler yapılıyor	2	8.7
Hastalık sürecinde beslenme alışkanlıklarında değişim durumu (23)		
Değişme oldu	22	95.7
Değişme olmadı	1	4.3
Değişiklik niteliği* (47)		
İştahı azaldı/ Yiyecek tüketimi azaldı	23	49.0
İştahı arttı/ Yiyecek tüketimi arttı	8	17.2
Yiyecek tercihleri değişti	2	4.3
Tükettiği besinlerin çeşidi azaldı	2	4.3
Diğer*	9	19.2

* Çorba, ekmek, tatlı yeme isteği arttı, ne yediğinin farkında değil, yiyecekleri tanımıyor, çok yavaş yiyor, yemeği reddediyor, çatal, kaşık tutamıyor

Bakım vericilerin yaklaşık %70'i hastaların beslenmesi konusunda yaşadığı güçlükler olduğunu ifade etmiştir. Bu güçlükler; hareket güçlüğü ve bilinç kaybı nedeni ile yemek yedirmede zorluk, besin ihtiyacının yeterince karşılanamaması, çiğneme ve yutmada zorluk, besinleri dil altında tutma, acıktığını farketmeme, sevdiği yemeklerin her gün değişmesi, besin olmayan maddelerin tüketilmesi, koyu renkli besinlerin yemekten ayrılıp tüketilmemesi (nane, maydonoz gibi), ne yediğini bilmeme, başkalarının tabağından yeme isteği, elle yemek yeme isteği, çatal, kaşık tutamama, yere düşen yemekleri yemek isteme, sulu yemekleri bile elle yeme isteği, yemeklerle oynama, çok yavaş yemek yeme, sürekli yemek yeme isteği, su içememe ve yemek yeme istememidir (Tablo 4).

Tablo 4. Bakım vericilerin hastaların beslenmesi ile ilgili yaşadıkları güçlükler

Beslenme ile ilgili güçlük yaşama durumu	Sayı	%
Güçlük yaşayan	16	69.6
Güçlük yaşamayan	7	30.4
Yaşanan güçlükler		
Yemek yedirmede zorluk	2	12.5
Aşırı yeme isteği	3	18.8
Ne yediğini bilmeme/doyduğunu anlamama	2	12.5
Besin olmayan maddeleri yemek isteme	2	12.5
Yemek seçme	1	6.2
Çok yavaş yemek yeme	2	12.5
Yemekleri tanımama	1	6.2
Sulu yemekleri bile eliyle yemek isteme	1	6.2
Su içmek istememe	1	6.2
Yutkunma güçlüğü	1	6.2

Bakım vericilerin bu güçlüklerle baş etmek için en sık kullandığı yöntemler sırası ile; sorunu kendi yöntemleri ile çözmek (%54.8), hasta yakınlarından yardım alma (%12.9), sağlık personelinin yardım alma (%12.9), diğer bakıcıların görüşünü alma (%12.9) ve TV’de konu ile ilgili yayınları izleyerek çözüm bulma (%6.5)’dir (Tablo 5).

Tablo 5. Bakım vericilerin beslenme ile ilgili güçlüklerle baş etme yöntemleri

Yöntemler	Sayı	%
Kendi yöntemleri ile çözmek	17	54.8
Hasta yakınlarından yardım alma	4	12.9
Sağlık personelinin yardım alma	4	12.9
Diğer bakım vericilerin deneyimlerinden yararlanma	4	12.9
TV’deki yayınları izleme	2	6.5
TOPLAM	31*	100.0

*Çoklu analiz yöntemi ile hesaplanmıştır.

Bakım vericilerin Alzheimer hastalarının beslenmesi konusundaki bilgi sorularından aldıkları puan ortalaması 14 tam puan üzerinden 10.5±2.1 olarak bulunmuştur (6-14 puan). Buna göre bakım vericilerin %17.4’ü yetersiz, % 52.2’si orta düzeyde, % 47.8’i ise yeterli düzeyde bilgiye sahiptir.

Tablo 6. Bakım vericilerin Alzheimerlı hastaların beslenmesi konusundaki bilgi düzeylerinin cinsiyet, eğitim düzeyi ve hastaya yakınlık durumuna göre dağılımı(%)

Cinsiyet	Bilgi düzeyi					
	Yetersiz	Orta düzey	Yeterli			
Kadın	15.0	30.0	55.0			
Erkek	33.3	66.7	-			
Eğitim düzeyi						
İlkokul ve altı	14.4	42.8	42.8			
Orta/lise	28.6	28.6	42.8			
Yüksek okul/üniversite	-	-	100.0			
Alzheimer hastasına yakınlık derecesi						
Eşi	25.0	50.0	25.0			
Çocuğu	20.0	40.0	40.0			
Akrabası	-	100.0	-			
Bakıcı	12.5	12.5	75.0			
TOPLAM	4	17.4	8	34.8	11	47.8

Yüksekokul mezunlarının tümü, lise mezunlarının % 50’si, ilkokul mezunlarının %57’si, okur-yazar olanların % 20’si yeterli düzeyde bilgiye sahiptir.

Hasta eşi olarak bakım verenlerin % 25’i, hasta çocuğu olarak bakım verenlerin %40’ı, bakımevinde bakım verenlerin % 75’i hastaların beslenmesi konusunda yeterli bilgiye sahiptir. Bakım verme süresi ile bilgi düzeyi ilişkili bulunmazken kadın bakım vericilerin erkeklere göre daha fazla bilgiye sahip olduğu saptanmıştır (Tablo 6).

Bakım vericilerin % 70'i hastaların beslenmesi konusunda eğitim alınması gerektiğini, % 64'ü de kendisinin bu konuda eğitim almaya ihtiyacı olduğunu düşünmektedir.

Sonuç

Bu çalışmanın sonucunda Alzheimer hastaları bakım vericilerinin, hastaların besin ihtiyaçları ve beslenmesi konusunda yaşadıkları güçlüklerle baş edebilme konusunda eğitim gereksinimleri olduğu belirlenmiştir.

Bu sonuç doğrultusunda, aile bireyleri başta olmak üzere tüm bakım vericilere beslenmenin de içinde yer aldığı günlük yaşam aktivitelerine yardım konusunda eğitim verilmesi, bakım vericilerin ve konunun uzmanlarının deneyimlerinin paylaşılabilmesi için uygun platformlar oluşturulması, sağlıkla ilgili eğitim veren kurumlarda Alzheimer hastalığı konusunda gerekli eğitimin verilmesi ve toplumun bu hastalık konusundaki bilinç düzeyini artıracak uygulamaların yaygınlaştırılması önerilmektedir.

Ayrıca ülkemizde Alzheimer hastaları bakım vericileri konusunda yapılmış çalışma sayısı yetersizdir. Özellikle bu hastaların beslenmesi ve bakım vericilerin bu konudaki deneyimleri, bilgi düzeyleri ve benzeri konularda yapılmış çalışmaya rastlanmamıştır. Bu çalışmaların sayılarının artması konu ile ilgili gereksinimlerin belirlenmesi ve bu gereksinimler doğrultusunda çözümlerin planlanması açısından son derece önemlidir.

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ABSTRACTS



Spousal Caregiving, Stress and Mental Health: A Canadian Study of Caregivers in Middle and Later Life

Authors: Zheng Wu, PhD and Margaret J. Penning, PhD¹

Background: Despite extensive attention to the implications of caregiving for the mental health and well-being of caregivers, little is known regarding the impact of the relationship of the caregiver to care receiver. Where studied, it tends to be from the vantage point of the caregiver rather than the care recipient. Consequently, the implications of spousal caregiving compared to those associated with caregiving to children or to others remains unclear.

Objectives: This study compared the stress and overall mental health implications of spousal caregiving to those associated with providing care for other family members, friends and others (child, sibling, other family, non-family).

Methodology: Data were drawn from the 2007 General Social Survey conducted by Statistics Canada. A subsample of those aged 45 and over who reported having provided unpaid care to others in the last 12 months (N = 6,073) was used.

Findings: Multivariate regression models revealed that for women, caring for a spouse and caring for children were more stressful and more detrimental to mental health than caring for others. Similarly, for men, caring for a spouse and for children was more stressful than caring for others. However, for overall mental health, caring for one's spouse was more harmful than caring for other family members but no more harmful than caring for others.

Conclusion These findings suggest that spousal caregiving tends to be more rather than less stressful and detrimental to middle-aged and older caregivers' mental health than is caregiving to most others but that gender differences need to be considered.

Key words: caregiving, mental health, spousal caregiving, stress

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Older Women Count: Addressing The Harm of A Lifetime of Systemic Neglect, Abuse And Violence Against Older Women.

Author: Susan B. Somers, JD, President INPEA¹

Background: This presentation will focus on the impact of the insufficient attention and lack of comprehension of the harm of cumulative violence, neglect and abuse women experience across their entire life course. In Nov 2013 the United Nations convened the first Expert Group Meeting on neglect, abuse and violence against older women (EGMVOW), aimed at "informing the debate on neglect, abuse and violence against older women from various perspectives by addressing urgent and relevant issues in regard to assessing and preventing neglect, abuse and violence against older women as well as considering new measures to address these issues." UN DESA issued a publication reflecting the expert's findings: challenges due to a lack of data; lack of informed services with a rights based approach and deprivation from full participation in decision making. These findings have been the ongoing basis of concern and action by NGO's and other members of Civil Society who are dedicated to the belief that "Older Women Count."

The presenter will reflect on the global and local efforts and lessons learned by NGO's and other diverse stakeholders as they move to expose the barriers to overcoming these challenges.

Objectives:

1. Expose systemic causes and harmful impact of neglect, abuse and violence against older women across the lifespan.
2. Recommend effective ways for NGO's and Civil Society to share information, good practices, and lessons learned to empower older women themselves to meet the challenges and remove barriers.
3. Participants will be encouraged to use Social Media and tweet using #olderwomenscount

Key Words: Neglect, abuse, older women, human rights, elder abuse

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Communicating As Part of Caring: Direct Care Workers Caring for People With Dementia

Author: Dena Shenk¹

Background: Increasing numbers of direct care workers are required to assist the growing numbers of elders in need of help and support, yet it is difficult to retain well-trained people for these positions.

Objectives: The study “Direct Care Workers with Older Adults: In Their Own Words” was conducted from 2006-2008 and was designed to present the voices of direct care workers themselves.

Methodology: That study included 20 direct care workers at an assisted living community and a special care community for people with dementia in Charlotte, North Carolina and was based on extensive narrative interviews, video recorded observations and analysis of photographs taken by the direct care workers. This paper is based on an extension of that project, which included a series of video recorded open-ended discussions conducted fall 2013-spring 2014 with Ms. Portia Rezk, a former DCW and med tech who is now the Activities Director at the special care assisted living community for people with dementia.

Findings and Conclusions: This paper will report on her perceptions of good caregiving for people with dementia, the challenges in providing excellent care, and her caregiving journey. In particular, it will emphasize the findings of those discussions focusing on communication as the key to “good care” and what that means for the Executive Director, Wellness Director, direct care workers, and family members who are part of the caregiving team.

Key words: direct care workers, dementia, communication as caring

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A Gerontechnology Experience

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Background: Europe is facing a great challenge. The population over 60 years of age is growing faster than any other group. In health care there is a growing demand for gerontechnology. This is a new trend to cope with the aging population in Europe and the decreasing workforce in health care. Seven universities participated in an Erasmus Intensive Programme (IP) on Gerontechnology.

Objectives were: share inspiring examples, experience and best practices; learn students how to formulate and investigate challenges of an ageing society; challenge students to use a multidisciplinary approach to solve problems; provide participating universities with new experience and educational methods.

Methods: Twenty-seven students and twelve tutors from Turkey, the Netherlands, Germany, Denmark and Finland, came together to work in a two-week IP, in Rotterdam. Students prepared themselves during a pre-assignment at home. Tutors gave various lectures and coached the students working together in four groups on complex assignments.

The innovative and challenging character of the international context of this IP is shown in the fact that it moves beyond knowledge of the challenges of an ageing population and the application of technology. The multidisciplinary (health care and engineering) and multinational views make it possible to open different viewpoints and stimulate original concepts.

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Results: Students presented new solutions and how to implement technology at home to create a nursing home of the future.

Conclusion: This first experience is worth to be shared with others, to inspire different disciplines, from gerontologists to other health care professionals, and give a new perspective on this issue.

Key words: gerontechnology, education, multidisciplinary, multinational

Changes in Family Structures and The Care Of Older Adults Across The Globe

Author: Karen A. Roberto¹

Background. The structure of families is changing worldwide. While an increase in life expectancy is resulting in the greater likelihood of more multigenerational families, population trends show future generations of families with fewer members.

Objective. This presentation highlights current research addressing changes in family structures by expanding upon normative models of kinship to develop perspectives more relevant for examining the roles and responsibilities of contemporary families in light of a rapidly expanding aging population.

Methodology. A critical analysis and synthesis of the current literature provided insights into the changes in family structures and care.

Findings. With demographic shifts, individuals in the middle generations will feel the emotional and financial pressures of supporting both their children and older parents, and possibly grandparents simultaneously and for a longer duration than in the past. Additionally, family structures and relationships are becoming more complex, requiring a new understanding of kinship beyond the nuclear family as the conceptual and ideological standard. Older adults acquire or develop relationships as new individuals enter their lives (e.g., in-laws; grandchildren; friends). Other relationships evolve as they expand or renegotiate existing roles (e.g., caregiver; sibling).

Conclusions. Ties with partners, biological kin, step kin, chosen kin, and friends have implications for the care of old people. Scholars and practitioners around the world must attend to transformations of family structures and interpretations of family relationships and roles, both within families of origin and within families created through marriage, choice, adoption, or necessity, as they provide new opportunities and challenges for elder care.

Keywords: Aging; Caregiving; Families; Informal Care

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Writing for Publication in GSA Journals: Increasing The Odds

Author: Rachel Pruchno

Background: GSA-sponsored journals such as *The Gerontologist* aim to increase manuscript submissions from international colleagues. Although international submissions have increased over the past several years, acceptance rates have been low.

Objectives: This talk identifies common errors made by international scholars submitting manuscripts to *The Gerontologist* and makes suggestions that will lead to higher acceptance rates.

Methodology: The talk will identify strategies for increasing the likelihood that a manuscript will be accepted for publication. I'll discuss things to think about before the paper is written, how to choose a journal, and writing the paper. I'll discuss the peer review process from the perspective of author, editor, and reviewer, and suggest what authors should do if a manuscript is rejected.

Conclusion: This talk should be of interest to scholars at all stages of their careers.

Key words: Publication, peer review, journals

Türkiye’de Yaşlı Dostu Ortamların Oluşturulması: Hastane Örneği

Yazarlar: Sema Oğlak¹ ve Ayşe Canatan²

Arkaplan: Fiziksel ve sosyal çevre, yaşlıların ilerleyen dönemlerinde başkalarına bağımlı olmadan yaşamını sürdürebilmesi ve sağlığını koruyabilmesinde önemli bir etkidir. Yaşlı dostu ortamların oluşturulmasında; dış mekan ve binalar, ulaşım, ev içi koşullar, sosyal katılım, toplumsal saygınlık ve toplumla bütünleşme, çalışma yaşamına katılım ve istihdam, iletişim ve bilgilendirme ve sağlık hizmetleri gibi temel ihtiyaçların yaşlıların gereksinimleri doğrultusunda düzenlenmesi yaşlıların yaşadığı topluma daha aktif katılımlarını sağlayacak çözümler üretilmesine dayanak oluşturmaktadır. Yaşlıların fiziksel ve psikolojik sağlıklarının daha iyi olması, ileri yaştaki bireylerin daha uzun süre iş yaşamında kalabilmesi, bakım ve desteğe daha az ihtiyaç hissederek yüksek yaşam kalitesiyle yaşamını sürdürmesi yaşlı dostu ortamların varlığı ile daha olanaklı görülmektedir.

Amaçlar: Bu çalışmanın amacı diğer yaş gruplarına göre yaşlıların daha fazla kullandığı öngörüsüne dayanarak özellikle hastanelerin yaşlı dostu ortam kriterlerine uygun yapılandırılıp yapılandırılmadığını belirlemek ve yaşlı dostu ortamlar konusunda farkındalığın artırılmasına katkıda bulunmaktır.

Metod: Ankara ve İstanbul’da ki bazı özel hastanelerin (N= 8) yöneticilerine yönelik hazırlanmış olan derinlemesine görüşme soruları ile bir çalışma yapılmış ve elde edilen sonuçlar değerlendirilmiştir.

Sonuç: Çalışma yapılan hastanelerin yaşlı bireylerin ihtiyacını karşılayacak yaşlı dostu ortamların oluşturulması ile ilgili kriterleri yeterince bilmedikleri bu konu ile ilgili farkındalıklarının yetersiz olduğu görülmektedir. Sağlık hizmeti sunan hastanelerde gerek çalışanlar gerekse sağlık hizmeti alanlar açısından yaşlı dostu ortamların oluşturulması büyük önem taşımaktadır. Bu bağlamda, hastanelerde yaşlı dostu ortamların oluşturulması ile ilgili farkındalığın geliştirilmesi önemli görülmektedir.

Anahtar Kelimeler: yaşlı, hastane, yaşlı dostu ortamlar, yaşam kalitesi

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Session on MOPACT - Mobilizing the Potential of Active Ageing in Europe – Interim results from an interdisciplinary European 7th Framework Research project

Authors: Rolf Heinze¹ and Josef Hilbert²

Background and objectives: The central aim of MOPACT is to make longevity an asset for social and economic development. To achieve this aim MOPACT concentrates the highest possible quality of scientific analyses into the development of innovative policies and approaches that can assist public authorities and other key actors, at all levels in Europe. MOPACT starts from the conviction that Europe requires a new paradigm of ageing if it is to respond successfully to the challenges of demographic change.

Keywords: Active ageing, longevity as an asset, innovative policies, social Innovation

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Potentials of Social Support and Long-term Care

Authors: Monika Reichert¹ and Sandra Schulze²

Background: The mission of MOPACT is to concentrate the highest possible quality of scientific analyses into the development of innovative policies and approaches that can assist public authorities and other key actors at all level in Europe to make longevity an asset for social and economic development. In the case of Workpackage 8 it concerns the field of Social Support and Long-Term Care.

Objectives: One of the main economic and social challenges deriving from population ageing concerns the matching between supply and demand for social support and long-term care. To achieve a more active and inclusive understanding and experience of the ageing process, also in case of long-term care needs, it is necessary to change current socio-economic perceptions and approaches to care.

Methods: Finding best-practice examples of social innovative activities (to support dependent older people and their carers) in the field of long-term care via literature review, expert interviews and internet based research in all “MOPACT “ countries including Germany. Identify main drivers of change in delivering social support and long-term care by using a mix of different qualitative methodological approaches, such as expert interviews, focus groups, case studies and policy analysis.

Findings: Up to now the German team identified many social innovative projects in the field of long-term care. Three will be presented during the symposium:

1. Bielefelder Modell (attendance and care in the neighbourhood)
2. Pflegestützpunkt Mönchengladbach (nursing care base Mönchengladbach)
3. TAPA-K: day-care center for people (relatives) in need of long term care of employees of hospitals

Conclusions: There are good examples of social innovation in long term care in Germany. However, it remains to be seen whether these initiatives are sustainable and transferable to other countries.

Keywords: Social innovation, home care, social responsibility

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ICT-Based Products and Services Supporting Independent Living in Old Age

Authors: Rolf G. Heinze¹ and Sebastian Merkel²

Background: Information and communication technologies (ICT) can help supporting an independent living as ICT-based devices help persons to stay in their own home as long as possible, support their mobility and provide access to daily services, especially healthcare. Much effort has been put into R&D of ICT-based solutions on the European level as well as on national level in recent years. But up to now not many products and services have been implemented on a large basis, the lack of diffusion can be seen as the most relevant challenge – due to various reasons.

Objectives: The paper evaluates the chances of ICT-based assistant systems aiming at supporting independent living in old age. This is done for Germany however embedded into an international comparison.

Methods: Literature review, expert interviews, evaluation of best practices in Germany and selected Scandinavian countries.

Findings: In Germany in recent years a variety of models of ICT-based “good practices” has been developed. However these models neither could be successful on the market nor enter the social security systems. The paper discusses the respective reasons and shows possible solutions.

Conclusions: Against the background of demographic change and collective ageing of the population the importance of ICT-based measures to promote independent living in old age will increase. It will be shown that certain prerequisites are necessary which require political support and new “strategic alliances” of relevant groups of actors.

Keywords: ICT-based solutions for independent living, telemedicine, ambient assisted living, good practices

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Where Are Older Persons in the United Nations Post-2015 Development Agenda?

Authors: James Collins¹

Background: Poverty and lack of access to affordable health care afflict too many of the world's population. The United Nations (UN) Millennium Development Goals (MDGs) for 2015 sought to address these global problems but failed to include older persons as a target population. The UN General Assembly is currently debating a successor "Post-2015 Development Agenda" with the goal of reaching an agreed text for adoption by Heads of State in September 2015.

Objectives:

- explain why older persons need to be explicitly included in the next UN development agenda
- provide summary of issues currently being argued
- propose how aging professionals might inform the debates

Methodology: Presentation will report on the status of negotiations by the UN's member-states, including Turkey, through September 2014 as reflected in the meetings of the UN General Assembly's Open Working Group on Sustainable Development Goals, the General Assembly President's six special events scheduled for 2014, and other relevant processes.

Findings: Currently (January 2014), explicit reference to older persons in any post-2015 Goals appears improbable, but possible in some post-2015 Targets and most likely in numerous post-2015 Indicators.

Key Words: Goals, Targets, Indicators, Sustainable Development

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A Danish Nursing Home with A Multi-Ethnic Profile. Challenges, Negotiations, Experiences.

Authors: Anne Leonora Blaakilde¹, Eva Algreen-Petersen, Christine E. Swane

Background: For more than 100 years Denmark has offered public nursing homes to frail older persons. Hence, Denmark represents a culture where institutional caretaking is accepted and expected. Today, the major part of homecare and nursing homes in Denmark are public or subsidised by state and municipalities. However, the migration populations in Denmark do not utilize public help and care in old age at any significant level.

This is the reason why the municipality of Copenhagen is developing a specific 'diversity profile' in an existing public nursing home in Copenhagen with the aim of attracting especially older migrants and refugees for the next three years. The largest minority population in Denmark is of Turkish origin.

Objectives: The municipality of Copenhagen together with the EGV Foundation carries out a research project during the three years of developing the 'diversity profile'. The research project focuses on everyday life of particularly inhabitants but also of family caregivers and staff.

Methodology: The methodological approach is phenomenological through ethnographic fieldwork and qualitative interviews. The aim is to follow the discourses and practices related to concepts of diversity as they may change during the three years, as well as the everyday life communication, care routines and rituals related to individual social and cultural needs.

Findings and Conclusion: This presentation will report about the beginning of the process; focusing on negotiations, expectations, and experiences represented by staff, new inhabitants of different ethnic origin and their family members.

Keywords: Denmark, nursing home, elderly migrants, care.

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Innovative Leadership in Postgraduate Curriculum: The Key For Effective Leadership and Management in Aged Care Services

Author: Jocelyn Angus¹

Background: In the next decades of the 21st Century, the global ageing of populations will challenge every nation's ability to provide leadership, by qualified health and allied professionals, to reshape and advance aged care delivery systems. The challenge for educators is to design and deliver cross-disciplinary courses that give students the interdisciplinary knowledge and skills they need to develop their intercultural understanding and sense of ethical citizenship to confidently fill those leadership roles in the delivery of aged care services.

Objective: This paper explores the ways in which a curriculum can develop graduates who are equipped with critical and work-ready skills to lead in culturally diverse contexts; and to find and lead in creative and evidence-based solutions to important contemporary challenges of a globally ageing population.

Methodology: The *Master of Health Science - Aged Services* program at Victoria University, Melbourne, Australia is used as a case study to articulate the process by which the concept of leadership is applied as the key driver in developing effective strategies for aged and dementia management in postgraduate curriculum.

Findings: This case study will demonstrate the process in which students develop as innovative leaders with management confidence and skills to communicate effectively and work collaboratively in a rapidly growing and increasingly corporatized Aged Services Industry.

Conclusion: The provision of cross-disciplinary postgraduate curriculum focussed on leadership provides students with the skills to confidently meet both the challenges of a rapidly changing demographic, political and economic climate; and increased public demand for excellence in delivery of aged services in the new millennium.

Keywords: effective management; aged care services; leadership; gerontology; curriculum development.

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