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Original Article

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Assessment of Knowledge on Osteoporosis among Middle Aged Women in Maraimalai Nagar, Kattankulathur

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Abstract

Introduction: Osteoporosis is one of the major public health problems from which more and more people in the world are suffering. There is evidence suggesting that osteoporosis knowledge is one contributor to osteoporosis preventive behaviour. Low literacy rates, lack of awareness regarding disease consequences and risk factors ultimately results in increased incidence of this combatable disease. *Objective:* The objective of the study was to assess the knowledge on osteoporosis among middle aged women in Maraimali Nagar. *Methodology:* The research approach was quantitative and the research design adopted was descriptive research design. The investigator adopted non-probability convenient sampling technique Data was collected from 160 samples in the selected setting. Knowledge on osteoporosis was assessed by using structured questionnaire developed by the investigator. The collected data was analysed using descriptive and inferential statistics. *Results:* Among 160 samples taken for the study, Majority 108 (67.5%) middle aged women had moderate knowledge on osteoporosis, 45 (28.1%) women had inadequate knowledge and only 7 (4.4%) women had adequate knowledge on osteoporosis. *Conclusion:* The results revealed that majority of the samples had moderate knowledge on osteoporosis, hence knowledge on osteoporosis among middle aged can be imparted through periodic mass awareness programme in the community to prevent osteoporosis and to improve the quality of life among middle aged women.

Keywords: Osteoporosis; Knowledge; Complications; Prevention.

Introduction

Osteoporosis is one of the major public health problems associated with aging. It is a serious metabolic bone disease, from which more and more people in the world are suffering [1]. It is more prevalent among women than among men .Osteoporosis is a "silent killer" that millions of people around the world suffer from it and are unaware that they have the condition until they experience a fracture. Several risk factors for osteoporosis have been identified. These include female sex, Asian or Caucasian race, advancing age, family history of osteoporosis or fragility fractures, a low body mass index, menopause before age 45 years, prolonged amenorrhea unrelated to menopause, nulliparity, prolonged lactation, diet low in calcium and vitamin D, poor intestinal absorption of calcium, lactose intolerance, excessive caffeine or alcohol consumption; smoking,sedentary life style, and prolonged treatment with thyroid hormones, glucocorticoids, anticonvulsants, aluminium antacids, and use of anticoagulants [1].

Approximately 20% of bone mass is genetically determined; however, the risk of osteoporosis can be reduced by optimizing bone mass increasing during youth, conserving bone mass during adulthood and minimizing bone mass loss during advancing age. Among most important preventive habits is a) weight-bearing exercise (e.g. going up and down stairs, jogging, aerobics, swimming, and isometrics for at least 30 minutes daily), b) diet or supplements containing adequate levels of calcium and vitamin D, and c) absence or cessation of smoking and no greater than moderate alcohol and/or caffeine consumption [2].

Worldwide, osteoporosis causes more than 8.9million fractures annually, resulting in a fracture every 3 second [3]. About half of all women above the age fifty develop fracture of hip, wrist or vertebra during their lifetime. It affects 200 million women worldwide approximately one-tenth of women aged 60, one fifth of women aged 70, two-fifths of women aged 80 and two thirds of women aged 90 [4]. After menopause, 54% of females are considered to have osteopenia, and 30% of them could develop osteoporosis in the future. Prevalence of osteoporosis increases with age; it can range from some 5% in women of 50 years old to about 50% in women over 85 years [5].

In India the number of osteoporosis patients is approximately 28 million in 2011among which 80% are women and is expected to increase another 5million in just 12-14 month [6]. In a study among Indian women aged 30-60 years from low income groups, bone mineral density at all the skeletal sites were much lower than values reported from developed countries, with a high prevalence of osteopenia (52%) and osteoporosis (29%) thought to be due to inadequate nutrition [7] According 2011 census in India the total slum population is 65.5 million out of which 31.5 million are female [8].

Osteoporosis prevention programmes for the young women have the potential to reduce osteoporosis risk and thus prevent or delay the development of the disease. The rationale for early primary intervention is that attaining and maintaining strong, dense bone as a young adult is a critical factor in the prevention of osteoporosis in later life [9]. A key component in developing successful education interventions by health care professionals is understandingWhat women know about the disease and to what extent they practice preventive behaviours.

Knowledge of modifiable risk factors (smoking, lack of physical exercise, dietary habits, multiparity) and treatment for osteoporosis should be targeted by prevention programmes. Estimating the level of knowledge of the population can help to guide public health programmes. Some studies have revealed that education programmes for the elderly were effective in improving health promotion knowledge and behaviours [10].

Materials and Methods

Quantitative approach anddescriptive research design was adopted for the study. The variables studied were study variable and demographic variables. The study variables was Knowledge on osteoporosis among middle aged women whereas the demographic variables includes Age, religion, education, occupation, monthly income, type of diet and type of family. The study was conducted in Maraimalai Nagar, Kancheepuram district. The setting was chosen on the basis of feasibility in terms of availability of adequate samples and co-operation extended by mothers in various houses. The accessible population includes middle aged women those who were resided in Marai Malai Nagar. Sample consisted of the middle aged women those who fulfilled the inclusion criteria. Thesample size for the study was estimated based on previous studies and formula applied was $n=4pq/L^2$, based on this formula the sample size was 150 but the investigator took 160 samples.Non probability purposive sampling technique was adopted to select the samples for the study. The Inclusion criteria comprised of the women who were between the age group of 36-55 years, women who were willing to participate in this study, women, who were able to read, write, speak and understand Tamil or English. The exclusion criteria includes women who were recently underwent educational sessions on Osteoporosis, middle aged women who were physically ill during the time of data collection, middle aged women who were diagnosed with Osteoporosis.

Instruments

Instrument used for data collection was structured questionnaire developed by the investigators which consist of two sections

Section A: Questionnaire to assess the demographic variables of the samples.

Section B: Structured questionnaires to assess the knowledge on Osteoporosis among middle aged women which includes 30 questions.

The items of the instrument were established on the basis of opinion of nursing experts. Suggestions were incorporated in the tool. The reliability of the tool was done by test re-test method and its correlation coefficient r- value was 0.81 which indicated positive co-relation to proceed for the main study. The proposed study was approved by Institutional Ethics Committee of SRM Medical college Hospital and Research Centre, SRM University, Kattankulathur, Kancheepuram District on 28.10.2016 at 10.00am. Ethical clearance number: 1074/IEC/2016. Permission was obtained from the Dean, SRM college of Nursing and informed consent was obtained from each participant for the study before starting data collection.

After obtaining formal approval from administration, Maraimalai Nagar ward counsellor. The investigator explained the objectives and method of data collection. Data collection was done within the given period of 1 week in Maraimalai Nagar. The data collection was done during the day time. Self-introduction about the investigator and details about the study was explained to the samples and their consent was obtained. The knowledge on osteoporosis was assessed among middle aged women in Maraimalai Nagar using the tool. The confidentiality about the data and finding were assured to the participants. The participants took 30 minutes to complete the tool and their co-operation was imperative. Descriptive and inferential statistics were used to analyse the collected data. Inferential statistics- chi square was used to find out the association.

Results

Table 1: Frequency and percentage distributions of demographic data of the middle aged women

N=160

Name of the Variables	Division of the Variables	Frequency	Percent
Age	36-45Years	91	56.9
	46-55 Years	69	43.1
Religion	Hindu	132	82.5
	Muslim	8	11.9
	Christian	19	5.0
	Others	1	0.6
Occupation	Unemployed	32	20.0
	Unskilled workers	113	70.6
	Skilled worker	13	8.1
	Clerical, shopkeeper, farmer	2	1.3
Mother's Education	Illiterate	7	4.4
	Primary School Certificate	20	12.5
	Middle School Certificate	31	19.4
	High School Certificate	51	31.9
	Intermediate Or Post High School Diploma	17	10.5
	Graduate Or Post Graduate	34	21.3
Income	Rs.1590-4726	33	20.6
	Rs.4727- Rs.7877	29	18.1
	Rs.7877-Rs.11876	22	13.8
	Rs.11,877-Rs.15,753	30	18.8
	Above 15,754	46	28.7
Type of Family	Nuclear family	98	61.3
	Joint family	57	35.6
	Extended family	5	3.1
Type of Diet	Vegetarian	54	33.7
	Non-vegetarian	106	66.3

Table 2: Objective 1: To assess the level of knowledge on Osteoporosis among middle aged women

N=160

		Frequency	Percent
Knowledge	Inadequate knowledge	45	28.1
	Moderate knowledge	108	67.5
	Adequate knowledge	7	4.4

Table 3: Objective 2:- To associate the knowledge on Osteoporosisamong middle aged women with their demographic variable N=160

Demographic variables		Knowledge					
		Inadequate Knowledge N (%)	Moderate Knowledge N (%)	Adequate Knowledge N (%)	Total N (%)	Chi Square Value	P Value
Age	36-45Years	24 (53.3)	64 (59.3)	3 (42.9)	91 (56.9)	1.041	0.594
	46-55Years	21 (46.7)	44 (40.7)	4 (57.1)	69 (43.1)	DF = 2	NS
Type of Family	Nuclear Family	27 (60.0)	70 (64.8)	1(14.3)	98 (61.3)	8.511	0.075
	Joint Family	16 (35.6)	35 (32.4)	6 (85.7)	57 (35.6)	DF =4	NS
	Extended Family	2 (4.4)	3 (2.8)	0(0)	5 (3.1)		
Dietary Pattern	Vegetarian	13 (28.9)	40 (37.0)	1 (14.3)	54 (33.8)	2.184	0.336NS
	Non Vegetarian	32 (71.1)	68 (63.0)	6 (85.7)	106 (66.3)	DF= 2	
Religion	Hindu	31 (68.9)	95 (88.0)	6 (85.7)	132 (82.5)	10.346 DF = 6	0.111 NS
	Muslim	5(11.1)	3(2.8)	0(0)	8(5.0)		
	Christian	9 (20.0)	9(8.3)	1(14.3)	19(11.9)		
	Others	0(0)	1(0.9)	0(0)	1(0.6)		
Mother's Education	Illiterate	3(6.7)	4(3.7)	0(0)	7(4.4)	26.020	0.004
	Primary School Certificate	9(20.0)	11(10.2)	0(0)	20(12.5)	DF = 10	***
	Middle School Certificate	6(13.3)	25(23.1)	0(0)	31(19.4)		
	High School Certificate	18(40.0)	31(28.7)	2(28.6)	51(31.9)		
	Intermediate Or Post High School Diploma	8(17.8)	7(6.5)	2(28.6)	17(10.6)		
	Graduate Or Post Graduate	1(2.2)	30(27.8)	3(42.8)	34(21.3)		
Income	Rs.1590-4726	10(22.2)	23(23.1)	0(0)	33(20.6)	12.062	0.148
	Rs.4727- Rs.7877	8(17.8)	21(19.4)	0(0)	29(18.1)	DF = 8	NS
	Rs.7877-Rs.11876	7(15.6)	13(12.0)	2(28.6)	22(13.8)		
	Rs.11,877-Rs.15,753	12(26.7)	15(13.9)	3(42.9)	30(18.8)		
	Rs>15,754	8(17.8)	36(33.3)	2(28.6)	46(28.8)		
Occupation	Unemployed	14(31.1)	18(16.7)	0(0)	32(20.0)	7.826	0.251
	Unskilled workers	27(60.0)	79(73.1)	7(100)	113(70.6)	DF = 6	NS
	Skilled worker	3(6.7)	10(9.3)	0(0)	13(8.1)		
	Clerical, shopkeeper, farmer	1(2.2)	1(0.9)	0(0)	2(1.3)		

***-There is Statistical significant association between Mother's Education and Knowledge at 95%($p< 0.05$).

Discussion

Osteoporosis is a significant global public health issue, expected to affect more people world-wide than ever by 2050. It is no longer confined to the growing older population but has implications for all age groups. Publicawareness of osteoporosis remains low, especially in less developed countries [11]. The purpose of the present study was to assess the knowledge on osteoporosis among middle aged women. The study results revealed that majority 108 (67.5%) women had moderate knowledge regarding Osteoporosis.

A similar study was conducted by Ellen T. Edmonds and Lori W. Turner to assess osteoporosis knowledge, beliefs and preventive behaviours among 321 premenopausal adult women and to identify sources that they would mostly likely utilize to learn more about the disease. The findings revealed that 277 (86%) of the participants had heard about osteoporosis, but only 3.8% of them were following adequate exercise and intake of recommended 1,200 mg of calcium per day. They believed that they were unlikely to develop osteoporosis and that osteoporosis is less serious than heart disease and breast cancer [12].

Another study wasconductedby K Pande et al on knowledge about osteoporosis in learned Indian women; identify their source of knowledge and to study the correlation of level of knowledge with other variables. The results shown that the correct definition of osteoporosis was given by 74%, but there was general lack of awareness in all the areas assessed [13].

Though it is not a common cause of mortality but it contributes to high morbidity among this age group of womenMaking the vulnerable aware of the disease will bring there by enhance the quality of life of

women in old age. Public seminars, leaflet distribution, television programme, A pro-active role by health policy planners, medical associations and other non-government organisations will be useful in this regard.

Conclusion

The study concludes that majority 108 (67.5%) middle aged women had moderate knowledge on osteoporosis, only 7 (4.4%) women had adequate knowledge on osteoporosis and 45 (28.1%) women had inadequate knowledge The results revealed that majority of the samples had moderate knowledge on osteoporosis, hence knowledge on osteoporosis among middle aged can be imparted through periodic mass awareness programme in the community to prevent osteoporosis and to improve the quality of life among middle aged women.

Acknowledgement

The investigator acknowledges Dean, SRM college of nursing ward counselor for granting permission to conduct the study in selected setting. Sincere gratitude to Dr. Christopher HOD department of community health, SRM medical college for estimated the sample size and thanks to all the study participants who co-operated during data collection.

Conflicts of Interest

The author declares no conflict of interest.

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Original Article

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Effectiveness of Scheduled Ambulation on Immediate Postoperative Outcomes among Patients Following Major Abdominal Surgeries in Government Medical College and Hospital at Tiruvannamalai

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Abstract

Early mobilization is a widely practiced and important component of post-operative care following open abdominal surgery. Mobilization involving an upright position appears to be of greatest benefit in the early postoperative period with evidence of improvements in pulmonary function. A study to determine the effectiveness of scheduled ambulation on immediate postoperative outcomes among patients following major abdominal surgeries in government medical college and hospital at Tiruvannamalai. 50 subjects were selected by using convenient sampling technique. The findings revealed that that majority 15 (60%) of respondents in experimental group is moderate activity. In control group majority 16 (64%) is in poor activity. In comparative findings the mean experimental group score is 44.2 and control group was 24 and 't' test value is 4.42 result was found to be statistically significant at P< 0.05 level.

Keywords: Scheduled Ambulation; Major Abdominal Surgeries and Post Operative Period.

Introduction

'Those who do not find time for exercise, will have to find time for illness''

Almost 70% of surgeries performed in the hospitals are related to the abdomen. Many patients develop complications after the surgery and nurses are at the high priority care giver to the patients after surgery. A major change in the past decade has been the emergency of outpatient surgery centers and ambulatory surgery. 60% of all the major surgeries are requiring on the basis of early ambulation. This is a development that is changing the focus of nursing care of postoperative patients based on scientific knowledge of all the phases of rehabilitation after surgery.

The common problems arising after surgery performed under general anesthesia are, circulatory complications, problem of consciousness, discomfort, and respiratory tract complications. When a patient develops the postoperative complications it will result into increase in hospital stay as well as economical loss.

Pulmonary complications are high priority after major abdominal surgery. According to presentation at 'Society for hospital medicine,' it is observed that the number of pulmonary complications after major abdominal surgery has been increased between 2010 and 2012. Pulmonary complications after abdominal surgery also increases hospital stay as well as cost of care. This leads to poor prognosis of the patient. There is a need of proper interventions to overcome these problems, so that the patients will have the immediate postoperative recovery without any complication from the surgical illness.

Statement of the Problem

A study to determine the effectiveness of scheduled ambulation on immediate postoperative outcomes among patients following major abdominal surgeries in government medical college and hospital at Tiruvannamalai.

Objectives of the Study

1. Assess the effectiveness of scheduled ambulation on immediate post operative outcomes in the

experimental group.

2. Determine the effectiveness of early ambulation measured by postoperative outcomes between experimental group and control group.
3. Associate the effectiveness of scheduled ambulation with selected demographic variable age, sex, religion, type of family, income and type of surgery.

Operational Definitions

1. Effectiveness: Refers to the difference of scores obtained from the subjects on patient outcomes between experimental group and control group.
2. Scheduled ambulation: Refers to the planned activity which comprises of bodily movement and exercises, which would be performed and taught to the patient every four hourly for the first 72 hours after major abdominal surgery.
3. Major abdominal surgery: Refers to operation done through anterior abdominal wall.
4. Immediate Postoperative Period: Refers to the period from patient transferred from the operation theater to the 72 hours.
5. Immediate Postoperative Outcomes: Refers to the assessment of parameters such as level of pain, level of fatigue, urinary retention, orthostatic hypotension, collection of flatus, constipation, and activity of daily living.

Hypothesis

H_1: There will be significant difference between the postoperative outcome scores in the subjects exposed to scheduled ambulation than those who are not exposed to scheduled ambulation.

Research Methodology

Research Design

Quasi – experimental design (Non equivalent control group post test only design) to assess the effectiveness of scheduled ambulation on immediate copulative outcomes among patients with major abdominal surgical ward in Government Medical College & Hospital, Tiruvannamalai.

Variables

- *Independent Variable - Scheduled* ambulation among major abdominal surgery patients.
- *Dependent Variable* - Immediate outcomes of surgery among major abdominal surgery patients.

Setting of the Study

The study was conducted who is admitted in surgical ward of Government Medical College & Hospital, Tiruvannamalai. This hospital is situated 2 km away for our college campus.

Population

The population of the study is surgery patients who admitted in Government Medical College & Hospital, Tiruvannamalai.

Sample

Major abdominal surgery under general anesthesia patients who admitted in Government Medical College & Hospital, Tiruvannamalai.

Sample Size

Sample size is 50 people. (Experimental group 25 and control group 25)

Sample Technique

Sample was selected by using convenient sample technique.

Inclusion Criteria

1. Patients following major abdominal surgeries under general anaesthesia.
2. Postoperative patients who are admitted for three days in surgical units.
3. Patients who give consent for the study.
4. Postoperative patients who are available at the period of study.
5. Patients who are conscious and able to follow oral commands.

Exclusion Criteria

1. Patients who have undergone minor abdominal surgery under spinal anaesthesia.
2. Patients with shock.
3. Patients having cardiac problems.
4. Patient who have not given consent for the study.
5. Patients associated with neurological disorders manifesting altered sensorium.

6. Patients not following oral commands.

Develepment of the Data Collection Instrument:-

The research tool was the help of literature & experts opinion. The tool used for data collection was observational check list and structured questionnaire.

Data Collection Procedure

The formal permission for conducting the study was obtaining from the nursing superintend of Government Medical College & Hospital, Tiruvannamalai. The investigator was established within the subject & brief introduction about research purpose and the tool given. The subjects were assured confidently they were requested to reply frankly and truly. Scheduled ambulation will be implemented on experimental group every fourth hourly for first 72 hours. The patient's outcomes will be measured on fourth post operative day using observation checklist and questionnaire from experimental group. The same tool will be used for controlled group without intervention. The proposed data collection duration is 30 days.

Data Analysis and Interpretation

Distribution of ambulation status in posttest among experimental and control group. Distribution of samples according to ambulation status should that 15 (60%) of experimented group were moderate activity. 6 (24%) of were good activity control group 16 (64%) were poor activity, 7 (28%) were moderate activity and 2 (8%) were good activity.

Table 1: Show that Distribution of Demographic Characteristics among Major Abdominal Surgery People N = 50

S. No	Variables	Experimental group		Control group	
		Frequency	Percentage	Frequency	Percentage
1.	**Age**				
	20-35 years	10	40	11	44
	36-50 years	8	32	6	24
	51-65 years	5	20	5	20
	66-80years	2	8	3	12
2.	**Sex**				
	male	6	24	4	16
	female	19	76	21	84
3.	**Religion**				
	Hindu	18	72	22	88
	Christian	5	20	2	8
	Muslim	2	8	1	4
4.	**Type of family**				
	nuclear family	17	68	22	88
	joint family	8	32	3	12
5.	**Income**				
	< 3000	8	32	8	32
	3001 – 5000	9	36	10	40
	5001 – 7000	5	20	2	8
	> 7000	3	12	5	20
6.	**Education**				
	Illiterate	8	32	15	60
	primary school level	7	28	6	24
	higher secondary level	8	32	2	8
	graduation	2	8	2	8
7.	**Area of resident**				
	urban	3	12	6	24
	rural	22	88	19	76
8.	**Type of surgery**				
	Appendectomy	7	28	2	8
	Gastrectomy	6	24	7	28
	LSCS	5	20	7	28
	Colostomy	3	12	2	8
	laparotomy	3	12	7	28

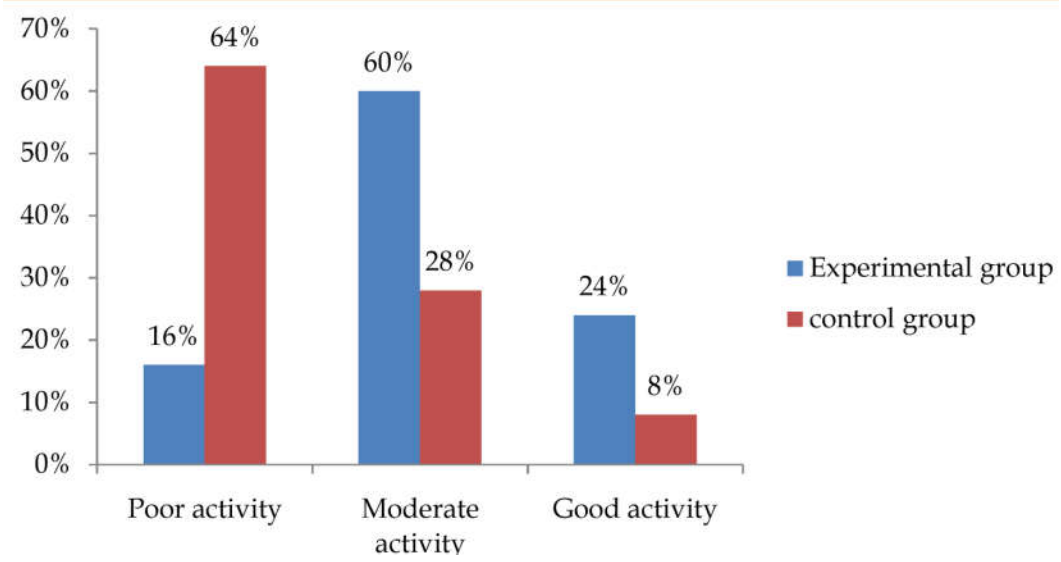

Fig. 1: Shows the distribution of ambulation status in post test among abdominal surgery patients

Table 2: Distribution of comparison between post test in experimental and control group N = 50

Group	Mean	Median	Mode	Standard deviation	't' test	P value
Experimental Group	44.2	40	37	17.63	4.42	< 0.05
Control Group	24	18	17	14.48		

Above the table depict that the mean experimental group score is 44.2 and control group was 24, t – test value is 4.42 at statistically significant at P< 0.05 level.

Discussion

Demographic Variables (Sample Characteristics)

The finding of experimental group should that majority of respondents 10 (40%) were in the age group of 20 - 35 years, 8 (32%) respondents in 36 -50 years, 5 (20%) were in the age group of 51- 65 years and 2 (8%) respondents in 66 – 80 years. In sex 19 (76%) to respondents in female, 6 (24%) of the respondents in male. In relation 18 (72%) belong to Hindu 5 (20%) were belong to Christian and family 2 (8%) of respondents were to belong to Muslim. Result shows that the majority of respondents 17 (68%) were in nuclear family and 8 (325) were in joint family. In income the majority 9 (36%) of respondents had income between Rs. 3001 to 5000. 8 (32%) had less than Rs.3000, 5 (20%) had income between 5001 to 7000 and 3 (12%) had income of more than Rs.7000/-. In education majority 8 (32%) of respondents in illiterate and higher secondary level, 7 (28%) were primary school level and 2 (8%) were graduated. In area of resident majority 22 (88%) were in rural resident and 3 (12%) were in urban resident.

Among control group the majority 11 (44%) were in the age group of 20 – 35 years, 6 (24%) were in 36 – 50 years, 5 (20%) were in 51 – 65 years and 3 (12%) were in the age group of 66 - 80 years. In sex majority is 21 (84%) in female and 4 (26%) were in male. In religion majority 22 (88%) of respondents belongs to Hindus, 2 (8%) were in Christian 1 (4%) were in Muslim. In type of family majority 22 (88%) of respondents were in nuclear family and 3 (12%) were in joint family. In education majority 15 (60%) were in illiterate group, 6 (24%) were in the primary school level and 2 (8%) were in the higher secondary school level and graduation.

The first objective of the study was to assess the effectiveness of scheduled ambulation on immediate post Operative outcome in the experimental group.

The findings showed that 4 (16%) of respondents have poor activity, 15 (60%) have moderate activity and 6 (24%) good activity.

The second objective of the study was to determine the effectiveness of early ambulation measured by postoperative outcomes between experimental group and control group.

Distribution of samples according to ambulation status showed that 15 (60%) of experimental group were moderate activity, 6 (24%) of were good activity. Control group 16 (64%) were poor activity, 7 (28%) were moderate activity and 2 (8%) were good activity.

The third objective of the study was to determine the comparison of early ambulation measured by postoperative outcomes between experimental and control group.

In comparative findings the mean experimental group score is 44.2 and control group was 24, t – test value is 4.42 at statistically significant at P< 0.05 level.

The fourth objective of the study was to associate the post test ambulation with selected demographic variables.

Chi square test was used to find the association & selected variable. The result shows that in age chi square value is 2.86 & table value is 7.82. In sex chi square value is 0.56, table value is 3.84. In religion chi square value is 2.016 & table value is 5.99. In type of family chi square value is 2.872 & table value is 3.84. In income chi square value is 1.836 & table value is 7.82.

It shows that there is significant association between age, sex, religion, type of family & income.

Conclusion

The study findings may be helpful to abdominal surgical patients to prevent post operative complication. Healths workers can be motivate and demonstrate scheduled ambulation on major abdominal surgeries patients to improve patients health status.

Recommendations for Further Study

Based on the finding of the study, following recommendations are made:

- Study can be supplicated using large number of samples to make it more reliable.
- The study can be done comparing abdominal surgery people from different techniques in postoperative interventions.
- A comparative study can be done between to various surgery people providing various techniques.

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Review Article

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Child vs Elderly: A Relationship Beyond *Role Reversal* at Family Level

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Abstract

Children and elder members are important part of community. Seniors are helping hand and a guide for junior members, whereas, children are the source of excitement, motivation and caregiver for an elderly Though the relationship between immediate family members like parents and siblings is important, but the attachment beyond this can make a positive contribution to child psycho-social, emotional development as well as overall growth and development. Many seniors take the responsibility as parents whereas many others describe the mere pleasure of spending time with a young generation without being burdened by the responsibility. Healthcare workers are responsible to promote healthy relationship between the child parents and elderly

Keywords: Child Elderly; Old Age; Geriatric.

Introduction

Society without a child or an elderly is impossible. The share of *India's population* of age group 60 and older is projected to climb from 8 percent in 2010 to 19 percent in 2050, according to the United Nations Population Division (UN 2011). Whereas, India has one of the largest proportions of population in the younger age groups in the world. Around 35.3% of the population of the country has been in the age group 0-14 years as per the Census 2001. Approximately, 41% of the population account for less than 18 years of age [1].

The US census bureau defines "family as two or more people living together and who are related by birth, marriage or adoption" [2]. Though this definition limits the members to be counted in the family, no matter co-habiting in one home or living in distance they are members of same family. An independent and developing relationship between grand children and grand parents is "invaluable" for everybody in the family. Grandparents or other seniors in family are helping hand and a guide for junior members, whereas, children are the source of excitement, motivation and caregiver for an elderly [3].

Grandchildren Provide New Focus to Family Relationship

Presence of young child in the family gives a new focus for a family relationship. This can be rekindling in the form of intimacy that might have got lost along the way enriching lives across the three generation. Though the relationship between immediate family members like parents and siblings is important, but the attachment beyond this can make a positive contribution to child psycho-social, emotional development as well as overall growth and development.

Being Grandparents Presents an Exciting Opportunity for Growth and Change

Becoming the senior-most in the family provides an exciting opportunity for an elderly at this stage and also for the growth and change within the family. After passing the significant stages of life, this experience gives a blend of new life experiences to the aged. Today, many grandparents stay with family and children by taking the responsibility of the parents whereas many others describe the mere pleasure of spending time with a young generation without being burdened by the responsibility. Currently many elderly are active in profession or

social life of their own. Whatever the situation, becoming a senior gives a direct connection to the whole world and an opportunity to stay in touch with new ideas and the generation ahead.

Role of Elderly in Life of a Child – *G-R-A-C-E*

Seniors like Grandparents play an indispensible role in life of child .It includes **G**reat friend, **R**ole model, **A**nnalist (historian), **C**aregiver and **E**ducator.

Great Friend

Grandparent provides an opportunity for a child to expand relationship as a friend. As Grandparents, many times they are not only responsible for caring or disciplining a child, but also to act as a special friend and inculcate the value of friendship.

Role Model

Social scientist proved that much of learning during childhood is acquired thought observation and imitation. Good role models create life long impression on children. Elders in the family grandparents, parents, or other seniors act as role model or hero whom they follow. They teach them how to react in difficult situation and they will inevitably face the play of life.

Annalist (Historian)

History, general background, genealogy, family customs and traditions are shared by elders of the family to their grandchildren as children are in a phase of learning through stories. These historical events mesmerize them and thus the seniors play a role of historians.

Caregiver

In most of the culture, families with elders played an important role as caretakers of child. Today many working parents rely on their grandparents to help with child care. As it is considered as safe, economical and also fosters the family relationship, many times, grandparents are called upon for supervision of outside activities camps, sports, so on and so forth. This valuable support is becoming an integral piece for today's family functioning.

Educator

Seniors in the family are often seen as adopting a role as an experienced teacher for the young generation. The vast life experiences help them to gain knowledge and expertise that they pass on to their next to next generation.

Responsibilities of Grand Parents

As an elderly or senior in the family they do have certain responsibilities. They should:

1. Gain insight about their own strength, limitation and express these feelings to the family members.
2. Rebuilt and strengthen the relationship with the members who have adopted a new role and to those who are new members of the family.
3. Attend to everyone.
4. Be neutral and non-judgmental.
5. Create a bridge for the child to move between the lives at home with parents and outside world.

Responsibilities of Family

Child is an important part in the life of elders. Parents and other significant members in the family should bridge the generation gap between the child and grandparents. As parents, they should take the responsibility to flourish child-elderly relationship. They should: [3,4,5]

1. Act like a role model while dealing with elders as children tend to follow the same.
2. Instill positive values.
3. Start expressing feelings to the elders like "I love you" in presence of younger ones.
4. Encourage and appreciate the child's act of kindness and love for elderly.
5. If the grandparents are staying away, arrange frequent visit and sensitize the child to the needs of seniors.
6. Share your experiences to boost grandparent – grand children relationship.
7. Teach children to wish and congratulate their grandparents on occasions.
8. Never control or correct parents in front of their children.
9. Involve children in care of elderly.
10. Arrange visit of seniors to the child's school on special occasions like grandparents day.

Health Professionals as Facilitators of Elder-Family- Child Bond

According to Brubaker and Brubaker, (1992) Tennstedt (1999), care of elderly is a major concern

of nursing, gerontology and policy makers as need of aging societies continues to increase in dramatic proportion [5]. The statistics in United States shows that 80% of the elders are cared by family members primarily by spouse or adult daughters. In India, because of family oriented society most of the elders are cared and valued by family members [6]. The Nurses and other healthcare professionals play a pivotal role in maintaining elderly family and child bond. The health care professional's role includes:

1. Helping the care giver to cope with increasing demand.
2. To help the family members to balance the responsibilities towards elderly for self and to other family members.
3. To guide therapeutic interactions with child and adults involved in parental care.
4. Redirect emphasis to long-term benefits of care giving as well as to draw attention to the roles and needs of other family members.
5. Access and manage the state of stress and crisis.
6. Respect the cultural diversities and family preferences and adopt family friendly policy.
7. Access the family structure and find out the potential resources (child or adult) for the care of elder.
8. Recognize and respect the caregivers' expression of negative or positive emotions like guilt, anxiety, worry, frustration, comfort and counsel them.
9. Nurses act as an educator for the family members require information for care of elderly. She/he facilitates the caregiver's need for learning. Nurse should create awareness among school children regarding needs and care of elderly.
10. Be alert for the caregiver's reactions burnout and depression (Skaff and Pearlin, 1992) and build in support for the long term. Theses supports can be facilitated more by encouraging them to join support groups [7].
11. Encourage quality family time that enhances the positive relationship and also contribute insensitising children about the care of elderly.
12. Maintain coordination between school, parents, child and elderly.

Grandparents are really important for children. Children of all age feel that somebody has time for them. Through their relationship with the seniors, a child can feel another level of support and care [7]. A child can gain not only just a reliable and interested caregiver or babysitter but someone who is a friend and a guide, whereas, grandparents accomplish a great sense of responsibility and satisfaction. Thus a young one in the life of an old or an old in the child is beyond mere role reversal it's an intimate deep relationship.

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