THE PSYCHOSOCIAL NEEDS OF THE ELDERLY AND ITS IMPLICATIONS (A CASE STUDY OF OKPUNO OTOLO COMMUNITY IN NNEWI NORTH LOCAL GOVERNMENT AREA ANAMARA STATE)

BY

UCHE EBUKA HENRY

SSC1608525

DEPARTMENT OF SOCIAL WORK
FACUTY OF SOCIAL SCIENCE
UNIVERSITY OF BENIN

JULY, 2021

THE PSYCHOSOCIAL NEEDS OF THE ELDERLY AND ITS IMPLICATIONS (A CASE STUDY OF OKPUNO OTOLO COMMUNITY IN NNEWI NORTH LOCAL GOVERNMENT AREA ANAMARA STATE)

BY

UCHE EBUKA HENRY

SSC1608525

A PROJECT WORK SUBMITTED TO THE DEPARTMENT OF SOCIAL WORK, FACULTY OF SOCIAL SCIENCES, UNIVERSITY OF BENIN BENIN CITY. IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS FOR AWARD OF BACHELOR OF SCIENCE BSc. (HONS) DEGREE IN SOCIAL WORK UNIVERSITY OF BENIN BENIN CITY.

JULY, 2021.

CERTIFICATION

We the undersigned certify that this work was carried out by **UCHE EBUKA HENRY** and we approved of it as adequate both in scope and quality for partial fulfillment of the requirement for the Award of Bachelor of Social Science (B.Sc) Degree in Social Work, University of Benin, Benin City, Nigeria

______________________	______________________
Michael. U. Esin	**Dr. (Mrs.) T. B. E. Omorogiuwa**
(Project Supervisor)	(Head of Department)

______________________	______________________
Date	**Date**

DEDICATION

I dedicate this project work to God almighty my creator, my strong pillar, my source of inspiration, wisdom, knowledge and understanding. He has been the source of my strength throughout this program and on his wings only have i soared.

I also dedicate this work to my late Father **Chief Clement Uche** for his moral support and fatherly care when he was alive. May your soul continue resting in peace Dad. (Amen).

ACKNOWLEDGEMENTS

My profound gratitude goes to God almighty for his strength, Wisdom, guidance, protection and divine mercy during the course of my project. My sincere Appreciation goes to my project supervisor **Mr. Michael. U. Esin** for his immense guidance, contributions, commitment, encouragement, and his prompt attention given to this work. May the good lord fulfil and grant all your heart desires (Amen). I remain indebted to my family, to my Loving and caring Mum. **Mrs. Nkolika Uche**, for your prayers, encouragement, moral and financial support and your advice. I pray that God will keep you to leap the fruit of your Labour Mum. To my dear uncle, Mr. Chidinma Esomeju thank you for your moral advice and financial support all this years. I'm grateful and i pray that God will bless you more.

Special thanks to the Head of Department of Social Work **Dr. (Mrs.) Tracy B. E Omorogiuwa** and also my lectures who worked tirelessly to impact knowledge to me, hence I say a big thank to all of you but I want to acknowledge; Dr. Mrs. Isemila, Dr. Ofili ibobor, Dr. Ugiagbe, Dr. Yesufu, Mr. Owie, Mrs. Eweka, Mr. Omigie, Mr. Charles, Dr. Kelly, Mr. Osagie, Mrs. imudia, and Mr. Eugene. I say thank you to you all.

To my siblings, Chiamaka Uche, Onyedika Uche, Uchenna, Ebere, Chijioke, Nnamdi, thank you all for your advice, encouragement, financial support and your Love all through these years. I love u all. Furthermore, I want to say thank you to my cousin sister Uchechukwu. To my brother, Emelie I thank you for your support.

My warmest gratitude goes to my friends, Chidi, Prosper, Favour, Nonso, Rachael, Peace, Victor, Chidozie, Newman, Uju, Chinaza, as well as other friends not mentioned due to the space shortage. Thanks for making my stay in the University of Benin a remarkable one. I love you all, May God Almighty in his infinite mercy abundantly bless you all Amen.

TABLE OF CONTENTS

Cover Page - - - - - - - - - - i

Title Page - - - - - - - - - - ii

Certification - - - - - - - - - - iii

Dedication - - - - - - - - - iv

Acknowledgements - - - - - - - - - v

Table of contents - - - - - - - - - vi

Abstract - - - - - - - - - - ix

CHAPTER ONE; INTRODUCTION

Background of the Study - - - - - - - - 1

Statement of the Problem - - - - - - - - 2

Objectives of the Study - - - - - - - - 5

Research Questions - - - - - - - - - 5

Significance of the Study - - - - - - - - 5

Area of Study - - - - - - - - - - 6

Operational Definition of Terms - - - - - - - 7

CHAPTER TWO; LITERATURE REVIEW

Introduction - - - - - - - - - - 8

Optimum Ageing; Optimum Quality of Life - - - - - - 8

Factors Affecting the Facilitation of Psychosocial Well-being - - - 11

Comprehensive Knowledge - - - - - - - - 12

Staff and Organizational Factors - - - - - - - 15

The Socialization of Older People - - - - - - - 18

Need for Reform - - - - - - - - - 21

Implication/ Determinants of Health and Quality of Life - - - - 22

Meaningful Relationships Among Aged Elderly - - - - - 26

Psychosocial Care in Practice - - - - - - - - 28

Factors Affecting the Facilitation of Psychosocial Well-being - - - 33

Knowledge and Continuing Education - - - - - - 34

Care of the elderly In Nigeria: Implications for Policy - - - - 36

The Neoliberal State and Care and Support for the Elderly In Nigeria - - 38

Challenges that Come with Ageing and Care of the Elderly In Nigeria - - 39

General and Social Policy aimed at the Elderly - - - - - 44

Elderly Challenges in Nigeria - - - - - - - - 45

Review of Relevant Theory - - - - - - - - 47

CHAPTER THREE: RESEARCH METHODS

Introduction - - - - - - - - - - 55

3.1 Research Design - - - - - - - - 55

3.2 Population of the Study - - - - - - - 55

3.3 Sample Size - - - - - - - - - 56

3.4 Sampling Technique - - - - - - - - 56

3.5 Instrument for Data Collection - - - - - - 57

3.6 Method of Data Collection - - - - - - - 57

3.7 Method of Data Presentation and Analysis - - - - - 57

3.8 Ethical Considerations - - - - - - - 58

CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION

4.1 Introduction - - - - - - - - - 59

4.2 Analysis of Research Question- - - - - - - 61

4.3 Research Question 2 - - - - - - - - 62

CHAPTER FIVE; SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary of Findings - - - - - - - 72

5.2 Conclusion - - - - - - - - - 72

5.3 Recommendations - - - - - - - - 73

REFERENCES 74

APPENDIX 88

ABSTRACT

Nigeria has no functional national policy on the care and welfare of older persons. Changing demographics in Nigeria, in addition to the breakdown of the family structure and absence of a social security system, present unique challenges to the elderly in Nigeria. This paper analyzes the current policy lacuna and future issues concerning older persons in Nigeria. It posits that the introduction of neoliberal economic policies created a vacuum in policy formulation and execution in which the older persons are not provided for within the social safety nets in the neoliberal state. This exploratory, qualitative study is based on interviews and narratives of interviews with government officials. The findings of the study show that, in the face of rapid demographic change, one of the major challenges facing Nigeria is developing policies and appointing personnel capable of understanding and responding to the current social priorities and complex needs of an increasingly ageing population in the country.

Furthermore, the findings of this study shows that modernization has brought a lot of changes in ageing population in Nigeria. The more modernized a society becomes the more the status of the other declines. The extended family no longer care for aged parents at home because of modernization. Based on the findings, the study provides recommendations that may assist the government to table policies that will promote the well-being of the elderly in Nigeria.

CHAPTER ONE

INTRODUCTION

Background of the study

Globally**,** aging is inevitable and a universal term of human existence in developed and developing society. population of the people older than 60 years is growing at a faster rate compared to other classes of people below 60. The responsible factor is more connected with increase in life expectancy and decline in number of children being given birth to in a year (Plank, Schneider, Eysholdt, Schützenberger & Rosanowski, 2009). Reliable data shows that (the older population represents 17%of the total population) which means that elderly has the fastest growing population in the world, especially in the developed world where good standards of living and medical advancement is the order of the day (Toner, Kampen & Scholz, 2003).

There has been continuous pursuit in all disciplines such as (Social work, Gerontology, Sociology, Economics, policy scientist etc) to move beyond the understanding of the elderly. Simple processes to understanding the complexities that exist in the social and physical world (McCormack, Taylor, McConville, Slater & Murray, 2008). Research in ageing now looks to the oldest old and the greater challenges they face given the higher risk of loss across psychological, physical and social aspects of aging (Baltes & Smith, 2003). While often overlooked, the psychosocial dimensions of health among older people are of paramount importance, significantly given the nature of change and adaptation associated with the ageing process. it is observed that the transition to an extended care facility constitutes one of the most difficult developmental challenges for older people (Baltes, 1996).

Furthermore, psycho social conditions are said to exacerbate physical conditions (Harwood, Ownby, Barker & Duara, 1998). Thus, holistic care of older people in extended care settings must endeavour to facilitate optimum psychosocial well-being through the appropriate management of individual personal, social and psychological factors. In Nigeria, the aging population needs care inform of psycho social need that will enhance smooth aging. This study intends to research on the psycho social needs of the elderly and it's implications.

Statement of the problem

In Nigeria unlike other developed country, elderly were not properly cared for and planned for. According to According to Judith, (2014) majority of the elderly are unable to access health care due to its cost as many of them are limited to out-of-pocket payment, majority of them are faced with depression, loss of vision, diabetes, hypertension, tooth loss, pathological bone fracture, arthritis and rheumatism, stroke, Alzheimer's disease as a result of lack of access to health care and effective policy for elderly in the country.

Over the past few decades the demographic transformation has evolved from a distant prediction to a certain reality. Worldwide, the proportion of people aged 60 years and over is growing faster than any other age group (WHO, 2002). In 2005, the United Nations estimated that there were 690 million older persons worldwide, a figure that is predicted to double by the year 2025, and to reach nearly two billion by 2050 (WHO, 2002). In Nigeria, the older population represents 17% of the total population; this figure is expected to increase to 30% by 2050. The National Census 2006 indicated that there were 470,000 older persons aged 65 years and over living in Nigeria, portraying 11% of the country's overall population (Central Statistics

Office, 2006). Furthermore, it is estimated that this figure will rise from 11% to almost 25% within the next 30 years, implying that almost one quarter of Nigerians entire population will be aged 65 years and over by 2036 (Central Statistics Office, 2004). Not only that, it is predicted that the most significant growth will occur among those aged 80 years and over (Organization for Economic Cooperation and Development, 2005), the reality of this prediction is already evident in Nigeria with a 24.9% increase among those aged 80 years and over in the last ten years (Central Statistics Office, 2006). This rapid growth in the "very old", coupled with the predicted decline in the economically active age groups (15-64 years), will result in substantial increases in dependency ratios, particularly the old age dependency ratio (Connell & Pringle, 2004). Although Nigerians current old age dependency ratio is low by Nigerian standards, it is projected to increase to almost 45.3% by 2050, more than double the 2005 figure of 16.5%.

The significance of this demographic transformation is reflected by the substantial volume of literature which considers the increasing pressure on health services as a result of changing demographic profiles and subsequent inclines in the dependency ratio (Jacobzone, Choi & Miguet, 2007) Functional ability is a key factor for individuals to maintain optimum independence and involvement in social activities (Christensen, Frederiksen, Vaupel & McGue, 2003). Studies on changes in functional ability show that those aged 85 years or more experience the most deterioration (Bowling & Grundy, 1997; Avlund, Lund, Holstein & Due, 2004); inevitably impinging upon individuals' ability to carry out basic activities of daily living. The relationship between reduced functional ability and the need for formal or informal care is quite apparent as functional decline has been associated with reduced independence (Hoogerduijn,

Schuurmans, Duijnstee, Rooki & Grypdonck, 2006). At present, approximately 5% of older people reside in extended care settings in Nigeria. While the majority of international data claims that informal care could account for up to 80% of total care (Jacobzone, Cambois, Chaplain & Robine, 1998), when one considers the reality of modern society this option is not always feasible.

The availability of carers is declining as more women, the traditional family carers, are now in employment outside the home thus, the demand for formal care will increase substantially. Despite predictions that advancements in biomedical therapies reduce the incidence of disability and mortality the need for extended care is expected to increase in developed countries as any reductions will not compensate for population ageing (Manton, Larry & Eric, 1993). The predicted increase in demands for extended care services will have repercussions on a number of levels, all of which will be reflected in government expenditure.

Spending on health and long-term care is expected to account for 8.4% of GDP in 2050, while expenditure on pensions is expected to increase to 11.1% of GDP in 2050, from 4.6% in 2005 (Christine & Joaquim, 2015). The National Treasury Management Agency (2001) predicts that an additional annual Exchequer expenditure of approximately 7% of GNP will be needed by 2050 to maintain current levels of pension and health service provision. Expenditure on age-specific healthcare is predicted to increase in response to the growing life expectancy of frail older people, whose health care needs are greater due to the existence of co-morbidities (Polder, et al. 2002). Hence, despite the fact that increased longevity is one of the greatest achievements of the 20th century, it is perceived as a precursor to dwindling health and social budgets as a

result of caring for dependent older persons (McMurdo, 2000). Thus, a concentrated effort is needed to reduce the cost associated with ageing.

Objectives of the Study

The main objective of the study is to examine the Psychosocial Needs of the Elderly and its Implication (a case study of its implication of Okpuno otolo community in Nnewi North Local Government Area Anambra State. Specific objectives are:

i. To explore the concept of psychosocial needs among the elderly in Okpuno otolo community in Nnewi North Local Government Area Anambra State

ii. To identify the impact of the psychosocial needs on the elderly in Okpuno Otolo community in Nnewi North Local Government Area Anambra State

iii. To explore the implication of psychosocial need of the elderly in Okpuno Otolo community in Nnewi North Local Government Area Anambra State

iv. To identify practices which facilitate psychosocial well-being and to explore the perceived effectiveness of these.

Research Question

1. What entails the psychosocial needs among the elderly in Okpuno otolo community in Nnewi North Local Government Area Anambra State?
2. To what extent does psychosocial needs have impact on the elderly in Okpuno Otolo community in Nnewi North Local Government Area Anambra State?
3. What are the implication of psychosocial need of the elderly in Okpuno Otolo community in Nnewi North Local Government Area Anambra State?

4. What are the legislative that facilitate psychosocial well-being and to explore the perceived effectiveness of these.?

Significance of the study

This study is critical as it affects not only the psychosocial needs of the elderly, but also it's implications. The study will expose the society to the impact of developing the psychosocial needs of the elderly and the demerits of ignoring the elders of the country in terms of their psychosocial needs. It results will add to already existing literatures on related subject matter, it will aid policy formulation on matters concerning the elders.

Although it is clear that psychosocial problems influence health, evidence is still emerging on just how they do so. Moreover, some such problems (such as poverty) obviously cannot be resolved by the health care system. Nevertheless, evidence clearly supports the need for attention to psychosocial problems as an integral part of good-quality health care. Psychosocial health services can enable patients, their families, and health care providers to optimize biomedical health care, manage the psychological/behavioral and social aspects of the disease, and thereby promote better health. Hence this project work seeks to examine The Psychosocial Needs Of The Elderly And Its Implication (A Case Study Of Okpuno Otolo Community In Nnewi Local Government Area Anambra State.

Area of Study

This study will be carried out amongst elderly individuals in Okpuno Otolo Community in Nnewi North Local Government Area Anambra State.

Operational Definition of Terms

Older person: There appears to be a lack of consensus as to what the term older person denotes. To universally classify an older person, be it by chronology, social role or capabilities, is undoubtedly a complex task

Chronological age is predominantly used as the criterion to define an older person with many developed countries accepting that the chronological age of 65 years instigates old age (WHO, 2008).

Old; those aged 80 years and over.

Extended Care: In this study, extended care refers to an institution that provides prolonged care or assistance to those unable to independently fulfil some or all of their personal needs.

Caregiver: For the purpose of this study, caregiver shall encompass all those involved in the provision of care in the facilities under exploration.

Psychosocial care: In this study, psychosocial care refers to practice which encompasses measures to facilitate individuals' needs beyond one's physical entity that is;

Meaningful activity: For the purpose of this study, meaningful activity refers to any action/interaction, whether in group situation or in isolation, that has positive effects on individuals' psychosocial being.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

Introduction

This review of the literature will attempt to evaluate the implications of psychosocial needs among older people and factors which may affect its attainment. Literature from an international knowledge base will be reviewed as pertinent to the multidimensional phenomenon under exploration. Contrary to the classic grounded theory approach (Glaser & Strauss, 1967; Glaser, 1978) a preliminary review of the literature was undertaken.

Optimum Ageing; Optimum Quality of Life

The growing volumes of literature concerned with the concept of quality of life among residents of extended care facilities is reflective of the increasing desire to evaluate factors likely to affect quality of life in an effort to optimise individuals experience (OECD, 2005) particularly for those with chronic conditions, where cure is unlikely (Moons, Budts & De Geest, 2006). Thus, while advances in technology and standards of living have led to increased quantity of life, greater emphasis is now being placed on assuring quality of the years added to life (NCAOP\DOHC, 1998). Furthermore, there is a considerable volume of literature on ageing which is centred on the concept of successful ageing and how it may be achieved (Rowe & Kahn, 1998; Baltes & Baltes, 1990, Strawbridge et al., 2002). Some theories remain focused on biomedical approaches, whereas broader interpretations of the concept acknowledge the more inclusive biopsychosocial approaches (Bowling & Dieppe, 2005). Although widely accepted, the concept of successful ageing has been mostly applied to the "young old"; those who are active,

independent and living in their own home (Rowe & Kahn, 1998). The concept of quality of life however, applicable to all age groups, extends to those in the latter years of life; aged 80 years and over. A large proportion of the existing literature attempts to define quality of life and what it is composed of (Anderson & Burckhardt, 1999; Moons et al., 2006), however, it's subjective nature has generated ambiguity regarding its definition thus, it is often depicted as an elusive multidimensional phenomenon (Borglin, KaJakobsson, Edberg & Hallberg, 2005). On the other hand, it is understood that quality of life has the same basic constituents for all people. Although the relative importance of individual dimensions may vary depending on personal characteristics and circumstances (Anderson & Burckhardt, 1999), there appears to be general consensus that participation in meaningful social activity is a determinant of both health and quality of life (Browne, O'Boyle, McGee, Joyce, McDonald, Malley & Hiltbrunner, 1994; Bowling, Fleissig, Gabriel, Banister, Dykes, Dowding, Sutton & Evans, 2003; Murphy, O'Shea & Cooney, 2007).

Hence, it is understood that quality of life components surpass physiological processes and are inclusive of interrelated psychological and social processes (Banister & Bowling, 2004; Borglin et al., 2005). Psychosocial factors are increasingly being recognised as important dimensions in quality of life of those in receipt of extended care services (Mackenzie, Knox, Gekoski, & Macaulay, 2004). Hence, the incorporation of holistic care practices that facilitate the known constituents of quality of life is crucial to fulfilling the individual needs of those residing in extended care facilities. An important aspect in the facilitation of this process may be the ascertainment of elements instrumental to quality of life and well-being in old age.

Optimum Ageing;

Optimum Quality of Life

The growing volumes of literature concerned with the concept of quality of life among residents of extended care facilities is reflective of the increasing desire to evaluate factors likely to affect quality of life in an effort to optimise individuals experience (OECD, 2005) particularly for those with chronic conditions, where cure is unlikely (Moons et al. 2006). Thus, while advances in technology and standards of living have led to increased quantity of life, greater emphasis is now being placed on assuring quality of the years added to life (NCAOP\DOHC, 1998). Furthermore, there is a considerable volume of literature on ageing which is centred on the concept of successful ageing and how it may be achieved (Rowe & Kahn, 1998; Baltes & Baltes, 1990, Strawbridge et al., 2002). Some theories remain focused on biomedical approaches, whereas broader interpretations of the concept acknowledge the more inclusive biopsychosocial approaches (Bowling & Dieppe, 2005).

Although widely accepted, the concept of successful ageing has been mostly applied to the "young old"; those who are active, independent and living in their own home (Rowe & Kahn, 1998). The concept of quality of life however, applicable to all age groups, extends to those in the latter years of life; aged 80 years and over. A large proportion of the existing literature attempts to define quality of life and what it is composed of (Anderson & Burckhardt, 1999; Moons et al., 2006).

However, it's subjective nature has generated ambiguity regarding its definition thus, it is often depicted as an elusive multidimensional phenomenon (Borglin et al., 2005). On the other

hand, it is understood that quality of life has the same basic constituents for all people. Although the relative importance of individual dimensions may vary depending on personal characteristics and circumstances (Anderson & Burckhardt, 1999), there appears to be general consensus that participation in meaningful social activity is a determinant of both health and quality of life (Browne at al., 1994; Bowling et al., 2003; Murphy et al., 2007). Hence, it is understood that quality of life components surpass physiological processes and are inclusive of interrelated psychological and social processes (Banister & Bowling, 2004; Borglin et al., 2005).

Psychosocial factors are increasingly being recognised as important dimensions in quality of life of those in receipt of extended care services (Mackenzie et al., 2004). Hence, the incorporation of holistic care practices that facilitate the known constituents of quality of life is crucial to fulfilling the individual needs of those residing in extended care facilities. An important aspect in the facilitation of this process may be the ascertainment of elements instrumental to quality of life and well-being in old age.

Factors Affecting the Facilitation of Psychosocial Well-being

The provision of care for older people is affected by the knowledge and views that staff and society have about the implications of ageing. Individuals' priorities when caring for older people largely depend on their personal and theoretical perspective (Wadensten, 2006). Conversely, Engel (1978) proposed that it is not one's professional knowledge that permits them to cater for patients' psychosocial needs but rather one's basic interpersonal skills, empathy and social awareness and level of understanding.

Roach (2001) defined some attributes of importance for gerontological nurses: the ability to form a therapeutic relationship with older people, appreciation of the uniqueness of older people, clinical competence in basic nursing skills, good communication skills and knowledge of physical and psychosocial changes that occur with age. The impact of caregivers' personal characteristics and social behaviour on patient outcomes is well documented (Castle & Engberg, 2007), as is the value of nurse patient interaction (McGilton, 2002; Arnold and Underman-Boggs, 2003). However, it is the content and the manner in which the interaction is conveyed which dictates the outcome of this routine practice , all of which may be influenced by the caregivers knowledge and perceptions of holistic well-being. It has been conceded that the broader determinants of health are often neglected due to nurses' preoccupation with physiological health and tendency to think in disease-specific terms (Andersen & Burckhardt, 1999). Therefore, the challenge for health care practitioners is to differentiate between gerontological and acute general nursing and to recognise that while physical care is important it is only part of the whole self, one aspect of holistic care. However, such challenges may be exacerbated by the absence of appropriate gerontological theory (McCormack, Manley & Titchen, 2013).

Comprehensive Knowledge

It is contended that while nursing curriculum advocates patient-centred care and biopsychosocial health, in reality the concept of psychosocial care is very often associated with psychosocial interventions such as cognitive behaviour therapy, psychotherapy and motivational therapy often restricted to the mental health and intellectual disability

disciplines (Sarafino, 2006; Bradshaw, Sawyer & O'Brennan, 2007). While some evidence exists regarding effectiveness of psychosocial interventions in reducing the symptoms of dementia (Fossey, Ballard, Juszczak, James, Alder, Jacoby, & Howard, 2006), there remains a significant dearth of evidence which evaluates psychosocial care in older person nursing. However, findings from a quasi-experimental study which evaluates the effect of the implementation of workplace-based supervision for mental health nurses undertaking a programme of psychosocial education found that psychosocial intervention education can enhance knowledge outcomes for nurses who complete such courses and outcomes for the service users whom they work with (Bradshaw et al., 2007).

Although these findings may be limited to the mental health discipline, they reveal how effective support and education may enhance learning opportunities for staff leading to enhanced psychosocial outcomes among service users. In gerontological nursing, appropriate education may direct attentions to the psychosocial theories of ageing which attempt to describe the ageing process and what ageing implies in terms of individual changes in cognitive functions, behaviour, roles, relationships, coping ability and social changes, thus may be useful in devising care that is conducive to older persons holistic needs (Schroots, 1996, in Wadensten, 2006). However, while a number of theories on ageing exist (Atchley, 1989; Cumming & Henry, 1961; Havighurst, 1961, Havighurst, Neugarten, & Tobin, 1963; Erikson, Erikson & Kivnick, 1986, Erikson & Erikson, 1997; Tornstam, 1989) these theories do not describe how holistic proactive care of the older people could be implemented (Wadensten, 2006). In the absence of a clear description of what gerontological nursing

entails, Kelly, Tolson, Schofield & Booth, (2005) conducted action research with a representative sample of thirty community gerontological nurses to develop a common understanding of the principles which underpin nursing older persons. Significantly all the participants agreed that the concepts of enablement, therapeutic intervention, health promotion and negotiated goals comprised the foundation of their practice, all of which are predominantly seen to be positively associated with the older person's psychosocial well-being.

Accordingly, gerontological nursing was described as a person-centred approach to promoting healthy ageing and the achievement of well-being, enabling positive adaptation to changing processes. It is accepted that this description is derived from nurses with specialist gerontological knowledge, therefore greater knowledge and insight into the needs of older persons may have contributed to the development of such person-centred, holistic principles. While specialist knowledge is desirable, it is not feasible for all staff members to have specialist education, for this reason the sharing of knowledge is essential (McCormack et al, 2008). Hence, there is an urgent need to incorporate such evidence based principles into clear polices which facilitate all members of the multidisciplinary team to facilitate optimal ageing. In a prospective, non-randomized controlled study, Arnetz and Hasson (2007) evaluated the effects of an educational intervention in two extended care facilities in Sweden and found improvements in competencies specific to older person care through multidisciplinary peer group interventions devised specifically to meet identified deficits in knowledge of staff. Hence, the value of the multidisciplinary team in providing accurate

care to meet diverse and evolving needs must not be underestimated. While staffing characteristics inevitably impact on healthcare outcomes, accurate and timely care is dependant on a number of interrelated concepts, including organisational factors.

Staff and Organisational Factors

A qualitative descriptive case study carried out in the UK, which explored the impact of health and social care organisational structures on older persons' experiences of whole systems found that general services fail to understand the complexity of need associated with advancing age (McCormack et al., 2008). McCormack et al. (2008) propose that the divide that exists between generalist and specialist services may lead to inadequate care underpinned by poor collaboration among the multidisciplinary team. Findings from this study highlight how effective communication is essential to care provision that is reflective of older persons' individual needs. While McCormack et al. (2008) commend the significance of maintaining psychological well-being through promoting personal autonomy and client involvement in the planning of care, they found that older people felt disempowered by the system of care delivery which they felt did not include them in decision making; providing "routinized" care rather than individualised care. Although the above study specifically looks at the older persons' journey through the whole care system it is applicable to specialist areas of practice. For instance, the extended care setting is a component of the whole system whereby a receptive interdisciplinary approach is necessary for the provision of accurate and timely care. Hence, the above findings highlight the tendency to provide standardised care in spite of older persons' heterogeneous needs.

Upon recognition that existing services fell short of providing appropriate, timely and co-ordinated care for older people, Reed, Cook, Childs & McCormack, (2005) conducted a literature review to explore integrated care for older people. This review concedes that older people have complex and interacting needs, which often necessitate treatment and care from a range of professionals and carers, services and agencies at the same time, thus inadequate use of available services led to poor patient outcomes associated with greater costs. The value of the multidisciplinary team and collaborated service provision is well documented as role boundaries begin to merge (Reed et al., 2005). Professional relationships provide a unique opportunity to approach client care from a holistic perspective by drawing on the expertise of various disciplines (Arnold & Underman-Boggs, 2003). McCormack et al. (2008) praises the concept of integrated care contending that without it healthcare systems will support services that are organisationally focused rather than person-centred. Hence, McCormack et al. (2008) acknowledges the significant impact of individual and organisational system factors on care processes and outcomes.

Management and organisational structures are intrinsic to the quality of life of those living in extended care facilities (Murphy et al., 2007). The impact of the organisational issues at macro level on the individuals' outcomes at micro level is well documented (Currie, Harvey, West, McKenna & Keeney, 2005).

Reed et al. (2005) found that societal and organisational strategies impacted on health outcomes for older persons. Furthermore, Johnson, Sarkisian & Williamson, (2015) acknowledges the combined input of micro, as well as macro influences on implementing

change and practice development initiatives, thus consensus and support at an individual level; encompassing both service users and services providers contribution, and structural change at a more macro level; including the development of best practice polices and guidelines are mutually essential components. McCormack et al. (2008) further highlights the need for care managers to ensure accurate assessments and subsequent interventions and to advocate on behalf of the patient to ensure they received the most appropriate care.

Moreover, McCormack et al. (2008) found the absence of a strong relationship with a primary career resulted in many older people feeling vulnerable and unsure about their plan of care; the patients often did not know what was happening to them nor understood the rationale underpinning decisions and actions (McCormack et al., 2008). The limited information made it difficult for them to challenge the existing system. This evidence is consistent with the literature supporting patient empowerment and person-centred care which suggests person-centered initiatives designed to give power and autonomy to residents over their physical and social environment are prerequisites in facilitating optimum well-being among older persons (McCormack 2004; Bennett, Schneider, Arvanitakis, Kelly, Aggarwal, Shah & Wilson, 2006). Identifying and allowing for the articulation of identities of older people has the potential to inform organisations and policies that better respond to the older persons' unique situation (Bennett et al, 2006). However, capacity to involve older people in the planning of their care may be dependent on how older people are socialised.

The Socialization of Older People

It is the role of the health care provider to advocate for patients' rights of autonomy and independence; maximising their opportunities for improved physical health, supportive social conditions and opportunities for personal growth through the provision of appropriate care and information (Arnold & Underman-Boggs, 2003).

A press release by The Irish Human Rights Commission (2005) expressed concern that individuals residing in extended care facilities may be particularly vulnerable to human rights violations as standards are dictated by physical conditions, and are thus rarely inclusive of broader quality of life or social gain issues. Factors such as discrimination and marginalisation may impede the fulfilment of individuals' human rights. Goffman (1968) contends that every society has stereotypical expectations about how individuals ought to be (Porter, 1998).

Ageing has traditionally been thought of as a period of decline, loss and dependency (McMurdo, 2000). Ageism may construe the application of assumed homogeneous age-based characteristics to an individual, regardless of that individual's actual personal characteristics (Macnicol, 2006). Hence, it is regrettable that the socialisation of older people largely conjures a negative image of ageing; that of a homogenous group, frail and highly dependent and thus a burden on society (Lovell, 2006; Castle and Engberg, 2007). "Our society sees the growing number of older people more as a demographic problem than a demographic bounty" (O'Shea, 2007). Resistance to accept the humanitarian implications of ageing within the political environment leads to marginalisation of older people (Baltes & Smith 2002).

In a recent position paper, O'Shea (2007) contends that continued emphasis on the financial implications of ageing populations representing older people as a burden on society, will inevitably contribute to the marginalisation of older people. O'Shea (2007) recommends a new strategy for older people whereby all government policies are "age proofed" to remove discrimination against older people, with the development of clear and consistent legislation on the rights and entitlements of older people. However, such policies may result in mere transcripts if stereotyping and negatives attitudes continue to permeate society, which according to Scrutton (1990);"restrict the social role of older people, structure their expectation of themselves, prevent them achieving their potential and deny them equal opportunities".

Furthermore, stigma and ageism are two phenomena that together greatly affect assessment of the older people and their subsequent health care. Awareness of the impact of these phenomena can assist healthcare providers and, specifically, nurses caring for the older people to provide holistic care (Herrick, Ashcroft, Ireland, Horan, McCollum, & Ferguson, 1997). Hence, the issue is not the individuals' impairment but societal and organisational structures that may impede individuals' potential. The relationship between impairment and disability depends not just on the severity of the underlying pathological processes but also on host-environment interactions including therapeutic, social and other interventions, as well as the expectations of society (Geertzen, Dijkstra, van Sonderen, Groothoff, ten Duis, & Eisma, 1998). Barrett (2006) makes a case for the examination of the social context of frailty in later life as a dynamic social phenomenon. Barrett (2006)

differentiates between disability and frailty, and contends that while disability is resulting from specific impairments, frailty is associated with a multitude of interrelated individual and environmental factors. Nevertheless, as with other authors of critical gerontology, Barrett (2006) acknowledges the negative effects of social structures on adult ageing, maintaining disabilities can be exacerbated or even created by societies disabling processes, such as stereotyping and stigmatization of minority groups (Albrecht & Devlieger, 1999; Imrie, 2004). Therefore, the attitudes of healthcare providers may be influential to client assessment and subsequent outcomes. In a paper which explores stigma and ageism and their potential and actual influences on assessment and interventions for older people, Herrick et al. (1997) present strategies for overcoming the impact of stigma and ageism to assist healthcare providers to advocate for clients. This paper maintains that healthcare providers must be aware of their own attitudes toward ageing which may unconsciously contribute to stigma and ageism. Crucially, when assessing older persons, healthcare providers must avoid separating the mind from the body (Herrick et al., 1997). The collective nature of stigma means that those who associate with the stigmatized victim also are stereotyped (Herrick et al., 1997). Age and Opportunity (2001) concede that negative attitudes and stereotypical notions can signify that, "the act of caring for a dependent or vulnerable older person becomes regarded as a low prestige, low priority, occupation by both health professional and society in general" (p.12).

Ford & McCormack (2000) acknowledge the societal influence on gerontological nursing and its resultant impact on service provision; such as perceptions of under

developed services for older people influence how individuals including health care professionals think about nursing older people. It is suggested that the low status afforded to older people by society deprives a large proportion of them of a fair share of social resources (Age & Opportunity, 2001). For instance, many extended care facilities remain inappropriate in design and reflect the poor status in which care provision for older people was viewed in the past (Coffey, 2004). O'Shea (2007) further highlights the discrepancies relating to appropriate and timely polices for older people, stating that much of the frameworks which inform current policy are dated, thus the service in is need of great reform in order to effectively meet the evolving needs of this heterogeneous client group. According to the National Council on Ageing and Older People (2005) institutional policies and practices that fuel negative stereotypes about older people, which reduce their life satisfaction and undermine their personal dignity, must be eradicated. Thus, the importance of empowering older people to determine and subsequently fulfil their personal needs is paramount, aspiring to create practice that is needs driven rather than society driven.

Need for Reform

The complex and dynamic nature of society demands a certain degree of flexibility from health service organisations, thus nurses must be flexible in their approach to care and willing to take on new roles and responsibilities (Bloom & Williamson, 1998). The implications of demographic transformations call for a revised approach to caring for older persons, facilitating optimal health and well-being. In an era where longevity is celebrated and

seen as one of mankind's greatest triumphs, society fails to appropriately acknowledge those that actually achieve it (Kabir, 2008).

The above literature suggests that current health care systems are not conducive to the ongoing health needs of older persons as emphasis appears to be on cure rather than rehabilitation and optimisation. Furthermore, McCormack et al. (2008) acknowledges that many policy developments in healthcare practice are not transcending into clinical practice; highlighting the need for greater integration and clinical governance.

Implication/ Determinants of Health and Quality of Life

Social Interaction

In a national correlational survey of the quality of life of older people aged 65 years and over living in their own home in Britain, Bowling, Bannister, Sutton, Evans & Windsor, (2002) acknowledge the need for a multidimensional model; encompassing health, psychological and social variables, and social circumstances. This study is particularly significant in the psychosocial dimension of health care for older persons as, unlike other studies which focus on perceived health and functional ability, this study explores the broader components of quality of life. The findings, which were derived form a Quality-of-Life Survey Questionnaire, suggest an optimistic locus of internal control together with positive social capital leads to greater self-esteem, greater perceived self-efficacy, and thus influences independence, behaviour and ultimately well-being (Bowling et al., 2002).

Thus, engagement in social activities is acknowledged as being a strong foundation in development of quality of life in later years. Comparably, Bowling, Gabriel, Dykes, Marriott-

Dowding, Fleissig, Evans, Banister, & Sutton, (2003) sought older persons' definition of, and priorities for a good quality of life, findings show that having good social relationships was the most commonly stated determinant of quality of life. While the above findings may be limited as they are reflective of the perceptions of older persons living independently in their home, such findings are nonetheless invaluable to research on quality of life as it is a subjective concept that is often interpreted with much ambiguity. Furthermore, these findings are noteworthy to practice development leading to improved client outcomes as they highlight significant determinants of quality of life among older people thus, offer guidance and support to policy makers and practitioners in the endeavour to facilitate optimum quality of life among older persons, irrelevant of their place of dwelling.

In the United Sates, Nezlek, Richardson, Green & Schatten-Jones, (2002) investigated psychological well-being in relation to daily social interaction among healthy older persons living in the community. Using a variant of the Rochester Interaction Record in addition to various measures of psychological well-being, (outlined in the summary of literature reviewed; appendix one) findings suggest that positive social interactions can enhance psychological well-being including life satisfaction and loneliness, in the same way low-level social engagement predicts intermediate declines in physical health and morale. This report strongly acknowledges the value of quality interactions on psychological well-being among spousal partners, however for those who were unmarried the quantity of interactions rather than the quality was most influential. Nezlek et al. (2002) consider that the quantity of interaction may be significant due to concerns of social isolation as frequent social interaction is psychologically rewarding. It is

considered that the lack of qualitative content may contribute to the limited insight as to why the significance of the quality and quantity of social interaction varies among married and single older persons. Furthermore, Nezlek et al. (2002) assert that in the absence of random sampling, generalisation of the findings may be limited. Nevertheless, the intricate relationship between social networks and psychological health is well recognised, a clear association between participation in meaningful social activity, social supports, well-being and quality of life amongst older persons is evident (Browne at al., 1994; Albrecht & Devieger, 1999; Murphy et al., 2007). Durkheim's infamous writings on suicide are perhaps the most seminal accounts of the association between a positive social environment and psychological well-being (Lehmann, 1995).

However, not only does low level social engagement result in poor psychological well-being, it may also have an adverse effect on cognitive functioning. A recent longitudinal clinicopathologic cohort study conducted in the USA, which examined the association between loneliness and cognitive function among older persons residing in extended care facilities, found that while not the primary cause, loneliness contributes to an increased risk of developing dementia in later life (Wilson, Krueger, Arnold, Schneider, Kelly, Barnes, Tang, & Bennett, 2007). Using a variety of scales outlined in appendix one, in addition to performing brain autopsy post mortem, Wilson et al. (2007) found the risk of Alzheimer's disease more than doubled among lonely older persons. What's more, loneliness was associated with lower level of cognition at baseline and with more rapid cognitive decline during follow-up.

Although one of the limitations of this study may be its lack of qualitative inquiry to capture the subjective elements of this phenomenon, it's findings acknowledge the influence of social support on the multidimensional components of self, which ultimately determines individuals' holistic well-being. Furthermore, there is a growing body of evidence which clearly correlates low levels of social engagement and loneliness with intermediate declines in psychological health; including cognitive function, depressive symptoms, and morale (Luanaigh & Lawlor, 2008). Furthermore, the above findings are all the more significant upon considering the profile of the older population in receipt of extended care services. Although the value of social interaction and social supports on quality of life and well-being among older persons is well established, it is important to consider older individuals' social circumstances. It is accepted that social networks diminish with age; while at the same time the incidence of loneliness has been shown to increase, primarily due to loss of loved ones and the move to an extended care facility (Tijhuis, de Jong Gierveld, Festiens, & Kromhout, 1999). Although detailed information on the profile of those residing in extended care facilities is limited, it is reasonable to note the Department of Health's Long Stay Activity Report for 2006 which shows that the percentage of widowed persons increases with age, while the percentage of residents aged 85 years and over in receipt of extended care services has steadily increased by 5.5% between the years 1999 and 2005.

Thus, it is reasonable to query the level of social support and extent of social networks retained by those currently in receipt of extended care services. Consequently, upon acknowledging the value of social interaction and social support on psychological well-being in

old age, the imperative need to consider changing social processes among older persons in receipt of extended care services is emphasised. Furthermore, the vulnerability of this client group's psychosocial well-being is accentuated upon consideration of older person's changing social networks as review of the consolidated evidence infers that the impact on psychosocial well-being may be momentous. Hence, the significance of meaningful and frequent interactions with staff and fellow residents may be considerable; extended care facilities must be responsive to the sensitive needs and changing circumstances of older people.

Meaningful Relationships Among Aged Elderly

It is proposed that the transition to an extended care facility may improve social outcomes and reduce the incidence of loneliness through increased opportunities for social interaction (Russell, Cutrona, de la Mora, & Wallace, 1997). Conversely, it is contended that the transition to an extended care facility can result in diminished social contacts whereby opportunities for socialization occur primarily through interactions with staff (McGilton, 2002). Whatever the case may be, it is suggested that the concept of caregiver-resident relationships represents an underestimated resource for improving quality of life (McGilton, 2002). Bergland & Kirkevold (2008) carried out a descriptive study which explores the significance of peer relationships on thriving and well-being among nursing home residents with varying cognitive ability in Oslo. Findings derived from field observations and interviews acknowledge the heterogeneity of the sample population and subsequently show that personal characteristics such as wishes and capacity to interact varied as did the significance of peer relationships to personal well-being.

Nevertheless, involvement in peer relationships did serve to promote thriving for those who wished to interact. However, Bergland & Kirkevold (2008) acknowledge that many opportunities to form relationships are unsuccessful to the regret of the individual, the most significant finding being the caregiver's potential to impact on whether or not social encounters developed into positive and meaningful interactions, particularly among those who were unable to from relationships themselves. Bergland & Kirkevold (2008) also note how individual caregivers' knowledge, skills and personal characteristics are instrumental in creating and facilitating positive and meaningful interactions to promote thriving among residents. A comparable observational study, also conducted in Oslo, describes the pattern of social interaction between nursing home caregivers and residents.

Findings suggest that the caregivers did not always maximize the potential of interactions with residents in so far as needs were often facilitated in the absence of significant communication or meaningful interaction. Although Bergland & Kirkevold (2007) commend the role of caregiver in facilitating meaningful interaction with others, both Bergland & Kirkevold (2007) found the effectiveness of caregivers' role in facilitating meaningful interaction was very much dependent on knowledge and personal characteristics. While the possibility of the Hawthorne effect is questionable, both studies highlight the potential for inconsistent outcomes depending on caregivers' knowledge and personal characteristics. It is accepted that barriers in communication often arise through the socialization of older people and a lack of understanding about the ageing process (Ryan, 2003). Hence, the implementation of measures to aid care staff to meet the broader psychosocial needs of residents may be warranted. Bergland & Kirkevold

(2008) suggest how the caregiver may facilitate the introductions of themes of interests to residents as foundations for social interaction, which can then be elaborated through relating them to individuals' life experiences. However, it is contended that this method of interaction may only be successful upon formation of a dyadic relationship whereby information is shared between the caregiver and resident. McCormack et al. (2008) acknowledge the benefits of knowing the individual and their family in providing personalised care which appropriately addresses individuals' needs. Thus, the importance of facilitating positive relationships, not only among residents, but also between caregivers and residents is paramount. Hence, the imperative role of the therapeutic relationship in understanding the uniqueness of the older person is acknowledged, as is the fundamental role of the caregiver in facilitating one of the most significant determinants of quality of life and positive psychological health, that is social engagement (Bowling et al.,2003; Wilson et al., 2007).

However, it is not only staffing characteristics that influence social interaction and the quality of relationships formed, residents' characteristics and abilities may also be influential (Hubbard et al., 2003). In the United States, a cross sectional study conducted by Poon et al. (1992) formed the initial phase of the renowned longitudinal study; The Georgia Centenarian Study. This initial study examined the biomedical and psychosocial predictors of longevity and survival among centenarians. Findings suggest positive correlations between personal characteristics, wellbeing and longevity; attributes included optimism, meaningful social engagement, and the ability to cope with loss. Significantly, studies have shown that personal

control, along with social support, are amongst the most important psychosocial predictors of morbidity, mortality, psychological well-being and quality of life (Rodin, 1986)

Psychosocial Care in Practice

Throughout the 21st century there is consistent evidence of healthcare professionals' continued adherence to the biomedical therapies (Bowling & Dieppe, 2005) and failure to encompass the broader determinants of health. In the 1960's it was argued that the culture of professionals and the needs and practices of organisations were among the main barriers to the achievement of health goals (Levine, Scotch and Vlasak, 1969, in Levine, 1987).

Although the biopsychosocial model was developed to address the medical model's inability to encompass the psychosocial dimension of care, healthcare practices continue to receive criticism for their persistent focus on the physical self as with the biomedical model (Andersen & Burckhardt, 1999). Engel (1978) claimed that neglect of this important dimension of care was partly attributed to practitioners being mechanical in their approaches due to over reliance on the biomedical model. Haight et al. (2002) claims that older persons living in extended care settings enjoy few stimulating activities as care organisations work from a predominantly medical model, thus many of their residents' psychological needs go unmet. Therefore, it is accepted that a biomedical approach is not conducive to older person's well-being and quality of life. Alas, while there is a growing volume of evidence to support a more inclusive approach to caring for older persons (Mackenzie et al., 2004; Wadensten, 2006) a review of the literature depicts current practices based on tradition rather than evidence. Qualitative research, guided by a grounded theory approach, explores the experience of older

person nursing care in Bangkok; findings show that while the nursing curriculum and rhetoric related to care of the older person is based on a holistic model, everyday practice appears to be consistent with the biomedical model (Choowattanapakorn et al., 2004).

Findings portrayed the overwhelming task-orientated nature of care to the extent that unfinished tasks were cause for disciplinary action, whereas neglect of broader requirements, such as psychological needs, was acceptable. Although, derived from a culturally diverse health care system, these findings are momentous in the psychosocial dimension of healthcare for older persons as they highlight the need for greater acknowledgement of such determinants in fulfilling individuals' optimum well-being and quality of life. Nonetheless, disparity of economic, social and cultural environments across countries and regions gives rise to culturally unique practices, thus the need for evidence applicable to the Irish health care system is quite apparent. Findings from a hermeneutic phenomenological study verify the occurrence of such practices in the Irish healthcare system (McCabe, 2004). In exploring patients' experiences as to how nurses communicate, McCabe (2004) found that patients believed nurses' actions were dictated by a need to fulfill tasks rather than communicate with patients.

Thus, a task-centred rather than patient-centred approach to care was dominant. Although the transferability of these findings is limited as they are derived from an acute rather than an extended care setting, they are nonetheless significant as they are reflective of cultural practices in the Irish healthcare system. This inference is justified upon noting the context from which the data were derived as it is revealed that the study site was in fact a teaching hospital. Significantly, there is a large body of evidence to suggest that the prevailing philosophy of nurses and work

practices greatly impacts on student nurse's demeanour (Ahmed and Kitson, 1993; Robinson and Hill, 1995). Therefore, it is inferred that such practices are observed, learned and replicated by student nurses in their own practice, regardless of theoretical knowledge. Accordingly, it is considered that if task-centered rather than patient-centered approach to care is dominant in teaching hospitals, it has presumably transpired into other healthcare services as nurses carry forward their knowledge and professional conduct into their postgraduate practice.

The propensity for such learned behaviour is acknowledged by McCabe (2004) as she highlights literature which suggests that the professional socialization of nurses results in task-centered rather than patient-centered practices (Telford, 1992; Graham, 1994; McColl et al., 1996). Thus, it is inferred those current practices may not appropriately meet services users' needs due to a preoccupation with customary tasks rather than human needs. In recognition of the intrinsic role of effective assessment procedures to the provision of accurate and timely care, Worden, Moon, Samlowski, Clark, Dakhii, Williamson, Urba, Ensley, Hussain, & Southwest Oncology Group, (2006) carried out a correlation study to examine the accuracy of assessment documentation of older person's needs in extended care settings in Britain. Findings reveal that many important domains, including mental health, were infrequently mentioned on the assessment documents (Worden et al., 2006). The most frequently covered items were the activities of daily living and physical care. In the psychosocial domains only two out of eight domains, 'activity pursuit patterns' and 'social contacts, relationships and involvement/psychosocial wellbeing' were found on just over 50% of the documents. Therefore, findings suggest the significantly high percentage of remaining assessments failed to

appropriately evaluate individuals' psychosocial needs. There was also low coverage of the individual's pattern of activities and routines prior to admission, a lack of which may have implications for older persons continuity of self. While this data shows evidence of psychosocial needs being addressed in some cases, it highlights the lack of standardized assessments to include determinants of health and well-being beyond activities of daily living, thus the holistic well-being and quality of life of some residents may be poorly addressed (Worden et al., 2006). Furthermore, little attention was paid to the wider uses of information derived from the initial assessment.

This is in direct contrast to the USA where the Minimum Data Set/Resident Assessment Instrument (MDS/RAI), a systematic assessment, has been mandated for use in nursing homes (Worden et al., 2006), thus the need for standardized assessments which encompass all domains necessary for high quality care and optimum resident outcomes is evident. As findings were dependent on care settings willingness to respond to postal intervention, research sampling procedures may give way to bias in so far as managers controlled the content of the data requested. For instance, while, 71% of homes returned questionnaires only 49% returned assessment forms which might indicate that only homes with better established assessment systems wished to explicate their practice.

Furthermore, data is reflective of the UK health services, therefore is not entirely amenable to an Irish context. Recent policy developments in Ireland have placed further emphasis on standardized holistic continuous assessment and the use of best practice and clinical governance (HIQA, 2008). National policy initiatives such as Quality and Fairness (2001) and

Adding years to life and life to years (1998) emphasize the non-medical aspects of achieving optimum health potential; minimizing the impact of disability and disease on older people (O'Shea, 2007). Nevertheless, the pervasive influence of the biomedical model in practice is quiet apparent. The above research conducted by Worden et al. (2006) has considerable relevance to practice development as findings clearly show that physical care currently dominates practice, often to the point where the broader determinants of health are overlooked. While there is a considerable volume of evidence to support a more inclusive approach to caring for older persons, there appears to be a number of factors which influence the accomplishment of such practice. Incorporating the complex physical, psychological and social dimensions into care practices demands a more comprehensive assessment and diverse interventions that are not always achievable (Anderson & Burckhardt, 1999; Mackenzie et al., 2004). The implementation and outcomes of psychosocial interventions are influenced by a diversity of factors such as patient and family characteristics, the social environmental conditions such as the interpersonal skills, knowledge and staffing of healthcare professionals, structural issues and the environment; and cultural context such as philosophy of care and attitudes may be influential (Hubbard et al., 2003).

Factors Affecting the Facilitation of Psychosocial Well-being

The provision of care for older people is affected by the knowledge and views that staff and society have about the implications of ageing. Individuals' priorities when caring for older people largely depend on their personal and theoretical perspective (Wadensten, 2006). Conversely, Engel (1978) proposed that it is not one's professional knowledge that permits them

to cater for patients' psychosocial needs but rather one's basic interpersonal skills, empathy and social awareness and level of understanding.

Roach (2001) defined some attributes of importance for gerontological nurses: the ability to form a therapeutic relationship with older people, appreciation of the uniqueness of older people, clinical competence in basic nursing skills, good communication skills and knowledge of physical and psychosocial changes that occur with age. The impact of caregivers' personal characteristics and social behaviour on patient outcomes is well documented (Castle & Engberg, 2007), as is the value of nurse patient interaction (McGilton, 2002; Arnold & Underman-Boggs, 2003).

However, it is the content and the manner in which the interaction is conveyed which dictates the outcome of this routine practice, all of which may be influenced by the caregiver's knowledge and perceptions of holistic well-being. It has been conceded that the broader determinants of health are often neglected due to nurses' preoccupation with physiological health and tendency to think in disease-specific terms (Andersen & Burckhardt, 1999). Therefore, the challenge for health care practitioners is to differentiate between gerontological and acute general nursing and to recognise that while physical care is important it is only part of the whole self, one aspect of holistic care. However, such challenges may be exacerbated by the absence of appropriate gerontological theory.

Knowledge and Continuing Education

In a review of seventeen traditional nursing theories, Wadensten & Carlsson (2003) assess the applicability of such theories to age-related care nursing. Findings suggest that these

traditional theories fail to provide any guidance on how to care for older people and how to support them in the process of ageing. Moreover, it has been suggested that traditional conceptual nursing frameworks such as The Activities of Daily Living Model, Roper, Logan and Tierney (1976) used in practice, impede holistic care as such frameworks are based on observable, measurable behaviour and scientific tests. Despite its holistic intentions, the Activities of Daily Living model can lead to an emphasis on physical nursing problems in practice, as it is often the case that the intention of the model is lost in the pursuit of physical achievements (Aggleton & Chalmers, 1986; in Robinson and Hill, 1995). Hence, there is a need to develop a nursing care model that takes human ageing into consideration as individuals without age specific education may work from traditional nursing theories which inadequately support the ageing process. Therefore, the need for specialist gerontological knowledge may be justifiable in the endeavour to accurately meet the individual needs of this specialist client group. The need for specialist education is further justified upon recognition of the dominant medical model and lack of emphasis on health maintenance interventions achieved through a more appropriate biopsychosocial framework of care (Bowling & Grundy, 1997). It was thought the inclusion of theoretical components relating to social science into the current curriculum would help nurses to understand that health status is related to a wide range of factors beyond the one's physical entity (Robinson and Hill, 1995).

However, criticism of nurse education tends to regard competency training as leading to a role that is reductionist in nature as it fortifies task orientated, rather that patient-centred holistic care (Coffey, 2004). The need for nurses to support and engage in continuing education practices

is further highlighted in a seminal paper which reviews practice developments through the integration of theory to practice (Robinson and Hill, 1995). This review paper suggests that the new paradigm for nurse education is being prevented from fulfilling itself because of factors operating within the taught, hidden and wider curriculum. Robinson and Hill (1995) refer to the importance of the organisations ethos of care and role modelling, contending that the taught curriculum needs to be supported by a suitable hidden curriculum both within the educational and clinical setting. Furthermore, Robinson and Hill (1995) believe that role models who demonstrate integrated theory occurring in practice are vital to achieving evidence-based practice developments. It is contended that the prevailing philosophy of nurses and work practices greatly impacts on healthcare assistants and student nurse's demeanour (Ahmed & Kitson, 1993; Robinson & Hill, 1995).

Johnstone (2006) suggests that continued adoption of the traditional biomedical model limits the scope of the professions ability, as junior staff and student nurses adapt to routine practice rather that initiating change through utilising their critical awareness of practices and evidence based knowledge. The taught curriculum of nurse education needs to relate to what students see and experience in both education and clinical settings, and ultimately, this needs to occur within a supportive social and political framework. Although the content of nurse education curriculum may be changing, it is how this knowledge is facilitated in practice which truly determines evidence-based practice. As the primary providers of care to older persons, nurses are held accountable for defining standards of care and increasingly for delivering psychosocial care (Boeckxstaens & De Graaf, 2011).

Care of the elderly In Nigeria: Implications for Policy

The fast-growing number of older adults during the last few decades has impacted significantly on the political, economic, and social functions of societies in both industrialized and developing regions. According to the Population Division of the United Nations Department of Economic and Social Affairs (United Nations Department of Economic and Social Affairs: Population Division [UNDESA], 2015), the proportion of older persons aged 60 years and above make up 12.3% of the global population, and by 2050 that proportion will rise to almost 22%. Sub-Saharan Africa, which has the smallest proportion of elderly and which is ageing slower than the developed regions, is projected to see the absolute size of its older population grows by 2.3 times between 2000 and 2030 (UNDESA, 2015). People are living longer because of better nutrition, sanitation, health care, education, and economic well-being. An ageing population poses numerous social and economic challenges, but the right set of policies can equip society to address these challenges in time. Like any other country in sub-Saharan African, Nigeria's elderly too is increasing rapidly. In Nigeria, those aged 65 years and above (the elderly) make up 3.1% or 5.9 million of the total population of 191 million, which in crude numbers represents an increase of 600,000 during the 5-year period 2012–2017 (Population Reference Bureau, 2012).

The rising numbers of the elderly in Nigeria are among others attributed to the crude mortality rate that is gradually decreasing (Adebowale, Atte, and Ayeni, 2012). Ageing in Nigeria is occurring against the background of socioeconomic hardship, widespread poverty, the HIV/AIDS epidemic, and the rapid transformation of the traditional extended family structure (Adebanjoko and Ugwuoke, 2014). Another cause for the increase in the older segment of the

Nigerian population can be found in the declining fertility rate (although still one of the highest in Africa) that has continued to drop since the 1980s. In 2017, the total fertility rate registered at 5.5 compared with 6.8 in 1980 (Population Reference Bureau, 2017). Apart from the decline in fertility, improved health and sanitary conditions have also contributed to the rise in life expectancy. Ageing causes people to be less active, frail, and exposed to more risks of contracting a disease, leading to prejudice or discrimination against the elderly, social isolation, and, sometimes, abandonment.

Despite the demographic impact of the AIDS epidemic, the Nigerian population is projected to continue ageing over the next two decades. Current demographic projections indicate that Nigeria will experience a doubling of the population over the age of 65 by the year 2020 (Population Reference Bureau, 2017). Furthermore, of all age groups, the group over age 85—i.e. the oldest old—is increasing the fastest. Amidst this demographic reality and the challenges it is about to unleash in future, Nigeria will be hard-pressed to meet the economic, health, psychological, and material well-being challenges of the elderly, especially as traditional family support systems for the elderly are breaking down and disappearing in the country (Okoye, 2012).

The Neoliberal State and Care and Support for the Elderly In Nigeria

Nigeria, the country with the largest population in Africa (191 million), has an elderly projected Population growth rate of 3.2% (Population Reference Bureau 2012, 2017)—a rate that has been estimated to double by 2050 (Mbah, 2016). This trend calls for concern as it poses major economic, psychological, health, and social challenges to the Nigerian state. What really

heightens the challenge is the absence of clear policy, or any functional social security service, for the elderly people in Nigeria. Consequently, social policy for the elderly people remains turbulent, especially with the retrenchment of the welfare system in favor of the adoption of neoliberal policies in Nigeria.

Two major distinguishing attributes of the neoliberal state are privatization, which trades on the profit motive, and the removal of state subsidies. The latter in particular marginalized both the elderly and the poor (Ekanade, 2014). Studies of the elderly have always emphasized the need for Nigeria to make serious efforts to cater for the needs of this group and highlighted the fact that the elderly needs special policy intervention for care and protection (Animasahun & Chapman, 2017). Hence, it has become imperative to explain why the poor and challenging situation of the elderly exists and why policy intervention aimed at the interests of the elderly has become a pressing issue in Nigeria. During the oil boom era (1971–1980) in Nigeria, the period saw free medical services, including food for hospitalized patients who were admitted to public health facilities (Alubo, 1987, p. 453).

In this sense, the government was really spending a huge amount of money on social welfare Services, not only for the elderly people who retired from the civil service but for the entire populace. However, the drop in oil prices in the international market resulted in a deficit of Nigeria's balance of payment. This led to the retrenchment of the welfare system and the provision of basic amenities and to the introduction of a neoliberal policy in 1986 (Ekanade, 2014; Mbah, 2016). In the neoliberal context, democracy was reestablished to satisfy market demands without adequate regard to social needs. Neoliberal reforms were not concerned with

social issues, but with market efficiency, which worked against the basic tenets of human rights and constitutional safeguards for Nigerian citizens.

Challenges that Come with Ageing and Care of the Elderly In Nigeria

Studies carried out by Animasahun & Chapman (2017) reveal that demographic changes in Nigeria present several challenges that may influence the modification of federal regulations, health policies, or social programs that may promote physical, social, and health through active ageing. Interviews with our participants revealed that the elderly in Nigeria are faced with challenges of retirement, ageism, and social isolation.

Retirement

Many people envisage the idea of retirement as a life stage of leisure, untroubled and carefree living, relaxation, and traveling. However, this vision of retirement does not happen too often in Nigeria. In the current economic dispensation, more and more individuals have no choice but to work well past the age of even 80 years if they are given a chance, because going on retirement poses several challenges in Nigeria (Odaman & Ibiezugbe, 2014; Oladeji, 2011). The abrasive reality is that most of the elderly in Nigeria find it very difficult to adjust to life after retirement.

The Nigerian government has failed pensioners who had high expectations of the implementation of pension regulation schemes existing in the country. These expectations arose from the need to have a sustainable standard of living in retirement and their benefits paid when due. The different pension regimes operating in Nigeria, namely a defined benefit (DB) and a contributory pension scheme (CPS), gave rise to a varying set of problems that limited the capacity of key

stakeholders within the Nigerian pension industry to meet pensioners' expectations. According to Apere (2015), the problems that surround pensioners in Nigeria include:

1. Delayed or nonpayment of pension entitlements and misappropriation of existing pension funds;
2. Low standard of living (or high poverty incidence) among pensioners due to pension increases not in line with salary inflation or no pension increase at all.
3. Too frequent verification of pensioners by pension transitional arrangements directorate (PTAD) (section 42 of PRA 2014) leading to pensioners dying during verification exercises.
4. Inadequate enforcement of pension regulation: After more than 10 years of existence of the CPS, not all state governments had enacted their pension laws to establish the CPS, which is a sign of regulatory weakness (Apere, 2015). The actuarial valuations of the old DB schemes required by PenCoM (National Pension Commission) at the point of implementation of the new CPS have not been carried out even for those State Governments that have already established their CPS.

The greatest problem we have in this country is that our leaders don't keep to their words. The people managing the pension scheme don't keep their word. Many elderly who depend on pension suffer to get their pension, many even die before the pension starts coming. Some of the elderly who are retired cannot even pay their rents. Some who retire and move to the rural areas die immediately they get home because of suffering. (48-year-old local government chairperson; rural dweller) Since poverty remains a major challenge in Nigeria, elderly persons who have

retired from the economic productive phase are most vulnerable to experiencing economic hardship. Since the statutory age of retirement in Nigeria is 60 and 70 years (depending on where you work) and is the cut-off for being categorized as an elderly person, the majority of this group of (elderly) people are not socially and economically secure (Oladeji, 2011).

Elderly people are usually forced to cope with the paradox of dwindling financial resources, increased health challenges, and a geometric rise in medical expenses. In particular, elderly people living in urban areas in Nigeria only utilized health services and other services when they were available, accessible, and affordable (Odaman & Ibiezugbe, 2014). The patterns of the economic lives of older persons in Nigeria vary by urban and rural residences (Odaman & Ibiezugbe, 2014). In urban Nigeria, elders with high physical and psychological functioning are forced to retire once they reach the statutory retirement age. They face abrupt declines in their income and can feel less self-worth or even experience depression, since they perceive themselves as still being fit to work.

Ageism

Another challenge of ageing that seems more obvious than retirement is ageism. Although it can target any age group, ageism generally refers to prejudice and/or discrimination against older people (Abrams & Swift, 2012). Ageism can be either blatant or subtle. For example, it involves anything from refusing to hire an elderly worker to assuming an older woman needs help crossing the road. The elderly are often victims of negative stereotypes: They are perceived as slow, confused, helpless, resistant to change, and/or generally unhappy (Abrams & Swift, 2012). Like racism and sexism, discrimination can happen when unfair generalizations

like this are made. Although the stereotype is not true of every older individual, age-related bias, unfortunately, exists in some settings in Nigeria.

Social isolation

Another major challenge the respondents identified when it comes to the elderly is that of social isolation. Social disengagement theory argues that ageing can be thought of as a mutual withdrawal or disengagement which inevitably takes place between the ageing person and others (Cumming & Henry, 1961). The process leads to a relinquishment of roles since the ageing person drops out of the working sphere and children move out of the house. In addition, older people face a reduction of ties since peers start to die off. This process is conceived as removing the individual from a certain amount of normative control, free to become more individualized, and less likely to be easily assimilated into new groupings (Cumming & Henry, 1961).

While many older adults experience ageing as a positive time because they remain active and connected to others, the majority of other elders become disconnected from family, friends, and community. Understanding the causes of isolation can help position policymakers to help mitigate feelings of isolation among the elderly and contribute to a much-needed societal change. The environment can play a big role in isolation among the elderly. Many community settings are not ageing-friendly. The vast majority of older adults prefer to age in place. As reported by Partners for Livable Communities (2007), a design that makes it difficult to walk may contribute to older adults' isolation and therefore may negatively impact their quality of life. Research has shown that rural areas have higher incidences of poverty and less access to community resources,

such as activity centers, grocery stores, pharmacies, and town halls (Fochingong, 2014; Hartman & Weierbach, 2013; Snedeka, 2017).

For older adults in rural areas, lack of access to these services is often the greatest challenge faced. Without them, it is difficult to continue to live independently and meaningfully. But regardless of whether isolation is imposed by one's environment or chosen by the individual, its effects are of significant concern for the growing ageing population and require more attention. There may be an assumption that urban areas, which offer public transportation, are more supportive to older adults. However, what many do not realize is that the physical problems that can make driving difficult for older individuals can also make using public transportation difficult. For example, individuals with physical disabilities may have trouble crossing wide streets to reach bus stops or may have difficulty climbing the high stairs of a bus or train. Or, perhaps, an individual has always driven but now has to rely on public transit and needs assistance with navigating the route or timetable. Customer service may not always be willing or able to respond to those needs (Burkhardt, McGavok, & Nelson, 2002).

Undoubtedly, retirement can cause a decrease in the amount of social contact an individual experiences throughout the day. Retirement not only impacts social connectedness but also can cause a shift in income and social roles (Kaplan & Berkman, 2016). For some, retirement can be symbolic of an end. In as much as Nigerians live a communal type of life, the issue of social isolation is becoming an issue now, especially among the elderly people.

General and Social Policy aimed at the Elderly

Provision of social services such as income, security, health care, housing, and legal assistance can positively influence the well-being and health of the elderly (Oladeji, 2011). However, in Nigeria, there is no national social security system to provide an economic buffer in old age. In 1989, the Nigerian government developed the national social development policy which aimed to provide a framework for protecting elderly persons from moral and material neglect and provide public assistance when necessary. Despite the development of the national social development policy to care for the elderly, there has been no effective execution of this policy by any federal agency (Abdulkadir, 2016; Oladeji, 2011). For older adults in rural areas, lack of there are indications of policy frameworks for the elderly to be carried out in Africa, policy changes have not been observed in Nigeria (Mudiare, 2013).

The failure of the Nigerian federal institutions to regularly disburse pension funds to retirees and provide adequate social services for the aged poses a significant threat to food security, social security, and national security (Ajomale, 2007). If there were any cultural practices that contribute to the care of the elderly or stopping the government from taking care of the elderly. All the local government chairpersons made us understand that there is no cultural practice stopping the government from taking care of the elderly in Nigeria. Culturally, we respect the elderly in our communities. We take care of them when we have the resources. In our culture, we consider the elderly people first in everything we are doing, so if there were any policy from the government they would have been considered first. However, the respect is supposed to be incorporated that, the oldest should be catered for first. The elderly are not supposed to be undermined. However, the reverse is the case in Nigeria. You will notice that the government has

all kinds of policies for children and reproductive health, but they don't have any functional policy for the older people. (56-yearold local government chairperson; urban dweller)

Elderly Challenges in Nigeria

The growth in the number of older people has brought an increase in the range and intensity of their problems and need. The older persons in Nigeria suffer different hardship in an intolerable society. Olayinka, (2007) argued that older people constitute the poorest group in Nigeria which may be a threat to the full implementation of the millennium development goals (MDGs) by the Nigeria government.

According to the UN population report in 2005 has it that Nigeria among the Africa and West Africa and nation., has the largest population in Africa and Nine (9) in the world.

Thus, the table below shows the population distribution of the older people in Nigeria and Africa and west African with a projection between 2005 and 2050.

Table projected population if aging /elderly Africa and Nigeria from 2005-2050

	Population 60 years + in percentages			Population 60 years+ in million		
	2005	2025	2050	2005	2025	2050
Africa	5.2	6.4	10.0	47.7	85.8	192.9
West. Africa	4.7	5.5	9.0	12.0	21.8	51.6
Nigeria	4.9	6.0	9.7	6.4	11.5	25.6

Source: un population division (2005)

In this, when a project increase in the number of people expected to be older by 20250 revealed that the world is ageing older people, making it one out of every five people to be older by 2025 (UN, 2005).

However, this situation will eventually put developing countries into different resources challenges. According to Olayinka (2007) one of the causal factors of problems being faced by the aged/elderly today in the society is due to changes in the structure and function of family due to industrialization and modernization.

The pre-industrial family used to consist of members of the extended lineage including grandparent, and families members have gradually decreased due to economic problems, rural urban migration and influence by foreign culture these changes in Nigeria have cursed gradual disintegration of the extended family and of the communal sense of living in Nigeria society. Thus, neglect of philial obligation due to the structural changes was further improvised the social distance between family members leaving a lot of the older people to resolve to begging in order

to survive or getting employed as cleaners, security guard, load carriers or pretty traders (Olayinka, 2007).

Despite the enormous problems being faced by the elderly in Nigeria, social security policies for the aged are yet to be given full attention.

Review of Relevant Theory

The theories relevant in understanding the psychosocial needs of the elderly and its implication are the Social disengagement theory and the self-management theory. The rationale for using these two theories is due to the fact that the social disengagement theory addresses situation and needs of the elderly while the self-management theory addresses the issues that come with caring for the elderly.

Disengagement Theory

Disengagement theory was postulated by social scientists Elaine Cumming and William Earle Henry, and presented in the book Growing Old, published in 1961. It is notable for being the first social science theory of aging, because it was controversially received, sparked further development of social science research, and theories about the elderly, their social relationships and their roles in the society (Ashley, 2020). Ashley (2020) stated that disengagement theory presents a social systematic discussion of the aging process and the evolution of the social lives of elderly and was inspired by functionalist theory. He further stated that with the theory, Cumming and Henry situated aging within the social system and offer a set of steps that outline how the process of disengagement occurs as one ages and why this is important and beneficial to

the social system as a whole. They based their theory on a data from the Kansas City study of Adult life.

Based on this data, Cumming and Henry created the following nine postulates that comprise the theory of disengagement.

1. People loose social ties to those around them because they expect death, and their abilities to engage with others deteriorate over time.
2. As a person begins to disengage, they are increasingly freed from social norms which guide interaction. Losing touch with norms reinforces and fuels the process of disengagement.
3. The disengagement process for men and women differs due to their different social roles
4. The process of disengaging is spurred by an individual's desire to not have their reputation damaged by losing skills and abilities while they are still fully engaged in their social roles. Simultaneously younger adults are trained to develop the knowledge and skills necessary to take over the roles played by those who disengage.
5. Complete disengagement happens when both the individual and society are ready for this to occur. A disjunction between the two will occur when one is ready but not the other.
6. People who have disengaged adopt new social roles so as not to suffer a crisis of identity or become demoralized.
7. A person is ready to disengage when they are aware of the short time remaining in their life and they no longer wish to fulfill their current social roles; and society allows for disengagement in order to provide jobs for those coming of age, to satisfy the social needs of a nuclear family, and because people die.

8. Once disengaged, remaining relationships shift, rewards of them may change, and hierarchies may also shift.
9. Disengagement occurs across all cultures but is shaped by culture in which it occurs.

Application of Theory

In applying this theory this theory helps us to understand the genesis nature and effect of the aged living on the fringe of the Nigerian society. For example most pensioners move out Based on this postulates, Cummings and Henry suggested that the elderly are happiest when they accept and of their the city where they were residing when they were still in active service to their villages or where they can manage their meager pension and their savings and in the process they lose their contacts and are isolated. This theory suggest that there should be group activities; for example discussion; self-help; social activation; bereavement support. Also, social assistance should be deliberately initiated by the government and non-governmental organization in the reduction of poverty among the aged in Nigeria.

This theory contends that psychological adjustment to ageing comes through a reduction of activity and social contact because research shows that engagement in social interaction is far more beneficial for health and wellbeing of older persons (Fratiglioni & Wang, 2000; Victor et al, 2000; Pennington, 1992, cited in Ugiagbe, 2018).

Critiques of Disengagement Theory

Some critics pointed out that this was a flawed social science theory because Cummings and Henry, (1961) assume that the process is natural, innate, and inevitable, as well as universal. Some also pointed out that the theory completely ignores the role of class in shaping the

experience of aging, while others critiqued the assumption that the elderly have seemingly no agency in this process, but rather are complaint tools of the social system (Ashley, 2019). In applying both perspectives to the nature of poverty in Nigeria, there are evidences to show how poverty ravages socially excluded people (e.g. People living with disability, rural/slum dwellers) and how poverty is experienced at an individual level. Both perspectives appear to be valid in understanding the manifestations of Poverty in Nigeria.

The Self-management Theory

The self-management of wellbeing theory was postulated by Kdhneman in 1999. The theory posit that although the universal human needs basically remain the same across the entire life span, the relative ease with which they are fulfilled changes because the opportunities and resources that are available for fulfilling them change and decline important resources include physical resources such as energy, health, mobility, e.t.c. and social resources and opportunities. Fulfillment of need for status often depends on having a paid job or being recognized for having specific assets or wisdom or skills, e.t.c . at advance age, it becomes relatively more difficult to fulfill need for status, not only because of retirement, but also because of age-related physical declines that may undermine specific skills.

Application of Theory

The consideration for intervention in the context of this theory is that the key self-management activities must be adequately manages, gain maintenance and loss of external key resources. Self-management theory must serve both present and future outcomes. The theory of self-management help us to understand behavioral and cognitive processes underlying successful

again and how people can realize and maintain their own well-being over the life span. The theory reveals that the elderly are in their present pitiable condition because of their self-inflicted problems. This because of their inability to save for the future during their active service years. This mistake later compound their problem when they leave active service or grow old with little or nothing to sustain them. On the other hand the social worker faces challenges to cater for them due to the failure of the government in implementing workable policies that will cater for the elderly. Social work practices in caring for the elderly becomes very difficult because there is no working template for them to provide succor for the elderly. This scenario will in turn affect their social relationship with others, their self-worth and this result in isolation, exclusion, self-condemnation and pity.

It should be stated that these theory helps to establish the nexus between self-inflicted problems, systematic problems and failures on the part of the government in the context of the scourge of poverty among the elderly and the challenges of the social work practice.

Modernization Theory and The Study Of Aging

Modernization theory was formalized in social gerontology mainly through the work of sociologists. In 1972, Donald Cowgill and Lowell Holmes developed a theory of modernization as it related to aging and old age. Their position was that as societies modernized—undertaking the shift from farm and craft production within families to a dominantly industrial mode of production—repercussions of modernization would diminish the status of older people. Cowgill's later theoretical refinements (1974) identified four key aspects of modernization that

undermined the status of older people: health technology, economic and industrial technology, urbanization, and education.

According to Cowgill's theory, improved health technology, including advances in both medical practice and public health, has positive effects of improving health and increasing longevity, but it also has negative effects for older people. When people live longer, there is more competition in the labor market. Employers in industrializing societies prefer younger workers with new occupational skills to older workers, forcing older workers out of the labor market into retirement. Once retired, according to modernization theory, loss of income, prestige, and honor arising from labor market participation lead to a decline in the status of older people.

Modernizing advances in economic and industrial technology create new occupations in factories located near transportation and services. Younger people acquire the skills for new occupational slots and join the industrial work force, relegating older people to less prestigious and increasingly obsolete jobs. This often leads to retirement, reversing the roles of old and young. In traditional societies, older family members control family production, and younger ones are dependent on the old. When older people are excluded from the industrial labor market, they become dependent on the young, losing social status.

Factory locations in urban areas are a magnet to young workers. The process of urbanization leaves older family members behind in rural areas, undermining the traditional extended family and the prominent position of older members within them. The new family form in modernizing societies is the nuclear family, and both social and spatial distance are increased between the young and the old, changing intergenerational relations. Modernization theorists viewed upward

mobility of the young as being accompanied by downward mobility among the elders in their families.

Increased literacy, emphasis on the superiority of scientific over traditional forms of knowledge, and education targeted toward children can all create inequalities in the knowledge base among family members of different generations, making the generation gaps between young and old even wider. Developments in science and technology render much of the traditional knowledge and many of the skills of older people that previously contributed to their high social status obsolete, since direct contribution to an industrialized economy becomes impossible.

This general model of the relationship between modernization and aging predicts a linear relationship between the status of older people and the degree of modernization experienced in a given society. According to this theory, the more modernized a society becomes, the more the status of older people declines. Modernization thus inevitably affects the entire social structure of newly modernized societies, including the position customarily held by its elderly community, regardless of when or where it occurred.

The institutionalization of modernization theory as one of the foundational theoretical approaches to the study of aging gave impetus to further study. Not long after Cowgill and Holmes's original work, Erdman Palmore and Kenneth Manton used data from thirty-one countries to test modernization theory. Their findings suggested a refinement to modernization theory that involved taking the phase of modernization into account when exploring status changes among older people. Palmore and Manton's results showed that in the early stages of

modernization, older people's social status was relatively lower, but that the decline in status leveled off and even rose somewhat after a period of modernization.

In both its original and more elaborate variants, modernization theory provided a springboard to theorizing and research into the relationship between aging and social change. Some researchers sought to improve modernization theory by refining it. Others contended that modernization theory was too flawed to be a useful general theory explaining the relationship between social change and aging.

CHAPTER THREE

RESEARCH METHODS

Introduction

This section will focus on the systematic approach for solving the research problem in the study and highlights the instruments and techniques that will be used to seek solutions to the research problem. It consists of the research design, sample population, sample size, sampling techniques, research instruments, validity and reliability of research instruments and methods of data analysis. The purpose of this research is the psychosocial needs of the elderly and its implication (A Case Study Of Okpuno Otolo Community In Nnewi North Local Government Area Anambra State.

3.1 Research Design

This study will adopt the survey research design being a descriptive research. This was considered appropriate because psychosocial needs of the elderly will be observed. The design is also considered appropriate for this study because it described the nature of the psychosocial needs of the elderly.

3.2 Population of the Study

The population of this study will comprise of resident between the age of sixty (60) to eighty (80) years and above. according to the national bureau of statistics and the national

population commission there are a total of eight Thousand Four Hundred (8,400) Elderly in Anambra, including male and females. (National Bureau of Statistics, 2018)

3.3 Sample Size

For this study a sample size of 140 respondents will be derived and the sample size will be drawn from some selected communities in Nnewi Local Government Area of Anambra State. This study will adopt the Taro Yamane's sample size formula of 1973 which will be used to determine the sample size. The formula is stated thus:

$$n = \frac{N}{1+N(e)2}$$

3.4 Sampling Technique

For the purpose of gathering quantitative data, a Stratified Random Sampling Technique will be used in selecting the respondents according to their cells. Since the sample size is 140. The stratified random sampling will be utilized in this study. This technique is appropriate in order to ensure that every element in the sampling frame has an equal opportunity of being selected. For the purpose of collecting qualitative data Ten (10) persons will be purposively selected from the various wards and street. The respondents will be selected using purposive sampling technique. The researcher will purposively select the various wards and street.

3.5 Instrument for Data Collection

The instrument for data collection for this study will be made up from both questionnaire. The questionnaire will be adopted because of the advantage of reaching out to a large proportion of the population; while the in-depth interview will be adopted to address the challenges of social work practices to give deeper insight and to make up for the short comings of the questionnaire.

3.6 Method of Data Collection

For the purpose of this study the researcher will recruit two research assistant that will be of assistance in collecting data. The study will make use of both the primary and secondary sources of data collection. The primary source will involve the use of one time face to face distribution of the questionnaires to respondents, while the secondary sources will include information from the internet, journals, textbooks and Government gazette. The data and information from the secondary sources will be used to supplement the information that will be gotten from the primary sources (questionnaire). The questionnaire and interview guide will be administered and collected from respondents within two weeks.

3.7 Method of Data Presentation and Analysis

For the analysis of data, the statistical package for social sciences (SPSS) will be used. The statistical tools will be use to analyze the data include the following: descriptive analysis using frequency tables and percentages, frequency tables, cross tabulation, graphs and charts. Furthermore, distribution tables and frequency and percentages would be used for data

interpretation. Also, a master data sheet will be prepared with the use of the SPSS. Finally, findings associated with the study will be discussed in chapter 4.

3.8 Ethical Considerations

i. Oral consent will be sought officially by the researcher from the respondents
ii. Researcher will be ensued confidentiality and privacy of participant's information
iii. The researcher will avoid the use of deceptive statement and questions during the course of the research
iv. The researcher will ensure that participants were not coerced but participated willingly.
v. The researcher will also ensure that no form of injury physical or mental affected the participants

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1. INTRODUCTION

This chapter focuses on the analysis of data collected from the respondents. A total of 165 questionnaires were administrated. Out of the one hundred and sixty-five questionnaires (140) were returned, 18 was wrongly filled and 7 were not returned. Thus, the analysis of this study is based on the 140 respondents as against 165 respondents in the sample drawn from this study.

SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTIC OF THE RESPONDENTS

TABLE 1: DISTRIBUTION OF RESPONDENTS BY SEX

SEX	RESPONDENTS	PERCENTAGE (%)
MALE	45	32.1
FEMALE	95	67.8
TOTAL	140	100

Table 1 reveals that 32.1% of the total respondents are male, while 67.8% of the respondent are females. This implies that majority of the respondents are females.

TABLE 2: DISTRIBUTION OF RESPONDENTS BY AGE

AGE	RESPONDENTS	PERCENTAGE (%)
60.64	25	17.8
65.69	35	25
70.74	44	31.4
75 and above	36	25.7
TOTAL	140	100

Source: field work 2021.

Table 2 reveals that 17.8 of the total respondents are within the age of 60-64; also 30% of the total respondents are within the age of 65-69. While 31.4% of the total respondents are within the age of 70-74.

Lastly, 25.7% of the total respondents are 75years and above. This clearly indicates that the majority of the respondents are between the age of 70-74years

TABLE 3: DISTRIBUTION OF RESPONDENT BY RELIGION

RELIGION	RESPONDENTS	PERCENTAGE (%)
Christian	90	64.2
Islam	50	35.7
Total	140	100

Source: field work 2021.

Table 3 indicates that majority of the respondents; specifically, 64.2% of the respondents are Christians, while 35.7% of the total respondents are Muslims. This implies that the data was collected from respondents of religion.

4.2 ANALYSIS OF RESEARCH QUESTION

RESEARCH QUESTION 1

Table 4: If monthly payment is meant to be elderly populated in Nigeria, will it improve the quality of life.

RESPONSE	RESPONDENTS	PERCENTAGE (%)
Agree	30	21.4
Disagree	24	17.1
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: Field work 2021.

Table 4 showed that 21.4(%) of the respondents agreed that if monthly payment is elderly populated in Nigeria it will improve the quality of life.

While 17.1% of the respondents disagreed that if monthly payment is elderly populated it will improve the quality of life.

While 28.5% of the respondents strongly agreed that if monthly payment is elderly populated in Nigeria it will improve the quality of life. While 14.2% of the respondents strongly disagreed that if monthly payment is elderly populated it will not improve the quality of life. Lastly 18.5% of the respondents were indecisive as to whether monthly payment is elderly populated will improve or will not improve the quality of life in Nigeria. This implies that if monthly payment is meant to be elderly populated in Nigeria it will improve the quality of life.

4.3 RESEARCH QUESTION 2

Table 5: Do you think if health care service are made free, it will improve the quality of life?

RESPONSE	RESPONDENTS	PERCENTAGE (%)
Agree	29	20.7
Disagree	25	17.8
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: field work 2021.

Table 5 showed that 20.7(%) of the respondents agreed that if health care service are made free, it will improve the quality of life.

While 17.8% of the respondents disagreed that if health care service are made free, it will improve the quality of life.

While 28.5% of the respondents strongly agreed that if health care service are made free, it will improve the quality of life. While 14.2% of the respondents strongly disagreed that if health care service are made free, it will improve the quality of life. Lastly 18.5% of the respondents were indecisive as to whether if health care service are made free, it will improve the quality of life in Nigeria. This implies that if health care service are made free, it will improve the quality of life?

RESEARCH QUESTION 3

Table 6: Do you think elderly people can live longer when a good accommodation is provided to them when they get to a certain age?

RESPONSE	RESPONDENTS	PERCENTAGE (%)
Agree	29	20.7
Disagree	25	17.8
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: field work 2021.

Table 6 indicates that while 20.7% of the respondents agreed that elderly people can live longer when a good accommodation is provided to them when they get to a certain age. While 17.8% of the respondents disagreed that elderly people can live longer when a good accommodation is provided to them when they get to a certain age. While 28.5% of the respondents strongly agreed

that elderly people can live longer when a good accommodation is provided to them when they get to a certain age. While 14.2% of the respondents strongly disagreed that elderly people can live longer when a good accommodation is provided to them when they get to a certain age in Nigeria. Lastly 18.5 were indecisive as to whether elderly people can live longer when a good accommodation is provided to them when they get to a certain age. This implies that elderly people can live longer when a good accommodation is provided to them when they get to a certain age

RESEARCH QUESTION 4

Table 7: When you have someone to talk to all the time you wish, do you think they will be limit to early aging to an extent?

RESPONSE	RESPONDENTS	PERCENTAGE (%)
Agree	29	20.7
Disagree	25	17.8
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: field work 2021.

Table 7 indicate that 20.7% of the respondents agreed that When you have someone to talk to all the time you wish, they will be limit to early aging to an extent. While 17.8% of the respondents disagreed that When you have someone to talk to all the time you wish, they will be limit to early

aging to an extent. While 28.5% of the respondents strongly agreed that when you have someone to talk to all the time you wish, they will be limit to early aging to an extent. While 14.2% of the respondents strongly disagreed that when you have someone to talk to all the time you wish, they will be limit to early aging to an extent in Nigeria. Lastly 18.5 were indecisive as to whether if you have someone to talk to all the time you wish, they will be limit to early aging to an extent. This implies that when you have someone to talk to all the time you wish, they will be limit to early aging to an extent

RESEARCH QUESTION 5

Table 8: Do you think communication is one of the tools to keep the elderly healthy?

RESPONSE	**RESPONDENTS**	**PERCENTAGE (%)**
Agree	30	21.4
Disagree	24	17.1
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: field work 2021.

Table 8 showed that 21.4(%) of the respondents agreed that communication is one of the tools to keep the elderly healthy? While 17.1% of the respondents disagreed that communication is one of the tools to keep the elderly healthy. While 28.5% of the respondents strongly agreed that

communication is one of the tools to keep the elderly healthy? While 14.2% of the respondents strongly disagreed that communication is one of the tools to keep the elderly healthy. Lastly 18.5% of the respondents were indecisive as to whether communication is one of the tools to keep the elderly healthy in Nigeria. This implies that if monthly payment is meant to be elderly populated in Nigeria it will improve the quality of life. This implies that communication is one of the tools to keep the elderly healthy.

RESEARCH QUESTION 6

Table 9: Do you think having someone to talk to all the time will reduce the level of anxiety?

RESPONSE	RESPONDENTS	PERCENTAGE (%)
Agree	30	21.4
Disagree	24	17.1
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: field work 2021.

Table 9 showed that 21.4(%) of the respondents agreed that having someone to talk to all the time will reduce the level of anxiety. While 17.1% of the respondents disagreed that having someone to talk to all the time will reduce the level of anxiety. While 28.5% of the respondents strongly agreed that having someone to talk to all the time will reduce the level of anxiety. While

14.2% of the respondents strongly disagreed that having someone to talk to all the time will reduce the level of anxiety. Lastly 18.5% of the respondents were indecisive as to whether having someone to talk to all the time will reduce the level of anxiety in Nigeria. This implies that if having someone to talk to all the time will reduce the level of anxiety in.

RESEARCH QUESTION 7

Table 10: Do you think having someone to help you with house chores will reduce some stress factors to some extent?

RESPONSE	**RESPONDENTS**	**PERCENTAGE (%)**
Agree	29	20.7
Disagree	25	17.8
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: field work 2021.

Table 10 indicates that 20.7% of the respondents agreed that having someone to help you with house chores will reduce some stress factors to some extent. While 17.8% of the respondents disagreed that having someone to help you with house chores will reduce some stress factors to some extent. While 28.5% of the respondents strongly agreed that having someone to help you with house chores will reduce some stress factors to some extent. While 14.2% of the

respondents strongly disagreed that having someone to help you with house chores will reduce some stress factors to some extent in Nigeria. Lastly 18.5 were indecisive as to whether having someone to help you with house chores will reduce some stress factors to some extent. This implies that having someone to help you with house chores will reduce some stress factors to some extent.

RESEARCH QUESTION 8

Table 11: Do you think in Nigeria for elderly people who feel lonely or isolated, social workers assistance can increase social contacts may prevent morbidity and postpone death for those who are depressed?

RESPONSE	RESPONDENTS	PERCENTAGE (%)
Agree	30	21.4
Disagree	24	17.1
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: field work 2021.

Table 11 showed that 21.4(%) of the respondents agreed that for elderly people who feel lonely or isolated, social workers assistance can increase social contacts may prevent morbidity and postpone death for those who are depressed. While 17.1% of the respondents disagreed that for elderly people who feel lonely or isolated, social workers assistance can increase social contacts

may prevent morbidity and postpone death for those who are depressed. While 28.5% of the respondents strongly agreed that for elderly people who feel lonely or isolated, social workers assistance can increase social contacts may prevent morbidity and postpone death for those who are depressed. While 14.2% of the respondents strongly disagreed that for elderly people who feel lonely or isolated, social workers assistance can increase social contacts may prevent morbidity and postpone death for those who are depressed. Lastly 18.5% of the respondents were indecisive as to whether for elderly people who feel lonely or isolated, social workers assistance can increase social contacts may prevent morbidity and postpone death for those who are depressed in Nigeria. This implies that for elderly people who feel lonely or isolated, social workers assistance can increase social contacts and may prevent morbidity and postpone death for those who are depressed

RESEARCH QUESTION 9

Table 12: In Nigeria if policies are made to create a monitoring team to guide and educate people of certain age, will it help to curtail malnutrition?

RESPONSE	**RESPONDENTS**	**PERCENTAGE (%)**
Agree	29	20.7
Disagree	25	17.8
Strongly agree	40	28.5
Strongly Disagree	20	14.2
Undecided	26	18.5
Total	140	100

Source: field work 2021.

Table 12 indicate that 20.7% of the respondents agreed that if policies are made to create a monitoring team to guide and educate people of certain age, it will help to curtail malnutrition. While 17.8% of the respondents disagreed that if policies are made to create a monitoring team to guide and educate people of certain age, it will help to curtail malnutrition While 28.5% of the respondents strongly agreed that if policies are made to create a monitoring team to guide and educate people of certain age, it will help to curtail malnutrition While 14.2% of the respondents strongly disagreed that if policies are made to create a monitoring team to guide and educate people of certain age, it will help to curtail malnutrition in Nigeria. Lastly 18.5 were indecisive as to whether if policies are made to create a monitoring team to guide and educate people of certain age, it will help to curtail malnutrition. This implies that if policies are made to create a monitoring team to guide and educate people of certain age, it will help to curtail malnutrition.

Table 13: What do you think can be done to improve the psycho-social need of the elderly in Nigeria?

RESPONSE	**RESPONDENTS**	**PERCENTAGE (%)**
Government policies should be made concerning the psycho-social need of the elderly.	25	17.8
Funds should be approved annually for the psych-social need of the elderly.	35	25.1
Teams should be set up to monitor the welfare of the elderly.	36	25.7
All of the above	44	31.4

Total	140	100

Source: field work 2021.

Table 13 indicates that 17.8% of the total respondent stated that the government should make policies concerning the psycho-social need of the elderly in Nigeria. While 25.1% of the respondent stated that funds should be approved annually for the psycho-social wellbeing of the elderly while 25.4% of the total respondent stated that teams should be set up to monitor the welfare of the elderly. Lastly 31.7% of the total respondent stated that the psycho-social wellbeing of the elderly and its implications can be improved by applying all the options stated above. This implies that all the option stated are viable solutions to improving the psycho-social wellbeing of the elderly and its implications in Nigeria.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1. SUMMARY OF FINDINGS

Nigeria is faced with many psycho-social problems, among them is the dilapidating state of the elderly psycho-socio needs, hence it is pertinent to examine the falling standard of the psycho-socio needs of the elderly and its effect using Okpuno-otolo Community in Nnewi North Local Government Area Anambra State as a case study. After analyzing the data, it was revealed that the psycho –socio need of the elderly in Nigeria is declining also the study showed that the causes responsible for the declining state of the elderly psycho-socio need in Nigeria are incidences of government policies and corruption. Also, it was found out in this study that government policies have an effect on the elderly psycho-socio need. Furthermore, this study showed that the effect of the elderly psycho-socio needs down turn is majorly negative. Also, the psycho-socio need of the elderly effect the society at large. Furthermore, it was revealed from this study that the ways to improve the elderly psycho-socio need in Nigeria is by allocating more funds towards the psycho-socio need of the elderly, monthly payment should be elderly populated, and the elderly should be provided accommodation by the government.

5.2. CONCLUSION

As a result of the findings obtained from this study, the study concludes that the psycho-socio needs of the elderly in Nigeria is declining hence something should be done to revamp it. Also, the study concludes that the causes responsible for the elderly lack of psycho-socio need

are incidences of corruption, government polices and poor agencies. In addition the study concludes that the down turn on the elderly psycho-socio needs affect the society at large.

5.3. RECOMMENDATIONS

In other to improve the standard of the elderly psycho-socio need in Nigeria, the following recommendation where made:

1. Monthly stipends should be elderly populated in Nigeria, to improve the quality of life.
2. Health care services should be made free for the elderly to improve the quality of life.
3. Good accommodations should be provided to them
4. Elderly people who feel lonely or isolated should be provided with social workers assistance to increase social contacts and postponed death among those who are depressed.

In conclusion, the recommendations stated above should be considered in other to improve on the standard of the elderly psycho-socio need in Okpuno-otolo Community in Nnewi North Local Government Area, Anambra State. The government, organizations and private bodies should work together to improve on the standard of the elderly psycho-socio need in Nigeria.

REFERENCES

Abdulkadir, R.I., Abdullah, N.A.H. and Wong, W. (2016). Dividend payment behaviour and its determinants: The Nigerian evidence. *African Development Review*, 28(1): 53–63. doi: 10.1111/1467-8268.12166.

Abrams, D. and Swift, H.J. (2012). Ageism doesn't work. *Public Policy & Ageing Report*, 22(3), 3–8. doi:10.1093/22.3.3

Adebanjoko, A. and Ugwuoke, O.W. (2014). Poverty and the challenges of insecurity to development. *European Scientific Journal*, 10(14): 361–372.

Adebowale, S., Atte, O. and Ayeni, O. (2012). Elderly Well-being in a Rural Community in North Cenral Nigeria, Sub-Saharan Africa. *Public Health Research*, 2(4): 92-101.

Aggleton P., Chalmers H. (1986). Roper, Logan and Tierney's Activities of Living Model of Nursing. In: Nursing Models and the Nursing Process. Palgrave, London. https://doi.org/10.1007/978-1-349-18450-7_4

Ahmed, L, and Kitson, A. (1993). The role of the health care assistant Within a professional nursing culture. Report No. 3. National Institute for Nursing, Oxford.

Ajomale, O. (2007). *Country report: Ageing in Nigeria — Current state, social and economic implications. Summer newsletter of the research committee (RC11) of the sociology of aging of the International Sociological Association (ISA)* (pp. 15–20).

Albrecht, G. and Devlieger, P. (1999). The Disability Paradox: High Quality of Life Against All Odds. *Social Science & Medicine*, 48: 977-988.

Alubo, O. (1987). Power and privileges in medical care: An analysis of medical services in post-Colonial Nigeria. *Social Science and Medicine*, 24: 453–462.

Anderson, K.L. and Burckhardt, C.S. (1999). Conceptualization and measurement of quality of life as an outcome variable for health care intervention and research. *Journal of Advance Nursing*, 29(2):298-306. doi: 10.1046/j.1365-2648.1999.00889.x. PMID: 10197928.

Animasahun, V.J. and Chapman, H.J. (2017). Psychosocial health challenges of the elderly in Nigeria: A narrative review. *Africa Health Sciences*, 17(2): 575–583. doi:10.4314/ahs.v17i2.35

Apere, P. (2015). Key challenges of Nigerian Pension Industry and possible solutions (1). *The Nation*. Retrieved September 3, 2015, from http://thenationonlineng.net/key-challenges-of-nigerian-pension-industry-and-possible-solutions-1/

Arnetz, J.E. and Hasson, H. (2007). Evaluation of an educational "toolbox" for improving nursing staff competence and psychosocial work environment in elderly care: results of a prospective, non-randomized controlled intervention. *International Journal of Nursing Studies*, 44(5):723-35. doi: 10.1016/j.ijnurstu.2006.01.012. Epub 2006 Mar 24. PMID: 16563398.

Arnold, E. and Underman-Boggs, K. (2003). Interpersonal Relationships: Professional Communication Skills for Nurses. 4th Edition, Saunders, 629pp.

Ashley, C. (2020). Disengagement Theory. Retrieved from https://www.thoughtco.com/disengagement-theory-3026258.

Atchley, R.C. (1989). A continuity theory or normal aging. *Gerontologist*, 29: 183-90.

Avlund, K., Lund, R., Holstein, B.E. and Due, P. (2004). Social relations as determinants of onset of disability in aging. *Archies of Gerontology and Geriatrics*, 38: 85-99.

Baltes, M.M. (1996). *The many faces of dependency in old age.* Cambridge University Press.

Baltes, P.B. and Baltes, M.M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In: Baltes P.B. and Baltes M.M., Eds., Successful Aging. Perspectives from the Behavioral Sciences, Cambridge University Press, Cambridge. doi:10.1017/CBO9780511665684.003.

Baltes, P.B. and Smith, J. (2003). New frontiers in the future of aging: from successful aging of the young old to the dilemmas of the fourth age. *Gerontology*, 49(2):123-35. doi: 10.1159/000067946. PMID: 12574672.

Banister, D. and Bowling, A. (2004). Quality of life for the elderly: the transport dimension. *Transport Policy*, 11(2): 105-115. https://doi.org/10.1016/S0967-070X(03)00052-0.

Barrett, L.F. (2006). Are Emotions Natural Kinds? *Perspectives of Psychological Science*, 1: 28-58.

Bennett, D.A., Schneider, J.A., Arvanitakis, Z., Kelly, J.F., Aggarwal, N.T., Shah, R. C.R. and Wilson, S. (2006). Neuropathology of older persons without cognitive impairment from two community-based studies. *Neurology*, 66(12): 1837-1844; DOI: 10.1212/01.wnl.0000219668.47116.e6

Bergland, A. and Kirkevold, M. (2008). The significance of peer relationships to thriving in nursing homes. *Journal of Clinical Nursing*, 17(10):1295-302. doi: 10.1111/j.1365-2702.2007.02069.x.

Bloom, D., and Williamson, J. (1998). Demographic Transition and Economic Miracles in Emerging Asia. *World Bank Economic Review*, 12(3): 419–56.

Boeckxstaens, P. and De Graaf, P. (2011). Primary care and care for older persons: position paper of the European Forum for Primary Care. *Quality Primary Care*, 19(6):369-89. PMID: 22340900.

Borglin, G., Jakobsson, U., Edberg, A-K, and Hallberg, I.R. (2005). Self-reported health complaints and their prediction of overall and health-related quality of life among elderly people. *International Journal of Nursing Studies*, 42(2): 147-158.

Bowling, A. and Dieppe, P. (2005). What is successful ageing and who should define it? *British Medical Journal*, 331: 1548 doi:10.1136/bmj.331.7531.1548.

Bowling, A. and Grundy, E. (1997). Activities of daily living: changes in functional ability in three samples of elderly and very elderly people. *Age and Ageing*, 26(2): 107–114. https://doi.org/10.1093/ageing/26.2.107.

Bowling, A., Bannister, D., Sutton, S., Evans, O. and Windsor, J. (2002). A multi-dimensional model of QoL in older age. *Ageing and Mental Health*, 6: 355–371.

Bowling, A., Fleissig, A., Gabriel, Z., Banister, D., Dykes, J., Dowding, L.M., Sutton, S. and Evans, O. (2003). Let's ask them: A national survey of definitions of quality of life and its enhancement among people aged 65 and over. *International Journal of Aging and Human Development*, 56: 269-306.

Bowling, A., Gabriel, Z., Dykes, J., Marriott-Dowding, L., Fleissig, A., Evans, O., Banister, D. and Sutton, S. (2003). Let's ask them: definitions of quality of life and its enhancement

among people aged 65 and over. *International Journal of Aging and Human Development*, 56: 269–306.

Bradshaw, C.P., Sawyer, A.L. and O'Brennan, L.M. (2007). Bullying and peer victimization at school: Perceptual differences between students and school staff. *School Psychology Review*, 36(3), 361-382.

Browne, J.P., O'Boyle, C.A., McGee, H.M., Joyce, C.R.B., McDonald, N.J., Malley, K.O. and Hiltbrunner, B. (1994). Individual quality of life in the healthy elderly. *Quality of Life Research*, 3:235-244.

Burkhardt, J.E., McGavock, A.T., Nelson, C.A. and Mitchell, C.B.G. (2002). *Improving public transit options for older persons*. Federal Transit Administration, Transit Cooperative Research Program, Report 82. Retrieved from http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_rpt_82v1a.pdf

Castle, N.G. and Engberg, J. (2007). The Influence of Staffing Characteristics on Quality of Care in Nursing Homes. *Health Services Research*, 42(5): 1822–1847.

Central Statistics Office (2004). Volume 10: Disability and Carers, Dublin, Stationery Office.

Central Statistics Office (2006). Volume 11: Disability, Carers and Voluntary Activities. 02& Persons, males and females in each Province, County and City, classified by type of disability. [CSO Database Direct]

Choowattanapakorn, T., Nay, R. and Fetherstonhaugh, D. (2004). Nursing older people in Thailand: embryonicholistic rhetoric and the biomedical reality of practice. *Geriatric Nursing*, 25: 17–23.

Christensen, K., Frederiksen, H., Vaupel, J.W. and McGue, M. (2003). Age trajectories of genetic variance in physical functioning: A longitudinal study of Danish twins aged 70 years and older. *Behavior Genetics*, 33, 125–135.

Christine D.L.M. and Joaquim, O.M. (2015). The Future of Health and Long-term Care Spending. OECD Journal: Economic Studies, 2014: 61-96.

Coffey, A. (2004). Perceptions of training for care attendants employed in the care of older people. *Journal of Nursing Management*, 12(5):322-328. doi: 10.1111/j.1365-2834.2004.00442.x. PMID: 15315488.

Connell, P. and Pringle, D. (2004). Population Ageing in Ireland: Projections 2002-2021, Dublin, National Council on Ageing and Older People.

Cowgill, D. O. and Holmes, L. D. (1972). Aging and Modernization. New York: Appleton – century – Croft. Google Scholar.

Cumming, E. and Henry, W.E. (1961). Growing Old: The Process of Disengagement. New York: Basic Books, 293 pp.

Currie, V., Harvey, G., West, E., McKenna, H. and Keeney, S. (2005). Relationship between quality of care, staffing levels, skill mix and nurse autonomy: literature review. *Journal of Advanced Nursing*, 51(1): 73-82.

Ekanade, O.V. (2014). The dynamics of forced Neoliberalism in Nigeria since the 1980s. *Journal of Retracing Africa*, 1(1): 1–24.

Engel, G.L. (1978). The biopsychosocial model and the education of health professionals. *Annals of the New York Academy Science,* 310:169–87.

Erikson, E.H. and Erikson, J.M. (1997). *The life cycle completed.* Extended edition. New York: W. W. Norton & Co.

Erikson, E.H., Erikson, J.M. and Kivnick, H.Q. (1986). *Vital involvement in old age.* New York: W. W. Norton & Co.

Fonchingong, C.C. (2014). Firming up institutional policy for deprived elderly in Cameroon: Policy for deprived elderly in Cameroon. *Politics & Policy*, 42(6): 948–980. doi:10.1111/polp.12101

Ford, P. and McCormack, B. (2000). Keeping the person in the centre of nursing. *Nursing Standard*, 14(46):40-44. doi: 10.7748/ns2000.08.14.46.40.c2894

Fossey, J., Ballard, C., Juszczak, E., James, I., Alder, N., Jacoby, R. and Howard, R. (2006). Effect of enhanced psychosocial care on antipsychotic use in nursing home

residents with severe dementia: cluster randomized trial. *British Medical Journal*, 332:756-758. doi:10.1136/bmj.38782.575868.7C

Fratiglioni, L. and Wang, H-X. (2000). Smoking and Parkinson's and Alzheimer's disease: review of the epidemiological studies. *Behavioural Brain Research*, 113: 117–120.

Geertzen, J.H., Dijkstra, P.U., van Sonderen, E.L., Groothoff, J.W., ten Duis, H.J. and Eisma, W.H. (1998). Relationship between impairments, disability and handicap in reflex sympathetic dystrophy patients: a long-term follow-up study. *Clinical Rehabilitation*, 12(5):402-412. doi: 10.1191/026921598676761735.

Glaser, B. and Strauss, A. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Mill Valley, CA: Sociology Press.

Glaser, B. G. (1978). Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley, CA: Sociology Press.

Goffman, E. (1968). Stigma Notes On The Management of Spoiled Identity. Simon & Shuster, New York,

Graham, I. (1994). How do registered nurses think and experience nursing. A phenomenological investigation. *Journal of Clinical Nursing* 3: 235–242.

Grew R. (1977). Modernization and its discontents. "*Amer. Behavioural Scientist* **21** (November/December): 289 – 312.

Haight, B.K., Barba, B.E., Courts, N.F. and Tesh, A.S. (2002). Thriving: A Life Span Theory. *Journal of Gerontological Nursing*, 28(3): 14-22.

Hartman, R.M. and Weierbach, F.M. (2013). *National rural health association policy brief: Elder health in rural America*. Retrieved from https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/

Harwood, D.G., Ownby, R.L., Barker, W.W. and Duara, R. (1998). The behavioral pathology in Alzheimer's disease scale (BEHAVE-AD): Factor structure among community-dwelling Alzheimer's disease patients. *International Journal of Geriatric Psychiatry*, 13(11):793–800.

Havighurst, R.J. (1961). Successful aging. *Gerontologist*. https://doi.org/10.1093/geront/1.1.8

Havighurst, R.J., Neugarten, B.L. and Tobin, S.S. (1963). Disengagement, personality and life satisfaction in the later years. In: Hansen PF (ed) Age with a future. Munksgaard, Copenhagen, pp 419–425.

Herrick, S., Ashcroft, G., Ireland, G., Horan, M., McCollum, C. and Ferguson, M. (1997). Up-regulation of elastase in acute wounds of healthy aged humans and chronicvenous leg ulcers are associated with matrix degradation. *Laboratory Investigation*, 77:281-288.

Hoogerduijn, J.G., Schuurmans, R.J., Duijnstee, M.S.H., Rooki, S.E. and Grypdonck, M.J.H. (2006). A systematic review of predictors and screening instruments to identify older hospitalized patients at risk for functional decline. *Journal of Clinical Nursing*, 16: 46- 57. doi: 10.1111/j.1365-2702.2006.01579.x

Hubbard, R.L., Craddock, S.G. and Anderson, J. (2003). Overview of 5-year follow-up outcomes in the drug abuse treatment outcome studies (DATOS). *Journal of Substance Abuse Treatment*, 25(3):125-34. doi: 10.1016/s0740-5472(03)00130-2.

Imrie, R. (2004). Demystifying disability: a review of the International Classification of Functioning, Disability and Health. *Sociology of Health & Illness*, 26(3): 287-305.

Jacobzone, S., Cambois, E., Chaplain, E. and Robine, J.M. (1998). The Health of Older Persons in OECD Countries: Is it improving fast enough to compensate for population ageing? Labour Market and Social Policy, Occasional Papers, No 37. Paris: Organisation for Economic Co-operation and Development.

Jacobzone, S., Choi, C. and Miguet, C. (2007) Indicators of Regulatory Management Systems. OECD Working Papers on Public Governance, 2007/4, OECD Publishing, Paris. https://doi.org/10.1787/112082475604

Johnson, J.K., Sarkisian, N. and Williamson, J.B. (2015). Using a micro-level model to generate a macro-level model of productive successful aging. *Gerontologist*, 55(1):107-119. doi: 10.1093/geront/gnu089.

Johnstone, L. (2006). The Limits of Biomedical Models of Distress. In: Double D.B. (eds) Critical Psychiatry. Palgrave Macmillan, London. https://doi.org/10.1057/9780230599192_5

Judith, I.A. (2014). Care and Support for the Elderly in Nigeria: A review. *The Nigerian Journal of Sociology and Anthropology*: Special Edition on Ageing in Nigeria, 12(1): 9-27.

Kabir, M. (2008). Determinants of Life Expectancy in Developing Countries. *The Journal of Developing Areas,* 41(2): 185-204.

Kahneman, D. (1999). Objective Happiness. In: Kahneman, D., Diener, E. and Schwarz, N., Eds., Well-Being: The Foundations of Hedonic Psychology, Russell Sage Foundation, New York, 3-25.

Kaplan, D.B. and Berkman, B.J. (2016). *Effects of life transitions on the elderly*. Retrieved from https://www.merckmanuals.com/professional/geriatrics/social-issues-in-the-elderly/effects-of-life-transitions-on-the-elderly.

Kelly, T., Tolson, D., Schofield, I. and Booth, J. (2005). Describing gerontological nursing: an academic exercise or prerequisite for progress? *International Journal of Nursing Older People*, 14; 1–11.

Lehmann, J.M. (1995). Durkheim's Theories of Deviance and Suicide: A Feminist Reconsideration. *American Journal of Sociology*, 100(4): 904-930.

Levine, S., Scotch, N.A. and Vlasak, G.J. (1969). Unravelling technology and culture in public health. *American Journal of Public Health and the Nation's Health*, 59(2):237-44. doi: 10.2105/ajph.59.2.237.

Levy M. J. (1966). *Modernization and the Structure of Society*. Princeton, NJ: Princeton University Press. Google Scholar.

Lovell, M. (2006). Caring for the elderly: changing perceptions and attitudes. *Journal of Vascular Nursing*, 24(1): 22–26. doi:10.1016/j.jvn.2005.11.001.

Luanaigh, C.O. and Lawlor, B.A. (2008). Loneliness and the health of older people. *International Journal of Geriatric Psychiatry*, 23(12): 1213-1221.

Mackenzie, C., Knox, V., Gekoski, W. and Macaulay, H. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. *Journal of Applied Social Psychology*, 34: 2410-2435.

Macnicol, J. (2006). *Age Discrimination: An Historical and Contemporary Analysis*, Cambridge University Press, Cambridge, 308 pp.

Manton, K.G., Larry, C. and Eric, S. (1993). Estimates of Change in Chronic Disability and Institutional Incidence and Prevalence Rates in the U.S. Elderly Population from the 1982, 1984, and 1989 National Long Term Care Survey. *Journal of Gerontology: Social Sciences*, 48(4): S153-66.

Mbah, P.O. (2016). The Neoliberal state and administrative reforms in Nigeria. *Afro Asian Journal of Social Science*, VII(III): 1–30.

McCabe, C. (2004). Nurse-Patient Communication: An Exploration of Patients' Experiences. *Journal of Clinical Nursing*, 13: 41-49. http://dx.doi.org/10.1111/j.1365-2702.2004.00817.x

McColl, E., Thomas, L. and Bond, S. (1996). A study to determine patient satisfaction with nursing care. *Nursing Standard* 10: 34– 38.

McCormack, B., Manley, K. and Titchen, A. (2013) Introduction. Chp 1 in McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) Practice Development in Nursing and Healthcare. (2nd edition). Oxford: Blackwell. pp 1-17.

McCormack, B.G. (2004). Person-centredness in gerontological nursing: an overview of the literature. *Journal of Clinical Nursing*, 13(1): 31-38. https://doi.org/10.1111/j.1365-2702.2004.00924.x.

McCormack, B.G., Taylor, B.J., McConville, J.E., Slater, P.F. and Murray, B.J. (2008). *Developing the Northern Ireland Single Assessment Tool (NISAT) for the Health and Social Care of Older People*. Unknown Publisher.

McGilton, K.S. (2002). Enhancing relationships between care providers and residents in long-term care. Designing a model of care. Journal of Gerontological Nursing. 28: 13-21. doi: 10.3928/0098-9134-20021201-05.

McMurdo, M.E.T. (2000). A healthy old age: realistic or futile goal? British Medical Journal, 321: 1149. doi:10.1136/bmj.321.7269.1149

Moons, P., Budts, W. and De Geest, S. (2006). Critique on the conceptualisation of quality of life: a review and evaluation of different conceptual approaches. *International Journal of Nursing Studies,* 43(7):891-901. doi: 10.1016/j.ijnurstu.2006.03.015. Epub 2006 May 11. PMID: 16696978.

Mudiare, P.E. (2013). Abuse of the aged in Nigeria: Elders also cry. *American International Journal of Contemporary Research*, 3(9): 79–87.

Murphy, K., O'Shea, E. and Cooney, A. (2007). Quality of life for older people living in long-stay settings in Ireland. *Journal of Clinical Nursing*, 16(11): 2167-2177.

National Council on Ageing and Older People (2005). Population Ageing in Ireland: Projections 2002-2021, Report 81, Dublin.

Nezlek, J.B., Richardson, D.S., Green, L.R. and Schatten-Jones, E.C. (2002). Psychological well-being and day-to-day social interaction among older adults. *Personal Relationships*, 9: 57–71.

Odaman, M.O. and Ibiezugbe, M.I. (2014). Health seeking behavior among the elderly in edo central Nigeria. *International Review of Social Sciences and Humanities*, 7(1): 201–210.

Okoye, U.O. (2012). Family care-giving for ageing parents in Nigeria: Gender differences, cultural imperatives and the role of education. *International Journal of Education and Ageing*, 2(2): 139–154.

Oladeji, D. (2011). Family care, social services, and living arrangements factors influencing psychosocial wellbeing of elderly from selected households in Ibadan, Nigeria. *Education Research International*, 2011: 1–6.

Organization for Economic Cooperation and Development (2005). Draft Report on Long-term care policies for older people, Paris, OECD, quoted in NCAOP (2005), Submission to the Department of Health and Children on the Financing of Long-term Care of Older People, Dublin, NCAOP, p.12.

O'Shea, E. (2007). Towards a strategy for older people in Ireland. *Irish Medical Journal*, 100(8):suppl 67-69.

Partners for Livable Communities and The National Association of Area Agencies on Ageing. (2007). *A blueprint for action: Developing a livable community for all ages*. Retrieved from http://livable.org/storage/documents/reports/AIP/blueprint4actionsinglepages.pdf

Plank, C., Schneider, S., Eysholdt, U., Schützenberger, A. and Rosanowski, F. (2009). Voice- and health – related quality of life in the elderly. *Journal of Voice*, 25(3): 265-268. doi.org/10.1016/j.jvoice.2009.11.002.

Poon, L.W., Clayton, G.M., Martin, P., Johnson, M.A., Courtenay, B.C., Sweaney, A.L., Merriam, S.B., Pless, B.S. and Thielman, S.B. (1992). The Georgia Centenarian Study. *Int J Aging Hum Dev*, 34:1– 17.

Population Reference Bureau. (2012). *World population data sheet (2012)*. Washington, DC: Author.

Population Reference Bureau. (2017). *World population data sheet (2012)*. Washington, DC: Author.

Porter, M.E. (1998). Competitive Strategy: Techniques for Analyzing Industries and Competitors. 1st Edition, Free Press, New York.

Reed, J., Cook, G., Childs, S. and McCormack, B. (2005). A literature review to explore integrated care for older people. *International Journal of Integrated Care*, 5:e17. doi: 10.5334/ijic.119.

Roach, M.S. (2001). *Caring: The Human Mode of Being, Implications for Nursing.* Ottawa: The Canadian Hospital Association Press. ISBN 0-7727-3740-1

Robinson, S. and Hill, Y. (1995). Miracles take a little longer: Project2000 and the health promoting nurse. *International Journal of Nursing Studies*, 32(6): 568–579.

Rodin, J. (1986). Aging and health: effects of the sense of control. *Science*, 233(4770):1271-1276. doi: 10.1126/science.3749877

Rowe, J.W. and Kahn, R.L. (1998). *Successful aging*. New York: Pantheon.

Russell, D.W., Cutrona, C.E., de la Mora, A. and Wallace, R.B. (1997). Loneliness and nursing home admission among rural older adults. *Psychological Aging*, 12:574–589.

Sarafino, E.P. (2006). Health psychology: Biopsychosocial interactions. New York: John Willey.

Schroots, J.J.C. (1996). The fractal structure of lives: Continuity and discontinuity in autobiography, Birren, J.E., Kenyan, G.M., Ruth, J-E. et al. eds., Aging and Biography: Explorations in adult development, 117-130, Springer (New York).

Snedeker, L. (2017). Ageing and isolation – Causes and impacts. *Social Work Today*, 17(1): 24.

Strawbridge, W.J., Wallhagen, M.I. and Cohen, R.D. (2002). Successful aging and well-being. Self-rated compared with Rowe and Kahn. *Gerontologist*, 42: 72733.

Telford, A. (1992). Nurses must learn to communicate. *British Journal of Nursing* 2: 4.

The Irish Human Rights Commission (2005). Submission of the Irish Human Rights Commission to the UN Committee on the Elimination of Discrimination Against Women in respect of Ireland's Combined 4th and 5th Periodic Reports under the Convention on the Elimination of all Forms of Discrimination Against Women. Last accessed from http://www.ihrec.ie/publications/list/ihrc-report-on-irelands-record-on-womens-rights-20/ on 15 October 2015.

Tijhuis, M. A., de Jong Gierveld, J., Festiens, E.J. and Kromhout, D. (1999). Changes in and factors related to loneliness in men: the Lutphen elderly study. *Age and Ageing*, 28(5): 491–495.

Toner, P.H., Kampen, J. and Scholz, J. (2003). Pathophysiological changes in the elderly, n: Best Practice & Clinical Anaesthesiology, 17(2): 163-177. doi.org/10.1016/S1521-6896(03)00010-7.

Tornstam, L. (1989). Gero-transcendcncc: A reformulation of the disengagement theory. *Aging Clinical and Experimental Research*, 1: 55–63. https://doi.org/10.1007/BF03323876.

Ugiagbe, E.O. (2018). Social Work Theory. Justice Jeco Printing and Publishing Global, Benin City, Nigeria.

United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, Methodology of the United Nations Population Estimates and Projections. ESA/P/WP.242.

Wadensten, B. (2006). An analysis of psychosocial theories of ageing and their relevance to practical gerontological nursing in Sweden. *Scandinavian Journal of Caring Sciences*, 20(3): 347-354. https://doi.org/10.1111/j.1471-6712.2006.00414.x.

Wadensten, B. and Carlsson, M. (2003). Nursing theory views on how to support the process of ageing. *Journal of Advanced Nursing*, 42(2): 118-224.

Wilson, R.S., Krueger, K.R., Arnold, S.E., Schneider, J.A., Kelly, J.F., Barnes, L.L., Tang, Y. and Bennett, D.A. (2007). Loneliness and risk of Alzheimer disease. *Archives of General Psychiatry*, 64(2):234-40. doi: 10.1001/archpsyc.64.2.234.

Worden, F.P., Moon, J., Samlowski, W., Clark, J.I., Dakhii, S.R., Williamson, S., Urba, S.G., Ensley, J., Hussain, M.H. and Southwest Oncology Group (2006). A phase II evaluation of a 3-hour infusion of paclitaxel, cisplatin, and 5-fluorouracil in patients with advanced or recurrent squamous cell carcinoma of the head and neck – Southwest Oncology Group study 0007. *Cancer,* 107:319–327.

World Health Organization. (2002). Active ageing: A policy framework. Geneva, Switzerland: WHO.

APPENDIX I

QUESTIONNAIRE
DEPARTMENT OF SOCIAL WORK
FACULTY OF SOCIAL SCIENCES
UNIVERSITY OF BENIN, BENIN CITY, EDO STATE.

Letter of Introduction

I am a student of the above-named institution and am conducting a research on the psycho social needs of the elderly and it's implications using my community (Okpuno-otolo, in Nnewi North Local Government Area, Anambra State) as a case study and this research is purely academic and will be used for this purpose, I would highly appreciate you for your response to the question as it will be treated well

(SECTION A)

BIODATA

Age (A) 60-65years (B) 66-70years (C) 71-75years (D) 76years and

above Religion (A) Christianity (B) Islamic (C) Traditional/other religion

Level of education (A) No formal education (B) Primary school education (C)Secondary school education (D) Post-secondary education

Marital Status (A)Single (B)Married (C)Divorced (D) Widower (E)Widowed (F)Separated

Ethnic Group (A) Yoruba (B) Igbo (C) Hausa (D)Others

Present Occupation (A) Artisan (B) Self-employed (C)Farmer (D)Retiree (E)Unemployed No of children Alive (A) 0-4children (B) 5-l 1 children (C) 12children and above Main source of source

of support financially (A) Self (B) Spouse (C) Children/grandchildren (D) Other relatives (E)Friends

(SECTION B)

1. If monthly payment is meant to be elderly population in Nigeria, will it improve the quality of life? Agree ( ) Disagree ( ) strongly Agree ( ) strong disagrees ( ) undecided ( )
2. Do you think if health care services are made free it will improve the quality of life? Agree ( ) Disagree ( ) Strongly agree ( ) Strongly disagree ( ) Undecided ( )
3. Do you think Nigerian government can create policies that can make people get monthly stipends when they get to a particular age? Agree ( ) Disagree ( ) Strongly agree ( ) Strongly Disagree ( ) Undecided ( )
4. Do you think elderly people people can live longer when a good accommodation is provided to them when they get to a certain age? Agree ( ) Disagree ( ) Strongly agree ( ) Strongly Disagree ( ) Undecided ( )
5. When you have someone to talk to all the time you wish, do you think there will be a limit to early aging to an extent? Agree ( ) Disagree ( ) Strongly agree ( ) Strongly Disagree ( ) Undecided ( )
6. Do you think communication is one of the tools to keep the elderly healthy? Agree □ Disagree □ Strongly agree ( ) Strongly Disagree ( ) Undecided ( )
7. Do you think having someone to talk to all the time will reduce the level of anxiety and

depression to an extent? Agree ( ) Disagree ( ) Strongly agree ( ) Strongly Disagree ( ) Undecided ( )

8. Do you think having someone to help you with house chores will reduce some stress factors to some extent? Agree ( ) Disagrees Strongly agree ( ) Strongly Disagree ( ) Undecided ( )
9. So, you think in Nigeria for elderly people who feel lonely or isolated, social workers assistance to increase social contacts may prevent morbidity and postpone death for those who are depressed? Agree ( ) Disagree ( ) Strongly agree ( ) Strongly Disagree ( ) Undecided ( )
10. Do you think a sense of self-worth may contribute to better health? Agree ( ) Disagree ( ) Strongly agree ( ) Strongly Disagree ( ) Undecided ( )
11. In Nigeria if policies are made to create a monitoring team to guide and educate people from certain age, will it help to curtail malnutrition? Agree ( ) Disagree ( ) Strongly agree ( ) Strongly Disagree ( ) Undecided ( )