A STUDY OF THE COUNSELLING NEEDS OF THE ELDERLY IN FUNYULA DIVISION, BUSIA DISTRICT AND NAKURU MUNICIPALITY, KENYA

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A project report submitted to the Graduate School in partial fulfillment for the requirements of the degree of Master of Education in Guidance and Counselling of Egerton University

SEPTEMBER 2003

DECLARATION

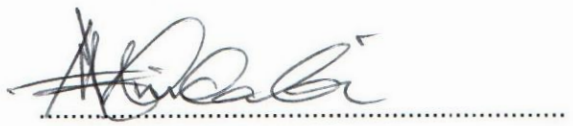
I declare that this project is my original work and has not been previously published or presented for the award of a degree in any University.

.....Nabwire..... .....15.10.2003.....

MWARO – CHRISTINE J. NABWIRE DATE

RECOMMENDATION

This project has been submitted for examination with my approval as the University Supervisor.



PROF. AGGREY M. SINDABI, PhD.

15/10/2023

DATE

Dedication

I dedicate this work to my late Husband George whose gentle encouragement, unfailing offer of love and financial support saw me embark on this project. I too dedicate it to my children Laura, Tabibu and Immanuel, George Junior for all the love and support they offered to me during this period. And to my Dad, Nelson Nakhone, a strong pillar at all times.

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I feel particularly indebted to Professor Aggrey M. Sindabi who supervised my work and patiently helped me to put this project in the right direction. His unfailing support and show of confidence in my work encouraged me a great deal. I would also like to sincerely thank Owen Ngumi, Catherine Khakasa, and Tabitha Mwaniki for all the support they offered during data analysis. Thank you for being there for me. I also wish to thank KANCO, especially Peter Kamau and Andrew Mwangi for their support in typing of this document. Special thanks go to Wilberforce Mmene, the Principal, Kilimo High School for his support. I wish to thank my sister Linda Wanyama for all the preparations she involved herself in to help in making this project a success. Finally, yet importantly, I would like to say a big thank you to Joyce Mutahi and Lucy Ndung'u for the typing services offered. Above all, I thank God for the gift of life and favour; that enabled me to complete this work. Without each of your assistance, this project would not have come to reality. To each one of you, I say a big THANK YOU.

Abstract

The psychological and physical changes that take place in the lives of the elderly people have a direct impact on their ability as individuals. Counselling is an important and integral part of the life of the aging members of our society. Counsellors are important in these people's lives as they are charged with the duty of guiding and counselling the elderly. This research project was aimed at assessing the nature of guidance and counselling provided to the elderly persons in our Kenyan society. The study also looked into the facilities provided, the basis for the appointment of those charged with counselling the elderly, the methods used today in the provision of adequate care in counselling of the elderly. The purpose of this research project was to assess the nature of preparedness made for these elderly by our Kenyan society and the facilities provided to them; the competence and efficiency in handling the changes that come in their lives as a result of their advanced age. The study looked at the counsellor qualifications in a direct relevance to helping the aged as a special population within the country. The study was a survey, which involved a sample size of thirty elderly persons, fifteen caretakers and five counselors. It focused on institutions and home based care for the elderly. The population was looked at in three categories: men and women, under home based care, and in the home for the aged. Data was collected using questionnaires, responded to by both the caretakers of the elderly, the available counsellors and the elderly. The data collected was analyzed by use of descriptive statistics. The statistical package for social sciences was used to analyze data. The study revealed that most of the elderly were depressed and had physical disabilities. The subjects were unable to cope with psychological and physical changes that had taken place in their lives. It was also reported that both the caretakers and the counsellors were not adequately prepared to take care of the psychological needs of the elderly. The results of this study will be used to recommend how the lives of the elderly can be improved and how the society as a whole can support guidance and counselling of the elderly by providing time and facilities to make their lives comfortable.

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CHAPTER ONE

INTRODUCTION

1.1 Background Information

The social welfare policy adopted by the Kenyan government after independence did not lay much weight on guidance and counselling as a means of assisting the elderly. This could be partly because it was assumed that the care of the elderly was a service that was to be provided at home by the offspring of the aged individual. The aged were looked upon in the Kenyan society as repositories of wisdom, wealth and were accorded high status. In the traditional Kenyan setting, the elderly were accorded respect and veneration. In fact, they were the ones charged with the duty of guiding and counselling of their grandchildren. They would even settle marital disputes between warring spouses.

However, in recent years, economic, social and leisure trends changed, giving rise to new pressures and circumstances on the elderly members of our society. There was a noted increase of negligence of the needs of the elderly, leading to starvation and in some cases eventual suicide attempts by the senior citizens in our society. This was a sure sign that the assumption that the elderly were being properly taken care of by members of the immediate family was no longer operational. In the current Kenyan society, the elderly become devalued once they become unproductive.

From the functionalist point of view, Bernard (1996) stated that the elderly needed to be progressively disengaged from socially important roles in order for others to take over and for the society to function without disruption. Therefore, retirement is essential to pave way for others. As people age, they become more miserable, inflexible, unproductive and isolated. Once individuals retire, the society conveniently forgets about them; they are not sufficiently prepared to face the later years of their lives. The duty of providing guidance and counselling had been left to the immediate members of the

family. However, were the family members able to assist these aging people in terms of adjustment and psychological changes in their lives?

It is a fact that most people do not always like being around old people. Most of us have slipped into the mind - set that portrays most of them as being like that group of befuddled senior citizens, that is endlessly forgetful, hopelessly confused and in general, a pain to be around. The only way to avoid getting old is to die young, since it may not be God's plan for us, old age happens anyway. One thing about old age is that it happens to us without any effort at all on our part. Most old people are living between gender, estrogen and death.

However, these elderly people need not act their age. There is need to get an anti-aging remedy. It is true, it may not actually turn the clock back, but it could help make aging progressively acceptable with time. There are so many psychological changes that are experienced in the aging process, that it is easy for the elderly to find things to complain about, as they grow older. During menopause, a woman experiences hormonal imbalances, emotions swinging wildly, and uncomfortable heat flashes. These aging women need a helper to assure them that menopause is a season, not a disease and it is not fatal.

In the later years, long odds and few roadblocks confront people. It may even seem like they are running out of time to accomplish the dreams they have about themselves. It is essential that during the later years, the aging be encouraged or aided not to face the challenge of accomplishing some life long dreams but rather just to cope, and to live one day at a time.

"Whatever your years, there is in every being's heart the love of wonder, the undaunted challenges of events, the unfailing childlike appetite for what comes next and the joy of the game of life. You are young as your hope, as old as your despair"(Johnson, 1997, pg 62).

Therefore, these aging people need a Counsellor to assist them to choose not to wallow in their despair and age quickly, and miserably.

1.2 Statement of the Problem

The Ministry of Culture and Social Services did not put in place any sound directives concerning the welfare of the aged. The Kenyan Constitution did not explicitly look at the welfare of the aged in terms of guidance and counselling. It did not even provide guidelines on how to initiate and implement guidance and counselling programmes for the elderly. There was no provision of time, facilities, and incentives to the service providers of the elderly. This study was therefore to establish the nature of guidance and counselling needs of the elderly.

This study aimed at establishing the various areas of counselling that the elderly have been exposed to, areas in which they needed more guidance and counselling in order to become more flexible, productive and less miserable and isolated members of our society. The study also looked at the psychological changes and fears that the elderly went through. It also determined the criteria for the appointment of counsellors for the elderly in special institutions.

1.3 Purpose of the Study

The purpose of this study was to assess the guidance and counselling needs of the elderly members of our society.

1.4 Objectives of the Study

The objectives of the study were as follows:

1. To establish if there is need for counselling of the elderly.
2. To assess the counseling needs of the elderly.
3. To assess the effectiveness of the current methods of counselling the elderly.
4. To determine the training programmes for counsellors of the elderly.
5. To make recommendations about the care of the elderly.

1.5 Research Questions

This study aimed at answering the following questions:

1. Is there need for the counselling of the elderly?
2. What are the counseling needs of the elderly?
3. Are the current methods of counselling of the elderly effective?
4. Are there training programmes for the counsellors of the elderly?
5. What should be done to improve the care of the elderly?

1.6 Significance of the Study

The findings of the study were to serve to improve the provision of guidance and counselling in the lives of the aged members of our society. Skills of caretakers were determined and recommendations made with a view of improving the care of the elderly. These results were to be useful to service providers in view of educating them about the kind of preparations they needed in order to become counsellors of the elderly. The Ministry of Culture and Social Services was to make use of the results of the study to restructure training programmes for the counsellors of the elderly.

1.7 Assumptions of the Study

This study was based on the following assumptions:

- Socio-economic status had minimal effect on the counselling needs of the elderly.
- Gender had an effect on the counselling needs of the elderly.
- The society was not interested in the welfare of the elderly.

1.8 Scope and Limitations of the Study

The study of the elderly covered Funyula division of Busia district and Nakuru Municipality. The caretakers who were charged with the duty of looking after the aged were interviewed. The old people themselves were also interviewed. It covered Nakuru Municipality, Alms House. The Caretakers who were charged with the duty of looking after the aged were interviewed, together with the service providers/counsellors. The elderly who were institutionalized in this facility were interviewed. The limitations experienced in this study were:

- Funds and time allocated for the study were a major problem.

- Accessibility to respondents in Funyula Division was a problem due to road infrastructure.
- The refusal by some of the respondents to trust and cooperate in giving information about themselves to research assistants was a problem.

1.9 Definition of Terms

Caretakers: People charged with the duty of looking after the elderly.

Professional Counsellor: An individual who has undergone formal training in guidance and counselling. The qualifications vary from diploma, undergraduate and postgraduate levels.

Hospice/Institution: Special rehabilitation home for the elderly.

Elderly: People within the age bracket of sixty-five and beyond.

Menopause: A time when a woman's menstruation stops.

Estrogen: Any one of a group of female hormones, which induces estros in mature mammals. It stimulates ovulation.

Service Providers: Trained social workers who are charged with the duty of identifying and counselling the elderly.

Counseling: A process in which a trained professional uses appropriate resources to develop according to mutually agreeable guidelines.

Vegetative: A person who lives a dull life with little activity or interest.

CHAPTER TWO

LITERATURE REVIEW

2.1 Counselling

Counselling is a process in which a trained professional Counsellor uses or applies appropriate resources to assist a client's development according to mutually agreeable guidelines. These resources include principles, theories, skills, or knowledge. Development involves emotional, social, cognitive, and psychomotor aspects of a person.

Counselling involves identifying developmental needs, problems, or concerns of the individual and providing assistance to facilitate their coping and adjustment. McDaniels (1956) outlines the counsellor's role as involving the following:

- To challenge, encourage, educate, assist, change, and grow. The responsibility is mainly on the client as the Counsellor mainly facilitates the change process.
- A Counsellor will typically assist the elderly deal with problems such as interpersonal relationships, family conflicts, sexual problems, and personal self-concept.
- Help the elderly person to discover and develop his psychological potentialities and thereby achieve an optimal level of personal happiness and social usefulness.

The elderly persons

Andy and Terry (1996) define the term elderly from two perspectives:

- **Protetarianisation theory**: defines the elderly as a homogeneous group, pushed towards poverty by the fact of age and constituting an under-class.
- **Labour market continuity theory**: defines the elderly as social inequality persisting into old age. While Kephar et al (1988) defines the elderly as later years beginning age sixty forward.

For the purpose of this study, the elderly is defined as an age bracket of sixty-five years and beyond. That category of people who are deemed by the society as being past the age of productivity both socially, economically and even politically; those who are approaching the dusk of their lives.

2.2 Background of Old Age

A French writer André Maurois, as quoted by Gary Collins (1988), describes aging experience in the following terms.

"Growing old is no more than a bad habit which a busy man has no time to form. Grow old with me, the best is yet to come"(pg 127).

Collins (1988) makes an observation that, owing to the improvement of medical care, improved diet and increasing interest in physical fitness, the number of people over sixty five has doubled in the past thirty five years. He categorizes the old into two categories: the Young Old - these are people between sixty-five and eighty years of age, and the Oldest Old - these are those from eighty-five years of age onwards.

Collins states that, amongst the sixty-five to eighty five year olds, there are wide differences with the oldest old. These differences are in health, abilities, beliefs, physical appearance, intellectual alertness, spiritual maturity, and capability for handling stress and managing one's life. According to Collins (1988), old age is not something new: In past generations there were always old people although their numbers were few. Many of the Old Testament patriarchs lived well past a hundred years. Such people are Abraham, Lot, Isaac, Noah, and Jacob the list is endless. However, we can say that even in the biblical Old Testament, old people faced rejection. In the book of Psalms, the Psalmist David said: *'Forsake me not, O God, when I am old and gray' (pg.128).*

Ecclesiastes Chapter 12 gives a clear picture of old age; verses four and five give a clear picture of the feelings of the elderly: *'And the doors shall be shut in the streets, when the sound of the grinding is low...' (pg. 128).* A psychologist G. Stanley Hall, as quoted by Collins (1988), termed this quotation as "the most pessimistic description of old age ever written."

However, Collins (1988) insists that, that is reality. He states further that the old could be helped to find meaning in life through hope in God. The society can be sensitized to respect the elderly for their experience and wisdom. The aged should also be assisted to be temperate, dignified, sensible, sound in faith, loving, willing to persevere, teaching what is good and avoid malicious gossips, and excessive drinking. This picture of assisting the aged is best portrayed in the Bible. In Ephesians, Christians are commanded to honor their parents *'... that it may go well with you and that you may enjoy long life on earth'. (pg. 128).*

Therefore, we can say that the Bible is: Realistic in its portrayal of old age, positive in its attitude towards the value of old age, and specific in its commands concerning how we should treat persons in old age. Christians therefore have no option but to treat older persons with respect, care for them and love them as human beings - Collins (1988).

2.3 The Justification of Guidance and Counselling of the Aged

Unruh (1983) states that: *"unlike the traits that selectively render other populations problematic, all of us must face the prospect of growing old,"* pg. 120).

Therefore, the status and treatment of older people with a variety of social worlds should be a major concern of the society. Collins (1988) notes that, growing old and adjusting to the realities of old age can be a source of new problems and challenges that can be met more efficiently with the help of a Christian Counsellor. Sell (1985) came up with a TLC theory (tender loving care), meaning: *'Handle the elderly with care'.* He states that the elderly need change in environment, counselling or physical care. He suggests companionship as the most effective prevention and treatment for mental and emotional problems among the aged.

"Circumstances, however, scratch and claw at many older adults to tear away self respect. I see the sick and the despised, the defeated and the bitter, the rejected and the lonely, I see them clustered together and alone. I see them deprived and forgotten, masters yesterday, outcasts today. What we owe them is reverence, but all they ask for is consideration, attention, not to be discarded and forgotten." (Sell, 1985, pg. 267).

Heschel as quoted by Sell (1985) maintains that:

'The test of a people is how it behaves towards the old'. It is easy to love children, he claims, even tyrants and dictators make a point of being fond of children. But there is a missing affection and care for the old, the incurable, the helpless who are the true goldmines of a people". The question asked is: *"How can old be made beautiful and be made to regain the authenticity that belongs to old age?"* (Pg 267)

Unruh (1983) suggests the concept of integration that may be used to help the aged to live comfortable and even satisfying lives through various types of involvements. The elderly can be helped to achieve and maintain integration through behavioural and symbolic participation in a variety of social words.

Losses in Old Age: (The Downhill Slide)

Sell (1985) states that one word that states the problems of age is *loss*. He attributes the high rate of depression and suicide attempts amongst the aged to the pain from multiple bereavements. The older adult has little hope of recouping losses. Some of them occur so rapidly that the aged may face additional grief while the *"grief works"* of a previous loss is yet unfinished.

2.4 Physical Changes

As people age, Collins (1988) states that, bodies run down. Some bodies wear out sooner than others. This depends on the lifestyle one has led. For instance, those who have deprived their bodies' exercises and sufficient rest, or the bodies that have been abused by excessive use of alcohol, smoking and unhealthy practices, these bodies wear out faster. Collins (1988) categorizes physical changes in four categories:

i) Cosmetic Changes

These are characterized by graying and thinning of hair, loss of teeth, decreasing of weight, wrinkling skin, including bags under the eyes, and dark spots on the hands.

ii) Sensory Changes

The dimming of the sight and hearing, stiffness in the joints hindering movements, decline in strength, slower reaction time, changes in kinesthetic sensitivity, therefore, balance becomes difficult and there are noted problems with memory.

iii) System Changes

This is mainly physiological degeneration seen in body's organs and systems. In the skeletal system, bones become brittle, less able to resist stress and they are much slower to heal. There is a rise of *rheumatoid arthritis* restricting movement and creating pain. In women, *osteoporosis* brings pain, restricted movement, and shriveling of the spine. Other changes that occur are muscular, reproductive gastrointestinal, cardiovascular, respiratory and central nervous systems. These changes, Collins says, can lead to elderly hypochondriacs.

iv) Sexual Changes

Reproductive capacities diminish, however, sexual interest and activity does not diminish. Older people need physical closeness and human contact. Older people take longer to achieve orgasm and the intensity is reduced. However, sexual activity and satisfaction increase as they grow old, Collins (1988).

v) Disease and Illness

There is an assumption that old age is a time for inevitable physical decline, incapacitating illness and immobility. Collins (1988) discounts this, he states that a survey carried out showed that half of eighty four year olds and above are disease free. A negligible percentage of older people experience four major conditions of later life, i.e. arthritis, high blood pressure, hearing impairment, and heart diseases. However, Collins agrees that with time, older people eventually suffer from diseases such as cancer or serious heart ailments as internal organs begin to breakdown. This illness can arouse anxiety, diminish mobility, and create discouragement in the aged individual.

vi) Mental Losses and Senility

Collins (1988) agrees that older people think more slowly, are less able to understand new ideas, have difficulty with short-term memory. According to Sell (1985), some physiological disorders may not necessarily be due to aging. There are also physical causes of mental impairment. For instance, he says that there are instances of brain being damaged and may stop working properly, leading to a condition called *organic brain syndrome*. As a result, the aged individuals:

1. are unable to remain oriented to what is going on;
2. have problems with short and long term memory;
3. have problems in visual-motor coordination
4. have spatially arranged ability to learn and retain things.

Therefore, an aged person suffering from this may have a hard time in:

1. recalling phone numbers;
2. getting food from plate to mouth;
3. remembering the names of his children.

2.5 Forced Retirement and Loss of Economic Resources

The reaction towards retirement depends entirely on the financial circumstances of the individual. How valuable the job has been to the individual and the satisfaction and the meaning the retiree derived from the job. Sell (1985) concedes that, retirement is the most crucial life changes of the older people. The major area of adjustment of the retiree is living with one's spouse. For instance, a wife needs to adjust to having her husband around the house all day; this demands some changes in attitudes and practical effort. Sell (1985) further notes that coping with loss of involvement is the major occupation of the retired person and it is central to the older person's state of affairs. Some older people cope with this loss by continuing a high level of activities, while others tend to disengage from life altogether.

Both of these are okay, only that they should be discouraged from overdoing the tasks or withdrawing from life altogether. Schulz (1980) states that retirement and the accompanying relocation of income affects the nature and degree of social integration. Because the aged find themselves with fewer resources to exchange than their working counterparts, they are unable to extend the kinds of aid they might have had in the past. As a result, their social value is reduced leading to diminished social contacts and involvement with others. This income reduction places limitations on mobility and the kinds of leisure activities that might be pursued.

2.6 Death and Divorce of a Spouse in Old Age

Since old age may be ridden with illness, death is imminent. In some cases, the healthier looking spouse may die earlier than the ill one. In this case, the ill survivor may feel cheated or abandoned by the other (Sell 1985). Further, Sell (1985) states that older adults may have a premonition that their partner may die. It is assumed that by that time, the couple may have faced numerous losses in life. Therefore, they are used to encouraging each other about the impending loss. In this case, Sell (1985) states, both parties are undergoing *anticipatory grief*, that is, they are expecting ultimate separation. Both the dying person and the spouse may go through the bereavement process before the actual death. Therefore, all signs of grief may present themselves. These are anger, resentment, sadness, depression, remembering past events, they even run from relationships. In this case, Sell (1985) suggests that it could be helpful if both parties are counselled together. According to Sell (1985), getting divorced in old age is worse than being widowed. Divorce is more glaring. This means loss of self-esteem. The loss of a whole lot of a social network of friends. There is no hope of remarriage in old age.

2.7 Relocation

Several factors may make it possible for the older people to relocate. It maybe due to terminal illness or moving to stay with their children. While Collins (1988) is very much in favour of relocating, Sell (1985) thinks otherwise, that it may have negative psychological influence. For instance, he states that sometimes these old people have

made emotional investments in their homes. To the elderly, according to Sell (1985), moving is experienced as a major loss, one more in the expanding list of losses, i.e. leaving familiarity, security and sense of belonging that the old neighbourhood gave them. Unruh (1983) argues that even when the aged manage to overcome demographic, social and physical obstacles and establish new relationships, the quality of the new marriages, friendships and neighbourhood ties may not equal those of the past because the aged are not likely to have shared pasts. Doro as quoted by Unruh (1983) says that institutionalization is another factor that may push the aged towards social isolation. Nursing homes, long-term care hospitals, homes for the aged limit contacts and associations with others.

2.8 Social Integration in Old Age

Roscow (1974) defines social integration of the aged as:
"The integration of old individuals into the society resulting from forces which place them within the system and govern their participation and patterned associations with others" (pg. 26.)

Roscow seems to imply that social values, group memberships, and social roles are taken to be the axes providing the ties that structure social interactions place the person in the society and order relations with others. In effect the aged are integrated into the society through the beliefs they hold, the positions they occupy and the groups to which they belong. Lockwood (1964) as quoted by Unruh (1983) states that aging often brings with it losses of central social roles resulting from status changes in the arenas of marriage, work, family, and others. Gerontologists have chronicled the decreasing participation and commitment of older people in formal organizations, voluntary associations, and other community involvements. According to Unruh (1979), the whole social set up seems to pull the aged out of satisfactory social integration and push them into social isolation.

2.9 Suggested Patterns of Integrating the Aged in the Society

Unruh (1983) suggests the need for integrative experience in supplying personal meaning to the aged. He states that specific involvements serve as source of personal identity, self-concept and feelings of social value. Most of these older people may tend to order their personal identities on the value of their personal effort, sacrifice and economic expenditure. Therefore, the aged should be encouraged to make decisions regarding the focus of their involvement in cases, when faced with losses and limitations of various kinds.

Therefore Unruh (1983) insists that there is a possibility that the aged may structure their expectations, organize their conduct and derive personal meaning in reference to some social worlds rooted in the past, situated in the present or occasionally projected into the future. As such for a Counsellor, Unruh (1983) suggests that it is important to focus on certain aspects of older peoples' social lives by:

i) Remembering the past

Because the number of years lived coupled with multiple role, losses in old age tend to make past experiences and memories a central component of everyday life, this can be done by analyzing the origins of the aged individual, their personal identities and the social worlds in which they are located. This will make it possible to understand the degree to which their lives are rooted in the past, present, and the future.

ii) Organizing the present

The aged must consciously and forthrightly enter a network of communication, establish linkages with others, maintain shared interests and keep abreast of inevitable changes in that world (Unruh, 1983, pg. 37).

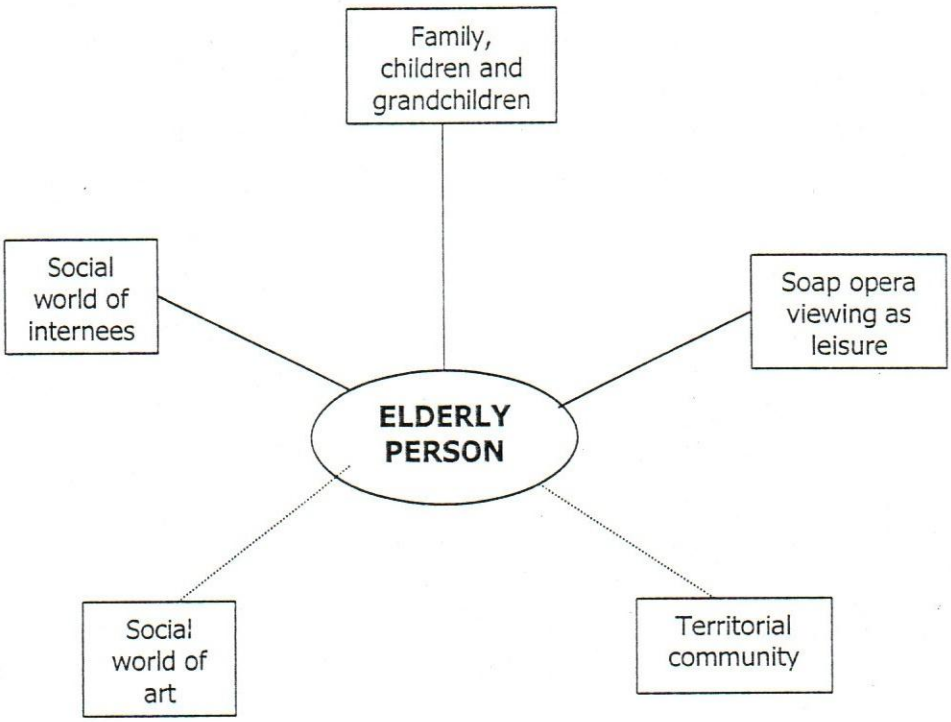
iii) The aged be encouraged to maintain enduring worlds

Unruh (1983) notes that among some old people, their desires and talents do not change much over the years. Therefore, some involvement in the past may be

instrumental and vital to their lives in old age, e.g. ballroom dancing, theatre, and football.

The diagram below illustrates how the aged can occupy their time:

Figure 2.1 How the aged can occupy their time



Adapted from Unruh (1983) pg. 37

iv) Be encouraged to seek new worlds

This involves the attempt to meet new demands. This seeking is stimulated by crises of social involvement. The aging people may be faced with retirement, divorce, widowhood, or disability and may find some incentives for discovering new sources of social integration.

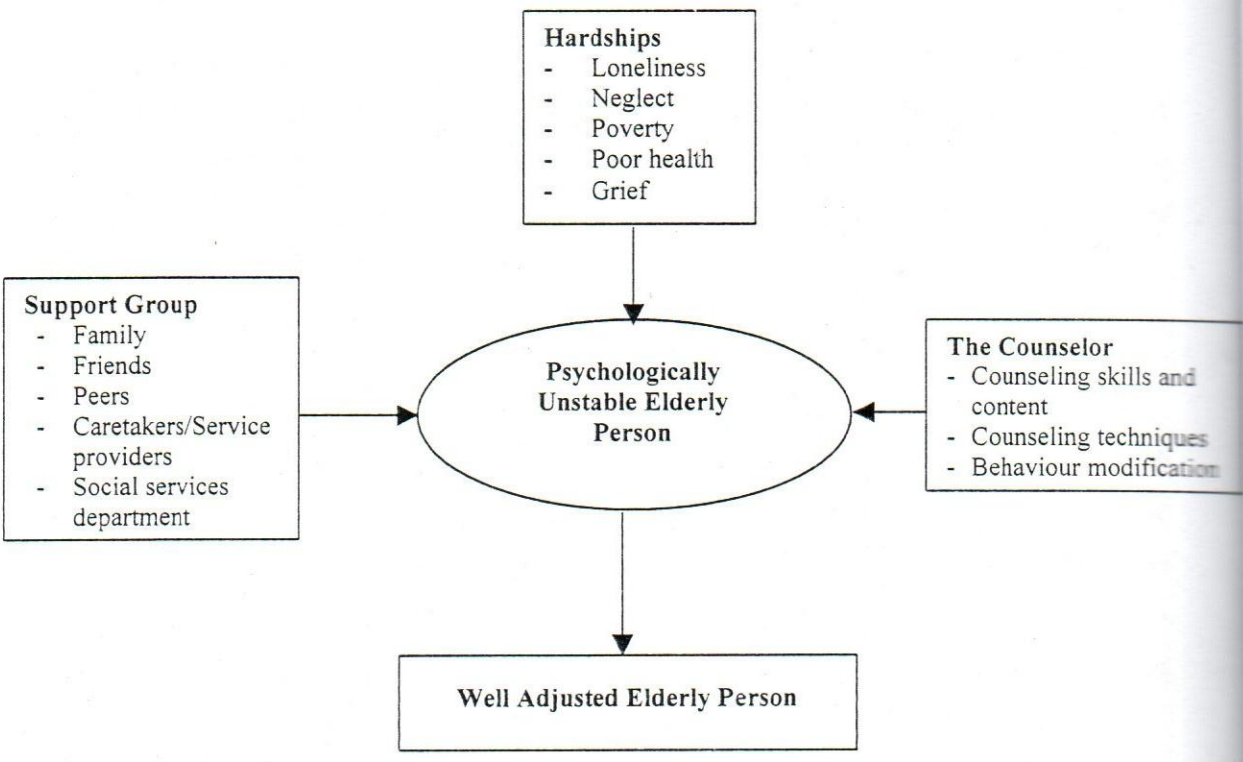
2.10 Conceptual Framework

Growing old and adjusting to the realities of old age can be a source of new problems and challenges. Due to this an elderly person experiences hardships which makes him/her become a psychologically unstable person. These hardships could be physical disabilities, since the body could be wearing out. These illnesses could arouse anxiety and create discouragement in the aged individual. The aged also experience neglect from the family members. This is because most of the young men and women are forced by social and economic changes to stay away from their aging parents. As such the old people feel lonely, and due to low income some live under very poor conditions. All these hardships compounded together cause the elderly person to experience depression, as result their health deteriorates. Therefore, there is need for counseling; so that an elderly person could be assisted to develop a positive self esteem, and not feel unworthy. The aged person also needs to be taught social integration in order for him to live a satisfying life through various forms of involvements in a variety of social worlds. He should be encouraged to be independent and try not to rely on his children. He should be taught to enjoy leisure time, like taking exercises. He also needs to be assisted to be more flexible and accept the social changes; which include the fact that the children can no longer look after their aged parents as tradition demands. And above all the elderly person should be encouraged to accept their situation, that is , to appreciate the physical changes that may be taking place in their bodies and, to know that it is just another phase of growth.

There are groups of people who could support the elderly to accept these changes. Friends should make frequent visits and the peers should share their experiences in

order to make the elderly person know that other people of his/her age also experience the same. The family members of the aged person need to support him by providing basic needs and the social services department could support the aged person by dispatching the service providers to various locations of their districts to counsel the aged on survival techniques. Lastly, a counselor is an important part of the support group. He/she could assist the aged by employing basic counseling skills. As a result all these put together will give rise to a well-adjusted elderly person. These relationships can be represented diagrammatically as shown in figure 2.2 below.

Figure 2.2 Conceptual framework



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

The research design, which was used for this study, was *ex post facto*, because no treatment was given to the respondents before the interview. The study was a descriptive survey, aimed at looking into the nature of guidance and counselling needs of the elderly, and also the time, physical facilities and support provided to the old people, describing their abilities and inabilities. It also looked into the various means used in taking care of the elderly.

3.2 Location

This study was conducted within Funyula Division of Busia District in Western Province of Kenya. This was for the convenience of the researcher within the available resources. It was also conducted within one home for the aged, (Alms house) in Nakuru Municipality.

3.3 Population

The study targeted the elderly both male and female within the two locations of the study. These old people were living in their homes being cared for by their family members and those who were institutionalized. From a population of the elderly in Funyula Division fifteen elderly and five caretakers were sampled. In the Almshouse, it was a purposive sampling therefore; fifteen elderly, five caretakers, and five counsellors/service providers within Nakuru Municipality were interviewed.

3.4 Sampling

Stratified sampling was used to account for homogeneity. The aged within Funyula Division were stratified according to administrative locations as indicated in Table 3.1 below.

Table 3.1 Sample Distribution by Location in Funyula Division

Location	SAMPLE
Bukangala location	5
Nambuku location	5
Mulwanda location	5
Caretakers	5
Total	20

Table 3.2 shows the distribution of the subjects within the Almshouse in Nakuru Municipality.

Table 3.2 Sample Distribution by Hospice in Nakuru Municipality

HOSPICE	POPULATION	SAMPLE
Alms House ✓ Elderly ✓ Caretakers	 15 5	 15 5
Service Providers	5	5
Total	25	25

The aged within both locations had undergone various psychological changes and had a variety of guidance and counselling needs. Under the above stratification, the locations were also clustered into age and gender. This clustering was done because it was assumed that, the gender and the age bracket of the aged in various settings influenced the guidance and counselling needs of a particular group. The facilities available, the gender of the caretaker and the general support given to the individual also had an impact on the elderly. Sampling was done for the convenience of the researcher within the available resources. All the caretakers, counsellors and the elderly people who were involved in the study constituted a sample of 45 subjects.

3.5 Instrumentation

Two questionnaires were used to collect information from the respondents. The first questionnaire was administered to the elderly both in the home setting and in the rehabilitation centres respectively, to obtain information about:

- The physical limitations they experienced.
- Their emotional state of mind

The Likert rating scale was used to measure perception, attitude, values and behaviour of the subjects. The scale had two sections.

Section A = questions measured depression

Sections B = questions measured disability and activity limitation

The psychological assessment of the elderly was carried out to measure the relationship between depression and disability in order to assess their counselling needs.

Objective of the Test

- It was used to demonstrate the usefulness of measures of depression and disability in learning more about the quality of life of elderly persons.
- Among the most frequent problems accompanying the advancement of old age are depression and disability. They have a vital bearing on the quality of life of the elderly. Since there are uncertainties about the role of age itself in influencing the relationships between depression and disability, clarifying these issues was to help set the record straight on the quality of life in old age.
- It was also to help to decide whether the association between depression and disability was determined by factors that can be brought under clinical control.

Depression: Scores

10 - 15 - Limited depression

16 - 20 - Pervasive depression

21 - 30 - Vegetative symptoms

31 - FF - Self-depreciation, suicidal and psychotic tendencies

Physical disability level

10 - 20 - Physiology disability

21 - 39 - Faulty and inconsistent awareness

31 - 40 - Limitation in instrumental activities of daily living

41 - 50 - Inadequate emotional autonomy and inadequate social initiative.

The second questionnaire was administered to the caretakers and the counsellors to obtain information about the criteria they used in handling the aged. The challenges they experienced and the support they got from the society.

3.6 Data Collection

The researcher travelled to various locations within Funyala Division and Nakuru Municipality to administer the questionnaires to the individual aged and their respective caretakers. The responses to the items in the questionnaire were individual and the researcher did clarification in order to hold objectivity. The researcher used interview method since most of the respondents turned up to be illiterate. However, the service providers within the municipality answered the questionnaires individually and their comments were noted.

3.7 Data Analysis

Both descriptive and inferential statistics were used to analyze the data. Descriptive statistics were used to describe:

- Percentage of the female and male aged in need of help under home based care
- Percentage of male and female aged in need of help in institution.
- Percentage of the caretakers with basic counselling skills in handling the aged.
- Percentage of caretakers without basic skills as in handling the aged.
- Percentage of counsellors/service providers with basic skills in handling the aged.

Some of the data obtained was nominal. The computer statistical package for social sciences (SPSS) was used to analyse data.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This Chapter will deal with presentation of research findings and interpretation. It also aims at answering research questions proposed for the study.

"When Grace is joined with wrinkles it is adorable", (Johnson, 1997, pg.4). It is reasonable to hypothesize that psychosocial development is dramatically affected by old age. Such things as retirement, maturing children and grandchildren, increased leisure time, decreased income, failing health and the imminence of death all create new pressures that the elderly must face. How do the elderly typically react to such pressures? This has given rise to the need of counselling of the elderly. This study aimed at assessing the counselling needs of the elderly within Nakuru Municipality and Funyula Division, Busia District Kenya.

The study aimed at answering the research questions.

4.2 General Findings about the Population

This study targeted the elderly people and their Caretakers in Funyula Division and Nakuru Municipality respectively. A total of 30 aged people together with 10 caretakers and 5 counsellors were interviewed. The following were the general findings:

Elderly Under Home-based Care

The following were the results and observations about the elderly in Funyula Division. Table 4.1 shows the number of the elderly under home based care who were interviewed.

Table 4.1 Distribution of sample by Gender of the elderly under home based care

Gender	Frequency	Percent
Male	8	53.3
Female	7	46.7
Total	15	100.0

About 53% of the subjects were males and approximately 47% were females. About 40% of the subjects in the sample, who were all male, ranged between the ages of 65-85. They fell in the category of the independent old, that is, young old. Approximately 5 of the males were between the ages of 70-75. They had just retired. About 60% of the subjects were 8 females and 1 male who were 86 years. Although the females were the oldest, they appeared more active than their younger male counter parts.

Table 4.2 Distribution of Sample by Age

Age	Frequency	Percent
65-85	6	40.0
85-100	9	60.0
Total	15	100.0

Table 4.2 shows the distribution of the aged by age. It was reported that most male died earlier than their female counterparts since the number of males decreases as the age advances. Coping with the loss of involvement affects men more than the female. The men find themselves with more time and less economic power. In this case as Schultz (1980) puts it, that retirement affects the nature and degree of social integration, their inability to extend aids reduces their social value; so most men tend to disengage from life altogether. This causes them to sink into depression and this could be the reason why men died faster than their female counterparts.

Table 4.3 Depression Level of the Elderly under home based care

Scale	Frequency	Percent
21-30	2	13.3
31-40	13	86.7
Total	15	100.0

As indicated in the Table 4.3, 13.3% of the sample scored 21-30 showing that they experienced limited depression, which lasted only two hours and they snapped of out it. They also agreed that they experienced occasional low days. They were worried about specific problems, that is food, death of their children who had left them to care for the grandchildren. They overcame this depression by turning their minds to other pressing issues such as running of their households. However, the majority of the population, 86.7% scored between 31-40 which showed vegetative symptoms, such as trembling of limbs, palpitation of the heart, they also experienced dizziness, constipation, poor concentration span, dimming of the eyesight and hearing problems. They also complained of joint pains like backaches. These findings agreed with Collins (1988) who stated that old people suffer brain damage leading to a condition called organic brain syndrome therefore making them to have difficulty with short-term memory. However, none of this population showed any suicidal tendencies. They still felt needed by their children. Although, they were reported to be very domineering and constantly interfered in the running of their children's domestic affairs.

Table 4.4 Physical disability level of the aged under home based care

Scale	Frequency	Percent
10-20	1	6.7
21-30	6	40.0
31-40	7	46.7
41-50	1	6.7
Total	15	100.0

About 6.7% of the population, as indicated in table 4.4 experienced physiological disability, that is they experienced automatic movements such as swallowing, shifting

movements, inability to control bladder and bowel movements, they also had very slow healing processes. The above results agreed with Collins (1988) who stated that, due to physiological degeneration seen in body-organs and systems, the older people have a much slower healing process. They also experience muscular changes in the central nervous system leading to automatic movements.

Approximately 40% experienced both physiological disability and disability in activities of daily living. As such, they had disturbances of coordinated movements such as feeding, standing, moving about, outside bathing, dressing, and grooming. These results agreed with Collins (1988) who pointed out that the old people experienced system changes in the skeletal system, which made the bones to become brittle; leading to the rise of rheumatoid arthritis thus restricting movements. He also pointed out that women experienced osteoporosis, which led to pain and shriveling of the spine.

About 46.7% of the sample experienced both physiological disability, disability in daily activities and they too had faulty or inconsistence in awareness. They were unable to avoid simple dangers, could not remember episodes, and could not make plans for the future. They also had limitations in instrumental activities of daily living: could not carry out tasks such as household cleaning chores, managing cash, shopping and preparing meals.

About 6.7% of the sample had the extreme of each of these disabilities. In addition, to experiencing physiological disability, inability to perform daily tasks, they also experienced inadequate emotional autonomy that is they could not tolerate being alone, could not take needed exercises or activities. They also had inadequate social initiative that is they could not socialize by communicating, could not obtain medical help, could not tolerate contact with the public, and could not maintain interpersonal relationships.

Relationship between disability and depression

It was observed that those respondents who were severely disabled and had great activity limitations were also severely depressed. Those who had inadequate social initiative and could not move around spent most of their time brooding and were quite

irritable. They felt frustrated by their inability to perform simple tasks, especially when they could not control their bowel movement. These results agree with Collins (1988) who stated that illness in old age could arouse anxiety, diminish mobility, and create discouragement in the aged individual. Therefore, it can be concluded that a great disability can lead to depression amongst the aged.

These are the results of the observations made at the Alms House:

Home for the Aged- Alms House:

Alms House is situated in Nakuru town, Bondeni next to the Nakuru south cemetery. It is under the department of social services and it is run by the County Council. The County Council of Nakuru felt the need for the desperate and homeless aged to be assisted in order to enjoy the services of the government. It was also aimed at enabling the homeless aged to continue with normal life. It was also to make the desperate abandoned elderly have a sense of belonging in the society. In this way, the social services department felt, they were enhancing the continuation of culture which dictated that the elderly be looked after.

Who were legible for the rehabilitation?

These were people in their latter years, who were completely destitute with no next of kin. This was because the Council took full responsibility of the said aged upon rehabilitation. The responsibility included, provision of food, medication (here they worked in close collaboration with the Provincial General Hospital). The Council also provided clothing, accommodation, security and funeral expenses including the burial site.

Methods of Recruiting

There were three methods of recruiting the elderly for admission at the Alms House. Normally, the service providers in conjunction with the County Council did recruitment. The aged person in need of assistance was often identified by a good samaritan who reported to the area Chief, who in turn notified the social services department. The senior social services officer waited for at least two reports, then he would send a service provider to go and assess the situation by taking the case history of the elderly.

He then reported to the senior social services officer who in turn notified the area councilor, only then could recommendation for rehabilitation take effect; after ascertaining that the elderly was homeless and completely destitute.

There were also cases that were so desperate, in this case, the report was immediately taken to the area councilor, or opinion leader and the social worker went and immediately took the aged person for rehabilitation. Some elderly people were admitted in the general hospital and abandoned there, in this case, the social workers in the hospital worked in collaboration with the social services department, and had the person rehabilitated immediately.

Residential Conditions:

- The elderly were allowed freedom to leave the institution as they wished. Most of the elderly were reported to have ran away, but the service providers were expected to make a follow up.
- Those who were under rehabilitation were provided with a room per person.
- Upon their death, the Council buried them in the cemetery; the family was not allowed to claim the body, otherwise the Council would sue that family for negligence.
- The Council allocates money to Alms House for a duration of three months for the purchase of food.
- A certain percentage from the Mayor's Christmas Tree Fund is allocated for the upkeep of the elderly in the Alms House.

Table 4.5 Distribution of Sample by Gender in institutions

Gender	Frequency	Percent
Male	7	46.7
Female	8	53.3
Total	15	100.0

About 46.7% of the sample, as indicated in table 4.5, of the aged under rehabilitation were male. While approximately 53.3% were female. Ethnically, these were three Kalenjins and the rest were Kikuyus by tribe. Table 4.6 shows their ages.

Table 4.6 Distribution of Sample by Age in institutions

Age	Frequency	Percent
65-85	7	46.7
85-100	8	53.3
Total	15	100.0

From the findings, 46.7% of the aged in the institution ranged between ages 65 – 85 with majority of them being in their early seventies. All of them were men; they were in the category of the independent old, that is the young old. It was reported that the death rate of men in the institution was quite high with at least four deaths per year. The remaining 53.3% were female who belonged to the category of the oldest old. Majority were in the age bracket of 89 – 93. The death rate of females was not high. Most of the females ran away and either roamed the streets or preferred to stay at the Provincial General Hospital, where they offered services to the patients who were incapacitated, and had nobody to look after them. Table 4.7 below shows the aged in the institutions.

Table 4.7 Depression Level of the aged in institution

Scale	Frequency	Percent
21-30	3	20.0
31-40	12	80.0
Total	15	100.0

As shown in table 4.7 above, only 20% of the aged in the institution manifested signs of pervasive depression; they looked at the future with despair. The presence of the graveyard in the immediate neighbourhood constantly reminded them that they were waiting to die. They experienced depression, which lasted a whole day. They cried often, they could not stop worrying. Through much of the interview, they kept wishing

for contact with their family members. They were scared of the idea of being buried in a mass grave, away from their family members.

However, 80% of the respondents exhibited serious vegetative symptoms. They all experienced loss of weight, sleep disturbances, poor concentration as they kept shifting to other topics during the interview. They lay awake with anxious or depressive thoughts. Few respondents showed suicidal and psychotic tendencies. They were immobile, they felt they had failed in their lives and were very guilty about their past behaviour. Some respondents were slow in speech; they experienced unexplained aches and pains. They also voiced subjective complaints of impaired memory. Other respondents experienced early morning awakening and reported that depression is worst in the mornings. Through much of the interview they all looked depressed and either cried or felt like crying. They all acknowledged the fact that they could not stop worrying. They felt like they had been cast away by their families and they found this painfully humiliating.

Looking at it from the gender angle, male respondents wore a façade and pretended like all was well. However, most of them were reported to be withdrawn, very uncommunicative and spent most of the time lying down and brooding. Throughout the interview, it was observed, that most men experienced self-depreciation symptoms; they felt very self-conscious in public and preferred to stay in seclusion; this was due to the embarrassment they felt. They felt that they were failures and even their families had rejected item.

On the other hand, the women experienced limited depression. They all seemed worried about their imminent death. They were not comfortable about being buried in the cemetery away from their loved ones. They desperately wished that their next of kin would be notified to collect them. Some of them cried when the issue of families was discussed, proving the fact that they missed their family members. The close proximity of the graveyard was a permanent reminder that they were conveniently waiting to die. The Alms House location, though neat, was quite a gloomy and deserted place. It was

actually a very scary place to live in; the location and atmosphere looming over the place befitted a mortuary.

Activity Limitation

The table 4.8 shows the activity limitation experienced by the aged in the institution.

Table 4.8 Physical disability level of the aged in institution

Scale	Frequency	Percent
10-20	1	6.7
21-30	3	20.0
31-40	4	26.7
41-50	7	46.7
Total	15	100.0

About 6.7% of the aged experienced physiological disability. They complained of problems in automatic movements such as swallowing, shifting movements, control of bladder and bowel. They also experienced a very slow healing process. Approximately 20% of respondents, in addition to physiological disabilities, also experienced disabilities in activities of daily living. They experienced disturbances of coordinated movements such as feeding, standing, moving about, bathing, dressing, and grooming.

About 26.7% in addition to physiological disabilities and disabilities in activities of daily living, the elderly experienced inconsistence in awareness. They remained aware of basic needs such as food, bowel movements; however, they could hardly make plans for the future. The majority (46.7%) had severe cases of disability. In addition to all the three mentioned above, they experienced limitation in instrumental activities of daily living such as household chores. They too reported of inadequate emotional autonomy. They were unable to take needed exercises and could not maintain interest in activities they once enjoyed. They had inadequate social initiative; they did not take social action such as communicating and could not tolerate contact with the public.

Generally, all the aged under the rehabilitation needed personal assistance. They were disabled, as such; they needed the personal time of others to enable them to survive.

These observations agreed with Sell (1985) who pointed out that relocation might have negative influence; since these old people had emotionally invested in their homes. Therefore, relocation is experienced as a major loss since the aged leave familiarity, security, and a sense of belonging that the old neighbourhood gave them. The respondents were evasive in answering questions about the treatment they received. Probably they feared the repercussions they would get after and they virtually had nowhere to go.

General observations about Caretakers of the elderly under home based care

All the five caretakers under the home-based care were female, relations of their aged.

Table 4.9 Distribution of Caretakers by Age under home based

Age	Frequency	Percent
15	1	20.0
30	1	20.0
34	1	20.0
35	1	20.0
36	1	20.0
Total	5	100.0

As indicated in Table 4.9, 20% of the caretakers were children of fifteen years old who had been left to look after their aging grandparents. They were orphans. About 20% were aged 30, mostly unmarried or divorced daughters who took care of their aged parents. The remaining 40% were daughters in law who were forced by circumstances to look after their aging parents in law.

Caretakers at the home for the aged: Alms House

All caretakers were females who were employees of the Nakuru County Council. They earned a salary of Kshs.2, 000/=. They were charged with duties of looking after the basic needs of the elderly, cooking for them, cleaning their rooms, and bathing those who were unable to groom themselves. By the time the researcher went to the field, two of the caretakers were facing early retirement. One had been sent on compulsory leave. There were only two caretakers who alternated in their duty on daily basis.

Table 4.10 Distribution of institution caretakers by age

Age	Frequency	Percent
37.00	1	20.0
38.00	1	20.0
40.00	1	20.0
41.00	1	20.0
46.00	1	20.0
Total	5	100.0

Approximately 40% of caretakers were between 37-38 years of age as indicated in table 4.10. The remaining 60% were between the ages 40-46. They were quite mature and they were family women. Given their middle age the caretakers seemed well placed to carry out their duties.

Counsellor or Service Providers General Observations

Table 4.11 below shows the gender of the service providers. Approximately 80% were male while 20% were female.

Table 4.11 Distribution of Service Providers by Gender

Gender	Frequency	Percent
Male	4	80.0
Female	1	20.0
Total	5	100.0

Service providers were aged between 35 and 48 years of age as indicated in table 4.12. Their main duty was to identify the aged in need of help and make recommendations to the county council. They were also expected to make a follow up on the elderly while in the institutions. Three of the respondents in this category were from the District Social Services office, while two came from the Provincial General Hospital. This was because they worked in a network.

Table 4.12 Distribution of Service Providers by Age

Age	Frequency	Percent
35	1	20.0
43	1	20.0
45	1	20.0
46	1	20.0
48	1	20.0
Total	5	100.0

4.3 Need of counseling of the elderly

This question (Is there need for the counseling of the elderly?) was aimed at finding out if the aged people needed counselling. The results as shown in table 4.13 indicate the depression and disability levels of the elderly.

Table 4.13 Depression level scores of the aged under home based care

Scores	Frequency	Percent
28.00	1	6.7
30.00	1	6.7
33.00	1	6.7
34.00	1	6.7
39.00	2	13.3
41.00	1	6.7
43.00	3	20.0
44.00	1	6.7
46.00	1	6.7
48.00	2	13.3
50.00	1	6.7
Total	15	100.0

Approximately, 26.7% of the aged interviewed under the home based care exhibited symptoms of limited depression. They complained of misunderstandings between themselves and their children or daughter's in law. They complained of harassment by their caretakers and their children ignored their roles as the heads of their families. The remaining 73% were seriously depressed, following severe losses in their lives, that is

death of their children. They also lacked necessities for the orphans they were left to look after. There was need for counselling these elderly to come to terms with their loses that is jobs, children, spouses. They also needed counselling to accept the social changes that they would no longer control their children and should not expect to be looked after by their children in their homes; this was because economic trend dictated that their children live away from them in urban areas. These results agreed with Kephart (1988) who pointed out that although not researched, there could be tendencies of elderly abuse from the part of the caregivers, especially in the case of the confused frail aged. The results also agree with Unruh (1983) who suggested that the old people needed companionship as the effective prevention and treatment for mental and emotional problems among the aged.

Table 4.14 Physical Disability Level Scores of the aged under home based care

Scores	Frequency	Percent
20.00	1	6.7
21.00	2	13.3
25.00	1	6.7
28.00	1	6.7
29.00	1	6.7
30.00	1	6.7
33.00	3	20.0
34.00	1	6.7
35.00	2	13.3
36.00	1	6.7
44.00	1	6.7
Total	15	100.0

As shown in Table 4.14, 40% of the aged experienced physiological disability and disability in activities of daily living, while 60% experienced limitation in instrumental activities of daily living, and had inadequate emotional autonomy. The above results agree with previous studies which found that old people experience physical handicaps that make it difficult to integrate into society. Collins (1988) reports that the aged

experience sensory changes which lead to the dimming of the eyesight, stiffness in the joints, decline in strength, difficulty in balancing, and problems in memory.

Table 4.15 Depression level scores of aged in the Institution

Scores	Frequency	Percent
22.00	1	6.7
26.00	1	6.7
33.00	2	13.3
40.00	2	13.3
42.00	2	13.3
44.00	2	13.3
45.00	1	6.7
46.00	1	6.7
47.00	2	13.3
50.00	1	6.7
Total	15	100.0

As shown in Table 4.15, 26.7% of the subjects in the institution showed tendencies of limited depression. They tried to cope and seemed to have accepted their condition. However, the remaining 73.7% were extremely depressed, as they exhibited high vegetative symptoms. Some were suicidal and they felt quite useless. Serious counselling was highly needed here to create a sense of self worth in these individuals. They needed to be taught to live each day as it came and to learn self-acceptance. The above results agree with the observations made by Sell (1988) who stated that institutionalization is a factor that may push the aged towards social isolation. This is because it limits contacts and associations with others.

Table 4.16 Physical Disability Level Scores of the Aged in the Institution

Scores	Frequency	Percent
19.00	1	6.7
24.00	1	6.7
27.00	1	6.7
28.00	1	6.7
31.00	1	6.7
33.00	1	6.7
38.00	1	6.7
40.00	1	6.7
42.00	1	6.7
43.00	1	6.7
44.00	1	6.7
47.00	1	6.7
48.00	2	13.3
50.00	1	6.7
Total	15	100.0

As shown in Table 4.16, 46.7% exhibited tendencies of physiological limitations. They had disturbances of automatic movements. However, the remaining 53.3% were severely handicapped. They had a related need for donation of personal time from caretaker. They needed supervision, encouragement, and persuasion to take exercises, to carry out tasks and engage in activities. They needed companionship. This could only be provided for by a trained counsellor. The service providers who were supposed to offer these services did not visit them at all, so they were neglected, and they felt rejected by the society as well.

4.4 The needs of the elderly

This question(What are the needs of the elderly?) was aimed at finding out both physical and psychological needs of the elderly, which could improve their lives and

make their aging process comfortable. The caretakers and the counsellors answered this question. Table 4.17 below shows the needs of the elderly under home based care as suggested by their caretakers.

Table 4.17 The needs of the elderly under home based care

NEEDS	FREQUENCY	PERCENT
Food	4	10.0
	1	20.0
	5	100.0
Clothing	3	60.0
	2	40.0
	5	100.0
Interdependence	2	40.0
	3	60.0
	5	100.0
Caretakers relations	2	40.0
	3	60.0
	5	100.0
Medical Care	4	80.0
	1	20.0
	5	100.0

As indicated in Table 4.17, 80% the caretakers of the elderly under the home based care suggested food, while 60% clothing and 80% medication as major needs of the elderly. This was because most of the aged lived in abject poverty. About 60% suggested the need for frequent visits from their children residing in urban areas while 40% felt that there was need for interdependence that is family members to depend upon the elderly on certain issues so as to make them feel useful. However, there was also need for counselling to enable them to fit well in the changing society. As we have already seen, they exhibited tendencies of depression and disability.

Table 4.18 The needs of the elderly in the institution

NEEDS	FREQUENCY	PERCENTAGE
Indoor games	5	100.0
Gardening	1	20.0
	4	80.0
	5	100.0
Entertainment	3	60.0
	2	40.0
	5	100.0
Socialization (Visitors)	3	60.0
	2	40.0
	5	100.0
Counselling	1	20.0
	4	80.0
	5	100.0
Food	4	80.0
	1	20.0
	5	100.0
Clothing	3	60.0
	2	40.0
	5	100.0

About 80% of the caretakers in the institutions suggested the need for counselling as shown in Table 4.18. This was because most of the elderly were reported as being quite irritable and experienced extreme mood swings. Approximately 80% of the caretakers suggested food as a primary need. The caretakers complained that most of the money allocated to the elderly ended up in the pockets of the social workers. Even the food brought from the Mayor's Christmas Tree Fund did not reach the Alms House. Therefore, the diet was limited to ugali and sukuma wiki, occasionally, beans and rice. They rarely ate meat. The elderly ate two meals a day, that is lunch and supper, but no breakfast. The caretakers suggested that the aged needed proper medication. About 60% of the caretakers suggested the need of visits from the public. Approximately 60% suggested the need for some form of recreation for the aged to help them avoid lying around idly. They recommended television, video, and indoor games as a form of recreation. This

would enable those who were severely disabled also to enjoy the facilities of recreation. Approximately 60% suggested donations of clothing from well wishers for the aged in the institution.

The Table 4.19 The needs of the elderly as suggested by the Counsellors

NEEDS	FREQUENCY	PERCENTAGE
Indoor Games	5	100.0
Entertainment	5	100.0
Socialization (Visitors)	2	40.0
	3	60.0
	5	100.0
Counselling	5	100.0
Food	5	100.0
Clothing	3	60.0
	2	40.0
	5	100.0
Interdependence	2	40.0
	3	60.0
	5	100.0
Caretaker Relations	3	60.0
	2	40.0
	5	100.0
Medical Care	3	60.0
	2	40.0
	5	100.0

As shown in table 4.19 all the respondents in this category strongly suggested recreational activities as a major need for their subjects. They suggested a need for entertainment and socialization. They recommended counselling; apparently, the available service providers did not carry out this duty. They also suggested food and proper medication as a need. They also felt that the elderly needed to be taught self-independence to avoid becoming a liability to the caretakers. Some suggested various

activities in order to keep the elderly busy and active. Such activities were: - gardening, Christian literature, and warm beddings. They also suggested that those who were unable to walk be given wheel chairs. The elderly also needed regular medical checkup. They felt that the elderly be allowed to make social calls on people outside the institution so as not to feel isolated. The above results agree with observations made by Unruh (1983) who pointed out that the elderly needed social integration in the society; through the beliefs and positions, they hold. He also suggested that the older people needed to be encouraged to participate in formal organizations and voluntary associations.

4.5 Effectiveness of the current methods of Counselling of the elderly

This question (Are the current methods of counseling of the elderly effective?) aimed at finding out if the methods of counselling the elderly were effective. In Funyula Division, there was no counselling of the elderly taking place. All the caretakers interviewed had no formal training; their level of education was primary. We therefore tested their perception of the work and whether they felt competent to handle the aged. Table 4.20 shows the perception of the work by caretakers under the home based care.

Table 4.20 Perception of work by caretakers of the elderly under home based care

Responses	Frequency	Percent
Enjoyable	2	40.0
Tedious	2	40.0
Boring	1	20.0
Total	5	100.0

The caretakers of the elderly under home based care were forced into the circumstances by being related to the aged. They provided care and food. About 40% of the sample said they enjoyed looking after the elderly. These were the daughters of the aged, while

approximately 40% of the caretakers under home based care were reported to find the work of looking after the elderly tedious. About 20% were reported as finding the work boring. These were the daughters in law.

Table 4.21 shows the competence of the caretakers, in handling the aged.

Table 4.21 Competence to handle the aged by caretakers in the home based

Responses	Frequency	Percent
Yes	4	80.0
No	1	20.0
Total	5	100.0

About 80% claimed to enjoy looking after the elderly, given that some of the caretakers were the aged people's children. The others were the daughters-in-law. However, 20% who were young children of 15 years of age, preferred rather to be left alone to play. The 80% who reported to be competent, only provided basic needs. They did not do any counselling. In Funyula Division, the reverse was true; it was the elderly who did the counselling and not the other way round.

Table 4.22 below shows the competency of the caretakers to handle the aged under the institutions. All the caretakers and service providers reported that, they did not carry out any counselling.

Table 4.22 Perception of work by caretakers in institutions

Responses	Frequency	Percent
Enjoyable	3	60.0
Tedious	2	40.0
Total	5	100

About 60% of care takers in the institution reported that they found their work enjoyable while 20% reported that they found their work tedious. The perception of work and competence to handle the aged was tested instead. Table 4.23 indicates the competence to handle the aged.

Table 4.23 Competence of counselors to handle the aged

Responses	Frequency	Percent
Yes	3	60.0
Neutral	1	20.0
No	1	20.0
Total	5	100.0

All caretakers claimed to enjoy working with the elderly and felt competent. However, they all stated that they did not counsel the aged. The service providers who were charged with the duty of counselling the elderly did not even visit the Alms House, once they identified a case in need and had the case rehabilitated. They did not make a follow up. In fact, they were of the opinion that counsellors be employed to deal with what they termed as an exhausting task. The study therefore revealed that there was no counselling taking place. Most of the caretakers felt competent to handle the aged in their physical needs but not their psychological needs. The caretakers reported tense relationships with the elderly and they felt helpless to handle their unpredictable mood swings.

4.6 Training programmes for the counsellors of the elderly

The question (Are there training programmes for the counselors of the elderly?) aimed at finding out whether the counsellors or service providers had undergone any special

training in the care of the elderly. The table 4.24 below shows the level of training of the available counsellors.

Table 4.24 Counsellor distribution by qualifications

Qualification	Frequency	Percent
Diploma in Guidance and Counselling	1	20
Certificate in Guidance/counselling	4	80
Total	5	100.0

All of the interviewed service providers had formal basic training in guidance and counselling. About 80% had certificates in counselling and only 20% had a diploma in guidance and counselling. However, they all reported that they had not undergone any formal training specializing in the field of the care of the elderly. Therefore, the choice of both the caretakers and service providers depended entirely on the availability of the personnel. Asked on what they felt should be done by the government to make them more competent to handle the aged, they all wished for in service courses and seminars in counselling the aged. Since they felt that the aged needed a lot of patience and tactic in being handled properly.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

This research was aimed at finding out the counseling needs of the elderly. The study was carried out in two locations, namely, in Funyula Division in Busia District and in Nakuru Municipality Alms House. The depression and physical disability levels were tested and scored. The results revealed that the elderly in both locations had a number of needs. They were reported to be depressed and had physical disabilities due to their advanced age.

5.2 Conclusions

Based on the findings of this study, which were discussed in the previous Chapter, the researcher drew the following conclusions:

- There was a great need for the counselling of the elderly. This was because most of the aged interviewed felt lonely, miserable, bored, frustrated and the future for them looked bleak. This was particularly true for those in the Rehabilitation Centre, because they felt rejected by their family members. Most of those in the rehabilitation centre had to run away, due to the location of the Alms House near a cemetery which they detested.
- The elderly in the Rehabilitation Centre wished to be frequently visited by their family members. Those in the home setting wished they could be allowed to spend

more time with their grandchildren. They needed to be counselled to realize that due to the socio-economic changes, their children could not visit them as often as they would wish. Those in the rehabilitation center needed to be assisted to accept their situation.

- Most of the elderly were reported as being forgetful, having problems with hearing, and lack of control of their bowel movement. Some had experienced many losses in their lives and so they felt depressed and deprived of their loved ones. Those living in home settings were quite domineering and greatly interfered in the affairs of their children; as such, they needed counselling to allow their children to comfortably run their lives. While in the institutions they needed to be taught to accept their losses and develop a positive attitude towards life.
- The Ministry of Social Services has done very little with the regard to the welfare of the elderly in the institutions. The location of Alms House in Nakuru Municipality left alot to be desired. It was close to a cemetery and the aged had been told that upon their death they would be buried in a mass grave. The food was not good; a diet of Ugali and Suma-wiki (Kales) characterized the Menu. Most of the donations to the Alms House were misappropriated by the Social Workers. The place looked quite deserted and gloomy.

5.3 Recommendations

The following are the recommendations made from the study:

- Since the aged seemed happier in the company of their family members, the Ministry of Social Services could mobilize a team of trained social workers and counsellors to make home visits and to counsel the elderly in village barazas.
- The aged should be allowed to participate in village development projects so that they do not feel unproductive. They need to be encouraged to participate in community welfare and Church activities.
- Most of the elderly should be taught how to be economically independent, since most of those under home-based care were completely dependent upon their children and some were very idle. They could be taught to be self-reliant.
- The elderly should be encouraged to do volunteer work, for instance looking after the young ones, fellow old and the sick. This could make them have continued self-achievement.
- After retirement, the men should be advised to help out around the home to keep busy.
- In cases of widow-hood, the elderly should be encouraged to remarry in order to have companionship and sexual gratification.
- The impoverished elderly were those who lived in abject poverty all their lives. There is need to reach out to the elderly who are poor, alone and in ill health.
- There is need for provision of adequate housing since most of the elderly under home based care live in rural areas and live in sub-standard housing.
- Since most of the elderly were poor, health care was quite out of their reach. The quality of care received at the Alms House was far from adequate. For one

to qualify to be rehabilitated in the Alms House he or she must be completely destitute, no home, no children and relatives, which left many deserving cases out, because there were others with families but they were quite destitute. The method of recruitment needs to be revised.

- The demand of providing care for the frail elderly should not be under estimated. In many cases, the care givers were forced to forego all other activities since the physical work and psychological stress of caring for the aged was overwhelming. There is need for the caregivers to receive adequate training and preparations in the handling of the elderly.
- There could be tendencies of abuse of the elderly by caregivers especially in the case of the frail and the confused elderly. Caregivers should be properly trained to show empathy when handling the elderly.
- Caring for a dependent and needy older person could lead to frustration, anger and abuse from the caregiver. Greater support from the community is required for the frail elderly living at home.
- For those placed in the institutions, the quality of their final years depended on the quality of the home. Alms House needs to improve the services provided to the elderly admitted there.
- As Unruh (1983) puts it, there was need for the aged to be assisted to structure their expectations, organize their conduct and derive some meaning in reference to some social worlds rooted in their past.
- There is need for the elderly people to be assisted to learn to cope successfully with; death of friends or spouse, learn to accept reduced physical vigour, to

accept retirement and reduction of income and have more leisure time and also learn to deal with their adult children.

- There is need for the education of the elderly, stressing on their need to obtain relevant information that will improve their physical and mental health. It will also assist them in financial planning and adjustment to retirement.
- The elderly should be helped to keep up with a rapidly changing social world through education. This is because, education, recreation, and cultural activities are important for maintaining: physical condition, mental alertness, and social contact.

5.4 Suggestions for Future Research

- There could be tendencies of abuse of the elderly by caregivers especially in the case of the frail and confused old. This needs to be researched.
- There is need to research on the quality of life given in other institutions other than Alms House.
- There is need to research on the appropriate recreation facilities that can be provided to the elderly.

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APPENDIX A

INTRODUCTION LETTER

Dear Respondent,

My Name is Christine J. N. Mwaro. I am a Post Graduate Student at Egerton University pursuing a Masters degree in Guidance and Counselling. Currently, I am conducting a research on the counselling needs of the elderly. You can help to bring out the counselling needs of the elderly by cooperating and answering the questionnaire below. I therefore kindly request you to give your candid and honest answer on the questions below.

Fill in the Questionnaires after this.

APPENDIX B

QUESTIONNAIRE FOR THE AGED

Gender Male ❑ Female ❑

Age 65 – 85 ❑ 85 - 100 ❑

Where do you stay? - Alone ❑ In a family setting ❑ Home for the aged ❑

A. Please circle the number that best describes your feelings

1 - Strongly disagree 2 - Disagree 3 - Neutral 4 - Agree 5 - Strongly agree

1.	I worry about almost everything	1 2 3 4 5
2.	The future looks bleak and unbearable	1 2 3 4 5
3.	In past months I have been in a miserable mood and I have felt like crying	1 2 3 4 5
4.	I feel like life is not worth living and wished I was dead	1 2 3 4 5
5.	I am bored and frustrated, I do not go out at all	1 2 3 4 5
6.	I hardly sleep lately, but I feel very tired and I lie around most of the time 5	1 2 3 4
7.	I experience frequent headaches	1 2 3 4 5
8.	I no longer enjoy the activities I previously enjoyed	1 2 3 4 5
9.	I blame my past or present behaviour	1 2 3 4 5
10.	I have not felt happy in the last one month	1 2 3 4 5

B. Questions

1. I have not gone out as often as I used to	1	2	3	4	5
2. I have difficulty in preparing my own meals	1	2	3	4	5
3. I am unable to do my own shopping	1	2	3	4	5
4. I have difficulty in cutting my toe nails	1	2	3	4	5
5. I have difficulty in reaching my arms overhead	1	2	3	4	5
6. I cannot make long distance travel	1	2	3	4	5
7. I have problems using the toilet by myself	1	2	3	4	5
8. I have difficulty bathing myself	1	2	3	4	5
9. I have a physical problem making washing a problem	1	2	3	4	5
10. I tend to forget names of people and events frequently of late	1	2	3	4	5
11. I feel better now that I am in the home for the aged	1	2	3	4	5

12. I wish the people concerned should do the following to improve our lot.

i) _____

ii) _____

iii) _____

iv) _____

APPENDIX C

QUESTIONNAIRE FOR THE CARETAKERS/COUNSELLORS

1. Gender Male ❑ Female ❑

2. Age _____

3. Level of training:
   - None ❑
   - Diploma in Guidance/Counselling ❑
   - Degree in Guidance/Counselling ❑
   - Post Graduate in Guidance/Counselling ❑
   - Others ❑

4. What do you perceive to be the counselling needs of the elderly?

_____

_____

_____

_____

_____

_____

_____

5. I find the work of looking after the elderly

enjoyable ❑ Tedious ❑ Boring ❑

6. Are there challenges you experience in dealing with the elderly

1. _____

2. _____

3. _____

4. _____

5. _____

7. Suggest ways that improve the lives of the elderly

1. _____

2. _____

3. _____

4. _____

5. _____

8. Give suggestions on support that could better equip you for the adequate handling of the aged.

_____

_____

_____

_____

_____

_____

_____

9. I feel competent to handle the aged.

Yes ❑ Neutral ❑ No ❑