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Mental Health Problems of Old Age People

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Abstract – In India, mental wellbeing has not yet achieved its due acknowledgment. Public wellbeing is afflicted with several problems that hinder its programs from improving and advancing. This essay is a narrative analysis that discusses the diverse issues confronting mental wellbeing in India. The article explains various individual and general individual mental health issues and explores in depth the existence of what needs to be learned to solve them. The concerns vary from Indian ageing trends to elderly marital problems, geriatric addiction, diabetes, homosexual, queer, bisexual and transgender ageing. Different policy and study concerns which question mental wellbeing are also addressed. There is a stress on the need to bring mental wellbeing into primary care, the need to prepare primary care staff and preventive work for prevention of suicide of older adults. The article discusses these issues with the goal of introducing the numerous mental wellbeing problems in India during the current period to the clinician.

Key Words: - Mental Health, Old Age, Disorder

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INTRODUCTION

India's evolving demographic dynamics and future estimates show that the growth rate of older Indians is comparatively higher than in other regions of the world. Over the modern past, the population of older adults is rising increasingly leading to a significant rise in life expectancy, rise in the amount and percentage of older adults (age 60 and over). In India, older people actually make up 7.6% of the overall population. For the past three decades the number of older adults has more than doubled from 43 million in 1981 to 92 million in 2011 and is projected to grow, i.e. 316 million over the next four decades. This obviously shows that Indian older adults have a reasonably high growth rate compared to other areas of the world. Life expectancy at birth also rose from 62.5 in 2000 to 66.8 in 2011. Rapid increase in the number and share of older people in the world is synonymous with and would continue to have significant repercussions and effects in all aspects of daily life. As a consequence, the elderly is expected to suffer from employment, health, family structure, living conditions, accommodation and relocation issues.

The family was historically the key source of treatment and financial assistance for the aged in Asia. And the Indian family structure is also highly respected for its virtues such as the elderly's assistance, determination, responsibility, affection, and care. The children's obligation for the protection of their parents is not only recognized in the country culturally and economically, but is also part of the legal code in many India states. Yet urbanization, growth, industrialization and globalization, in the context of systemic and functional shifts, have introduced great changes in the family. Older people are at times compelled, owing to these socio-demographic shifts, to transfer from their own locations to other institutions / old houses.

This portion of the community is more vulnerable to health disorders, particularly mental wellbeing disorders. Different incidence surveys report that mental health issues are far higher in older people than among other age groups. The existing literature reveals that no attempt is taken to consider the morbidity and desires of these elderly people and that detailed research relating to the problem are challenging to identify. A research was organized and performed by Lucknow, Department of Geriatric Mental Wellbeing, in order to determine mental stability and other related morbidity in old-age citizens.

The definition and complexities of mental disorders

Health research has become profoundly conscious of the critical connexon between physical wellbeing and mental / emotional wellness. Mind and body are related, impacted by each other and both are conditioned by the hereditary background, climate and experience of an individual. Much when the avoidance of an illness does not characterize physical wellbeing properly, mental wellness is more than the absence of psychiatric illnesses.

Mental wellbeing is often shown to pass along a curve that fluctuates all over time both through persons and in a particular case.

Mental illnesses are, as described in this highlights, diagnostic disorders that are marked by differences in perception, attitude or actions (or a combination) correlated with anxiety or diminished functioning. As for clinical manifestations, a continuum of moderate to extreme psychiatric illnesses exists. However, those with psychiatric illness also have to face the unique pressure synonymous with social shame. This stress also stops individuals from identifying and finding care and appropriate treatment for their condition. Like physical wellbeing, inability to treat symptoms at an early level may have significant detrimental effects.

REVIEW OF LITERATURE

Sachin Tiwari et al. (2012), The surprisingly higher proportion and percentage of older adults in the world, the dramatic rise in the number of nuclear families, and contemporary shifts in psychosocial structure and values frequently cause this segment of society to reside alone or in aged homes. Although this category of individuals was more prone to mental health issues, a pilot study was undertaken by Geriatric Mental Health Department Lucknow to determine mental health concerns in the elderly. It was an exploratory analysis that gathered knowledge regarding accessible old-fashioned homes at Lucknow and randomly picked three. Both the heads of these organizations were consulted and authorization was received to carry out the research. Consent was sought from the participants. Applied for review by a qualified testing team, Survey-Psychiatric Appraisal Service (SPAS), Micro Mental Condition Test (MMSE), Mood Disturbance Questionnaire (MDQ) and SCAN-based professional interviews. The outcome is 45 elderly (20 males + 25 females) who were questioned for approval in the sample. Depression has been shown to be the most prevalent issue for dementia in mental wellbeing. A lot of elderly people had mental morbidity and nothing was physically healthy. Large sample studies are needed to validate hypotheses and to establish intervention strategies.

Shubhangi R. Parkar et al. (2015), Unique problems in elderly treatment are induced by rapid urbanization in Indian community. There is clear proof of an improvement in morbidity, disability, hospitalization and functioning status of elderly patients. Depression and anxiety overlaps are very prominent in about half of the elderly patients with severe signs of depression and anxiety. Rise in the elderly population implies significant growth of age-related illnesses, such as dementia and deteriorating mental wellbeing consequences, such as depression, anxiety, suicide and extreme limits on the standard of life for elderly people. The susceptibility of the older generation has also risen in India because of the generational change, rapid industrialization and urbanization, the Westernization of Indian society and the disintegration into nuclear of shared or extended family systems.

The time is required to transform all organizations and societies in order to increase the quality of life of the elderly. More study is needed to establish suitable service models for the management of long-term care services, including institutionalization. In conventional communities like India, we do need to know about appropriate models of the structure of formal treatment and then settle on informal care from the same viewpoint as cultural change, which is important for the elderly to feel safe and secure.

Howard H. Goldman et al. (2006) The concept can at different periods be narrow or wide in relation to the extent of the requirements of a particular program. The preference given to the seriousness of impairments is the most critical and permanent political problem. Mainstream clinical and welfare services are important for the health and well-being of individuals who reside in their neighborhoods with psychiatric disabilities. This service diagnosed inadequate capital based on intensity and necessity, but this strategy was not sufficient.

AIMS OF THE STUDY

1. To assess the degree of mental wellbeing between age and sex.
2. To measure the mental wellbeing standard of young people (60-69).
3. To determine the extent of old-age mental wellbeing (70-79).
4. To measure the mental wellbeing standard of the aged 80 years old and above.

METHODOLOGY

It was an exploratory analysis of old-age homes of Lucknow Area. The occurrence of mental and physical health issues in old-age residents was studied. Of seven old homes, three were chosen randomly and heads of these organizations were asked for the study permission. The research selected three distinct styles of old age homes. One of them was founded by a Gayatri Pariwar, a religious organization in which the inhabitants had to pay Rs. 2500. The last two old homes were free of charge.

The elderly people in these older homes were approached and their approval was obtained to engage in the research. Screening and diagnostic methods were used for the Psychological Screening Plan (SPAS), the Mini-Mental State Review (MMSE), Mood Disturbance Questionnaire (MDQ) Method of Neuropsychiatric Clinical

Screening (SCAN). Ses instruments were introduced by a skilled study team educated by SCAN. In order to find out the physical morbidity among these topics, they received knowledge by investigating their physical health and scanning the related papers (medical medications, etc.). For the screening of old-age detainees, MMSE, MDQ and SPAS were included. The division into positive and negative situations was focused on the available criteria for the relevant instrument. Many subjects that were shown to be positive in the screening tools were further interviewed to arrive at a diagnosis using SCAN-based clinical interview. The test and SCAN clinical evaluation was performed by skilled and trained practitioners in mental wellbeing. Qualitative details such as medications and medical results as well as their own descriptions (concerning clinical symptoms/illnesses) is taken into consideration to determine physical morbidity in individuals.

Both participants were sub grouped into three groups: younger: 60 to 70 years, old: 70 to 80 years and older: 80 years and older, and data analyses were carried out using percentages and relevance measures.

Performance Results

The research was performed in three old-age homes and the descriptions of the people residing in these old-aged homes are presented in Table 1.

A total of 45 residents (20 males and 25 females) were permitted to take part in the analysis in three old houses. Figures 1 and 2, respectively, provide descriptions of the age-wise and sociodemographic statistics for older adults. In addition, data are evaluated with age and ethnicity in mind.

Figure 1 indicates that most of the elderly were in the subcategories of aged people (Male = 50%; Female = 64%) led by disabled adults (M= 35%; Female = 20%) and disabled adults (Male = 15%; Female = 16%). The bulk of these citizens were women (55.6 percent). As individuals of various categories of age have not been defined as having the same distribution or generic proportions in the population, the socio-demographic data are focused solely on ethnicity.

The bulk of the people were illiterate (28.9%), accompanied by elementary school (20%), university and higher education (17.8%). Just 6.7% of the populace had technical skills. The plurality of females had either an analphabet (32%) or a smaller schooling (primary = 28%; literary only = 12%). The bulk of the population was widowed (females = 88%; males = 65%). 15 percent of males

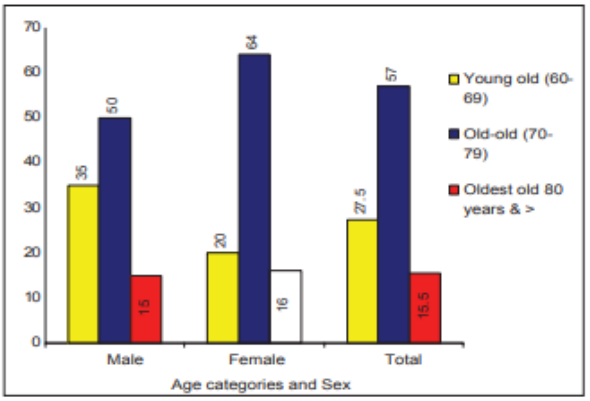

Figure 1: Inhabitants of old age home by age & sex

Table 1: Details of inhabitants and participants of old age homes

Old age homes details	Inhabitants	Unable to provide details due to disability (hearing impairment, unable to speak)	Older adults refused to participate in the study	Older adults given consent for the study
Samarpan (Established by a religious organization)	22 (35.4)	3	5	14
%	35.48	4.84	8.06	22.58
Dharmarth old age home (Established by a trust)	35	4	3	29
%	56.45	6.45	4.84	46.77
Government	5	1	2	2
%	8.06	1.61	3.22	3.23
Total	62 (100)	8 (12.9)	10 (16,1)	45 (72.6)

Figures in parenthesis are in percentage

The population was married and a comparable percentage of men was unmarried; just 12% of women had marriage status. Many women were financially reliant (84%), although the rest (75%) were financially autonomous.

Mental health problems are shown in Table 2

Table 2 indicates that the bulk of the population has depression (Males = 50.0%; Females = 28%). In persons, the following condition was dementia (20%), accompanied by paranoia and schizophrenia (both 5%). Female anxiety disorders were considered to be the second leading disorders (16%). Dementia was shown to be more common in men (20%) than in women (4%). In the younger generation, mental wellbeing issues were found to be more prevalent. In persons, with the exception of one in each category, all the others had one mental health condition or another. For young people everyone suffered from one or more mental illnesses, while for older women, 43.7% (depression 25%; anxiety 12.5%; schizophrenia 6.25%) suffered from one or two more mental disorders. Surprisingly, none of the women was psychologically ill in the oldest community. The Actual P-value of Fishers was considered non-significant in different men 's ages, only important in the case of women, i.e. the Actual P-value of Fishers = 0.2379 (males) only 0.0212 (females).

Pattern of physical illnesses

Figure 2 reveals almost all occupants in old-age facilities have one or two physical health issues. Much of the subjects had numerous physical morbidities of both men and women and men dominated (Male=60%; Male=68%).

DISCUSSION

In Lucknow, a total of seven old-age homes were found to be operating. Three of them were chosen supposedly to provide a rundown of these citizens' mental health issues. Much of the older adults resided in old-age Dharmarth homes (56.45%) which were formed through a trust followed through old-age homes (35.48% and 8.06%), respectively. All these old homes were residential and were meant for men and women who were older people.

Table 2: Socio-demographic details of participants

Socio-demographic details	Male		Female		Total	
	Number	%	Number	%	Number	%
Education						
Illiterate	5	25.0	8	32.0	13	28.9
Just literate	1	5.0	3	12.0	4	8.9
Primary	2	10.0	7	28.0	9	20.0
High school	5	25.0	1	4.0	6	13.3
Intermediate	1	5.0	1	4.0	2	4.4
Graduation and above	4	20.0	4	16.0	8	17.8
Professional	2	10.0	1	4.0	3	6.7
Total	20	100.0	25	100.0	45	100.0
Marital status						
Married	3	15.0	3	12.0	6	13.3
Unmarried	3	15.0	0	0	3	6.7
Separated	1	5.0	0	0	1	2.2
Widowed	13	65.0	22	88.0	35	77.8
Total	20	100.0	25	100.0	45	100.0
Financial dependence						
Dependent	5	25.0	21	84.0	26	57.8
Partially dependent	0	0	0	0	0	0
Independent	15	75.0	4	16.0	19	42.2
Total	20	100.0	25	100.0	45	100.0

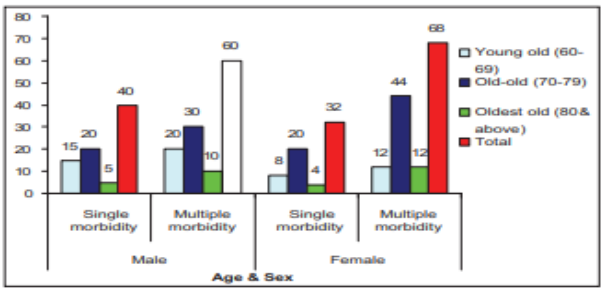

Figure 2: Pertcenage of inhabitans of old age homes suffering with physical morbidity

The bulk of the occupants of these elderly homes aged from 70 to 79 years of age, accompanied by youth and elderly individuals (57.8%, 26.7% and 15.5%, respectively). In old and older classes, women outnumbered male (Males = 50% and 15%; Females = 64% and 20%), but in the younger community males outnumbered females (Males = 35%; Females = 20%) which reflect the new.

Table 3: Inhabitants suffering from mental health problems

Descriptions	Male (20)					Female (25)				
	No psychiatric disorder	Depression	Dementia	Anxiety	Schizophrenia	No problem	Depression	Dementia	Anxiety	Schizophrenia
Young old 60-69	01 (5)	05 (25)	0	1 (5)	0	0	3 (12)	0	2 (8)	0
Old-old 70-79	01 (5)	4 (20)	3 (15)	1 (5)	1 (5)	9 (36)	4 (16)	1 (4)	2 (8)	0
Oldest old 80 and >	1 (5)	1 (5)	1 (5)	0	0	4 (16)	0	0	0	0
Total	3 (15)	10 (50)	4 (20)	2 (10)	1 (5)	13 (52)	7 (28)	1 (4)	4 (16)	0 (0)

Figures in parenthesis are in percentage

The feminization pattern in older adults. Educationally female women were more analphabets (30 percent) compared with male (25 percent) in line with the 2001 Census of India report Female (88 percent) outnumbered males (65 performing) by widowed status endorse the results of a recent epidemiological study.

The general incidence of mental disease among the elderly offers a startling result that males was greater than females (Male = 85% and female = 48%) not associated with the most current epidemiological study. Depression was the most prevalent psychiatric condition. Dementia, anxiety, schizophrenia and autism and dementia in women have been identified in the earlier results. Some have also indicated that in population surveys of senior citizens, the share of depression disorders was the highest. Cognitive dysfunction in the diseases was found to be, however, the second highest; the incidence of dementia in India was reported to be variable from 1.

Many of the citizens of old age homes suffered from physical morbidity, and nobody declared himself to be well. A majority of the population had many diseases (male=60%; female=68%) which confirm previous study findings, where mental health morbidity is rarely an isolated case in elderly people, with at least 2/3 other clinical diagnoses becoming a rule.

The incidence of mental health issues and physical disorders among older households was found to be greater than in the population. This may be induced by considerably more psychological tension, negligible family assistance, shortage of treatment and services for doctors, a restrictive atmosphere for the elderly and financial limitations, etc. The results of these observations are important from the points of action. Various stressors and explanations for experiencing psychological disorders in old-age offenders must be investigated. Related experiments are also required to test the effects of this research.

LIMITATIONS

The research was performed in a short time on a restricted number of old-age households, so the general public cannot be generalized.

CONCLUSIONS

1. More than half of old-age seniors suffered from one mental health condition or another.
2. The most prevalent mental health issues is depression.
3. The individuals with mental disorder have one or more similar physical morbidities.
4. The old-age citizens have one or more clinical morbidities.

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