Chapter-II

REVIEW OF LITERATURE
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Review of relevant studies would assist the researcher to identify and understand the gaps in the research and guides the researcher to plan and execute the current study. The topic of present research on psychological problems and anxiety in older adults is one of the gray areas of research in gerontology. For purposes of relevance, only studies carried out on older adults living in the community and in care homes are included in this chapter. The researches are presented in terms of anxiety, depression and psychological problems in the elderly across socio-demographic subgroups.

The review of available studies on problems in old age, particularly in the context of old age adjustment has revealed that the aged persons as such, constitutes a considerable section of the population who deserves research attention. A large number of studies have examined adjustment and well-being of the aged persons and their relationship to various factors like institutionalization, health, belief in religions and participation in religious activities, economic dependence, presence of children, loneliness, and the like. The results of various studies highlighted that the aged persons residing in old age homes are confronted with more negative elements in their life and lag behind in adjustment and well-being (Sivaraju, 2011).

Changing structure of population today is a global phenomenon resulting from two almost universal trends like declining fertility and increasing life expectancy. As a consequence, in the 21st century most parts of the world, there is a demographic ageing, defined as a rise in median age of populations and a growing share of people above age 65. In fact, mortality declined significantly long before fertility in all populations, but the former decline was not adequate in itself to aging population (Henry, 1976). The ageing process in India has been initiated from the “apex” rather than from the “base” due to improvement of survival first in the old age range. This is reflected in the old age structure of the population in which the proportions of young – old (60 – 64) have been decreasing and those of 65–69, 70–79 and 80+ increasing. It is pertinent to note that 80+ elderly are the fastest growing elderly among the geriatric population leading to increasingly border “apex” of population pyramid – an
indication of the shift of the age structure of elderly from “young-old” to oldest-old”. As per world population ageing 2007 report, increase in 80+ elderly globally; which 0.7 for Asia, and male, female being 0.6 and 0.9 respectively. The growth rate of 80+ elderly worldwide is 3.9 in contrast to Asian which being fastest in world is 4.5. India ranking for population of 60 or over is 90, in contrast to Japan’s no.1; median age of Indian is 24.3 with the rank of 100 and ageing index of India is 26.1 with rank for the same being 94 (UN Dept. of Economic and Social Affairs, Population Division, 2007). As per Indian census released in October, 2004, the elderly population in 1961 was 25 million, in 1971, it was 33 million (increase of 8 million) in 1981 it was 43 million (increase of 10 million), in 1991 it was 57 million (increase of 14 million) in 2001, 76 million (increase of 18 million). By 2025, the older is estimated to become 168 millions i.e. about 12.7% of the total population. The dependency ratio is projected to increase from the present 9% to over 12% by year 2050. Unique feature of demographic transition is that the population of 80+ is increasing rapidly at present, it has already reached more then 12% through out the country of total population of elderly, viz., more than 12 million are 80+ which is a big absolute number (Khan & Dharmesh, 2011).

Psychological Problems – Depression in Older adults

Ageing is a inevitable and universal process. As per Seneca “old age is an incurable disease”, however as Sir James Sterling commented “you do not heal old age, you protect it, you promote it and you extend it.” These are in fact the underlying principles of Preventive Medicine. Psychological and physical morbidities are common in old age.

Depression in older adults is a major health concern. It is a more common problem than people might think. However, it must be emphasized that depression is not a part of normal aging. Death anxiety refers to the fear and apprehension of one’s own death. Elderly with higher scores in depression also have higher levels of death anxiety. The study aims to find the relationship between depression and death anxiety among the 240 elderly. Analyses revealed that as depression increases death anxiety also increases among elderly (Deepa & Balakrishna, 2013). Martha et al (2002) found that 13.5% of newly admitted elderly in senior homes, suffered from major
depression. Many studies have been carried out in India to evaluate the prevalence of mental illness in elderly were found to be 2 to 43% (Dube, 1970; Tiwari, et al 2013). Several factors viz., female sex, low education, marital status, medical comorbidities are known to affect mental health in later years. Economic dependence, nuclear families are known to play a significant role in psychiatric illness among elderly (Rajkumar, et al 2009). Risk factors leading to development of late life depression are multiplex interactions among genetic vulnerabilities, cognitive diathesis, age associated neurobiological changes and stressful life events (Blazer, 2003). Studies have noted that older adults frequently tend to cope with stressful events in various ways than do younger adults; older adults depend on emotion focused forms of coping as opposed to active problem solving approaches. Nonetheless the other research has pointed out that as one gets older, difference in coping styles are reduced (Staudinger, & Pasupathi, 2010).

Depression in old age is often related with other co-morbid conditions, such as frailty, dementia and anxiety that aggravate the distress experienced by older adults and their carers and studies also revealed that geriatric depression is prevalent in rural south India. Though depression is a common, it is frequently unrecognized or inadequately treated condition in the elderly (Cindy & Helen 2011). Depression is the commonest mental illness. In the elderly population, either in the institution or non institution (Nandi et al., 1997), depression is a widespread problem that is often frequently under treated and under diagnosed in India and Korea (Gopal, Veena, Vijayan & Nambootiri, 2009; Yang & Rim, 2006; Kim et al., 2009). Study by Gopal, Veena, Vijayan, and Nambootiri, (2009), stated that depressive mood is common among elderly population aged above 60 years living in old age homes and in the community. Deepa and Balakrishna (2012) found that gender differences in depression among institutionalized and non institutionalized elderly.

Recent studies found that the prevalence of depression was 56%, of which 23.2% had severe depression and 60% of the female population and 52% of the male population were found to have depression. Findings show that depression was more in inmates of old age homes. Gender wise analysis shows that depression was found to be more among female elderly. The levels of depression reported to be higher in institutionalized Korean elderly than those of community residing elderly (Oh &
Worsening health and loneliness have been shown to be risk factors for depressive symptoms. Cacioppo et al., (2006) stated that higher levels of loneliness were associated with more depressive symptoms in older adults. Elderly people experience decreasing physical function and worsened general health in the process of aging (Crews & Zavotka 2006; Bishop et al., 2006; & Kim et al., 2009). It has been found that when considering psychosocial status such depression has a relationship with health (Jeon, Kim, & Kim, 2005; & Kim et al., 2009) people who move into nursing homes experience a rapid change in their psycho-physical balance (Degenholtz et al., 2005; Scocco et al., 2006 & Kim et al., 2009).

Joao, Patricia, Susana and Carla (2015) assessed the association between institutionalization and depression in the elderly. The findings indicated that the prevalence of depression symptoms was higher in single and widowed elders than in married elders. The fact that the widowed elderly were more prone to depression, which highlights the importance to find therapeutic strategies to minimize the impact of institutionalization.

Along with those chronic diseases, elderly with family conflicts, and lack of psychological support found to have higher prevalence of depression. There was no significant association with age, lack of financial support, literacy level, marital status and absence of a leisure time activity (Wijeratne, et al., 2000). The state of well being varies from 22.1% to 52.1% in the elders and the prevalence rate of mental morbidity is 89/1000 elders with geriatric depression accounting for 60/1000 (Rao, 1993). Dubey et al., (2011) study also revealed that geriatric depression is prevalent in rural south India. Studies disclosed that institutionalized elderly have more stress and less quality of life compared to community dwelling ones (Mathew et al., 2009).

Cindy and Helen (2011) found that the institutionalized elders are having significant depression and suicidal ideation than non-institutionalized elders and single elders reported significant depression and suicidal ideation than coupled elders. Male elders are having more depression than female elders but in suicidal ideation female elders are having more than male elders. The study also revealed that there is no significant difference in suicidal ideation and depression between institutionalized elders and non-institutionalized elders based on age, educational background, socio
economic status but urban elders are showing significant suicidal ideation than rural elders (Sridevi, 2014). The prevalence of elderly suicidal ideation was 6.1%. Female gender, age over 85 years, low level of education, single status, unemployment, no income, disability, current smoking, self-perceived bad to very bad health, depressive symptoms, different physical diseases (heart disease, diabetes, asthma, osteoporosis), and pain symptoms (joint pains, lower back pain, neck pain, sciatica, headache) were strongly associated with suicidal ideation (Hsiang-Lin et al., 2011). Depression in terms of poor physical health including poor vision problems, hearing problem, greater number of diseases and poor mental health especially in the form of depression are predictors of suicidal ideation in older adults (Yip et al., 2003). A research on the social networks of older persons in India found to have an impact on residency in old-age homes, sex differences, and joint and nuclear family residence. Studies concluded that there is a need to pay interdisciplinary attention to the psychological health or older adults of nursing homes, particularly in the preliminary stages of placement and adjustment (Ron, 2004). Therefore, healthcare providers need to recognize the factors associated with depression biopsychosocial dimensions targeting mood, cognition and functional ability in the institutionalized elderly so that can be prevented.

Yadav (2014) examined the association between institutionalization and depression in the elderly and discussed the need to create awareness among caregivers and health care professionals to acknowledge institutionalization as a factor that may predispose depression. Early identification of signs and symptoms may be early identified and/or diagnosed, thus allowing for a timely implementation of measures and strategies that seek to minimize the impact of institutionalization on the elderly mental health, and on health in general, with consequent health gains.

A cross sectional study by Venkatesan and Anupama (2011) sought to map the ground trends of depression in institutionalized and non-institutionalized elderly in association with connected socio-demographic variables. The findings paint a rather grim picture of the most typical hypothetically affected senior citizen of this sample as one who is a widowed institutionalized female hailing from low socio economic status group with complaints of felt anxiety and sleeplessness along with severe depression (Cindy & Helen 2011). This contrasts the much better counterpart of the
non-institutionalized aged familial male, preferably with the spouse, from a high socio economic status, who scores consistently better scores on all health dimensions as measured in this study. The results are discussed in the light of the need and their implications for improving the quality of life of the institutionalized elderly in the contemporary Indian context.

The number of aged persons are also increasing as a result of longevity of life in modern era. India is the second largest nation with number of older persons in the world. It is noteworthy that psychological problems among the aged is also in rise as well as rise in the population of aged. The idea of old age home is now being popularized in India. Yet, Indian aged prefer to have traditional family as their care provider. Alternative living for many of them is in old age homes. The elderly women who are residing in old age homes have much depression, loneliness and insecurity feeling than the elderly who live with their families (Arpita, 2012).

Globally, and developing countries in particular need measures to help older people to remain healthy and active. Narkhede, Likhar and Rava (2012), study was aimed to assess depression among elderly inmates in old age homes (OAH). Depression was observed more in non active inmates (65.8%), as well as in those who stayed for shorter duration (64.1%). Also, it was noticeably present in those having visual problem (66.7%), hearing problem (83.3%) and sleeping problem (66.7%). Incidence of depression was less in inmates who were living with spouse (57.7%) outward migration of younger people away from parents as a result of urbanization and industrialization. Prevalence of depression was significantly more with increased age, in females and with hearing and sleeping problem. The prevalence was significantly higher in inmates who stayed for shorter duration in old age homes (Narkhede, Likhar & Rana, 2012).

Aging is a natural and continuous process, characterized by progressive generalized impairment of function occur which results in loss of adaptive response to stress in later age. Unfortunately for the past 50 years, the traditional Indian family system has been changed to nuclear family. As a result providing safety and security has been shared by institutions such as old age homes. Loneliness and depression is raised due to absence of family care surrounding. Late-life depression is usually
confused with the effects of multiple illnesses associated with age and the medication used for their treatment, or it is considered normal among elders. However, it must be emphasized that depression is not part of normal aging. Depression can cause emotional pain for elders and their families when it is undiagnosed. Depression in elderly is caused due to psychological, physical and social factors. Anxiety, sadness, incapacity to feel pleasure in normal activities, persistent, vague or unexplained physical complaints, difficulties falling asleep, discouragement, memory problems and difficulties concentrating, social withdrawal and isolation, negligence about personal care, confusion, delusions and hallucinations are some of the depressive symptoms in elderly. Higher levels of depression can lead to higher levels of death anxiety (Deepa & Balakrishna, 2012).

Mood disorders are one of the most common health problems in the elderly and responsible for the loss of autonomy and worsening of pre-existing conditions. A higher risk of morbidity and mortality, increased use of health care services, negligence of self-care, non-adherence to therapeutic regimens and increased risk of suicide are frequently associated with depression (Salgueiro, 2007). Studies on suicide, in Portugal showed a higher prevalence in the age groups above 75 years, particularly among males (Gusmao & Miranda, 2005). International studies estimated that depression affected 6% to 10% of the elderly population in Portugal. The advanced age has been identified as a predisposing factor for depression (Bergdhal et al., 2005). 15% of the general population had been affected by depression (Pamerlee, Katz, & Lawton, 1989). Also, it affected between 2% to 14% of non-institutionalized elderly and reaches 30% of institutionalized elderly people (Pamerlee et al., 1989). Gusmao and Miranda (2005) pointed out to a high general psychiatric morbidity, mainly depression, in the group of retired elderly people.

Depression may be associated with other health problems or even accidents. At this level, some estimates indicated that healthcare costs with depressed elderly individuals are three times higher than those with non-depressed individuals (Riedel-Heller, Weyerer, Konig, & Luppa, 2012). Depressive disorder may also be associated with fall risks in some cases (Yun-Chang et al., 2012). Nevertheless, the signs and symptoms of depression are belatedly identified by health care professionals, the patients themselves and their caregivers and family members. This highly contributes
to intensifying the suffering of those who do not receive adequate and timely care (Riedel-Heller et al., 2012; Pocinho, Farate, Amaral, Lee, & Yesavage, 2009). This situation is even more serious among institutionalized older adults in nursing homes, where care should be closer and an early diagnosis should be promptly established. Pointed out that the potential lack of more attentive and diligent medical and nursing care in these institutions as a probable cause for the high prevalence at the level of the elderly population and based on the sample of institutionalized and non-institutionalized elderly people. The fact that elders were away from home and subject to the specific routine of the nursing home may suggest some predisposition to depression. This will probably result from a late diagnosis of depression but, above all, the routine of institutionalization, which is substantially different to that of the home settings (Salgueiro, 2007). However, we should bear in mind that institutionalized elderly people usually have low levels of support from society and family and a high prevalence of other co morbidities, which may aggravate the depressive symptoms pre-existing at the time of institutionalization (Leite, Carvalho, Barreto & Falcao, 2006; Siqueira et al., 2009). Further female sex, medical comorbidity, poor social-economic status, widowed state, disability have been identified as strong predictors of geriatric depression (Ramachandran, Sarada Menon & Arunagiri, 1982; Nandi, Banerjee & Mukherjee, 1997; Cary et al 2005; Sood, Singh & Gargi, 2006). Nonetheless there is no solid evidence as to living in community with one’s own people has a positive influence on one’s psychological status than living in old age homes. Conversely, the available scant documents favours residents of senior care homes (Rothera, Jones, Harwood, Avery & Waite, 2003; Tiple, Sharma & Srivastava, 2006).

The senior care homes take care of several various aspects of their inmates. Senior care homes since being a total institution, it has no other choices but to cater to all the needs of the inmates in the best possible way. The fact that the elderly are frequently not in a position to identify their needs make the institutions more responsible in providing their services. Tiwari, Nisha, Pandey & Singh (2012) noticed that the senior old age care institutions provide services with an aim to give good care to the elderly. Many of the elderly were not satisfied over their survival for long years. It was noticed that the institutional care offered by senior care homes seems to
be a spark in the darkness, as somehow they feel happy over the care given by these senior care homes living. Residents in senior care homes have unique and different attitudes, as there were differences in their respective social, economic, religious and cultural background. In many instances their own children and relatives treat them as strangers indicates the deterioration in social values and as a consequence, these older adults are susceptible to a state of depression. The senior citizens in general (91.0 percent) are of the opinion that the institutional care given to them in the old age homes is not up to their satisfaction and not reported by him/her as healthy. As all the residents of old age homes generally suffer from one or other physical morbidity, many of the inhabitants were having multiple morbidities (male = 60%; female = 68%) supporting the findings of earlier studies where it was reported that mental health morbidity was seldom an isolated event in elderly and a minimum of two/three other clinical diagnoses is a must. Tiwari, Pandey and Singh (2012) evaluated mental health problems among inhabitants of old age homes. Depression was found to be the most common mental health problem followed by dementia. Most of the inhabitants of senior care homes were having geriatric morbidity and no one was observed physically fit. Studies with large sample studies are needed to provide evidence to the observations to generalize and design intervention (Tiwari, Nisha, Pandey & Singh, 2012).

Vishal, Bansal, Swati and Bimal (2010) documented that elderly are more prone to psychological problems and depression is the commonest geriatric psychiatric disorders. In fact the elderly in India face a multitude of psychological, social, and physical health problems. As age advances there is an increased morbidity and functional loss, also presence of a variety of depressive factors and occurrence of varying life events, greatly impact on one’s psychological status, making them more prone to depression. Rao and Madhavan (1983) carried out a study to assess the prevalence of psychiatric, physical morbidity, coping factors, stressful life events and well being in inmates of old age home. Stressful life events were found to be correlated to psychiatric and physical morbidities. In a study by ICMR (Sethi, Gupta, Mahendru, Kumari, 1974, 1987) it was reported that prevalence of mental morbidity among elderly was 20.2 per thousand persons (Rahul, Choudhary & Uday, 2004). The aim that they explored the magnitude and risk factors of problem of depression in
elderly people living in senior care homes and among those living at home in both, affluent and slums of Surat city (Jariwala, Bansal et al., 2010). The prevalence of depression was moderately high (39.04%) among the elderly in their study population and it was observed that several important socio-demographic variables had shown a significant correlation with depression in the elderly. Studies disclosed that the prevalence measures for depression in community samples of elderly in India vary from 6% to 50% (Rao 1993; Nandi, et al., 1997). The prevalence of depression in Caucasian elderly populations in the West vary from 1% to 42% (Djernes, 2006). It was found that those aged who are severely depressed and who require an institutional treatment are more in old age homes (25.71%), followed by those living in the affluent areas (22.8%) and those living in the slums (11.4%). Studies disclosed that the prevalence of causes of mental disorders needing institutional treatment is around 67 per 1000 population (Sethi, et al 1974). The prevalence of depression was 26%, GAD was found in 2%, psychosis in 2%, cognitive impairment was found in 10%. The risk factors for depression in the study are female sex, widowed status and urban background, nuclear family, low socioeconomic status, lesser education. All inmates were found to have physical illness (100%). Subjects with mental illness used emotion focused, denial subtype coping strategy and those without mental illness used more religious subtype of coping. Subjects with mental illness used less of problem solving and emotion solving coping than those without mental illness.

Nuclear family seems to be one of the risk factors for depression (Sireesha & Siva Kumar, 2014). A higher proportion of old age residents (67%) perceived their health status as ‘average’ in comparison to 42 per cent of the community elderly. A larger number of community elderly (41%) perceived a ‘good’ health status with only 22 per cent of the residents of old age home reporting the same on the other hand. There prevail a significant relation between perceived health status and gender of the elderly in both Mumbai and out of Mumbai samples. Most of the male residents from old age homes (31%) felt their health status was ‘good’ in comparison to only 10 per cent among female residents. Female elderly in institutions were residents for a longer period than the male elderly, less educated had lower paid occupations, poorer economic status with greater impact on their health. Data on their emotional status showed that they frequently worry and feel depressed, thus, influence their perception.
of their health. Also, the female residents in senior care homes in Gujarat reported poorer health as a result of their earlier poorer economic condition and probably its possible impact on prevent health (Carol, 2007).

Elderly people living in senior care homes are more influenced in terms of depression as compared to community dwelling older people those living in their own homes were most able to cope effectively, more support was received by their relative’s and friends than support from health and social services (Vanshika et al, 2013). Ghimire, Pokharel, Shyangwa, Baral, Aryan & Mishra, (2012) compared the prevalence of depression between elderly people living in old-age homes and community setting. Prevalence rate of depression was 52.73% in old-age homes and 25.45% in community. Females had higher prevalence rate of depression than male in old-age homes (93.1% vs. 6.9%), whereas in the community group, it was higher in males (64.3% vs. 35.7%). Logistic study revealed non-social support (P=0.017), illiteracy (P=0.035), female sex (P=0.036) and low income (P=0.049) as the predictors of depression. The high prevalence rate of depression among the elderly in old-age homes and community suggests lower productivity and higher burden on family and society. Nisha and Revati (2012) assessed the prevalence of depression and its correlates among the elderly living in vriddashram (senior care home). Findings revealed that the prevalence of depression was 57.8%. Among them 46.7% had mild, 8.9% had moderate and 2.2% had severe depression. A significant relationship was found between feelings of depression and age, sex, previous family type, ethnicity, feeling of loneliness and instrumental activities of daily living. Regression analysis shows that being women, feeling of loneliness and higher the dependency in IADL were predictors of depression. This study revealed that many elderly living in the vriddashram are suffering from depression.

Inspite of large number of studies have identified the prevalence of depression experienced by older adults living in the community and the factors that may precipitate this depression, few have focused on depression in older adults who attend day centres. Henminardi and Blanchard (2004) presented the results of a pilot study investigating the occurrence of depression in older people attending a London Age Concern day centre, and its relationship associations with perceptions of handicap, loneliness, social support networks, satisfaction with social support, and satisfaction
with life. There was a severe level of depression in this day centre setting than that found in other community-based studies. Anticipated significant relation between depression and loneliness, and depression and satisfaction with life were noticed. However, unexpectedly, there were no association between depression and social support, or depression and handicap. The severe level of depression was significantly related to depression, loneliness and satisfaction with life may suggested that the social function of day centres is not meeting the expectations.

A cross sectional study by Abhishek et al (2015) explored that 27.7% among elderly people residing in OAHs while it was 15.6% those residing at their own homes. In community most frequent morbidity was hypertension (17.7%) while 41.1% elderly people had no diagnosed morbidity. In OAHs out of total the musculoskeletal morbidity (33.7%) was most frequent and 18.8% had no diagnosed morbidity. The findings revealed that depression was more common among elderly living in Old Age Homes as compared to those living in community with Hypertension, musculoskeletal morbidities and eye related morbidities. Financial dependency and education were found to be primary forecasting variables to depression. Among elderly, disorders like depression, anxiety, cognitive and psychotic disorders have a high prevalence. There is some preliminary evidence show that in mates reported as perceived by in mates more need for supportive life in old age homes. Thus, irrespective of the setting in which they live the psychiatric morbidity is high in elderly (Anil Kumar, Mathew, Nanjegowda, Majgi & Purushothama, 2011).

Cusker et al., (2007) in their study found that 25% of the inmates are suffering from mental illness. 40% of them were cured and the rest of them are under treatment. It is observed that 25% of the respondents living in senior care homes were sad and hopeless about future. They expressed they were waiting for the impending death. It is seen that the majority of older residents have one or other physical problem. It is noticed that as age advances the incidents of physical problems too increased, pointing to the fact that the oldest old suffer the most in senior care homes.
Anxiety in Older Adults

The lives of most elderly people today adversely affected by changing lifestyle, migration and urbanization, making them prone to anxiety and requiring lot of adjustments. Elderly females had significantly higher anxiety levels as well as higher adjustment problems in home, health and emotional subscales, compared to their male elderly counterparts. More researches on psychological health of elderly especially in their socio-cultural context is needed so as to evolve practical and effective preventive and remedial strategies (Arunima & Sarvdeep, 2011).

Most elder people are afraid of dying, and there can be various reasons for this fear. Among the various death attitudes, death anxiety has received considerable attention. Logically speaking, death is an unknown entity and this is partly because man has a tendency of fearing everything which is not known to him. Nearer to death in old age higher would be the death anxiety among the elderly in comparison to the young adults. Nonetheless, studies contradict this notion that death involves the loss of loved ones control of achievements and aspirations, and so on free-floating anxiety is result. The feeling of helplessness over not being able to control one’s death about the unforeseen in old age. Deepika and Panchal (2014) proposed that elder people engages in life review when person reaches late adulthood. Elderly find meaning and purpose in life ego integrity is attained and hence should have lower death anxiety.

Parameswari and Elango (2010) assessed the death anxiety among institutionalized and non-institutionalized elderly in the age of 60, living in and around Coimbatore city. The findings of the study indicate that: non-institutionalized elderly tend to have relatively higher level of death anxiety compared to institutionalized elderly. The institutionalized elderly males have relatively lower level of death anxiety than non-institutionalized elderly males, but the institutionalized elderly males and females are not differed in death anxiety. Pankaj (2013) investigated the effect of institutionalization, gender and age of older adults on death anxiety and found that the death anxiety of institutionalized is higher than the non-institutionalized aged.

The process of industrialization, urbanization and modernization has brought changes in value system and traditional family system. With decline of family care
many institutions have come up to take care of aged. Commonly in India negative factors frequently predominate the decision to enter senior care home. As the field of gerontology has its objective as: “Livelier Longevity”, the life in old age home is an important correlate of death anxiety of elderly. Death anxiety is defined as “the thoughts, fears, and emotion about that final event of living that one experience under more normal conditions of life (Belsky, 1999).

The number of elderly people is growing very fast in both developed and developing countries. The gradual rapid change in social and cultural values had made a tremendous influence on psychological well being of elders. Death anxiety is a complicated factor that is experienced with variable severity during one’s life, and is influenced by a numerous factors such as environmental events, age, and sex. Death anxiety is defined as a apprehensive feeling that one has when preoccupied about death and dying and is used interchangeably with fear of death. Various studies have revealed that when thinking about death and its related anxiety is increased, individuals respond by defending and/or intensifying their cultural beliefs. Some studies on life satisfaction found that female elderly experienced lower death anxiety, and death anxiety levels would not differ between young adults and older adults (Chuin & Choo, 2014). Another study found that 69.5% females and 68.2% males had an average condition; while, 16.3% and 19.6% males showed low level of death anxiety and whereas, 14.2% females and 12.2% males reported high death anxiety (Tavakoli & Behrooz, 2011).

Death is very near to old age, hence a logical belief would be that death anxiety is more among the older adults comparing the young adults. Nevertheless, studies contradict this notion. The age of 60 or 65 years in most advanced countries is said to be the starting of old age. Study found that variations in death anxiety among institutionalized and non-institutionalized older widows and widowers. Also it was found there was no significant difference in death anxiety among elderly widows and widowers (Deepa & Balakrishna, 2012). Psychologists have studied the factors viz., age, environment, religious faith and ego integrity, or a personal sense of fulfillment and/or self-worth were crucial in understanding death anxiety. A complicating aspect of studying death anxiety is that in “measuring” anxiety as it relates to these variables has been difficult. The studies used in examining death anxiety do not experimentally
manipulate the variables, thus limiting conclusions to correlations (Fortner & Neimeyer, 1999).

In order to inform potential changes in the DSM-V, Kate, et al. (2010) aimed to address issues unique to older adults with the prevalence of anxiety disorders and risk factor comorbidity, cognitive decline, age of onset, symptom expression of anxiety disorder in late life and treatment efficacy for older adults were reviewed. Overall, the current literature suggests that anxiety disorders are common among older age individuals, but less common than in younger adults; although there are some differences as well as limitations to the assessment of symptoms among older adults; overlap exists between anxiety symptoms of younger and older adults. Anxiety disorders are big by comorbid with a number of medical illnesses, associations between cognitive decline and anxiety have been observed. Certain recommendations viz., including extending the text section on age specific features of anxiety disorders in late life and providing information about the complexities of diagnosing anxiety disorders in older adults are provided (Kate, 2010).

Roshani (2012) investigated the association between religious beliefs and life satisfaction with death anxiety in the elderly. Findings showed a negative correlation between religious beliefs and death anxiety as well as between life satisfaction and death anxiety in the elderly. The findings revealed that among the predictive variables, life satisfaction was the best predictor of death anxiety (Roshani, 2012).

Patricia and Wisockie (2006) explored the construct of worry as it pertains to the elderly. The elderly seem particularly susceptible to worry with characteristics of worry and its facilitating conditions. Findings indicated that respondents were generally a healthy and worry-free group of people. Concern over sensory and motor losses, failing memory, illness or accident affecting close family members, relocation, loss of independence, getting depressed and losing family and friends are included as primary worries. Findings revealed that there were no significant sex differences, nor differentiation by socioeconomic status or marital status on the Worry Scale. Only worries about health correlated significantly with increased age. Respondents high in worry were shown more anxious and less healthy, vigorous, and contented than respondents lower in worry.
The most exceptional differences in contents of worry as a function of severity of anxiety take place in the domains of worries about health and personal worries. Furthermore, elderly people with high levels of worry experience more anxiety and perceive less control over their worrying. There were no differences in the temporal orientation of worry. General Anxiety Disorder (GAD) facilitates more worries frequently but they were oriented mainly towards everyday problems in both GAD and non-clinical people. Moreover, worry about every day problem together with the extent to which worry interferes in daily life were the best discriminate variables for GAD, being better than the core DSM-IV GAD criteria. It was concluded that this pattern of results suggests that daily well-being and quality of life is strongly affected by potential of a specific worry (Montorio, Nuevo, Rquez, Izal & Losada, 2003).

Longitudinal Aging Study in LAS Amsterdam investigated the relationship between anxiety symptoms and cognitive decline over 9 years, taking into account confounding variables. A curvilinear effect of anxiety on cognitive performance was found. Furthermore Ellis et al., (2008) found that previous measurement of anxiety symptoms were not predictive of cognitive decline at a later age. Brenes, Penninx & Judd (2008) suggested that the effect of anxiety on cognition depends on the severity of the present anxiety symptoms i.e. mild anxiety is associated with better cognition, whereas severe anxiety is associated with worse cognition. The effect of anxiety symptoms on cognitive functioning seems to be a temporary effect thus; anxiety is not predictive of cognitive decline.

Sivaraju (2011) stated that a significant proportion of the community elderly stated that they did worry about their personal, familial problems and this response was relatively more among the female respondents than their male counterparts. However, in comparison to the community elderly, a larger number of residents of old age homes expressed such worry and the data showed sex-wise variations, while a higher proportion of female residents would worry sometimes (48%), and the male residents responded that they would do so very often (40%). Despite their old age and institutionalisation, the elderly continued to perceive themselves as an integral part of their family and perhaps utilised the ample time in thinking about their personal familial problems, rather than taking up some activity to keep busy and remain mentally alert.
David, Maya Tzur and Anusha et al., (2008) examined the relationship between anxiety, depression and physical disability in older adults, after controlling factors such as age, gender, income, self-rated health, number of medical conditions and number of physician visits in the past year. Furthermore, anxiety, depression and comorbid anxiety and depression have a differential effect on disability according to age. Older people with any of these symptoms reporting higher levels of disability than younger adults reported depression and anxiety. These findings suggest that physicians working with older people should assess for and treat anxiety as well as depressive symptoms.

Many senior citizens of our society are able to live a very meaningful and independent life, but at the same time the fact remains that there are some who are unable to do so. Elderly individuals, who develop dementia, develop progressive and more often irreversible decline in their cognitive abilities, neurological deficits and behavioral and psychological symptoms associated with dementia. This results in considerable impairment to lead an independent and meaningful life and their ability to carry out activities of daily living. A rehabilitation program may help them to live life meaningfully and independently by overcoming this disability since some senior citizens require residential care facility, unable to lead an independent life in their own homes. These clinical practice guidelines suggest some of the rehabilitative measures to improve the quality of life of senior citizens.

Inspite of the fact that many older people highly prefer to be with their children, grandchildren, friends and relatives during the last phase of their life, Rani and Pushpa (2001) observed that there are a large number of destitute elderly who need senior care homes, for the basic needs of food, shelter and medicine. The life in old age homes, either destitute homes or paid ones they are deprived of love, contact and care from their children, grand children, friends and relatives, which warrants major readjustment in their lives. Aged persons living in old age homes lag behind in adjustment and mental health especially anxiety (Chandrika & Anantharaman, 1982; Joseph & George, 2011; Mathew, 1993). However, Bharati (2009) has noted down, that old age homes become a place of solace for them, where they could meet like-minded people of their own generation, can have much better social interaction and
provide opportunities for joy and recreation that suits their age in addition to providing for the essential needs of the aged.

Anxiety and Depression in Older Adults

Anxiety and depression are common in elderly. Studies have shown a relatively low prevalence of anxiety disorders in older individuals. While, other studies have shown that anxiety disorders occur two to seven times more often among elderly, than depression. The rate of anxiety disorders at institutional settings may be even higher among elderly. This study evaluated the prevalence of anxiety & depression in single elderly living at their own homes and going to geriatric clubs regularly or living at geriatric homes. Living at geriatric homes and age group 60 to 70 are independent risk factors for anxiety, depression or mixed anxiety and depression. An independent risk factor for depression and anxiety were male gender and living alone at institutional settings such as geriatric homes. In many countries mixed anxiety and depression is more prevalent than anxiety. Therefore, the consequences of ageing in general, older adults and their caregivers and its implications for society need to be considered (Smoliner, et al., 2009). An attempt was made to examine the problems confronted by aged persons. In view of the increasing proportion of aged persons in our society and consequent psychosocial challenges, the adjustment status and spirituality in aged persons residing in old age homes and own homes, and the impact of relevant socio-demographic variables on old age adjustment and spirituality were examined by Joseph, Jayanthy and Nair (2013). The results revealed poor adjustment status for the aged persons residing in old age males and less spirituality oriented than the females (Joseph & Jayanthy 2013).

Overall, the current literature suggested that anxiety disorders are common among older age individuals, but less common than in younger adults; overlap exists between anxiety symptoms of younger and older adults. Although there are some differences as well as limitations to the assessment of symptoms among older adults; anxiety disorders are highly comorbid with depression in older adults with a number of medical illnesses; cognitive decline and anxiety have been observed.
Sridevi and Swathi (2014) investigated the death anxiety, death depression, geriatric depression and suicidal ideations among institutionalized and non-institutionalized elders. The findings show that 47.5% elders are having mild death anxiety and 52.5% are having moderate level of death anxiety in both institutionalized and non-institutionalized elders. The institutionalized elders are having significant death depression, geriatric depression and suicidal ideation than non-institutionalized elders but there is no significant difference in death anxiety among institutionalized and non-institutionalized elders. There is no significant gender difference in death anxiety and depression among institutionalized elders but non-institutionalized male elders are having significant death anxiety than female elders. The single elders are having significant death anxiety, geriatric depression and suicidal ideation than couple elders. There is no significant gender difference between death anxiety, geriatric depression and suicidal ideation based on age, SES, educational background of elders. It is also found that rural elders are showing significant death anxiety than urban elders and urban elders are showing significant suicidal ideation than rural elders. There is a correlation between death anxiety and geriatric depression.

Disorders such as anxiety, depression, cognitive and psychotic disorders have a high prevalence among elderly. There is some preliminary evidence that life in senior care homes is perceived by inmates as more supportive, though the issue is not well studied. In a study on the psychiatric morbidity and quality of life of elderly people residing in community and old age homes found that depression was present in 22% of people in the community and 36% of old age home inmates. Psychosis was present in 26% of people in the community and 20% of old age home inmates irrespective of the setting in which elderly live the psychiatric morbidity is high (Anil Kumar et al, 2011).

**Somatic/ Physical Distress, Behavioural Problems and Psychological Morbidities**

Ageing is a multi-dimensional process involving physical, psychological and social changes. Older adults are prone to infections, injuries, degenerative disorders, psychological problems, risk of disability consequently resulting in death. Arthritis, hypertension, breathing problems, indigestion etc are the major physical problems among residents of care homes (Vanitha, 2014).
Elin, Hanslorge, Torill and Knut (2009) examined psychological distress in older people receiving nursing home care. The influence of risk factors and personal resources on their perceived psychological distress suggest that current morbidity and dearth of personal resources is the main source for somatic distress. Psychological distress significantly related to sense of coherence, education and subjective health complaints. Inner strength was related to that low psychological distress conceptualized as sense of coherence. Psychological distress was not related to commonly reported risk factors viz., sex, household composition and perceived social support, and objective measures of somatic and mental health and bodily dysfunctions suggested reasons for this are greater acceptance of bodily and functional shortcomings and of changes related to goal achievement in old age, according to the model of selective optimization with compensation. Bindu, Shivani, and Janak (2014) examined types of health problems based on knowledge, awareness and perception of the institutionalized elderly in Vadodara city Gujarat, India. It is observed from their studies that major health problems found among inmates are blood pressure (54%); weakness (44%) followed by pain/tingling in lower limbs (38%), disturbed sleep 36%, and breathlessness (32%), back pain and gastric problem. Thyroid, heart attack, arthritis and hysteria problems were also observed. It is observed that majority of inmates were suffering from health problems associated with ageing. The elderly comprise a very important vulnerable group who are being ignored and need urgent attention (Bindu, Shivani, &n Janak, 2014). Naveen, Aashish,Himanshu, Prasanna and Pandey (2014) found that level of physiological problems among 50 older adults are, 78% have mild physiological problems, 20% have moderate physiological problems and 2% have severe physiological problems. This study revealed that the older adults are having physiological problems. Thus, the assumption by the researcher is accepted as there will be geriatric problems among inmates of old age home.

Tiwari, et al (2012) study by in Lucknow stated that all the inmates suffered from single or multiple physical problems and majority of them having multiple physical problems (males=60%, females=68%). Multiple morbidity was more common among inmates who hail from urban background (Rao et al., 2014). Urban people suffer from lifestyle problems more often than rural. This is in contrast with
study by Joshi and Avasthi, (2003), which implies that multiple morbidity was more common in rural elderly. Most common health problems among inmates of old age home was hypertension (25%), diabetes (20%) and arthritis (15%) and others (40%). The most common morbidity pattern was higher among females than males. Similar findings were observed in the study done on morbidity profiles of elderly in old age home in Chennai which showed hypertension (39.5%), diabetes (20.5%), and hearing problems (17%) (Rani, Palan & Sathiyasekaran, 2012).

Elderly are increasing in number in developing countries. The care of the elderly aged is slowly shifting from the family to community level to old age homes for those who are financially poor, lacking family care or the destitute. The health problems of the elderly in most of the developing countries who were institutionalized for shelter, health care, rehabilitation and recreation are not known adequately. Jaiganesh, Prasad and Janaki, (2013) estimated the problems among residents in old age homes located in urban area. Elderly of 60-69 years constituted the maximum percentage (47%), number of females is more than the number of males and most of the elders were from lower socio economic status. The prevalence of individual health problems were visual problems (67%) followed by hypertension (54%), depression (45%), arthritis (43%), diabetes mellitus (32%) and hearing problems (24%). The overall prevalence of visual impairment and blind was 46% and 21% respectively. The prevalence of health problems among the inmates of old age homes are high and periodic health check up to identify the comorbid conditions at the early stage and adequate treatment are necessary for better quality of life.

In the developed and industrialized countries, the last century has witnessed a rapid increase in the population of the elderly people. In terms of absolute size of elderly population India ranks 2nd. The country is not adequately equipped to look after their special health needs and the changing traditional value system. (Col and Col, 2015) findings of the study disclosed that 45% of the inmates were in the age group of 70-79 years. Most of the elderly widow females and males preferring to live in old age homes with 53% of elderly being financially supported by family members and 25% having spent more than 3 years in the old age homes. The most common morbidities found were vision problems affecting 83.3%, anemia 48.7%, hypertension 43.3% and diabetes in 40.7% of the elderly. Col and Col, (2015) also found a
significant association between hypertension and diabetes with age, diet and exercise. Significant association was found between anaemia and age of the inmates. A significant association was also observed between hypertension and diabetes mellitus. Elderly to curtail the prevalence of non-communicable diseases and improve the quality of life of an elderly health care service are required. In accordance with the common existing problems in old age homes needs strengthening of geriatric health care services.

The perception of health status by marital status of the community elderly showed that good health status was indicated more by the single/never married (46%) closely followed by the married elderly (40%) and it was the least among the widowed (25%). A similar assessment of their health status was reported by the residents of the old age homes from different marital status groups who perceived a ‘good’ health status (Reji & Sarvjeet, 2013). The residents of the old age homes showed a different trend as 98 per cent responses were for poor health particularly loneliness (90%) in all the females, especially among the males poor housing (82%), insufficient money/ finances and lack of companionship (80% each). The data clearly indicated that, familial problems such as housing and children were not given as much priority as personal factors, namely, poor health and loneliness among the institutionalized (Sivaraju, 2011). A cross-sectional study by Nandi et al. (1997) compared the psychiatric morbidity of elderly people in two set ups i.e. community and old age homes. It is an established fact that, older the age, low education levels and past history of psychiatric illness are the predictors of cognitive disorders among elderly (Nandi, Banerjee, Nandi & Nandi, 1997; Cooper & Holmes, 1998).

Elderly having mild cognitive impairment will have to be screened for depressive symptoms and treated accordingly. Medical morbidity in old age homes show that all the inmates suffering from one or multiple medical morbidities, none of them reported themselves healthy (100%). Multiple health problems were more among old-old groups is compared to young-old (66.67%) and had multiple morbidities in oldest old group. Multiple morbidities were more common among females (40%) than males (25%). This is in line with study done in Lucknow, which stated that all the inmates suffered from single or multiple physical problems and majority of them having multiple physical problems (males=60%, females=68%)
Among inmates who hail from urban background (53.54%), multiple morbidity was more common may be because (Rao et al., 2014), urban people suffer from lifestyle problems more often than rural. This is in contrast with study by Joshi and Avasthi (2003) which state that in rural older adults multiple morbidity was more common. Most common health problems among inmates of old age home was hypertension (25%), diabetes (20%) and arthritis (15%) and others (40%). The most common morbidity pattern was higher among females than males. Similar findings were observed in the study done on morbidity profiles of elderly in old age homes in Chennai which showed hypertension (39.5%), diabetes (20.5%), hearing problems (17%) (Rani, Palani & Sathiyasekaran, 2012).

Vaishali, Srinivas, Satheesh, Nagesh and Shankarappa, (2012) determined the frequency of psychiatric and physical morbidity and also to look into the association between psycho- social factors, morbidity and disability among residents of old age homes. The average prevalence of psychiatric disorders was found to be 58.2% depressive disorders, 30 % dysthymia, 8.2 % psychotic disorders, 2.7% GAD, 0.9 % dysthymia and GAD. Among physical disorders prevalence of cardiovascular problems were found in 57.6%, ophthalmological problems in 38.7% and respiratory problems in 28.8%. Further 86.7% of residents had variable degrees of cognitive difficulties. Past physical illness was found in 24.5% of residents, 22.6% of residents had family history of psychiatric illness. Forty percent of residents had moderate to good social support. 37.3% of residents had moderate disability. Frequency of psychiatric disorders showed high degree of correlation with gender, past history of psychiatric illness and MMSE scores. Similarly, duration of stay at old age home (in years) and monthly income before entry into the residential care was highly correlated with disability. High prevalence rates of psychiatric and physical morbidity and their high degree of correlation with various physical and psychosocial factors warrant the urgent need to address psychological, psycho-social and physical needs of the elderly staying at old age homes.

India is a developing country and recent developments like industrialization and urbanization are resulting in changes in social structure of the country resulting in the changing relationships and generation gap. In turn, family bonds are shrinking day by day perceiving elderly as a burden on the family, useless, barrier in the families.
Some proportion of elderly are being neglected and are forcibly put in to old age homes or expelled from the home due to abuse by their children. Therefore, stress and stress related diseases are more in elderly. Moreover, because of advancement in science and medicine, life expectancy has increased (Ramamurti & Jamuna, 1998).

In a traditional culture like India, it is difficult to understand the reasons for staying in old age homes. An attempt has been made here to understand the major reason that forced elderly to stay in old age homes (Ramamurti & Jamuna, 1998). Findings reveal that ill health and lack of money are the two major reasons reported by the elderly for choosing to reside in old age homes. Family conflict is yet another reason cited as intention for staying in old age homes. Nearly 38 per cent of the respondents reported not having children as the reason for residing in old age home. A small proportion of both males and females also reported that they preferred to be in old age homes to have their independence, economic and health related reasons for staying in the old age homes. Inspite of a higher proportion of males reported family conflict as the reason for opting to reside in old age homes, more females reported that lack of children is the major reason for living in an old age home (Mishra, 2008). In vast majority of the cases, family conflict arises due to economic constraints.

Research work on preferences of living arrangement of elderly in the Indian context is very scanty. A few studies dealing with the living arrangement preferences of the elderly concentrates on the elderly living in households, leaving out the institutionalised elderly. Major reasons for the elderly to depend on old age homes are family conflicts, lack of money and ill health. Among the institutionalized elderly the incidence of poor health and disability is the major reason for selecting old age home as an alternative for care and also in the event of family conflict. But majority of elders preferred to live with their family. The old age homes may be the next alternative care especially for those who are poor, sick and have no family (Panigrahi & Syamala, 2012).

In most of the developing countries, including India, living arrangements of elderly was never an issue a few decades ago. In the recent decades, issues concerning household structure and support for older persons in developing countries are becoming increasingly important. The increase in the number of old age homes is a
clear indication of the changes in the care meted out to the elderly. Studies conducted in India show that the most popular living arrangement pattern is co-residence. However, in certain sections of the society living alone is also prevalent (Panigrahi, 2010). Further, a small proportion of the elderly also depend on old age homes for their stay.

Comparing to their female counterparts (33%) the male residents of the old age homes were largely single/never married (60%). Once again, the widowed female residents were higher in proportion (48%) than the male residents (13%). One of the few reasons behind joining senior care home clearly emerged by the marital status of the elderly as the data showed that it was mostly those who had not married. Planning residential care is more required for women than men who are likely to precede their wives in death and are more likely to seek care (Siva Raju, 2011).

Mental health in old age is affected by multiple factors viz., female sex, low education or illiteracy, being widow/ widower/ divorcee, medical comorbidities, poor socio-economic status and disability (Sood, Singh & Gargi, 2006; Nandi, Banerjee & Mukherjee, et al., 1997; Bogner, Cary & Bruce, et al., 2005). Elder people living conditions depend upon their co-residence with children and/or their ability to work and earn an income beyond the officially designated age of retirement. As the majority of elderly in India are illiterate (Irudaya Rajan, 2006), more and more elders are compelled to stay in old age homes. Due to increased physical and economic dependence, there is some preliminary evidence that life in old age homes is perceived by inmates as more supportive. Elderly people living in old age homes are mentally better and experience less cognitive impairment (Rothera, Jones, Harwood, Avery & Waite, 2003; Tiple, Sharma & Srivastava, 2006).

The elderly held an enviable place in family and society when life was simpler and values were more valuable since elderly had to move to old age homes as their final haven changes in the structure and functions of family, many elderly lost their space in family. Ageing is an significant socio-psychological problem in taking care of the elderly in almost every family that involved strains and stresses. Longevity attendant issues of disease, disability and psycho - physical deteriorations have increased longevity. The changes in the structure and functions of family and changes
in social values resulted in decline in status of elderly in the family and old age homes are gaining attention in the recent years (Vanitha, 2014).

Jaiprakash (1999) conducted a study among the elderly, aged 60 years and above in Mangalore. It was a comparative study of quality of life of elderly institutionalized with those who are living in families, using a semi-structured interview schedule. Study found that reasons for institutionalization were lack of family support, dissatisfaction with children, absence of children, death of spouse and ill health. The study also found that the homebound elderly were more active, more satisfied and had more social contacts and hence they were in a more privileged (better adjusted) position than the elderly in old age homes.

There has been a change in socio familial context over a period of time in India. The elderly are being displaced to the old age homes from a joint family. There is a need to assess the psychiatric morbidity in socio-familial context to frame policies for future. Statistically significant psychiatric morbidity differences were found between the two groups in socio demographic factors like age, educational status, socio economic status, marital status, having no male children and having employed children. Anxiety, moderate depression, obsession and alcohol use were found to be higher in the community group where as mild depression; cognitive impairment and somatic dysfunction were found to be higher in old age homes, but statistically not significant, except for alcohol use. Elderly people in community and old age homes differed in socio demographic factors but not much in psychiatric morbidity. The elderly inmates of old age homes and the elderly people living in the community differed much in socio-demographic profile but there is no such difference with regard to psychiatric morbidity in the elderly. There are very few studies examined the psychiatric morbidity, psychopathology of the elderly living in old age homes compared with community dwelling elderly. The future studies should aim at studying this special population. As there is a rise in the number of old age homes to cater to the needs of the elderly (Anitha, Nageswar, Gowridevi & Bhagaraju, 2014).

The prevalence of mental disorder in people over age 64 in the UK is about 20-25% and dementia accounts for about 20-25% of that morbidity (Copeland, Dewey, Wood, Searle, Davidson, & McWilliiam, 1987). In the UK, mental health
problems are present in 40% of older people attending their General Practitioner (GP), 50% in general hospitals and at least 60% in care homes, (Health Care Commission, UK, 2009). A report from the Kings Fund (Mc Crone, Dhanasiri, Knapp & Smith, 2008) shows that by 2026 the only increase in the number of people with any form of impaired independent function, more than cognitive function, predicts need for long term care. For older people with cognitive impairment alone reside in care homes, those with impaired activities of daily living alone (25%) and those with both (85%) (Wanless, Forder & Fernandez 2006). It has been estimated that with successful transfer to community care and more specialized homes for people with dementia, the number of care homes for people with dementia will still need to rise by 20% by 2023 (MacDonald & Cooper, 2007). This takes no account of any reduction in informal care. As it stands, the capability of care homes to meet need and provide quality care is very limited (Alzheimer’s Society International, 2008).

Delivering older people’s mental health services to care homes improves quality of life, reduced prescribing of antipsychotic drugs, use of General Practitioner (GP) time and days spent in hospital (Ballard, Powell, James, Reichelt, Myint, Potkins et al., 2002; Fossey, Ballard, Juszczak, James, Alder, Jacoby et al., 2006). There is serious concern about excessive prescribing of antipsychotic drugs to people with dementia and it is estimated that reducing prescribing to clinically indicated levels may save £14 million per year (All-Party Parliamentary Group on dementia, UK, 2008). There is a need to recognize and understand the differences of mental health problems in older people, particularly, those in primary care, general hospitals, care homes and social care (Royal College of Psychiatrists, 2005, 2008; Alzheimer’s Society International, 2008). The separation of health and social care, physical and mental health care is a barrier to provide adequate services to older adults. Integration of services is most liaison function of older people’s mental health services and will be crucial and most important (Royal College of Psychiatrists, 2008).

Psychiatric morbidity and cognitive impairment in senior care homes was second highest (45%) (Tiwari, Pandey & Singh, 2012). Prevalence of dementia was 9.52% in old age homes (Tiple, Sharma & Srivastava, 2006). In other Indian studies prevalence of dementia has been reported as 0.1% in West Bengal, 4.9% in Kerala, 0.8% in Vellore (Nandi, et al., 2000; Jacob, Kumar, Gayathri, Abraham & Prince,
Recent studies suggested that over half of older adults in senior care homes have some degree of dementia (Matthews & Dening, 2002). Prevalence of cognitive impairment increased with age from 7.13% in young old age group to 25% in old age group to 100% in oldest-old age group. It is well known that prevalence of dementia every five years increases two times (Henderson, 1994). Cognitive impairment was found to be significantly related with lack of education and primary school education (SebyChaudhary & Chakraburthy, 2011).

Age is an important determinant of mental illness. Due to the normal ageing of the brain, deteriorating physical health and cerebral pathology, the overall prevalence of mental and behavioural disorders tends to increase with age (Ingle & Nath, 2008). Other important contributing factors, viz., lack of family support, restricted personal autonomy and psychiatric morbidity among elderly people are frequent, severe and diverse. In the segment of the population disorders such as depression, anxiety, cognitive and psychotic disorders have a high prevalence (Dening & Bains, 2004). Global trends in the incidence and prevalence of geropsychiatric disorders are reflected in India (Dube, 1970; Ramachandran, Menon & Ramamurthy, 1979). Nandi and co-workers in 1976 reported that 33.3% had mental health problems and Tiwari (2000) found it to be much higher in the geriatric group (43.32%, compared to 4.66% in the non-geriatric group) (Dube, 1970). Tiwari and Srivastava (1998) reported that depression, adjustment disorders, anxiety disorders, dementia and delirium (cognitive disorders), psychoses, bipolar disorders and substance-related psychiatric illnesses are most common psychiatric morbidities in the Indian set up.

**Behavioural Problems and Ageing**

Verbally disruptive behaviors (VDB) are common among elderly persons suffering from Alzheimer's disease (Rosin, 1977; Maletta, 1988), although estimates of the prevalence of these behaviors vary. Prevalence rates for noisiness or disruptive verbal behaviors range between 10% and 30% in institutional settings (ZimmerWatson & Treat 1984; Ray et al., 1992). The variations in prevalence rates probably stem from lack of a consistent definition for the operationalization of verbally disruptive behaviors (VDB) (Sood, Singh & Gargi, 2006).
In the geriatric nursing home the manifestation of VDB is one of the most disruptive problems. VDBs are an outcome of sensory deprivation and social isolation in the elderly. Demented persons in the nursing home suffer from sensory deprivation stemming from their inability to interact with their environment because of dementia, lack of actual sensory stimulation in the sterile environment of the nursing home, and decreased physical ability to process sensory stimulation due to age and disease, which may evoke underlying emotions of fear, loneliness, boredom and social isolation in nursing homes residents which result in manifesting VDB. Several studies showed that sensory stimulation has decreased behavioral disturbances in general and vocally disruptive behaviors in particular to nursing home residents (Zachow & Helen 1984; Birchmore & Clague, 1983; Mayers & Griffin, 1990.)

A verbally disruptive behaviors (VDB) is an operant, reinforced by attention from staff and other residents. Any attention is a potent reinforcer within the social vacuum of nursing home. Dementia negatively affect quality of life, quality of care and resource efficiency of older adults (Garrard et al., 1991; Jenck & and Clauser, 1991; Sloane et al., 1991; Jackson et al., 1989; Tinetti, Speeclees,Ginter et al., 1991). Disruptive behaviors are framed as "behavior resulting in negative consequences for the resident caregiver or other residents" (Rossby, Beck & Heacock 1992).

Elderly people in long-term care settings represent a growing population of individuals in need of effective behavioral supports in the United States. According to the population reports, the elderly individuals will double from 35 million to 70 million in the next 30 years. Approximately 1.6 million (5%) of those older adults live in long-term care facilities (Aiken & Charles, 2001). Most common precipitating factor for institutionalization is problem behaviors (O' Donnell, Drachman, Barnes, Peterson, Swearer & Lew, 1992; MobergPlaud & Ferraro, 1998). Problem behaviors such as physical aggression, wandering, and repetitive vocalizations are exhibited by nursing home residents (Allen-Burge, Stevens & Burgio 1999; Meeks, 1996).

Only three studies have experimentally examined the functional determinants of these problem behaviors and intervened with function-based treatments. In spite of common occurrence of problem behavior in nursing homes (Buchanan & Fisher, 2002), it was demonstrated that disruptive vocalizations of elderly individuals were
sensitive to attention, reductions in disruptive vocalizations, non-contingent reinforcement interventions with a secondary function of sensory stimulation for participant. Baker, Hanley and Mathew, (2006) demonstrated that the aggression of an elder with dementia was maintained by escape from tasks such as toileting and that noncontingent escape effectively reduced aggression.

The prevalence of disruptive behaviour displayed by older people in community and residential respite care settings. The specific objectives were to obtain an estimate of the frequency of disruptive behaviour displayed by older people in the community setting before residential respite care; characterize older people being admitted for residential respite care; and obtain an estimate of the frequency of disruptive behaviour displayed by older people in residential respite care in the community and in the residential aged care facilities. A quantitative approach using a cross-sectional survey was employed older people were being admitted from their homes for booked respite care at residential aged care facilities (Neville & Byrne, 2007).

Both in the community and in institutional settings, disruptive behaviour is common (Burgio 1999; Cohen, & Werner 1998; Baumgarten et al., 1990). As DB has been identified as a strong predictor of burden, it is a critical issue for home caregivers and nurses working with older people including specialist psychogeriatric nurses because (Clinton & Moyle 1995; Coen et al., 1997), disruptive behaviour is a common for referral to specialist mental health services for older people (Turner & Turner 2005) and is frequently associated with admission for permanent placement to a residential aged care facility (Coen et al., 1997). One option for support is residential respite care, where the older person is provided with alternative, short-term respite care (Australian Institute of Health and Welfare, 2006). Although these behaviours were not necessarily displayed all the time, it was found that 28 subjects (80%) showed one or more DBDS behaviours.

Psychological stressors, negligible family support, lack of medical (physical/mental) care and facilities, restricted environment of old age homes and financial constraints, etc would be significant among elderly (Tiwari, Pandey & Singh, 2012). The implications of these findings are significant from interventional
points. There is a need to screen out various stressor and reasons responsible for developing psychiatric problems in inmates of old age homes. Physical illness and cognitive impairment is the result of growing global population of elderly. The prevalence of cognitive impairment and pattern of physical morbidity and association between cognitive impairment and physical morbidity among inmates of old age home was found to be 38%. Cognitive impairment was correlated with age, female sex, low socioeconomic status, less education, nuclear family, widow and unmarried status. Cognitive impairment was correlated more with geriatric depression less with medical morbidities like diabetes and hypertension. Among oldest-old age group, female gender, urban domicile, medical morbidities were more common. It can be concluded that geriatric clinics can improve the health and mental status of the elderly population by screening to detect the morbidities early and creating the awareness in them (Sireesha & Sivakumar, 2014). In India, there has been a change in sociofamilial context over a period of time. The elderly are being displaced from a joint family set up to the old age home set up. There is a need to assess the psychiatric morbidity in these settings to frame policies for future (Anitha et al, 2014).

Older adults who were identified as being psychologically distressed were significantly and more likely to report having physically abused older people in their care. In residential care homes a number of factors were identified as being significantly related to the reported psychological abuse of residents receiving care. These included: principally working night duty, working with older people for between 11 to 20 years, reporting low levels of job satisfaction and high levels of burnout. Staff who found aspects of their work with residents as stressful were also proportionally more likely to report that they had committed acts of psychological abuse. The frequency with which facility-related stressful events occurred in the residential care setting and the extent to which staff found these events stressful was also associated with reported psychological abuse of older people. The strongest predictors of the physical abuse of older people included staff working in smaller sized residential care homes, staff reporting working with older people as stressful, and staff intention to leave the nursing home in which they were currently employed. Poorer physical health and psychological health, high levels of burnout and night duty...
were identified as the strongest predictors of psychological abuse (Drennan, Lafferty, Treacy, Fealy, Phelan, Lyons & Hall, 2012).

At policy and legislative level in Ireland to protect older people in the residential care sector from neglect and abuse a broad and comprehensive approach has been taken. The establishment of HIQA and the Proactive role taken by the HSE have provided a framework to reduce incidents of abuse as well as monitoring the standards of care provided to older people in residential care settings. However, as reported by staff who responded to this survey, a minority of older people in residential care in Ireland do experience neglect and physical, psychological, financial and sexual abuse. The impact of this neglect and abuse on older people can be detrimental and harmful to the older person’s physical and psychological health and well-being and greatly reduces their quality of life.

The vast majority of older people in receipt of care in the residential sector in Western context are cared for in high quality, safe and supportive settings. However, there is an international evidence to suggest that a significant minority of older people in residential homes are nursed in inadequate physical environments and experience a loss of personal freedom. In addition, many older people in receipt of residential care have enhanced physical and cognitive disabilities and reduced social networks. These issues, in conjunction with staffing factors, may lead to the possibility of older people in residential settings being neglected or physically, psychologically, financially or sexually abused (Pillemer & Moore, 1989; Hawes, 2003; Goergen, 2004).

O’Brien, Begley, Anand, Killick, Taylor, Doyle, McCarthy, McCrossan, and Moran (2011) explored older people’s understanding of the term elder abuse due to the expectation that there is a duty upon nursing home staff to provide care. Abuse or neglect in residential settings was perceived as being ‘worse or less understandable’ than neglect in other settings. Older people also expressed anxiety at the thoughts of having to go into a nursing home due to the fear that they would have to depend on others for their care. One participant in O’Brien et al., (2011) study expressed the view that abuse was more likely to occur in the private nursing home sector as they are ‘saving on staff’.
The study on Older People's Experience of Abuse and Mistreatment (Lafferty, Treacy, Fealy, Drennan & Lyons, 2012) reported on older people's experience of neglect and abuse 'involving someone with whom they had a relationship of trust' in Ireland. Effects included poor or deteriorating physical health, sleep disturbance, feelings of loneliness and isolation, distress and anxiety, as well as increased financial pressures and strained family relations. The experience of being abused had a detrimental effect on the physical, emotional and social well-being of the participants. A number of older people reported that they were threatened with being placed in a nursing home or psychiatric institution; elder people spoke about the difficulties in reporting the abuse. Although none of the respondents resided in a residential setting.

Old age is the age when a human being feels more in need of someone to interact with and someone to share their feelings with. Government should concern about their (old people) health and application of many helpful programmes (Nath, 2012). The problem of elder abuse cannot be solved if the essential needs of older people-for food, shelter, security and access to health care-are not met. The nations of the world must create an environment in which ageing is accepted as a natural part of the life cycle, where older people are given the right to live in dignity-free of abuse and exploitation-and are given opportunities to participate fully in educational, where anti-ageing attitudes are discouraged, cultural and economic activities (McDonald & Sharma, 2011).

With an increasing population ageing and by the changing context of the world, elderly has been pushed into a state of loneliness, helplessness, frustration and meaninglessness leading them to various psychosocial problems. Rakesh, Babita, Beulah and Varidmala (2013) compared the psychosocial problems and determine its relationship with the selected demographic variables of the elderly living in institutional and community dwelling elderly in Kathmandu, Nepal. The psychosocial problems were greater in institutionalized elderly and there was a significant difference between psychosocial problems of the elderly living in institutional and community dwelling elderly. The psychosocial problems had dependency on type of family, interpersonal relations, and gender in institutionalized elderly and with educational status, marital status, monthly income, interpersonal relations, and gender in home living elderly. The institutionalized elderly are facing more psychosocial
problems. The study shows the need of encouragement towards joint family norms. As elderly were not able to cope with problems in an effective manner as the elderly in home settings and institutionalized elderly were facing more psychosocial problems from the family members.

Recent studies suggest that over half of the residents of old age homes have some degree of dementia (Matthews & Dening 2002; Macdonald & Carpenter, Box, Roberts, & sahu, 2002). Dementias in those were not diagnosed with cognitive decline, using diagnostic manuals. Many studies have used MMSE alone for assessment of cognitive impairment (Yaffe, Fiocco, Lindquist et al., 2009; Fratiglioni, Jorm, Grut, et al., 1993). In a prospective study, over eight years, it was identified using MMSE that 53% of the elderly suffered minor cognitive decline and 16% major cognitive decline (Yaffe, Fiocco, Lindquist et al., 2009). Though Mathews & Denig (2006) is a cross-sectional study, the rate of cognitive impairment detected is low comparable to other studies.

Elderly people (between 60 to 70 yrs. both male and female) from Maharashtra state of India were given Shamshad Hussain and Jasbir Kaur’s Old Age Adjustment Inventory & Dr. Pramod Kumar’s Mental Health Checklist. There is a slight difference in health, home, social, marital, emotional and financial adjustment of elderly persons living in their own homes and living in old age homes. The old age persons living in their own homes are connected to their family and those who are living in old age homes are alienated from their family (Vani Bhushanam, & Sreedevi Janaki, 2013).

Recent census revealed that, population of senior citizens in India has been increased over last 3 decades due to medical advancement, economic development, upliftment of standard of living, improvement in health and nutritional status and prevention of diseases with increase in life expectancy of the person. Current research studies on senior citizens highlighted that distress, behavioral and health problems increased among aged people.

The burden of illness from distress, psychiatric and behavioral disorders is enormous. The psychological disorders account for increase in disability and functioning of productive population. It has been projected that neuropsychiatric
disorders may increase disability up to 15 per cent by the year 2020 (Agarwal & Jhingan, 2002). Research in psychological disorder pointed out that early treatment is essential for better recovery. Though, treatments for depressed and distressed disorder are available yet, there are millions of aged affected by depression and suffering from disability due to undetected condition and inadequate treatment as well as due to limited services for mental health distress is a state of unpleasant condition of the body physical, psychological and or emotional distress. Level of distress experienced by the elderly living with family and in geriatric institutions (old age homes) varies (Ganguli, 2005).

A number of earlier studies have reported that older persons staying with families have better adjustment than those staying in old age homes and the latter group has less favorable attitudes towards others, themselves, and has poor physical and mental health (Mathew, 1993; Poorkaj, 1972). Pinto and Prakash (1991) found that home based elderly are more active, more satisfied, and hence more privileged than their counterparts dwelling in old age homes (Chandrika & Anantharaman, 1982) have pointed out that the main reason for poor adjustment of institutionalized elderly is that they are constantly surrounded by other elderly who experience dejection and loneliness in their life. Findings reveal that there are significant differences between the two groups in most of the spiritualistic dimensions except in Psi and total spiritualism. Of these, the persons residing in own homes have higher scores (high spiritualistic orientation) in the dimensions of God and mysticism, while those residing in old age homes have higher spiritualistic orientations in the dimensions of religion, spirits, and character. This indicates that the aged persons residing in old age homes have strong belief in the value of religions and religious practices and beliefs. They also have greater belief in the existence of spirits and survival of the human personality of bodily death. Moreover, the old age home dwellers have greater belief in the direct personal value to the individual of altruism, unselfishness, celibacy, kindness, morality, and the like. The life experiences and the style of life in old age homes may be the reasons for their greater spiritualistic orientation in these dimensions (Joseph & Jayanthy, 2013).

Nearly all the respondents from the community (91%) and the old age homes (88%) prayed regularly and the male respondents were less in proportion than their
female counterparts. While the community elderly largely stated that it would be God's will when they come face with death (49%) with little sex-wise variation, majority of the residents of the old age homes (51%), particularly the male residents, wished that death should come before they became mentally and physically helpless (Archana Rai, 2012).

Sum Up

The review of some relevant studies pertaining to the variables being included in the present investigation were reported in the foregoing pages. According to the objectives of the investigation, relevant studies on psychological problems viz., depression, anxiety, somatic distress, psychological morbidities and anxieties in residents of free and pay senior care homes across various socio-demographic sub groups were reviewed.

Studies on psychological problems and anxieties indicate that adjustment and well-being of the aged persons are related to various factors like institutionalization, health, participation in religious activities, economic dependence, presence of adult children and loneliness. The results of various studies highlighted that the aged persons residing in old age homes are confronted with more negative experiences in their life and lag behind in adjustment and well-being. Studies on depression and anxieties indicate that depression in older adults is a major mental health concern. Studies show that depression and death anxiety increases as age advances in the elderly.

Many studies view that economic dependence is known to play a significant role in psychiatric illness among elderly. Depression in old age is often related with other co-morbid conditions, such as frailty, dementia and anxiety that aggravate the distress experienced by older adults. Also significant gender differences was found in depression among institutionalized and non institutionalized elderly. Findings show that depression was more in residents of old age homes. Some researches indicated that higher levels of loneliness were associated with more health problems and depressive symptoms in older adults. Also the prevalence of symptoms of depression was found to be higher in single and widowed elders than in married. Institutionalized elderly people usually have low levels of support from society and family and a high
prevalence of other co-morbidities, which may aggravate the depressive symptoms pre-existing at the time of institutionalization. Further female sex, medical comorbidity, poor social-economic status, widowed state, disability have been identified as strong predictors of geriatric depression. The institutionalized elders are having significant death anxiety, geriatric depression and suicidal ideation than non-institutionalized elders.

Studies disclosed that institutionalized elderly have more stress and poor quality of life compared to community dwelling elderly. The institutionalized elders are having significant levels of depression and suicidal ideation than non-institutionalized elders. Similarly elders those who were alone reported significant levels of depression and suicidal ideation than coupled elders. A higher risk of morbidity and mortality, increased use of health care services, negligence of self-care, non-adherence to therapeutic regimens and increased risk of suicide are frequently associated with depression.

The elderly in India face a multitude of psychological, social, and physical health problems. As age advances there is an increased morbidity and functional loss. Stressful life events were found to be correlated to psychiatric and physical morbidities. Nuclear family seems to be one of the risk factors for depression. Some view that the severe level of depression was significantly related to loneliness and poor satisfaction with life suggesting that the social functions of day centres is not meeting the expectations.

Some studies reported low prevalence of anxiety disorders in older individuals. It is stated that anxiety disorders occur two to seven times more often among elderly, than depression. The rate of anxiety disorders at institutional settings may be even higher among elderly. In many countries, mixed anxiety and depression is more prevalent than anxiety. Therefore, the consequences of ageing on older adults in general and on their caregivers and its implications for society need to be considered. The institutionalized elderly males found to have relatively lower level of death anxiety than non-institutionalized elderly males, but the institutionalized elderly males and females are not differed in death anxiety. However, some studies reported effect of gender and age of older adults on death anxiety.
Mental health in old age is affected by multiple factors viz., female sex, low education or illiteracy, being a widow/widower/divorced, medical comorbidities, poor socio-economic status and disability. Studies found that reasons for institutionalization were lack of family support, dissatisfaction with children, absence of children, death of spouse and ill health. The psychosocial problems were greater in institutionalized elderly and there was a significant difference between elderly living in institutional and community dwelling elderly.

Some studies on life satisfaction found that female elderly experienced lower death anxiety, and death anxiety levels would not differ between young adults and older adults. Study found that variations in death anxiety among institutionalized and non-institutionalized older widows and widowers. Psychologists have studied the factors viz., age, environment, religious faith and ego integrity, or a personal sense of fulfillment and/or self-worth were crucial in understanding death anxiety. Worries about health are correlated with age but with most exceptional differences in contents of worry. The most exceptional differences in contents of worry as a function of severity of anxiety take place in the domains of worries about health and personal worries. Elderly people with high levels of worry experience more anxiety and perceive less control over their worrying. Daily well-being and quality of life are strongly affected by potential of a specific worry. Furthermore, elderly people with high levels of worry experience more anxiety and perceive less control over their worrying. There were no differences in the temporal orientation of worry.

Review of studies on physical distress and psychological morbidities among residents of senior care homes reveal that ageing is a multi-dimensional process involving physical, psychological and social changes. The influence of risk factors and personal resources on their perceived psychological distress suggest that current morbidity and dearth of personal resources are the main sources of somatic distress. Psychological distress significantly related to sense of coherence, education and subjective health complaints. There is a considerable evidence suggesting that high prevalence rates of psychiatric and physical morbidity and their high degree of correlation with various physical and psychosocial factors warrant the urgent need to address psychological, psycho-social and physical needs of the elderly staying at old age homes.
Recent developments like industrialization and urbanization in the Indian context are resulting in the changing intergenerational relationships and generation gap. In turn, family bonds are shrinking day by day perceiving elderly as a burden on the family and as barriers in the families. Some proportion of elderly are being neglected and are forcibly put in to old age homes or expelled from the home due to abuse by their children. Therefore, stress and stress related diseases are more in elderly.

Studies on socio demographic variables highlighted that many studies reported that ill health and lack of money are the two major reasons reported by the elderly for choosing to reside in old age homes. Family conflict is yet another reason cited as intention for staying in old age homes. Inspite of a higher proportion of males reported family conflict as the reason for opting to reside in old age homes, more number of females reported that lack of children is the major reason for living in an old age home. In vast majority of the cases, family conflict arises due to economic constraints. Among the institutionalized elderly the incidence of poor health and disability is the major reason for selecting old age home as an alternative care facility. Studies conducted in India show that the most popular living arrangement pattern is co-residence. However, in certain sections of the society living alone is also prevalent.

Studies on psychological abuse on elderly disclosed that in senior care homes, a number of factors were identified as being significantly related to the psychological abuse of residents receiving care. Abuse was more likely to occur in the private care home sector as they are ‘saving on staff’. The nations of the world must create an environment in which ageing is accepted as a natural part of the life cycle, where older people are given the right to live in dignity and free of abuse exploitation.

The review of studies under various sub-heads provides a comprehensive picture about certain variables included in the present study. There are very few studies on Indian elderly especially on residents of free and pay & stay senior care homes by considering somatic distress, depression, behavioural problems and anxiety. Hence to fill the gap, the present study has been contemplated to investigate the psychological problems and anxieties among residents of free and pay & stay senior care homes.