



Psychological Problems in Geriatric-Age Group in Rural Area

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

Article Information

DOI: 10.9734/JPRI/2021/v33i60B35091

Open Peer Review History:

This journal follows the Advanced Open Peer Review policy. Identity of the Reviewers, Editor(s) and additional Reviewers, peer review comments, different versions of the manuscript, comments of the editors, etc are available here: <https://www.sdiarticle5.com/review-history/71150>

Original Research Article

Received 20 October 2021
Accepted 27 December 2021
Published 28 December 2021

ABSTRACT

Background: The study focuses on the factors that affect psychological health, medical ailments, nutrition, family support to the elderly of the rural area in the Wardha district of Maharashtra and also the solutions of the same.

Aim: To assess psychological problems in the geriatric age group in rural area.

Objectives: To find out the occurrence of health problems, common psychological and physical stressors faced, and the percentage of old age people residing with family who feel neglected in rural areas.

Methodology: Cross sectional study with simple random sampling of 200 elderly above 60yrs of age residing in rural area of Wardha district from February 1, 2020 to March 1, 2020 with a preformed questionnaire.

Results: amongst the study sample, it was found that tobacco chewing (50%), anaemia (40%) and hypertension (46%) were found to be major physical stressors. While poor concentration (40%), sleep disturbances (50%) and family neglect (71%), increased health expenditure (82%), limitation in physical activity (48%), decrease in social life (68%) were common psychological stressors affecting the life of geriatric population.

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Conclusion: Based on the results of the above study, there is an crucial need for the government to make action plans regarding old age pensions, proper nutrition and essential health facilities and sustaining the moral values which can make the younger generations feel more responsible towards the geriatric age group.

Keywords: Old age; psychological problems; geriatric age; elderly.

1. INTRODUCTION

Each and every living being taking birth in the world has an end; may it be animals, plants, or the most evolved animals on the earth: human beings. Starting from a simple two celled zygote in the womb to a complex structured form, human life undergoes various phases in life- from taking birth, infancy, childhood, teenage, adulthood, old age to terminate into death finally. Aging is an inevitable event for all human beings irrespective of gender, caste, creed, race, or habitat [1].

India is a democratic country with significantly rich cultural & social values. Being in its developing stage, it has a large no. of geriatric population. According to the estimations stated by UNESCO, 12.3% of the world's total geriatric population would be in India itself, around the year 2025. The number of the female geriatric population exceeds the male geriatric population [2]. This transposition in the demographic configurations in developing countries like India has made the senior population discernible [3].

Looking at the rapid growth of psychological problems in elderly, it is estimated to rise fourfold by the year 2030 compared to last three decades [4]. Correspondingly, moderate and extreme impairments are repeatedly observed in the black and institutionalized elders with minimal education [5]. These numbers show that government needs to set new goals regarding the challenges and issues that old age population in India faces and to build more better and healthy society.

The generation gap, increasing nuclear family structure, not so good attitude towards the aged, rapidly changing thought processes, profound influence of the western culture has made the geriatric population socially, mentally and physically unhealthy somewhere.

It leads to decline in the quality of life, which commonly includes loss of pleasure in life, loss of interest in oneself and others, low self-esteem, ideas of hopelessness and worthlessness, self-

blame, feelings of excessive or inappropriate guilt.

Studies on well-being advancing in old age revolve around the concept of healthy ageing [6,7] His concept was formerly based on factual indicators like lack of physical disabilities, cognitive impairment, and social curtailment [8]; lately it was widened to inculcate positive psychological indicators like, a complicated construct incorporating emotional balance, rational decision-making, wisdom based on life knowledge, benevolence [9,10]. Despite the enormous socio-physical changes taking place with senescence, the subjective outlook towards these transformations have a crucial part in anticipating physical health, well-being in old age [11-14].

Psychological disturbances in elderly population differ from those at younger ages. The presenting symptoms initiate with increase in somatic complaints like joint pain, indigestion, backache etc. and are more similar seen to the phrase "smiling depression" which means no as such signs of sadness or depression seen on the face. The ingenious ability to mask the sadness, aloofness and anxiety in the older population is quite disturbing and dangerous as well as it may left undiagnosed and untreated. This difference is seen due to dissimilarities in the etiology of the both types. The depressive behaviour found in the elderly population is biological meaning to the individual genetic makeup, brain structure and neuronal functioning efficacy and its methodology of processing in majority but psychosocial factors also play an equal crucial role; the most important reason still being the deficiency of the neurotransmitters at the synapses. Dementia related diseases like Alzheimer disease and Parkinson disease can cause depression due to this cause. Heredity and aging further enhance the risk.

There is also remarkable relationship between metabolic syndromes like Diabetes, Hypertension, Stroke, Paralysis and the psychological problems which can be called as vascular depression and acts as a complicating

factor for old age depression. Moreover, there can also be the symptomatic overlap of depression, psychosis, dementia, movement disorders and medical conditions and the drugs.

The type of personality according to the psychiatric classification also decides the thought process and ability to tackle the stress related issues and the type of coping mechanism used for it. There is also a great variation in the way of treatment in old age patients from the relatively younger ones. The diagnosis is done based on the DSM-5 criteria and treatment and always started slow and at the lower doses (gradual increasing) but trying to come to the standard therapeutic dose according to the patient's ability to absorb, breakdown and excrete the medication.

At least one in five persons above the age of 65 suffers from a mental illness [15] The generation gap, increasing nuclear family structure, not so good attitude towards the aged people, rapidly changing thought processes, deep influence of the western culture has made the geriatric population socially, mentally and physically unhealthy somewhere. It leads to decline in quality of life, loss of pleasure in life, disinterested behaviour towards oneself and the others, lack of self-esteem, feeling of misery and negligibility, self-accusation, feelings of excessive or unseemly guilt.

The study focuses on the factors that affect psychological health, medical ailments, nutrition, family support to the elderly of the rural area in the Wardha district of Maharashtra and also the solutions of the same. So, it has become extremely important to study the psychological problems, understand them, find the ways out for them and apply them so that the population over 60 years of age can spend more healthy, happy and carefree lives as depression in late life is common; but not inevitable.

1.1 Aim: to assess psychological problems in geriatric age group in rural area.

1.2 Objectives

- To find out demographic distribution of old age person living with family in rural area.
- To find occurrence of health problems in old age person living with family in rural area.
- To find out the common stressor faced by senior citizens living with family.

- To identify various items of physical stressors of old age people residing with family.
- To identify various items of psychosocial stressors of old age people residing with family.
- To find out the percentage of old age people residing with family who feel neglected.

2. MATERIALS AND METHODS

2.1 Study Setting

Old age people residing in rural area of Wardha district.

2.2 Study Participants

Old age people above 60 years of age living in rural area of Wardha District.

2.3 Sample Size Selection

Sample size studied was 200 subjects from rural areas of Wardha districts

2.4 Study Design

Old age people living with family of rural area of Wardha district by Simple Random Sampling.

2.5 Duration of Study

February 1,2020 to March 1, 2020 (1 month).

2.6 Study Variables

Sex, age, marital status, religion, education, occupation income, health problems, physical stressors, psychosocial stressors and general questions.

2.7 Data Collection (Methodology)

This cross-sectional study of old age person living with family conducted at rural area of Wardha district. Old age people residing in rural area were included in the study. Verbal consent was obtained and those who were not willing to participate were excluded. A pretested questionnaire was used. Over a period of one month all consecutive old age people living with family in rural area were interviewed until the sample size of 200 was reached.

3. OBSERVATIONS AND RESULTS

Table 1. Distribution of old age people according to Demographic characteristics

Variables	No. of old age people (%) (n=200)
Sex	
Male	130(65)
Female	70(35)
Age(Yrs)	
60-65	108(54)
66-69	20(10)
70-75	52(26)
76-80	12(6)
>80	8(4)
Marital status	
Married	160(80)
Unmarried	0(0)
Widower/Widow	40(20)
Religion	
Hindu	128(64)
Muslim	8(4)
Buddhism	16(8)
Other	48(24)
Education	
Illiterate	36(18)
Primary	32(16)
Secondary	28(14)
Higher secondary	80(40)
Graduate	24(12)
Occupation	
Unemployed	40(20)
Labourers	56(28)
Govt pensioner	20(10)
Any other	84(42)
Income	
<2000 Rs	60(30)
2000-3000 Rs	28(14)
3001-4000 Rs	0(0)
4001-5000 Rs	20(10)
> 5000 Rs	48(24)
No income	44(22)

Highest percentage(54%) of the senior citizens living with family were in the age group of 60-65 years and only 4% belongs to >80 years of age. 65% of the samples were male and only 35% were female. Highest percentage (80%) of the senior citizens living with family were married and only 20% were unmarried. Highest percentage (64%) of the senior citizens living with family were Hindus and only 4% were Muslim. Highest percentage (40%) of the senior citizens living with family were from educated up to higher secondary and only 12% were educated up to graduation.

3.1 Distribution of Samples

With regards to dietary pattern shows that majority (54%) were vegetarian and only 8%

were non vegetarian. Majority (96%) were non-smokers and only 4% were smokers. 98% of senior citizen living with family were non-alcoholic. Majority 50% of senior citizen living with family need not chew tobacco. 40% of senior citizens living with their family have pallor. 78% of senior citizens living with family need not have history of diabetes mellitus. 54% of senior citizens living with family need not have history of hypertension. 80% of senior citizen living with family need not have the history of major surgeries. 98% of senior citizen living with family need not have the history of fracture of limb. 98% of senior citizen living with family need not have the history of coronary artery diseases. 80% of senior citizen living with family need not have the history of counselling.

Physical stressors are experienced some of the times, certain time and most of the times 36(18%), psychosocial stressors are experienced some of the time 36(18%) and most of the times 64(32%) by senior citizen living with family.

Majority 72(36%) of senior citizen living with family most of the time had poor concentration, 80(40%) had poor concentration certain times, 84(42%) rarely had difficulty in chewing, 164(82%) rarely had difficulty in breathing, 56(28%) most of the times had history of joint pains.

Majority 100(50%) of senior citizen living with family most of the times had sleep disturbance, 96(48%) most of the times had limitation of physical activity, 136(68%) most of the times had decrease in social life, 76(38%) rarely had

financial dependency on family members, 120(60%) of them get respect from children and grand-children and 170(85%) rarely have family members dependent on them.

Mean physical stressor score for poor concentration was 2.92 ± 1.10 , for back pain 2.70 ± 1.12 , for difficulty in chewing 2.34 ± 1.31 , for difficulty in breathing 1.26 ± 0.59 and for joint pain 2.62 ± 1.10 .

Mean psychosocial stressor score for sleep disturbance was 3.28 ± 0.92 , for limitation of physical activity 3.22 ± 0.88 , for decrease in social life 3.44 ± 0.99 , for dependency on others 2.26 ± 1.25 , for financial dependency 2.24 ± 1.13 , for respect from children and grand children 2.01 ± 1.11 and for Dependency of any other family members on them was 1.56 ± 0.96 .

Table 2. Distribution of samples with regards to general assessment

Variables	No. of old age people (n=200)
Dietary Pattern	
Vegetarian	108(54)
Non-vegetarian	16(8)
Mixed	76(38)
Smoking	
Yes	8(4)
No	192(96)
Alcoholism	
Yes	4(2)
No	196(98)
Tobacco chewing	
Yes	100(50)
No	100(50)
Pallor	
Yes	80(40)
No	120(60)
Diabetes	
Yes	44(22)
No	156(78)
Hypertension	
Yes	92(46)
No	108(54)
H/O of major surgery	
Yes	40(20)
No	160(80)
H/O of # of limb	
Yes	8(4)
No	192(96)
H/O of CAD	
Yes	4(2)
No	196(98)
Counselling	
Yes	4(2)
No	196(98)

Table 3. Identification of common stressors faced by senior citizens living with family

SN	Stressors	Rarely	Some of the times	Certain times	Most of the times
1	Physical stressors	92(46%)	36(18%)	36(18%)	36(18%)
2	Psychosocial stressors	48(24%)	36(18%)	52(26%)	64(32%)

Table 4. Identification of various items of physical stressors of old age people residing with family

SN	Physical Stressors	Rarely	Some of the times	Certain times	Most of the times
1	Poor concentration	40(20)	8(4)	80(40)	72(36)
2	Back pain	48(24)	20(10)	76(38)	56(28)
3	Difficulty in chewing	84(42)	28(14)	24(12)	64(32)
4	Difficulty in breathing	164(82)	20(10)	16(8)	0(0)
5	Joint pain	40(20)	52(26)	52(26)	56(28)

Table 5. Identification of various items of psychosocial stressors of old age people living with family

SN	Psychosocial Stressors	Rarely	Some of the times	Certain times	Most of the times
1	Sleep disturbance	20(10%)	4(2%)	76(38%)	100(50%)
2	Limitation of physical activity	8(4%)	36(18%)	60(30%)	96(48%)
3	Decrease in social life	24(12%)	0(0%)	40(20%)	136(68%)
4	Dependency on others	88(44%)	20(10%)	44(22%)	48(24%)
5	Financial dependency	76(38%)	32(16%)	60(30%)	32(16%)
6	Respect from children and grand children	120(60%)	24(12%)	16(8%)	40(20%)
7	Dependency of any other family members on them	170(85%)	24(12%)	6(3%)	0(0%)

Table 6. Mean physical stressor score in old age people living with family

Items	Variables	Living with family	
		Mean	SD
1	Poor concentration	2.92	1.10
2	Back pain	2.70	1.12
3	Difficulty in chewing	2.34	1.31
4	Difficulty in breathing	1.26	0.59
5	Joint pain	2.62	1.10

Table 7. Mean psychosocial stressor score in old age people living with family

Items	Variables	Living with family	
		Mean	SD
1	Sleep disturbance	3.28	0.92
2	Limitation of physical activity	3.22	0.88
3	Decrease in social life	3.44	0.99
4	Dependency on others	2.26	1.25
5	Financial dependency	2.24	1.13
6	Respect from children and grand children	2.01	1.11
7	Dependency of any other family members on them	1.56	0.96

Table 8. Economic problems faced by the respondents

SN	Problems	No. of old age people	Percentage (%)
1	Increased medical expenditure	164	82%
2	Lack of freedom on spending	142	71%
3	Reduced personal income	122	61%
4	Lack of support from family	78	39%
5	Liability of children	40	20%

Table 9. Distribution of old age people according to general questions

SN	General Questions	No. of old age people	Percentage (%)
1	Spouse Alive	120	60%
2	Feeling neglected	142	71%
3	Take time for entertainment	44	22%
4	Aware of government scheme for old age	50	25%
5	Using government schemes	40	20%
6	Happy with their family	80	40%
7	Taking food regularly	160	80%

82% of elderly person living with family increased medical expenditure, at this stage followed by lack of freedom on spending 71%, reduced personal income 61%, lack of support from family 39% and liability of children 20%.

Distribution of old age people according to general assessment shows that 60% of the old age people’s spouse were alive, 71% were feeling neglected, 22% take time for entertainment, 25% of them aware of Government scheme for old age, 20% were using Government schemes, 40% were happy with their family and 80% of them were taking food regularly.

An apprehensive thing that found during the studies is how an unhealthy shift in the mind-set of the elderly people occurs as the age progresses. It was found that due to the feeling of neglect and left out from the family members, the elderly people had developed more of an attention seeking behaviour. An example observed in few of the families can be quoted as- this elderly female was always appreciated by her in laws during her young age. Now she has an extended family of 2 sons with their wives and kids respectively who apparently take their own decisions and doesn’t involve the old lady in the discussion. This attitude from her family has made her a kind of attention seeker through various acts. Some of them included- she has a tendency to fake the medical conditions and exaggerate the ill condition and incapacities for gaining medical attention. These people attend the nearby clinics almost every single day. Such elderly persons have increased danger of drug toxicity or side effects due easily available over the counter drugs especially NSAIDS owing to increased risk of even fatality for example renal failure and hepatic failure . It is an extremely difficult and challenging task for the medical professionals to differentiate such patients from the other ones. Placebo technique to some extent is considerably helpful in management for these patients. But the main issue of building healthy relations with their respective

families is exigent as well as difficult at the same time.

4. DISCUSSION

In a study which was undertaken in Dharwad amongst the urban slum, the geriatric psychological problems were notably linked to the socioeconomic status, literacy status and the civil status. In our study highest percentage(54%) of the senior citizens living with family were in the age group of 60-65 years and only 4% belongs to >80 years of age, 65% of the samples were male and only 35% were female, highest percentage(80%) of the senior citizens living with family were married and only 20% were unmarried, 64% of the senior citizens living with family were Hindus and only 4% were Muslims, 40% of the senior citizens living with family were from educated up to higher secondary and only 12% were educated up to graduation.

In our study 54% were vegetarian and only 8% were non vegetarian, 96% were non- smokers and only 4% were smokers, 98% of senior citizen living with family were non- alcoholic, 50% of senior citizen living with family need not chew tobacco, 40% of senior citizens living with their family have pallor, 78% of senior citizens living with family need not have history of diabetes mellitus, 54% of senior citizens living with family need not have history of hypertension, 80% of senior citizen living with family need not have the history of major surgeries, 98% of senior citizen living with family need not have the history of fracture of limb, 98% of senior citizen living with family need not have the history of coronary artery diseases, 80% of senior citizen living with family need not have the history of counselling.

Our study also supports the present finding which revealed that in relation to physical problems 72(36%) of senior citizen living with family most of the time had poor concentration, 80(40%) had poor concentration certain times, 84(42%) rarely had difficulty in chewing,

164(82%) rarely had difficulty in breathing, 56(28%) most of the times had history of joint pains. In relation to psychosocial problems 100(50%) of senior citizen living with family most of the times had sleep disturbance. despite certain physiological changes that affect sleep quality are held as normal with an increment in age, cognitive behavioral therapy (CBT) is used as a standard first-line treatment to minimize the sleep related issues in the elderly [16,17]. Mental disorder in elderly is associated with significant age related degenerative issues, but rates of specialized psychiatric consultation is low, even for those with comorbidities [18]. 96(48%) most of the times had limitation of physical activity, 136(68%) most of the times had decrease in social life, 76(38%) rarely had financial dependency on family members, 120(60%) of them get respect from children and grandchildren and 170(85%) rarely have family members dependent on them. Study by Ransing et. al. reflect on psychosis and depression in this region [19]. Few of the key studies on Geriatric issues were reviewed [20-23]. Articles on psychiatric problems and mental health issues in Maharashtra were reviewed [24-26].

Distribution of old age people according to general assessment shows that 60% of the old age people's spouse were alive, 71% were feeling neglected, 22% take time for entertainment, 25% of them aware of Government scheme for old age, 20% were using Government schemes, 40% were happy with their family and 80% of them were taking food regularly [27-30].

5. SUMMARY

- 54% of the senior citizens living with family were in the age group of 60-65 years.
- 65% of the samples were male.
- 80% of the senior citizens living with family were married.
- 64% of the senior citizens living with family were Hindus and only 4% were Muslim.
- 40% of the senior citizens living with family were from educated up to higher secondary.
- 54% were vegetarian and only 8% were non vegetarian.
- 96% were non-smokers and only 4% were smokers.
- 98% of senior citizen living with family were non-alcoholic.

- 50% of senior citizen living with family need not chew tobacco.
- 40% of senior citizens living with their family have pallor.
- 78% of senior citizens living with family need not have history of diabetes mellitus.
- 54% of senior citizens living with family need not have history of hypertension.
- 80% of senior citizen living with family need not have the history of major surgeries.
- 98% of senior citizen living with family need not have the history of fracture of limb.
- 98% of senior citizen living with family need not have the history of coronary artery diseases.
- 80% of senior citizen living with family need not have the history of counselling.
- 72(36%) of senior citizen living with family most of the time had poor concentration, 80(40%) had poor concentration certain times, 84(42%) rarely had difficulty in chewing.
- 100(50%) of senior citizen living with family most of the times had sleep disturbance, 96(48%) most of the times had limitation of physical activity.
- 82% of elderly person living with family increased medical expenditure, which was associated with exemption on expending 71%.
- 60% of the old age people's spouse were alive, 71% were feeling neglected, 22% take time for entertainment

6. CONCLUSION

Based on the results of the above study, there is an crucial need for the government to make action plans regarding old age pensions, proper nutrition and essential health facilities.

Along with the government schemes and services government can provide, other ways like nongovernment organisation can contribute immense support regarding the Moreover, sustaining the moral values that are passed on from generations can make the younger generations feel more responsible towards the geriatric age group.

The preventive medicine in geriatrics:

Levels of prevention:

- a. Primordial prevention- pre geriatric care

- b. Primary prevention- education and awareness regarding the health, exercise, yoga, pranayama
- c. Secondary prevention- annual/monthly medical check-up, early detection using universal or selective perspective, therapeutic measures related to the same.
- d. Tertiary prevention- A better and effective tertiary way to face the challenges is rehabilitation. It consists of psychological rehabilitation which includes counselling the aged population and their family members, increment in the number of population receiving the therapy to psychological ailments. Financial rehabilitation can be achieved by government aid, family support as discussed earlier. Social rehabilitation could be reached by same age gatherings, cultural meet-ups, non-government organizations, etc. Medical care rehabilitation can be done by organisation of regular health camps, as stated earlier. Welfare activities like "Sanjay Niradhar Yojana", institutionalisation of old age homes are also included.
- e. Improvisation of quality of life in all aspects and dimensions is supportive.

7. RECOMMENDATIONS

1. A similar study can be replicated with a control group and on a larger population.
2. A survey to assess the knowledge, belief and practices can be undertaken.
3. An alike study can be carried out in community with an illiterate group using different modes of communication.
4. A study can be undertaken to identify the subsisting knowledge and outlook of adolescent regarding prevention of HIV.
5. A study needs to be undertaken regarding the psychosocial problems in the elderly population residing in the old age homes and shelter homes to compare the impact of family support and alike people staying together at one place.
6. A major chunk of elderly population is facing dilemma of financial grievances. Majority of them do not get old age pensions and hence they consider themselves as the burden on their respective families. Government needs to categorize the elderly who or their families cannot meet their bare necessities. Such geriatric population should be offered

financial help to spend their life little smoothly.

7. Regarding the behavioural and the communication problem faced by the elderly amongst their family members, there is an urgent need to spread awareness about how the mental and physical dimensions mould in this population. It will help the families to understand the vulnerabilities more clearly and be a little sympathetic towards the old. For this, youth should be inculcated with moral values and concept of nuclear family could be substituted with joint families.
8. Routine check-up camps can be organised by the health sector monthly to follow up the health of the geriatric population. Various government schemes concerning around the lives of the elderly should be reached till the needy so that the old population of India spend better lives. Involving themselves in the leisure activities like gardening, reading meeting the similar aged people, cultural meet ups can positively impact the psychological dilemmas effectively.
9. Aging is physiological process of nature which can be slowed down but cannot be avoided. A healthy mind and body plays crucial role in this. . There are certain cognitive alterations happening with the increasing in age like decline and difficulty in holding a piece of information in mind, spatial disorientation, slowing down the pace of reasoning and problem solving ability. These issues can be better tackled by keeping oneself indulged in creative activities, using all the senses, following healthy lifestyle like daily exercise, yoga, pranayama and a good diet.
10. The concept of positive ageing in the "second innings" of life as described sportily by the people can bring a drastic bliss in the lives of the aged people. It is basically built on the foundation of adapting an optimistic attitude in life and the mind-set of self-love and embracing oneself is of utmost importance.

CONSENT

As per international standard or university standard, patients' written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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