A qualitative study on the mental health needs of elderly in Odisha, Eastern India.

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Abstract

Background: The percentage of elderly has been consistently increasing in India.According to the United Nations Department of Economic and Social Affairs, by 2050, almost 20% of India's population would be 60 years or above, doubling the current figure. Despite this, geriatric mental illnesses is hardly paid attention to. In the light of the pandemic which affects the elderly more harshly than others, it's important to understand the mental health needs specific to them. The aims of this study were to identify the unmet Mental Health(MH) needs of elderly population in Odisha.

Methods: A cross-sectional, qualitative study was undertaken in five districts of Odisha, selected purposively, ensuring representativeness, using 116 in-depth interviews and nine focus group discussions with elderly people. The interviews were transcribed and translated from Odia to English. Free listing of responses, domain identification, coding, summarization, and cross-tabulation were done. Semi-quantitative approach was used in analysis and presentation of report.

Results: Depression, anxiety, insomnia, somatization, and dementia were the commonly reported mental health problems in elderly people. Loneliness, isolation, neglect, and elder abuse were the major psychosocial issues identified. Lack of social lives and poor utilization of MH services were also observed. Caregiver burden was found to be high and the available family support services were reported to be inadequate.

Conclusions: Mental Health problems were common in elderly, but utilization of MH services was low. This study highlights the need to improve accessibility, availability, and quality of MH services and family-support services for elderly.

Keywords: Geriatric mental health, mental health services for elderly, psychiatric morbidity in elderly.

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Introduction

The prevalence of probable depression among the elderly aged 60 and above is 10 times higher than the self-reported prevalence of diagnosed depression, suggesting a higher burden of undiagnosed depression. Almost 30% of the population that is 60 years or above shows depressive symptoms and 8% of the total elderly population is likely to be diagnosed with major depression, situating India directly above the global average of 6.6%. Concerning for the population living alone, with a low level of education and among the widowed. This data is supported by several pieces of research highlighting risk factors of depression among the elderly. Evaluating the data on the basis residence, females and rural residents are far more likely to be affected by depression than their counterparts. Existing literature suggests differences may be attributed to reproductive health, lack of resources, widowhood, and the disadvantaged position of women.

Over the years, governments have implemented policies like National Policy on Older Persons, Maintenance and Welfare of Parents and Senior Citizens Act of 2007, and the National Programme for the Health Care for the Elderly, but none of them are equipped to deal with the burden of depleting mental health among the elderly [1]. Along with good infrastructure, development of inclusive and accessible community care is significant for tackling this problem.Noncommunicable diseases are extremely common in old age, affect their activities of daily living and cause disability. Elderly population is also highly prone to develop mental morbidities due to various factors such as aging of the brain, cerebral pathology, comorbid physical illnesses, and socioeconomic problems such as poor social support and reduced economic independence. Breakdown of family values and family support systems have led to social isolation, economic insecurity, physical and psychological abuse, and psychological problems. The number of Mental Health (MH) professionals in India is inadequate to meet the mental health needs of geriatric population.

Literature Review

A cross-sectional study was conducted using qualitative methods to obtain in-depth understanding about the unmet MH needs of older persons and the process of delivering MH services to them. The study was carried out in five districts of Odisha selected purposively, namely, Khorda,Ganjam, Cuttack, Jajapur and Puri. Data were collected primarily through In-Depth Interviews (IDIs) and supplemented by Focus Group Discussions (FGDs). Various categories of stakeholders including policy and program managers, service providers, facilitators, and clients (elderly people) from community and institutions were the key informants for the IDIs. At client level, elderly from homes and institutions, both males and

females, covering rural and urban population, from different socioeconomic strata and age groups were included. In addition, interviews were done with client categories belonging to special groups, namely, widows, disabled persons, slum dwellers, fisher folk, return migrants, and tribal communities. Caregivers of bedridden elderly, from both urban and rural areas, were also included in the study to identify their specific issues. Purposive sampling was followed in the selection of participants till redundancy of data. A total of 116 IDIs and nine FGDs were carried out across all categories covering the five districts. Interview schedules with open-ended questions, separate for each major category of stakeholders, were used to collect data through IDI. FGD guides were also prepared in tune with the study objective.

Semi-quantitative approach was followed in the analyses and presentation of report wherever possible. The steps used for analysis included free-listing of responses, grouping of segments showing similar ideas, identifying the emerging themes (domains), giving numerical codes to the domains, summarizing the different categories, and preparation of comparative tables [2].

Mental health needs and mental illnesses

Only one-third of the elderly reported that their mental well-being was satisfactory. Half of them were sad, unhappy, or worried, for the following reasons: absence of financial security, being dependent on children, lack of emotional support, ill treatment by children, or loneliness. The feelings of helplessness and hopelessness, suicidal thoughts, and anxiety about the future were reported by nearly half of the elderly from institutions, but by very few from the community.

“I feel isolated. My children don't want to live with us. It gives me a lot of grief that I can't see my grandchildren. Being retired brings its own problems. I used to be in government service before and didn’t have to worry about all this” reported an above poverty line, rural, elderly from Berhampur.

Most of the superintendents of old age homes and doctors posted in medical facilities around the area mentioned that mental illnesses such as Alzheimer's disease, depression, anxiety, and sleep disorders were distressing problems for senior citizens, especially in the age group above 80 years. However, only some of the elderly identified these as major problems. Loneliness, isolation, neglect, demise of spouse, and subsequent sense of insecurity of widowhood were reported as distressing psychological problems of elderly, by some from the community and half of those from institutions. Some reproted somatization problems such as aches and pains, tiredness, or loss of sleep among elderly.

Half of the elderly from the community said that the intrafamily relationships were satisfactory, citing adjustment problems like poor interaction among family members, lack of feeling of togetherness, loneliness, isolation, and having no role in decision-making regarding family matters. This view was shared by other stakeholders. Some of the elderly participants were living alone, either due to widowhood or children's migration, and had problems-related to that, like poor health-seeking behavior. Lack of opportunity for social interaction was mentioned by some participants as a social issue [3]. Majority of the clients from community reported that they did not partake in any social activities, festivals, or get-togethers and were not members of any social, religious, or political groups. This was mainly due to lack of interest, physical illness, weakness, etc. Hospital visits were the only occasions for exposure to the outside world.

“I am old, living alone. Sometimes I can't cook for myself and have to take food from the neighboring houses. My biggest woe is this isolation and loneliness. I brought up my children giving them utmost love and care. Now what is my fate? I am also a human being. I can't help worrying. Moreover, my illnesses add to my worries,” reported a below poverty line, rural, elderly from Cuttack.

Majority of the elderly from institutions and community were having no source of income on their own. More than half of them from the community were dependent only on their children for financial support, but only some from the institution were so, and less than a quarter of the clients from community and some from institutions were having their own sources of income by the way of business or pension or property. This led to diminishing nutritional status and poor health-seeking practices.

“If there is financial independence and physical fitness, elderly parents will be looked after to a greater extent by children. If both are lacking, life becomes miserable for them. This is more a problem for women as their life expectancy is more than that of men,” opined a district-level provider from Rourkela.

Abuse from family members, primarily from in-laws or their own children, was reported by some elderly. Nearly half of the facilitators and some of the other stakeholder categories considered elder abuse to be a serious issue. Physical, verbal, and psychological abuse were the major forms of abuse mentioned by the participants. Psychological abuse included neglect and disrespect by children or other family members and imposing financial restrictions. Either the elderly were avoided by the society or social interactions were prohibited by their families. The shift from joint family to nuclear family type and the resultant family and social environment was reported as unfavorable to elderly by some from all the stakeholder categories. When the responsibility of caring for two generations falls on the family, priority goes to the younger generation. Older people are provided with food and clothing without any consideration for their emotional needs. Sometimes, they lack privacy in their homes.

“In many homes, older people are considered as furniture. Let me put it bluntly; the elderly segment is considered as a commodity by people in many families and communities and would like to dispose of at the earliest. They are given food just as we give to a dog. Since hunger is a basic need, they eat a little out of it,” opined a Medical Officer from Puri.

Social interaction in old age homes

The elderly in the institutions were asked about visits by their relatives and other social interactions. Majority gave a negative reply, while some of them had occasional visitors; one of the important reasons being that they were ashamed of the elderly staying in Old Age Homes (OAHs).

Occasional telephone calls from friends and well-wishers were reported by some. Other means of social interaction reported by very few were visits by students and teachers from schools and colleges, people from church-based groups and interactions while attending the prayer at churches or festivals.

“No one comes to visit me here. Here there are people who have 8-9 children each, nobody comes to visit them. Even if I need something, I do not contact anybody at my home,” reported an elderly from OAH at Bhubaneswar.

Majority of elderly from OAHs did not like to go back to their families, as their past experiences were not good or their children were not financially sound and did not want to disturb them. Only some wished to go back, but half among them were apprehensive of not being accepted by family members. Very few elderly mentioned about any steps being taken at institutional level to help them go back to their families, but majority of superintendents (except those of private homes) claimed that they tried their best to send them back home [4].

Utilization of mental health services

Very few older persons from the community and institutions reported that they consulted a psychiatrist or availed counseling services. A quarter of them from institutions said that they consulted general physicians or doctors visiting the old age homes. Lack of family support on the one hand, and the absence of a comprehensive social security system and dedicated health services approachable and comprehensive enough to meet the needs of the elderly on the other hand, led to poor-health seeking, irregular treatment, and lack of control of chronic illnesses.

Specific problems of elderly above the age of 80 years (oldest old) included nutritional problems and MH issues such as memory loss and Alzheimer's dementia. Acute and chronic physical problems worsen with advancing age, leading to more dependent states physically, socially, and financially. Mental Health needs were poorly addressed among the bedridden elderly.

“Ninety percent of Alzheimer patients are elderly, most of them above 75 years. All elderly's problems are applicable to them. Added to that, they have memory loss too,” reported a facilitator from Bhubaneswar.

Since primary caregivers were mostly family members, the specific problems that they faced in caregiving were enquired about. The caregivers of the oldest old population themselves were also elderly, and they were distressed with similar problems. Deteriorating health status (due to physical and mental stress) was noted as an important issue if an elderly spouse, son, or daughter was the primary caregiver. There were adjustment problems in the family when the daily routine of the family members got affected owing to the demand on the caregiver's time to care for the elderly person. When the primary caregiver was a son/daughter, lack of sharing of responsibility of caregiving by other children of the bedridden elderly was a major concern voiced by them. Limited social interaction and recreation were also pointed out as problems faced by them. All these problems impair the emotional bonding and sincerity of caregivers, and at times, the elderly persons become victims of their harassment.

“The condition in my house is pathetic. I want him to die at the earliest, bedridden for the last 10 years, nobody to help us. None of the married children support us. Myself and an unmarried daughter look after everything,” said an urban caregiver from Jajpur.

Discussion

Depression, anxiety, insomnia, somatization, and dementia were reported to be the common MH problems in older people, especially above 80 years. Severe symptoms of depression, including suicidal thoughts, were more common in elderly people in OAHs compared to those living with their families. There was a dearth of qualitative studies assessing MH needs of elderly. In a cross-sectional study done on elderly aged 60 years and above, in Mysore, anxiety and insomnia, somatic symptoms and depression were found to be the most common MH problems. In 2011, a comparative study done in Kolkata on elderly population found that greater depression and maladjustment were reported by institutionalized, compared to non institutionalized individuals. Bhatia reported loneliness to be higher in elderly females than males, especially in those living alone. Singh and Kiran reported that loneliness correlated positively with widowhood, economic deprivation, and poor health.

Elderly women, especially widows, the oldest old, and physically immobile were more vulnerable to abuse than others. A cross-sectional study conducted in Maharashtra found that most of the elderly individuals, being unemployed, were neglected by family members; they felt loneliness, sadness, and depression. A content analysis of newspaper reports done in India found that physical, verbal, psychological and financial abuse, and neglect were the various types of elder abuse. Older women were found to be predominantly at risk for financial, physical, particularly after the death of spouse and when financially dependent. In my study, it was found that the social activities and interactions of elderly population was generally poor, especially so for the institutionalized group. Majority of the latter seldom interacted with their family members and even preferred not to return to their families. In contrast to the findings from this study, a cross-sectional study done in inmates of OAHs in Gujarat in 2004 reported that 49.2% inmates had good social interaction with family members and 59.8% were visited by family members in the OAHs. Interestingly, desire to go back home was not significantly associated with social interaction with inmates or family members.

In an evidence-based commentary, Tiwari gave suggestions to bridge the vast gap between the availability and requirement of Geriatric MH (GMH) services in India by deprofessionalization and decentralization of GMH services and also through workforce and infrastructure development. Caregivers of older people, primarily the family members, were burdened with their own physical and psychological distress. Difficulties in time management, lack of sharing of the responsibility of caregiving by significant others, shrinkage of their own social milieu, and lack of family support systems were the common problems reported by caregivers [5]. A cross-sectional survey done in Pakistan found that the caregivers of dementia patients had a significant decline in MH compared to those of physically disabled ones, but no significant difference was observed in the burden of care between the two groups.

Conclusions

Mental health issues are prevalent among among elderly, especially in widows and institutionalized population. Loneliness, isolation, financial insecurity and neglect were reported to be frequent. Accessibility and availability of treatment options was found to be low which adds to the caregiver burden. Efforts are to be taken at the community level to increase social interactions among senior citizens. Setting up geriatric units and training medical/paramedical professionals in geriatric care should be made a priority. Enhancement of family support services like palliative care, home-nursing care, DCCs, and respite care centers are urgently required.

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