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# Gender and domicile effects on mental health status among older people in Visakhapatnam district : A descriptive study.

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***Abstract:*** *This study examined the differential effect of gender and domicile resources on the mental health of rural and urban men and women 65 years of age or older in Visakha districts. Gender differences in various mental health issues from adolescence to adulthood to older people. The study sample was a weighted population of 302 age group 65 years or older who responded to the GSHQ survey, several epidemiological reports have found that older women with somatic complaints are more likely to be diagnosed with mental health problems as well as report more symptoms of depression than older men of the same age. Domicile has been shown to be a significant sign of a mental health condition in older people. We discuss the intriguing evidence of gender differences in mental health in the context of elderly mental health status screening, suggesting further research on the social components of gender differences in mental health across different cultures. More research is needed to determine which factors are the strongest predictors of gender differences in mental health issues in late life, specifically what factors appear to be responsible for gender differences in mental health so that to estimate the gender gap among the elderly. And/or whether or not new factors come into play late in life.*

***Key Words:*** *mental health, gender gap, domicile, older adult.*

## 1. INTRODUCTION:

Aging is an inevitable developmental event that brings about many changes in physical, psychological, hormonal and social conditions. Age." Old age has been seen as a problematic period of one's life and this is true to some extent. Older people are becoming increasingly dependent on others. As a man grows, his less activities, income and the resultant decline in the status of family and society makes his life more vulnerable. Older people feel neglected and humiliated. Worldwide, countries are experiencing the aging of population. Vulnerable population suffers from poor physical, psychological and/or social health3 and requires special care and attention 3. Accordingly, care recipients see informal care as an expression of their importance and care as an individual. Huh.

It is estimated that 70% of the world's elderly population is in developing countries. India being the second most populous country in the world, an earlier research study stated that the elderly population in India is projected to reach 137 million by the year 2017. In addition, social scientists report that there has been a general decrease in social status. The condition of elderly people in India, and increasingly, older people are perceived as a burden by family members because of their disability or dependence. Informal care for the elderly: Today, the elderly demand that society not only ensure independence and participate, but also provide care, fulfillment and respect. There are two perspectives about the relationship between informal and formal care: substitutive and complementary familial closeness and closeness with a vulnerable older person.

It happens every day that women are more prone to depression than men in terms of unipolar depressive episodes and signs of depression, although for some ages there is a lot of data on this but there are very few facts about others. For example, it is well established that there is no gender difference in depression compared to the early years. Over the years, common sense has it that in gender the gender gap has become smaller and even disappears completely in the elderly, although there is once a prevalent recognition that there are very few records. Since there has been so much focus on depression in the elderly in recent years, it seems like the perfect opportunity to look at the literature to see the picture of gender discrimination in depression among the developing elderly. So far, in-depth discussion of gender differences in unipolar depression in the elderly has generally not included major criticisms of gender differences in depression. There are countless reasons for this. First, sad criticism of gender differences has focused on the emergence of gender differences at some point in early life and, as a result, there has been an additional focus on empirical studies of adolescent, college, and center adult institutions. When the elderly are preserved in mixed samples, the gender differences may not be categorized according to estimated age or the elderly sample dimensions may be added too little.

Although it does not necessarily indicate a decline in the risk of aging, there may be some uncertainty from theories and data that show that the effect of standard values of sadness and negativity on older groups is weakening. It reduces gender differences. Due to the relative lack of studies and the exclusion of survival periods with data with individuals between the ages of 60, previous critiques inevitably focused on research with a record of middle-aged and young-older than the elderly population.

It seems like a clear variable to examine the gender difference in suffering from depression as fitness decreases as a person ages. Health can be measured in many ways: the range of circumstances, the ability to perform daily tasks, and the self-rating of fitness strategies often used in senior research. However, the first question is whether there is gender difference in somatic issues. Do women older than the elderly have poor fitness and frequent stipends? In general, the answer to this question seems to be yes. Elderly people have a gender difference in fitness form, women face additional conditions, exhibit very low ability to perform daily tasks and report poor fitness. Depending on this, fitness becomes a reputation candidate for assessing gender differences in distress in the elderly. Only one searcher requested this question directly. Noah et al. (2016) found that there was no difference in grief ratings between men and women who were no longer recognized as disabled, but at least one women who were identified as disabled. People who have been diagnosed with at least one disability are far more likely to be depressed.

## 2. The rationale of the study:

The researcher assesses what is identified about gender differences in mental health status in old age (60 years and older). The most important question we will try to answer is whether there are enough empirical records to help the existence of gender differences in mental health status in the elderly. If there are gender differences in mental health status in the elderly, the basic psychosocial variables that are considered responsible play a role in at least some part of the mental health status in adults. Attempts to specify the most essential research questions that need to be answered in order to advance the full picture of the gender gap that is depressing at some point in old age.

Literary review suggested that Aurima Stankuniene et.al. (2012) a study on the fundamental relationship between self-rating health, somatic complaints, and refraining from buying prescription drugs. Further investigation is needed in this area. Results show that 32.7% of respondents refrained from purchasing the prescribed drugs. This decision has been significantly linked to significant complaints. However, more research is needed to explain the relationship between buying prescription drugs and somatic complaints. Strainer, John, Welduygen, and Scott (2006) conducted a research study to determine the prevalence of mood, anxiety, and other disorders in a population of Canadians 55 years of age and older. Method: We conducted an analysis of the Canadian Community Health Survey: Mental Health and Wellness (CCHS 1.2). Results: After 55 years there is a linear reduction for all disorders. This is true for both men and women; For Anglophones, Francophones and Allophones; and for persons born in Canada and immigrating to Canada after the age of 18 years. According to previous research, the prevalence is higher in women than in men. Immigrants reported fewer problems than immigrants, and the differences narrow with age. Bisexual Francophones have reported more mental disorders than Anglophones, while Frankfone men have less anxiety disorder than Anglophone men. Conclusions: Unlike other studies that have found progress in the prevalence of depression and anxiety in the elderly, our results suggest a consistent decrease in these disorders. Our research for age-related differences in psychiatric disorders is discussed in terms of explanations.

A research study by Carsten Vrosh, et al., (2007) examined the protective role played by control behaviors aimed at overcoming the physical health problems of the elderly, depressive mood, and health engagement control strategies (HECS). And daily cortisol secretion. Positive levels of HECS are predicted to buffer the negative effects of physical health problems on depressive mood and daily cortisol secretion. Physical health issues and HECS 215 are measured in the community-resident elderly cross-sectional model. In addition, samples of participants' depressive mood and daily cortisol secretion were assessed at 3 days. Physical health problems were found to predict high levels of depressive mood and daily cortisol secretion, but only in the elderly who reported low levels of HECS (and not in the elderly who reported high levels of HECS). Furthermore, depressive mood fully mediates the buffering effect of HECS on the association between physical health problems and cortisol secretion. The results suggest that positive levels of HECS may be a psychological mechanism that can protect the elderly from experiencing the negative emotional and biological consequences of physical health problems.

Manjit-Talwar and Gaurav Malik (2013) Life expectancy increases as the percentage of the elderly gradually increases as a result of population changes in the Indian population. Aging is characterized by physical changes, physical health problems (physical and mental), decreased daily lifestyle and increased drug intake. Providing dental care to the elderly should not be biased and should be based on the medical, cognitive and functional status of the elderly patient. Oral health services are provided in a hospital or domicile setting. For the dentist, the main rule of oral health care for the elderly is to carefully examine multiple issues before starting treatment. Oral infections can have implications for systemic health. Maintaining proper oral health status is important for general well-being and quality of life. It should be upgraded to handle the current and future workload, taking into account the special needs of the elderly and the existing dimensions in providing oral health care, infrastructure and manpower in hospitals.

**3. Method and Tools Used :**

**General Health Questionnaire- 28**

In clinical studies, the 28-item "scale" version (there are four sub-categories: somatization, socialization, procrastination, anxiety, depression) is the most commonly used version. GHQ-28 was developed by Goldberg in 1978 (Goldberg 1978) and has since been translated into 38 languages. Developed as a screening tool to identify people at or at risk for mental disorders, GHQ-28 is a 28-factor measurement of emotional distress in medical settings. By factor analysis, GHQ-28 is divided into four subcategories. These are: somatic symptoms (items 1-7); Anxiety / insomnia (Items 8-14); Social dysfunction (items 15-21), and severe depression (22-28) (Goldberg 1978). It takes less than 5 minutes to complete.

**The following are four subcategories**

A. Somatic symptoms. Seven in this subcategory indicate how well a person experiences somatic symptoms. Anxiety / insomnia. Seven in this sub-category indicate the extent to which a person experiences anxiety / insomnia. Social dysfunction. Seven in this subcategory represents the extent to which an individual experiences social failure. High pressure. Seven in this sub-category indicate that one person is experiencing severe depression.

B. Scoring

Suggestions for Clients and Scoring: Examples of Some Items to Use 'Have you found that everything is happening to you, and that you are irritable and have a bad temper? There are four possible responses to each topic: not at all, not more than normal, more than normal and much more than normal. There are various methods to score GHQ-28. It is scored from 0 to 3 with a total score of 0 to 84 for each response. Using this method, a total 23/24 score is an entry into the existence of suffering. Alternatively, GHQ-28 can be scored in binary mode, they are not at all, and scores higher than normal are not 0, but higher than normal and much higher than normal scores. Crisis or 'Case Ness'.

**Reliability and validity:**

Several studies have examined the reliability and validity of GHQ-28 in different clinical populations. Test - Retest reliability has been reported to be high (0.78 to 0.9) (Robinson & Price 1982) and Intrator reliability have both been shown to be excellent ( 0.9 - .95 by Kronebach) (Felde and Ramos 2000). High internal stability has also been reported (Felde and Ramos 2000). GHQ-28 is closely related to the Depression and Anxiety Scale (HADS) (Sakakibara et al. 2009) and other measures of depression (Robinson et al. 1982). GHQ-28 was developed as a screening tool and for this reason, the response in terms of minimally detectable change (MDC) and minimally clinically significant difference (MCID) has not been established.

**Sample design**

The study was conducted on the mental health and general health of the elderly in Visakhapatnam district, Andhra Pradesh, India. Data were randomly collected from 302, 60 to 85 year olds residing in Visakhapatnam city, various urban, rural towns and tribal areas of Visakhapatnam district. The sample consisted of 153 males and 149 females. Details of age, duration of practice, health condition and medicine are given in the result section.

**Process and data collection**

First, consent was obtained from the study participants from different parts of the urban, rural and tribal areas of Visakhapatnam district. The researcher explained the purpose of the study and also explained each of the actions. Subsequently, the psychological scales were distributed and collected at a later date. Data were collected over a 6-month period. Incomplete and missing data forms are not considered for analysis. All the question papers are provided with standard English question paper along with Telugu translation version for better understanding. Data analysis was performed using the following statistical methods.

Data obtained from the samples were analyzed using SPSS. Detailed statistics were used to describe the data and to find the mean value. 'T-Test' and One Way Analysis of Variations (ANOVA) were used to find significant differences between groups.

**4. Objectives of the study :**

- Find out the state of mental health to know the effect of gender on the elderly

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- Knowing the impact of residence on the mental health status of the elderly

**Hypothesis**

- There are significant differences between gender groups based on mental health status.
- There are significant differences between habitat groups according to mental health status.

**5. Discussion and Results :**

**Table: 1 Gender and mental health status**

| GHQ Dimension | | Males | Females | t-value |
|---|---|---|---|---|
| | | (N=153) | (N=149) | |
| | | | | |
| Somatic Symptoms | Mean | 14.44 | 15.24 | |
| | SD | 3.13 | 3.23 | **2.18*** |

*p≤.05 level; **p≤.01 level

The table above shows the average, SD, male and female elderly for their gender and mental health status. Found [female, M = 15.24, S.D = 3.23) (male, M = 14.44, S.D = 3.13) and t-value = 2.18]. Hence the magnitude of the mental health status women differ significantly from men on somatic symptoms.

**Table 2: Place of residence and Self-Report**

| **Dimension** | | Tribal Area (N=66) | Town (90) | City (N=146) | f-value |
|---|---|---|---|---|---|
| Personal Strengths | Mean | 17.36 | 21.38 | 21.92 | 28.98** |
| | SD | 5.24 | 4.63 | 4.37 | |
| Anxious/ Depressed | Mean | 15.32 | 18.92 | 19.07 | 20.67** |
| | SD | 4.21 | 4.93 | 5.21 | |
| Worries | Mean | 5.86 | 8.02 | 8.00 | 32.98** |
| | SD | 2.22 | 2.24 | 2.18 | |
| Somatic Complaints | Mean | 4.55 | 5.24 | 5.13 | 4.41* |
| | SD | 1.65 | 1.83 | 1.86 | |
| Functional Impairment | Mean | 8.80 | 10.93 | 10.41 | 14.04** |
| | SD | 2.46 | 2.81 | 3.53 | |
| Memory/Cognition Problems | Mean | 6.21 | 8.81 | 8.22 | 30.91** |
| | SD | 1.94 | 2.69 | 2.73 | |
| Thought Problems | Mean | 10.75 | 13.97 | 15.10 | 29.53** |
| | SD | 3.60 | 4.47 | 4.41 | |
| Irritable/ Disinhibited | Mean | 14.63 | 18.66 | 18.43 | 26.30** |
| | SD | 3.77 | 4.86 | 4.85 | |

Note: *p≤.05 level; **p≤.01 level

- The table above shows the average, SD, male and female elderly for their gender and mental health status. Achieving the indicated results according to individual strengths is significantly different from city elders tribal and town. Indicated f-value = 28.98 ** <0.01 level. City elders differ significantly from tribal and town in terms of anxiety / depression. Indicated f-value = 20.67 ** <0.01 level. City elders disagreed significantly with tribal and town elders on issues of thought. Indicated f-value = 20.67 ** <0.01 level 29.53 ** Thus the elderly in the city differed significantly from tribal and urban in terms of mental health status on personal strengths, anxiety / depression and thought issues.
- F- value = 32.98 ** 4.41, 14.04 * *, 30.91 **, 26.30 ** <, stating that urban elders are in great disagreement with tribals and the city by obtaining results indicated by worries, somatic complaints, functional impairment, memory / cognitive problems, irritability / inhibited measurements 0.01,0.05 level. Thus the elderly in the town

differ significantly with the tribals and cities on mental health conditions, concerns, somatic complaints and functional impairment, memory / cognitive problems, irritating / inseparable aspects.

- Discussion: Current study results confirm that there are more somatic complaints in female elderly than in male older. A significant difference between the mean scores of the mental health status with respect to gender was also found, with a significant t-value obtained at the level of 0.05. Hence the first hypothesis is accepted. The null hypothesis is therefore accepted that there can be significant gender difference in mental health status measurements.
- On the other hand, significant differences were shown between the average scores of residential tribal, town, and city subjects in relation to our mental health status. The obtained t-value was found to be as low as 0.05, so it was agreed that our second hypothesis affects mental health status in the elderly. The adult urban area in which they currently live shows a much more significant difference than the tribal and urban elderly population.

**6. Major discoveries of research study:**

- There are no significant differences between male and female aging individuals resulting in anxiety / insomnia, social dysfunction and severe depression measurements of mental health status. Excellent observation from the results found that urban and urban seniors experience significantly higher levels of mental health status in all areas than in tribal areas. The study found that older people from urban and suburban areas were more likely to experience somatic symptoms, anxiety / insomnia, social dysfunction and severe depression compared to tribal people.
- The current study yielded results related to the impact of elderly living space on their adult self-report. It can be observed that older people living in tribal areas have significantly lower scores on all dimensions of self-report compared to those living in towns and cities.
- In the analysis of personal belongings, older people from urban and suburban areas reported significantly higher personal strength, anxiety / depression, anxiety, somatic complaints, functional impairment, memory / cognitive problems, thought problems, and irritability / living. In tribal areas.

**7. Suggestions from research :**

- The rapid growth of the aging population, the wide variation in their profiles and the diverse inter-related environmental impacts require significant consideration by researchers, policy planners and service providers.
- The research agenda for aging in the 21st century has been developed by the United Nations Program on Aging and the International Association of Gerontology.
- As the second most populous country in the world, India should prioritize issues for research on aging in the future and improve the methods for undertaking such studies. This report is an attempt in that direction.
- Earlier studies on aging have enabled us to understand issues concerning the elderly, especially their problems. However, besides being exploratory, descriptive, and localized, most of the studies focused on urban, male retirees/pensioners, who were viewed as passive receivers of care.
- Profiles of the elderly population are changing. Today, the proportion that intends to lead active lives of fulfillment for themselves, their family, and the community is on an increase.
- These changes affect their quality of life both directly and indirectly. Consequently, it is imperative to prioritize research efforts and evolve alternative methodologies for the study of aging issues.
- A present study suggesting that the difference between the two Factors for sadness in adults accounted for, establishing gender in despair that is why there are significant major variations between 'diagnoses of mental health status within the traditional assessment.
- According to current empirical research, there can possible to get awareness to contact on applications of such discoveries to medical practice, from the program specifically related to the research of elders depression of the population.

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