Assessment of Psychological Problems for Institutionalized and Noninstitutionalized Geriatric People in Baghdad City

Dr. Abdullah Eiada Mecheser Al-Elaiawy*
Dr. Saja Hashem Mohammed / Assistant professor**

الخلاصة

أجريت دراسة وصفية على المسنين في دار المسنين والمجتمع تقييم المشاكل النفسية للمسنين وصفاتهم الديموغرافية.أجريت الدراسة ما بين الأول من كانون ألأول عام٢٠٠٤و الخامس عشر من شهرأذار عام ٢٠٠٥.صممت الاستمارة الاستبانية لغرض الدراسة، تتكون من جزأين يتعلقان بالصفات الديمغرافية للمسنين ومشاكلهم النفسية.تم اختيار عينة (غرضية) تتكون من (١٠٠) مسن والتي تضمنت (٥٠) مسن من دار المسنين و(٥٠) مسن من المجتمع .جمعت البيانات وتم تحليلها من خلال الأسلوب الإحصائي ألوصفي (التكرار، النسبة المئوية، الوسط الحسابي، الانحراف المعياري، والكفاية النسبية، وأجراء التحليل الإحصائي ألاستنتاجي (بيرسون مربع كأي)).استنتجت الدراسة بان اغلب المسنين في دار رعاية المسنين يعانون من المشاكل النفسية تقديرا بالكفاية النسبية (اضطرابات المعرفة (النسيان الشديد ٧٣,٣٣%)، تعاني من شرود الذهن وعدم التركيز (٧١,٣٣%) ، القلق (٨٨%) ، الكآبة(الحزن الشديد ٨٤,٦٧%) ، الغضب (٩٤,٦٧%) ،ضعف اعتبارات الثقة بالنفس (الشعور بفقدان الثقة بالمستقبل ٧٥,٣٣%) .أوصت الدراسة بان العوائل الذين يعتنون بالأشخاص المسنين يجب دعمهم ماليا من قبل الدولة وإنشاء مركز للمسنين يتعامل مع المشاكل الخاصة بالباطنية والنفسية.

Abstract

objective : To assess for Psychological Problems. The study was carried out from 1st of December 2004 to 15th March, 2005.

Mythology : A descriptive comparative study was conducted for elder in the geriatric home and the community; A questionnaire was constructed to achieve the purposes of the study; it includes two parts dealing with the elder demographic characteristics and psychological problems.

A purposive (no probability) sampling of (100) elderly include (50) elderly from the Geriatric Home and (50) elderly from the community.

Data were collected and analyzed through a descriptive statistical approach (frequency, percentage, mean and mean of scores, Standard deviation, Relative Sufficiency).

Result : the study concluded that Most of institutionalized geriatric people suffer from psychological problems (Cognitive disorders(Sever Amnesia (RS(73.33%)), Mental confusion (RS(71.33%));Anxiety (RS(88%)); Depression (Sever sadness (RS(84.67%)); Anger(RS(94.67%)) ; and Low self-esteem (Feeling of in confidence about future (RS(75.33%)) more than those who live in noninstitutionalized. The study recommended that families who were caring for elderly person should receive financial support from government and establishing geriatric centers for dealing with special medical, and psychological problems...

Key words : Geriatric people in the institutionalized and noninstitutionalized .

Introduction

Old age is a normal part of human development and it is the final phase of the life cycle. Aging is a process of time related change that occurs throughout life. It involves all aspects of the organism. It does not necessary occur in an interrelated or synchronous manner, but it does involve physiological, psychological and social changes that interact to influence behavior and adaptation [(1)]. The problems of aging are mainly chronic and degenerative illnesses. The probability of sefive percenteing the incidence of these health problems is in a big increase with the advance of the age [(2)]. runty

95% of mentally affected elderly people over the age of 65 years live in the community rather than instituted of nursing home or mental hospitals. And yet many people incorrectly continue to view elder people as generally debilitated, frail, and demented. Only (10%) of elderly people are severely affected in those ways. Elder adults suffer from some of the same psychological disorders that are common to younger people. The most common psychological problems of the later years, however, are affective disorders and organic mental disorders [(3)]. But aging can also bring many changes at a time when they are least able to adapt to change .

* **Teacher / College of medical and health Technology**

** **Assistant Professor /Head of psychiatric department – Nursing College /University of Baghdad**

It is a well-known axiom that elderly persons have problem, not just physical disease [4].

The study of the aging process and its effects on older persons becomes more important with each passing day .The elderly person is vulnerable to emotional and stress because of the sense of loss that can come from the death of friends and family members as well as from retirement. A somatic changes and failure to adapt during any time of life cycle can result in physical and emotional illness [5].

Elderly people can also experience periods of depression, anxiety, and grief, which can be natural consequences of living in an aging body. In the early years of our nation most people did not live to be as old as persons do today and those who were usually cared for by their own families. However, as mentioned earlier, people are living longer and the elderly concern as more and more people are living into the eight ninth decade of life [6].

Another major contributing factor is increased longevity. Improvements in medical treatment and the use of advanced technologies to sustain life have resulted in a live expectancy of (71.8) years of men and (78.8) years of women [7]. The aging people and society inevitably withdraw from each other physically ,emotionally , and socially, in this process both society and the person prepare for the person's death .

The older person does reduce activities in some areas such as Work . Disengagement may occur involuntarily due to death of spouse and peer and concomitant lack of social opportunities , lack of finances or transportation or poor health . Elderly people are sometimes complaining from psychosocial problems like cognition dysfunction, emotional disturbance, mood affected, social isolation, personality disorders, spiritual beliefs, financial, neglecting and elder's abuse. Quality of life of elderly people has been broken and affected through psychosocial problems to pass suddenly into life cycle, to made imbalance and confusion .In addition, all these problems cause the burden for their families and caregivers .It is important to study this phenomenon among geriatric people to indicate psychological and social problems upon of them , either in an institutionalized or in a noninstitutionalized.

The study aims to identify geriatrics demographic characteristics, and to assess the psychological problems for institutionalized and noninstitutionalized geriatric people , and to compare geriatric's psychological problems between institutionalized and noninstitutionalized geriatric people.

Methodology

Descriptive comparative study using the approach of assessment, it was carried out on geriatric people from 1st December, 2004 to 15th March , 2005.The study was carried out to assess their psychological problems.

The study was carried out at the :

1.Community (noninstitutionalized) where the geriatric people live with their family alone and their relatives in Baghdad city (Karkh and Rusafa).

2.Geriatric home (institutionalized) which includes three parts:

The 1st part for men who were at the age of (65) years and more .

The 2nd part for women who were at the age of 50 years and more .

The third part for elderly who were couples.

The total residents are (144) elderly people, their ages ranged between (50-89) years .

The geriatric home was opened in 1973 and it has given care to old people till now. There are many a criteria to select the elderly people to be residents in the geriatric home:

I . Those who are formally registered by the geriatric home.

II. Those who were 65 years old and more for males and 50 years old and more for female

III. Those who have no families or they , were rejected by their families. The purposive non-probability sampling of the study consists of :

1. (50) Persons who are living in the geriatric home (institutionalized).

2. (50) persons who are living in the community (noninstitutionalized).

Baghdad city has two regions (Karkh and Rusafa) , each one of the regions divided in five areas The study took five elderly persons from each one of them ,the study recieved their addresses from the office of social affairs .

The study instrument was constructed by the investigator for the purpose of the study to investigate the psychological of elderly people who they were participated in this study. The items formulas were based on:

1.Extensive review of related literature and studies.

2.preliminary study by giving open-ended questions to ten geriatric people and ask them about their psychological problems.

3.General health questionnaire (GHQ) [8] and (DSM-IV) [9] classification for psychological problems. These instruments were presented as follows:

Part I : This part is consisted of Demographic characteristics .

Part II : That is concerned with psychological problems.

This part of the studys instrument is concerned with the demographic characteristics of the geriatric population through a designed sheet consisted of (13) items which included, gender, age, religion, weight , height, education level, marital status, occupational status,residence status, duration of residence , financial sources, smoking , alcohol intake .

This consists of one sections which contains of psychological problems include;

(29) items which is divided into:cognitive disorders(9), anxiety(7) , depression(7), anger(3), and low self – esteem(3).

To make the instrument more valid, it was presented to a panel of (20) expert from different fields. They were (7) Psychiatrist Medicine Professionals, (2) Psychiatric Health Nursing Professions, (3) Community Health Nursing Professionals, (7) Psychology Science Professionals, (1) Sociology Science Professional. Their responses indicated that all of them had agreed upon the questionnaire content clarity, relevancy and adequacy.Then, the questionnaire was considered valid after taking into consideration their suggestions and recommendation for modification.

Results:

Table (1) Distribution of the Sample according to the Demographic Characteristics.

No	Characteristic of the Sample.	Noninstitutionalized =In Community		Institutionalized =In Geriatric Home	
		F	%	F	%
1-	Gender.				
	Male	30	60	30	60
	Female	20	40	20	40
	Total	50	100	50	100
2-	Age.				
	65-69	13	26	16	32
	70-74	16	32	20	40
	75-79	6	12	9	18
	80-84	10	20	3	6
	85 -more	5	10	2	4
	Total	50 M =75.300 SD = 6.713	100	50 M=73.000 SD = 5.273	100
3-	Religion.				
	Muslim	37	74	45	90
	Christian	13	26	5	10
	Total	50	100	50	100
4-	Weight.	50 M =67.70 SD=11.54	100	50 M =69.86 SD=21.49	100
5-	Height.	50 M =159.42 SD=17.50	100	50 M =161.08 SD=11.24	

Table (1) Continued.

No	Characteristic of the Sample	Noninstitutionalized=In Community		Institutionalized=In Geriatric Home	
		F	%	F	%
6-	**Educational Level.**				
	Illiterate	18	36	19	38
	Read and write.	4	8	4	8
	Primary school graduate.	11	22	11	22
	Intermediate school graduate.	7	14	3	6
	Secondary school graduate.	5	10	0	0
	Institute graduate .	2	4	2	4
	College graduate	3	6	10	20
	Post graduate	-	-	1	2
	Total	50	100	50	100
7-	**Marital Status.**				
	Separated	2	4	8	16
	Married	28	56	4	8
	Divorced	0	0	17	34
	Widowed	20	40	21	42
	Total	50	100	50	100
8-	**Occupational Status.**				
	Retired.	31	62	31	62
	Retired and employed.	1	2	0	0
	Earner.	5	10	1	2
	Unemployed.	13	26	18	36
	Total	50	100	50	100
9-	**Residential Status.**				
	Living alone.	3	6	-	-
	Living with spouse alone.	9	18	-	-
	Living with spouse and children.	19	38	-	-
	Living with son and daughters married(no spouse).	16	32	-	-
	Living with relatives.	3	6	-	-
	Total	50	100	-	-

Table (1) Continued.

No	Characteristic of the Sample	Noninstitutionalized=In Community		Institutionalized=In Geriatric Home	
		F	%	F	%
10-	**Duration of residence. (years)**				
	1-5	-	-	33	66
	6-10	-	-	10	20
	10-15	-	-	4	8
	16-20	-	-	1	2
	20 > more than 20	-	-	2	4
	Total	-	-	50	100
	M =5.24 SD=5.68				
11-	**Financial source.**				
11-1	**Source of income from Government.**				
	No.	18	36	17	34
	Yes.	32	64	33	66
	Total	50	100	50	100
11-2	**Source of income from Family.**				
	No.	23	46	47	94
	Yes.	27	54	3	6
	Total	50	100	50	100
11-3	**Monthly income.**				
	Sufficient.	9	18	17	34
	Some where sufficient.	26	52	10	20
	Insufficient.	15	30	23	46
	Total	50	100	50	100
12	**Smoking .**				
	No.	37	74	29	58
	Yes.	13	26	21	42
	Total	50	100	50	100

Table (1) Continued.

No	Characteristic of the Sample	Non institutionalized=In Community		Institutionalized=In Geriatric Home	
		F	%	F	%
13-	**Alcohol intake.**				
	No.	46	92	42	84
	Yes.	4	8	8	16
	Total	50	100	50	100

This table presents the demographic characteristics of the sample. The majority of studied group (60%)were males .In regard to age (32%) of the community sample (non institutionalized) and (40%) of the institutionalized sample were of age group (70-74) years. While the lowest frequent (10%) for community sample and (4%) for institutionalized sample were of age group (85) and more. The mean of the age is (75.300+_ 6.713) for community sample and (73.000+_5.273) for institutionalized sample respectively. (74%) of community sample and (90%) in the institutionalized sample were Muslim. The majority of the studied samples had the mean of weight, for the Community sample was (67.70+_11.54) and for institution lized sample was (69.86+_21.49).The majority of the studied samples had the mean of height, for community sample was (159.42+_17.50) and for institutionalized sample was (161.8+_11.24). (38%) of study sample were illiterate in institutionalized sample ,while in community sample (36%) (56%) in the community sample and (8%) in the institutionalized sample were married. The retired persons comprised (62%) of both groups. (38%) of the community sample live with spouse and children. While (100%) of the institutionalized sample live in the geriatric home. The majority of the institutionalized sample live in the geriatric home (1-5) years. (66%) of the institutionalized sample were retired and receive governmental pension , while (64%) of community sample were retired. (94%) of the institutionalized sample have no salary or support by their families. (52%) of the community sample and (20%) of institutionalized sample were satisfied with their income. (42%) of the institutionalized sample and (26 %) in the community sample were smokers. (16 %) of the institutionalized sample and (8%) of the community sample were drinking alcoho

The relative sufficiency test in table (2) showed that items (Don't know the date), (Don't remember recent events during the last week),Don't remember previous events during youth) were no effected , RS<66.67%. And there was no effect through all the scale.

Item (Sever Amnesia). The mean score (MS) (2.20+_ 0.90); RS= (73.33%) for institutionalized sample was affected at mild level.

Item (Complaining from mental confusion). The mean score (MS) (2.14+_0.93); RS=(71.33%) for institutionalized sample was affected at mild level .Both of the study samples were not affected during items (Complaining from loss of simple memory) , (Don't calculate of your money) , (Inability to make a decision) , the RS<66.67%.

Item (Anxious about your social level). The mean score (MS)(2.72+_0.70); RS=(90.67%) for institutionalized sample was affected at sever level .

Item (Feeling anxious and irritable). The MS (2.64+_0.72); RS=(88%) for the institutionalized sample was affect at moderate level and MS (2.06 +_ 0.77); RS = (68.67%) for the community sample was affected at mild level.

Item (Complaining from frustration becomes of previous painful events). The mean score (MS) (2.84+_0.55); RS= (94.67%) for institutionalized sample was affected at sever level and (MS) (2.04+_0.88); RS= (68%) for community sample was affected at mild level.

Item (Don't feel the youth energy). The mean score (MS)(2.38+_0.85); RS=(79.33%) for community sample was affected at moderate level and the institutionalized sample was not affected with MS (2.02+_0.94); RS= (63.33%).

Item (Feeling of near end of the life) .The mean score (MS) (2.70+_0.71); RS= (90%) for institutionalized sample was affected at sever level and the community sample was affected at mild level within MS (2.06+_0.84); RS= (68.67%) .

Item (Grave and death phobia). The mean score (MS) (2.14+_0.93); RS= (71.33%) for community sample was affected at mild level and the institutionalized sample was not affected within MS (1.58+_0.91); RS= (52.67%).

Item (Anxious about your family because your feeling of a near end life). The mean score (MS) (2.48+_0.89); RS= (82.67%) for the institutionalized sample was affected at moderate level and the mean score (MS) (2.26+_0.83); RS= (75.33%) for community sample was affected at mild level.

Regarding of item (Don't share in solving your family's problems). The results showed that the institutionalized sample was affected at sever level MS (2.72+_0.70); RS=(90.67%). While the community sample was not affected MS (1.54+_0.76); RS= (51.33%).

Item (Complaining from severs sadness). The mean score (MS) (2.54+_0.79); RS=(84.67%) for the institutionalized sample was affected at moderate level and the community sample was no affected MS (1.98+_0.80); RS= (66%).

Item (Complaining from crying spells). The results showed the severity level was moderate for the institutionalized sample comprise the mean score MS (2.66+_0.72); RS=(88.67%). While the community group was not affected, MS (1.94+_0.84); RS= (64.67%).

Item (Feel of aimless about your health). The severity level was moderate for institutionalized sample MS (2.58+_0.81); RS=(86%). While the community sample was not

affected MS (1.88+_0.85); RS= (62.67%).

Item (Do you feel that is no value to life). The MS (2.52+_0.84); RS = (84%) for institutionalized sample was affected at moderate level while the community was not affected MS (1.82+_0.94); RS (60.67).

Item (Feeling of loneliness). The sever level was for institutionalized sample MS (2.86+_0.45); RS= (95.33%) while the community sample was affected at mild level MS (1.88 +_0.90); RS= (67%) .

Item (Feel neglected from your family). The results showed that the institutionalized sample comprised MS (2.86+_0.50); RS= (95.33%), this group was affected at sever level while the community sample was not affected MS (1.60+_0.81); RS= (53.33%).

Item (Rapid angry for simple events). The MS (2.84+_ 0.55); RS =(94.67%) for institutionalized sample was affected at sever level while the community sample was affected at mild level MS (2.06+_0.82); RS= (68.67%) .

Item (Feeling to rapid excitement and stubbornness in the dependent of others). The MS (2.52+_0.79); RS= (84%) for institutionalized sample was affected at moderate level while the community sample was not affected MS (1.96 +_0.86); RS= (65.33%) .

Item (Feeling of in confidence about future). The MS (2.26+_. 96); RS= (75.33%) for institutionalized sample was affected at mild level while the community sample was not affected.

In regarding of item (Feeling of unimportant in your family) .The results showed that the institutionalized sample was affected at mild level MS (2+_1.01); RS =(66.67%) .

Item (Don't have ability to criticize the other). The MS (2.02+_0.98); RS= (67.33%) for institutionalized sample was affected at mild level, While the community sample was not affected MS (1.40+_0.73); RS= (46.67%).

Discussion

PART I: General Description of the Sample (Community Sample and Geriatric Home ample) according to their Demographic Characteristics.

These findings coincide with the findings with one study [10] that (45%) in geriatric home in age group >_ 70 years, while (46%) in the community in age group (70-80) years he found also (79%) in the geriatric home and (80%) in the community they were male.

In relation to sex, 68% of the elderly persons were males and 32% were females for both the study and control groups .In regarding to their age, the highest percentage 32% of elderly persons in the study and control groups was within the age range from 70-74 and the lowest percentage (8%) was within the age group from 85-89 years old [11].

The increase in life expectancy has been due to the decreased mortality among the middle age and elderly population. Life expectancy from birth has risen dramatically from an average of47.3 years to (75.4) years in 1990, with women of (79.0) years living about (7) years longer than men [12].The average of human life span is 75- 80 years. In 1994, life expectancy at birth was (73.9) years for males and (79.2) years for females [13].

The population of American elders is growing faster than the nation as a whole, in (2000) , the United States Bureau of Census reported that by the year (2050) ,(21%) of the population will be at the age of (65) and older .The over (65) population, which includes the middle old (75) to (84) and the old –old 85+ reached 34.8 million or more than (12%) of the United States population in 2000 [14].

The elderly people in the muslim religions are more than the Elderly people in the Christian religion in the arabic world. In our nation, existences of the elderly people in the Muslim religion more than the elderly people in the christian religion. This may be because the population of the Iraq is Muslim more than christian people.

Weight loss in the elderly can result from a variety of causes , these include social problems such as isolation and lack of money or transportation, and psychological problems such as depression, medical conditions such as Diabetes, Tuberculosis, Hyperthyroidism, Cancer, and excessive Diuretic therapy and Mal nutrition, Mal absorption will also cause weight loss. The other major causes of weight loss are Malignant disease of rectal bleeding, peptic ulcer, Carcinoma of the Pancreas, Psychiatric disease such as Depression, Dementia, and Senile [15].

There are several differences among elderly's height either of the elderly in the community and geriatric home.

These individuals were unfortunately did not have the opportunity to be enrolled in the education system due to the nature of their life.

This results supported with findings that the majority of elderly (60%) read and write and only 4% were of high educational level graduation for both groups (community and geriatric home) [11] .

Group who were unable to read and write (28%) in the geriatric home group and (37%) in the community respectively [10].

The elderly populations are much less educated than younger population. The educational level of the older population graduated from high school and in 1992 (12%) had a Bachelor degree, (13.5) men and (8.5) women [16].

Education attainment in the elderly is well below that of younger population .I n1985, approximately (45%) of individuals of age (75) years old and over had discontinued their formal education at eight grade or earlier ,as compared to (14%) of population of age 25 and older . About (40%)of the group aged 75 and older had completed high school , as compared to(74%) of individuals aged 25 and over (17) .

Iraq people under family care while in the institutionalized they have no spouse.

This results is supported with findings that although most of the elderly men are married, two-thirds of elderly women are widowed. Even when men have been widowed, their chance for remarriage is twice those of women. A review of literature on widowhood indicates some variables that relate to the adjustment of widowed persons to a single- life patterns [18].In 1995, individuals of age 65and older, (76 %) of men and (43%) of women were married, (47%) of all women in this age group were widowed. There were five times as many widows as widowers because women live longer than men and tend to marry men older than themselves [19].The social status, the highest percentage (40%) of elderly people in the study and control groups were widowed, lowest percentage (16%) were divorced [11].

In 1900, two of three older men were employed. In recent years, retirement has become less a matter of choice with only one of six older men employed [18].Because women were less likely to work outside the home earlier in the Century, the numbers of older female workers were less and have remained stable. Adjustment to retirement remains a significant crisis for a working person.

For many old persons, retirement is a time for the pursuit of leisure and freedom from the responsibility of previous working commitments .For others ,it is a time of stress , especially if retirement results in economic problems or a loss of self esteem . Ideally, employment after age 65 should be a matter of choice. With the passage of the age, discrimination in employment act of 1967 and its amendments, forced retirement at age 70 has been virtually eliminated in the private sector, and is not legal in federal employment. Of those persons who voluntarily retire , a majority reenter the work force within two years. They do so for a

variety of reasons – negative reactions to being retired, feelings of being unproductive, economic hardship, and loneliness. The amount of time spent in retirement has increased as the life span has nearly doubled since 1900 [20].

The majority of the geriatric home elderly were accounted for the retirement category as the community elderly .Such result had justified that these individuals had served their society through various official sectors end up with retirement but unfortunately they did not seek appropriately paid person [10] .

This results are supported by Stuck and Aronow (1995) they found that elderly people living in the community were 75 years of age or older .The (215) elderly people in the intervention group were seen at home by gerontologist nurse practitioners who were in collaboration with geriatricians .The elderly people were cooking, handling finances and medication, house keeping, and shopping.

Most of people who they were older than 65 years of age live at home and are responsible for taking their own medications[18].

In fact, in more than (45%) of all marriages, one or both partners were married previously, with either or both spouses having children from previous marriages, resulting in what is called a blended family. Families of older adults also reflect this diversity in family structure. Family, however defined, provides intimacy, affection, and instrumental support to older adults. Also, older adults may be part of multigenerational families and households. Sometimes four or five generations live together and share resources and family tasks .For some adults , family intimacy and support take place in unrelated (by blood) groups who may or may not live in the same household [21].

The majority of elderly , regardless of the setting , were living at the urban area and most of those at the community setting were living with spouses .Due to the urbanization factor, such finding had existed and elderly in the community had presented better family and social ties than those in the geriatric home [10] .

As a consequence , more women live alone in later life than men . Almost (65%) of impaired elders live with someone else because of their health problems with the remaining (35%) living alone [22] [23].

Turkey is a society who looks after elderly with their traditions and customs. The big majority of the elderly live with their children, the ones who live apart are in close contact that the old person can continue his or her house and family life's duty and responsibility as in the past [2].

This results are supported with findings that the majority of the geriatric home and the community elderly had somehow sufficient income. This finding had confirmed that the majority of our society residents were living at moderate socioeconomic status [10].

In 1966, (12.2%) of the elderly had income below the poverty level. Many of elderly want to work after retirement but they usually prefer part – time work [22].

Supported this finding and indicated that in 1935, many elderly were economically impoverished .Since that time , there has been a gradual shift from a program that was intended to provide minimal supplement to retires' sources of income for many people [18].

This finding is confirmed that although older adults are less likely to smoke than younger adult , tobacco dependence is the most common of all substances causes disorders in the elderly .United community survey data for 1987 showed that among persons aged (65-74) years old , (20%) of men and(18%) of women were regular cigarette smokers; in the group aged 74 years and older , respective rates were (11%) and (7.5%) [24][25] .

This results are supported with findings that of the (26) to (30) million people in the United States over age 65, (4%) are estimated to abuse alcohol ; and approximately one third of these people began to drink after age 65 .Alcoholism is the third most prevalent psychiatric disorder among elderly men , following dementia and anxiety [26]. Also supported

with findings that alcohol problems now constitute a public health problem of moderate proportion in men aged (60- 75) years [25].

PART II: General Description of the Sample (Community Sample and Geriatric Home Sample) according to Psychological Problems.

Delirium, also known as acute confusional state, is a clinical syndrome characterized by reduced attention. The patient's spontaneous speech is rambling and incoherent. In addition, at least two of the following features are usually present: (decreased arousal, perceptual disturbances (i.e., illusions, hallucinations), and abnormalities of the sleep- wake cycle, increased or decreased psychomotor activity, disorientation for time or place, and memory impairment [27].

Delirium is usually seen in clients with Alzheimer's disease when a sever infection or other medical condition is super imposed on the preexisting conditions. At least (22%) of elderly clients become delirious at some point during hospitalization [28].

This is supported with findings that amnesia is an acquired disturbance of memory characterized by the inability to store new information or by the very rapid loss of information from storage. Attention, general intellectual function, and remote memory are intact. Those with this condition are unable to recall information and benefit little from clues such as multiple – choice list containing the correct answer [27].

Amnesic disorders are characterized by a disturbance in memory that is due to either the direct physiologic effects of a general medication condition or the persisting effects of a substance use /abuse or toxin exposure [28].

Dementia is syndrome of acquired persistent compromise of mental function affecting memory and producing deficits in one or more of the following neuropsychological domains: language, visuspatial function ,calculation ,executive functions (abstraction , judgment , planning , sequencing) ,or personality (apathy , indifference , disinhibition) [27] .

The prevalence of dementing illness between age 65 to 70 years of age is less than (5%). The prevalence increases with age. (50%) of all dementia are a result of Alzheimer's disease [28] [20].

People with dementia have ever – increasing trouble with changes of pace, changes in location, fatigue, groups of people, changes of time zone, and noise. In a familiar environment there are many environmental cues that help a person with dementia to remain moored in reality. A favorite chair, a well – learned TV control and familiar floor plan are taken for granted. Unfamiliar places, however, lack these well – known moorings and result in increased confusion, anxiety, and fear. Even places that once were familiar, such as a winter home, can seem new or alien, triggering fear or anger [29].

The result supported with findings that anxiety disorders begin in early to middle adulthood, but some appear for the first time after age 65 . In older adults, symptoms of anxiety and depression related to accompany each other, making it difficult to decrease which disorder is dominant [19].

Anxiety is a common disorder in the elderly, and it may be hard to detect where the patient also has depressive symptoms, or where the anxiety state has led to successful patterns of avoidance of the feared situation. Specific fears, general anxiety, the autonomic symptoms of anxiety, and avoidance should all be explicitly enquired fear .Anxieties about physical health in someone who also has demonstrable physical illness [25].

Depression disorders are the most common effect at illnesses occurring after the middle years. The insidious of increased depression among the elderly population, influenced by the variables of physical illness functional, Disability, Cognitive impairment, and loss of spouse [19].

Depression is far more common than Alzheimer's .(13%) of elderly community (30% in medical setting), are depressed .Depression in the aging can develop for a multitude of

reasons ,including failing health ,as part of grieving the loss loved ones , inactivity , and fear of pain or death . Older people find themselves in environments where it's hard to keep busy, or where little is expected of them. This inactivity can cause an onset of depression [30].

The most common mental health disorder in late life is depression .It is often manifested as a recurrent illness or as a co-morbid condition occurring with chronic disease .Among older adults living in the community, 3% have a major depressive symptoms . And 10% to 14% have depressive symptoms .Depression has a wide severity and morbidity range and is conceptualized as an abnormal mood state, pattern of symptoms, or a clinical syndrome ranging from sadness to major depression [31].

The most of elderly live and waiting their end life and sorrow on their youth .And feeling of social isolation or withdraw from relationship with friends , job , sometimes feeling aloneness in order to encourage their children to marriage [32] .Most of elderly live alone because lost their spouse or family . Progress of age after retirement to decrease social communication and reduce their family day after day by death. Then, of all those situations the elderly feel of the end of life and feeling that their own lives become to have not value. Feeling of loneliness was seen in (21.05%) males and followed by the feeling of neglect [33].

This results supported with findings that anger is a sense of intense tension or discomfort that arises when a good is thwarted. It is one way of handling anxiety, particularly in response to real or perceived threat, insult, or injury. A person who has been anger, unhappy, and chronically dissatisfied with himself and others brings this behavior with him to the clinical setting. It is not unusual for people to displace feelings of anger, that is, to express them to ward someone or something other than the original frustration. The usual social responses to anger are counter attack, withdrawal or avoidance of the situation .Generally , direct expression of anger are not socially acceptable and outbursts are followed by guilt , shame, and profuse apologies . Moreover , because of cultural and socioeconomic differences in the expression of anger [1].

Anger can result in depression and low self-esteem. When it is expressed in appropriately, it commonly interferes with turn into resentment, which often manifests itself in negative, passive aggressive behavior [19].

The elderly people have anger with or without simple events that is according to their situations. Most of elderly persons have feelings that are not having value among family members .Those Feelings related to age and retirement [19].

This results supported with findings that people feel competent when they are able to control their own lives. Yet many elderly are living in state of poverty, are barely able to meet physiologic needs for food and shelter, and are without hope or motivation to tackle or seek gratification of higher level goals [18].

The maintenance of self esteem is a major task of old age . Self –esteem can be promoted by several factors: (1) economic security, which allows the person to secure the basic necessities of life; (2) supportive persons, who protect against isolation and allow dependence needs to be gratified ;(3) psychological health, which allows mature coping and defense mechanisms to function; and (4) physical health, which enables the person to pursue productive or pleasurable activities. When all or any of those factors are affected adversely, the aged person is unable to maintain self –esteem; tension, anxiety, frustration, anger, and depression can result. In addition, the perceived changes in physical and psychological functioning cause aging persons to question their continued adequacy [4] .

Recommendation

Based on the early stated conclusions, the researcher recommends the following points:

1. The researcher recommended that families who were caring for a geriatric person or an old person should receive financial support from government to their old age.

2. Medication for chronic disease should be dispensed freely to those who need them.
3. Continuous nursing education and training programs should be arranged concerning the concept of geriatric care.
4. A special education and training program should be arranged for geriatric families to be ready to give care for them.
5. Community centered clinics for geriatric people and their families should be established.
6.Preparation of medical teams for visiting geriatric people at their homes at regular intervals in order to follow up their health status .
7. Put a governmental program for providing free services for geriatric people, such as transportations , medical care .
8 Establishing geriatric city for elderly people with library, sport units, café, mini markets for their shopping.
9. Establishing geriatric centers for dealing with special medical, and psychological problems..
10. Nurses should take a role in geriatric home and have the ability to handle them.
11. Encouraging the marriage of geriatric people in geriatric homes.
12. Psychological rehabilitation for geriatric people who suffering from mental illness advised to be introduced.

References

1. Brunner, L; and Suddarth, D**: Textbook of Medical Surgical Nursing,** Fifth edition, Philadelphia, J- B.LippincottCompany, 19984, PP: 25-255, 263-267,271-272.
2. Ersin ,F;Cevike ; Aksoy ,S ; AND Aksoy ,**N :Aging and Nursing in Turkey** : An Ethical perspective Harran University School of during faculty of Medicine .Eubios Ethics institute , 2003 , Email. Fatmauers @ mynet . com .
3. Billig, N: **To be old and Sad :understanding Depression in the elderly** –Lexington , MA,Lexington Books 1987,PP:231-236.
4. Armstrong ,M : Briefing paper on recent psychological research which is of significance to delivery of health care in Scotland , C.M.O. **Psychology Advisory Committee Briefing paper** –April ,2004.
5. Strumpf, N: Probing the temporal world of the elderly , inter **, J OF Nursing study** ,2(3) , 1987 , PP : 201 –214 .
6. Phipps, WS; Cassmeyer, VL; Sands, JK; Lehman, MK :**Medical –Surgical Nursing** , Fifth edition , Philadelphia ,Mosby ,1995 ,PP :13-70 ,74 ,86 – 88 .
7. Clark,M :**Nursing in the community** ,2nd edition ,USA : Application and Longe ,USA 1996, pp: 521-265.
8. Goldberg , DP; Hillier **: A Scaled version of the general Health questionnaire psychological medicine** , vol (9) , 1979 , PP: 139 –146.
9. Diagnostic and statistical manual of mental Disorders **(DSM)**, 4th edition, Washington, Dc, American psychiatric Association, 1994.
10. Mohammed ,KS : Evaluation of elderlys' Knowledge , Attitudes and practices towards Disease prevention a comparative study ,Iraq , Baghdad ,Nursing college , 2002 ,PP : 29 – 44 .Unpublished thesis university of Baghdad – College of nursing .
11. Gorgies, S: **Evaluation of basically constructed self – care educational program for elderly population in Baghdad geriatric home** , 1998 . Unpublished thesis ,university of Baghdad –College of nursing .
12. Smeltzer,S ; and Bare ,B :Brunner and Saddarth Textbook **Medical Surgical Nursing** , 8th edition , Philadelphia , Lippincott, 1996, PP: 144- 152.
13. Armour , D; and Cairns , C **:Medicine in the elderly** , First edition , London , Pharmaceutical press , 2002, p : 9 ,42 .

14. Kneisl, C R; Wilson, HS; Trigoboff ,E : **Contemporary psychiatric Mental Health Nursing** , USA ,New jersey , 2004 ,pp : 640 – 654 .
15. Chenitz , WC ; Stone , JH ; Salisbury ;SA **:Clinical Gerontological Nursing , Philadelphia** , W.B .Saunders Company , 1991 , PP: 56-57 , 364- 365 ,492 , 189 – 198 , 199 .
16. Eliopoulos , S : **Gerontological Nursing** , Philadelphia ,Lippincott and Raven , 1993 , PP: 72-98 .
17. Hazzard , WR ; Andres ,R ; Bierman , E ; Blass , J : **Principles of Geriatric Medicine and Gerontology** ,2nd edition , Newyork , McGraw –Hill information services company , 1990 , PP : 115 – 116 , 101 – 110 , 232.
18. Gnatavicius ,DD ; Bayne ,MV : **Medical – Surgical Nursing** : A Nursing Process Approach , Philadelphia ,W.B .Saunders company , 1991 , PP: 71 –83 . .
19. Townsend, M: **Psychiatric Mental Health Nursing concepts of care** , Third edition , London , Mosby ,1999, PP : 684 –696 .
20. Kaplan, H I; Sadock , B J; and Grebb , JA: **Synopsis of psychiatry** , 7th edition , Baltimore , Williams and Wilkins , 1994 , PP: 65 –75 ,1155.
21. Phipps, WJ; Sands, JK; M ark, JF: **Medical Surgical Nursing Concepts and Clinical Practice** , Sixth edition , Philadelphia , Msoby ,1999 , PP : 72 – 80 .
22. Barer ,BM : Men and Women Aging differently, **Journal Aging Human Development** , 38(1) , 1994 , pp: 29 –40 .
23. Green ,V ; Monahan ,D; and Cleman , P : Demographies .In Ham RJ Sloans PD editors . **Primary Care Geriatric : a case – Based Approach** , St . Louis : Mosby , 1992 , PP : 120- 130.
24. Swanson, J; and Nies, M: **Community health Nursing Promoting the health of aggregates** , 2nd edition , Philadelphia ,W.B.Saunders company , 1997 , PP: 348 – 355 .
25. Jacoby ,R ; and Oppenherimer : **Psychiatry in the elderly** ,Second edition,Newyork ,Oxford university press , 1997, P: 152 .
26. Burke , MM ; and Laramie , JA : **Primary Care of the older Adult Multidisciplinary Approach** , First edition , Philadelphia , Mosby , 2000 , PP : 7 – 23 , 161 , 509 , 534 , 551-559 .
27. Simpson, GM: **Psychiatric disorders** First edition ,Newyork, California school of medicine , 1995 , PP: 116-120 .
28. Murphy: **Alzheimer disease in elderly patients with substance abuse toxic** , USPHS ,2000 .
29. Moxley, J; and Kathleen, C: Tote bag and tooth brush: Alzheimer, travel tips for the caregiver, **Geriatric Education** Center, 1996, geri – hall @ uiowa – edu .
30.Biersdorrff, KK :Out of focus : Developing a picture of aging people with Development Disabilities **. Reh, Review**, Vol (10), No (5), May, 1999 . .
31. Fitzpartrick,j ;Fulmer ,T ; FLaherty , E: **Geriatric Nursing Research Digest** ,First edition , Newyork , Springer publish company , 2000, PP : 123-133 .
٣٢.د.زهران ، حامد عبد السلام ، الصحة النفسية ، الطبعة الثانية ، مصر – القاهرة ،الناشر ،عالم الكتب ،١٩٨٠،ص ٣٤٣ـ ٥٥٠ .
33. Prakash, R ; Choudhavy , SK; Shankar ,U : A study of morbity pattern among Geriatric population in an udaipur rajasthan, **Indian Journal of community Medicine** , January – March ,2004 vol (xx1x) No (1)