Chapter 11
Interventions for Enhancing Health and Well-Being Among Indian Elderly

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Elderly-the Concept

Definition of elderly has been long debated and there is not a single acceptable one. The US and other developed countries consider the age of 65 and above as elderly. Some others classify elderly as: (1) *Young old:* aged 55–65 years; (2) *Old: aged* 66–85 years, and (3) *Oldest old:* aged 85 years and above (Carey 2003). According to Indian studies categorization of the elderly have been done in terms of y*oung-old:* 60–70 years, *old-old:* 70–80 years and *oldest-old:* 80 years and above (Rao 1993; Rajan 2003). Further, the Census of India provides age-wise data in different age sub-groups, up to 80 years and identifies the elderly with age 60 years and above.

There are bio-medical and philosophical views to define aging and the elderly. Studies suggest that along with chronological age, change in social role (i.e., change in work patterns, adult status of children and menopause) and change in capabilities (i.e., invalid status, senility and change in physical characteristics) are also important components for defining old age or elderly (Glascock and Feinman 1980) In general, the 60th year has been considered as the point of turning old in India. The 'National Policy on Older Persons' (1999) the Government of India defines 'senior citizen' or the 'elderly' as an individual of 60 years or above.

Elderly are often perceived as reservoir of wisdom and intelligence and also perceived as 'deadly desert' with disease, disability and decomposed fraternity. The latter viewpoint is significantly prevailing in society and addressing it is one of the biggest challenges. They have to confront with a number of difficulties including

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physical, mental, familial, social, environmental, etc. This directly affects their well-being and health. Sense of well-being prevails only in a small proportion of the elderly varying from 20 to 50% (Rao 2001). National Sample Survey Organisation, 2006 also reveal that the elderly experience a greater burden of health morbidity (illness, sickness, injury and poisoning).

There are some physiological/biological causes and a few environmental ones which manipulate the health and well-being of elderly; thus, before finding out ways and strategies to enhance the well-being and health of elderly, one needs to scrutinize the process of age and ageing as well as their status.

Age Related Changes vis à vis State of Mind

The multiple processes of degeneration, which is associated with old age, can be categorized as primary and secondary ageing (Busse 1987). Primary ageing is intrinsic to the organism and is influenced by inherited or hereditary factors, whereas secondary ageing is caused by hostile factors of the environment including trauma and acquired diseases and disabilities in the individual. In human organism, ageing is determined genetically but individual variations are influenced by different environmental factors like nutrition, lifestyle, social and familial environment, illnesses, etc. (Busse 1987).

The objective study of the human ageing is difficult. Many age-related changes often restrict a person in continuing with the normal functions, meet personal needs, maintain dignity and place in family and society as well as fulfil others' demands. The biological, psychological and social problems of human ageing cannot be evaded. These problems are related to physical limitations, occupational redundancy, physical and mental ill health, socio-economic conditions, leisure, retirement as well as maintenance of capacity and performance.

With age the risk for developing certain chronic and incapacitating diseases is significantly high. In the main stages of human life all these factors are closely interwoven; physical and mental declines are added and in the later stage of life. This is the peak year for social and authoritarian achievement, partial/full disengagement from occupational role and community affairs, diminution of sexual function, full or partial dependency because of physical/mental impairment/handicap or disability. Cognitive changes with ageing are well documented and affect a broad range of functions (Spar and Rue 2009). According to Spar and Rue (2009), effects of ageing on various cognitive functions and ability are explained in subsequent paragraphs.

Intelligence

Vocabulary and knowledge remains stable or increase with age however, in very old age it may decline which is most remarkable for novel tasks. Perceptual motor skills start to decline with chronological age 50–60.

Attention

General attention span may remain the same or there may be minor decline with age but in complex attention, mild decline starts with age and problems with dividing attention, filtering out noise, shift of attention takes place with age.

Language

If there is no sensory deficit, communication ability remains stable at any age. Grammatical and word knowledge which is variable with education, remains the same and stable. Sometimes there is mild decline in verbal fluency or naming and one may often find lapses in occasional word finding. The ability to comprehend also sometimes mildly deteriorates and there may be some worsening in processing of complex messages; however, communication is found to be variable with age and it may be vaguer and repetitive.

Memory

Short-term memory often remains stable or sometimes mild decline occurs. Generally, recall of forward digit span remain intact (7 ± 2 items) but easily disrupted by interference. There is mild to moderate decline in working memory as the ability to manipulate information in short-term memory reduce with age. In general, recent memory also deteriorates moderately though storage remains intact but encoding and retrieval deficits are found to be significantly prevalent with age. Remote memory for major aspects of personal history is found to be variable with age, however, most of the time it remains intact. There is mild to moderate decline on laboratory tasks but the elderly often do better than their younger counterparts on naturalistic prospective memory tasks.

Visio-Spatial Ability

The ability to reproduce drawings (design copying) varies with ageing; however, it is found to be intact for simple designs but not for complex forms/figures. The ability of topographic orientation starts declining with age and it is most noticeable unfamiliar surroundings.

Executive Functions

There is mild to moderate decline in cognitive flexibility. This can be observed in one's thought or action which gets slower and less accurate while shifting from one thought or action with the advancement of age. There is some redundancy and disorganizations in logical problem which also deteriorates with age. The ability of practical reasoning also get affected and mild to moderate decline may be observed in this ability; qualitative practical reasoning remains intact and efficiency on complex and novel tasks worsen with age.

Speed

Slowing of thought and action is the most reliable change of ageing, the velocity to perform different activities also deteriorates with age.

Age-related changes during adult life are less stunning; these changes are generally progressive and cumulative with advancement in age. In later stage of life, biological changes are remarkable and cause progressive, systematic and cumulative adverse changes in physical status and therefore, the psychological and social characteristics also get influenced adversely. Before elaborating on the interventional strategies for enhancing health and well-being various characteristics and environmental aspects need to be discussed clearly.

Socio-Demographic Profile of the Indian Elderly

Reports reveal that in 1901 the proportion of the elderly aged 60 years or above was about 5%, which marginally increased to 5.4% in 1951 (Das et al. 2011). In 2001 there were 7.6% elderly in the country which now has swelled up to 8.6% (Chandramouli 2013). In three decades, the number of older adults has more than doubled, i.e., from 43 million in 1981 to 103 million in 2011 (Chandramouli 2013) and is expected to triple in the next four decades i.e., 316 million (James and Sathyanarayana 2011). Further, there is a steady increase in the expected length of

life or life expectancy at birth or life expectancy at the age of 0; it has risen from 49.7 (male = 50.5, female = 49.0) years in 1970–75 to over 63.5 (male = 62.6, female = 64.2) in 2002–06 (Das et al. 2011) and 68.8 in 2017 (https://www.indexmundi.com 2017 accessed on May 7, 2018).

Adding to it, the dependency ratio of elderly is also increasing. Majority of the elderly reported to be dependent and have problem to preserve their lives. According to a recent report (Das et al. 2011) approximately 65% of the elderly have to depend on others for their day-to-day maintenance and the situation of elderly females was reported to be worst than their counterpart males. The analysis further reports that less than 20% of females were financially independent whereas in males majority were found to be economically independent. Feminization of elderly is also on the rise. In the younger population, males outnumber females whereas in the elderly population females outnumber males. According to reports of situation analysis of India (Das et al. 2011), among the elderly 65% individuals are illiterate.

Psycho-Social Profile of Indian Elderly

The Indian society is changing markedly as newer and newer concepts, principles, values and morals are taking place which is eroding our cultural heritage significantly. The traditional Indian societies believe in the concept of '*Vasudhav Kutumkam*' (*the entire world is a family*) and there is a common saying, '*sarve bhavantu sukhinh, sarve santu niramaya; sarve bhadradi pashyantu ma kashchid dukhbhag bhavet*' (*everyone be happy, everyone be healthy; everyone be delighted, no one get any kind of grief/sorrow*). The psycho-social environment was advocated with basic principle of a holistic approach. Generally, collective efforts and responsibilities were being shared. To tackle any situation or problem, the lexicon of 'we' was used. However, with passage of time, the concept of 'we' is being replaced with 'I' in an ever-changing individualistic society. This pattern of egocentricity in the society is negatively affecting the status of the elderly. Lifestyle issues as well as the changing psycho-social milieu adversely affect the health and well-being of the elderly (Tiwari and Pandey 2014).

In the present scenario, due to influence of the materialistic world and many more transformations in society, newer challenges and problems are taking place (Misra 2010). Verses like '*abhivadansheelasya nitya vriddhopsevinh; chatwari tasya vardhante aayuh, vidya yashbalam* (respecting and serving elderly improves life span, knowledge, fame and strength) (Manusmriti Chapter 2: 121) have became obsolete in today's Indian society. The elderly who previously were respected and revered, now suffer and at times left alone without a single caregiver. Additionally, they have to confront various psycho-social, financial and care-related problems, which directly affect their health and well-being. Such changes adversely affect the social status and relationships with the elderly.

Changes in the family structure, social milieu, technological advancements and transformation in our own values and morals changed the entire psycho-social

milieu. As a result, they are not getting adequate care and attention; they have to face an unfriendly, isolated environment and at times feel lonely. Their power of decision making, involvement in family affairs and economic expenditures etc. are gradually declining.

Such familial and social pressures bound the elderly to think themselves as per their own inability and incompetence. Many times they try to cope with the situation and compromise with their desires so that their children or family members do not face any difficulty with them. Sometimes they succeed in developing such changes, especially when they opt for such changes on their own. But if such changes are undertaken due to some compulsion, their well-being get disturbed. Decline in physical health, financial resources, rupture in daily routine, etc., contribute to various social and psychological problems in the elderly and ultimately affect their health and well-being.

Health and Well-Being of the Indian Elderly: An Overview

Health and well-being of the elderly is a challenging issue. Along with physiological, biological, psycho-social issues, they experience health-related problems owing to their high susceptibility to infection, inability to cope with physical and psychological stress, degenerative diseases, cardio-vascular disease, cognitive impairment, etc. Amongst the elderly, certain chronic and incapacitating diseases are significantly high.

Studies report that lifestyle, lack of family support, gender discrimination, socio-economic status, disturbances in families, loneliness and feeling of negligence often lead to psycho-social problems and is clearly associated with increase in psychiatric morbidity among the elderly (Jamuna 1994; Tiwari 2000; Chadha and John 2003; Prakash et al 2004). Low literacy rate and dependency on others also have an adverse effect on health.

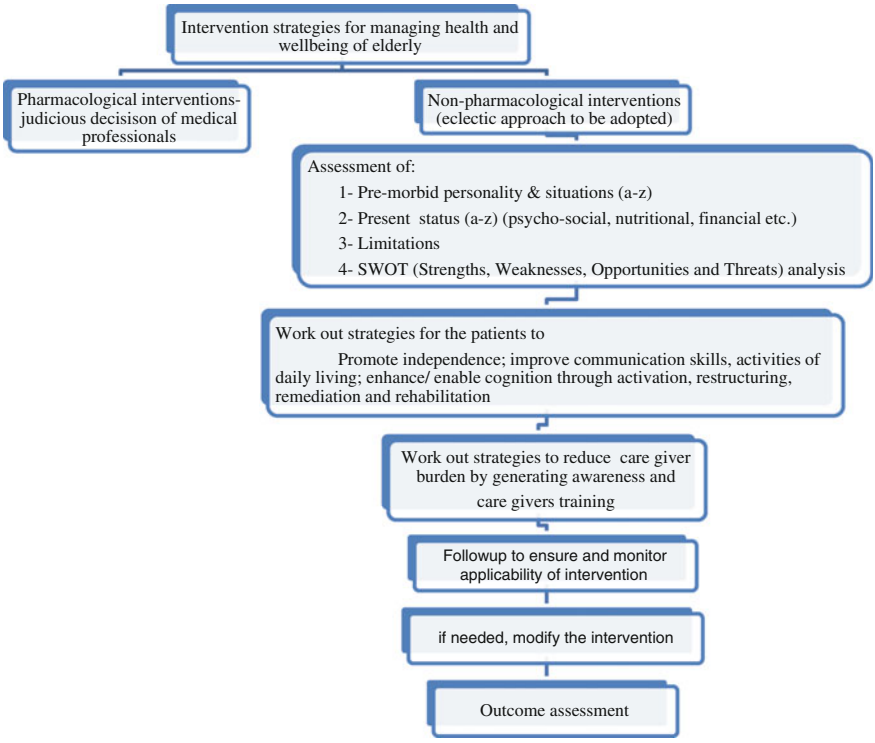
It is also reported that majority of elderly suffer with cardiovascular illness, circulatory diseases and cancers (Alam 2000; Ingle and Nath 2008). The prevalence rate of geriatric morbidity because of re-emerging infectious diseases also reported to be high. Recent studies report that rural older people are more susceptible to develop psychiatric morbidity (Tiwari and Pandey 2012; Tiwari et al. 2013) than urban older adults (Tiwari et al. 2014). Studies further reveal that more than 50% of geriatrics are facing physical (Tiwari et al. 2013, 2014) and 20.5% mental morbidity (Tiwari and Pandey 2012).

Co-morbidity may be labelled as a common feature for the elderly as degeneration and deterioration starts in the human organism at the age of 45 or early. However, old age should not be perceived as the age for disease and disability. It is noteworthy that though life expectancy is determined by genes, many of the health hazards may be managed on our own. Environmental factors and lifestyle plays significant role in maintaining and managing the health and well-being of the individual.

Strategies for Enhancing Health and Well-Being of the Elderly

Whenever someone gets ill, some kind of intervention (pharmacological and/non pharmacological) is provided for the improvement and management of the problem. However, the elderly and their caregivers often remain unaware about the available interventional strategies as well as its application. The problem increases, if the healthcare providers do not have clear and proper information regarding available healthcare strategies. One can't refute the significance of pharmacological and non-pharmacological interventions to enhance well-being and health of an elderly. By adopting the following steps carefully and through judicious selection of both type of interventions and their combination as per the need of the subject, problems could be managed more efficiently.

Flowchart-Steps of Interventions
(flowchart near here)



Pharmacological Interventions

The elderly are one of the most vulnerable groups to suffer from drug-induced adverse effects like constipation, urinary retention, delirium, cognitive dysfunction, sedation, postural hypotension, etc. The reasons for such sufferings may be varied (complicated drug regimen, co-morbidity, improper drug selection or dosing, etc.). Careful and conscious therapeutic strategies including non-pharmacological interventions are supposed to be the best option in enhancing elderly health and well-being in today's perspective.

Non-pharmacological Interventions

A number of non-pharmacological interventions are there to enhance well-being and health. It is well recognized that both pharmacological and non-pharmacological type of interventions and treatment strategies are complementary in managing the elderly with multiple morbidity. Studies report that many times non-pharmacological interventions play a significant role in dealing with several common chronic conditions in the elderly (Naci and Ioannidis 2013; Taylor et al. 2014). Individualized and focused interventions are more useful in case of managing the health of elderly. A systemic review provides evidence-based recommendations for non-pharmacological interventions for various common geriatric conditions. (Abraha et al. 2015). For non-pharmacological management one requires proper information regarding patients' illness and his pre-morbid personality as well as habits and lifestyle. In view of overall information the professional may identify and recognize/determine the intensity of problems and then can devise particular steps for interventions. Single interventional strategy is hardly used in most cases as providing a combination of interventions is found to be more useful. Thus, familiarity with various non-pharmacological interventional approaches as well as proper knowledge of its combination use is mandatory.

A number of standard and alternative methods/therapies like-cognitive behaviour therapy, dialectic behaviour therapy, supportive therapies, sensory stimulation therapy, reminiscence therapy, simulated presence therapy, validation therapy, acupuncture, aromatherapy, light therapy, massage or touch therapy, music therapy, yoga therapy etc. are used to improve health and well-being of an individual. These therapies involve certain interventional strategies. The knowledge and understanding about these therapies provides an insight of better management techniques.

Cognitive Behaviour Therapy (CBT)

CBT is a dynamic, systematic, time-bound, structured and investigative method which follows an abstract model of therapeutic interventions. In CBT intervention

includes strategies to facilitate learning through repeated presentation of information using different modalities. The elderly are taught to recognize, observe and challenge negative thoughts, behaviour as well as roles and encouraged to develop more adaptive and flexible thoughts, behaviours and roles. As per appropriateness of the strategies, one need to educate and instruct the subject and their caregiver and also monitor the same. This helps in developing pleasant and positive measures. Such interventional sessions consists of 30–45 min sessions following structured guidelines.

CBT aimed to improve cognitive functions and behaviour of the individual. A set of tasks are applied to improve cognitive functions including verbal recall and fluency, concentration, attention, comprehension, reasoning, learning abilities, language and executive functions. At the first step, one needs to recognize the level of deficiency as well as pre-morbid status of the elderly. On the basis of subject's deficiencies one decides frequency, duration, difficulty levels and scope of training sessions. If applied properly, interventions of this therapeutic technique generally helps in improving depressive symptoms, somatization, mild levels of memory deficits, anxiety disorders, etc., as cognitive training helps in improving the 'core' abilities of an individual.

Behavioural Interventions

In behavioural therapies one needs to assess the subject in detail and know the ABC (antecedents, behaviours and consequences) of the particular disorder applying relevant assessment tools. On the basis of findings of the assessment, roots of the particular problems and associated behaviours as well as its impact on the individual should be identified and analysed thoroughly. Behavioural therapies include functional analysis of the particular behaviour. Further, professionals try to find out influences of the stimuli on behaviour, positive reinforcers for behaviours and techniques for strengthening behaviour. In the clinical set-up we found that behavioural interventions not only improve patients' physical and mental health condition but also the well-being and quality of life of the care providers. Generally, behavioural interventions are based on the analysis of these findings. By behavioural interventions the elderly accept their changed roles and get adjusted with their environment in a better way (Ramamurti and Jamuna 2010).

Reality Orientation

Reality orientation aimed to help people by reminding them of facts about themselves and their environment. It is provided in the form of consistent positive reinforcement to correct confused behaviour of the elderly. In this therapy, generally orientation is being provided to the individual specifically regarding their environment using a range of materials and activities. This involves consistent use of orientation devices such as signposts, notices and other memory aids. When an

elderly forgets about his/her meal, we often train the caregiver that s/he may provide the meal to the patient and leave the used utensils till the other meal is served so that the patient could recognize that the particular meal is taken by him/her. It is author's own experience during treating patients that reality orientation sessions increase people's verbal orientation and sometimes increase recall.

Validation Therapy

This therapy incorporates a range of specific techniques based on general principles of validation. It can be considered as a kind of philosophy of care. In validation therapy one has to provide a high degree of empathy identifying the subject's entire frame of references. Validation therapy's steps incorporate: classification of particular behaviour/s; stipulation of easy, effortless and practical interventions which facilitate in restoring the dignity; and prevention of worsening conditions of vegetative functions. Further, the therapist should be an emphatic listener as s/he attempts to communicate with individuals by empathizing with the feelings and meanings hidden behind their confused speech and behaviour. It is the emotional content of what is being said that is more important than the person's orientation with the present. Validation therapy promotes contentment, leads to positive affect and behavioural disturbance, produces positive effects and provides the individual with insight into external reality (Hitch 1994).

Reminiscence Therapy

It involves the discussion of past activities, events and experiences with another person or group of people. Revival of past experiences is the core feature of this therapy, especially life's happy events which are intensely there in the memory of the subject like wedding or birth of a child. This therapy can be applied in groups or with individuals. Evidence of significant impact was found to be little in cognitive improvement in one of our study however, after the therapy subject develops feeling of well-being. The application of reminiscence therapy significantly improves the behaviour, well-being, social interaction, self-care (O'Donovan 1993) and motivation (Gibson 1994).

To enhance health and well-being of the elderly there are some alternative non-pharmacological therapies which may play an important role. However, these therapies often lack evidences regarding their impact; thus, they need to be acknowledged and practiced.

Art Therapy

This therapy may be used as a treatment option for those elderly who have some previous (pre-morbid) interests in making drawings or craft. It may provide

meaningful stimulation to the subject. A study carried out on patients with dementia (PwD) reports that it improves social interaction and levels of self-esteem (Killick and Allan 1999). Craft-related work as well as drawing and painting stimulates the degenerated brain. If some of the cognitive domains are intact and patients are being involved in such kinds of activities, chances of improvement in cognition will be always there. Such activities provide the patient an opportunity for self-expression and choice for choosing colours and themes for their creations; which also may be analysed further.

Music Therapy

Music therapy involves listening to music or singing. Studies report that people with dementia get benefitted from music therapy (Lord and Garner 1993). Patients get benefits from music, if they get involved in the activity such as singing or playing or listening. Studies report that music therapy helps in increasing the level of well-being; patient may have better social interaction and improvement in autobiographical memory, behaviour as well as agitation (Cohen-Mansfield 2000; Gerdner 2000).

Activity Therapy

Exercises, yoga, meditation, leisure, hobby, etc., related indefinite types of activities may be involved in this therapy. It is a formless group of recreation such as dance, sport and drama. It has been shown that physical exercise can have a number of health benefits for people with dementia.

Aromatherapy

Aromatherapy is one of the fastest growing fields amongst all complementary therapies (Burns et al. 2002). It is advantageous over other treatment options as its application is easy risk of adverse effects is almost negligible. It has a positive image and its use aids interaction while providing a sensory experience. The oil which are usually applied in aromatherapy improve behavioural symptoms; however, supportive studies to establish its significance are minimal.

Spirituality-as Non Pharmacological Intervention

Observing the limitations of the chemical model it is declared that life could be beyond molecules. According to many, including Swami Vivekananda, unselfish love for God as well as for HIS creations—human beings, flora and fauna, environment and all things around in this universe—is the hallmark of a spiritually

aroused human being. An individual with spiritual support easily realizes that there are many more important things for long-term happiness and peace of mind than merely taking proper care of one's human form and making adequate provision for material comforts in life. Spiritual care/therapy is usually given in a one-to-one relationship, it is completely personal and makes no assumptions about individual's conviction or life orientation (Singh et al. 2014). Singh et al. (2014) further advocate that comprehensive multidimensional model that combines psychological, social, genetic and neurobiological factors, based on previous research and theory, is needed to guide future research in the area of spirituality. Integrated use of spiritual interventions enhancing individual resilience to stress and the mind–body approaches to stress reduction (e.g., meditation, yoga, mindfulness and Tai Chi) are likely to improve the overall functioning and well-being in older adults.

A study was carried out by the authors in the department on elderly caregivers with adjustment disorders and it was found that spiritual intervention had a positive impact. However, the data is yet to be published. Many individuals with spiritual practices emphasizes that it provides a feeling of contentment as it give calmness, happiness and feeling of emotional balance, peace and love to the elderly and also helps in healing traumatic conditions and gaining health. Again, such experiences need evidence-based documentation, which definitely help in improving the health and well-being of the elderly at large.

All such non-pharmacological therapeutic interventions have positive impact on health and well-being of elderly. Studies reveal that the burden of morbidity among the elderly is enormous; number and proportion of care providers is almost negligible (Tiwari and Pandey 2012). In such a situation, people who are interested in maintaining health and well-being of the elderly need to wake up and join their hands for the betterment of this segment of population. It will be worth mentioning here that there are a number of therapeutic interventions and the application of a combination of these interventions is found to be more result oriented (authors own experience). In managing the health and well-being of the elderly, person-centred approach is more acceptable; however, hardly much study has been conducted in India. Generally, combinations of these therapies are being provided by the professional to get positive, long lasting and significant changes. Few cases involving illiterate elderly with cognitive impairment, who were studied during the authors' post doctoral fellowship in the Department of Geriatric Mental Health (DGMH), are shared here.

Cases and Strategies for Improving Health and Wellbeing of Elderly with Dementia-Evidence Based Interventions

With funding support from Indian Council of Social Sciences Research (ICSSR) during 8 March 2013 to 8 March 2015 authors had an opportunity to carry out a post doctoral fellowship awarded study titled '*Developing Modules for Cognitive Enhancement for Illiterate Older Adults with Cognitive Deficits*'. Some of the case vignettes of this particular project are discussed

Case 1: Smt. DD, 72 years old, widowed mother of three sons and one daughter, living with her middle son and grandchildren since a period of about three years, became more forgetful. Further, she became irritable, agitated and suspicious and also started complaining to others that she didn't get food. She was gradually losing her ability to take care of her day-to-day activities. When she started complaining to everyone that she didn't get food she was brought in the department for consultation and treatment. Specific problems to be addressed, which were pointed out by the caregiver:

- Forgetfulness
- Irritability
- Decrease in complains as it was embarrassing for the care giver and his wife

On a detailed assessment by the DGMH team she was diagnosed as case of mild Alzheimer's Dementia (AD)

Caregivers were taught to involve Smt. DV in one or other kind of activities of her interest so that she gets engaged

They were also taught that the task given by them should be given by accounting her past skills and enjoyments and assist accordingly

For remembrance of food intake caregivers were educated that whenever they give them one meal or breakfast keep the utensils there so that she had the remembrance of the same and take away the first meal/BF utensils when the second is to be served

They were also taught that the environment of the family should be empathetic for her

According to the primary caregiver of the patient DV's irritability and agitation was almost abolished as she was now made engaged with small domestic activities as per her earlier tests and now she was not getting irritated nor was complaining for food. The primary caregiver also shared his view that probably there was no need to provide medication as she was better on non-pharmacological management. However, he advocated that without consultation of the clinician he should not stop medication

Case 2: Mr. MB 61 years a married male living with his wife and children came to the department with chief complaints of forgetfulness. MB is a *feriwala* (street vendor) and only earning person in the family. He realized that forgetfulness was his major problem when he was unable to recall prices of the particular items which he sold

On detailed assessment he was diagnosed as a case of mild cognitive impairment.

The major solution for Mr. MB's problem was to provide some memory aid so that he could be able to perform his occupational duties properly. He was very much disturbed as he was the only earning member of the family and at times due to forgetfulness he became unable to sell his items or give it on less prices. The second problem with him that he was illiterate, therefore, unable to stick a price tag and read the same during his duty hours. A detailed discussion was carried out with him and his major problem was related with his occupation. He was suggested to purchase some rice papers and name them a particular amount and stick its pieces on the items, which are to be sold. Further, he was suggested to purchase a dairy or notepad and stick dummy of rupees and rice papers of different colours accordingly so that if any time he gets confused he may be able to identify the price of a particular colour

Practical demonstration was given to him so that he may be able to recall the process

This memory facilitation technique along with persistent follow-up enabled Mr. MB to execute his occupational work properly

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Case 3:

Smt. GD living with her husband came with her son-in-law and daughter to the department with complaints of forgetfulness and suspiciousness. She had moderate dementia. Her daughter reported that though she enjoyed receiving friends and relatives, but often became agitated and angry when her father had visitors. The daughter also reported that she often became suspicious and started complaining that her belongings has been stolen by the maid, which often created chaos at home

On detailed assessment it was found that initially Smt. GD was an active member of the house and most of the time she used to remain in the kitchen for making some breakfast or edible recipes for family members. Since her daughter-in-law came she took all the responsibilities and gradually she confined herself to her room. Initially nobody noticed, but within a span of three years her cognitive functions declined moderately

It is a general principle that for helping anyone one should try to maintain his/her independence as much as possible. Known surroundings, regular and reassuring routine helps the subject in getting well. Unnecessary noise and too many visitors should be avoided. If the subject is embarrassed about his inability to do things, he should be reassured and encouraged. Humour may help in defusing tension. These interventions were provided to caregivers and they were able to manage the subject well

For managing illiterate patients suffering from dementia, many other interventions as per patient's/caregiver's needs were provided which have shown beneficial impact. It is well recognized that during the course of illness, patients with dementia lose everyday skills and often become dependent on the care provider. The level of impairment varies from person to person. For maintaining the skills of dementia patients they should remain active. They should be assisted for continuing their previous activities as many as they can. Least required help should be offered to them so that their independence and dignity could be maintained

Some Guidelines for Maintaining Independence and Dignity of the Elderly Patient/Subject

- Daily care routines should be monitored, as these are opportunities for social interaction and physical stimulation
- Provide them with some task to stimulate and get them busy; however, their past skills and enjoyments should be taken into account. For instance, if one enjoys cooking her assistance in kitchen activities may be beneficial for her
- One should be sensitive about the energy level of the subject so that s/he should not be burdened unduly. If the person doesn't remember things, rather than asking the person to try and remember, simply give the information. This will help in reducing anxiety and securing cooperation
- During providing help the patient should get involved as much as possible. Assistance or help doesn't mean to take over the task from the patient
- Support, appreciation and admiration make the patient more confident. Identify what the patient can and actually do and try to de-emphasize the lost skills

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- Many times subject don't remember what they were told as their concentration is poor. Therefore, caregivers should give enough time and trial for performing a task; training is to be given just like a child and s/he should be encouraged and reinforced for positive actions
- Don't criticize the patient
- While providing care one should be mindful of one's own mental state. One should be careful for taking time to rest and relax. Looking after oneself during providing care is a sensitive skill of a caregiver
- If there is strong resistance to get help, the caregiver should take a break and return later
- Caregivers should also take training for skilful management of dementia patients. Study reports that proper understanding of prognosis and complications of interventions helps in avoiding unnecessary aggressive interventions (McCurry et al. 2009) and that reduces caregivers burden and depression as well as delays hospital admission (Brodaty and Donkin 2009).

Along with pharmacological interventions offering dialectic remedies, environmental modifications do wonder. There is a need between synchronization of nutrition (*ahar*), leisure (*vihar*) and thoughts (*vichar*) in proper order (Dalal and Misra 2006).

Some General Interventional Strategies to Improve Health and Well-Being of the Elderly

Maintaining health and well-being of the elderly can be improved only if we are able to provide proper psycho-social environment, economic and social security, and maintain the functional status, well-being and health of elderly. Optimal health is essential at any stage of life and so in old age. Optimal health for the elderly refers to (i) feeling free from disease, (ii) adequate functioning in the particular genetic and environmental condition, (iii) adequate familial and social support, and (iv) ability for continuous personal development. To attain these objectives we need to generate awareness regarding healthy lifestyle and can be achieved if the elderly adopt various healthcare strategies at primary, secondary and tertiary care levels.

Provide Primary, Secondary and Tertiary Care to the Elderly

It can be observed that to address the huge burden of health problems of the elderly, especially mental health, there is an immediate need to identify and involve primary (medical and para medical) and secondary (MD-psychiatry: providing provincial health care services) healthcare providers and give them training to equip geriatric mental health better. With this strategy, the cadre of primary and secondary healthcare providers will be available to make an early diagnosis and initiate treatment in a short period. At the same time, some minimum infrastructures

(earmarking some of the existing beds) at least at the district headquarter levels with provisions of medicines to treat and manage the older adults may be made available for geriatric mental healthcare. Basic and elementary healthcare services for elderly in the community itself need to be ensured. Such type of healthcare initiatives and health programmes for the elderly need to be developed according to the ratio of the elderly population in a particular community. For tertiary level care, one full-fledged teaching and training department are to be established in each state to provide superspecialty care for geriatric mental health.

Develop Elderly-Friendly Environment

To maintain emotional state, coping and well-being of the elderly, we need to provide elderly-friendly environment. Their interaction with family and friends develops supportive environment. Engagement of the elderly in their past enjoyable activities may provide physical stimulation. A person who enjoyed cooking or cleaning like activities may be involved in monitoring these activities. Proper arrangements of light, hurdle-free places are to be provided to the elderly to make them more comfortable. If an elderly is not able to handle his/her day-to-day activities, assistance should be given without delay to make them feel relaxed.

Fabricate Better and Strong Individual, Family and Social Relationship

This will help the elderly to remain healthy. Family and society need to understand the emotional and psychological needs of the elderly. Intimate and close relationships are found to be more valuable in old age. Social and family involvement as well as dependency on others is enjoyed by the elderly. It provides a sense of self-efficacy and satisfies a sense of social worth. If the elderly feel himself/herself to be useful for the family, their well-being and mental health will definitely improve.

Provide Economic Protection

Paying capacity of the average Indian elderly is poor; in such a situation, they need a proper policy to maintain their financial status. Healthcare expenditure of the elderly needs to be identified and financial security need to be provided.

Conclusion

It is clearly indicated that the population of the elderly in India is increasing at a fast rate; managing and maintaining their health and well-being from a general perspective to disease level is a prudent issue. Elderly health and well-being may be enhanced by providing peaceful, quiet, composed and conflict-free environment. The government is taking initiatives in this direction by introducing new policies and plans, which will bring more help for the elderly. However, awareness in this population about their needs and rights may also be helpful in upgrading their health and well-being.

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