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AN EVALUATION OF THE IMPACT OF RADICAL MUSCLE RELAXATION THERAPY ON ANXIETY RELIEF IN SELECTED RAJASTHAN NURSING HOMES

Shakti Singh Soni[1], Dr. Virendera Singh Choudhary[2]

Department of Nursing

[1,2]Shri Venkateshwara University, Gajraula (Uttar Pradesh) – India

Abstract-Therapies such as PMR are increasingly being embraced by military service members. It is natural to wonder if it can be beneficial to practise PMR against the often intense pressures of military service, but there are definitely advantages worth exploring. More than half of the Military Treatment Facilities (MTFs) currently have PMR as a treatment alternative, most usually for anxiety and stress management, but also for chronic pain and post-traumatic stress. Progressive muscle relaxation can not only help you enhance your performance, but PMR exercises can also support your children. Relaxation strategies are an effective coping mechanism for children to grow when they experience stress or other significant emotions more and more. Instead of "emotion-focused" coping, children frequently tend toward using "problem-focused" coping (targeting the external situation around them) (changing their internal response to the situation). The methods of breathing and calming help facilitate dealing with feelings, so it may be a good idea to do PMR with your children to help them practise. Consider getting creative with your PMR scripts: turn it into a storey and come up with a plot to help calm each muscle group instead of only providing instructions. This article compares the degree of anxiety among elderly in experimental and control group after administration of Progressive Muscle Relaxation therapy in Rajasthan. It also demonstrates the effectiveness of dance and movement therapy and progressive muscle relaxation on depression and quality of life among elderly.

Keywords: Therapies, Pmr, Military Treatment Facilities, Relaxation Strategies

1. RELAXATION TECHNIQUES FOR HEALTH

A variety of activities, such as progressive calming, directed visualisation, biofeedback, self-hypnosis, and deep breathing exercises, are relaxation methods. In all the objective is similar:

to generate the normal relaxation response of the body, marked by slower breathing, lower blood pressure, and a sense of enhanced well-being.

Meditation and activities that include movement meditation, such as yoga and tai chi, can also facilitate relaxation. Details about these activities can be found elsewhere on the NCCIH Web site.

Stress management programmes usually provide methods of relaxation. Relaxation strategies have also been tested to see whether the treatment of different health conditions may be of benefit.

- **The importance of practices**

Relaxation techniques are skills and they require practise, like other skills. People who regularly use relaxation methods are more likely to benefit from them. If you are using relaxation methods to help treat a chronic health condition, routine, daily practise is especially crucial. The continued use of techniques of relaxation is more powerful than the short-term use.

Relaxation techniques include the following:

Autogenic Training

In autogenic training, you learn to concentrate on the physical sensations of warmth, heaviness, and relaxation in different parts of your body.

Biofeedback-Assisted Relaxation

The techniques of biofeedback calculate body functions and send you data about them so that you can learn to monitor them. Biofeedback-assisted relaxation uses electronic devices to teach you to create relaxation-related changes in your body, such as decreased muscle tension.

Deep Breathing or Breathing Exercises

This technique involves focusing on taking slow, deep, even breaths.

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Guided Imagery

For this technique, people are taught to focus on pleasant images to replace negative or stressful feelings. Guided imagery may be self-directed or led by a practitioner or a recording.

- **Progressive Relaxation**

This process, also called Jacobson relaxation or progressive relaxation of the muscle, involves tightening and relaxing different groups of muscles. Progressive relaxation and guided imaging and breathing exercises are also paired with.

Self-Hypnosis

In self-hypnosis programs, people are taught to produce the relaxation response when prompted by a phrase or nonverbal cue (called a "suggestion").

2. LIFE SPAN DEVELOPMENTAL DIATHESIS-STRESS MODEL

Beyond placing the onset of disorder in the life course, a life span perspective situates risk and protective factors developmentally, as illustrated in Figure 1. We discuss these factors in respective sections below. Inclusion of protective factors as well as risk factors in a developmental model is crucial to crafting an explanation for decreasing rates of depression in old age.

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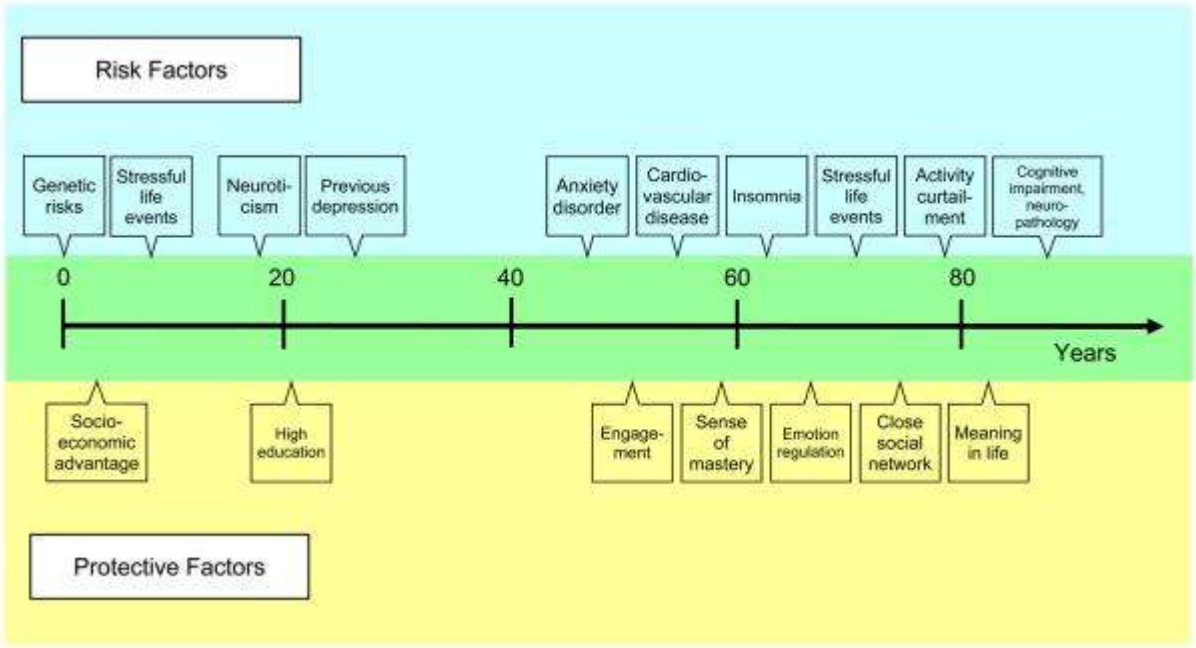

Figure: Life Indian perspective on risk and protective factors for late life major depression. Schematic illustrating risk and protective factors corresponding to when they emerge over the life Indian

3. EPIDEMIOLOGY

In the Diagnostic and Statistical Manual for Mental Disorders, multiple depressive disorders are described, including major depressive disorder, dysthymic disorder, bipolar disorder, and mood disorder due to a general medical condition. Depressed-mood adjustment disorder can also be considered a form of depression.

Recently, much attention has been paid to the experience of depressive symptoms that do not meet the requirements for a major depressive disorder diagnosis. Using more or less well-known categories, e.g. minor depression, subsyndromal depression, etc., some research has studied this phenomenon, whereas other studies have defined clinically significant depressive symptoms as a score on a depressive symptom checklist above a threshold.

Some, but not all, research indicates that depression may occur on a continuum, with symptoms that do not meet syndromal criteria indicating a less extreme form of the same

condition for major depressive disorder. The prevalence of major depressive disorder varies from that of clinically relevant depressive symptoms in older adulthood, as discussed below. Nonetheless, the same vulnerability and protective variables are correlated with both in most situations. Where distinctions have been documented, we indicate that. We are focusing mainly on major depressive disorder in the present study.

In most large-scale epidemiological studies in the United States and abroad, the incidence of major depressive disorder at any given time in population samples of adults aged 65 and older varies from 1-5 percent, with the majority of studies reporting prevalence at the lower end. In about 15 percent of community-dwelling older adults, clinically relevant depressive symptoms are present. Depression rates tend to be higher in older women than in older men, but in this age group, particularly among the oldest, the gender disparity is much narrower than the two-fold difference seen over the rest of the adult lifespan.

There are few disparities in the incidence of depression according to race or ethnicity, while depressive symptoms may be more prevalent among older Hispanic women than among non-Hispanic whites. In specific subsets of the older adult population, including medical outpatients (5-10 percent, although estimates differ widely), medical inpatients (10-12 percent), and residents of long-term care facilities, rates of major depression among older adults are significantly higher (14 to 42 percent).

Congregate living arrangements, as demonstrated by the lower rate of depression among older kibbutz residents relative to group samples, are not depressogenic per se (Blumenstein et al., 2004); rather, relocation to congregate living is generally caused by health conditions and/or loss of a caregiving spouse.

The prevalence of major depression in population samples of older adults represents a substantial decrease in both male and female midlife prevalence rates. In comparison, most research evaluating elevated scores on a checklist of depressive symptoms (rather than a diagnosis of depressive disorder) show higher rates of depressive symptoms of clinical significance in older adults than in midlife.

How should such prevalence disparities be interpreted? The diagnostic rubric for major depressive disorder in older adults may underestimate the disorder. Dysphoria, a symptom less often endorsed by older adults relative to younger adults, is privileged by existing diagnostic standards and involves a determination that symptoms are not due to the immediate physiological effects of a drug or general medical disorder, or to a recent bereavement. Depressive symptom checklists, on the other hand, are inflated since they do not preclude symptoms that are specifically associated with a physical disorder or deprivation, all of which rise with age in frequency.

In fact, depressive symptoms decrease in frequency with age after accounting for the effects of gender, education, physical illness and deprivation; although it should be noted that physical illness and deprivation may be causes of depression rather than mere confusion.

Therefore the preponderance of evidence suggests that with age, depression becomes less frequent and less extreme, but that depressive symptoms of lower severity, which may also be consequential and treatable, should not be ignored. We explain the explanations for age differences in the incidence of depressive symptoms below; we turn first to age differences in depression presentation.

4. ETIOLOGY AND RISK AND PROTECTIVE FACTORS

Etiology

Why, particularly for the first time, in old age, could a person become depressed? The lifespan view of risk factors that can help to explain the incidence of depression in an older individual is given in Figure 1. In late life, biological variables loom large. The susceptibility to depression appears to be heightened by both cardiovascular and neurological changes that arise with natural ageing or with age-related diseases.

However in view of the fact that neurobiological changes are widespread with ageing and physical disorder is not unusual, these reasons are not appropriate, yet only a small fraction of older adults become depressed.

Many of the losses that define later life will also be easy to point to yet, older people undergo traumatic life experiences and only a small proportion become depressed. For these reasons, we believe that it is possible to recognize the emergence and maintenance of depression in late life as an association between certain vulnerabilities, including genetic influences, cognitive diathesis and age-related neurobiological shifts, as well as the types of traumatic events that occur more often in late life than in the past.

A relative absence of incidents with positive results focuses on behavioural explanations of depression that are not unique to late life disorder. Since involvement in activities is not strengthened, frequency decreases, contributing in turn to less opportunity for positive results of experiences with the environment.

Many those are depressed, relative to non-depressed people show social ability deficiencies that are likely to lead to less involvement and more negative results. Self-critical cognition can also play a role in reducing the participation of a depressed person in activities. Activities are frequently accompanied by self-critical cognitions in the depressed person, which will have a punitive impact on the efforts of the person, leading to a further reduction in participation in activities. Since self-critical internal verbalizations often work to provide a justification for not engaging in potential actions that are considered likely to result in failure, cognition may be reinforced negatively and therefore be more likely to occur in the future. The effect will be a feedback loop in which the degree of active interaction with the environment is decreased by negative cognitions, and the cognitions are sustained by the relief associated with not risking extra failure.

5. DATA ANALYSIS AND INTERPRETATION

Data analysis and interpretation is the process of assigning meaning to the collected information and determining the conclusions, significance and implications of the findings. It is an important and exciting step in the process of research. In all research studies, **analysis** follows **data** collection. The measurable examinations were completed utilizing the all-around perceived factual programming SPSS 15.0. Microsoft Word and Microsoft Excel were utilized to produce diagrams and tables.

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Patient's Age	No. of respondent
40-50 years	19
51-60 years	59
61-70 years	46
71-80 years	41
Above to 81 years	35

Table 4.1: Age of Patients

Now we were discussing about the age of respondents, out of 200 respondents, 19 of respondents were between ages 40-50s, 59 of respondents were in between 51-60 years, 46 of respondents were between 61-70 years, 41 of respondents were between age 71-80 years and rest of respondents agree with age of above 81 years.

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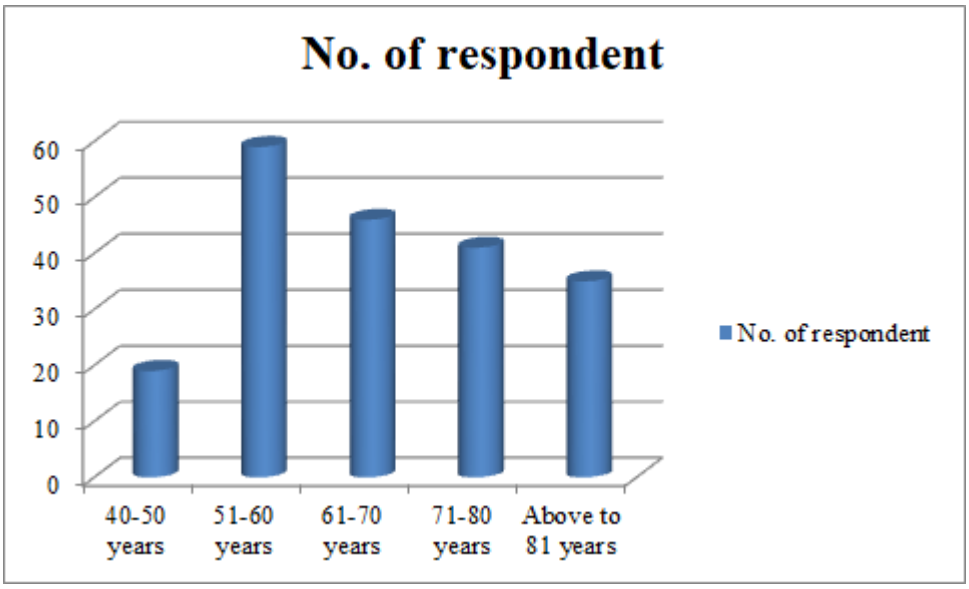

Figure: Age of Patients

Heart rate	No. of respondent
100-130	69
120-140	49
110-150	45

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140-160	37

Table 4.1: (a) Heart rate intervention with progressive muscle relaxation therapy

Above table 4.1 descriptive the heart rate intervention before progressive muscle therapy, 69 respondents agree with 100-130, 49 respondents agree with 120-140, 45 respondents agree with heart rate of 110-150 and rest of respondents agree with 140-160 heart rate.

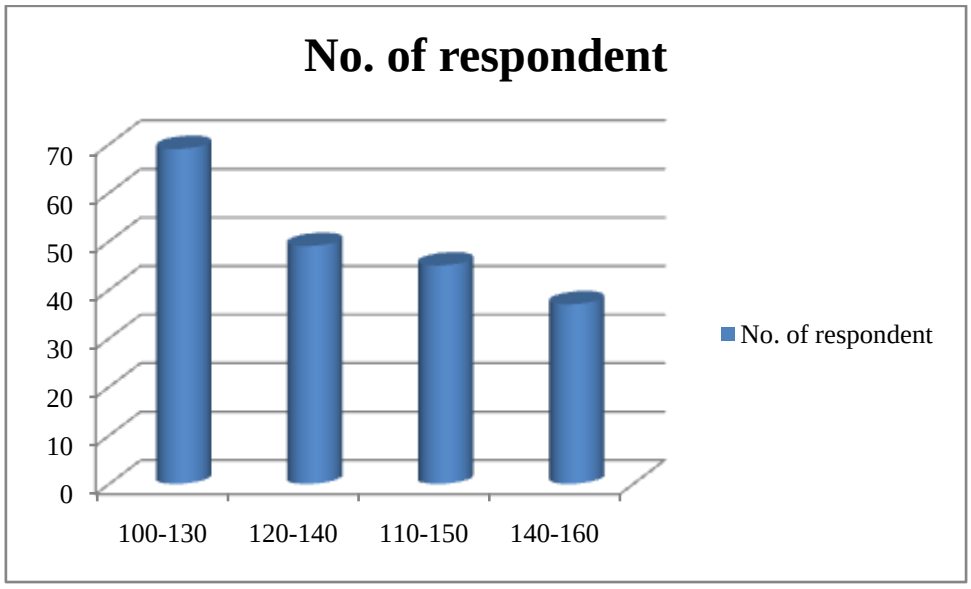

Figure: (a) Heart rate intervention with progressive muscle relaxation therapy

Heart rate	No. of respondent
100-130	35
120-140	53
110-150	68
140-160	44

6. CONCLUSION

Depression, even in a more delimited form, is less common in late life than in mid-life. While depression in late life is often less serious, the effects may be devastating. From a lifetime developmental diathesis-stress viewpoint, depression in older adults can be understood. In the aetiology of depression, risk and protective factors become more or less dominant as they vary in frequency or significance over the life period. Like some life events, biological threats

become significantly more prevalent in late life, while psychological vulnerability decreases and psychological resilience increases.

Given the biological and social difficulties associated with older adulthood, the importance of protective factors is illustrated by the fact that depressive disorders are less prevalent in this age group rather than more prevalent. The etiological image of late-life depression is complex. Heterogeneity characterises late life depression, with age of first onset a possible predictor of etiological differences.

Early onset depression is caused by depression genes, whereas late onset can be either a dementia prodrome or a biological or psychological reaction to events that are more normal in late life (e.g., physical illness, bereavement, caregiving). In late-life depression, comorbidity is especially common, growing from possible biological, psychological and social mechanisms. In broad categories of risk factors for late life depression, which include most prominently neurological vulnerability, physical disease and impairment, and traumatic life events such as bereavement and caregiving, there is strong agreement.

The relationships between these risk factors are just starting to be investigated by research. As the data about risk and protective factors accumulates, it becomes possible to design and evaluate novel preventive approaches. In view of the results obtained, the hypothesis that Progressive Muscle Relaxation induces the experience of pain relief as manifested by the patients was confirmed. During the implementation of the relaxation technique, it is important to point out the potential impact of the researcher's interference with the data collected.

In this way, in the event of post-surgery pain issues, we advise health care teams to prepare for the implementation of the progressive Muscle Relaxation strategy, which will definitely deliver beneficial outcomes to patients. We also recommend that patients be taught the self-application of such a pain management technique. It is necessary; however to note that post-surgery pain is real and all members of the health team must always recognise it. Analgesics must be accessible to all patients who have undergone surgical procedures to manage and treat pain.

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