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Psychological & Physical Aspect of Old Age Home Inmates: Review

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ABSTRACT: Aging, progressive physiological changes in an organism that lead to senescence, or a decline of biological functions and of the organism's ability to adapt to metabolic stress. Behavioral and psychological factors — for example, physical activity, smoking and other health behaviours, cognitive and social engagement, personality, and psychosocial stress — play a critical role in health across the lifespan. Psychological and Physical aspect are closely linked at older ages. The aspects of psychological can be related with life satisfaction, feelings of happiness and sense of purpose and meaning in life. We review recent advances/studies in this field, and present new analyses concerning the pattern of Psychological and Physical aspect across ageing.

KEYWORDS: Psychological, Physical, Ageing.

I. INTRODUCTION

People worldwide are living longer. Today most people can expect to live into their sixties and beyond. Every country in the world is experiencing growth in both the size and the proportion of older persons in the population. By 2030, 1 in 6 people in the world will be aged 60 years or over. At this time the share of the population aged 60 years and over will increase from 1 billion in 2020 to 1.4 billion. By 2050, the world's population of people aged 60 years and older will double (2.1 billion). The number of persons aged 80 years or older is expected to triple between 2020 and 2050 to reach 426 million.

Common conditions in older age include hearing loss, cataracts and refractive errors, back and neck pain and osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression and dementia. As people age, they are more likely to experience several conditions at the same time. Older age is also characterized by the emergence of several complex health states commonly called geriatric syndromes. They are often the consequence of multiple underlying factors and include frailty, urinary incontinence, falls, delirium and pressure ulcers. A longer life brings with it opportunities, not only for older people and their families, but also for societies as a whole. Additional years provide the chance to pursue new activities such as further education, a new career or a long-neglected passion. Older people also contribute in many ways to their families and communities. Yet the extent of these opportunities and contributions depends heavily on one factor: health. Evidence suggests that the proportion of life in good health has remained broadly constant, implying that the additional years are in poor health. If people can experience these extra years of life in good health and if they live in a supportive environment, their ability to do the things they value will be little different from that of a younger person. If these added years are dominated by declines in physical and mental capacity, the implications for older people and for society are more negative.

II. STUDIES RELATED TO PHYSICAL ASPECT

Journal of Ageing and Physical Activity (2009) published an article 'Health related quality of life in frail Institutionalized elderly: effects of a cognition- action intervention and Tai chi'. A new intervention based approach using familiarity based movements and non judgmental approach of 'cognition-action' was proposed and was tested with Tai chi on health related quality of life in frail institutionalized elderly. Aged from 65 to 94, 52 participants took part in a 2 week programme. Changes in mini mental state score, falls efficacy scale and exercise self-efficacy were explored. Adapted CA programs and Tai chi were both efficient in improving HRQOL of frail elderly.

Bharati Bhosale and Rohini Devi (2008) examined the health status of institutionalized elderly in Maharashtra state. In 19 old age homes, 500 institutionalized elderly were selected from the regions of Maharashtra (Maharashtra state). These subjects were interviewed individually to elicit information on commonly prevalent health problems. Health status of the institutionalized elderly was assessed in the investigation. Majority of the selected elderly complained of impairment in vision (61.6%) followed by arthritis (47%), loss of memory (46.4%), insomnia (42.6%),

and headache (39.4%) and impaired hearing (38.4%). It can be concluded that majority of elderly were suffering from different health problems. Prevalence of health problems was significantly high in elderly women as compared to men. Prevalence of health problems increased with advancement in age. **Agarwal (2006)** examined that the elderly living alone are more prone to environmental and nutritional risk factors. Their health status is poorer than elderly living with family members.

Ajay et al., (2010) focused the study of Morbidity pattern in inmates of old age homes in urban area of central India. The study was conducted in Nagpur. A Cross sectional study was carried out among all 221 inmates of three old age homes. Majority of inmates 62 were in the age group 80 years and above. 164 belonged to Hindu religion. 147 were widow or widowers. 179 were dependent economically. 77 inmates loneliness was the reason for admission. The most common morbidities found were anemia in 145, arthritis in 87, hypertension in 83, cataract in 69, and acid peptic disease in 47. Other morbidities found were impaired hearing in 38, bronchial asthma in 31, and diabetes mellitus in 28 inmates. The results of study showed that major portion of elderly were dependent economically, neglected, lived alone and suffering from various health problems. Health education regarding stress management exercises, yoga, etc., should be given to inmates of home for aged.

Heydari, Khani and Shahhosseini (2012) analysed the health related quality of life of elderly people living in two settings. (i) Residents in a nursing home and (ii) Old age homes in a district of North Iran. The data were drawn from 220 elderly (60 years of age) sampled from both settings. The average scores for several domains including total physical health, total mental health and overall health were less than 50, which can be interpreted as a less desirable level of health related quality of life in Iranian elderly people. Residents living at homes scored better in all domains of SF-36. Multiple regression analysis indicated that residency, marital status and education had a significant coefficient for total SF36 score. The health related quality of life of elderly people in one city in Iran, particularly those in nursing homes, is inadequate. There is a need to design programs to increase elderly people's interaction with others and establish social networks for them and opined that these may enhance a sense of positive quality of life among the elderly.

Rekha and Vijaya (2011) in their study 'Dental prosthetic status and prosthetic need of the institutionalized elderly living in geriatric homes in Mangalore' reported that a high unmet need for prosthetic care existed among the institutionalized elderly surveyed. To promote oral health among the elderly, there was need to know prosthetic status and prosthetic need. The inmates of old age homes in Mangalore were interviewed. A cross sectional study was undertaken and 133 subjects aged 60 years and above was examined (54.1% males and 45.1% females). 88% of those examined were fully edentulous and only 12% had complete dentures. None of the study subjects had partial dentures.

Nekar and Mahesh (2011) worked on quality of life among the old aged in Karnataka. They aimed to determine the health related problems among the elderly; to determine the different domains of quality of life affected and restricted activity days in elderly population. The method was community based cross sectional study on 200 geriatric subjects (greater than 60 years) by simple random sampling method. WHOQOL-Bref scale was used to assess the quality of life. Results showed that 72.5% were in the age group of 61 to 70 years, 52% were males and 50% belonged to poor socio-economic status and 94% were literates. Vision problems (64%), arthritis (55.5%), hypertension (47.5%), diabetes (38.5%) constituted the bulk of morbidity. Physical domain was affected significantly in quality of life. Vision problems, arthritis, hypertension, diabetes constituted the bulk of morbidity. Geriatric clinics can improve the health status of the elderly population by screening to detect the morbidities early and creating some awareness in them.

Prabhavathy (2011) examined Nutritional profile of institutionalized elderly women in Chennai. The study focused on understanding the background information and life style pattern of 300 elderly women residing in ten old age homes i.e. five paid and five unpaid category and to assess their nutritional status. Interview schedule were used to collect data from the elderly women i.e., 150 samples from paid homes and 150 samples from unpaid homes, based on their willingness and co-operation. The maximum age of the elderly studied was between 70 to 79 years. The data shows that finding communicates those childless elders likely to consider the option of staying in an old age home. Majority of them were not earning, but their relatives / friends financially supported them. More than 50% of the elders did not have anybody to take care of their needs. Out of 300, 21% disagreed with son/daughter/son-in-law/daughter-in-law and therefore, opted for old age homes. 12% in unpaid homes and 13% in paid homes chose to be independent without being burden to their children. Though both paid and unpaid elders were satisfied with their basic needs only 2% in paid homes and 6% in unpaid homes were satisfied with psychological needs; only 7% of unpaid elders were satisfied with financial needs.



Lai et al., (2010) examined Health ... related quality of life and Health utility for the institutional elderly in Taiwan. 465 elderly persons living in long-term care institutions in Taiwan were interviewed using Taiwan's abbreviated version of the world health organization quality of life (WHOQOL-Bref), rating scale (RS) and the Time-Trade-Off (TTO) utility measurement. Educational level, number of chronic diseases, physical performance, and number of caregivers had significant ($p < 0.05$) impacts on the domain scores of the WHOQOL-Bref. Physical performance had the strongest impact on the physical domain.

Kashyap and Sharma (2010) analyzed the ergonomic assessment of old age homes and related health hazards on elderly people. The purposive random sampling was adapted to select districts and blocks. Sixty elderly people from four old age homes were selected randomly for the study. The study was conducted in Kumaon and Garhwal regions of Uttarakhand. Descriptive cum experimental research design was adopted. The data were analyzed using both descriptive and the relational statistics. The finding showed that the elderly people belonged to 60-80 years age group and the mean age was 72.5 years. Unmarried female and widows dramatically outnumbered male widowers. The females had better smell and hearing capabilities than males. However, general health status of males was better than females.

III. STUDIES RELATED TO PSYCHOLOGICAL ASPECT

There is a relationship between mental state and physical performance; e.g. when we respond to a situation with a physical reaction, concentrate on a task and try not to let our nerves get the better of us, or simply do a job where we are under a certain amount of stress/pressure. The ability to relax mentally and physically is of great benefit to those subjected to worries and anxieties during the course of everyday life. Occasionally, these problems need to be dealt with by someone other than the person him/herself. On the whole, exercise increases general well-being, renewing mental energy and drive, which is where the expertise of physiotherapist is most beneficial.

The four major pathological conditions in the older population are:

1. Acute confusional state (Delirium). Characteristically occurs over hours or days, usually accompanied by acute physical illness. Levels of alertness fluctuate, being worse at night, with lucid spells during the day, although the person can be disorientated to time and place. They may be fearful, irritable and aggressive. Paranoid ideas are common as are visual and auditory hallucinations. Symptoms generally resolve when the underlying cause is treated.
2. Depression, characterised by abnormally lowered mood may develop over weeks or months. The signs include loss of interest in life, neglect of personal appearance and hygiene plus expression of recurrent thoughts of death or suicidal ideas. Concentration levels are low, decisions difficult to make as are the carrying out of daily tasks. The person may complain of multiple physical symptoms, sleep (insomnia or hypersomnia) and appetite also become affected with a resultant decrease in energy.
3. Paraphrenia is not universally accepted as a distinct syndrome. The person is often female, lives alone, and has evidence of difficult social interactions earlier in life. They report of plots against them, focusing on family members, which are persistent, extreme, and elaborate. Usually, cognitive impairment is not present, but a hearing impairment is common. Although the person is physically independent (diet and hygiene are rarely compromised), social functioning and cooperation with staff members are greatly impaired.
4. Dementia is an umbrella term used for signs and symptoms characterised by a generalised and irredeemable impairment of intellect, memory and personality. The decline is permanent and progressive. The three most common types of dementia are:
 - ✓ Alzheimer's disease: a neurodegenerative disorder with generalised brain cell loss, especially in the cortex, plus extracellular plaques and intracellular neurofibrillary tangles. It has a progressive unremitting course with widespread loss of function and abilities. Alzheimer's disease is slightly more common in women than in men.
 - ✓ Vascular dementia: small or large vascular lesions cause focal damage in the brain with resultant focal neurological signs. Stepwise deterioration in cognitive and physical function occurs. It is more common in men than in women, and there is usually past history of cardiovascular pathology (e.g. hypertension).



- ✓ Lewy Body dementia: presents with a very different patterns of symptoms including clouding of consciousness, paranoid delusions, complex visual hallucinations, falls, depressive symptoms and auditory hallucinations.

Vishal et al., (2011) stated the depression among aged in Surat city. A cross sectional study was conducted among elderly belonging to different socio economic and varying demographic groups of Surat city. A total of 105 elderly were interviewed, comprising of 35 people each from the elderly living in the old age homes, those living in the affluent areas and those living in the slums of Surat city. A probability sample was obtained by approaching all the subjects in a consecutive manner. The majority (80.8%) of the subjects was in the age range of 64-76 years. Out of 105 in the sample, 43 were males and 62 were females. It was observed that lesser percent of illiterates (26.6%) reported depression compared to literates (44%). The prevalence of depression was moderately high (39%) among the elderly in old age home. The severely depressed and those who require an institutional treatment were more in old age homes (25.7%). Among those staying single 74.4% reported of depression.

Aruna et al., (2011) analysed the feeling of institutionalized elderly people. A study was conducted to understand the feeling of the elderly residing in the old age homes and within the family setup in Jammu. The sample of 30 elderly women from the old age home and 30 elderly women from households were selected using a purposive sampling technique. Non-working status of these women and above 60 years of age were criteria for sample selection. Results of the study revealed that most of the elderly felt the attitude of the younger generation towards them was unsatisfactory. Research reported that life satisfaction was strongly related to socio-demographic and psycho-social variables. Out of 30 women living with their families, 43.3% had interest towards reading religious books, magazines, and watching T.V. In the institutions, 33% of the elderly women stated that listening to music relaxed them and helped them to forget their tension, worries and stress. It could be concluded that the general feelings of the elderly women living in the families were better than those in the institutions.

Anil Kumar (2011) examined psychiatric morbidity among elderly people living in old age homes and in the community. The study sample was selected from two of the largest old age homes and three different localities in urban Mysore. Subjects were selected by simple random sampling technique. The total sample size was 100, of whom 50 resided in the community and 50 stayed in homes for the aged. Out of 50 in community, 22% were found to have mild to moderate depression as compared to 36% of old age homes. People in old age homes had a significantly better perception of social support and felt better than those living with their children's family. Finally, the psychiatric morbidity is high in elderly irrespective of the setting in which they live. Education and living with spouse are the factors associated with better psychological health.

Vishnu et al., (2009) examined Depression among Elderly, living in old age homes and in other domiciles in Trivandrum corporation area. They devised a descriptive study among elderly population aged above 69 years living in old age homes and in the community. 50 cases from each group were interviewed using a structured questionnaire using ODS (Geriatric Depression Scale) which is widely accepted for assessing the depression among the elderly. Results revealed that depression was found to be more in inmates of old age homes. Among the 50 cases in old age homes, 4 of them were having mild depression, 28 were having moderate depression and 18 were having severe depression. Among the 50 cases studied from the community 34 were having mild depression, 14 were having moderate depression and 2 were having severe depression. On sex wise analysis depression was found to be more among females. Occupation wise and age wise analysis proved to be insignificant. They concluded that depression was more among the inmates of old age homes.

IV. CONCLUSION

Psychological and Physical aspect are closely related, and the link may become more important at older ages, if only because the prevalence of chronic illness increases with advancing age. As life expectancy increases and treatments for life-threatening disease become more effective, the issue of maintaining wellbeing at advanced ages is growing in importance. Studies of older people indicate that evaluations of quality of life are affected by the person's state of health, but the frequent finding that average self-reported life evaluation in the population increases with age suggests that psychological wellbeing is affected by many factors other than health. In old age, people experience profound changes and face important challenges, including modifications in their roles, retirement, and the death of loved ones (friends and family members). These experiences can increase their levels of stress and lead to a decrease in the resources that individuals feel they have in dealing with their daily lives (Sachs-Ericsson et al., 2014). For the analysis of psychological factors that expose the elderly to the risk of malaise, it has been evidenced that depressive symptoms



affect the QoL of the elderly population (Beekman et al., 1999; Blane et al., 2008). Concerning adult life, according to Blazer (2003), among the causes of emotional distress, the presence of depressive symptoms is the most frequent, as this condition significantly contributes to decreasing the QoL of the older segment of the population. For example, depressive symptoms have been proven to be associated with functional impairment, chronic diseases, and mortality (Schoevers et al., 2000; Nilsson et al., 2011; Djukanovic et al., 2015).

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