

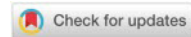
RELEVANCE OF THE TYPE OF ACCOMMODATION IN THE EMOTIONAL STATE AND HEALTH STATUS OF THE ELDERLY

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Abstract: The study aimed to explore differences between the elderly who lived in the institutions and those who lived with their family in terms of emotional state, generativeness, integrity, and psychophysical health. The sample included respondents (N=101) with an average age of 67 years, ranging from 65 to 85. The Current Emotional State Scale, the Adapted Loyola Scale of Generativity, the Integrity Scale and the RAND-36 Health Survey, were used. Higher scores on the scales of happiness, relaxation and pride as well as on the scale of generativeness and integrity were found in respondents living with family. In comparison, higher scores of anger, unhappiness, humiliation and fear/anxiety were found in elderly living in institutions (nursing homes). Statistically significant differences were confirmed in emotional well-being (U=586,000; p=0.001), social functioning (U=803,500; p=0.024), physical functioning (U=557,500; p=0.001), limitations in physical functioning (U=825,000; p=0.016) and general health (U=827,000; p=0.040). The findings of this study suggest the need to maximise the inclusion and participation of the family as a caring and long-term partner in the geriatric organisation of nursing homes, as well as to introduce the activities that would be feasible and adjusted to family members of the elderly in the residential accommodation. Improving such care would contribute to the current inquiries dealing with emotional state and health in the elderly. The assessment of the incidence of chronic morbidities in relation to the functional health of the elderly, along with continuous training of professional caregivers, who are in regular contact with the elderly, remain some of the crucial factors in establishing future preventive and long-term policies of care by the government.

Keywords: elderly, emotional state, type of accommodation, health status.

Field: Social sciences

1. INTRODUCTION

It is well known that the high living standard, better living conditions and increasingly improved medical care contribute to an increase in population above the age of 65. The trend of an ever-growing share of the elderly in the population, along with migrations from underdeveloped to developed regions, has been the most significant tendency globally. Nowadays in Serbia, every fifth person is 65 or above that age. In the past ten years, the percentage of the elderly in the overall population increased from 17.3% to 21.3% and the share of older people is slightly above the EU average (21.1%) (UNDP, 2022; Eurostat Statistics, 2022). Projections show that the elderly will constitute 24% of the Serbian population by 2041 (Stojilković Gnjatović & Devedžić, 2020) and 31.5% by 2050 (Fiscal Council of the Republic of Serbia, 2013).

It is a universal truth that relation to children, people with disabilities and the elderly measures a society's humanity. Providing care for the elderly is more efficient if it rests on one's solid knowledge of physical, physiological and mental characteristics, which is why the greatest attention in their institutionalisation is paid to the physical needs and characteristics of the elderly. What is particularly emphasized is the issue of institutionalisation through understanding the intention and personal attitude of the elderly toward nursing homes (de Madeiros et al., 2020). Home accommodation may be a humane way of caring for the elderly, but at the same time, it may imply their segregation and rejection. It is genuinely important to understand the decision a person has to make alone, or under the pressure of their closest relatives, most frequently children (Robinson et al., 2020).

Contemporary psychology literature nowadays refers to a great number of theories dealing with changes in the ageing process. There are many similarities among them, as well as significant conceptual differences. According to the life course theory, which describes the parallel course between biological growth processes and psychosocial development processes, people above the age of 65 are characterized by a period of declining biological functions and a sense of accomplishment or failure

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(Büchler, 1930; according to: Despot Lučanin, 2022), On the other hand, Havighurst's Developmental Task Model (Havighurst, 1950; according to: Despot Lučanin, 2022) analyses a person's satisfaction through their success in completing the developmental tasks in particular stages of life. He associates successful ageing with getting used to decreased physical strength and establishing satisfactory physical living arrangements, along with a voluntary or involuntary decline of social activism, underlining, at the same time, the importance of life experience and environment in adequate ageing.

Still, the most well-known and most widely analysed theory of ageing is associated with Erikson, whose model attempts to integrate an individual's psychological and spiritual development by resolving the crises that were initially established in each of the eight life cycle stages. His generativity concept becomes one of the constructs frequently referred to in the literature on personality development in adult age. He considered generativity to be a dominant characteristic of the seventh development stage (middle adulthood), but he also thought that it was present, in a certain form, in other development stages as well (Erikson, Erikson, 1997; Schoklitsch, Baumann, 2011). When we talk about generativity in the older age, it is defined as one's attitude toward life and the world, in terms of understanding one's position in the sequence of generations. It is a retrospection and evaluation of the complete life experience, while the achievement of ego integrity and prevalence of despair means an appropriate acceptance of one's life continuum as unique and consistent (Joronen, Rantanen, 2014).

Many recent studies have confirmed the important role of generativity in successful ageing, both in theory and practice (Schoklitsch & Baumann, 2011; Versey et al., 2013). Taking into account the environment of an elderly person, some research have proved a positive impact of the good family relations' continuum and living in a family environment on the forming of generativity and life satisfaction (Lao, Low & Wong, 2019). Positive feelings such as happiness, delight and excitement were registered even in those elderly persons placed in old people's homes, due to severe illness or inability to walk, who had regular contact with and support of their family members (Lao et al., 2019).

Use of the overall measure of health status, particularly health self-assessment, has become common in the research of population and clinical practice worldwide (Peruccio, 2009). A number of studies, mainly cross-sectional ones, have both directly and indirectly, analysed the correlates of health, conducted in the self-assessment. Physical health is perhaps the most important of all dimensions, and many studies indicate that it is significantly correlated with the experience of physical symptoms, including chronic conditions, functional ability and severity of current disease. On the other hand, mental well-being and general social health are two other health dimensions that have shown a potential correlation with self-assessment of health (Belem et al., 2016). When it comes to mental well-being, its significant indicators include depression, anxiety, psychological stress, ability and self-confidence (Bambauer et al., 2005). Some of the underlying predictors of social health are social functioning, including measures of social engagement, participation in social activities and availability of social support and presence of social networks (Dunn et al., 2006)

All of the previously specified findings have led many to characterise health self-assessment as a multi-dimensional construct. Due to that, different studies emphasise different dimensions that are of special importance in health self-assessment. In our study, we have analysed dimensions of physical and mental health, derived from the Medical Outcomes Study (MOS) and incorporated in the dimensions within the 36-Item Short Form Health Survey (SF-36) (Hays & Shapiro, 1992; Stewart et al., 1992). The dimensions and the overall model of health self-assessment have been described in detail in the instruments section.

The purpose of this paper is to analyse the emotional state, level of generativity, the achieved ego-integrity and different aspects of psychophysical health in the elderly, in relation to the type of their accommodation.

2. MATERIALS AND METHODS

Sample: The sample included 101 respondents from Novi Pazar, Serbia (43% males). The average age was 67, and ranged from 65 to 85. A total of 65 (65,6%) respondents lived in their own households, in contrast to 34 (34,3%) who lived in a nursing home i.e. it was institutionalized.

The survey was organised in cooperation with expert associates at the premises of the Nursing Home in Novi Pazar and in households of the elderly who took part in the research. The selection of respondents was convenient, regardless of the presence of acute or chronic, mental or physical illnesses. The survey was anonymous and the process of completing the questionnaire did not take more than 45 minutes.

Instruments: The questionnaire for examining the socio-demographic characteristics was designed for research purposes, and is intended to collect general data on respondents and socio-demographic data from their families.

Emotional State Scale (Sorić, 2002), comprises 47 items – adjectives, divided into seven subscales: Happiness, Relaxedness, Pride, Anger, Unhappiness, Humiliation and Fear/Anxiety. The respondents used a five-step scale to assess the extent to which they experienced the described emotion by each particle. All subscales demonstrated satisfactory and high reliability (Cronbach-Alpha coefficients ranged from 0.75 to 0.93). The overall result on each subscale represented the average value of response on all related particles of that particular scale.

The Adapted Loyola Generativity Scale (ALGS) (McAdams, de St Aubin, 1992; Lackovic-Grgin, Tucak, 2006) is based on the McAdams and St. Aubin model and is designed to estimate generative concern, which is the key component of generativity. It is relevant in altruistic and professional research, as well as in the successful ageing process. It consists of twelve claims that contain several forms of generativity, such as: the transfer of knowledge and skills, contributing to the community and society, striving to be creative and productive, and so on. The ALGS is treated as a single-factor scale and, based on a five-step scale, respondents assess the extent to which the content of a particular claim is characteristic for them. The theoretical minimum on this scale is 12 points and the maximum is 60, where the higher score indicates a higher degree of the presence of generativity. In our research, the scale showed high internal consistency $\alpha = 0.93$.

The Scale of Integrity (SI) (Lacković-Grgin et al., 2006b) is intended to measure integrity as an integrated system of all components of personality. It is based on Erikson's theory of psychosocial development, where the eighth stage of development represents the evaluation, summarisation and integration of the previous life. The SI is used as a single-factor scale and consists of 11 items, where respondents assess, on a five-step Likert type scale, how each of these claims relates to their past life. The theoretical minimum on this scale is 11 points and the maximum is 55, where the higher score indicates a higher degree of integration in the respondents. The scale reliability in our sample is $\alpha = .85$.

The RAND-36 Health Survey (Version 1.0) (Hays and Shapiro, 1992; Stewart, et al., 1992) was designed to assess the psychosocial and physical health of both healthy and chronically ill adult individuals. It consists of 8 subscales: Dimensions of mental health - emotional well-being, role limitations due to emotional problems, social functioning, energy fatigue, as well as the dimensions of physical health - physical functioning, role limitations due to physical health problems, physical pain and general health. In addition to demographic data, there is another additional item in the questionnaire, which is an indicator of the perceived change in the respondents' health status. The scale consists of 36 questions that are identical to the questions used by Hays and Shapiro in their health assessment instrument (Medical Outcomes Study MOS) (Hays and Shapiro, 1992; Stewart Sherbourne, Hays, et al., 1992).

Higher scores on all subscales indicate a better health status of an individual. The reliability of instruments in our sample is within acceptable limits, with the Cronbach's Alpha coefficient ranging from .785 to .955.

3. RESULTS

The data were processed using the SPSS statistical package, Version 23. Results of skewness, kurtosis and the Kolmogorov-Smirnov test indicate that the data distribution in most variables is not according to the principle of normal distribution ($p > 0.05$). Due to this fact, in order to analyse the differences in variables, a nonparametric method, i.e. the Mann-Whitney U test was used in our research.

Table 1. *Descriptive indicators of emotional state in relation to accommodation type of respondents*

Variables	Categories	<i>M</i>	<i>SD</i>	<i>Mdn</i>	<i>Min</i>	<i>Max</i>
Happiness	With family	23.62	6.82	25	7	34
	At institution	18.47	7.16	18	7	35
Relaxedness	With family	13.58	4.05	14	4	20
	At institution	10.88	4.37	11	4	20
Pride	With family	15.57	4.40	16	5	24
	At institution	11.88	5.40	11.5	5	24
Anger	With family	10.62	4.37	9	7	26
	At institution	13.06	7.12	10.20	7	32
Unhappiness	With family	10.93	5.28	9	6	26
	At institution	11.93	5.86	10.5	6	26
Humiliation	With family	16.33	8.33	12	10	44
	At institution	21.06	10.78	18	10	47
Fear/Anxiety	With family	15.39	7.66	13	8	37
	At institution	17.51	9.32	14.5	8	39

Respondents living with their family generally achieve higher scores on the scales of happiness, relaxedness and pride, whereas the respondents living in institutions (nursing homes) achieve higher scores on the scales of anger, unhappiness, humiliation and fear/anxiety (Table 1).

When it comes to emotional state variables, the results of the Mann-Whitney U test indicate statistically significant differences with the variables of happiness (U=628.000; p=0.000), relaxedness (U=678.500; p=0.002), pride (U=622.500; p=0.000) and humiliation (U=803.000; p=0.025), where higher scores for emotions related to happiness, relaxedness and pride are registered in the elderly living with their family, while higher scores for the emotion related to humiliation are registered in those with institutional accommodation.

Table 2. *Descriptive indicators of generativity and integrity in relation to accommodation type of respondents*

Variables	Categories	M	SD	Mdn.	Min.	Max.
Generativity	With family	39.03	9.30	41	12	60
	At institution	29.85	15.56	25.5	12	60
Integrity	With family	37.40	9.13	39	19	53
	At institution	34.94	9.19	35	18	55

The respondents living with their families achieve slightly higher scores on both the scale of generativity and that of integrity (Table 2).

When it comes to integrity and generativity, the results of the Mann-Whitney U test indicate the presence of statistically significant differences in generativity scores only (U=646.500; p=0.001). In this case, the respondents living with their family (Mdn=41), achieve higher, statistically significant scores on the generativity scale compared to the respondents living in nursery homes (Mdn=25.5).

Table 3. *Descriptive indicators of health status (psychosocial and physical health variables) in relation to accommodation type of respondents*

Variables	Categories	M	SD	Mdn	Min	Max
Emotional well-being	With family	65.60	20.30	68	20	100
	At institution	49.03	22.58	48	8	96
Role limitations due to emotional problems	With family	47.18	47.47	33.33	0	100
	At institution	37.25	46.97	0	0	100
Social functioning	With family	70.77	27.71	75	0	100
	At institution	56.62	30.96	62.5	0	100
Energy fatigue	With family	48.79	22.26	50	5	95
	At institution	42.42	21.01	35	10	85
Physical functioning	With family	59.40	27.02	65	0	100
	At institution	33.38	29.79	35	0	100
Role limitations due to physical health	With family	36.79	44.78	0	0	100
	At institution	16.18	35.82	0	0	100
Physical pain	With family	56.42	26.19	55	10	100
	At institution	47.58	32.58	45	0	100
General health	With family	48.94	19.42	50	0	90
	At institution	39.12	25.24	35	0	90

Respondents living with their families generally achieved higher scores in all variables than the respondents living in institutions (Table 3).

Results of the Mann-Whitney U test indicate statistically significant differences in scores in two dimensions of psychosocial health: emotional well-being (U=586.000; p=0.001) and social functioning (U=803.500; p=0.024), as well as in three dimensions of physical health: physical functioning (U=557.500; p=0.000), role limitations due to physical health (U=825.000; p=0.016) and general health (U=827.000; p=0.040) depending on whether the respondents have institutional or family accommodation. The Mann-Whitney U test indicates that the respondents living with their family achieve higher statistically significant scores in the specified variables, compared to those living in institutions (nursing homes).

4. DISCUSSION AND CONCLUSIONS

There is increasing research stressing the supportive role of emotions in the elderly. According to Wang and Stumbo (Wang & Stumbo, 2009), emotional support is a significant factor of the subjective

well-being in the elderly, faced with limits due to poor health. The significance of emotional support is particularly reflected in the support of family members (de Jong Gierveld et al., 2009), but there are studies indicating that the elderly will feel more secure and satisfied in the course of ageing if they also have the emotional support from professional caregivers in old people's homes (Chao, 2012).

According to our research, elderly people who live with their families tend to have better psychophysical health, including emotional well-being, social functioning, physical functioning, and general health. They also report feeling happier, more relaxed, and more proud. However, due to various practical and financial constraints, families are increasingly opting to place their elderly relatives in institutions such as nursing homes. The respondents living in the family environment have a higher level of achieved generativity compared to the elderly in the home accommodation. This finding could indicate that an active relationship with the broader environment has favourable effects on the achievement of personal integrity (Vaillant, 2007). Due to the reasons specified, it is important to further understand the emotional status of the elderly both in the family and in institutional accommodation. The existing resources could be used to improve the emotional intelligence and resilience of elderly. In fact, the experimental study (authored by Delhom, Sattores & Melendez, 2020) demonstrated that interventions aimed at improving the emotional intelligence in the elderly, in terms of focusing on, understanding and recognising emotions in the elderly, successfully shaped the emotional state, quality of life and resilience in the last stage of life, emphasising those situations and emotions that are helpful in the process of coming to terms with it.

This study and the obtained results will contribute to the current inquiries dealing with the health and emotional state of the elderly. However, the assessment of the incidence of chronic morbidities in relation to the functional health of the elderly, along with continuous training of professional caregivers, who are in regular contact with the elderly, remain some of the crucial factors in establishing the future preventive and long-term policy of care by the government. On the other hand, the findings of this study suggest the need to maximise the inclusion and participation of the family as a caring and long-term partner in the geriatric organisation of nursing homes, as well as to introduce the activities that would be feasible and adjusted to family members of the elderly in the residential accommodation.

The optimal model of long-term care for the elderly could also include service provision in the social community. Improving such care could provide many third-age persons with better quality and prolonged stay in their own homes, which would certainly have a positive impact on their involvement in social contacts, as well as a better emotional state.

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