

Clinical and psychosocial evaluation of older adults in a health area

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Abstract: Introduction: ageing is defined as a dynamic, progressive and irreversible process, involving multiple biological, psychical and social processes that are interrelated. The ageing of the world population advances at an accelerated pace. Objective: to characterize clinical-epidemiological and psycho-social aspects present in the elderly. Materials and methods: an epidemiological, descriptive, exploratory and cross-sectional study was carried out on the population of older people from two family doctor's offices belonging to the Teaching Polyclinic Raul Sanchez, from Pinar del Rio, between January 2020 and January 2021. The universe consisted of 252 patients of both sexes. The sample consisted of 232 persons, and was chosen through an intentional sampling by criteria. In the research, a survey was used to obtain the information of each elderly people, and the perceptual method for the statistical analysis. Results: the female sex, ages between 65 and 69 years; primary schooling level, married marital status, living with relatives and good family functioning predominated in the studied sample. Regarding toxic habits, smoking predominated, and arterial hypertension and ischemic heart disease, with a high consumption of medications, were among the most frequent diseases. Conclusions: there was a high rate of elder people with epidemiological factors related to older age, as well as with others of the psycho-social kind that affect their health.

Key words: older adults; ageing; epidemiology

1 Introduction

Ageing is defined as a dynamic, progressive, and irreversible process involving multiple biological, psychological, and social factors that are interrelated. In pathological aging or senility, at the biological level, there is a loss of homeostasis in diseases, leading to frequent hospitalizations. Psychologically, it manifests as a progressive and irreversible loss of mental functions, poor stress coping, pessimism, and negative self-esteem. On the social level, there is a total loss of roles without replacement, a lack of social support, dependence, loneliness, generational conflicts, and inactivity; in contrast to normal aging or old age, where there is greater synchrony in organ function, greater psychological compensation, and social support [1].

Demographic aging, meanwhile, is a phenomenon observed worldwide and particularly among the Cuban population. Cuba is experiencing accelerated aging, meaning that the number of people over 60 will double within a 25-year period—in contrast to the 100 years it took in European countries, which have aged more slowly and under better conditions. Rank-

-ed as the fourth-oldest country in Latin America—behind Uruguay, Argentina, and Barbados—Cuba is, however, aging at the fastest rate, having moved into the top ranks by 2015 [1,2].

At the end of 2019, the population aged 60 and over in Cuba stood at 2,307,647, which is equivalent to 20.6% of the total projected population for that year [3]. The outlook for the elderly in the coming years is as follows: globally, according to WHO data, the number of people aged 60 and older will increase from 613.6 million in 2000 to 1,207.6 million in 2025, 70% of whom will live in developing countries. The improvement in the population's quality of life and increased life expectancy at birth are closely linked to sociodemographic characteristics. According to statistical data, the province of Pinar del Río has the fourth-oldest population in Cuba, with 21.3% of its population aged 60 and older [3,4].

Aware that the aging of the Cuban population is an irreversible process, following a pattern similar to that of developed countries, and that the elderly of 2025 are already living throughout the archipelago, health authorities are preparing for the long-term challenge of accommodating an ever-increasing number of older adults within their services, providing care aimed at supporting their lives (prolonging them, increasing life expectancy, and improving quality of life) [2].

Taking the above into account, along with the fact that in the Health Region the rate of population aging is a tangible phenomenon and is in line with United Nations projections; the increase in life expectancy among Cubans; and the fact that, due to the multifaceted nature of health issues among the elderly, a prudent medical and political commitment is required to drive a reform of healthcare services capable of addressing this wave of people over the age of 60, it has been decided to conduct a study on the elderly that encompasses clinical-epidemiological, social, and psychological aspects.

In light of this aging challenge, and given that no other study in the field of health places equal emphasis on both clinical and epidemiological issues as well as psychological factors, this research was conducted to address how older adults perceive the psychosocial factors of their aging, given the need to continue improving the health status of our population, particularly among the elderly.

2 Materials and methods

A cross-sectional, descriptive, exploratory epidemiological study was conducted among the elderly population at two family medicine clinics of the Celso Maragoto People's Council, which are part of the Raúl Sánchez Teaching Polyclinic in Pinar del Río, between January 2020 and January 2021. The aim was to characterize older adults according to clinical and epidemiological variables and to identify the most common psychosocial factors at this age, based on their self-perception.

The study population consisted of 252 patients of both sexes. The sample comprised 232 individuals and was selected using purposive sampling.

Inclusion criteria: all older adults aged 60 and older from the two clinics.

Exclusion criteria: Older adults with a certain degree of disability, such as deafness, muteness, mental retardation, and blindness, were excluded. Additionally, those who lacked the capacity to give informed consent and those with cognitive impairment that prevented communication or comprehension were excluded. A total of 20 older adults were excluded, including: 2 who died during the study period, 3 with a high degree of disability, 5 who lacked the capacity to consent, 5 who were hospitalized, and 5 who lived outside the study area. There were no patients with cognitive impairment.

Empirical methods were used in the study, including a survey and a questionnaire on the psychosocial factors of the elderly, which has a total score of 100 points and was adjusted to suit the elderly population.

To collect the information, the survey was administered to all older adults in the sample on an individual basis, with the assistance of nurses from family health clinics. The questionnaire's questions were simple and accessible to older adults regardless of their educational background.

An observation guide, complete with instructions, was applied in a structured, indirect, deliberate, guided, and planned manner. The interviews were conducted in the patients' homes, in complete privacy, using a pre-prepared questionnaire. These were in-depth, semi-structured interviews that allowed the interviewee to express themselves freely, without interruption, judgment, or evaluation. Individual medical records were also used during these interviews to gather information.

Descriptive statistical methods were used in the study, and the data are presented in tables and graphs based on these methods. The percentage method was used for statistical analysis.

3 Results

Upon examining Table 1 and applying statistical analysis, it was found that the 65–69 age group had the highest number of elderly patients, with 60 patients, representing 25.9%, followed by the 60–64 age group, with a total of 54 patients, accounting for 23.3%.

In terms of sex, females predominated, with 121 patients, accounting for 52.2%.

Table 1. Distribution of older adults by age and sex

Age group (years)	Female		Male		Total	
	No.	%	No.	%	No.	%
60–64	28	23.1	26	23.4	54	23.3
65–69	33	27.3	27	24.3	60	25.9
70–74	23	19	22	19.8	45	19.4
75–79	15	12.4	17	15.3	32	13.8
80–84	13	10.7	11	9.9	24	10.3
85 and over	9	7.4	8	7.2	17	7.3
Total	121	52.2	111	47.8	232	100

The study found that the vast majority of older adults live with family members, representing 146 patients, or 62.9% (Figure 1).

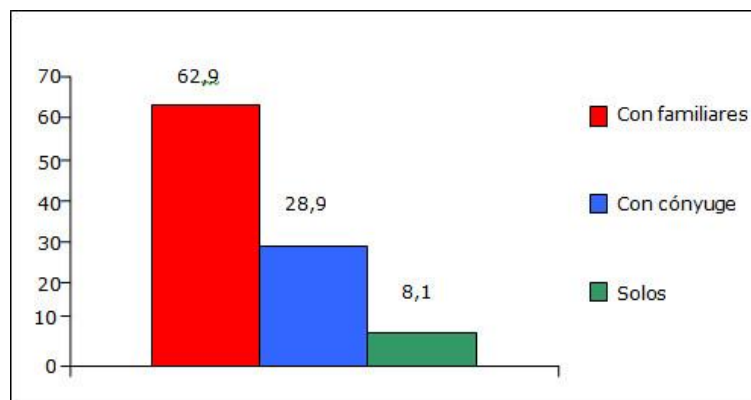


Figure 1. Distribution of patients by living arrangement with family members

With regard to the prevalence of chronic diseases, hypertension ranked first by a significant margin, at 73.7%, followed by ischemic heart disease, at 67.7%. (Table 2)

Table 2. Distribution of older adults by conditions they suffer from

Most prevalent chronic diseases	Absolute frequency	Relative frequency
Arterial hypertension	171	73.7
Diabetes mellitus	21	9.1
Ischemic heart disease	157	67.7
Cerebrovascular disease	9	3.9
Osteoarthritis	154	66.4
Cancer	7	3
Obstructive pulmonary disease	29	12.5
Heart failure	96	41.4
Others	47	20.3

Table 3 shows that anti-hypertensive medications are used most frequently, accounting for 73.7%. There was also high use of analgesics and anti-inflammatory drugs (71.6%) and psychotropic medications (68.1%).

Table 3. Distribution of older adults by most commonly used medication groups

Most commonly used drug groups	Absolute frequency	Relative frequency
Analgesics and anti-inflammatory agents	166	71.6
Digitalis preparations	85	36.7
Antihypertensives	171	73.7
Psychopharmaceuticals	158	68.1
Oral antidiabetic agents	18	7.8

Table 4 shows the distribution of the sample according to the psychosocial factors that most commonly affect older adults, as identified by their own perceptions. The main psychological factors were: fear of illness and concern about the loss of family members and friends, accounting for 94.4% and 91.4%, respectively. In addition, there were issues related to the need to be heard (79.7%), expressions of sadness, crying, and fear of death (71.9%).

Table 4. Distribution of psychological factors reported by older adults

Psychological factors	Absolute frequency (n = 232)	Relative frequency
Fear of illness and death	219	94.4
Concern over loss of family and friends	212	91.4
Feelings of restlessness and unease	154	66.4
Expressions of sadness and weeping	167	71.9
Feelings of loneliness	109	46.9
Poor adaptation to retirement	45	19.4
Need to be listened to	185	79.7
Regret over loss of authority	97	41.8

Table 5 shows the social factors self-reported by older adults; the need for social interaction reached 96.6%, particularly with peers, children, and grandchildren. Of the older adults surveyed, 52 were widowed, which is considered a social and behavioral risk factor in their lifestyle.

The presence of architectural barriers (90%), problems in family dynamics (89.2%), and lack of medication (87.5%)—followed by insufficient income, difficulties in accessing recreational activities, difficulties in purchasing food items beyond the basic food basket, and difficulties related to housing and food shopping—were aspects to be considered.

Table 5. Distribution of social factors reported by older adults

Social factors	Absolute frequency (n = 232)	Relative frequency
Poor community support	147	63.4
Difficulties in accessing recreation	196	84.5
Need for social communication	224	96.6
Housing difficulties	199	85.8
Difficulties purchasing medications	114	49.1
Difficulty acquiring food outside the basic food basket	62	26.8
Presence of architectural barriers	209	90
Problems in family dynamics	207	89.2
Shortage of medicines	203	87.5
Insufficient economic income	202	87.1

4 Discussion

Statistics show that in Cuba, at the end of 1999, 13.9% of the population (just over 1.5 million people) was in the 60-and-over age group; in 2000, 14% of the population was 60 years of age or older; by 2010, this figure had risen to 16.7%, and according to population projections, 24% of the population is expected to fall into this group by 2025; it is estimated that one in four Cubans will be 60 years of age or older. The growth of the elderly population has not been uniform, with relatively higher growth in rural areas and a higher proportion of elderly people in the western and central provinces than in the eastern provinces [2,3].

When comparing the 60–70 age group with other studies, similarities were observed in the results; these figures were consistent with national and international statistics, as the global trend is one of rapid growth in this population group. These results can be explained by the fact that life expectancy in Cuba is 76.2 years; after this age, mortality increases and the population in this age group decreases [5].

It is believed that women have a higher life expectancy due to the protective effect of estrogen and lower exposure to risk factors for chronic diseases [6,7].

The results were consistent with reports that male mortality is higher than female mortality at nearly all ages; consequently, the percentage of women increases with age, and the numerical advantage of men diminishes over time. There is some evidence of a genetic advantage for women regarding longevity, though this finding is not yet conclusive; others emphasize the social roles of each sex and the environmental influences surrounding men and women [8].

In Cuba, older adults do not live marginalized or alone, nor without support from their children—an aspect of great importance for achieving physiological longevity, since for the elderly, the community, along with their children, spouse, and relatives, holds great significance. The need for companionship and for others to understand their convictions, values, feelings, and other aspects of life has a positive influence on the final stage of their lives [9].

According to Alfonso Figueroa et al.[9], high blood pressure constitutes a major risk factor for the cardiovascular system, and it becomes a greater concern because it tends to increase with age, in conjunction with other epidemiological factors in the elderly.

This is explained by age-related cardiovascular changes, such as: stiffness of the arteriolar tree, present with or without the contribution of atherosclerosis; arteries tend to lose their elasticity, which increases resistance to blood flow and, consequently, blood pressure. According to reports by international authors, such as Carrasco, older adults have a higher prevalence of hypertension than younger adults, ranging from 60 to 70% [10].

Most cases of geriatric hypertension are primary in nature, although secondary causes can be identified, such as renovascular hypertension due to atherosclerotic plaque in the renal artery and primary hyperaldosteronism. In these cases, hypertension occurs suddenly or is resistant to treatment [11]. The relationship between blood pressure and the risk of cerebrovascular events is continuous, consistent, and independent of other risk factors. The higher the blood pressure, the greater the risk of myocardial infarction, heart failure, stroke, and chronic kidney disease.

Cardiovascular diseases are most prevalent in older adults, as the prevalence of major conditions affecting this system increases with age. The ongoing use of medications among older adults is a reality, due to multi-morbidity and the fact that many older adults are on multiple medications [12].

At this age, physiological changes resulting from aging lead to alterations in the pharmacokinetics and pharmacodynamics of drugs. Rationalizing and stratifying the use of these medications in the elderly remains a challenge, as their use can be highly detrimental—causing significant adverse effects—rather than beneficial [13].

A study conducted by Ramos Toro [14] found that more than 50% of older adults used anti-hypertensives and analgesics as first-line medications for hypertension and joint pain, in addition to being easy to administer and dose, without the need for specialized personnel.

The most significant factors—such as fear of falling ill, concern about the loss of family members and friends, and fear of death—are very common among older adults, especially as they enter the most vulnerable stage of their lives, which is after age 75, and are accompanied by symptoms of anxiety and depression. These feelings are influenced by frequent medical checkups and excessive worry, stemming from the belief that death is imminent. Examples of this include regular attendance at medical appointments and strict adherence to medication regimens [15].

The need to be heard by family and the community was one of the most frequently cited issues, perhaps influenced by the fast pace of modern life, lack of time, inter-generational problems, and a lack of affection and understanding [10–13].

Problems in family dynamics and significant social factors lead to a lack of understanding toward the elderly, as well as reduced availability to care for them due to women entering the workforce, migration, and declining birth rates, among other factors. Because of this, it is important to highlight the role of the family physician in involving the elderly in senior citizens' club activities, where they can socialize with one another and their problems are alleviated. Older adults feel more useful when integrated into society, and their feelings of depression diminish. This helps boost their self-esteem and quality of life [9].

It is concluded that population aging is a tangible reality, and that we are approaching the largest wave of older adults. In the Health Area, a high rate of older adults with epidemiological factors closely related to old age was observed, and closely associated with these factors was the presence of psychological and social factors that impair the quality of life of older adults.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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