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ASSESSMENT TOOLS AND MEASUREMENT OF ELDERLY POPULATION'S WELL BEING IN MODERN PSYCHOLOGY

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ABSTRACT

As is known, the science of psychology studies human behavior; it aims to scientifically determine what human behavior is and what influences it. All observable actions and activities of humans constitute human behavior. Humans are in a constant state of development throughout their lives. As an individual, a person is in a state of physical, mental, emotional, sexual, moral, and social development. These developments encompass the prenatal, infancy, kindergarten, primary school, adolescence, youth, maturity, retirement, old age, and advanced old age stages. The differences in abilities among people in various developmental stages are very large, and learned behavioral patterns are also very different from each other. While studies in the field of psychology worldwide are concentrated on child psychology, educational psychology, organizational psychology, etc., the need for research on geriatric psychology is also coming to the fore. Because the share of the elderly in the world's population pyramid is increasing. Therefore, new problems are emerging in the physical and mental health of the elderly. The behaviors of the elderly are unique. For this reason, the examination of the psychological state of the elderly should also be on the agenda of those working in psychology. Therefore, this article will attempt to provide an introduction to the psychology of aging and emphasize the importance of the subject.

KEYWORDS

Elderly Population, Mental Health, Diagnostic Tools, Assessment, Measurement Scales

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Introduction

Human being is not only a biological organism but also a social being, a carrier of culture, and a product of the society in which they live. Every person is born into a group and acquires their social characteristics within groups. The lifestyles of a society, the knowledge and values necessary for living in that society are transmitted to the individual through groups, and with this knowledge and these values, the individual acquires the quality of being a member of a particular society. Economic life requires individuals to adapt to their professional environment, changing jobs within that environment, evolving technology, new organizations, and new lifestyles. Geographical mobility means migration, new neighbors, new behavioral standards, retirement, old age, etc., new ways of life, and even new political connections.

Today, health policies in both developed and developing countries prioritize the independent living and social integration of the elderly. According to the World Health Organization (WHO), the number of people aged 60 and over, which was 600 million in 2000, will rise to 1.2 billion in 2025 and 2 billion in 2050 (World Health Organization, 2007). The WHO also notes that industrialized countries became wealthy before aging, while developing countries will age before becoming wealthy. Therefore, it emphasizes that all countries in the world must be prepared for the negative consequences of the demographic process, which signifies an increase in aging populations. The rationale behind the WHO's Programme on Aging and Health states: "When considering the health of older people, disease prevalence or absence alone cannot and should not be the determining factor. While a large proportion of older people may have diseases, they can feel fully healthy if the negative consequences of their diseases that seriously affect their daily lives can be eliminated." (World Health Organization, 1998). For these reasons, the concept of "self-reported health" is of great importance for the aging period.

Social and mental health problems

The first signs and symptoms of problems that an elderly person may encounter can range from mental depression to unwarranted and excessive optimism and joy; or from excessive worry about the future to impulsive and thoughtless behavior. Many elderly people begin to criticize themselves or express irrational feelings of anger towards others. If these signs and symptoms are not diagnosed in time, the problems that arise can become serious enough to require the intervention of a psychiatrist. Although elderly people may not accurately describe their state of mind, they appear to be in a state of mental collapse, believing they are finished. They are quick to anger and openly display their anger; or their anger is easily discernible in their behavior and speech. They see themselves as different. They express feelings of failure and disappointment and, consequently, blame their surroundings, exhibiting behaviors generally seen in mentally ill individuals. Out of fear of retaliation, they confess to being guilty, and under the influence of this guilt, they say they are considering suicide or wish to die.

Other coping mechanisms seen in elderly individuals to overcome fear and anxiety include sensitivity, suspicion, hoarding, resistance to change, and excessively anxious attitudes. In the elderly, mental depression is the most common symptom. This is especially evident in societies that place excessive importance on the young but disregard the elderly. In such societies, the elderly fall into self-denial, and feelings of hostility directed towards themselves lead to mental depression and feelings of worthlessness. Distortion of reality is also a frequently observed symptom. The individual does not want to accept that they have lost many things physically and intellectually due to old age. For retired elderly individuals, the fact that their financial resources are limited compared to their previous state, and therefore they become a greater burden on others, is also a significant problem. They are now dependent not only on material or physical support, but also, and most importantly, on the emotional support and care of their loved ones. Differences in appearance between older and younger generations often create tension and lead to unstable and unsatisfactory relationships between the two generations. As a person ages and becomes more dependent on their loved ones, they can become a problem for the younger generation who are now their protectors.

At the same time, being in this state causes the person to feel "useless." In response, older people insist on being given more assurance and respect. They may even become stubborn and try to give advice without being asked. Such reactions cause feelings of hostility, increase disharmony, and create tension. An older person may also face difficulties in their married life in later years. This situation is even more delicate for couples who have already had an unsuccessful marriage. In such marriages, the decrease in interest and activities outside the home leads to the deterioration of relations between spouses. A kind of "competition" arises between spouses in order to attract feelings of care and compassion. There is a great similarity between the feeling of being separated from or losing those to whom one is attached and the feeling of retirement. Retirement is one of the interconnected periods of crisis that occur in middle age and later years, and like the others, it should be given attention. These crises have one thing in common: the threat of losing the affection or emotional support of someone to whom one is deeply emotionally attached. These individuals are usually parents, spouses, or children. The death of a parent, children leaving home for school or marriage, the illness of a spouse, and a transitional period can be given as examples of these crises.

The disruptive effects of retirement, or impending retirement, are partly based on a person's sense of security. A person who trusts others is less anxious about being alone. Another important factor is the person's subconscious sense of self-worth. Essentially, someone who sees themselves as worthless is deprived of the confidence that comes from accomplishing a good job, or the appreciation of their own worth as a civil servant. They will likely experience greater sadness than others in situations such as the death of parents, the illness of a spouse, a decrease in the attention of children, or the loss of emotional bonds with their boss or colleagues. Fear of death or a philosophical approach to it; financial insecurity or the ability to comfortably accept a lower standard of living; loneliness or acceptance of separation; seeking affection and attention by using psychosomatic illnesses as an excuse; making unreasonable demands or appearing mentally broken; or seeking care and companionship through more reasonable means—all these factors generally indicate adjustment, good or bad, in old age as well as in retirement.

Methods

The study explored the quantitative research design that focused methods analyzing regarding to previous literature material. The methodological paradigm of the research is positivism that assert knowledge is valid based on reality.

Results

Health-related Quality of Life (HQL) is a relatively new concept focusing on "perceived health and well-being," which is crucial in older age. HQL is a highly sensitive concept for measuring the harmful and destructive effects of chronic diseases in the aging population. Since treatment is not always possible in this age group, improving HQL in older adults is of particular importance. Measuring HQL in older adults involves numerous dimensions; These include pain, fatigue, and functional competence, as well as social and emotional well-being (Piquart et al. 2000, Contança et al. 2003, Efklides et al. 2003, Borg et al. 2006, Paskulin et al. (2007, Low et al. 2007, Lucas et al. 2007). Quality of life assessments are increasingly used to identify at-risk individuals in the elderly population and develop targeted interventions for them, but the lack of assessment tools makes it difficult to assess quality of life. Generic scales are particularly important in assessing the quality of life of older adults, as most individuals in this age group have multiple health and social problems in their lives. Brown et al. (1994) showed that the top three factors affecting quality of life in old age are social activities, leisure activities, and health. WHOQOLOLD Czech Republic center data showed that the most important factor affecting the quality of life of older adults is depressive mood. (Dragomirická 2008).

A recent study by Molzahn and Gail (2007) also showed that the conceptual factors underlying quality of life in older adults are health, financial status, and meaning of life. In contrast, personal relationships, health, and sexuality are identified as the most important factors in explaining the differences in overall quality of life in older adults (Robinson et al. 2007). Reviewing general purpose scales in the literature, Haywood et al. (2005) mention quality of life scales developed not only for older adults but for the adult population in general. Of the currently existing quality of life scales, only a few have a comprehensive conceptual structure to assess quality of life. Among these, the number of general purpose tools that can be used for the older age group is also very small, for example, the Philadelphia Geriatric Center Morale Scale (PGC), Instrumental Activities of Daily Living (IADL), and Bodily Physical Self-Maintenance Scale and London Handicap Scale (LHS) (Lawton et al. 1975, Brody et al. 1988, Harwood et al. 1994). Based on this need, the WHOQOL Group developed and validated the WHOQOL-OLD module, the WHOQOL module for older adults, using a simultaneous approach in 22 countries (Bullinger et al. 1996).

The WHOQOL, a general-purpose quality of life profile scale, has two versions: long and short: WHOQOL-100 and the 26-item WHOQOL-BREF. The WHOQOL-100 has 25 facets and six domains, while the WHOQOL-BREF consists of only four dimensions. The scale structure of the WHOQOL, the psychometric properties of the international version, and the Turkish validity of this scale have been previously published (The WHOQOL group 1994, The WHOQOL group 1995, Skevington et al. 2004, Eser et al. 1999). The WHOQOL-OLD Project was supported by the European Commission Fifth Framework Programme. Findings obtained in other countries regarding this module have been previously published (Power et al. 2005). As with the other 22 study centers, the center in Turkey (Izmir) simultaneously developed the Turkish version of the scale.

The WHOQOL-OLD - Project was funded by the European Commission's Fifth Framework Programme (QLRT-2000-00320) and implemented in 22 countries with the support of the World Health Organization Quality of Life Group (WHOQOL Group). The project's working protocol is based on the previously published WHOQOL standard project methodology (The WHOQOL Group 1998a, The WHOQOL Group 1998b) and includes focus group work, question generation, pilot trial, question reduction, and dimension research. In the first stage of the methodology, a WHOQOL-OLD module with 40 questions emerged as a result of the global analysis of the international project and focus group studies. This module was reduced to a WHOQOL-OLD module with 24 questions by conducting a trial study in 6 dimensions (Power et al. 1998).

The WHOQOL-OLD module consists of 24 questions, with responses measured using a five-point Likert scale, within six dimensions. These six dimensions are: "Sensory Functions" (questions 1, 2, 10, and 20), "Autonomy" (questions 3, 4, 5, and 11), "Past, Present, and Future Activities" (questions 12, 13, 15, and 19), "Social Participation" (questions 14, 16, 17, and 18), "Death and Dying" (questions 6, 7, 8, and 9), and "Intimacy" (questions 21, 22, 23, and 24). Possible dimension scores range from 4 to 20. Additionally, a "total score" can be calculated by summing each individual score. As the score increases, the quality of life improves. The "Sensory Functions" dimension evaluates sensory functions and the effects of their loss on quality of life. The "Autonomy" dimension refers to independence in old age and expresses the ability to live independently.

The "Past, Present, Future Activities" dimension shows the satisfaction derived from life achievements and future outlook. The "Social Participation" dimension specifically describes the ability to participate in daily life activities within society. The "Death and Dying" dimension is about anxieties, worries, and fears related to death and dying, while the "Intimacy" dimension evaluates the ability to establish personal and intimate relationships.

WHOQOL Bref

WHOQOL-BREF is the short form of the WHOQOL-100 scale. It was created by taking one question for each of the 24 sections from the WHOQOL-100 and adding two questions related to general health and quality of life. This instrument is currently scored in four dimensions (= "domain"):

1. Dimension: Physical health;
2. Dimension: Psychological health;
3. Dimension: Social relationships; and
4. Dimension: Environmental health.

How WHOQOL was developed has been described in detail in a number of publications (The WHOQOL Group, 1994; The WHOQOL Group, 1995).

Germ Depression Scale (GDS)

The GDS, consisting of 30 questions, was developed by Yesavage (1983) and adapted into Turkish by Ertan et al. (1997). As the scale score increases, depressive mood increases. Statistical analysis (reliability and validity analyses) A "confirmatory approach" was used in both the reliability and validity analyses of the instrument. That is, the structural fit of the scale to the hypothetical structure initially proposed jointly by the researchers was attempted to be shown. The new scale was defined using indicators such as means, standard deviations, ceiling and floor effects, and then reliability and validity analyses were applied.

Reliability analyses

Reliability analysis includes calculating the internal consistency of the responses given to each dimension and sub-dimension, and question analysis (Ware et al. 1997). A correlation matrix was created between all individual questions and dimension scores. If a question shows a higher correlation with its own dimension score(after removing the question's contribution to the dimension score) than with other dimensions, it means that the dimensions of WHOQOL-OLD represent separate and unique concepts. This also points to the unique nature of each question. The internal consistency of the dimensions was evaluated using Cronbach's alpha. As an additional approach to evaluating the performance of individual questions in internal consistency analyses, alpha values were calculated for each dimension by removing questions one by one. It is expected that when a suitable question contributing to a dimension is removed, the alpha value of that dimension should decrease or remain the same. The MAP statistical package was used in reliability analyses.

Validity Analyses

Validity analyses consist of internal and external validity tests. As a structural validity test, convergent and divergent validity analyses and confirmatory factor analysis were performed for each question. Multiple linear regression analysis was used to evaluate criterion validity. The "discriminant validity" of the instrument between a subgroup with no health problems and a subgroup with at least one health problem was evaluated using Student t-test analysis and Cohen's approach to Effect Size (Cohen et al. 1998). This type of validity can also be called "known group validity of the scale". The structural validity of the instrument was tested using confirmatory factor analysis with LISREL 8.54 (Scientific Software International, 2009).

Recommendation

The cross-cultural nature of the study and the sample's composition, which does not represent all older adults in our country, limit the certainty and generalizability of the results. A national data pool needs to be established to create community standards and conduct further validity studies.

The psychometric properties of the WHOQOL-OLD module in multiple languages are generally good and acceptable; this scale can be considered valid and reliable for older individuals in many countries. The module is promising for use in our country to evaluate the effects of health services provided to older people to improve their quality of life. Further, long-term studies are recommended on the respondency of this tool to different situations in the treatment dimension and clinical setting.

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