MODULE 2

THE AGING PROCESS AND COMMON ILLNESSES AND CONDITIONS

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I. Aging

A. Stereotypes

Within American society, commonly held myths, stereotypes, and negative attitudes about aging greatly influence the expectations that the elderly have of themselves and the interactions of others with elderly individuals. Expectations about the later years of life are formed very early and are reinforced throughout life. Often ignored is the fact that there is as much variety among individuals in later life as at other stages. Individuals are what they have always been. However, problems arise when there is a difference between the way an individual is and the assumptions other people make about that person which affect the way they treat the older individual.

Some of the more prominent stereotypes are:

Stereotype: The elderly are disengaged, want to live by themselves or with other elderly; have lost interest in life; are more introspective and withdrawn; don't want to associate with other people.

Reality: Opportunities for the elderly to associate with other people may be very limited. Physical handicaps, lack of transportation, lack of alternatives, and the death of a spouse or close friends may cause an older person to appear disengaged. The elderly may have disconnected from the elderly person. The elderly prefer to stay involved in life as much as possible.

Stereotype: The Elderly are sick; disease and disabilities are automatic with advancing age; the elderly are not expected to feel well.

Reality: The development of chronic conditions such as arthritis or diabetes usually begin in middle age and may worsen with advancing age. Disabilities assumed to be automatic accompaniments of aging may have other causes and are influenced by diet, exercise, and life style. The elderly do not suddenly become sick when they become aged. The elder person may need or want some encouragement to participate in activities.

Stereotype: The elderly become childish, return to a second childhood, and must be treated like children.

Reality: Adults remain adults; childlike behaviors do not return a person to childhood. If a person is expected to act like a child, that person may conform to those expectations. On the other hand, a person expected to exhibit adult behavior will likely function on an adult level.

Stereotype: The elderly are dependent and need someone to take care of them.

Reality: Many of the elderly are independent, living in the community and taking care of themselves. Many times "help" is given to the elderly because others are too impatient to wait long enough for the elderly to do the tasks themselves.

Stereotypes: The old are unproductive; they have already made their contribution to society.

Reality: The majority of the elderly remain actively and productively involved in life. Opportunities for meaningful work, education, or leisure activities may be

unavailable. Productivity may have to be redefined to include sharing reminiscences or knowledge as well as producing tangible products or results.

Stereotypes: The aged are asexual. Sexual desire is "only in their heads" and sexual function ceases in old age.

Reality: Sexual desire continues throughout life. With advancing age sexual function may change, but it does not automatically cease. If a person has remained sexually active throughout adulthood, there is no reason that should change in the later years.

Stereotype: The elderly become senile; eventually all elderly individuals become forgetful, confused, and have reduced attention spans.

Reality: There are multiple causes of the behaviors that are associated with senility. These will be discussed later in the section on psychological aspects of aging. The expectation of senility puts many elderly on guard against actions which may be viewed as indicative of mental loss.

Stereotype: All elderly individuals end up in nursing homes.

Reality: The majority of elderly individuals live in community settings. Nursing home care is not inevitable, particularly as alternative services are developed. It is true that about forty percent of the total elderly population will spend some time in a nursing home, but many may be there only temporarily for rehabilitation services.

B. Profile Of The Elderly[1]

The elder population--persons 65 years or older--numbered 35.0 million in 2000 (the latest year for which data is available). They represented 12.4% of the U.S. population, about one in every eight Americans. The number of older Americans increased by 3.7 million or 12.0% since 1990, compared to an increase of 13.3% for the under-65 population. However, the number of Americans aged 45-64, the "baby boomers" who will reach 65 over the next two decades, increased by 34% during this period.

In 2000, there were 20.6 million elderly women and 14.4 million elderly men. The female to male gender ratio increases with age, ranging from 117 for the 65-69 age group to a high of 245 for persons 85 and over.

Since 1900, the percentage of Americans aged 65+ has more than tripled (4.1% in 1900 to 12.4% in 2000), and the number has increased eleven times (from 3.1 million to 35.0 million). The older population itself is getting older. In 2000, the 65-74 age group (18.4 million) was eight times larger than in 1900, but the 75-84 group (12.4 million) was 16 times larger and the 85+ group (4.2 million) was 34 times larger.

[1] The following data is from the Administration on Aging's website, www.aoa.gov.

The elder population will continue to grow significantly in the future, especially between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

By 2030, there are projected to be over 75 million elder persons, more than twice their number in 2000. People 65+ represented 12.4% of the population in the year 2000 but are expected to be over 20% of the population by 2030.

Minority populations are projected to represent 25.4% of the elderly population in 2030, up from 16.4% in 2000. Between 1999 and 2030, the white** population 65+ is projected to increase by 81% compared with 219% for elder minorities, including Hispanics (328%), African-Americans** (131%), American Indians, Eskimos, and Aleuts** (147%), and Asians and Pacific Islanders** (285%).

Over half (55%) of non-institutionalized persons aged 65+ lived with their spouse in 2000. Approximately 10.1 million or 73% of older men, and 7.7 million or 41% of elder women, lived with their spouse. The proportion living with their spouse decreased with age, especially for women. Only 28.8% of women 75+ years old lived with a spouse.

About 30% (9.7 million) of all non-institutionalized 65+ persons in 2000 lived alone (7.4 million women, 2.4 million men). They represented 40% of elderly women and 17% of elderly men. The proportion living alone increases with age. Among women aged 75 and over, for example, half (49.4%) lived alone.

While a relatively small number (1.56 million) and percentage (4.5%) of the 65+ population lived in nursing homes in 2000, the percentage increases dramatically with age, ranging from 1.1% for persons 65-74 years to 4.7% for persons 75-84 years and 18.2% for persons 85+.

In 2000 there were 1,720,500 nursing homes residents.

II. Biological Aspects Of Aging

A. Structural

Muscles: Muscles lose mass and tone. While exercise helps to maintain strength and tone, it does not prevent some loss. This change is observable in the looseness of underarm skin, sagging of breasts, and stooped posture.

Skeleton: Another change affecting appearance is the flattening of the spongy “cushion” between the vertebrae. Over the years, this material loses its resiliency, so elderly individuals may be shorter than they were in their younger years. Bones become more porous, a process known as osteoporosis. More women are affected by osteoporosis than men. The bones also become more brittle and are more easily broken. It is possible for bones to spontaneously break. For example, a hip may break and lead to a fall rather than a fall leading to a broken hip.

Skin: The skin loses some its elasticity, resulting in wrinkles. The skin does not stretch and conform to its original shape as it once did. There is a loss in the natural oils in the skin which may lead to dryness and scratchiness. Individuals may need to use

moisturizer to replace the loss in oils. With aging, the skin becomes thinner and thus more susceptible to being broken or cut. Elder people may become more sensitive to temperature changes. Some individuals may develop "aging" spots (dark areas of pigmentation). The presence of such spots does not indicate a problem, but, generally, spots or bumps on the skin of older people should be closely observed for sudden growth or changes in appearance. Such changes should be reported to a physician.

B. Sensory

Mouth: Several changes in the mouth may affect eating patterns and appetite. The bone structure of the jaws may change, altering the way dentures fit. It is possible for an individual to develop problems with a set of dentures that he/she has had for years.

Taste: The sensitivity of taste buds decreases with age, especially with men. The tastes which decline first are sweet and salty, with bitter and sour decreasing more slowly. Those changes mean that foods may not taste the way they used to. The elderly may overseason food or may accuse others of omitting all seasonings in food preparation. Changes in taste may lead to a loss of appetite, which can lead to nutritional deficiencies.

Smell: As individuals age, there is a decreased sensitivity to smell. Older individuals may be more oblivious to certain odors, even body odors, than younger people. The decreased sensitivity to smell may also adversely affect appetite.

Vision: Apart from glaucoma, cataracts, or other eye disorders, there are several normal age-related changes in vision. In the fourth decade of life, visual capacity begins to decline.

a. Distance. The lens of the eye may lose some of its ability to accommodate changes in distance vision, it may take an elder person a few seconds longer to recognize someone across the room when he/she has been reading or doing handwork.

b. Light. The eyes have a decreasing ability to adjust to changing amounts of light, and glare becomes a problem. If an elder person has been sitting in a semi-dark room and opens a door to find a visitor standing in bright sunlight, the elderly person may not immediately recognize the visitor.

c. Color. Other changes in the lens of the eyes may make it difficult to distinguish blues and greens or pinks and yellows. An elderly person may comment on her green dress when it is actually blue. Colors that are very similar in shade, like beige and brown, may be difficult for elder individuals to distinguish. Contrasting colors such as black and white may be more readily identified.

d. Depth. Changes in depth perception may affect an elder person's mobility. The floor may appear to be rolling, so older people may shuffle along to ensure stable footing. Changes in depth perception make it difficult to judge the height of curbs or steps. A person may take a large step and receive a jolt. It is helpful to edge steps or curbs in a bright, contrasting color to facilitate the elderly person's ability to judge depth. Baseboards that contrast with the walls and floor make it easier to distinguish distances and surface areas.

e. Print. The lens of the eyes also lose some of its ability to focus on small print, such as the body of a newspaper, reading invoices, statements of benefits, residents' rights, and control knobs on equipment.

The cumulative effect of these vision changes can alter a person's sense of independence and self-confidence. If vision changes make it difficult for a senior citizen to negotiate a "strange" or unfamiliar environment, that person may go shopping or take trips less often. Also, an elderly person may appear to be two different people: one who is very efficient, steady, and independent when observed in her own environment, and one who may appear confused, disoriented, and slow in an unfamiliar environment.

Eye examinations are also important to ensure that eye diseases or impairments are detected and promptly treated.

Hearing: Hearing loss can cause depression and social isolation. Because it can lead to paranoia and suspicion, hearing loss is potentially the most problematic of perceptual losses. Individuals who have some degree of hearing loss may not realize that they have a loss. When an individual with a hearing loss is in a group, the person with the hearing loss may begin to think that others are talking about him or her, or are deliberately excluding that person from the conversation. In reality, group members may not realize the need to face the person and to speak so that he/she follows the conversation. Individuals with hearing losses may hear part of what is said and not know they have heard only part of the statement or question.

The mind may automatically compensate for unintelligible conversation by inserting information which seems to make sense. The person may then give an inappropriate response and not realize that the communication has been misunderstood.

There are three major types of hearing loss. One is the loss of hearing tones of higher frequency; therefore, low deep sounds are more readily heard than higher sounds. Conductive hearing loss occurs when sound waves are not properly conducted to the inner ear. Sounds become muffled and difficult to understand. A central hearing loss allows speech to be heard but not understood. Signals from the ear either don't reach the brain or the brain misinterprets them.

When communicating with an elderly person, an individual should face the person who is being addressed and speak slowly and distinctly. Lowering the voice tone may facilitate understanding. A touch on the hand may also aid the concentration, and comprehension, of a person with a hearing loss.

C. Systems

Circulatory System: The heart, like other muscles, weakens and has a diminished pumping capacity. Arteries or veins may become rigid or blocked, restricting blood flow and circulation. Under routine circumstances these changes do not greatly alter the daily functioning of an individual. These changes may be observed when an elderly person who has been sitting for a while suddenly stands and walks across the room. Unless a few extra seconds are allowed for the heart to supply sufficient blood to all the body extremities, the person may stumble, fall, or seem confused. After the heart has had sufficient time to pump blood throughout the body, the unsteadiness or confusion usually disappears.

Digestive System: One of the systems least affected by aging is the digestive system. There is virtually no change. As in earlier years, diet and exercise are extremely important to maintain proper functioning.

Urinary System: The urinary system experiences several changes. A general weakening of the bladder muscles means that the impulse to urinate cannot be delayed as long as in earlier years. The bladder doesn't stretch to hold as much as it used to, so urination may be more frequent. With weakened muscles, the bladder may not empty completely, thus increasing susceptibility to urinary infections. Also, the kidneys filter the blood more slowly, so medications remain in the bloodstream longer than they do in younger people. This change in functioning compounds the danger of over-medication, so dosages of medicine need to be closely and continuously monitored. In addition, interaction effects between prescribed medicine and over-the counter drugs, even aspirin or Bufferin, are more likely to occur.

Reproductive System: There is little change in the reproductive system. Vaginal secretions diminish; erections may require more stimulation. In men, the prostate may become enlarged. Regular check-ups are particularly important for men. Prostate trouble may go untreated until it requires radical treatment.

D. Summary

The cumulative effect of these changes is minimal in everyday functioning. These changes occur gradually, thus allowing individuals to adapt to the changes. The impact of these changes is more apparent when an older person is in an unfamiliar environment or subjected to physical or psychological stress. Proper exercise and diet significantly impact the rate of these changes by slowing down the processes. In spite of normal, age-related changes, most elderly function well enough to maintain daily functioning.

III. Psychological Aspects Of Aging

A. Memory

Short-term memory seems to decrease as one ages. It becomes more difficult to remember events in the immediate past, like what a person ate for breakfast, who came to visit yesterday, or the date and time of an appointment. There are ways to compensate for decreases in short-term memory function. For example, one may write notes that serve as reminders if they are kept in a specific place. Freedom from distractions may also help one remember immediate events or information. Long term memory seems to improve with increasing age. Events that occurred forty or fifty years ago may become easier to remember. As events are remembered and retold, they become more vivid and detailed.

B. Adaptation to Change

By the time a person acquires senior citizen status, he/she has experienced numerous changes. Individuals who have witnessed great changes have established patterns of adjusting to change. They know better what they can and can't tolerate and what is important to them.

Reactions to change vary from person to person. Sometimes older people are seen as resistant to change, or "set in their ways." It may be that their refusal to accept change is their way of maintaining control. To say "No" is to keep one area of their lives stable. At other times, change may be refused because it may not be understood. More information or different words may be needed to clarify the reason for the change, even if it is about a service being offered. The elderly may need more time to consider the proposed change, to think it through, and to decide. Providing assurance that the change can be tried on a temporary basis and then reevaluated may encourage someone to accept the change. If an elder person is offered a service or activity, the person may need reassurance about the terms of the service, other people who have utilized the service, and the ability to easily terminate the service before he/she accepts the service. There may be a very good reason for saying "No." People need to be listened to in order to understand their needs. Sometimes it is hard to find a balance between trusting their own priorities and understanding the enabling supports that they need. Change, whether positive or negative, is stressful. All individuals need time to adjust.

C. Reminiscence

One method of coping with change is through reminiscence. There are several positive benefits of engaging in reminiscence. The present may be depressing or very unsatisfactory. By recalling a happier time, an elder person may derive some contentment or the ability to endure the present. The strength to adjust to change may be derived from remembering previous successful adjustments.

D. Identity

Through story-telling, an older person can reveal personal achievements and characteristics. Indirectly, the older person may be saying, "This is how I was before I became old." Story-telling may serve as an introduction to that person prior to any limitations on energy or functioning. Personal characteristics are often revealed; a new acquaintance can begin to understand what the elderly person has been throughout his/her life by listening to reminiscences.

E. Self-Assessment

In recalling the past, an elder person may engage in self-assessment, deciding what kind of life he/she has lived. A review of the totality of one's life imparts a sense of integration of self. Self esteem can be reinforced by listening to an elder person's advice, wisdom, or history through reminiscence.

F. Grieving

Reminiscence can be a productive method of dealing with loss and grief. In verbally sharing a loss, an individual may come to accept it. In grief there is a need to remember, to relive past experiences. Reminiscence provides that opportunity. There may be conflicts in the past which are unresolved or which need to be re-evaluated. By remembering past events, a person may decide to make amends with someone, to be forgiving, or to seek forgiveness. Losses that were suppressed may surface and grieving may need to be completed. Some elderly may not have people with whom to share an experience. If only one or two people are around that elderly person, those individuals may hear the same story several times.

G. Intelligence

Intelligence does not decline with normal aging. Although, when tested, elder people respond less well on timed tests than do younger people; on tests with no time limits, elderly people perform better than younger individuals.

H. Senility

Senility has often been used as a "catch-all" word covering a range of symptoms with various underlying causes. In common usage, the word generally refers to forgetfulness, confusion, and disoriented behavior. There are treatable causes for the symptoms frequently labeled senility. Many problems can be classified as either organic disorders or functional disorders.

1. Organic Disorders. Organic disorders are caused by impairment of brain tissue. The symptoms may include disturbed or impaired intellectual functioning, impaired judgment, impaired orientation, or inappropriate emotional responses. The symptoms vary in intensity from individual to individual. A person who has an organic disorder may not know what day it is or may laugh when there is nothing humorous.

a. Acute Temporary: Acute disorders are caused by physiological stress and are reversible if treated in time. There are numerous possible causes, all of which are treatable. Hypoxia, the lack of oxygen to the brain, may result from surgery or from very hot baths. During a very hot bath, blood vessels dilate which causes more blood than usual to remain in the hands, feet, and legs. That leaves less blood to circulate to the brain. Temporary confusion may result. Another cause may be the increased time required for an aged heart to circulate sufficient oxygen to the brain and throughout the body. Other causes of acute organic disorders are heart failure, anemia, and fluid and electrolyte imbalance. A doctor may tell a patient to drink a glass of orange juice every day. If the patient skips the orange juice for several days, the person may become disoriented, confused. The patient's medicine was depleting potassium from his/her system. The body's chemistry was out of balance. Nutritional deficiencies can have a similar effect. A person may lose interest in eating or decide not to cook. A meal is skipped, then the person may decide to eat a snack instead of the next meal. Several days of nutritional deficiencies may result in mild confusion.

Elevated temperature, drugs or alcohol intake, and pathological conditions are other possible causes of acute organic disorders. Fever or an illness may produce some confusion. Drugs or alcohol can also cause disorientation, forgetfulness, or impaired judgment. Prescribed drugs may not be monitored closely enough or may have adverse interaction effects with other drugs.

b. Chronic. In contrast to acute disorders, chronic disorders are irreversible. The result is permanent brain damage. Treatment for individuals with chronic disorders may slow the deterioration process. There are several types of chronic disorders. Senile psychosis results

from a dissolution of brain cells. It is eventually fatal. The brain loses weight. Cerebral arteriosclerosis is caused by widespread brain tissue death due to a series of minor strokes. This accounts for 20 percent of the irreversible cases of mental impairment.

Alzheimer's disease causes the death of a large number of cells in the outer layer of the brain. It affects 4-6 percent of the population over age 65. Of all elderly individuals with mental impairments, Alzheimer's disease accounts for 50-60 percent.

2. Functional Disorders. Other causes of symptoms often labeled senility are due to functional disorders, not physiological changes. The symptoms are triggered by the interaction of stressful situations and the individual's personality.

a. Grief. In reaction to mild or severe grief, a person may be unable to sleep, experience loss of appetite, forgetfulness, restlessness, or other symptoms. The grief may be due to the loss of a relationship, either through death or by a change of circumstances. Physical relocation and the resulting severing of ties with familiar places may also cause grief. A sudden environmental change sometimes produces disorientation. A move from home or hospital to a nursing home is an example of such a change. It may take a while for the relocated individual to function in an ordered manner. The adverse affects of relocation can be minimized by involving the individual in planning for the move.

A further source of grief is a loss of function, such as mobility, or independence, or a decrease in physical abilities.

b. Depression. Depression is characterized by helplessness, sadness, lack of vitality, loneliness, or boredom. It can become a functional disorder if it disrupts an individual's ability to perform normal daily tasks. Physical reactions to depression include constipation, sexual disinterest, impotence, early morning fatigue, loss of appetite, or hypochondria. Depression may be caused by guilt, loss, or grief, or by pain and/or physical incapacity. It is also a cause of suicide in the elderly. Mental health counseling or psychotherapy can be beneficial. It is not too late for an elder person to work through emotional or psychological problems. This can be a time for resolving conflicts or unresolved problems and for further personal growth.

I. Assisting Confused Residents

There are positive ways to respond to confused individuals regardless of the cause of confusion or whether it is reversible or irreversible. The expectation for improvement needs to be present. Individuals sometimes rise to meet our expectations, even confused individuals. Voice tones, as well as words and actions, convey much meaning. A person communicating with a confused individual must be aware of all messages being given.

There are several ways to decrease confusion, but not all methods work for every individual.

- Increase sensory stimulation: for example, by playing music, taking the person outdoors, giving the person something to hold and stroke
- Provide adequate daily nutrition, exercise, and proper medication
- Encourage social contacts
- Allow ample time for the person to respond to conversation
- Ask questions when something is unclear
- Give clues to reality: for example, "I am ____ and I've come to visit you." "It is so cloudy and dark this morning that it seems like evening."

When an individual is confused, it is appropriate to respond to that person's feelings. For example, someone may say that her daughter is coming to visit her today. You may know that the daughter is not coming and respond by saying, "You must miss your daughter and are anxious to see her." That response allows the elderly person an opportunity to discuss the relationship or her feelings, but it does not reinforce the false expectation that the daughter will come that day. Confrontational conversations, such as directly stating that the daughter will not visit today, may cause the elderly person serious emotional trauma.

Before assuming that a person is confused or out of touch with reality, it is important to ask questions, such as: What do you mean? What were you thinking about before I came? What did you hear? The answers may help you to better understand the elderly person's statements. What had previously seemed confusion may make sense once a complete explanation is obtained.

IV. Sociological Aspects Of Aging

A. Introduction

As with individuals of any age, family relationships are important to the elderly. In later life, family composition often undergoes some changes. A majority of people over 65 years of age are married, but about half of elderly women are widowed. Among today's elderly population, divorced elderly are relatively few in number, but the percentage is increasing rapidly as younger generations with higher divorce rates are becoming senior citizens.

As familial composition changes with age, so do familial relationships. However, relationship patterns that were established in earlier years usually prevail. If a parent and child have always had personality clashes, they will continue to have them unless they learn new ways of dealing with each other. The parent who listened primarily to one child or turned to one child for advice will continue that pattern unless something intervenes.

B. Role Reversal

While an elderly person may become more dependent and exhibit childlike behaviors, that person is still an adult. Individuals may act like children because they feel they are being treated as children.

Dependency in one area does not mean a person is dependent in all area. For example, an individual may need assistance in completing forms, but that does not mean he/she needs someone to make financial decisions for him/her. In some cases, an aged individual who is recovering from an illness or stress may require temporary assistance in managing personal affairs but only until that person is able to assume total responsibility. If an elderly person makes a decision contrary to the family's advice, that does not mean that the person is incapable of independence.

The elderly need to be encouraged to do as much for themselves as possible. Caregivers need to patiently allow sufficient time for persons to respond to questions or to accomplish tasks. The emphasis should not be on perfection, but on personal accomplishment. The decision-making ability of the elderly person should be reinforced and adult behavior expected in as many areas as possible.

C. Crisis

It can be productive for the elderly and their families to anticipate potential crises before a stressful situation develops and to explore alternative solutions in advance. Areas of possible exploration include: living arrangements, finances, wills, and funeral arrangements. Prior discussion helps prepare strategies for resolving crisis situations when they occur. It is easier to make decisions when everyone's wishes are known.

D. Limitations

There are limitations to familial support. Financial support, as well as emotional energy, may be limited. It is not uncommon for a middle-aged couple to have dependent children in the home and increasing responsibility for aged parents. A retired couple trying to adjust to less financial flexibility may be caring for aged parents. When resources are limited, families may be pulled in more than one direction. Time to spend with elderly relatives and provide assistance also may be restricted. Priorities must be established, limitations acknowledged, and expectations discussed.

E. Guilt

Family relationships may involve some guilt whether justified or not. If due to unreasonable expectations, a personal re-assessment with realistic goals may be needed. If an aged relative makes excessive demands, a family conference or a one-on-one discussion may be in order. Problems, limitations, expectations, and responsibilities must be discussed. The aged relative should be involved in the discussion and in problem-solving. A workable solution must be found.

F. Losses

Throughout our lives losses are experienced: loss of friends, relatives, objects, physical abilities, roles and responsibilities, and opportunities. Some losses are more difficult to overcome than others. Objects that represent special relationships or personal achievement may be particularly important to an older person.

Physical abilities may be lost: the use of an arm or leg, vision, hearing, manual dexterity. Those losses are usually accompanied by losses in roles and activities. Retirement or physical impairments may force a loss of roles or responsibilities. The activities or functions which once gave meaning to life may be dramatically altered. Opportunities to make new friends, acquire new skills, or accomplish lifelong goals may be gone or greatly restricted. Recovery from loss may not be as rapid as in earlier years.

There are two primary reactions to loss: anger and grief. Both are natural and may be expressed in various ways depending on the individual. Talking about the loss is a therapeutic way to come to terms with it, to grieve and accept the loss.

G. Death

Although death and dying may trigger strong feelings and negative thoughts, they are a natural part of the life cycle. Five major reactions to death or dying have been identified by researchers: denial, anger, bargaining, depression, and acceptance. People do not always experience every feeling, nor do they always experience the feelings in the sequence indicated. Reactions may be repeated or skipped. Families or friends may experience these reactions just as individuals who are dying experience them. The reactions of families or friends may not be parallel to those of the dying person. They may be in different stages at the same time.

1. Stages of Dying

The stages follow along with indications of appropriate responses.[2]

Denial: When the awareness of a serious or fatal illness comes, persons react with shock and denial: "No, not me! It can't be me!" "This is not really happening. Someone has made a mistake."

Anger: When denial can no longer be maintained, anger takes over. The question becomes "Why me?" or "Why did God let this happen to me?" The person feels angry, bitter and envious of others who are not dying.

Bargaining: The person hopes that if she/he carries out promises, he/she will be rewarded with a longer life. This postponement is expressed in the hope that she/he will live to see some special event: "Yes me, but...." Many of these bargains are made with God and may be kept secret from family or friends.

2. Role Of Ombudsman And Caregiver

1. Listening is very important. The dying person may not talk much and should not be pushed. The resident should be allowed to daydream about happier things regardless of how improbable these may seem.

2. Family and friends usually find the anger stage difficult and mistake the anger as a personal attack. Be careful not to shorten or avoid visits or to react with anger. The resident needs an opportunity to ventilate his/her feelings. If the person feels respected and understood and is given attention by those important to him/her, he/she may soon begin to reduce the angry demands.

[2] Adapted from Elisabeth Kubler-Ross

3. The resident needs someone to listen to him/her and to recognize his/her feelings. Ventilation of fears often helps to relieve the resident's feelings and enables the person to work through this stage in a more satisfying manner.

V. Common Illnesses And Conditions Associated With Aging

A. Digestive

1. Malnutrition:

- Causes of malnutrition include:
- Eating alone after the death of a spouse
- Diminished absorption of nutrients due to physical decline of endocrine system
- Not enough saliva which aids in the breaking down of food in the mouth
- Diminished ability to swallow, known as peristalsis
- Rebellion through food. They may be angry with their relatives for deserting them in a nursing home, angry at being sick, angry with the staff or angry with their physician

Non-eaters are at risk of malnutrition due to limited protein reserve in the organs of the body. A person suffering from malnutrition will have little energy and, in its more advanced stages, will be mentally confused. Staff and relatives may become frustrated and resentful, thus causing further resistance from the resident and retaliation from the nursing home staff.

2. Hiatus Hernia:

Sixty-nine percent of people 70 years and older have hiatus hernias, which are protrusions of the stomach upward through the esophageal opening of the diaphragm. The hernias can be somewhat minimized if the resident is sitting up straight while eating. As part of treatment, smaller, more frequent meals are helpful. Staff may not realize the importance of positioning a person correctly.

3. Constipation:

The most common digestive problem among bedridden or inactive people is constipation. Constipation can be caused by:

- Lack of fiber and fluid intake
- Decreased muscle tone
- Ignoring or being unable to heed the normal urge to defecate
- Laxative abuse
- Prolonged bed rest
- Insufficient food intake
- Tumors

- Certain medications, primarily tranquilizers, sedatives and antacids
- Residents may complain about or have:
- Abdomen pain
- Distention of stomach
- Cramping

Many older people are dependent on laxatives. This dependency becomes counterproductive. If the person uses laxatives for any length of time, the digestive system will not function without them.

Extreme constipation can become a medical emergency. It also can cause mental confusion as the system becomes poisoned by waste products that cannot be eliminated. However, a person who is dependent on laxatives needs to be taken off them slowly. A hearty breakfast, six or more glasses of liquid a day and moderate exercise all are helpful in improving elimination.

4. Dehydration:

Dehydration symptoms include the following:

- Sunken eyes
- Dry tongue
- Dry skin
- Cracks in the corners of the mouth
- Loose and less elastic skin
- Confusion

Having water available at all times is imperative to the health of the resident. Since elderly do not retain as much water as younger persons, they need to drink more frequently. Many residents cannot drink by themselves or cannot reach the water left on their night stand. Some residents do not drink water late in the day to avoid getting up at night or wetting themselves. Sometimes, an elder person may not feel thirsty even though he/she is dehydrated.

B. Neuromuscular-Skeletal

1. Osteoporosis: Osteoporosis is loss of calcium from the bones caused by insufficient calcium intake and lack of exercise. It is most prevalent in elderly white women. The vertebrae and other bones decrease in mass, causing a gradual loss of height accompanied by a "dowager's hump" (curving of the upper spine). Inactivity increases calcium depletion. Upon admission to a nursing facility, a resident is generally less active than they would be in their home which further accelerates the problem.

2. Parkinson's Disease: Parkinson's is a disease of the central nervous system characterized by tremors in the extremities, rigidity, and slowness of movement. It is an incurable, degenerative, and progressive disease. Its symptoms include poor grasp, poor mouth-hand coordination, inability to suck

or close the lips well and limited ability to bite, chew and swallow. As time goes on, the person will need frequent help with eating or drinking and may also need special utensils, special diets, and extended time to eat.

3. Decubitus Ulcers (bedsores): Bedsores are caused by pressure from lying or sitting for prolonged periods. Bedsores are most common in patients who are completely immobile. Most ulcers appear on heels, buttocks, back of heads, elbows or hips. The skin is reddened and usually is broken or blistered. There may be necrosis of the tissue (dead tissue) which can cause exposure of the bone. Decubitus ulcers are the most obvious sign of neglect. Left unattended, they can lead to infection and ultimately to death. Sometimes these ulcers are bandaged to cover up neglect, but they have a very strong odor, similar to decaying meat. Development of these ulcers can be affected by unmade beds, or improper bedding, wet or soiled linen, radiation therapy, barbiturate sensitivity, sensory loss and the condition of the skin.

Prevention and treatment of decubitus ulcers include:

- Turning patients every two hours to avoid breakdown of the skin.
- Adequate nutrition to improve the condition of the skin.
- Using "egg-crate" or waterbed mattresses, which assist in shifting a resident's weight from one spot to spreading the weight out over a larger surface.

Hyperglycemia (elevated blood sugar) increases the likelihood of developing the ulcers as does arteriosclerosis, which reduces the blood supply to the tissues. Dehydration, which causes fragile, inelastic skin, is another factor. However, none of these conditions will cause bedsores in the absence of persistent pressure.

C. Neurological

Alzheimer's Disease: An estimated 4.5 million American have Alzheimer's Disease. Increasing age is the greatest risk factor for Alzheimer's. One in ten individuals over 65 and nearly half of those over 85 are affected. Half of all nursing home residents have Alzheimer's or a related disorder.

Alzheimer's is a progressive disease that starts with a loss of short-term recall and progresses until death. During the course of the disease, the person becomes unable to perform day to day functions due to progressive loss of short term, and eventually long term, recall.

Persons will eventually fail to recognize their family and become a danger to themselves when they are unable to remember to turn off a stove or remember where they live.

It is often the loss of memory that causes a family to seek their loved one's institutionalization. Because of the lack of normal memory, the person needs to be watched constantly and protected from wandering into danger.

Alzheimer's victims also can adopt screaming and/or aggressive behavior that disturbs other residents. Some nursing homes have special wings for

Alzheimer's patients that are geared to structuring the activities of patients and monitoring for wandering behavior.

D. Urinary Incontinence:

Inability to control excretory functions and occurs more frequently in the very old. Caused by weakness in the sphincter (valve) to the urinary tract, incontinence is particularly common in people who get little or no exercise. The diminishing ability to store urine in the bladder causes the frequency of voiding to increase. An elder person may not feel the sensation alerting him/her to void until the bladder is almost full. In a young person this sensation occurs when the bladder is about half full. When an elder person realizes he/she has to go to the bathroom, it may be too late.

Incontinence can be caused by urinary tract infections, tumors, and injury to the central nervous system. It is common in people with Alzheimer's disease and other chronic brain syndromes, particularly in the later stages of these diseases, as these diseases affect the central nervous system. Incontinence also can be caused by stress, worry, anger, fear, frustration, anxiety, and confusion. Sometimes residents become incontinent due to **lack of attention** by nursing staff if they are made to sit for hours without assistance.

Incontinence can be devastating to the residents' self-esteem. They feel frustration and shame when they can no longer control their bodily functions. Insensitivity on the part of staff can further diminish the resident's self-esteem. Staff should check residents who are incontinent frequently so they can be changed to avoid discomfort or skin breakdown.

Continence can be regained by bladder and bowel training. The chance of success with bladder and bowel training increases if the resident maintains adequate fluid intake (2000 cc, approximately 2 quarts, or more per day). Regular trips to the bathroom at designated times of day, prompt attention to the call light for assistance, and involvement of the resident and sometimes the family in the retraining plan, all are necessary steps toward retraining. The chart should be marked as to time of day the resident soils him/herself so the plan can be adapted to his/her personal schedule. Bowel and bladder retraining take time and consistent effort, but the rewards in self-esteem and the quality of life more than make up for the effort.

VI. Drugs And Their Side Effects In The Elderly

Most nursing home residents are on seven or more drugs at any time. Ombudsmen will often notice side effects of these drugs on residents. This section familiarizes ombudsmen with common drugs in nursing homes and the side effects many residents experience. Ombudsmen should be familiar with this basic terminology of drugs so that when residents'/families' complaints involve drugs, ombudsmen recognize the terms and can investigate the complaint reliably.

Prescribing appropriate drugs is the domain of the physician. However, pharmacists in nursing homes are supposed to review the drug regime of residents on a

monthly basis to ascertain if there are adverse drug reactions, allergies, contraindication or ineffectiveness.

A. Narcotics

Narcotics are used for the relief of moderate to severe pain. They have the potential for both physical and psychological dependence because they produce relaxation, indifference to pain and stress, lethargy, and euphoria. Mild symptoms of withdrawal may be seen upon discontinuation of narcotics if the patient received the drugs regularly. The symptoms maybe more intense if the narcotics were used for a prolonged period.

Possible Adverse Effects:

Lightheadedness	Dizziness
Sedation — most frequent	Nausea/Vomiting
Sweating	Weakness
Mental Clouding	Insomnia
Agitation	

Examples of commonly prescribed narcotics:

Morphine	Oxycodone
Tylenol with codeine	Percocet

B. Sedatives/Hypnotics

Sedatives/hypnotics are used as a sleep aid.

Possible Adverse Effects:

Non-barbiturates	**Barbiturates**
Dizziness	Somnolence
Disorientation	Agitation
Headache	Confusion
Hangover feeling	Central Nervous System
Depression	Staggering gait
Nightmares	Confusion
Hallucinations	Ataxia (muscular incoordination)
Decreased blood pressure	Decreased heart rate
Breathing irregularities	

Examples of commonly prescribed sedatives/hypnotics:

Non-barbiturate	**Barbiturate**
Ambien	Nembural
Ativan	Seconal
Dalmane	
Restoril	

C. Anti-Anxiety Agents

These agents are used for the relief of anxiety.

Possible Adverse Effects:

Drowsiness	Confusion
Muscular incoordination	Depression
Lethargy	Disorientation
Agitation	Slurred speech
Stupor	Euphoria
Constipation	Dry Mouth

Examples of commonly prescribed anti-anxiety agents:

Librium	Klonopin
Valium	Ativan
Xanax	Diazepan

D. Antidepressants

Antidepressants are used for the relief of symptoms of depression.

Possible Adverse Effects:

Sedation	Dry mouth
Blurred vision	Constipation

Urinary retention

Confusion (including disturbed concentration, dizziness, memory loss, numbness, anxiety, headaches, anorexia, incoordination, photosensitivity, hallucinations)

Examples of commonly prescribed antidepressants:

Elavil	Sinequan
Lexapro	Wellbutin
Paxil	Zoloft
Tofranil	Remeron

E. Antipsychotic Agents

These agents are used for the management of mental disorders. Some are used to control the symptoms of the manic phase of manic depressive illness for apprehension prior to surgery or for control of nausea and vomiting.

Possible Adverse Effects:

May impair mental and physical abilities (especially during first few days of therapy)

Drowsiness (especially first and second week of therapy)

Pseudoparkinsonism — tremors

Inability to sit still

Restless and urgent need for movement

Tardive dyskinesia — movement of the tongue, puffing of cheeks, puckering of mouth, chewing movement (may occur in patients on long term therapy)

Other effects occurring in the elderly because of decreased tolerance include:

lethargy	dry mouth
agitation	nasal congestion
confusion	constipation
insomnia	urinary retention
euphoria	nausea, vomiting

Examples of commonly prescribed antipsychotic agents:

Thorazine	Seroquel
Mellaril	Compazine
Risperdal	Haldol
Navane	Zyprexa

F. Miscellaneous

Nasal decongestant sprays used for the relief of nasal congestion may have adverse effects, such as “rebound congestion,” burning/stinging, sneezing.

Caffeine, used as an aid in staying awake, and found in beverages like coffee, tea, colas, and cocoa, may cause adverse effects, such as nausea/vomiting, insomnia, restlessness, excitement, nervousness, ringing in the ears, increased urination.