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WHAT ARE THE CHALLENGES FACED BY ADULTS WHEN THEY BECOME AGED?
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**Methodology**  

Introduction
Abstract

Today the ageing population is growing larger and larger. And governments and families alike around the world need to take necessary actions to tend to the needs of these elders in order to ensure they have a comfortable life during the late ages of their life.

There are many challenges faced by the elders and there are many factors that affect the wellbeing of their lives. This research paper aims to find out what are the most critical factors that affect the wellbeing of the elders with special reference to the senior citizens.

Using past literature it was determined that physical wellbeing, mental wellbeing, financial wellbeing and Social wellbeing are the areas which will impact the wellbeing of an elderly person. In order to test these hypotheses, the researcher conducted interviews personally with ten participants who live in an elderly care home. And the researcher was able to find out which has the highest impact on elderly citizens life and which has the least effect.
Chapter 01

1. Introduction

1.1. Research Rationale

Many studies have shown that Sri Lanka has an ageing population and soon the retired population will outnumber the active earning population. Therefore the government and all the authorities should make appropriate plans in order to serve these senior citizens. There has to be a permanent system to take care of our elderly. This is the responsibility of both the community as well as the government. It can be observed that many developed countries have an appropriate measure in order to look after their elderly. But before taking action on how to address this issue, it is always better to understand what happens to adults when they are growing old.

The aim of this study is to understand what aspects of a person’s life would be affected when they are growing old as well as to understand how these elements would affect their day to day life. By studying these aspects the researcher aims to understand a better perspective of how to care for these elders. Additionally, by understanding what happens to adults when they age, the researcher aims to understand how to adopt the caregiving the practice to benefit the elderly and ensure they would have a comfortable family life.

1.2. Objectives

- To understand how age affects physical health in adults
- To understand how age affects mental health in adults
- To understand how age affects social interactions in adults

1.3. Questions

The purpose of this research is to understand the relationship between age and the challenges faced by adults.

The outcome and conclusions of this study will help the stakeholders in the caregiving industry to understand the challenges and how to adopt the care system accordingly. Additionally, the findings will ensure future caregivers to understand more about their patients and take appropriate actions to anticipate these challenges and train to address them.
1.3.1. Problem Statement

According to the above-discussed discussion and below given literature survey, there is a literature gap which did not fulfil the requirement by recent studies and an empirical gap that indicates the importance of this research in the current context. Therefore, this research is centred on finding “what are the problems / challenges faced by elders”.

1.4. Elderly Care

Using the secondary data which was collected for this research, the researcher found out how does the elderly care process happens. Many nations have legislated the elderly care process in to their governing law. This was established to ensure that all the senior citizens are taken care of properly as well as they are given the due respect.

In order to fulfill this legislative requirement coupled with the lifestyle, the necessity of elderly care homes were born. But these legislation requires that elderly care facilities provide a standard of care that keeps clients comfortable, safe, and as healthy as possible given the conditions a person may suffer from. There are different levels of care available, including assisted living facilities, memory care units, nursing care, and hospice care.

Under the laws and NHS system elderly care is provided, although exceptions may apply. The facility chosen may have a partial payment from the elderly care NHS system and require any additional payments be made by the resident. An assisted living facility or residential care home that is not part of the NHS system, such as a privately owned facility, requires payment from the resident and this will generally be quite costly. Disability waivers and care, social welfare, and other programs exist to help elderly residents pay for the care they require. Availability of facilities can be scarce depending on the location in which a person is looking to reside.

A consultation is usually required from the elderly care facility one seeks to assess whether the place would be the right fit. If there is an agreement about the facility then the waiting list or lack thereof is discussed. Payment details will also be discussed once it is determined that the facility will be able to provide the required care.
Chapter 02

2. Literature survey

2.1. Introduction

There are many studies conducted in order to find out the challenges faced by adults when they age. In order to form the basis for this thesis, the researcher studied past literature which was conducted in a similar capacity. Using the finding of these studies the researcher was able to defend the research question, the research objectives and the tools which should be used in order to conduct this research.

2.2. Physical challenges

There are many studies that highlight issues and problems that our society faces an ageing population and the epidemic of functional limitations and physical disability—the process of physical disablement. Many older adults will live with, rather than die from, the disablement that accompanies chronic diseases (Rothenberg & Koplan 1990). Several of the previous studies have examined the potential benefits of various forms of physical activity for the older adult.

As an example of the challenge of behaviour change, consider that the Surgeon General’s report (U.S. Department of Health 1996) encourages all adults to participate in 30 minutes of moderate physical activity on most, if not all, days of the week (i.e., 5 days a week). The 30 minutes of activity can be done at one time or split into smaller 10-minute segments. To counter the effects of inactivity and achieve desirable health outcomes, people must adhere to regular physical activity. However, the recommendations that emerge from various levels of scientific dose-response evidence are goals toward which people must strive. Due to low initial fitness or health restrictions, some older adults may take several months to reach the recommended goal. Even for healthy individuals, the recommended goals are not attained overnight.

In addition, maintaining the motivation for the necessary adherence is often a challenge, as reflected by reports of sizeable attrition from programs of structured physical activity for older adults and from personal home-based regimens[3]. The dose-response goals do not address areas of the older adults’ life that require self-management in order to accomplish these goals. For example, how do older adults cope with barriers to initiate and maintain a program of physical activity? Nonadherent older adults’ reticence about activity is understandable when one considers the perceived barriers that they face and the culture that reinforces these barriers. The influence of these forces on the older adult complicates the process of changing older adults’ physical activity.
2.2.1. Commonly Identified Barriers to Physical Activity for Older Adults

Similar to older individuals with clinically identified chronic diseases, a significant proportion (i.e., approximately 70%) of generally asymptomatic individuals aged 50 years do not meet current national guidelines for regular physical activity (Dishman 1990). The Behavioral Risk Factor Surveillance System (BRFSS) report provides statistics on barriers to physical activity and suggests that the elderly are particularly vulnerable to barriers. For example, people aged 65 were less likely than younger adults to engage in walking as a leisure-time physical activity when their neighborhood was perceived as unsafe (Center for Disease Control and Prevention 1999). As might be expected, perceived poor health and the symptoms of physical disabilities associated with chronic disease are frequently reported as major barriers (e.g., poor perceived health, pain, fear of pain) (Lian at el. 1999). A cross-sectional household survey of 2494 older adults revealed that a lack of time was a key barrier to leisure-time physical activity in this population (Lian at el. 1999). The Canadian Physical Activity Benchmarks Report indicated that the major barriers for active and inactive individuals were time, energy, motivation, illness, fear/injury, and lack of skill (Craig, Russell, Cameron & Beaulieu 1997). In contrast to the barriers reported by the young, long-term illness, injury, and lack of skill were rated as far more important barriers for older adults.

Barriers have also been examined among socioeconomically disadvantaged older adults. A study of 1088 urban, primary care-center adults aged 55 years indicated that over two-thirds of patients reported perceived environmental barriers to physical activity in addition to expected physical symptom barriers [10]. Environmental barriers included weather, extreme temperatures, presence or quality of sidewalks, and no place to sit down during a walk. In this same low-income population, both symptom and motivational barriers were associated with less physical activity. Major barrier differences between genders were that women reported more barriers than men and, specifically, more symptom and environmental barriers. Age differences were that the youngest group (aged 55 to 69 years) reported significantly more symptom and motivational barriers whereas the oldest reported more environmental barriers.

Finally, misconceptions about physical activity, including that it must be strenuous or uncomfortable to benefit health (Lee 1993) and a lack of understanding related to how regular, moderate physical activity can benefit health (Caserta & Gillett 1998) are also problems. Such cognitive or attitudinal misconceptions may be exacerbated by the self-serving biases of social comparison where ageing adults falsely believe they are more active than same-aged peers (Wilcox & King 2003) this unrealistic optimism may, in turn, reduce their motivation to become more active.
2.2.2. Cultural Influences

To understand older adults’ lack of participation in physical activity and the problem of their no adherence after initiation, we should also consider the influence of the cultural environment. Despite the dearth of research on determinants of physical activity in older adults (Shephard 1994) growing evidence indicates differences for older adult subcultures of America (Macera et al. 1995). Subcultural differences in language, ethnicity, education, and income present unique challenges for interventions that are targeted to increase physical activity. Scientific evidence and recommendations about types of physical activity for the older adult tend to be based on data gathered from asymptomatic older adults. There is less evidence about various ethnic, socioeconomic, and chronic disease subgroups for different health outcomes. As a consequence, the applicability of recommendations varies greatly for older adult subgroups that have focused needs (e.g., improving mobility before improvements can be made in cardiovascular function).

Beyond these unique differences is the larger, normative influence of culture. Is there a cultural norm to treat the old as frail, in effect reinforcing a personal schema of dependency? Does our medical establishment contribute to this cultural stereotype? At least some groups of older urban adults (aged 70) report that their physicians do not discuss physical activity in clinic visits (Clark 1005) the stereotypic response, “you are doing fine for someone of your age,” is meant to reassure older patients. Yet, if their lifestyle is currently inactive, has this behavior been unintentionally reinforced? Indeed, as researchers and interventionists, we need to consider whether our current approaches to helping older adults may reflect ageism in our own thinking and research.

2.3. Mental Challenges

First, the ageing process is believed to begin earlier in individuals with mental retardation/developmental disability (MR/DD). Some researchers maintain that the ageing process begins at age 55 for persons with mental retardation (Seltzer & Seltzer, 1985). Secondly, advances in medical technology and health care have helped to increase the longevity of persons with MR/DD. For instance, persons with Down Syndrome had a life expectancy of fewer than 10 years old in 1929, but with advances in cardiac care and surgical procedures, the life expectancy of these persons are beginning to mirror that of the non-disabled population (Chicoine & McGuire, 1997). Lastly, this population has become more visible in the general community. Elder adults with MR/DD are increasingly using community health care systems to address medical issues associated with ageing as well as those conditions associated with specific syndromes.

Individuals with MR/DD often experience a need for additional support in daily activities due to physiological and psychological changes associated with ageing. Chronic health problems similar
to those experienced in the general population have been identified in elder adults with MR/DD (Anderson, 1993). These include arthritis, hypertension, osteoporosis, hip fractures, cerebral vascular accidents (CVA), and cardiac anomalies. However, the population of adults with MR/DD may have a higher incidence of specific disabilities associated with their primary diagnoses and syndromes. For example, Kapell et al. (1998) reported a high incidence of thyroid disorders, nonischemic heart disorders and visual impairments associated with Down Syndrome. Beange, McElduff and Baker (1995) found that elders with mental retardation have increased risk factors for cardiovascular disease as well as a higher number of chronic diseases with increased morbidity and mortality rates compared to the general public.

There are also psychological issues related to ageing. The elder adult with MR/DD may be experiencing emotional disorders, anxiety, phobias and depression (Foelker & Luke, 1989). These can result from physiological changes, long term pharmaceutical use or changes in living situation or lifestyle (Foelker & Luke, 1989). The elder adult with mental retardation is also at risk for dementia (Foelker & Luke, 1989). Lastly, individuals with MR/DD often have led sedentary lifestyles which may be complicated by eating a diet high in sugar, fat and cholesterol and perhaps, excessive use of caffeine and tobacco (Edgerton, Gaston, Kelly & Ward, 1994).

Along with changes in health status, the adult with MR/DD may experience changes within family and living arrangements. Family caregivers are also encountering the health and social changes that accompany the ageing process—decreased stamina and energy, increased use of health care resources, changes in financial status and changes in family constellation with illness and death of spouses (Bonder & Wagner, 1994). These families may be connecting with support systems for their ageing relative with DD, for themselves and/or for other family members, after 50-60 years of privately caring for their family member. This reliance on social support systems may be new, and the unfamiliar systems can be unfamiliar overwhelming for families. Likewise, social support systems may become overwhelmed by the complex needs of these families who are entering the system "late in the game" (Herge & Campbell, 1999).

2.3.1. **Historical and Current Perspectives**

At the turn of the 20th century, persons with MR/DD had limited housing options, particularly if they were from poor or low-income families. Options included living in poorhouses, hospitals or at home. Other persons, generally those from more affluent families, were placed in small private residential schools (Ferguson, 1994). Medical, nursing and therapeutic services were typically provided on site and these were regarded as limited in quality (Wolfensberger, 1991). Later, in
the 1970s therapeutic care may have been coordinated through a type of individual treatment plan (e.g., Individual Habituation Plan) or some other team generated a plan. Additionally, care providers were often on-site, which facilitated coordination and communication between providers and reduced the need for the individual with mental retardation to access community-based health care services.

2.4. Social Challenges

Social isolation and loneliness among seniors has been well-researched in gerontology. Peter Townsend, in his classic text The Family Life of Old People, writes that: ‘to be socially isolated is to have few contacts with family and community; to be lonely is to have an unwelcome feeling of lack or loss of companionship. While he regarded loneliness as subjective and difficult to measure, he saw social isolation as objective. He tried to measure it by attributing scores to the number and types of social contact, such as attending a club or a church, or more instrumental forms of interaction such as work relationships or seeing the doctor. He acknowledged that this failed to account for the ‘function, intensity or duration’ of the various forms of contact. For Townsend, social isolation emerged from not one, but a combination of factors, with the most socially isolated being those ‘usually living alone, older than average, without children or other relatives living nearby, retired from work, and infirm’. Following Townsend, Robert Weiss argues that loneliness is not easily overcome through social contact, such as through seniors’ groups. Loneliness is not simply a desire for company, but the desire for specific types of company, or relationships. Once these are found, loneliness can quickly dissolve.

While such relationships are not guaranteed in seniors’ groups, within gerontological literature, seniors’ centres are frequently discussed as spaces to reduce social isolation. As Ronald Aday and his colleagues note, seniors’ centres can provide an optimal environment for social support to help reduce loneliness and depression. They offer opportunities for ‘social interaction, friendship, and ego integrity and feelings of self-worth that may successfully counter the social isolation and loneliness’ which can threaten the mental and physical health of seniors (Aday et al., 2006: 58). Meals programs at centres are constantly referred to as important vehicles for reducing social isolation. As Kirk and colleagues note, they offer opportunities to develop social relationships with other participants. They argue that sharing a meal can help to establish new connections, but also re-establish connections which may have been slowly eroding through death, relocation or demographic changes in the neighbourhood. K.W. Turner (2004) found that the overwhelming majority of her seniors’ centre participants (87%) came ‘as much for the opportunity to socialize
as for the meals they receive. For more than half, this was their only daytime social interaction, with the majority viewing this personal social contact as important to them (Turner, 2004).

Where social contact is important, social support may be just as crucial a reason for seniors to attend centres and join groups. Social support can be broken into two categories, instrumental and emotional support (Ashido and Heaney, 2008), both of which are found in seniors’ centres and groups. Instrumental support refers to practical forms of assistance, such as helping with transport or financial aid, which can be accessed formally through contact with staff (if available) or informally through other members (Kirk et al., 2001). Emotional support involves the formation of close bonds with others at the centre. We need to be careful in our approach to systems of social support for seniors, including seniors’ centres and groups. Christina Victor and her colleagues have been quick to point out that much work on social support too readily focuses on how social resources are mobilized in times of need. They suggest that this approach can problematize older people’s social relationships as resources which are used to provide care in periods of crisis, like illness, thus reducing social interaction to an instrumental process. But we also need to be cautious about celebrating seniors’ centres and groups as spaces of meaningful emotional interaction, for they fluctuate along a continuum of emotional contact and functional interaction, even within a day. I will return to these issues of social interaction later, when exploring the role of community in seniors’ groups, but first I want to explore what forms these groups take.

### 2.5. Financial Challenges

Cases of elder financial abuse, which range from telemarketing scams to illegal transfers of property, pose myriad challenges to professionals. Many of these cases challenge society’s basic understanding of such complex matters as cognitive functioning, mental capacity, and undue influence as workers attempt to interpret victims’ ability to understand complex financial transactions and withstand increasingly sophisticated forms of persuasion. Further complicating matters is the fact that financial abuse exceeds the boundaries of any single discipline or jurisdiction. The lines between criminal conduct and “civil matters” are often unclear, which sometimes results in law enforcement personnel referring to the civil system cases involving the misuse of civil instruments (e.g., powers of attorney) even though the conduct may also be criminal. Because the roles and relationships between the two systems are not well understood, coordination between them is often poor. Even in cases that are clearly criminal, a lack of clarity may exist with respect to where jurisdiction lies as financial crimes may cross county, state, and
federal boundaries. Depending on the nature of the offence, financial crimes may be handled by police, Medicaid fraud and control units, the Federal Bureau of Investigation, the Federal Trade Commission, the Secret Service, or others.

In addition to this lack of clarity with respect to the appropriate systems or jurisdictions for handling abuse cases, a variety of additional obstacles prevent many victims from getting the help they need and perpetrators from being brought to justice. Physical or cognitive disability prevents some victims from participating in the justice system. Particularly frail individuals are likely to decline, become incapacitated, or even die during the course of protracted proceedings; and it is not uncommon for cases to continue for many years, particularly when defendants must be extradited. Victims with diminished mental capacity who are unable to recall details of a crime or explain the impact it had on them may be poor witnesses. Although victim advocates could have a significant role in addressing these barriers to the legal system, many advocates lack familiarity with financial crime and abuse and their potential role has not yet been fully recognized or realized.

Finally, public and professional perceptions and attitudes about financial crime and abuse also impede efforts to prevent it. Many victims fail to perceive financial crimes as crimes. A study on telemarketing fraud conducted by AARP showed that although victims felt that what had been done to them was wrong, the majority did not understand it also was criminal. Some victims fail to report because they distrust the system, fear retaliation, or believe offenders might sue them while others lack confidence in the system’s ability to help them. Many victims simply want to recover what they have lost and do not believe that reporting to the police will accomplish this.

### 2.5.1. Challenges Faced in Stopping Financial Crimes.

Foremost among the challenges the many kinds of literature addressed was the critical lack of available training for all levels of law enforcement personnel in handling financial abuse cases. Proving financial crimes frequently requires familiarity with such diverse topics as contract law, real estate, guardianship, and mental capacity. Investigators and prosecutors may need to decipher civil contracts and financial documents, prove what victims did and did not understand (often at earlier points in time), and determine what defendants knew or reasonably should have known about victims’ levels of understanding. Because these topics are not covered in traditional law enforcement training curricula or programs, few police officers within local precincts, even command staff, possess this expertise. Similarly, prosecutors are unlikely to have received training in these areas. Those officers and prosecutors with this type of expertise are likely to be
so inundated with cases that they are forced to prioritize those that involve a large number of victims and large losses. Without training, law enforcement personnel who come into contact with financial crimes are forced to pick up needed skills “on the run.” Exacerbating the problem further is the fact that law enforcement agencies typically rotate staff through their various units. By the time fraud investigation personnel have acquired the expertise that is needed, they are likely to be transferred back to other divisions or may be ready for retirement.

Chapter 03

3. Methodology

3.1. Introduction

In this section, the researcher discusses methods which are used in to conduct this research. Future this section talks about the bare bones of the study, which is the conceptual framework. Using the conceptual framework the researcher formulated the hypotheses which will be tested in this study. Finally, this section talks about the sample size of this study as well as research design.

3.2. Conceptual framework

Using past literature, the researcher identified the independent and dependent variables accordingly. The independent variable was broken down to four different measurement indicators which are:

- Physical wellbeing
- Mental wellbeing
- Financial wellbeing
- Social Wellbeing

While the dependent variable is set to be Challenges faced by Elders. Therefore the conceptual framework can be represented as below:
3.3. **Hypothesis**

- There is a relationship between physical wellbeing and challenges faced by elders
- There is a relationship between mental wellbeing and challenges faced by elders
- There is a relationship between financial wellbeing and challenges faced by elders
- There is a relationship between social wellbeing and challenges faced by elders

3.4. **Research design**

This research will be conducted using a qualitative approach. The researcher used various sources to collect secondary data, such as government reports, etc. Using this data the researcher was able to identify if the problems stated in past literature. For example, if an elder is always complaining and refusing to take their prescribed medication, it can be an indication of a challenge faced by them which they would not want to talk or confront about. In order to collect primary data, the researcher used an interview as the main tool to collect primary data from the population.
3.5. Questioner

In order to give a general direction and to ensure that none of the information is missing, the researcher used a standard questioner in the interview. This questioner was used just as generic guidance and was not disclosed to the interviewee.

The questioner which was used is given in appendix 01. The first set of questions in this questioner was to understand the general demographics of the person (Questions 1 to 19). The second set of questions is aimed toward understanding their memory and ability to recall an individual’s childhood. These questions are from question number 20 to 28. There onwards the questions move on to memories around young adulthood. Where an individual transitioned from their academic life into a professional one. These set of questions start from question number 29 to 33. Questions number 34 to question number 50 the questions aim to find out about their family life, after the point of getting married. The next set of questions are aimed to understand the post-retirement status of the adult. These questions range from question number 51 to 64. The rest of the questions were formed to understand the post-retirement lifestyle the adults would lead. These covered their physical mental and social aspects.

Chapter 04

4. Data analysis

4.1. Introduction

This chapter showcases the analysis performed on collected primary data and the outcome of it. The data were coded from the interviews in order to be analyzed. The data was analysed using statistical tools mentioned above in order to find out if they fulfil the established hypothesis. The conclusion and all discussions are all based on the outcome of the analysed data.

4.2. Preparation of data

According to Gibbs (2007) Coding is a way of indexing or categorizing the text in order to establish a framework of thematic ideas about it. In data coding, there are two main approaches. Which are concept driven coding and data-driven coding. Concept-driven coding is where a researcher approaches the data with a developed system of codes and look for concepts/ideas in the text. Data-driven coding or also known as open coding is where the researcher looks for
In this study, the researcher opted to use data-driven coding or open coding. This is mainly because of the structure of the interviews and how the participants behaved.

The answers given by the elders and the coding is attached on appendix 01 below.

4.3. Coding definitions

In order to analyze the data, all the interview transcripts were Coded. The same set of codes were used to code all the transcripts and the definitions of the codes are given below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adulthood</td>
<td>Representation of the interviewees adulthood. This can be a representation of a significant life event.</td>
</tr>
<tr>
<td>Adulthood memories</td>
<td>Memories that the respondent could recall during the interview. Those memories were created during the adult life of the interviewee.</td>
</tr>
<tr>
<td>Care Received</td>
<td>The level of care received by the respondent in the current care home.</td>
</tr>
<tr>
<td>Childhood</td>
<td>A significant life event of the respondent which occurred in their childhood.</td>
</tr>
<tr>
<td>childhood memories</td>
<td>Memories that the respondent could recall during the interview. Those memories were created during the childhood of the interviewee.</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Children</td>
<td>Information about the interviewee's own children.</td>
</tr>
<tr>
<td>Current Situation</td>
<td>The situation the respondent is facing currently. This is not related to any physical or mental health, but a general representation of their life in overall.</td>
</tr>
<tr>
<td>Early Adulthood</td>
<td>Representation of the interviewee's early adulthood. This can be a representation of a significant life event.</td>
</tr>
<tr>
<td>Early Adulthood Memories</td>
<td>Memories that the respondent could recall during the interview. There memories were created during the early adulthood of the interviewee.</td>
</tr>
<tr>
<td>Education</td>
<td>The education received by an accredited institution during the life of the interviewee.</td>
</tr>
<tr>
<td>Elderly Memories</td>
<td>Memories that the respondent could recall during the interview. There memories were created during the elderly stage of the interviewee's life.</td>
</tr>
<tr>
<td>Family</td>
<td>The family background of the interviewee.</td>
</tr>
<tr>
<td>Family Wealth</td>
<td>The wealth the interviewee's family had during their upbringing.</td>
</tr>
<tr>
<td>Hobbies</td>
<td>Hobbies taken up by the respondent during their life.</td>
</tr>
<tr>
<td>Illness</td>
<td>Current illnesses the respondent has.</td>
</tr>
</tbody>
</table>
### 4.4. Results

Based on the coding and the responses given by the individual interview participants. The below graph shows how often a certain code was mentioned.
Additionally, the exact breakdowns of the responses are given below. These responses are arranged in an ascending order. Looking at the data it can be observed that 12% of the responses were related to social wellbeing. Which is the highest response from the participants. As a number of social wellbeings were brought up 21 times in responses given by the interviewees. Secondly, Physical Health was the second most popular making it 9.9% of the total responses. The number of responses given to Physical health was 17. With 16 each responses Childhood memories and Current care received are the third highest response category. This makes up around 9.3% of responses. Finally, in the fifth place, the mental health-related questions make up 8.7%. The total number of responses given related to mental health was 15. In the 6th place of the ranking was the children. The participants brought up stories about their children 12 times. Making it 6.9% of the responses.

Finally, Family wealth makes up 6.4% of the responses. Making it the seventh highest response.

<table>
<thead>
<tr>
<th>Response</th>
<th>No. Responses</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Wellbeing</td>
<td>21</td>
<td>12.21%</td>
</tr>
<tr>
<td>Physical Health</td>
<td>17</td>
<td>9.88%</td>
</tr>
<tr>
<td>Childhood Memories</td>
<td>16</td>
<td>9.30%</td>
</tr>
<tr>
<td>Category</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Care Received</td>
<td>16</td>
<td>9.30%</td>
</tr>
<tr>
<td>Mental Health</td>
<td>15</td>
<td>8.72%</td>
</tr>
<tr>
<td>Children</td>
<td>12</td>
<td>6.98%</td>
</tr>
<tr>
<td>Family wealth</td>
<td>11</td>
<td>6.40%</td>
</tr>
<tr>
<td>Family</td>
<td>11</td>
<td>6.40%</td>
</tr>
<tr>
<td>Spouse</td>
<td>8</td>
<td>4.65%</td>
</tr>
<tr>
<td>Personal Wealth</td>
<td>7</td>
<td>4.07%</td>
</tr>
<tr>
<td>Parents</td>
<td>7</td>
<td>4.07%</td>
</tr>
<tr>
<td>Siblings</td>
<td>6</td>
<td>3.49%</td>
</tr>
<tr>
<td>Education</td>
<td>6</td>
<td>3.49%</td>
</tr>
<tr>
<td>Early Adulthood</td>
<td>4</td>
<td>2.33%</td>
</tr>
<tr>
<td>Adulthood</td>
<td>4</td>
<td>2.33%</td>
</tr>
<tr>
<td>Adulthood Memories</td>
<td>3</td>
<td>1.74%</td>
</tr>
<tr>
<td>Marriage</td>
<td>2</td>
<td>1.16%</td>
</tr>
<tr>
<td>Elderly Memories</td>
<td>2</td>
<td>1.16%</td>
</tr>
<tr>
<td>Early Adulthood Memories</td>
<td>2</td>
<td>1.16%</td>
</tr>
<tr>
<td>Hobbies</td>
<td>1</td>
<td>0.58%</td>
</tr>
<tr>
<td>Childhood</td>
<td>1</td>
<td>0.58%</td>
</tr>
</tbody>
</table>

4.5. **Hypothesis validation**

According to the nature of the study, the researcher has developed four hypotheses to study challenges faced by adults when they become aged. With special reference to adults living in the UK. However, the relationships can be analysed based on the mean value of the responses and the frequency it has been repeated. Therefore the researcher used the coding and simple Excel formulas to identify the frequency.
4.5.1. **Hypothesis 01:**

The first hypothesis talks about how physical wellbeing would affect the life of elders. When looking at the data, 9.8% of the respondents spoke about their physical wellbeing. Therefore it can be assumed that there is physical wellbeing has a significant impact on elders. Additionally, this is the second highest response category given by the interviewees. Therefore it can be concluded that the first hypothesis which is “**There is a relationship between physical wellbeing and challenges faced by elders**” is valid.

4.5.2. **Hypothesis 02:**

The second hypothesis evaluates the effect mental wellbeing has on elders. The mental wellbeing of leaders was identified using the mental health and childhood memories codes. This is because the current mental health was identified using the code of mental health while the ability to recall old memories were identified by childhood memories. When analyzing the results it can be observed that childhood memories were brought up 16 times which is 9.3% of responses making it the second highest of the responses. Additionally, respondents have spoken about mental health 8.7% of the time. Making it the fifth highest response given by the interview participants. Therefore it can be concluded that the second hypothesis “**There is a relationship between mental wellbeing and challenges faced by elders**” is acceptable.

4.5.3. **Hypothesis 03:**

The third hypothesis aims to study the relationship between financial well-being and the challenges faced by elders. The financial wellbeing was identified by family wealth and personal wealth. Even though both were considered, personal wealth is the most significant factor that would affect the personal wellbeing, Both aspects cumulatively would rate 10.7% which means a very high score when compared with other responses. Therefore it can be concluded that personal wealth has a significant impact on the personal wellbeing of elders. Therefore the third hypothesis “**There is a relationship between financial wellbeing and challenges faced by elders**” is accepted.
4.5.4. Hypothesis 04:

The final hypothesis is to understand the relationship between social wellbeing and how it would affect elders with their lives. To identify the social wellbeing among elders, the interview transcripts were coded using social wellbeing. Social wellbeing was the highest rated answer given by the respondents. Social wellbeing was given 21 as responded by respondents making it 12.2% of the total answers. Therefore it can be assumed that the fourth and final hypothesis which is “There is a relationship between social wellbeing and challenges faced by elders” also acceptable.

Chapter 05

5. Findings and conclusion

5.1. Introduction

Upon analyzing the data and understanding the outcomes the researcher has summarized the findings in this section. Here the researcher would keep the focus on answering the research questions set for earlier in this report as well as discussing the validity of the hypothesis. Finally, this section is written to fulfill the research objectives.

Furthermore, the researcher has discussed the limitations of this study and how it can be improved in future studies. Finally based on the findings the researcher has set forward some recommendations which can be implemented in real life. This will help to improve the care system for the elderly in Sri Lanka.

5.2. Key findings

After analyzing the data to validate the hypothesis the researcher was able to relate the findings and apply to the industry norms. Here it was observed that the most important aspect for elders to live a happy life is their social wellbeing. This was concluded because it was the highest answers given by the respondents. When applying this observation to reality, it can be concluded that this finding is consistent with the real-life scenarios. This is because most of the time the wellbeing of the elders are determined based on social wellbeing. If a society has a set of rules, regulations and guidelines it will result in the better care system for the elders. Additionally, this will help the families and support groups to frame the mindset in order to take care of the elderly.
Additionally having the necessary infrastructure to help the elders live their lives normally would also benefit them a lot. Therefore it can be said that social wellbeing is one of the most important aspects when ensuring a better life for elderly citizens.

Secondly, the physical health of the elderly also affects drastically on the social wellbeing of the elders. This is proven to be true since even in practice the physical wellbeing of a person would drastically impact the way the person lives the life. When looking at the responses given by the interviewees it is observable that all the participants lived a happy life and they worked hard to ensure that their children would have a better life and also they have some savings for themselves. And for a person as such to be in one place is arguable quite hard since they are used to being so active. Therefore any physical illnesses which confine them will directly affect the wellbeing of the person. Additionally, the current care they receive is quite high in quality which ensures that all the elders are in great shape as much as they can be. Therefore directly influencing the wellbeing of the elders.

Going along those lines mental health can also be considered very important. Even though this is true it was rated as the fifth important aspect of wellbeing. Before mental health, there are childhood memories and current care received. When looking at the findings objectively these findings can be justified. Having good childhood memories also can be considered as a good healthy mental state. If the respondent is mental health is deteriorated then the chances of them remembering their childhood would be lower. Therefore good memory of their childhood is a sign of good mental health.

Finally, the current care they received also has a significant impact on the wellbeing of the elders. Again this is proven in real life examples as well. If the care they received is not up to standard it will directly affect their physical and mental health. Which will determine the wellbeing of the person. Additionally, it was observed the care they receive was not only the medical attention they received. Other additional activities such as evening walks, get together with other residents and other activities which would keep them occupied helped the elders to live a happy elderly life without any regrets.

### 5.3. Future Studies

Even though this research was thoroughly conducted to determine how the care they receive would impact the personal wellbeing of elders, this research can be followed by further studies. Also, this study can be referred to as a source of information for further researchers.
The main focus of this study was to identify what areas would impact the well-being of elders. Which means this research can be extended to other impacts such as government involvement, children's perception and socio-economic background.

Further due to the time duration and the practicality of data collection, not all residents were interviewed. Therefore, it is recommended to conduct further studies using a bigger sample and from various other elderly homes as well.

6. References


