Eating Disorder among Elderly Causing Heart Attack: A Study on Impact of Life Style Management in Post Retirement Life

Harasankar Adhikari*

Monihar Co-operative Housing Society, Flat No-7/2, 1050/2, Survey Park, Kolkata-700075, India

Abstract: In the era of globalization growing elderly faces multifaceted problems regardless of social, economical, cultural as well as religion in their retired life. Among such health problem is a prime concerned. The mental crises among them are a major issue. Thus thinking about their end of life they usually try to fulfill their many desires like eating. The present study was conducted to explore the relationship of eating disorder with increasing incidents heart attack among elderly. For the purpose of this study, 100 elderly populations of 60-70 years selected regardless of their gender, socio-economy, education, family relation and so forth. They were interviewed in a reputed hospital namely Rabindranath Tagore Institute of Cardiac Sciences of Kolkata Metro City of eastern India where they took admission for their treatment after their heart attack. The data was also collected from medical practitioners and family members of elderly patients. The simple random sampling method was used with case study. From the study, it was revealed that 70% of them was suffering from heart problem after taking heavy fatty foods and of them 40% was diabetic. They used to control their eating habits with strict monitoring of their family members. But they faced heart attacked after taking food from ceremonial party or otherwise. Among them, 22% were experienced for second time. So, the control of eating habits might longer their survival and for this they need counseling and guidance with supervision of their family members or immediate caregivers.

Keywords: Cardiac/heart attack, eating disorder, elderly population, family members.

INTRODUCTION

The elderly population in India faces a number of problems. These problems range from absence of ensured and sufficient income to support themselves and their dependents, to ill-health, absence of social security, loss of social role and recognition, and non-availability of opportunities for creative use of free time. For a developing country like India, the rapid growth in the number of older population presents issues, barely perceived as yet, that must be addressed if social and economic development is to proceed effectively [1]. Gore [2] opined that in developed countries population ageing has resulted in a substantial shift in social programmes. It causes a significant change in the share of social programmes going to older age groups. But in developing society, these transfers will take place informally and will be accompanied by high social and psychological costs by way of intra-familial misunderstanding and strife. In the later years of life, arthritis, rheumatism, heart problems and high blood pressure are the most prevalent chronic diseases affecting the people [3].

The health problems of the elderly vary according to their socio-economic status. Siva Raju [1] studied while the poor elderly largely attribute their health problems, on the basis of easily identifiable symptoms, like chest pain, shortness of breath, prolonged cough, breathlessness / asthma, eye problems, difficulty in movements, tiredness and teeth problems; the upper class elderly, in view of their greater knowledge of illnesses, mentioned blood pressure, heart attacks, and diabetes which are largely diagnosed through clinical examination. Through his clinical study of the elderly, Joshi [4] opined that both physical and mental health problems depend on environmental and social factors such as diet, type of education, adjustment to family and professional life, and consumption of tobacco and alcohol. At an advanced age, due to restricted physical activity, a majority of elderly changes their living habits, especially their dietary intake and duration of sleep. There is a general perception in the community that since the old leads a sedentary life, they should eat less food, have more rest and develop more religious interest to occupy themselves. Several factors like lack of physical movement, absence of a work routine, ill-health, etc. are observed to be responsible for irregularity in the sleeping schedule of the elderly [4]. The allocation of less time to sleep among the lower strata of the elderly, probably indicates the compulsions for them to work. Besides, inadequate facilities in the household go against resting or sleeping during the day.

Coronary heart disease (CHD) is the most common cause of mortality and morbidity in the elderly. In western countries, it accounts for 80 – 85 percent of all cardiac deaths in older people. When a person ages, his or her cardiovascular system will undergo some normal and expected changes [5]. These can be age-associated changes in cardiac anatomy; age-

*Address correspondence to this author at the Monihar Co-operative Housing Society, Flat No-7/2, 1050/2, Survey Park, Kolkata-700075, India; Tel: 91-9748031763; E-mail: jaoya123@yahoo.co.in

E-ISSN: 2309-6128/14

associated changes in cardiovascular physiology; and age-associated changes in pharmacokinetics and pharmacodynamics. Various conventional risk factors for CHD among younger people such as smoking, hypertension, hyperlipidemia and diabetes mellitus remain important factors for elderly [6]. Silent heart attack is also common. As reported in the Cardiovascular Health Study and the Framingham Heart Study, some 40 percent of unrecognized heart attack was found in those aged between 75 and 84 years [7].

The different dietary habits of various communities, lack of medical personnel in rural areas, selective admissions of cardiac patients to hospitals, inadequacy of necropsy data (mostly through religious prejudices), lack of uniformity of methods of certification and classification of diseases, socio-economic discrepancies, and variations of climate in the different provinces or states are but a few of the many obstacles that beset the worker interested in the compilation of statistical data in India. Despite these drawbacks, several careful studies on the incidence of heart disease in India have been published by Sanjivi [8], Vakil [9], Siva Raju S [10], Malhotra [11], Samani [12], Dezoysa [13], Padmavati [14], and Mathur [15]. The great majority of these studies are based on low income groups or hospital populations.

Very few studies have been made on the incidence of coronary heart disease in high and middle income groups, encountered in private or consulting practice [9, 15].

So from the above studies, we find that the heart attack among elderly is a common aged phenomenon. Like various responsible factors, dietary intake/food intake is one. The objective of the present study was to explore the dietary habits among elderly and how it was a responsible factor of increasing incidents of heart attack.

METHODS

There were 100 elderly populations of 60-70 years of age selected through purposive sampling because in India, 60-62 years of age is officially considered as the age of retirement so that both pre-retirement and postretirement are significant for their health condition. All of them were admitted in a private reputed super specialty heart hospital namely Rabindranath Tagore Institute of Cardiac Sciences at Kolkata, India due to their sudden heart attack within 6 months of the study period during last half of 2012.

For collecting data, a structures interview schedule was used. The patients were interviewed on average 1-2 days after their admission and the interview session was lasted for 20-30 minutes. The researcher was assigned informally to interact with the patients and physician and para-professional to the hospital assisted researcher to know about his/her lifestyle and dietary habits. The family members were also well-informed and asked to participate. Physician and para-professional staff were supplied information relating to the particular patient and his/her family. In this situation, participation was cent percent. Basic demographic information(age, gender, religion, nature of inhabitants, educational background, occupation, marital status and family size, etc) was collected from patients and their family members. Researcher also collected data on their lifestyle habits i.e. smoking history, consumption of alcohol, diseases- history hypertension, diabetics, family history, cardiovascular diseases, dietary intake, etc. The emphasis was given particularly on regular dietary intake/food intake just before their sudden heart attack. Qualitative data on their regular dietary intake in relation to their physical activity that focused on occupational and other non-leisure-time activities in addition to leisure time activities. The information was collected on their self realization of aging and the views of their family members/care givers on aging were also recorded.

RESULT

Demography of the Selected Elderly Population

Table **1** describes that 83% of the elderly population in this study was male and 45% of them was 60-65 years of old. They were dominated by Hindu (25%). Rest of them was within the age bracket of 66-70 years and they belonged to Hindu mostly. Seventy four percent was living in urban area and among them 32% was graduate. On the other hand, 17% of them was female and of them 13% was 66-70 years of age. Of them 2% lived in urban area and 5% of them completed matriculation so far as education background was concerned. Only 3 of them was graduate.

The marital status shows in Table **2** that 23% of them lived in urban area was married and they were living their nuclear family with their off-spring. Similarly, 8% of them were widow(er). In case of rural respondents, it was 8% and 4% respectively. The second category of elderly population in this study was living in a nuclear family under care of their maidservants/relatives. Among them, 6% was single in

Table 1: Social, Religious and Educational Status of Elderly according to their Age

Educational status according to their nature and inhabitant	Religion												Total
	Hindu				Muslim				Christen				
	60-65 yrs		66-70 yrs		60-65 yrs		66-70 yrs		60-65 yrs		66-70 yrs		
	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	
Urban													
Lettered	2	-	2	-	3	-	2	4	-	-	-	-	13
Matriculate	6	2	6	3	4	-	2	-	4	-	-	2	29
Graduate & above	13	1	4	2	4	-	2	-	4	-	2	-	
Rural													
Lettered	-	-	1	1	2	1	2	-	-	-	-	-	7
Matriculate	4	-	4	-	2	-	1	-	2	-	-	-	13
Graduate & above	-	-	2	1	1	-	1	-	-	-	1	-	6
Total	25	3	19	7	16	1	10	4	10	-	3	2	100

Table 2: Marital Status and Living Status including Family Size

Nature of Inhabitant	Family size						Total
	Nuclear family living with off-springs			Nuclear family looking after by maids/relatives			
	Single (%)	Married (%)	Widow(er) (%)	Single (%)	Married (%)	Widow(er) (%)	
Urban	-	22	8	6	24	14	**74**
Rural	-	8	4	2	5	7	**26**
Total	**-**	**30**	**12**	**8**	**29**	**21**	100

Table 3: Economic Status of Elderly

Educational status to their nature of inhabitant	Occupation						Total
	Service (public/private sectors)		Business		Others including household management		
	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	
Urban							
Lettered	-	-	4	-	5	4	13
Matriculate	8	2	7	1	7	4	29
Graduate & above	15	1	8	-	6	2	32
Rural							
Lettered	-	-	1	-	4	2	7
Matriculate	4	-	6	-	3	-	13
Graduate & above	5	1	-	-	-	-	6
Total	32	4	26	1	25	12	100

urban area, 24% of them were married and 14% of them were widow(er). In rural setting, 2% of them were single, 5% of them were married and 7% of them were widow(er).

Occupation and Economic Status of the Elderly

The occupational status in respect of their educational background (Table **3**) reveals that 32% of them(male) was employed in public/private sectors. It was 23% more than the elderly from rural area. Only 4% of them were female. Altogether 22% of them were graduate. On the other hand, 27% (including 1% female) used to operate their business and 8% of them were graduate. Thirdly, 37% of them were engaged in their household management and out of which, 12% of them was female.

Table **4** describes their engagement pattern at their post retirement life. Among them, 57% (including 15%

female) was in domestic work. Of them 15% was in some official works and it was one forth in rural area. There was no such engagement of 10% respondents and out of which, 2% was female.

Table 4: Regular Activities Performed by the Elderly

Nature of inhabitant	Regular activities						Total
	Domestic		Officials		No such		
	M (%)	F (%)	M (%)	F (%)	M (%)	F (%)	
Urban	42	12	12	-	6	2	74
Rural	18	3	3	-	2	-	26
Total	60	15	15	-	8	2	100

Description on their Lifestyle Habits and Diseases

Their life style habits (Table **5**) states that only male population had smoking habits (70, out of 83) and 23(out of 83) was alcoholic. Their history of illness shows that 22 males (out of 83) had chronic illness and in case of female it was 7 (out of 17). Among male, 65(out of 83) was diabetic and 12 female (out of 17) had same problem. Fifty five (out of 83) was in hyper cholestoralnomia and in case of females, it was 15(out of 17). Out of 83 male, 42 had heart problem and it was 15(out of 17) in case female. Fifty two males (out of 83) were suffering from hyper tension/high blood pressure and it was 15 (out of 17) in case of female.

Table 5: Records of Habits and Diseases

Habits	Male		Female		Total
	Yes (%)	No (%)	Yes (%)	No (%)	
Smoking	70	13	-	17	100
Alcohol consumption	23	60	-	17	100
Diseases/ Chronic illness	22	61	7	10	100
Diabetic	65	18	12	5	100
Hyper Cholestoralsomia	55	28	15	2	100
Heart problem	42	41	7	10	100
Hyper tension/high blood pressure	52	21	15	2	100

Frequency of Heart Attack among Elderly

From the study, we recorded information of second time attack or more than that. The records state that 22% of them were second time and out of which 2% was female. According to their age, it was found that 18% of them were within the age bracket of 66-70 years. A little percent (3%) faced third time attacked and all of them were male of 66-70 years of age.

Heart Attacked in Relation to Dietary Intake

From this study, it reveals that there was a relation of heart attacked in relation to their dietary intake. The age related chronic illness restricted their dietary intake. They used to follow a regular routine of diets. It was their routine of life. It was informed that they did not allow the food according to their choice and the amount of food intake was also regulated. But among them, 70% was joined in some celebration/family occasion and they had broken their restriction particularly in terms of consumption of foods. It facilitated their heart attack.

DISCUSSION

Self-Opinion of Elderly on Ageing

In their own opinion, what was shared by elderly respondents, they had reached to less valued, non-functional heads from valued and functional heads of their family. They were burden to the family as well as in the society. After reaching to their post retirement life, they conceived that it was a time to counting the days of death only. The transcended 'God' is their most reliable director to replace them in the heavenly world. All of them desired a peaceful death. In their working life, they had struggled a lot for maintaining their family's liabilities and responsibilities as functional head. Their some willingness was unfulfilled and among various desires, the food was their most favourite one. It was uncontrollable, in spite of; self aware disadvantages might push them into some physiological deformities. Nonetheless, they reminded that their intake capability of food from childhood to young hood did not create any complication. But at present, the age bar made them unhappy with restriction everywhere. They also shared that they were feeling loneliness and unfortunate in the present state of life.

Views of the Younger Off-Spring in their Family/Caregivers of Elderly

The younger off-spring of their family/caregivers of elderly opined that they used to manage their hectic working life with stress and strain matching with their

job demand including a rigorous competition. They were very self-centred regarding their career and earning. So, they did not get much time for the care of elderly. And the caregivers rather than family members were only performing their routine paid job to assist the elderly. Moreover, they shared that the elderly had adjustment problem with their growing age. They used to be very rigid and demanding. They used to feel insecure and used to create scene many times to bring attention of other. They did not follow restriction that was advised by their physician. They felt that the elderly should not act according to their wish considering to their successful aging. The perception towards aging should be rebuilt for their happiness.

Food Intake/Dietary Habits of Elderly - Myth and Reality

At postretirement life, elderly used to consider it as the flag end of their life. They were workless and they had nothing to do for betterment of society. They had to suffer from isolation in general. They were well informed about their physical and physiological strength and weakness. But they did not agree to adjust this mentally. They had to pass their life with various restriction and these were justified for the sake of their rest life. But in reality, they thought that they were walled by boundary of their younger. In their rest life, they used to consume various foods and the myth was enjoyed food because they would be died any day.

CONCLUSION

The growing population in India is in a critical situation. Socio-psychological problems are the giant factors of their unhappiness. Social structure and cultural myth on aging had been isolated and pushed them to loneliness. The post retirement was an indication in relation to their official retirement from their jobs. The globalization influenced towards a truncated family relation because their attachment to their off-spring was thinner. In this study, the elderly population was economically secured. In their post retirement life, they were unable to use their time and experience for fruitful purpose. They were submerged with a myth that they would die any day any moment. As a conse-quence of this, they used to change in their life style management causing life style diseases like heart attack.

Overall familial situation had changed their mindset. That's why, they had to suffer from various physical and psychological problems. Their realization had been turned to omnipresent world. Their self-cultivated notion was that before expiry they should meet their desired need of foods. Their complication and restriction were not being sensitized them as they felt as valueless. This type of mental state used to create more complication in their elderly life. Here, we found that 70% of them were suddenly faced heart attack only to break their restriction in food intake. It had been insulted by their off-spring and their situation had become worse.

So, there is a need of proper supervision and sincere care for elderly. They would be sensitized with proper attention by their younger/care-givers. The family members should be closely being associated with them for their mental strength. Perhaps, it would show a light of happy survival and last of all, they would lead a happy death.

REFERENCE

[1] Siva Raju S. Health of the elderly in India: Issues and Implications, Bombay, Tata Institute of Social Sciences, (Mimeo) 2002.

[2] Gore MS. The elderly in an ageing society, Contributed to Volume IV of Encyclopedia on Ageing, Japan, 1993.

[3] Purohit CK, Sharma R. A study of aged 60 years and above in social profile, indian. Journal of Gerontology 1972; 4 (3&4): 71-83.

[4] Joshi CK. Medical problems of old age. Indian Journal of Gerontology 1997; 4(3, 4).

[5] Rosamo W, Flegal K, Friday G, Furie K, Go A, Greenlund K, *et al*. Heart disease and stroke statistics 2007 update: a report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Circulation 2007; 115: e69-171. http://dx.doi.org/10.1161/CIRCULATIONAHA.106.179918

[6] Jessup M & Brozena, S. (2003), Heart Failure, *N Engl J Med.,* 348(20): 2007-18.

[7] Kenchaiah S, Narula J, Vasan RS, Risk factors for heart failure. 3. Med Clin North Am 2004; 88: 1145-72. http://dx.doi.org/10.1016/j.mcna.2004.04.016

[8] Sanjivi, KS. Proceedings of the Annual Conference of Association of Physicians of India, 1946.

[9] Vakil RJ. ISchaemic Heart Disease in India. Indian J. Med. Sci. 1948; 2: 465.

[10] Siva Raju S. Medico- Social Study on the Assessment of Health Status of the Urban Elderly, Bombay, Tata Institute of Social Sciences, (Mimeo), 1997.

[11] Malhotra RP. Some Biological aspects of coronary heart disease; an Indian point of view. Indian J. Med. Sci. 1951; 617.

[12] Samani. Indian Year Book of Medical Science. Current Medical 1960; p. 110.

[13] Dezoysa, VP. Clinical variations of the diabetic syndrome in a tropical country (Ceylon). *AMA Arch Intern Med.* 1951 Dec; 88(6): 812-818.

[14] Padmavati S. Epidemiology of Cardiovascular Disease in India Indian Heart J. 1958; 10: 33.

[15] Mathur KS. Problem of Heart Disease in India. Amer. J. Cardiol. 1960; 5: 60. http://dx.doi.org/10.1016/0002-9149(60)90009-6

Received on 05-10-2014 Accepted on 26-11-2014 Published on 31-12-2014

DOI: http://dx.doi.org/10.12974/2309-6128.2014.02.02.4