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Life After Home: Elders Experiences of Abandonment and Institutional Living.

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ABSTRACT:
India's rapid demographic ageing and decline of joint families increasingly consign older adults to institutional care that secures material needs but overlooks psychosocial wellbeing. This study explores how abandonment is experienced by elders living in old-age homes in Thiruvananthapuram, Kerala. A qualitative multiple-case approach was adopted; purposive sampling identified ten residents (≥60 years, ≥6 months stay) across seven homes. Semi- structured interviews, field observations and reflexive notes generated rich narratives, which were analysed thematically ,Thematic analysis revealed six inter-related themes, family rejection and abandonment, emotional distress and loneliness, coping mechanisms and
resilience, adjustment to institutional life, unmet need for social connection, and fear of the future (including death and financial insecurity). These insights show that the old age home based care ensures basic physical needs,but it leaves significant psychosocial needs unmet, underscoring the urgency of person-centred, emotionally informed interventions in
institutional care settings for ederly.
Keywords: *Institutional elderly, psychosocial wellbeing, loneliness, family abandonment, old age homes*

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I. INTRODUCTION:

Aging is an inevitable complex and multidimensional process in which an organism gradually declines physiological functioning and homeostasis, leading to increased vulnerability and mortality. The process of aging encompasses biological, environmental, and social factors that interact with each other and contribute to different aging experiences. There is no denying that India's demographics are changing to become more elderly. The old population is expected to double by 2050, which will have a significant impact on social networks, familial ties, and psychosocial behavior(Jabade & Joshi, 2024). There are approximately 600 million people in]this world above 60 years of age and it is expected to grow four times by the year 2050. India has around 100 million older people and the figure is expected to reach up to 323 million by 2050, taking the ageing population of India up to 20% of the total population.(Maheshwari et al., 2021). In India, the joint family system has long been common, and children ,particularly sons have long taken care of their elderly parents. However, the family structure has changed recently, and the conventional joint family system is becoming less prevalent. Indians are abandoning the conventional methods of aging, such as taking care of their elderly parents at home, as nuclear families become more prevalent. As older individuals' physical and mental health deteriorates, the family structure is changing significantly. This has resulted in the problem of providing community care for elderly parents and the rise of old age homes in India. (Lamb,2007). .Because of increased vulnerability the elderly care demands more importance. In India, the responsibility of caring for seniors is shifting from families to the state bacause of eroding family structure and values and higher number of eldrly population, necessitating the development of adequate institutional support systems(Hegde et al., 2012). There has been increase in the number of Old Age Homes according to the Indian Ageing Report 2023, to accommodate the growing senior population.

The existing literatures highlights several significant psychosocial difficulties the elderly encounter, particularly in care facilities. Social isolation and feelings of loneliness are widespread issues, often associated with the decline of traditional family support due to societal changes like increased workforce participation and a move away from joint family structures(Diyali, 2021). Conditions such as depression, anxiety, and sensations of neglect are frequently observed in older adults, aggravated by limited social engagement and fewer family visits, with research in Kerala indicating higher instances of emotional and verbal abuse among elderly women and those

living alone (Chandran & Chacko, 2021; Joseph et al., 2014). Health challenges, including chronic ailments like hypertension, diabetes, and arthritis, further intensify these psychological issues, causing many elderly individuals to feel overwhelmed by their physical conditions, which isolates them from social engagement (Lena A et al., 2009; Shivarudraiah et al., 2021). Financial instability and dependence also add to the psychosocial strain, especially among seniors without reliable income or social security (Boralingaiah et al., 2012). Gender and age play additional roles in these challenges, with older women and individuals over 80 experiencing heightened levels of depression and anxiety (Barakat et al., 2019). The standard of care in nursing homes serves as another vital aspect of healthy ageing; research indicates dissatisfaction with staff conduct and a sense of neglect, which can diminish psychological health and highlight the necessity for better-trained caregivers to offer compassionate support(Shivarudraiah et al., 2021) . As per a survey conducted by the Madras Institute of Ageing, there were 529 old age homes in India in 1953. While Help Age India has reported700 old age homes in 1998.4 In addition it has beenreported that the southern part of India account for 52% of all old age homes.The present study aims to find the lived experiences of elderly individuals residing in Old Age Homes in Thiruvananthapuram, Kerala, with a particular emphasis on their experiences of abandonment and emotional disconnection in later life. Although institutional care settings in India often ensure the provision of basic needs such as food, shelter, and medical attention, they frequently lack adequate psychosocial support, emotional engagement, and opportunities for recreation and meaningful social interaction. Many residents report persistent feelings of loneliness, neglect, and a loss of purpose, pointing to deeper concerns that extend beyond material care. By drawing on case studies and capturing personal narratives, emotional expressions, and day-to-day reflections, this study aims to illuminate the complex realities of institutional ageing. Ultimately, this research highlights the importance of developing holistic elder care interventions that uphold dignity, connection, and quality of life for older adults in Kerala's care institutions.

II. MATERIALS AND METHODS

This study has been conducted in 7 old age homes in different geographic and socio economic zones of Thiruvananthapuram , a qualitative case study design is used to explore the lived experiences of elderly individuals residing in institutional care settings. Purposive sampling was used to recruit information-rich cases. Administrators first identified residents who met the inclusion criteria, after which the researcher approached each potential participant individually, explained the study, and obtained consent. The inclusion criteria for participant selection were: individuals aged 60 years and above, those who had been residing in the old age home for a minimum of six months, cognitively and physically capable of participating in in-depth interviews and observational activities, and willing to share their personal experiences. The exclusion criteria included individuals diagnosed with psychiatric illness or severe cognitive impairment as documented in medical records, as well as those who were bedridden or had conditions that hindered meaningful participation in the study. Based on these criteria, a total of ten residents six women and four men were selected for the study.Data was collected using semi-structured interview guide and field notes to gain insights into the physical, emotional, and social aspects of their daily lives. The objectives of the study were to explore the socio-demographic characteristics of elderly individuals residing in old age homes in Thiruvananthapuram, to examine their lived experiences with particular focus on emotional well-being, social relationships, and to understand their perceptions of abandonment, loneliness, and purpose in later life in order to identify areas requiring psychosocial interventions in institutional care settings. After data collection, collected qualitative data were thematically analysed,enabling the identification of recurring patterns, meanings, and themes across the case narratives.

SOCIO-DEMOGRAPHIC PROFILE OF PARTICIPANTS

case	age	gender	education	Marital status	Number of children	Previous occupation	Religion	Duration of stay
1	76	male	6th	widower	2	cook	Hindu	15 years
2	68	Female	2nd	Widowd	2	Cook	christian	10months
3	75	Female	8th	Widowed	1	Nil	Hindu	12 tears
4	68	female	3rd	Widowed	2	nil	Hindu	5 years
5	68	Female	3rd	Widowed	2	teacher	Hindu	3 years
6	86	Male	10th	Married	2	Tailor	Hindu	3 years
7	70	Female	5th	Widowed	3	Nil	Muslim	3 years
8	63	Female	10th	Married	1	Nil	Christian	1 year
9	72	Male	7th	Married	2	Driver	Muslim	2 years

10	72	Male	10th	Unmarried	0	tailor	Hindu	1 year

III. CASE VIGNETTES

Case 1 – C

Mr. C is a 76-year-old widowed male, his native is Varkala and previously worked as a cook in a hospital canteen and has two children. Mr. C was admitted to the old age home 15 years ago by his elder son after his wife's death as there was no one at home ready to provide care. Mr. C is living with multiple lifestyle diseases and age-related issues, including diabetes, hypertension, and the aftermath of a stroke that left him paralyzed on one side. He describes his current health status as poor and does not perceive himself as healthy or active. His lifestyle is largely sedentary. The major psychosocial issues observed in Mr. C are a lack of purpose in life, persistent loneliness, and social withdrawal. Although he states, "It has been 15 years, and everyone here became my friend," the absence of expression and the visibly unhappy demeanor while speaking these words suggest underlying sadness. He mentioned that his family last visited a year ago, which adds to his feelings of abandonment and neglect,

His coping strategies are limited to passive activities such as watching television and listening to the news. He appears emotionally disengaged and quietly follows the institutional routine without complaint. Over the years, the old age home has become a substitute for his original home, providing him with food, medicines, and a sense of stability that he acknowledges he would not receive in his household. Mr. C continues to hold on to a faint hope that his son may one day take him back, his family will accept him, and he will get the opportunity to live with his children and grandchildren. However, he also realistically acknowledges that this is unlikely, given the family's inability to care for him. The depth of his emotional pain and loneliness is most profoundly expressed through his silent demeanor and eyes that reflect unspoken sorrow.

Case 2 - V

Ms. V is a 68-year-old widowed female from Trivandrum. She has two children and formely she lived with her son. Ten months ago, she was admitted to the old age home by her daughter, as neither of her children was able to provide full-time care to her. Her son, who is unmarried, lives alone and is unable to take on caregiving responsibilities, while her daughter is occupied with her own family responsibilities. The decision to admit Ms. V to the institution was mutual, and she has accepted the situation with maturity.Ms. V has significant health concerns, including hypertension, severe body pain, and a heart attack that occurred around the time of her admission. However, she presently considers herself to be in good health. She did not express major psychosocial challenges, although she admitted to occasional difficulty sleeping due to memories of her family.

Ms. V having sense of acceptance, emotional resilience, and gratitude. She actively interacts with other residents and staffs and maintains a positive relationship with others. Throughout the session, she frequently expressed her appreciation for the institution, stating, "It is the kindness of people that makes this place run." she showed no complaints regarding her living conditions.

Unlike other residents in the study, Ms. V appears to be well-adjusted and socially engaged. The researcher observed her being energetic throughout the day and interacting warmly with visitors. Her emotional well-being is supported by the frequent contact and visits from her family, which provide her a continued sense of connection. Her only expressed concern was about her unmarried son; she stated that once he is settled, she would feel even more at peace.

This case stands out in the study as an example of positive adjustment to institutional life, where emotional stability is supported by ongoing family contact, self-acceptance, and a supportive environment within the old age home.

Case 3 – A

Ms. A is a 75-year-old widowed woman who lost her only son at the age of 18 . After death of her husband, she initially lived with her sister, who eventually abandoned her. With no family support, Ms. A made the decision herself to move into the old age home, where she has now been residing for the past 12 years.Ms. A suffers from multiple physical ailments related to her age, including hypertension, diabetes, and chronic muscle pain, for which she takes regular medication.she does not percieve herself healthy and expresses persistent feelings of sadness, depression, and anxiety. Ms. A is highly distressed by the financial difficulties faced by the old age home. She expressed fear that the home might close due to a lack of adequate sponsorship and support. This fear fuels her anxiety about ending up homeless along with other elderly residents who also lack family or financial backup.

Ms. A's coping mechanisms are limited to singing songs and cooking for others in the home small acts through which she finds temporary distraction and meaning. She has received no visits from family members for several years, which has further deepened her emotional isolation. During the session, she frequently engaged in self-talk, often reflecting hopelessness about her future.One significant source of distress is the delay in receiving

her pension, which she is entitled to but is unable to access due to documentation issues. This case highlights the critical gap between government welfare provisions and their actual implementation. For elderly individuals like Ms. A, bureaucratic obstacles become a matter of survival and dignity. She broke down in tears while expressing her wish to receive that money, not for personal luxuries, but to secure enough funds for her own funeral expenses. Her voice reflected resignation and despair, as she repeatedly said, "Nothing will go in my favour."

Ms. A fervently hopes that the institution will receive support from kind-hearted individuals, yet she remains overwhelmed by uncertainty. Throughout the session, she was visibly

Case 4 - L

Ms. L is a 68-year-old woman; she is widowed and has two children. After her husband's death, she was mentally suffered and she made repeated disagreements with her family, regarding taking prescribed medications, taking care of her became a burden for both of the children and they admitted her to the old age home 5 years before. Ms L suffers from diabetes, high cholesterol, and hypertension, and recently experienced a fall that has made her more physically dependent and emotionally vulnerable. Throughout the interaction, she appeared emotionally neutral, not exhibiting visible sadness, anxiety, or joy; the stillness she carried suggested her internal disengagement. Although she did not express direct dissatisfaction with the institution, it became evident that her silence stemmed from a fear of consequences. As she stated, "If I say anything bad, it might affect my life here." She experiences sleeping difficulties at night, and when she unintentionally sleeps during the day, caregivers scold her, which reinforces her sense of being under control and losing autonomy. No other activities going on to make the residents active and joyful. Her social world within the home is limited to two close friends with whom she shares her feelings, happiness, and sorrows. Rare family visits have left her feeling abandoned and excluded. She quietly expressed her wish for more people to visit the institution, indicating an unmet need for social connection. Ms. L does not articulate any hopes for the future, saying, "What hope is left for us? Next is death. I don't want to be a problem for anyone," reflecting deep hopelessness and resignation. Her coping strategies are minimal, with short daily walks and occasional conversations with her friends, but her overall experience is marked by emotional withdrawal, institutional fear, and a profound lack of social support. Her case exemplifies a form of invisible psychosocial distress, where emotional numbness conceals deeper feelings of abandonment, helplessness, and diminished self-worth.

Case 5 – A

Ms A is a 68-year-old widowed female ,formely worked as a teacher .She has two children. Her husband passed away at a young age, and she raised her children with immense effort and care.Both of her daughters are married.After a physical injury, her son-in-law refused to allow her to stay in their house. Consequently, three years ago, she was admitted to old age home based on the decision made by her children and in-laws,she accepted the decision due to the lack of proper medical care and respect she experienced at home. She suffers from diabetes and asthma and appears physically weak and emotionally fragile. L reports persistent sadness and overwhelming anxiety, which disrupt her sleepcycle. She openly shares that overthinking and crying are her only outlets, as she has no effective coping mechanisms. Her sense of abandonment is profound, and she often expresses despair over her children's neglect, saying, "The children I raised with utmost pain have given me real pain." She is distressed by the thought of dying alone, worrying that no one would be there to conduct her cremation. Although she acknowledges the staff are supportive and the institution provides good facilities,at the same time she feels that her deeper emotional needs remain unaddressed and neglected,beacuese of staffs workload.she speaks to only one co-resident occasionally and otherwise remains socially withdrawn. To distract herself, she participates in kitchen work and gardening, which give her some temporary relief. A expresses hope for inner peace and wishes to reunite with her daughters and grandchildren before her death. Despite her depression and feelings of hopelessness, she remains grateful to the institution for their care and continues to hope that happiness may return to her life one day.

Case 6 – S

Mr. S is an 86-year-old male,he was a tailor, having two children, and prior to admission, Mr. S and his wife lived with his younger son's family. However, he and his wife experienced feelings of neglect and emotional abuse within the household. After his wife's health deteriorated, he initially attempted to take care of her, but it became increasingly difficult due to his own advancing age and health issues, as well as their son also busy with their own lives. As a result, three years ago, his son made the decision to admit both parents into separate care facilities where their individual needs could be better met.

Mr. S is physically weak due to age-related decline and diabetes. Though he enjoys social interaction and has a pleasant disposition, his health limitations prevent him from participating in many group activities. He maintains contact with fellow residents through conversations and also visits his wife occasionally, with the assistance of the staff. Despite the physical separation from his spouse and family, he remains emotionally strong.

He expresses sadness regarding his distant relationship with his family but appreciates the support and affection he receives from the institution's staff, who treat him like family.

He spends his days watching television, reading,remarkably, three newspapers daily and playing carroms. Known for his sociable nature, Mr. S is often the first to initiate conversations with visitors and fellow residents. He feels safe, protected, and satisfied with the facilities and care provided at the old age home. While he has no expectations of reuniting with his family under one roof, he wishes to remain socially engaged in the final phase of his life. He strongly believes that social isolation is a growing concern for elderly individuals and emphasizes the need for meaningful interaction. Mr. S's resilience, acceptance of reality, and desire to stay connected highlight his enduring spirit and adaptability, even in the twilight years of life.

Case 7 – R.

Ms. R is a 70-year-old widowed woman and mother of three. After facing emotional and verbal abuse from her daughter-in-law while living with her elder son's family, she could no longer bear the stress and loneliness at home so she was admitted to an old age home by her son.

Ms. R has mild arthritis and hypertension but manages most of her daily tasks independently. She shared that she doesn't want to live alone, as the silence and isolation at home have been overwhelming. At the old age home, she actively talks to fellow residents not just out of interest, but as a way to survive emotionally. She says, "I talk to everyone because I can't live this last phase of life alone."

She treats others in the home like family and has love for the staff, whom she describes as respectful and caring. Her coping mechanisms include reading magazines and listening to devotional songs, which help her stay calm. However, the sadness inside her is still strong. "This place gives me peace, but not happiness," she says. "My children and even God seem to have abandoned me. I haven't done anything bad to anyone, but this is what life gave me. Even if I smile, I'm crying inside."

Ms. R experiences waves of loneliness and sadness, especially during festivals when old memories come flooding back. Despite the supportive environment, the emotional pain she carries is deep and constant. She hopes for more than just peaceful surroundings, she hopes for connection, meaning, and some happiness in the days she has ahead.

Case 8 -J

Ms J lives as a 63-year-old widowed woman who has one daughter. The ongoing conflicts with her son-in-law forced her to move into her elder sister's home after her husband passed away. Her niece brought her to the old age home one year ago after the living situation became too challenging. Ms J experiences diabetes while experiencing persistent body pain and headaches which staff members believe stem from psychological factors yet she feels the pain as genuine. The interviews show minimal engagement from her as she directs all discussions toward her health issues. She communicates with only one person and shows no interest in any of the available activities. Ms J declines to return to her daughter's house because she believes it would be unsafe despite her niece's occasional visits which include short trips together. She reveals that most of her time passes while thinking excessively about death while feeling disconnected from others. She expresses that her life lacks any positive expectations because death and pain continue to dominate her existence. The facility experience for her consists of deep isolation and fear and hopelessness which requires essential emotional support and meaningful engagement for her ongoing care.

Case 9 – X

Mr X is a 72-year-old unmarried man who spent most of his working life driving an auto-rickshaw in the city. He lived quietly with his mother until her death; with no remaining relatives willing or able to look after him, he entered an old age home two years ago. Mr X reports feeling generally unwell"just worn-out," as he puts it though he sleeps soundly and has no major diagnosed illnesses beyond the usual aches of age. What troubles him more is the emptiness he carries: he has no fond family memories to revisit and says he has "been alone from the start and alone again now." A lifetime of keeping to himself makes conversation with co-residents difficult; he rarely speaks unless spoken to, and no one has visited since his admission. When sadness creeps in, he retreats into silence. His only regular diversions are tending a small patch of garden and spending long periods in prayer, convinced that "only God keeps me going." Yet beneath this stoic exterior lies a quiet yearning: Mr X admits he would like to feel connected to people and to "die in peace," but he also calls himself "a curse," convinced there is nothing left to hope for. The gap between his deep need for companionship and his lifelong habit of isolation is the central challenge in his care, highlighting the importance of gentle, consistent outreach and opportunities for safe social engagement within the home.

Case 10 -Y

Mr. Y is a 72-year-old unmarried male who worked as a tailor for many years. He lived alone in a rented house until his health started to decline. Due to poor eyesight, he had to stop working, and as his age-related health issues increased, he became fully dependent on others. He was admitted to the old age home a year ago. Recently, he underwent cataract surgery on one eye. He also has mild diabetes and complains of body pain. Mr. Y appears weak and undernourished and does not eat well.

He often stays alone and does not maintain friendly relations with others in the home. He has frequent conflicts with both staff and other residents and shows signs of anger. He has said, "I'm okay with being alone. Don't try to be friends with me," and is often perceived as rude or arrogant. However, beneath this behavior, there seems to be a deep sense of sadness and emptiness. He becomes visibly emotional when he sees other residents receiving visits from their families.

Although he has two sisters, they only call him occasionally and have not visited. Mr. Y keeps a notebook where he writes regularly, but he does not let anyone read it. He shared that staff should be more caring and that "we all want to live a happy life." His statements suggest that despite his anger and isolation, he is longing for kindness and connection. Mr. Y may be struggling with loneliness, unresolved emotions, and a loss of purpose in life. He needs support not just physically, but emotionally to feel heard, cared for, and respected in his later years.

IV. FINDINGS AND DISCUSSION

1.Family Rejection and Abandonment

A prominent issue facing by elderly in old age homes is family neglect and abandonment, with elderly participants expressing profound grief and betrayal by their children and relatives.

One participant stated, "The children I raised with utmost pain have given me real pain," reflecting the depth of emotional disillusionment when parental love and sacrifice go unreciprocated. In another case, institutionalization was a decision made by family without the elder's full consent: "My son made the decision to admit us to separate old age homes." The sense of abandonment is further deepened by the absence of continued family contact: "No one has visited since my admission.".

2.Emotional Distress and Loneliness

The experience of emotional suffering permeated nearly all narratives, manifesting as hopelessness, anxiety, and fear of dying alone. Such emotional states were both a result of abandonment and a consequence of institutional living.Participants described deep internal despair, often hidden behind a composed exterior. One shared, "Even if I smile, I'm crying inside," while another voiced existential anguish: "What hope is left for us? Next is death." The fear of dying alone and forgotten was echoed in the statement: "I worry no one will be there to do my cremation."These expressions indicate psychological trauma and unmet emotional needs. This theme supports findings in gerontological literature, which identify loneliness and existential fear as significant predictors of poor psychological wellbeing in older adults residing in care institutions.

3.Institutional Life and Adjustment

Participants expressed mixed feelings about life in the institution. While many acknowledged the care and safety provided, there were also indications of limited autonomy, emotional suppression, and occasional fear of retribution.One participant admitted, "If I say anything bad, 15 it might affect my life here," suggesting a culture where dissatisfaction remains unvoiced due to fear. At the same time, expressions of gratitude were evident: "It is the kindness of people that makes this place run," and "Staff treat me like family."These perspectives reflect an emotional dichotomy—residents appreciate the physical support but often mourn the loss of freedom, personal choice, and a more vibrant social life.

4.Need for Social Connection

The desire for emotional intimacy and companionship stood out as a powerful unmet need. Sub-themes included desire for meaningful interaction, isolation despite community, and selective friendships.One elder shared, "I talk to everyone because I can't live this last phase of life alone," emphasizing socialization as a survival mechanism. In contrast, some residents showed emotional guardedness: "Don't try to be friends with me." Others maintained very limited close relationships: "I have two close friends only."

These variations highlight how past life experiences, personality, and emotional trauma influence one's willingness or ability to form new connections, even in a shared residential environment. The results suggest the need for targeted social work interventions to foster safe, meaningful, and personalized social engagement in institutional care setting.

5.Fear of the Future

An overarching theme of existential anxiety emerged from participants' reflections on financial insecurity, institutional dependence, and fear of homelessness. These fears often coexisted with a deep sense of helplessness and resignation.Participants expressed worry about the stability of their living arrangements: "What if the home shuts down? Where will we go?" Financial hardship, especially delays in pension or lack of savings, exacerbated these fears: "I want money only to secure my funeral." The underlying sense of powerlessness was captured in the quote: "Nothing will go in my favour."Such concerns reveal how institutional care must address not just physical and emotional wellbeing but also financial literacy, security, and policy support to uphold the dignity and rights of elderly individuals.

6.Coping Mechanisms and Resilience

Despite their emotional burdens, many residents employed personal strategies to manage their distress, demonstrating pockets of resilience and adaptability. The sub-themes observed were faith and spirituality, engagement in chores and hobbies, and positive acceptance of their circumstances.Faith emerged as a recurring coping strategy: "Only God keeps me going." Similarly, physical engagement in simple activities such as gardening or helping in the kitchen offered participants temporary relief: "I do kitchen work and gardening to distract myself." Others expressed a sense of reluctant contentment: "This place gives me peace, but not happiness."Such coping reflects the psychological need for routine, autonomy, and meaning- making. Even passive or spiritual coping can serve as protective factors against severe mental health decline.

V. SUGGESTIONS:

This study shows that old-age homes must go beyond meeting physical needs and focus on residents' emotional and social wellbeing, as supported by growing research in gerontological and institutional care literature. Studies have shown that unresolved emotional distress, lack of social connection, and perceived abandonment significantly impact the psychological wellbeing of institutionalised elderly(anjali us&sathyamurthi,2018.). Based on the findings, homes should have trained counsellors and social workers available regularly to provide emotional support, and offer meaningful tasks such as gardening or assisting with small responsibilities that give residents a sense of purpose and control. Research also highlights the importance of staff training in trauma-informed, rights-based care approaches and the role of intergenerational engagement in reducing loneliness and enhancing self-worth. Future research should employ longitudinal mixed-method approaches to evaluate the sustained impact of psychosocial care initiatives, while also examining how intersecting factors such as gender, caste, and socioeconomic status shape the diverse experiences of ageing within institutional settings. Robust financial and legal safeguards are essential to reduce anxieties about the future. These measures, when supported by policy such as required psychosocial staffing ratios, regular monitoring, and secure funding can transform old-age homes into spaces of dignity, autonomy, and holistic wellbeing.

VI. CONCLUSION:

The findings highlight that while institutional care provides physical safety and basic necessities, it often falls short in addressing the emotional, psychological, and social needs of the elderly. Themes such as family rejection, loneliness, fear of dying alone, and financial insecurity emerged as central challenges. Despite these hardships, several participants demonstrated resilience by engaging in spiritual practices, simple tasks, and forming limited but meaningful social bonds.

The study also emphasized the duality of institutional life: for some, it is a place of refuge and structure; for others, it is a setting of quiet despair, constrained autonomy, and unmet emotional needs. This underscores the urgent need to expand the role of old age homes beyond caregiving to become spaces of healing, dignity, and emotional inclusion.

In conclusion, the aging process within institutional settings must be viewed not just through a medical lens, but as a deeply human journey. Integrating emotional support systems, promoting meaningful engagement, and preserving the dignity of elderly individuals are not optional enhancements,they are fundamental responsibilities in creating truly elder-friendly environments. The voices of the elderly, as documented in this study, serve as a compelling call for more compassionate, person-centered models of elder care.

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