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Physical, psychological, and social factors related to help-seeking preferences among older adults living in a community

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Abstract

Background Examining the nature of help seeking and related factors among community-dwelling older adults is important to address social problems, such as loneliness and consumer damage. This study aimed to clarify factors related to the help-seeking preferences of community-dwelling older adults.

Methods A questionnaire survey was conducted among men and women aged 65 or older in Tokyo, in 2021. Overall, 5,576 respondents agreed to provide personal information. The survey items included a shortened version of the Help-seeking Preference Scale and measures to evaluate basic attributes, physical and mental health, and social relationships, which were predicted to be associated with help-seeking preferences. Multiple regression analysis was used to analyze the participants' desire for and resistance to help.

Results Multiple regression analysis revealed significant associations between high desire for help and being female, poor financial status, living alone, low subjective health, subjective forgetfulness, low mental health, low frequency of going out, high trust in community, and lack of social support. Significant associations were also found between high resistance to help and old age, low education level, difficult financial status, low mental health, social isolation, and low trust in the community.

Conclusions Older adults who are struggling with mental health may have a high desire for help but also a high level of resistance to help, which may discourage them from requesting assistance. This suggests the importance of professionals' outreach. Further, the results indicate the importance of fostering social capital in the community.

Keywords Help-seeking preferences, Help-seeking behavior, Social support, Older adults, Cross-sectional study

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Background

Empirical background

Recently, reports of solitary deaths and consumer damage among older adults have brought attention to the "refusal of help by older people," which refers to situations in which older adults who, from the perspective of their support providers, are "in need of assistance" refuse to accept help from those around them. As reported by Ogawa et al. [1], 61.1% of the care managers surveyed had experienced refusal of assistance. Professionals and supporters, such as community welfare volunteers, are aware that a certain number of older adults stubbornly refuse assistance from others. Since such a refusal may lead to difficulties in providing assistance, which may lead to serious problems in older adults' lives, including social isolation and solitary death in old age, to confront these social problems, it is important to consider the characteristics of older adults who are less inclined to seek help.

Providers of various support services assume older adults as users based on the "tacit assumption, so to speak, that the response of the recipient to assistance is positive" [2]. However, this assumption is not valid for older adults who refuse help. Furthermore, if refusal of help makes it difficult for supporters to take a proactive approach, older adults who refuse help may lose the opportunity to obtain the help they need to solve their problems. Thus, they may be at even greater risk in life. Given that problems that increase risk caused by individuals' tendency to not seek help, such as lonely deaths and consumer damage, occur among older adults for whom supporters' outreach is difficult, the relationship between help-seeking preferences and physical, psychological, and social characteristics among older adults should be examined. Moreover, we believe that concrete interventions to reduce the number of older adults who put themselves at risk by not seeking the necessary support from those who are around them can be identified.

Based on the above, this study aimed to clarify the physical, psychological, and social factors related to older adults' help-seeking preferences in the community, especially those living in urban areas in Japan where the population growth of individuals who are aged 65 and over is expected to be significant [3]. As Mizuno and Ishikuma [4] pointed out, for conducting research on help-seeking, a detailed definition of the subject should be established. Invoking the definition of DePaulo [5] and Takahashi [6], this study defines help-seeking preferences of older adults as "a cognitive framework regarding the extent to which older adults seek help from familiar helpers such as family and relatives, public institutions and professionals who provide help, and friends with whom they interact on a daily basis."

Table 1 Generation of help-seeking behavior

1 Whether or not you are aware of your problem.
2 Whether or not you judge the problem to be important.
3 Whether or not you decide that you are capable of solving your problem.
4 Whether or not you decide to request help from others to solve your problem.
5 Whether or not you can find a suitable helper.
6 Whether or not you can come up with a suitable strategy for requesting help.
7 Whether or not your request for help was accepted.

Theoretical background

This study examines related theories on help-seeking in the daily lives of older adults. Help-seeking is defined as individuals' need to solve a problem—which would be solved or alleviated if others would spend time, effort, or resources on it—and the individuals' efforts to directly request assistance from others [5]. The concept originated with Phillips' report [7] on the relationship between help-seeking behavior and stigma and has accumulated a diverse body of findings to date. For example, Takagi [8] presented the process of help-seeking in the form of "a model for the generation of help-seeking behavior" (Table 1).

Previous studies have often mentioned help-seeking preference and behavior as independent concepts, with the former assumed to facilitate the latter. This assumption is based on the Theory of Planned Behavior (TPB) [9], which states that behavior is primarily determined by behavioral intentions. In fact, Armitage and Conner [10], in their review of the TPB literature, showed that individuals' intention to adopt a certain behavior predicts the occurrence of the actual behavior. Previous studies dealing with help-seeking preferences have shown that these preferences are key to "problem-solving situations for professionals engaged in human services" [11, 12], "counseling situations for childcare problems" [13], or "determinants of help-seeking behavior of people with major depression" [14]. Many of these studies assume specific situations, such as consultations within the organization to which the participants belong, or consultations with public institutions, psychological consultation offices, or medical institutions.

Conversely, research that examines help-seeking preferences in daily life is "essentially different" [4] from the above-mentioned studies, which investigate help-seeking preferences in specific situations because of the lack of restrictions on the donor, content of help, or situation.

Few studies address help-seeking preferences in daily situations. Among these are studies that comparatively analyze help-seeking preferences and behaviors in the daily lives of older adults and those of younger adults [15], examine the factors that cause a virtuous cycle of help-seeking behavior and helping behavior in older

adults [16], and study life events that affect help-seeking preferences among older adults [17]. Other studies analyze the creation of a scale for measuring older adults' help-seeking preferences considering two aspects — "desire for help" and "resistance to help" [6], while others examine the relationship between help-seeking behavior and quality of life in rural areas [18]. However, although the problem of older adults' refusal to provide help has already become apparent among supporters, studies examining older adults' tendency to receive help in their daily lives are lacking [19]. Furthermore, based on our review of previous research, this situation does not appear to have changed.

Hypotheses and research question of the present study

Prior research has suggested that the factors associated with help-seeking preferences include demographic variables, such as gender, education, subjective financial status, and greater availability of social support. First, regarding gender, systematic reviews and meta-analyses of previous studies have shown that women seek more support from their surroundings than men [20, 21], and a study on older adults living alone in Japan [22] showed similar results. Conversely, some studies [23, 24] have reported that the direct association between gender and help-seeking preferences disappears when factors such as greater availability of social support are controlled for; thus, further research is needed to accumulate more knowledge. Next, regarding educational background, studies have shown an association between help-seeking preferences and mental health services [25], and a significant association between low educational background and high resistance to help through a survey of older adults living alone [6]. Regarding subjective financial status, income has reportedly the greatest impact on older adults with disability when they seek help [26], and subjective financial status affects attitudes toward receiving support from others [27]. Furthermore, regarding the richness of social support, a survey of university students by Nagai [28] showed that subjective help needs did not promote help-seeking behavior among those with poor social support. Further, Yajima and Yaniwa [29] found a significant association between receiving help and help-seeking preferences among older adults living in mountainous areas.

Thus, while studies have examined factors associated with help-seeking preferences, reviews have not identified any study that used large-scale surveys with a focus on help-seeking preferences among community-dwelling older adults. Based on the above, this study clarified the characteristics of "desire for help" and "resistance to help" among community-dwelling older adults using a shortened version of the Help-seeking Preferences Scale [6] and examined demographic variables, such as age and living conditions, which previous studies have examined in relation to help-seeking preferences. Specifically, the following hypotheses (H) were tested and the research question (RQ) was investigated.

H_1 As shown by previous studies, gender differences exist in assistance orientation among older adults living in the community. Specifically, women have a higher desire for and lower resistance to help than men.

H_2 Related to H_1, the association between gender and help-seeking preferences disappears after demographic, psychosomatic, and social variables are controlled for.

H_3 There is a significant association between community-dwelling older adults' subjective financial status and help-seeking preferences. Specifically, the desire for help is higher among older adults with a poor financial status.

H_4 There is a significant relationship between community-dwelling older adults' educational background and help-seeking preferences. Specifically, older adults with higher educational backgrounds are less resistant to help.

H_5 There is a significant relationship between the abundance of social support and helping orientation among community-dwelling older adults. Specifically, older adults who receive social support are less resistant to help.

RQ What are the factors associated with and that influence desire for and resistance to help among older adults living in urban areas?

Methods

Fifteen thousand men and women aged 65 years or older living in Toshima Ward, Tokyo (area: 13.01 km^2; total population as of October 2021: 284,699; population of 65 older adults: 56,959; mean age: 76.5 years; aging rate: 20.0%; women: 56.8%) were randomly selected and a questionnaire survey was conducted by mail from September to October 2021. In total, 5,576 respondents (mean age: 75.6 years, SD: 7.0, women: 52.5%, valid response rate: 37.2%) who agreed to provide personal information in writing were eligible for analysis. Among them, 4,203 responded to all analysis items without omission, whereas 1,373 omitted one or more items. To confirm whether there were any differences from the results of the analysis of the data of complete responses (complete data), we also generated data for the entire 5,576 participants, supplemented by the multiple assignment method (imputed data) with 10 imputed datasets using all the variables used in the analysis.

If we consider the population size of individuals aged 65 and over in Toshima Ward, which is 56,959, with a

confidence level of 99%, a margin of error of ± 3% (0.03), and a population proportion of 50% (0.5), the required sample size would be 1,849. In practice, as mentioned above, 5,576 individuals responded to the survey, which is significantly higher than the required sample size, and the final analysis sample consisted of 4,203 individuals. Therefore, the sample size in this study was considered sufficient.

In this study, we utilized a newly developed questionnaire (see Supplementary File 1) to investigate nursing care prevention and daily life needs. The survey items were basic attributes: (1) gender: male/female, (2) age, (3) education: high school graduate or less, vocational school graduate or more, (4) subjective financial status: good, poor, or neither, (5) employment: yes/no, and (6) living alone: yes/no. They also included (7) a short version of the Help-seeking Preferences Scale [6], which consists of two factors (desire for help and resistance to help, score range, (5–15 for both), each with three items, for a total of six items, in which higher total scores indicate a stronger desire for help or resistance to help, (8) subjective health: good or poor; (9) subjective forgetfulness: yes or no; (10) mental health: good or poor, based on WHO-5 (score range: 0–25), in which the crude score is less than 13 points based on the cut-off point of the scale, or if any of the five items is answered as 0 or 1 point, then mental health is defined as poor [30]; (11) frequency of going out: more than once a day, less than once a day; and (12) social isolation: non-isolated/isolated. Moreover, based on Saito et al. [31] and other previous studies on social isolation among older adults, this study defined isolation as an individual's lack of face-to-face or non-face-to-face interaction with other individuals who have lived with them for less than once a week; (13) trust in the community (four-point scale): untrustworthy, somewhat untrustworthy, somewhat trustworthy, and trustworthy, indicating better social relationships; (14) receipt of social support: yes/no; and (15) provision of social support: yes/no.

Chi-square and t-tests were used to compare gender differences by variable. Multiple regression analysis was used to examine the factors associated with individuals' desire for and resistance to help, considering them dependent variables and other survey items independent variables. Missing responses in the items necessary for multiple regression analysis were preliminarily supplemented by multiple-assignment methods. IBM SPSS 29 (Statistics Standard and Missing Values) was used for data analysis.

Results

Descriptive statistics and statistical-hypothesis tests

Table 2 shows the results of descriptive statistics and statistical hypothesis testing of the survey responses. Gender comparisons showed that more men than women had a junior college or higher degree, were employed, went out, and were socially isolated; whereas more women than men lived alone, had a higher scale score in desire for help, a higher percentage of those with good mental health, and a higher level of trust in their community,

Table 2 Descriptive statistics, chi-square test, and t-test results for each subgroup with complete data ($N = 4203$)

Variable/Group	All participants ($N = 4203$)	Men ($N = 2029$)	Women ($N = 2174$)	p-value (t or χ^2 test)
Age (mean ± SD[1])	74.52 ± 6.56	73.99 ± 6.36	75.02 ± 6.69	$t(4201) = 5.08^{***}$
Academic background (Junior college or higher, %)	2292 (55%)	1249 (62%)	1043 (48%)	$\chi^2(1) = 78.08^{***}$
Subjective financial status				
good (%)	1046 (25%)	493 (24%)	553 (25%)	$\chi^2(2) = 13.10^{**}$
neither (%)	2228 (53%)	1039(51%)	1189 (55%)	
poor (%)	929 (22%)	497 (25%)	432 (20%)	
Current employment (yes, %)	1672 (40%)	996 (49%)	676 (31%)	$\chi^2(1) = 141.84^{***}$
Living alone (yes, %)	1220 (29%)	497 (25%)	723 (33%)	$\chi^2(1) = 39.11^{***}$
Desire for help (mean ± SD)	8.58 ± 3.04	8.28 ± 3.06	8.85 ± 2.99	$t(4201) = 6.13^{***}$
Resistance to help (mean ± SD)	8.30 ± 2.65	8.34 ± 2.77	8.27 ± 2.52	$t(4201) = 0.84$
Subjective health (good, %)	3529 (84%)	1705 (84%)	1824 (84%)	$\chi^2(1) = 0.13$
Subjective forgetfulness (yes, %)	1539 (37%)	714 (35%)	825 (38%)	$\chi^2(1) = 3.44$
WHO-5 Well-being Index (good, %)	2552 (61%)	1186 (59%)	1366 (63%)	$\chi^2(1) = 8.45^{**}$
Frequency of going out (more than once a day, %)	1899 (45%)	1035 (51%)	864 (40%)	$\chi^2(1) = 53.80^{***}$
Social isolation (yes, %)	1615 (38%)	1027 (51%)	588 (27%)	$\chi^2(1) = 246.41^{***}$
Relying on the community (mean ± SD)	2.80 ± 0.84	2.76 ± 0.84	2.84 ± 0.83	$t(4201) = 3.18^{**}$
Receiving social support (yes, %)	3883 (92%)	1784 (88%)	2099 (97%)	$\chi^2(1) = 111.00^{***}$
Providing social support (yes, %)	3823 (91%)	1759 (87%)	2064 (95%)	$\chi^2(1) = 86.80^{***}$

$^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$. SD: standard deviation

Table 3 Multiple regression analysis results for desire for and resistance to help with complete and imputed data

	Complete data						Imputed data					
	Desire for help			Resistance to help			Desire for help				Resistance to help	
	(*N* = 4203)			(*N* = 4203)			(*N* = 5576)				(*N* = 5576)	
	model 1	model 2	model 3	model 1	model 2	model 3	model 1	model 2	model 3	model 1	model 2	model 3
	β[1]	*β*	*β*	*β*	*β*	*β*	*B*[2]	*B*	*B*	*B*	*B*	*B*
Men/women (→women)	0.09***	0.09***	0.07***	−0.04*	−0.03	0.00	0.58***	0.60***	0.49***	−0.18*	−0.12	0.02
Age (per year)	0.05**	0.04*	0.02	0.05**	0.04**	0.06***	0.02**	0.01	0.01	0.02**	0.01*	0.02***
Academic background (→ Junior college or higher)	−0.01	0.00	−0.01	−0.08***	−0.06***	−0.06***	−0.03	0.00	−0.03	−0.36***	−0.29***	−0.25**
Subjective financial status (good/neither/poor)	0.08***	0.05***	0.06***	0.11***	0.07***	0.06***	0.29***	0.18**	0.21**	0.36***	0.22***	0.16**
Current employment (yes/no)	0.01	0.00	0.00	0.04*	0.03	0.01	0.09	0.02	0.01	0.25**	0.15	0.08
Living alone (yes/no)	−0.04*	−0.03*	−0.05**	−0.06***	−0.04*	−0.03	−0.28**	−0.24*	−0.35***	−0.28**	−0.20*	−0.13
Subjective Health (good/poor)	——	0.05**	0.05**	——	0.03	0.02	——	0.39**	0.41**	——	0.15	0.08
Subjective forgetfulness (yes/no)	——	−0.08***	−0.08***	——	−0.03*	−0.03*	——	−0.51***	−0.50***	——	−0.17	−0.17
WHO-5 Well-being Index (good/poor)	——	0.05**	0.06***	——	0.14***	0.10***	——	0.38***	0.50***	——	0.82***	0.60***
Frequency of going out (more than once a day / less than once a day)	——	——	0.04*	——	——	0.01	——	——	0.23*	——	——	0.14
Social Isolation (→ Isolated)	——	——	0.00	——	——	0.08***	——	——	−0.02	——	——	0.35***
Sense of community trust (→ good)	——	——	0.09***	——	——	−0.13***	——	——	0.32***	——	——	−0.41***
Receiving social support (yes/no)	——	——	−0.04*	——	——	−0.02	——	——	−0.55**	——	——	0.05
Providing social support (yes/no)	——	——	0.00	——	——	0.06**	——	——	−0.10	——	——	0.29

***p <.001, **p <.01, *p <.05.β: standardized partial regression coefficient. B: partial regression coefficient. model 1: used only demographic variables as independent variable. model 2: included demographic variables and physical/mental health as independent variables. model 3: included demographic variables, physical/mental health, and social variables as independent variables

as well as were more likely to receive and provide social support. Women were more likely to have a desire for help, partially supporting H_1: the desire for help is higher among women. Conversely, there were no significant gender differences in resistance to help. The reliability coefficients α for desire for and resistance to help scales were 0.82 and 0.68, respectively. Although the reliability coefficient for the latter scale was slightly lower, both were at acceptable levels for scales.

Multiple regression analysis

The results of the multiple regression analysis using the complete data (N = 4,203), which excluded the data of those whose answers to the analysis items were missing, are described below. Incidentally, the multiple regression analysis using data (N = 5,576) supplemented with missing values using multiple assignment did not show any loss of association or directionality for each independent variable compared to the full data. This result suggested that the exclusion of missing data did not distort the data (Table 3).

First, regarding the desire for help, there was a significant association between high desire for help and being female (p <.05), having a poor financial status (p <.05), living alone (p <.05), having low subjective health (p <.05), subjective forgetfulness (p <.05), having low mental health (p <.05), going out less often (p <.05), having more trust in the community (p <.05), and receiving social support (p <.05). These results support H_3 that the desire for help is higher among older adults with a poor financial status. However, the findings did not support H_2 because the desire for help, for which there was a significant difference in scale scores between men and women, was still associated with gender even after other factors were controlled for.

Second, regarding resistance to help, there was a significant association between higher resistance to help and older age (p <.05), lower education (p <.05), having a poor financial status (p <.05), having low mental health

($p < .05$), social isolation ($p < .05$), and having lower trust in the community ($p < .05$). The results supported H_4: older adults with lower educational attainment have higher resistance to receiving help. However, the findings did not support H_5, and there was a significant negative association between trust in the community and resistance to help.

Discussion

This study aimed to examine the factors associated with desire for and resistance to help among urban-dwelling older adults.

Examination of factors associated with desire for and resistance to help

The factors found to be related only to desire for help were gender and residential status (living alone) as demographic variables, subjective health and subjective forgetfulness as physical and psychological variables, and the frequency of going out and the receipt of social support as social variables. First, regarding gender in the demographic variables, the scale score for desire for help was significantly higher for women than for men. Even after adjusting for other variables, such as the greater availability of social support, a significant association with the desire for help was observed. Mackenzie et al. [15] showed that women's desire for help was higher than that of men owing to women's positive attitude toward receiving help from others, which was attributed to their psychological openness. The current study found that even in old age, women's attitudes toward receiving help may be more positive than that of men. In addition, living alone is equivalent to not being able to expect the fulfillment of one's need for help from one's closest potential provider; thus, many individuals may be in a high state of unfulfilled need for help. Additionally, low subjective health and subjective forgetfulness may reveal a sense of anxiety about individuals' health and risks in daily life, arousing the desire to seek assistance from others around them. Moreover, the low frequency of going out and the lack of social support may also place them in a situation where they have little contact with sources of support, and it is assumed that their desire for assistance remains high and unresolved.

The factors that were only associated with resistance to help were age and education in demographic variables and social isolation in social variables. Mackenzie et al. [15] reported that older age was associated with stronger help-seeking preferences and may have contributed to normative attitudes as expressed in statements such as "I should solve my problems on my own without depending on others," feelings of guilt, and sociocultural backgrounds. Further, the factors associated with low educational attainment and social isolation are the following: (1) the lack of knowledge and understanding of the benefits that can be gained from accessing nearby support sources; (2) a high degree of resistance caused by a lack of awareness that receiving assistance will increase the possibility of solving one's problem; and (3) reluctance to receive help caused by cognitive dissonance with being isolated from the surroundings. Harada [32] found that individuals with higher educational backgrounds have more friends and that educational background and income are resources that expand personal networks. Therefore, it can be inferred that older adults with low educational backgrounds have small personal networks—limiting their ability to form mutually supportive relationships with those around them—and that they are highly resistant to receiving assistance.

Factors associated with both desire for and resistance to help

Factors that were found to be associated with both desire for and resistance to help were subjective financial status as a demographic variable, mental health as a psychological variable, and trust in the community as a social variable. The reason for a high level of desire for and resistance to help among those who have a poor financial status might be that with their desire for help to resolve or alleviate distress in their financial status, their anxiety about help (embarrassment about asking for help and uncertainty about whether or not a request for help will be responded to appropriately [33]) also increases. This shows that older adults with a poor financial status have an ambivalent psychological state in which their desire for assistance to solve or alleviate suffering in their lives increases, while their resistance to receiving assistance also increases because of anxiety about receiving assistance. This result supports a previous study by Takahashi [6], which suggested, through an interview survey among older adults living alone, that both desire for and resistance to help are high among older adults in ambivalent psychological states. Similar results were found for those who had low mental health, suggesting that such individuals may also be in an ambivalent psychological state toward receiving help.

Thus, while older adults with a poor financial status or low mental health may have a high desire for help, they may also have a high level of resistance to help, which may discourage them from requesting help. Based on this finding, the current study suggests that to realize a society where no one is left behind, professionals should consider outreach strategies, such as door-to-door visits or proactive strategies, to respond preemptively to older adults' difficult situations before they worsen. Furthermore, the fact that individuals with a high sense of trust in the community had a high desire for help and those with a low sense of trust had a high level of resistance

suggests that increasing social capital in the community contributes to creating an environment in which seeking assistance from the surrounding community is easier.

Strengths and limitations of this study

To the best of our knowledge, previous studies have not examined community-dwelling older adults' preferences concerning requesting and receiving assistance through large-scale surveys, which is a strength of the present study. However, this study also has some limitations. First, because of its cross-sectional design, the study could not identify causal relationships. This study will continue to be conducted as a cohort study, and we hope to identify causal relationships using a delayed crossover model. Further, this survey was conducted in a large city located in the metropolitan area; thus, sampling bias may exist. We believe that future surveys conducted in multiple cities with different characteristics will provide results that better reflect the attributes of older adults who live in the region.

In addition, older individuals who actively participated in the survey may already have a more positive attitude toward seeking help, or at least less resistance to it. On the other hand, it is also possible that those who are hesitant or resistant to seeking help chose not to participate. As a result, the findings of this study may overestimate the overall willingness of older individuals in the community to seek help. In the future, it would be advisable to consider alternative survey methods different from the large-scale mail survey used in this study. Specifically, conducting interviews with older individuals who were previously resistant to seeking help but are now receiving support from local governments or other sources could be a viable approach.

Next, we did not include individuals' preferences for solitude loneliness as a survey item, but this preference may also influence attitudes toward seeking help. Thus, future research should consider including it as a survey item. Furthermore, a short version of the Help-seeking Preferences Scale used in this study did not examine the differences in support resources (such as formal vs. informal support) or types of support (such as instrumental vs. emotional support), but simply measured the desire for and resistance to help. Future research that focuses on the differences in support resources and types of support is expected to provide a more detailed understanding of the help-seeking preferences of community-dwelling older adults.

Conclusions

Some hypotheses from earlier research were supported while others were not. Factors related to both desire for and resistance to help were identified. Life issues, particularly financial difficulties and mental health problems, were linked to increased desire for and resistance to help, aligning with previous findings on older adults' ambivalence about assistance. Furthermore, a high level of trust in the community may be associated with a higher desire for assistance, and conversely, a lack of these may be associated with a higher level of resistance to assistance.

Abbreviations

H Hypothesis
RQ Research question
TPB Theory of planned behavior

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12889-025-22049-z.

Appendix 1. Short version of the Help-seeking Preferences Scale

Appendix 2. The Questionnaire in this study

Author contributions

T.T: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Resources, Software, Validation, Visualization, Writing – original draft, Writing – review & editing.Y.Y: Data curation, Investigation, Project administration.S.S: Data curation, Investigation, Project administration.K.N: Funding acquisition, Supervision.H.M: Data curation, Investigation.M.Y: Data curation, Investigation.H.S: Supervision, Validation.Y.M: Supervision.Y.F: Funding acquisition, Investigation, Project administration, Resources, Supervision.E.K: Data curation, Project administration, Supervision.

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Data availability

The data used in this study are not publicly available in an online repository in order to maintain data use priority. However, they can be provided upon reasonable request after confirming the intended use by the requester.

Declarations

Ethics approval and consent to participate

This study was conducted in compliance with the Code of Ethics of the World Medical Association (Declaration of Helsinki), and the participants provided written informed consent. The study was also conducted with the review and approval of the Ethical Review Committee of Tokyo Metropolitan Geriatric Medical Center, which is part of the Tokyo Metropolitan Institute for Geriatrics and Gerontology (approval date: 05/07/2021, approval number: R21-007).

Consent for publication

Not Applicable.

Competing interests

The authors declare no competing interests.

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