CGC-01
BLOCK-3

ଓଡ଼ିଶା ରାଜ୍ୟ ମୁକ୍ତ ବିଶ୍ୱବିଦ୍ୟାଳୟ,
ସମ୍ବଲପୁର
Odisha State Open University
Sambalpur

CERTIFICATE IN GERIATRIC CARE (CGC)

PSYCHOSOCIAL ASPECTS OF AGEING

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CGC-01
Basic Geriatric Care

Block -3

Psychosocial Aspects of Ageing

UNIT : I	**Psychological Theories**
UNIT : II	**Psychological Changes In Ageing**
UNIT:III	**Depression In Elderly**
UNIT : IV	**Coping with Psychosocial Changes of Ageing**

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UNIT-1: PSYCHOLOGICAL THEORIES

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1.0 OBJECTIVES

After the completion of this unit, you will be able to

- Understand the various types of psychological theories
- Explain the evolution of psychological theories
- Tell the Impact of psychological theories to understand geriatrics

1.1 INTRODUCTION

Psychology as a science has laborious relations with the adjacent biological and social sciences. Sometimes, psychological theories of aging are labelled as "psychosocial" (with the emphasis on "social"), at other times they are conceived as bio behavioural, behavioural genetic, or neuropsychological, with the emphasis on the biological substrate. In either case, the aging individual falls into the trap of biological or social reductionism.

Adding to the conceptual confusion, distinguishing between psychological and social, psychosocial, theories of aging can be conceptually challenging and may be more useful theoretically than practically. However, just like an individual's "psyche" cannot be analyzed in isolation, one should not make assumptions about individuals without taking into account their immediate and broader social, cultural, and historical context.

The process of ageing into elderly years often involves a number of progressive physiological changes. Within the context of these changes and often related to them prominent issues of psychological and social adjustments emerge. Such issues include coping with decline in physical and functional abilities, changing social relationships and role and dealing with multiple losses. Throughout this period of life, which presents individuals with an increasing number of life stressors and adjustments, elderly people try to maintain a sense and wellbeing. The various areas include life satisfaction, retirement, marriage, sexuality, bereavement.

Understanding the role of psychosocial factors in late life requires a high-altitude view of human development to identify the basic biological and social forces that fundamentally shape the development of the person and the ways in which they respond to life challenges. These forces are typically viewed as constraints and can be briefly summarized in four propositions.

1. Biological development follows a sequential pattern. Although there is considerable inter individual variability in biological development, the overall biological resources across the life span resemble an inverted U-function. During childhood and adolescence, cognitive and physical abilities increase and provide the basis for the development of complex motor and cognitive skills. Physical development plateaus during early adulthood and then later declines. In old age, declines in both physical and cognitive functioning are evident.

2. Societies impose age-graded socio structural constraints on development. Life span psychologists and life course sociologists emphasize that all societies can be characterized as having age-graded systems, which constrain and provide a scaffold for life course patterns. These patterns provide predictability and structure at both individual and societal levels. A prototypical case is childbearing in women, which is shaped by both social institutions and biological constraints.

3. Life is finite. Whatever is to be achieved or experienced in life has to be done in a limited period of time, typically less than 80 years. At any given point in an individual's life, the anticipated amount of time left to live may shape behaviour and affect in important ways.

4. Genetic endowment is a limiting factor on the biological and behavioural functioning of the individual. Although the potential behavioural repertoire of humans is vast, the capacity to achieve extraordinary levels of functioning in a given domain is often constrained by the genetic makeup of the individual.

This view of development emphasizes that accumulated resilience or adaptive capacity of individuals will vary as function of the individual's location in the life course. For example, the biological and physical reserves of an individual will generally be greater for persons in young adulthood than for persons in old age. Conversely, behavioural resources and psychological reserves may be greater at older ages because of accumulated life experiences, acquisition of skills, and increased knowledge. In addition, a given stressor will likely activate different psychological and behavioural processes in varying intensities as a function of the individual's location in the life course. Finally, because of fundamental changes in age-related biological functioning, the type and intensity of biological pathways activated by stressful encounters as well as the manifestation of overt disease will vary substantially as a function of the individual's location in the life course.

When we get to **psychosocial theories of aging**, defined as a focus on social and psychological aspects leading to successful aging, we have different ways of defining 'success' and varied ways of reaching it. While we all have the dream of being old

people who yell at young people, there are other and more varied ways we can define successful aging and how to get there. We will look at each of the main psychosocial theories and see exactly what they are.

1.2 PSYCHOLOGICAL THEORIES OF AGING:

Psychological theories of aging can refer to both psychological changes as a result of aging and adaptive psychological mechanisms (or lack thereof) to counteract the losses associated with physical decline. For example, the field of cognitive psychology addresses age-related changes in cognitive performance as well as the use of strategies to compensate for these changes.

1.3. TYPES OF PSYCHOLOGICAL THEORIES OF AGING:

Theoretical developments in the subject matter can be broadly classified into three groups or periods:

- the Classical period ('40s-70s),
- the Modern period (70s-'90s),
- the New period ('80s-90s')

From each group the most distinctive psychological theories of aging are represented in Table 1.
Briefly, before we dive into our first theory, here is the list of the theories we will explore:

- Classical theories
- Modern theories
- New theories

THEORIES AUTHOR(S)
Classical Theories

- Developmental Tasks/Activity Theory
  Havighurst (1948)
- Psychosocial Theory of Personality Development
  Erikson (1950)
- Counterpart Theory
  Birren (1960)
- Disengagement Theory
  Cumming & Henry (1961)
- Personality Theory of Age and Aging
  Neugarten (1968)

- Cognitive Theory of Personality and Aging
  Thomae (1970)

Modern Theories

2 Life-span Development and Aging
Baltes et al. (1980,1987,1992)

3 Continuity theory
Atchley(1989)

4 Reduced Processing Resources
Salthouse (1985,1988,1991)

5 Personality and Aging Erikson (1950); Levinson (1978); Costa & McCrae

6 Behavioral Genetics and Aging Plomin & McClearn (1990); Pedersen (1996)

New Theories

- Gerotranscendence
  Tornstam (1989,1992,1994)
- Gerodynamics/Branching Theory
  Schroots (1988,1995a, b)

1.4 CLASSICAL THEORIES

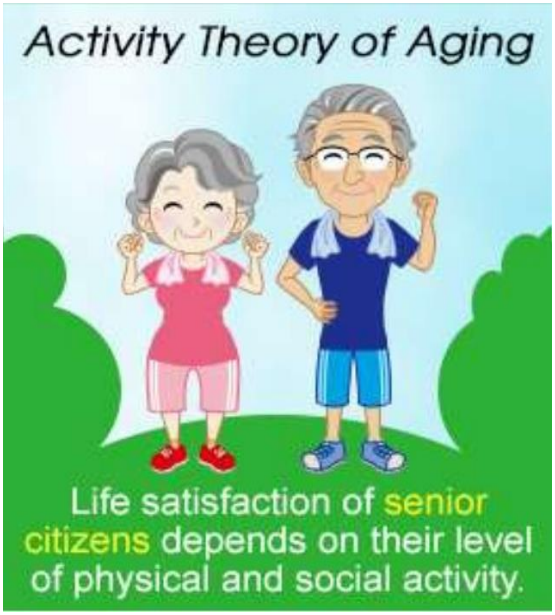
These theories are developed in the classical period of 40s and 70s, hence called as classical theories. The various classical theories are:

- Developmental Tasks/Activity Theory
- Psychosocial Theory of Personality Development
- Counterpart Theory
- Disengagement Theory
- Personality Theory of Age and Aging
- Cognitive Theory of Personality and Aging

1.4.1 Developmental Tasks/Activity Theory

In 1948 Robert J. Havighurst published his often reprinted book on the concept of developmental tasks in a lifespan perspective. A developmental task arises at or about a certain period in the life of the individual, successful achievement of which leads to his happiness and success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society, and difficulty with later tasks. All of these tasks have biological (physical maturation), psychological (aspiration or values), and

cultural (expectations of society) bases. Havighurst has described six developmental stages or age periods in total, each with its own developmental task. Later on, the central organizing concept of age-related developmental tasks has been named "activity theory," as opposed to "disengagement theory. The activity theory rose in opposing response to the disengagement theory. The activity theory and the disengagement theory were the two major theories that outlined successful ageing in the early 1960s.The theory was developed by Robert J. Havighurst in 1961. In 1964, Bernice Neugarten asserted that satisfaction in old age depended on active maintenance of personal relationships and endeavours.



The activity theory occurs when individuals engage in a full day of activities and maintain a level of productivity to age successfully. The activity theory basically says: the more you do, the better you will age. It makes a certain kind of sense, too. People who remain active and engaged tend to be happier, healthier, and more in touch with what is going on around them. Same goes for people of any age.

The **activity theory**, also known as the **implicit theory of ageing**, **normal theory of ageing**, and **lay theory of ageing**, proposes that successful ageing occurs when older adults stay active and maintain social interactions. It takes the view that the ageing process is delayed and the quality of life is enhanced when old people remain socially active. The theory assumes that a positive relationship between activity and life satisfaction. One author suggests that activity enables older adults adjust to retirement and is named “the busy ethic”.

The critics of the activity theory state that it overlooks inequalities in health and economics that hinders the ability for older people to engage in such activities. Also, some older adults do not desire to engage in new challenges.

Activity theory reflects the functionalist perspective that the equilibrium that an individual develops in middle age should be maintained in later years. The theory predicts that older adults that face role loss will substitute former roles with other alternatives.

Though in recent years the acceptance activity theory has diminished, it is still used as a standard to compare observed activity and life satisfaction patterns.

Often, the activity theory is dismissed to some degree because it falls a little flat. It isn't sufficient to just be busy, like the definition states. You can't wake up every day and do the same thing, like riding a stationary bike, and expect to age well. This theory was taken and used by many program designers for the elderly, who filled older folks' schedules with busy work and required them to complete tasks. A heightened level of activity is needed, but it needs to be engaging and fulfilling, rather than just busy work.

The theory also fails to consider maintenance of one's mid-life or changes that are made when entering retired or older life. If I was a high-powered, high-stress executive and I retire and go into pottery making, am I going to age successfully? Not likely, particularly if I enjoyed my job as an executive. Maybe what is needed is another theory that looks at the lifespan instead of just older age.

1.4.2 Psychosocial Theory of Personality Development

In 1950 Erik Erikson formulated a psychosocial theory of eight stages of personality development, each with its own characteristic crisis that arises out of the conflict between two opposite tendencies. The developmental task of each age period is to resolve its conflict, which requires the integration of personal needs with the demands of society. The successful resolution of each conflict leads to developmental strength in terms of a new virtue. Failure, however, to deal adequately with a task during its period of ascendancy is damaging to personality development. Erikson's psychosocial stages of development are not tied closely to specific age periods. The early stages are defined in much more detail than the later ones: post adolescence, for example, includes about three quarters of the life span, but only the last three stages. This division reflects the increase in psychosocial variability with age: the developmental tasks of an infant are relatively universal, but the tasks in later life are dependent as much on personal experiences as on general principles.

Erikson's Stages of Personality Development (1963) is a theory that focuses on individual development, with older adults experiencing the developmental stage known as "ego integrity versus despair." Erikson characterized this stage as the evaluation of a person's accomplishments. In a recent study of older adults by Neumann (2000), Erikson's theoretical framework was used to inquire about elders' perceptions of their lives' meaning. Older adults who expressed higher levels of energy and meaning felt a sense of connectedness, self-worth, love, and respect that was absent in those who felt little meaning for life. The nurse can assist patients in appreciating their accomplishments, finding meaning in life, adapting to physical changes, and even preparing for life's end in a realistic manner.

Block of Erikson's Stages of Personality Development

Life Stage	Psychological Crisis	Adaptive Ego quality	Ego care pathology
1. Infancy. 0-2 yrs.	Trusts or mistrusts	Hope	Withdrawal
2. Toddler. 2-3 yrs.	Autonomy vs. shame and doubt	Will	Compulsion
3. Early school age 4-5 yrs	Initiative vs. guilt	Purpose	Inhibition
4. Middle school age 6-12 yrs	Industry vs. inferiority	Competence	Inertia
5. Adolescence	Identity vs. identity confusion	Fidelity	Repudiation
6. Young adulthood	Intimacy vs. isolation	Love	Exclusivity
7. Adulthood (middle adulthood)	Generativity vs.	Care	Rejectivity
8. Old age (later adulthood)	Integrity vs. despair	Wisdom	Disdain

Counterpart Theory-

In 1960 James E. Birren presented a general theory of aging as a counterpart of development. The term "counterpart" is meant to express the idea that there are latent structures of behaviour (emotions, cognition, and motivations) carried forward from earlier experience that interact with present situations. Counterpart theory advocates indirect selection for positive late-life characteristics that embrace a wide range of complex biological (e.g., potential for a long life) and behavioural (e.g., intelligence) characteristics. For example, although individual differences in longevity do not appear until long after reproduction has been completed, intelligent, long-lived parents are able to provide an environment (in terms of food and protection) favourable for their young to survive. Birren's counterpart theory expanded the classical "hill" metaphor of development and aging to include questions about their relationships and how behaviour comes to be organized over the adult years of life, if not over the whole life span.

1.4.4 Continuity Theory

Continuity Theory holds that, in making adaptive choices, middle-aged and older adults attempt to preserve and maintain existing internal and external structures and they prefer to accomplish this objective by using strategies tied to their past experiences of themselves and their social world. Change is linked to the person's perceived past, producing continuity in inner psychological characteristics as well as in social behaviour and in social circumstances. Continuity is thus a grand adaptive strategy that is promoted by both individual preference and social approval.

Continuity Theory is a psychosocial theory of aging, which posits that as middle-aged and elderly adults adapt to changes associated with the normal aging process, their past experiences, decisions, and behaviours will form the foundation for their present and future decisions and behaviours.

The theory deals with the internal structure and the external structure of continuity to describe how people adapt to their situation and set their goals. The internal structure of an individual such as personality, ideas and beliefs remain constant throughout the life course. This provides the individual a way to make future decisions based on their internal foundation of the past. The external structure of an individual such as relationships and social roles provides a support for maintaining a stable self-concept and lifestyle.

The major criticism for the theory is its definition of normal aging. The theory distinguishes normal aging from pathological aging, neglecting the older adults with chronic illness.

They criticize the continuity theory for defining normal aging around a male model.

Another weakness of the theory is that it fails to demonstrate how social institutions impact the individuals and the way they age.

1.4.5 Disengagement theory

The term "disengagement" refers to the withdrawal of people from previous roles or activities. Starting from the assumption that people turn inward from middle age and over, Cumming and Henry theorized in 1961 that this primary mental process produces:

(a) a natural and normal withdrawal from social roles and activities,
(b) An increasing preoccupation with self and decreasing emotional involvement with others.

The **disengagement theory** of aging states that "aging is an inevitable, mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social system he belongs to". The theory claims that it is natural and acceptable for older adults to withdraw from society. The theory was developed by Cumming and Henry in 1961 in the book *Growing Old*, and it was the first theory of aging that social scientists developed. Thus, this theory has historical significance in. Since then, it has faced strong criticism since the theory was proposed as innate, and unidirectional.

They formulate their argument along nine postulates to explain why it is rational for individuals who know that death is approaching and who have seen friends of their age pass to begin to anticipate their own deaths and disengage.
The postulates are as follows:

- **Postulate one**: Everyone expects death, and one's abilities will likely deteriorate over time. As a result, every person will lose ties to others in his or her society.
- **Postulate two**: Because individual interactions between people strengthen norms, an individual who has fewer varieties of interactions has greater freedom from the norms imposed by interaction. Consequently, this form of disengagement becomes a circular or self-perpetuating process.
- **Postulate three**: Because men have a centrally instrumental role, and women a socio emotional one, disengagement differs between men and women.

- **Postulate four:** The individual's life is punctuated by ego changes. For example, aging, a form of ego change, causes knowledge and skill to deteriorate. However, success in an industrialized society demands certain knowledge and skill. To satisfy these demands, age-grading ensures that the young possess sufficient knowledge and skill to assume authority and that the old retire before they lose their skills. This kind of disengagement is affected by the individual, prompted by either ego changes or the organization, which is bound to organizational imperatives, or both.

- **Postulate five:** When both the individual and society are ready for disengagement, complete disengagement results. When neither are ready, continuing engagement results. When the individual is ready and society is not, a disjunction between the expectations of the individual and of the members of this social systems results, but engagement usually continues. When society is ready and the individual is not, the result of the disjunction is usually disengagement.

- **Postulate six:** A man's central role is work, and a woman's is marriage and family. If individuals abandon their central roles, they drastically lose social life space, and so suffer crisis and demoralization unless they assume the different roles required by the disengaged state.

- **Postulate seven:** Readiness for disengagement occurs if the individual is aware of the shortness of life and scarcity of time, the individual perceives his or her life space decreasing, and the individual loses ego energy. Each level of society grants individuals permission to disengage because of the following:

  -Requirements of the rational-legal occupational system in an affluent society.

  -The nature of the nuclear family.

  -And the differential death rate.

- **Postulate eight**: Fewer interactions and disengagement from central roles lead to the relationships in the

remaining roles changing. In turn, relational rewards become more diverse, and vertical solidarities are transformed to horizontal ones.

- **Postulate nine:** Disengagement theory is independent of culture, but the form it takes is bound by culture.

Disengagement theory, suffering from a lack of empirical support, has largely been dismissed by social scientists and gerontologists. Although the disengagement theory professes to explain general psychological and social processes of aging, it offers in fact a one-sided view of the aged, given the significant proportion of older people who do not lose interest in life and do not withdraw from society. Disengagement theory encouraged the development of an opposing theory of the aged, activity theory, which is based on the concept of developmental tasks.

According to its main proponent, Robert J. Havighurst, activity theory states that in order to maintain a positive sense of self, elderly persons must substitute new roles for those lost in old age. As such, activity theory presents a more realistic view of older people.

1.4.6 Personality Theory of Age and Aging —

Starting in the 1950s, Bernice L. Neugarten (1968) and associates studied the life cycle with two theoretical emphases:

- The first emphasis is on the timing of transitional events in the lives and roles of individuals. Life events, such as marriage or parenthood, are normatively scheduled: that is, they are expected to occur within certain ages and in a certain sequence. As such, they lead to changes in self-concept and identity. However, unexpected events (e.g., accidents) or age-normative events that occur "off time" (e.g., early widowhood) may have negative developmental consequences, such as life crises.
- The second emphasis is on the study of personality type as predictor for successful aging. Aging is viewed as a process of adaptation in which personality is the key element. Eight different patterns (stages) of aging have been distinguished. The successfully aging individual not only plays an active role in adapting to the biological and social changes that occur with the passage of time, but also in creating patterns of life that will give him or her greatest ego involvement and life satisfaction

Personality changes

The effect of aging on a person's personality is difficult to predict.

- Some people become less demanding and more forgiving with the passage of time. They may be at peace with themselves and more understanding of others. They may also be less wary and defensive, more open to new experiences, and more appreciative of kindness and beauty.If your loved one fits in this category, the experience of care giving will draw the two of you even closer together, strengthening the bond of love and respect you feel for each other.

- For other people, aging brings personality changes that can make the act of providing care more difficult. Some seniors become withdrawn, while others become more controlling and demanding. In these situations, it is only natural for caregivers to feel frustrated. It is also natural to feel like their best efforts to be helpful are ineffective or unappreciated.

Changes in a person`s usual behaviour and routine can indicate a change in health and mental status.
Some citation of difficult behaviour is

- Restlessness
- Agitation
- Combativeness, aggressiveness
- Restlessness and wandering
- Mood-swings
- Hallucinations
- Mistrust
- Over-controlling behaviour
- Critical and demanding behaviour.

1.4.7 Cognitive Theory of Aging —

According to the American Heritage and *Stedman's Medical Dictionary*, cognition is defined as "the mental faculty of knowing, which includes perceiving, recognizing, conceiving, judging, reasoning, and imagining." Cognition is often divided into smaller components that include intellectual ability, learning, and memory. Intelligence, defined as "the capacity to acquire and apply knowledge, especially toward a purposeful goal" can also be subdivided into "fluid" and "crystallized" intelligence.

In 1970 Hans Thomae described briefly a cognitive theory of the aging personality, one which is intended to integrate various biological, sociological, and interactionist perspectives while at the same time focusing upon the psychodynamics of aging.

Central concepts in his theory are those of perception, perceived situation, and perceived self. Thomae postulates, for example, that perceived change rather than objective change is related to behavioural change, and that change is perceived and evaluated in terms of the aging person's dominant concerns and expectations.

Successful adaptation to age-related changes, then, relates to the maintenance and restructuring of the balance between cognitive and motivational systems, for instance, the balance between acceptances of oneself as old or rejection of this perception, which is one of the developmental tasks of aging persons.

This theory can be more clearly elaborated by via postulates as:

- Cognition in later life
- Cognitive plasticity
- Cognitive reserve

❖ Cognition in later life

Age and intelligence: the classic aging pattern

Intelligence is not the same as cognition; both concepts are closely related in that cognitive processes, such as attention, working memory, and reasoning, are needed to develop the ability to "intelligently" understand the world. In the 1960s, Raymond Cattell introduced the distinction between fluid and crystallized intelligence.

- Fluid intelligence describes a person's cognitive flexibility that is inherent, for example, in the ability to reason abstractly and to solve problems in novel situations, fluid intelligence is equated with "native intelligence" and exists independently of knowledge acquired through experience and learning.
- Crystallized intelligence, on the other hand, describes acquired knowledge and skills, such as vocabulary and social judgment.

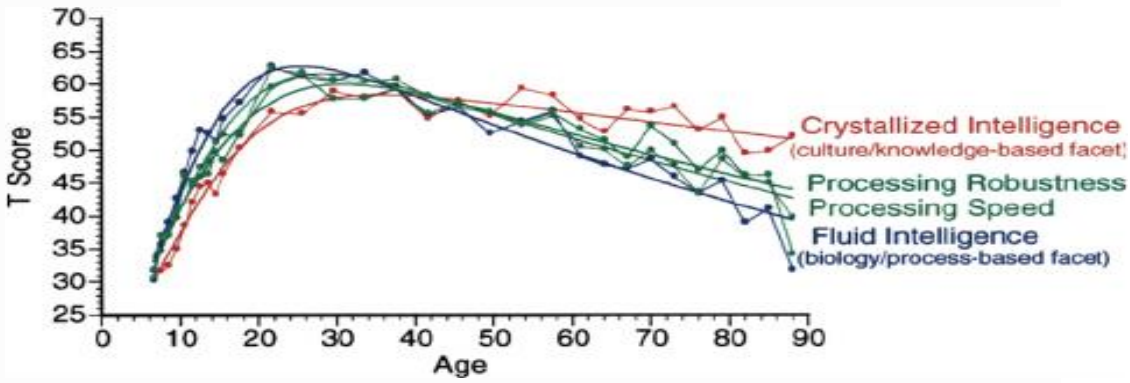


Fig.1 : Age gradients of fluid intelligence, crystallized intelligence, processing speed, and processing robustness i.e., the degree of performance stability.

Many studies demonstrate that older adults tend to perform more poorly than their younger counterparts when it comes to tasks that require fluid intelligence; however, they perform equally well or better in situations requiring the use of crystallized intelligence (Fig.1).This phenomenon is referred to as the "classic aging pattern" and is due to normal age-related decline in our information processing speed. Another noteworthy finding with regard to fluid intelligence is that more recently born cohort groups tend to perform better in cognitive tests.

One reason why older adults experience losses in their fluid intelligence is because age-related physical changes lead to decrease in information processing speed, attention, memory, and learning capacity. In our fast-paced, achievement-oriented Western societies, the ability to perform quickly often equates with the perception of a person's cognitive capacity, or intelligence. What is often overlooked is that, if the time factor is eliminated, older adults perform equally well as younger people, particularly in tasks related to acquired skills and knowledge. In clinical practice, this means that care providers should be aware that older adults may simply need more time to complete a task, such as completing forms or responding to complex questions. Practitioners who administer cognitive tests like those used to screen for dementia need to compare the test scores to a reference population of similar education and age to avoid misinterpreting the results. Patients who are concerned about cognitive decline often find relief in the reassurance that a certain degree of slowing down is a normal part of aging and not a sign of dementia. Older adults in particular may also benefit from auxiliary strategies, such as the use of mnemonics to acquire new knowledge or the manipulation of their environment to facilitate undisturbed, selective attention to the task at hand.

❖ Cognitive plasticity:

Cognitive plasticity is a multi-faceted concept that describes a person's ability to adapt to varying conditions and refers to the "contrast between an individual's current average level of [cognitive] performance under normative conditions and one's latent potential."As Willis et al. point out; cognitive plasticity is closely connected to a life course perspective since it emphasizes human development as a lifelong process of adaptation to changing circum-stances.

Similar to the life course perspective, the concept of cognitive plasticity underlines both the existence and importance of lifelong adaptability and learning. While

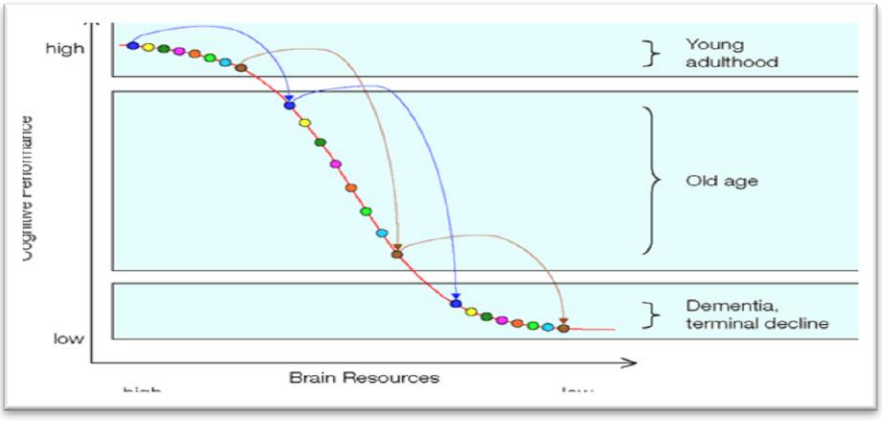
experiencing natural losses with aging, older individuals are also capable of experiencing gains. A clinician should not discourage an older patient from adopting new cognitive strategies or from drawing on existing skills to maintain an adequate and/or satisfying day-to-day performance. However, evaluating a patients cognitive status carefully helps direct interventions. For example, in the case of an underlying illness, such as Alzheimer's disease, a patient may not be able to acquire new strategies. In this case, the focus should shift to retaining skills and supporting existing abilities

❖ Cognitive reserve

While our capacity to adapt to changes, including age-related losses is naturally limited, there is agreement among scientists that this capacity can be enhanced through training and experience. This assumption is supported by a clinical observation known as "cognitive reserve"—a sort of "backup capacity" that enables individuals to function on an adequate cognitive level even in the face of pathological changes in the brain. In the case of passive cognitive reserve, the threshold for expressing clinically significant symptoms is increased.

Dementia also clinically illustrates the principle of cognitive reserve. While a higher level of education cannot prevent Alzheimer's and related diseases, it is considered a protective factor because the onset of clinically relevant symptoms can be delayed. One important implication is that for highly educated individuals, even if a cognitive screening test such as the Folstein MMSE score falls within the normal range, a dementing process cannot be excluded. In those with high educational attainment, close attention needs to be paid to any changes a patient reports regarding their "usual" performance. If in doubt, referral to a neurologist or psychiatrist for more detailed testing should be considered

Fig: showing the relationship of cognitive performance with age



1.5: Modern

Theories

These theories are formulated in 70s and 90s

1.5.1 Life-span Development and Aging –

Since the beginning of the 1980s, Paul B. Baltes and his associates (Baltes, 1987; Baltes, Reese, & Lipsitt, 1980; Baltes, Smith, & Staudinger, 1992) have conducted a series of studies on psychological processes of development and aging from a life-span perspective. In line with the tradition of life-span developmental psychology, development and aging are conceived as synonyms for behavioural changes across the life span. Starting from these studies, Baltes has developed a theoretical framework of seven propositions about the nature of human aging from a psychological point of view:

1. There are major differences between normal, pathological, and optimal aging, the latter defined as aging under development enhancing and age-friendly environmental conditions.
2. The course of aging shows much inter individual variability (heterogeneity)
3. There is much latent reserve capacity in old age
4. There is aging loss in the range of reserve capacity or adaptivity.
5. Individual and social knowledge (crystallized intelligence) enriches the mind and can compensate for age-related decline in fluid intelligence (aging losses)
6. With age, the balance between gains and losses becomes increasingly negative.
7. The self in old age remains a resilient system of coping and maintaining integrity.

Based on this framework of propositions, a psychological model of successful aging has been devised, called "selective optimization with compensation." The central focus of this model is on the management of the dynamics between gains and losses, i.e., a general process of adaptation, consisting of three interacting elements.

- First, there is the element of selection, which refers to an increasing restriction of one's life to fewer domains of functioning because of an age-related loss in the range of adaptive potential.
- The second element, optimization, reflects the view that people engage in behaviours to enrich and augment their general reserves and to

maximize their chosen life courses (and associated forms of behaviour) with regard to quantity and quality.

- The third element, compensation, results also (like selection) from restrictions in the range of adaptive potential. It becomes operative when specific behavioural capacities are lost or are reduced below a standard required for adequate functioning.

The lifelong process of selective optimization with compensation allows people to age successfully, i.e., to engage in life tasks that are important to them despite a reduction in energy. For instance, the famous pianist Rubinstein remarked in a television interview that he conquers the weaknesses of aging (adaptation) in his piano playing in the following manner. First, he reduces his repertoire and plays a smaller number of pieces (selection). Second, he practices these more often (optimization), and third, he slows down his speed of playing prior to fast movements, thereby producing a contrast that enhances the impression of speed in the fast movements (compensation).

1.5.2 Reduced Processing Resources —

In this view, aging leads to a reduction in the quantity of one or more processing resources, such as attention capacity, working memory capacity or speed of processing. According to Timothy A. Salt house — a typical exponent of this view since the eighties processing resources are characterized by three properties:

1. They are limited in quantity, with a measurable aspect such as quantity or effectiveness of allocation increasing up until maturity and then decreasing across the adult years
2. They enable or enhance cognitive processing so that performance in many cognitive tasks is improved when greater amounts of the resources are available
3. They are not local or specific in the sense that they are restricted to a small number of highly similar cognitive tasks, but instead are relevant to a broad range of cognitive processes.

The three properties of processing resources have generated a number of specific theories. They can be classified into three categories, based on the dominant metaphor used in theorizing on resource reduction, i.e., metaphors of space, energy, and/or time. That is,

- space limitations correspond to restrictions on the size of the computational or working memory region available for processing
- energy limitations correspond to attention capacity restrictions
- time limitations refer to restrictions imposed by tradeoffs between the rate at which information can be processed

- the rate at which it becomes unavailable through decay, interference or some other mechanism

In a series of experimental studies, Salt house and his associates have focused on the time metaphor of processing speed as explanatory construct of cognitive aging. Their findings indicate that processing speed is a fundamental construct in human cognition, linked to explicit changes in neural structure and functioning on the one hand and to higher-order cognitive processes like reasoning and abstraction on the other. As such, Salthouse hypothesizes that processing speed may well provide the cornerstone for integrative theories of cognitive aging. It should be noted, however, that the resource-reduction view leaves unanswered the fundamental questions of why the reduction in resources occurs, and how that reduction results in lower levels of cognitive performance.

1.5.3 Personality and Aging —

A definition of personality is likely to include an organized, distinctive 'pattern of behaviour' that is characteristic of a particular person .Characteristics may include physical, mental, emotional, and social behaviours.

Studies of personality and aging reflect the concept of personality behind them, here defined as the set of characteristic dispositions that determine emotional, interpersonal, experiential, attitudinal, and motivational styles. Generally speaking, two theoretical traditions can be distinguished in this field, trait and developmental stage models. In both traditions, the central issue concerns the extent and nature of personality stability and change over the life span; or, to put it differently, the extent to which aging processes per se are responsible for personality changes. Theoretical models of adult personality development represent the first and oldest tradition in the personality-and-aging field. Two theories, developed by Erik Erikson (1950) and Daniel Levinson (1978), respectively, offer developmental stages beyond the period of early adulthood.

Erikson's eight stages, extending from infancy to old age, were formulated more than 45 years ago. From this perspective, it is surprising that there has been collected only limited empirical evidence for the maturity and old age stages, i.e., Generativity vs. stagnation and integrity vs. despair. There are no longitudinal studies, for example, that ask whether the achievement of generativity in midlife is a necessary precursor for the achievement of integrity in the later years.

In Levinson's theory of personality development, based on a series of in-depth interviews with 40 men, each man's life structure goes through an orderly sequence of three periods: early adulthood, middle adulthood, and late adulthood. The timing and length of each period and the development that takes place within it vary from man to man depending on the biological, psychological, and social conditions of his life.

Nevertheless, a close linkage of periods with age intervals is suggested. Levinson's theory can be severely criticized on many grounds, of which the impossibility of replicating the in-depth interviews poses the most serious problem in aging research. Trait models represent the second tradition.

Overall, longitudinal studies of personality traits have consistently found structural invariance of personality over time, i.e., a marked pattern of similarity in factor structure across instruments, cohorts, types and times of measurement. According to Paul Costa and Robert McCrae — typical proponents of the trait model—the same five major factors (neuroticism, extroversion, openness to experience, agreeableness, and conscientiousness) have emerged from longitudinal studies using somewhat different approaches. In conclusion of the evidence, they state that people stay much the same in their basic dispositions and show a high degree of stability of personality, particularly during the latter half of their life course. More recent extensions of the trait model pertain to personality-linked constructs like locus of control and self-concept. Generalizations about stability and change are limited by the relatively small number of studies available, the large majority of which are cross-sectional in design. However, there is a growing consensus that personality traits tend to be stable with age whereas key aspects of self such as goals, values, coping styles and control

beliefs are more amenable to change

1.5.4 Behavioural Genetics and Aging —

Behavioural geneticists of aging are concerned with the extent to which hereditary factors influence age-related changes over the life span of the individual. Here, heritability is defined as a descriptive statistic referring to the portion of observed, phenotypic variation in the population that can be accounted for by genetic

differences among individuals; the rest of the variation, the non genetic portion, is called environmental. Thus, change in heritability over the life span indicates that the relative roles of genetic and environmental influences can change with age in terms of their effects on biological and behavioural differences among individuals in the population. Robert Plomin and Gerald E. McClearn (1990), two leading researchers since the eighties, have convincingly shown that behavioural genetics provides a theory and methods that can go beyond simple nature nurture comparisons to consider age differences, age changes, shared and non shared environments, and multivariate analyses. Nevertheless, theory formation in gerontological behavioural genetics is still in its infancy. On the basis of recent analyses of mostly twin studies of aging, the third leading researcher in this field, Nancy L. Pedersen (1996), comes to the following tentative conclusion:

(a) The relative importance of genetic and environmental effects on individual differences in the elderly is phenotype specific. Heritability is low to moderate for personality traits and measures of well-being, moderate for health-related phenotypes, and greater for cognitive abilities, whereas heritability for memory is lower than for verbal and spatial abilities or perceptual speed.

(b) There are age differences in heritability, the pattern of which is phenotype-dependent. For some measures, particularly health-related characteristics, the relative importance of genetic effects appears to decrease across age groups. For others, heritability is stable, increases, or reflects an inverted L-shaped function. Variance changes may reflect either an increase in environmental or genetic influences, depending on the phenotype. More often, environmental effects account for the increase in variability in health-related phenotypes.

(c) Across short spans of time, genetic effects are more stable than environmental effects for personality and cognition. Environmental effects of importance for individual differences late in life are changing. Nevertheless, environmental influences are at least as important for phenotypic stability across short (3-6- year) spans of time.

1.6. New Theories

1.6.1 Gero transcendence

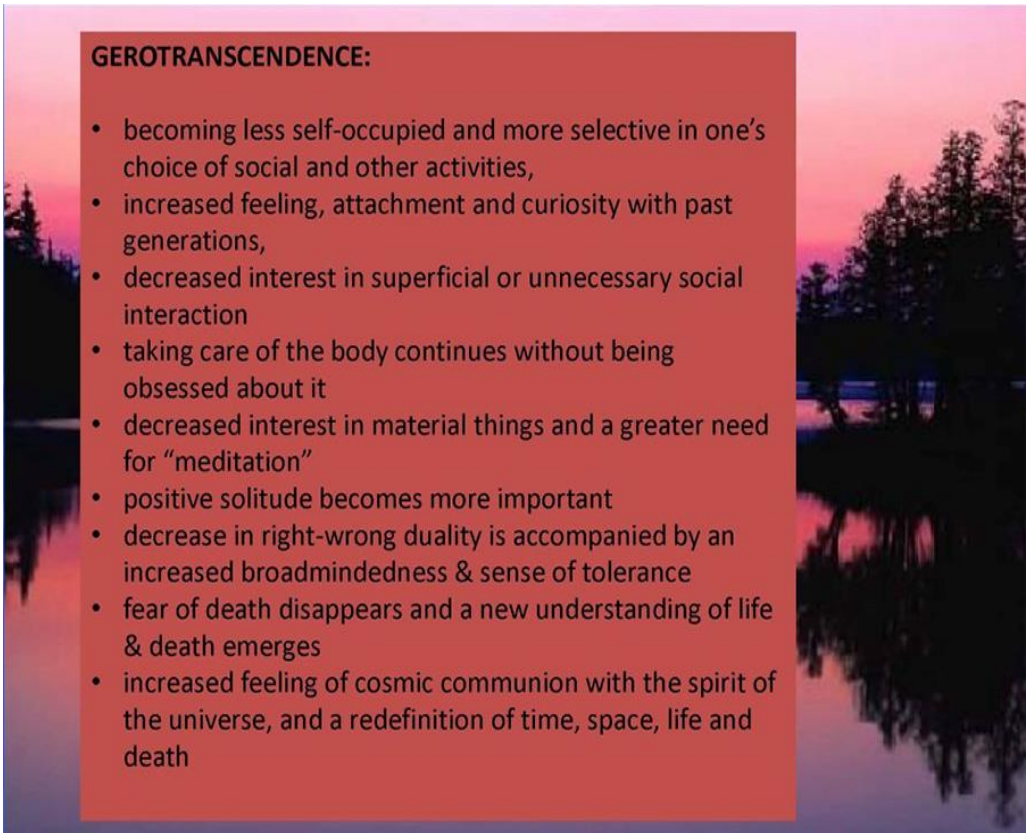
In 1989 Lars Tornstam suggested that human aging, the very process of living into old age, encompasses a general potential towards gero transcendence; that is, a shift in meta perspective from a materialistic and rational vision to a more cosmic and transcendent one, normally followed by an increase in life satisfaction. On the basis of qualitative and quantitative studies, Tornstam (1992, 1994) developed the

theoretical concept of gero transcendence at three levels of age-related ontological change:

- **Cosmic level** — changes in the perception of time, space and objects, increase of affinity with past and coming generations, changes in the perception of life, disappearing fear of death, acceptance of the mystery dimension in life, and increase of cosmic communion with the spirit of the universe;

- **Self** — discovery of hidden (both good and bad) aspects of the self, decrease of self-centeredness, self-transcendence from egoism to altruism, rediscovery of the child within, and ego integrity

- **Social and individual relations** — less interest in superficial relations, increasing need for solitude, more understanding of the difference between self and role, decreasing interest in material things, an increase of reflection. The new theory of gero transcendence reminds one of the classical concepts of disengagement (Cumming & Henry, 1961) and integrity (Erikson, 1950), but differs qualitatively in some opposite aspects. For example, gero transcendence implies a "redefinition of reality," while disengagement is restricted to "turning inwards"; also, gero transcendence is connected with "social activity" and a need for solitary "philosophizing" at the same time, while disengagement encompasses social withdrawal only. Gero transcendence refers to offensive, multi-coping strategies, while disengagement implies defensive coping strategies and social breakdown. Finally, Erikson's integrity refers primarily to the integration of elements in a life that have passed, while gero transcendence implies more of a forward or outward direction, including the redefinition of reality. Summarizing, even though Tornstam's theory of gero transcendence is based on limited empirical evidence, it nevertheless makes a promising attempt to integrate and further develop some classical and modern psychosocial theories of aging.



1.6.2. Gero dynamics/Branching Theory

Gero dynamics is primarily based on general and dynamic systems theory, and conceptualizes the ageing of individuals as a non linear series of formations into higher or lower order structures and processes of entropic region, showing a progressive trend towards more disorder than order over the lifespan, and ultimately results in the death of the individual. The intra individual variations in terms of functional variations, explain behavioural transformations across the lifespan. Behavioural development is the result of the dynamic interaction of genetic and environmental factors as one passes through the lifespan.

Recently, the author (Schroots,) presented a brief outline of a dynamic systems theory of aging, called gero dynamics. This theory at its inception, which elaborates his 1988 essay, is based on general systems theory, notably the second law of thermodynamics, and dynamic systems theory (chaos theory). The 2nd law states that there is an increase of entropy or disorder with age in living systems, resulting in the system's death. Chaos theory postulates that internal or external fluctuations of dynamic, far-from-equilibrium systems can pass a critical point — the transformation point — and create order out of disorder through a process of self-organization, that is, a process by which a structure or pattern of change emerges with the passage of time. From this meta theoretical viewpoint, the aging of living systems can be conceived as a

nonlinear series of transformations into higher and/ or lower order structures or processes, showing a progressive trend toward more disorder than order over the life span, and resulting in the system's death.

Gero dynamics lies at the root of a new aspect theory of aging, called branching theory. The basic principle of this theory is the bifurcation or branching behaviour of the individual at the biological, psychological or social level of functioning. Metaphorically speaking, bifurcation means that the fluctuating individual (organism) passes a critical point — the bifurcation, branching or transformation point — and can branch off into higher and/or lower order structures or processes. Higher and lower order structures can be translated in terms of mortality (probability of dying, life expectancy), morbidity (disease, disorder, disability or dysfunction) and quality of life (well-being, life satisfaction). For example, traumatic life events and a healthy life style may result in lower and higher order structures, respectively, and consequently in higher and lower probabilities of dying. It should be noted, however, that lower order bifurcations at the biological or psychological level of functioning (e.g., illness or divorce) do not always result in lower order branching behaviour. Some people, for instance, are strengthened by illness, and divorce may have a positive rather than a negative effect on mental health in terms of life expectancy and quality of life.

Branching theory studies the determinants and patterns of branching behaviour across the life span. As yet, this innovative theory of aging is not based on empirical evidence. It remains to be seen how empirical research in progress lends support to its theoretical claims.

1.7 LETS SUM UP:

Psychological changes will vary as will the way an individual adapts and develops the skills needed to enjoy life to the fullest. Some may develop mental health disorders however it is how these individuals cope and move forward that will determine how successfully they age. The Ulsyssean lifestyle is ideal not only to those who have no mental health issues but especially important to those who have developed some form of mental health barrier. Having a positive outlook and seeking positive social support systems will help during the aging process.

Erik Erikson, who took a special interest in this final stage of life, concluded that the primary psychosocial task of late adulthood (65 and beyond) is to maintain **ego integrity** (holding on to one's sense of wholeness), while avoiding **despair** (fearing there is too little time to begin a new life course). Those who succeed at this final task also develop wisdom, which includes accepting without major regrets the life that one has lived, as well as the inescapability of death. However, even older adults who

achieve a high degree of integrity may feel some despair at this stage as they contemplate their past. No one makes it through life without wondering if another path may have been happier and more productive.

Two major theories explain the psychosocial aspects of aging in older adults. **Disengagement theory** views aging as a process of mutual withdrawal in which older adults voluntarily slow down by retiring, as expected by society. Proponents of disengagement theory hold that mutual social withdrawal benefits both individuals and society. **Activity theory,** on the other hand, sees a positive correlation between keeping active and aging well. Proponents of activity theory hold that mutual social withdrawal runs counter to traditional activity, energy, and industry. To date, research has not shown either of these models to be superior to the other. In other words, growing old means different things for different people. Individuals who led active lives as young and middle adults will probably remain active as older adults, while those who were less active may become more disengaged as they age.

Cognitive theories of aging seek to explain differences in measured cognitive ability between younger and older people. These differences may be due to a myriad of factors that include: real physical and sensory age-related changes, cohort effects, characteristics of cognitive tests, or differences in the mechanisms by which older and younger people process information.

As older adults approach the end of their life span, they are more apt to conduct a life review. The elderly may reminisce for hours on end, take trips to favourite childhood places, or muse over photo albums and scrapbooks. Throughout the process, they look back to try to find the meaning and purpose that characterized their lives. In their quest to find life's meaning, older adults often have a vital need to share their reminisces with others who care, especially family.

In the theory of **personality development** personality remains consistent in men and women throughout life. Personality impacts roles and life satisfaction. Particular traits in youth and middle age will not only persist but may be more pronounced in later life. Gero transcendence and gero dynamics theory of ageing are the innovative theory of aging that is not based on empirical evidence. It remains to be seen how empirical research in progress lends support to its theoretical claims.

1.8 GLOSSARY:

- Reductionism: the practice of analyzing and describing a complex phenomenon in terms of its simple or fundamental constituents, especially when this is said to provide a sufficient explanation.

- Bereavement: - a state of intense grief, as after the loss of a loved one; desolation.
- Inverted U-Function: - The relationship between changes in arousal and motivation is often expressed as an **inverted-U function** (also known as the Yerkes-Dodson law). The basic concept is that, as arousal level increases, performance improves, but only to a point, beyond which increases in arousal lead to deterioration in performance.
- Repertoire: - a stock of skills or types of behaviour that a person habitually uses.
- Genetic Endowment: - are the things that are passed down from parents and ancestors. Things can be physical characteristics as well as hereditary health issues.
- Connectedness:- a feeling of belonging to or having affinity with a particular person or group
- Self-Perpetuating:- the capability of something to cause itself to continue to exist is one of the main characteristics of life.
- Psychodynamics: - the interrelation of the unconscious and conscious mental and emotional forces that determine personality and motivation.
- Alzheimer's disease: -A progressive disease that destroys memory and other important mental functions.
- Dementia: - It's an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities.
- Folstein MMSE: - The **Mini–Mental State Examination** (**MMSE**) or **Folstein test** is a 30-point questionnaire that is used extensively in clinical and research settings to measure cognitive impairment.
- Metaphors: - a thing regarded as representative or symbolic of something else.
- Phenotype: - The term "**phenotype**" refers to the observable physical properties of an organism; these include the organism's appearance, development, and behaviour.
- Cosmic Communion:-the sharing or exchanging of intimate thoughts and feelings, especially on a mental or spiritual level

1.9. Self Assessment Questions:

1. Choose the correct answer:

i. Psychological theories that deal with the social aspects of life are called _____ theories.

a) psychological-social
b) psychosocial
c) societal
d) social-psycho

ii. Which of the following is TRUE about the disengagement theory?
a) Older adults may naturally pull away from society
b) Older adults fully participate in society
c) Older adults leave their legacy on society
d) Older adults are forced to withdraw from society

iii. Which of the following theories proposes that that life satisfaction is largely determined by how active a person is?
a) Personality theory of development
b) Activity theory
c) Continuity theory
d) Disengagement theory

iv) Which of the following theories proposed that people withdraw more and more from society as they age and society also withdraws from aging people?
a) Disengagement theory
b) Gerodynamic theory
c) Activity theory
d) Continuity theory

v. The activity theory of aging is also referred to by which of the following terms?
a) Lay theory of aging
b) Implicit theory of aging
c) Normal theory of aging
d) All of the options are correct

vi Theory which formulates that the hereditary factors influence age-related changes over the life span of the individual.
a) Continuity theory
b) Activity theory
c) Disengagement theory
d) Behavioural geneticis of aging

vii. According to Erikson, the final developmental stage is called
a) Generativity versus stagnation
b) Intimacy versus isolation.
c) Integrity versus despair

d) Ageism versus activity theory

viii. Which of the following statements is TRUE about the continuity theory?
   a) Aging adults will maintain only internal structures as they did in their earlier years of life
   b) Aging adults will maintain both internal and external structures as they did when they were young.
   c) Aging adults will not maintain internal and external structures as they did in their earlier years of life.
   d) Aging adults will maintain only external structures as they did in their earlier years of life.

ix. Which statement is consistent with research on cognitive processing and aging?
   a) Older people typically respond faster than younger people in memory experiments.
   b) Fluid intelligence develops and improves from adolescence through old age
   c) Memory decline in older people is the result of an enlargement of the hippocampus.
   d) Crystallized intelligence continues to grow throughout the aging process.

x. A 70-year-old woman who is given a touch-screen tablet becomes hopelessly frustrated when she tries to use it. Which of the following best explains her lack of success?
   a) A decline in crystallized intelligence makes it difficult for her to apply previous knowledge to a new situation
   b) A decline in fluid intelligence keeps her from reasoning abstractly when confronted with an unfamiliar object
   c) The similarity between her laptop computer and the tablet causes confusion between crystallized and fluid intelligence.
   d) The unfamiliarity of the tablet's technology causes a breakdown of her crystallized intelligence

2. Write in your own words?

i. What are psychological theories of ageing ? Write in detail about the theoretical development of ageing in psychology.
ii. Differentiate between activity theory and disengagement theory?
iii. What are the various theories proposed in modern era?
iv. How cognitive theory explains the performance level in ageing? Explain.
v. Explain gero transcedence and gero dynamic theory of psychological ageing?

1.10. Evaluate your progress:

- Answers to questions 1.9.1

  i)[b] :ii) [a]: iii) [b] :iv) [a]: v)[b] :vi[d] : vii) [c]: viii) [b] :ix) [d]: x) [d]

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Unit – 2 :Psychological changes in Ageing

Structure

2.1 Introduction

2.2 Self-esteem

2.3 Personality

2.4 Depression

2.5 Social Changes

2.6 Psychosocial problems

2.7 Developmental tasks needed for successful aging

2.8 Role of the gerontological nurse to promote psychosocial adaptation

2.9 Self assessment questions:

2.10 References and further reading

2.11 Evaluate your progress:

2.1 Introduction

- Most elderly people seem to be most vulnerable to psychological dysfunction when they experience change.

- Affective function refers to the mood, emotions (such as happiness, sadness, fear, pain, anger, and confusion).
- Cognitive function refers to memory, learning, and intelligence.
- Cognitive and affective functioning affects the person's self-esteem.

Affective functioning

- It is influenced by the way an individual views the world and self.
- A positive view of self and surrounding environment promotes positive expression of mood and emotions.

2.2 Self-esteem

- It is the way a person views himself/herself.
- A positive view of self promotes health and enables the person to cope better with the changes and challenges of growing older.

Factors contribute to a decreased in self-esteem

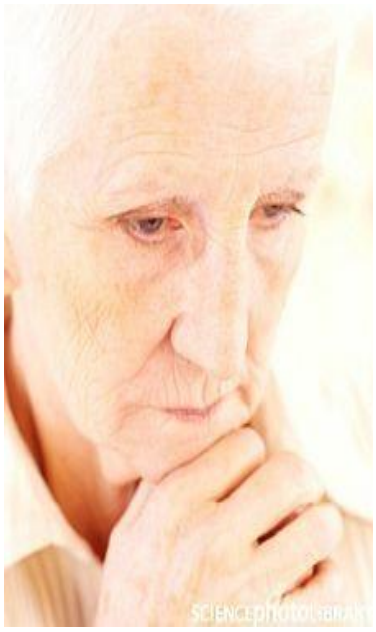
- Age related changes.
- losses that occur with aging
- Chronic diseases.
- Increased dependency.
- Function impairment.
- Lack of control over the person environment

2.3 Personality

- The basic personality does not change as a result of aging process.
- The personality will be consistent with that of earlier years.

2.4 Depression

- Depression occurs 16-65% of elders living in the community.
- Depression including: sleep disturbance, lake of interest, feelings of guilt, lack of energy, decreased concentration and, loss of appetite.
- Losses can lead to depression.



Cognitive functioning

Intelligent, learning, attention and memory are all related to cognitive functioning and how well the mind is able to reason and make sound judgments

1- Intelligent

- Intelligent is a mental alertness and includes the ability to learn new material, make wise decisions, and deal with stressful situation.
- Intelligent does not become less with age.
- IQ test performance of older adults may be hindered because of sensory deficits or the stress of being tested. These factors must be considered when assessing

2- Memory

- Recent memory is defined as a recall of items learned more than a few minutes earlier, e.g. the day's new events, what was eaten for breakfast, the date. Recent memory generally declines with age.
- Remote memory is defined as a recall of items learned many years earlier, e.g. the dates of wars, names of presidents, remote memory does not experience significant change with age.

3- Learning

- Learning is the acquisition of new knowledge or skills.
- The ability of the mind to learn and retain new information remains unaltered, particularly when mind is stimulated through regular use.
- The ability to solve complex problems decline with age.
- Hearing and visual deficits related to aging process can affect learning

4- Attention span

- There is decrease in vigilance performance.
- Vigilance performance is the ability to retain attention longer than 45 minutes.
- The elderly is more liable to distract (divert) attention by irrelevant information and stimuli.
- Deficits in attention may affect learning and memory.

2.5 Social Changes

- The social changes that come with life are change in life style, loss of other family members, neighbours and friends.
- The main social problems, which confront elderly persons, are:
  - Social isolation
  - Finance
  - Loneliness
  - Rejection and loss of purpose in life.

- Deterioration in housing standard and poor nutritional level.

1-Retirement

- A change in work role comes with retirement.
- It changes the way time is managed and daily activities are carried out.
- Retirement alters identity, status, and financial problem, lack of self-satisfaction and self-esteem and sometimes friendships

2- Widowhood

- A common event that alters family life for the aged is the death of a spouse.
- The spousal role composed of many sub roles, such as companion, sexual partner, confidante, cook, house-keeping, and care provider.
- Loss of spouse is a highly stressful experience. Death of a spouse affects more women than men because older men will marry again

3-Loneliness

- Loneliness is the feeling of emotional isolation, being locked inside one self and unable to obtain the warmth and comfort from others.

- Any loss that creates a deficit in intimacy and inner personal relationships can lead to loneliness

3 Role change (role reversal)

Numerous role changes occur with the aging process, but the transitions expected by most elders are related to the work role and the role of spouse or partner.

4- Multiple losses

Aging is associated with major physical, psychological and sociologic losses as well as a reduced ability to adapt and compensate for stressors

Examples of some losses

- Loss of job (retirement)
- Loss of status
- Change role
- Loss related to normal age-related changes
- Decreased income
- Increase expenditure on medical services
- Loss of significant person
- Loss of housing

- Decreased the ability to adapt and compensate for stressors
- Limitations impose as a result of multiple chronic diseases

Awareness of Mortality

- Widowhood, death of friends, and the recognition of declining functions make older person more aware of the reality of their own death.
- Attitudes about death vary with aging.
- The elderly tend to think and talk about death, but they find the prospect of death less frightening.

2.6 Psychosocial problems

- Poor adjustment to role changes
- Poor adjustment to lifestyle changes
- Family relationship problems
- Grief
- Low self-esteem
- Anxiety and depression
- Aggressive behaviour
- Loneliness
- Isolation
- Problems with sexuality
- Elderly abuse
- Withdrawing and having a negative attitude toward life in general

2.7 Developmental tasks needed for successful aging

1. Adjusting to declining health and physical strength.
2. Adjusting to retirement and reduce income
3. Adjusting to death of a spouse.
4. Establish associations with others in the same age.

5. Maintaining a satisfactory living arrangement.
6. Adapting to changes in social roles

2.8 Role of the gerontological nurse to promote psychosocial adaptation

1. **The psychosocial assessment is an essential component of the overall health assessment**
2. **Nursing intervention to enhance mental alertness**

- Allow the client to do as many tasks for himself as possible.
- Encourage use of the mind in problem solving.
- Encourage use of numbers and calculations.
- Encourage creative activities (e.g. painting, storytelling).
- Encourage the discovery of new talents and abilities.
- **3- Nursing intervention when caring for a client with a short-term memory loss**
- Identify yourself each time there is an interaction with the client.
- Give instructions in simple, direct terms.
- Repeat instructions several times.
- Explain everything that is happening, even if the client does not seem to understand.
- Perform only one activity at a time.
- Report any sudden confusion.

4- Nursing intervention when teaching an older person new information

- Assess current knowledge.
- Evaluate for any visual or hearing deficit. Make sure the hearing aid is working or glasses are available, if indicated.
- Determine the person's ability to learn.
- Identify any language barrier.

- Determine if the information to be taught is thought to be important or relevant to the elderly person.
- Begin by reviewing familiar information and then more to new information.
- Teach the spouse or family member as well as the elderly person if possible.
- Plan teaching over several days, with small increments of information presented at one time.
- Actively involve the client in the learning process.
- Allow time for feed back to evaluate knowledge

4 Nursing role to increased self-esteem

- Develop a trusting relationship
- Treat the elderly with dignity and respect
- Allow sufficient time for the performance of daily activities of self-care
- Encourage verbalization
- Practice active listening
- Give positive reinforcement for progress.
- Use reminiscence therapy (encourage the elderly to recall or remember past events).
- Be alert for opportunities to include the patient in decision making.
- Use verbal and non verbal communication
- Encourage socialization**.**

5 Nursing intervention that foster positive personality traits in elderly

1. Accept the elderly.
2. Identify the positive characteristic of each elderly.
3. Encourage verbalization.
4. Reward positive behaviour.
5. Avoid a judgmental attitude.

7- Adjusting to retirement

- It is easier if activities that will become prominent after retirement are begun during the working years.
- Therefore, adjustments to retirement are influenced by pre-retirement plan and engaging in other activities before withdrawing completely from their work.

8-Find a new role

Such as a grandparent role; the grandparent role is generally one that brings great satisfaction and contentment

9- Facilitating maximum independence

- Make sure that the person has access to all necessary assistive devices and personal accessories.
- Allow enough time for the person to perform tasks at her or his own place
- Make sure that the environment has been adapted as much as possible to compensate for sensory losses and other functional impairments.

10- Intervention that promotes social support

- Use interventions to deal with hearing impairments and other communication barriers.
- Encourage participation in group activities.
- For people in wheelchairs, especially those who cannot move independently, position the chairs in a way that promotes social interaction.
- For nursing home residents, plan tables and room arrangements in such a way that social relationships are fostered

2.9. Self Assessment Questions:

1. A positive view of self promotes health and enables the person to cope better with the changes and challenges of growing older is called as_____
2. Factors contribute to a decreased in self-esteem
   a) Chronic diseases
   b) Function impairment.
   c) Increased dependency
   d) All of the above
3. Recent memory _____

4. **Write in your own words?**

   i. Cognitive functioning.
   ii. Psychosocial problems.
   iii. How to care a person with short term memory loss.

2.10 Evaluate your progress:

- Answers to questions

  1) Self Esteem

  2) [d]

  3) recall of items learned more than a few minutes earlier.

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Unit-3 : DEPRESSION IN ELDERLY

Structure

3.1 Introduction:

3.2 Amda Clinical Practice Guideline for Depression in Long-Term Care

3.3 Differential Diagnosis

3.4 Clinical Course in Major Depression

3.5 Steps in Treating Depression

3.6 Types of Therapy for Depression

3.7 Self Assessment Questions:

3.8 Evaluate Your Progress:

3.9 References and Further Reading:

3.1 Introduction

Depression: **A** spectrum of mood disorders characterized by a sustained disturbance in emotional, cognitive, behavioural, or somatic regulation and associated with significant functional impairment and a reduction in the capacity for pleasure and enjoyment

Epidemiology among Older Adults

- Minor depression is common
  - 15% of older persons overall
  - 50% long-term care
  - Causes ↑ use of health services, excess disability, poor health outcomes, including ↑ mortality
- Major depression is not common
  - 1%–2% of physically healthy community dwellers
  - 12-16% in long-term care

- Elders less likely to recognize or endorse depressed mood

- Up to 70% of residents in long-term care may feel sad, depressed or blue mood

- Bipolar disorder: incidence declines with age

    - However, bipolar disorder remains a common diagnosis among aged psychiatric patients

AMDA Clinical Practice Guideline for Depression in Long-Term Care

- Standard of Care
- Stepwise Approach
- Panel of Experts reviewing medical literature

***DSM-IV* DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSION**

- Gateway symptoms (must have 1)
    - Depressed mood
    - Loss of interest or pleasure (anhedonia)
    - Other symptoms
    - Appetite change or weight loss
    - Insomnia or hypersomnia
    - Psychomotor agitation or retardation
    - Loss of energy
    - Feelings of worthlessness or guilt
    - Difficulty concentrating, making decisions
    - Recurrent thoughts of suicide or death

3.2 AMDA Clinical Practice Guideline for Depression in Long-Term Care

- **Step I – Recognition**
    - History of Depression
    - Positive depression screening test

- Appropriate for facilities to formally screen all residents
- Some options for tools:
    - Geriatric Depression Scale (GDS)
    - Cornell Scale for Depression in Dementia (CSDD)

- **Step 2 – Signs/Symptoms of Depression**
    - DSM IV Criteria
    - Mood and behaviour patterns
    - Nutritional problems
    - Weight changes
    - Depressed mood most of day
    - Diminished interest/pleasure most activities –social withdrawal
    - Thoughts of death or suicide
    - Helpless/Hopeless – psychomotor agitation
    - Increased somatic symptoms – fatigue, pain, insomnia
    - USE YOUR MDS

Diagnostic Approach to Clinical Depression

S - Sleep disturbance
I - Interest diminished
G - Guilt excessive and inappropriate
E - Energy diminished
C- Concentration impaired
A- Appetite disturbance
P- Psychomotor disturbance
S- Suicidal ideation

- **Step 3 – Risk factors for Depression**
    - Alcohol or substance abuse
    - Medication contributing to depression (see slide)
    - Hearing or Vision impairment

- History attempted suicide
- Psychiatric hospitalization
- Medical diagnosis with high risk depression (see slide)
- Change in environment
- Personal or family history depression
- New stress, loss

Medications causing symptoms of depression

- Anabolic steroids
- Digitalis
- Glucocorticoids
- H2 Blockers
- Metoclopramide
- Opioids
- Some Beta-blockers
- Anti-arrythmics
- Anti-convulsants
- Barbituates
- Benzodiazepenes
- Carbidopa / Levodopa Clonidine

Comorbid Conditions with High Risk Depression

- Alcohol dependency/Substance abuse
- Cerebrovascular/neurodegenerative disease
- Cancer
- COPD
- Chronic pain
- CHF/CAD/MI

- DM/electrolyte imbalance
- Head trauma/ Orthostatic hypotension
- Abuse
- Schizophrenia

Step 4 – Has the patient had a persistently depressed mood or loss of interest or pleasure for at least 2 weeks?

- **Step 5 –** Consider medical work-up
    - H&P
    - Basic labs, serum drug levels, thyroid
    - Consider other testing based on patient condition

  Medical work-up may not be indication in some patients (i.e. terminal patients) MAKE NOTE IF WORK-UP NOT DONE
- **Step 6** – Review Medications
- **Step 7 –** Review medical conditions and optimize treatment
- **Step 8** – Do depressive symptoms improve with treatment medical conditions?

  May still need to treat both conditions
- **Step 9** – Clarify the diagnosis
    - Mild episode of major depression
    - Moderate episode of major depression
    - Severe episode of major depression
    - Severe episode of major depression with psychotic features
    - Minor depression disorder
    - Bipolar Type II
    - Dysthymic disorder
    - Adjustment disorder with depressed mood or with mixed anxiety and depressed mood
- **Step 10** – Is additional psychiatric support needed?

- Low threshold in LTC to consult psychiatry, especially with significant behaviour issues, suicidal ideation, psychosis

- **Step 11** – Does depression exhibit complications that may pose a risk to the patient or to others?

DIAGNOSTIC CHALLENGES IN MEDICAL SETTINGS

- Symptoms of depressive and physical disorders often overlap, e.g.,
    - Fatigue
    - Disturbed sleep
    - Diminished appetite
    - Depression can present atypically in the elderly
    - Seriously ill or disabled persons may focus on thoughts of death or worthlessness, but not suicide
- Side effects of drugs for other illnesses may be confused with depressive symptoms

DIAGNOSIS IN OLDER PATIENTS IS DIFFICULT BECAUSE THEY

- More often report somatic symptoms
- May be considered part of normal aging
- Cognitive impairment may interfere with diagnosis
- Practitioners may focus more on physical symptoms
- Less often report depressed mood, guilt
- May present with "masked" depression cloaked in preoccupation with physical concerns and complicated by overlap of physical and emotional symptoms

HALLMARKS OF PSYCHOTIC DEPRESSION

- Patients have sustained paranoid, guilty, or somatic delusions (plausible but inexplicably irrational beliefs)
- Among older patients, most commonly seen in those needing inpatient psychiatric care
- In primary care, may be seen when patients exhibit unwarranted suspicions, somatic symptoms, or physical preoccupations

3.3 DIFFERENTIAL DIAGNOSIS

- Medical illness can mimic
- Depression
    - Thyroid disease
    - Conditions that promote
    - apathy
    - Dementia has overlapping symptoms
    - Impaired concentration
    - Lack of motivation, loss of interest, apathy
    - Psychomotor retardation
    - Sleep disturbance
    - Pseudo - Dementia

Bereavement is different because:

Most disturbing symptoms resolve in 2 months

Not associated with marked functional impairment

- Pseudo - Dementia
- Bereavement is different because:
    - Most disturbing symptoms resolve in 2 months
    - Not associated with marked functional impairment

3.4. CLINICAL COURSE IN MAJOR DEPRESSION

- Often slow onset, recurrence, partial recovery, and chronicity . . .
    - Increase disability
    - Increase use of health care resources
    - Increase morbidity and mortality
    - Suicide

OLDER ADULTS AND SUICIDE

- Older age associated with increasing risk of suicide
- One fourth of all suicides occur in persons ≥ 65
- Risk factors: depression, physical illness, living alone, male gender, alcoholism
- Violent suicides (e.g. firearms, hanging) are more common than non-violent methods among older adults, despite the potential for drug overdosing

3.5. STEPS IN TREATING DEPRESSION

- Acute—reverse current episode
- Continuation—prevent a relapse
    - ➢ Continue for 6 months
- Prophylaxis or maintenance—prevent future recurrence
    - ➢ Continue for 3 years or longer Implement appropriate treatment for the patient's depression

Common threads of treatment in LTC:

- o Minimize institutional
- o Feel of environment Facilitate interaction with
- o Family members and friends Provide opportunities for patients to engage in spiritual or religious activities if they so desire

- o Common threads of treatment in LTC, continued:Provide socialization interventions and structured, meaningful physical and intellectual activities, (age and gender appropriate)
- o Common threads of treatment in LTC, continued:
    - INTERDISCIPLINARY
    - INCLUDE FAMILY/DECISION MAKER
    - Complete Psychotropic
    - paperwork

3.6. TYPES OF THERAPY FOR DEPRESSION

- Psychotherapy
- Pharmacotherapy
- Electroconvulsive therapy (ECT)

PSYCHOTHERAPY

- Individualize standard approaches
    - Cognitive-behavioural therapy
    - Interpersonal psychotherapy
    - Problem-solving therapy
- Combine with an antidepressant (has been shown to extend remission after recovery)
- Watch for depressive syndromes in caregivers, who might benefit from therapy
- Psychosocial interventions – bereavement groups, family counselling

PHARMACOTHERAPY

- Individualize choice of drug on basis of:
    - Patient's co morbidities, age
    - Drug's side-effect profile
    - Patient's sensitivity to these effects
    - Drug's potential for interacting with other medications
    - Drug cost
    - Prior med use and response

ANTIDEPRESSANTS

- Tricyclic antidepressants (TCAs)
- Selective serotonin-reuptake inhibitors (SSRIs)

- Others: bupropion, venlafaxine, duloxetine, nefazodone, mirtazapine, MAOIs, methylphenidate

TRICYCLIC ANTIDEPRESSANTS (TCAs)

- Secondary amine TCAs most appropriate for older patients are nortriptyline and desipramine (caution now with Beers List)
- For severe depression with melancholic features
- Avoid in the presence of conduction disturbance, heart disease, intolerance to anticholinergic side effects
- Most patients achieve target concentrations at:
    - Nortriptyline: 50–75 mg per day
    - Desipramine: 100–150 mg per day

SELECTIVE SEROTONIN-REUPTAKE INHIBITORS (SSRIs)

- Citalopram, escitalopram, fluoxetine, paroxetine, sertraline
- For mild to moderately severe depression
- Use if TCA is contraindicated or not tolerated
- Side effects:
    - Anxiety, agitation, nausea & diarrhoea, sexual effects, pseudo parkinsonism, increase warfarin effect, other drug interactions, hyponatremia/SIADH, anorexia
    - Falls and fractures in nursing-home patients

BUPROPION

- Generally safe & well tolerated
- ↑ activity of dopamine & norepinephrine
- Side effects:
    - Insomnia, anxiety, tremor, myoclonus
    - Associated with 0.4% risk of seizures

VENLAFAXINE

- Acts as SSRI at low doses; at higher doses SNRI (selective norepinephrine reuptake inhibitor)
- Effective for major depression & generalized anxiety
- Side effects:
    - Nausea
    - Hypertension
    - Sexual dysfunction

DULOXETINE

- Equally SSRI and SNRI
- Effective for major depression and FDA- approved for neuropathic pain
- Precautions: drug interactions (CYP450 1A2, 2D6 substrate), chronic liver disease, alcoholism, serum transaminase elevation

NEFAZODONE

- Has SSRI and 5-HT_2 antagonist properties
- Approved for depression & anxiety
- Not associated with insomnia, sexual dysfunction
- Potent inhibitor of CYP-450 3A4 system—use with caution with other medications

MIRTAZAPINE

- Norepinephrine, 5-HT_2 , and 5-HT_3 antagonist
- Associated with weight gain, increased appetite
- May be used for nursing-home residents with depression & dementia, night time agitation, weight loss
- May be given as single bedtime dose (sedative side effects); available in sublingual form

METHYLPHENIDATE

- No controlled data demonstrating efficacy for depression
- Has been used for decades to treat major depression
- May have role in reversing apathy, lack of energy in patients with dementia or disabling medical conditions
- Short term use, often as a bridge to other treatment
- Can use with appropriate documentation

PHARMACOLOGIC ALGORITHM

Initiate citalopram, escitalopram, or sertraline

If response is inadequate, switch to paroxetine or fluoxetine, OR switch class based on symptom profile

Apathy, retardation	Insomnia, anxiety, anorexia	Pain	Atypical, melancholic, anxious
↓	↓	↓	↓
bupropion	mirtazapine	duloxetine	venlafaxine

If inadequate response…

↓↓

Atypical	Melancholic, anxious
↓↓	
MAOI	TCA

- Individual response to treatment
- May take weeks to see response so high risk premature discontinuation

- Risk for poorer outcome – multiple stressors, older age, difficulty with ADLs, prior depression at younger age, poor sleep, higher anxiety, poor social support
- Can sometimes use one medication to treat more than one need/behaviour
- Step 13 – Monitor patient response to treatment
    - Possible goals of treatment
        - Resolution of signs and symptoms
        - Improvement in score on screening tool
        - Improvement in attendance at and participation in usual activities
        - Improvement in sleep pattern
    - Monitor for side effects of treatment
    - Duration of treatment
        - First episode 6 months to a year, longer if complicated
        - 2-3 years if recurrent

Adjuvant Medical Treatment

- Anxiety
- Insomnia
- Constipation
- Shortness of Breath
- FAMILY!!

Non pharmacologic Treatment

- Physical/Occupational therapy
- Touch – massage
- Increased social interaction
- Support groups if patient is able

MANAGING NONRESPONSE

- *The most common prescribing error is failure to increase the dose to the recommended level within the first 2 weeks of treatment*
- When mono therapy fails:
    - Consider switch to another drug class
    - Combine lithium carbonate, methylphenidate, or triiodothyronine with secondary amine TCA
    - Add psychotherapy
    - Consult a geriatric psychiatrist

REASONS TO USE ECT (Electroconvulsive Therapy)

- Effective for treatment of major depression & mania; response rates exceed 70% in older adults
- First-line treatment for patients at serious risk for suicide, life-threatening poor intake
- Standard for psychotic depression in older adults; response rates 80%

3.7 Self assessment questions:

1. Disturbance in emotional, cognitive, behavioural, or somatic regulation and associated with significant functional impairment and a reduction in the capacity for pleasure and enjoyment called as_____
2. GDS_____

3 DSM IV_____

4. TCA_____

5. ECT_____

2. Write in your own words?

vi. Depression causes

vii. Pharmaco therapy for depression.

viii. Types of therapies for depression

3.8 Evaluate your progress:

- Answers to questions
  1) Depression 2) Geriatric Depression Scale 3). Diagnostic Statistical manual 4).Tricyclic Anti-Depressants 5).Electro Convulsive therapy.

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Unit -4: PSYCHOSOCIAL CHANGES OF AGEING

STRUCTURE

4.1 Introduction

4.2 Facts About Aging

4.3 Demographics, Economic And Social Issues

4.4 Aging: Myth Vs Fact

4.5 Common Adjustments Which Occur With Aging

4.6 Stress And Coping In The Older Adult

4.7 Coping Strategies To Combat Psycho Social Changes With Ageing

4.7.1 Types Of Coping Strategies

4.8 Psychosocial Theories Of Aging

4.9 Cognitive Aspects Of Aging

4.10 Changes In Mental Health And Mental Processes

4.11 Psychological Problems Of Older Adults

4.12 Environmental Aspects Of Aging

4.13 Psychosocial Assessment And Intervention

4.14 Summary

4.15 Check Your Progress

4.16 key terms

4.17 references

4.1 INTRODUCTION

Successful psychological aging is reflected in the older person's ability to adapt to physical, social and emotional losses and to achieve contentment, serenity, and life satisfactions. Because changes in life patterns are inevitable over a lifetime, the older person needs resiliency and copying skills when confronting stresses and change. A positive self-image enhances risk taking and participation in new, untested roles.

Although attitudes toward old people differ in ethnic subcultures, a subtle theme of "AGEISM" prejudice or discrimination against older people-predominates

in our society. It is often based on stereotypes, simplified and often untrue beliefs that reinforce societies' negative image of the aged person. Elderly people makeup an extremely heterogeneous groups, at negative stereotypes or attributed to all of them.

Fear of aging and the inability of many to confront their own aging process may trigger ageist beliefs. Retirement and perceived non productivity are also responsible for negative feelings, since the younger working person may see the older person as not contributing to the society and draining economic resources. This negative image is so common in American society that the elderly themselves often believe it. Only through an understanding of the aging process and respect for each person as an individual can the myths of aging be dispelled. If the elderly are treated with dignity and encouraged to maintain autonomy, the quality of their lives will improve.

The psychosocial approach looks at individuals in the context of the combined influence that psychological factors and the surrounding social environment have on their physical and mental wellness and their ability to function. This approach is used in a broad range of helping professions in health and social care settings as well as by medical and social science researchers.

People may not be fully aware of the relationship between their mental and emotional wellbeing and the environment. It was first commonly used by psychologist Erik Erikson in his description of the stages of psychosocial development. Mary Richmond, pioneer of American social work regarded there to be a linear relationship between cause and effect in a diagnostic process. In 1941 Gordon Hamilton renamed the 1917 concept of "social diagnosis" as "psychosocial study". Psychosocial study was further developed by Hollis in 1964 with emphasis in treatment model. It is contrasted with diverse social psychology, which attempts to explain social patterns within the individual. Problems that occur in one's psychosocial functioning can be referred to as "psychosocial dysfunction" or "psychosocial morbidity." This refers to the lack of development or diverse atrophy of the psychosocial self, often occurring alongside other dysfunctions that may be physical, emotional, or cognitive in nature.

Scholarly societies in this field brings together researchers, academics and practitioners who are interested in contributing to the development of this inter/trans-disciplinary field of study. There are organization's such as Transcultural Psychosocial Organization (United Nations High Commissioner for Refugees), Association for Psychosocial Studies, etc.

4.2 FACTS ABOUT AGING

As with many stereotypes, the stereotypes about aging are often inaccurate. Older adults in the developed countries live independently and maintain close relationships with family and friends. Most peoples' personalities remain relatively stable throughout their lives. Depression among non institutionalized older adults is less prevalent than depression in younger adults. However, most older adults do experience normal, age-related changes that may affect their lifestyle. Common age-related physical changes include hearing impairment, weakening vision, and the increasing probability of arthritis, hypertension, heart disease, diabetes, and osteoporosis. The speed with which information is encoded, stored, and received may decrease as we age, and older Americans may experience memory loss.

4.3 DEMOGRAPHICS, ECONOMIC AND SOCIAL ISSUES

Life expectancy for men is now 73 years; for women, it is 80 years.

- Thirteen percent of older adults live in poverty, as compared with 15 percent of Americans under age 65. However, the figure is 33 percent for African-Americans, 22 percent for Hispanics, and 20 percent for adults over age 85.
- The primary source of income for those over age 65 is social security benefits.
- Religious affiliation is the most common form of organizational participation among older adults, with 50 percent reporting attending services weekly.

4.4 AGING: MYTH Vs FACT

MYTH	FACT
Most of the older adults are pretty much alike.	They are a very diverse age group.
They are generally alone and lonely.	Most older adults maintain close contact with family.
They are sick, frail and dependent on others.	Most of the older people live independently.
They are often cognitively impaired.	For older adults, if there is decline in some intellectual abilities, it is not severe enough to cause problems in daily living.
They are depressed.	Community dwelling older adults have a lower rates of diagnostic depression than younger adults.
They become more difficult and rigid with advancing years.	Personality remains relatively consistent throughout the life span.
They barely cope with the inevitable declines associated with aging.	Most older people successfully adjust to the challenges of aging.

4.5 COMMON ADJUSTMENTS WHICH OCCUR WITH AGING

Growing old is not easy. Changes which come about as people age demand multiple adjustments. These adjustments demand flexibility and stamina. Here are some changes:

4.5.1 Family changes: The family unit is a major source of satisfaction for older adults as they enjoy the love, companionship, and achievement of spouse, children, and grandchildren. Their role within the family has changed multiple times in their lifetime. In old age they are cared for by their children versus the other way around.

4.5.2 Retirement: This can be a difficult time because our society places so much emphasis on what a person does. Often one's work gives social position and influence, is a source of social contacts, and provides a feeling of satisfaction from productivity.

4.5.3 Awareness of one's own mortality: Not only do spouses die—but friends do also. Older adults may also experience health decline. Often, older adults review the significance of their life through reminiscences. They love to tell stories of life events. They need to be encouraged to tell stories. They often are faced with multiple losses at one time.

4.5.4 Widowhood: This affects more women than men, as women tend to live longer. Adjusting to the loss of someone you have shared life with is often difficult. Many older women have lived family-oriented lives and have been dependent on their husbands. They find themselves in new roles—such as financial manager—that they need to learn.

4.5.5 Declining physical reserves: As all of us age, the wear and tear on our bodies causes changes to occur. Fatigue sets in. Our responses become slower, and our appearance changes. Chronic illness affects body systems. The fear of loss of independence is great. Being independent is a strong value for most.

4.5.6 Changes in income: Often retirement income is less than half the income earned when the person was fully employed. Social security income for many is the main source of income. If a spouse dies, the income is usually further decreased. This decrease can cause significant adjustments in a person's social and leisure activities.

4.5.7 Shrinking social world for some: Loneliness commonly occurs as a spouse or friend becomes ill or dies. Children and grandchildren are often very busy and may live at a distance. Often older adults choose not to drive—further limiting their socializing. Senses, such as hearing and seeing, diminish, making communication difficult. Think of an aging family member or friend. Which of the changes listed above do you think he or she is experiencing? Adapting to these changes is often more demanding than adapting to physical changes and chronic illness.

4.6 STRESS AND COPING IN THE OLDER ADULT

Coping patterns and the ability to adapt to stress are developed over the course of a lifetime and remain consistent later in life. Experiencing success in younger adulthood helps a person develop a positive self-image that remains solid through even the adversities of old age. A person's abilities to adapt to changes, make decisions and respond predictably are also determined by past experiences. A flexible, well-functioning person will probably continue as such. Losses may accumulate within a short period of time, however, and become overwhelming. The older person will often have fewer choices and diminished resources to deal with stressful events. Common stressors of old age include, normal aging changes that impair physical function, activities, and appearance; disabilities from chronic illness; social and environmental losses related to loss of income and decreased ability to perform previous roles and activities; and the deaths of significant other. Many older adults rely strongly on their spiritual belies for comfort during stressful times.

Lack of social engagement (interaction with people within their environment) may be a modifiable risk factor for death in older persons residing in nursing homes. In older people of average age 87 years, were not able to receive social interaction were two three times more likely to die during the follow up period.

4.7 COPING STRATEGIES TO COMBAT PSYCHO SOCIAL CHANGES WITH AGEING

The effectiveness of the coping effort depends on the type of stress, the individual, and the circumstances. Coping responses are partly controlled by personality (habitual traits), but also partly by the social environment, particularly the nature of the stressful environment.

4.7.1 TYPES OF COPING STARATEGIES

Hundreds of coping strategies have been identified. Classification of these strategies into a broader architecture has not been agreed upon. Common distinctions are often made between various contrasting strategies, for example: problem-focused versus emotion-focused; engagement versus disengagement; cognitive versus behavioral. Weiten for instance, identifies four types of coping strategies:

- **Appraisal-Focused** (adaptive cognitive): directed towards challenging personal assumptions.
- **Problem-Focused** (adaptive behavioral): reducing or eliminating stressors.
- **Emotion-Focused**: changing personal emotional reactions.
- **Occupation-Focused**: directed towards lasting occupation(s), which generates positive feedback

Appraisal-focused strategies occur when the person modifies the way they think, for example: employing denial, or distancing oneself from the problem. People may alter the way they think about a problem by altering their goals and values, such as by seeing the humor in a situation: "some have suggested that humor may play a greater role as a stress moderator among women than men".

People using problem-focused strategies try to deal with the cause of their problem. They do this by finding out information on the problem and learning new skills to manage the problem. Problem-focused coping is aimed at changing or eliminating the source of the stress.

Emotion-focused strategies involve:

- releasing pent-up emotions
- distracting oneself
- managing hostile feelings
- meditating
- using systematic relaxation procedures.

Emotion-focused coping "is oriented toward managing the emotions that accompany the perception of stress". The five emotion-focused coping strategies identified by Folkman and Lazarus are:

- disclaiming
- escape-avoidance
- accepting responsibility or blame
- exercising self-control

- positive reappraisal.

Emotion-focused coping is a mechanism to alleviate distress by minimizing, reducing, or preventing, the emotional components of a stressor. This mechanism can be applied through a variety of ways, such as:

- seeking social support
- reappraising the stressor in a positive light
- accepting responsibility
- using avoidance
- exercising self-control
- distancing.

The focus of this coping mechanism is to change the meaning of the stressor or transfer attention away from it. For example, reappraising tries to find a more positive meaning of the cause of the stress in order to reduce the emotional component of the stressor. Avoidance of the emotional distress will distract from the negative feelings associated with the stressor. Emotion-focused coping is well suited for stressors that seem uncontrollable (ex. a terminal illness diagnosis, or the loss of a loved one). Some mechanisms of emotion focused coping, such as distancing or avoidance, can have alleviating outcomes for a short period of time, however they can be detrimental when used over an extended period. Positive emotion-focused mechanisms, such as seeking social support, and positive re-appraisal, are associated with beneficial outcomes. Emotional approach coping is one form of emotion-focused coping in which emotional expression and processing is used to adaptively manage a response to a stressor.

Typically, people use a mixture of several types of coping strategies, which may change over time. All these methods can prove useful, but some claim that those using problem-focused coping strategies will adjust better to life. Problem-focused coping mechanisms may allow an individual greater perceived control over their problem, whereas emotion-focused coping may sometimes lead to a reduction in perceived control (maladaptive coping).

4.7.1.1 POSITIVE TECHNIQUES (adaptive or constructive coping)

One positive coping strategy, anticipating a problem, is known as proactive coping. Anticipation is when one reduces the stress of some difficult challenge by anticipating what it will be like and preparing for how one is going to cope with it. Adequate nutrition, exercise, sleep contribute to stress management, as do physical fitness and relaxation techniques such as progressive muscle relaxation.

Humor used as a positive coping strategy may have useful benefits to emotional and mental health well-being. By having a humorous outlook on life, stressful experiences can be and are often minimized. This coping strategy corresponds with positive emotional states and is known to be an indicator of mental health. Physiological processes are also influenced within the exercise of humor. For example, laughing may reduce muscle tension, increase the flow of oxygen to the blood, exercise the cardiovascular region, and produce endorphins in the body. Using humor in coping while processing through feelings can vary depending on life circumstance and individual humor styles. In regards to grief and loss in life occurrences, it has been found that genuine laughs/smiles when speaking about the loss predicted later adjustment and evoked more positive responses from other people. A person of the deceased family member may resort to making jokes of when the deceased person used to give unwanted "wet willies" (term used for when a person sticks their finger inside their mouth then inserts the finger into another person's ear) to any unwilling participant. A person might also find comedic relief with others around irrational possible outcomes for the deceased funeral service. It is also possible that humor would be used by people to feel a sense of control over a more powerless situation and used as way to temporarily escape a feeling of helplessness. Exercised humor can be a sign of positive adjustment as well as drawing support and interaction from others around the loss.

While dealing with stress it is important to deal with your physical, mental, and social well being. One should maintain one's health and learn to relax if one finds oneself under stress. Mentally it is important to think positive thoughts, value oneself, demonstrate good time management, plan and think ahead, and express emotions.

Socially one should communicate with people and seek new activities. By following these simple strategies, one will have an easier time responding to stresses in one's life.

4.7.1.2 NEGATIVE TECHNIQUES (maladaptive coping or non-coping)

While adaptive coping methods improve functioning, a maladaptive coping technique will just reduce symptoms while maintaining and strengthening the disorder. Maladaptive techniques are more effective in the short term rather than long term coping process. Examples of maladaptive behavior strategies include dissociation, sensitization, safety behaviors, anxious avoidance, and escape (including self-medication). These coping strategies interfere with the person's ability to unlearn, or break apart, the paired association between the situation and the associated anxiety symptoms. These are maladaptive strategies as they serve to maintain the disorder.

Dissociation is the ability of the mind to separate and compartmentalize thoughts, memories, and emotions. This is often associated with post traumatic stress syndrome. Sensitization is when a person seeks to learn about, rehearse, and/or anticipate fearful events in a protective effort to prevent these events from occurring in the first place. Safety behaviors are demonstrated when individuals with anxiety disorders come to rely on something, or someone, as a means of coping with their excessive anxiety.

Anxious avoidance is when a person avoids anxiety provoking situations by all means. This is the most common strategy. Escape is closely related to avoidance. This technique is often demonstrated by people who experience panic attacks or have phobias. These people want to flee the situation at the first sign of anxiety.

4.8 PSYCHOSOCIAL THEORIES OF AGING

1.8.1 DEVELOPMENTAL THEORY

Erickson (1963) theorized that a person’s life consist of 8 stages, each stage representing crucial turning point in the lifespan stretching from birth to death with its own developmental conflict to be resolve. According to Erickson, the major

developmental task of old age is to either achieve ego integrity or suffer despair. Achieving ego integrity requires accepting one's lifestyle, believing that one's choices were the best that could be made at a particular time, and being in control of one's life. Despair results when an older person feels dissatisfied and disappointed with his or her life, and would live differently if given another chance.

Havighurst (1972) also suggested a list of developmental tasks that occur during a lifetime. The tasks of the older person include adjusting to retirement after a lifetime of employment with a possible in reduction of income, decreases in physical strength and health, the death of a spouse, establishing affiliation with one's age group, adopting to new social roles in a flexible way and establishing satisfactory physical living arrangements.

Combining the concepts of both Erickson and Havighurst suggests the following developmental tasks for the older adult:

- Maintenance of self-worth.
- Conflict resolution.
- Adjustment to the loss of dominant roles.
- Adjustment to the deaths of significant others.
- Environmental adaptation,
- Maintenance of optimal levels of wellness.

4.8.2 SOCIOLOGIC THEORIES OF AGING

Sociologic theories of aging attempt to predict and explain the social interactions and roles that contribute to the older adults successful adjustment to old age. The activity theory proposes that life satisfaction in normal aging requires maintaining the active life style of middle age. The continuity theory proposes that successful adjustment to old age requires continuing life patterns across a lifetime. Continuity and a connection to the past or maintain through a continuation of well-established habits, values and interests that are integral to the person's present life style.

4.9 COGNITIVE ASPECTS OF AGING

Cognition can be affected by many variables, including sensory impairment, physiologic health, environment, and physiological influences. Older adults may

experience temporary changes in cognitive function when hospitalized or admitted to skilled nursing facilities, rehabilitation centers, or long-term care facilities. The changes are related to differences in environment or in medical therapy, or to alteration in role performance.

4.9.1 INTELLIGENCE: When intelligence test scores from people of all ages are compared (cross-sectional testing), test scores for older adults show a progressive decline beginning in midlife. Research has shown, however, that environment and health have a considerable influence on scores and that certain types of intelligence (eg, spatial perceptions and retentions of nonintellectual information) decline, whereas other types do not (problem-solving ability based on past experiences, verbal comprehension, mathematical ability). Cardiovascular health, a stimulating environment, high levels of education, occupational status, and income all appear to have a positive effect on intelligence scores in later life.

4.9.2 LEARNING AND MEMORY: The ability to learn and acquire new skills and information decreases in the older adult, particularly after the seventh decade of life. Despite this, many older people continue to learn and participate in varied educational experiences. Motivation, speed of performance, and physical status all are important influences on learning.

The components of memory, an integral part of learning, include short-term memory (5-30 seconds), recent memory (1 hour to several days), and long-term memory (lifetime). Acquisition of information, registration (recording), retention (storing), and recall (retrieval) are essential components of the memory process. Sensory losses, distractions and disinterest interfere with acquiring and recording information. Age-related loss occurs more frequently with short-term and recent memory, in the absence of a pathologic process, this is called benign senescent forgetfulness. A nurse considers the process by which older adults learn when he/she uses the following strategies:

- Supplies mnemonics to enhance recall of related data.
- Encourages ongoing learning.
- Links new information with familiar information.
- Uses visual, auditory and other sensory cues.

- Encourages learners to wear prescribed glasses and hearing aids.
- Provides glare-free lighting.
- Provides a quite non distracting environment.
- Keeps teaching periods short.
- Paces learning tasks according to the endurance of the learner.
- Encourages verbal participation by learners.
- Reinforces successful learning in a positive manner.

4.10 CHANGES IN MENTAL HEALTH AND MENTAL PROCESSES

Cognitive changes, which are associated with mental processes such as sensation and perception, memory, intelligence, language, thought, and problem-solving, occur among aging adults.

- Because it may take older adults more time to encode, store, and retrieve information, the rate at which new information is learned can be slower among aging adults, and older adults often have a greater need for repetition of new information. Although it may take older adults longer to input and retrieve new information, daily occupational and social functioning among those over age 65 is not impaired.
- Short-term memory shows substantial changes with age, while long-term memory shows less age-related decline.
- Most aspects of language ability remain strong, yet word-finding ability declines with age.
- Three-dimensional drawing similarly declines with age.
- Wisdom and creativity often continue to the very end of life.
- Overall prevalence of mental disorders in older adults is less than in any other age group, and general life satisfaction among elderly is as good as, if not better, than any other age group.

4.11 PSYCHOLOGICAL PROBLEMS OF OLDER ADULTS

There are a number of psychological problems associated with aging:

- Dementia, the irreversible deterioration of intellectual ability accompanied by emotional disturbance, afflicts between 5 and 7 percent of adults over age 65 and 30

percent of those over age 85. Unlike milder forms of mental decline with normal aging, dementia may lead to significant impairment in social functioning. People with dementia often suffer from depression, anxiety, and paranoia.

- Six percent of older adults suffer from anxiety disorders, and the most common anxiety diagnosis is generalized anxiety disorder, in which a person experiences dread, apprehension, and tension for a period of at least 6 months.
- The highest suicide rate of any age group is in older adults, primarily older Caucasian men who live alone.
- The incidence of sexual dysfunction increases with age for both men and women. Sleep problems increase with age, and about one-half of those over age 80 complain of sleep difficulty.
- Ten to 15 percent of older adults exhibit hypochondriasis, the persistent belief that one has a medical disorder despite the lack of medical findings.
- Prevalence of alcohol abuse and substance dependence among those age 65 and over is 2 to 5 percent for men and 1 percent for women.
- Drug abuse among older adults typically takes the form of prescription medication abuse, and older adults take 25 percent of the medication taken in the United States, which underscores that drug abuse among aging adults is often a result of having too many medications prescribed for them.
- Depression is a negative emotion frequently characterized by sadness, feelings of helplessness, and a sense of loss. Those with depression are likely to have an abrupt onset of symptoms, a history of psychiatric problems, decreased motivation, and a tendency to complain about their memory problems. However, depression among non institutionalized older adults is less prevalent than depression in younger adults.
- Behavior disorders in those over age 65 can take the form of physical aggression, motor overactivity (wandering), and disruptive verbal outbursts. Common causes of behavior disorders include delirium, depression, dementia, and psychosis.
- Alzheimer's Disease is a progressive disease that leaves a victim unable to form new memories and is marked by the loss of other mental functions. One of the primary symptoms of Alzheimer's disease is the inability to recall newly learned information, such as a change of address, and disorientation. The onset of

Alzheimer's is often gradual, occurring over a period of 8 to 20 years. At first, victims suffer memory loss and often get lost--even in their own homes. Eventually, they may fail to recognize other people, including family; show childish emotions; and lose the ability to dress and clean themselves.

4.12 ENVIRONMENTAL ASPECTS OF AGING

About 95% of the elderly live in the community, and 75% own their homes. In 1991, about 31% of elderly persons were living alone (79% of these were women). In the 65 years and older age group, half as many women as men were married and living with their spouses: 40% of women compared with 74% of men. About 48% of the women older than 65 years of age were widowed, compared with only 15% of the men. This difference in marital status is a result of several factors: women have a longer life expectancy than men do, women tend to marry older men, and women tend to remain widowed, whereas men often remarry.

4.13 PSYCHOSOCIAL ASSESSMENT AND INTERVENTION

Psychosocial assessment considers several key areas related to psychological and social functioning and the availability of supports. It is a systematic inquiry that rise up from the introduction of dynamic interaction, with this diagnosis is constituted as an ongoing process that continues throughout a treatment, and is characterized by the circularity of cause-effect/effect-cause. In assessment the clinician/health care professional identifies the problem with the client, takes stock of the resources that are available for dealing with it, and consider the ways in which it might be solved.

There are five internal steps in assessment:

- Data collection (relevant and current) of the problem presented.
- Integrating collected facts with relevant theories.
- Formulating hypothesis (case theory) that gives the presented problem more clarity.

- Hypothesis substantiation through exploration of the problem like life history of the client, etiology, personality, environment, stigmas, etc.
- Further integration of newer facts identified in the treatment period and preparing psychosocial report for psychosocial intervention.

Assessment include psychiatric, psychological and social functioning, risks posed to the individual and others, problems required to address from any co-morbidity, personal circumstances including family or other carers. Other factors are the person's housing, financial and occupational status and physical needs. Assessments when categorized, it particularly includes Life history of the client that include data collection of living situation and finances, social history and supports, family history, coping skills, religious/cultural factors, trauma from systemic issues or abuse and medico-legal factors (Assess client's awareness of legal documents, surrogate decision-making, power of attorney and consent). Components that include in resource assessment of the client include psycho-spiritual strengths, substance abuse, coping mechanisms, styles and patterns (Individual, family level, workplace, and use of social support systems); sleeping pattern; needs and impacts of the problem etc. Advanced clinician's incorporate individual scales, batteries and testing instruments in their assessments.

In the late 1980s by Hans Eysenck through an issue of Psychological Inquiry raised controversies on then assessment methods and it gave way to comprehensive Bio-Psycho-Social assessment, this theoretical model states behavior as a function of biological factors, psychological issues and the social context. Qualified healthcare professionals conduct physiological part of these assessments. This thrust on biology expands the field of approach for the client with the client through the interaction of these disciplines and in a domain that mental illnesses are also physical, just as physical conditions have mental components. Likewise, the emotional is both psychological and physical.

The clinician's comprehension and set of judgments about the client situation, assessment, through a theory of each case, predicts the intervention. Hence a good psychosocial assessment leads to a good psychosocial intervention that aims to reduce

complaints and improve functioning related to mental disorders and/or social problems (e.g., problems with personal relationships, work, or school) by addressing the different psychological and social factors influencing the individual. For example, a psychosocial intervention for an older adult client with a mental disorder might include psychotherapy and a referral to a psychiatrist while also addressing the caregiver's needs in an effort to reduce stress for the entire family system as a method of improving the client's quality of life. Treatment for psychosocial disorders in a medical model usually only involve using drugs and talk therapy.

4.13.1 PSYCHOSOCIAL SUPPORT

Psychosocial support is an approach to victims of terminal illness, disaster, war, catastrophe or violence to foster resilience of communities and individuals. It aims at easing resumption of normal life, facilitating affected people's participation to their convalescence and preventing pathological consequences of potentially traumatic situations.

4.14 SUMMARY

Armed with the facts about the myths and realities surrounding aging, society can better prepare itself to assist its older population, as can individual families. Regular mood and memory checkups should be encouraged for all older adults, just as we now encourage regular physicals. What's important to remember is that depression and social isolation are not normal for older Americans--living happily and productively is the norm for today's older adults.

4.15 CHECK YOUR PROGRESS

4.15.1 OBJECTIVE TYPE QUESTIONS

1. Psychological aging is reflected with adaptation to …….. environment.
2. Problems that occur due to psychosocial functioning is called ……
3. Stereotypes related to aging are ……
4. Personality of the older people remains ……throughout lifespan.

5. The……. Is a major source of satisfaction for older adults.

4.15.2 SHORT ANSWER QUESTIONS

1. Discuss the facts and myths about aging?
2. Describe the cognitive aspects associated with aging?
3. Write a note on psychological theories of aging?

4.15.3 ESSAY QUESTIONS

1. List the various psychosocial problems associated with aging and brief out the psychological assessment and nursing management?
2. Describe the various common adjustments which occur with aging?

4.15.4 ANSWERS TO OBJECTIVE TYPE QUESTIONS

1. Surrounding.
2. psychosocial dysfunction.
3. inaccurate.
4. consistent.
5. family.

4.16 KEY TERMS

1. Serenity- the state of being calm, peaceful, and untroubled.

2. Self image- the idea one has of one's abilities, appearance, and personality.

3. Stereotype- a widely held but fixed and oversimplified image or idea of a particular type of person or thing.

4. Stress- is a response to pressure or threat. Under stress**,** one may feel tense, nervous, or on edge.

5. Cognition- the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses.

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