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PSYCHOLOGICAL INTERVENTION IN ELDERHOOD.

THE IMPORTANCE OF BIOPSYCHOSOCIAL MODEL, CULTURAL & SYSTEMATIC APROACH.

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Introduction

The study relate to psychological intervention to be more effective in elderhood. A discussion is been made to implement a sucessful process of psychological treatment applying a biopsychosocial model which combines biological declaines or other biological concerns with older people together with socal and cultural factors to understand better psychoemotional or psychocognitive impairments with older people for a longlasting and effective intervention during their last years of life. Sometimes techniques integrated are not always possible to apply at this age. The purpose is to explore and identify some data that will help to understand those challenges. The importance of biopsychosocial model, systematic approach and cultural influence in understanding older people.

Age-related myths and biases: Many myths and biases regarding the aging process are apparent in today's society. Such myths often create a negative impression on the aging process and lead to stereotypes against older adults. Six main myths regarding older adults are perpetuated in today's society (Rowe & Kahn, 1998). These myths imply that older adults are sick, incapable of learning new information or skills, unable to benefit from healthy changes or risk-reduction strategies, dependent solely on their genetics in regard to how well they age, incapable of sexual desires or interests, and unable to be a productive part of society. Rowe and Kahn provide discrediting information and statistics for each myth, thereby indicating that many age-related stereotypes and myths are no more than false beliefs. Despite the fact that myths relating to later life can be discredited with empirical evidence, the myths nevertheless are damaging and permeate society with an unfavorable image of aging. (Eldestein. Pg. 647)

What is the best way to address the modal psychosocial problems of late life, taking into account what science has to offer, what seems commonsensical, and what can be done? What are the reasonable concepts and learning required for care of older adults? With older adults we witness a decline in being, a (likely) medically impacted person, a psychologically complex entity who is most often bothered by anxiety and depression, as well as somatic issues, and who has (probably) less cognitive power and in some cases considerably less. Older adults are also living longer and experience the vagaries of various adjustment concerns (Suthers et al., 2010). The need to transition from simple care to more intensive, multimodal care for the late-life patient with multiple needs is upon us.

Objectives

First objective is *to identify valid and reliable data about challenges* that could be faced applying psychological treatment in older age. A second objective is *to understand how these challenges are*

influenced by rapid changes in current years in a lot of aspects of life (family relationships, social activities, life styles, cultural changes, technology and interaction, ect.)

Method

This is a qualitative study design where ***38 professionals*** (psychologists, occupational therapists, psychiatrists) are interviewed. Content analyse it is applyed to analize the data cllected.

PARTICIPANTS OR SUBJECTS OF STUDY: Subjects in this study are profesionists working with older people's mental health for at least 15 years. 38 of them working as psychologists, psychiatrists, ect, were selected convienantly and interviewd. A model of semi-strucured interview was used for data collection.

VARIABLES OF INTEREST:

Variables of interest are: - interventions applied in psychological treatment

- impact of bio, psycho, cultural and social factors

SOURCES OF INFORMATION

Semi-structured interviews with descriptive and evaluative questions and *transcripted verbatims* were used for data analysis using *thematic analysis method*

PROCEDURE

Sample participants were identified by an convenient procedure firstly identifying their working institutions (specifically institutions of care in elderhood)

Literature Review and Previews Research for Psychological Intervention in Elderhood.

The American Association of Geriatric Psychiatry (AAGP) also has advocated for clinical prudence when there is no or a partial response early in the treatment. So far, however, the empirical basis for personalizing treatment principally consists of post hoc analyses of unitary treatments (e.g., a course of an antidepressant or psychotherapy). Although this knowledge is necessary, it is insufficient for two reasons. First, a one-disorder patient, like a depressed elder, faces a bewildering constellation of other health threats and social constraints, and thus has many different contributors to poor treatment outcomes. Second, the skills available in various treatment settings and sectors can promote or inhibit treatment success. We need an all-encompassing model to effect change. Accordingly, the model of geriatric depression has to integrate the current biological concepts of depression with patients' unique reactions to adverse experiences and with their unmet social and health care needs. The care algorithms based on this model should target clinical/biological predictors of adverse outcomes of depression but also address unmet needs through linkage to appropriate social services; enhance the competencies of elderly persons so that they make use of their resources; and attend to patient psychotherapy issues of psychoeducation, behaviors, thoughts, and emotions. We need models of care, then, that encompass more than one diagnosis (Pg 7, chap 1.)

Older age involves chronic conditions.

Mental and physical illness are conjoined. Current psychological treatment is inadequate. Current assessments address dichotomous problems, but a focus on continuous and individual symptoms is required. Primary care is the new psychiatric care. Professional silos are a problem: teams are complex and necessary. Current models of care (e.g., IMPACT, PEARLS) are helpful. Step care works: specialty clinics are applied last. Patient-centered care is underperformed and critical. Public health models work well. The clinician's attitude and skills are critical. Psychoeducation is chief among the curative agents. The Watch and Wait model is understudied. (Pg 10-11 General Issues)

Older adults face many challenges, as society's view of their role transforms once they enter their sixth and seventh decades of life. The attitudes, values, and norms that have previously been constructed by society regarding aging are constantly evolving to accommodate the growing older adult population. However, a large segment of our culture adheres to negative stereotypes and prejudices associated with the process of aging. The practice of expressing prejudice and holding undesirable views toward a person due to his or her age—particularly older adults—is known as ageism. Ageism may have an effect on the perceived physical functioning, cognition, and emotional health of an older adult who is faced with this form of social prejudice. Coudin and Alexopoulos (2010) determined that older adults who were presented with a narrative-focused cognitive task after having read materials imbued with negative stereotyping toward older adults reported lower levels of subjective health and extraversion, higher feelings of loneliness, and more frequent help-seeking behavior. These findings can be extrapolated to the notion that older adults who internalize negative messages that they receive from society regarding aging may experience problems in maintaining a positive self-image and developing suitable coping skills to adjust to biopsychosocial changes they encounter as they age. (Pg.13)

Older patients with depression may present with somatic complaints for which a medical etiology cannot be found or that are disproportionate to the extent of medical illness. Patients who express somatic symptoms as a manifestation of depression seem to be less willing to mention psychological symptoms to their physician. Certainly, illnesses such as pancreatic carcinoma or hypothyroidism might cause symptoms that mimic depression. Therefore, addressing the patient's psychological distress, while appropriately evaluating the possible diagnoses, is important. Clinical experience suggests too that physicians are less likely to move from recognition to treatment of the illness in older patients than in younger patients. Physicians, like patients and their families, are usually able to find a "reason" for depression in the older person. That said, treatment is often delayed or not pursued at all. Of interest too is that there are no clear biomarkers of depression. (Pg18)

Medical/Somatic Issues

Older adults have historically used health services at higher rates than anyone and mental health services at substantially low rates.

Patients with depression and significant comorbidities are especially costly to the health care system. Depressed patients with diabetes, for example, have more trouble adhering to their diets and checking blood glucose levels, and they exercise less, smoke more, and die at about twice the rate as those without depression

The pathways leading to comorbidity of mental and medical disorders are complex or bidirectional. Medical disorders may lead to mental disorders, mental conditions may place a person at risk for medical disorders, and mental and medical disorders may share common risk factors

Adjustment

Adjustment problems are always salient but become a big issue if one of the following components is present. First, adjustment suffers just by getting older; at age 80, 60% of adults start having problems with IADL. As noted above, this increases as spousal loss occurs and presence in long-term care facilities (LTC) expands. Second, adjustment is at issue when there are ADL or IADL functional problems. A 75-year-old male with one ADL problem has the roughly the life expectancy of an 85-year-old without one. Third, cognition and function cohabit.

How the person lives, with whom, with what supports, money, options, and with ability to act as she or he would like become central to well-being. What is involved in happiness is complex, but clearly involves the desire to be ambulatory, to have reasonable resources, to be social, to feel some self-ef-

ficacy, and to live where the person desires (pg 21-22)

During the late 1930s, scientists began to study living systems in their entirety, and the aging process began to be examined in an interdisciplinary context. By the early 1940s, conferences and interdisciplinary volumes helped to create a growing acceptance of genetic and environmental factors as pertinent to the psychology of aging. Most importantly, however, interdisciplinary collaboration made it possible to advance the field of gerontology in a broader context.

Changes in physical appearance may alter one's body image, self-esteem, and identity; these changes may impact one's feelings of sexual desirability (Badeau, 1995). Pg 649

The Aging Body pg 650

There are many physiological, sensory, and cognitive changes related to normal aging. Age-related declines in these domains tend to be linear through the 8th and 9th decades (Rowe & Devons, 1996), yet there is great variability in the rate of decline between individuals.

Physiological Changes Age-related changes may be observed in many parts of the body, including the brain, nervous, cardiovascular, pulmonary, and gastrointestinal systems (see Rowe & Devons, 1996, for an overview).

The heart is a vital organ, and problems associated with the cardiovascular system may remind individuals of their own mortality and lead to associated anxiety (Whitbourne, 1998).

Older adults may experience fatigue during physical activity due to less efficient gas exchange in the lungs (Whitbourne, 1998). Additionally, shortness of breath and difficulty breathing may approximate symptoms experienced during panic attacks, which can be a frightening sensation for many individuals (Whitbourne, 1998). Pg 651

Sensory and Perceptual Changes Age-related changes in vision, hearing, taste, touch, and smell are common among older adults.

Declines in sensation may eventually impact several aspects of an individual's life, however. Pg 651

Visual impairments can have an emotional impact (Owsley et al., 2006; Savikko, Routasalo, Tilvis, Strandberg, & Pitk¨al¨a, 2005). Visual impairments among older adults may create problems in psychological testing 652. It is important to always ask the person being evaluated whether he or she wears corrective lenses and encourage their use. 652

Behaviors exhibited by individuals that may be indicative of hearing impairment include asking for others to repeat statements, complaints that others mumble, and showing difficulty understanding others in noisy or reverberant environments where sounds may be distorted (Cook & Hawkins, 2006; Helfer & Wilber, 1990) 653

Although hearing aids amplify sound intensity, they do not reduce any cognitive demands of listening, such as memory demands or ability to alternate attention between speakers (Gordon-Salant, 2005). 653

Cognition and Memory 654

Declines in cognitive performance and executive functioning of individuals throughout later life has been well documented and include declines in explicit memory, executive functioning, and information processing speed (e.g., Keller, 2006; Rowe & Kahn, 1998; Salthouse, 1996; Span, Ridderinkhof, & van der Molen, 2004; Zelazo, Craik, & Booth, 2004).

A lack of motivation to perform as well as possible or one's acceptance of the stereotype that older adults can't perform as well as younger adults on some tasks may partially account for some of the

memory and cognitive performance differences between younger and older adults (Bienenfeld, 1990; Chasteen, Bhattacharyya, Horhota, Tam, & Hasher, 2005). Additionally, declines in cognition and memory across the life span are highly variable among individuals.

Sleep

Insufficient sleep can significantly impact the daily functioning of an older adult. For example, it is associated with a greater need to nap, impaired cognitive abilities, slowed reaction time, impaired interpersonal relationships, and increased mortality (Ancoli-Israel & Cooke, 2005).

Age-Related Health and Medical Issues

Additionally, it is important to be aware of commonly used medications, their adverse effects, and how their interaction may produce adverse effects. Finally, it is important to understand the relations between physical diseases and their psychiatric manifestations. (Pg. 656)

Social Interaction

Changes in social relationships in older adulthood have implications for therapy with older adults

Negative Social Interactions 663

For many years researchers assumed that all social relationships were beneficial, but recent research indicates that negative social interactions can have an impact on older adult emotional health (e.g., Newsom, Nishishiba, Morgan, & Rook, 2003; Rook, 1990). More recent research provides support for the disproportional impact of negative interactions on emotional well-being (Newsom, Rook, Nishishiba, Sorkin, & Mahan, 2005). From an intervention standpoint, it is important to keep in mind that negative interactions encountered by certain individuals are relatively stable across a number of years, indicating that for some individuals, social interactions are a source of chronic stress. For older adults, these relationships may be particularly difficult to terminate (Krause & Rook, 2003).

RESULTS

Issues identified during psychological intervention in elderhood from the study are:

- The presence of several physical health issues may interfere with the treatment and the disponibility of sessions on older adults more frequently compared with other cases
- Cognitive aspects lead to a more long lasting treatment as more time it is needed to evaluate, explain, understand and process information for an older adult
- Life Experiences from the past has a large impact and must be considered as will interfere the actual treatment
- Somatic and Biological Limitations combined with Anxiety and Depression older people experience related with their health limited behvaioral issues must be considered part of case conceptualization and intervention
- Medical Interventions and/or Cronic Illness Conditions together with sensory and motory declines in elderhood are to be evaluated and part of intervention objectives as they influence every day emotional well-being in elderhood
- Fears related with death and the death process is an everyday reality in older adults and must

be a focus of therapy combined with the improvement of wealthy personal and interpersonal relationships in older life including client-therapist realtionship.

- Culture background of an elder client has an enormous impact in his/her total psychological well-being and perception of his/her daily functioning and an important part of therapy must be to identify clients own stereotypes about aging or other people in the sorrounding of older adult.
- Feeling of loneliness and ideas about death are always present and self-efficasy is an aspect to work with
- Technology is a helpful tool maintaining social and family interaction but the difficulties of use by age may interefere negatively

DISCUSSION/CONCLUSIONS

Clinical Psychologists that offer psychological treatment with people in elderhood need to have an advanced knowledge about culture background of old adults clients and other specific factors of biological and social influence present during their life span. The specific impact these factors could have on actual emotional and cognitive well-being in interaction with other factors must be evaluated.

Psychological problems in late life are best dealt with by addressing several targets noted here. This overview of problems warrants a Watch and Wait strategy. Eventually, the therapeutic response can be based on modular interventions. The modal problems at late life—anxiety, depression, somatization (pain), and cognitive decline, as well as adjustment—are interactive. Dealing with these issues requires much of the health care provider. (Pg 28)

Something more than standard care is required. In a review of longterm care and the value of psychiatric medication, Reichman and Conn (2010) noted the evidence in support of various models of psychogeriatric services in nursing homes reported on nine controlled trials and concluded that liaison-style services that employed educational approaches, treatment guidelines, and ongoing involvement of mental health staff are more effective than a purely case-based consultation model. We need changes in the treatment of mental health for older adults. We need a newer and broader definition of what constitutes empirically supported treatments (ESTs) in psychotherapy for older adults.

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