GIVINGCARE
Empowering Caregivers

A2.2 – Educative resources for teachers

Module: 1. BASIC CONCEPTS IN CAREGIVING

Sub-Module: 1.6 - PSYCHOSOCIAL ASPECTS & INCLUSION

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Introduction

Module	CONCEITOS BÁSICOS NO CUIDADO
Sub-module	Aspetos psicossociais e inclusão
Lesson nr.	#6
Duration (minutes)	300 minutes
Date	

Learning Outcomes

1. Identify the main psychological aspects of adult care
2. Identify the main psychological risks involved
3. Understand the importance of care psychology as a key competence

Summary:

1. Psychological aspects in care
    - 1.1. Adult and Elderly Psychology
    - 1.2. Physical and mental psychology of patients
    - 1.3. Caregiver psychology
2. Psychological risks
    - 2.1. Stress in old age
    - 2.2. Anxiety Disorders
    - 2.3. Disturbances in cognitive processes
    - 2.4. Depression
    - 2.5. Insomnia
    - 2.6. Suicide
    - 2.7. Substance abuse
3. Isolation, social discrimination and inclusion
4. Care institutions and caregivers - psycho-affective impacts.

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1.1 Adult and Elderly Psychology

1.2 Adult and Elderly Psychology

Regardless of culture, race or gender, what are the Myths/Stereotype and Truth about the elderly

	Myth	Truth
Elderly people, even though they are not sick, are unable to develop and show an inability to learn.	X	
Old age corresponds to a kind of “Second Childhood” (infanthood, dependence and reduction of individual responsibility).	X	
The elderly are responsible for a wide variety of knowledge/knowledge transmitted orally, from generation to generation		X
Elderly people are perceived as having limited initiative power and difficulties in embracing new projects.	X	
Elderly people show conservative, inflexible and resistant to change behaviors.	X	
Elderly people contributed to the development of society, honored their commitments		X

1.1 Adult and Elderly Psychology

The end of adult life and the beginning of aging:

When does it start

- Chronological type index: more arbitrary, typically the middle-age period runs from 40 to 60 or 65

- Index associated with biological and social events: The growing feeling that we have limited time to live and to reach our goals is probably the most important “criterion” that we are getting older. The body, society, others, send "signs"/"messages" that the aging process is underway when the following changes occur:
  - Changes in the body image of the “I”: of a physical nature (dry skin, mistaken, hair loss, strength, endurance), changes in sleep, weight, diseases, among others;
  - Changes in professional life: reaching the top of a professional career, becoming suddenly unemployed, or reaching retirement;
  - Changes in family life: the children leaving home, the need to assist the eldest members of the family, the death of the parents, the new role of grandfather/grandmother, widowhood.
  - Changes in everyday life.

Change is not synonymous with disability!

(Neugarten & Datan, 1974, Cit. In. Gpmnseca, 2005)

1.1 Adult and Elderly Psychology

Concepts:

Aging: is a universal process, genetically determined for individuals of the species (normal aging). This process begins soon after sexual maturity and accelerates from the fifth decade of life onwards, marked by the cessation or reduction of the possibility of reproducing the species and by typical physiological and morphological changes.

(Neri, 2013)

Old age: Term with an essentially sociological and anthropological meaning. Old age should be understood as a concept referred to:

- to the way each society conceptualizes this phase of the life cycle,
- to a social construction inscribed in a given historical context

(Fernandes, 1997 e Lima & Viegas, 1988 Cit. In. Fonseca. 2005)

Elderly: Individuals so named in a given sociocultural context, due to the differences they exhibit in appearance, strength, functionality, productivity and performance of primary social roles compared to non-elderly adults.

(Neri, 2009 Cit. In. Fonseca. 2005)

1.1 Adult and Elderly Psychology

Aging and Development are two parallel and related processes, two sides of the same life trajectory.

(Fonseca, 2005)

1.1 Adult and Elderly Psychology

1st half of the 20th century:
Development takes place "within" the person with the growth-stability-decay sequence.
Emphasis is given on childhood/adolescence and developmental stages

Organicism
- Biological root
- Stages
- Stages succeed one another unidirectionally
- Hierarchical, sequential, universal path
- Final goals
- Piaget, Freud...

2nd half of the 20th century:
Development as an interaction of "internal" and "external" forces – life-span development

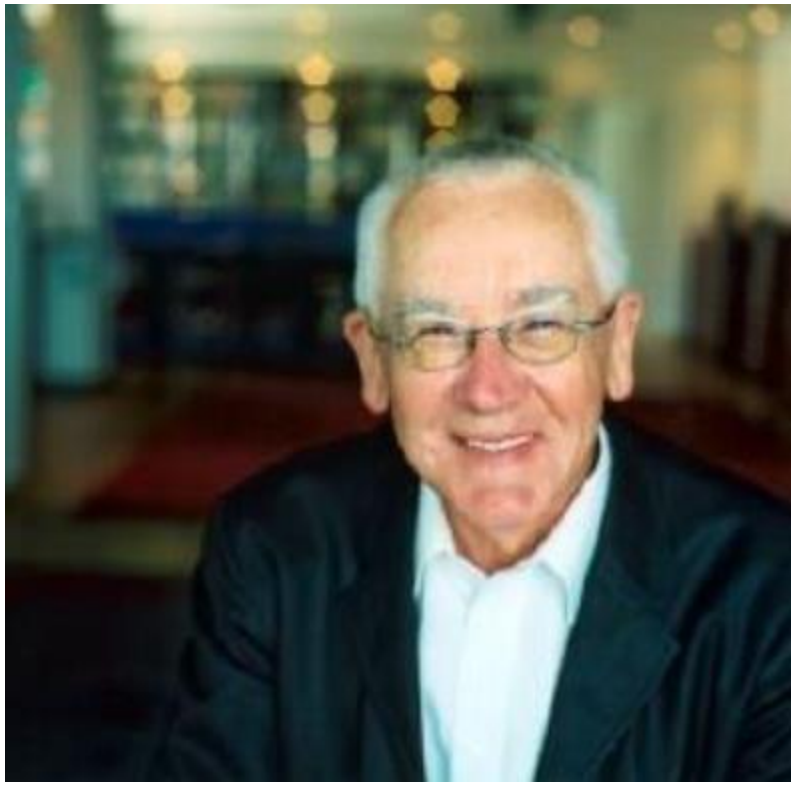
contextualism
- Social and historical insertion of the individual
- Individual-environment transactions
- Reciprocity
- Plasticity
- No ultimate goals
- Approaches: ecological, contextualist, life-span

From a lifelong development perspective, aging takes on a completely new meaning.

(Fonseca, 2005)

1.1 Adult and Elderly Psychology

The perspective of the life cycle of Paul B. Baltes(1939–2006)



1.1 Adult and Elderly Psychology

Life span developmental approach

- Human development is a **continuous process**: As people move through life, they continually experience processes of change, transition and adaptation – processes of continuity (cumulative) and discontinuity (innovative) occur:

  These processes result in the emergence of new behaviors, new relationships and new perceptions of oneself and reality

- Development is **multidimensional** (biological, cognitive and socio-emotional changes)

- Development is **multidisciplinary** (development must be looked at and studied in its various dimensions - biology, psychology, neuroscience, sociology,)

- Development is **multidirectional**: Diversity and pluralism in the direction of change, even within the same domain during the same developmental period, certain dimensions of cognitive and socio-emotional development may show growth, others but decrease

(Fonseca, 2005)

1.2 Adult and Elderly Psychology

Life span developmental approach

- <u>Potential for plasticity:</u> It refuses any form of determinism and proposes a "plastic" understanding of human development (integration of social, biological and behavioral dimensions in the "production" of this development)

The person is a producer of their own development

- Since there is a potential for plasticity, there is also:
  - a potential for intervention in the psychological development of each individual throughout their life
  - a potential for developmental change. The change is:
    - ✓ Continuous
    - ✓ Cumulative
    - ✓ Targeted
    - ✓ Differentiator
    - ✓ Organized
    - ✓ Holistic

(Fonseca, 2005)

1.1 Adult and Elderly Psychology

Life span developmental approach

- The reciprocal organism-environment interaction acts on development by considering the existence of developmental **gains and losses**

- There are no pre-defined and universal stages, life cycle psychology points to the search for a successful adaptation between organism and environment as a **specific objective for development**.

This adaptation understands that the development process constitutes a joint occurrence of:

- "gains" (which translate to growth);
- "losses" (which translate to decline) in adaptive capacity.

(Fonseca, 2005)

1.1 Adult and Elderly Psychology

Life span developmental approach

Three general adaptive functions involved in human development:

- Growth: increasingly complex behaviors that allow you to reach ever higher levels of adaptive capacity
- Maintenance: behaviors that ensure functional stability in the face of life-threatening events or losses;
- Loss regulation: behaviors that organize functioning in "basic levels" of adaptation

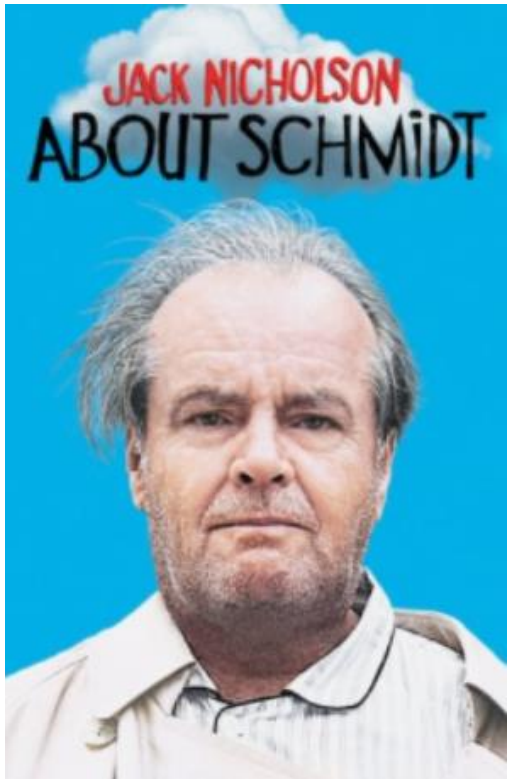
Introduction of the SOC Model developed by Baltes e Baltes (1980)

The adaptive process follows a model composed of three interactive mechanisms – "selection, optimization and compensation" (SOC model). According to this model, it is possible to identify and select potential areas and optimize their functioning, compensating for failures in areas of greater functional impairment (Santos et al., 2008).

- **Selection:** Development of preferences; Definition of goals and desirable results;
- **Optimization:** acquisition, application and improvement of useful means and resources to achieve high levels of functioning
- **Compensation:** production of functional responses to the occurrence of losses capable of compromising the achievement of developmental goals

(Fonseca, 2005)

1.1 Adult and Elderly Psychology



Jack Nicholson stars as Warren Schmidt, a man who is set adrift following retirement and the sudden death of his wife. Uncertain about his future as well as his past, Warren packs up his 30-foot Winnebago to set out on a journey across the Nebraska plains to attend his daughter's (Hope Davis) wedding to a waterbed salesman (Dermot Mulroney). But every step he takes seems wrong, and Warren seems destined to end his life as he lived it: a failure. But along the way, Warren recounts his journey and shares his observations with an unexpected friend - a poor Tanzanian boy he is sponsoring for 73 cents a day. In his long letters to the boy, Warren begins to see himself and the life he has lived with new eyes.

1.1 Adult and Elderly Psychology

Successful aging

WHO defends the need for successful aging to translate into active aging, whose determinants are:

- economic and social aspects
- health
- behaviors/lifestyles
- biology/genetics
- physical environment where you live

The WHO says that active aging is an optimization process based on three pillars – health, participation and safety that aim to improve the quality of life as people get older

1.1 Adult and Elderly Psychology

Active aging

<u>Success indicators for active aging:</u>

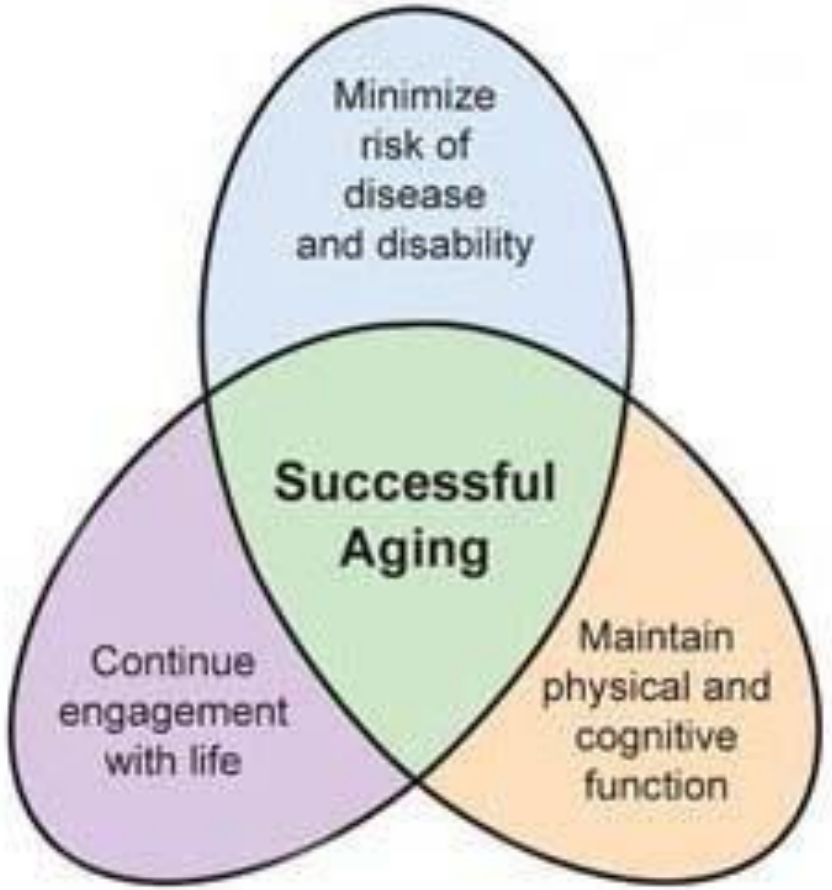
- High functional capacity/independence and positive adaptation
- Satisfaction with life,
- Longevity,
- Absence of disability,
- Domain/growth,
- Active social participation,

<u>Predictors:</u>

- high educational level;
- regular physical activity practice;
- feeling of self-efficacy;
- social participation and absence of chronic diseases.

1.1 Adult and Elderly Psychology

Rowe e Kahn Model (1997)



1.1 Adult and Elderly Psychology

Active aging - The importance of prevention and lifestyle

- Adopting a healthy lifestyle (diet, physical exercise)
- Stay cognitively active (have an optimistic attitude, be creative, and remain interested in things)
- Maintain a supportive social network and keep in touch with others
- Maintaining a healthy mind-body relationship (eg meditation, growth in spirituality)
- Maintain good economic habits to avoid financial dependency

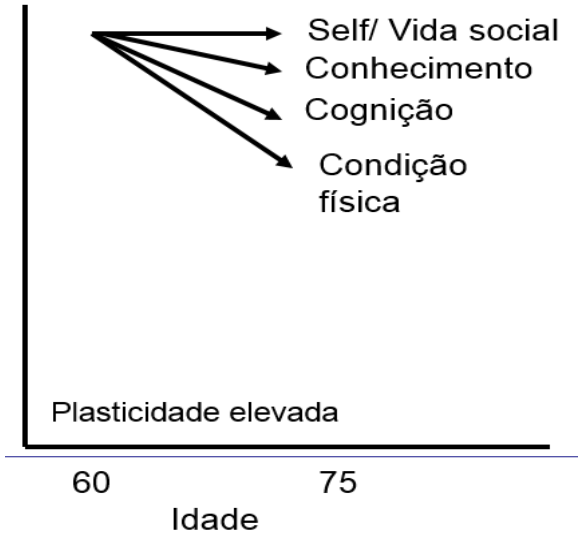
1.1 Adult and Elderly Psychology

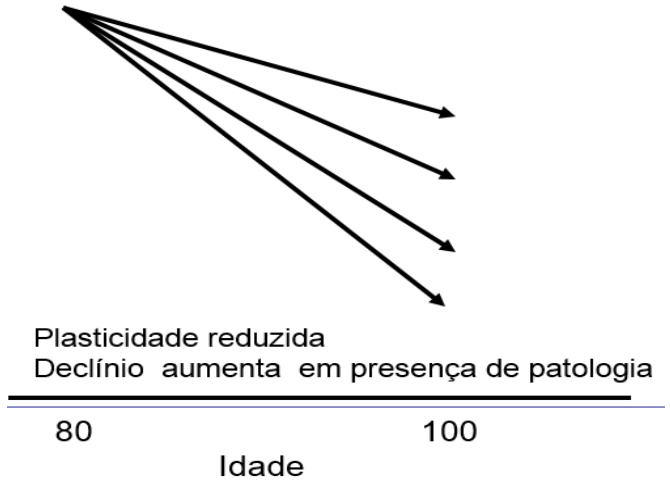
The "good news" about seniors (ca. 60-80 years) ?

- Increased life expectancy
- High potential for maintaining fitness (physical and mental)
- Cognitive and Emotional Reserves
- High levels of personal well-being
- Effective profit and loss management strategies
- More and more people are aging successfully

The "bad news" about the 4th age (ca. 80-100 years)?

- Considerable losses in cognitive potential
- Increased chronic stress symptoms
- Considerable prevalence of dementias
- High levels of frailty, dysfunctionality and multimorbidity





(Baltes, 2002 e Baltes & Smith, 2003)

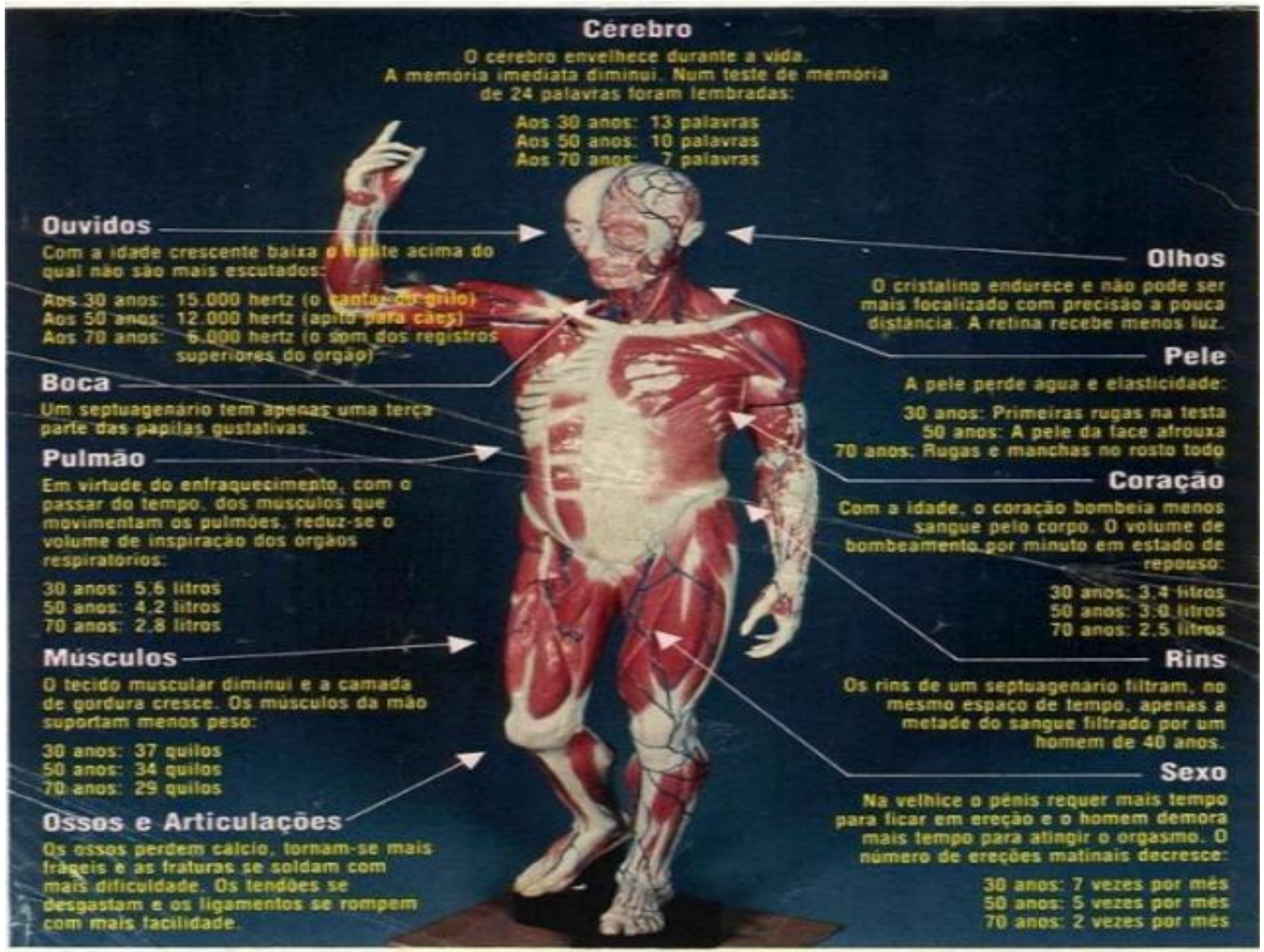
What are the challenges of longevity to quality of life and well-being

How long will we live?
Would we like to live forever?
How far can the life cycle be extended?

1.2 Physical and Mental Psychology of Patients

Biopsychosocial framework of aging and the elderly

- **Biological aging** (senescence) includes all genetic and physical health-related factors (reflects increasing vulnerability)
- **Psychological aging** includes all perceptive, cognitive, emotional and personality factors (individual's capacity for self-regulation in the face of the senescence process)
- **Social aging**: includes interpersonal, social and cultural factors that affect development (social roles appropriate to society's expectations)



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1.2 Physical and Mental Psychology of Patients

- Biological aging

1.2 Physical and Mental Psychology of Patients

- **Psychological Aging**

Cognitive functions that are better preserved with advancing age include aspects of language and vocabulary, wisdom, reasoning and other skills that depend mainly on stored information and knowledge. (Baltes, 1993).

Older adults are still able to learn new things, although usually at a somewhat slower pace than younger individuals.

Many older adults experience changes in their executive abilities (e.g., planning and organizing information), and they are those who suffer the most changes in relation to other domains. (West, 1996).

Slower psychomotricity, reduced overall information processing speed, and reduced motor control abilities are other changes commonly associated with normal aging. (Salthouse, 1996; Sliwinski & Buschke, 1999).

1.2 Physical and Mental Psychology of Patients

- **Psychological Aging**

Declining Memory Functions:

- working memory (retention of information that is being used while performing another mental task), episodic memory (the explicit recall of events),
- source memory (the context in which the information was learned)
- short-term memory (the short-term passive storage of information).

Preserved memory functions:

- semantic memory (the evocation of acquired general or factual knowledge),
- procedural memory (learning and competence recall)
- preactivation or priming (an implicit memory effect in which previous exposure to a particular stimulus influences the response given later when it is presented)

Brickman & Stern, 2009, cit. in. Ordem dos Psicólogos Portugueses (2020). *Linhas De Orientação Para A Prática Profissional Intervenção Psicológica Com Adultos Mais Velhos. Disponível em:* https://www.ordemdospsicologos.pt/pt/noticia/2643

1.2 Physical and Mental Psychology of Patients

Older adults may experience physical and cognitive symptoms that occur in co-morbidity with physical illness.

While these symptoms are often explored and treated as physical problems, they may reflect an underlying mental picture of health issues.
(Gallagher - Thompson et al., 2000).

(cit. in. Austin, M. C. A, 2009)

1.2 Physical and Mental Psychology of Patients

Since the mid-19th century, advances in medicine have brought significant changes to developed countries:

Greater longevity and increased prevalence of chronic health conditions, conditions of disability and total dependence on others for care.

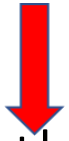
Chronic conditions such as diabetes, respiratory disease, cancer, cardiovascular problems, arthritis, hypertension, osteoporosis and dementia are much more common among older adults than among younger counterparts.

Other conditions such as injuries from falls, incontinence and frailty are also commonly associated with aging and as such are sometimes referred to as geriatric syndromes.

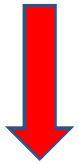
(Stephens, M. A. P & F, M. M., 2009)

1.2 Physical and Mental Psychology of Patients

As individuals progress into the later years of life, they become increasingly vulnerable to chronic health problems, as well as physical and mental limitations associated with these conditions.



They will need help to carry out the simpler Activities of Daily Living (ADL).



The needs of older adults have

profound implications for their families (Caregivers)

(Stephens, M. A. P & F, M. M., 2009)

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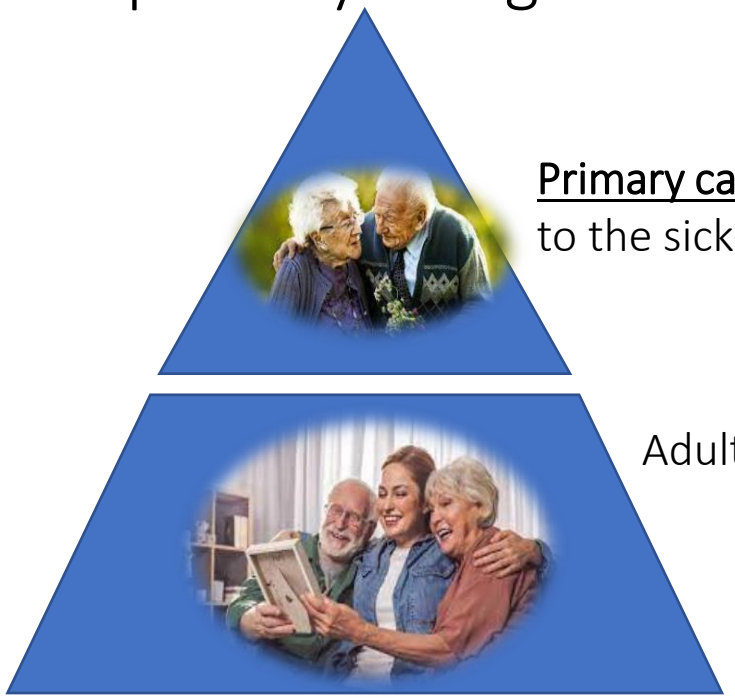
1.3. Caregiver Psychology

1.3. Caregiver Psychology

There is a well-established hierarchy for determining who will become a primary caregiver.



Primary caregiver: the one who provides the most care. The responsibility for care usually falls first to the sick elder's spouse.

Adult children or other family members are often involved as **secondary caregivers**.

When a spouse is unavailable or unable to assume the role of primary caregiver, it is the adult children who assume the role of primary caregiver.

(Stephens, M. A. P & F, M. M., 2009)

1.3. Caregiver Psychology

Informal or Family caregiver

The informal caregiver is any person, family or not, who is responsible for assisting the dependent person in their daily life, promoting their quality of life, ensuring that their daily needs are met. They are people who perform this function on an informal basis, without prior professional training or any contractual relationship and without any kind of remuneration.

Formal or Professional caregiver

A formal caregiver is any person with specific training and who plays a specific role in all the care provided and who is normally paid. This typology of care can include care provided by public institutions for which payment may not be made, but which falls within the sphere of formal care (eg provision of health care).

(Stephens, M. A. P & F, M. M., 2009)

1.3. Caregiver Psychology

What are the motivations for caring?

- As a result of the bonding relationships established since childhood
- Altruism and reciprocity
- Sense of duty (social and moral obligation)
- Material reward - financial benefits
- Avoidance of institutionalization

(Stephens, M. A. P & F, M. M., 2009)

1.3. Caregiver Psychology

Types of care

- Emotional support and counseling
- Instrumental help such as cleaning, cooking, laundry, etc.
- Personal care, eg showering, dressing, going to the bathroom, assistance with walking, medication
- finance management
- Decision making about care for formal service providers such as nurses and aides
- direct financial assistance

1.3. Caregiver Psychology

Caregivers spend time, energy, emotional and financial resources to meet the needs of the person to be cared for.

Risks associated with the care process:

- Financial risks;
- Social Risks;
- Psychological Risks

(Liu & Thompson, 2009)

1.3. Caregiver Psychology

Risks associated with the care process:

Physical risks

Caregivers consistently report decreased general health and increased health problems, which also contribute to psychiatric morbidity in the form of increased depression.

(Schulz et al., 1995; Vitaliano, Scanlan, Krenz, Schwartz e Marcovina, 1996).

(Stephens, M. A. P & F, M. M., 2009)

1.3. Caregiver Psychology

Risks associated with the care process:

Financial risks

- The economic issues associated with providing care can be burdensome, especially for caregivers of Alzheimer's disease or dementia.
- Many caregivers make large financial sacrifices, both in direct expenses and in reduced earnings, to care – as a result of their care responsibilities, they have had to go to work later, leave early, or take time off during the day to provide care .
- Caregivers of people with dementia report a greater need for less demanding jobs, to retire earlier, lose employment benefits, or give up work altogether than other caregivers (Ory et al., 1999).

(Liu & Thompson, 2009)

1.3. Caregiver Psychology

Risks associated with the care process:

Social risks

- Family relationships change when care needs to be more intensive
- A higher percentage of caregivers reported having less time for other relatives and friends
- Dementia caregivers report having to give up pleasurable personal activities and experience a greater degree of family conflict.
- Increased family conflict is common among dementia caregivers.
- Caregivers of people with dementia report a higher incidence of marital conflict and a decreased incidence of positive interactions between couples (Narayan, Lewis, Tornatore, Hepburn, & Corcoran- Perry, 2001; Pruchno, Pruchno, Kleban, Michaels e Dempsey, 1990).

(Liu & Thompson, 2009)

1.3. Caregiver Psychology

Risks associated with the care process:

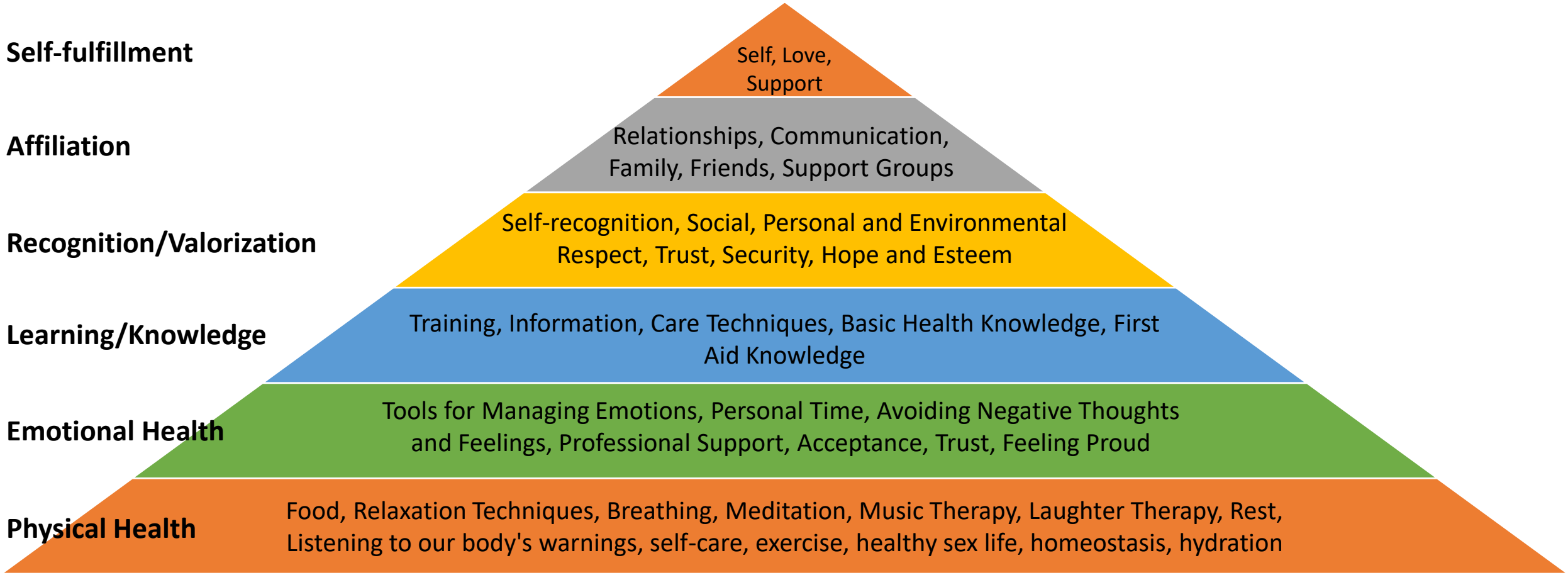
Psychological risks

- Depression, one of the main mental health problems, is a serious risk factor for dementia caregivers. Depression in its various forms, such as insomnia, fatigue, anxiety, stress and headache, is one of the most frequent disorders (Tabora & Flaskerud, 1994).
- The caregiver feels captive in their role – a feeling of annulment.
- Factors that contribute to caregiver depression include: behavior problems of the person being cared for, perception of incompetence, isolation, family conflicts, lack of support and abdication of other functions and activities
- Caregivers reported significant problems with the control and frequency of emotions of anger and hostility and difficulty expressing them constructively. (Liu & Thompson, 2009)

1.3. Caregiver Psychology

Caregivers' Needs Pyramid

Fundamental aspects to be able to take care of and take care of oneself



2. Psychological Risks

2.1. Stress in old age

2.2. Anxiety Disorders

2.3. Disturbances in cognitive processes

2.4. Depression

2.5. Insomnia

2.6. Suicide

2.7. Substance abuse

2.1 Stress in old age

2.1 Stress in old age

- Caregiver-related issues: (eg, frustration or exhaustion)
- Functional weakness
- Long-term chronic illness
- Cognitive limitation
- Social isolation
- Scarce economic, social resources
- Low income, precarious health conditions
- Poor quality of relationship with the caregiver
- Lack of social support

2.2 Anxiety Disorders

2.2 Anxiety Disorders

Anxiety disorder, which refers to a long-lasting state of anxiety, characterized by symptoms such as extreme restlessness, insomnia, and fatigue, producing suffering and impaired function.
It can manifest itself in a number of ways, including:

- Phobias
- Generalized anxiety
- Obsessive-compulsive disorder
- panic disorder

Of the phobias, one of the most common is agoraphobia (fear of open spaces), which tends to combine with a more specific fear of leaving the house." Other common sources of concern include falling, dying, and social situations(see Woods, 1 999) .

(Teixeira, 2010)

2.2 Anxiety Disorders

Clinical features

SOMATICS

Muscle tension
Tremors
Dizziness
Palpitations
Sleep disorders
Perspiration
Nausea
Diarrhea
Difficulty in swallowing
Frequent need to urinate
Blushing
Fatigue

AFFECTIVE	COGNITIVE
Anxiety Irritability Feelings of inadequacy and inadequacy to deal with danger Fear of not being competent Fear of not being accepted by others	Perception of danger and threat Ruminative processes Concern about the negative evaluation of others Decreased ability to concentrate

COMPORTAMENTAL

Psychomotor agitation
Hypervigilance
Avoidance, Escape

2.2 Anxiety Disorders

Anxiety disorders, although relatively common in older people, are less prevalent than in younger populations (Wolitzky-Taylor et al., 2010).

Although older adults tend to have similar anxiety symptoms as younger adults, the content of their fears and concerns tends to be age-related (eg, health problems; Stanley & Beck, 2000).

Older adults who present with panic disorder tend to have patterns of symptoms that differ from those exhibited by younger adults (e.g., less arousal symptoms or more intrusive recall, respectively) (Lauderdale et al., 2011).

Ordem dos Psicólogos Portugueses (2020). Linhas De Orientação Para A Prática Profissional Intervenção Psicológica Com Adultos Mais Velhos. Disponível em: https://www.ordemdospsicologos.pt/pt/noticia/2643

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2.3 Disturbances in Cognitive Processes

2.3 Disturbances in Cognitive Processes

Elderly people may show some memory disturbances, an increase in the time needed to internalize new learnings or to remember important events, but old age does not inevitably lead to dementia.

However, if the global deterioration of intellectual capacities is pronounced, with evident disturbances in their personal and professional activities, the person may be facing pathological and disturbed aging, they may be facing a situation of dementia.

(Paiva, 2013)

2.3 Disturbances in Cognitive Processes

Aging has had a profound impact on the emergence of the global epidemic of dementia, particularly in countries such as China, India and Latin America, where the population is markedly aging and with a tendency for these numbers to increase rapidly and drastically. It is estimated that, by 2050, people aged 60 years and over will comprise around 22% of the world's population, mostly distributed across Africa, Asia or Latin America (World Health Organization, 2012).

(Paiva, 2013)

2.3 Disturbances in Cognitive Processes

What is dementia?

Dementia is the term used to describe the symptoms of a wide range of illnesses that cause a progressive decline in a person's functioning. It is an umbrella term that describes loss of memory, intellectual ability, reasoning, social skills, and changes in normal emotional reactions.

Who Develops Dementia?

Although most people with Dementia are elderly, it is important to note that not all elderly people develop Dementia and that it is not part of the natural aging process. Dementia can occur in anyone, but it is more frequent after 65 years of age. In some situations, it can occur in people aged between 40 and 60 years.

https://alzheimerportugal.org/pt

2.3 Disturbances in Cognitive Processes

Prevalence of Dementia

The World Health Organization estimates that worldwide there are 47.5 million people with dementia, a number that could reach 75.6 million in 2030 and almost triple in 2050 to 135.5 million.

In this context, Alzheimer's disease assumes a prominent place, representing about 60 to 70% of all dementia cases (World Health Organization [WHO], 2015).

In Portugal, as there is no epidemiological study to date that portrays the real situation of the problem, we can refer to data from Alzheimer Europe that point to more than 193,000 and 500 people with dementia (Alzheimer Europe, 2019).

https://alzheimerportugal.org/pt

2.3 Disturbances in Cognitive Processes

Most Common Forms of Dementia

- Alzheimer's Disease
- Vascular dementia
- Parkinson's disease
- Dementia of Lewy Bodies
- Frontotemporal dementia
- Huntington's Disease
- Alcohol Dementia (Korsakoff's Syndrome)
- Creutzfeldt-Jacob Disease

https://alzheimerportugal.org/pt

2.3 Disturbances in Cognitive Processes

Warning Signs for an Early Diagnosis

It can often be difficult to perceive the difference between the changes in cognitive functions resulting from the natural aging process, with symptoms that could translate into the onset of a pathological condition.

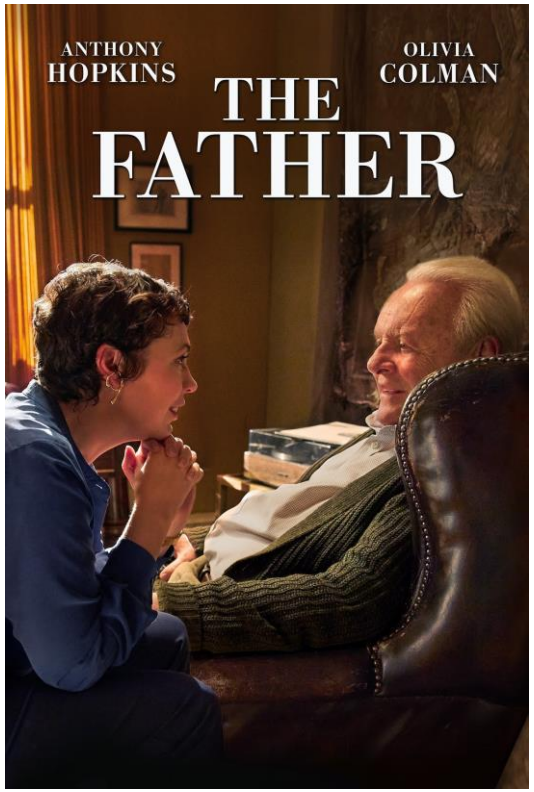
- Frequent and progressive memory loss
- Confusion
- Personality changes
- Apathy and isolation
- Loss of ability to perform daily tasks

Warning signs	What is normal in aging
Forgetting part or all of an event	Have a vague memory of an event
Progressively lose the ability to follow verbal or written directions	Maintain the ability to follow verbal or written directions
Progressively lose the ability to follow the story of a novel or movie	Maintaining the ability to follow the story of a novel or movie
Progressively forgetting information you knew, such as historical or political data	Forgetting names or words, but remembering them later
Progressively lose the ability to independently wash, dress or feed	Maintain the ability to wash, dress, feed, despite the difficulties imposed by physical limitations
Progressively lose the ability to make decisions	Make a wrong decision on time
Progressively lose the ability to manage your budget	Make occasional mistakes, for example writing a check.
Not knowing what date or season it is	Getting confused about what day of the week you are on, but remembering later
Having difficulty carrying on a conversation, not being able to keep reasoning or remember the words	Sometimes forgetting the best word to use
Forgetting where you kept an object and not being able to do the retractive mental process to remember	Losing something every now and then, but finding it through your logical reasoning

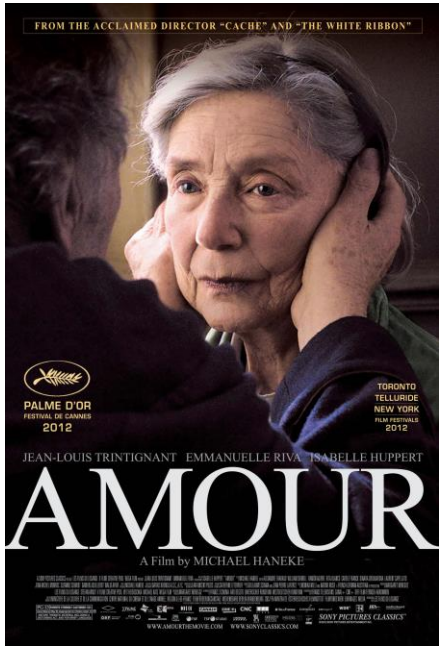
https://alzheimerportugal.org/pt/text-0-9-33-34-sinais-de-alerta-para-um-diagnostico-precoce

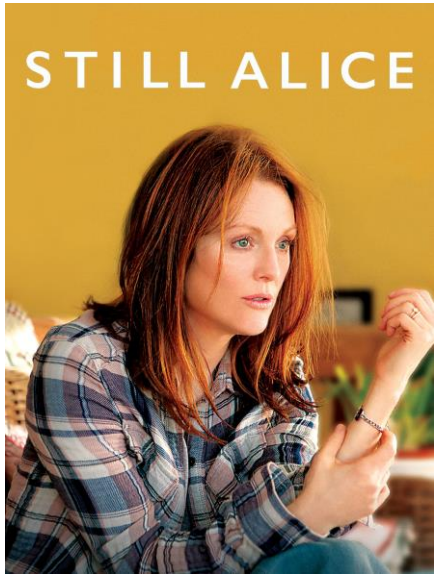
2.3 Perturbações nos processos cognitivos

Some suggestions -Movies about dementia



Anthony (Academy Award Winner, Anthony Hopkins) is 80, mischievous, living defiantly alone and rejecting the carers that his daughter, Anne (Academy Award and Golden Globe Winner, Olivia Colman), encouragingly introduces. Yet help is also becoming a necessity for Anne; she can't make daily visits anymore and Anthony's grip on reality is unraveling. As we experience the ebb and flow of his memory, how much of his own identity and past can Anthony cling to? How does Anne cope as she grieves the loss of her father, while he still lives and breathes before her? THE FATHER warmly embraces real life, through loving reflection upon the vibrant human condition; heart-breaking and uncompromisingly poignant -- a movie that nestles in the truth of our own lives.





2.3 Disturbances in Cognitive Processes

Some suggestions
Movies about dementia

2.4 Depression

2.4 Depression

Clinical depression: long-lasting is severe enough to interfere\with normal functioning

Clinical depression is not just about "feeling sad" - the person is actually incapacitated by the condition, that is, the person runs out of mental and physical energy

(Hamilton, I. S., 2002)

A depressed person may manifest cognitive and behavioral changes: lack of motivation, disturbances in will, disinterest, loss of appetite, somatization, physical pain, irritability, difficulty concentrating, sleep problems, loss of zest for life, physical weakness, difficulty with socializing with friends, colleagues and family

(Zimerman, 2000).

(Teixeira, 2010)

2.4 Depression

Areas affected by depression

Affection (sadness, crying, irritability, sad appearance)

Motivation (decreased interest in activities)

Physical and motor functioning (loss of appetite, pattern change, vague somatic complaints)

Cognition (anticipates failure, expresses and verbalizes failure and self-devaluation, difficulty concentrating)

2.4 Depression

Older people are exposed to more depressive events, which are due to:

- Stressful and negative events (eg, loss of a loved one)
- Illnesses and side effects of medications;
- The loss of functional and cognitive abilities;
- Financial problems;
- Social and relationship issues.

(Hamilton, I. S., 2002)

- Continuous loss process;
- Need to adapt to the aging process.

(Teixeira, 2010)

2.4 Depression

From an experiential point of view, the elderly is in a situation of continuous losses:

There are three major determinants that are commonly important in the onset of depression in the elderly:

a) **Environmental determinants**: isolation and lack of social interaction, absence of work, the death of a spouse, and social and professional devaluation;
b) **Genetic determinants**: predisposing factors for depression at later ages;
c) **Organic determinants**: which refer to the huge variety of organic diseases that can present symptoms of this nature.

(Marques e col., 1989 cit. por Fernandes, 2000, cit. por Teixeira, 2010)

2.5 Insomnia

2.5 Insomnia

Factors that contribute to sleep problems in old age can be grouped into the following categories:

1) pain or physical discomfort;

2) environmental factors;

3) emotional discomforts

4) changes in sleep pattern (complaints related to time spent in bed without sleep, difficulty in resuming sleep, shorter duration of nighttime sleep, longer sleep latency, and awakening in the morning earlier than desired.)

Drowsiness and daytime fatigue are also prevalent, with increased naps

.

2.5 Insomnia

Insomnia is defined as a difficulty in falling asleep or staying asleep, when there may be a total or partial decrease in the quantity and/or quality of sleep. It can be classified as initial, intermediate or final, and, in terms of duration, as transient (< 1 month), short-term (1 – 6 months) or chronic (> 6 months).

(Geib; Neto; Wainberg, Nunes, Magda, 2003)

2.5 Insomnia

Intrinsic sleep disorders:

- Psychophysiological Insomnia
- Sleep Apnea Syndrome
- Restless Legs Syndrome

(Geib; Neto; Wainberg, Nunes, Magda, 2003)

2.5 Insomnia

Extrinsic sleep disorders:

Types of characteristics	
Sleeping conditions	Lightness, noise, temperature, roommate, inappropriate activities in bed, ingestion of food and liquids before bedtime, time to use diuretics.
Psychosocial Factors	Grief, Retirement Changes in the social environment (isolation, institutionalization, financial difficulties)
Behavioral factors	Reduction of physical activity and exposure to sunlight

(Geib; Neto; Wainberg, Nunes, Magda, 2003)

2.5 Insomnia

Sleep hygiene

Regular time to go to bed and get up

It is important to respect these times, including on weekends, as it favors the functioning of the biological clock. Habit changes can disrupt sleep.

Environment preparation

Excessive heat and cold affect sleep a lot, so try to keep the room at a pleasant temperature.
Noise can be the cause of poor sleep.
When:

- lots of light: darken the room;
- lots of noise: eliminate or reduce noise;

2.5 Insomnia

Sleep hygiene

What to eat before bed

Try to eat lighter meals before going to bed and not going to bed right after eating. The ideal is to wait about 1 hour.

Do not smoke before bedtime

Nicotine promotes insomnia and non-restorative sleep.

Relax

Try to relax your body and mind before going to bed. Never try to solve problems before bed.

2.6 Suicide

2.6 Suicide

Suicidal ideation - This specifically designates thoughts and cognitions of self-destruction, of ending one's own life. In a hierarchical crescent, suicidal ideation can range from general thoughts about death to more serious idealizations about correct ways to commit suicide.

(Hamilton, 2002)

The highest suicide rates in all countries of the World Health Organization are above 75 years

Older adults often attempt suicide to escape a life of pain and suffering.

(see Fremouw, Perezel e Ellis, 1990).

Suicide among the elderly is an important public health problem.

2.6 Suicide

The suicide rate is traditionally higher among the elderly.

There are 3 main categories of risk factors:

- Individual,
- Sociocultural
- Situational

2.6 Suicide

Risk Factors - Main Features
Individual factors

Age
In Portugal, about 50% of suicides occur after the age of 64 (mainly males)

Marital status
Single, widowed or divorced people are most at risk.

Mental disorder
Depression is the most frequent risk factor. Research shows that 4% of patients with any type of depression and about 15 to 20% with severe depression die from suicide, affecting men and the elderly more.

Resiliences and vulnerabilities of personality
Traits often associated with risk are hostility, helplessness, dependency, rigidity and perfectionism. High levels of hopelessness with or without depression are associated with an elevated risk factor.

Physical illnesses
Physical illness can increase the risk, especially if it is associated with functional deficits, changes in body image, chronic pain, dependence on others.

2.6 Suicide

Risk Factors - Main Features
Sociocultural factors

Social isolation

The current aging of our population and the insufficient family and social support have a great impact on the isolation of the elderly.

The current change in the social structure, characterized by growing individualism and loss of neighborhood solidarities, accentuates previous vulnerabilities.

2.6 Suicide

Risk Factors - Main Features
Situational factors

Poverty, low social status, domestic difficulties and hopelessness.

Recent negative life events

Divorce, widowhood, significant relational losses, loss of socioeconomic status, sexual or physical abuse and domestic violence.

Substance abuse

Substance abuse represents one of the most frequent forms of suicide, especially among women and the elderly

Anxiolytics, especially benzodiazepines, are more prescribed to women and the elderly, constituting the group of drugs most frequently used in suicide attempts, alone or in association with alcohol

2.6 Suicide

Typical mindsets

- “The best thing is to disappear for good…” – **ESCAPE**
- “I don't have the strength anymore, I'll give up…” – **EXHAUSTION**
- “I feel useless, I'm useless…” – **GUILT**
- “I won't give anyone more work…” – **SACRIFICE**
- “You'll still regret it…! – **HOSTILITY / REVENGE**

2.6 Suicide

Cartas e bilhetes de despedida

- “Tentem compreender, já não aguento...”
- “Estou cansado de tudo, cansado...”
- “Perdoem-me por todo o mal que fiz...”
- “Foi melhor assim, não sofram mais...”

2.6 Suicide

Danger Signs

- Threat of suicide or affirmation of the wish or intention to die
- previous suicide attempt
- Depression
- Alcoholism
- Significant changes in behavior
- Engage in final preparations

2.6 Suicide

Protective factors:

- Individual factors: ability to solve problems and conflicts, initiative in asking for help, notion of personal value, openness to new experiences and learning, communication strategies developed, commitment to life projects;
- Family factors: good family relationships, family support and support, trusting relationships;
- Social factors: being employed, having easy access to health services, articulation between the various levels of health services and partnerships with institutions that provide social and community services, cultural values, belonging to a religion

2.7 Substance Abuse

2.7 Substance Abuse

Elderly people are in fact heavy users of (legitimately prescribed) hypnotic (ie, sleep-inducing) and sedative drugs, and their misuse is the single most common cause of admission to US hospital emergency rooms (LaRue , Dessonville and Jarvik, 1985).

In many cases, the reason for this is that the aging body cannot properly metabolize the drug in question, leading to serious health problems.

More clearly harmful is excessive alcohol consumption.

Studies generally confirm that older men are more likely to abuse alcohol and older women to abuse prescription drugs (eg, Graham et al., 1996)

(Hamilton, 2002)

3. Isolation, social discrimination and inclusion

3. Isolation, social discrimination and inclusion

Isolation associated with:

- Retirement, widowhood, and declining health deprive people of many essential roles and relationships around which their identities had been built.
- Decrease in social networks.
- Economic, social and family transformations together with changes and/or loss of intellectual skills
- Reduced participation in the community
- The reform generates a drop in income

3. Isolation, social discrimination and inclusion

Social discrimination

In society, beliefs that value youth prevail, but often generate a devaluation of older people who can become victims of social exclusion (Veloz, Nascimento-Schulze & Camargo, 1999).

There are a number of stereotypes associated with the elderly, namely:

- “Older people are not able to learn”
- "Old age corresponds to a kind of "Second Childhood"
- "Older people are conservative, inflexible and resistant to change"
- "The increase in the number of elderly people in the population causes an increase in the costs of health services and social security"
- "This is no longer for your age"

Ageism: form of discrimination based on age that usually occurs in relation to older people

(Fonseca, 2005)

3. Isolation, social discrimination and inclusion

Social discrimination

Ageism begins at home, within the family, in the way in which older people are “coded”, more or less consciously by younger relatives (“even the grandfather can go…”), extending to the whole society. sometimes through prejudice, other times through discrimination (a more serious attitude, charged with hostility).

(Fonseca, 2005)

3. Isolation, social discrimination and inclusion

Social discrimination

Consequences of “Ageism” for the Elderly:

- Perception of incompetence and incapacity;
- Adoption of less active behaviors (physically and mentally)
- “Gerontophobia”: attitude that results from the attempt to deny one's own aging
- Repercussions on self-esteem, well-being and quality of life

(Fonseca, 2005)

3. Isolation, social discrimination and inclusion

Inclusion - Political-Social Action

- Adequate training for formal and informal caregivers
- Intervention with younger generations (inclusion in the curriculum of information about the life cycle, educating for a positive perspective on aging; development of intergenerational programs and direct work with the elderly population - in the labor market, volunteering...)
- Age friendly cities Adapted housing Adequate outdoor spaces Adequate transport Community and healthcare support Promoting the social participation of the elderly Promoting their social inclusion; Promoting respect for the elderly Creating jobs adapted to age and aging

4. Institutionalization and Caregivers - Psychoaffective Impacts

4. Institutionalization and Caregivers - Psychoaffective Impacts

Who are the elderly people living in nursing homes?

Did they make a choice?
Personal choice, "pushed", inevitability ("social internments")...

4. Institutionalization and Caregivers - Psychoaffective Impacts

Institutionalization

"Social response, developed in a facility, intended for collective housing, for temporary or permanent use, for elderly people or others at greater risk of loss of independence and/or autonomy"

In some cases, institutionalization in a Home for the Elderly becomes the last and most viable solution: "Institutionalization usually appears, for the family or for the elderly without a family, as the last alternative, when all the others are not viable"

4. Institutionalization and Caregivers - Psychoaffective Impacts

Key aspects of providing care to the elderly

- Respond to personal needs
- Promote social contacts
- Encourage autonomy
- Encourage risk acceptance
- Promote self-esteem
- Respect individuality
- Protect privacy

4. Institutionalization and Caregivers - Psychoaffective Impacts

Key aspects of providing care to the elderly

Knowledge needed to work with dependent elderly people

- Normal aging: biological, psychological and social changes
- Mental disorders, including dementias
- Mood and Anxiety Disorders
- Changes in aging that require psychiatric treatment: types of treatment, medication, drug interaction
- Social and physical problems: grief, loss of roles, physical pain, sleep disturbances, etc.

4. Institutionalization and Caregivers - Psychoaffective Impacts

Key aspects of providing care to the elderly

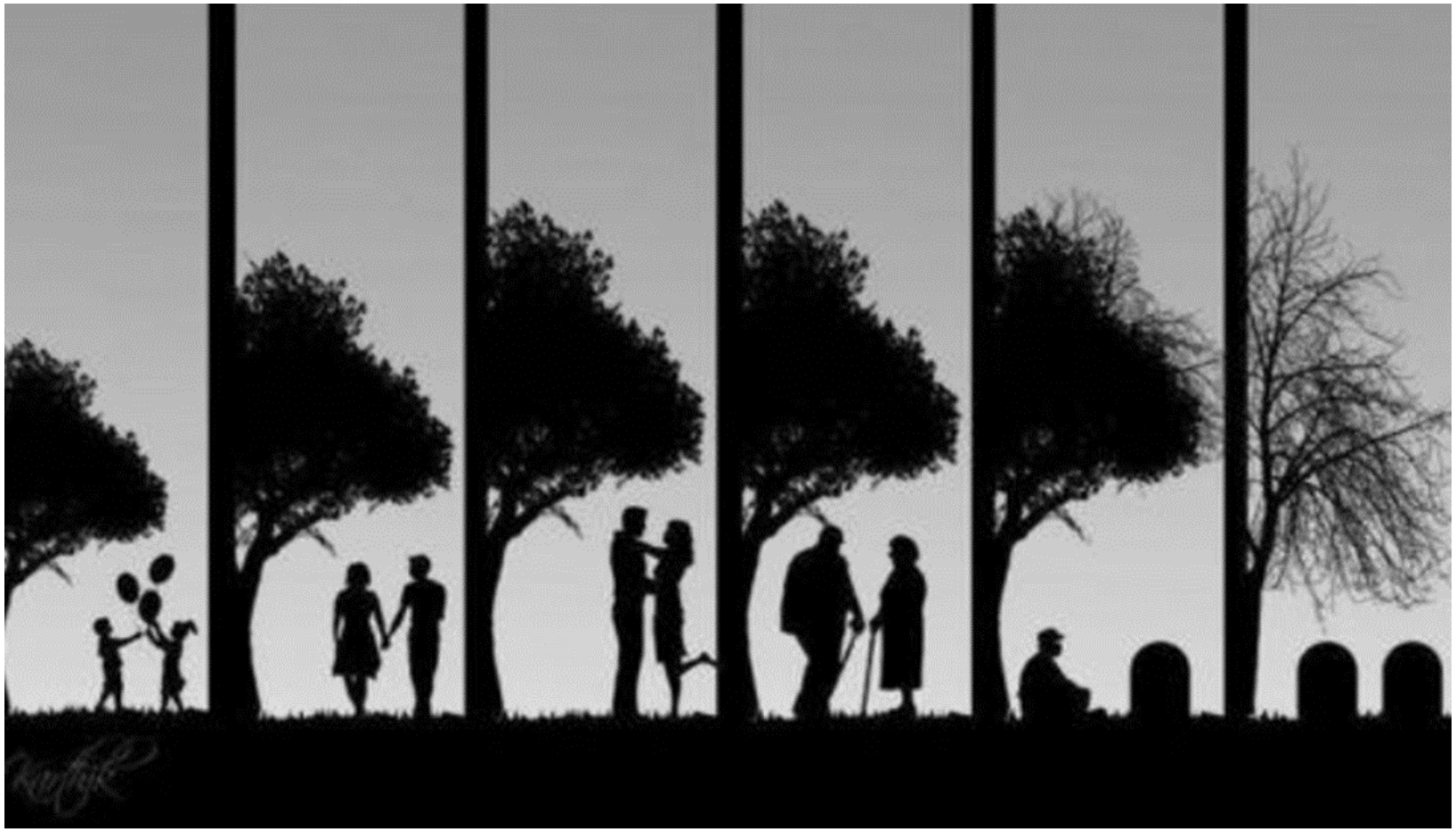
Personal qualities for working with dependent elderly people

- Ability to cope with your own feelings about aging
- Be capable of flexible and broad acting
- Enjoy working in a team with other professionals
- Have the patience and ability to inform and support medical and social decisions
- Accept limited therapeutic goals (don't get discouraged)
- Valuing small gains
- Being able to remain optimistic in the face of a bad prognosis
- Viewing the elderly as a developing individual

4. Institutionalization and Caregivers - Psychoaffective Impacts

Psychoaffective Impacts

- Absolute obedience to the institution's rules
- Absence of intimacy and private spaces: sometimes there are no individual rooms, no furniture or personal items, the closet or bedside table is arranged according to strict criteria and regularly inspected, etc.;
- Lack of personal rhythms: all interned are forced to live according to the same schedules, defined according to the organization of work;
- Depersonalization: including, very often, social identity and appearance (often a haircut, choice of clothing, etc.);
- Close surveillance of external relations: prohibited or authorized departures as a reward, restricted rights to visit dependent on the goodwill of caregivers, etc.



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GIVINGCARE
Empowering Caregivers

Thank you!

Teachers's name

Teachers e-mail

Date of the session