Aging and Long-Term Care

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a behavioral health professional or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Accreditations & Approvals

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This course, Aging and Long-Term Care, Approval #202406-1935, provided by NetCE, is approved for continuing education by the New Jersey Social Work Continuing Education Approval Collaborative, which is administered by NASW-NJ. CE Approval Collaborative Approval Period: September 1, 2020 through August 31, 2022. New Jersey social workers will receive 3 Clinical and Social & Cultural Competence CE credits for participating in this course.

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This course is considered self-study by the New York State Board of Mental Health Counseling.

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NetCE designates this continuing education activity for 3 ANCC contact hours.

AACN Synergy CERP Category B.

Social Workers participating in this intermediate to advanced course will receive 3 Clinical continuing education clock hours.

NetCE designates this continuing education activity for 3 NBCC clock hours.

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Special Approvals

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About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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Disclosure Statement

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Course Objective

The purpose of this course is to provide the tools necessary for social workers, counselors, mental health professionals, and allied health professionals to successfully assess and care for older adults, an increasingly large portion of the U.S. population.

Learning Objectives

Upon completion of this course, you should be able to:

1. Review the demographic profile and associated myths of the elderly population in the United States.
2. Discuss age-related biologic and physiologic changes experienced by older adults.
3. Identify psychologic and social challenges and adjustments commonly encountered in the elderly population, with particular attention to elderly subpopulations, including custodial grandparents, racial/ethnic minority elders, gay and lesbian elders, and elderly women.
4. Outline the impact of long-term care on older adults and their care providers.
5. Describe assessments for depression, suicide, substance abuse, and elder abuse that specifically target older adults.
6. Discuss interventions that are sensitive to the biopsychosocial needs of the elderly and are appropriate ethically and legally.

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Western society holds many myths about aging and the elderly. These myths can be positive or negative and stem from ageism. Ageism is defined as societal stereotypes, prejudice, and/or discrimination toward an outgroup that is associated with their chronologic age. More often than not, these myths can have negative consequences on individual, family, workplace, and/or societal levels [188]. Generally, Americans tend to attribute more problems to advanced age than are actually reported, such as being dependent on others for financial support, transportation, and medical care. There is an image of the elderly as being highly dependent or living in nursing homes [50]. In the workforce, elderly workers are often believed to be untrainable [52]. Yet, simultaneously, these years are often viewed as the "golden years," when one retires, travels, and has a certain amount of leisure time. It is difficult for the public, and healthcare professionals, to reconcile these seemingly opposing views of aging.

When 41 female nurses were asked about their fears of aging, and specifically of growing old as a woman, they used terms like: "dependency," "ill health," "loneliness," "loss of dignity," and "looking old" [1]. Cross-culturally, these myths are remarkably similar. For example, college students in Taiwan reported believing that older adults (e.g., older teachers) are resistant to change, not motivated to learn new things, and not willing to listen to new ideas [4]. Okoye and Obikeze conducted focus groups with 800 Nigerian youths, and the participants described the elderly as dependent, sickly, child-like, conservative, and suspicious [33]. In a study of adults in Colombia, individuals with negative stereotypes about the elderly were also more concerned about aging [53]. This gives some insight into societal perceptions about the elderly and aging. Qualms and fears toward aging often stem from negative cultural images and stereotypes of aging [1].

DEFINITION OF AGING

There is no one agreed upon definition of aging. One approach defines aging according to four key dimensions [86]:

- Aging is universal. All species experience the phenomenon of aging.
- Aging is intrinsic. External factors are not the primary cause of origin.
- Aging is progressive. It occurs progressively throughout the life cycle.
- Aging is deleterious. There will be negative physical ramifications.

It is important to distinguish chronologic aging from physiologic aging. All persons, without exception, grow old chronologically. However, physiologic aging is unique process and varies from person to person. It involves changes in how an individual responds to internal and external stressors as well as inalterable variables, such as genetic predisposition [7]. In addition, studies are now focusing on aging as a process and underscoring the concept of successful aging [89].

Several subtly different terms are commonly employed when exploring aging. Successful aging refers to the physical and biologic advantages of remaining engaged throughout life. Active aging describes being active and engaged and maximizing opportunities to promote a good quality of life. Productive aging emphasizes integrating older adults into society and recognizing their unique contributions [189]. The World Health Organization uses the term healthy aging to describe the process of maintaining one's functional abilities throughout life [190].

AN OVERVIEW OF THE ELDERLY IN THE UNITED STATES

CURRENT TRENDS AND PROJECTIONS

The age at which one is considered "older" or "senior" is always evolving and is influenced by culture and societal life expectancy. In England in 1875, old age was defined as 50 years or older, as stated in the Friendly Societies Act [88]. Today, most developed countries in the world use the chronologic marker of 65 years as a definition of old age; in some cases, the age of 62 years is used as a chronologic marker because, in the United States, one could receive social security benefits starting at this age [87]. However, Mohanty notes that using the criterion of age at retirement or when one becomes eligible to receive retirement benefits is not universal, given the fact that there are so many in the world who live in areas in which there are no formal definitions of retirement [88]. Using these chronologic markers to define old age is arbitrary, but they can be useful when studying the group as a whole [2]. The elderly can be further divided into various segments: the young-old, defined as 65 to 74 years of age; middle-old, defined as 75 to 84 years of age; and the oldest-old, defined as those who are 85 years of age and older [3]. In 2010, there were 53,364 persons 100 years of age and older in the United States [94]. Worldwide, in 2015, there were more than 500,000 centenarians, and it is estimated by 2050, there will be 3.7 million, with the greatest growth in China [90]. In the United States, it is projected that there will be 9.7 centenarians per 10,000 people by 2050 [90].

According to the U.S. Census, there were 52.4 million Americans 65 years of age or older in 2018, which translates to 16% of the U.S. population [42; 31]. Maine led the country in older population, with 20.6% of the state's population comprised of those 65 years of age or older, followed by Florida at 20.5% [91; 42]. By 2060, it is estimated that nearly 114.3 million Americans will be 65 years of age or older [31]. This is due to the aging of the "baby boomer" generation (i.e., those born between 1946 and 1964).

The average life expectancy has continued to increase; it is estimated that by 2060, 19.7 million Americans will be 85 years of age or older [42]. In 2017, the average life expectancy in the United States was 79.7 years of age, but it is projected to be 85.6 years of age by 2060. In 2060, the youngest baby boomers will be 96 years of age [42; 41]. The oldest-old are one of the fastest growing population groups in the United States.

COMMON MYTHS OF AGING

As mentioned, society holds several myths about the elderly. Many of these myths may be easily disputed based on data from the U.S. Census and other studies.

- **Myth**: Most older adults do not have enough money and end up becoming destitute.

  Fact: As of 2017, 9.2% of Americans 65 years of age and older lived in poverty. This population is also more likely to have health insurance coverage than the general population. As of 2017, 93% were insured by Medicare [92].

- **Myth**: Most older adults live alone and are isolated.

  Fact: In 2018, 70% of men and 46% of women 65 years and older were married. An estimated 28% lived alone [92]. According to a survey conducted in 2009, 9 out of 10 individuals 65 years of age and older stated they talked to family and friends on a daily basis [93]. In 2016, an estimated 20% of the U.S. population lived in a household comprised of two adult generations or a grandparent or at least one other generation, compared with 12% in 1980 [93; 43]. This multigenerational household trend particularly affects those 65 years and older, with 21% of these individuals living in multigenerational households in 2016. This group was second only to individuals 25 to 29 years of age (33%) [43]. Several factors have contributed to this trend, including growing racial and ethnic diversity and adults getting married later [93; 43].

- **Myth**: Many older Americans end up living in nursing homes.

  Fact: In 2016, only about 3.1% of adults 65 years of age and older lived in nursing homes. Of those who reside in nursing homes, they tend to be the oldest-old (10.6% of those 85 years of age and older) [44].

- **Myth**: Most older adults engage in very minimal productive activity.

  Fact: In 2019, 20% of persons 65 years and older were employed or actively looking for work, and this population represents approximately 8% of the total labor force in the United States [49]. The elderly are more engaged in self-employed activities than younger persons. In 2016, 16.4% of those 65 years of age and older were self-employed, compared with an average of 5.5% of those 16 years to 64 years of age [103].

- **Myth**: Life satisfaction is low among the elderly.

  Fact: Field examined data from the Berkeley Older Generation Study and found that many elders are quite satisfied with their life [9]. More than one-third (36%) of persons older than 59 years of age and 15% of those older than 79 years of age stated they were currently experiencing the best time in their lives. A 2009 survey found that 60% of individuals 65 years of age and older stated they were very happy. A 2012 survey found that 65% of individuals 65 years of age and older indicated that the past year of their life has been normal or better than normal, and more than 80% of respondents agreed with the statement, "I have a strong sense of purpose and passion about my life and my future" [105]. Most of the factors that predict happiness for the young, such as good health and financial stability, also apply to the elderly. Older adults tend to report higher levels of well-being in part due to the quality of their social relationships [191].

- **Myth**: Old people feel old.

  Fact: According to a 2009 telephone survey, only 21% of individuals 65 to 74 years of age stated they felt old, and only 35% of those 75 years of age and older reported feeling old. Another study in 2018 showed that individuals 50 years of age report feeling 10 years younger, and also found that as age increased individuals felt approximately 20% younger than their actual age [110].

BIOLOGIC PROCESSES AND PHYSICAL WELL-BEING IN OLDER ADULTS

Biologic and physiologic changes are part of aging. Although it is not known why these changes occur, biologic theories of physiologic aging include [3; 7; 86; 95; 121; 140; 143]:

- Wear and tear: Aging is genetically determined, and as a result, the tissues and muscles eventually deteriorate.
- Cross-linkage: The body's proteins attach to other structural substances, thus decreasing elasticity in the skin and causing other physical changes in the organs and slowing of physiologic processes.
- Autoimmune: As the body ages, it is unable to recognize the difference between healthy and diseased cells, causing it to react against itself.
- Cellular aging: The replication of cells slows as a result of aging.
- Apoptosis theory: Aging is due to inevitable pre-programmed cell death in our bodies. Apoptosis is a normal process in the body, but it is speculated that if dysregulated apoptosis could lead to Alzheimer disease, Parkinson disease, or cancer.

- Free radical: As free radical exposure increases in older organisms, the antioxidant system is not able to counteract the free radicals that have been generated and accumulated during the life of the cell, resulting in cellular death. Experimental findings have not conclusively supported this theory.
- Evolutionary: Humans' developmental life cycles are affected by mutation and selection. In other words, all biologic dimensions are affected by mutation, and there will be variations among human beings. This will lead to a natural selection of those who are more fit to survive in an environment. Aging leads to vulnerability.

The losses in the physical arena for the elderly can be numerous, which may then compound and/or have implications in social and psychologic arenas. Studies have shown that brain tissues atrophy due to natural cell degeneration, with the volume of the brain decreasing by 15% or more between adolescence and old age [122]. Crews notes that the health status of older persons with vision and hearing loss is poorer compared with those without vision or hearing loss [10]. Rates of heart disease, hypertension, hip fractures, and stroke are higher among those with sensory loss [10]. In a study of more than 1,000 elders, 53.7% of those with impaired vision also had hypertension, compared with 43.1% of those without impaired vision. Of those with impaired hearing, 27.6% experienced heart disease, compared with 18.6% of those without a hearing loss [10]. Interestingly, the rates double when persons have both hearing and vision impairment. Almost one-fifth (19.9%) of persons with both impairments had experienced a stroke, while only 8% with no sensory loss had experienced a stroke [10].

Mobility is affected by muscle atrophy associated with advanced age. Muscle strength, for example, can decline 30% to 40% between 30 and 80 years of age [11]. This can lead to falls, which are common among the elderly. It is estimated that half of Americans 75 years of age and older experience some form of functional disability that affects their mobility [192]. Women tend to experience more disabilities throughout the life span than men [192]. Thirty percent of those 65 years of age and older have fallen within the last 12 months, and 50% of persons older than 80 years of age have experienced a fall in the last 12 months [11]. The causes of these falls vary and include environmental factors, sensory losses, medical factors, and psychiatric conditions, such as depression or cognitive impairments [11; 12]. Most falls among the elderly occur in the morning. This is not surprising given that the majority of activity and movement occur during this time [146]. Loss of ambulatory mobility is also common after hospitalization among older adults. This phenomenon, known as hospital-associated disability, is present in previously independent and ambulatory adults who have impaired mobility upon hospital discharge. It occurs among 16% to 65% of adults 65 years and older [123]. Infrequent ambulation and bed rest are the most commonly cited causes [123].

With the increase in life expectancy, there is also an increase in the incidence of acute and chronic illnesses, such as cardiovascular diseases and hypertension. As a part of the aging process, the composition of vascular structures changes, affecting how peripheral arteries dilate and constrict [13]. The result is often hypertension, which affects 1 billion individuals worldwide [14]. Epidemiologic studies have noted that 12% to 14% of adults 65 years of age and older have hypertension [13]. However, it is important not to use age as the only criterion to determine the type of treatment for hypertension among the elderly. Frail elders should be assessed and treatment tailored for their specific needs [163].

Arthritis is also a leading cause of disability among older adults, accounting for 29% of chronic disease diagnoses in the United States [5; 193]. Arthritis may refer to rheumatoid arthritis or osteoarthritis. Rheumatoid arthritis is a systemic autoimmune disorder that attacks the joints, causing inflammation in the hands, feet, and other parts of the body [15]. Osteoarthritis breaks down the cartilage of joints, such as the shoulder, knee, hip, and ankle, causing pain and limitation of movement [15]. Osteoarthritis is one of the most common pain disorders in the United States and is the leading cause of disability among elders [124]. The knee is most commonly affected area, and experts predict that 3.5 million total knee replacements will be done annually by 2030 [124]. Because chronic arthritis pain and depressive symptoms are often comorbid, it is important for practitioners to assess these patients' mood and mental state. In a four-year longitudinal study with 299 elders living in a retirement community, strong social support and intact cognitive functioning were protective against chronic pain-related depression [164].

Sleep problems are also more common among the elderly, primarily stemming from changes in the sleep cycle that occur with age (e.g., decreased time spent in slow-wave sleep) [125; 194]. Sleep difficulties, such as insomnia, are correlated with impaired physical and psychologic well-being and quality and length of life [96]. In a longitudinal study with elderly individuals in the United Kingdom, 44.7% complained of sleep dysfunction. Those who had greater restrictions of activities of daily living, greater numbers of reported physical illnesses, poor social support, higher levels of depression, and were widowed, divorced, or separated were more likely to report sleep complaints. One year later, of those who reported no sleep problems at baseline, an additional 21.4% reported increased impairment in obtaining adequate rest or sleep [96]. Depression was the strongest predictor of sleep problems. Ultimately, insomnia can increase the risk for other medical and psychologic complications in addition to adversely affecting a patient's quality of life [125; 194]. Practitioners might suggest increasing activities such as walking, running, resistance exercise, and tai chi, as some studies have shown that the sleep quality of older adults can improve when these activities are included in daily life [165].

HIV/AIDS

In industrialized countries, it is estimated that 10% to 15% of human immunodeficiency virus (HIV) infections occur in adults 50 years of age and older, and approximately one of every nine new HIV diagnoses in the United States occur in those 50 years of age or older [17; 18; 126]. This prevalence may be higher in developing countries [18]. In 2016, there were an estimated 6,812 newly diagnosed cases of HIV among adults 50 years of age and older, accounting for 17% of total diagnoses in the United States. Of these, 841 diagnoses occurred in persons 65 years of age and older. In 2015, approximately 47% of all individuals with living with HIV were 50 years of age and older, and 2,749 people 55 years of age and older died from HIV disease [97]. However, older adults are not generally considered an at-risk group. This has led to a lack of targeted education and screening among older adults. For example, only 32% of state departments of public health websites contained information about HIV/AIDS in elderly individuals [167].

Older adults living with HIV experience a variety of other medical conditions that place them at even further risk for frailty and other diseases of aging. Among older persons with HIV, more than half are considered pre-frail and experience challenges with instrumental activities of daily living (e.g., cooking, cleaning, managing finances, doing laundry) [195].

Because the symptoms of HIV infection (i.e., fatigue, weight loss, memory loss) are similar to those of other age-related illnesses, such as dementia, and because many older adults harbor the misconception that they are not at risk, this population frequently goes untested for the virus [17]. When these individuals do seek medical help, symptoms are often attributed to other disorders, such as Alzheimer disease or a respiratory disorder [17]. It has been argued that women 50 years of age and older are more vulnerable to HIV infection during heterosexual encounters than men or younger women for several reasons [19]. Older women often do not insist on condom use because there is no longer the risk of pregnancy. Furthermore, male-to-female transmission of HIV is higher than female-to-male transmission [19]. Due to divorce or being widowed, increasing numbers of older people are becoming sexually active with multiple partners. This increase in sexual activity can also be partially attributed to older men more commonly using medication in order to maintain erections [20; 21]. Vaginal drying and thinning associated with menopause and aging can result in small tears or cuts during sexual activity, which also raises women's risk for infection with HIV [22]. Lusti-Narasimhan and Beard note that older women are generally more vulnerable to sexually transmitted infections because menopause affects the lining of the vagina, making it less protective to infection [127]. Furthermore, as one ages, the immune system also declines.

Ultimately, practitioners should be vigilant when working with older adults with HIV due to age-related comorbidities. Perhaps due in part to the misconception that the elderly are not sexual beings, practitioners often do not have conversations with their elderly clients about HIV/AIDS and other sexually transmitted infections [168]. In addition, polypharmacy is common in the older population, and drug interaction with HIV medications should be considered [128]. Generally, older adults metabolize antiretroviral medications slower, which could place them at risk for higher levels of toxicity [126]. Older adults who are diagnosed with HIV/AIDS are also at greater risks for being diagnosed with cancers [126].

CHALLENGES AND ADJUSTMENTS ASSOCIATED WITH AGING

PSYCHOLOGIC THEORETICAL FRAMEWORKS

Disengagement Theory

Disengagement theory, originally proposed by Cumming and Henry, maintains that successful aging involves whole or partial disengagement [23; 196]. In other words, as individuals age, they must accept a decline in status and forfeit some of their social and leadership roles [23]. The goal is to help older individuals disengage so they can die more peacefully [169]. However, this theory is controversial, particularly in Western society, where work is central in defining one's identity. Furthermore, other theorists argue that it is not disengagement or alienation from society that defines successful aging; rather, some assert that new activities may be assumed for those roles that are given up [24]. According to this theory, for elders to successfully journey through the aging process they must remain active [24].

Gerotranscendence Theory

The gerotranscendence theory was developed by Lars Tornstam in reaction to the tenets of disengagement theory. Tornstam posited that older people do not retreat into themselves and withdraw socially. Instead, aging can be viewed from a positive perspective, as older adults become less occupied with themselves, material things, and achievement. They redefine themselves in terms of the world and their relationships with others [129]. This theory assumes that gerotranscendence is a natural developmental process that yields greater life satisfaction. As part of this process, a person's values and worldviews evolve to become more spiritual [197].

This theory is not a revised version of disengagement theory, which focuses on pursuits of external things [169]. Instead, this theory emphasizes inner-development. For example, an older adult may appear to be disengaging and withdrawing by not participating as many social activities, and a practitioner might even speculate a diagnosis of depression. However, according to gerotranscendence theory, it is possible that the elder is simply becoming more deliberate and reflective [170]. In an interview study of 14 older adults between 80 and 96 years of age, themes that emerged were consistent with this theory [130]. The study participants discussed reconnecting with the past and past generations, focusing less on themselves, and worrying less about money and material possessions.

Erikson's Stages of Development

Erik Erikson, a prominent developmental theorist, had a more optimistic view of aging, focusing on the positive ways of overcoming the various crises one encounters throughout life [25; 26]. Erikson postulated eight stages of psychosocial development. Each stage provides the individual with a choice of two alternatives to consider and accept; one is an opportunity for growth, while the other results in unhappiness. In late adulthood, individuals confront the challenge of integrity versus despair. During this stage, individuals reflect on their lives, and determine if they have lived a life of purpose. If so, the individual will feel contentment, having attained integrity [26].

Attainment of integrity is defined as the ability to examine all of one's life experiences and find a sense of peace and accomplishment. However, despair will be experienced by those who have not lived a meaningful life. In these cases, death is either viewed as welcome, a means to end a miserable life, or is feared because one can no longer compensate for past failures [27]. This theory, as in other stage theories, recognizes that psychologic and social growth continue throughout an individual's life [171]. In one study of women who graduated from college in 1964, generativity and ego integrity appeared to increase starting at 43 years of age, continuing past 72 years of age, without any decline [198].

Peck's Developmental Tasks of Aging

Peck's Developmental Tasks of Aging is another theoretical framework to understanding aging, maintaining that older adults must complete three development tasks to achieve happiness [28]. First, shifting from a work-role preoccupation to self-differentiation is necessary. As many older persons retire, a new identity and social role must be created. New interests should be explored, and ultimately, individuals should realize that their identities are worthwhile regardless of their occupation [28].

The second task involves shifting from body preoccupation to body transcendence [28]. Those who transcend preoccupations with health issues, physical changes, and youth-based beauty ideals will be more satisfied with life.

Finally, the third task is the shift from self-preoccupation to self-transcendence. As death becomes more of a reality, persons may become depressed. However, others accept it with a healthy and positive attitude; this improves the quality of life [28].

Activity Theory

Activity theory asserts that older adults must remain embedded in social activities and relationships in order to accomplish their goals [169]. Starting from middle age and progressing into the later developmental years, being intrinsically linked with others, activities, and tasks that are viewed as meaningful are believed to produce physically, psychologically, and emotionally good health [98]. In other words, sedentariness does not promote wellness for elders [169]. This theory has been criticized for being overly simple, as it does not take into account the social environment [199].

Socioemotional Selectivity Theory

Socioemotional selectivity theory focuses on elders' changed mentality, worldviews, and social networks. As individuals age, their goals may change from being knowledge-oriented to being more emotion-related [171]. According to this theory, the elderly become more purposeful with whom they interact, looking for and prioritizing emotionally rewarding relationships [200]. Conflicts tend to be avoided, knowing that their remaining time is short [171].

Age Stratification Theory

The historical context of an elder's life forms the basis for the age stratification theory. Individuals and their generational cohort may respond, behave, and adhere to certain worldviews due to the historical, social, and cultural events that occurred during their lifetimes. These experiences then shape how individuals view social roles, cope with stressors, and respond to various events [98].

DEPRESSION AND SUICIDE

An estimated 7% of the elderly population worldwide experiences depression [201]. Depression can affect the elderly and is more prevalent among those who have experienced the loss of friends and family members [29]. The death of a spouse is a stressful event that may precipitate depression and may predict the onset of illness and earlier death [3]. Older women tend to experience greater depression and, once depressed, tend to stay depressed for longer periods of time compared with their male counterparts [131]. Older women with long, stable marriages were more likely to experience depression compared with women who had been married for a short period of time or whose marital quality was not as good [131]. In one study, older adults who are socially isolated are more likely to experience depression, fatigue, and sleep disturbances [202].

Depression is a concern among older adults because it can place them at greater risk for developing medical illnesses. The converse is also true; those who have medical illnesses or disability are also at risk for depression [30; 203]. For example, older adults with high blood pressure and depression are three times more likely to experience a stroke compared with older hypertensive individuals who are not depressed [29]. It is interesting to note that older persons with rheumatoid arthritis or osteoarthritis experience higher levels of depressive symptoms [30]. As individuals age, it is more likely they will experience some form of chronic pain. Adults between 45 and 64 years of age are more likely to report that they experience physical suffering lasting more than 24 hours [172].

The highest rates of depression in the elderly occur in those who have had strokes, coronary artery disease, cancer, Parkinson disease, and Alzheimer disease [84]. Recurrence rates are also very high. Although it is a misconception that the elderly are more depressed than the general public, they may still be at risk. It is important to assess each person individually.

It is also crucial to remember that older person may not necessarily display dysphoria and feelings of sadness. Instead, depressive symptoms may be manifested somatically. Older adults who experience sadness or loss of pleasure in the things they normally enjoy are more likely to attribute these symptoms to aging rather than depression [203].

Suicide is also a concern, as individuals 65 years of age and older account for 18% of all suicides in the United States [32; 173]. It is important to note that the rate of suicide is higher among older persons who are divorced or widowed [32]. Men 75 years of age and older are the most vulnerable, with a rate of 39.7 deaths per 100,000 persons [99].

Practitioners should be mindful that older adults are less likely to express emotional pain compared with their younger counterparts and are also less likely to endorse suicidal ideations [132]. It is important to account for risk factors more common in an older population, such as chronic illness, pain, loneliness, and social isolation, some of which may not be part of suicide risk assessments [132].

GRIEF, MOURNING, AND BEREAVEMENT

Although the terms "grief," "mourning," and "bereavement" are often used interchangeably, they have specific and unique meanings. Grief is a normal reaction to a loss, while mourning is the expression of grief and the process by which individuals adjust to the loss. Bereavement is the period of time during which grief and mourning occur [35; 133]. Psychosocial support is essential for individuals who have lost loved ones and can help to decrease the risks of morbidity, substance abuse, and mortality commonly found among widows/widowers and other persons who have lost a loved one [36].

Grief

Grief comprises a range of feelings, thoughts, and behaviors in the realm of the physical, emotional, and social domains [35]. Individuals may have trouble sleeping, changes in appetite, or other physical symptoms or illness. Studies have shown that widowers may be at risk of poor nutrition and inadequate caloric intake, and widows who were financially dependent on their spouse are vulnerable to falling into a state of poverty [174]. Emotions can include sadness, anxiety, guilt, and anger. A return to work, activities with friends, and taking care of family are beneficial behaviors in the social domain. The issue of grief becomes more prevalent among older adults as they inevitably face the death of family members and friends. In a qualitative study with older adults 62 to 88 years of age, the participants described experiences that were laced with emotional distress [134]. They also talked about how their grief was unique and did not meet traditional expectations in terms of intensity and severity.

In cases of terminal illness, grief counseling should begin before death occurs, with a focus on life meaning and contributions [37]. Awareness and understanding of the mediators of grief responses can assist in recognizing individuals who may be at increased risk for adapting poorly to the loss. These mediators are [38]:

- Nature of attachment (how close and/or dependent the individual was with regard to the deceased)
- Mode of death (the suddenness of the death)
- Historical antecedents (how the individual has handled loss in the past)
- Personality variables (factors related to age, gender, ability to express feelings)
- Social factors (availability of social support; involvement in ethnic and religious groups)
- Changes and concurrent stressors (number of other stressors in the individual's life, as well as coping styles)

Mourning

Satisfactory adaptation to loss is dependent on tasks of mourning [38]. In the past, "stages" of mourning were discussed; however, the stages were not clear-cut and were not always followed in the same order. The tasks associated with mourning include [38]:

- Accepting the reality of the loss
- Experiencing the pain of the loss
- Adjusting to the environment in which the deceased is missing (external, internal, and spiritual adjustments)
- Finding a way to remember the deceased while moving forward with life

After an individual's death, the family should be encouraged to talk about the deceased, as this promotes acceptance of the death. A wide range of emotions is normal during the mourning process. Explaining the process can help family members understand that experiencing these emotions is a necessary aspect of grieving. Frequent contact with family members after the loved one's death can ensure that the family is adjusting to the loss. Referrals for psychosocial and spiritual interventions should be made as early as possible to optimize their efficacy.

Older adults who lose a spouse will not only mourn the loss but also be confronted with their own mortality. They also have to cope with assuming new roles and potentially learning new tasks. Those who had been married a long time may feel they have lost a part of themselves [133].

Bereavement

Bereavement can trigger a host of physical and psychologic issues because of its highly stressful nature [100]. An estimated 10% to 15% of individuals who have experienced a loss of a loved one will experience depression, prolonged grief disorder, and bereavement-related post-traumatic stress disorder [204]. In one study of persons 50 years of age and older who lost a parent, there was a 83% likelihood of body mass index (BMI) loss compared with counterparts who had not lost a parent [175]. Loss of a spouse resulted in a 37% increased risk of BMI loss compared with those who had not lost a spouse.

How bereavement services are provided vary. Programs usually involve contacting the family at regular intervals to provide resources on grieving, coping strategies, professional services, and support groups [36; 37; 39]. Notes or cards are especially beneficial at the time of the first holidays without the deceased, significant days for the family (deceased's birthday, spouse's birthday), and the anniversary of the death. Bereavement services should extend for at least one year, but a longer period may be necessary [36; 39].

ALCOHOL AND SUBSTANCE ABUSE

Alcohol and substance abuse/dependence in the elderly are generally hidden problems. However, between 2002 and 2006, substance use rates almost doubled among those 50 to 54 years of age. It is estimated that slightly more than 10% of the elderly abuse prescription drugs, with up to 5 million elderly individuals projected to have drug use disorders and 4.4 million requiring substance abuse treatment by 2030 [101; 135; 176]. It is estimated that more than 80% of patients 57 to 85 years of age are taking at least one prescription medication daily. In addition, more than 50% are taking more than five medications daily [177]. Several factors contribute to the invisibility of these disorders.

First, many elderly individuals do not disclose alcohol or substance abuse because they are ashamed. This is compounded by healthcare professionals' reluctance to ask older adults about substance abuse, mostly due to the prevalent images of young people misusing substances [40]. Additionally, the symptoms of alcohol and substance abuse can mimic or resemble conditions associated with aging, thereby masking an underlying drinking or substance disorder [40]. Finally, some older adults may be isolated, with minimal social contacts or networks to intervene in cases in which alcohol or substance use has become a problem.

A study comparing the 12-month prevalence of alcohol use, high-risk drinking, and *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-IV alcohol use disorder from 2001–2002 to 2012–2013 showed significant increases in the number of individuals 65 years of age that met those criteria. Alcohol use among the elderly increased from 45.1% to 55.2% (a 22.4% increase), high-risk drinking increased from 2.3% to 3.8% (a 65.2% increase), and alcohol use disorder according to the DSM-IV criteria rose from 1.5% to 3.1% (a 106.7% increase) [120].

Late-onset alcoholism is common in the elderly, and several risk factors may contribute to the development of alcohol use disorders in older age. Some may use alcohol to self-medicate to mitigate physical symptoms, such as difficulty sleeping or chronic pain. Chronic illnesses and depression are also risk factors [205]. Mourning a loved one, loss of social supports, and loneliness can also instigate alcoholism later in life [102]. In general, late-onset alcoholism is more common among older women than older adult men [136]. It is also more prevalent among older adults in higher socioeconomic brackets. Compared with early-onset alcoholism, individuals with late-onset alcoholism tend to experience less psychosocial and legal consequences as a result of the substance abuse [136].

Rigler argues that the DSM criteria for alcohol use disorder may be difficult to apply to older adults [45]. For example, age-related physiologic changes may change the individual's response to alcohol, increasing their sensitivity and levels of tolerance. Because of this, they may not spend a lot of time or expend a great amount of energy in activities related to alcohol or substance consumption [46]. Thus, these persons would not meet the DSM criteria for alcohol use disorder as they require smaller amounts of alcohol to become intoxicated. In addition, the DSM criterion of giving up activities or responsibilities as a result of substance use may not be appropriate for older adults because they may have fewer regular activities resulting from diminished vocational or social responsibilities [46]. Unfortunately, there are few evidence-based substance abuse treatment approaches that are targeted for older adults. Practitioners tend to simply adapt treatments created for younger populations for older adults [135].

ELDER ABUSE

The 2015 White House Conference on Aging identified elder abuse as a top priority in public health [178]. Elder abuse refers to "any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to an older adult" [47]. There are three general categories of elder abuse, which appeared for the first time in the 1987 Amendments to the Older Americans Act [48]. These three categories of elder abuse are: domestic elder abuse, institutional abuse, and self-neglect or self-abuse [48].

Definitions of elder abuse vary based upon state statutes. However, the National Center on Elder Abuse has identified seven types of behavior associated with elder abuse [47; 206]:

- Physical abuse: Use of physical force that results in injury, pain, and impairment, such as slapping, punching, kicking, or restraining

- Sexual abuse: Nonconsensual contact of any form
- Emotional abuse: Infliction of distress, anguish, and/or pain through verbal or nonverbal acts
- Financial/material exploitation: Illegal or improper use of an elder's resources, property, funds, and/or assets without the consent of the elder
- Caregiver abandonment/neglect: Refusal or failure to provide goods or services to an older adult, including denying food or medical-related services
- Abandonment: Desertion of an elderly person by the individual who has physical custody or who is the primary caretaker
- Self-neglect: Behaviors of elderly persons that jeopardize their own safety and/or physical health

Epidemiologic studies of the prevalence of elder abuse indicate a prevalence of between 2% and 10%, with 1.7% experiencing more than one type of abuse [48; 137; 207]. In a survey study with 3,005 adults between 57 and 85 years of age, 0.2% disclosed to physical abuse in the last year, 9% reported verbal abuse, and 3.5% indicated financial abuse [138]. These prevalence rates may be lower than the actual rate given the amount of under-reporting due to fear of reprisals, embarrassment/shame, and hopelessness [179]. A study of 441 elderly Michigan individuals living in nursing homes found that 21% of family members reported some type of elder neglect in the last year [139]. The factor most predictive of neglect was limited ability to engage in activities of daily living. Cognitive impairment also appears to be predictive of elder abuse [179].

SPECIAL POPULATIONS

GRANDPARENTS PARENTING

Typically, older adults do not think about parenting at their particular life stage; however, there has been an increase in grandparents parenting in the last decade. In 2016, it was estimated that 7.2 million children younger than 18 years of age in the United States resided with a grandparent; more than 2.5 million grandparents were responsible for the basic needs of one or more grandchildren younger than 18 years of age [144]. Between 2006 and 2015, there was an 8.3% increase in custodial grandparents [8]. The reasons for grandparents taking over parenting responsibilities of their grandchildren are numerous, ranging from parents' substance abuse, divorce, health and mental health concerns, reported child abuse, and death of a parental figure [180; 208]. Many grandparents assume these roles so their grandchildren do not enter the foster care system.

Often, grandparents are placed in these new roles without much preparation, making the task more difficult. Some older adults may feel uncomfortable addressing issues such as drugs, sexually transmitted infections, gangs, and school violence [54]. Some studies indicate that these new parenting roles, particularly if the grandchildren have physical or mental health problems, trigger anxiety and negative well-being for grandparents [55]. In one study, Ross studied 50 African American grandparents raising grandchildren, and a majority (94%) reported increased stress [56]. Those grandparents who were involved in counseling and special school programs reported less stress. In a separate study of African American custodial grandparents, sleep disorders were common, with most linking the lack of sleep or poor sleep quality on the stresses of parenting their grandchildren [16]. A separate survey of custodial grandparents showed that 95% of respondents had one or more concerns regarding finances, legal issues, and/or physical health.

Respondents also indicated that they had limited social supports and community resources, compounding the stress experienced [145].

Stress also results from the financial constraints associated with raising grandchildren. In the United States, more than 20% of grandparents raising grandchildren have incomes below the federal poverty level [57]. The unanticipated costs of raising children in retirement years may severely impact financial independence, as these individuals may already be living on a tight budget. With additional medical costs and, at times, costs associated with other therapies, many grandparents may experience caregiving burden [57]. Inadequate or inappropriate housing for children may also be an issue [209]. Custodial grandparents who are unable to work may have difficulty applying for Temporary Assistance for Needy Families (TANF) [34]. The TANF family grant offers financial support based on the income of the entire family, but it also has a work requirement for the grandparent [34].

The additional stress in assuming primary care of grandchildren may also be a contributing factor to the poorer physical health of custodial grandparents. Grandparents who are caring for their grandchildren report worse self-reported health symptoms, such as more body pain and general health perception, compared with their counterparts not providing care to their grandchildren [51]. Although there are negative effects, there are also positive outcomes for custodial grandparents. Some view it as a second chance to rectify mistakes they feel they made as parents [141]. In a study of custodial grandmothers, some reported enjoying parenting the second time because they felt they had more experience, had learned from past mistakes, and could now offer wisdom. In many respects, this created a sense of freedom, relaxation, and confidence [142]. Some grandmothers felt they had more time and attention to give to their grandchildren compared with raising their own children, when they had additional demands such as work [142]. Some custodial grandparents took on the role because they wanted to be useful in a time of need for their children [210]. In a mixed-methods study, grandparents related having peace of mind knowing that their grandchildren's basic needs were met. Aside from the knowing that their grandchildren will be secure, they also described how they enjoyed the simple pleasures of partaking in activities with them [210].

ELDERLY ETHNIC MINORITIES

The elderly population in the United States is far from homogeneous in terms of race and ethnicity. Minority populations have increased from 7.2 million in 2007 (19% of the elderly population) to 11.8 million in 2017 (23% of the elderly) and are projected to increase to 27.7 million in 2040 (34% of the elderly) [92]. In 2017, the largest racial/ethnic minority groups were African American (9%), Hispanic (8%), Asian American and Pacific Islanders (4%), and Native Americans and Alaskans (less than 1%) [92].

Given the discrimination and oppression that racial and ethnic minority elders may have experienced over the years, they may be reluctant to seek mainstream health and mental health services. In addition, some may be limited in English proficiency, which is often another barrier to help-seeking and compliance with health and mental health services. Practitioners should be aware of the dynamics that stem from the result of cultural differences in values, belief systems, health beliefs, attributions of causation to illness and problems, and communication styles [104]. Not understanding cultural differences can lead practitioners to take on a deficit or pathology perspective when viewing their clients.

ELDERLY WOMEN

In examining historical trends, there are gender differences in longevity rates; women tend to live longer than men [5; 92]. For example, women who reach 65 years of age are expected to have a life expectancy of an additional 20.6 years; men who reach 65 years of age have an average life expectancy of 18.1 years [92]. As such, there are significantly more older women (28.3 million) than men (22.6 million) [92]. This longer lifespan has social and economic ramifications. In general, elderly women are more likely to be widowed, living alone, and experience greater poverty than their male counterparts. According to the U.S. Census, 32% of women 65 years of age and older are widowed compared with 11% of men in this same age-group [92]. Approximately 34% of elderly women and 21% of elder men live by themselves [92]. Despite some of these negative social trends, a qualitative study of 15 urban elderly women related stories of survival, strength, and resilience [106]. The themes that emerged in these narratives were that of being able to rebound from adversity and tapping into social network systems that stemmed from their churches, community, and family.

GAY AND LESBIAN ELDERLY

There are an estimated 2.4 million lesbian, gay, bisexual, and transgender (LGBT) individuals 50 years of age and older, a number that is expected to double by 2030 [183]. The overall predominant attitude about sexuality is that it is a private matter, and the general myth is that elderly individuals are sexless [107]. Therefore, the unique needs of gay, lesbian, and transgendered/transsexual elderly are often ignored or unacknowledged. Furthermore, in a heteronormative society, older adults may have experienced (and continue to experience) discrimination [184]. Elderly homosexuals experience intersecting oppression stemming from ageism as well as homophobia. Older gay men, for example, are stereotyped as "dirty," "lecherous," and "oversexed" [108]. These stereotypes lead to discrimination, marginalization, and oppression and affect health, mental health, and social services. Chronic minority stress results in health disparities among older LGBT older individuals, including greater risk of cardiovascular disease, depression, and premature cognitive decline [211]. One of the major fears associated with aging in the gay community is decline in health status and not being able to access services that accommodate to gays' and lesbians' needs and concerns [107]. Lesbians tend to express concern about lack of recognition of same-sex partners and lack of services that are sensitive and relative to gays and lesbians. Gay men tend to fear being alone in later life. Discriminatory housing policies in assisted living facilities are also a concern [212]. It has been hypothesized that, due to the discriminatory policies affecting gay and lesbian individuals' access to different types of services, older gay and lesbian women are more vulnerable to needing long-term care than their same-age heterosexual counterparts [147; 212]. After controlling for race, age, and education, researchers found that women living with female partners were more likely to need help with bathing or dressing compared with women living with or married to male partners. Similarly, men living with male partners were more likely than men living with or married to female partners to need help with errands.

It is important to use the lifespan perspective to understand the experiences of older gay and lesbian adults [148]. Their reality is shaped by a culture that has historically criminalized, medicalized, and pathologized same-sex relationships. Therefore, they have historically been socially isolated and ostracized by their families and friends [109]. In addition, access to care and social services have been adversely impacted, which then has led to health disparities [148].

LONG-TERM CARE

In the United States, there were 1.3 million adults residing in nursing homes at the end of 2016 [149]. As age increases, the percentage of those residing in nursing home also increases. Only 16.5% of residents are younger than 65 years of age, 18.2% are 65 to 74 years of age, 26.7% are 75 to 84 years of age, and 38.6% are 85 years of age and older. Women are highly represented among nursing home residents, comprising 64.6% of this population. In addition, the majority (75.1%) are non-Hispanic white, followed by black (14.3%), and Hispanic (5.4%) [149]. Among residents in nursing homes, the majority require assistance with activities of daily living, including bathing (96.7%), dressing (92.7%), walking or locomotion (92%), toileting (89.3%), transferring in or out of bed (86.8%), and eating (59.9%) [149]. In addition, it is estimated that the number of older adults with significant physical or cognitive disabilities will increase from 6.3 million in 2015 to 15.7 million in 2065 [149].

In 2018 in the United States, 56% of those 65 years and older required long-term services [213]. Institutions providing long-term care to older individuals often provide a variety of services, including personal, social, and medical services. Key factors that predict elders entering a nursing home include [111]:

- Non-Hispanic white race
- Lower income bracket
- Restricted activities of daily living
- Cognitive impairments or a history of falls
- Chronic diseases (e.g., diabetes, cardiac conditions, stroke)
- Limited social supports (e.g., widowed, divorced, few or no children)

Although nursing homes remain an integral factor in long-term care, there have been concerted efforts to move away from institutionalized care and to home- or community-based options [80]. This may be in part due to most individuals' wishes to remain in their own homes for as long as possible, receiving more patient-centered and responsive care. It is important to note that family members provide the majority of care to older individuals. In 2015, 34.2 million people in the United States provided unpaid care to an adult 50 years of age or older [81].

Providing long-term care is complicated, as integrated psychosocial and medical care is often required. Specialized assessment tools, including the Resident Assessment Instrument, are available in order to assist in the development of care plans for residents in long-term care facilities [82].

Ten ethical issues have been identified has having significance in geriatrics and long-term care [79]:

- Beneficence: The main concern should be for the well-being of the client or patient.
- Non-maleficence: Harm should be avoided
- Futility of treatment: Interventions should be consistent with the individual's goals.
- Confidentiality: All laws should be conformed to in regards to confidentiality.
- Autonomy and informed consent: All patients have the right to self-determination, including the right to refuse treatment. Persons should also be encouraged to complete a healthcare directive and to name a proxy in the event that they are incapacitated.
- Clinician-patient relationship: All clinicians should strive to create a therapeutic alliance with the patient.
- Truth telling: Communication should be honest and thorough, and medical terminology should not be used to obscure the truth.

- Justice: An objective decision-making process should be used.
- Non-abandonment: Clinicians have the responsibility of ensuring that patients are provided with adequate therapy. If a therapeutic relationship must be terminated, it may not end until time has been given for the patient or his or her proxy to make other arrangements.
- Limited resources: Make decisions and allocate limited healthcare resources in a nondiscriminatory and objective manner.

For elders and their family members who believe their rights have been violated or who have complaints about their long-term care services, all states have an Ombudsman Program under the Title VII Older Americans Act that is overseen by the Administration on Aging [112]. Volunteers from this program work with elders and families to advocate on their behalf to provide information about long-term care, to investigate complaints, and to promote changes in institutions in order to improve the quality of life for long-term care residents.

ASSESSMENT TOOLS FOR OLDER ADULTS

This section will touch on key assessment tools in the areas of depression, suicidality, substance and alcohol abuse, and elder abuse. Elderly patients should be routinely screened for these conditions, in spite of some practitioners' discomfort with asking questions about sensitive topics. These population-appropriate assessments may be included in other health screening tools [58].

SCREENING TOOLS FOR DEPRESSION

Structured instruments like the Center for Epidemiologic Studies Depression-Revised scale (CESD-R) and the Beck Depression Inventory are brief self-reports that measure signs and symptoms of depression [59; 60; 166]. These practical tools are easily accessed and administered by practitioners. However, they are self-reports and can be unreliable, particularly for those with impaired memory. The CESD-R is a 20-item instrument consisting of closed-ended questions; the Beck Depression Inventory is a 21-item rating inventory. These assessment tools were not developed specifically for older adults.

The Institute for Clinical Systems Improvement asserts that clinicians should routinely screen all adults for depression using a standardized instrument. (https://www.icsi.org/wp-content/uploads/2019/01/Depr.pdf. Last accessed May 15, 2020.)

Strength of Recommendation/Level of Evidence: Strong recommendation/low-quality evidence (The work group feels that the evidence consistently indicates the benefit of this action outweighs the harms. This recommendation might change when higher quality evidence becomes available.)

In addition to these tools, a specific assessment measure for older adults, the Geriatric Depression Scale (GDS), has been developed [85]. Available in both a short and long form, this scale consists of 15 to 30 closed-ended questions. The GDS is recommended when screening older adults who are functioning well cognitively or are only slightly cognitively impaired for depressive symptoms [84; 203].

If a practitioner finds that an older individual scores positively for depression, the patient should be further evaluated in a clinical interview to determine whether the symptoms are of sufficient intensity, number, and duration to meet the criteria for major depression or dysthymia.

SCREENING TOOLS FOR COGNITIVE IMPAIRMENT

Older adults are more likely to experience cognitive decline, and presence of the early signs of impairment should prompt immediate intervention [83]. Patients who display symptoms of changes in psychologic status may be evaluated for dementia or cognitive impairment using the Mini Mental State Examination (MMSE). The MMSE consists of 11 items that assess five areas of cognitive function: orientation, registration, attention and calculation, recall, and language. A maximum score is 30, and any score less than 24 indicates cognitive impairment [83]. Because the MMSE takes little time to administer, it may be integrated into practice relatively easily.

The Mini-Cog is also another quick screening tool used to assess for cognitive impairment. It involves a three-item recall and a clock drawing test and takes about three to five minutes to administer. The patient is given three unrelated words to remember, then is asked to draw the face of a clock, with the time of 10 minutes after 11 o'clock. After drawing the clock, the patient is asked to repeat the original three words. He or she receives one point for each recalled word [150]. A score of 0 indicates likelihood of cognitive impairment, and a score of 3 indicates no concern of cognitive impairment. If the score is 1 or 2, the results of the clock drawing test are taken into account; an abnormal drawing is suggestive of cognitive impairment. This test has a sensitivity rate of 99% and classified a group of subjects correctly 96% of the time [150]. In a study of elderly veterans, researchers found that the majority of participants with no documented diagnoses of dementia failed the Mini-Cog [151]. The authors concluded that this simple screening tool can easily be incorporated into standard assessments.

The Montreal Cognitive Assessment (MoCA) assesses for memory, orientation, language, abstraction, executive functioning (i.e., ability to remember instructions, focus, and handle and execute multiple tasks), and constructional praxis (i.e., skill to join parts to make a whole). Some prefer this assessment because it detects milder forms of cognitive impairment compared with the MMSE [214]. It consists of 30 items and takes approximately 10 minutes to administer. More information on the MoCA is available at https://www.mocatest.org.

In addition, the Alzheimer's Association has published a cognitive assessment toolkit intended to allow practitioners to detect cognitive impairment quickly and efficiently during the Medicare annual wellness visits. The toolkit is available online at https://www.alz.org/media/documents/cognitive-assessment-toolkit.pdf.

ASSESSMENT TOOLS FOR SUICIDALITY

Asking questions about thoughts and/or intent to harm oneself is often uncomfortable for practitioners [61]. However, it can be done in a nonconfrontational manner that conveys caring and respect. It is also recommended that cultural sensitivity be at the forefront of practitioners' minds when assessing for risk of suicide. Individuals from certain cultural backgrounds may view suicide as sinful [61; 152]. Taking this into consideration, questions include: With this much stress, have you thought of hurting yourself? Do you think life is worth living? Have you ever thought of killing yourself? How would you do it? Do you have the tools to carry out your plan? What would stop you or what has stopped you from carrying out your plan?

CAGE QUESTIONNAIRE
Have you ever felt you should **C**ut down on your drinking?
Have people **A**nnoyed you by criticizing your drinking?
Have you ever felt bad or **G**uilty about your drinking?
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?
Source: [64] *Table 1*

When suicidal ideation is known or suspected, a more direct approach, using forced choice questioning, may be helpful [62]. Shea recommends inquiring about specific symptoms with an emphasis on overestimation in order to prevent individuals from underestimating the symptoms [62]. For example, a clinician might ask: "Do you think about hurting yourself 20 hours a day?"

The Geriatric Suicide Ideation Scale (GSIS) is targeted to older adults to specifically measure for suicidal ideations. It consists of 31 items in four subscales: suicidal ideation, death ideation, loss of personal and social worth, and perceived meaning of life [215].

The Depression and Suicide Screen (DSS) may also be useful. It consists of five items, is simple to administer, and can be used in health and mental health settings. The DSS requires patients to answer yes or no to following questions [113]:

- Is your life pretty full? If no, score 1 point.
- Do you still enjoy doing the things you used to do? If no, score 1 point.
- Do you think it is too much trouble to do the things you used to do? If yes, score 1 point.
- Do you feel that you are a useful person who is needed by others? If no, score 1 point.
- Do you feel tired without any specific reason? If yes, score 1 point.

A score of 2 or greater is considered sensitive for depression and/or suicidality.

SCREENING TOOLS FOR ALCOHOL ABUSE

There are several screening tools available for assessing older adults with problem drinking. The Drug Abuse Screening Test (DAST) is a 28-item questionnaire consisting of yes or no responses. The Short Michigan Alcohol Screening Test (SMAST) is a 13-item questionnaire with a similar response format. These instruments are commonly used but may not be appropriate for the elderly population. However, a longer version of the SMAST, the Michigan Alcohol Screening Test-Geriatric (MAST-G) was specifically developed in order to accurately assess alcohol abuse and dependence in older adults [46]. The MAST-G consists of 24 items, which may limit its incorporation into regular screening procedures. As opposed to the standard MAST, this version focuses more on drinking in response to grief and changes in drinking patterns over time.

The CAGE Questionnaire for Alcohol Abuse is a brief, easy-to-administer screening device that is easily incorporated into a medical or psychosocial assessment; it is the most widely used instrument in clinical practice (***Table 1***) [63]. The CAGE Questionnaire consists of four closed-ended items that assess an individual's perception of their drinking habits. Affirmative responses to any one item indicate a potential problem with alcohol abuse [64]. However, this tool does not identify those who may be in the early stages of alcohol abuse [63].

In general, patients will be willing to answer questions if they perceive that the practitioner is caring and nonthreatening. Responses to the screening questions will be most accurate when patients believe their responses will be kept confidential and will help with their health diagnosis [136].

SCREENING FOR ELDER ABUSE

There is no one single tool that is considered the criterion standard to assess and measure elder abuse [179]. One tool, the Indicators of Abuse form, is available for practitioners to use when observing and interviewing the client and family members for elder abuse [65]. This tool is not dependent upon self-reporting but is based on observation and assessment. Researchers have been able to isolate caregiver characteristics that are strongly related to elder abuse [65]. These characteristics include the caregiver's personal and emotional problems, financial dependence of a caregiver on the elder, and the caregiver's general lack of knowledge about the elder's health and psychologic concerns. Furthermore, elder abuse was also correlated with family conflict, the elder's lack of social support, and history of past abuse (though not by the caregiver) [65]. Using these findings, the Indicators of Abuse form was developed. Based on observations and lengthy interviews with both the elder and family members, it asks practitioners to estimate how large the problem is in two areas: dimensions related to the caregiver (e.g., behavior problems, financial status, alcohol/substance problem, or marital/family conflict) and dimensions related to the elder (e.g., social isolation, unrealistic expectations, suspicious falls/injuries, or behavior problems) [65].

Another good assessment instrument is the Elder Abuse Suspicion Index (EASI). It is a five-item tool that provides practitioners a very quick sense whether there is suspicion about the potential presence of elder abuse [114]. It was originally developed for physicians, but it may be used by practitioners in diverse disciplines. The screening questions are:

- Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
- Has anyone prevented you from having food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?
- Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
- Has anyone tried to force you to sign papers or use your money against your will?
- Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

The Brief Abuse Screen for the Elderly (BASE) is another instrument, consisting of only five questions, that takes less than one minute to complete [153]. This tool is designed for the practitioner to complete to determine level of suspicion—the patient is not questioned directly. It is ideally suited for practitioners to use in conjunction with a patient screening tool [153].

Assessing for elder abuse does not only involve asking questions to the elderly client. It is also about asking oneself difficult self-evaluative questions, such as: "Do I hold ageist attitudes? How are these attitudes translated when I conduct an assessment? Do I believe that older adults can be abused, even sexually abused?" Pervasive ageist attitudes held by practitioners can result in a failure to acknowledge that elder abuse (particularly sexual abuse) can occur [154]. This can impact whether certain assessment questions are even asked.

The U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults. (https://jamanetwork.com/journals/jama/fullarticle/2708121. Last accessed May 15, 2020.)

Strength of Recommendation: I (Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.)

GENERAL GUIDELINES FOR INTERVENTIONS

Wellness and purpose have become important emphases when working with older adults [66]. In the past, aging was associated with disability, loss, decline, and a separation from occupational productivity. Although client growth and positive change and development are values that practitioners embrace, the unconscious acceptance of societal myths and stereotypes of aging may prevent practitioners from promoting these values in elderly individuals [115]. In a study of 200 older adults residing in assisted living facilities, participants scored low on levels of depression and high for successful aging, despite having a variety of chronic health conditions [155]. Researchers also found few differences between the young-old and the old-old subgroups in terms of their ratings of successful aging. More than half of the residents exercised regularly, which had both physiologic and social benefits. It is important not to assume that older adults will automatically decline, and it is important to give these patients a sense of purpose and activities that promote successful aging. In a qualitative study conducted by Griffith, Caron, Desrosiers, and Thibeault, older adults defined meaningful occupational roles in a variety of ways [67]. For some, meaningful occupations involved using a skill they are good at; for others, meaningful occupations help to express an identity they value. According to Penick, there is no empirical evidence that older adults do not desire purposeful activities and goals, although their goals may be different from those in other stages of the developmental life cycle [68]. A study conducted by Greenfield and Marks found that elders who were not engaged in activities that promoted a sense of identity were more likely to experience negative psychologic well-being and less sense of a purpose in life [69]. However, those who were engaged in meaningful activities, like formal volunteering, were more likely to experience positive psychologic well-being. Consequently, caring for older adults necessitates a focus on wellness, goals, and purpose, which requires practitioners to shed stereotypical views of aging. Environments that provide older adults with opportunities to explore and formulate new goals are vital [68]. In assessments of older individuals, practitioners should encourage older adults to talk about what gives meaning to their lives and to identify goals based on their social interests [68]. Furthermore, Koenig and Spano argue that the concept of hope may have to be redefined given the context of the lives of elders [115]. For example, if hope is defined as achievement and control, this may be problematic for elders. However, if hope is reconceptualized to mean strengthening existing coping skills and capabilities to transcend challenges, then elders can be empowered to focus on their strengths versus their deficits.

Reminiscence interventions may also be beneficial for older adults. As a therapeutic intervention, reminiscing allows older adults to recall and relive past events in order to integrate their experiences [156]. However, this approach consists of more than simply recalling past memories; these interventions emphasize the importance of the reflective process in assisting individuals to define and redefine themselves [185]. Some counselors use photographs, videos, autobiographies, or other materials to help trigger memories. These concepts are reflected in nursing homes and other long-term care facilities that encourage residents to display family photos or create memory books [186]. This type of intervention can improve self-esteem, mood, cognition, and behavioral functioning. In reminiscence groups with caregivers participation, caregivers reported learning more about the patients and appreciating their lives and experiences [156].

One study evaluated a spiritual reminiscence group consisting of patients with mild-to-moderate dementia in Taiwan over six weeks [185]. Those who participated in the intervention showed increases in hope, life satisfaction, and spiritual well-being compared with the control group. Another study found that older adults who participated in a reminiscence intervention experienced greater levels of problem solving and social support seeking and were less likely to use avoidance coping compared with the control group [216].

ENGAGEMENT

Coping with loneliness can involve increasing the number of social contacts or intensifying certain specified relationships and lowering individuals' expectations about relationships [157]. Loneliness and social isolation impact older adults' mental and physical well-being. For example, living alone, loneliness, and social isolation are correlated with falls among older adults [219].

Increasing or intensifying social networks can involve various approaches. Cattan and White identified three key aspects of interventions for older adults that support active engagement: group activities that provide support (e.g., support for bereavement), interventions targeted to a specific subgroup (e.g., widowers), and activities or interventions emphasizing elders' control [70]. Several interventions for older adults that focus on decreasing social isolation have been identified and may be classified into four general categories [71]. The first type of intervention to address isolation is one-on-one telephone support services, whereby a counselor checks in with elders periodically. Second, teleconferencing, whereby a group of elders are brought together via a phone conference, has been found to be a cost-effective and useful intervention. Third, face-to-face support groups were found to be beneficial in reducing social isolation, particular groups that last for at least five months [71]. Lastly, with increasing Internet accessibility, e-mails and Internet support groups can also be beneficial for older individuals. Older adults who have access to and use computers have more social support and are less likely to experience loneliness [217]. A study exploring the use of videoconferencing with frail elders in Australia found that the patients preferred videoconferencing with a pain specialist over a face-to-face consultation [116]. A systematic review found that social connectedness and support were increased in elders who used Internet technologies, although the effects were short term [187]. As discussed, loneliness is often intertwined with other variables, such as shyness or limited resources. Therefore, interventions should not simply focus on providing venues for older adults to meet; interventions and programs that focus on people's expectations about friendships and relationships are equally important [157].

AUTONOMY AND EMPOWERMENT

Autonomy is a quality valued by all, but it may be even more important for persons whose movements are restricted by physical limitations, which is often the case with older individuals. Autonomy refers to the freedom and ability to act on one's own behalf [72]. It is described as having two attributes: independence and control. Independence entails the physical ability to act as one wishes; control is defined as perception of one's ability to exert power [72]. Control also refers to self-determination, or the ability to choose for oneself or formulating and executing a plan for oneself [117]. When older adults perceive they are losing their sense of autonomy, they are more vulnerable to becoming apathetic, depressed, powerless, and indecisive [158]. Family members become more involved as well [181]. For those living in nursing home facilities, it is crucial to provide them with choices and to empower them to make those choices, even simple decisions such as which foods to eat, activities to engage in, and clothes to wear [158].

Autonomy is central in promoting a sense of empowerment. Empowerment is the process by which individuals or groups perceive they can make positive changes or impact within their own lives related to interpersonal relationships and an array of social, political, and economic arenas [73]. In one small study of older adult women, the participants expressed the importance of relationships in the feeling of empowerment, including the significance of mutuality, problem solving based on collectivism, and mutual support and action [73]. Cox and Parsons recommend small group interventions, particularly for older women, that emphasize self- and mutual-help, meaningful relationships, and problem-solving skills [73].

With these overall themes in mind, Silverstone offers several practice guidelines when caring for older individuals [74]:

- Assessment and diagnosis of an older adult's needs should take place within the context of the individual, family, and environment.
- Differential features of practice with older adults should be listed. These features may include health, mental health, loss, control, spirituality, and adaptive behaviors. Listing these different areas should help practitioners consider the array of domains to be covered in psychosocial assessments. It also assists practitioners to identify areas in which they may need to seek additional education and/or information.
- Collaboration with members from multidisciplinary teams is vital in order to address areas of importance to older adults.
- Practitioners should seek evidence-based literature to inform their practice.

ETHICAL PRACTICE WITH ELDERS

General societal misconceptions regarding the elderly can influence practitioners' ethical decision-making capabilities when working with older adults [75]. The first misconception is that older adults are helpless victims and must be rescued [75]. Another misconception is that older adults cannot change at this stage in their lives. Some may also believe that because this life stage is characterized by decline, older individuals are not able to better themselves or heal [75]. If practitioners are influenced, consciously or unconsciously, by this bias, it can then affect or motivate their decision-making processes.

PROMOTING AUTONOMY AND SELF-DETERMINATION

The ethical principle of beneficence mandates the duty of practitioners to do good and avoid harm [76]. The balance of good and harm is continuously evaluated. All persons have the right to self-determination, and it should be assumed that all adults (with some exceptions) have the capability to make decisions. Practitioners are responsible for encouraging (but not pressuring) the client to be autonomous [77]. Family members and practitioners may pressure older adults to use certain devices (e.g., electronic pill dispensers, data-gathering devices, robotic pets) because they appear to be beneficial and life-improving [218]. However, if an individual does not want to use the device, it is important consider if the pressure compromises his or her autonomy. A four-step process to assist practitioners to promote beneficence and client autonomy has been developed [76]:

- Discuss each client's values and preferences.
- Evaluate care plans related to physical safety, independence, and each client's values and preferences.

- Protect the client's autonomy by considering the client's values and preferences and weighing them with potential negative consequences of implementing any care regimen.
- Support each client's values and preferences, even if they conflict with the practitioner's own value system.

The violation of clients' autonomy and self-determination can be very subtle. Practitioners should consider the role of power dynamics between the two parties and how the practitioner's expert status inadvertently reinforces a hierarchical relationship [118]. In a study of 21 older adults receiving in-home nursing care, one of the main themes that emerged was the elders' need to be treated as people—as unique individuals and not cases [159]. The participants reported wanting to be treated with respect and dignity and wanting to make decisions about their care. Furthermore, older adults with chronic conditions eventually learn to live with and have established competencies and routines to manage it. They are still active in their decision making and want to continue to be [160].

Informed consent is the direct expression of the principle of autonomy. The three criteria for informed consent are competence, voluntariness, and being informed [182].

CAPACITY

Decision-making capacity refers to an individual's ability to understand, appreciate, reason, and ultimately express choices. There are different categories of decision-making capacity, such as personal, medical, and financial [119]. It is important for practitioners not to assume that elders cannot make their own decisions, as this would be based on the ageist assumption that with age comes a lack of mental capacity. However, practitioners should remember that some losses may be associated with the normal process of aging. Loss of hearing, for example, can lead to miscommunication and a sense of isolation, anxiety, or paranoia. Therefore, effective communication, regardless of client disabilities, is key in helping elders make informed choices [78]. It is also important to remember that assessing an older adult's level of capacity should be continuous [161].

The issues of an elder's mental capacity and self-determination come into play with informed consent, particularly if cognitive impairments are present. Informed consent involves three dimensions: the communication of the information, the opportunity to ask questions, and the process of making a decision [162]. As stated, an elder's self-determination should be promoted. It must involve not only the communication of the information but also giving older adults the opportunity to ask questions about their care, the intervention, and/or services provided to them and empowering them to make the decision. However, there may be times when an elder cannot give informed consent. One way to assess if the elder understands the intervention is to have him/her reiterate what the intervention entails [6]. However, there are a few options when an elder's capacity is compromised. First, a surrogate caregiver could provide consent. Second, double informed consent could occur, whereby the surrogate caregiver gives informed consent and the elder client gives assent. Finally, it is possible to obtain early informed consent from the elder via legally binding documentation of wishes prior to any cognitive impairment [6].

Several tools are available to assess capacity, including [161]:

- Aid to Capacity Evaluation
- MacArthur Competence Assessment Tool for Treatment
- The Assessment of Capacity for Everyday Decision-Making
- Semi-Structured Clinical Interview for Financial Capacity

These tools evaluate different dimensions of capacity, highlighting the lack of consensus on the criteria to determine capacity.

CONFIDENTIALITY

The ethical principle of confidentiality is defined as the preservation of client privacy. When older individuals are at risk of harming themselves or being harmed by others, as in the case of elder abuse or cognitive impairment, the issue of confidentiality becomes a challenge. Surveillance devices offer the benefit of monitoring the whereabouts of an older adult with dementia at the cost of reduced privacy. The decision of whether or not to use these devices should consider the extent of the older person's cognitive deficits and his/her ability to make decisions [218]. In the case of elder abuse, the ethical intervention is dependent upon state and national laws. Therefore, practitioners should be well-versed in their state's laws regarding elder abuse, advance directives, and other relevant issues. In addition, practitioners should clearly present the limitations of confidentiality to the client.

CONCLUSION

Age-sensitive practice is crucial and will continue to grow more important as the nation's demographic shifts and life expectancy increases. The older segment of the population is extremely diverse in terms of the span of developmental, social, and psychologic needs. Resilience and potentiality rather than decline and deficits should be emphasized throughout all assessments and interventions. Practitioners should explore their beliefs and values to determine if any normative ageist assumptions about the elderly are present. Instead of viewing the elderly as a group with many problems, diseases, and pathologies, a strength perspective that emphasizes their rich and diverse life experiences should be infused into clinical practice. In order to facilitate the best care for older adults, the promotion of knowledge and skills in these areas is vital.

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

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