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Mental Health Promotion

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The number and proportion of the population age 65 years and older will grow rapidly after 2010 (Department of Health and Human Services [DHHS], 2000). As the nation ages, the growing mental health needs of older adults must be addressed. Mental health is a state of successful performance of mental functioning, resulting in productive activities, fulfilling relationships with other people, and the ability to cope with and adjust to the recurrent stresses of everyday living in an acceptable way. It is a state of balance that individuals establish within themselves and between themselves and their social and physical environments. Mental health is indispensable to personal well-being, family and interpersonal relationships, and one's contributions to community and society (DHHS).

To gain a deeper understanding of the meaning of mental health for older adults, Hedelin (2001) interviewed 16 women between the ages of 71 and 92. Participants in this study indicated that mental health is the experience of confirmation, trust, and confidence in the future, and a zest for life, development, and involvement in one's relationship to oneself and others.

Mental wellness is the capacity to perform well in any endeavor, to love and have friends, and to enjoy life with relative freedom from internal stress without causing stress to others. Promoting mental health is both any action to enhance the mental well-being of individuals, families, organizations, and communities, and a set of principles that recognize the mental health impact of how services, in the widest sense, are planned, designed, delivered, and evaluated. Mental health promotion works at three levels: (1) strengthening individuals or increasing emotional resilience through interventions designed to promote self-esteem, life skills, and coping skills (e.g., communicating, negotiating, and relationship skills); (2) strengthening communities by promoting social inclusion and participation, improving neighborhood environments, developing health and social services that support mental health, workplace health, community safety, and self-help networks; and (3) reducing structural barriers to mental health through initiatives to reduce discrimination and inequalities, and to promote access to education, meaningful employment, housing, services, and support for those who are vulnerable.

At each level, mental health promotion is relevant to the whole population, individuals at risk, vulnerable groups, and people with mental health problems. At each level, interventions may focus

on strengthening factors known to protect mental health (e.g., social support, physical health) or to reduce factors known to increase risk (e.g., racial discrimination and loneliness). Mental health promotion has a role in preventing certain mental health problems in older adults, notably depression, anxiety, and substance abuse. Also, mental health promotion may foster recovery from mental illness and improve the quality of life of older adults with mental health problems (Hogstel, 1995).

STRESSORS IMPACTING MENTAL HEALTH

Older adults' lives are not free of stress. Stressors are events that either have a direct effect on the body or an indirect effect through various mediators. The individual's reaction to stressors is an attempt at adaptation, and if the stressors are not extreme or chronic, the attempt is usually successful. In that sense, stress reactions are good, in that they are a part of the homeostatic mechanism of the body to transient disruptions of equilibrium. If, however, the stressor becomes chronic, the individual's ability to successfully adapt is often compromised with resulting undesirable consequences, such as mental ill health. Stressors that may challenge the lives of older adults include physical health problems, financial issues, difficulty accessing social services, transportation barriers, isolation, and finding affordable long-term care services.

However, it makes little sense to speak of, or to consider, older adults as a homogeneous group. Cook and Kramek (1986) suggested that older adults could be viewed as two distinct groups: those who are both financially poor and subject to chronic illness, and those who are both physically and financially well off. Moreover, issues of gender, race, and ethnicity create further distinctions. Ruiz (1995) noted, for example, that old men and old women are treated differently in the United States, as are older adults of various races and ethnic backgrounds. What is of interest here is that each of these variables may be considered a stressor, and to some degree may affect the mental health of older adults. From a mental health perspective, becoming aware of the basis of these stressors may be the first step toward mental health promotion and illness prevention.

Gender

Longevity and living arrangements have a significant impact on all older adults' quality of life and mental health, but more so on older women's. Because many more women than men survive into old age, the role of gender deserves special consideration in any discussion of mental health promotion in older adults. Women who reach age 65 can expect to live nearly 20 more years, whereas men at age 65 can only expect about 15 years (Moody, 2002). The typical fate is for men to die early and for women to survive with chronic disease. Because women tend to marry men who are older than they are, women are more likely to be widowed and live alone in old age than men. Because the family caregiving role of women often has the consequence of removing them from the paid labor force, they accumulate lower pension benefits than men. Retirement income for older women is on average only about 55% of what it is for older men, and nearly three out of four older Americans who fall below the poverty line are women (Moody).

Divorce is also becoming an increasingly prevalent influence on older women's living arrangements (Moody, 2002). Divorced women usually experience a sudden reduction in their financial circumstances and they, unlike men, are less likely to remarry. For older women, socioeconomic stressors, patterns of inequality involving social class, race, ethnicity, and gender reinforce one another. If women earn less than men, and if minority group members are subject to prejudice over their lifetime, it is not surprising that an older, divorced, or widowed woman, who is from a lower socioeconomic class and a member of a minority racial or ethnic group, would experience problems in the area of health status, income, and housing that could negatively affect her mental health.

Race and Ethnicity

The poor socioeconomic position of many individuals in minority ethnic populations in the United States is a major cause of poor mental health, and highlights the need for policies and programs to reduce inequalities in mental health services between the majority and minority populations (Chow, Jaffee, & Snowden, 2003). In studies conducted in South London, based on contact with psychiatric services over a 10-year period, Boydell et al. (2001) and Sharpley, Hutchinson, Murray, and McKenzie (2001) found that the incidence of schizophrenia in nonwhite minority groups increased significantly as the proportion of such minorities in the local population fell. The authors concluded that the increase may have been caused by reduced protection against stress and life events because of isolation and fewer social networks. They suggested that people from minority racial and ethnic groups may be more likely to be singled out or to be more vulnerable when they are few in number or dispersed. These findings point to the importance of social factors as an explanation for the increased rate of schizophrenia among British-born minority racial and ethnic individuals.

Psychosocial factors may have particular significance for minority racial and ethnic populations because of the impact of racism and discrimination on individual and collective self-esteem. Racism affects mental well-being in two main ways. First, it contributes to mental distress and can lead to feelings of isolation, fear, intimidation, low self-esteem, and anger. Depression may be caused by feelings of rejection, loss, helplessness, hopelessness, and an inability to have control over external forces (Bhugra & Bahl, 1999). Second, it can act as a barrier to the access and provision of appropriate services. Minority racial and ethnic individuals may feel excluded from services because of direct discrimination by staff or through indirect discrimination, such as being unable to access services because of language barriers.

Challenges of Late Life

During their later years, adults are confronted with what are possibly the greatest number of challenges in their lives, often with their lowest level of emotional resources and financial means because of fixed and limited incomes. It is a time when they may feel psychologically and physically fragile, in the midst of what constitutes for many individuals a very difficult period: aging and impending mortality. Issues of loss, disability, and identity are just a few of the many biopsychosocial concerns that older adults need to address for a continued sense of well-being. In facing these issues, older adults often find their biological and social families fractured or missing because of death, illness, or relocation.

Changes or loss in health, family, society, and finances can foster psychological disequilibrium and promote stress in older adults. According to Neugarten and Datan (1975), the stressful impact of an event is less intense when change is expected as opposed to when it is not expected. For example, the sudden onset of illness can be traumatic and can result in older adults feeling that their health is out of their control, creating a very stressful experience. Seligman (1992) pointed out that generally, adults with limited emotional and financial resources who perceive their lives as having progressive and unexpected problems often experience their situation as unstable and unpredictable and are more inclined to become depressed.

Successful aging implies that individuals are satisfied or content with their lives; that is, they have found ways of maximizing the positives in their lives while minimizing the impact of inevitable age-related losses. Maintaining connections with others is an important aspect of adult life. Mitchell (1990) found that older adults often affirm themselves through interrelationships. Maintaining such connections can become increasingly difficult during older adulthood as significant others die or are relocated. Physical deficits that occur with aging may also limit access to others. Visual impairment may limit older adults' ability to travel independently

outside their immediate surroundings, thereby reducing their ability to drive or use public transportation and thus reducing their opportunity to leave their homes.

Chronic Illness

Chronic illness, physical decline, and functional disability exert enormous strain on the mental health of older adults. Also, depressive symptoms are associated with many drugs used to manage chronic illness (Lueckenotte, 2000). Some chronic conditions, such as cataracts and hearing impairment, can be limiting but not life threatening. Other conditions, such as hypertension and heart disease, can lead to fatal disorders. Alzheimer's disease is probably one of the leading causes of disability and death afflicting people over age 65. Arthritis is the most familiar and the most prevalent chronic disease of later life and it is the most important cause of physical disability in the United States (Moody, 2002). The joint and bone degeneration that occurs as a result of arthritis and osteoporosis is a major problem for many sufferers, causing a loss of strength, weakened bones that are more likely to break, and reduced ability to perform independent activities of daily living (ADLs), a major source of self-esteem for older adults (Blair, 1999). Parkinson's disease, characterized by a loss of control over body movements, affects mainly older people. Dementia is quite prevalent, and depression is common among people with Parkinson's disease. Cancer is overwhelmingly a disease of old age and depressive symptoms occur as a side effect of the medications used to control the disease. Cardiovascular disease, which includes stroke and heart disease (Moody), is one of the leading causes of death among people over age 65. A stroke may cause immediate death or permanent disability including language or speech disturbance. For the disabled, the loss of quality of life can lead to frustration, anger, and depression. Alzheimer's disease involves progressive loss of the ability to think and remember. In its early stage, the symptoms of Alzheimer's disease may be severe enough to interfere with usual ADLs, work, or social relationships, the consequence of which may be emotional distress and depression.

Financial Problems

Morgan and Kunkel (2001) noted that there have been striking improvements in the economic well-being of the average older American in the past three decades. However, many still remain near or below the poverty level. Being African American, Hispanic, or a female living alone is related to serious economic disadvantage. The rate of poverty for older African Americans and Hispanic Americans is about three times that of European Americans. Women of all racial and ethnic backgrounds have poverty rates almost twice the rate of their male counterparts. This difference in economic well-being is reflected in differences in psychological well-being, with those who are economically distressed showing greater signs of depression (Morgan & Kunkel).

Admission to Nursing Home

Despite a decline in health and functional ability, older adults prefer to remain and receive care in their own homes (Moody, 2002). Because of the high cost of health care services, however, many older adults are forced to depend on federally funded services purchased through the Medicare and Medicaid financing programs. For many, nursing home placement is seen as a negative experience and viewed as institutionalization. Reliance on Medicare and Medicaid for payment of nursing home services is also stressful for some older adults.

There is an increased and immediate sense of loss for older adults on admission to nursing homes. Relocation to such an institution can be fraught with emotional and psychological turmoil. As a result, depression is widespread among residents (Lueckenotte, 2000). Often this is caused by fear of losing one's identity, friends, possessions, lifestyle, history, and personal space. Allen (2003)

noted that because residents live in an institutional setting, personal losses are inevitable. For many residents, the loss of control over their daily lives and the lack of decision-making opportunities constitute stressful living conditions. As far back as 1988, Phan and Reifler reported a high percentage of decreased interest, decreased energy, difficulty concentrating, feelings of helplessness and hopelessness, and psychomotor retardation in nursing home residents. Moody (2002) suggested that depression in nursing home residents may be a reaction to the fact that it is impossible for them to "start over" at this later stage of life.

COMPREHENSIVE MENTAL HEALTH ASSESSMENT IN CLINICAL PRACTICE

Nursing assessment calls for information about the nature and scale of clients' problems. The method in which assessment information is collected often depends on the problem involved. Because of the need to understand the "whole person," mental health nurses are required to assess all aspects of the person: biophysical, psychosocial, and spiritual. In this sense, mental health assessments may be formal or informal, but should always be rigorous and comprehensive (Campbell, 1995; Ritter & Watkins, 1997). Comprehensive assessment of older adults should identify not just weaknesses and problems, but also strengths and potentials. Comprehensive assessment of capabilities and incapacities, and social functioning and support systems, establishes a rational basis for the development of treatment plans tailored to the client's physical, psychological, and social needs. Accordingly, the essential components of comprehensive assessment should comprise physical functioning, mental and emotional functioning, family and social support, and living environmental characteristics.

Physical Functioning

A health history and assessment is essential to the psychiatric nursing assessment. Some physical problems can present with psychiatric complications. Similarly, some psychiatric disorders can present with physical problems. Loss of physical health has direct effects on the quality of life of older people. Bodily systems featured in the physical assessment include the cardiovascular, respiratory, endocrine, genitourinary, gastrointestinal, and musculoskeletal systems. Functional status is considered an important and significant component of an older adult's quality of life. Functional assessment determines the older person's capabilities in performing basic ADLs and the more complex instrumental ADLs (IADLs). Functional assessment also determines the person's nutritional status, ability to mobilize, sleep patterns, hearing and vision, and medication behavior. A widely used instrument for assessing ADLs is the Barthel Index (Mahoney & Barthel, 1965). A widely used instrument for assessing IADLs is the Instrumental Activities of Daily Living Scale (Lawton & Brody, 1969).

Pain history and assessment should be included in the assessment of physical functioning. Pain interferes with the proper physical functioning of older adults, especially their ability to mobilize, and this has a profound effect on perception of well-being. Pain correlates with less socialization with colleagues (Ritter & Watkins, 1997). The daily pain diary (McCaffery & Pasero, 1999) and the Self-Care Pain Management log (Ferrell & Ferrell, 1995) are useful tools for measuring pain in older adults.

Mental and Emotional Functioning

The mental status examination, one of the most important diagnostic screening measures available to nurses, is designed to assess the client's mental functioning level and estimate the effectiveness of the clients' mental capacity. The purpose of the mental status assessment in the older adult is to determine the client's level of cognitive functioning, the degree of cognitive impairment, and the effect of that impairment on functional ability. Cognitive functioning is the aspect of mental functioning most affected by aging (Moody, 2002).

"Cognition" refers to the mental organization or reorganization of information. Assessment of cognitive functioning is concerned with evaluating the older person's conscious processes: thoughts, memory, judgment, comprehension, reasoning, and problem-solving strategies used in daily living. Responses to cognitive demands may be tested in several ways. Abstract thinking, decision making, problem solving, and reasoning ability may be observed through such activities as budgeting, shopping, and other IADLs. Abstract reasoning involves the ability to think beyond a concrete way. Abstract reasoning may be tested by the interpretation of proverbs or the identification of similarities between items. Level of comprehension may be determined by the client's engagement and attentiveness to the interview and by the relevance and accuracy of the client's responses to questions and tasks. Memory may be tested in a simplistic way by asking the client to memorize and retrieve from memory a piece of information, such as a name or an address. Judgment is the end result of the client's ability to assess a situation, analyze it, come to an appropriate conclusion, and make sound decisions. Judgment can be assessed by listening as the client relates actual life events that required gathering and interpreting data, formulating a decision, and carrying out a plan. Judgment can be assessed by asking the client to make a decision about a hypothetical problem. Assessment of judgment also relies on observation and reports of informants who know the client well.

Older adults' cognitive functioning may be diminished by anxiety and worry, which may negatively influence recall and concentration (Morgan & Kunkel, 2001). Because of stereotypes of cognitive decline with aging that are held by society and the older adults themselves, mood and self-esteem of older adults are important factors to consider when measuring cognitive functioning. Ritter and Watkins (1997) noted that older clients tend to judge their memory as defective despite objective reports to the contrary. Consequently, self-report may not be a reliable way of estimating change in the cognitive functioning of older adults. Also, because diminished cognitive function in older adults is associated with lower educational achievement and lower socioeconomic status (Luis, Loewenstein, Acevedo, Barker, & Duara, 2003), any assessment of an elderly person's cognitive ability should include independent information about family patterns and about the person's educational achievement, so that individual measures are interpreted within their true social context.

Although the mental status examination done by the nurse may provide good subjective evidence of the client's mental functioning, it provides only a baseline that identifies the need for the administration of one of the standardized mental status tests. The tests that nurses can use clinically include the Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975) and the Short Portable Mental Status Questionnaire (Pfeiffer, 1975).

Emotional Functioning

The feeling element is perhaps the most commonly recognized aspect of the emotional dimension. Emotion refers to affective states and feelings. Each individual has the capacity to experience the entire realm of feelings, which is meant to be experienced, not ignored. Feelings, such as joy, anger, sadness, and fear, occur most naturally in young children who are not yet restricted, through social learning, in expressing their feelings. Adults, however, often attach judgments to their feelings and consequently ignore uncomfortable ones.

As with the young, older adults are not passive receptacles of emotional experiences. A related social event can elicit and define the nature of a particular emotional experience, such as fear in response to a loss of power. The emotional status of the client is assessed in terms of affect, appropriateness of the affect to the situation, quality and stability of the mood, physical signs of emotion, and emotional response patterns. The appropriateness of affect to the situation is based on the congruency between the affect the client is displaying and the client's culturally expected affective response

in a particular situation. Both affect and appropriateness of affect are in part culturally determined; also, emotional status is commonly altered in acute and chronic illness. Consequently, these circumstances must be considered in any interpretation by the nurse. Tools that may be used by nurses to measure affect include the Beck Depression Inventory, Short Form (Beck & Beck, 1972) and the Geriatric Depression Scale (Yesavage & Brink, 1983).

Family and Social Support

According to Morgan and Kunkel (2001), family members in all generations are involved in giving and receiving various types of assistance, including assistance during illness, child care, financial support, emotional support, and household management. Older adults who lack supportive ties on whom they can rely for assistance are at greatest risk for institutionalization when they can no longer care for themselves. Dwyer (1995) estimated that 80% of informal care to frail and disabled elders is provided by family caregivers. However, there are differences in the quality and quantity of support given to older adults by family members from different race, class, and ethnic groups.

The quality of life an older person experiences is closely linked to social functioning. Social support needs of older adults tend to increase with advancing years and functional limitations as a result of declining health. Although most older adults are assisted by family, many depend on friends and nonfamily social networks to maintain their independence and decrease loneliness and social isolation. Because many elderly individuals confront most of life's difficulties by seeking out information, advice, and support from trusted others, the contributions of this social support can positively influence their performance of everyday functional activities. Social interactions may also have negative consequences for the older adult. Interactions that are unwanted or unpleasant may be detrimental to social relationships.

Because social factors can be so influential in the mental health status of older adults, it is important that nurses take an adequate social history. The nurse must be careful to consider both familial and nonfamilial sources of social support when assessing older adults' social systems. Neff (1996) suggested nurses assess the client's living environment characteristics to determine how it is perceived by the client, and whether it is conducive to maximum functional abilities. The client's financial resources should also be assessed for change in income and ability to meet needs for food, clothing, shelter, recreational activities, or trips. The client's daily, weekly, and regular contacts should be noted. The client's verbalized insights into needs for services are also important. Client and family integration into the community should also be noted. Methods of transportation and the way the client spends a typical day should be assessed. Screening tools that nurses can use to assess clients' family and social support include the Family APGAR (Smilkstein, Ashworth, & Montano, 1982) and the OARS Social Resource Scale (Duke University Center for the Study of Aging and Human Development, 1988).

ASSERTIVENESS AND PROBLEM-SOLVING SKILLS TRAINING AS PART OF SOCIAL SKILLS TRAINING

Assertiveness is the ability to express one's needs and desires directly to the appropriate person in an appropriate manner. It involves standing up for personal rights and expressing thoughts, feelings, and beliefs, and making requests in direct, honest, and appropriate ways that respect the rights of others. It involves assuming responsibility for one's self and one's emotions and not projecting these onto others. In older adults, lowered interpersonal assertiveness has been found to be correlated with depression (Donohue, Acierno, Hersen, & Van Hasselt, 1995).

Because older adults with little or no effective interpersonal behaviors may be at risk of becoming depressed, it is incumbent on the nurse to help them gain the skills or make a referral for skills training to develop effective interpersonal

behaviors and increased interpersonal assertiveness. Skills training may be provided by clinicians including nurses, psychologists, and social workers who have been trained in behavioral principles and procedures. Skills training may involve anything from teaching clients how to shake hands to practicing conversational skills. Evidence of effective interpersonal functioning includes being goal-directed, showing signs of perception and integration of social signals, self-presentation, ability to take the role of others, use of appropriate social behavior, and ability to provide feedback to others.

Teaching older adults to behave in a highly assertive yet appropriate manner through social skills training may reduce their chances of developing depression. Specific techniques of assertiveness training include repeated modeling of appropriate skills, role playing, high levels of descriptive verbal reinforcement, and in vivo rehearsal-based homework assignments that require that the individual rehearse assertiveness in assigned real-life situations, rather than in his or her imagination. The outcome of assertiveness training may be an increase in the perceived, if not the actual, level of control in interpersonal relationships.

LATE LIFE CHALLENGES THAT CAN CONTRIBUTE TO MENTAL HEALTH PROBLEMS

Caregiving Role and Stressors

Increasingly, older adults are taking on informal caregiving roles for individuals who become dependent or need assistance because of physical or mental effects of chronic illness. One notable chronic illness is that caused by HIV infection. Research conducted in the past decade suggests that of the many adults living with HIV infection, half depend on older relatives for financial, physical, medical, or emotional support (Allers, 1990; Ory & Zablotsky, 1989). An estimated 50,000 to 100,000 adult Americans with AIDS receive help from older caregivers. In addition, there is a growing population of orphans whose caregiving parents have died, who are cared for by grandparents through standby adoption or guardianship (Goodkin et al., 2003). About 80% of the youths who are orphaned by HIV infection are people of color, and most older caregivers are members of minority ethnic groups. An estimated 70% of these caregivers are women, with 35% older than 65 years. As informal caregivers, older minority women face the multiple disadvantages of racial or ethnic inequities, compromised health status, poverty, aging, and sexism (Goodkin et al.). Despite the obvious benefits to care recipients, and regardless of their race, the stress experienced by most elderly caregivers often decreases their physical and psychological health (Given, Kozachik, Collins, DeVoss, & Given, 2001).

Dysphoria

Dysphoria is a disorder of affect characterized by distress and depression. Generally, the individual is in this state for understandable reasons. In older adults, the reasons may include the many losses and subsequent changes with which they are struggling to cope. The loss of physical health and independence, employment and income, family and friends, or house and comfortable environment are difficult to accept, especially if they all occur within a relatively short period. These losses may overwhelm some older adults, causing them to worry and preventing them from feeling in control of their lives. This type of disorder usually calls for major psychosocial intervention (Sadock & Sadock, 2000).

Loneliness and Isolation

Loneliness is a strong indicator that an individual is feeling isolated from others. A number of conditions support the notion that loneliness is more widespread among older adults. Social isolation and loneliness negatively affect older adults' physical and psychological well-being. Behaviors and symptoms associated with loneliness are similar to those of mild depressive mood and include isolation, constipation, weight loss, insomnia, fatigue, and loss of appetite (Allen, 2003).

Death of family and friends, retirement, relocation, and other life changes can reduce opportunities for social contacts and place older adults at risk for social isolation. Physical limitations, such as sensory deficits that limit communication or mobility, may prevent the visiting of friends and family. In studying the impact of loneliness on older adults, Pinquart and Sorensen (2001) noted that the old–old and oldest–old tend to experience the highest levels of loneliness because of physical and sensory decrements and loss of their spouse and friends; and older women, because of their higher risk of widowhood, tend to experience more loneliness than older men. Opportunities for social interaction also decrease with widowhood.

Lack of a social network may lead to nursing home admission. Pinquart and Sorensen (2001) found that older adults in nursing homes are lonelier than those in community dwellings. Allen (2003) noted that loneliness has a profound effect on the mental health of nursing home residents.

Role Loss, Change, and Coping

The mental, emotional, and physical health of people of all ages is related to their ability to cope with and adapt to the changes in their lives. Most changes in early life are often voluntary and involve assumption of greater responsibility. For the older adult the opposite is true (Bunten, 2001). Change in this group often represents a loss, and some interpret it as a role loss. Such losses as leaving a valued position in the workforce, losing parental authority as children leave home, losing physical ability because of chronic illness, and experiencing bereavement with the death of family and friends can create problems for those who are unable successfully to grieve their losses and establish new resources of morale and satisfaction (Moody, 2002).

Burden of Illness and Disability

Compared with the general population, older people on average have twice as many days in which activities are restricted because of chronic conditions, such as arthritis and heart conditions. Living with a chronic illness affects a person's lifestyle and interactions with others. Many chronically ill older adults become homebound, and this decreases contact with the community and leads to social isolation. As with other age groups, older adults with chronic illnesses typically have repeated hospitalization to treat exacerbations of their illnesses. Inability to control an illness or disability produces feelings of powerlessness, especially when there is realization of a loss of function and the loss of one's former self. Feelings of powerlessness can lead to a loss of hope and depression.

Common Maturational and Situational Crises of Older Adults

A crisis is an internal imbalance that results from a perceived threat to one's well-being. Crises are usually precipitated by situations of loss, transition, or change. When such situations arise, a series of behaviors are activated that lead either to mastery of the situation or to crisis. Blazer (1990) noted that some degree of cognitive and physical loss is expected as one matures into old age. These losses may provoke anxiety and depression in older adults whose coping resources are taxed beyond their customary capacity. As one slips into old age, occasional forgetfulness, especially of the recent past, and an increase in the time needed for processing information may occur. Likewise, older adults may take longer to respond to questions and requests, and to process multiple stimuli. Decrease in physical strength and changes in physical appearance, such as graying of the hair, wrinkled skin, and sagging bodies, may be difficult for some older adults to accept. Hearing difficulty is both the most common and the most disabling sensory problem of aging: a decrease in both pitch discrimination and hearing acuity may occur. Decreased visual acuity, accommodation, and adaptation to darkness, and increased sensitivity to glare are likely to occur. Presbyopia is one of the most common visual problems; however, age-related macular degeneration, cataracts, and glaucoma are more serious. Decline in cognitive and physical ability may lead to other

problems, such as lessened ability to perform ADLs and IADL tasks independently, including driving and shopping, and may increase the chance of social isolation.

A situational crisis may be thought of as a sudden unexpected threat to or loss of basic resources or life goals. In the older adult, these crises may be more common than the maturational ones. Much of the depression and anxiety in older adults is caused by situational factors in the environment, such as the deaths of family and friends, loss of or relocation from home, and loss or decline in economic stability. Such losses as the death of a spouse, or a divorce, are commonly accompanied by a transition to being single. Loss of a job or retirement may mean the loss of not only financial resources, but also companionship and a major source of pride and self-esteem.

THERAPEUTIC INTERVENTIONS TO ADDRESS MENTAL HEALTH PROMOTION AND WELLNESS

Counseling and Support

Counseling is the act of providing advice and guidance to clients. The task of counseling is to give the client an opportunity to explore, discover, and clarify ways of living more resourcefully and toward greater well-being. Minardi and Hays (2003a) noted that an important aspect of counseling is the formation of a unique therapeutic relationship with the client in which an agreement is made as to the type of psychological work that will take place. Counseling involves using skills, such as active and attentive listening, paraphrasing, questioning, and responding in such a way as to demonstrate to the client that the counselor is genuine, empathetic, and trying to understand the client's concerns, while not supporting unhealthy behaviors the client may exhibit. Because counseling is not therapy (Minardi & Hays), and does not require specialized training, geriatric nurses are amply qualified to use counseling skills within their work settings to assist older adults in the process of reminiscence, and to deal with their numerous losses. Through counseling, older adults can be helped to face the reality of the losses, deal with the effects, break down barriers to readjusting to those losses, and make healthy choices in selecting replacements or substitutes for them.

Crisis Intervention

Crisis intervention is an active entering into the life situation of the client who is experiencing the crisis, to decrease the impact of the crisis event, and to assist the individual to mobilize his or her resources and regain equilibrium (Jacobs, 1989). Although related to it, crisis intervention is not psychotherapy. It is the provision of short-term help by crisis workers, including nurses. The goal of crisis intervention is to resolve the most pressing problems within the shortest possible time through focused, directed intervention aimed at helping the older adult develop new adaptive coping methods. No attempt is made at in-depth analysis.

Older adults in crisis situations need to be provided immediate attention by therapists. Nothing will raise these clients' hope more than an immediate offer of help. An essential characteristic of a crisis is the highly motivated nature of clients. No one has to persuade them to accept help. Often, they plead for it and uncritically accept it when it is offered. Such trust among older adults allows maximum caregiver–client interaction.

The purpose of crisis intervention is to restore in the person the level of functioning that existed before the current crisis. Burgess (1998) suggests five therapeutic goals. (1) The first deals with safety and security. If there is danger of suicide, the family or significant others need to be informed and urged to exercise vigilance. In situations where the chance of self-harm is significant, the patient should be referred for emergency admission into the nearest hospital with an inpatient psychiatric service. Victims of crises often experience such intense turmoil that they fear they are going insane. (2) For this reason, the second goal is to allow victims the opportunity to ventilate and to

have their reactions validated. (3) A third goal is to assist the individual to examine the circumstances related to the crisis and help him or her to prepare for dealing with similar situations in the future. Individuals should be encouraged to talk or write about the crisis experience and to identify a person to whom he or she could turn in the event of impending disaster. (4) A fourth goal is to practice role-playing responses to a variety of calamitous scenarios. This is considered a practical way to plan for future events. (5) The fifth goal is to provide educational opportunities for the individual through writing and reading assignments, self-assessment exercises, crisis intervention and supportive counseling, and peer support groups.

Pharmacological Therapies

Pharmacotherapy is the use of substances to alleviate symptoms, maintain improvements, and prevent relapse in psychiatric clients. Psychotropic agents can be used to control violence and dangerous or destructive behavior, improve the client's subjective feelings, shorten inpatient treatment time, and hasten the recovery of some clients. Because many nursing home residents have diagnosed psychiatric problems, psychotropic medications are more likely to be prescribed for this group of older adults. Psychotropic agents used with the older adult population include neuroleptics or major tranquilizers, antidepressants, and sedative–hypnotics.

Appropriate indications for neuroleptic prescriptions include treatment of psychoses, such as schizophrenia, paranoia, major depression, mania, and psychotic symptoms, such as hallucinations and delusions, which may occur in other conditions. Because of the potentially severe side effects of these medications, they should be prescribed only where a clear need exists.

Antidepressants are used to treat depressive symptoms in clients. Three major groups of these medications are used: (1) tricyclic antidepressants, (2) selective serotonin reuptake inhibitors, and (3) monoamine oxidase inhibitors. The choice of antidepressant is dependent on its side-effect profile. Those with minimum potential for orthostatic hypotension, sedation, and anticholinergic effects are preferred. Antidepressants may be prescribed for dysthymia in older adults. For those with minor depression, it is suggested that antidepressants be given only when there is evidence of severe impairment as demonstrated by clients' need to make significantly increased effort to accomplish near-normal functioning in social, occupational, or other important areas of life.

Sedatives or antianxiety medications are used primarily to reduce anxiety in older adults. The major group of antianxiety agents is the benzodiazepines, which are also used to treat acute alcohol withdrawal and impending delirium tremens. Some benzodiazepines are used primarily to induce sleep and not to treat anxiety. Because of accumulation of their active metabolites older adults may be more sensitive to toxic effects of these medications, and they are generally prescribed the lowest possible dosages and for time-limited periods. Selective serotonin reuptake inhibitors may also be used in the treatment of anxiety in older adults.

Individual, Group, and Family-Focused Interventions and Treatment Modalities

Nurses are well placed to use psychosocial interventions therapeutically with older adults in institutional and community settings to promote mental health and wellness. Many psychosocial interventions (the psychotherapeutic interventions) are designed to help clients alter dysfunctional relationship patterns and to develop more effective problem-solving skills. Development of insight or awareness of factors that motivate feelings, thoughts, and behavior is generally seen as a necessary precondition for change. Because older adults' capacity for insight may vary, some psychosocial interventions may serve to stimulate change without the active participation of clients in the process. Minardi and Hays (2003a, 2003b) point to several individual and group psychosocially based

therapies available for use with older adults. These include psychotherapy; psychodynamic therapy; cognitive-behavioral therapy; reminiscence therapy; validation therapy; and the activity-based therapies of music, art, dance, drama, and exercise. Some of these psychosocial interventions are clearly within the nurse's role, whereas psychotherapies require advanced training to conduct. Minardi and Hays noted that, in using these interventions, nurses must establish a therapeutic relationship with older clients so that the clients feel psychologically safe enough to participate freely. An important aspect of using these therapies is the need for nurses to recognize the relationship boundaries between themselves, the clients, and the clients' significant others as they move in and out of the different interventions.

Psychotherapy, psychodynamic therapy, and cognitive behavioral therapy may be provided in either group or individual formats. The facilitators are trained therapists and the sessions are structured with precise start and end times. However, the principles on which these therapies are based can be accommodated easily by nurses, because they already possess some of the necessary skills and knowledge.

The activity-based therapies, such as music, art, dance, and exercise therapies, may be delivered formally or informally, as when they are incorporated into interventions to promote relaxation or increase self-esteem and a sense of achievement. These therapies may be used in individual or group formats. When used formally, it may be necessary to leave interpretations of client's behaviors to qualified therapists, who are more competent to examine and interpret issues in depth.

Reminiscence therapy may be used by nurses to assist older adults to reexamine the life they have lived. It may be useful in helping clients to remember their accomplishments, their failures, and their contribution to society. It may be an important process for boosting client's self-esteem. Validation therapy is used with demented older adults to relieve the client's distress and restore self-worth (Feil, 1992, 1999). Validation is a communication process. When using this therapy, the nurse focuses on the client's verbal and nonverbal communication and, rather than making interpretations based on the factual information presented in that communication, the nurse attempts to interpret only the emotions expressed in the communication. If the client's communication on a particular topic is repetitious, the nurse explores the client's feelings about the topic by prompting and shaping the client's communication on the topic. Minardi and Hays (2003b) noted that by not allowing factual errors to interrupt meaningful dialogue, nurses may use validation therapy to help demented older adults review their past and express feelings that may have been buried for a long time.

Complementary and Alternative Therapies

Older adults are taking herbal and other types of dietary supplements in record numbers (National Council for Reliable Healthy Information Newsletter, 2000). Although traditional therapies are the backbone of mental health care, botanical and nonbotanical complementary and alternative therapies, along with nontraditional psychosocial therapies, provide a break from the more regimented programs. These therapies encourage many of the same goals as traditional therapies and are thought to provide sensory and mental stimulation along with therapeutic benefits. According to McCabe (2002), an estimated one in three adults in the United States, including older adults, use botanical and nonbotanical complementary and alternative therapies to help promote mental well-being.

Botanical and Nonbotanical Therapies

Botanical agents include St. John's wort, a common weed that grows in the United States, which is frequently used for the treatment of depression. Despite its questionable efficacy, many take it on a regular basis. Ginkgo biloba comes from the leaves of a decorative tree. It is indicated for memory problems, and for this reason its common psychiatric use is with demented clients. Kava,

a psychoactive derivative of the pepper plant, is used most often to treat anxiety and on some occasions insomnia. Ginseng has no focused use, but rather is indicated broadly for improved quality of life and generalized well-being. Valerian, grown abundantly in most parts of the world, may be used as a sedative and hypnotic (Hodges & Kam, 2002; McCabe, 2002). Passion flower, a compound derived from the dried flowers of the passion flower plant, is used as a mild sedative and antianxiety agent (McCabe, 2002; Starbuck, 1999). Nonbotanical mineral–vitamin agents include the dietary supplement *S*-adenosylmethionine, an amino acid compound used widely as an antidepressant, and omega-3 fatty oils, which are thought to promote mood stability and decreased aggression (McCabe).

Nontraditional Psychosocial Therapies

Pet and Plant Therapy

This approach, dubbed the "Eden Alternative" (Thomas, 1994), is an effort to address the three major plagues of nursing home life: loneliness, helplessness, and boredom. Birds, dogs, cats, rabbits, and plants are introduced to the nursing home environment. Here, the residents have the opportunity to gain physical, emotional, spiritual, sensory, and intellectual benefits while experiencing natural, living things. Plants and animals not only provide the older residents a link with nature, but also create an opportunity for a more meaningful, homelike atmosphere.

Dance and Movement Therapy

Dance and movement can allow older adults to improve mobility, circulation, and self-esteem. It also strengthens the body, making it easier to deal effectively with mental and physical stressors. Dance and movement may help participants to experience an inner awareness of self while having open interaction with the environment. This interaction provides a therapeutic self-help process that can release tension and anxiety, reduce confusion, stimulate memory, decrease depression, and rechannel anger and frustration.

Music and Art Therapy

Music therapy is one of the most popular alternative therapies that allow older adults with various levels of cognition to experience many happy memories. Art therapy gives them the chance to express themselves and their emotions whether they can or cannot verbalize those emotions.

Consultation and Referral

Consultation in the mental health field involves the collaborative activity of professionals in the management of mental health problems. Generally, the problems presented for consultation are complex and potentially expensive. Caplan's (1970) model of mental health consultation identifies four types of consultation: (1) program-centered administrative consultation, (2) consultee-centered administrative consultation, (3) client-centered case consultation, and (4) consultee-centered case consultation. The latter two are the most relevant to this discussion.

The essence of consultation is personal and professional respect. The consultant's expertise in a specific area is sought by the consultee who needs help or advice to manage a client's mental health problem. The consultant and consultee may or may not be mental health professionals.

Referral in the mental health field is the process by which clients are introduced to other professionals for mental health-related services. Referral of clients may be from one mental health professional to another, from a non-mental health professional to a mental health specialist, or from a mental health professional to a non-mental health professional. Many psychiatric mental health nurses have a specialty focus to their work, and there is a wide range of medical settings (including critical care and burns units) and long-term care settings for older adults (including nursing homes and assisted living facilities) where consultant mental health nurses can use their expertise directly or indirectly to promote mental health care of older adults.

Education

Nurses are in a prime position to use education as a method of promoting mental health of older adults. Individual, family, and community-focused education intervention programs can be used to forge a partnership between mental health professionals, individuals, families, and communities, and thereby facilitate improved long-term mental health outcomes. Major objectives of these programs should be increasing knowledge of mental health promotion and illness prevention of the community at large, and supporting the self-care and daily management of mentally ill older adults by families.

Some educational interventions may be offered as formal stand-alone educational programs on mental health–related issues. Focus areas may include (1) coping needs that result from the decrements that occur naturally in the process of aging, (2) support systems, (3) socioeconomic changes caused by retirement and decreased earning ability, (3) ageism, and (4) community resources for the prevention or treatment of mental disorders. Some educational interventions may be imbedded in treatment programs for mentally ill clients, or physically ill clients at risk of mental illness. Emphasis should be placed on clients' and significant others' strengths rather than their weaknesses. Presentation formats may involve oral presentations, question-and-answer periods, discussion, and distribution of written materials. With the widening and almost universal availability of electronic media, presentation formats should include audiovideo formats, such as television, and the Internet.

FAMILY AND COMMUNITY RESOURCES TO ENHANCE MENTAL WELLNESS

The presence of a family has a positive influence on coping with aging. Family relationships are not only salient, but the support available within them is a key variable predicting well-being in older persons (Qualls, 2000). Often family members provide instrumental and intangible support to their elderly members, including assistance with ADLs, transportation, finances, and so forth. Social support systems, such as the family, can buffer the negative effects of stress on the mental health status of older adults, thus reducing their vulnerability to mental illness and institutionalization.

The community approach to mental health promotion in older adults requires an appropriate mix of resources and service (Buckwalter, Weiler, & Stolley, 1995). Community resources and services may be professional or nonprofessional in nature. Nonprofessional services may be offered by voluntary or state-funded agencies and include home-delivered meals, transportation services, and home upkeep services. Private-pay services include geriatric day care and assisted living centers. Professional resources include personnel, such as physicians and nurses, psychologists, social workers, and academic educators who provide appropriate health, psychological, social, and academic services. Structural resources for supporting mental health promotion include hospitals, psychiatric day care centers, nursing homes, community colleges and universities, senior centers, and places of worship. Ideally, professional and nonprofessional services should complement each other and strive to satisfy the service needs of older adults.

CLINICAL RESEARCH PERTAINING TO MENTAL HEALTH PROMOTION IN OLDER ADULTS

Clinical Issues

Silvera and Allebec (2001) conducted face-to-face interviews with 28 male Somali immigrants, aged 60 years and older, to explore views on mental health and well-being and identify sources of stress and support so as to gain a greater understanding of factors leading to life satisfaction and depression in this population. Social isolation, low level of control over one's life, helplessness, ageism, perceived racial or religious discrimination, and racial harassment were identified in people who were depressed. Family support was the main buffer against depression.

Reijneveld, Westhoff, and Hopman-Rock (2003), in a randomized clinical trial, assessed the effect of eight, 2-hour long sessions consisting of health education and physical exercises on the health of 126 elderly Turkish immigrants living in the Netherlands. Results showed an improvement in the mental health of the subjects in the intervention group.

In a 6-month-long program, Matuska, Giles-Heinz, Flinn, Neighbour, and Bass-Haugen (2003) taught 65 older adults from three senior apartment complexes the importance to the quality of their lives of participation in meaningful social and community work. As a result, subjects had significantly higher scores on vitality, social functioning, and mental health over baseline. Participants reported increased frequency of social and community participation. Participants who benefited the most were older, attended more classes, and were nondrivers.

Watt and Cappeliez (2000) tested the effectiveness of integrative and instrumental reminiscence therapies, implemented in a short-term group format, and active socialization on decreasing depression in 26 older adults. Evaluation of the clinical significance of the results showed that both reminiscence therapies led to significant improvements in the symptoms of depression at the end of the intervention.

CASE STUDY*

Mrs. Mabel L. is an 81-year-old, 98-lb, 5′7″ white woman, living alone following the admission 2 years ago of her husband of 62 years, Arthur, to a long-term care facility a 20-minute drive away. Her husband suffers from Alzheimer's disease and severe mobility impairment. Mabel's entire life has been devoted to being a homemaker, wife, and mother. Her four children live within a 1-hour's drive and usually visit or call at least weekly. A caring young family lives next door and provides assistance with snow removal and yard work. She has no other social supports or involvement with her community, other than her church. Mabel's own health problems include long-standing hypertension, osteoarthritis affecting bilateral knees and shoulders, osteoporosis, and glaucoma and she has had a cataract extraction with intraocular lens implants bilaterally. Her corrected vision is 20/100 OU with her glasses. Medications include atenolol, 50 mg orally daily; alendronate, 70 mg once a week; multivitamin with calcium and vitamin D once every day; and latanoprost, 0.005% ophthalmic solution, one drop once daily in the evening. Mabel is a nonsmoker. She denies current or past use of over-the-counter or herbal medications or therapies other than extra strength acetaminophen, two 500-mg tablets once or twice a day, 2 to 3 days per week. She is independent in ADLs and IADLs, although she expresses concern about her "memory not what it used to be." She limits driving to daytime use because of concerns she has about her vision with night time driving. She enjoys caring for her cat, visits to the nursing home to see her husband nearly every other day, and several television programs. Religion, prayer, and church attendance on Sunday are strong sources of support for Mabel.

Case Study Analysis

How can the nurse practitioner (NP) address mental health promotion for this client within the overall context of health promotion? One helpful framework is to consider the nursing paradigm with its key interrelated concepts: person–family, environment, health, and nursing. The

(continues)

CASE STUDY* (*continued*)

NP would assess the current state of mental well-being based on Mabel's self-report. A number of instruments and tools are available to conduct a formalized assessment. However, Hoff and Brown (2005) have described a detailed comprehensive mental health assessment method with an emphasis on functional assessment that is particularly relevant for older persons. In it, basic life functions (physical health, self-acceptance and self-esteem, vocational and occupation, immediate family, intimacy and significant others, residential and housing, financial security, decision-making ability, problem solving ability, life goal and spiritual values, leisure time and community involvement, and feeling management) are addressed. Additionally, signals of distress (violence experienced, injury to self, danger to others, substance use, legal issues, agency use) are assessed. Such a detailed assessment can serve as a significant guide to the treatment plans that will follow. For Mabel, the NP must determine what the loss of her long-time companion and husband of 62 years, Arthur, to the nursing home has meant and continues to mean to her. The following are examples of the questions that should be considered:

- What have her past coping mechanisms been in dealing with life stressors and are these now effective?
- What personal goals does she have for her own present and future?
- Where in her life does she derive social support, and how satisfied is she with this currently?
- Have her feelings and beliefs about her self-identify and self-concept changed, and if so, how?
- How have these changes in her roles, especially that of primary caregiver, and relationships impacted her?
- How does she describe her current level of life satisfaction?
- What immediate or future goals can she envision, and does she see these as achievable through her present activities or involvement?
- Does she have a confidante to whom she can turn?
- Has she ever had any interest in community service involvement?
- What current community service interests does she have that might substitute for her prior caregiving role?
- Does she find a sense of purpose and fulfillment in her current situation?
- Would she consider involvement in church or animal shelter volunteering, for example?

The environment is a major component of the nursing paradigm, and it has numerous dimensions that can impact the health and mental well-being of older adults. Mabel's NP needs to identify what living alone in a single-family home means to the client. For instance, is Mabel fearful about her surroundings or community? Too often, well-meaning providers and families alike observe a living situation and apply their own personal value judgment or beliefs about "what would be best" for another individual. Asking Mabel herself about her environment and living situation is a key. With that information collected, the NP will be better able to determine next steps, either the offer of needed supports and community services to maintain this living arrangement or the provision of needed information about and referrals to alternative housing or living arrangements that may be available to Mabel, depending on her financial means and desired interests.

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