

LITERATURE SCAN RELATED TO

Psychosocial Approaches to Mental Health Challenges of Late Life

An Aging Population

The percentage of seniors in the Canadian population is constantly increasing. In 2000, it was estimated that 13% of the population (approximately 3.8 million individuals) were 65 years of age and older. It is estimated that by 2016, seniors will represent over 16% of the population. By 2046, it is estimated that seniors will make up about 25% of the population (Statistics Canada, 2002).

These population trends have substantial implications for health and health care. Increasing percentages of older people may result in increases in people with disabilities and chronic illnesses, particularly with respect to those chronic diseases and conditions that are associated with aging, such as musculoskeletal diseases, cardiovascular diseases, sensory impairment and dementia (Khaw, 1999).

Although often treated as a single entity, the seniors' population is not a homogeneous group. The young-old, generally defined as individuals between 65 and 74 years of age, may be different in many ways from the middle old, those between 75 and 84 years of age, and the old-old, those 85 years of age and older. For example, Hogan, Ebly and Fung (1999) noted that seniors aged 85 years of age and older are the most likely to be characterized by many of the conditions normally associated with old age. Even within the old-old group, there may be differences between individuals 85 to 94 years of age, and those 95 years of age and older. This is particularly important since within the seniors' population, the fastest growth is occurring among those in the older age groups. In 1998, it was estimated that 56.8% of the seniors population was between 65 and 74 years of age, 32.9% was between 75 and 84 years of age, and 10.0% was 85 years of age and older. It is expected that by 2016, the comparable figures will be 57.6%, 28.9% and 13.5%, respectively (Statistics Canada, 1999).

Health and Health Promotion

Relatively little is known about the psychological and social impact of aging. There is, however, some evidence that seniors as a group are at risk for psychosocial problems such as increased loneliness and depression (Spencer, 1995; Wattis, 1996).

Determinants of Health

From a population health perspective, "health" involves more than the absence of illness. Health Canada (2002) has defined "health" as the product of complex interactions among individual characteristics, the physical environment, and social and economic factors. The determinants of health include:

Biology and Genetic Endowment – The basic biology of the human body is a primary determinant of health. Genetic endowment may predispose some individuals to particular diseases or health problems.

Gender – Gender refers to the variety of roles, attitudes, behaviours, values and influences that society differentially attributes to men and women. Many health issues may occur because of gender-biased roles or social status.

Education – Health may vary with education level because: It may improve one's ability to gain access to information and services that potentially keep an individual healthy; it could provide people with the skills they need to identify and solve problems; it increases choices and opportunities; and it may increase job satisfaction, job security, and financial security. Good health is associated with higher education.

Physical Environment – The physical environment includes the natural environment air, water, land as well as human environments that include housing, community safety, and transportation. Good health is associated with quality natural and human environments.

Employment and Working Conditions – Unemployment and underemployment are associated with poorer health. Individuals with more control over their work circumstances are healthier than those involved in more stressful work.

Income and Social Status (Linked to Education) – Health is directly related to income and social status. People with higher incomes are healthier than those with lower incomes, and individuals with higher socio-economic status are healthier than those with lower status.

Social Support Networks – Support from families, friends, and communities is associated with better health.

Social Environments – Supportive societies (those that are stable, recognize diversity, and promote safety, good working relationships and cohesiveness) can reduce or eliminate many potential risks to good health.

Culture – Culture and ethnicity are products of personal history and social, political, geographic, and economic factors. They affect how people view health and illness, link with the health system, access health information, participate in health promotion programs, and make life-style choices.

Healthy Child Development – Prenatal and early childhood experiences can have a substantial effect on subsequent health, well-being, coping skills and competence.

Personal Health Practices and Coping Skills – Personal health practices refer to behaviours individuals choose to do or not do in their daily lives. Coping skills refer to the internal resources individuals have to manage situations or problems, that is, to deal with outside influences and pressures. Good health practices and strong coping skills are associated with better health.

Health Services – Health services that are designed to prevent disease, restore health and function, and maintain and promote health contribute to population health.

While each of these determinants of health is important in its own right, it is the combined influences of the various factors that determine health status for individuals, for subgroups within a population, and for the population as a whole.

Determinants of health play a key role in the health and well-being of the elderly. Connell (1999) noted that age-related physical changes, the use of multiple medications, the presence of one or more chronic illnesses and different value and belief systems may all affect how seniors perceive physical health and well-being. Changes in social relationships and in the quantity and quality of social support may also affect how seniors view psychosocial health and well-being.

Health Promotion

Health promotion is a process that enables individuals to take control over and improve their health (Hamilton & Bhatti, 1996). It emphasizes the concepts of lifestyle, risk and preventive health behaviour (Power, French, Connelly, George, Hawes, Hinton, Klee, Robinson, Senior, Timms, & Warner, 1999; see also Heidrich, 1998). The concept of health promotion encompasses five basic strategies:

Building health public policy – to ensure that policy developed by all sectors contributes to health promoting conditions.

Creating supportive environments – that recognize the changing nature of physical, social, economic, cultural, and spiritual aspects of society and ensure positive impacts on the health of people.

Strengthening community action – to ensure that communities have the capacity to set priorities and make decisions on issues that influence their health.

Developing personal skills – to enable individuals to gain the knowledge and skills necessary to meet life's challenges and contribute to society.

Reorienting health services – to create systems that focus on the needs of the whole individual and which involve partnerships among providers and users of services.

There are two conflicting views in the literature regarding health promotion in the elderly. One view holds that health promotion in seniors is of limited benefit because the positive effects of health promotion require lifelong health practices. A related view is that older individuals are resistant to health promotion efforts since learning new behaviours is challenging and lifelong health practices are difficult to change (Heidrich, 1998). The second view holds that health promotion in the elderly is beneficial to both the individual and society since it can potentially increase the number of healthy years of life by preserving health and functional abilities. In turn, this is expected to increase quality of life and reduce health care costs by reducing the impact of disease and illness (Frenn, 1996; Heidrich, 1998, see also Joubert, 2001). This latter view assumes that older individuals are able to change their behaviours regarding health and that these changes will result in positive outcomes.

Mental Health

The concept of mental health cannot be disassociated from total health (Paul & Hagan, 1988). Health Canada (1997a) has defined mental health as:

The capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity. Thus, mental health involves the balance between the personal characteristics of an individual and the pressures of his or her environment.

Health Canada (1997a) has noted that the determinants of mental health include:

a sense of control - over one's self with respect to body, mind and spirit as well as one's social and physical environments;

a sense of identity - with respect to what makes an individual unique;

a sense of autonomy – with respect to one's strengths, creativity and industry;

a sense of belonging – both as an individual and as member of a group; and

a sense of survival – a desire to stay alive (Health Canada, 1997a).

While the determinants of mental health include external societal and environmental factors as well as internal individual and psychological factors, it is the interaction between the two that is important for determining the mental health and well-being of individuals (Health Canada, 1997a; Paul & Hagan, 1988).

Mental Health Promotion

Mental health promotion focuses on enhancing well-being and quality of life. Health Canada (1997a) has defined mental health promotion as “the process of enhancing the capacity of individuals and communities to take control over their lives and to improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience” (see also Hodgson, Abbasi, & Clarkson, 1996).

At an individual level, mental health promotion emphasizes the development of personal and social skills. At a social and environmental level, it emphasizes public and mental health policies, supportive and healthy environments, and community action (Hodgson, et al., 1996).

Risk and the Elderly

The literature does not provide a precise definition of "risk" and "at risk". However, there is a general understanding that the term “risk” refers to the probability of encountering harm or loss (Health Canada, 1997b; Spencer, 1995).

Risk involves the interrelation of risk factors, resources and life experiences (Spencer, 1995). Risk factors are biological, psychological, sociological, or environmental variables that affect a person or his or her environment. Risk factors may: exist before a disorder or problem manifests itself; may be time-limited or may continue over time; can derive from the individual, the family, the community, institutions, or the general environment; and may play a causal role or be a marker for a problem (Health Canada, 1997b). With increasing age, some risk factors may become more or less important than others (Gillis & Hirdes, 1996). Resources are personal, social, and environmental supports that serve as protective factors and help individuals to maintain health and well-being and to cope with life experiences. Differences in coping styles may make older adults more or less vulnerable to the effects of stress than younger individuals (Gillis & Hirdes, 1996). Life experiences can influence the way an individual views situations and can be either negative or positive. A reduction in mortality may not be as important for the elderly as improvement in quality of life (Gillis & Hirdes, 1996).

The concept of risk is applied to older adults more than to any other age group (Spencer, 1995). The most serious risks for older adults are those that deny them their basic physical, emotional and social needs (Spencer, 1995). Older individuals are susceptible to disease, disability, dependency, and premature death. Ostbye, Steenhuis, Wolfson, Walton and Hill (1999) for example, noted that in addition to gender and age, functional status, cognition, health status and self-perceptions of health were all important in predicting mortality. However, Tjihuis, de Jong-Gierveld, Feskens, and Kromhout (1999) have noted that greater exposure to risk events is probably more important than age itself.

Factors that affect psychosocial well-being

There are several changes that occur *as part of* the normal aging process. These life events or transitions disrupt or threaten to change an individual's normal routine and activities and consequently can affect an individual's well-being (McLeod, 1996). Life events which affect the majority of seniors include: retirement; changes in income level; physical changes (including illness); and changes in social support networks (including caring for another individual, and coping with the death of a spouse and peers). These events may negatively affect seniors' well-being by increasing social isolation, loneliness, depression, and suicidal thoughts.

I-I CRITICAL TRANSITIONS

Loss and abandonment & Widowhood

A married couple feels the stress associated with the critical transition of loss and abandonment with the thought of losing their spouse (Tower, 1996). This can be accompanied by a depressive experience and this feeling is often elevated in couples that are close and spend a lot of time together sharing their life and activities. The emotional bond or ties that exist between married/common-law couples are often strained when there is a change in routine or the familiarity of the relationship. This can occur with adverse health changes to one of the partners. Close couples could help to alleviate this situation by being more autonomous in their own rights.

Cancer diagnosis

Feelings of distress are expected with a diagnosis of cancer in an elderly person (Kurtz, Kurtz, Stommel, Given & Given, 2000). Another important factor is the nature of the depressive personality characteristic of the person prior to the cancer diagnosis. People who tend to get depressed easily in adverse situations will often suffer with additional depressive symptoms upon being diagnosed with cancer in late adulthood. Increased physical functioning at a time when cancer treatment is occurring can help to increase the overall health status and decrease the feelings of frustration with the individual.

Depression

Beekman, Pennix, Deeg, deBeurs, Geerlings & van Tilburg (2001) have found in their research that there are many health consequences in later life that can be attributed to the onset of depression. This can have a very big influence on a person's quality of life and can have quite a big economic impact if they cannot afford or have no access to available services. Proper treatment and prevention can help to lessen the effects of depression especially when combined with other health issues in later life.

Hedelin and Strandmark (2001) outlined a phenomenological study of elderly women and their lived experiences with depression. Five women agreed to participate in extensive qualitative interviews to understand their life situation and the depth of their depression. "Phenomenology seeks to understand the diversified life-world through the study of the essence of phenomena." (p. 415). Depression can be very destructive and life altering. "It's so difficult because this is a disease which is so frightening. Everybody who is depressed is regarded as mad. They are not clear in their mind and all sorts of things. People daren't talk about it. Well, I don't know, but I think it is very difficult...other things are okay to talk about but this...I'll just have to bear it."

Most of the women interviewed for this study kept dwelling on the incident that initiated the depression and could not transform this thought into just a painful memory and place it in the past. It is as if this painful moment or time in their lives has been transformed into the present and remains there.

According to Macdonald, 1977, physical health and daily activities can deteriorate from pre-depression times. “Important biological symptoms of depression in old age are change in sleep patterns (especially reduced sleep and early morning waking); decline in appetite and weight loss; regular variation of mood over day (especially worse in early morning); constipation; physical and mental slowing not accountable by other disorders; and suicidal thoughts.”

Retirement

Retirement may be seen as either a positive or negative event, depending on the circumstances surrounding the formal withdrawal from the labour force (Pitt, 1998). For some, retirement may be seen as an opportunity to actively engage in a number of activities which may have received little attention while an individual was working. For others, retirement may signal a reduction in income, a decrease in social contact, a loss of a support system and/or a conscious awareness of one's age and mortality.

Retirement will affect both the individual and his or spouse or partner. If the spouse/partner has never worked or has not worked for a long time, retirement may signal a change in roles within the household, the family, and the community in general. For example, a wife who has never worked may find it difficult to have her husband assist her with household chores if she is used to doing them by herself. In contrast, if the spouse/partner remains in the workforce, a situation that may be more common in the future as more women are in the workforce, the retiree may experience increased loneliness.

Advanced retirement planning for men appears to be the key element in regards to retirement satisfaction (Quick, 1998). Men who retire to do other things in their lives or have financial reasons for retirement have a very high chance of being quite highly satisfied in their retirement. Those men, however, who retire because of the health of a family member, or who are forced into retirement for external reasons, are less successful of experiencing retirement satisfaction. Women experience positive retirement experiences if they retire early, whereas late retirement for women can be conducive to a poor sense of retirement satisfaction. Therefore early retirement for women is usually successful unless it occurs unexpectedly such as health concerns and caregiving issues

Changes in Income Level

Seniors generally have lower incomes as compared to the rest of the population. (Statistics Canada, 2002). In general, senior men have higher incomes than senior women. Lewis (1997) has suggested that this may be the result of historical patterns of economic dependence on men and sporadic low wage or non-existent employment histories for women. Being unattached either through death or divorce may make women particularly vulnerable to poverty (Hungerford, 2001; Lewis, 1997; Statistics Canada, 2002). Lewis (1997) noted that improving educational and work opportunities for women may result in improved financial circumstances for future generations of older women (but see Whall, 1990).

Physical Changes

Physical changes such as changes in vision and hearing, loss of muscle mass and bone density, and increased risk for fractures are common in the elderly (Connell, 1999; Pitt, 1998). There are also several health conditions such as stroke, heart disease, chronic obstructive pulmonary disease, falls, arthritis, and cancer that are associated with the senior years. Memory loss may also occur, although most seniors do not develop dementia. There is some evidence, however, that the prevalence of disability is declining in successive cohorts of older individuals (Andrews, 2001; Khaw, 1999).

Physical changes and chronic health conditions can have substantial impact on the psychological and social well-being of older adults. Health problems may make it difficult to get out and about. In turn, there may be a reduction in social contact and an increase in mental health problems (see, for example, Ahto, Isoaho, Puolijoki, Laippala, Romo & Kivela, 1997).

Sullivan (1997) has suggested that subjective perceptions of well-being may be more tightly linked with morale than objective health. Several studies have provided support for this view. For example, Moore (1992) found that more health problems were associated with lower education, lower income, less health knowledge, and poorer health practices as well as lower perceived health status and lower self-efficacy. In contrast, older adults who felt they were healthy and self-sufficient had fewer health problems, greater knowledge of health issues and better health practices. More recently, Hogan, Fung, and Ebly (1999) examine how health status changed over a five year period in a group of 108 community-dwelling seniors 85 years of age and older. They found that, even though over two-thirds of the participants indicated they had experienced a decline in their functional abilities, approximately 79% felt that their health had stayed the same or improved over the five year period (see also Ebly, Hogan & Fung, 1996; Hogan, Ebly & Fung, 1999).

Caregiving

The physical, psychological and social declines seen in individuals with dementia can have a significant impact on caregivers. For example, Clyburn, Stones, Hadjistavropoulos and Tuokko (2000) found that caregivers experience a greater burden when the individual with dementia has a relative high number of disturbing behaviours and when caregivers receive little informal support from others. Bergman-Evans (1994) noted that spousal caregivers are particularly at risk for loneliness and decreased social support regardless of whether the individual with dementia remains at home or is institutionalized. Caregivers who are feeling burdened and/or lonely are more likely to also experience depression compared to those who have good social support (Bergman-Evans, 1994; Clyburn et al., 2000; Ross, Rosenthal & Dawson, 1997).

Spouses of older individuals with dementia are likely to be seniors themselves. As well daughters, sons, daughters-in-law, and sons-in-law of the old-old with dementia may also be seniors. Both groups of caregivers may experience their own age-associated health conditions, in addition to experiencing physical and mental health conditions *because of* providing care.

Spousal Bereavement & Widowhood

Spousal bereavement is often an important cause of medical and psychiatric morbidity (e.g. Bennett, 1997; Byrne & Raphael, 1999; Prigerson, Frank, Kasl, Reynolds, Anderson, Zubenko, Houck, George, & Kupfer, 1995; Rozenzweig, Prigerson, Miller, & Reynolds, 1997).

The majority of senior widowed individuals are women; in 1996, approximately 46% of senior women but only 11% of senior men were widowed (Bess, 1999). The death of a spouse can be very stressful, particularly for older women who may have spent much of their lives caring for a husband, children, and a home.

In Canada, 75% of widows 65 years of age and older live alone and widows 80 years of age and older are more likely to live alone than widows aged 65 to 69 (Bess, 1999). Widows who were healthier were more likely to live alone than those who were in fair to poor health. Widows with low incomes are less likely to live alone than those with higher incomes (Bess, 1999).

One of the major sources of stress that one has to deal with in the adult to late adulthood years is the loss of a spouse do to death (Balkwell, 1985). This high level of stress affects a person's behaviour, their health, and psychological state of mind. Older widowed persons are usually better able to adapt to the change of their life course as compared to those people who are younger.

Donahue (2000) speaks of the definition of the word widow from Hebrew and Greek terms. "The Hebrew and Greek terms for 'widow' come from roots that suggest helplessness, emptiness or being forsaken; and what these people had in common was their isolation from the web of love and support, and a deep sense of powerlessness."

There are many changes in life, which occur during the initial shock of widowhood.

"Widowhood is a significant event for several reasons. Losing a spouse is a major developmental transition for older adults that signifies the loss of a central role and is often associated with other life changes such as moving to a new residence and having to take on new responsibilities that previously were performed by the spouse." (Antonucci, Lansford, Schaberg, Smith, Baltes, Akiyama & Takahashi, 2001)

Social Isolation

People with broad social networks enjoy better physical and mental health. Conversely, isolation increases vulnerability to depression (National Advisory Council on Aging, 1997). Widowed women are particularly at risk for social isolation (Whall, 1990). Following the death of their husband, women may see less of couples with whom they previously had close contact. To compensate, widows who live alone may also look to strengthen their emotional ties with friends (Bess, 1999). Living alone in the family home may initially provide stability and emotional security but may not be beneficial in the long term. However, living in the same neighbourhood may help to maintain relationships with neighbours which in turn may allow for social contact, assistance with household tasks and emotional support during stressful times (Bess, 1999).

Kramarow (1995; see also Wolf, 1995) has noted that the proportion of elderly widows living alone has continued to rise over the last 100 years, although no single factor appears to be responsible for the increase. Macunovich, Easterlin, Schaeffer and Crimmins (1995; see also Wolf, 1995) have suggested that the trend may be affected by kin availability. Approximately 11% of Canadian widows live with an unmarried adult child while a further 11% live with a

married adult child and his or her family (Bess, 1999). Although the majority of Canadian widows live alone, children and grandchildren living nearby may provide relatively stable social support; approximately 44% of widows living on their own have weekly visits with adult children (Bess, 1999).

Loneliness

Loneliness has been defined as "an unwelcome feeling of lack or loss of companionship, or feeling that one is alone and not liking it" (Forbes, 1996, p. 352). While often confused with social isolation, loneliness cannot be considered the direct result of social circumstances. A situation resulting in loneliness for one person may be a source of contented aloneness for someone else (Forbes, 1996).

Loneliness in later life is problematic, as it is closely related to depression, which in turn is closely related to suicide (see for example, Mullins & Dugan, 1990; Rane-Szostak & Herth, 1995). In addition, loneliness may result in sleeping problems and disturbed appetite. These factors, along with increased depression may result in institutionalization (Tijhuis et al., 1999). Determinants of loneliness include: age, gender, health status, economic condition, a need for affection and security, a desire to be part of a social network, and the existence of friends (Forbes, 1999; Mullins & Dugan, 1990; Tijhuis et al., 1999). Very old people appear to be most prone to loneliness, perhaps because of the loss of close ties and increasing dependency (Tijhuis et al., 1999). Loneliness may be less prevalent in rural areas where a sense of community exists as compared to more densely populated areas (Forbes, 1999).

Loneliness may affect about 10% of seniors (Forbes, 1999). However, in a study involving 1725 individuals 75 years of age and older, Holmen, Ericsson, Andersson, and Winblad (1992) found that 35% of the participants experienced loneliness (see also Rokach, 2000). They noted that there was a gradual increase up to the age of 90, after which a leveling was found (see also Tijhuis et al., 1999). Loneliness is more common in women than in men (Holmen, et al., 1992).

Depression

There is a belief that depression is common in the elderly, but the evidence is inconsistent and contradictory. Gomez and Gomez (1993) noted prevalence rates of 1% to 29%. More recently, Macdonald (1997) cited a prevalence rate of 15% for seniors in the general community and 25% in general practice patients. Wattis (1996) noted that clinically significant depression affected about 10% of seniors in the general community, and that of these, approximately 25% experienced severe depression. The National Advisory Council on Aging (1997) cited a prevalence rate of 5%. The different rates may reflect different definitions of depression (Gomez & Gomez, 1993).

In the elderly, mild or situational depression that occurs in response to biological or social losses is more frequently than major depression (Tannock & Katona, 1995; Wattis, 1996).

Nevertheless, the directional nature of the association between loss and depression is not always clear (Macdonald, 1997; Pitt, 1998). Depression occurs more frequently in the old-old (for a review, see Tannock & Katona, 1995). Depression occurs more frequently in older women than in older men (Ostbye, Steenhuis, Walton & Cairney, 2000). Other risk factors include: being widowed or single; experiencing stressful life events including physical illness, loss of a loved

one, loss of certain capacities and roles, and having poor social support (Lepine & Bouchez, 1998; National Advisory Council on Aging, 1997).

Depression is characterized by feelings of sadness, despair and discouragement (National Advisory Council on Aging, 1997). In older individuals, depression commonly presents as a series of physical problems such as changes in sleep patterns, decline in appetite, weight loss, regular variation in mood, constipation, and repeated minor aches and pains (Gomez & Gomez, 1993; Macdonald, 1997; Wattis, 1996). Other symptoms of depression include: decreased involvement in social activities, loss of interest in activities that were once pleasurable, emotional changes such as increased anxiety or acute sadness, concentration difficulties and suicidal thoughts (National Advisory Council on Aging, 1997).

Suicide

By comparison with other age groups, suicide rates are highest among individuals 65 years of age and older (Bharucha & Satlin, 1997; Buchanan, Farran, & Clark, 1995; Devons, 1996; Schmitz-Scherzer, 1995). Men may be at greater risk for suicide than women (Devons, 1996; Li, 1995; Wattis, 1996). White men may be at even greater risk (Gomez & Gomez, 1993). Additional risk factors include: high levels of emotional disturbance; being depressed or anxious; having one or more physical illnesses; a history of stroke; being widowed; and living alone (Conwell, Rotenberg & Caine, 1990; Rich, Warstadt, Nemiroff, Fowler & Young, 1991; Scocco, Meneghel, Caon, Dello Buono & De Leo, 2001). Tadros and Salib (1999) noted that social isolation and physical impairment seem to be important risk factors for suicide in the elderly in contrast, they might be more important for younger individuals. Schmitz-Scherzer (1995) noted that uncertainty and fear regarding an inability to influence one's own dying and a certain weariness of life might also be risk factors for the elderly.

Suicidal thoughts may be relatively common within the elderly population. For example, in a recent study of 611 community-dwelling adults 65 years of age and older, Scocco et al. (2001) found that 17% of participants responded affirmatively to at least one question on suicidality. This finding is of major importance since 50% of suicide attempts by the elderly are successful as compared to 13% of suicide attempts in individuals under 50 years of age, (Gomez & Gomez, 1993). Successful suicides occur most often early in depression (Gomez & Gomez, 1993).

Aging Successfully

Not all individuals respond to aging processes in the same way. An understanding of what allows some seniors to age without difficulties is essential to understanding how to improve health in those that do experience problems (see for example, Rane-Szostak & Herth, 1995). While much of the older literature emphasizes the negative consequences of aging, it also suggests that most seniors do not experience aging negatively (e.g. Joubert, 2001). As a consequence, there is growing interest in understanding the factors that enable the majority of seniors to age with few psychological and/or social difficulties.

The mental and emotional health of people of all ages is related to how well they cope with or adapt to the stresses and changes in their lives (Solomon, 1996). Although risks to health increase with advancing age, stress is not an inevitable consequence of old age (Solomon, 1996).

Whether a risk factor results in challenges to psychosocial well-being depends on how a stressor or change is perceived. Adaptive coping responses involve removing or reducing the stressor, reducing an individual's emotional response to the stressor and changing the meaning of the stressor (Hodgson, et al., 1996).

Resiliency

Ryff, Singer, Love, and Essex (1998) have proposed that the majority of older individuals may stay healthy, recover, or even improve in view of challenging transitions because they are more resilient than individuals who experience aging more negatively. Ryff et al. (1998, p. 74) have defined resilience as "the maintenance, recovery, or improvement in mental or physical health following challenge". This definition assumes that challenges will occur and that it is how one responds to challenges that is important. Ryff et al. (1998) conceptualize resilience as a dynamic process that results from multiple protective factors. These factors include: psychological resources/personality characteristics such as perceived control and self-efficacy; socio-demographic resources such as education, income, and occupational status; and social-relational resources such as social support and social networks.

Personality Characteristics

There are a number of personality characteristics, which may enable some individuals to cope better than others with transitions that occur as part of growing older. The nature of these characteristics may be different, however, for different subgroups within the seniors' population. For example, in a study focusing on individuals 85 years of age and older, Long and Martin (2000) noted individuals who were more outgoing were less likely to be lonely than those who were more introverted.

Heathcote (2000) noted that social contact, emotional support, mental stimulation, a sense of belonging, and physical activity was all cited by older adults as being important for psychosocial well-being. Fundamental to these, however, was a positive self-image and positive self-esteem, together with the ability and opportunity to make decisions and exercise control over one's own life. Common variables seen as preserving autonomy in the elderly include: staying in one's own home, enjoying a supportive, safe environment; recognizing the need for emotional fulfillment and both mental and physical activity; being committed to regular contact with others of all ages and recognition of heterogeneity among elderly populations (Heathcote, 2000).

Social Relationships

One's perspective about life and life events may play a substantial role in how well an individual adjusts to changes associated with aging. Sullivan (1997; see also Ebly et al., 1996) has suggested that, in general, older individuals may have lower expectations regarding health than younger individuals. As individuals age, expectations about social relationships may also change, centering more often on family and friends than on colleagues and business clients (Graham, 2001).

Several authors have suggested that having good social support networks are critical for maintaining psychological and social well-being (e.g. Graham, 2001; Joubert, 2001; Long & Martin, 2000; Whall, 1990). Others have noted the importance of social contact per se. Forbes (1996), for example, suggests that well-designed housing options, adult education classes,

membership in local churches, and organized outings all provide opportunities for social interaction. Mittlemark (1999) has cautioned that social contact itself may be insufficient to promote psychosocial well-being; the quality of the contact is also important.

I-II Seniors' Lived Experiences of Critical Transitions and Normative Events

Caring for demented husband

Vergare, 1997, describes a case where a woman was experiencing depressive symptoms from caring for her demented husband. She visited him several times a day and refused to visit her children or get involved with the rest of her life. She felt that her role in life was to stay at her husband's side and be there for him, "I am too old to change. How can I be happy without him? What do you expect of someone who is almost ninety?" Medication and psychotherapy helped this woman to be able to leave his bedside and get involved with other factors in her life. Bookwala & Schulz, 2000, determined that husbands who provide caregiving to their wives experience lower levels of secondary stressors and also experience few depressive symptoms compared to the women who provide caregiving to their husbands. "Although women generally report higher levels of depression than men, comparisons between caregiving women and noncaregiving age-matched controls show that women caregivers experience excess depression that is attributable to the caregiving experience". The data used in this study only looked at the experiences by elderly spouse caregivers and not those persons who are in late adulthood (65-70 years of age).

Loss in late-life themes

- loss of strength and physical ability
- loss of youthful beauty
- loss of friends and affiliations
- loss of intimacy and sexual opportunities
- loss of power and prestige
- loss of recognition
- loss of a sense of possibility

According to Yalom (1987), the end of the life cycle is a time to "come to terms with contingency and ordinariness." We learn of "life's limits, the boundaries of biological law, and the indifference of the universe" (p. xi). There are three late lifelines: integrity vs. despair, intimacy vs. isolation and health vs. frailty. More specific concerns for the elderly are: home vs. housing, financial security vs. financial insecurity and occupation vs. retirement. Accepting depression as a normal consequence of aging is often detrimental to those who can be greatly relieved of symptoms through proper treatment.

Effects of long-term widowhood

Long-term widowhood tends to exhibit a lesser feeling of meaningfulness in life and more feelings of anxiety (Thuen, Reime, 1997). The male counterparts do not as often experience these feelings. Having a spouse in the very latter stages of life could provide mixed feelings which range from companionship, friendship and camaraderie to concern and hardship due to their deteriorating condition. Older widows, it seems, appear to receive less social support than elderly women who are still married. However, access to friends and confidants is a very

important aspect of overall well-being, sometimes even more significant than marital status. The study by Thuen & Reime concluded that widows might be more vulnerable and dependent on others than those individuals who are married.

There hasn't been much research done on the long-term effects of widowhood in late life for two reasons: it is so common and secondly there are very few longitudinal studies on aging. The results of a study by Bennett (1997) show that the effects of widowhood indicate a decline in mental health following the loss of their spouse. The declines in mental health are experienced in the form of anxiety, depression and personal disturbance. Other factors come into play with the level of bereavement such as the quality of the marriage, the length of time that the woman had been married and whether or not the death of a spouse had been anticipated.

I-III Self-Help/Coping Strategies re the Critical Transitions/Normative Events

Caregiving

In DeVries 1992 study there was a prediction that there would be a significant difference between male and female caregivers as far as coping strategies are concerned. Both women and men in the study were just as likely to use avoidant coping in terms of caring strategies. The sample used in this study was help-seeking caregivers, which could have resulted in selection bias. The results would have been different had the sample been obtained from caregivers who do not seek help.

Most frequently used cognitive strategies for caregivers:

prayed for guidance-strength

went over situation in mind

told self things to feel better

made promises that it would be better next time

Most frequently used behavioral strategies used by caregivers:

talked with a friend

got busy with other things to keep mind off problem

got away from things for a while

Female caregivers more often seek out social and recreational supports in order to cope with the stress of caring for a frail, older adult.

Widowhood.- Helping one's self through the process.

Van den Hoonaard (1999) describes the ability to maintain a positive self image while adjusting to widowhood is important as a widow's world changes from a 'couples' world to one of adapting to new strategies and coping skills to maintain friends and readjust relationships with their children. Sometimes a widow's friends will not associate with them anymore and sometimes their children will treat them like children and other men in their lives may misunderstand or misinterpret their actions. Stories in Van den Hoonaard's book describe 'personal rites of passage' which tell how the women moved from married life into widowhood. "A very peaceful death for him...he wasn't aware of anything...we had gone to bed later on a Friday night...we were laying there, and he had his arm under my pillow and his other arm around me...and about five minutes before he had...said, 'I love you so much.' And then he

said, 'I've got to move.' And I said, 'Have I got your arm pinched?' ...And he said, 'No, I'm dizzy.' And that was it."

The women who were represented in this book felt no regrets because they were still able to hang onto their identity of being wives of their deceased husbands. The author feels that the open-awareness attitude towards dying gives women the capacity to carry on with their husband's wishes. They were often told not to grieve too much, to get on with their lives and to make decisions for themselves. "The ability to maintain a positive self image is especially significant because becoming a widow means moving into an unwanted and stigmatized social status."

Widow's homes can become more meaningful after the death of their husbands (O'Bryant & Nocera, 1985). Many will create "shrines" of articles or furniture that represents the life they had as husband and wife. "Remaining in a home containing memorabilia from the past may enhance a widow's happiness by promoting reflection on past marital and family happenings." (pg. 408).

Widows are sometimes in the position to help themselves feel more competent in their own homes as compared to married women. A study done by Giesen & Datan in 1979 found that most of the women were pleased with their ability to function as an independent unit.

O'Bryant & Nocera concluded that practitioners, counselors and families should become more familiar with the psychological volume of the home to the older woman. This will aid them in their pursuit to assist widows should they have to leave their home for health reasons.

"Not old" coping mechanism

There are some elderly people who feel that they are "not old", they do not subscribe to the 'threatening messages and meanings concerning their youthful status'. They prefer to live their lives like they are still young and project a positive, youthful and upbeat image (Hurd, 1999). They recognize the realities of aging and will sometimes deny or make light of serious health problems they are facing or have the possibility of facing. The "not old" must constantly juggle with the reality and angst associated with the irreversibility of aging and ultimately dying.

"Widows have led the reinvention of old age. It is widows who have set the example for how to remain active and stay involved – despite the crushing losses that come with old age." (Shapiro, 2000 p.) In Colonial New England, widows were often accused of being a witch. Less than 100 years ago, women were considered almost useless after menopause except for their only role and that was being a grandmother. Ken Dychtwald, author of Age Power states, "There's been a creation of elder women tribes. Instead of the traditional husband and wife, you see three and four widows traveling together, going together to restaurants and movies, becoming caretakers of each other, sharing houses and apartments. It's a whole new social phenomenon." Many studies have indicated that approximately two years after becoming a widow, these women do not appear to be any more or less depressed than other women their same age. Some widows claim to have used this time in their lives to discover new talents and attributes they did not know they could do. Widows are becoming more of a powerful and predominate force in society and they are also becoming wealthier. "The baby boom generation is expected to receive history's biggest

transfer of inheritance, more than \$10 trillion. And as more women work and accumulate savings of their own, the number of well-off widows is expected to grow.”

Self Help

Phototherapy can be a very useful tool in helping seniors recapture many events that occurred during their lives, which can be useful for insightful purposes as well as reflection (Koretsky, 2001). Phototherapy can help with the end of life process. A person can create a collage of photos to pass on to the younger generation to show them what kind of person they were, what they did and what they experienced during their lives. This can be a great empowerment tool for the elderly person to take control of this collage and include in it what they want to show as a representation of their life.

Working can also be an effective self-help too for the elderly. “Today’s trend to retire at 65 or sooner took off after World War II, when economic and social forces aroused seniors’ appetites for leisure. Social Security benefits and private pensions vastly increased oldsters’ financial status, leaving the elderly as a group substantially better off today than the rest of the U.S. population. Many seniors clearly have little financial need to work. Perhaps more important, changing social mores have led many people to value free time more than the buying power or other benefits of a job.” (Dentzer, p.)

A study by Harlow (1996) determined that participation in daily life activity was a key factor in the realization of life satisfaction as was previously anticipated prior to the study. Mass media was considered to be an extremely popular pastime among the older adults represented in this study. “Some mass communication media (e.g., newspapers, educational television, and nonfiction) can strengthen people’s feelings of connectedness to their communities, and the regularity with which these are produced (e.g., daily newspapers or television shows) can impart structure to daily life.”

When an older adult lives through various life transitions, participation in new and different kinds of activities can help to change and shape new found life satisfaction. “Carol Channing recently remarked upon receiving a lifetime achievement award for her service to the theatrical community that, “achievement, apparently, is doing exactly what you want to do.”

Kwan (2003) speaks candidly about transitional challenges the elderly face. “Old age is a period replete with challenge and transition. Widowhood, death of friends and siblings, retirement, change in residence, and decline in physical and cognitive functioning are some of the normative, and frequently negative, experiences that confront the elderly.”

A greater ‘will to live’ is associated with a more positive self-perception of aging. Self-perceptions of aging vary with each individual’s definition of their own concept of ‘old age’. A study by Levy (2002) suggested that the positive stereotypes of aging should be promoted with the younger generation by introducing positive intergenerational activities. By de-emphasizing the negative stereotypes associated with aging, we can encourage how the elderly are targeted and in turn how they tend to target themselves.

We should also stress the importance of integrating complex leisure activities into our day. “Doing more complex leisure time activities increases intellectual functioning; doing less

complex activities decreases intellectual functioning.” (Schooler, 2001, p.) Doing more complex tasks, for example crossword puzzles, in old age substantially encourages older people to be able to deal with many and various intellectual challenges that different and changing life environments can offer.

I-IV What do seniors identify as being helpful from family/friends during these times?

There is a business called, ‘Gentle Transitions’ that was started in 1997 by a woman who moved her elderly mother from a small town in Wisconsin to the bigger city of Minneapolis (Hubler, 1997). When the move had been successfully completed, she decided that she could start a company that would help others in the same situation to ease the stress upon the family and the individual experiencing the move. “Combining the skills of logistics experts with the tact of professional counselors, the Gundersons help seniors deal with movers, estate-sale specialists, and utility companies. They clean out garages. They pack. They help decide what furniture to bring and what to discard. Best of all, on moving day, they set up the new apartment just like the client’s old home, from the knickknacks on the end tables to the pictures on the walls.” (pg.) It has been reported that siblings of widows play a significant role in assisting to ease the transition from married life to living alone (O’Bryant, 1988). Unmarried sisters, having experienced a single lifestyle are able to offer more assistance during this time of loneliness than married sisters. Brothers do not often play a very significant role when a sibling becomes a widow. There are many variables involved such as: family composition, relatives’ proximity, siblings’ sex and marital status when determining if a sibling may be of assistance to provide support and encouragement to an older widow’s well-being.

The Development of Programs for the Elderly

While the concepts of risk and vulnerability have long been a part of public health and medicine, the concept of resiliency is relatively new in the field of program planning (Health Canada, 1997b). In planning and providing programs for any age group, but particularly seniors, a balance must be sought between the identification of risk and building on an individual’s strengths (Health Canada, 1997b).

Risk identification exists in a social context (Health Canada, 1997b). Since other people (usually health and service providers and community agencies) define risk for individuals and groups, the identification of what are acceptable and unacceptable risks will be partially based upon their values, biases, experiences, beliefs and knowledge (Health Canada, 1997b). The identification of risks tends to focus on weaknesses rather than strengths, on limitations rather than abilities. This can bias how interventions are designed and how people are treated (Health Canada, 1997b). For example, programs or services may be paternalistic rather than empowering. Asking potential users of a program or service what is important to them with regards to their health may yield very different perspectives from what health care providers would suggest is important.

Hodgson et al (1996) conducted a review of effective mental health promotion programs. They noted that many successful programs are characterized by a focused or targeted approach to mental health rather than a broad approach. The emphasis has generally been on influencing known risk and protective factors. The best studies have focused on more than one factor. Clear outcomes are also targeted. There is usually a strong link between the intervention and the risk factors and outcomes. The reliability and validity of outcome measures is important.

Successful interventions are often developed over a long period of time, often 10 years or more. Program development may involve needs assessment, pilot studies and formative evaluations that result in further improvements (Hodgson et al., 1996). The long-term effect of an intervention should also be assessed. In some cases, the effectiveness of an intervention may emerge gradually. Ideally, short term changes in risk and protective factors should be assessed and related to longer term health and social gain. The literature, however, suggests that programs designed to promote physical, psychological and/or social well-being are often not evaluated well (e.g. Connell, 1999; Kaasalainen et al., 2000; Morris, Kerr, Wood, and Haughey, 2000); see also Glor, 1991).

As part of the development of a program, it is important to ensure that comparison groups are actually comparable since selection bias may influence results in subtle ways. It is also important to identify individuals who are unlikely to benefit from a program since resources may be wasted in attempting to intervene in groups that are not going to respond (Hodgson et al., 1996). Programs designed for individuals 65 years of age and older should examine whether the needs of various subgroups within the seniors population are met.

II SENIORS' REPORTS OF FACTORS/ELEMENTS THAT MAKE SERVICES/PROGRAMS HELPFUL OR NOT

The Development and Implementation of Policies

The development and implementation of policies regarding the promotion of mental health in seniors must explicitly incorporate the basic principles. For example, seniors need to be actively and meaningfully involved in the development, implementation, evaluation and review of policies. If policies are designed for specific subgroups, members of these subgroups should be included as part of the development process. Policies need to emphasize health promotion as well as the prevention of illness. Policies should be developed and implemented collaboratively with the active and meaningful involvement of representatives from various public, private, and not-for-profit sectors.

In 2002, Ashley Catania from the Stratford Beacon Herald wrote about a program new to the area called, "A Time for Me". The purpose of this program was to give people over the age of 55 an opportunity for personal growth and a means of connecting with their peers. The meetings were conducted by an informal means of group discussion and included many topics such as: self-esteem, changes with aging and communication amongst peers.

Dixon (2003), feels that counseling seniors requires a variety of skills in order to meet the varied demands of the elderly. These numerous skills are multi-faceted and include appropriate referrals, information regarding independent living, personal growth counseling, adjustment counseling, employment, financial, leisure, family, grief and peer counseling, medical case management, and advocacy for groups and individuals. A lack of training in these areas has previously been mentioned. These are considered specialized skills by most educational programs and therefore likely not available to many graduates of post secondary institutions. "Current predictions suggest that the number of persons 65 years of age and older will more than double in the United States during the next 30 years", (Miller et al, 2000). As older people experience more and more functional disabilities due to such ailments as arthritis, stroke,

diabetes, coronary artery disease, cancer, or cognitive impairment, there will be more opportunities for rehabilitation counselors to serve older consumers (Swett & Malachy, 2003). Finnerty-Fried, 1985 felt that barriers for rehabilitation counselors who work with the elderly population include:

a lack of information on aging,
a personal fear of aging, and
a limited outside involvement with older adults.

III PSYCHOLOGICAL APPROACHES (PROGRAMS, MODELS AND INTERVENTIONS) TO:

III- I Mental Health Promotion

Dorfman & Lubben (1995) feel that physicians should obtain more guidance on successfully treating elderly patients who are experiencing symptoms of depression. They have also agreed with the theory that only 25-30% of depressed elderly patients have their disorder actually diagnosed. Additional information regarding mental health and the elderly is required by physicians in order to better diagnose and treat serious mental health issues.

A study by Davis Jones and Beck-Little (2002) looked at the effectiveness of reminiscence therapy for the treatment of depression. "Reminiscence therapy is using the recall of past events, feelings and thoughts to facilitate adaptation to present circumstances." (p. 283) Reminiscence therapy can be a very successful means of treating depression for those older adults who live in rural communities, particularly women (Beck-Little, 2002). Reminiscence therapy involves trained nurses who assist those individuals who are in need. It is more cost effective than the traditional method of treatment and is seen to be quite therapeutic as well as social for the persons seeking the assistance. Many rural elderly try to avoid the traditional means of engaging in mental health services and are more acceptable to a program offered by nurses.

This type of therapy is very useful in the prevention and/or the reduction of depression as well as increasing life satisfaction, improving the ability for self-care, improving self-esteem and helping others to deal with crisis situations, losses, and late-life transitions. As previously mentioned, reminiscence therapy is very cost-effective, has few harmful side effects, and is very easy to use and adaptable to most care situations concerning the elderly in rural or other living arrangements.

Datan (1988) looked at the challenges in recognizing a mental health agenda for aging women. It was suggested that recommendations for the mental health system concerning elderly women should include providing education concerning gender issues in research and training. Bower (1999) suggests that there should be more research concerning mental disorders and the elderly. He also put forth the idea that geriatric mental health workers should receive better training. It was also noted by Datan (1988), that by increasing the visibility and leadership of women in the mental health professions, upcoming generations of aging women will have a voice and there will be studies to generate future knowledge. Some of the characteristics peculiar to older women's mental health that Datan has noted are as follows:

aging doesn't necessarily constitute a normal decline in psychological health,
psychological problems experienced in the elderly should be presumed to be treatable,
psychological problems in the elderly do not necessarily require drug therapy,
the elderly should have equal access to alternative interventions,
the most effective and coincidentally the least used method for dealing with psychological problems and elderly women is prevention,

an awareness of the sex differences with respect to prescriptions and drug use is very important in the treatment of mental health issues, the ability to use sensitivity regarding role changes and various social conditions, including poverty should be essential in dealing with elderly female clients. Datan's final point reads, "There is no clearly discernable, systematic, intentional prejudice against old women in mental health policies and services. However, social norms related to age and gender are formalized in mental health research, practice, and policy and are reflected in assumptions about normality, etiology, prognosis, and diagnosis.

Support intervention as seen through self-help/support groups as noted by Stewart et al (2001), demonstrated that widowers tend to have lower levels of support than married persons. This study noted that these support groups attended by bereaved seniors recorded an increased level of hope, an increase in the development of social relationships, an acceptance to new role identities, and a decrease in the levels of loneliness.

Rokach, (2001) speaks of the phase of late adulthood (60 years and older) as a period of personal adjustment. The most difficult adjustment of all is the inevitable death of friends, relatives and possibly a spouse. Many individuals will recognize the value of spirituality at this time in their lives. They will engage in activities, which are spiritual in nature, which has many benefits for some, the most noticeable being a strategy to cope with loneliness. To quote an Arabian proverb, "He who has health has hope; and he who has hope has everything."

Bower (1999), proposes a 15-25 year plan to conduct research in mental health and the elderly in the United States. There are several trends, which indicate there could be a crisis in mental health and the elderly in the near future. The first trend is that more mentally ill adults are reaching old age due to an improvement in physical health. The second trend is the increase in population of elderly people also increases the number of potential candidates that will suffer with mental illnesses. The third and also very interesting speculation is that the aging baby boomer population will be more prone to such mental disruptions as depression, anxiety disorders and substance abuse than their elder counterparts of today's generation.

Secker (1998) is seeking to promote the development of a mental health promotion agenda. The key principals he suggests are as follows:

Drawing on health promotion theory to reconceptualize mental health and illness.

A commitment to exploring and valuing lay understandings of mental health.

A proactive approach to defining the boundary between prevention and promotion based on needs assessment and evaluation research.

Alliances with anti-poverty and other organizations aiming to address social and economic inequalities.

The validation of participatory methods through evaluation research.

The development of research strategies, which are themselves consistent with health promotion principles. (p. 64)

The World Health Organization (WHO) has put forward the idea of a "life course" approach to dealing with the issues of aging and mental health and to focus on positive interventions early on in life as opposed to waiting until problems are much older (Andrews, 2001). The components of the aging and health program outlined by the WHO are: life course, promoting health and well-being, culture, gender, intergenerational relationships, and ethics. This program suggests a strong community component, leaving the emphasis off the individual and brings into perspective the social, mental, economic, and the role of the environment affecting elderly individuals.

The National Forum on Health (Dyck et al, 2002) describes two programs that have been successful with elderly people. The first one is the “Gatekeeper Model” for the isolated, at-risk elderly. These gatekeepers find out about at-risk seniors through their work environments and have the appropriate training and referral systems to aid the individuals in need. The second program is a “Suicide-Action Montreal Program” for widowers. This program was geared for men over the age of 55 who have become a widower two years prior to being accepted into the program. The men who take part in this program are asked to complete questionnaires regarding their level of bereavement, their well-being, their level of anxiety and depression. They complete questionnaires before their entrance to the program, again after a period of six months, and once more one year later. Results of this program had not been fully reported at the time this article was written.

Kaasalainen et al (2000) developed a formal evaluation program to determine the success of caregiver support programs. It was felt that with the increasing demands on family caregivers, programs that are currently available should be evaluated to maintain the standard of needs that ought to be met for those attending the programs. The name of the evaluation program is called CARG, Caring for Aging Relatives and it was thought to be very successful and beneficial.

III – II Prevention of Mental Health Problems

According to Stewart et al (2001), “Bereaved persons who attend self-help groups can gain hope, improve skills in developing social relationships, learn new role definitions, and become less lonely.” (pg. 59) This study was set up to look at the effect of a support group on widowed seniors. A network of peers was created to study the natural network of widowed seniors. The hypothesis used for this study was as follows,

It was expected that:

total support satisfaction would increase

total support need would decrease

positive affect would increase

negative affect would decrease, and

social and emotional loneliness and isolation would decrease (pg. 56)

McGloshen et al, (1988), looked at the psychological well-being of older and new widows. They agreed with previous research on the elderly, which suggested that the overall health of the individual has a very important impact on the psychological well-being when faced with widowhood. Three are other factors in their lives that also come into play such as: the death of other friends and/or family members prior to the death of their husbands, a sense of dissatisfaction with housing, and employment history. These all play a part in negative feelings associated with widowhood. Positive influences were those such as: participation in religious activities, the presence of siblings and positive support from other family members.

“The Final Course” is a workshop established in Oregon by Vicki Schmall in 1993. This workshop helps older people move out of their depressed state and back into a more healthy and happy life. There is a training package available for those wanting to run the workshop, which lasts two to three hours. The material presented at the workshop covers: types of depression, causes of depression, how to recognize depression, where to get help and different treatment methods.

Moving towards a healthy independence after becoming a widow is discussed in an article written by Fischer and Hegge, 2000. Nurses and other health professionals should be aware of the many factors involved with becoming a widow and help to prevent the occurrence of a possible mental health problem due to widowhood. Unresolved grief should be dealt with and recognized. Some of the symptoms that could be experienced include: sleep disruption, nutrition, medication compliance and other daily life activities. Signs of depression should be monitored and if required, the individual should be referred to the appropriate resource. Looking for potential hazards in the home as well as seeking out friends and family to assist in the transition can be ultimately helpful to the recent widow. Encouraging socialization is a key element and introspection about life should be turned around into external interests like volunteer work or activities to help establish a sense of being needed.

III – III Strategies to Address Mental Health Problems

Landreville and Gervais (1997), in their review of literature concluded that psychotherapy is a very useful tool for reducing the debilitating depressive symptoms in elderly people that have disabilities. They also determined that disabled people have improved with psychotherapy treatment just as much as those who are not disabled. These researchers are forthright in explaining that more research in this area is required. They feel that the studies in this area have been quite limited and that more well designed studies that gear themselves toward the treatment of depression and adapt themselves to the elderly population.

Shulman (1988), researches the idea of remarriage as a means to help cope with the loneliness associated with widowhood. Remarried widowed women appear to have fewer needs than those widows who do not remarry. There are, however, new concerns and developments upon remarriage that can be stressful. Some of these concerns include: children, getting along with people, the loss of free time and the interactions with new step-children and in-laws etc. Many women choose not to remarry as they state they cannot find anyone as nice as their husband and they will often idealize their deceased husband. Widows often feel that remarriage would not be an acceptable or appropriate alternative for them. They suggest that they are too old and are worried about disapproval from friends and family. Remarriage should not be looked upon as an automatic solution to the problems associated with widowhood. Some problems can be lessened by remarriage like loneliness, finances and home maintenance.

Dr. Eran Metzger (2000) feels that the elderly need more time to be able to tell their stories to help cope with any mental health issues. They have lived long lives and have many stories to share. He also suggests that professionals dealing with elderly suffering with depressive symptoms should become comfortable with end of life issues, death and dying. The best medicine, Dr. Metzger postulates, is regular family visits. “The elderly need to know that their family is still there for them and that they are still part of the community.” (p.1)

Self-help groups aimed at easing the burden of widowhood can be very effective (Tilford et al, 1996). Monthly self-help groups that are set up in a structured environment to discuss common experiences and feelings associated with widowhood are very productive. Many positive changes and feelings can be attributed to meetings and self-help groups. One year after the loss of a spouse can see a significant change in feelings of depression and a reduction in medication associated with depression if the widow has attended a group such as described.