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PSYCHOLOGICAL INTERVENTIONS IN DEPENDENCE-RELATED PREVENTION AND CARE

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Despite the traditional, simple view of dependency, research clearly shows the process leading to lack of autonomy in elderly persons as multi-causal. Beyond the biological dimension, psychosocial factors play a significant role. Health Psychology and Clinical Psychology provide forms of intervention as well as prevention and treatment tools. Moreover, those providing care to the elderly play a key role within the social process of caregiving. Apart from being social agents helping to meet the increasing social demands for care of the elderly and increase their autonomy, it is important for carers to avoid the negative implications of their activity for themselves.
Keywords: *Dependency, Psychological intervention, Elderly persons.*

Lejos de la visión tradicional de la dependencia, el proceso que conduce a la dependencia a las personas de más edad tiene un carácter multicausal, de tal forma que trascendiendo a la dimensión biológica de la dependencia, los factores psicosociales adquieren un papel significativo. Existen múltiples vías de intervención procedentes de la Psicología de la Salud y la Psicología Clínica que debieran ser herramientas terapéuticas esenciales para la prevención y tratamiento de la dependencia. Asimismo, los cuidadores que proveen de asistencia a las personas mayores dependientes son uno de los factores psicosociales más influyentes a la hora de iniciar, mantener o reducir el proceso de dependencia y que deben ser atendidos, no sólo por ser agentes sociales que responden a la demanda planteada por el aumento del número de personas mayores dependientes que pueden contribuir al mantenimiento de su autonomía, sino por las consecuencias negativas que para ellos mismos puede tener el mantenimiento de tal actividad.
Palabras clave: *Dependencia, Tratamiento psicológico, Personas mayores.*

THE IMPORTANCE OF INDEPENDENCE

The adaptation of elderly people to their environment and their well-being are primarily linked to the ability to perform essential everyday activities. The number and quality of years an elderly person can live without disabilities has come to form the basis of the notion of *independent life expectancy* (*health life expectancy*), considered by the WHO as a basic indicator of the health and, by extension, of the quality of life of a population (WHO 1984). Personal autonomy basically consists in control over the making and implementation of everyday decisions, whose loss severely affects both the individual and his/her context, since the capacity to function independently is what is considered, statistically and normatively, most desirable (in discourse analysis studies, maintenance of "one's own lifestyle" emerges as the most highly valued goal for elderly people (Bazo, 1992)). Moreover, the commonest fear among the elderly is of reaching a stage at which they have to depend on others (IMSERSO, 1995). Likewise, research has shown a close relationship between performing everyday activities and self-esteem in the elderly (Reitzes, Mutran & Verrill, 1995), as well as between the ability to do such tasks independently and the perception of self-efficacy (Willis, Jay, Diehl & Marsiske, 1992).

On the other hand, the phenomenon of dependence implies that the basic needs the elderly person cannot satisfy by him/herself must be covered by "the context", and more specifically, by those people close to the elderly individual, and from whom that he/she expects or demands care and assistance. Thus, the most important consequences of loss of personal autonomy can be seen as the *personal* kind, given the negative effects on the person's self-concept and self-perceived well-being, and the *socio-economic* kind, given that the need for care has to be covered by the family, implying changes in the routines, needs and relationships of its members, or by professionals, with the concomitant financial outlay by the individual him/herself, the family, the local or regional authorities or the state.

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LOSS OF AUTONOMY AND DEPENDENCE

The main consequence of a loss of personal autonomy is the individual's need to be helped or supported to adjust to his or her context and interact with it. Thus, from a functional approach, dependence can be defined in terms of individuals' adjustment to the demands of their physical and social context. This adjustment refers to functioning in a series of areas making up everyday life in modern Western-style society, the principal aspects being *economic dependence*, *physical dependence*, which occurs when the individual loses control of his/her bodily functions and interaction with the physical elements of the environment, *social dependence*, which is associated with the loss of significant people and relationships for the individual, and *mental dependence*, which emerges as the elderly lose the ability to resolve problems on their own and make their own decisions.

Generally, the concept of dependence has been limited to the physical sphere, dependence being assessed for making decisions about the type and degree of care necessary for palliating it. Thus, in epidemiological studies the term dependence is usually equivalent to "functional disability" in relation to the set of behaviours people perform every day or almost every day, in order to live independently and integrated in their environment and fulfil their social role – behaviours commonly referred to as *daily life activities*. Thus, a person is dependent when he or she presents limitations in the execution of one or more activities considered basic components of everyday life, and hence has to depend on another person.

THE CURRENT PICTURE OF DEPENDENCE

In the light of the above, the meaning of dependence in relation to old age appears a straightforward one. Dependence is generally thought of as a phenomenon that reflects a loss of personal autonomy, whose principal consequence is the elderly person's need to be helped or supported in order to adjust to his or her context and interact with it. Furthermore, the loss of personal autonomy is defined almost exclusively in physical or biological terms mainly associated with health problems, injuries such as broken hips and neurodegenerative illnesses –dementias– that prevent the person acting as they did previously. Likewise, dependence is explained as a natural consequence of the passage of time.

In short, dependence tends to be understood as a one-dimensional phenomenon, i.e., as a foreseeable physical decline of a greater or lesser degree. A reflection of this is the pragmatic definition of dependence customarily used by epidemiological studies that attempt to quantify the extent of the dependence, treating as synonymous "dependence" and "functional disability in relation to daily life activities". This view of dependence is easy to accept, since on the face of things it can be seen that physical dependence in elderly persons increases with age, ever greater amounts of help being demanded or accepted from others. Less intuitive and socially accepted is the recognition of how certain psychological aspects or people's social environment affect dependence

DEPENDENCE AS A MULTICAUSAL PHENOMENON

From a broad perspective, this one-dimensional conception of dependence should not be the only one; rather, it is preferable to consider dependence as a complex concept, with various facets, which is influenced by biological, psychological and social variables. The consideration of intervention in all these aspects is the principal goal of the present work. The multidimensional nature of dependence is reflected in the wide range of conceptions of it that can be found in the literature: mental, physical, economic, social, emotional, cognitive, imaginary, neurotic, functional, and so on. Likewise, dependence can be analyzed from different perspectives: behavioural, personal, situational and interpersonal. However, currently the different approaches generally focus on specific aspects of dependence, and rarely consider it in all its complexity (Horgas, Wahl & Baltes, 1996).

Furthermore, dependence can be studied on different levels of analysis, with greater or lesser degrees of generality. Thus, it can be approached in global or *macrolevel* terms, using the dependence concept to reflect aspect of a country's demographic structure (e.g., the dependence rate), whereas an *intermediate level* of analysis of dependence would reflect, for example, data on rates of need for help to cover specific daily life activities in particular contexts (such as residential care homes. These two levels of analysis, global and intermediate, are those most commonly used for the analysis of dependence. Another possibility, however, is the *microlevel* of analysis of dependence, person by person, through which it is possible to characterize the dependent behaviour of individuals in interaction with their immediate social environment. This level of analysis would determine, then, that dependence revolves around three factors; the characteristics of each elderly person, the social context in which the dependent

behaviour takes place, and the interaction between the two; in other words, this level of analysis reveals the quantity and nature of dependence that is socially induced. The microlevel is that which has been least widely analyzed, and for which there is still a lack of proposals for intervention programmes or protocols. However, it is the microlevel of analysis that can reveal the influence of non-biological variables on dependence, allowing the planning of preventive or palliative interventions.

In short, dependence should be seen as a multicausal construct in which biological, psychological and social factors are all antecedents of behavioural dependence –of the request for or acceptance (passive or active) of help from others (Baltes & Wahl, 1990). Let us now consider the main factors that cause dependence, which, in turn, provide the routes for intervention to prevent or palliate it.

Physical factors

Physical fragility. The deterioration of one or several of the biological systems of the organism (cardiovascular, respiratory, muscular, etc.) leads to a loss of physical strength, mobility, balance, resistance, and so on, which is in turn associated with decreased ability to perform basic and instrumental activities of everyday life. Despite the certainty of this decline, we should bear in mind the wide individual differences between elderly people, as well as the fact that the capacity to modify biological decline –delay it, prevent it, or even re-establish it– has been grossly underestimated (Rowe & Kahn, 1987). Today there is a considerable body of research evidence on the benefits of interventions that can improve physical functioning and thus reduce dependence. Physical exercise at different levels of intensity is an important predictor of morbidity and longevity. In relation to this, one of the principal challenges is to involve adults in physical activity, motivational and dispositional variables being important ingredients.

Chronic illnesses. Without doubt, chronic physical illnesses common in old age (osteoporosis, osteoarthritis, CVA, etc.,) and sensory limitations contribute markedly to physical disability and dependence. As in the case of physical fragility, the role of prevention in the appearance of chronic illnesses for delaying or reducing the severity of dependence is underestimated. The types of intervention normally undertaken in the Health Psychology framework for prevention and treatment in diabetes, cerebrovascular accidents, strokes, etc. should constitute one of the primary elements in this regard.

Use of medication. The high prevalence of illness among the elderly leads to extremely high levels of medicinal drug use, which can have substantial side effects, as well as undesirable pharmacological interactions (e.g., Vestal, 1990). For example, confusion, cognitive deterioration, affective flattening and so on are behavioural symptoms deriving from the use of medication found relatively frequently among the elderly, and these are factors that tend to increase physical dependence and contribute to behavioural dependence (Horgas et al., 1995). Better control by the health system of drug prescriptions and side effects could lead to lower levels of dependence, but another key factor is intervention aimed at improving therapeutic compliance.

Psychological factors

Mental disorders. Disorders such as anxiety and, especially, depression, contribute significantly to dependence in old age. It is common among the elderly to find high levels of depressive symptomatology, which is often neither diagnosed nor treated. However depressive symptoms are well known to be associated with social isolation, physical complaints and cognitive and functional decline – all factors that contribute to behavioural dependence (Frazer, Leicht & Baker, 1996). Of particular importance is the case of people with Alzheimer's disease, since it is estimated that around a third of those suffering its early or intermediate stages may have problems of depression (Teri & Gallagher, 1991).

Pain. Pain is one of the psychological dimensions that most contributes to dependence, not only through the direct reduction of activity, but also due to the indirect effect on the osteo-muscular apparatus deriving from that reduction of activity, which leads to greater pain. Moreover, there is a vicious circle involving pain, depression and loss of function. The usual treatment techniques have been proved useful also in the elderly population.

Falls and fear of falls. Likewise, the fact of having suffered a fall, or simply the fear of falling, is a substantial source of dependence as a consequence of reduced activity. Supervised training in postural

balance, muscle strengthening exercises, control of medication, modification of environmental "dangers", psychoeducation and the usual techniques for the treatment of anxiety are effective for dealing with these problems.

Personality factors. One's experiences and learning throughout life mean that on reaching old age people differ notably with regard to their demands for and acceptance of help from others in the different situations of everyday life, having a greater or lesser degree of dependence. Moreover, the *dependent personality* characteristic can increase the risk of suffering from physical and mental disorders, and thus indirectly increase dependence (Greenberg & Bornstein, 1988).

Contextual factors

Physical environment. Research, professional practice and the common experience of many relatives of elderly persons show clearly that physical environments rich in stimuli and with sufficient prosthetic aids, which strike the right balance between independence and security help the elderly to function at optimum levels of performance. In contrast, environments with a dearth of stimuli or without sufficient aids contribute to the increase of behavioural dependence.

Social environment. A final type of antecedent or cause of dependence can be found in the context in which the dependence occurs, that is, in a social environment that encourages dependence, or one which helps to prevent dependence. Among the various factors of this type, two emerge as particularly important:

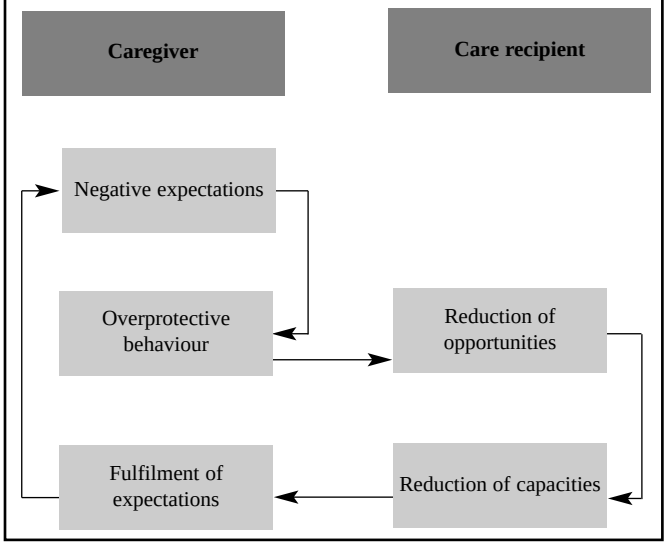
a) Environmental contingencies.

This is based on the operant learning model, from which the dependent behaviours of elderly people are understood and explained as instrumental behaviours. This paradigm has generated a large body of research, the most notable work being that of Margaret Baltes' team (e.g., Baltes, 1988). A series of interaction patterns between the elderly person and his or her carers have been commonly observed in various activities in a whole range of everyday contexts, from special care institutions to one's own home. Obviously, modifying the environmental contingencies that follow the manifestation of dependent behaviours has enabled the reduction of dependent behaviours; in other words, teaching those who interact with older people to respond positively to behaviours of autonomy and independence and, on the other hand, not reinforcing dependent behaviours have made it possible to re-establish, for example, habits related to self care (hygiene, eating or dressing) or to reduce dependent behaviours associated with wandering, hallucinations, depression or incontinence.

b) Expectations and stereotypes

Lastly, the social expectations of elderly persons are quite probably a principal factor in the production of dependence. Gerontologists have coined the term "ageism" to refer to the pejorative concept of judging, classifying or describing someone on the basis of their advanced chronological age. Old age is a consequence of a biological process, but it is also a cultural construction (Beauvoir, 1970). As is the case with any other type of social role or status concept, a person is old when other people consider them to be old. In the social interaction process, other people, through their behaviours, are the mirror in which one sees oneself reflected. The reactions of others towards elderly persons show them the image they present, constraining them to adopt the behaviours they know are expected of them. It has been suggested that ageism is maintained by the false beliefs socially prevailing about old age, which influence not only the way elderly persons are treated, but also the way they themselves behave. Figure 1 shows a model with the process of interaction between, on the one hand, negative stereotypes and expectations about old age, and on the other, dependence for daily life activities.

Figure 1
Mechanisms of influence on dependence



EXCESSIVE DISABILITY AND DEPENDENCE

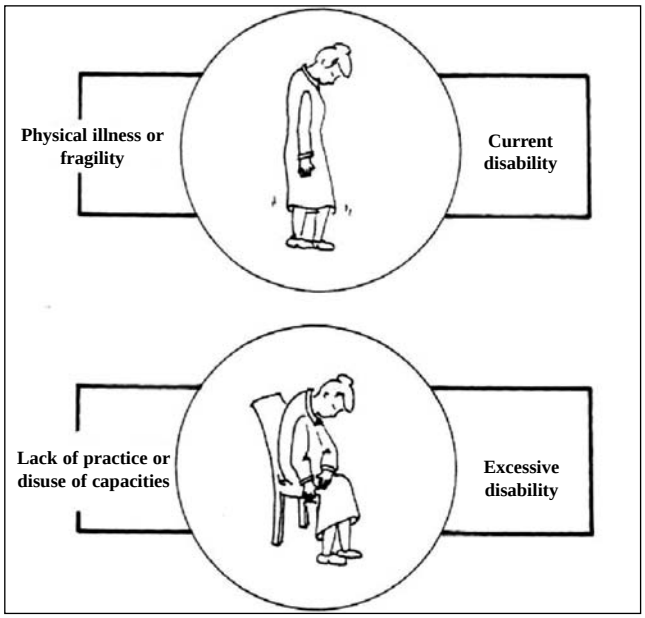
As Baltes and Baltes (1990) argue, given that functional dependence is a multicausal phenomenon (even though there are clearly a series of stable organic determining factors), it is important to stress the relevance of studying the weight of potentially modifiable factors, as well as the possibility of intervention on them with a view to avoiding what is referred to in the gerontological literature as *excessive disability*.

Thus, excessive disability denotes the deterioration caused by disuse of preserved capacities not directly affected by a state of physical fragility or illness, and which are of a reversible nature. Excessive disability means attributing dependence behaviours to illness when they in fact have another, more benign source that is reversible (side effects, behavioural alterations, inappropriate physical context, environmental contingencies that favour dependence, or negative stereotypes and attributions towards elderly people) (see Figure 2).

Care for carers as a way of enhancing independence

Informal carers, who provide approximately 86% of the care provided at home (IMSERSO, 2004), constitute the principal psychosocial influence with regard to care of the elderly. Providing care for carers and dealing with the obstacles they may encounter in looking after their relatives are not only legitimate goals of intervention for the phenomenon of dependence in the elderly, but are indeed among the goals set down in the Spanish legislation in this area (*Ley Básica sobre Autonomía Personal y Protección a las Personas en Situación de Dependencia*), which include the development of an integrated and comprehensive care system for the elderly and their families, as well as the drawing up and application of *care for carers* programmes. Thus, carers should be considered not merely as a resource for responding to the needs of the elderly, but also themselves as a primary target of social and health care (García-Calvente, 2000).

Figure 2
Excessive disability



Within the concept of care for carers, two different strands can be identified: on the one hand, the training of carers as social agents who promote the autonomy and prevent the dependence of their relatives, and on the other, interventions aimed at palliating the negative consequences of caring.

First of all, psychoeducational interventions with carers help to reduce the elderly person's dependence for instrumental activities. It is considered that an imbalance between individuals' competence and the environmental demands leads to problems of functioning and reduced well-being. Programmes developed to help family carers redress this imbalance provide them with skills and tools which enable them to manage and adapt in an effective way those elements of the home context associated with everyday problems of care. Some strategies for carers are aimed at modifying the physical dimension of the environment (e.g., installation of grab bars, simplification of environment through removal of objects), others address the dimension of the task (e.g., effective forms of communication), while there are also those whose goal is to modify the social environment (coordination of care activities, instructions on how to communicate with formal carers, etc.). In a specific programme with these intervention components it was found that, after the intervention, dependence levels for instrumental activities fell significantly more in the experimental group than in the control group, while for basic activities there was a non-significant trend in the same direction (Gitlin et al., 2001). Likewise, it has been found that behavioural interventions complemented with exercise significantly improve physical health and reduce depression in persons with Alzheimer's disease. An intervention programme aimed at training carers to identify and modify behavioural problems in Alzheimer's patients and to encourage a daily minimum of 30 minutes' exercise (e.g., aerobics and flexibility) had a substantial beneficial effect on the physical health

and depression of such patients. Those participating in the programme maintain, over a two-year period, better performance in physical functioning and lower depression levels than Alzheimer's patients receiving standard care (Teri et al., 2003). Figure 3 shows some general recommendations for working in situations of dependence.

And secondly, the combination of respite services and psychoeducational intervention is one of the most effective options for helping carers (Díaz, Montorio & Yanguas, 1999). This option involves a structured programme of goal-specific action, implemented by one or more professionals working with groups, and through which carers are provided with information about their elderly relative's illness and the resources and services available in the community, and about how to take better care of their relatives and of themselves.

Figure 3
General recommendations for action in a situation of dependence

- Adapt the elderly person's environment in order to facilitate independent behaviours (installing a walk-in shower, putting up reminders or signs in case of cognitive difficulties –e.g., in the bathroom–, adequate lighting, etc.).
- Observe the elderly person in order to ascertain everything he or she does for him/herself and do nothing that they can do for themselves. Give only the help that is necessary.
- Prepare the situation to make it easier to be independent.
- Behave with the elderly person in a way that favours autonomy: reinforcing independent behaviours.
- Respond appropriately when the person objects to attempts to favour their autonomy (encouraging, showing confidence in their capacity, being persistent).
- Promote the dependent person's self-esteem (letting them make decisions, however small, beginning with those related to simple tasks or activities they know how to do). It should not be overlooked that for these techniques to work, the carer (formal or informal) should have the following characteristics: patience, flexibility, sensitivity, kindness, creativity and, above all, genuine interest in fostering the autonomy of elderly persons.

CONCLUSIONS

Functional dependence can be partly explained by objective functional disability, such as severe cognitive decline or loss of mobility as a result of certain morbid processes, though even in these cases the dependence can be prevented and its intensity palliated with the appropriate treatment. But another part of dependence can be explained in terms of psychosocial variables and processes such as behaviour alterations, including depression or some symptoms of dementia-type disorders that are treatable (hallucinations, wandering, etc.), the physical environment and adaptive mechanisms of the elderly person in the face of certain environmental contingencies; by the continual interactions between psychosocial variables such as stereotypes, attributions, attitudes, support and communication behaviours and self-efficacy that can lead to dependence and are shared by society. In sum, dependence is a highly complex phenomenon, which can be approached in a wide range of ways, including through the classic social measures such as care services and financial help. Also, however, other types of intervention become essential when dependence behaviours are the result of conforming to stereotypes, of underestimating one's own resources, of environmental contingencies or of an unfavourable physical environment.

Finally, the processes that lead to dependence are multivariate in their course, so that many psychological interventions can become small ingredients that delay, palliate or prevent the processes leading to dependence. When an elderly person has an osteo-muscular problem, this should not be synonymous with dependence; rather, adequate medical examination and monitoring, together with interventions encouraging physical activity, programmes for preventing depression, multidisciplinary programmes for the treatment of pain and prevention of falls, and a social context involving active participation and collaboration in the maintenance of autonomy constitute genuine and well-trodden paths toward the prevention of dependence.

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