Attachment and Social Engagement in Late Life: Interventions for Older Adults

Stacy Ogbeide, MS, Barbara Farrell, BA, Gaston Rougeaux-Burnes, BS
Presentation Overview

• The “Graying” of America
• Attachment and Older Adults
• Applying Attachment Concepts to Interventions
• The Role of Social Engagement
• Older Adults and Dementia
• Conclusions/Implications
The “Graying” of America
Aging in America

• Baby Boomers entering older adult life
• Increasing life expectancy
  – Increased health issues with age
  – Multiple generations living in same era
  – Different expectations/needs regarding retirement
• Declining birth rates
  – Non-traditional families

http://www.prcdc.org/300million/The_Aging_of_America/
Life Expectancy at age 65

- Dramatic increase in longevity for persons reaching age 65
- Both genders but particularly for females
- Does quantity = quality?

<table>
<thead>
<tr>
<th>Year</th>
<th>Males age 65</th>
<th>Females age 65</th>
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<tbody>
<tr>
<td>1950</td>
<td>12.6 years</td>
<td>14.4 years</td>
</tr>
<tr>
<td>2000</td>
<td>15.9 years</td>
<td>19.0 years</td>
</tr>
<tr>
<td>2030</td>
<td>18.0 years</td>
<td>22.0 years</td>
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http://www.prcdc.org/300million/The_Aging_of_America/
“Graying” in America

- As of 2011 the Baby Boomers are reaching age 65
- In the 1950’s 1 in 10 Americans were over 65
- 1 in 8 Americans today are over 65
  - Approximately 6 million Americans 85 or older
- By 2030 1 in 5 will be 65 or older
  - Double the current population
  - By 2050 estimated 21 million Americans 85 or older

http://www.prcdc.org/300million/The_Aging_of_America/
Challenges and Benefits of Aging

• Older adults face some of the hardest challenges of life
  – Chronic illness
  – Disability
  – Frequent grieving
• Although not unique to older adults, challenges are more common
• Cannot assume older adults are frail, impaired, or in need of care
  – Greater emotional and cognitive complexity
  – Better comprehension and more emotional control
  – Experiential competence or wisdom

Knight & McCollum, 1998
The State of Mental Health and Aging in America

• CDC Behavioral Risk Factor Surveillance System
  – Social and Emotional Support
  – Life Satisfaction
  – Frequent Mental Distress
  – Lifetime Diagnosis of Depression
  – Lifetime Diagnosis of Anxiety D/O

http://apps.nccd.cdc.gov/MAHA/MahaHome.aspx
Social Support

• Social support serves major support functions
  – emotional support (e.g., sharing problems or venting emotions)
  – informational support (e.g., advice and guidance)
  – instrumental support (e.g., providing rides or assisting with housekeeping)
• Adequate social and emotional support is associated with reduced risk of mental illness, physical illness, and mortality.
• This indicator was assessed through the BRFSS question: “How often do you get the social and emotional support you need?”
• US - 12.2% stated rarely or never
• MO - 10.6 %

http://apps.nccd.cdc.gov/MAHA/MahaHome.aspx
Life Satisfaction

• Life satisfaction is the self-evaluation of one’s life as a whole, and is influenced by socioeconomic, health, and environmental factors.

• Life dissatisfaction is associated with obesity and risky health behaviors such as smoking, physical inactivity, and heavy drinking.

• This indicator was assessed through the BRFSS question: “In general, how satisfied are you with your life?”

• US - 3.5 % answered dissatisfied or very dissatisfied
• MO - 3.0%

http://apps.nccd.cdc.gov/MAHA/MahaHome.aspx
Frequent Mental Distress

- Frequent mental distress (FMD) may interfere with major life activities, such as eating well, maintaining a household, working, or sustaining personal relationships.
- FMD can also affect physical health. Older adults with FMD were more likely to engage in behaviors that can contribute to poor health, such as smoking, not getting recommend amounts of exercise, or eating a diet with few fruits and vegetables.
- This indicator was assessed through the BRFSS question: “Now thinking about your mental health, which includes stress, depression and problems with emotions, for how many days during the past 30 days was your mental health not good?”
- FMD defined as 14 or more days
- US 6.5%
- MO 7.4%

http://apps.nccd.cdc.gov/MAHA/MahaHome.aspx
Depression

• Risk factors for late-onset depression
  – widowhood
  – physical illness
  – low educational attainment (less than high school)
  – impaired functional status
  – heavy alcohol consumption

• Current Depression was defined by a PHQ-8 score of 10 or greater
  – US - 5.0%
  – MO - 5.4%

• Lifetime Depression Diagnosis
  – US -10.5%
  – MO -12.9%

http://apps.nccd.cdc.gov/MAHA/MahaHome.aspx
Lifetime Anxiety D/O

- Anxiety, along with depression, is among the most prevalent mental health problems among older adults
  - Often co-morbid with depression
  - Half adults with depression also meet criteria for anxiety d/o
- Late-life anxiety is believed to be as common in older adults as in younger age groups
  - May be under diagnosed because older adults more likely to report somatic complaints
- US-7.6%
- MO-8.2%

http://apps.nccd.cdc.gov/MAHA/MahaHome.aspx
Attachment and Older Adults
Attachment and Older Adults

- Avoidant or dismissing attachment appears to increase (or become more common) in older adults
  - Low base rates of ambivalent and/or preoccupied attachment
- Higher proportions of avoidant older adults due to a greater number of losses experienced or cohort effects
- Study examining 2 cohorts – younger cohort (1922-1932) compared to older cohort (1911-1921): lower numbers of those with secure attachment
  - Watsonian Behaviorism: advocated the withholding of affection from children and would have reached its height of influence between the 1920s and 1930s

Magai, 2008
Attachment and Older Adults

- Change in Attachment Styles:
- Child development literature: 32% of children showed a change in attachment classification over time
  - Rates of 46% have been found with adults
- Late life literature: one study found that both secure and dismissing attachment increased over time (affluent population) and the second study found that both decrease over time (low-income)
  - Differing methods to measure attachment
  - Second study: role changes, loss of members in social network, increasing value placed on intimate, emotionally rewarding relationships

Magai, 2008
Attachment and Older Adults

- Attachment in Ethnic Populations:
  - Haitians: greater dismissive avoidance and lower fearful avoidance than all other ethnic groups
    - Belief in supernatural to cause harm
    - Highly defensive and tend to repress negative emotions (the ability to forget negative events seen as a strength)
  - Eastern Europeans: Dismissive avoidance and preoccupation
    - Feelings of mistrust stemming from Communism
    - Self-reliance and independence of importance
    - Complex mixture of overprotection/infantilization and expectations of independence in childhood; led to overdependent adults who also have difficulties establishing trusting relationships
  - English-speaking Caribbeans: Dismissiveness
    - Punitive emotion socialization practices due to value placed on stoicism and achievement

Flori, Consedine, & Magai, 2009
Attachment and Older Adults

- Attachment in Ethnic Populations:
  - Puerto Ricans and Dominicans: high on preoccupation; low on dismissiveness
    - Interdependence valued over personal choice and exploration
    - *Familismo* (family concerns more important than individual concerns), *simpatia* (conflict avoidance), *personalismo* (trust and respect), *respeto* (adherence to authority), *educacion* (education in morality and interpersonal relationships)
  - European Americans: Secure
    - Independent cultural orientation
  - African Americans: Dismissive
    - Issues of racism and prejudice
    - No more dismissive than European Americans
    - Less dismissive than Haitian or Eastern European groups

Flori, Consedine, & Magai, 2009
Attachment and Older Adults

• Attachments between parents and children in later life:
• Most powerful affective bonds are possibly the bidirectional ones that develop between children and their parents.
  – And while that is able to be inferred from the literature, there is no direct literature which has measured this construct.

Cassidy & Shaver, 2008
Applying Attachment Concepts to Interventions
Conceptualizing the Aging Family

• Attachment patterns related to ability or willingness to access
  – Thoughts
  – Feelings
  – Memories
  in an effort to maintain security in face of threat
• Therapists can listen to the function of speech
  – How verbal bx relates to emotion
    • preoccupied-anxious – poorly regulated emotion, easily overwhelmed
    • Dismissing-avoidant – rigid, constricted, evasive
    • Secure family base – members collaborate and show sensitivity to each other
• Learn to distinguish b/w attachment-related and cohort effects
  – Belief that it’s inappropriate to show deep feeling
    • Usually only evident in casual or superficial conversation
    • Avoidants suppress verbal emotional expression related to emotional events

Bradley & Palmer, 2003
Applying Attachment Concepts

• Problems in family contexts
  – Excessive criticism/arguments
  – Withdrawal and emotional detachment
  – Manipulative and controlling Bx

• Distortions of “normal” attachment signals
  – Fear of abandonment
  – Desire of closeness
  – Needs for security

• Older families have larger range of life transitions
  – Attachment needs more prominent
  – Increase in distress symptoms

Bradley & Palmer, 2003
Psychoeducation

- Geared toward families with elder suffering from age-related impairment
- Reframe/relabel problem symptoms or bx
  - Aging adults needs often indirectly expressed
    - Avoidance of conflict or requests for help
    - Clinging, dependent, demanding bx
    - Hostility and paranoia
  - Shift focus from overt bx to attachment need
    - Comfort, reassurance, security
    - Ex: criticism could be an attempt to appear strong and attempt to cope with adverse situation

Bradley & Palmer, 2003
Life Review

- Commonly used with grieving clients
- Creative development of self-concept
  - Who we are
  - Who we have been
  - Who we will be
- Review of Eriksonian Development
  - Look for unresolved conflicts

Knight, 2004
Erikson’s Stages

- Individual change
  - Increasing complexity
  - Environmental change

- Basic trust vs. Mistrust
- Autonomy vs. Shame & Doubt
- Initiative vs. Guilt
- Industry vs. Inferiority
- Identity vs. Identity diffusion
- Intimacy vs. Isolation
- Generativity vs. Stagnation
- Integrity vs. Despair

- Parents
- and siblings
- and other family
- and school
- and peers
- & partner
- & kids
- & society

http://www.utdallas.edu/~kprager/erik_ekrikson%202002.htm
Life Course Perspective

• Biological time
  – Physiological change
  – Socially defined values of youth vs age
  – Health issues

• Cohort clock
  – Historical entry into flow of time
  – Life experience
  – Tastes in values (leisure, work, cultural beliefs)

• Family time – place in generational structure

• Age-linked roles
  – Career - school, work, retirement
  – Family life – ending and reforming over lifespan
  – Differing social roles based on gender, SES, religion, geography…..

“I used to be with it, then they changed what “it” was. Now what I’m with isn’t “it” and what is “it” seems weird and scary to me.” – Grandpa Simpson

Knight, 2004
Guiding a Life Review

• **When?**
  – Grief work
  – Major functional limitations (sight, hearing, etc)
  – Major new realizations
  – Role transitions

• **Developing a time-line**
  – Look for gaps and develop missing areas

• **Length and complexity of life informs depth**

• **Edits and reframes**

• **Future and how it is viewed**
  – planning

Knight, 2004
Emotionally Focused Therapy

- Couple or family approach
- Desire for attachment motivates bx in close relationships
- Goals of EFT
  - Access/identify primary emotions of attachment strategies
  - Use newly accessed emotions to restructure interactions
    - Promote shared sense of security and engagement
    - Follow emotions in session (not past experiences)
    - Frame problems as the result of interactional patterns adapted to promote security

Bradley & Palmer, 2003
CCMCS Model

• Contextual, Cohort-Based Maturity/Specific Challenge Model
  – Developmental process of aging alone is not sufficient
  – Sociocultural circumstances must be included
    • Maturation and family systems
    • Cohort differences
    • Social context
    • Challenges of late life

Knight & McCallum, 1998
Maturation and Family Systems

- Individuals pass through several family systems throughout life
  - Family of origin
  - Dispersed and extending family
  - Grandparenthood or great-grandparenthood
- Families often multigenerational
- Older adults can be the center of family crisis or crisis can be displaced onto older adult
- Maturational views – (ie the benefits of age)
  - Counteract negative views of aging

Knight & McCallum, 1998
Cohort Differences

- Therapy with older adults must include learning what it is like to have grown up in an earlier time.
- Family disagreements often evolve out of cohort differences
  - Differences in values
  - Life experiences
  - Often effective to use non-family acquaintances who are cohort-mates of target family member to help other family members gain perspective.

Knight & McCallum, 1998
Social Context of Older Adults

• Age-segregation (housing, social/recreational)
• Specific laws
  – Medicare
  – Conservatorship
• Other family members may not have considered these factors or made assumptions
  – Education for family about limitations and options
  – Consider age-integrated activities
  – Communication about idealism versus reality
    • “Oh, grandma, you’ll love it once you get there!”

Knight & McCallum, 1998
Specificity of Challenges

• Chronic illness and disability
  – Lift the Taboo – communication within the family
  – Families will respond as they have to other crises
  – Adjustment to new roles and duties

• Grieving
  – Expressing emotion
  – Putting loss in perspective
  – Life adjustments
  – Must account for grief work in whole family system – not just the elder adult

• Caregiving
  – Similar to grief work – mourning the loss of prior roles
  – Caregiving problems may be indication of other underlying family issues
    • Elders often the “scapegoat”

Knight & McCallum, 1998
Therapeutic Family Meetings

- Jarvik and Small (1988) - six steps to improved relations between older adults and family
  - Monitoring mood
  - Considering intensity of emotion
  - Constructive planning
  - Reassessment of the situation
  - Listening then negotiating
  - Compromise

Kennedy, 2000
Therapeutic Family Meetings

- Single meeting with telephone follow-up
- The key is in the preparation
  - Clinician, patient, & primary caregiver decide who needs to attend
    - Who is influential?
    - Who is the mediator?
    - Who are the leaders and followers?
    - What were the caregiver and patient roles prior to illness?
  - Home or office meeting?
- Address the patient needs then refocus to address caregiver and family
- Develop family plan that delegates responsibility and allows flexibility
  - Negotiate and allow for contingency planning
  - Follow-up to troubleshoot

Kennedy, 2000
The Importance of Social Engagement
Friendships and Social Networks among Older Adults

• It is understood that having a group of people with whom one can relate and on whom one can rely is an essential part of a person’s overall practical and emotional support system
  
  • However, the older an individual becomes, it often becomes clear that society no longer believes this is the case.
    – Do You?

Cavanaugh, 1998
Social Support

• Support that is accessible to people through social ties to others (social network)
  – Function:
    • Facilitate coping when an individual is experiencing stress
  – Continuing research supports the idea that the more social supports a person receives, the greater the protection or buffering from stressors

Pearson, 1996
Social Support

- Social networks that individuals use for support change across a lifetime.
  - Therefore, what a young man may view as important for the individuals he chooses to view as friends may change from the time he is 20 to the time he is 70.
- Cartensen (1995) stipulated that as individuals age, they become more selective in their choice of people with whom they want to have contact.
  - This viewpoint would be supported by Antonucci & Akiyama (1987) which found that in older adults it was their QUALITY of friends, not the QUANTITY.

Cartensen, 1995
Social Support

- Luscza & Andrews (2005)
  - Found that social networks conferred an adaptive advantage over and above those provided by demographic, health, and lifestyle variables
    - Better networks with friends were protective against mortality over the following decade

Cartensen, 1995
Gender Differences in Social Support

• Women
  – Tend to base friendships on intimacy and emotional sharing
  – More likely than men to get together for the shared purpose of providing emotional / personal support

• Men
  – Base friendships on shared activities

• Therefore, as both of these groups age, it is women who are seemingly better equipped to form close QUALITY relationships, than their male counterparts.

Rawlins, 1992
Siblings and Social Support

- Longest lasting relationship an individual normally has is with their sibling.
- The types of relationships older adults have with their siblings should be assessed.
  - This assessment would occur to ascertain whether the relationships may be appropriate resources to draw on in addressing practical and emotional problems

Rawlins, 1992
Attachment and Social Support

• Knowing what we know now about how individuals view social support as they age, what role does attachment play?
Working with Older Adults and Families with Dementia
Working with Dementia

• What is dementia?
  – Impairment of various aspects of memory as well as other cognitive domains, aspects of personality, and behavior
  – DSM criteria: memory impairment and at least one of the following disturbances: aphasia, apraxia, agnosia, executive functioning

• What are you experiences working with patients with dementia?

Fromholt & Bruhn, 1998
Working with Dementia

• Types of Dementia:
  • Alzheimer’s Disease (50% of cases)
  • Lewy Body Dementia
  • Mixed Dementia (AD and Vascular)
  • Vascular Dementia
  • Pick’s Disease (Frontotemporal Dementia)
  • Normal Pressure Hydrocephalus
  • Dementia secondary to metabolic disturbances
    – Thyroid Disease
    – Vitamin $B_{12}$ deficiency
  • Dementia with other neurologic illness
    – Parkinson’s/Huntington’s/MS
  • Infectious Dementia
  • Dementia from head trauma
  • Dementia from brain tumors
  • Dementia syndrome of depression
Working with Dementia

• Video:  
  http://www.youtube.com/watch?v=7wbYEK7O14E&feature=related

• Stages (AD):
  – Stage 1: No impairment
  – Stage 2: Very mild decline
  – Stage 3: Mild decline
  – Stage 4: Moderate decline
  – Stage 5: Moderately severe decline
  – Stage 6: Severe decline
  – Stage 7: Very severe decline

• Behaviors:
  – Agitation, restlessness, wandering, mood disorders, delusions, hallucinations, rage and violence, compulsive/bizarre behaviors, incontinence, phobias, shouting, sleep disturbances, sexual behaviors, disinhibition, sundowning

Herrmann & Madan, 2007
Working with Dementia

• Interventions:
• Video: http://www.youtube.com/watch?v=sIRb--Nauwk&feature=related
• Writing groups (Lifelines Writing Group):
  – Purpose: written self-expression to stimulate memories and feelings; writing is not taught or critiqued; early stage dementia and family members (to readings only)
  – Strategy: Writing is done during the group time and left at the end of each session; group members would write and read their work and discuss what comes up in the process; 1-2 topics presented each week (or their own)
Working with Dementia

• Interventions:
• The Storytelling Method (TimeSlips):
  – Purpose: Establishing a social role for the patient, a storyteller, which would provide access to meaningful self-expression; middle-stage dementia
  – Strategy: Facilitators used a different image each week that appeared to be staged/humorous; open ended questions were asked about the image; questions should also focus on sensory content and social environment; responses were written on a write board for all to see; lasts 30-60 minutes; story re-read periodically during the session; at the start of each session, story from the week prior is read; length: ~6 weeks

Basting, 2003
Working with Dementia

• Interventions:
• Reminiscence and Life Review:
  – Purpose: Ideal for those struggling with troubling events (i.e., dementia); meaningful degree of understanding; review of the past to help the patient find meaning in the present through partial resolution with self and others; early stage dementia and family members
  – Strategy: Review of memorabilia, photos, journals; writing and autobiography or reuniting with friends/family; family members may know the details of the event but it is more important to experience the patient’s reaction to the events; being willing to listen if the patient is willing to talk

Kennedy, 2000
Working with Dementia

- Interventions:
- Working with family members
  - Goal: monitor and regulate their own emotional reactions, change their behavior, or change the way they think
  - Accepting the diagnosis differs from understanding the diagnosis
  - We would not ask why someone with an amputated leg had trouble walking – why do we ask why someone with a brain disorder cannot remember?
  - Learning to attribute bx to dementia and not the person
  - E.g., accepting that Dad is deceased (grieving) but caring for “Dad-with-Dementia”

Knight, 2004
Working with Dementia

- Interventions:
- Stress and Coping Model (Stress-Based Caregiving Interventions):
  - Stress-based model: caregiving is innately stressful; coping strategies key
  - Social support (appraisal is more important than size)
  - Adjusting to the new balance as the abilities of the older person change (family members fulfilling roles instead – grieving the partial loss of the older person
    - Resumption of family issues
    - Care recipient’s prior personality and family role
  - Important questions: How was the primary caregiver chosen? (seen as a choice or job?) Are their others who could help – even those who want to help but have been blocked from assisting? Extent of the involvement of other family members in the intervention?

Knight, 2004
Working with Dementia

• Interventions:
• Cognitive-Behavioral (with family members):
  – Relaxation training
  – Problem solving
  – Activity scheduling (relaxing events)
  – Cognitive Reframing
  – Support Groups
  – **Commons goals:** resolving differing views of the seriousness of care recipients impairments and problems, barriers to sharing responsibilities, resolving interpersonal conflicts that create additional stressors

Knight, 2004
Conclusions/Implications

• Attachment concepts – viable to family interventions with older adults
• Education to patient and family members is key
• Education of provider is also key
Questions? Comments?

- Stacy Ogbeide: sogbeide@forest.edu
- Barbara Farrell: bfarrell@forest.edu
- Gaston Rougeaux-Burnes: grburnes@forest.edu
References

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