Depression and Anxiety in the Elderly: Translating Clinical Methods for Use by Non-Professionals

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Abstract

Because seniors suffer depression and anxiety and professional help is not always available, a simple structure is proposed for non-professionals to provide effective help to seniors. These potential helpers who are present in the seniors' daily environments can then assist the seniors in adjusting to their stage of life and avoid the distress arising from loneliness, purposelessness and physical/mental decline, the factors accounting for the bulk of seniors' problems. The few therapeutic skills these willing helpers need are described and embedded in a sequence of procedural steps they can use. Mental health professionals are encouraged to teach these skills at every opportunity.

Keywords: Elderly, senior, translational psychology, aging, senior care, non-professional help, cognitive therapy, behavioral therapy

Introduction

Reactive depression and anxiety are not triggered directly by adverse life events, but indirectly, by the perception or anticipation of those events (Ellis, 1962). This is the feature of depression and anxiety that make them effectively treatable by the cognitive therapies (Beck A., 1964, 2005; Beck, J., 2011). Adding behavioral therapy to cognitive treatment helps sustain the altered cognitions by teaching patients to live on the new perceptual landscape where emotional balance and enjoyment is again possible.

Since professional clinicians' services are often unavailable for the elderly(Fiske, Wetherell & Gatz, 2009) because of determinants of practice such as expense, travel difficulties, or because the elderly resist mental health treatment, effective methods are translated below for use by concerned relatives, friends, and non-clinical care providers.

For the elderly, the threat of depression and anxiety flow almost continually from unwelcome life events. Many of these are caused or exacerbated by the elderly patient's own behaviors and thoughts. Their environments are filled with reminders of the deficits resulting from aging and with reminders that they are members of the aged group. This stimulates both old and young to act in the stereotyped manner of the elderly, as Bargh, Chen & Burrows(1996) have demonstrated, which, for seniors, slows them further and increases their emotional burdens.

Cues about aging truly affect even on the young, but the young are more resistant and resilient. Their thoughts are engaged in finding behavioral answers to big questions. Many available, well-supported narratives keep them busy and motivated. As seniors, they now wonder what experiences can equal the ones they remember in seeking and finding friendship, making intimate connection and being in love. Without these, they experience loneliness. The other big questions such as "What will be my occupation?" "Will I be successful?" "Will I have a family?"are also all in the past for the elderly. The elderly wonder what can possibly replace planning a life and a family with so much available time, resources, hope as they had in their youth. Without replacements they experience purposelessness. From this perspective, combined with mental and physical decline, the future looks bleak indeed, and depression, anxiety or both ensue.

2 .Structure of assistance provided by non-professionals

The initial contact with the intent to provide help to the willing senior begins with a complete interview. After that, there are three paths. No matter how the senior's distress appears or is expressed, the helper surmises whether the chief distress is related to loneliness, purposelessness or physical/mental decline. The helper will use the basic techniques he/she has learned for that path in the order indicated. Each contact with the senior ends with the emergency plan: creating it, modifying it or reviewing it. The simple cognitive and behavioral techniques these helpers need to know are described at each step, with examples. These, together with being thoroughly instructed when 911 or a professional must be contacted, can constitute the helper as a new and plentiful resource for seniors.

3. The interview: foundation and beginning of the helping process

Professional treatment begins with the clinical interview. This includes a complete psychiatric-psychosocial history and a current evaluation of mental status. For elderly patients this examination can take longer than usual, both because their history is longer and the replies are often elaborate or delivered slowly.

Family, friends, other seniors and caregivers who wish to help but are not professional therapists, are easily taught this information gathering aspect of this process. Effective help requires a complete exploration of the senior's life, so the helpers are shown how to explore broadly and keep notes. This includes learning about the major events of the senior's life and current thinking processes, but goes further into a more complete background, including hopes, pleasures, fears, successes, and failures as well as the senior's current experience of daily living. This information is interesting for the helper to hear and pleasant for the senior to tell. It is the foundation for providing relief.

When reactive depression is professionally diagnosed, the goal of treatment is to reduce symptoms and restore the patient to pre-onset functioning. If risk of suicide is present, the first objective is to manage this risk, so both the intention to end one's life and even thinking about it cease to threaten. Additional objectives target improvement of mood, concentration, sleeping and eating, social relations and increasing of all activity, particularly the most rewarding activities.

The methods for achieving each objective are tailored to the patient and sequenced so the patient can progressively learn to alter problematic cognitions and behaviors and practice the required skills. The treatment plan will include methods, for example, for teaching patients how to identify and resist automatic thoughts, maladaptive assumptions and rumination. Methods for finding, scheduling and engaging in the most rewarding activities are also planned, along with skills for improving social connections, managing one's own behaviors, and improving role functioning as spouse, parent, friend or employee. It is hoped that after discharge from treatment the patient will continue to maintain the altered cognitions and use the learned skills to avoid depression. While recurrences of depression are not uncommon among younger patients, lengthy periods of symptom-free normal functioning between episodes are the rule.

Patients, however, are frequently discharged from treatment or discontinue of their own accord as soon as they start to feel dramatically better. Thoughts of death and suicide as well as depressed mood recede quickly as treatment effects take hold and the primary objectives of safety and euthymic mood are achieved. Fewer patients stay with treatment until the objectives concerning social linkages, supports, activity level, activity choice and other matters are fully achieved (Aahkus, Granlund, Oxman & Flottorp, 2015).

Elderly patients need all of those objectives achieved, and more. Their days are not structured by the demands of employment or the needs of a growing family and their thoughts and behaviors easily turn negative. In addition, their environments are smaller and less stimulating than the ones younger patients live in, leaving them with fewer opportunities for using their newly learned skills. Their range of activity is further limited both by real disabilities and by fear. Additional help and support are needed by the senior patients in their regular living environments.

Unless the senior is totally isolated, the senior's available peers, friends, family members, and the senior him/herself can be taught methods for achieving the same goals the therapist does. The instruction need not have the foundation or breadth the professional enjoys in training. Simple, direct, scripted responses to meet the senior's needs are readily learned. These can be taught on an individual basis, or in group presentations for these motivated helpers.

Even without diagnostic training, the helper can see into which of the problem areas of loneliness, purposelessness, or physical/mental decline the senior's main complaint falls, and follow that path. The authors' clinical experience indicates that these three categories contain the bulk of seniors' complaints, regardless of how they are expressed. Empirical research evidence of the factors these paths address awaits confirmatory factor analysis, but the authors predict high loadings on only these three factors, all others scree.

Instruction of seniors themselves in the use of these methods is also productive. They are able to use mentally healthy approaches to assist themselves and their peers.

4. The emergency plan: create it, repair it or review it at each contact

For times when an acute sense of loneliness, purposelessness or physical/mental decline suddenly arises and overwhelms the senior, provoking depressed feelings, discouragement or thoughts of death and dying, the helper prepares the senior to recognize the problem and respond to it immediately. The senior must learn when an emergency call must be made or a professional contacted. Possibly the most important new learning is how to resist and control these poisonous thoughts. Words that are associated with age and decline need to be avoided as can be concluded from the Bargh et al.(1996) research. Train the helper to use techniques for managing obsessive-compulsive disorder or, alternatively, methods useful for controlling panic attacks, depending upon how the senior experiences the acute distress. Many of these methods can be translated for use without further professional assistance.

Guide the helper to select methods appropriately and change them as needed. If there is no sign of over-arousal, an immediate response of a phrase, distracting thoughts or activities, and blocking of the distressing thoughts can be tried. On the other hand, if the patient is aroused, restless or panicky, relaxation and breathing methods may be more useful. At especially vulnerable times like upon awakening in the middle of the night, these initial methods can be followed by engaging in a practiced mental scenario, a story, either quieting or stimulating, in which the patient imagines him/herself in a role to help restore sleep.

During daylight hours activity is an additional help, as does seeking contact with others by phone, text message, email, Facebook or in person. To motivate the senior to resist these distressing thoughts immediately, the helper can illustrate from the senior's own experience that pursuing these distressing thoughts and thinking about possible negative outcomes is upsetting and serves no useful purpose. Therefore these intrusions are to be resisted as soon as they are recognized. Examining the content of these thoughts for any important insights they may contain is work to be done during the day, not at night. In the most difficult times, usually at night when the distress is making further sleep impossible and it is pointless to remain in bed, rising for physical activity such as yoga movements, poses and breathing exercises can also be used to relieve the distress.

5. The first problem: loneliness.

Even those elderly not troubled by clinical depression routinely identify loneliness as a problem. They miss time spent with their children who have grown up and whose lives keep them busy elsewhere. They enumerate the friends and relatives lost to death, most particularly spouses. They miss the emotional closeness, the physical closeness including touch, intimacy and sexual intimacy. The seniors not only miss the loved ones, they miss love and loving itself. The sadness from these losses can prevent them from making new connections with those available to them, and they maintain a protective emotional distance to avoid risk of further losses.

5.1 What progress against loneliness will look like.

The senior in distress from loneliness is focused on the lost companionship of earlier days, which cannot be restored. And yet, the elderly have experienced most all of life's transitions. Each transition involved loss, change, and discovery of new things and people. The new did not replace or improve upon the old, it was simply different, and ultimately worked out well enough. Childhood friends were lost at adolescence, but new companions were found and relationships changed. Jobs were lost and replaced; relocations occurred; children came along, then grew up and became independent; one's parents died along the way, a long-feared and significant loss. None of these losses were minimized, but life went on and new companions appeared and new joys and sorrows were experienced.

This stage of life is the same. Losses are grieved but then adjusted to, and the events of the new stage of life take hold with new experiences, both positive and negative, as in every other stage of life, if a successful transition is made.

5.2 The heart of the matter.

The senior can come to enjoy the new people and pleasures this stage of life brings without diminishing his/her love for the people and events of his/her past. The loves and successes of the past enable the senior to find new and different ones now.

5.3What must be done.

The professional therapist instructs the helper who has already completed a thorough interview of the senior, to address the following objectives in sequence with the described techniques.

5.3.1 Reduce the aversiveness of being alone

Teach the helper to discuss positive stories for his/her current solitude. In the process, the helper assists by adopting vocabulary changes. For examples, the word "loneliness" is replaced with the word "solitude" and the problem is not being "addressed", but is being "solved". Characters from literature for whom solitude was a positive resource are discussed, perhaps people like Thomas Edison, Marie Curie or William Wordsworth.

Teach the helper simple skills for enjoying solitude, which the helper can then teach the senior. These might include relaxation training, meditation training, and movement training. Music can be added, especially the music from the senior's youth (Feinberg, 2010). The senior's attempts at these things are discussed, and the helper makes needed adjustments: new activities, some thought of by the senior, are added to be tried. In the midst of this, the helper creates and shares story elements, such as the story of the senior now experimenting with enjoying the benefits of solitude, or the story of the senior learning new activities which can be enjoyed in solitude. These elements will become part of the senior's viewpoint, and likely provide some relief.

5.3.2 Restore old social connections where possible and helpful.

Non-professional helpers can be taught to provide relief for loneliness by discussing types and kinds of interpersonal connections the patient has or had in the past, the satisfactions these relationships provided, and the reason these satisfactions are now less than they were before. In the instances where the contacts are still living and not separated from the patient by persistent conflict (divorce, serious disagreement) the connection may be easily renewed. Where distance is a problem, the senior can be taught the skills needed to connect online, with email, Facebook, Facetime or other social network applications. The helper learns to guide the senior not to expect too much from any one person, but to form a network of people who, in aggregate, meet the patient's needs for contact.

5.3.3Initiate new social connections.

Forming new acquaintances and friends can present obstacles that are different from reconnecting family and friends. The elderly patient has experienced losses, and new connections involve both fear of rejection and fear of potential additional losses. The helper learns to assist the senior to discover, evaluate and discuss where social contacts are available. The helper then assists the senior in searching for those which are attractive to the senior and locally convenient. These may, in a given instance, include senior centers, senior events, and general events consistent with the senior's preferences, such as parties, amateur sports events, educational and performance events at local high schools, community colleges and universities. Classes, sometimes free or at reduced price are available in topics which interest the senior. Self-help groups of most any type are also welcoming to new members and beneficial to seniors, and thus are still another resource.

The helper or peer will find it important to accompany each senior at least once on a new experience. Let the senior discover the physical and emotional rewards of participating in classes and groups for dance movement, yoga, music, writing, arts areas, and even science, history and philosophy. Although the primary purpose is increasing social connections, many additional pleasurable and beneficial outcomes may be realized. Progress may be blocked at times by the patient's lack of a particular skill. When such skills are identified, the helper should be given instruction and practice in providing the senior at least with a scripted solution.

5.3.4 Explore fears and reluctance.

For the senior who desires to take a forward step but is inhibited by fears, teach the helper to subdivide the behavior into parts so each one is small enough first to contemplate comfortably, and then to carry out, as detailed in Sullivan & Sullivan-Nunes(2013).

5.3.5 Keep track of progress.

Teach the helper to show the senior how to keep track of any progress, because being aware of gains is very motivating to continue the effort. For example, if the objective is new social connections and the senior only went to an event but did not interact, score the gains: an event was attended and how long he/she stayed is recorded. Encourage more events and longer stays. When the patient finally speaks to someone, score that as an interaction. Discuss the interaction, allowing the senior to review it completely, take additional pleasure from it, view it as helpful and plan further interactions. No matter how small the steps the elderly patient has to take to move forward, keeping track provides daily evidence of his/her ability to solve the problem of loneliness. As the senior raises the stakes and begins to desire more, and perhaps pursues a path toward connection, friendship, intimacy and love, keeping track remains useful and supportive.

5.3.6 Finding new rewards.

Most importantly, teach the helper to introduce the search for new delights and possibilities that this stage of life makes possible. This can include showing the senior how to become aware of and sensitive to the many unnoticed pleasures available every day. But most important is finding and listing the advantages of the new stage of life, what the seniors can do and enjoy now that they never could before.

5.3.7 Create an emergency response plan. As discussed above.

6. The second problem: purposelessness.

The second crucial objective for elderly patients is to reduce the feeling of purposelessness. Busy people long for the day when they can do whatever they wish and fulfill their dreams without being prevented by the demands of a job, family life, and a multitude of responsibilities and demands on their time. They look with envy on those with leisure time because of their wealth. One day, they promise themselves, they will open that business, take that trip, write that book, or find true love.

That time arrives for many at retirement. Not for all: those whose inadequate finances or poor health cause them to struggle have less leisure. But there is some leisure for almost every senior. Responsibilities, expectations and demands are reduced. The time has arrived for pursuing at least some of those postponed dreams. Ironically, the lack of responsibilities and obligations becomes a source of distress, giving retired seniors the feeling that their life is over.

Those seniors, however, who are able to perceive that they have finally gotten their wish for the leisure to pursue their dreams adjust well and enjoy the senior stage of life as the unique, wished-for benefit and treasure it is. Once seeing it this way, some seniors may grumble about having fewer resources of money or energy or excellent memory to work with, but the helper will guide their perceptions toward the new resources they have now, which they did not have before. Chief among these is time.

6.1 What progress against purposelessness will look like.

Progress against a sense of purposelessness, apart from the senior's report of relief, will be evidenced by three things. First, there will be an increase of radius of activity, that is to say, the senior will venture greater distances in his/her planning, desires and activity. For those who rarely left their room or their favorite chair, this will be quite evident. Second, there will be an increase in goal-directed activity. This will be noted in the senior's discussions first, but after a time it will be plainly evident in her/his behavior.

Third, there will be a change from passive pleasures to active ones which require energy. Meals or TV shows will cease to be the preferred activities, and the replacements will include mentally, physically and socially more demanding activities which have higher payoffs.

6.2 The heart of the matter.

The elderly patients can come to realize first, that they have resources and abilities they are not using; second, that they were successful and purposeful in the past using just the resources and abilities they had; and third, that finding purpose begins with searching through the resources and abilities they now have to find what they can do and what they enjoy doing.

6.3 What must be done

The senior begins with recalling times in the past when she/he felt most purposeful. This provides hints so that the senior and the helpers know what they are looking for. After that, the senior can be made aware of the unused reservoir of resources and abilities, both new and old, which they presently have. The search for purpose begins there. As in the case of loneliness; the professional therapist instructs the helper who has already completed a thorough interview of the senior, to address the following objectives in sequence.

6.3.1 Explore the phenomenology of the experience.

Teach the helper to inquire about the senior's sense of purposelessness without using the word "purposelessness" itself. If the patient uses the word, soften it to "being unsure what you feel you need to accomplish each day," and see whether the senior accepts the change. Discover the types of activities which had purpose for the senior in the past, and whether the activities were active or passive, that is, whether they were in pursuit of chosen goals or in fulfillment of responsibilities and requirements demanded of them by others. Discover where the pleasure of activity was experienced, in the doing or in the having gotten it done. Explore the unfulfilled desires and hopes of the patient without challenging him/her as to why they aren't working on these things now. Arrive, with the senior, at a working view of her/his fulfilled and unfulfilled goals.

6.3.2 Stabilize undesirable emotion.

Show the helper how to make the patient aware that the problem has now been identified and is being worked on, with good hope of success. If the patient takes the view that his/her life is "over," "behind me," or was "wasted," invite the patient to illustrate the waste and lost resources. Lead the discussion toward conjecturing how the resources were wasted, and help the patient view unnoticed gains in the process. Then introduce the idea of preventing any resource of the present from being wasted. Find the resources specific to older persons and to this senior in particular, examine how they could be wasted and how the waste can be prevented.

6.3.3 Review times when patient felt most purposeful and effective.

Show the helper how to invite the patient to rediscover and describe these times in detail. The helper will underline the source of the satisfaction the patient got, and use it as a guide for searching now.

6.3.4 Begin the search for purpose.

The helper will encourage the senior to specify broadly whether he/she seeks a business goal (additional revenue), an altruistic goal, a personal goal, or a social goal, and whether the senior wants a goal about which he/she can be passionate. Decide how progress in the search will be recognized and how much progress the patient wants to make within the next day or week. Invite the patient to join a group with others engaged in different parts of this search, if available.

6.3.5 Inventory of skills, abilities and desires.

Teach the helper how one selects goals that are achievable because they are within the scope of resources and abilities. New skills can be learned, and acquiring needed skills is an important part of the process of overcoming purposelessness. The senior can come to realize that his/her resources were never limitless, and even at the most purposeful times in life she/he was able to achieve goals with fewer resources than might have been preferred.
The same is true now. Some resources are more plentiful, some less. Goals selected with the plentiful resources in mind will be more likely to be satisfactorily achieved. Assist the senior in finding and listing all skills, abilities, assets, talents, interests and desires. Adjoin group work if possible to gain the insights of other seniors to help this senior find all his/her resources.

Have the helper review the senior's specific skills and abilities with her/him, dividing them into two columns: ones that are currently being used and ones that are not. If the senior has mentioned any learnable skills they do not have and wish they did, make a third column for them. The helper then can turn attention to considering skills and abilities which are not being used. Discuss how others use such skills, and how the senior may have used them in the past. Search with the senior for ways these skills might be put to use now, giving the senior a chance to test whether doing so brings enjoyment and a sense of fulfillment. Help the senior begin learning the new skills he/she has mentioned.

6.3.6 Changing, expanding and modifying the self-story.

Teach the helper to use the methods of cognitive therapy to help the senior adopt a narrative self-story that supports selecting and pursuing goals, and then the goals that were selected (Ellis, 2008; Sullivan, Sullivan-Nunes & Nunes, 2015). The minimal story would depict the senior as exchanging passive or almost effortless pleasures (food, TV watching, sitting unoccupied, not having responsibilities, etc.) for ones that require effort, in the expectation that this will result in more pleasure and greater pleasures. This is meagre, but sufficient. A better story might depict the senior as finally realizing that he/she has the time and resources to pursue his/her dreams. The senior is now pursuing old dreams and new ones, working within the resources of knowledge, skills and abilities he/she has or is acquiring is restoring purpose and fulfillment.

For those seniors with a religious background of any variety, the self story could depict their finally deciding to play the role the creator or the universe assigned to them, even though they cannot see it in advance, using their preferences and abilities as clues, or subtle directions from the creator or the universe which show the way while permitting choice. This alignment with creator and universe and viewing oneself as having a role in it provides reserve against depression. The immediate effect can be increased effort to maintain abilities, gain new learning and skills, and seek potent use of them. The senior may also find new confidence that enough resources exist and will be made available to him/her as needed to fulfill his/her role. In any event, a story which fits the needs, desires and particulars of each senior is articulated in detail together with her/him. As pieces are accepted and fall into place, the senior will change his/her behavior to align with the story. Living the role the story creates causes changes in behavior because it suggests that the altered behaviors will produce the desired outcomes the story illustrates. The senior must view any change in behavior he/she is about to make as making more sense than any available alternative, and making more sense than making no change at all. This viewpoint will sustain the effort.

6.3.7 Finalize goal selection.

The senior may decide on multiple goals, some of them quite quickly and easily achieved. This outcome should be supported by the helper, as it will give the senior an opportunity to experience success sooner. Alternatively, the senior may choose an enormous goal (work to solve the problems of global poverty or undernourished children). These goals are also good choices. Any goal a senior selects is subdivided and pursued piece-by-piece, keeping track of progress and problem-solving obstacles as they appear. This type of large goal is also handled this way, and the extensive resources the patient will discover are needed may open the door to their learning about distributed problem solving. This leads to making connections with others who are working on the same problems. Patients working on large goals are not easily discouraged since the goal invites a passionate approach and connects the senior to others who are like themselves. These are very sustaining forces.

6.3.8 Create an emergency response plan. As discussed above.

7. The third problem: the fear of and the experience of physical and mental decline.

The elderly senior's experience of physical and mental decline is progressively exacerbated both by actual aging processes and the patient's reactive behavior. Cognitive intervention, however, combined with training in reducing joint stress, increasing flexibility and compensating real limitations can practically halt the process in the early senior years and create improvements at any age.

7.1What progress against mental/physical decline will look like.

Methods translated from basic cognitive therapy or from subsets of cognitive therapy methods developed by psychologist-researchers such as rational-emotive behavior therapy, the general cognitive model, client centered, transactional analysis, gestalt therapy, etc. can be taught to the helpers as was done with loneliness and purposelessness. Here they can help the seniors to realize, for example, that at their best they were never, at any age, the strongest and most athletic person on earth.

Yet they dealt with that, and they were able to live within the physical abilities they had. Their previous success demonstrates that they already know how to be successful living with the physical limitations they had, and they can do it again now. Beyond that, in cognitive therapy, the senior will come to see him/herself as able to take effective steps to remain more youthful as opposed to being caught in the grip of an accelerating downward process. Helpers need to be taught how to guide the seniors in building physical endurance, agility, flexibility and aerobic capacity, gently, into as many of the day's activities as possible. Social contact can be usefully added to these exercise sessions both for the social and exercise benefits. Including yoga, social dance and suitable sports will yield physical, mental and emotional gains which will surprise and delight the senior.

Experience of mental decline may initially be reported as memory problems. Using an approach parallel to the one used on distress from physical decline, cognitive therapy helps these patients to see that they never had perfect memories, but still did well. They know how to compensate, review, rehearse, pay closer attention, make lists, make notes, leave reminders, and can use these same methods now with great success.

7.2 The heart of the matter.

The optimal goal is *not* to slow the decline, *not* to get by with less, and *not* to adjust to reduced capabilities. The goal is to make new progress in new directions. This means seniors' discovering new things that they didn't know they were capable of, and discovering new experiences the world has to offer. Fighting decline and compensating losses is helpful, but the real reserve against depression comes from enjoying the new benefits this stage has to offer.

7.3What must be done.

For mental/physical decline, help the senior to remember past success in overcoming similar problems, in order to provide an expectation and proven means of success. Then help him/her to replace thoughts of decline with seeking new gains and experiences, compensating deficits along the way, exercising existing abilities and learning new ones.

Again for this source of distress, the professional therapist instructs the helper who has already completed a thorough interview of the senior, to address the following objectives in sequence.

7.3.1 Progressive physical exercise.

Exercise begins with a cognitive change. Seniors have to modify aspects of the story about themselves to describe a person more youthful, more capable, who is making gains, achieving satisfaction in learning and doing things. Changing one's self story can be done by oneself or with the assistance of a non-professional helper or friend who understands the process.

Helpers will accompany the senior in trying new things once, and then review the results with him/her, planning to continue or increase the ones that provide benefits. The target is always new gains and new experiences.
The activities selected should include some from each of three groups.

Group 1: those that improve the senior's balance, flexibility, and strength.
Group 2: those that improve aerobic ability, endurance, distance and speed.
Group 3: Those that improve overall conditioning and appearance: body weight, muscle tone, posture. The specific exercises used can vary greatly from things done independently (e.g. progressive weight training), to things done in class (e.g. yoga), to things done socially (e.g. dance). Keeping daily track of gains will provide believable evidence that he/she can improve.

7.3.2 Progressive mental exercise.

Mental training can begin with work on memory, since that is frequently identified as the main problem. The training is specific and effective, and is the same used for a person of any age who wishes to improve memory function. Instruct the helpers in these techniques, which include learning to make demands on one's memory, establishing cues, patterns, keeping notes, etc., and should provide some improvement fairly rapidly.
A more important mental exercise is further expanding the self-story of the senior to include a sense of exploration and adventure. This will provide the stimulus for pursuing new learning, exploring new thoughts and ideas, and possibly new places.

With these thoughts and skills in place, the senior is prepared to explore of his/her world, exactly as he/she did as a child, an adolescent, a young adult, etc. That world awaiting exploration is unique to the person, and will encompass whatever takes his/her interest.

7.3.3Maintain and articulate the self-story.

The role cognition plays in avoiding anxiety and depression is a crucial one. Explain to the helper that new thoughts do not exist in isolation. They are understood in the context of the thinker and the surroundings. A person who is enjoying a walk in the woods might encounter a dangerous wildcat. His/her thought would be "that is a dangerous wildcat." A person enjoying a hunt in the woods would have the same thought upon encountering a wildcat, but the understandings would be very different. The first person would understand an immediate need to avoid detection or escape, while the second would understand an opportunity for a trophy.

As with loneliness and purposelessness, the self-story of the senior has to change to include those elements which render him/her available for the rewards of this stage of life, prepared for the adventures and opportunities, and resistant to depression and anxiety. Creation and maintenance of this story can be done alone, but is better supported when others participate. A complete discussion of creating and modifying the self-story can be found in Sullivan et al. (2015). Maintaining the story consists in expanding it, and investigating and resolving contradictions to it.

The central tale of any religious faith serves well as a comprehensive self-story, and includes well-articulated relationships to others, to events, and to the creator. Accepting a very well-supported and complete story of this type and building one's self-story in conjunction with it is often quite effective in building a reserve against depression and anxiety.

7.3.4 Create an emergency plan. As discussed above.

8. Conclusion

The senior stage of life, like all the other stages, has challenges and possibilities unique to itself. The adjustment to this stage can be as difficult as any other stage. The point is the similarity. As with each stage, adjustment difficulties can seem insurmountable, but they can be met. The senior is quite familiar with this pattern, having lived through so many stages and transitions. When the challenges are met, this stage, like the others, is rewarding in its unique way.

Societal helps and supports for this stage transition are largely absent, however. Professional help is often inadequate or unused. But there exists a very large pool of potential non-professional helpers who can assist and support the seniors in enjoying this stage of life. These helpers, who include family, friends, relatives, peers, other residents at senior living facilities and even the seniors themselves, need a few basic therapeutic skills which can translate from professional use in the clinic.

With some explanation and a little training or practice, non-professional helpers can provide very effective assistance. This enhances work done by professionals, and can be a replacement when they are not available.
Successful adjustment will not be measured by the degree to which the senior comes to accept the limitations of diminished resources. Rather, the hallmark of successful adjustment will be the senior's discovering the new resources available and enjoying the rewards of this stage of life. In the process, human connections will be strengthened, healthy cognitive and behavioral changes will be made, support will be found and the senior's goals and dreams will be pursued.

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