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A THERAPEUTIC TECHNIQUE FOR SENIORS? AN AGENDA THAT INTENDS TO GET INVOLVED IN ACTIVE AGING

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Abstract: Introduction: Active aging is currently being talked about as a fundamental challenge in the trajectory of several international organizations. This study aimed to understand the therapeutic usefulness of an agenda for older adults, with original tasks distributed over the months between 2015 and 2016. **Methodology:** The tasks were administered to older people living in homes or day centres, as well as applying the Assessment Questionnaire of Quality of Life (SF-36) and the Geriatric Depression Scale. **Results:** The results demonstrate that the agenda can play a role in improving the promotion of active ageing and in reducing depression, contributing to a better quality of life. **Discussion and Conclusion:** During the process, it was possible to verify that the patients developed feelings of pleasure simultaneously with commitment and moments of reflection that showed a rise of opportunities for self-knowledge.
Keywords*:* Active Ageing, Elderly Homes, Therapeutic Tasks.

ACTIVE AGEING

In a period of rapid ageing, there are several discourses and measures that materialize and this were stimulated by demographic changes unprecedented in history, as, for example, the changes related to the determinants of Active Ageing (AA) of t older people. Older adults who experience longer and longer lives, see guaranteed conditions for participation in society, both in the community and in the family, as well as living conditions that allow them to cope with everyday situations.

The OECD defines AA as being: "(..) capacity of people, as they grow older, to lead productive lives in society and the economy. This means that people can make flexible choices in the way they spend time over life – learning, working, partaking in leisure activities, and giving care" (OECD, 2000, p.126). Therefore, AA is considered a responsibility present in each individual or collective duty of society, in which the emphasis is placed on the capacity/autonomy of people throughout the ageing process to carry out productive activities in society and the economy.

The WHO presents the following definition: "Active ageing is the process of optimizing opportunities for health, participation, and security to enhance quality of life as people age. (…) Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social, and mental well-being throughout the life course and to participate in society according to their needs, desires, and capacities, while providing them with adequate protection, security and care, when they require assistance" (WHO, 2002, p.12). The model developed by this entity is based on three pillars: participation, health, and safety. These three pillars, in turn, incorporate six determinants that can promote or constrain AA, such as: economic, health, environmental, personal, physical, and social, which depend on cultural and gender issues.

According to the EU, AA translates into: "Enabling both women and men to remain in employment longer – by overcoming structural barriers (including a lack of support for informal careers) and offering appropriate incentives, many older people can be helped to remain active in the labour market, with systemic and individual benefits; facilitating active citizenship through enabling environments that harness the contribution that older women and men can make to society; enabling both women and men to keep in good health and to live independently as they grow older, thanks to a life-course approach to healthy ageing combined with adapted housing and local environments that allow older adults people to remain in their

own homes as long as possible" (EUROPEAN UNION, 2012, p.3).

QUALITY OF LIFE

According to the WHO, QoL is: "The perception that the individual has of their place in life, in the context of the culture and the value system in which they live, in relation to their goals, their desires, its norms and its concerns. It is a very broad concept that can be influenced in a complex way by the individual's physical health, psychological state and level of independence, their social relationships, and their relationships with the essential elements of their environment"(WHO, 1997).

The QoL in old age translates into a multidimensional assessment with reference to social, normative, and interpersonal criteria, regarding current, past, and prospective relationships between the mature or older people individual and the environment that surrounds them (NERI, 2000). The decline in function associated with ageing is closely related to external factors, such as behavioural, environmental, and social factors. Clinical disorders such as depression are important examples of these situations, due to their prevalence.

DEPRESSION

In old age, depression reaches the highest rates of prevalence, presenting indeterminate forms, often difficult to diagnose and consequently to treat (SPAR and LA RUE, 2005).

The losses that elders experience, on a personal and social level, produce situations of mourning (BARRETO, 2006). The resolution of these experiences is not always easy, especially because of certain negative factors felt, such as: lack of family support; situation of in his charge dependents; lack of material resources and social isolation.

OBJECTIVES

Based on this research, it was considered pertinent to develop an activity that involved older people in various domains, whether physical, psychological, and social, namely, to encourage reflection on ageing and to encourage and involve older adults in a more active life by the construction of knowledge and themes that promote well-being. This activity is called the therapeutic agenda.

This quantitative and qualitative study aimed to understand the usefulness of an agenda developed for elders, addressing the concepts of AA, QoL, and depression in older people. In addition, this investigation intended to promote an AA and a better QoL.

METHODOLOGY

STUDY DESIGN

Taking into consideration the objectives outlined in this investigation, a cross-sectional study with an exploratory design was carried out, in which it was intended to characterize the sample and establish relationships between variables, thus analysing their magnitude and sense of relationship (FREIRE and ALMEIDA, 2000; PAIS-RIBEIRO, 1999).

PARTICIPANTS

The sample of this study is composed by 60 individuals, with 60% women and 40% men. The participants are aged between 65 and 92 years (M=79.82; SD=6.75). Regarding the other sociodemographic variables, it was found that most participants are widowed and live in their homes. As for the academic degrees, the 1st cycle is the one that is most represented.

The sample used in this study was a probabilistic convenience sample, as the probability of the participant being included in the sample is known. During the study, no refusal and/or give-up was recorded, and all

participants responded to the proposed data collection instruments.

PROCEDURES

After the selection/development of the material, the respective authorizations for the use of the questionnaires were obtained. Data collection was taken in nursing homes and day centres. At the time of collection, the corresponding author made a brief presentation of herself and the study that was intended to be carried out. Participants were informed, both verbally and in writing, that this would be a voluntary participation study, noting that nonparticipation would not have any penalty consequently. At the same time, the participants were also informed that they could withdraw at any time, without any harm or penalty, and that the data collected would only be used for research purposes.

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008, with confidentiality and anonymity guaranteed, with everyone being asked to give their informed consent in writing. The corresponding author was responsible for delivering the questionnaires and filling them out in the presence of the participants, according to the needs of each one, always keeping in touch with older adults to clarify any doubts. In this sense, participants were asked to fill out a brief sociodemographic questionnaire, which would not include any data that would allow their identification, as well as the therapeutic agenda over eight months (December 2015 to July 2016). For the evaluation of the remaining variables, the SF-36 and the Geriatric Depression Scale were used.

Finally, the administration of the instruments was performed individually and the results were analysed using the Statistical Package for Social Sciences (SPSS) in its version 22.0, based on the content analysis of the data obtained in the therapeutic agenda (IBM, 2013).

MATERIAL

Considering the outlined objectives, the following instruments were chosen for this investigation:

- Sociodemographic Questionnaire: Instrument was built for the present investigation, with a duration of about 3 minutes to complete. This instrument is composed of different sociodemographic variables such as gender, age, marital status, educational qualifications, profession, or place where they live.

- Therapeutic Agenda: Instrument was built for the present investigation, taking a few months to complete. This material includes activities that participants can share with whomever they want, and every week they have a sentence to comment or a task to perform, such as: "What are your thoughts for this year?"; "What would you like to do differently this year?" Therefore, this agenda distributed thoughts and suggestions for tasks throughout the year, allowing the individual to include in it whatever they want to make their year better (Figure 1).

- Quality of Life Assessment Questionnaire - SF 36: O *Short Form* 36 (SF-36) (WARE and GANDEK, 1998), is a work developed by the Rand Corporation in the USA during the 70's and was progressively adjusted and used in the Rand Medical Outcomes Study. This questionnaire translates into a reduced version that includes 36 items selected according to 245 existing in the original Medical Outcomes Study (MOS) questionnaire. In the present study, the Portuguese version of the MOS SF-36

was used, assuming itself as a questionnaire built to represent eight of the most important concepts in health: physical function, physical performance, pain, general health, vitality, social function, emotional performance and mental health (FERREIRA and MARQUES, 1998). The various dimensions of this instrument contain 2 to 10 items that are scored using a 5-point Likert scale, ranging from 1 to 5. The quotation criteria of the SF-36 items and scales were defined so that a high value indicates a better health status, and these values are quoted over four stages. Final values after coding and reversal of items were published by RIBEIRO (2005). In items 6, 8, 9a, 9d, 9h, 11b, and 11d, the quotation is inverted; the other items are quoted directly. Therefore, the data goes through a specific process, with the objective of making them coherent and capable of being interpreted in the following phases: data entry, transformation of values, treatment of missing data, calculation of scales and verification. Scores of 0 correspond to the minimum QoL satisfaction value and scores of 100 to the maximum value.

- Geriatric Depression Scale – GDS (YESSAVAGE et al. 1982). This scale is unique and created specifically for elders population (FERRARI and DALACORTE, 2007). Over time, this instrument came to be considered as a scale with satisfactory validity and reliability properties for tracking depression in older people. Translated, analysed and adapted for the Portuguese population by VERÍSSIMO (1988) in the "Diagnostic Assessment of Dementia Syndromes", it is composed of 30 questions about feelings and behaviours that occurred in the previous week. Answers are dichotomous (yes/no). The 30-item scale has remained unchanged since 1983 and has become an instrument frequently used by researchers and health professionals in the context of diagnosing depression. Item scores are as follows: 1 point for "yes" answers to questions 2-4,6,8,10-14,16-18,20,22-26 and 28 and 1 point for "no" answers to questions 1,5,7,9,15,19,21,27,29 and 30. Cutoff points range from 0-10= no depression; 11-20= mild depression and 21-30= severe depression.

Figure 1: Cover of the therapeutic agenda.

RESULTS

The internal consistency of the instruments used was considered high. Regarding the SF-36, Cronbach's alpha values ranged between .75 and .89. On the Geriatric Depression Scale, this value was .76. In all cases, the established criterion (>.70) was fulfilled (Table 1).

The intervention program with the agenda seems to have contributed to the decrease in the prevalence of depression, since there was a statistically significant decrease ($p<.01$) number of older adults, people with severe depression from 23.3% to 16.7%, fewer older people with mild depression from 26.7% to 25.0% and an increase in the number of the older population without clinical symptoms from 50.0% to 58.3% (Table 2).

The agenda also seems to have contributed to the improvement of QoL indices in older adults, namely, pain ($p=.02$), mental health ($p=.02$), emotional performance ($p=.01$), vitality ($p=.04$) and general health ($p<.001$). In the evaluation after the intervention program, the mean values of these dimensions were higher (Table 3).

Instrument	α
SF-36	
Physical Function	.88
Physical Performance	.89
Emotional Performance	.88
Vitality	.85
Mental Health	.86
Social Function	.79
Pain	.86
General Health	.75
Geriatric Depression Scale	.76

Table 1: Internal consistency of the instruments used.

Geriatric Depression Scale	Before n (%)	After n (%)	Wilcoxon Test
No Depression	30 (50.0%)	35 (58.3%)	p<.01
Mild Depression	16 (26.7%)	15 (25.0%)	
Severe Depression	14 (23.3%)	10 (16.7%)	
Geriatric Depression Scale	**Before n (%)**	**After n (%)**	**Wilcoxon Test**

Table 2: Effectiveness of the intervention program with the agenda in decreasing the prevalence of depression in older adults.

Instrument	*Before* M (SD)	*After M (SD)*	*T-Test*
SF-36			
Physical Function	58.08 (13.16)	61.04 (11.10)	t=1.33 (p=.19)
Physical Performance	46.89 (10.43)	48.43 (8.12)	t=0.27 (p=.79)
Pain	63.36 (11.39)	67.76 (8.14)	t=2.43 (p=.02*)
Mental Health	50.69 (12.21)	55.45 (10.18)	t=2.31 (p=.02*)
Emocional Performance	49.71 (10.68)	54.45 (9.63)	t=2.55 (p=.01*)
Vitality	48.30 (11.63)	52.76 (12.32)	t=2.04 (p=.04*)
Social Function	63.06 (11.15)	62.23 (10.51)	t=0.42 (p=.68)
General Health	49.41 (12.86)	58.24 (10.66)	t=4.09 (p<.001***)

Table 3: Effectiveness of the Intervention Program with the Agenda on the Quality of Life of Older Adults.

Regarding content analysis, it was found that most of the participants had similar qualities, such as honesty and humility. The most important people for 100% of the sample are family members and the question: "What makes you happy?" 60% of the sample mentioned the family. These participants always focused on familiar aspects and assumed an active posture of great curiosity. In addition, at the end of the administration of the agenda, the participants showed feelings of great reflection, for example, on the question: "How did you feel and think about the tasks on the agenda?" Many responded, and it is possible to mention:

"It made me think that even though I suffered a lot, it's worth living and seeing our family grow, so I felt very happy."

"I loved thinking more deeply about my life, how important it was and never forgetting my family that makes me happy."

"I felt good when doing the tasks I thought I could and I can do it better, although I'm an old man, I can still give a lot of myself."

DISCUSSION AND CONCLUSION

The ageing of the population has important implications for society, translating into economic and social challenges that encourage the promotion of policies that, without changing demographic trends, will allow people to live longer, with a healthier and more active, connected way to the labour market.

The leisure activities developed for elders should provide them with moments of pleasure (CARNEIRO et al. 2012).The statistical analysis determined significant values, as it was found that the agenda seems to have contributed to the decrease in the prevalence of depression in older people, as well as to the increase in quality of life, given that the values were higher in the second assessment.

During the agenda intervention process, it was inferred that the participants developed feelings of pleasure, with the commitment they showed and with the moments of great reflection they presented, providing opportunities for self-knowledge.

The intervention program with the agenda became healthy, mainly at the psychological level of the participants, based on healthy active ageing and a better quality of life, given that healthy active ageing is based on the promotion of autonomy that encompasses two principles: prevention of social isolation and prevention of loneliness among older adults.

In short, family activities and the fact that they feel useful are directly related to a better quality of life and greater well-being in elders (CARNEIRO et al. 2012).

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