

Managing Behavior and Emotional Issues in Older People

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Abstract: With the proportion of the population aged 65 or over increasing steadily. It is important to recognise that older men and women are important and they contribute to society with their wealth of experience and knowledge. By 2050, they are expected to reach the 2 billion mark which will be more than that of children under the age of 14. In Africa, traditional living arrangements are changing and values that used to ensure that older people were cared for and protected are crumbling. The contributions that older people make to their families, communities and society at large are ignored and all too often older people are the victims of abuse even by the very institutions that are supposed to protect them. Development processes that are supposed to meet the needs of all and especially the most vulnerable, routinely exclude older people. Arguably, negative attitudes are older people's biggest problem.

Key words: Behaviour, emotional, older people, dependence issue, independence issue, cultural awareness

INTRODUCTION

Managing behavior and emotional issues with older people is as crucial in the aging process as it is at any other time in life, we must anticipate a health span revolution that brings full functioning to almost the end of life: a revolution that will be triggered by coordinated research, clinical and educational efforts of professionals in the behavioral, social and biological sciences. Counselors must be prepared to help people resolve the issues they see related to aging and counselors can play a key role in helping people strive for and live out a vital, enjoyable and fruitful long life. Studying with older people posed serious challenges but to what extent should one expect older people to change their lifestyles as a result of counseling? What changes in society do counselors need to acquaint themselves in order to have realistic expectations of this patient group?. Before going into counseling with older people much consideration need to be taken into account such as the understanding of the realities the individuals with whom the counselor may be studying. Many researchers' articles have been written about the process of studying therapeutically with older people, though it is often stated that knowledge of the ageing process would be helpful to the psychotherapeutic process. This is intended to orient the counselor to some aspect of ageing that are important and to provide affirmation of existing knowledge of good practice for the experienced therapists.

MATERIALS AND METHODS

Current demographic projections: United Nation population division (UN, 2005) and National Population

Commission (NPC, 2006) revealed that Nigeria is the most populated nation in Africa and the ninth in the world with a population of approximately 150 million and Life expectancy at birth put at 50 years.

Ageing has become a global phenomenon and indeed a critical policy issue which calls for some recognition by governments of developing countries like Nigeria where it is reflected in the government's vital documents of economic and social development strategy.

The population growth rate between 2000 and 2005 has been put at 3.5% with 7% of the total population age 60 and above. Nigeria is federal Republic consisting of 37 states including Abuja, Federal Capital Territory (FCT) and further divided into about 739 districts or local government areas. The Federal states possess some degree of autonomy. The Federal Government control power and the economy by directing affairs of the whole nation. Nigeria is culturally heterogeneous with over 350 ethnic-linguistic groups with the predominant ones being the Hausa of the north, Yoruba of the south west and the Igbo of the South East.

All share a similar cultural background and thus perception of care for older persons. Globally, the greatest increase in the number of older people is occurring in the developing and middle income countries which are now experiencing rapid shifts from high mortality and high fertility to much reduced fertility and greater longevity. Nigeria is not an exception. While population ageing in developed countries evolved gradually as a result of an earlier decline in fertility and improving living standards for the majority of the population over a relatively long period of time after the industrial revolution. Population ageing in developing

nations is occurring more rapidly because of rapid fertility decline and an increasing life expectancy. Nigeria, like other African countries sees this emerging issue as a serious future challenge. The inability of government to cope with the regular payment of pensions to the retired study force, the inadequate social services and health facilities to cater for the needs of an aging population as well as a predominantly rural agrarian population all pose new threats to food security, social security and national security of Nigeria.

Older people's lives are characterized by growing inadequacies in customary family supports, social security targeted at them, thus being very vulnerable to poverty and diseases. A growth in numbers of older people inevitably has brought an increase in the range and intensity of their problems and needs. Older persons in Nigeria suffer a lot of hardship in an increasing hostile, competitive and intolerant society.

Older people constitute the poorest group in Nigeria society. The implementation of the Millennium Development Goals (MDGs) by the Nigerian Government has little or no consideration for them. Having the rate of poverty and hunger by 2015 without seriously considering older people will affect the success rate of the otherwise well-conceived programme. Nigeria is the most populous country in Africa and currently has the highest older persons population in Africa has been shown (Kinsella and Velkoff, 2001).

With the largest population in Africa and the ninth in the world, it is estimated that by the year 2025 (Table 1), the population of Nigeria aged 60 and above will constitute 6% of the entire population.

There is the potential for a rapid growth rate of the older population in coming years with a lower growth rate among the younger population. The implication is a major change in the age structure of Nigerian society. National Population Commission NPC (2006) confirmed an increase in the percentage and the number of those aged 60 years and above. In the coming years, the ageing population is expected to increase in number and life expectancy rates will gradually increase with significant social and economic implication to the individuals and the Nigerian government. For example, the old-age dependency ratio is not high at present (at least compared with the developed nations) but it will increase in the coming years. This

serves as pointer to problems to come. Neglect of filial obligations due to these structural changes has further improvised older people and created more physical and social distance between family members.

A lot of these older people have resolved to beg in order to survive or getting employed as cleaners, security guards, load carriers or petty traders. It is gratifying to note that social support traditionally given to older persons still exists; daughters and daughters-in-law coming to the rescue of older people, though sometimes with adverse effect to their own health and domestic relationship.

Traditionally, the older person heads the family and the extended clan that dominates the communities. They represent their families in the council of Elders meetings where decisions are taken to regulate and promote the general interest of citizens and to administer the affairs of their communities. They used to play leadership roles in the society and were seen as repositories of wisdom.

The elderly in the Nigeria society carry out traditional roles of guardians of the ancestral values, chief custodians of society's treasures and upholders of history, customs, folklores, cultural values and wisdom. Older persons settle disputes and conflicts arising from members of the family based on their position, skill, knowledge, wisdom, vision and experience acquired along the journey of old age.

They are extra-legal and political institutions through which the society's orderliness and progress is sustained. The older persons have remained traditional medicine practitioners as healers, diviners and herbalists who complement orthodox medical and health services delivery especially in areas where primary health care is non-existent. In Nigeria, the family is charged with the responsibility for the provision of care and support for the older persons: such care and support are voluntary and reciprocal, without any form of compensation.

Family members, especially adult children form the bulwark of informal support for older persons. The care of the older relative is a value which is culturally rooted and highly respected.

Care provision for older people in Nigeria: The lack of state provision of elder care in Nigeria required the family to provide the needs for the survival of the older people. Family members provide food, shelter, clothing, drugs and other basic necessities. Children now play the most important role of providing economic security in old-age. Older parents live in their adult children's home and receive care. On the other hand, they support their children in taking care of their grand children. When they live in their own homes, grandchildren or other relatives

Table1: Projected population ageing in Africa, west Africa and Nigeria (Un, 2005) from 2005-2050

Country	Population 60%			Population 60+(Million)		
	2005	2025	2050	2005	2025	2050
Africa	5.2	6.4	10.0	47.4	85.8	192.9
West Africa	4.7	5.5	9.0	12.0	21.8	51.6
Nigeria	4.9	6.0	9.9	6.4	11.5	25.5

Population Division (UN, 2005)

often live with them to give support such as washing clothes, running errands, cooking meals and taking care of the older people's environment.

The decline in the economy, gradual disintegration of the extended family system, unemployment increasing female employment to complement family income as well as rural-urban migration all contribute to the noticeable decline in the level of care provided by the family in recent times. The participation of government at all levels, federal and regional (states and local councils) in the provision of services to the older person is minimal. The Nigerian government and political leaders believe that the provision of care is the responsibility of families.

Policy emphasis is more on young people, women and children. NGOs and faith-based organizations such as the Anglican Gerontological society AGES Nigeria, the Catholic Church and the Sorophormist Society are examples of organizations in Nigeria that make effective contributions to the service provision to older people through day-care centre, residential home, libraries, regular medical checkups and creating a forum for raising the awareness on older people's right and avenues to seek redress when necessary.

In all Nigeria, there are 10 residential care homes facing an elderly population of over 5 million. The standard of in these care homes is inadequate; most of them are own by religious organizations such as the Catholic Church. Some of these homes are hospices where young people with terminal diseases or babies with life-threatening diseases are also kept.

Aboderin (2006) posited that the general assumption in Nigerian society that care for older people has always been provided by the extended social/family system and that this provision of care services has always been adequate is wrong (Apt, 1995) posited that Medical care is not easily accessible.

Older persons cannot afford quality medical care; the geographical distance to get to these services makes it difficult if not impossible for many older people to access, particularly in the rural areas. Hence, their health needs still have to be met by visiting traditional medicine men and herbalists.

At the family level, care services provided do not adequately meet the needs of the old person in Nigeria. Diminishing economic power has hindered the willing family members' capability to give.

Priorities are given to the needs of the members of the nuclear family spouse and children at the expense of older family members parents or grandparents. Care provided by the family attempts to satisfy the needs of older persons. But with changing social and economic configurations, older persons are most of the time left in

the care of strangers ie people who are not properly trained to be caregivers, many of them uneducated, young and frustrated.

Social policy and old age: In Nigeria today, social security policies for old age are yet to be formulated (Aboderin, 2006) posited that there is an increasing need in the wake of the apparent decline in the adequacy of material family support that has occurred in recent times and the rising deprivation and poverty to which growing numbers of older people are exposed.

The lack of a social security system for older people accelerates this process. The notion that investments in one's children serves as social security in old age is now disputed as adult children find it difficult securing employment and receiving an income sufficient to meet their immediate needs.

The contributory pension scheme (insurance) that was recently reformed does not cover many older persons. This pension scheme is mainly designed for those who studied in the formal sector. The scheme bedeviled with a lot of problems is yet to make appreciable impact on the lives of older people. Old Age brings with it reduced capacity for study as well as difficulties in accessing health care and other essential services, increasing the likelihood of older persons becoming and remaining poor.

The lack of social pensions has serious consequences on the well being of the older persons. The majority of older people who cannot earn an income and are not covered by the contributory scheme are left at the mercy of the vagaries of life. Social pension reduce old age poverty and support households. Social pensions target development aid to the poorest and contribute significantly to achieving the Millennium Development Goals (MDGs).

The local economies are regenerated and wealth distributed and general household health and nutrition are improved. For the privileged proportion of the population that is lucky to study in the formal sector, arrangement for social security funds is always made. In the Africa circumstances where the proportion of the population employed in the formal sector is very small, the numbers of elderly who benefit from this type of social security scheme are very few. The present economic realities of Nigeria with little or no consideration for the older people has created an army of beggars. Material deprivation and neglect of older people has emerged as an increasingly visible social problem particularly in cities.

The neglect and abuse of the older people: Issues of older people neglect occur every day in Nigeria. But abuse of

older people still has to be regarded as an abomination in Nigerian society that makes it difficult to report cases to the law enforcement agencies. Besides from the provision of the criminal code related to crimes of violence and assault there is yet no law on elder abuse.

Though, creation of awareness of abuse as a public health and social issues has been intensified since the first World Elder Abuse Awareness Day took place in most major cities in Nigeria in 2006 it is yet to receive the appropriate attention it deserves from the society and the government.

A lot of policymakers, lawmakers, the older people and members of the society have began to see elder abuse as a menace that needs the attention of all especially as older persons become more vulnerable in the countries with economies in transition (Hoff, 2007).

Counseling theories for use with older people: The application of cognitive therapy and life review therapy for gerontological counseling Weiss (1995) posited that these theories, when used to counsel more mature adults, have vast potential in the emerging field of gerontological counseling. Dychtwald and Howler found that life expectancy in 1930 was 58 years and by 1988 Smolak, posited that it had increased to 75 years.

In 2003, average life expectancy was expected to exceed 80 years. Capuzzi and Gross (2002) found that several group theories and approaches to studying with aging baby boomers include: reality orientation, milieu therapy, reminiscence groups and re-motivation therapy. Along with different theoretical models and different counseling methods suggested for use with older clients, one might ask, What are other counseling implications that might exist for those gerontological counselors? First, the very issues of living longer tend to reinforce the need for a speciality in the counseling of older adults.

Second, the standards cited by CACREP posited the need for skills, techniques and practices beyond the scope of the generalist counselor. The fact that the fastest growing segment of the U.S. population will live to be 85+ years of age indicates that counselors may need additional training and preparation.

Third, the specialized needs of these soon to be older adults the boomers (Capuzzi and Gross, 2002) found that the principles and competencies required to serve them will need to be unique to this population of clients. These researchers described the need for counseling applications specific to older adults both individually and in group settings.

Altekruse and Ray (1998) found that principles and recommendations important for use in the counseling of older adults included the following recommendations:

- Counselors need to demonstrate the benefits of counseling to the older people and should be cautious in the use of tests with this population
- Counselors must respect and enhance the dignity and worth of older persons and be sensitive to the possible age differences
- Counselors must attend to the physical environment of counseling more so than with a younger client
- Counselors might serve more actively in the role of client advocate and attend to the dependence/independence issue while studying with older adults
- Counselors might focus on short-term goals and emphasize the present life situation of the client
- Counselors need to be aware of the cultural, environmental and value orientation differences between themselves and their clients and to have some perspective on the clients' place in history

Competencies necessary for studying with older people:

Jane Myers has conducted several studies involving older clients. Her research and competencies for gerontological counseling are both comprehensive and specific. More important is the fact that she is one of the few researchers who takes a wellness approach to studying with older adults. Myers (1996) demonstrated 16 specific Minimal Essential Competencies (skills) for a gerontological counseling specialist. Ten pertinent skills are presented in the following list:

- Demonstrates and actively advocates for positive, respectful, wellness-enhancing attitudes toward older persons and a concern for empowerment of persons throughout the lifespan
- Demonstrates skill in applying extensive knowledge of human development for older persons, including major theories of aging, the relationship between physical and mental health and aging, the difference between normal and pathological aging processes, gender-related developmental differences and coping skills for life transitions and losses
- Demonstrates skill in applying extensive knowledge of social and cultural foundations for older persons, including characteristics and needs of older minority subgroups, factors affecting substance and medication misuse and abuse, recognition and treatment of elder abuse and knowledge of social service programs
- Demonstrates skill in recruiting, selecting, planning and implementing groups with older persons

- Demonstrates skill in applying extensive knowledge of career and lifestyle options for older persons, age-related assets and barriers to effective choices and resources for maximizing exploration of career and lifestyle options
- Demonstrates skill in applying extensive knowledge of current research related to older persons and the implications of research findings for helping relationships
- Demonstrates skill in applying extensive knowledge of the intellectual, physical, social, emotional, vocational and spiritual needs of older persons and strategies for helping to meet those needs
- Demonstrates skill in applying appropriate intervention techniques, in collaboration with medical and other care providers for physical and mental impairments common to older persons, such as acute, chronic and terminal illness, depression, suicide and organic brain syndromes
- Demonstrates skill in the use of a wide variety of specialized therapies to assist older persons in coping with both developmental and non-normative issues such as creative art therapies, pet therapy, peer counseling and family counseling
- Demonstrates skill in applying extensive knowledge of ethical issues in counseling older persons, their families and care providers

These competencies address some of the unique needs and issues that face the older people population in the next 20 years.

Who is an older person? When does ageing starts: In Europe and the USA, older people are most commonly defined by chronological age. For legal and occupational purposes an older person is generally defined as someone aged 65 years and older. It has become popular to characterize people as young-old (65-75 years), old-old (75-85 years) and oldest-old (85 years plus). In studying with older adults, it is important to understand the individuality of each person you see.

The age of an individual is more complex than chronological age (years since birth). In a sense, chronological age confuses the picture more than it clarifies it. To the individual capabilities of an older adult, it may be more important to take into account biological, psychological and social factors rather than age.

An important concept, functional ageing, refers to the ability of people to perform activities relative to their life experience. Two exemplary individuals, one from the U.K. and one from the USA are cited here as evidence that ageing does not automatically mean loss of abilities or

poor functioning. In the U.K., the late sir Stanly Matthews continued to play professional football (soccer) at a high level until he was 50 years of age.

When he was 41, sir Stanly Matthews won the first-ever European player of the year award, an immensely impressive achievement since this is an age when most athletes have long since retired from any active sport. As Matthews grew older during his professional soccer career, his pace diminished but his skills remained and were augmented with years of life experience.

Matthews had an American counterpart in the baseball player satchel Paige who defied chronological age to continue his career until his retirement from sport at the age of 59 years. When Paige was once asked by a reporter about his age, he replied, "How old would you be if you did not know what age you was"?

This is an important point to keep in mind when studying with older people. Do not assume that older age necessarily means decrepitude and do not assume that chronological age will tell you everything you need to know about individuals. Many people have a mental age that is years younger than their chronological age. Ask yourself, "How old do I feel"?. (Futterman *et al.*, 1995) demonstrated that older adults are the least homogeneous of all age groups and often have many more dissimilarities than similarities.

Also Zeiss and Steffen (1996) found that at least two generations are contained within this age grouping. With the increase in longevity there can be four decades separating the youngest-old from the oldest-old. Knight (1996) and Thompson (1996) found that the therapist also ought to bear in mind the important of cohort. Cohort refers to the set of cultural norms, historical events and personal events that occurred during a special generation.

For example, today's older people would be affected by great social upheavals such as the economic depression of the 1920s and 1930s. Brokaw (1998) posited that the cohort experience of the generation of adults who lived through World War II. Understanding older people in terms of their generational, cohort allows therapist a way of gaining insight into the societal norms and rules that may influence an individual's behavior.

The therapist may need to take account of the different cultural expectations regarding health-seeking behavior among older-adults as compared to younger adults, especially with regards to views on the care and treatment of conditions such as depression and anxiety. Understanding cohort experiences and taking these into account when studying psychotherapeutically with older people is no more difficult and no less important than when studying with cohorts such as ethnic minority groups.

Working definition of an older person in Africa: Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person but like many westernized concepts, this does not adapt well to the situation in Africa. While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits.

At the moment, there is no United Nations standard numerical criterion but the UN agreed cutoff is 60+ years to refer to the older population. Although, there are commonly used definitions of old age, there is no general agreement on the age at which a person becomes old. The common use of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous.

As far back as 1875 in Britain, the Friendly Societies Act, enacted the definition of old age as any age after 50 (Roebuck, 1979) posited that pension schemes mostly used age 60 or 65 years for eligibility and UN has not adopted a standard criterion but generally use 60+ years to refer to the older population. Realistically if a definition in Africa is to be developed, it should be either 50 or 55 years of age but even this is somewhat arbitrary and introduces additional problems of data comparability across nations.

The more traditional African definitions of an elder or elderly person correlate with the chronological ages of 50-65 years depending on the setting, the region and the country. Adding to the difficulty of establishing a definition, actual birthdates are quite often unknown because many individuals in Africa do not have an official record of their birth date.

In addition, chronological or official definitions of ageing can differ widely from traditional or community definitions of when a person is older. We will follow the lead of the developed worlds for better or worse and use the pensionable age limit often used by governments to set a standard for the definition.

Lack of an accepted and acceptable definition in many instances the age at which a person became eligible for statutory and occupational retirement pensions has become the default definition.

The ages of 60 and 65 years are often used despite its arbitrary nature for which the origins and surrounding debates can be followed from the end of the 1800's through the mid-1900 (Thane, 1978, 1989; Roebuck, 1979). Adding to the difficulty of establishing a definition, actual birthdates are quite often unknown because many individuals in Africa do not have an official record of their birth date.

Who's old: The ageing process is of course a biological reality which has its own dynamic, largely beyond human control. However, it is also subject to the constructions by which each society makes sense of old age. In the developed world chronological time plays a paramount role.

The age of 60 or 65 roughly equivalent to retirement ages in most developed countries is said to be the beginning of old age. In many parts of the developing world, chronological time has little or no importance in the meaning of old age. Other socially constructed meanings of age are more significant such as the roles assigned to older people in some cases, it is the loss of roles accompanying physical decline which is significant in defining old age.

Thus, in contrast to the chronological milestones which mark life stages in the developed world, old age (Gorman, 2000) posited that in many developing countries is seen to begin at the point when active contribution is no longer possible.

Age classification varied between countries and over time, reflecting in many instances the social class differences or functional ability related to the studyforce but more often than not was a reflection of the current political and economic situation. Thane (1978) posited that many times the definition is linked to the retirement age which in some instances was lower for women than men.

This transition in livelihood became the basis for the definition of old age which occurred between the ages of 45 and 55 years for women and between the ages of 55 and 75 years for men.

Old age by definitions: When attention was drawn to older populations in many developing countries, the definition of old age many times followed the same path as that in more developed countries that is the government sets the definition by stating a retirement age. Considering that a majority of old persons in Sub-Saharan Africa live in rural areas and study outside the formal sector and thus expect no formal retirement or retirement benefits, this imported logic seems quite illogical. Further, when this definition is applied to regions where relative life expectancy is much lower and size of older populations is much smaller, the utility of this definition becomes even more limited.

Glascook posited that the study results published in 1980 provides a basis for a definition of old age in developing countries this international anthropological study was conducted in the late 1970's and included multiple areas in Africa. Definitions fell into three main categories:

- Chronology
- Change in social role (i.e., change in study patterns, adult status of children and menopause)
- Change in capabilities (i.e., invalid status, senility and change in physical characteristics)

Results from this cultural analysis of old age suggested that change in social role is the predominant means of defining old age. When the preferred definition was chronological, it was most often accompanied by an additional definition. These results somewhat contradict the findings of a more recent study conducted in Nigeria regarding perceptions about the onset of old age. Togonu-Bickersteth (1987, 1988) found that the younger and older age groups had similar responses regarding the chronological onset of old age with differences in the stated age for men and women.

The results suggested that the generally accepted definition was similar to westernized definitions of old age; however, this was a unique community with culture-related norms that bestowed certain privileges and benefits at older ages. Brubaker and Powers (1976) and Freund and Smith (1997) found that the self-definition of old age that is old people defining old age as people enter older ages it seems their self-definitions of old age become increasingly multifaceted and increasingly related to health status.

While a single definition such as chronological age or social/cultural/functional markers is commonly used by, amongst others, demographers, sociologists, anthropologists, economists and researchers, it seems more appropriate in Africa to use a combination of chronological, functional and social definitions.

However, the challenge of how to incorporate a suitable multidimensional definition into the pensionable age concept remains.

Cognitive behavioral therapy: Beck (1993) found that how a person appraises a situation is generally evident in his cognitions. These cognitions constitute the person's stream of consciousness or phenomenal fields which reflect the person's configuration of himself or herself, his or her world, his or her past and future. Any alterations in the content of the person's underlying cognitive structure affect his/her affective state and behavioral patterns. Ellis described the ABC theory as a core concept in Rational Emotive Behavior Therapy and this has become one of the most popular forms of CBT.

According to this concept, emotional and behavioral consequences (C) result from belief (B) about activating events (A). Some people overestimate risks or danger and underestimate their ability to cope something, Ellis calls

catastrophising. Older people who need help are struggling with problems that are very real to them; very often they have to endure debilitating and demanding medical treatments. In fact, sadness over multiple and disabling illness is a normal reaction but clinical depression or anticipating that my life is over or I cannot go out is likely to be due to catastrophising or overgeneralization of the courses or effect of bad events. Unlike most psychotherapy, CBT does not delve into childhood but deals with the present.

The therapy is based on the assumption that both cognitive and behavioral responses to event are learned. For this reason, the therapy is constructed as a collaborative enterprise, with therapists as respectful teachers who enable clients to understand themselves better, examine their belief critically and develop more constructive ways of thinking and this avoid their unrealistic sadness.

To help alleviate client distress enhance their coping and problem-solving abilities, CBT incorporates both behavioral and cognitive strategies. Yost *et al.* (1986) found that during CBT, behavioral components be introduced to the helping process. Behavioral approaches applied in the above case or in the case of Eunice Kalu were relaxation training and modeling, teaching self-management and monitoring and participation in various activities. Cognitive skills employed in the therapy included:

- Discovering clients basic irrational beliefs
- Disputing these irrational ideas
- Reconstructing a positive cognitive framework
- Changing the client negative or maladaptive thought into more healthy ones leading to more positive emotions

Cognitive behavioral therapy practice: Clients suffering from multiple, chronic and disabling illness tend to be very frustrated. They may withdraw from activities prematurely because of fear of embarrassment when mixing with others or they may become passive from long suffering with little motivation to initiate any kind of change. Some may avoid problem-solving tasks. All these can boil down into catastrophic thinking, making them feel useless and hopeless.

A common practice in CBT is elimination of the client's irrational thinking through cognitive change and the provision of skills training to enable them to feel more effective in their daily life. The following paragraphs describes how CBT can be put into practice when studying with older people suffering from severe physical illness including helping them recognize their negative

thoughts, despite these irrational thoughts using gentle confrontation and construct positive views. At the same time, some adaptations of CBT practice principles are required to enhance its effectiveness and cultural sensitivity.

Application of cognitive behavioral therapy principles

Pre-requisites of clients: For cognitive Behavioral Therapy to be effective, clients need to have some prerequisites:

- The client must be verbally competent and have no cognitive impairment because CBT requires client to identify thoughts and discuss feelings
- The ability to engage in abstract thinking and analyse behavior is the cornerstone of the CBT approach. So before commencing any intervention, there is a need to assess whether clients can fulfill these prerequisites. This is especially crucial for old-old women, many of whom are illiterates and have very limited life experiences, thus making it more challenging for them to engage in abstract thinking, to analyse their own behavior and to examine the underlying scheme. Therefore, in the initial contact with Eunice, information about her literacy and studying experiences were explored. Though Eunice was not all that educated but her verbal ability was above average because she had been active business woman for many years and therefore had many opportunities to interact with other people

Making the structure of therapy explicit: Cognitive Behavioral Therapy is a structure and short-term psychotherapy; treatment is directed towards helping patient to reach explicit goals agreed at the start of the intervention and at each meeting.

Elderly people suffering multiple illnesses usually present with a range of problem: some are more recent. To make the treatment as productive as possible, therapists need to make the structure of therapy explicit to their client. With Eunice, even though she had numerous problems including relationship problems with her daughters the counselor identified, together with her, that the main concern was her pain problem.

This specific goal was mentioned at the start of each session and the discussion would always focus on this. Sometimes Eunice would start with other problems e.g., a recent conflict with her daughter and the counselor would allow her to ventilate for a while but would direct her to the pain problem once Eunice had settled down a bit.

Client self-determination: During the counseling process, the client's will and readiness are important. The therapy is a self debating process. If clients are willing

and committed they can come up with alternate thinking. So, the counselor helps client to decide whether they prefer to stay with the present situation or to lead a new life. Here is what the counselor raised with Eunice after rapport was established. Do you prefer not to do anything to stop your health from deterioration? With the counselor's unconditional support and empathy, Eunice expressed the need to change her perception in a more positive way and indicated her readiness to join more activities in the elderly home.

Acknowledging irrational thoughts: Through careful questioning and discussion or guided discovery the clients were helped to identify obvious evidence about inaccurate and irrational perceptions. They were then helped to acknowledge that holding a rigid attitudes was producing their emotional distress and preventing them from pursuing meaningful and satisfying activities. For instance, Eunice was asked to supply proof that staying in her room was better for her health and mood than joining activities.

Using gentle confrontation: Two major causes of frustration are the physical restrictions patients are forced to accept and the pain and suffering brought about by their diseases. Those frustrations are sometimes too much for them; as a result, the lose motivation for change. Eunice, for example, found it hard to find ways to reduce her suffering. It has been found that confronting such clients gently might enable them to explore options and take some positive action.

Thus, in the interview with Eunice, the counselor agreed with the difficulty but confronted her preference for employing a self defeating way to handle her situation. Confrontation in a friendly, caring and non threatening way such as yes, I agree it would be hard to change but do you prefer not to do anything to stop your health from deterioration?

This question helped Eunice critically examine her own thoughts processes. It also conveyed a message that the counselor cared about and recognized her suffering. In response to the question, Eunice was silent at first. Afterwards, she revealed that she preferred death to life.

To clarify her intention, the counselor further confronted her with the suggestion that it may not be what she really wanted since she loved her family very much. After musing upon what the counselor said for a while, Eunice confessed that death was not her choice for she would not like to leave her daughter. This guided discovery stimulated her to face an avoided situation and to think differently and less destructively.

Cognitive reconstructing: An awareness of dysfunctional thought is not enough; elderly people must take active steps to facilitate more positive feelings as well as to regain mastery over lives. Eunice, who suffers from partial stroke leading to deformed leg and hands, received inadequate attention from her doctor when she complained about the poor effect of her pain control medication. Under the perception widely held by older people that the doctor is an researchersity figure, she did not elaborate on her situation further but simply stopped taking the medicine. This resulted in her daily activities being seriously hampered by her pain problem, to extend that she could not even comb her hair or get dressed.

Helping Eunice to alleviate her dysfunctional thinking pattern, the counselor suggested that Eunice re-evaluate her response towards doctors. Could one doctor's reaction be generalized to all doctors? Did she try to reveal her situation to other doctors and receive similar treatment? The counselor understood that Eunice did not have self-confidence so reminded her of a patient's right to proper treatment. Clients were helped to diminish negative self-talk to reframe obstacles as challenges and to expand their consideration of possibilities and alternatives.

In Eunice's case, the counselor showed her that there were many frail or demented residents in the institution needing help so she could, despite her poor health, still contribute and be a volunteer, serving in ways that might be different from what she did in the past.

This enable her to identify her self-defeating beliefs such as I am no good because I have deformed leg and hands or my mobility problem means I will not lead a quality life and to replace them with more self enhancing beliefs (e.g., my mobility problem cannot stop me from going out and enjoying my life or my mobility problem has nothing to do with my ability to contribute to other resident since there ere many different ways to serve others).

Very often, older people find it difficult to come with positive or alternative thoughts. The Counselor can help them to recall positive experiences from the past. For example, the counselor reminded Eunice of happy episodes such as having tea with other residents. In a restaurant in order too motivate her to participate in social activities or client can be invited to explore what is controllable in their lives (like exercising every morning) rather than what they cannot control (like ending the illness).

Since it takes time fro elderly people to consolidate, techniques make connections and generate alternative thoughts, the therapist's patience and support are very important.

RESULTS AND DISCUSSION

Cognitive Behavioral Therapy (CBT) is effective when counseling older people suffering multiple diseases to change irrational thought into more positive ones and reduce their distress. This can be exemplified from counseling session with an older women (Eunice Kalu) suffering from partial stroke and other crippling diseases. Tatemichi, Pohjasvaara and Hochstenbach found that stroke often causes cognitive impairment, the domains most frequently affected being memory, orientation, language and attention and constructional and visuospatial functions.

Austin *et al.* (1992) and Veiel (1997) found that depressive patients without brain damage perform poorly on cognitive tasks, especially those involving memory and concentration. In the study of Austin, the most vulnerable functions in major depression were memory and psychomotor speed. Austin found that the depressive stroke patients also performed poorly in the tests of non-verbal problem solving which has not been found in the depressive patients without brain damage.

The presence of PSD (Post Stroke Depression) was associated with old age in the present study. Neau found that in time past depression has been frequent in young patients while in some studies, Sharpe and Kotila found that it has been related to old age. The lack of social support and both functional and cognitive impairment Sharpe found that it may increase the risk of depressive disorders in the elderly.

The depressive patients of the present study were more dependent in the ADL and had more severe impairment and handicap than those without depression both at 3 and 12 months post-stroke, CBT when put into practice can help older people recognize their automatic or negative thoughts, how to use gentle confrontation to challenge those thoughts and how to consider alternatives, construct positive views and develop problem-solving behavior.

At the same time, some CBT practice adaptations are proposed to enhance its effectiveness, including making it culturally sensitive, the building and use of a good client-counselor relationships as a platform for change. Older people may face a lot of losses including loss of their job, loss of functional abilities and loss of loved ones. If they also suffer from multiple and disabling illness they may experience major psychosocial challenges which impact negatively on their self concept, leading to anxiety, depression and a feeling of inadequacy.

Some of their physiological stressors are pain, discomfort, restrictions on their physical activities, fatigue

and weakness. Even though physical illness is the most common stressor leading to adjustment problems and a depressed mood, clients may still be able to reduce their distress by changing receptive thoughts about their various health and adjustment issues. One strategy is to adopt Cognitive Behavior Therapy (CBT), aiming to eliminate the client's irrational thinking.

Cognitive Behavior Therapy has been found to be a particularly appropriate counseling approach for older people with multiple physical illnesses. Using the case Eunice Kalu to illustrate the discussion which cognitive behavioral therapy can be applied to enable older people to alter destructive beliefs about their illness and thus help them to adopt more effectively to their new life.

It is also suggested that some CBT practice principle be adapted to enhance its effectiveness in this particular setting, taking into consideration the value systems and cultural heritage of Nigeria older people, the need to build and use a good client-counselor relationship as the platform for change the value of recall of past experiences and of the provision of concrete assistance while studying at the cognitive and/or behavioral levels. Some information about Eunice Kalu (client) involved as follows:

Illustration: Eunice Kalu was 75 years old. She was a widow who had five daughters. The client lived with the elder daughter who is married to husband in another part of the country in Nigeria and both reside in Lagos.

She had suffered from partial stroke since mid 2005, with deformities to both hands and legs (i.e., the left leg and hands) not functioning as a result of the stroke. Prior to this time Eunice Kalu had been an active trader (or business woman) not until after her disease, her mobility deteriorated so sharply that she could no longer participate actively in her day-to-day business.

She avoided talking about her feeling and the suffering caused by her illness. She only expresses her reluctance to both others who took care of her. Two years ago, her attitude changed, she began to see anybody around her as evil and witches, she sees every object on ground as poison or evil when she is left alone inside room she will be screaming and saying they have come again. Consequently she was taken to several psychiatric hospitals for treatment, though some months later she was admitted to a home for the elderly.

Use of behavioral strategies: Cognitive Behavioral Therapy helps to correct distorted thinking but hearing reliance on reasoning is simply neither appropriate nor effective for older people. Behavioral Strategies when employed in very specific ways can make a great deal of

difference towards bringing satisfaction to client's and motivating them to change. Client was made to understand and to accept that she is in a state of loss instead of confiding herself to mourning that loss, she was encouraged to cope with her problems by resuming some social life or physical activities. For example Eunice always claimed she was too frail to join any activities. Her responses encouraged others not to invite her to participate in any activities. As a result, her life became more dull and miserable. To break the vicious cycle, the counselor invited her to come and enjoy the soft breeze in a nearby park. At first, she was rather reluctant to try this, it took a lot of encouragement to get her to agree to go out. To increase her enjoyment, she was encouraged to smell and touch the plants. After enjoying the walk, her confidence and interest in activities were strengthened. Afterwards, she became quite ready to attend other activities. Her mood as well as her physical condition improved at other time clients were encouraged to read positive and calming self-statements and for those with religious beliefs, to read from religion literatures, in order to reduce their negative emotions.

These behavioral strategies could be incorporated as homework and give to the client to complete after counseling session.

Factors to be considered while counseling

Culture: To be effective, CBT must build an accurate understanding of the value system, the cultural heritage and life circumstance of the clients. Cultural factor that are of special relevance to CBT are as follows:

Harmony and face-saving: Harmony and face-saving are two important communication characteristics among African people especially, Nigerian people. In order to maintain harmony and face-saving, Nigeria people prefer indirectness, implicitness and non-verbal expressions instead of aggressive, argumentative and confrontational modes of communication. That was possibly why Eunice was initially hesitant about revealing her concerns additive emotional responses. She considered it a loss of face to reveal her personal problems to people who are not her family members, relatives or friends.

Moreover, she was worried that her problems were too trivial to take up the counselor's time. In response to these communication characteristics, the counselor needed to be alert to her verbal and non-verbal communication and was active in exploring her hidden problems and emotional reactions.

Unfamiliarity with psychotherapy: Older African people seldom got to counselors to handle their emotional

problems. There are far fewer psychotherapists and counselors than physicians in African societies including Nigeria. Because there is little understanding about counseling and a lack of access to the service, very few older Nigerians look to psychotherapists for professional help, they usually only approach physicians for their emotional problems.

To enhance the client's acceptance of the counselor as a member of the helping professions, the counselor paired up with the nursing staff and took health issues as the entry point for the counseling study.

Good client-counselor relationship: In CBT, the therapeutic relationship is seen as an essential ingredient but unlike either psychotherapy, it is not taken as the main vehicle of change. Clinical experience suggests that establishing a good and reliable client-therapist relationship is important for effective intervention.

The rapport helps clients become willing to venture out, to reveal their concerns and to identify their underlying schemes to the counselor. It also fits the client needs as facing losses in health and being of advance age, these clients long for concern and support. How do therapists build up relationships with older clients? Studying experience describes that it is important that counselors see their studying strategies in terms of client.

Older adults have in some ways, more complex and subtle emotions than younger adults. The clients are often physically weak and have poor memories. In addition, due to the need to save face, older people tend to exercise emotional restraint and self control. They tend to be reluctant to express or discuss their thinking or emotions.

To facilitate relationship building, counselors need to listen actively and empathically: counselors should repeatedly help clients to clarify their ideas about what they expect to change through participating in the counseling process. On the other hand, the counselor should be sensible and tactful about the timing and frequency of visits (e.g., short but frequent contacts/greetings of the start of the intervention) and about their responses to clients queries.

When studying with older people who are acutely and chronically ill, we need to be sensitive to their feelings. Pushing to speak up does not study. Active listening and a show of empathy are much appreciated by clients upon finishing an interview, the counselor was told numerous things, thanks for listening or I'm glad that I was finally heard.

These mean more than thank for the advice/help, even though many Nigerian clients expect counselors to

take on active, researchers itarian roles providing guidance and suggestions. Client's appreciation of therapists understanding and empathy was highlighted by Kuehl as early as 1990. They found that a therapist's caring and understanding attitude, ability to generate relevant suggestions and flexibility were features especially valued by clients.

Give the emphasis put on collaboration by CBT providing empathy and taking account of the older person's perspective are all valuable tools contributing to the effectiveness of therapy. Research has also clearly indicated that in CBT like other forms of therapy, a positive therapeutic alliance is an essential component of effective therapy.

Reminiscences: Even though CBT focuses on the present, we found that selective use of reminiscences when counseling elders will bring about several positive results:

- Many older clients want to talk about the past and resent being stopped
- Clients feel the counselor cares and listens. They respected and become more receptive to the counselor and the counseling process
- Recalling past happy experiences often generate joy and a positive mood
- Reminiscences may be taken as a reworking of the client's life span and might take the client towards a more abstract level of cognitive intervention

Finally, it may eliminate their feelings of uselessness as it did for Eunice who expressed a sense of satisfaction when she illustrated how tough she was by raising her five daughters all by herself.

Provision of concrete assistance: It is important to solve specific problems that are solvable when adopting CBT in psychotherapy. Older people can become overwhelmed when they do not get enough help to deal with their individual problems. Therefore, the counselor joined with nursing staff to equip Eunice with information about managing their physical illness. With more understanding about their health, Eunice better collaborated with staff to promote health. For example, they showed initiative by reporting any changes to their health and held a more positive attitude towards their illness.

The counselor also accompanied Eunice to a medical appointment in order to provide moral support while she expressed her concerns about her pain control to the physician. Noticing that Eunice was overwhelmed by a depressive mood, the counselor accompanied her when exercising or walking in nearby parks, in order to motivate her and to create a better environment for change.

Slower pace: Due to client's poor physical health and mental abilities, the pace of the therapy needs to be slowed down.

For example, Eunice whose cognitive ability was hindered by multiple illnesses resulting from partial stroke could not manage a lot of information and had a short attention span.

The speed of therapeutic conversation and the amount of cognitive study done was consequently reduced. It was also necessary for the counselor to frequently repeat what the clients were to learn such as breathing exercises and positive thinking styles and to ask them to repeat these in order to be sure that they understood. Also, counseling sessions could not be long, usually lasting only half an hour or so.

CONCLUSION

The increase in life expectancy brings a set of physiological and psychological challenges for severely and chronically ill older people. Counseling experiences confirmed the CBT psychotherapeutic techniques effectively enable African older patients suffering chronic and multiple diseases to discover their automatic thoughts and to move away from extreme and unhelpful ways of perceiving things to more helpful and positive ideas and behaviors. It is strongly recommended that, to be more effective, CBT practice principles be adapted to take into account cultural factors affecting older people.

RECOMMENDATIONS

The adaptation should include the building of and use of a good- client- counselor relationship as a platform for change, the recall of past experience, the provision of concrete assistance in addition to study at the cognitive and behavioral levels and using a slower-pace to fit in with the physical and mental abilities of older clients.

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