



Wellbeing, resilience, and coping: Are there differences between healthy older adults, adults with mild cognitive impairment, and adults with Alzheimer-type dementia?



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ABSTRACT

The changes that occur with cognitive impairment and Alzheimer's disease could affect psychological aspects unrelated to memory. The purpose of this study is to compare 32 healthy older adults, 31 amnesic mild cognitively impaired (aMCI) adults, and 32 patients diagnosed with Alzheimer's disease (AD), in order to determine whether there are differences in their psychological wellbeing, resilience, and coping strategies. Unifactorial MANOVAS and ANOVAS were performed to analyze the between-group differences. The results reveal that the AD group showed lower levels of resilience and orientation toward problem-solving and greater use of religious strategies. In addition, they had significantly lower wellbeing scores than the other groups. The worsening of the pathology impedes the capacity for adaptation and resilience and the application of strategies oriented toward the problem, and it increases the application of strategies based on magical thinking. Moreover, it also produces a reduction in wellbeing.

The study of neurodegenerative diseases such as Alzheimer's type dementia or mild cognitive impairment offers important information about the accompanying cognitive changes. However, there is less information about the associated emotional changes that occur in psychological variables such as resilience, coping, and wellbeing.

According to the literature (Jonker, Comijs Knipscheer, & Deeg, 2009), there is a clear relationship between resilience, coping strategies, and psychological wellbeing, and they all have a clear influence on the level of adaptation to changes and the establishment of personal objectives the person can develop. People can make use of coping strategies and resilience to perceive their own resources and strengths, which helps them to manage contexts where they carry out their day to day lives and establish new objectives and goals and possible ways to achieve them (Mayordomo, Viguier, Sales, Satorres, & Meléndez, 2016). In healthy older adults, these three variables present age-related changes compared to younger adults, but in subjects with MCI or AD, changes produced by the pathology, mainly associated with memory and the disease itself, and could involve psychological modifications compared to healthy older adults.

Although resilience has a variety of definitions, there is consensus in assuming that it means competence or positive and effective adaptation

in response to significant threats to an individual's life or function. Luthar, Crossman, and Small (2015) define resilience as a phenomenon characterized by positive outcomes in spite of threats to adaptation or development, where people can emerge even stronger from the situation, improve their coping strategies, and improve adaptation and wellbeing. Zautra, Hall, and Murray (2010) point to two dominant themes that are central to the meaning of this concept. First, as a response to stressful events, resilience focuses on recovery, the ability to rebound from stress, and a capacity to regain equilibrium quickly and return to an initial state of health. A second definition involves continuing to pursue the positive, which implies staying on the recovery path and even experiencing growth and enhanced functioning as a result of healthy reactions to the stressful experience.

Investigations have generally suggested that older age protects people from dysfunctions related to loss or other potentially traumatic events, perhaps because loss is viewed as a normative experience of late life (Neugarten, 1979). Older adults generally show a better capacity to regulate their own emotional experience. Carstensen and Mikels (2005) propose that people place increasing value on emotionally meaningful goals as they get older, and this promotes emotion regulation (control over the emotions an individual experiences and expresses). These age

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differences in the regulation and complexity of emotions suggest that older people may be particularly competent managers of their emotional states. According to Mancini and Bonanno (2010), together the findings largely support the view that older age is associated with more resilient responses to potentially traumatic events than younger age.

Coping is defined as constantly changing cognitive and behavioral efforts to manage specific external and/or internal situations that seem to exceed or overwhelm the individual’s resources (Lazarus & Folkman, 1984). In this model, there are two types of coping, problem-focused coping and emotion-focused coping. Problem-focused coping or active coping has the purpose of managing or modifying the problem causing the discomfort, whereas emotion-focused coping or passive coping uses methods that regulate the emotional response to the problem. Carver, Scheier, and Weintraub (1989) indicate that active forms of coping, that is, efforts to cope with the conflictive event directly, are described as successful because they have positive effects on adaptation, mental health, or wellbeing. However, passive forms, which consist of the absence of confrontation or the use of avoidance behaviors and denial, are considered less successful. Coping plays a critical role in the way individuals deal with the day-to-day challenges of adult life and influences their long-term developmental outcomes (Mayordomo et al., 2016). Moreover, it emerges as a key factor in adaptation that may influence the appraisal of one’s situation and make it possible to deal adequately with demands. In addition, coping has recently been found to have other adaptive functions, and the role of positive beliefs in health promotion has been emphasized (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000).

As people age, they become more passive in the application of coping strategies. In other words, they go from a problem-focused coping strategy to an emotion-focused strategy (Folkman, Lazarus, Pimley, & Novacek, 1987; Lachapelle & Hadjistavropoulos, 2005). The results obtained by Meléndez, Mayordomo, Sancho, and Tomás (2012) show a main effect of age on the use of coping strategies. Different patterns are obtained in each stage of the cycle, including a reduction in the problem-solving focused strategy due to an increase in routine activities and a decrease in novel life events, as well as an increase in situations of loss that are beyond the person’s control. In addition, in emotion-focused coping, an increase is observed in religion and negative self-focusing, along with a reduction in the search for support.

Well-being is one of the keys to successful and optimal development across the lifespan. Development involves continuous changes in individuals’ adaptive capacity to meet their own needs over time, which requires effort to adapt to the new reality, leading to changes in psychological well-being (Ryff, 1989). Based on the eudaimonic approach, Ryff and Keyes (1995), in the context of developing a lifespan theory, defined psychological well-being as an effort to grow and fulfill one’s potential. Its development is related to having a purpose in life, giving life meaning, facing challenges and making an effort to overcome them, and achieving worthwhile goals through adaptation processes. Ryff’s model is a multidimensional approach to the measurement of psychological well-being that taps six distinct aspects or facets: autonomy, personal growth, self-acceptance, purpose in life, environmental mastery, and positive relations with others.

The developmental paths of the dimensions of psychological well-being seem to follow different patterns. Recently, Ryff (2014) found that the scientific output in the field of development and aging reveals that progression through the developmental tasks of adult life is linked to greater well-being, even though aging is accompanied by a decline in purpose in life and personal growth. In addition, Meléndez, Tomás, and Navarro. (2011) observed a reduction in the dimensions of positive relationships with others and in autonomy. Developmental changes that occur during the second half of life produce changes in the notion of well-being. The adaptation process can attenuate these changes, which focuses on the person’s ability to modify his/her functioning in order to achieve successful aging, with this process becoming quite important in the last stage of the life cycle.

Mild cognitive impairment (MCI) is a diagnosis that has been developed using detailed diagnostic criteria (Petersen, 2004), and it is increasingly being used in research and clinical settings such as memory disorder clinics. People with MCI have cognitive deficits that are not severe enough to warrant a diagnosis of dementia but may be at risk of developing it. Research on wellbeing in people with MCI has found that they have higher levels of depression and lower well-being than healthy older adults (Rickenbach, Condeelis, & Haley, 2015). They also experience frustration in their daily lives, difficulties in completing complex activities, and interpersonal problems. These aspects generate frequent daily stress, including general stressors and stressors related to memory. MCI subjects, based on the Lazarus and Folkman (1984) stress model, can appraise stressors as being more stressful or severe if their coping resources are reduced due to decreased cognitive ability. In addition, cognitive deficits will reduce the application of effective strategies based on experience, thus attenuating age-related, emotion-regulation benefits.

Alzheimer’s disease (AD) is an age-related progressive dementia that is considered a chronic, degenerative disease of gradual evolution, leading to a decline in cognitive and overall functioning, even in non-cognitive domains. AD interferes with the ability to perform everyday activities (APA, 2013), making the patient dependent on support. The interplay between biological and psychosocial factors is mediated by the individual psychology in terms of the way the individual adapts to and copes with the onset and progression of dementia (Clare, 2002). People who develop dementia have a personal history and a wealth of life experiences that have shaped their capacity to cope effectively with the resulting challenges, but cognitive impairment involves greater difficulties in responding to daily life demands that affect AD patients. For the person with dementia, the development of adaptive coping strategies is important in order to maximize well-being and minimize disability (Clare, 2002).

Identifying the changes in resilience, coping, and well-being in MCI and dementia provides a basis for developing interventions to promote adjustment and facilitate management of the condition. The objective of the present study was to ascertain whether patients with MCI and dementia experience changes in resilience, coping, and well-being, compared to subjects without cognitive impairment.

1. Methods

1.1. Participants

We compare three samples of volunteers consisting of: 32 healthy elderly people, 31 amnesic mild cognitively impaired (aMCI) patients, and 32 Alzheimer’s disease (AD) diagnosed patients. The healthy older participants were recruited from various senior citizen centers in the city of Valencia (mean age = 73.9 years, *SD* = 5.05, range 65–87 years old). The aMCI and AD older participants were patients from the Neurology Department of the General Hospital of Valencia (aMCI group mean age = 75.93 years, *SD* = 6.23, range 64–88 years old; AD group mean age = 76.84 years, *SD* = 4.57, range 65–83 years old). The three samples were matched on gender ($\chi^2(2) = 2.036; p = .361$), age ($F(2,95) = 2.54; p = .084$), cultural level (Kruskal-Wallis(2) = .693, $p = .770$), and depressive symptomatology ($F(2,95) = .035; p = .966$) (see Table 1).

Table 1
Means and standard deviations between groups.

	a. healthy elderly people	b. aMCI	c. AD
Age	73.91 (5.05)	75.93 (6.23)	76.84 (5.57)
Gender (male/female)	12/20	11/20	16/16
Education (1–4 scale)	2.65 (.93)	2.35 (.78)	2.19 (.73)
CES-D	11.47 (10.88)	11.91 (10.19)	13.46 (7.81)

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