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ANTALYA
NATIONAL ASSOCIATION of SOCIAL and APPLIED GERONTOLOGY

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REVIEW ARTICLE

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Mitigating the Existential Suffering of Older People Transitioning Through Loss and Grief: Understanding the Liberating Influence of Compassionate Care

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ABSTRACT

Later life is seen as the forerunner to multiple transitions involving loss and grief that have implications for the health and well-being status of older people. Common transitional challenges in later life involve bereavement, retirement, and relocation, including losses relating to the aging process per se. In essence, life-related transitions in later life present a range of possibilities for growth or decline in developmental capacities. This critical commentary draws attention to the need for awareness among health professionals and family caregivers to understand the potential for a disconnect of empathy and compassion from the existential loss and grief experiences of people in later life. A case is made for healthcare workers to explore the aging process more carefully and thoughtfully, with particular attention to the relationship of compassionate care to the existential aspects of loss and grief in later life. Shortfalls in the healthcare system are shown to hinder or endanger the provision of a high-quality, compassionate care culture for older people. It is suggested that any serious psychology of aging requires improved depths of study and understanding surrounding the existential dimensions of loss, grief, and bereavement.

KEYWORDS: Compassion fatigue; existentialism; inner world; opportunity value; perspective-taking; unconditional positive regard.

KEY PRACTITIONER MESSAGE

1. This article provides useful material for healthcare professionals working with older adults experiencing unresolved issues and anxieties surrounding loss, grief, and bereavement.
2. This article provides information and insights considered helpful for planning and delivering professional development workshops that recognize and respond to loss, grief, and bereavement among older adults.
3. This article is a valuable resource for healthcare professionals committed to providing empathetic and compassionate care for older adults experiencing complex and debilitating issues surrounding loss and grief.
4. This article offers essential insights and understandings considered necessary for the initial education and training of healthcare professionals destined to work with older people, particularly those held to be vulnerable and at-risk concerning loss, grief, and bereavement

INTRODUCTION

Older age can be seen as a time of reckoning for facing existential questions concerning the meaning and purpose of life while having to face sooner or later the stark reality surrounding the transitory nature of personal existence (Baars, 2012; Langle, 2001). Peterson (2018), based on his experience as a clinical psychologist, offers a view applicable to vulnerable older people "The heightened knowledge of fragility and mortality produced by death can terrify, embitter, and separate. It can also awaken" (p. 366). Indeed, later life confronts the older person with a mix of existential issues, not the least of which concern loss and grief.

The transition from middle age to later adulthood challenges a person's sense of self as they experience and face a range of changes and discontinuities involving physical, psychological, and social losses that threaten their overall sense of worth and purpose (Brandtstädter & Greve, 1994). Failure to successfully deal with these existential issues may result in a decline in health with implications for psychological disorders, often leading to protracted bouts of depression and illness.

Vrkljan et al. (2019) suggest that the three most common transitional challenges resulting from major life events involve bereavement, retirement, and relocation in later life. There is, of course, the issue relating to losses related to the aging process itself that include both normal and pathological changes that impact "the individual's construction of self and personal continuity" (Brandtstädter & Greve, 1994, p. 55).

Laceulle (2013), on the matter of age-related vulnerability and loss of one kind or another, contends that "losses" rather than being seen as preventing further growth in developmental capacities and self-realization offer instead "a new perspective that transcends the common language of decline and opens up new possibilities for meaning" (p. 112). For Adams et al. (1977), transitional events in the life of each present a range of "possibilities for both danger and opportunity" (p. xi).

The preceding authors posit that a transition embodies the potential for allowing the individual to grasp the "opportunity value" for personal growth and development. On the other hand, the experience of traversing a transitional pathway following a significant life event can often be the precursor for a mix of dysfunctional coping behaviors with subsequent deleterious consequences for an individual's health and well-being. Robertson (2014) reminds us that transitions do not occur in a vacuum per se but result from significant life events that may be predictable or unexpected. For Robertson, major life events "are defined as significant occurrences involving relatively abrupt changes that may produce serious and long-lasting effects" (p. 9). While transitions generally follow from a significant life event, they are accompanied by a grief response to the loss or losses arising from the ending of a previous way of life.

The pathway through a transition can be complicated and, for some people, complicated due to a pervading sense of instability until a new, balanced and acceptable beginning is found. There is, of course, the reality for some older persons who may be faced with the daunting challenge of having to deal with two or more significant transitions either simultaneously or over a short period. For example, older people receiving palliative care may experience several negative and challenging transitions involving changing treatment regimes, differential levels of functional status, symptoms diversity, and changes in the overall sense of well-being (Duggleby et al., 2010).This paper aims to provoke meaningful ongoing discussions relating to philosophical and ethical issues facing the helping professions, including family caregivers surrounding the need for adopting a more open and humane approach to understanding and supporting older people during times of loss, transition, bereavement, and change. The stance taken in the present situation involves adopting a phenomenological or existential perspective, thereby valuing and giving voice to the unique personal experience of each older person. It is perhaps important from the outset to emphasize the importance of allowing a person who is experiencing loss to engage in a proper grieving process. For those involved in helping older adults who are bereaved, there must be awareness and recognition of the need for the application of humane care and support that includes patience and the provision of a compassionate, caring culture aimed at enabling the individual to resolve existential questions, anguish, and related issues and suffering. (Firestein, 1989) provides a timely reminder to all and sundry that loss is an inevitable part of the life journey:

> *The experience of loss of something prized-a person, a thing, or a condition-is genuinely universal. No one is exempt from this experience* (p. 37).

Thoughts on Change in Later Life

The speed and rapidity of social change have brought new questions regarding aging and old age's social and personal meaning. While aging is a natural phenomenon, most people are deceptively unprepared for the experience. Aging is irrefutably liked to change, ranging from a series of gradual and somewhat small and often imperceptible losses to significant losses with the potential for significant negative impact on the individual's health and overall well-being.

Evans et al. (2019) released a report on older adults confronted with life-altering events. They explore the repercussions of life-altering events in this report, claiming that "transitions in older age, whether this is retiring from paid work, changing careers, or terminating or starting a relationship, may have a considerable impact on people's lives and well-being" (p. 8). However, change for some older people presents new opportunities to flourish and embrace a different and invigorating lifestyle approach to living. Schwartz (1974) identified the need for practitioners to pay attention to the accumulating series of losses that accompany the aging process. Indeed, Schwartz refers to "a high price one pays for survival into the latter decades of life is that most (eventually all) those persons with whom one grows up are eliminated from the network-parents, siblings, friends, co-workers. Certainly, if one survives long enough, the attrition rate is increased because of death" (p. 9).

Palmér et al. (2019) highlight that we are socially connected to others, making our lives meaningful. When we lose longstanding relations, our connection with our life-world changes forever. Robertson (2014) draws attention to the challenging and negative situation whereby an individual is in the unfortunate position of experiencing what is termed "revolving transitions" that involves, in a brief period of time, a series of negative and compounding life-changing events, each with its own transitional dynamics.

O'Connor (1988) identified that the aging experience is often impacted by a complex array of uncertainties and fears and that it is not uncommon for an older individual to feel somewhat disconnected from the self, arising in part from "The development of competence in the outer world, the pursuit of success and power often require some diminution or underdevelopment of the inner world regardless of whether one is male or female" (p. xiv). It is in this context that older people are likely to have a close encounter with a range of significant and challenging questions that may include: (1) What is happening in my life?, (2) How can I adapt with meaning?, (3) What is my mission?, (4) How can I increase my effectiveness and purpose as a human being?, (5) Is my life worthwhile?, (6) What will be my legacy when I am gone?, (7) How can I cope when my life is falling apart?

While aging brings with it the accompanying prospect of radical change, it also raises a range of existential uncertainties relating to the usefulness of the self to family and the wider community. As human beings, our experiences of loss and grief expose our vulnerability, frailty, anger, rage, strength, courage, resilience, and adaptive capacities. All of us, both individually and collectively, have to face adversity, trauma, and life changes at one time or another. Major losses in our lives always require some form of personal adjustment and reorganization of thinking and acting in favor of new, healthy, and realistic interpretations of past, present, and future. Allowing for individual differences begins with acknowledging and understanding that no one's attitude, or perception of change is the same. Basseches and Gruber (1984) offer a novel yet realistic perspective on the nature of change:

> *We can never bathe twice in the same stream, for it is ever-changing- and so are we. To those who want to rest, this changefulness is a burden; to those who can embrace change, a challenge and a pleasure* (p. xii).

The Existential Side of Aging and Compassionate Care

Morris (2020) puts a case for exploring the aging process more broadly and thoughtfully, which opens opportunities to consider how loss, grief, and bereavement in later life can be related to "the existential parts of aging, such as senescence, the "medicalization of life"; the issue of where, how, and with whom one will be living in one's later years; and the family dynamics that assist in and impinge on the aging process" (p. 195).

Langle (2001) suggests that when healthcare professionals encounter an older person seeking help and emotional support during bereavement, loss, and grieving that they draw upon an approach that incorporates the existential reality of the older person rather than relying solely on a fixed or prescriptive model of medical and nursing care. Tanner et al. (2015) offer an important caveat for

social workers assisting older people to navigate major life-based transitions "Practitioners working with older people experiencing transitions have to be sensitive, not only to individual meanings and strategies but also to the possible tensions between their professional stance and that of the older person's" (p. 2060). Parkes (1988) speaks of people who have great difficulty in coping with major life-changing events and offers the view that "Social workers and other primary caregivers in the community are in a good position to identify people in transition, to assess their vulnerability, and where necessary, to provide the support needed or refer them to those who can" (p. 63). Likewise, Hashim et al. (2013) contend that primary care physicians can play a supporting role in identifying and preventing serious depression and subsequent health decline among older people transitioning through bereavement, loss, and grief. However, there is no guarantee that professional support for older people facing challenging transitions is readily available or always necessarily of the right kind of quality.

Sinclair et al. (2017), based on a review of the literature on sympathy, empathy, and compassion, report a disturbing trend that highlights the decline in the relevance and importance of empathy in healthcare education and clinical practice, which has implications for overall quality of care (Hojat et al., 2009). Consequently, there is an unfortunate situation where there can be a failure to acknowledge the significance of the existential side of aging regarding issues and concerns relating to loss and grief. Facilitating the opportunity for an older person to speak more freely about loss and grief embodies the essence of compassionate care while at the same time helping the older person to feel that his / her presence as a person is valued (Bourgeois-Guérin et al., 2021).

Compassion may be seen as a humane quality of understanding the suffering of others and rests heavily on honest and virtuous intentions ((Sinclair et al., 2017) and involves, in part, an action-oriented response of listening ethically, which entails a) being receptive to the person when they speak and b) adopting an attitude of unconditional positive regard that avoids impatience or condescension. Cole-King and Gilbert (2011) propose that "the human capacity for compassion appears to involve two "different" psychologies: on the one hand for awareness and engagement, on the other for skilled intervention in action" (p. 30). While empathy is not compassion per se, it does, however, allow for an acceptance, sharing, and understanding of the feelings and emotions of another person (Eklund & Meranius, 2021).

Empathy is essentially a necessary precursor for compassionate action (Singer & Klimecki, 2014). More attention should be given to the fact that empathy and compassion can co-jointly promote a caring culture that facilitates the health and well=being of older adults leading to more open and humanistic ways of working with the existential side of aging. Recognition must be given to the reality that much work remains to be undertaken concerning care and support interventions relating to loss and grief (Forte et al., 2004). Boston et al. (2011), in a literature review of existential suffering in palliative care settings, provide an insightful perspective for healthcare professionals on the provision of compassionate care:

> *Knowing how to provide compassionate care requires an awareness that this may involve embracing personal and emotional risks. The notion of whole-person care calls for attention to all domains, including the physical, psychological, spiritual, and existential, with skills that demand much more from our person and that may move beyond our training in scientific and technical skills* (p. 615).

A report by Evans et al. (2019) on Navigating Transitions in Later Life highlights the possibility and, in some cases, the reality that "support is largely focused on "firefighting" the effects of negative transitions, rather than prevention to mitigate the risk" (p. 8). Sikstrom et al. (2019) point out that very little is known about the extent of grief training for physicians and emphasize the need for medical education to include opportunities for the development of skills and competencies in dealing with loss and grief that will inevitably occur as part of healthcare practice.

Palmer et al. (2020), in a study of older adults' perception of the finality of life, conclude that professional healthcare workers should adopt a life-world approach that embodies respectful dialogue that focuses on existential issues. Similar calls for meaningful and practical loss and grief medical education have been made by Zisook and Shear (2009) and Sanchez-Reilly et al. (2013). In the interest of fostering a culture of compassionate care in the caring professions, it would seem relevant to initiate more profound probing research undertakings into the extent to which professional education is committed to developing compassionate health

professionals (Bray et al., 2014). Croxall (2016) brings to light the unbelievable situation in the UK whereby bereavement support in later life is not a priority policy matter due to "socially constructed assumptions that bereavement is unproblematic for older people" (p. 131).

Davidson (1991) offers essential insights on health and aging that provide clues on how easy it is for health systems to ignore the existential issues of loss and grief among older people "Overwhelmingly, the traditional healthcare system emphasizes acute care, crises intervention, and the illness model of health. Within this system, the consumer is most often looked upon as part of a whole" (p. 178). Hillman (2012), while speaking, generally makes the point that all too often in contemporary culture, there exists a pervasive tendency whereby "We hurry people to "get on with it," "spare me the details," "get to the point" (p. 172). Christiansen et al. (2015) suggest that a combination of staff shortages, unrealistic workloads, and resultant time restraints can create an environment that values completing work duties efficiently and as soon as possible. However, it must be acknowledged that the operation of a highly efficient healthcare system by, or in itself, may very well hinder the provision of compassionate care. Zisook and Shear (2009) provide a resounding message to psychiatrists on grief and bereavement that is also applicable to all those who offer assistance to people dealing with the burden of bereavement and loss:

> *For most bereaved individuals, the arduous journey through grief will ultimately culminate in an acceptable level of adjustment to a life without their loved ones. Thus, most bereaved individuals do fine without treatment. Certainly, if someone struggling with grief seeks help, they should have access to empathic support and information that validates that their response is typical after a loss* (p. 69).

Further Thoughts on the Existential Dimension of Loss and Grief

The heterogeneity of the aging population means that each older individual is like no other, and therefore, any support interventions about loss and grief warrants respect for the uniqueness of his / her experiences. The fear of aging, including death, presents differential levels of concern among older people. Erikson et al. (1994), in their landmark study Vital Involvement in Old Age: The Experience of Old Age in Our Time, emphasize the final stage of letting go when the older person recognizes the unavoidable task of having to come "to accept the inevitability of death's enforced leave-taking" (p. 63). Seedsman (1994) argues that in pursuit of a balanced life in old age, overindulgence with thoughts of death and dying, or concerns about the possibility of future functional loss, may compromise the ability to live an authentic life. Older people experiencing major bouts of loss and grief will often have periodic encounters with an "identity crisis" which requires a satisfactory resolution to protect and stabilize a positive view of self. Unresolved aspects of loss and grief in later life can be understood as existential suffering and related to a vulnerability that deserves unmitigated consideration in delivering high-quality care. Moody (2009) provides a valuable insight into the onset of illness in later life and the likely set of existential questions arising due to the pervading sense of multiple losses:

> *Illness raises questions: Who are you when you stop doing? When you cannot be productive or are no longer indispensable to others? When you can no longer go on as before because you are sick when you lose status? Who are you when you can't be a caretaker or a boss or do your job, whatever this might be? Do you matter?* (p. 73).

Entry into old age brings forth an accumulation of losses which inevitably "brings to the surface existential questions and issues of the meaning in life" (Birren & Lanum, 1991, p. 112). According to Ivancovich and Wong (2008), "there is a venerable history in existential philosophy and psychology of focus on the central role of personal meaning in the ever-enfolding of the human drama of coping with adversities and suffering" (p. 218). Supporting the older person who is experiencing major loss and grief requires an emphatic, sensitive and compassionate intrusion into the life-world of the individual akin to getting "inside" or tapping into their existential concerns and issues. Health professionals and informal caregivers committed to the provision of compassionate care for older people suffering existential anguish with loss and grief might well consider the value of supporting the person to give voice to their feelings and suffering and, in so doing, offer the opportunity for a measure of resolution in line with the notion that "A burden shared is a burden halved" (Whyte, 2009, p. 141).

Taylor (1985) argues that "Human beings are self-interpreting animals" (p. 45), and this viewpoint lends support to the stance that it is the individual who determines the true essence of the meanings embedded in their lived experiences with loss and grief. Healthcare practitioners who are genuinely

aligned to and sensitive to the existential concerns and suffering related to loss and grief among older people enhance their potential for fostering compassionate care. At the same time, they position themselves to acquire a deeper understanding of the existential dimensions of vulnerability related to lose and grief in older age. For Morris (2020), the existential dimension of aging is intertwined with issues of "medicalization" and overall health status with implications for differential impacts on the "psychological, social, financial, familial, sexual, and so forth" (p. 204).

Laceulle (2013) reminds us that the existential vulnerability confronting older persons during times of loss "are often transformed into experiences of meaning, resulting in attitudes of wisdom and acceptance" (p. 111). Indeed, (Hildon et al., 2008) examined the relationship between adversity and resilience among older people and found that "Participants with resilient outcomes drew upon social and individual resources in the face of adversity, in particular resources that stabilized life change by providing continuity" (p. 726). For Dohmen (2013), resilience can be fostered by older people living an "engaged life" illustrated by maintaining or creating meaningful roles and activities as well as being open and willing to receive support from ongoing relationships with close family and friends. However, the COVID-19 pandemic has certainly tested the capacity for resiliency and recovery of older people, both community-dwelling and those residing in aged care facilities. In particular, the isolation directives have negatively impacted older people's overall sense of security and social connectedness, resulting in marked increases in depression, anxiety, and loss of control with implications for mental health and well-being. In particular, the pandemic has disproportionately affected aged care residents, evidenced by widespread feelings of loneliness, fear of dying, and panic caused by the difficulties associated with accessing regular medical and nursing care (Cohen et al., 2021; Goveas & Shear, 2020; Ishikawa, 2020).

Farran (1997) sees existentialism operating within a philosophical framework and, in so doing, acknowledges that human beings across all ages:

> *... have the potential to experience existential vacuum — times when one's goals are not met, times when there are feelings of nothingness, meaninglessness, anxiety, and isolation. This perspective also identifies the tension between being free to make choices while at the same time assuming responsibility for what life sets before one and the natural consequences of actions. Furthermore, it addresses the tremendous capacity that humans have to experience hope, to transcend and find meaning in the midst of difficult life experiences* (p. 252).

Later Life Losses Threatening Safety, Mastery, and Control

Later life is a forerunner for multiple transitions that have implications for the health and well-being of older people and include retirement, loss of a spouse or partner, relocation to a new living arrangement, frailty, or the onset of illness and disability. Two significant life events warrant attention as examples among many that impact the level of self-management and control in later life. The first is that a diagnosis of early-onset cognitive impairment causes significant disruption in people's lives. Alzheimer's disease or any other dementia creates existential concerns for older adults in relation to personal agency, identity, and anxiety arising from a pervading fear of losing control. Grenier and Phillipson (2013) argue that agency refers to the notion of control on the part of the individual with the suggestion that "agency exists on a continuum" (p. 72). When a personal agency is severely reduced in later life due to impairment, there exists a high potential for loss of control, and for (De Lange, 2021), "Lack of control refers to a special kind of loss, the loss of the self" (p. 367). The call for humanistic, person-centered care and support for the person living with dementia presents a clear mandate for informal carers and healthcare professionals to provide services and programs in supportive environments aligned with the following affirming approach to care:

> *In effect, what we need to do is simple. We must support people in such a way that they continue to see themselves as good, valuable individuals, surrounded by those they love and who also love them. Ultimately, those with dementia need to hold onto the sense that they are both changed yet still the same person they have always been. This is a profoundly human challenge. It is one that we must all strive to meet* (Cheston & Christopher, 2019).

A second and confronting life event surrounds an older person transitioning into residential aged care. In a call for humanistic care in residential aged care facilities, Seedsman and Seedsman (2019) stress the importance of giving adequate time to listen to older aged care residents genuinely. Failure to respect the identity and history of the older resident leads

to little interest in listening to any existential issues surrounding loss and grief. For Gierck (2018), "The opposite to listening is indifference and a painful lack of interest. It is worse than anger. It is a lack of regard for human beings" (p. 30). While the quality of life is a subjective concept, it is undoubtedly under siege when an older person enters a residential aged care environment.

Older adults facing a transition into residential aged care face new demands on their ability to adjust, made even more difficult by a series of profound changes that collectively usher in a period of disequilibrium and upheaval from a familiar life world (Schumacher et al., 1999; Zizzo et al., 2020). A change in the nature and availability of support from family and social relations can create a heightened vulnerability and sense of alienation leading to a complex mix of loss and grief experiences. The most vulnerable are the very old and those with a history of poor social relationships, including those with frailty and multiple comorbidities that impact their capacity for autonomous behavior.

Riedl et al. (2013), in a study of aged care residents in Austria, found that "To be able to cope with the demand on their identity, they need identity-forming conversations in new social networks in the nursing home as well as the support from their family members and professional helpers" (p. 8). Long-term facilities for the aged have the potential to be disempowering environments arising from managerial and organizational practices that tend to marginalize aged care residents. An interesting example is provided by the psychologist Marie de Hennezel (2011), who provides the following telling statement made by a female aged care resident "Everyone does their work according to the established protocols, without taking any account of the patient's well-being. They work with their arms, but their heads and hearts are missing" (p. 31). Likewise, in a non-related context, (Whyte, 2009) offers the following words that have some measure of explanatory power in helping to understand the failure to deliver compassionate and caring care for older people transitioning through loss and grief "... we have eyes, yet see not, ears that hear not, and hearts that neither feel nor understand" (p. 70).

Sadly, genuine person-centered care is under threat arising from "a healthcare climate in which cost-cutting is leading to significant constraints on practice" (Schumacher et al., 1999, p. 22). Therefore, it is not surprising to find situations whereby there exists little or no realistic opportunities for aged care residents to give voice to personal concerns and anxieties relating to loss and grief matters. Unfortunately, with increasing numbers of older people entering nursing homes and intensive care units, there exists the genuine possibility that healthcare professionals may fail to "honestly examine the experience of aging and dying" (Gawande, 2014, p. 9). It is not unusual for healthcare professionals to find themselves in situations where patients share their personal experiences with loss and grief, which may not always be solely focused upon end-of-life matters. For some practitioners, such situations create a sense of awkwardness and anxiety, resulting in a general feeling of inadequacy and embarrassment.

CONCLUSION

This paper aims to emphasize the need to think and act more "thoughtfully" about how to support the older person experiencing loss, grief, and bereavement. (Olsson, 2021), an experienced family-centered psychologist, contends that when a person is unable to engage in a proper grieving process, there exists a high chance that "normal grieving can turn to complicated grief, and for some, diagnosable as prolonged grief disorder" (p. 21). However, it must be recognized that the older person first and foremost represents a unique human being whose actions, beliefs, attitudes, and encounters with loss and grief are an outcome of lived experiences, including their psychological makeup and the influential aspects of society to which they belong. A particular loss experience can represent a profound life transition that remains unresolved for some older people. Neimeyer et al. (2008) make the point that the undertaking of any assessment and support for prolonged grief matters must "be guided by the character of the loss itself as well as of the client who suffers it" (p. 269). While experiences with loss and grief are part and parcel of the life journey, the entry into older age signals a deeper awareness of personal finitude (Fonseca, 2011; Fung et al., 2005) combined with a set of ongoing challenges whereby "Man [woman] has to say good-bye to many things in the course of life, but never more than in old age: the loss of physical performance and strength, the loss of psychological and mental flexibility, the loss of social and professional rank, financial means, friends and relatives" (Langle & Probst, 2000, p. 194). It is suggested that any serious psychology of aging requires improved depths of study and understanding surrounding the existential dimensions of loss and grief. On the phenomenon concerning the experience

of loss and grief in older age, there is a strong case to be made for practitioners' taking steps to better understand such existential matters from the perspective of older adults themselves. The need for empathetic and compassionate care and support is obvious during loss and grief. Perhaps the following insightful words by the American poet Maya Angelou might well help to foster a genuine reflection by healthcare professionals on the need to practice within an ethical context that treats people in a manner that respects and protects their human dignity "I have learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel" (Maya Angelou, cited in Riess, 2017, p. 74).

Efforts to understand loss, grief, and bereavement in later life must provide opportunities for the older person to express their inner feelings which are linked to change and transition and ultimately discovered in part or whole "...in the phenomenological experiences of ageing-those actual accounts of personal experience with space, time, body and social relations as lived by older persons" (Seedsman & Carmel, 2003, p. 11). Dewar (2013) reminds us that sometimes the emotional shortfalls of practitioners may prevent the delivery of compassionate care. When healthcare professionals suffer fatigue and stress through heavy workloads, there is every possibility of burnout, resulting in missed opportunities to sensitively and emphatically understand the nature and impact of transitions involving loss and grief on the "inner world" of older patients (Aronson, 2019; Lathrop, 2017). Speaking specifically from a medical point of view, Aronson (2019) argues that burnout can threaten the delivery of quality care with implications for differential levels of neglect of the patient's personhood. Baruch (2004), a strong advocate for self-care among counselors and therapists, offers valuable insights on the prevention of "compassion fatigue" (burnout) that should form part of mandatory professional development workshops.

Ramsey (1970), in his text The Patient as Person, provided ethical insights into the importance of respecting human personhood as an essential component of healthcare. There is always the danger in healthcare systems for a person's selfhood (personhood) to be neglected or "discounted," failing to connect to the inner existential needs of the patient. Taylor offers the proposition that "the way human agents interpret themselves and their situation cannot be neglected, but should be taken into account in social scientific explanations" (1989, cited in Olay, 2020, p. 123). Mutter (2018) argues that with the increasing medicalization of care for older people, the medical system often fails to attend to the condition of the whole person. Failure within the healthcare system to provide person-centered care for older patients can inadvertently deprive formal caregivers of many opportunities to address and resolve longstanding issues relating to loss and grief. Mannion (2014) argues a need for more nuanced explorations surrounding the world of healthcare and the organizational settings that hinder or nurture the practice of compassionate care. Acting from a humanistic approach (Riess, 2017), drawing upon the work of Batson et al. (2007), provides an important clue on activating an empathic and compassionate care culture by a) valuing the welfare of the person and b) adopting a "perspective-taking" approach which entails "feeling one's way into the experience of another" (p. 75). The preceding pathway to empathic and compassionate care warrants the facilitation of a sensitive and person-centered orientation while all the time is giving unconditional attention to the unfolding life story of another. Malouf (2002) provides an insightful and challenging perspective on the task at hand "... to step beyond what we are, and what we think we know and believe, into other skins and other lives, to become, in imagination and for a time, the children of other histories; to understand from within how the world might look from there, and how we might, in other circumstances, respond" (p. 6). It is important to accept that there is no single or unified theory of loss and grief. The point must be made that all too often that, little or no recognition, either intentionally or inadvertently, is given to the reality that the experience of loss is a uniquely personal process often requiring due acknowledgment and compassionate support that provides an opportunity for the individual to give voice to his / her inner turmoil and distress. To say to any person experiencing loss and grief, "I know how you are feeling," does not sit comfortably with compassionate ways of working and reflects a shortfall in the emotional intelligence of the individual using this expression. In the end, it must be emphasized that nobody can firmly assume that they understand the emotional feelings and depth of loss experienced by another individual. The following perspective offered by Weston et al. (1998) provides what they see as "unconditional positive regard for the person going through their loss and grief process:

> *Every person perceives and experiences loss in their own cultural, personal, and individual way, so*

> *what might seem an unimportant loss to us may be devastating for them. We cannot use our mind map and perceptions to judge the effects of loss for other people. There is a need to emphatically view it through their own perceptual world or frame of reference* (p. 14).

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Testing the Psychometric Properties of the Geriatric Anxiety Scale in a Sample of Older Adults in Turkey

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ABSTRACT

Anxiety is a prevalent illness among older adults, and it should be assessed using psychometrically robust diagnostic tools owing to the fact that physical symptoms suppress geriatric anxiety. It is challenging to assess anxiety in older people due to variations in worries, such as older adults being more concerned about their lives and complaining of decreased arousal. The Geriatric Anxiety Inventory (GAI) is a new, well-known, and adaptable measure created to evaluate anxiety in the older population while avoiding the abovementioned issues. The present study aims to measure the psychometric properties of the Turkish version of the GAI in a Turkish sample of older adults (n = 199). In the current research, ninety-four male (47.2%) and one hundred five female (52.8%) participants are enrolled. Confirmatory factor analysis (CFA) proves that the GAI three-dimensional model is statistically significant. Good internal consistency results and corrected item-total correlations prove the inventory's reliability. Additionally, concurrent validity is shown to be reasonable based on the association between geriatric anxiety and many conceptually related variables (general anxiety, life satisfaction, positive and negative affect), and discriminant validity is found to be satisfactory based on the correlation between geriatric anxiety and an unrelated measure (social desirability). The psychometric characteristics of the GAI are discussed in light of current findings on the value of evidence-based evaluation in older people.

KEYWORDS: Geriatric Anxiety Inventory; GAI; older adults' anxiety; psychometric; confirmatory factor analyses; reliability.

KEY PRACTITIONER MESSAGE

1. Appropriate assessment tools are needed to disentangle difficulties that occur as a consequence of aging and the physical and psychological symptoms that accompany it.
2. GAI has a high degree of reliability and validity. Thus, professionals in psychology, gerontology, psychiatry, medicine, and social work may use the inventory to evaluate Turkish older individuals' geriatric anxiety.
3. Research on older people with geriatric anxiety is also encouraged because these studies help clinicians figure out how to help older people improve their health-related quality of life.

INTRODUCTION

Psycho-social and physical challenges in old age render older people more prone to psychiatric problems. Anxiety is one of these issues studied in a population of older people (Areán, 1997; Ayers et al., 2007) with a high prevalence (Kogan et al., 2000). If anxiety is not appropriately managed, the well-being of older people deteriorates. For instance, older people with generalized anxiety disorder had poorer health-related quality of life scores than their counterparts (Wetherell et al., 2004). Contrary to popular opinion, research shows that anxiety in older individuals is a frequent but understudied problem. According to Alwahhabi, this is an "underestimated, undertreated, and understudied condition" (Alwahhabi, 2003, p. 180). The severity of their bodily ailments overshadows their anxiety levels. Some physical symptoms might be caused by anxiety, so it is essential to look at older adults' anxiety with evidence-based practices when diagnosing and treating them (Therrien & Hunsley, 2012). In terms of anxiety, there are certain similarities and differences between adults and older adults. To begin with, the common characteristics in older people and other age groups include certain anxiety features, symptom presentation in panic disorder, social anxiety in social phobia, symptom presentation in obsessive-compulsive disorder, and functional impairment in each anxiety disorder (Wolitzky-Taylor et al., 2010).

Older adults, however, have a number of unique features that make assessing anxiety more difficult and complicated (Gould et al., 2021). It is also said that older people do not suffer from overwhelming and unmanageable anxiety but rather have cognitive worries about their lives (Gould et al., 2021). They are also less likely to report negative emotional experiences (Wolitzky-Taylor et al., 2010), which might be due to changes in sympathetic nervous system activity with aging (Kogan et al., 2000). Older adults are more concerned about their health than younger ones, which is reflected in their level of anxiety (Wolitzky-Taylor et al., 2010). As a result, the nature of anxiety in old age is relatively different from that in other age groups. Additionally, professionals will benefit from assessing anxiety using procedures that are applicable in the real world (Gould et al., 2021).

Since their medical illnesses may be part of their psychological well-being, it is critical to identify anxiety in the older adult population (Areán, 1997; Therrien & Hunsley, 2012). Individuals receiving home care are also at risk of developing psychological disorders such as anxiety, which should be assessed by professionals (Diefenbach et al., 2009). Similarly, in order to assess anxiety, professionals would focus on the medical conditions of older people as well as their functional level, both of which complicate evaluation (Ayers et al., 2007). Certain symptoms indicative of physical difficulties may be a result of their anxiety. Distinguishing physical and psychological challenges in old age is tricky. Additionally, as indicated before, specific anxiety symptoms might alter in the sample of older persons (Alwahhabi, 2003); thus, evaluating anxiety in the older adult using generic anxiety measures is deemed "imprudent" (Kogan et al., 2000).

Several self-report questionnaires are available to assess anxiety in a sample of older people, such as the State-Trait Anxiety Inventory (STAI; Kvaal et al., 2005), Beck Anxiety Inventory (BAI; Areán, 1997), Penn State Worry Questionnaire (PSWQ; Meyer et al., 1990), General Health Questionnaire (GHQ; Goldberg & Hillier, 1979), and Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983). These instruments are available on scales that are used to measure the anxiety of people of all ages. They are not designed to assess older adults' anxiety or address the objections expressed to such assessments. Researchers attempt to compensate for the shortcomings of such assessments (i.e., STAI) by using equivalent alternative scales and contemplating higher cut-off points for older adults (Kvaal et al., 2005). Additionally, certain items associated with cognitive components of these measures, such as those in the BAI (Areán, 1997) and items including somatic claims (Byrne et al., 2010), do not function properly in the population of older adults. The response style of some of these scales, such as the STAI, has been criticized as being excessively complex for older adults, and reversal items, such as those in the HADS, add to older adults' doubts about such statements (Byrne et al., 2010). Additionally, researchers recommend taking extreme caution when administering these scales (e.g., BAI) to older adults for therapeutic purposes (Areán, 1997).

The Geriatric Anxiety Inventory (GAI) is a well-known questionnaire used to measure the anxiety level of older adults (Pachana et al., 2007). GAI is designed to resolve the aforementioned criticisms by using a less convoluted answer style, fewer somatic items, and no reverse items (Byrne et al., 2010). GAI items are chosen based on existing measurements with the assistance of focus groups that include older people,

geropsychologists, and geriatric psychiatrists (Pachana et al., 2007). The GAI is composed of twenty items arranged in an agree-disagree style. The inventory has high discriminant validity to distinguish patients with and without generalized anxiety disorder (GAD), with satisfactory reliability and validity outcomes. According to receiver operating characteristic analysis (ROC), using a cut-off score of 10/11, 83% of psychogeriatric patients accurately categorized generalized anxiety disorder with high sensitivity (73%) and specificity (80%). When the psychometric features of a sample of older Australian women are examined, it is discovered that the cut-off score of the inventory is 8/9 on the inventory (Byrne et al., 2010). Similarly, the Portuguese adaptation of the GAI demonstrates that a cut-off score of 8/9 differentiates severe anxiety from other types of anxiety in older adults with or without a mental illness (Ribeiro et al., 2011). Similarly, using ROC analysis, the cut-off values for generalized anxiety disorder are determined to be 13 points (83.3% sensitivity and 84.6% specificity) in the Brazilian Portuguese language (Massena et al., 2015).

The inventory developers propose modifying a few terms in the GAI items to improve comprehension when evaluating psychometric properties in another culture (Byrne & Pachana, 2011). The inventory is translated into Brazilian Portuguese (Massena et al., 2015), Portuguese (Ribeiro et al., 2011), French-Canadian (Champagne et al., 2018), Japanese (Kashimura et al., 2021), Spanish (Marquez-Gonzalez et al., 2012), and Persian (Shati et al., 2021). To make cultural sense in the Portuguese translation, the item " I often feel like I have butterflies in my stomach " is changed to " I feel like having a knot in the throat" (Ribeiro et al., 2011). In that version, there are two components to the inventory, according to Bartlett's Test of Sphericity and Kaiser-Meyer-Olkin (KMO), with anxiety symptoms accounting for 43.4% of the total variance and somatic symptoms accounting for 18% of the total variance, respectively. In contrast to the two-factor structure, the Spanish version of the study with older adults demonstrates that the GAI has a three-factor structure (cognitive, arousal/physical activation, and somatic dimensions), with varimax rotation accounting for 51% of the variance (Marquez-Gonzalez et al., 2012). The internal consistency of this version is excellent (.91). In recent publications, the one-dimensional structure of the GAI has been discovered in the Japanese version (Kashimura et al., 2021), the Chilean version (Miranda-Castillo et al., 2019), and the French-Canadian version (Champagne et al., 2018), as well as in studies with the geriatric population (Johnco et al., 2015). Furthermore, the inventory's unidimensionality is noted in a meta-analysis of GAI. As a result, there is no consensus on the factor structure of the inventory, as illustrated by a metanalysis of GAI (Champagne et al., 2021).

GAI has been recognized as an effective tool for assessing the anxiety of older people living in the community, primary care centers, or geriatric hospital (Byrne & Pachana, 2011; Johnco et al., 2015; Massena et al., 2015). The earlier anxiety measures, which are constructed for an adult population, are insufficient to assess the extent of anxiety in older people. There are several instruments for assessing anxiety; however, the GAI's benefits include being set up for older people, offering an agree/disagree response style, not needing to reverse items, and getting a small number of items. The purpose of this research is to examine the psychometric properties of the GAI in terms of reliability, factor structure, and concurrent and discriminant validity in a sample of older Turkish people. Confirmatory factor analyses are performed to explore the factor structure of the GAI; Cronbach's alpha is calculated to assess the inventory's reliability; and correlations between the scale and related or unrelated constructs such as general anxiety, life satisfaction, positive and negative affect, and social desirability are investigated to figure out the GAI's concurrent or discriminant validity.

METHOD

Participants

The current research included 94 male (47.2%) and 105 female (52.8%) individuals (N = 199), with a mean age of 69.92 (SD = 7.53; range = 60 to 92).The majority (n = 104; 52.3%) of participants are married, while others are single (N = 63; 31.7%), divorced (N = 18; 9.0%), and separated (N = 8; 4.0%). In terms of education, the participants have completed an elementary school (N = 59; 29.6%), a secondary school (N = 18; 9.0%), a high school (N = 41; 20.6%), a two-year vocational school (N = 19; 9.5%), and an university (N = 23; 11.6%), or not completed any school but are literate (N = 39; 19.6%). Over two-thirds of the individuals (67.8%; n = 135) live in apartments, while only one-third (32.2%; n = 64) live in retirement facilities. Additionally, two groups were formed using the responses of participants to the following question: how would you assess your current general health status? Individuals who rated their current health condition as "very bad" and

and "not good" were grouped together, but those who rated it as "good" or "very good" were grouped together. The first group was dubbed "perception of poor health" (N = 105; 52.8%), whereas the second was dubbed "perception of excellent health" (N = 94; 47.2%).

Measures

To assess the Geriatric Anxiety Inventory's psychometric properties, the Beck Anxiety Scale, Satisfaction with Life Scale, Positive Negative Affect Scale, and Social Desirability Scale are employed in the present study.

The Geriatric Anxiety Inventory (GAI) is developed to assess anxiety symptoms in older people with twenty items arranged in an agree-disagree style (Pachana et al., 2007). The inventory's psychometric properties are thoroughly explained in the introduction section.

The Beck Anxiety Inventory (BAI) is a twenty-one-item questionnaire designed to assess the presence of anxiety on a four-point Likert scale (Beck et al., 1988). Cronbach's alpha for the BAI is .92, and its test-retest reliability over a one-week period is .75. The inventory has two subscales: subjective anxiety/panic symptoms and somatic complaints. Although the inventory is not explicitly designed for older adults, it has been utilized in studies conducted with older people (Areán, 1997). Ulusoy et al. (1998) translated the BAI into Turkish with a high internal consistency (.93) and current validity, as shown by STAI.

The Social Desirability Scale-17 (SDS-17) is a true/false format scale designed to evaluate socially desirable responses (Stöber, 2001). A higher score on the scale indicates a greater degree of social desirability. The scale's reliability and validity were investigated with people ranging in age from 18 to 89. The SDS-17's internal consistency is good and acceptable (α = .75), and its scores correlated satisfactorily (varying from .52 to .85) with alternative measures of social desirability in terms of convergent validity (e.g., Eysenck Personality Questionnaire-Lie Scale, Sets of Four Scale, Marlowe-Crowne Scale).

The Satisfaction with Life Scale (SWLS) is a five-item, seven-point Likert-type scale that measures overall life satisfaction (Diener et al., 1985). Higher scores indicate a higher level of life satisfaction. The scale's internal consistency (.87) and test-retest reliability (.82) are acceptable. The scale is composed of a single factor. Scale is adapted into Turkish by Durak et al. (2010).

The Positive and Negative Affective Scale (PANAS) is a five-point Likert-type scale with twenty items assessing positive and negative affect (Watson et al., 1988). The scale assesses both positive and negative aspects of affect. For the Turkish version of the scale, Gencoz (2000) found that the factors' internal consistency ranged from .83 to .86, while their test-retest reliability ranged from .40 to .54.

Procedure Control of Data for Analyses

Prior to data collection, permission was obtained from the inventories' creators for adaptation. GAI items were translated into Turkish by four independent English-speaking translators who were fluent in Turkish and specialists in the field of psychology. Following that, the text's authors double-checked the accuracy of the item translations. Any disagreements were settled by a joint agreement. The inventory items were then translated backward from Turkish to English, and English-Turkish comparison forms were sent to the GAI developers. The measures were given to older adults who live at home or in two rest homes. All participants were informed of the goal of the present study, and their permission was obtained.

RESULTS

Control of Data for Analyses

The descriptive statistics and correlational analyses were conducted using IBM's SPSS-26 software (IBM-Corp, 2019). Confirmatory factor analysis (CFA) is used to validate the GAI's factor structure using the AMOS-26 program (Arbuckle, 2019). The p-value threshold was set at .05 in all analyses to determine significance. In order to prevent probable outliers in the data from influencing the results, data cleaning and outlier control were carried out (Tabachnick & Fidell, 2013). After one multivariate outlier was eliminated from the analysis, analyses were performed on the remaining 199 cases.

Confirmatory Factor Analyses

To examine the adequacy of the unidimensional and three-dimensional (cognitive, arousal/physical activation, and somatic anxiety) models of the GAI, confirmatory factor analyses are performed by AMOS 26 program (Arbuckle, 2019). Those factorial solutions are mentioned by psychometric studies of the GAI in different languages (Champagne et al., 2018; Kashimura et al., 2021; Marquez-Gonzalez et al., 2012; Massena et al., 2015; Ribeiro et al., 2011; Shati et al., 2021).

The confirmatory factor analysis (CFA) was used to ascertain the inventory's unidimensionality and multidimensionality based on model fit indices. The Tucker-Lewis Index (TLI), Comparative Fit Index (CFI), Incremental Fit Indices (IFI), p of Close Fit (PCLOSE), Root Mean Square Error of Approximation (RMSEA), Chi-Square (X^2), and Standardized Root Mean Square Residual (SRMR) were all employed to determine model fit (Hu & Bentler, 1999; Kline, 2016). If a model's fit indicators of IFI, TLI, and CFI exceed .90 (Bentler & Bonett, 1980), it is deemed more fit. Additionally, RMSEA and SRMR values between 0 and .05 and PCLOSE values greater than .05 are important markers of the best fitting model owing to their ability to detect subtle model changes (Hu & Bentler, 1999; Schermelleh-Engel et al., 2003).

The model was tested to investigate the association between previously identified factorial structure and data acquired from Turkish older adults using AMOS 26 (Arbuckle, 2019). The tested one-factor solution did not satisfy the desired criteria; X^2 (167, N = 199) = 466.84, p = .001; RMSEA = .094, IFI = .861, TLI = .843, CFI = .860, X^2/df = 2.76. On the other hand, three-factor solution presented better adequate fit, X^2 (167, N = 199) = 363.72, p = .001; RMSEA = .077, IFI = .908, TLI = .894, CFI = .907, X^2/df = 2.178. Freeing parameter constraints between e2 (Item-10) and e3 (Item-13) may help improve the model, as shown by modification indices. The model fit improved considerably further when the covariance between error terms of two items was taken into account as a free parameter in the new analysis; X^2 (166, N = 199) = 336.72, p = .001; RMSEA = .072, IFI = .920, TLI = .908, CFI = .920, X^2/df = 2.028. The standard regression weights in this analysis are demonstrated in Figure-1. The three-factor solution model matches the data better than the single-factor solution model, based on these findings.

Internal Consistency Results

The internal consistency was assessed independently for the whole scale and each factor. Internal consistency coefficient for the whole inventory was .94, with corrected item-total correlations ranging between .45 (item-12) to .77 (item-17). In terms of three factors; internal consistency coefficient for cognitive anxiety was .91, with corrected item-total correlations ranging between .53 (item-2) to .78 (item-17), internal consistency coefficient for arousal/physical activation was .84, with corrected item-total correlations ranging between .56 (item-20) to .73 (item-10), internal consistency coefficient for somatic anxiety was .78, with corrected item-total correlations ranging between .42 (item-6) to .67 (item-19).

Concurrent and Discriminant Validity

To examine concurrent validity, participants' scores on GAI are compared with conceptually related constructs of general anxiety (BAI scores), life satisfaction (SWLS scores), and positive and negative affect (PANAS scores). The GAI was positively correlated with general anxiety (r = .50 p = .001) and negative affect (r = .57, p = .001).

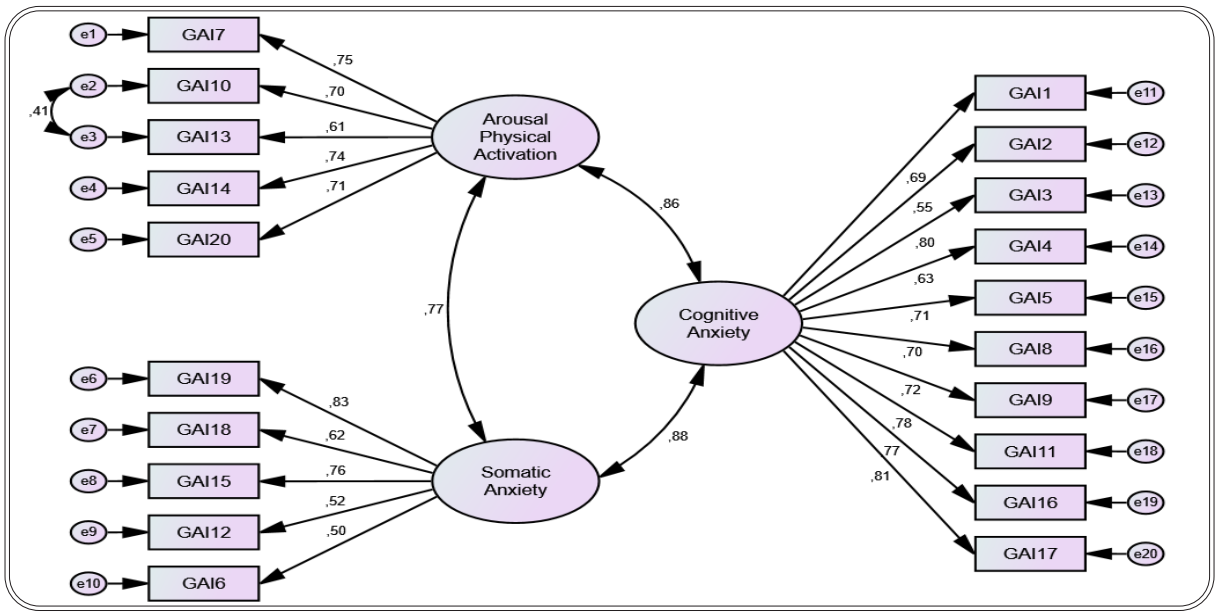

Figure-1. The standard regression weights

On the other hand, the GAI was negatively correlated with positive affect (r = -.29, p = .001) and SWLS (r = -.19, p = .008) (see Table-1). To examine discriminant validity by social desirability, participants' scores on GAI were compared with SDS-17. The GAI was not significantly correlated with social desirability (r = .02, p = .822) (see Table 1). Furthermore, the discriminant validity of the GAI was tested using an independent-samples t-test. GAI scores for the perception of poor health group (X = 6.66, SD = 6.18) were significantly higher than for excellent health group (X = 4.05, SD = 5.39), t(197) = 3.15, p = .002.

ratio of X^2 to df revealed that the GAI's three-factor solutions provided the most satisfactory fit.

Correlations between errors might obfuscate model testing findings and diminish the likelihood of a repeatable perfect fitting model. Using comparable language or phrases with remarkably similar meanings while building a scale, on the other hand, increases the possibility of correlations between error terms. This perspective is consistent with Bollen and Lennox's (1991) statement that researchers often assume errors are unrelated in order to facilitate

Table-1. Correlations between variables and descriptive values of the variable

		1.	2.	3.	4.	5.	6.
1. Geriatric Anxiety (GAI)			.50***	-.29***	.57***	-.19**	.02
2. General Anxiety (BAI)				-.28***	.57***	-.29***	-.15*
3. Life Satisfaction (SWLS)					-.40***	.32***	.10
4. Negative Affect (PANAS-P)						-.22**	-.17*
5. Positive Affect (PANAS-N)							-.04
6. Social Desirability (SDS-17)							
	X	5.43	14.42	25.31	16.94	30.44	11.05
	SD	5.95	12.08	5.96	5.57	6.95	2.75
	Min. (Possible)	0	0	5	10	10	0
	Max. (Possible)	20	63	35	50	50	17

Note (1). ***p ≤ .001, **p ≤ .01, *p ≤ .05

Note (2). X = mean, SD = standard deviation

DISCUSSION

Aging includes several physical and psychological difficulties that are overshadowed by each other. Therefore, as evidence-based practices, proper assessment tools are necessary to differentiate problems (Therrien & Hunsley, 2012). As one of the well-known and widely used measures in different languages, the present study aims to evaluate the psychometric aspects of the GAI.

Based on the GAI results in distinct cultures, the unidimensionality of the factor structure is assessed by CFA. The findings proved that the evaluated one-factor solution did not satisfy the essential criteria for model fit. Multidimensionality of inventory is revealed in Portuguese (two-factor structure, Ribeiro et al., 2011) and Spanish (three-factor structure, Marquez-Gonzalez et al., 2012) versions of the GAI, while mostly unidimensionality of the inventory is supported in other versions (French-Canadian version Champagne et al., 2018; Japanese version, Kashimura et al., 2021; Chilean version Miranda-Castillo et al., 2019). CFA results by fit indices and the debate. However, correlations between error terms are permissible when applied conservatively other than random changes to improve model fit. After performing confirmatory factor analysis (CFA), the model fit was even better when the covariance between e2 (Item-10) and e3 (Item-13) was taken into account as a free parameter in the new analysis. Both items are related to the same latent factor (arousal/physical activation). "I often feel nervous" (item-10) and "I think of myself as a nervous person" (item-13) are comparable statements that sound equal to the ear.

The inventory's internal consistency is satisfactory as the original version of the inventory (Pachana et al., 2007). Regarding concurrent validity examinations by conceptually related constructs, the GAI significantly correlated with BAI, supporting Pachana et al.'s (2007) results. Like Diefenbach et al.'s study (2009), GAI with BAI's factorial structure relations is consistent. Furthermore, GAI's concurrent validity with SWLS and SPANE is also satisfactory. As expected, there is a positive correlation between the GAI and negative affect, and there is a negative correlation between

the GAI and positive affect and satisfaction with life. As proved by discriminant validity with SDS-17, the inventory's relations with social desirability are in the expected range. Therefore, the GAI can be a more distinct concept than desirability.

There are methodological limitations in the present study. Test-retest reliability of the inventory cannot be examined in the present study. Also, factor structure cannot be examined in terms of the living place of older adults (at home versus in institution), physical health problems (having problems versus not having problems) (Gould et al., 2014), and presence of having an anxiety disorder. Also, the role of cognitive impairment on psychometric findings cannot be compared in the present study, which is evaluated by (Rozzini et al., 2009). The psychometric aspects of the GAI are recommended to be assessed with different older adult groups in future studies.

The GAI has satisfactory reliability and validity results. Therefore, the inventory can be used by professionals (psychologists, gerontologists, psychiatrists, physicians, social workers) in the professional field to evaluate Turkish older adults in describing their geriatric anxiety. Additionally, the inventory may be used to assess three subdimensions of geriatric anxiety. With GAD, it will be feasible to identify the anxiety areas of older adults and tailor the therapeutic process to the sub-area (cognitive, arousal, or somatic) in which they score the highest. For instance, practitioners may save time using cognitive psychotherapy strategies with older adults with high cognitive geriatric anxiety scores. Similarly, depending on the amount of arousal, it may occur to apply behavioral approaches in the first place in those who feel anxiety. Strengthening communication skills to assist clients with high somatic anxiety ratings in lowering their anxiety would save the expert time. Further studies exploring psycho-social difficulties in geriatric anxiety are also encouraged. Those studies help professionals set a target of help in promoting health-related quality of life among older adults.

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INSTRUCTIONS TO AUTHORS

JALTC Journal Rules

The Journal of Aging and Long-Term Care (JALTC) is being established as open access and quarterly peer-reviewed journal that accepts articles in English. Open Access publishing allows higher visibility of an author's research as articles are available for anyone to access worldwide. Articles published in JALTC are highly visible and gather more citations and publicity than stand-alone articles.

JALTC is published three times a year. Articles submitted should not have been previously published or be currently under consideration for publication any place else and should report original unpublished research results. The journal does not expect any fees for publication. All articles are available on the website of the journal with membership.

The quantitative, qualitative and mixed-method research approaches are welcome from disciplines including but not limited to education, gerontology, geriatrics, nursing, care and hospice, social work, psychology, sociology, biology, anthropology, economics and business administration, engineering, gerontechnology, law, human rights, public policy, architecture, women studies, rehabilitation, and dietetics.

Prospective authors are cordially invited to contribute clearly written original empirical research manuscripts, reviews, brief reports, hypothesis & theory, clinical trial, case report or discussion, short communications, and case studies, general commentary, debates and controversies, care facility and services, book review, editorial or guest editorial and erratum including innovative practices from the field as well as relevant philosophical and ethical perspectives on long-term care and older adults.

The review process for submitted manuscripts has been planned **not to exceed four months.** All research articles submitted to the journal will undergo **rigorous peer review,** based on initial editor screening and anonymous refereeing by two peers.

Scientific and Ethical Responsibility

Authors, as they contribute to the academic-scientific article on the cover page, share the scientific and ethical responsibility. After acceptance of manuscripts, then is confirmed that it belongs to the Journal and copyright passes on the publisher.

Authors should ensure accepting scientific and ethical responsibility by avoiding unacceptable or improper behaviors of falsified research, fraudulent data, paraphrasing, duplication, and blatant plagiarism. Authors should also keep in mind the terms emphasizing "ageism" need to be avoided in using to describe the pop-ulation. Discrimination based on age should be avoided by considering two statements:

> *"Elderly is not acceptable as a noun and is considered pejorative by some as an adjective. Older person is preferred. Age groups may also be described with adjectives: gerontologists may prefer to use combination terms for older age groups (young-old, old-old, very old, and oldest old), which should be used only as adjectives. Dementia is preferred to senility; senile dementia of the Alzheimer's type is an accepted term" (The American Psychological Association, Section 2.17 Age, p. 69).*

> *"Age.–Discrimination based on age is ageism, usually relevant to older persons. Avoid using age descriptors as nouns be-cause of the tendency to stereotype a particular group as having a common set of characteristics. While in general the phrase the elderly should be avoided, use of the elderly may be appropriate (as in the impact of Medicare cuts on the elderly, for example). Otherwise terms such as older person, older people, elderly patients, geriatric patients, older patients, aging adult, or the older population are preferred" (The American Medical Association, Inclusive Language Section, 9.10.3, p. 268).*

The Copyright Transfer Form should be signed by all the authors.

Preparation of Manuscripts

Only the articles sent online can be evaluated. The authors should submit their manuscripts online via the journal's website at http://agingandlongtermcare.com. In addition, the authors can register to the link https://dergipark.org.tr/en/ site to send the article and track the progress of evaluation.

Information about the application should be entered into the system in nine complete steps: (1) Manuscript and Abstract Information (2) Affiliation(s) (3) Author(s) (4) Corresponding Author Information (5) Manuscript Title (6) Abstract (7) Keywords (8) Comments to Editorial Office (9) Upload Files. The information about manuscript type and category, the author name(s), name of the institution, affiliations, an address for cor-respondence (including the name of the corresponding author with an e-mail address and fax and phone numbers) and ORCID ID for author(s) should be entered in the system.

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ORCID is part of the wider digital infrastructure needed for researchers to share information on a global scale. In this respect, the authors should use an internationally recognized ORCID identification number to avoid difficulties that occasionally arise as a result of similarities in names and surnames also to enable transparent and trustworthy connections between researchers.

The latest version of The American Psychological Association (APA) Style, namely the APA 6th Edition, should be followed when formatting articles. The manuscript file must be double spaced, including the references and tables, and the text should be left justified. Tables and figures must be fully prepared for publication according to APA guidelines. Detailed information on the latest APA Style can be found on the following website: http://www.apastyle.org

Language:

It is recommended that authors use American English spelling.

Length of Articles:

The whole manuscript must not exceed maximum 8000 words, including abstract, keywords, key practi-tioners message, the article itself, tables and figures, and references.

Line Spacing and Font:

Articles should be double-spaced excluding abstracts, notes and references and should be submitted in 12pt Times New Roman font.

Title Page and Abstract:

The **Title** should consist of 30 or fewer words.

An **Abstract** must include a maximum of 300 words (including citations if used) and be provided on a sep-arate page.

Keywords must include a minimum of 5 to 8 words and/or phrases.

Key Practitioner Message must include 3 to 5 bullets

Reference Citation:

Reference citations in the text and in the reference list proper should follow conventions listed in the Pub-lication Manual of the American Psychological Association latest edition (6th ed.), referred to hereinafter as the APA Manual. Provide a reference or bibliography that lists every work cited by you in the text. It is recommended that authors use Citation Management Software Programs for reference citation; please look at web pages of EndNote (www.endnote.com), RefWorks (www.refworks.com), Papers (www.mekentosj. com), Zotero (www.zotero.org), and Mendeley (www.mendeley.com).

Journal Articles:

Lo, C. L., & Su, Z. Y. (2018). Developing multiple evaluation frameworks in an older adults care informa-tion system project: A case study of aging country. Journal of Aging and Long-Term Care, 1(1), 34-48. doi:10.5505/jaltc.2017.65375.

Edited Book:

Whitbourne, S. K. (Ed.) (2000). Wiley Series on Adulthood and Aging. Psychopathology in Later Adulthood. Hoboken, NJ, US: John Wiley & Sons Inc.

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Book Section:

Bowen, C. E., Noack, M. G., & Staudinger, U. M. (2011). Aging in the Work Context. In K. W. Schaie & S. Willis (Eds.), Handbook of the Psychology of Aging (7th Ed.) (pp. 263-277). San Diego: Academic Press.

Web Page:

Borji, H. S. (2016, 25.07.2016). Global Economic Issues of an Aging Population. Retrieved from http://www.investopedia.com/articles/investing/011216/4-global-economic-issues-aging-population.asp.

Figures and Tables:

Figures and tables should be numbered using Arabic numerals. The same information should not appear in both a figure and a table. Each table and figure must be cited in the text and should be accompanied by a legend on a separate sheet.

Authors are responsible for all statements made in their work, and for obtaining permission from copyright owners to reprint or adapt a table or figure or to reprint quotations from one source exceeding the limits of fair use.

Plagiarism Checking:

All manuscripts are scanned with a plagiarism checker to deter and prevent plagiarism issues before sub-mission.

Copyediting and Proofs:

Manuscripts will be evaluated on the basis of style as well as content. Some minor copyediting may be done, but authors must take responsibility for clarity, conciseness, and felicity of expression. PDF proofs will be sent to the corresponding author. Changes of content or stylistic changes may only be made in ex-ceptional cases in the proofs.

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Vision and Mission

The major goal of the Journal of Aging and Long-Term Care (JALTC) is to advance the scholarly contri-butions that address the theoretical, clinical and practical issues related to aging and long-term care. The JALTC, while making efforts to create care services for older people at the best quality available that are more humane, that pay special attention to people's dignity, aims from the perspective of the whole aging process- to discuss Social Care Insurance as a human right, to contribute care for older people to be trans-formed into an interdisciplinary field, to integrate care services for older people and gerontological concepts and to create more effective collaboration between them, to enhance the quality of care services for older people and the quality of life of caregivers from medical, psychological and sociological perspectives, to highlight the cultural factors in care for older people, to increase the potential of formal and informal care services, to provide wide and reachable gerontological education and training opportunities for caregivers, families and the older people.

Aims and Scope

"National Association of Social and Applied Gerontology (NASAG)"has recently assumed responsi-bility for the planning and introduction of a new international journal, namely, the Journal of Aging and Long-Term Care (JALTC). With world societies facing rapid increases in their respective older populations, there is a need for new 21st century visions, practices, cultural sensitivities and evidenced-based policies that assist in balancing the tensions between informal and formal longterm care support and services as well as examining topics about aging.

The JALTC is being launched as the official journal of the NASAG. The preceding journal aims to foster new scholarship contributions that address theoretical, clinical and practical issues related to aging and long-term care. It is intended that the JALTC will be the first and foremost a multidisciplinary and interdis-ciplinary journal seeking to use research to build quality-based public policies for long-term health care for older people.

It is accepted that aging and long-term care is open to a diverse range of interpretations which in turn cre-ates a differential set of implications for research, policy, and practice. As a consequence, the focus of the journal will be to include the full gamut of health, family, and social services that are available in the home and the wider community to assist those older people who have or are losing the capacity to fully care for themselves. The adoption of a broader view of aging and long term care allows for a continuum of care support and service systems that include home base family and nursing care, respite day care centers, hospital and hospice care, residential care, and rehabilitation services. It is also crucial to be aware that life circumstances can change suddenly and dramatically resulting in the need for transitional care arrange ments requiring responsive, available, accessible, affordable and flexible health care service provision.

For further assistance and more detailed information about the JALTC and the publishing process, please do not hesitate to contact Editor-in-Chief of the JALTC via sending an e-mail: editor-in-chief@jaltc.net Editor-in-Chief: Emre SENOL-DURAK

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