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Using the Language of Wellbeing in the Care of the Elderly in Mexico

Abstract

The language we use with others derives from hidden assumptions about them and commands expectations and outcomes. That is why the constructs and language used in health services provided to the elderly are a worthwhile object of study.

This paper addresses the language used in the services provided to the elderly population in Mexico and many other Latin-American countries. The psychological, linguistic and practical aspects of the wellbeing language paradigm are discussed. The linguistic analysis of the discourse used by health care providers conveys important implications to the kind, quality and purpose of intervention.

It is argued that by using the language of wellness, health professionals are in a better position to listen and assess the degree of satisfaction and happiness, to explore for conditions that may promote or hinder quality of life, and also, they are in a better position for planning services to the elderly that reach beyond physical health and economic indicators.

It is posited that quality of life in old age is incomplete without a sense of the patient's wellbeing.

1. Using the Language of Wellbeing in the Care of the Elderly in Mexico

Language and services

In Mexico, as in the rest of Latin America, senior citizens have recently demanded so many services so fast that little time has been given to reflect upon the philosophy, moral framework and professional ethics in the care of this population. This is highly important considering that our perspective and view of this particular group of people has changed over recent years, from the general idea of being small groups of survivors with low expectations toward life, to the idea of a large group of people striving for services and goods. Furthermore, many think that it is normal for the elderly to expect an extended and fruitful life-span. Thus language used to address this segment of the population deserves careful attention.

The purpose of this paper is to analyze the language of wellbeing in the care of the elderly in Mexico. The psychological, linguistic and practical aspects of the wellbeing linguistic paradigm are discussed. It is argued that the discourse used by health care providers conveys important implications to the kind, quality and purpose of intervention. Mostly, if one considers that nowadays in many developing countries, life expectancy has grown substantially. Therefore, there has been a change in our paradigm to understand the elderly, rather than considering them as a burden to society; for many service providers, they are, indeed, seen as a privileged stratum of the population, which is able to enjoy the fruits of a previous productive life.

The language used in the health services is an important object of study because expressions and words used by professionals reflect the ideas, beliefs and notions of the public health provider. As Pennebaker et al. (2003) assert, the words people use in their daily lives can reveal important aspects of their social and psychological worlds and they can serve as markers of emotional state, social identity and cognitive styles. Hence, the particular language used in medical dis-

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course at health service settings also evidences a conceptual framework that guides intervention. Thus, language has an impact on the quality of services and, indeed, on the outcomes. This is particularly true with elderly people, a rapidly increasing population in Latin America.

In fact, our perspective of the aged population has changed from the early statement of Karl Jung who claimed that "What is a normal goal to a young person becomes a neurotic hindrance in old age" (Jung 1993: 13), to the current and more positive vision of the elderly as a large fraction of the population with resources, interests and opportunities that have boosted a number of industries in various fields, such as travel, entertainment, medicine and nutrition, to mention just but a few

2. The concept of 'Wellness'

Although this term is difficult to define accurately, it refers to a whole and holistic state of health that is characterized by positive affection and adaptive behaviors in the physical, physiological, social, and productive domains (Salinas et al. 1994).

Historically, the concept of wellbeing has been constructed twofold. On one hand, from the *hedonistic view*, which focuses on achieving happiness by actively seeking pleasure and avoiding discomfort. On the other hand, the *Eudemonic view* based upon fostering human potential and self-realization.

Likewise, the study of factors related to wellbeing has evolved. Initially, this concept was analyzed either from an economic view or from a biological perspective. The former is based on the availability of resources for a minimal quality of life, whereas the latter emphasizes the preservation of mental and physical health in spite of senility.

Carmona (2009) claims that the emphasis on wellbeing is a recent construct which is, in turn, a probable consequence of the phenomenon of industrialization. As a result of the industrial expansion and concerns for the effects of alienating working practices, there was an attempt to establish quantitative indicators of social, physical and living conditions that could give a measure of the person's wellbeing. However, a formal analysis of the language used and its consequent implications for the provision of services was absent in these early times.

In the United States, emphasis on the psychological dimension of the concept of wellbeing emerged in the 50s, perhaps with the seminal research work conducted by Maslow and his studies about his needs pyramid; Rogers throughout the theory of self-actualization (Rogers, 1961) as well as the global mental positive health movement (see http://www.globalmentalhealth.org/).

Bearing in mind all these views, the concept of wellness has achieved positive acceptance among health services providers. That is to say, rather than focusing merely on a state of disability, loss or health deficit; they focus on hope, ability and productivity in the last stage of life. Not surprisingly, wellness is a concept that has been pragmatically derived to guide health services. In fact, this concept was inspired by many treaties regarding happiness in life that in the scientific field is concretized in the concept of wellness.

Diener (2000) claims that there are three key elements in the concept of wellness, which will be mentioned as follows: subjectivity, presence of positive indicator, and global assessment of life. In other words, wellness is characterized by a high and positive appreciation of life for a significant period of time, which encompasses coping and survival of setbacks and losses natural to the aging process. As Díaz/Sánchez (2002) assert, persons with adequate wellbeing possess a general sense of satisfaction in life and portray a positive balance between negative and positive emotions.

Overall, the concept of wellbeing from a psychological perspective is now used to assess the levels of comfort, happiness, harmony and interior peace of mind.

Wellbeing encompasses a state of health; both mental and physical. It also focuses on adaptive behaviors in uppers levels of functioning, closely related to quality of life, life satisfaction and self-realization. No doubt, this is why this concept is poignant to the study of aging and the el-

derly population. Who would not like to end life with positive thoughts and a sense of fulfillment and self-realization?

The reader can notice an evolution of this term toward a more complex and subjective status, and that it has become an important descriptor of quality of life. In sum, in recent years there has been a shift from the ~~medical's~~ estimate of quality of life in terms of health/disease, to the consideration of individual's subjective feelings of their own living situation and relative wellness. Likewise, the linguistic approach to the elderly has shifted from medical terminology to a more humanistic and adaptive language aimed to discover the potential and gains and not the deficits and lacks.

3. Health discourse in service providers

The language we use with others derives from hidden assumptions about them and commands expectations and outcomes. That is why the constructs and language used in health services provided to the elderly are a worthwhile objet of study. Furthermore, health professionals working with elderly people are more likely to get burnout more frequently (Salinas et al. 1994). Thus, assessing language used by practitioners on a daily basis may be an indicator of the quality of the services, as well as a measure of their own sense of wellbeing, and, indeed, it could be an indicator of the degree of burnout in the worker.

For instance, discourses focusing on pain, discomfort, limitation and diseases tend to focus on medical and daily living negative aspects of the person. In contrast, words related to aspirations, adaptation, enjoyment and abilities tend to stress positive thinking and coping. Quality of services in this perspective relates to language that relates to rapport, interest, compassion and dedication to the patient. Within the framework of wellness, health discourse should be based upon aspiration, visions, desires, and projects in order to replace health negative language concepts focusing on deficits, impediments, deficits and disabilities.

Bowling (1997) asserts that there is little consensus over the definition of wellness and quality of life. Early work in the field of public health focused on the negative impact of illness in a person's life with terms such as morbidity, mortality and service utilization being widely required. Wellness depends on both personal and social conditions as well as individuals as they face them. According to Ryff (1989), the diverse perspectives that exist with respect to the subjective and psychological well-being can be integrated in six key concepts.

1. Self-acceptance. It is the criterion used to define well-being, and it is conceptualized as the central figure of mental health, as a characteristic of maturity, personal fulfillment and optimal performance.

2. Positive relationships with others. The importance of the warmth and confidence in interpersonal relationships, as well as the capacity to love, are seen as one of the main components of the mental health, at the same time being a criterion of maturity.

3. Autonomy. It emphasizes self-determination, independence and the regulation of the conduct.

4. Mastery of the environment. The ability to choose or create environments according to their own physical conditions is defined as a characteristic of mental health. It implies the ability to manipulate and control complex environments or environments with the participation of the medium.

5. Purpose in life. It emphasizes understanding a purpose or meaning of life, a sense of direction or intent. ~~Who~~ works positively has goals, intentions and a sense of direction.

6. Personal growth. The optimal psychological functioning requires not only development of the above features, but also continuation of the development of their own potential, growth and expansion as a person.

4. Wellness in the elderly population

Aging is a natural and progressive biological and psychosocial process influenced by genetics, life style, world view and culture, among many other factors. Aging conveys stress since it eventually involves a decline on physical and cognitive functioning. In Mexico, many families cope with an elderly member who requires special attention and care. As in many other Latin American countries, families seldom prepare and make provisions for the care of the elderly, and, even worse, young adults rarely think on how to prepare for old age. The Mexican societal population has abandoned its pyramidal structure with a large base conformed by children; and, nowadays, it affords a larger stratum of old people population. This rapid growth of the elderly in Latin-American is hidden under a large amount of uncertainty in many families that need to learn how to cope, care and provide services to their elderly.

The reason for the growth of elderly population in Mexico may be due to advances in the field of medical sciences which, in turn, have improved survival rates within the country. Consequently, the improvement of the general conditions of life have increased life expectancy in Mexico from 71 years in 1990 to 77 years in 2012 (García 2010).

Throughout the old age status, personal well-being and life satisfaction constitute the main criteria for facing a successful aging process (Blanch et al. 2010). At this stage of life, the concept of wellbeing is broad and more inclusive, including feelings regarding the satisfaction of lived experiences, general happiness, and a good personal adjustment to the circumstances of life.

By using the language of wellness, health professionals are in a better position to listen and assess the degree of satisfaction and happiness, to explore for conditions that may promote or hinder quality of life, and, also, they are in a better position for planning services to the elderly. In fact, planning is more effective when considering factors that may promote satisfaction and wellbeing.

When using terms related to wellbeing and personal realization in planning health services, professionals may reach beyond physical health and economic indicators, to include those aspects of life that are more subjective, but equally important factors in the health service outcomes. In other words, being old need to de described in terms of happiness, satisfaction and self-realization. As a matter of fact, quality of life is more likely to be incomprehensible without a measure of well-being.

In this perspective, the estimation of the wellbeing of the elderly correlates with the overall satisfaction with life that is consistent with the basic indicator of happiness, that is to say, the difference between achievements and aspirations over time. In other words, wellness can be estimated by the perceived difference between their ambitions and their profits.

Wellness in the elderly has as a compulsive referent in the seminal study of Zahava/Bowling (2004) in which they describe the factors associated with the well-being and quality of life of a nationwide sample of elderly in Britain. The authors identified the perception of having good social relations and quality in affective relationship, the availability of help and support within the environment and the feasibility of transporting to recreational sites as key factors that lead to accepting the circumstances of life that cannot be changed.

5. Risks and limitations in the old age

We have argued before that the golden years are the last stage of the development of the human being, which starts at around age 65. This last stage of human development is characterized by a period of progressive deterioration in all areas of operation, to biological, psychological and social level.

From the biological point of view, these changes are identified as a decline in the physiological body, leading to the origin and maintenance of a myriad of illness and discomfort. For example, starting from the common vision impairment (which begins at age of 40), to common diseases such as hypertension and diabetes, which may condition a disability at elderly levels (Díaz et al. 2006).

Not surprisingly, language related to the care of the elderly is influenced by this vision of 'natural disability over time' that has helped to create stereotypes of the old person as someone with inherent deficits and with constant demands and needs. This pre-conceived notion fails to recognize the many elderly people who are happy, fulfilled, adapted and rather functional in spite of the aging process. It is important to challenge these stereotypes in Latin-American countries, where there is an extended and subconscious notion that elderly equals poor and sickness (Rodríguez et al. 2006).

A paradigm of public health service providers based upon the language of wellness may lead to a new philosophy in servicing the elderly, from a perspective grounded on deficit and need to a new and positive vision that helps prevention of accidents, lowers risks of decease, but more importantly, to a language discourse which fosters happiness, fulfillment and self-realization.

Bottom-line, language used in the public health services should be intended to preserve quality of life rather than extend it at any price.

5.1. Physical risks

As regards the physical condition, the fact of not exercising the functions that still one possesses leads to the deterioration of these functions and even to physical pain. Statistically, a high prevalence has been found in older adults of chronic diseases, including hypertension, diabetes, heart disease and arthritis, visual and auditory problems (Casullo 2001). With the impressive increase of life expectancy at birth in the past years, the public health care has been directed primarily to measure the quality of the years of life more than the chronological indicator group, i.e., to measure quality of life related with health and morbidity as well as mortality. This has led epidemiologists to the development of indicators of health compounds or burden of disease (EC), proposed by Sullivan in 1971 (See Murray 1994) , where losses of health through mortality and morbidity are combined and which include the Disability-Adjusted Life Year (DALY) index. However, we are still developing theories to help us understand how psychological factors, general mental health and the general well-being impact these indicators.

In this sense, physical factors explain many cases of absence of well-being related to the deterioration of physical strength, mobility, balance, strength, among the most relevant. These factors are associated with a decrease in the execution of basic and instrumental activities of daily living. Today, there is a significant body of research that demonstrates the benefits of interventions that can improve physical functioning and reduce dependence. The practice of physical exercise at different intensities is an important predictor of morbidity and longevity. In relation to this, one of the main challenges is to involve older persons in physical activity in which the motivational and dispositional variables are important components.

On the other hand, the suffering of chronic physical diseases during aging and sensory limitations contributes significantly to disability and physical dependence. Just as with the overall physical strength, the role of prevention in the onset of chronic diseases which can delay or reduce the severity of dependence is underestimated. Intervention usually employed within the framework of health psychology for prevention and treatment of diabetes, strokes, and heart attacks, etc., would be an element of primary treatment, since many of these diseases have a behavioral component, as is the case of obesity, smoking, sedentary lifestyle and other unhealthy practices.

In this line of thinking, it must be also considered that the high prevalence of diseases among the elderly causes a very high consumption of drugs that sometimes have important side effects, as well as unwanted drug interactions, e.g., confusion, cognitive impairment or affective flatte-

ning. These signs and symptoms are derived from the consumption of drugs which are relatively common among the elderly. Furthermore, these are factors that tend to increase the physical dependence and contribute to dependency. All this without considering the economic burden involved in many cases like the cost of purchasing medicines.

5.2. Psychological factors

Some disorders such as anxiety and, especially depression, which is dealt with in a separate section below, contribute significantly to the dependence in the elderly. It is common among older people suffering from elevated symptoms of depression that depression is often not diagnosed or inappropriately treated. However, it is well known that depressive symptomatology is associated with social isolation, physical complaints, cognitive and functional decline; and all these factors contribute to a decrease in wellness.

The suffering of pain is one of the psychological dimensions that contribute most to dependence, not only because of the direct decrease in activity, but as a consequence of the indirect effect caused on the musculoskeletal apparatus given the reduction of mobility. Furthermore, there is also a vicious circle between pain, depression and functional loss. In this sense, it is common to find in old-age people a fear of falling down, either by having experienced one or simply because the fear that falling down is supposed to result in an important source of dependence as a result of the reduction in activity. Various studies have shown that the incidence of falls increases with age, and they constitute a significant clinical problem of morbidity, mortality and costs for older adults, their family and society (Estrella et al. 2011).

Finally, there is the relevant psychological aspect of recognizing that lifetime experiences undergone by old people differ considerably in terms of their demands and acceptance of help from others in various situations of everyday life. In addition, this feature of dependent personality may increase the risk of physical and mental health disorders and, therefore, indirectly increase dependency.

Other lifestyle risk factors include smoking, obesity, and excessive alcohol consumption, overconsumption of fast food, low consumption of fruits and vegetables, and sedentary habits.

5.3. Contextual factors

Research has consistently demonstrated that the immediate social and physical conditions surrounding the elderly impact their life quality, maintain a sense of wellness and contribute to their ability to perform their work at optimum levels. By contrast, a little stimulant milieu or absence of sufficient aid from the environment contributes to undermine wellbeing.

We must also avoid language that promotes what some gerontologists have called *ageism* to refer to a prejudice consisting in characterizing someone based on his advanced chronological age. Old age is the result of a biological process, but it is also a cultural construction. A person is old, as in any other role and social status, when other people see the person as old. In the process of social interaction, other persons, through their behavior, are the mirror in which self is reflected. The reactions of others towards a person with certain pre-established stigmas convey reactions and expectations which are consistent with these ideas.

It has been suggested that the ageism is maintained by the false beliefs that prevail socially about old age, by using adjectives that negatively qualify old age, people unintentionally hinder the quality of life of the elderly.

Other contextual risks to the quality of life in the elderly are low schooling, unemployment, dissatisfaction with everyday activities, loss of social roles, loss of family, friends, spouse, feelings of loneliness, the absence of confidence, the low economic level, the sensation of inactivity, and the unsuitability to retirement.

5.4. Internal factors

5.4.1. Depression in old age

It is mistaken to believe that depressive states in the elderly are a normal and expected event associated to aging. On the contrary, many studies have shown that many old persons feel satisfied with their lives.

When it is not diagnosed in time, depression in the elderly population causes unnecessary suffering for the elderly and for their families. With proper treatment, an old person may improve his/her quality of life. Many health professionals fail to recognize mental health symptoms and focus only on physical symptoms. By using the language of wellness, professionals may facilitate that the elderly talk about their feelings and it may help to identify despair and sadness --- commonly associated with morbid depressive states--. The older people may not want to talk about their lack of interest in normally pleasurable activities, or their grief after the death of a loved one, even when their mourning lasts for long time.

Professionals have recognizing that depressive symptoms in the elderly can be overlooked easily. Also, the professionals are better at detecting depressive symptoms that are due to side effects of prescribed medication, or due to a concomitant physical illness. If the diagnosis of depression is accurate, treatment with medications and psychotherapy helps the depressed person recover his ability to have a happy and fulfilling life. Recently, scientific research indicates that once the patient has been medicated, brief psychotherapy is effective in reducing short-term symptoms of depression in the elderly. Early screening, diagnosis, and treatment of depression in old age will make this period of life more enjoyable.

Researchers indicate a prevalence of severe mental disorders in 20% of the elderly who are living in their own homes, and the prevalence of mental disorders has been reported to reach 45% in residential care (Kermis 1986). Countries such as Chile have reported a prevalence of up to 47% of depression in a sample of older adults (Salinas et al. 1994)

Depression is also more often diagnosed in older adults with lower levels of physical exercise. Actually, depression is strongly correlated with limitations such as difficulty in preparing food, bathing, and going shopping, and so on. Even a low sense of control over one's life increases depression. A setting of physical features and sense of control would eliminate some of the occurrences of depression associated with this age (Rodríguez et al. 2010).

5.4.2. Cognitive decline

Wellness is increasingly affected in the elderly by the growing number of cases of dementia: a revealing syndrome indicative of a progressive deterioration of brain tissue that affects thinking processes. Dementia affects roughly 20% of all persons over 80 years and it is becoming a problem of significant relevance in the medical and public health fields. Professional should focus on a discourse that is able to identify dementia signs, but also to discourse that supports positive thinking and focuses on remaining cognitive resources.

Memory loss is the most common and dreaded dementia sign. In fact, many elderly people feel frightened at their loss of memory, thinking that it may be the first sign of dementia which will lead them to lose their self-sufficiency and becoming totally dependent on others. Fortunately, this is not necessarily true as in many cases of memory loss there is no dementia process. Many people have had bad memory all his life and this exacerbates with age.

It should be noted that the fact that a person can feel suddenly confused does not necessarily imply suffering from dementia. This disorder is characterized by a comprehensive, progressive and significant deterioration of mental ability and deserves immediate medical action. Dementia needs a sound diagnosis with both medical and psychological procedures. In general, clinicians identified two large groups, the degenerative of Alzheimer type and the non-Alzheimer type, often of vascular or metabolic origin in which another disease may cause dementia, e.g., poor function-

ing of the thyroid gland, severe vitamin deficiencies, rare genetic disorders such as Huntington's chorea, brain infection with AIDS, increased cerebrospinal fluid and brain neoplasm.

Alzheimer's disease is the most common form of dementia, about 60% of all dementia patients suffer from it. The cause of Alzheimer's disease is still unknown, and usually begins with an alteration of short-term memory. The affected person forgets appointments, does not remember who visited him/her the day before, or what he/she has just eaten. After these signs appear, people suffering from this illness begin to have difficulties continuing with certain tasks and activities; they face language problems and find it difficult to perform calculations, to get dressed, among other daily life activities. Since these are the earliest symptoms of the disease, this process of deterioration can take between 5 and 10 years. The course is always progressive and irreversible (Zahava/ Bowling 2004).

Roughly, 15% of dementia cases are due to degeneration of the vascular system that irrigates the CNS, so nerve cells suffer from a lack of oxygen. Clinically speaking, it is not easy to distinguish between vascular and Alzheimer types and, often, both syndromes occur simultaneously. Generally, vascular dementia evolves faster, and it is usually paroxysmal in course.

6. Promoting wellness through language

In providing services to the elderly, awareness of the language used in the health discourse is relevant because language implies categorization that effectively guides our thinking and thus our deeds. When developing a specific discourse, health professionals attempt to assimilate diverse instances into a compact, simplified strategy of summarization, considering visible clues or marks which are assumed common to a group of individuals.

Actually, the language used in health care services evidences social judgment, and such judgment can be either conscious or not. The language used by professionals imposes - overtly or in thought - a dispositional quality to the individual they are servicing.

Language reflects stereotypes that convey implications in both emotional as well as cognitive terms. Focusing on ability or disability, on weakness or strengths as well as on virtues or defects makes a difference. Language referring to one or the other side of the same coin is not merely a short cut; it is the projection upon the world of our own sense, values, position and rights. Such projections are charged with feelings, for instance, when a stereotype is negative, it leads to stigma, avoidance, rejections or simply to a cold impersonal approach to the patient. When it is positive, it fosters rapport, promotes caring and acceptance, and warms up the relationship with the patient. This second venue is associated with a better prognosis, and may help establish a sense of wellbeing associated with a better quality of life.

6.1. Recommendations

Language is, in fact, often dependent upon situational conditions. The best technique for changing the content of our language is to alter the sense and purpose of the interaction with the target (Fishman 1960). Professionals willing to shift toward a paradigm of the language of wellness need to consider some central issues. The following 10 key issues are important to consider:

1. Focus on abilities rather than disabilities
2. Describe opportunities rather than limitations.
3. Talk about preservation rather than progressive involution.
4. Enrich your words with touch and physical closeness.
5. Mental and physical conditions are equally important.
6. Speak about quality of life.
7. Discuss social networks and relationships.
8. Implement thanatology and counseling actions to help people prepare to die.
9. Dialog on occupation and independence.

10. Promote pleasure! (Not only promote pain-avoidance).

In sum, the language of wellness has a positive impact on intervention because it fosters the self-fulfilling prophecy: it will happen what you expect best (Pygmalion effect). It also helps to create a positive atmosphere in service facilities that prevents burnout in health services workers.

As Rohr (2011) asserts, " Most of us think about the second half of life as getting old and dealing with losses and health issues…but it can be experienced as falling upward into a broader and deeper world where the soul has found its fullness…" (p. 153).

7. Conclusions

Although wellness is a complex issue which lacks a consensus regarding its conceptualization and measurement (García C. 2010) nowadays, it seems to be a promising paradigm to improve services to the elderly.

The language of wellness may help overcome barriers created in Latin-American countries based upon negative stereotypes toward the elderly. It may also facilitate the recognition of socially meaningful relationships and opportunities at this stage of life and may help change the general view of age as a phase of decline and social isolation towards a more optimistic and positive view of this last stage of life.

The language of wellness in the elderly should be directed to enhance the quality of relationships with family or relatives, the judgment about one's own health, the perception of the health of another close person, and the status of the financial situation and living conditions. In other words, health care professionals should speak more often about the patient's quality of life which is inclusive of a sense of positive wellbeing.

As a professional or worker in the health and medical care fields: Be aware of what you say and how you say it!

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