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COMMENTARY

Identifying strengths, globally

Lifespan is increasing internationally, and older adults suffer from an array of medical, cognitive, and psychiatric symptoms and illnesses. While medical illness and neurocognitive disorders may be readily recognized in the clinical setting, psychiatric illnesses are often missed. There are many reasons for this—poor insight of patients, inconsistencies between patient and caregiver reports, and lack of questioning. Additionally, cultural factors may impact how psychiatric symptoms are recognized and described. It is important to have standardized scales to assess psychiatric symptoms from the perspective of patients and collateral informants that are valid across societies, both for research and clinical assessment.

Rescorla *et al.* (2020), authors of "Older adult psychopathology: international comparisons of self-reports, collateral reports, and cross-informant agreement," internationally compared the Older Adult Self Report (OASR) and the Older Adult Behavior Checklist (OABCL; Achenbach *et al.*, 2004), examining self-report, informant report, and cross-informant agreement. This study is an extension of prior research by the group which evaluated cross-societal relevance of similar scales for younger adults (Rescorla *et al.*, 2016) and which also supported the generalizability of OASR across different societies (Ivanova *et al.*, 2020).

In this study, data for adults age 65 and over were obtained from OASR collected across 19 societies and OABCL collected across 12 societies, which included a wide variety of ethnic, cultural, political, and socioeconomic systems. Findings included that the most- and least-endorsed items on the OASR and OABCL were similar across societies, with cross-societal agreement for low, medium, and high ratings for items. Variance was greater for rating of emotional problems than cognitive problems, suggesting a greater cultural impact on perception and/or report of emotional symptoms. Future research should include additional societies from areas not represented in the current sample (such as African and South Asian countries) to expand assessment of cross-societal relevance of these scales.

The writers assert that the OASR and OABCL are low-cost rating scales that can be administered internationally to an older adult population. Cross-societal agreement of this scale has relevance for epidemiological research in older adult mental health, which is increasingly important as the global population ages. Although one might question the clinical practicality of a rating scale containing over 100 discrete items, items on these scales target a range of psychiatric, cognitive, and functional symptoms. If one was to clinically administer separate screens for each target symptom included in the OASR and OABCL with common scales for depression, anxiety, somatic symptoms, irritability, functional assessment, and cognitive performance, the total number of discrete items likely would exceed 100. Thus, there may be value in implementation of the OASR and OABCL as one comprehensive screening tool in a clinical setting. Cross-societal relevance is not limited to work across national borders: in an increasingly global society, clinics in many areas serve ever more culturally diverse patient populations, hence the value of studying agreement of rating scales among different societies.

The OASR and OABCL stand out among other rating scales for older adults in that they screen for patients' strengths in addition to patients' symptoms. Many of these statements emphasize physical and emotional wellness (e.g. "I feel younger than my age" and "I am a happy person"), functional independence (e.g. "I make my own meals" and "I do my own shopping"), and ethics (e.g. "I try to be fair to others" and "I stand up for my rights"). It is clinically relevant to assess patient's perceptions of health and self-efficacy. Older adults with self-perceptions of physical health as good are less likely to suffer from clinically significant depression (Vaccaro *et al.*, 2017). In contrast, poor self-perception of health is associated with polypharmacy and decreased engagement in social or cognitively stimulating activities (Machon *et al.*, 2016). Higher self-efficacy is associated with better physical and mental health outcomes (Holahan and Holahan, 1987, Blazer, 2002; Doba *et al.*, 2016). Understanding older patients' self-perceptions of physical and emotional strength and independence can be of tremendous value prognostically and in treatment planning. Despite this, patient strengths are not routinely screened for during routine office visits.

One might speculate that ageism plays a role in the clinical tendency to screen for symptoms but not strengths in older adults. Ageism, a term first used

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by Robert Butler in the 1960s (Butler, 1969), refers to discrimination based upon the perceived age of older adults and associated stereotypes. In a clinical setting, ageism may manifest by focusing on what a patient cannot do, versus what the patient can do. It may manifest by speaking loudly, assuming that an older adult has a hearing impairment. It may manifest by questioning a younger relative accompanying the patient to the visit, rather than the patient directly. It may manifest by attributing symptoms to "old age" instead of an underlying cause (Palmore, 2004).

Decades after Robert Butler coined the term, ageism persists, an example being use of the popular catchphrase "OK, Boomer" to express dismissiveness toward members of the Baby Boomer generation (Lorenz, 2019). During the COVID-19 pandemic, this slang term evolved on social media with many references to the virus as "the boomer remover" (Sparks, 2020). This expression was based on the increased risk of COVID-related morbidity and mortality in older adults and embodies the ageism that prominently emerged during the pandemic. In some countries whose healthcare systems were overwhelmed due to an extraordinary volume of patients and lack of resources, a patient's age was a consideration in the triage of access to hospital care and life-saving interventions (Ehni *et al.*, 2021).

Vale *et al.* (2020) explored the role of ageism in the pandemic and highlighted two varieties: "hostile ageism" and "benevolent ageism." Hostile ageism, referring to more negative attitudes toward older adults, was associated with lower behavioral modification (e.g. a younger person who views the pandemic as an illness of older people would be less likely to practice social distancing). Benevolent ageism, in contrast, is based on more "favorable" stereotypes of older adults. This form of ageism was associated with greater pandemic-related fear, which in turn was associated with more pandemic-related behavioral change and increased social distancing. In benevolent ageism, older adults' self-efficacy and functional independence may be inadvertently overlooked, yielding patronizing behaviors (Cary *et al.*, 2017). The use of standardized rating scales such as the OASR and OABCL to identify strengths, then, may be of benefit in a clinical context to objectively assess patients independent of any unconscious biases the interviewer may hold.

Perhaps those who employ the "boomer remover" phrase would be surprised to learn that despite physical vulnerability, older adults demonstrated tremendous resilience during the COVID-19 pandemic. Resilience is "the capacity to navigate adversity in a manner that protects health, well-being, and life satisfaction" (Kiosses and Sachs-Ericsson, 2020). As an example of resilience during the pandemic, contrary to what some with ageist stereotypes might expect, prevalence of anxiety and depression was observed to be lower among adults over the age of 65 relative to younger age groups (Czeisler *et al.*, 2021). And while others might assume that pandemic-related stressors would correlate with negative health outcomes for older adults, a variety of moderating protective factors may result in positive adaptation (Wister and Speechley, 2020).

The OASR and OABCL are comprehensive assessments that have value not only in the breadth of symptoms included in the screening but also in their emphasis on patient strengths which are far too often overlooked in clinical assessment and in society more broadly. In establishing cross-societal relevance of these tools, Rescorla *et al.* show the universal importance of recognizing these positive attributes at a time when the impact of ageism is being felt worldwide. As summarized in a United Nations Policy Brief (Guterres, 2020) during COVID-19: *"Efforts to protect older persons should not overlook the many variations within this category, their incredible resilience and positivity, and the multiple roles they have in society, including as caregivers, volunteers, and community leaders… We must do everything possible to preserve their rights and dignity at all times… bring in the voices of older persons, harness their knowledge and ensure their free, active and meaningful participation."*

Conflict of interest

The author reports no conflicts of interest to disclose.

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