

Updates from the Past 10 Years of Scholarly Inquiry on Clinical Interventions to Empower Older Women

Jennifer L. O'Brien^{1,*}

¹University of Massachusetts, Boston, Boston MA, USA

*Correspondence should be addressed to Jennifer L. O'Brien, Jennifer.Obrien@umb.edu

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Abstract

This author's contribution, "Clinical Interventions to Empower Older Women" drew on topical research related to older women's mental health and offered concrete directions for mental health clinicians to explore with older women. This commentary offers an update on the last ten years of research in this area and focuses on the impact of the COVID-19 pandemic on the landscape of older women's mental health needs and related clinical and non-clinical interventions. The results of this commentary demonstrate that older women's mental health needs have increased due to the direct and indirect impact of the COVID-19 pandemic and discusses how growth in digitalization of both clinical and non-clinical interventions post-pandemic has improved access to those interventions. Lastly, expanding on our discussion of the feminist-based lens that was emphasized in the original chapter, this commentary explains how the development of more inclusive frameworks in clinical practice can be especially effective in treating older women.

Introduction

Published in 2015, the volume "Women and Aging: An International, Intersectional Power Perspective" [1] included chapters by a range of authors on topics that spoke to the diverse experience of women's aging. In our original 2015 chapter titled "Clinical Interventions to Empower Older Women" [2], we explored gender-related factors that influenced older women's mental health through a biopsychosocial lens. We also posited that clinicians should utilize a feminist-based framework to help build on the resilience of older women and minimize the impact of stereotypes and other barriers to wellbeing. The chapter provided some specific examples of mental health interventions that could be beneficial for older women, as well as non-psychotherapeutic approaches that healthcare clinicians could suggest to their patients. In the chapter, we cited different barriers to effective treatments that could end up negatively impacting wellbeing for older women. These include lack of physical access to providers, anti-mental health stigma held by both older women and their clinicians, as well as general bias such as ageism among clinicians. In this commentary, we will discuss historical events that have shifted how older women access clinical and non-

clinical wellness interventions. We will also examine how clinicians are broadening their approach to working with vulnerable populations through a more inclusive lens, beyond feminist frameworks.

Updates on Mental Health Care Needs for Older Women

Since our chapter was published, the COVID-19 pandemic completely changed the way that healthcare and mental health services have been accessed by older adults worldwide and across different healthcare settings [3]. In 2015, we pointed to the impact of lack of physical access to healthcare as a barrier for older women, especially in terms of mental health care. Salient to this point, the pandemic created a lasting effect on mental health utilization rates, especially among older adults [4]. Prior to the pandemic, telehealth was just beginning to show promise as a means of increasing physical access to visits with healthcare and mental healthcare professionals [5]. Given the immediate need to serve patients in a socially distant format in the pandemic, the use of telehealth services through virtual video and telephone platforms expanded and almost instantly became the standard of care [6]. It was fortunate that these technologies already existed [7] because at the time of

the pandemic, the need for mental health services spiked due to increases in stress, anxiety, depression, and social isolation that many experienced in that time [8].

The mental health impacts of the pandemic relate to the direct effects which forced people worldwide into lockdown-mode for months on end [9], and thus limiting access to social support, community, and healthcare treatment [10]. However indirect effects are also thought to have stoked anxiety and depression, due to the nature of the COVID-19 virus quickly spreading throughout the globe [11], with rates of vaccine availability widely ranging throughout the globe [12]. Research since the pandemic shows that during that period, older women were at nearly twice the risk than older men for development of depressive symptoms, as well as higher risk for anxiety and loneliness [13]. These findings may correlate with the higher likelihood for older women to be either widowed or living alone, have less economic stability, or to be in a caretaking role for a spouse [14,15].

Research on mental health effects of the pandemic on older women indicates the critical need for access to quality mental health interventions [13,16]. This echoes our findings from the original chapter, but that need is now even greater post-pandemic. However, the proliferation of telehealth among mental health clinicians seems to have filled that need dramatically. Since the pandemic both clinicians and patients have embraced this technology as a suitable alternative to in-person treatment that is sometimes even preferred due to the flexibility it often allows (e.g. no need to commute to a physical office). Fortunately, studies comparing telehealth to traditional in-person mental health interventions demonstrate that telehealth delivers robust, quality care that is equally effective to in-person care [17,18]. Such findings are encouraging for older women seeking mental health treatment but who might not be able to easily access in-person treatment.

Updates on Non-Psychotherapeutic Interventions

In our chapter we discussed the role of social connection for improving the wellbeing of older women and argue here that the proliferation of digital and virtual means to social connection should be embraced as a way to increase overall access to these interventions. For instance, Sen *et al.* [19] provided evidence that virtual social connections- such as using digital devices to make video calls or text- showed could enhance the wellbeing of older adults. Of course, this is not a one-size-fits-all solution, but it is encouraging that despite stereotypes about older adults' use of technology (i.e. that they are unable to adapt to advancements in new technologies) research shows that they are able to learn, adapt and use technology at increasing rates to help expand their connection to social support [20].

Digital connections can also be an important means to gain greater access to some of the other non-psychotherapeutic

interventions we mentioned in the original chapter. Recent research in this area on older adults suggests that there is still much to learn about their uptake of digital interventions [21], but here we can point to some potential areas that provide promise. Post-pandemic life in the United States has seen expansions in digitalization as well as improved technology in the realms of organized religious practice, access to mental activity and different types of video games, and platforms for physical exercise. Campbell [22] explored the impact of the pandemic on the digitalization of church services in various Christian communities in the United States. In their study, they called attention to the "digital divide" that many churches encountered when attempting to expand services to be made available online during the height of the pandemic. This divide revealed limited access for many congregants and created some controversy within church leadership as to how to navigate around the growing needs for digitalization of their services. At the same time the study pointed out how provision of online services created greater opportunities for access to services for those who would otherwise be reluctant to attend services or would face geographical hurdles. This framework is often referred to as digital justice [23]. We argue that just as virtual services can effectively increase physical access to healthcare for older women, so can digitally access to an important source of well-being such as religious community.

Physical fitness and exercise were also explored in our original chapter as an important means of empowering older women's wellbeing. Technological advances since the pandemic have impacted the realm of fitness, and in the time since the writing of the last chapter, commercial virtual fitness apps and technologies have become commonplace worldwide [24]. These programs often provide users live and on-demand fitness classes that participants can use in a location of their choice, such as home settings. Encouragingly Neda *et al.* [25], found that virtual fitness programs were just as effective as in-person programs in a sample of older adults. A major caveat however is that virtual fitness programs- which often entail pricey subscription fees, are expensive and thus not always seen an option for many older adults [26]. These findings suggest that the transition to digital means for access to empowering resources is less than straightforward, despite the promise they show. Future work on digital justice can help to bridge the gap for older women who may be left behind by these technological shifts that grant ease of access to interventions, but usually at a cost.

Updates in Clinical Approaches with Older Women

In terms of clinical approaches to working with older women, our original chapter highlighted feminist psychotherapy as a framework in which clinicians could challenge their biases about older adults and through doing so more effectively empower them, even when using other evidence-based techniques such as cognitive behavioral therapy (CBT). We

should note here that feminist psychotherapy, or feminist-informed psychotherapy is a treatment approach that centers equity and social justice in work with all patients. It views clinical work as a means of creating an environment of equanimity where the therapist aims to neutralize any sense of power imbalance in the clinical space, helping to empower the patient who may not otherwise feel a sense of agency in other spaces in their life. Further, feminist psychotherapy is not limited specifically to clinical work with women- any therapist treating any patient can utilize a feminist approach. Updating our idea here, we argue that using a feminist lens in psychotherapy can be especially useful in addressing the needs of older women with intersecting marginalized identities-including women of color, and people identifying along the LGBTQ+ spectrum. The original chapter failed to explicitly address broader populations of older women, and in the ten years since its publication, the field of psychology has greatly expanded its focus on treating vulnerable populations and taking modern clinical perspectives into account such as: cultural humility [27], decolonization of psychotherapy [28], and affirmative psychotherapy (see Burger & Pachankis [29] for a recent review). These approaches, paired with a feminist lens which views clinical work as a deliberate form of social justice, can help to account for the specific needs of vulnerable subpopulations among older women. They also emphasize the need for clinicians to address and dismantle their own biases about those with marginalized identities. In turn, this can also improve the therapeutic relationship and lead to greater effectiveness in their interventions [30].

In the 2015 chapter, we pointed to the need for geropsychology training to help fill the gaps in terms of mental health interventions for older women, especially given the potential for clinician bias in working with this population. Although there is still progress to be made, there have been some positive updates. Band, Fitzpatrick & Steffen [31] surveyed a sample of licensed psychologists who reported that they had favorable, positive experiences working with older adults and that helped to push back the notion that clinicians have bias with this population. The American Psychological Association (APA) published updated guidelines for work with older adults in 2024 [32]. Psychologists and clinicians can use this as a guide to help reflect on their own training and educational needs and develop greater insight for ways that they can empower older adults.

Conclusion

The demand for mental health care for older women will continue to increase as the population ages, and as historical events shape their experiences and related mental health needs. Clinicians must continue to address their own biases and frame approaches to working with older women through an inclusive, feminist lens that is attuned to the specific needs for older women and aims to empower them by minimizing

barriers to achieving wellbeing. Technological advances and advances in clinical frameworks provide great promise toward that end, and it is our hope that psychological science can continue to evolve as it has in the last ten years, to help effectively support and empower older women.

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