



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

Name: Folashade Oyeogbe

Student's ID number: 2421280

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Lecturer: Peace Ukachukwu

Context

Transitioning to a residential care home often represents a significant life change for older adults, marking the shift from independent living to continuous, round-the-clock support. This transition is commonly necessitated by declining physical or cognitive health, reduced mobility, chronic illness, or the absence of informal caregivers. While moving into a care home can provide essential safety, regular medical supervision, and structured support, it can simultaneously challenge residents' sense of identity, autonomy, and social connectedness. Many older adults experience feelings of uncertainty or perceive a loss in the everyday freedoms and routines they previously enjoyed. Nevertheless, thoughtfully designed care environments that prioritise social engagement, personal choice, and meaningful activities have the potential to foster a positive living experience, even for individuals who require substantial assistance (Samsi et al., 2024).

The decision to enter a care home often arises from practical needs. Some residents relocate due to chronic health conditions, cognitive decline, repeated falls, or the loss of a primary caregiver who previously provided day-to-day support. In other situations, admission follows a crisis event, such as a sudden illness or hospital discharge, when the demands of care can no longer be safely met in the individual's home environment. Residential care facilities are typically staffed around the clock by trained professionals and may be purpose-built or adapted to accommodate accessibility, safety, and health requirements, particularly for older adults with complex or multiple health conditions. These provisions aim to support residents' wellbeing while meeting essential safety standards (Jenkins and Emanuel, 2018).

Despite these advantages, the transition into residential care can involve significant psychosocial challenges. Older adults may face a perceived loss of independence, increased vulnerability, and the need to adapt to structured routines that differ markedly from their previous lifestyles. Many individuals experience apprehension about relocation, often due to fears of losing autonomy, individuality, or connections with family and friends. These changes can also impact personal identity, with some residents perceiving their former life as their "real life", while others gradually develop a sense of belonging within the care setting. Consequently, supporting residents' autonomy, personal choice, and sense of agency is a key ethical priority. At the same time, care providers must address the emotional dimensions of adjustment, including insecurity, anxiety, and grief associated with ageing, dependency, and the loss of familiar routines. Effective care strategies that balance safety with personal autonomy can therefore play a crucial role in helping older adults maintain dignity, purpose, and wellbeing within residential care (Smith, 2021).

Application in the Health and Social Care context

Psychological theories of adult development and health behaviour are essential for understanding the experiences of older adults living in dementia care homes. These frameworks support person-centred practice by helping professionals promote wellbeing, dignity, and meaningful engagement, rather than focusing solely on cognitive decline. Two particularly relevant theories are Erikson's Psychosocial Theory and Baltes' Selective Optimisation with Compensation (SOC) model (McCallum, 2019).

Erikson's Psychosocial Theory: Integrity vs Despair

Erikson's theory is particularly relevant to late adulthood, as it emphasises the psychosocial task of achieving life satisfaction and acceptance. In dementia care homes, this framework supports interventions such as reminiscence and life-story work, which can enhance emotional wellbeing and reinforce identity. These approaches align well with person-centred care by valuing residents' histories rather than defining them by cognitive impairment (Erikson, 1982).

A significant limitation of Erikson's psychosocial theory lies in its underlying assumption that individuals possess the reflective capacity to consciously review and integrate their life experiences. In the context of advanced dementia, cognitive decline can severely restrict this ability, making it difficult for residents to engage in meaningful life reflection. Consequently, assessments of "integrity" often depend on interpretations by staff or family members rather than the resident's own perspective, which introduces the risk of misrepresenting the individual's subjective experience and emotional state.

Furthermore, Erikson's stage-based framework may oversimplify the ageing process by presenting it as a linear and universal progression, thereby failing to fully capture the wide variation in physical health, cognitive ability, cultural background, and social circumstances that influence older adults' experiences. These limitations suggest that the theory should not be applied rigidly. Nevertheless, when adapted with flexibility and applied sensitively to account for cognitive capacity, Erikson's model continues to provide valuable insights into supporting emotional wellbeing, identity, and meaning-making in older adults, particularly through interventions such as reminiscence therapy, life-story work, and person-centred care planning (Smith and Baltes, 2020).

Baltes' Selective Optimisation with Compensation (SOC) Model

The SOC (Selection, Optimisation, and Compensation) model provides a strengths-based framework for understanding the ageing process, which makes it particularly relevant in dementia care contexts. By emphasising the potential for adaptation, the model challenges the assumption that cognitive or functional decline inevitably leads to diminished wellbeing.

Instead, it offers a practical approach for supporting individuals to maintain autonomy and quality of life through personalised strategies. By encouraging a focus on remaining abilities rather than losses, and promoting compensatory techniques to address emerging challenges, the SOC model aligns closely with contemporary principles of dementia care, which prioritise person-centered approaches and the facilitation of positive health behaviours.

Despite these advantages, the practical application of the SOC model is heavily influenced by environmental and organisational factors. In many care settings, limitations such as staffing shortages, time constraints, and inflexible routines can significantly reduce opportunities for meaningful optimisation and the implementation of compensatory strategies. Moreover, the progressive nature of dementia can undermine an individual's capacity to actively select and prioritise goals. This shift in decision-making responsibility to caregivers can unintentionally foster paternalistic practices, where choices are made on behalf of the person with dementia rather than collaboratively with them. Consequently, while the SOC model highlights the importance of maintaining autonomy, it does not fully resolve the inherent tension between promoting independence and managing risk, which is a critical consideration in real-world dementia care (Baltes and Baltes, 1990).

Overall Evaluation

Both theories offer valuable insights into adult development and health behaviour in later life, yet neither fully captures the complexity of living with dementia in institutional care. Erikson's theory is strongest in addressing emotional and identity related needs, while the SOC model excels in guiding practical adaptations to cognitive and physical decline. However, their effectiveness depends on flexible application, adequate staff training, and supportive care environments. A combined, person centred approach that integrates psychological theory with social and organisational awareness is therefore essential for improving wellbeing and quality of life for older adults in dementia care homes (Kitwood, 1997).

Conclusion

In conclusion, the application of health behavioural theories in practice represents a complex but highly valuable undertaking that extends far beyond intuitive or common-sense approaches. Effective implementation requires recognising the multifaceted nature of human behaviour, which is shaped by biological, psychological, social, and environmental factors, particularly in older adults living with chronic conditions or cognitive impairments. Professionals must adopt comprehensive theoretical frameworks that integrate both individual and systemic perspectives, ensuring interventions are evidence-based, person-centred, and contextually relevant. Prioritising practical training and ongoing professional development is essential to equip staff with the skills needed to translate theoretical concepts into real-world

strategies. Equally important is fostering empowerment among individuals and communities, enabling older adults to actively participate in decisions regarding their care, maintain autonomy, and engage meaningfully in social, physical, and cognitive activities. By approaching health behaviour through this structured yet flexible lens, practitioners can overcome common challenges such as fragmented knowledge, time constraints, and resistance to change, ultimately promoting improved health outcomes, enhanced wellbeing, and a higher quality of life for the populations they serve (Koulouvari et al., 2025).

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