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Rehabilitation Psychology of Older Adults with Disabilities

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Abstract

A person who is older with a disability may have problems that go beyond disability. These can include ongoing and persistent pain, less mobility, reliance on other people for daily activities, loss of valued roles, feeling isolated, financial concerns, ageism, concerns for the future. Rehabilitation psychology takes on the challenge of these concerns by applying psychological knowledge to adjustment, participation, independence and/or quality of life. In this paper, authors examined the many psychological and social issues with which older patients with physical, sensory, cognitive and multiple disabilities frequently struggle and described such interventions that can be carried out in a hospital, rehabilitation center, home and community setting. The biopsychosocial model, Bandura's self-efficacy theory, the stress-and-coping model of Lazarus and Folkman, Baltes selection, optimization and compensation model and Ryff model of psychological well-being guide the analysis. The paper recognizes an important research gap: studies on rehabilitation tend to focus on mobility and basic functioning with less attention during the assessment of identity, autonomy, loneliness, meaningfulness, marital/ family relations and long-term psychological adaptation. Additionally, the literature is too limited in its focus on individuals with disabilities who are ageing onto its issues of diversity and culture, limited resources and infrastructure, and accessibility of older adults for digital services. It is suggested that rehabilitation should be person-centered, interdisciplinary, accessible and ever present in the individual's daily life to ensure effective rehabilitation. Psychological interventions including problem solving, motivational support, grief work, family counselling, peer support, foci on self-management, (SM) education, participation in the community and physical rehabilitation including AT should be combined. A simple practice framework is proposed that an ongoing cycle of assessment, shared goal setting, intervention, practice and review. The paper represents a consensus that the best rehabilitation approach is one that not only enables older adults to accomplish a task but restores their confidence, freedom of choice, social support and sense of dignity and helps them to once again enjoy a rich, fulfilling life.

Keywords: Rehabilitation Psychology, Older Adults, Disability, Ageing, Psychological Well-Being, Self-Efficacy, Coping.

Purpose and Scope

This is a narrative review and conceptual paper. It does not report a new clinical trial or invent participant data. Its purpose is to organize established knowledge into a clear framework suitable for academic discussion and future empirical research.

Contents at a Glance

- Introduction and conceptual foundation
- Psychological, social and service-related challenges
- Major theories used in rehabilitation psychology
- Research gap and objectives

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- Assessment and evidence-informed interventions
- Integrated practice model, recommendations and conclusion

1. Introduction

Population ageing is contributing to the growing population with long-term chronic healthcare issues, disability or functional limitations. Later life disability can be diagnosed after a stroke, arthritis, sensory loss, neurological disease, injury or amputation, a cardio-pulmonary illness or progressive frailty. Some people experience disability for a lifetime; others arrive to old age as they age. These groups should not be effectively thought of as psychologically synonymous. Someone adjusting after a recent loss of function may be experiencing grief, shock and uncertainty; while someone with a lifelong disability may have a strong adaptation ability and yet encounter barriers as things in the physical world, services or family changes. Rehabilitation Psychology is a area of psychology that focuses on the psychosocial issues of disability and chronic diseases. It's not to make an excuse for not being impaired nor to imply that all impairments are overcome with positive thinking. Instead, it looks at ways that personal beliefs, emotional reactions, behavior, relationships and environmental situations impact on adjustment and participation. It also facilitates the effective communication among the rehabilitation team, the setting of relevant rehabilitation goals, the engagement of treatments and the management of distress, as well as the support of long-term self-management.

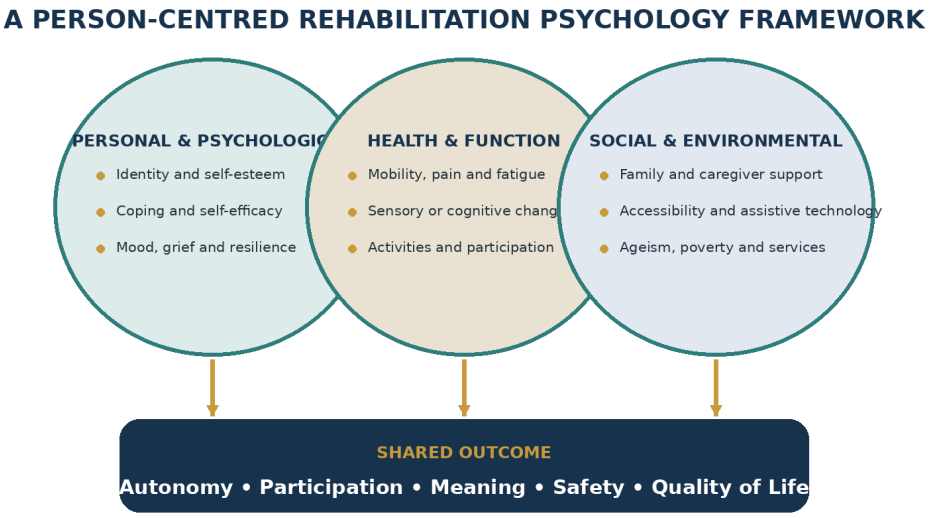

Figure 1. A person-centered biopsychosocial framework for rehabilitation psychology.

A narrow medical approach may only include meeting only the criteria of increased strength, balance or symptom control. In a rehabilitation psychology perspective, new questions raised are whether the individual is able to make choices? Are they able to maintain positive relationships? Are they empowered and secure? Can they fit in family, leisure, spiritual, civic or productive activities? The following questions expand the concept of rehabilitation from the correction of the impairment to the restoration of a lifestyle that has meaning.

2. Understanding Disability and Ageing

2.1. Disability Is Not a Single Experience

As one would expect, there is a great diversity in the population of older adults with disabilities. Disability can be physical, sensory, intellectual, or a combination of these; permanent or temporary; mild or disabling; and affect one or more functions, including mobility, speech or language, hearing, sight, thought, emotional behavior or multiple functions. Disability has other psychological connotations, too. For some, assistive equipment is a symbol of their independence, while, for others, it first comes as a measure of their loss of independence. Some have supportive families, and some live alone or rely on a carer who has only a limited amount of time and resources to devote to them.

2.2. Late-Onset Disability and Ageing with Disability

Having a disability, particularly a one with late onset, may involve a significant change in how one does things day to day. They may require a change in routine, help, cessation of driving, and/or employment change, or relocation to a more accessible home. These changes may lead to identity and control issues. A person's life goes through a different cycle when born with a life-long disability. The individual could already have good problem-solving skills and a disability identity and face increased fatigue and/or secondary health conditions, loss of long-standing carers and/or a split of care provision for disabled people and older people.

2.3. Functional Ability and Psychological Well-being

Healthy ageing does not mean that people should not have any diseases. Substantial reliance of functional ability - mobility, decision-making, relationships, contribution, meeting basic needs, valuable activity. Authenticity, mastery of the environment, purpose in life, positive relationships, personal growth and self-assurance are, therefore, aspects of psychological wellbeing. Rehabilitation that results in an improvement in the test score but the person remains alone, frightened or excluded from the community is incomplete.

2.4. A Rights-Based and Strengths-Based View

Using a rights-based approach considers older people with disabilities as active decision-makers, not passive receivers. It highlights informed consent, for instance, accessibility, reasonable adjustment and accommodation, privacy, freedom from abuse and participation in decision making. A strengths-based approach seeks to uncover current coping skills, knowledge, cultural resources, family relationships, interests and past successes. These strategies decrease the possibility they will perceive everything they see as a sign of weakness or every challenge as the inevitable progress of time.

2.5. Core Principles

- Person before diagnosis: goals should reflect the individual's own priorities.
- Function in context: barriers in the home and community matter as much as impairment.
- Autonomy with support: assistance should expand choice, not replace the person's voice.
- Adaptation rather than perfection: success may involve new methods, pacing or assistive technology.
- Continuity: psychological support should continue beyond hospital discharge.

3. Major Challenges

Too many seniors with disabilities face problems that relate to each other. There may be a reduction in activity because of pain, decreased activity can decrease confidence, decreased confidence can increase dependence, and increased dependence can increase isolation and depressed mood. Thus, rehabilitation planning should take into account that each problem cannot be dealt with separately.

Domain	Common Difficulties	Likely Psychological Effect
Physical and functional	Pain, fatigue, weakness, falls, reduced mobility, difficulty with self-care	Fear, frustration, avoidance, loss of confidence
Emotional	Depression, anxiety, grief, anger, shame, fear of dependence	Reduced motivation and poor engagement in rehabilitation
Cognitive and sensory	Memory problems, executive difficulties, hearing or vision loss	Communication problems, confusion and reduced treatment adherence
Social	Bereavement, loneliness, shrinking networks, inaccessible transport	Isolation, low mood and reduced participation
Identity and roles	Retirement, inability to perform family or community roles	Loss of purpose, altered self-image and helplessness
Family and caregiving	Caregiver burden, conflict, overprotection or neglect	Reduced autonomy and strained relationships
Environmental	Inaccessible housing, public spaces, information or technology	Dependence and preventable activity restriction
Service-related	Fragmented care, cost, travel, shortage of trained professionals	Delayed treatment and unequal outcomes
Social attitudes	Ageism, ableism, stigma and low expectations	Internalized stigma and exclusion from decisions

Table 1. Interrelated challenges affecting adjustment and participation.

3.1. Depression, Anxiety and Grief

Depression and anxiety can be caused by pain, decreased functional ability to be independent, unknown prognosis for health, loss of supportive relationships, loss of a loved one, or feeling a loss of usefulness to the environment. These problems are not the expected or expected when you age. Meanwhile, an excessive and premature pathologization of emotional responses should be avoided. If the loss of a vital organ is very significant, there can be a legitimate grieving process that results in feelings of sadness. Duration, level of severity, suicidal thoughts, sleeping, changes in appetite, fun/making things happy, concentration or how the person is expressing distress culturally must also be taken into account when evaluating for assessment.

3.2. Fear of Falling and Activity Avoidance

The fear of falling may remain even after the physical healing has taken place. Excessive avoidance may lead to further weakness and imbalance, reinforcing the person's sense of danger and avarice. Rehabilitation psychology can help dismantle this cycle by providing a graded approach to exposure, realistic risk education, and confidence building along with physiotherapy and occupational therapy.

4. Psychological and Social Adjustment

4.1. Loss of Independence and Control

Independence should be considered as self-sufficiency in doing everything instead of relying on any other for assistance. Older adults are able to take the first step in decision making, opting when, how, and from whom they will get help. Support imposed without consent; saying things on behalf of the person; or a focus on safety rather than dignity and preference increases psychological distress. Rehabilitative measures should differentiate what is needed from what's not.

4.2. Identity, Self-Esteem and Meaning

Disability can impact identities associated with employment, caring, physical ability, social position and household duties. When these older people ask themselves ‘who am I if am I not a good mother?', they’re asking a question. These older people ask themselves ‘who am I if am I not a good mother?', and they're asking a question. Interventions should assist the individual in developing a bridge from past and present situation, role development and ability to see contribution in terms of mentoring, decision making, relationship, creative activity, spirituality and/or community service.

4.3. Chronic Pain, Fatigue and Sleep

Attention, mood, irritability and motivation are affected by pain and fatigue. Failure to improve and worry about walking may result from repeated treatment failure. Rehabilitation involves medical management, pacing, relaxation, sleep routines, activity scheduling, and cognitive restructuring and self-management education. Aim is not to convince the individual that their symptoms are nonexistent, but to promote control of behavioral/emotional symptoms effects.

4.4. Social Isolation and Loneliness

Poor mobility, deafness, ill access to transport or bereavement may limit opportunities for contact with others. Social isolation is the social distancing; loneliness is the feeling of the inadequacy of social connections. One or zero of these may occur. Therefore, interventions should coincide with need; transport and accessibility for objective isolation, emotionally significant relationship for loneliness and communication support for sensory disability.

4.5. Caregiver Relationships

Night care can be given by family members, who often offer much needed assistance but can also lead to stress, guilt, conflict, overprotecting or abuse. Some forms of reduced independence occur by accident as a caregiver will do something that is capable of doing themselves. Some might be tired and not be able to support friend relentlessly. Rehabilitation psychologists can make communication easier, explain the roles, provide information about problem solving, discuss unrealistic expectations, and guide families to find respite and community support.

4.6. Ageism and Ableism

Ageism suggests that laziness, loss of self-sufficiency, and loss of desire can be expected as part of age. Ableism sees disability as a personal tragedy, or a lack of competence. All of these attitudes can combine to create a low target for the older person, to involve the family and professional partner in decision-making, or to ignore treatable pain and depression, causing workers and families to aim lower than they should. UN Universal Rights-based practice is an integral psychological intervention as social attitudes directly influence on social self-belief and social participation.

5. Theoretical Foundations

Theory provides an explanation as to why two individuals with the same type of impairment can have different psychological outcomes. Theories that relate personal beliefs and adaptation to behavior in relation to environmental demands are particularly useful in the following:

Theory	Central Idea	Rehabilitation Application
George Engel: Biopsychosocial Model	Health and disability result from interaction among biological, psychological and social	Assess symptoms, emotions, behaviour, relationships and environment together.

	factors.	
Albert Bandura: Self-Efficacy Theory	Belief in one's ability to perform a task influences effort, persistence and recovery after setbacks.	Use achievable goals, mastery experiences, modelling and constructive feedback.
Lazarus and Folkman: Stress and Coping	Stress depends on how a person appraises demands and available coping resources.	Identify threat appraisals; strengthen problem-focused and emotion-focused coping.
Paul and Margret Baltes: Selection, Optimization and Compensation	Successful adaptation involves selecting priorities, optimizing remaining abilities and compensating for losses.	Prioritize meaningful activities, practise skills and use aids or alternative methods.
Carol Ryff: Psychological Well-being	Well-being includes autonomy, purpose, self-acceptance, relationships, growth and environmental mastery.	Measure success beyond symptom reduction and physical function.
Laura Carstensen: Socioemotional Selectivity	As time is perceived as limited, people often prioritize emotionally meaningful goals and relationships.	Support quality of relationships and personally meaningful participation rather than activity for its own sake.

Table 2. Psychological theories relevant to rehabilitation of older adults with disabilities.

5.1. Integrating the Theories

These theories are complementary: According to the biopsychosocial model, there are existing overarching domains that need to be taken into consideration. The theory to be used is stress and coping theory that examines emotional responses to disability. Motivation and persistence are explained in terms of self-efficacy theory. The selection, optimization and compensation model offers an approach to adjusting goals in a practical manner. The notion of well-being, identity and purpose are maintained in the model and the socioemotional selectivity theory accounts for the kind of emotional significance given to relationships.

Variations in use of a place of worship after a stroke could include physical, fear of falling, embarrassment due to changes in speech, or reduced mobility for transportation. An older person whose attendance at a place of worship has ceased, for example, following a stroke, may have physical issues, fear of falling, embarrassment caused by changes in their speech, or reduced ability for transport. A holistic approach can entail mobility training, gradual exposure, speech therapy, family assistance, accessible modes of transport, and adjusting their role in the community. There is no single theory for these, but they are a guide to a realistic plan.

6. Research Gap

Much is known already about ageing, disability and rehabilitation in social care, but there is still significant research to complete that needs to be done. First, much of the rehabilitation literature tends to emphasize physical aspects of rehabilitation alone—such as walking speed, strength, activities of daily living or hospital re-admission. These measures have value but can't indicate whether that person experiences a sense of autonomy, connectedness to others, a sense of being respected, a sense of hope for renewal or a sense of having meaningful roles.

Secondly, the literature frequently lumped older adults with disabilities together. It fails to respond to differences among people with a late onset of disability, ageing with a lifelong disability, physical, sensory, cognitive and multiple disabilities. Access and adjustment might also be affected by gender, poverty, rural residence, caste or ethnicity, culture, sexuality and family structure; however, these forms of difference are rarely included in analyses.

Third, psychological services are often divorced from physical rehabilitation services. Depression, anxiety, and pain-related fear and caregiver conflict may be recognized but left untreated along the rehabilitation pathway. A number of programmed are dependent on referral to specialist mental health services, the

availability of which is limited, expensive, inaccessible to people with mobility/hearing/visual/crippled ability and/or cognition. Fourth, relative to low- and middle-income countries, there is more research evidence from high-income countries.

Each of these factors may work differently in community rehab, in a family, in informal care, in poverty, and where transport is limited and/or there is a shortage of trained people. Well-resourced clinic interventions may not easily translate to rural and lower resource settings. Fifth, digital rehabilitation and telepsychology have grown, but older people with disability are potentially at risk of experiencing negative exclusions because of poor connectivity, inaccessible software, limited digital literacy, sensory impairments and can't afford the tools. Common approach to studies is to recruit users who already know how to use the technology, thus underestimating barriers.

Lastly, long-term effects have not been adequately researched. Short programmed have been shown to help with the mood or confidence but there is less evidence as to the ongoing benefits after 6 or a year later or whether they will still be seen if health deteriorates or there are changes in the organization of care. Longitudinal, culturally appropriate, and participatory designs involving older adults with disabilities in determining outcomes and interventions should be used in future research.

6.1. Objectives of the Paper

- To explain the psychological, social and environmental challenges experienced by older adults with disabilities.
- To connect major psychological theories with rehabilitation practice.
- To review practical psychological and multidisciplinary interventions.
- To identify research gaps and propose priorities for person-centred services.

6.2. Guiding Research Questions

- Which psychological and social factors most strongly influence rehabilitation adjustment?
- How can established psychological theories guide practical intervention?
- Which interventions support autonomy, participation and psychological well-being?
- What changes are required in future research and service delivery?

7. Assessment and Person-Centred Planning

Assessment should be collaborative and proportionate. A long list of tests can exhaust an older adult and may not improve care. The purpose is to understand the person's current functioning, priorities, strengths, barriers and risks. Communication accommodations are essential, including large print, hearing support, plain language, additional time, interpreters, visual prompts or involvement of a trusted supporter with the person's consent.

7.1. Core Areas of Assessment

- Presenting disability, pain, fatigue, sleep, medication effects and functional limitations.
- Depression, anxiety, grief, trauma, fear of falling, anger and adjustment.
- Cognition, decision-making capacity, memory, communication, hearing and vision.

- Activities of daily living, mobility, community access and valued participation.
- Self-efficacy, coping style, motivation, health literacy and previous adaptation skills.
- Family relationships, caregiver stress, social support, loneliness and risk of abuse.
- Home accessibility, transport, finances, assistive devices and service access.
- Personal goals, culture, spirituality, identity, roles and sources of meaning.

7.2. Shared Goal-Setting

Goals should be specific in that they can be used to help direct the person's behavior, and significant in that they concern values that are important to the person. Clinical targets are things like 'improve mobility' and meaningful goals are like 'walk safely to our nearby garden with my granddaughter'. Common objectives facilitate engagement: the link between exercises and psychological strategies and real-life situations. If a goal is not feasible anymore, the team should support the person to make the goal more attainable without "sounding" like they are failing.

7.3. Useful Outcome Domains

Domain	Examples of Outcomes
Function	Daily activities, mobility, falls, use of assistance
Psychological health	Mood, anxiety, confidence, coping, fear of falling
Participation	Family, social, leisure, spiritual and community roles
Quality of life	Satisfaction, dignity, comfort, choice and safety
Caregiver outcomes	Burden, confidence, conflict and support needs
Environment	Home accessibility, transport and assistive technology use

Table 3. Outcomes that extend beyond impairment alone.

7.4. Risk and Safeguarding

Assessment should cover suicidal thinking, self-neglect, misuse of medications, strain of the caregiver, financial exploitation/abuse. Risk management can't take away autonomy; it has to be respectful. The least restrictive response to ensure safety should be utilized, should be documented and should be appropriately referred.

8. Psychological Interventions

8.1. Psychoeducation and Supportive Counselling

Good communication can minimize fear and feelings of responsibility. Psychoeducation can include a description of the condition, typical emotional responses, pacing, relapse prevention, assisting individuals with communicating with her/his providers, and utilization of assistive devices. Grief and changes in identity, together with anger and uncertainty, can be expressed in supportive counselling. It's particularly helpful when times get stressful, like when people move away, or when they retire from driving, or move into an assisted living facility.

8.2. Cognitive-Behavioral Strategies

CBT can challenge unhelpful thoughts such as 'I'm useless I need help' or if I move, I will fall. The therapist doesn't minimize real risk or loss. Rather, the individual is taught to look at evidence, develop balanced thoughts, plan for meaningfully engaged activities, address practical problems, and begin to confront

activities that they are avoiding. When the child has a cognitive impairment, methods may be simplified and require repetition and/or written prompts and caregiver assistance.

8.3. Problem-Solving and Problem Adaptation Therapy

The solving approach process is taught for problem solving: Define the problem, list of alternatives, evaluate pros and cons, choose a step, take action, Review. For older adults with depression and cognitive decline and disability, Problem Adaptation Therapy extends this approach through the work with adaptations to their environment, compensatory tools and the involvement of caregivers. There is some evidence that these activities carried out at home can reduce the symptoms of depression and disability in those who are well-suited to use of this type of intervention.

8.4. Self-Efficacy and Motivational Support

Self-efficacy is increased with successful experience. Rehabilitation exercises should therefore be graded and give the person “room to grow”. Peer demonstrations, supportive legit professionals and understanding of bodily sensations are also important. Motivational interviewing can be useful when it helps to support the person with ambivalence for exercise or for helping to adopt an assistive device or behavior change. Uses values and reasons for change not pressure or blame.

8.5. Pain, Fatigue and Stress Management

Relaxation breathing, attention management, pacing, planned rest, pleasant activity scheduling and sleep routines are some of the interventions. Treatment based on acceptance can lead the sufferer to minimize the fight with the symptoms but retain the meaningful activity within limits. These should be in relation to medical and physical treatment.

8.6. Life Review, Meaning and Grief Work

Sensory integration of past accomplishments, failures and experiences in relationships creates the sense of self in life review and reminiscence. It's not about looking back in anniversary but about finding what has stayed the same to inform the now of adaptation. Grief work can refer to losing loved ones, illness, losing a loved one's roles, or "ambiguous losses" like the phasing or slowing down of mental or physical functioning.

9. Social, Environmental and Multidisciplinary Interventions

If the person continues to live in an inaccessible environment, psychological intervention is unlikely to be effective. Rehabilitation Psychologists should collaborate with Physiotherapists, Occupational Therapists, Physicians, Nurses, Speech & Language professionals, Social Workers, Rehabilitation Counsellors, Community workers & caregivers.

Intervention Area	Examples	Psychological Contribution
Occupational and environmental adaptation	Home assessment, task simplification, adaptive equipment, energy conservation and falls prevention	Improves mastery and reduces avoidable dependence
Physical activity and graded rehabilitation	Strength, balance, mobility and endurance programmes adapted to health status	Supports mood, confidence, participation and function
Assistive technology	Mobility aids, hearing and vision support, communication devices, medication reminders	Compensates for loss and increases autonomy when properly fitted and accepted
Family and caregiver intervention	Education, communication training, role negotiation, respite and coping support	Reduces conflict and caregiver burden; protects autonomy
Peer and group support	Condition-specific groups, activity groups, mutual aid and mentoring	Normalizes experience, models coping and reduces isolation
Community participation	Accessible transport, volunteering, leisure, spiritual	Restores identity, belonging and

	and civic participation	meaning
Tele-rehabilitation	Telephone or accessible video support, remote monitoring and guided home practice	Extends reach but requires digital accessibility and alternatives
Case management	Coordination across health, disability, social care and welfare services	Reduces fragmentation and missed follow-up

Table 4. Interventions that combine psychological, functional and environmental support.

9.1. Family Involvement without Loss of Autonomy

Teaming up with families to ensure student integration with equal rights and opportunities (no loss of autonomy) The participation of the family is best when the elder person is in control of information shared and is engaged in decision making. Caregiver reinforcement of practice; support routines, and notice changes in mood. In instances where professionals are worried about coercion, abuse, or overprotection, however, there should be a private meeting between the older adult and the professional as well.

9.2. Community-Based Rehabilitation

Models that involve partners within the communities are valuable when providers of specialist services are scarce. Basic psychoeducation, monitoring for mood and involvement, helping to solve family problems, and linking them to health, welfare and disability services, all of these are skills that can be trained by community workers. Specialized mental health support, through supervision and referral, is required for complex/combined mental health needs.

9.3. Accessible Tele-Rehabilitation

Digital services may lessen travel or help with continuity; however, they are not an either or. Platforms should have captions, screen-reader-friendly, easy-to-navigate, easy-to-read text, lower bandwidth options and caregiver training as needed. People who are "left behind" by technology are still connected by telephone sessions and home visits.

10. An Integrated Rehabilitation Psychology Model

A useful service model is a recyclable not a linear one. An older person's health and things they value and their support network evolve with time. Assessment and intervention needs will thus need to be reviewed on a number of occasions, particularly since hospitalization, going down, up or out of things, change of caregiver and bereavement.

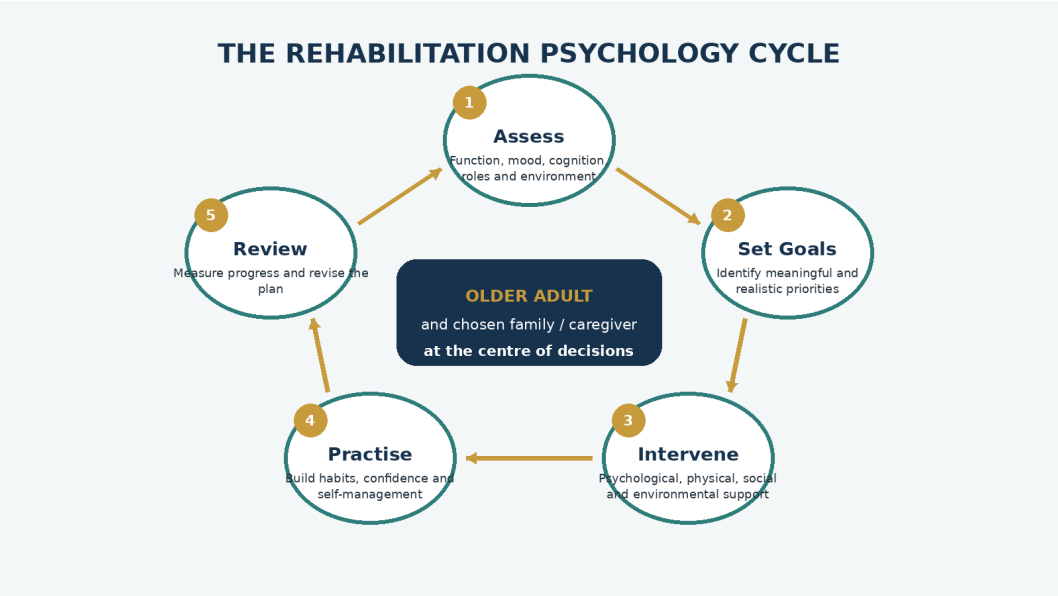

Figure 2. A continuing cycle of assessment, shared goals, intervention, practice and review.

- **Stage One:** Assessment: The team identifies functional, psychological, cognitive, social and environmental needs, together with strengths and risks. The older adult's own account is central.
- **Stage Two**: Shared Goals: Priorities are translated into realistic goals connected with everyday life. The team clarifies what success would look like from the person's perspective.
- **Stage Three:** Integrated Intervention: Psychological strategies are delivered alongside physical, occupational, medical and social interventions. Barriers such as transport or caregiver strain are addressed rather than treated as outside the rehabilitation plan.
- **Stage Four:** Practice and Self-Management: Skills are practiced in the real environment. Written plans, prompts, assistive technology and family support may be used. Mastery experiences build confidence.
- **Stage Five:** Review and Adaptation: Progress is evaluated using functional and psychological outcomes. Goals are continued, modified or replaced as circumstances change. Adaptation is treated as intelligent adjustment rather than failure.

11. Discussion

For future disability-related outcomes the literature shows that it is not enough to be diagnosed; further factors play an important role. Psychological adjustment is mediated by the understanding of the condition as well as degree of control, meaningful roles, quality of support and environment access. For this reason, rehabilitation programmed, may yield varying degrees of involvement, and hence different quality of life.

One of the mechanisms is self-efficacy. Persist with older adults who are convinced they can manage their symptoms, exercise and solve their everyday problems. Professionals should not adopt self-efficacy language to point fingers at those who are unable to get a safe place to stay or fail to escape from poverty or receive services.

Confidence is something that comes from REAL opportunity, success and help from the environment. The selection, optimization and compensation model is particularly applicable. Selection enables the individual to concentrate small quantities of effort on worth-while targets. Optimization requires practice, health management and make the most of the other abilities. Compensation is equipment, changes to the

environment, helpers or alternative methods. This model takes decisions on loss seriously, and distinguishes adaptation and agency.

Psychological intervention can work best when it comes to life every day. While it might be helpful to have one of these subjects discussed at a clinic, without having access to transportation it will make it hard for them to maintain the discussion on their own. Balance training and practice at the home or the community works better if complemented by therapy for fear of falling. Depression treatment may involve pain management, caregiver involvement and re-establishment of meaningful activity.

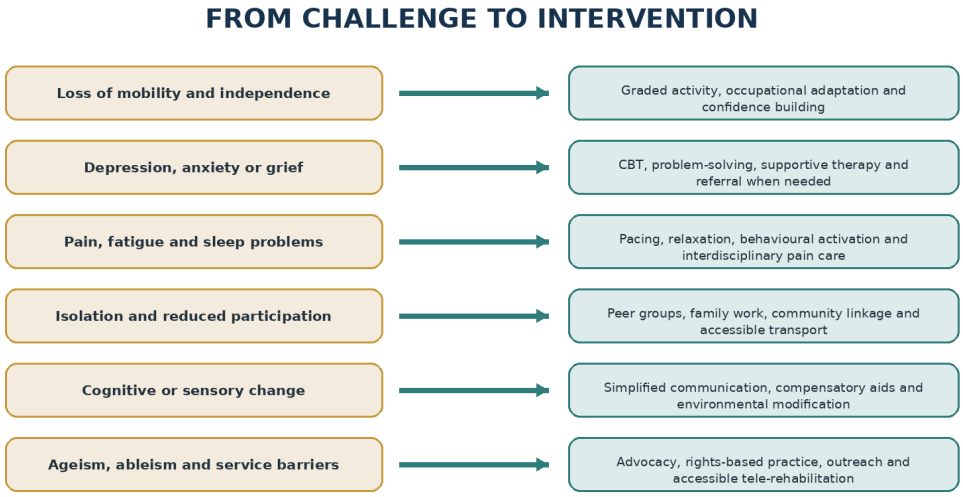

Figure 3. Matching common challenges with integrated interventions.

The discussion also highlights the importance of prevention. Early identification of fear, low mood, caregiver strain and social withdrawal may prevent a cycle of inactivity and dependence. Routine screening should therefore be built into rehabilitation services, with clear pathways for brief intervention and specialist referral.

12. Practical Implications and Recommendations

- Include psychological screening and intervention as a routine part of geriatric and disability rehabilitation.
- Use goals based on meaningful activities and social roles, not only clinical test scores.
- Train teams in ageism, ableism, accessible communication and supported decision-making.
- Provide home- and community-based options for people unable to travel.
- Support caregivers while protecting the older adult’s autonomy and privacy.
- Offer non-digital alternatives alongside accessible tele-rehabilitation.
- Measure participation, confidence, loneliness, purpose and quality of life in addition to physical function.
- Develop culturally adapted services and strengthen evidence from low-resource settings.

13. Limitations of This Paper

It is a paper intended to provide a narrative format review and not a systematic review or meta-analysis. It provides a general review of key ideas and of selected evidence, and does not perform a calculation of pooled effects nor formally assess the quality of each study. The term 'older adult' also includes a wide age range and diverse conditions. Recommendations should, then, be individualized to the diagnosis, diagnosis-culture, local resources, and cognitive ability.

14. Future Research

Comparing the psychological needs of individuals with disability experienced during late adulthood, with the needs of those who experience disability throughout life is a suggestion for further research. There is a need for longitudinal study to produce investigation of adaptation over a number of years. Future trials should examine integrated interventions (combination of psychological intervention, physical rehabilitation, environment and caregiver support). Rural communities, individuals with sensory and cognitive impairments, limited digital access, and culturally diverse communities should be included in the research. Older people with a disability need to be able to select the outcome and plan the service through a participatory approach.

15. Conclusion

Rehabilitation Psychology is that essential link between physical rehabilitation and living well. There may be a depression, anxiety, grief, pain, fear, isolation, change in identity, and strain among caregivers among the dangers of older adults with disabilities may come with depression. Physical rehabilitation does not sufficiently take the level of the role and associated difficulties. Care is effective when it includes functional training, accessibility to the surroundings, social participation, protection and care for rights and psychological intervention.

But total independence in all tasks is the most important outcome. This is the power of choice, life with dignity, engaging in valued life, using support without losing identity and not being overwhelmed by changes. When older adults are seen and known as a partner, rather than a patient, they become recognized as having histories, strengths, relationships and goals, not just age and disability, then they are viewed in a more positive light during rehabilitation.

Suggested Simple Conceptual Proposition

Combining person-centered psychological support, building up self-efficacy, making the environment accessible and facilitating social participation with a physical rehabilitation programmed in older adults with disabilities, facilitates better adjustment, sense of autonomy and quality of life.

References

[1] American Psychological Association. (n.d.). Rehabilitation psychology. APA Psychology Careers.

[2] Baltes, P. B. (1997). On the incomplete architecture of human ontogeny: Selection, optimization, and compensation as foundation of developmental theory. American Psychologist, 52(4), 366–380. https://doi.org/10.1037/0003-066X.52.4.366

[3] Baltes, P. B., & Baltes, M. M. (Eds.). (1990). Successful aging: Perspectives from the behavioral sciences. Cambridge University Press.

[4] Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. Psychological Review, 84(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

[5] Beard, J. R., Officer, A., de Carvalho, I. A., et al. (2016). The World report on ageing and health: A policy framework for healthy ageing. The Lancet, 387(10033), 2145–2154. https://doi.org/10.1016/S0140-6736(15)00516-4

[6] Carstensen, L. L. (1992). Social and emotional patterns in adulthood: Support for socioemotional selectivity theory. Psychology and Aging, 7(3), 331–338. https://doi.org/10.1037/0882-7974.7.3.331

[7] Ciechanowski, P., Wagner, E., Schmaling, K., et al. (2004). Community-integrated home-based depression treatment in older adults: A randomized controlled trial. JAMA, 291(13), 1569–1577. https://doi.org/10.1001/jama.291.13.1569

[8] de Vries, N. M., van Ravensberg, C. D., Hobbelen, J. S. M., et al. (2012). Effects of physical exercise therapy on mobility, physical functioning, physical activity and quality of life in community-dwelling older adults with impaired mobility, physical disability and/or multi-morbidity: A meta-analysis. Ageing Research Reviews, 11(1), 136–149.

[9] Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. Science, 196(4286), 129–136. https://doi.org/10.1126/science.847460

[10] Gitlin, L. N., Winter, L., Dennis, M. P., Corcoran, M., Schinfeld, S., & Hauck, W. W. (2006). A randomized trial of a multicomponent home intervention to reduce functional difficulties in older adults. Journal of the American Geriatrics Society, 54(5), 809–816.

[11] Kiosses, D. N., Ravdin, L. D., Gross, J. J., Raue, P. J., Kotbi, N., & Alexopoulos, G. S. (2015). Problem adaptation therapy for older adults with major depression and cognitive impairment: A randomized clinical trial. JAMA Psychiatry, 72(1), 22–30. https://doi.org/10.1001/jamapsychiatry.2014.1305Lazarus, R. S., & Folkman, S. (1984). Stress, appraisal, and coping. Springer.

[12] McAuley, E., Szabo, A., Gothe, N., & Olson, E. A. (2011). Self-efficacy: Implications for physical activity, function, and functional limitations in older adults. American Journal of Lifestyle Medicine, 5(4), 361–369.

[13] Motl, R. W., & McAuley, E. (2010). Physical activity, disability, and quality of life in older adults. Physical Medicine and Rehabilitation Clinics of North America, 21(2), 299–308.

[14] National Academies of Sciences, Engineering, and Medicine. (2020). Social isolation and loneliness in older adults: Opportunities for the health care system. National Academies Press. https://doi.org/10.17226/25663

[15] Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. Journal of Personality and Social Psychology, 57(6), 1069–1081. https://doi.org/10.1037/0022-3514.57.6.1069

[16] United Nations. (2006). Convention on the Rights of Persons with Disabilities.

[17] Verbrugge, L. M., & Jette, A. M. (1994). The disablement process. Social Science & Medicine, 38(1), 1–14. https://doi.org/10.1016/0277-9536(94)90294-1

[18] World Health Organization. (2001). International classification of functioning, disability and health (ICF).

[19] World Health Organization. (2015). World report on ageing and health.

[20] World Health Organization. (2024). Rehabilitation: Fact sheet.

[21] World Health Organization. (2025). Mental health of older adults: Fact sheet.