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Abstracts

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to the Joanna Briggs Institute guidelines. The research was carried out in the Virtual Health Library, CAPES Journal Portal, Latin American and Caribbean Health Sciences Literature (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE), American Psychological Association (Psyc Net), and Education Resources Information Center (ERIC). Indexed search terms included: Cognitive Reserve AND Cognitive Decline AND Elderly AND NOT Dementia. A total of 214 articles were identified, with 64 selected for analysis. The results showed that the topic is studied in Asian countries (China, Japan), Oceania (Australia), Europe (Italy, Spain, France, Sweden, United Kingdom), and the Americas (United States, Mexico, Argentina, Chile), highlighting the need for studies in Brazil. Methodological designs are predominantly longitudinal, using neurological (Magnetic Resonance Imaging) and neuropsychological assessment tools (Mini-Mental State Examination, Trail Making Test). Key findings indicate that Cognitive Reserve is developed through multiple factors such as lifestyle, cognitive and executive function use, higher educational levels, occupational complexity, bilingualism, physical activities, and social engagement. The study concludes that Cognitive Reserve is a protective factor that can help prevent dementia and other neurological diseases and should be fostered in elderly rehabilitation programs.

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Boost your health with a click! MyPocketHealth app as a tool to promote healthy behaviors

Maria Elide Vanutelli¹, Roberta Adorni¹, Francesco Zanatta¹, Marco D'Addario¹, Patrizia Steca¹

¹University of Milano-Bicocca, Department of Psychology, Italy

Mobile health (mHealth) interventions are becoming increasingly widespread in promoting individual well-being. Mobile apps offer accessible and personalized tools to monitor and improve health, encouraging positive behaviors. However, clear evidence of the effectiveness of mHealth programs is needed. The aim of the present work is to assess the efficacy of two protocols based on the Health Action Process Approach (HAPA). The protocols are delivered through the "MyPocketHealth" app developed by the research team and involve increasing fruit and vegetable portions (F&V), and daily steps (DS) by using tailored communication. The first study phase (I) consists in profiling participants based on the variables from the HAPA model, including self-efficacy, risk perception, and outcome expectancy. Also, baseline behavior is assessed in terms of the average number of portions or steps. Second (II): participants set either a personalized or the recommended goal (5 daily portions/7000 daily steps: goal setting). Third (III): for 14 days, participants receive tailored (T) or standard (non-tailored; NT) notifications about the target behavior. At the same time, they keep track of the behavior daily via a tracker (self-monitoring). A third group only tracks the behavior (no communication group; NC). When the goal is achieved, participants receive a badge that reinforces behavior. Finally (IV), psychological variables are assessed again as in phase (I). We expect that tailored communication can have a positive effect on both behavior implementation and psychological variables. This approach is not without limitation. The use of self-report methodology for behavior monitoring may suffer from potential bias, such as social desirability. However, it is widespread, practical, and sensitive in capturing subjective experience. At the same time, these protocols can be considered innovative since they combine a theoretical, solid framework together with tailored communication to boost healthy behaviors that can easily be scaled to a wider population.