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A Comparison of Cognitive Group Therapy to Life Review Group Therapy With Older Adults

DISSERTATION

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Chapter I

Introduction

Longevity.

The stereotypical notion of aging as a gradual winding down of activities and a withdrawal from society at the age of 65 is a fallacy that propagates an impoverished myth of older adults. Currently, it is common for older adults to live in good health for twenty to thirty years past the conventional retirement age of sixty-five.

Due to advances in science, medicine, and health-care, nearly 80% of Americans will live beyond sixty-five. The average life expectancy for males is seventy-six and females, seventy-eight. Today, approximately 1 out of 9 people are over 65, but by the year 2030 as much as 1 out of 5 will be over 65 (Dychtwald & Flower, 1989). Increased longevity brings a new spectrum of biopsychosocial concerns, which need to be addressed to enable older adults to have an optimum quality of life.

Psychological factors.

The aging process is accompanied by significant biopsychosocial changes which raises numerous concerns for older adults. Issues of loss, self-identity, quality

of life and ability to cope with the changes due to aging are a few of the prominent psychological concerns. For older adults who enter a nursing home or a personal care center the issues of aging are compounded by additional psycho-social challenges and adjustments.

The transition to a nursing home or personal care center often begins with an illness or accident whereupon the individual needs assistance to take care of himself or herself. The psychological ramifications of illness and the transition into a personal care or nursing home can have traumatic effects for the individual. The alteration of the older adults' physical abilities, living arrangements, and network of friends and intimate relationships can beget a sense of psychological instability, and bring about a need for reappraisal of one's sense of identity and life goals.

For older adults, depression is the psychological problem of greatest frequency and magnitude (Myers, 1989, p. 41). It is often prompted by a physical or emotional loss. In the recent psychological research there has been noted a significant relationship between physical illness and depression. Those who are physically ill have a greater chance of being depressed (Borson, 1987),

and those who are depressed have a greater susceptibility to be ill (Haag & Stuhr, 1987).

Chronic illness.

Eighty percent of the older adult population have at least one chronic condition and nearly half of the senior citizen population are unable to perform some activities of daily living (Ebersole & Hess, 1990). Those with chronic health problems are frequently subjected to secondary depression related to the disease process. Older adults suffering from chronic, debilitating, physical health problems often enter nursing homes and personal care homes for assistance in activities of daily living and nursing care. At this time only about 5% of older adults live in a nursing home and the average age of admission to the home is 80 (Dychtwald & Flower, 1989). But, with the increase in the lifespan due to the advances of medicine, within the near future there will most probably be an increase in the number of people needing assistance in their activities of daily living and entering personal care homes and nursing homes.

Biopsychosocial needs.

Abraham Maslow's hierarchy of needs range from the most basic need of survival and physiological concerns to

safety needs, to belonging needs, to self-esteem needs, to self-actualization which he claims to be the highest level of human motives (Carson, Butcher & Coleman, 1988). As an individual is able to satisfy needs at each level, he or she is then able to progressively develop on the next level. If an individual becomes preoccupied with certain base needs, higher order needs become ancillary considerations. For many, self-actualization is an uncommon goal because of their struggle at more fundamental levels.

Examining the biopsychosocial changes in aging, from the perspective of Maslow's hierarchy of needs, we can pinpoint issues of major proportion and concern which can lead to symptoms of depression, anxiety and related psychological problems. Maslow's hierarchy of needs related to issues facing older adults are:

1. Physiological needs. At the most basic level of the hierarchy, physiological needs related to the individual's biological integrity is threatened with chronic illness or other health concerns.
2. Safety needs. At the next level "safety and security" are questioned when moving to a new and unfamiliar residence. It is most evident for

individuals who had lived alone or with a spouse and who have to adjust to living with strangers in a dormitory style setting or sharing a room.

3. Belonging needs. When an individual's home setting changes their feeling of belonging within a community and with friends may change which can effect their sense of self-worth and relationship with others. Also, as friends and relatives pass away an individual's sense of belonging and place in the family and community may need to be redefined.
4. Esteem needs. Self-esteem which was previously based on a lifestyle, a history of work and relationships may be effected by the circumstances brought about by aging and significantly impact upon a person's sense of self-worth. At this time there often is a need for reevaluation of one's sense of self, purpose in life, relationship to and responsibility for oneself and others.
5. Self-actualization. At the peak of the hierarchy, self-actualization needs are often not attended to because of precarious health

conditions, often less than optimum living situations and unfulfilled needs at more basic levels which are the focus of the individual's attention and energy.

Statement of the Problem

To address the multifaceted issues of older adults, psychotherapeutic intervention, be it behavioral therapy, cognitive therapy, insight-oriented therapy, brief therapy, supportive therapy or a related branch of psychotherapy, has been found to aid older adults to cope and optimize their abilities in meeting the needs of the situation (Belsky, 1990). Unfortunately, only a small proportion of older adults seek counseling and psychological assistance. In 1971 the American Psychological Association estimated that approximately 15% of older adults were in need of mental health services (Butler & Lewis, 1977). But, older adults constituted only 5% of visits made to mental health clinics and 2% of visits in private practice offices of mental health care professionals (Nesbit, 1987). Many older adults may discuss mental health concerns with their primary physician and possibly receive medications for related symptoms, but may not obtain the needed

psychological assistance to alleviate or resolve root issues, or address how to cope with related problems.

During their retirement years, due to the vast number of changes in their life, older adults are facing a period when they may possess the least amount of emotional and financial resources. This is a time when they feel the most fragile psychologically while facing one of the most difficult experiences in their lives. Older adults who live in personal care and nursing homes may be contending with various health problems, dealing with issues of grief and loss, changes in their social and physical environment and can face various psychological conflicts on several biopsychosocial levels. These psychological issues may be aided through counseling. A counselor can assess the individuals needs, coping abilities, responses to the environment and develop and implement a treatment plan to aid the older adult (Myers, 1989). But, older adults who live in personal care homes or nursing homes are often not as mobile as those who live in the community and who have easier access to a mental health or other counseling centers. It is an additional burden for them to arrange for transportation to a clinic and one which may

psychologically deter them from seeking help. Therefore, it would be most advantageous to bring counselors to a nursing home or a personal care center rather than trying to bring the residents to mental health centers. Having counselors come to nursing homes would offer more discretion for residents who may feel embarrassed in going to a mental health clinic. Also, the proximity of the counselor may enable more residents to more easily avail themselves of receiving professional mental health services.

Purpose of the Study

The purpose of the study is to compare the effectiveness of two types of group therapies, cognitive group therapy and life review group therapy, in aiding older adults who reside in a personal care home. The effectiveness of the group therapies will be examined in two psychological domains, depression and life satisfaction.

Cognitive group therapy has been a useful treatment for older adults and others coping with depression (Rush, Beck, Kovacs, Weissenburger, & Hollon, 1982). Cognitive therapy focuses on replacing dysfunctional thought patterns, which negatively affect the state of the

individual, and replaces them with more functional, ego-syntonic, adaptive cognitive schemas and thought patterns.

Life review therapy focuses on a systematic retrospect of life experiences. The therapy engages in the validation and reassessment of one's life experience toward the goal of further self-understanding, resolution of conflicts and issues, and reconciliation with people. Life review group therapy has been used extensively with older adults, but its effectiveness in aiding in depression, coping, and life satisfaction has not been assessed relative to cognitive therapy.

A comparison of life review group therapy to cognitive group therapy should show areas of strength and weakness for each therapeutic orientation. Therefore, a comparison of therapies, using valid dependent measures, will provide a guide for therapists in deciding upon the appropriate use of cognitive group therapy and life review group therapy with older adult populations.

Research Questions

The study is designed to address the following question. With older adults, will life review group therapy, as compared to cognitive group therapy, result

in differences in treatment gains in subjects' level of depression and life satisfaction?

At the end of treatment, both therapies, life review and cognitive therapy, are expected to demonstrate two significant findings in varying degrees:

1. a decrease in the depression rating on the Beck Depression Inventory, and
2. an increase in the Salamon-Conte Life Satisfaction in the Elderly Scale score, indicating an increased level of life satisfaction.

Limitations of the Study

1. The subjects from the study come from one personal care home in Salem, West Virginia which may not be a representative sample of senior citizens in personal care homes.
2. To provide an equal distribution of subjects in each group, the groups were balanced for gender and age grouping (young-old, old-old). But the groups were not balanced for differences in income, education, ethnicity or religion which may be significant variables.
3. The age category young-old is considered to be between

65 and 75. I have stretched the category to include personal care home residents between ages 50 to 74. The rationale for this decision is because many personal care home residents between the ages of 50 and 64, who due to illness, have to face similar psycho-social issues that community based retiring adults have to cope with at the age of 65. Therefore, the young-old age category within this study is not equivalent to the criteria other researchers use for studying the young-old and these findings may only be generalizable to young-old individuals between the age of 50 and 74 who reside in a long-term care facility.

4. Due to the limited amount of subjects at the facility, and in order to keep the size of the group between 8 and 10 subjects, the author was not able to employ an attention placebo control group. The principal investigator did employ a standard control group of 8 subjects who received no treatment.

An attention placebo control group would have consisted of a group of subjects who are engaged in a cognitive verbal activity such as a current events group, for comparison with the group therapies. Commonly known as the Hawthorne effect, subjects may

alter their behavior because of the researchers' attention regardless of the treatment (Morris, 1990). This factor could be assessed by an attention placebo control group.

5. The study compares life review therapy to cognitive therapy within the context of group therapy. Due to the group dynamic variable, which is not present in individual therapy, to generalize the results of the study to individual therapy may be questionable, and lack validity.
6. The life review therapy protocol has not been standardized, but rather various related versions are used by professionals in the field of gerontology. The protocol for the research project is adapted from the work of Dr. Haight (1988) which is one of the most up to date versions of life review. Dr. Haight's life review program is based on the work of the pioneers in the field of life review such as Robert Butler (1963), Bernice Neugarten (1961), Morton Leiberman and Sheldon Tobin (1983).

Definition of Terms

Older Adults: Individuals who are between the age of 50 and 100.

Young-old: Young-old will refer to older adults between the age of 50 and 74.

Old-old: Old-old will refer to older adults between the age of 75 and 100.

Cognitive therapy: This therapeutic orientation focuses on thought patterns which affect the cognitive and affective state of the individual. The outlined protocol developed by Yost, Beutler, Corbishley & Allender (1986), focuses on cognitive therapy interventions within a group process format, specifically addressing problems of the elderly.

Life review therapy: Life review therapy focuses on a systematic retrospect of the subject's life experiences. The therapy engages in the validation and reassessment of one's life, toward the goal of further self-understanding, resolution of conflicts, and reconciliation with issues and people. The life review protocol is adapted from Barbara Haight's Life Review and Experiencing Form (Haight, 1989) and is used within a group discussion format.

Biopsychosocial: The biopsychosocial perspective looks at the interaction of the biological, psychological and social influences on the individual.

Level of Depression: The level of depression refers to the severity of depression due to various depressive symptoms. Depression is assessed in the Beck Depression Inventory by the following characteristics: mood, pessimism, sense of failure, self-dissatisfaction, guilt, punishment, self-dislike, self-accusations, suicidal ideas, crying, irritability, social withdrawal, indecisiveness, body image change, work difficulty, insomnia, fatigability, loss of appetite, weight loss, somatic preoccupation, and loss of libido (Beck & Steer, 1987).

Life Satisfaction: Life satisfaction is a measure of subjective well-being. In the Salamon-Conte Life Satisfaction in the Elderly Scale, life satisfaction is characterized by 8 factors: pleasure in daily activities, meaning of life, goodness of fit between desired and achieved goals, mood tone, self-concept, perceived level of health, financial security, and social contact.

Chapter II

Literature Review

The following chapter will focus on developmental issues facing older adults who live in long-term care settings, specifically examining two of the most prominent issues, loss and grief. Furthermore, it will describe two therapeutic treatments, cognitive therapy and life review therapy, which address the psychological needs of the elderly. Specific topics covered in this chapter are: developmental life span issues, young-old vs old-old, grief and loss, clinical incidence of grief, psychoanalytic perspective of grief, group therapy intervention, life review therapy, cognitive group therapy, and comparison studies.

Developmental Life Span Issues

The longevity of older adults increases their odds of experiencing unexpected health, family, social and possible financial loss or change. Unexpected change can cause psychological disequilibrium and foster additional stress. Neugarten and Datan (1975) claim that the stressful impact of an event is less intense when the change in on time and expected as compared with an unexpected event.

Prolonged stress has been cited in numerous articles to impair the psycho-social well-being of individuals and the physical health of older adults. Weg (1983) notes that the process of aging can raise blood pressure causing hypertension which is correlated with an increase risk of cerebrovascular disease, and increase cholesterol levels which is associated with an increase risk of cardiovascular disease, and lower the effectiveness of the immune system (Bylinsky, 1976) which can lead to increased incidence of cancer with age (Holmes & Hearne, 1981). Impaired cognitive capacities can be related to the inability to adapt to stress. The decrease in functioning becomes more evident among the elderly as these capacities become more central in adapting to stress (Lieberman & Tobin, 1983).

Adults who view their life as having progressive and unexpected social, financial, health and/or environmental problems with limited resources often experience their situation as unstable and unpredictable. With an increased sense of external locus of control, these factors become a contingency for depression. Furthermore, coping ability and quality of life is often dependent on whether the individual's ego-strength

continues to mature and develop or weaken and regress when confronted by life stressors (Shock, Greulich, Andres, Arenberg, Costa, Lakatta, & Tobin, 1984).

Those individuals who do not adapt and cope well are often victims of depression, illness and suicide. Though, older adults account for 12% of the population they represent about 25% of the reported suicides (Fry, 1984). Many more suicidal behaviors go unreported, disguised as drug overdoses or underdoses or death from malnutrition or dehydration (Myers, 1989).

In coping with emotional loss, aging, and disability older adults often find their biological and social families fractured or missing and their social network diminished due to sickness or relocation. Many older adults long for the emotional support, rapport and intimacy of friends, family, and social resources they were accustomed to having. In this time of their life, the accumulation of years of wisdom and experience can appear to be decimated through the turmoil of the aging process, culminating in feelings of depression, loneliness, isolation, and grief.

Living in a transitional environment and culture, the increased longevity of older adults brings new life

span challenges and needs for coping with multifaceted biopsychosocial issues. With age and increasing health concerns, they must learn to adapt and find personal meaning and fulfillment in light of diminishing psychosocial and environmental resources.

In a developmental context, Klaus Riegal (1976) theorized a dialectical approach identifying four dimensions of development that are interacting with each other throughout the life span: inner-biological; individual-psychological; cultural-sociological; and outer-physical. These four dimensions directly affect four prominent issues in aging: changing physical health (inner-biological); role changes (individual-psychological); identity changes in relation to adaptation, assimilation and accommodation to the family system, and social and environmental situation (cultural-sociological); and environmental crisis and change (outer-physical). With the increased longevity of older adults, these issues are crucial to address for continued biopsychosocial well-being.

In an ecological perspective Belsky (1980) looks at the individual through the interaction of four systems - the ontogenic, the microsystem, the exosystem, and the

macrosystem. At a time when older adults may have the most needs and least resources, the four systems have multiple factors within them and between them which interact to compound the complexity of the situation facing older adults.

The ontogenic or person oriented system focuses on the psychological, historical, and medical characteristics of the individual. The microsystem looks at the characteristics of the family (for those persons who have no living family members intimate others would substitute for family members), its structure, and the interactional dynamics between family members. The exosystem includes the influences of the formal and informal social structures and processes in which the individual is embedded, including the neighborhood (or the environment of the residential setting) and the social network. The macrosystem refers to the cultural beliefs and values that influence the person, as well as his or her exosystem and microsystem. The interactive forces of the four systems impinge upon and encompass the immediate setting, influencing the dynamics of the individual, family and/or residential facility.

Without resolution of developmental life span

transitions and progressive biopsychosocial concerns, individuals may increasingly develop chronic stress related symptoms and be susceptible to depression. As in the learned helplessness model of Martin Seligman (1975), after a series of losses or problems older adults may develop the feeling that they are helpless, unable to control their destiny and therefore become depressed (Belsky, 1990). Resolution of ongoing psycho-social challenges and conflicts in aging can offer individuals new avenues, opportunities and horizons, bringing a new vitality and sense of identity.

Young-Old vs. Old-Old

Grouping older adults into one category is a misnomer because there can be a difference of 3 or 4 generations between individuals. Due to wide spectrum of ages, older adults may be facing different psycho-social issues. To address this issues, researchers have divided the older adult population into two groups, the young-old arbitrarily defined as those people between 65 and 75, and the old-old as those beyond age 75. The young-old may be typified as being free of major disabling illnesses while the old-old are more likely to have physical and mental disabilities (Belsky, 1990).

Psychologically the young-old may have more recently faced issues of retirement and the fragility of their life as they begin experiencing losses of health, family, friends and status. The "old-old" individual, who has usually been retired for a number of years, may now be more psychologically focused on issues of physical and mental loss and illness, with an increasing awareness of death. But, both groups of individuals often look for a sense of meaning, enjoyment and a feeling of equilibrium in their life whether they have recently retired or retired twenty years ago.

The young-old individual may have been planning to retire and prepared for his or her change in life. But as he or she becomes older and enters the category of old-old, the individual may increasingly have to cope with unexpected health problems. Bernice Neugarten and Nancy Datan (1975) stated that the stressful impact of an event is less intense when the change is expected and "on time" such as preparing for retirement rather than when it is not expected and is "off time' such as sudden illness or a death of a younger friend. Therefore, the planning for retirement a young-old person does as he or she reaches 65 helps the individual to cope in

establishing one's sense of equilibrium. But, the old-old person who has to cope with unexpected health or life changes can be viewed as more vulnerable, with increased amount of stress, in coping with daily changes.

As people age and face new difficulties their coping responses may change to fit the situation (Shock et al., 1984). As the upsetting events of old age such as illness and widowhood become more unchangeable than many earlier life situations, older adults tend to use more passive strategies such as "I relied on the Lord" or "I went on as if nothing happened" (Belsky, 1990).

The old-old population is the fastest growing population in the United States (Myers, 1989). Since they tend to be the most physically frail, with possibly the least resources, they are often in most need of both mental and physical health care (Myers, 1989).

Grief and Loss

Older adults who reside in a long-term care setting, live in a home founded on the experience of loss. The move to a long-term care setting can be fraught with emotional and psychological turmoil. This includes a fear of losing one's identity, friends, possessions, lifestyle, history and personal space. By moving into a

long-term care setting the individual often comes into contact with many people who are in the final stage of life and are ill or are preparing for possible illness and loss.

With aging comes the natural consequence of many types of losses: people; possessions; status; abilities. When the emotional pain over the loss of a loved one is not mourned for and dealt with in a healthy manner it may constrict, burden and depress an individual's life. Furthermore, it can foster a fear of intimacy and an avoidance of emotional attachments to guard against further losses (Weiss, 1984). Yost et al. (1986) state that the experience of loss for the elderly may lead to increased depression, somatic complaints, medical illness, drug usage, as well as disturbing sleeping patterns, and decreasing social contacts and social functioning.

In uncomplicated bereavement, guilt, if present, is often focused on things done or not done by the survivor at the time of the death. It is common to experience difficulty in thinking or concentration, tearfulness, anxiety, brooding or obsessive rumination and even recurrent thoughts of death. Thoughts of death are

usually limited to the bereaved pondering that he or she should have died with the deceased person and now he or she may be better off dead (American Psychiatric Association, 1987).

Morbid preoccupation with feelings of worthlessness, suicidal ideation, marked functional impairment or psychomotor retardation for a prolonged duration suggests that the bereavement is complicated by the development of a major depressive disorder. Approximately one-half of those who survive losses develop clinical levels of depression (Clayton, Halikas & Maurice, 1972). In cases of a sudden and unexpected loss, the emotional shock to the individual may cause a brief reactive psychosis, denoting a sudden onset of psychotic symptoms of a minimum of a few hours to one month in duration (American Psychiatric Association, 1987).

Clinical Incidence of Grief

Loss accompanied by a grief reaction contributes to increased depression, somatic complaints, medical illness, hospital admissions, and drug use, as well as changed sleeping patterns, loss of social contacts, and decreased social functioning (Rando, 1984). Due to the stigma many older adults (especially men) feel in regard

to receiving mental health services, grief related illness often goes unreported until it is complicated by symptoms of a somatic illness and/or exacerbated by intrapsychic difficulties and/or interpersonal problems.

As much as a 40% increase in somatic symptoms has been reported to accompany bereavement (Clayton, 1974). During the first 13 months following a loss, the physical and psychological symptoms due to grief can be accountable for up to a 25% deterioration in health, with somewhat higher levels of health problems among surviving women than among men (Vachon, 1976). It is reported that two-thirds of bereaved spouses at the end of the first year of bereavement continue to have some symptoms of apathy, aimlessness, and a disinclination to look to the future (Clayton, Halikas, & Maurice, 1971).

Statistics show that approximately 80% of bereaved people are depressed and have disturbed sleep while 40% exhibit symptoms of weight loss, difficulty in concentration, and general loss of interest in daily life (Clayton, Halikas, & Maurice, 1971). In studies of bereaved people, Parkes (1971) noted that it is very common for them to suffer panic attacks and other symptoms of anxiety. Roth (1959) reported that in

examining 135 cases of agoraphobia, a bereavement or sudden illness of a close relative (usually a parent with whom the person was very dependent upon) is reported in 37% of the cases. As noted in these studies the relationship between physical illness and bereavement is evident.

Blau (1984), based on the findings of Fulconer (1941), Ogg (1976), and Shneidman (1978), states that the research suggests that in 70% of families which experience a tragic death, another member dies within an 18-month to 2 year period following the tragedy . Though the findings may appear to be an overestimate, if the percentage was cut in half and in 35% of families who experience a tragic death another member dies within a 2 year period, there are dire consequences for 1 out of 3 families. The significance of this finding can pose grave repercussions in a nursing home where residents may see many intimate friends and acquaintances pass away. The residents may become deconditioned to death or sensitized to illness to such a degree that it decreases their health and well-being.

Older adults who experience the death of their spouse, have a significantly increased risk of illness or

death within the next two years. Mortality rates increase as much as sevenfold over baseline expectancies during the first year after a significant loss (Cox & Ford, 1967). For men the risk of mortality is particularly high during the first year following the death of their wives (Young, Benjamin & Wallis, 1963); among women the rate of mortality following such a loss is initially lower but continues for a longer period of times and may increase during the second and third years as well (Cox & Ford, 1967).

In looking at grief and loss through a theoretical model, I will examine a psychoanalytical and a cognitive theoretical perspective. The psychoanalytical model was chosen because of its emphasis on the psycho-historical aspect of the individual similar to the autobiographical life review therapy process.

Psychoanalytical Perspective of Grief

Freud viewed bereavement in terms of how the psyche copes with loss through the displacement of anger that is originally targeted to the deceased but which becomes self-directed and results in depression. Freud noted that the self-reproach individuals feel upon the death of a loved one might eventuate in hysteria, obsessions, or

depression (which he labeled melancholia). The anger over the loss is displaced by self-reproaches, which actually are feelings against the loved object but have been directed to the patient's own ego. In mourning, feelings of worthlessness and loss of interest in life are based on the ego's absorption with the pain of the lost object (person), the loss of the introject (Gay, 1989).

The attachment of the libido to a particular person is shattered with the death. The bereaved must de-cathect from the lost object-relationship which is left only in memory and has now become an ego-loss. Mourning exemplifies an identification of the ego with the abandoned object (the deceased). The therapeutic resolution of bereavement is a withdrawal of libido from the object (the deceased) followed by a displacement onto another object (Gay, 1989).

Bowlby (1969) notes that in bereavement, anger and aggressive behavior increases. He claims the bereaved person, in the early stages of grieving, does not fully believe the loss is permanent; and continues to act as though he/she could not only find the deceased but also be reproached for his/her actions. Thereby the lost

person, in his/her death (desertion), is held in part responsible for what has happened. As a result of the desertion, anger is directed toward the lost person and others who are thought to have played a part in the loss.

Parkes (1971) in his study of widows finds anger with the absent figure to be a common theme and interpreted as a way to recover the lost person. The (unconscious) goal of anger, reproachful and punishing behavior is a reunion with the deceased person and a discouragement from further separation.

Cognitive Perspective of Grief

Since the cognitions in bereavement and depression are closely aligned, cognitive therapy, a recommended treatment for depression, is also apropos for the treatment of bereavement. Cognitive therapy, developed by Aaron Beck (Yost et al., 1986), is designed to help clients become aware of maladaptive cognitions, to recognize the disruptive impact of such cognitions, and to replace them with more adaptive thought patterns. In cognitive therapy, clients are led to make personal discoveries by a tactful progression of questions and inquiry (Prochaska, 1984).

Beck uses behavioral strategies to eliminate overt

symptoms which then reinforces the effectiveness of the cognitive strategies. For symptom relief, Beck focuses on contingency management procedures (homework assignments) which are structured to be successful and reinforcing, thereby increasing the client's internal locus of control and sense of self-efficacy. As symptoms lift, the client is more easily able to focus on underlying cognitions.

Beck claims (Prochaska, 1984) that the basic ideation of depressed individuals consist of three themes or rules, noted as the cognitive triad: (1) External - events are interpreted negatively, (2) Internal - depressed individuals dislike themselves, and (3) Future - the future is viewed negatively. These themes give rise to maladaptive self-talk and/or images which become experienced as automatic thoughts and subsequently self-fulfilling prophecies.

In cognitive therapy clients learn to look at their thoughts objectively (distancing); reevaluate thoughts rather than automatically accepting and reacting to them; and reframe problems, expectations of the self and their world. By becoming aware of the rules and assumptions they view and use to experience their world, clients are

then more easily able to change maladaptive or ego-dystonic cognitions. Some of the basic rules which Beck (Prochaska, 1984) identifies that predispose people to depression are:

1. To be happy, I must be successful in whatever I do.
2. To be happy, I must be accepted by all people.
3. If I make a mistake, it means that I am unworthy.
4. I cannot live without love.

Assumptions a bereaved person may hold are:

1. Internal - I cannot feel peace without that person;
2. External - I cannot cope without that person;
3. Future - I feel it was my fault that he/she died (self-blame) and now my future is ruined (catastrophizing).

By developing awareness of their basic assumptions and reevaluating their rules of living, clients can begin to free themselves from debilitating expectations which result in depression or other forms of pathology. The positive effects of cognitive therapy on self-concept and dealing with hopelessness, two primary issues of older adults, makes the treatment particularly useful as a treatment for older adults who are depressed (Rush, Beck, Kovas, Weissenburger, & Hollon, 1982).

Group Therapy Intervention

Group therapy can provide an environment for supportive relationships promoting a feeling of universality of life experiences. The group promotes interpersonal recognition and a deeper understanding of participants' life experiences. The self-acceptance older adults can experience in the nurturing peer group process is one of the ingredients which aids them to commit to positive life-affirming changes (Burnside, 1986).

Group therapy, is a cost effective approach that has the flexibility to offer a range of targeted therapeutic interventions and approaches (psychodynamic, psycho-educational, supportive psychotherapy) in a non-threatening, peer supportive environment. The identification and interpersonal learning older adults experience aids in strengthening their sense of identity. It can also provide insight into ways of coping, with direction and strategies for finding fulfillment in life.

Group therapy, in its peer supportive and social nature, assists older adults in expressing feelings and thoughts. Thereby, it helps to improve their social skills and is an effective way to help older adults cope

with issues of loss, grief, and remotivation. The group process aids elders in working toward resolving psycho-social conflicts in a non-threatening and accepting environment. As noted by Yalom (1985) "It is not the sheer process of ventilation that is important...it is the affective sharing of one's inner world, and then the acceptance by others, that seems of paramount importance" (p.50). Furthermore, the group support may help senior citizens normalize their aging process, gain an increased sense of control over their lives, and provide them with an expanded vision of opportunities and horizons, bringing a renewed sense of identity to participants.

Life Review Group Therapy

Life review was coined by Robert Butler in the 1960's. Butler (1963) claimed that the purpose of life review was to provide a means for the successful integration of experiences which provides a new significance and meaning to an individual's life.

Life review comes under the broader concept of reminiscence. Life review is a structured recollection of life experiences. The personal sense and meaning of the life cycle may be more clearly unfolded by those who have nearly completed it. One reason it is more commonly

observed with the elderly is because of the increasing awareness of the termination of life or of an aspect of one's life (retirement) which promotes a desire for resolution of intrapsychic conflicts, reconciliation with people, issues and concerns, and a longing to find or give meaning to one's experience (Butler, 1963). The reconsideration of life experiences offers the individual an opportunity to reframe, revise and expand ones understanding of his or her personal history and current feelings. Therefore, life review is inherently a psychotherapeutic process of insight and self-understanding which may be accompanied by cognitive, affective and behavioral changes.

Life review therapy is one type of reminiscence which covers the whole life span. Wong and Watt (1991) developed a taxonomy of reminiscence describing six different types of reminiscence: integrative, instrumental, transmissive, narrative, escapist, and obsessive.

1. Integrative reminiscence, similar to life review, focuses on achieving a sense of self-worth and reconciliation with one's past.
2. Instrumental reminiscence focuses on the

subjective perception of competence and continuity, including the recollections of past plans, the attainment of goals, and drawing from past experiences to solve present problems.

3. Transmissive reminiscence, similar to oral history, connotes the passing on of one's cultural heritage and personal legacy. Carl Jung (1933) stated that the transmission of knowledge and experience provides meaning and a sense of purpose to the second half of life.
4. Escapist reminiscence is a type of defensive activity noted by the tendency to glorify the past and depreciate the present. This form of reminiscence is used to foster the image of the mythical past of splendor to compensate and protect one's self-esteem in the face of loss and declining health.
5. Obsessive reminiscence stems from guilt over one's past and is evidenced by statements of bitterness, guilt and despair. It is indicative of the individual's failure to come to terms with the problems of the past and their influence on the present, resulting in rumination on

disturbing past events.

6. Narrative reminiscence, similar to an informative reminiscence, is a descriptive rather than an interpretive recollection of the past. It is used to provide routine biographical information and to recount past anecdotes that may be of interest to the listener.

Within the reminiscence activity people often use more than one type of reminiscence in their discussion. Also, there are various factors which can change the dynamics of the reminiscence activity. Group reminiscing is different from individual reminiscence, structured life review from random reminiscence, evaluative from non-evaluative reminiscing, and external from internal reminiscing (Haight, 1991).

Reminiscence has been a popular therapeutic activity with older adults for the last 30 years with positive outcomes cited in various articles. Lesser, Lazarus, Frankl, and Havasg (1981) working with psychotic geriatric patients found that reminiscence groups fostered cohesiveness. Parson (1986) noted that it decreased levels of depression. Others commented that it reduced state anxiety, decreased denial of death,

improved cognitive functioning and mental adaptability (Haight, 1991).

Though there have been many positive reports and substantial amount of anecdotal evidence supporting the efficacy of life review, there has been no formal standardization of the activity but only suggestions from those using the activity. The lack of standardization in life review therapy creates difficulties for comparison between groups and therapeutic modalities. The life review technique may be applied slightly differently among professionals in the field of gerontology, but the goals of the activity are similar.

Cognitive Group Therapy

Cognitive therapy which appears as a single theoretical entity has a variety of procedures and orientations which have been used to aid in cognitive change and subjective well-being. Some cognitive approaches emphasize the systematic restructuring of cognitions as the primary objective of treatment while others (cognitive-behavioral approach) emphasize behavioral skills such as relaxation, desensitization and coping strategies.

Global and specific issues of coping, depression and

life satisfaction can be adequately addressed with cognitive therapy. Three integrated approaches have been developed for cognitive restructuring and applied to older adult populations with efficacious results (Hyer, Swanson, Lefkowitz, Hillesland, Davis, & Woods, 1990). These include Albert Ellis and Harper's work in Rational Emotive Therapy (1961), Meichenbaum's (Meichenbaum & Deffenbacher, 1988) work on cognitions that precipitate uncomfortable feelings and inappropriate behavior, and the work of Beck and colleagues (Beck, Rush, Show, & Emery, 1979).

One of the early modifications of cognitive therapy was Albert Ellis' work entitled Rational Emotive Therapy (Ellis & Harper, 1961). Ellis stated that the basic mediating influences of cognitions and values influenced feelings and behaviors. Meichenbaum (1977) in a similar vein focuses on cognitive constructs but rather than the argumentative position that Ellis takes, Meichenbaum states that the therapist should take the role of advocate and teacher. He believes in training clients to assume the role of an external observer in viewing their own behavior followed by providing a systematic self-instruction in coping strategies.

Beck's cognitive model of depression is based on three concepts: the cognitive triad, schemas, and cognitive miss-perceptions (Beck et al., 1979). The cognitive triad is the individual's negative view of him or herself, experiences, and the future which form long standing schemas. These schemas, aid the individual to select relevant details from the environment and recall related memories or associations based on the schematic pattern which leads to cognitive miss-perceptions.

Schemas develop from the core beliefs and expectations about the self and others. They serve as filters or lenses in information processing. Early life experiences shape schemes about the self, others, and the world. These schemes are activated later in life by conditions that affectively and/or cognitively resemble those conditions present when they first developed (Beck, 1972). Beck divides schemas into two parts, a cognitive set or perspective specific to the situation and a cognitive mode or affect based on a superordinate concept that provides direction to the cognitive set.

McCann, Sakheim and Abrahamson (1988) developed a model to describe the relationship between life experiences, schemas and psychological adaptation. They

note five basic schemas related to self and others, safety, trust, power, esteem and intimacy. The schemas are developmentally based on adaptation to the environment, starting from safety and culminating with intimacy. Over time positive and negative attributions in these five areas coalesce and become stabilized to create distinct psychological response patterns. The five schematic patterns are similar to Maslow's hierarchy of needs, physiological needs, safety needs, belonging needs, esteem needs, and self-actualization.

The schema provides the clinician with insight into how the individual evaluates, simulates and understands the environment. The dominant schemas act as an organizing focus for perceptions, thoughts, emotions and choices. When trauma occurs, a negative schema develops which provides the person the ability to rationalize and understand their vulnerability and pain. The negative schema serves to protect the individual from further vulnerability. In working with issues of depression the clinician's task is to challenge negative schemas and decrease the arousal associated between schemas and current life experiences (Hyer, et al., 1990). Furthermore, it is the clinicians task to aid the client

in building more positive and adaptive schemas to assist the older adult in coping strategies.

Comparison Studies

As previously cited, there are substantial anecdotal and experimental research findings for the efficacy of life review therapy and cognitive therapy with older adults. The findings exemplify their therapeutic value related to decreasing levels of depression and promoting life satisfaction for older adults, but there are a lack of comparison studies examining the differences, between the therapies, in the literature.

A literature review of articles that compared life review group therapy with cognitive group therapy or cognitive-behavioral group therapy was conducted on the PsycLIT compact disc from 1974 to December of 1991, on the Educational Resource Information Center (ERIC) compact disc from 1982 to March 1992, and on the last 11 years in the Dissertation Abstracts International. No published articles were found from the search, but a few dissertations in related areas were discovered.

The dissertation most closely related to the topic was by Scates, 1983, Comparison of Two Group Methods For Improvements Of Life Satisfaction and Reduction of

Anxiety Among Older Adults comparing cognitive-behavioral therapy with reminiscence therapy. Unfortunately, there were no significant findings between the reminiscence group, the cognitive-behavioral group and the activity group (control group) on the Life Satisfaction Index A and the Trait Anxiety Inventory. Scates' lack of significant finding may be due to the construct validity and the efficacy of her treatment. Group therapy can easily become an unfocused discussion group, which decreases the therapeutic efficacy, when it does not follow a prescribed protocol. Two major weaknesses of Scates research are:

1. The protocol for the group leader was not clearly outlined to ensure that the protocol was followed. For example, Scates cites that the group format in the cognitive-behavioral group was didactic lecture, discussion, role play, modeling, and homework but she did not elaborate upon these aspects beyond a one sentence description, such as "Discussion of stress-related anxiety and its causes." Without a clear protocol the group leaders may have presented a variety of discussion items which questions the content validity of her treatment.

In contrast, the research study the investigator designed provides a clear outline of the specific cognitive therapy lecture to be covered in each group, with time periods allocated for each aspect of the group.

The reminiscence protocol of Scates' dissertation followed a format of didactic lecture, discussion, and homework with a one sentence description of each agenda item. The six reminiscence sessions had a different focus without a clear pattern or progression of topics which may have prevented participants from fully integrating and benefiting from their reminiscence group experience.

In contrast, the reminiscence protocol presented in this study will follow a progression of topics to guide participants through the life review experience and allow time (2 sessions) for the integration of material.

2. In Scates' research, subjects were exposed to only six, one hour, weekly sessions with up to 20 participants in each group. The primary investigator feels that Scates' study had too many participants in each group, and the time length of the sessions was inadequate to ensure any therapeutic results besides socialization. Also, subjects may not have participated in enough

sessions (only six) to develop group trust and cohesion, and therapeutic group interaction. The program the investigator has outlined provides for eight, one and a half hour, weekly sessions with a maximum of 12 subjects per group.

In summary, the lack of adequate comparison studies between cognitive therapy and life review therapy with older adults is a clear deficit in the literature. Though both therapeutic processes exhibit strengths, without a comparison study of these treatments their true effectiveness and weaknesses cannot be fully understood.

Chapter 3

Methods

This chapter will describe the structure of the research study. It will cover the following areas: setting, screening assessment, subjects, design and variables, methods of measurement, testing administrator, treatment administrators, treatment administrator training, procedures, and analysis of data.

Setting

All subjects were drawn from the Salem College Personal Care home where the research study was conducted. The Salem College Personal Care home is in the town of Salem, West Virginia, which has a population of 2,000. The Salem College Personal Care home has a total of 98 residents, 51 female and 47 male. It is staffed with an L.P.N. nursing supervisor, a social worker, an activity leader, 19 nursing aids, and an R.N on weekly consultation. The facility distributes medication as ordered by doctors, but provides no psychological or physical therapy. The Salem Personal Care facility is primarily for ambulatory residents, but does have one resident who uses a wheelchair full-time, and others who use a wheelchair periodically.

Screening Assessment

To participate in the study subjects had to meet five criteria which were evaluated by both the nursing supervisor and social worker of the Salem College Personal Care facility. The criteria were:

1. Minimum age of 50 and living at the Salem College Personal Care Home in Salem, West Virginia.
2. Individuals who are under psycho-social stress due to aging and residing in a personal care facility.
3. Individuals who do not have significant cognitive deficits and are able to:
   A. carry on a conversation in a group setting and have no major expressive speech problems,
   B. have insight and understanding into their behavior and life activities,
   C. retain information discussed,
   D. remember past events.
4. Individuals who have no major hearing problem which would make group conversations inaudible and/or incomprehensible.
5. Individuals who exhibit no mental or behavioral problems which would inhibit them and/or others from participating, contributing and benefiting from group

discussions.

All subjects who met the screening criteria were asked by the primary investigator to participate in the "Seniors Speak Out" discussion groups.

Subjects

There were 48 older adult subjects who passed the screening and agreed to participate in the study. The subjects ranged in ages between 50 and 96, 21 male (44%) and 27 female (56%) subjects. In the age grouping classified as young-old (50-74 years of age), there was an almost even distribution of males (12) to females (11) subjects. But, in the old-old age grouping (75-100 years of age), there were 36% males (9) to 64% females (16). There was an almost even distribution between the age categories of young-old and old-old, (23 young-olds to 25 old-olds) (see Table 1, p. 48). The years of formal education achieved for males was a mean of 8.2 and for females was a mean of 9.5, with no significant difference between groups $p > .05$.

Table 1

Subjects by Age Category and Gender

Age	Male	Female	Row Total
50-74 (Young-old)	12	11	23/48%
75-100 (old-old)	9	16	25/52%
Column Total	21/44%	27/56%	48/100%

Design and Variables

The structure of the research design was a 2 (therapist) X 3 (treatment: cognitive therapy, life review therapy, control group) X 3 (occasion of measurement: pre-test, post-test, follow-up test) X 2 (age groupings: young-old 50-74 and old-old 75-100). The groups were balanced for gender and age grouping. The control group consisted of 8 subjects, 4 male (2 young-old, 2 old-old) and 4 female (2 young-old, 2 old-old). Subjects were randomly assigned to one of five groups by means of throwing dice (see Table 2, p. 49).

The research design administered 2 types of treatment, cognitive and life review therapy, with 2 therapists (each therapist conducting both treatments) to

Table 2

Subject Assignment

	Cog. Th. Therap.1	Cog. Th. Therap.2	Life Rev. Therap.1	Life Rev. Therap.2	Control
Age	M / F	M / F	M / F	M / F	M / F
50-74	2 / 2	3 / 2	3 / 2	2 / 3	2 / 2
75-100	2 / 4	2 / 3	1 / 4	2 / 3	2 / 2
M/F Total	4 / 6	5 / 5	4 / 6	4 / 6	4 / 4
Total	10	10	10	10	8

Note. Therap.1 = Therapist 1 M = Male
Therap.2 = Therapist 2 F = Female
Cog. Th. = Cognitive Therapy
Life Rev. = Life Review

determine if the outcome differences are due to the therapists, the interaction between therapist and treatment, or the treatments. The subject assignment to therapist by age grouping was randomly and evenly distributed (see Table 3, p. 50). The therapy groups

Table 3

Subject Assignment to Therapist by Age Grouping

	Therapist 1	Therapist 2	
Age			Total
50-74	11 (2 control)	12 (2 control)	23
75-100	13 (2 control)	12 (2 control)	25
Total	24 (4 control)	24 (4 control)	48

were conducted at the same time on different days to control for the effect of time of day on subjects. A pre and post-test was used to record the effects of the treatment and a 6 week follow-up test was given to determine if the treatment effects were sustained over time.

Methods of Measurement

Two dependent measures were used in the research study, the Beck Depression Inventory to assess the level of depression, and the Salamon-Conte Life Satisfaction in the Elderly Scale to assess subjective well-being. The measurements were used for the pre-test, post-test and follow-up tests (see Table 4, page 51).

Table 4

Dependent Measures

Pre-Test	Post-Test	Follow-Up Test
BDI	BDI	BDI
LSES	LSES	LSES
	Therapist Assessment Rating	

Beck Depression Inventory

The Beck Depression Inventory (Beck, Rush, Shaw & Emery, 1979) is a 21 item-instrument designed to assess the severity of depression for a range normal and psychiatric populations from adolescents to older adults. It takes approximately 10 minutes to complete when self administered and 15 minutes with oral administration. The vocabulary on the test represents a 5th grade level. Due to copyright laws the Beck Depression Inventory cannot be reproduced in part or whole (see Appendix A for the address of test publisher).

Test-retest reliability of the inventory was .90 in a study of 38 psychiatric patients (Beck, 1970). The Beck Depression Inventory (BDI) scores tended to parallel

the changes of clients' state of depression, indicating a consistent relationship between BDI scores and the patient's clinical state. Internal consistency studies of the BDI demonstrated a correlation coefficient of .86 for the test items, and the Spearman-Brown correlation for the reliability was a coefficient of .93.

It is apparent that the BDI has face validity. Its content validity is shown by its ability to evaluate a wide variety of symptoms and attitudes related to depression (Stehouwer, 1985). Concurrent validity has been reported in several studies (Schaefer et al., 1985; Hamilton, 1960). In a study with psychiatric patients, Beck (1970) cited a correlation of .66 between the BDI and the Depression Adjective Check List (Zarske, 1989) and .75 between the BDI and the MMPI D scale.

Within the last 26 years the Beck Depression Inventory has been a widely accepted instrument in clinical psychology for assessing the severity of depression in psychiatric patients (Piotrowski, Sherry & Keller, 1985), and for detecting depression in normal populations (Streer, Back, & Garrison, 1985).

The Beck Depression Inventory has been employed extensively with older adult populations (Gallagher,

Nies, & Thompson, 1982; Zenmore & Eames, 1979). It has been found to be highly reliable with older adults (Gallagher et al, 1982) with good concurrent reliability (Gallagher, Breckenridge, Steinmetz, & Thompson, 1983). These studies exemplify its usefulness for identifying depression in older adults, and for assessing treatment effectiveness.

Salamon-Conte Life Satisfaction in the Elderly Scale

The Salamon-Conte Life Satisfaction in the Elderly Scale (LSES) is a 40-item Likert scale that measures subjective well-being in 8 categories. Five of the categories are those hypothesized by Neugarten, Havighurst, and Tobin (1961) and are modeled in the Life Satisfaction Inventory. Three additional categories were drawn from a review of the literature (Larson, 1978). The 8 categories (scales) are: (1) Daily Activities - taking pleasure in daily activities; (2) Meaning - regarding life as meaningful; (3) Goals - goodness of fit between desired and achieved goals; (4) Mood; (5) Self-Concept; (6) Health - perceived level of health; (7) Finances - financial security; (8) Social Contacts (Salamon & Conte, 1984). Each of the 8 categories contain 5 questions with 5 response options. Due to

copyright restrictions the Salamon-Conte Life Satisfaction in the Elderly Scale cannot be reproduced (see Appendix A for the address of the test publisher).

Factor analytic and clustering techniques support the validity of the 8 categories (Salamon and Conte, 1984). Studies to assess the reliability and validity of the LSES indicated that it is a psychometrically sound instrument with coefficient alpha's ranging from α = .50 to α = .92 (Conte and Salamon, 1982; Salamon, 1983).

The Salamon-Conte Life Satisfaction in the Elderly Scale (LSES) is a more elaborate version of Neugarten Life Satisfaction Index. The LSES was chosen as a dependent measure over the Life Satisfaction Index by Neugarten et al because the Salamon-Conte's scale contains three more factors and is a more thorough assessment with 40 questions that are answered on a 1 to 5 sale (with gradations clearly delineated), as opposed to Neugarten's scale having only 20 questions with agree, disagree, or ? as answer choices.

Ways of Coping Questionnaire

The Ways of Coping Questionnaire (see Appendix A) by Folkman and Lazarus (1988) was originally proposed to be used as a dependent measure to assess the style and

degree of the subjects' coping ability. After pre-testing 25 participants, the primary investigator realized that the Ways of Coping Questionnaire was not an appropriate assessment for the population. Therefore, the Ways of Coping Questionnaire was eliminated as a dependent measure. The primary investigator received verbal approval for this action from the dissertation committee (Dr. Marinelli, Dr. Srebalus, Dr. Delo, Dr. S. Cormier, Dr. Parker, and Rick Briggs) on September 3, 1992.

The Ways of Coping Questionnaire is a 66 item-instrument using a 4-point Likert scale to assess thoughts and actions (coping processes) individuals use to cope with a stressful situation. The instrument focuses on coping processes as opposed to coping dispositions or styles. The operational definition of coping is "the cognitive and behavioral efforts to manage specific external and/or internal demands appraised as taxing or exceeding the resources of the individual" (Folkman & Lazarus, 1988, p.2). The Ways of Coping Questionnaire manual (Folkman & Lazarus, 1988) stated that it took approximately 10 minutes for the respondent to complete the questionnaire.

The Ways of Coping Questionnaire was found to be an inappropriate dependent measure due to the subjects' inability to sufficiently comprehend and answer the test questions to ensure reliability and validity. Following the administration of the Questionnaire to 25 subjects, 50% of the subject pool, the primary investigator found that the subjects were not able to appropriately respond to the answers. Although the test administrator gave the Ways of Coping Questionnaire as the last assessment to most of the subjects, when he switched the order of the dependent measures and gave it as the first assessment to two subjects (who were quite alert and verbal) they still had considerable difficulty and could not complete the test.

The directions to the respondent of the Ways of Coping Questionnaire are as follows. The respondent is asked to focus on the most stressful experience in the past week and respond to the listed coping statements by indicating to what extent you used it in the situation (choosing one of four possible answers: does not apply or not used, used somewhat, used quite a bit, used a great deal). The respondents had two problems with the task. They were not able to clearly delineate between the four

possible answers in regard to their coping ability and had difficulty recalling their method of coping during a stressful experience in the past week, therefore reducing the reliability and validity of the questionnaire.

The assessment also took considerably more time for the subjects to complete than reported in the manual. In the first 10 minutes they could only complete about 10 questions, 1/6 of the assessment.

Although the Ways of Coping Questionnaire has been used with an older adult population (McCrae, 1984; Folkman, Lazarus, Pimley, & Novacek, 1987), the inability of the subjects to answer the questionnaire is most probably due to the decline in their intellectual acuity due to various physical and/or psychological conditions or limitations. The older adult population which the Ways of Coping Questionnaire was previously tested on, were community based groups. Since community based groups normally do not need nursing care and would probably have a more enriched and multidimensional life than subjects at a long-term care facility, they were probably physically and psychologically healthier than the subjects in the study. Due to the differences in lifestyle and health of the two populations, community

based groups may exhibit greater cognitive acuity than respondents of a long-term care facility.

The research project used two other dependent measures, the Beck Depression Inventory and the Salamon-Conte Life Satisfaction in the Elderly Scale. It took 20 to 30 minutes to administer the two assessments, which appeared to be the subjects' limit of attention span in the task, and further testing could have been experienced as physically and/or psychologically aversive.

Therapist Assessment Rating

The Therapist Assessment Rating form (see Appendix A) was given to participants at post-test to evaluate and rate the group leader. The Therapist Assessment Rating form is adapted from a group leader evaluation form listed in Groups: Process and Practice (3rd ed.) by Cory and Cory (1987). The form was designed to evaluate important functions of counselors within a group context. This form was chosen because of its apparent content and face validity.

The therapist rating scale includes 20 items that describe the leaders abilities on a 1 to 5 rating scale with 1 being extremely low degree, 2 being below average, 3 average degree, 4 above average and 5 high degree.

The therapist rating will be based on the sum of the scores, with the highest possible score of 100 and with the lowest possible score of 20.

The Therapist Assessment Rating was used to determine if there is a relationship between the overall subjects' attitude toward the therapist and the change in their dependent measure scores. The Therapist Assessment Rating was correlated with amount of change in the subjects score from pre-test to post-test.

In a review of the literature, no adequately reliable or valid measurement of group leaders by participants, was found. The review covered an on-line database search on BRS Information Technologies of the Educational Testing Service Test Collection, the Mental Measurements Yearbook 1972-1992, and Health and Psychological Instruments 1985 to present. Also reviewed was the PsycLIT compact disc from 1974 to December of 1991 and the Educational Resource Information Center (ERIC) compact disc from 1982 to March 1992.

In conversations with several professors of the Counseling Psychology Department at West Virginia University, no instrument was found. The investigator contacted Dr. Stockton of the Department of Counseling at

Indiana University (chairperson of Division 17 Special Interest Group in group counseling), who also knew of no instruments, but referred me to Dr. Robinson of Indiana University-Purdue University at Indianapolis. Dr. Robinson stated that he knew of no published instrument, but is currently working on an assessment designed for group participants to evaluate group leaders. He stated he was field testing the instrument and since he has no reliability or validity measurements on it, the instrument was not ready for distribution.

Testing Administrator

The primary investigator, administered the pre, post, and follow-up assessments to each subject individually, in a private and confidential area. The assessments were all self-administered paper and pencil tests. For subjects who were not able to read the questionnaire, the primary investigator read the questions and answer choices to the respondents and had them to either verbally reply or point to the answer to be checked off.

Treatment Administrators

Two graduates of the West Virginia University Masters degree program in Counseling conducted the group

therapy sessions. They both work as counselors at Salem-Teikyo University. Therapist 1 worked in the Upward Bound program, and counseled high school students in the surrounding counties who were interested in attending college. Therapist 2 was employed in the Student Support Services department, and served as a counselor for college students. Both Therapist 1 and 2 had worked for other agencies as counselors. Therapist 1 worked part-time as a mental health specialist in the inpatient adults and adolescent program at Chestnut-Ridge Hospital where he provided counseling and nursing support to patients. Therapist 2 worked part-time as a counselor for Summit Center, a community mental health clinic.

Therapist 1 and 2 had an equal amount of experience and training in counseling. They had taken one course in group counseling in their Master's program. They both graduated within a year of each other from their Master's degree program. They had very limited experience conducting group therapy, and have approximately one year post-graduate experience conducting individual therapy.

An alternate therapist served in place of Therapist 1 and 2 if they were not able to conduct a group due to illness or other problems. The designated alternate

therapist had been the Director of Counseling and Career Services for two years at Salem-Teikyo University. He had a masters degree in College Student Personnel from Bowling Green State University. Before coming to Salem-Teikyo University he worked for six years at the University of Alaska as the student counselor and advisor for international students.

Treatment Administrator Training

The primary investigator, provided the training and protocol in cognitive group therapy and life review group therapy. He has over 12 years post-masters experience as a counselor and art therapist conducting group therapy, and specializing in working with older adults. He is the author of one book and several articles on therapeutic intervention and older adults.

The training consisted of 6 hours of didactic teaching: 2 hours on group therapy with older adults, 2 hours on cognitive group therapy, and 2 hours on life-review group therapy. The topics covered in the training session were: psycho-social issues facing elders; group therapy process and techniques with the elderly; and the cognitive and life review group therapy protocols. One month prior to the training the therapists received the

protocol of the group therapies to review (see Appendix B) and several articles on cognitive therapy, life review therapy, and group therapy with the elderly.

To ensure reliability of the therapists delivering the specific group therapy protocol, following each session the primary investigator reviewed with the counselor a checklist of discussion items which were to be covered in the session. The primary investigator had ensured that in all sessions the topics and material to be covered were followed as prescribed by the protocol.

Procedures

Screening

With the list of residents who passed the initial screening (as determined by the nursing supervisor and social worker), the primary investigator set up individual meetings with the residents. The meetings were held 6 weeks prior to the start of the 8 week "Seniors Speak Out" discussion program. At the meetings, the research project was described, a flyer on the program was distributed (see Appendix C) and the following points were discussed:

a. The discussion group, "Seniors Speak Out", was explained to residents as an 8 session weekly

program which focused on issues and problems they face now and in the past. It was cited that the program was designed to help them to express their feelings and thoughts and discuss their situation in a confidential setting with their peers and a group leader.

b. Residents who join the program were requested to try to attend all eight sessions. If they missed 4 sessions they would be asked to withdraw from the group.

c. Free coffee and cookies were provided at the discussion groups by the Salem Personal Care Home.

d. Everything that was said in group would be confidential and they can voluntarily terminate participation in the group at any time.

e. Participants were either assigned to a "Seniors Speak Out" group having 10 residents with one group leader, which met for one and a half hours per session (from 3:30 to 5:00), once a week, or were assigned to a control group.

f. Eight out of the 48 participants were randomly selected as a control group and did not

participate in the Seniors Speak Out program but would take the pre, post and follow-up tests. At the completion of the follow-up tests a "Seniors Speak Out" discussion group would be provided to the control group, led by the activities director at the facility. The activities director and social worker of the facility were trained in both cognitive group therapy and life review group therapy by the primary investigator at the completion of the follow-up tests.

g. All participants were requested to take a pre-test, a post-test the week the program ends, and a follow-up test six weeks after the completion of the program.

Informed Consent Form

At the private meetings between the primary investigator and the residents, all participants who agreed to participate in the program signed two copies of the Informed Consent Form. One copy of the Informed Consent Form was given to the participant and the other was kept on file with the primary investigator.

Demographic Information Form

Following the signing of the Informed Consent Form

participants were asked to fill out a demographic information sheet noting their age, birth date, gender, and years of formal education achieved (see Appendix A).

Medication Effects

To account for conditions which may affect the subjects' participation in the program, the nursing supervisor noted if any of the participants had their medication changed during the time period between the pre-test and the post-test.

Group Assignment

Following the agreement to participate in the program, subjects were randomly assigned (by means of throwing dice) to treatment groups or to a control group, evenly distributing male and female, young-old and old-old participants to each group.

Pre-Test

Two weeks prior to the beginning of the program the primary investigator set up individualized meetings with all participants of the research project and notified them on what day of the week their group would meet or if they were in the control group. At this time the pre-test was administrated, consisting of the Beck Depression Scale and the Salamon-Conte Life Satisfaction Scale.

Treatment

Participants were randomly assigned to one of four "Seniors Speak Out" discussion groups. Subjects were blind to the type of group they were assigned to (cognitive therapy or life review therapy). Participants were asked to attend all 8 discussion group sessions and notified that if they missed 4 sessions they would be dropped from the project.

The discussion groups were conducted for one and a half hours per session, from 3:30 to 5:00, Monday to Thursday, September 14 to November 6. Therapist 1, conducted the cognitive therapy group on Monday and the life review group on Wednesday. Therapist 2 conducted the cognitive therapy group on Tuesday and the life review group on Thursday.

Post-test

Within four days after the "Senior's Speak Out" program concluded, all participants were given the post-tests. The post-test was a re-administration of the Beck Depression Scale and the Salamon-Conte Life Satisfaction Scale, along with the Therapist Assessment Rating. The control group did not fill out the Therapist Assessment Rating.

Follow-up test

Six weeks after the conclusion of the "Seniors Speak Out" program all participants were given a follow-up test. The follow-up test was a re-administration of the Beck Depression Scale and the Salamon-Conte Life Satisfaction Scale.

Analysis of Data

Pre-test, post-test and follow-up test scores were calculated for each subject on two dependent measures, the Beck Depression Scale and the Life Satisfaction Scale. Two 2 (therapist) X 3 (treatment) X 3 (occasion of measurement) X 2 (age groupings) analysis of covariance was conducted, one for each dependent measure, using the pre-test as the baseline measure (covariate). The use of analysis of covariance was chosen to compensate for variances in the pre-test scores.

At post-test both treatments, life review and cognitive therapy, were expected to show two significant findings in varying degrees:

1. a decrease in the depression rating on the Beck Depression Inventory, and
2. an increase in the Salamon-Conte Life Satisfaction in the Elderly Scale score,

indicating an increased level of life satisfaction.

Since the therapists' training and experience were comparable there was expected to be no overall differences on the subjects' dependent measures between therapists and between therapists and a particular treatment. If there was a significant difference between therapists, it was hypothesized that this difference would appear on the Therapist Rating Scale, and therefore show the influence of the particular therapist on the subjects or on a specific treatment.

At the follow-up test the effect of cognitive therapy and life review therapy, as noted on the dependent measures, were expected to decline from the post-test scores due to lack of maintenance of treatment and reinforcement. The control group was expected to show no significant differences on the dependent measures. A significance level of .05 was established.

Chapter Four

Results

The following chapter will present the results of the pre-test, post-test, and follow-up test. The post-test and follow-up test ANCOVA tables are listed in Appendix D and E. A discussion of the results will be addressed in Chapter Five.

Pre-Test Findings

Forty-eight subjects were given the Beck Depression Inventory (BDI) and the Salamon-Conte Life Satisfaction in the Elderly Scale (LSES), 7 to 14 days prior to participating in the "Seniors Speak Out program."

Beck Depression Inventory

The mean score on the Beck Depression Inventory for males was 17.7, for females 15.9, for subjects in the young-old category 20.3 and for those in the old-old category 13.5. An analysis of variance was conducted on the BDI scores and no significant differences were found between treatment groups, therapists' assigned groups, or age categories, $p > .05$.

As noted in the Beck Depression Inventory Manual (Beck & Steer, 1987) a BDI score between 10 to 18 indicates mild-moderate depression and a BDI score of 19

to 29 indicate moderate-severe depression. The general sample population were in the mild-moderate depression category. But in terms of age categories, the young-old population obtained an overall higher depression rating, classifying them in the moderate-severe depression category. The old-old population were almost 7 points lower than the young-old population and were ranked in the mild-moderate depression category.

There was a significant correlation, -.5269 at $p < .01$, between the Beck Depression Inventory and Scale 4 (mood scale) of the Salamon-Conte Life Satisfaction in the Elderly assessment. The correlation was negative because of the inverse relationship between the scores on the BDI and Scale 4. An increase in the BDI score signifies an increase in the level of depression, while the greater the Scale 4 (mood) LSES score denotes the better the mood, signifying less depression.

Salamon-Conte Life Satisfaction in the Elderly Scale

On the total score of the Salamon-Conte Life Satisfaction in the Elderly Scale (LSES), there were no significant main effect differences in age categories, treatments, or therapists, $p > .05$. But, there was a significant two-way interaction between age groupings

(young-old, old-old) and therapists on the total LSES score at $F(1,36)$, $p = .05$ level and on Scale 1 (Daily Activities) at $F(1,36)$, $p < .05$ level. There was a significant three-way interaction among age groupings, treatments, and therapists on Scale 4 (mood) and Scale 6 (health) at $F(2,36)$, $p < .05$.

The scoring of the LSES is cumulative, the higher the score of the individual or group, the higher the level of satisfaction or well-being on a particular scale. For example, the higher the score is on Scale 6, health, the greater the perception of good health. The larger the total cumulative scores on the eight LSES scales, the greater the total life satisfaction.

Total LSES score.

To explain the significant two-way interaction between age categories and therapists, the means of the total LSES scores for age categories were examined. Therapist 1's young-old subjects had a mean score of 129 while the old-old subjects had a higher mean score of 146. But, with therapist 2 the age groupings had an inverse relationship. Therapist 2's young-old subjects had a mean score of 146 and the old-old subjects had a lower mean score of 135. Therefore, therapist 1's old-

old subjects had a higher life satisfaction score than the young-old subjects but therapist 2's old-old subjects had a lower life satisfaction score than the young-old subjects (see graph 1, p. 74).

Scale 1 (Daily Activities).

On Scale 1 of the LSES, there was a significant two-way interaction between therapist and age category. Therapist 1's young-old age group had a lower mean score (15.5) than the old-old age group (18.8). While in reverse direction, therapist 2's young-old age group had a higher mean score (18.6) than the old-old age group (15.4) (see graph 2, p. 75).

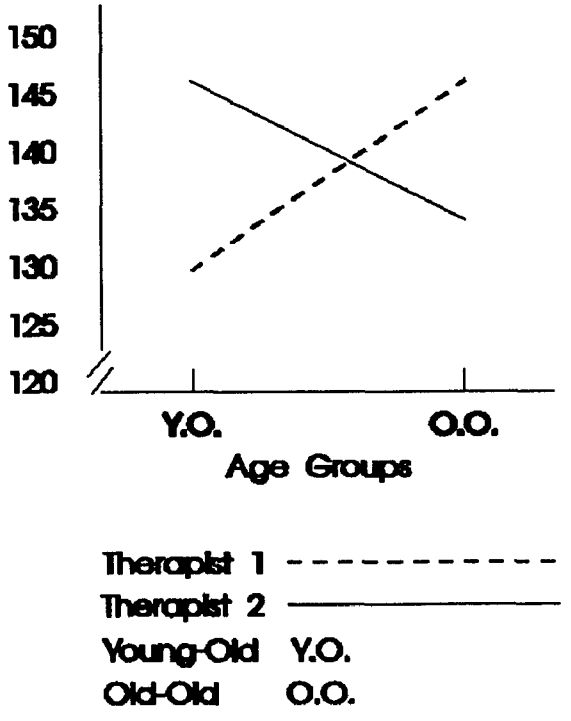
Scale 4 (Mood).

On Scale 4, there was a significant three-way interaction between therapist, age category, and treatment. The young-old and old-old subjects assigned to therapist 1 and cognitive group therapy had similar mean scores (20). But, in the life review group the young-old subjects had a lower score (15.6) than the old-old subjects (19.2) (see graph 3, p. 76).

In contrast, the young-old subjects assigned to therapist 2 and cognitive group therapy had a lower score (17.6) than the old-old subjects (19.8). While the

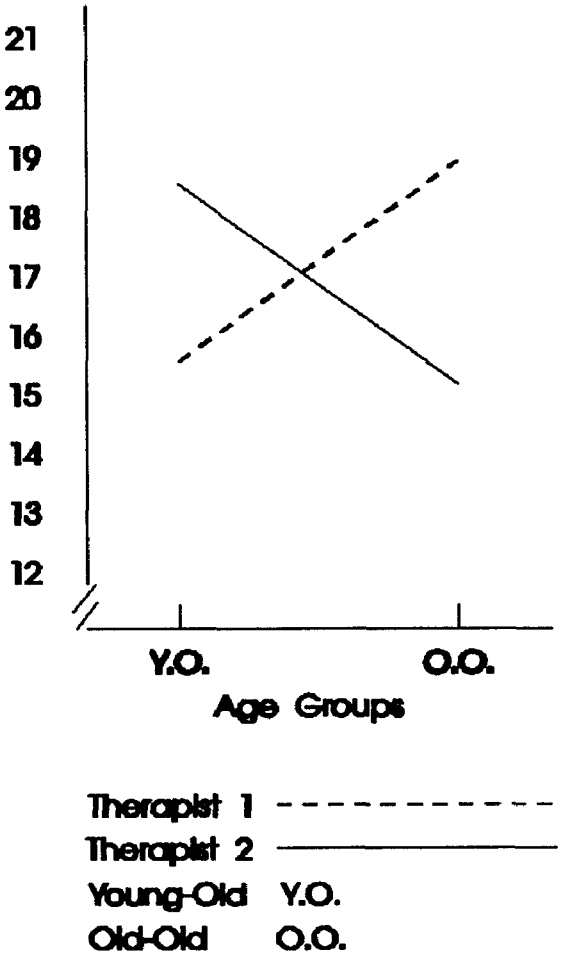
Graph 1

Total LSES scores of subjects within age groupings and between therapists at pre-test.



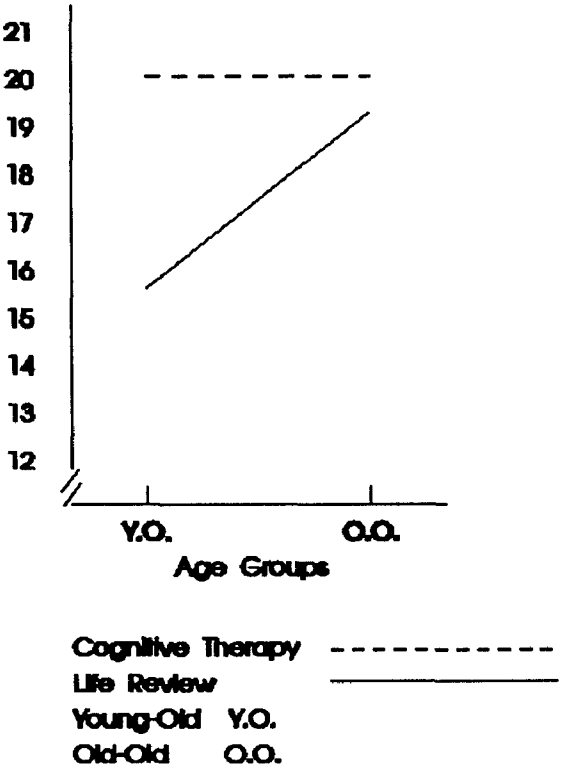
Graph 2

Scale 1 (Daily Activities) LSES scores of subjects, within age groupings and between therapists at pre-test.



Graph 3

Scale 4 (Mood) LSES scores of subjects assigned to therapist 1, within age groupings and treatments at pre-test.



young-old subjects in the life review group had a higher score (20.4) than the old-old subjects (19.8) (see graph 4, p. 79).

Scale 6 (Health).

On Scale 6, there was also a significant three-way interaction between therapist, age grouping, and treatment. The young-old subjects in therapist 1's cognitive group therapy had a higher score (15.5) than the old-old subjects (14.5). But both age groups assigned to therapist 1 and the life review group had a very similar score (young-old 12.8, old-old 12.4) (see graph 5, p. 80).

In contrast, therapist 2 young-old subjects in the cognitive group therapy had a lower scale 6 score (12.6) than the old-old subjects (13.4) as was with those assigned to life review (young-old subjects 14.2, and the old-old subjects 15.2) (see graph 6, p. 81).

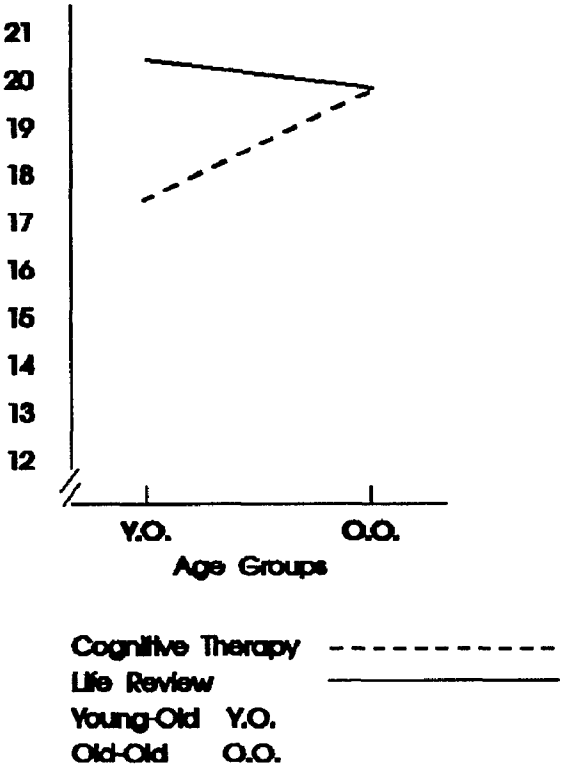
Conclusions

Since the noted significant differences in scores are secondary to random assignment and not to any treatment or therapist effects, and because an analysis of covariance was used for the post-test and follow-up test, the pre-test differences does not impair the

validity and reliability of the measurement.

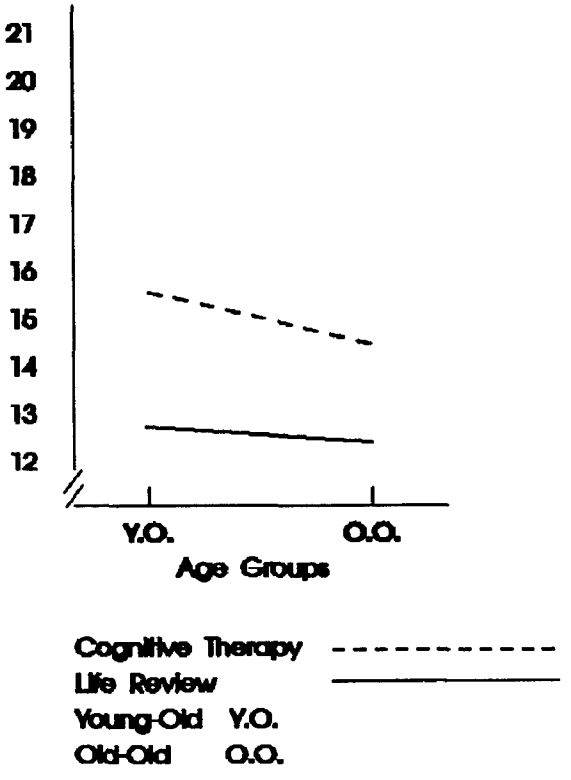
Graph 4

Scale 4 (Mood) LSES scores of subjects assigned to therapist 2, within age groupings and treatments at pre-test.



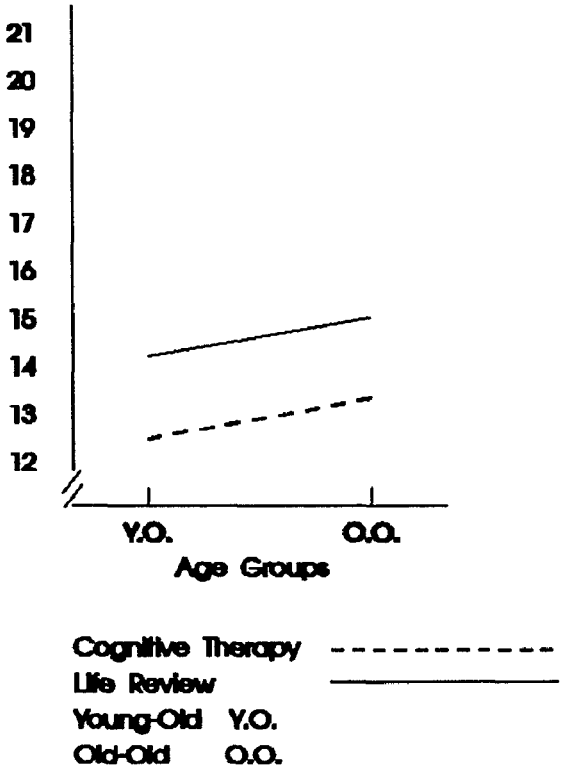
Graph 5

Scale 6 (Health) LSES scores of subjects assigned to therapist 1, within age groupings and treatments at pre-test.



Graph 6

Scale 6 (Health) LSES scores of subjects assigned to therapist 2, within age groupings and treatments at pre-test.



Post-Test Findings

Out of the 48 subjects accepted into the research project, 34 subjects were post-tested (71%), and 14 subjects (who were previously assigned to treatment groups) dropped out for various reasons. Fifty-eight percent of the post-tested subjects were in the young-old category and 42% were in the old-old category, 58% were female and 42% were male (see Table 5). All 8 subjects assigned to the control group were post-tested.

Fourteen subjects, 6 males and 8 females, did not complete the study, constituting 35% of the treatment group. Of the 20 subjects assigned to a cognitive therapy group, 12 completed the treatment program, and of the 20 subjects assigned a life review group, 14 completed the treatment program (see Table 6).

Sixty-five percent of subjects assigned to a treatment group, and 100% of subjects assigned to a control group were eligible for and took the post-test. Based on the total subject pool, the percentage of individuals, in the two age groups, who took the post test were: 83% of the male participants in the young-old age grouping and 56% in the old-old age grouping; 82% of the female participants in the young-old age grouping and

Table 5

Subjects, by Age Category and Gender, Who Took the Post-Test

Age	Male	Female	Row Total
50-74 (Young-old)	8	7	15/58%
75-100 (old-old)	3	8	11/42%
Column Total	11/42%	15/58%	26/100%

63% in the old-old age grouping. Therapist 1 and 2, both, had a total of 13 out of 20 subjects completing the treatment programs.

Subjects gave two reasons for withdrawing from the study, illness or a change of mind about participating. A total of 9 subjects, 2 males and 7 females, dropped out due to illness, which comprised 19% of the total subject pool. Four male subjects (8% of the subject pool) decided not to attend (three in the cognitive therapy group and one in the life review group). One female subject was found to be inappropriate for the group based on the group therapist's judgement. The group therapist reported that the female subject exhibited a very limited

Table 6

Subjects by Treatment, Age Category and Gender Who Took the Post-Test

	Cog. Th. Therap.1	Cog. Th. Therap.2	Life Rev. Therap.1	Life Rev. Therap.2	Control
Age	M / F	M / F	M / F	M / F	M / F
50-74	1 / 2	2 / 2	3 / 1	2 / 1	2 / 2
75-100	1 / 1	0 / 3	1 / 3	1 / 2	2 / 2
M/F Total	2 / 3	2 / 5	4 / 4	3 / 3	4 / 4
Total	5	7	8	6	8
Treatment	12		14		8

Note. Therap.1 = Therapist 1 M = Male
Therap.2 = Therapist 2 F = Female
Cog. Th. = Cognitive Therapy
Life Rev. = Life Review

attention span, along with excessive wandering during the group session. The remaining 26 subjects, 15 female and 11 male, attended a mean of 7 sessions (out of eight sessions). The group average for attendance in the cognitive therapy and the life review groups, both, were a mean of 7 sessions.

Of the 34 participants who were post-tested, 6 subjects (18% of subject pool) had their psychotropic medication changed between the time of the pre-test and post-test. The 6 subjects were from the following groups: 2 were in each of the cognitive therapy groups (4 subjects total); 1 subject was in the life review group; and 1 subject was in the control group. The effect of medication on subjects in the overall post-test results is considered to be minimal, since only a few subjects had a psychotropic medication change, and those who did were almost evenly distributed in 4 out of the 5 groups.

Beck Depression Inventory

An analysis of covariance was conducted on the post-test administration of the Beck Depression Inventory with the pre-test BDI as the covariate. The analysis of covariance showed no significant differences between treatment groups, therapists' assigned groups, or age

categories, p >.05.

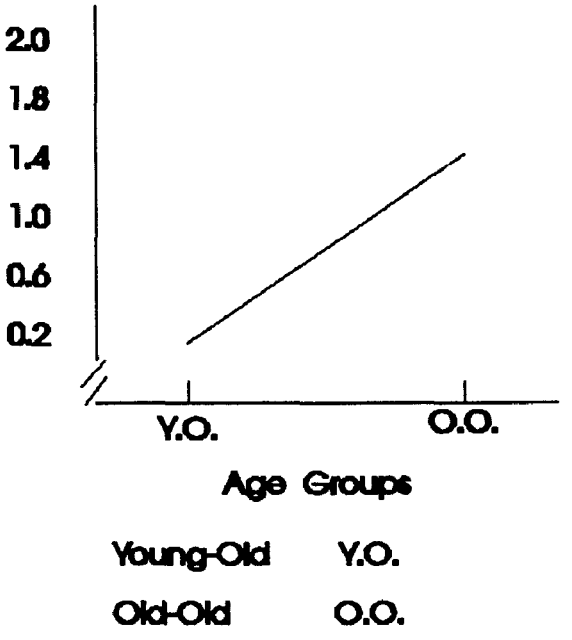
Salamon-Conte Life Satisfaction in the Elderly Scale

An analysis of covariance was also conducted on the post-test of the Salamon-Conte Life Satisfaction in the Elderly Scale, examining the total LSES score and the 8 scales, with the pre-test LSES as the covariate. The analysis of covariance showed one significant main effect on scale 7 and one significant two-way interaction on scale 8. All other main effects and interactions for the scales and the total LSES score were non-significant p >.05.

The significant main effect for scale 7 (Finances) was in age groupings (young-old, old-old), F(1,21), p =.04. Scale 7 measures financial security and satisfaction with one's financial situation in the present, and recent past. The post-test results, accounting for pre-test differences, showed a mean for the total sample of .53, while the young-old age grouping had a mean of .28 and the old-old age grouping had a mean of 1.44 (see graph 7). The post-test findings indicated that subjects in the old-old age grouping had an increased level of satisfaction in regard to their financial security in the present and recent past, over

Graph 7

Scale 7 (Finances) LSES post-test mean scores, adjusted for pre-test differences, within age grouping.



subjects in the young-old age grouping.

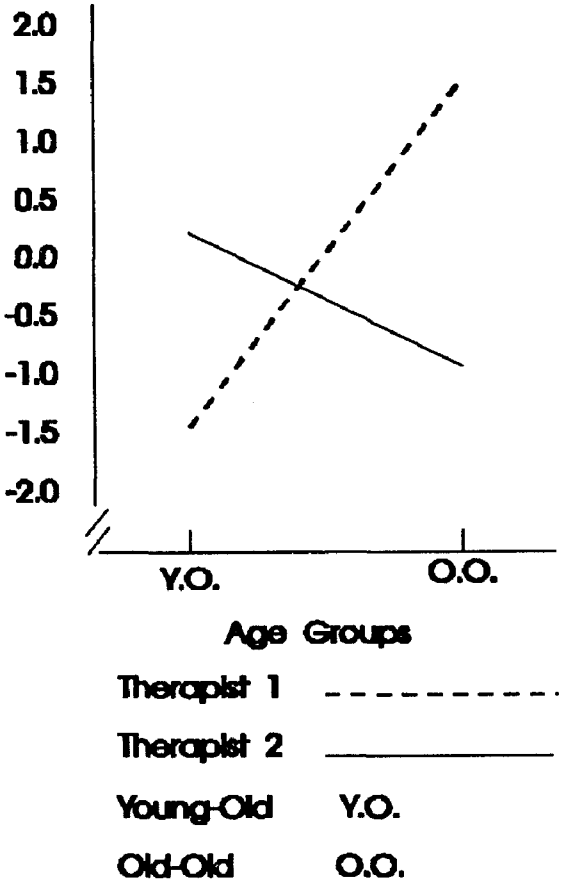
There was a significant two-way interaction on scale 8 (Social Contact) between age grouping and therapists $F(1,21)$, p =.03. Scale 8, Social Contact, refers to a perceived satisfaction with the amount and quality of social contacts in a person's daily life. The post-test results, again accounting for pre-test differences, showed that therapist 1's young-old subjects had a mean of -1.56 and his old-old age subjects had a mean of 1.5. But, in contrast Therapist 2's young-old age grouping had a mean of .22 while the old-old age grouping had a mean of -.88 (see graph 8). The increased satisfaction in the quality of social contacts for one age grouping over the other is not a finding that is representative of the study as will be discussed in Chapter Five.

Therapist Assessment Rating

Based on an analysis of variance of the Therapist Assessment Rating, which was completed by all subjects who were assigned to treatment groups, there were no significant differences between therapists p >.05. Subjects rated both therapists at a similar level, lending more validity to the equality of the treatments between therapists.

Graph 8

Scale 8 (Social Contact) LSES post-test mean scores, adjusted for pre-test differences, within age groupings and between therapists.



Conclusions

For subjects assigned to a cognitive therapy group, a life review group, or the control group the results of the post-test showed no significant improvement in level of depression, as cited on the Beck Depression Inventory, or life satisfaction, as noted on the Salamon-Conte Life Satisfaction in the Elderly assessment.

Though no significant findings were found with the Beck Depression Inventory and the only significant finding for the Salamon-Conte Life Satisfaction in the Elderly assessment was a main effect for age grouping (young-old, old-old) on Scale 7 (Financial Security), along with a two-way interaction on Scale 8 (Social Contact) between age grouping and therapists, these limited findings may be due to various contributing issues and factors as further discussed in Chapter 5.

Follow-up Test Findings

The follow-up assessment was given 6 weeks after the post-test. The follow-up assessment consisted of a re-administration of the Beck Depression Inventory and the Salamon-Conte Life Satisfaction in the Elderly Scale. An Analysis of Covariance (ANOCVA), with the pre-test as the covariate, was conducted.

All 34 subjects who were post-tested took the follow-up test. Between the time of the post-test and the follow-up test, 3 subjects had their psychotropic medication changed, 1 male and 2 female subjects. The male subject was in the Monday cognitive therapy group, one female subject was in the Tuesday cognitive therapy group, and one female subject was in the Wednesday life review group. The effect of medication on subjects in the overall follow-up test results is considered to be minimal, since only 9% of the subjects who took the follow-up test had a psychotropic medication changed between the time of the post-test and follow-up test, and because these individuals were evenly distributed in 3 out of the 5 groups.

Beck Depression Inventory

The follow-up test with the Beck Depression

Inventory, using an analysis of covariance (with the pre-test as the covariate), showed no significant differences, $p>.05$, between treatment groups, therapists' assigned groups, or age categories.

Salamon-Conte Life Satisfaction in the Elderly Scale

The follow-up test of the Salamon-Conte Life Satisfaction in the Elderly Scale, using an analysis of covariance (with the pre-test as the covariate), showed no significant differences between treatment groups, therapists' assigned groups, or age categories, $p>.05$, on the total LSES score and on Scales 1, 3, 4, 5, 6, 7, and 8. But, on Scale 2 (Meaning) there was a significant difference between treatment groups (cognitive therapy, life review therapy, and the control group) at $F(2,21)$, $p = .04$. Scale 2 reports on the subject's perceived meaning of life and is a measure of the individual's sense of usefulness and purpose in life (Salamon, 1987).

On Scale 2 the control group with 8 subjects had a mean of 15.13, the cognitive therapy group with 12 subjects had a mean of 19.08 and the life review group with 14 subjects had a mean of 19.43. The mean difference between the two treatments was only .35 points but the difference between the treatment groups (mean of

19.26) and the control group was 4.13 points. The Duncan Multiple Range Test was conducted on Scale 2 which confirmed that the two treatment groups were not significantly different from each other, but were significantly different from the control group at the $p = .05$ level. It is evident from the follow-up results, with both treatment groups reporting over 4 points higher than the control group on Scale 2, that participation in either cognitive group therapy or life review therapy group therapy increased subjects' perception of the meaning and purpose in their life.

Conclusions

The analysis of covariance on the follow-up assessments, the Beck Depression Scale and the Salamon-Conte Life Satisfaction Scale, exhibited only one significant finding which was on Scale 2 (Meaning) of the LSES and was related to the efficacy of treatment. Participants assigned to treatment groups had an increased sense of meaning and purpose in their life over participants assigned to the control group. Though at the post-test this finding was not significant at the $p > .05$, it was approaching a level of significance at $p = .09$.

The importance of the finding on Scale 2 suggests that, over time, participants of the therapy groups were able to incorporate the material presented and issues discussed in group therapy and consequently showed an increase in their sense of value and purpose in life as opposed to the participants in the control group. It may also signify the need for a longer length of treatment to fully assimilate the material presented in group therapy. But, this finding could have been influenced by the Hawthorne effect. The increased attention given to participants of the treatment groups, as compared with the control group, may have produced the increase in their sense of value and purpose in life, especially in a 100 bed personal care setting where personal attention from the staff is often desired.

Chapter Five

Discussion, Implications, Summary

The following chapter will discuss the results of the study and consider the implications for further research and clinical practice.

Discussion

The purpose of the study was to compare the effectiveness of cognitive group therapy and life review group therapy, in the psychological domains of depression and life satisfaction, for older adults who reside in a personal care facility. The outcome of the study showed no significant differences between the two treatments in level of depression or life satisfaction as measured on the Beck Depression Inventory and the Salamon-Conte Life Satisfaction in the Elderly Scale.

The post-test findings did indicate significant findings on two Scales of the Salamon-Conte Life Satisfaction in the Elderly Scale. On Scale 7 (Finances) the subjects in the old-old age grouping had an increased level of satisfaction in regard to financial security over the subjects in the young-old age grouping. Since all subjects in the study were on a fixed income, the only aspect of their financial situation that could have

changed is their perception of their finances. Increased financial security can be viewed as subjects having an elevated sense of psychological comfort in fiscal matters.

A possible explanation for the difference between the young-old and old-old scores on Scale 7, is that with the economy in flux and the presidential elections being a prominent topic during the 8 week treatment program, the young-old participants may have become more aware of the increased financial instability of the country and possibly of their future, than the old-old participants. Therefore, the young-old participants may have a more realistic sense of their economic picture, which would portray a decreased sense of financial security than subjects in the old-old age grouping. Or, it may be hypothesized that the old-old age group, over the 10 week period, had become more resigned and satisfied with their financial condition.

At post-test, a significant two-way interaction on Scale 8 (Social Contact) of the LSES was found between age grouping and therapists. This finding shows that with Therapist 1, one age group had a higher level of satisfaction in their social relations than the other age

group, with the reverse dynamics between age groupings and Therapist 2. It implied that Therapist 1 addressed the social needs of old-old subjects more than young-old subjects and Therapist 2 addressed the social needs of young-old subjects more than old-old subjects. The validity of this assumption is weak at best, because this conclusion was not supported by any other significant findings, particularly on scale 1, Daily Activities and scale 2, Meaning of Life, nor on the Therapist Assessment Rating. Therefore, the investigator feels that though the finding on Scale 8 was significant, $p < .05$, it was probably due to subject assignment within groups and not to the explicit effects of the therapists.

On the follow-up assessments, which consisted of a re-administration of the Beck Depression Inventory and the Salamon-Conte Life Satisfaction in the Elderly Scale, the only significant finding was on Scale 2, meaning in life scale. Participants who were assigned to treatment groups obtained a significantly higher score on Scale 2 of the LSES follow-up test than those in the control group. Although at post-test this scale was not significant it was approaching a level of significance at $p = .09$. Therefore, it appears that participants of the

group therapy program began to think more about the meaning of their life.

The post-test findings for Scale 2 is especially important for older adults, who at this stage in their life may be focusing more on the value of their life and less on goal oriented matters. Additionally, this finding is particularly significant in an institutional setting with older adults where the primary focus is on activities of daily living and not on existential or spiritual matters. For older adults, who often have few external goals, and who may be contemplating the value of their life and preparing for their death, the personal meaning of one's life is often a crucial factor contributing toward their psycho-social wellbeing (Reker, Peacock, & Wong, 1987).

The reason for significant results on Scale 2 within the follow-up test and not on the post-test can be due to participants needing more time to fully incorporate the issues discussed. It may also have been encouraged by the therapists' attention to participants, as suggested by the literature on the Hawthorne effect (Morris, 1990). It is notable that the only significant treatment effect in the study was found on Scale 2, Meaning, showing a

direct relationship between participation in group therapy and an increase in the subjects' sense of meaning and purpose in life.

Factors Which Affected the Study

Within this research five prominent factors and two therapeutic issues were found to be especially important in affecting the outcome of the study and which may have inhibited the efficacy of treatment. These factors and issues are discussed below.

In light of the fact that the treatment programs were conducted, in a rigorous manner, similar to other studies with older adults which have resulted in significant outcomes (Haight, 1991; Rush, et al., 1982), several elements of this study appear to have suppressed the outcome of significant results. Through analysis of the data, and in discussions with participants and therapists, the investigator discovered five factors contributing to the lack of significant findings:

1. loss of statistical power due to too few subjects;
2. need for dependent measures which can more accurately reflect the older adults experience;
3. the multiple factors in a personal care home

which impinge upon the quality of the older adults' life;

4. the number of sessions of group therapy;
5. the random distribution of participants created groups which were widely heterogeneous in cognitive ability and needs. Participants ranged from the mildly confused to the highly intellectual with a wide a variety of needs, from needing help to contact their social worker, to developmental issues of grief and loss, to psychiatric issues of coping with paranoid ideation. The wide range of cognitive abilities and psycho-social needs lowered the cohesion and effectiveness of the group process.

These five factors are explored in more detail below.

Factor 1, loss of statistical power.

The original pool of 48 subjects appeared adequate but the loss of 9 subjects due to illness accounted for 19% of the total group. Four subjects dropped out due to changing their mind about their participation, which was 8% of the subject pool and was expected with this population. The four subjects who dropped out were males assigned to a treatment group, and who may have had

difficulty being comfortable expressing themselves within a group setting. No subjects in the control group withdrew due to illness. One subject was dropped from the study for being inappropriate for the group which can be expected in any research study. A total of fourteen subjects (29%) withdrew from the study out of 48 subjects which significantly lessened the statistical power to find significant results.

The majority of the subjects who dropped out due to illness were women (7 women and 2 men). But, the primary investigator who was responsible for assisting residents to the group room felt that some of the women who claimed to be ill (with headaches or just not feeling up to par), dropped out due to feeling uncomfortable in the group. Claiming to be ill may have been their "polite" way to withdraw from the group without offending anyone. Another reason for the high drop out rate may be related to the disengagement theory as discussed by Belsky (1990). The disengagement theory based on the research of Cumming and Henry (1961), defines old age as a gradual process of distancing and disengaging from society as a normal and adaptive activity. Therefore, according to the disengagement theory, older adult participants may be

more likely to drop out of therapy groups to distance themselves from others, especially when these groups focus on discussions of intimate matters and difficulties which can arouse considerable anxiety.

Factor 2, need for more specific dependent measures.

Though the Beck Depression Inventory and the Salamon-Conte Life Satisfaction in the Elderly Scale have been used reliably as a measurement of depression and life satisfaction with the older adult population, a question to consider in light of the lack of significant findings is, are these dependent measures sensitive enough to detect moderate short-term psychotherapeutic treatment differences? They are noted to detect global differences in various psychological domains, but it may be questionable if they are refined enough to detect moderate individual cognitive-affective differences resulting from a brief psychotherapeutic treatment program. The Beck Depression Scale is often used as a clinical screening tool for depression. Other depression scales which are more sensitive to the older adult population and to assessing participants' psychotherapeutic growth may be more appropriate to use for assessment of older adults in group therapy.

The assessments use a likert-type scale, and are designed and standardized for the general population. They do not afford the individual an opportunity to provide unsolicited feedback like a self-report. Often, while administrating the post-test, the primary investigator had many subjects report that the questions did not relate to their situation and they felt that their feelings and thoughts were not acknowledged through the assessment.

In retrospect, a more thorough evaluation would include a self-report on the individuals' mood, perception and insight into self and others, activity level, and level of social interaction, in combination with an assessment for depression and the LSES. Additionally, a standardized questionnaire should be filled out by the individual who has the most consistent cooperative daily contact with the resident, which in this case would be the activity director. This type of assessment would provide an objective external evaluation tool. The questionnaire would use a likert-type scale (1 to 10, with 1 as the highest and 10 the lowest) and focus on specific realms of affect, mood, and personal and interpersonal activity level.

The battery of assessments would be composed of two standardized likert-type assessments completed by the individual, one self-report, and one standardized objective report from a significant other, thereby evaluating the individual from several perspectives including one external source.

For comparison of treatment outcomes, it is recommended to have an attention placebo control group that would discuss current events, along with a standard control group.

Factor 3, length of time in treatment.

In light of the fact that on the follow-up LSES assessment, Scale 2 meaning in life, members of the treatment groups had significantly higher scores, the length of time in treatment may be a crucial factor. Group cognitive therapy and group life review therapy may take longer than 8 weeks to achieve significant treatment effects. Usually short-term group therapy is considered around 14 weeks with long-term group therapy lasting 6 months to a year. But since this study was on a volunteer basis, with a frail senior citizen population, the primary investigator did not feel that participants would make a commitment longer than 8 weeks. It appeared

that an 8 week program was not a sufficient length of time to develop group trust and cohesion and thereby allowing the therapeutic interventions to make a substantial impact and change in the respondents' behavior.

At the post-test, some subjects told the primary investigator that they wanted the program to continue and some were ready for the program to end. Those who wanted the program to continue were very excited about the discussion topics, the issues raised, and their participation. In future studies, it is recommended that the outcome differences between those participants who expressed an interest in wanting to continue in group therapy be compared with those who did not want to continue in group therapy. This may provide further insight into the benefits of the therapeutic program.

The two group leaders also did not want the groups to end and were hoping to be hired by the facility to continue the program. Since the group leaders and participants felt the sessions were productive, the primary investigator felt that even with non-significant results on two dependent measures, substantial therapeutic interaction was occurring within the

sessions.

Furthermore, the reason the follow-up test results showed that participants of the treatment group had a significantly higher score on Scale 2, meaning of life, of the LSES than the control group, may be due to the older adults' need for more time to fully digest and incorporate the ideas presented and the discussions held.

Use of group.

Another factor relative to the length of time in treatment is the time it takes for subjects to learn how to use the group therapy experience. With the therapy groups named "Seniors Speak Out" and held in the recreation room, residents may have assumed it was a recreational group and had difficulty switching the context to discuss significant personal matters. Since an "outside" leader was conducting the session, his prominence should have changed the context of the group for participants, unless they did not know how to respond in a group therapy situation and thought that their role was to be educated by the group leader or to socialize.

The "Seniors Speak Out" group atmosphere was conducive for discussion of personal issues and obtaining support from others. But, participants needed to be

educated in how to use the group to meet their needs. Within the eight sessions, they were just beginning to learn the difference between a social group and a therapeutic group, and beginning to let down their defenses to share their feelings and thoughts. If participation in group therapy was required for all residents when they first entered the facility (to aid in their adjustment), then residents would have more of an understanding of how to use and benefit from the group process. Having residents participate in group therapy when they first enter a personal care facility could help them in coping with the psychological, sociological, and physical changes in their life, along with providing emotional support and bonding with other residents.

Factor 4, the multiple factors impinging on the residents' quality of life.

In presenting the pre-, post and follow-up assessment tests to subjects, each time the primary investigator (without any initiation by him) was enlisted by subjects to listen to their problems for at least 10 to 20 minutes. They talked about how bad their day was, who was irritating them, current family problems, their feelings about their doctor or the staff, or even the

history of their life with an explanation of why they are in the nursing home. It appeared that the assessments where not exactly reflecting how much the participants achieved from the treatment program but rather were an indication of how their day was going.

A personal care home is a home born out of the loss of one's community based home and family. It is a type of institution where the individual is related to others not out of choice, or love, or family relations but out of financial and health-related necessity.

A personal care home is a community, a residential setting which shapes the daily activities and lives of residents, especially those who are ill and under some medical treatment (which accounts for most of the population). Few active and independent residents leave the nursing home and interact with the community at large, and many other residents are not able to leave the facility due to their physical condition and/or their psychological health. Living in a nursing home, the residents daily face the prospect of their declining future, and the loss of fellow residents who die or are transferred to another facility. Even for the few healthy older adults at the personal care center, being

around ill people all day, within a regimented institutionalized lifestyle, probably contributes to a degree of depression and apathy.

The residents' life is not only surrounded by physically and psychologically ill adults but also by a variety of staff, namely aids, med-aids, an L.P.N., the housekeeping staff, the social worker and the activities coordinator. The staff are like the residents' family, and they play a prominent role contributing to the residents' sense of well-being, self-efficacy and self-esteem.

For residents to benefit, psychologically, from participating in a therapeutic program, their behavioral changes must be encouraged and supported in the environment, otherwise their new behavioral repertoire may slowly extinguish along with the benefits of the program. Therefore, it is suggested that therapeutic programs are to be incorporated into the mainstream of a facility. They should be first introduced to the staff to allow them to understand the benefits of the program and then offered to the residents, who would be verbally reinforced by the staff for participating in the program and for the positive changes they make in their lives.

Factor 5, heterogeneous groups.

The use of random assignment of 48 older adult participants, between the ages of 50 and 93, balancing for age and gender, produced groups which were very heterogeneous relative to the participants' abilities and needs. In group therapy the group cohesion and dynamics are influenced by two crucial elements, participants' cognitive ability and their psycho-social needs. The increased heterogeneity of these two factors reduces the cohesiveness of the group and therefore the effectiveness of the therapeutic process.

Cognitive ability.

Though the ANOVA on education did not show significant differences between groups, some participants had a college education and were well read, while others had less than a 6th grade education and were illiterate. Some of the well educated participants, along with the therapists, mentioned that group members did not discuss matters on similar intellectual levels, which contributed to a lack of group cohesion and a breakdown in the group dialogue.

The most striking difference was between those participants who were verbal and alert and those who were

mildly confused or slow to respond in a perceptive manner due to their limited cognitive awareness. The division of cognitive ability was a crucial factor in reducing group cohesiveness, especially in small groups. For example, if out of 8 participants 3 were alert and talkative, and 2 were alert but quiet, and 3 were mildly confused and were just following the discussions, there was a tendency for the talkative participants to take over the group discussion or everyone to be fairly quiet to avoid showing off. In therapy groups which have a wide range of intellectual abilities, there may be an increased sense of group cohesion when participants are assigned to groups according to levels of cognitive ability (average, low).

Psycho-social-physical needs.

There were three major differences in needs noted by participants: basic problems such as activities of daily living; developmental issues of aging; and psychiatric issues such as paranoia. A major division between these needs is between problem-solving needs (activities of daily living) and emotional growth needs (developmental issues). Subjects who had major psychiatric issues may be appropriate in either group.

In problem-solving groups or cognitive therapy groups low cognitive functioning participants can benefit from learning and participating with normal cognitive functioning group members, but the normal cognitive functioning participants may not benefit to their level of need, besides obtaining altruistic and supportive helping needs. In cognitive therapy, participants with a normal level of cognitive functioning are most easily able to understand the concepts and their application. Having participants with a diversity of cognitive levels may frustrate the normal and high cognitive functioning individuals and reduce their involvement and investment in the group. In life review therapy the level of cognitive functioning is not as critical but still makes a significant difference in the quality and depth of the discussion.

The heterogeneous needs and the variety of levels of intellectual ability within the groups slowed up the depth and personal investment in discussions, which then reduced the group cohesion, and effected their ability to relate to each other. In future practice and research with an heterogeneous older adult community it may be advantageous to assign subjects to groups based on low

and average cognitive ability, and on emotional growth needs or activities of daily living needs.

Therapeutic Issues

Two issues became prominent during the course of the therapy program. The issue of denial and boundaries were found to be especially important relative to the group member and the group process.

Denial.

Participants who begin to be increasingly aware of current or past problems in life review or cognitive therapy, which they have successfully avoided through denial, can become depressed and upset due to the increased awareness of their situation.

Participants in life review and cognitive therapy should be made aware that the discussions may raise issues which they had forgotten and new anxieties can arise. It is the therapists ethical responsibility to provide informed consent concerning the therapeutic process, and make participants aware that during some of the discussions (especially those focused on life difficulties) they may feel emotionally upset as their awareness of particular events increases. Furthermore, it should be explained that the purpose of therapy is to

deal with and resolve underlying and overt anxieties and conflicts, toward the goal of feeling better about oneself and one's life.

Due to issues of denial and, as previously discussed, the time it takes for members to learn how to interact in group therapy, treatment may take longer than an eight week program. It is recommended that a group therapy program for older adults should be conducted for 12 to 16 weeks to allow for the full expression of feelings and thoughts, the development of group process, the resolution of issues, and closure within the group.

Boundary Issues.

Issues may be raised in group discussions which participants feel uncomfortable discussing within the group setting due to confidentiality and members opinions. Some older adults (especially men) may not be accustomed to intimate group discussions which previously may have been shared only with family members. These issues are compounded within a residential setting where there often is a loss of physical and psychological boundaries, and residents struggle for autonomy and privacy within the institutional setting. Revealing oneself in a group setting can beget a fear of losing the

respect of other residents or becoming too vulnerable, especially since they live in close proximity to each other with daily contact.

Members should be given the opportunity, if needed, to discuss certain concerns in private with the group therapist who will then help them find a discreet manner in which they can discuss it with the group, or will offer a short amount of individual time to deal with the matter, or if necessary will refer the person to individual therapy. Within the eight week program the need for individual time with a therapist was only requested by one subject who was suffering from paranoid ideation. She met with the group leader on two occasions after group, for 15 minutes, and was directed to discuss the matter within the group, which she did.

Implications

In light of the non-significant findings on the dependent measures, the primary researcher felt that a combination of the therapies employed (cognitive therapy, life review therapy) may be more effective for future practice and research in group therapy with older adults.

Since older adults may feel more of an affinity with their past (a time when they possessed more personal

power) than the present, life review therapy may be a more appealing activity than cognitive therapy which primarily focuses on the here and now. But, by using a combination of cognitive therapy and life review, participants can review their life and re-evaluate their experiences, re-examining dysfunctional conceptions and erroneous thoughts through reframing and other cognitive techniques. By itself, life review is a way to become aware of one's life history, and cognitive therapy focuses on the perception of one's life, but together, both therapeutic approaches offer a way to view one's full life in a healthy manner.

It is recommended for future studies to employ a 12 week life review/cognitive therapy group, combining and integrating both protocols used within this study. To combine the protocols first a life review theme would be presented followed by a cognitive therapy lecturette. For example, in session 1 the life review theme is childhood and the cognitive therapy lecturette 1 is "overgeneralization." The group would spend the first 30 minutes discussing childhood memories followed by a 30 minute lecturette on "overgeneralization." The last 30 minutes of the group would be devoted to discussing how

participants used overgeneralization in their childhood and what significance it had in their life. The other session themes would be:

Group 2: Life review discussion on "Adolescence" and cognitive therapy lecturette 2 on "Awfulizing"

Group 3: Life review discussion on "Adolescence and Early Adulthood" and cognitive therapy lecturette 3 on "Mind Reading"

Group 4: Life review discussion on "Family and Home" and cognitive therapy lecturette 4 on "Self-Blame"

Group 5: Life review discussion on "Adulthood" and cognitive therapy lecturette 5 on "Demand on Others"

Group 6: Life review discussion on "Adulthood" and cognitive therapy lecturette 6 on "Unrealistic Expectations of Self"

Group 7: Life review discussion on the "life review summary" and cognitive therapy lecturette 7 on "Exaggerating Self-Importance"

Group 8: Life review discussion on the "life review summary" and cognitive therapy lecturette 8 on "Building Support Networks"

Group 9: Life review discussion on areas of special

importance during childhood and cognitive therapy theme is on members' current issues.

Group 10: Life review discussion on areas of special importance during adolescence and cognitive therapy theme is on members' current issues.

Group 11: Life review discussion is on areas of special importance during adulthood and cognitive therapy theme is on the group process and the topic of group support.

Group 12: Life review discussion is on current areas of special importance and cognitive therapy theme is on members' evaluating the changes they have made and setting goals for the desired changes they want to make in the future.

Summary

Significant results are always desired by researchers to prove a hypothesis, but when the results are not significant it is the researchers' duty to carefully analyze the experiment to further understand the limitations of the study. Social scientists do not only seek significant results in their studies, they also strive to understand why and under what conditions did the results occur; searching for a deeper understanding

of the research which can guide them in future studies. Often, a careful examination of the study can reveal new questions and insights relative to the complexity of the research, providing a wealth of information.

This study sought to compare the effectiveness of cognitive group therapy with life review group therapy, in the areas of depression and life satisfaction, with older adults who live in a personal care facility. Based on two objective likert-type scales there were no differences found between the two therapeutic approaches. Particular intervening variables were found within the research study which inhibited treatment outcomes, and which are presented in the discussion section.

The study described two group therapy programs and presented a discussion of the implications of providing group therapy to older adults who reside in a personal care facility, which can aid future clinicians in designing group therapy programs. Though, the treatments examined did not result in significant findings, it did provide many insights into the dynamics of group therapy with older adults, who reside in a personal care facility.

In retrospect, since there was a fairly small

subject pool, if the study would have resulted in significant findings for both dependent measures, the findings may have only been due to a very specific sample of the population within the groups, and therefore not be a representative finding which can be generalizable.

The biopsychosocial complexity of the older adults' situation in this study is vast. It included residents whose ages span over 40 years (50-93) and a variety of psychological, social, and medical needs. The group therapy programs employed were not limited to a singular aspect of the clients' lives but rather dealt with a range of needs related to the individuals' past, present, and future. This study was confronted with a wide diversity of client needs, limitations and abilities which was felt by subjects and therapists to limit the effectiveness of the therapeutic process.

In a residential facility with a diversity of residents, who face a variety of biopsychosocial problems, the needs of clients in group therapy are quite diverse. Without an understanding and appreciation of the complexity of the situation, the therapist may not recognize the depth and breadth of treatment needs and psychological issues facing clients. The therapist not

only has the task of keeping a therapeutic focus within a group of older adults who have diverse needs and abilities, but also may need to address underlying existential questions related to aging, which clients face and try to answer. The underlying questions can easily be overlooked, by the therapist and client, in pursuit of quick solutions to recent difficulties which overshadow the in-depth problems and questions.

From the non-significant findings of this study several questions still face us regarding the effectiveness of therapy for older adults. Particular therapeutic approaches may be more effective to help people deal with specific issues such as grief therapy. The underlying research question presented in this study is not which approach is better, but rather why is one approach more effective for certain populations, issues, personalities, and time periods than another approach. What does one approach, for example cognitive therapy, offer clients that life review does not offer and vice versa?

In conducting the study new questions arose such as how to most effectively assign participants to therapy groups who have a variety of needs and cognitive

abilities; issues of boundaries; length of time in treatment; the multiple psychosocial effects on residents of residential settings; and appropriate and sensitive dependent measures.

Cognitive therapy and life review therapy, both, have shown positive results for older adults (Haight, 1991; Rush, et al., 1982). For older individuals residing in a personal care facility and whose lives are shaped by the multiple psycho-social factors in an institutional setting, we may still question which therapy is more effective and apropos, and at what time or for which issues in their lives is a particular therapy more effective? We are living longer and life has become more complex. At this time, with the increased aging of the population, we need to further study the effectiveness of psychotherapeutic modalities and approaches for older adults.

The results of this study provides a springboard to new research questions, with an enhanced sensitivity to the older adults' situation. Group therapy may now be a luxury for a select few older adults, but someday it can prove to be an essential therapeutic tool for coping in the later years of life.

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Appendix A:

Demographic Information

Date of Screening _____

Name _____ Code _____

Codes: Age 1. _____ , Sex 2._____, Ed. 3._____,

4. Group _____, 5. Therapist _____

1. 50 to 74 = (1) _____

   75 to 100 = (2) _____

Age _____

Birth Date _____

2. Sex: Female (0) Male (1) _____

3. Years of formal education: _____

4. Group (1-5)_____

5. Therapist (1-2)_____

Beck Depression Inventory

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Salamon-Conte Life Satisfaction in the Elderly Scale

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SAMPLE ITEMS FOR THE

WAYS OF COPING QUESTIONNAIRE

by Susan Folkman, Ph.D. and Richard S. Lazarus, Ph.D.

Directions: To respond to the statements in this questionnaire, you must have a specific stressful situation in mind. Take a few moments and think about the most stressful situation that you have experienced in the *past week.*

By "stressful" we mean a situation that was difficult or troubling for you, either because you felt distressed about what happened, or because you had to use considerable effort to deal with the situation. The situation may have involved your family, your job, your friends, or something else important to you. Before responding to the statements, think about the *details* of this stressful situation, such as where it happened, who was involved, how you acted, and why it was important to you. While you may still be involved in the situation, or it could have already happened, it should be the most stressful situation that you experienced during the week.

As you respond to each of the statements, please keep this stressful situation in mind. Read each statement carefully and, using the scale below, indicate to what extent you used it in the situation. Please respond to each item.

1 - Does not apply or not used
2 - Used somewhat
3 - Used quite a bit
4 - Used a great deal

Confrontive Coping

_____ Tried to get the person responsible to change his or her mind.

Seeking Social Support

_____ Talked to someone to find out more about the situation.

Self-Controlling

_____ Tried not to burn my bridges, but leave things open somewhat.

Distancing

_____ Went along with fate; sometimes I just have bad luck.

SAMPLE ITEMS FOR THE

WAYS OF COPING QUESTIONNAIRE

by Susan Folkman, Ph.D. and Richard S. Lazarus, Ph.D.

1 - Does not apply or not used 2 - Used somewhat 3 - Used quite a bit 4 - Used a great deal

Escape-Avoidance

_____ Slept more than usual.

Positive Reappraisal

_____ I was inspired to do something creative.

Accepting Responsibility

_____ I apologized or did something to make up.

Planful Problem Solving

_____ I knew what had to be done, so I doubled my efforts to make things work.

Therapist Assessment Rating *

I.D. _____ Sum total score _____

Rate the group therapist from 1 to 5 on all items. Rating scale: 1 = extremely low degree, 2= below average 3 = average degree, 4 = above average, 5 = high degree.

___1. To what degree does the group leader encourage members to express their feelings?

___2. To what degree is the group leader able to explain the meaning of behavior?

___3. To what degree is the group leader able to confront members when they are engaged in behavior that is inconsistent with what they are saying or is distracting to the group?

___4. To what degree is the group leader able to demonstrate behaviors that he wishes members to practice during and after the session?

___5. To what degree is the group leader able to direct members on improving existing behavior patterns and aid in developing homework assignments?

* The Therapist Assessment Rating is adapted from the Evaluation of Group Leaders form by Cory and Cory in **Groups, Process and Practice** (3rd edition), 1987.

___6. To what degree does the group leader demonstrate empathy with group members and communicate that they are being understood?

___7. To what degree is the group leader able to obtain interaction among members and between the leader and members?

___8. To what degree is the group leader able to help members clarify their goals and take steps to reach those goals?

___9. To what degree is the group leader able to identify specific areas of struggle and conflict within each member?

___10. To what degree is the group leader able to follow through with a member on a specific issue or concern to a satisfactory end?

___11. To what degree does the group leader actively and fully listen to and hear the messages communicated by group members?

___12. To what degree is the group leader able to accurately extract the meanings from verbal and nonverbal communication?

___13. To what degree is the group leader able to express thoughts and feelings clearly to members?

___14. To what degree is the group leader able to help a group of people work together effectively.

___15. To what degree is the group leader aware of members' value systems, respects their value systems, and is able to avoid imposing his values on the members?

___16. To what degree does the group leader communicate an attitude of respect for the dignity and autonomy of members?

___17. To what degree does the group leader communicate an attitude of genuine caring and concern for members.

___18. To what degree is the group leader able to use therapeutic techniques to help members work through conflicts and concerns.

___19. To what degree does the group leader behave in an ethical manner demonstrating a sensitivity to the boundaries of the relationship and the privacy of group members.

___20. To what degree does the group leader exhibit professional competence as a therapist.

Appendix B: Protocol

Page Number

Cognitive Group Therapy Protocol

The protocol is derived from Group Cognitive Therapy: A Treatment Approach for Depressed Older Adults, (Pergamon Press, 1986) by Yost et al., pages 83-94 and 111-113 with minor adaptations. Permission to reproduce the protocol was granted by Pergamon Press (see Appendix C).

The interaction within a cognitive group therapy session offers older adults a time for socialization, an activity to help others (altruism), and a place to share difficulties and issues. The group dynamics promotes the acknowledgment of the universality of problems and aids in normalizing the aging experience. The group cognitive therapy model provides participants an opportunity to discuss and reflect on problems, learn new cognitive skills in addressing their problems, plan homework assignments, practice the skills they are learning, and obtain feedback on their experiences and progress.

Listed below is an outline of a cognitive group therapy session, from Group Therapy by Yost and Corbishley (1985).

1. Preliminaries (10 minutes)

    a. Social time

b. Agenda

2. Homework Review (30 minutes)
    a. Successes
    b. Problems
    c. Contact work and individualized homework assignments
    d. Feedback on contact work
3. Lecturette (40 minutes)
    a. Lecturette (5 minutes)
    b. Feedback regarding comprehension of lecturette
    c. Personal application
    d. General homework assignments
    e. Contact work and individualized homework (if appropriate)
    f. Feedback on contact work
4. Concluding Activities (10 minutes)
    a. Review homework assignments to ensure tasks are understood
    b. Feedback on the session

The group cognitive therapy session is divided into four stages. The time length has been adjusted from the original design of two hours to one and a half hours to accommodate those who are frail, with a shorter attention

span, and those who may not be able to sit in a group discussion for two hours.

Stage 1: Preliminaries

The first stage of the group, the preliminaries which can take up to 10 minutes, is an opportunity for socialization and a time to set the agenda. In setting the agenda the therapist invites clients to suggest personal issues they would like to discuss in the group. The issues are written on a blackboard and later referred to in group discussions and in contact work. (Contact work is individualized work within a group session focusing on a participant's problem.)

Because of the varying issues the therapist will want to focus on issues with a particular theme such as family, friends, or issues of aging. Some clients may present unsuitable issues and non-therapeutic topics like current events, philosophical questions or social events at which time the therapist will have to educate the individual about the purpose of the group and steer the conversation to a topic upon which the individual and group can work. Techniques such as rounds can stimulate discussion, focus the topic on a particular issue, and aid in bringing to the surface individual agendas.

Stage 2: Homework Review

The second stage of the group is the homework review which lasts up to 30 minutes. The homework review includes discussing participants' successes, problems, deciding on the contact work and individualized homework assignments, and providing group feedback on the contact work. The assignment of homework is an essential aspect of cognitive therapy whereby residents can transfer in-session learning to in vivo practice.

To better ensure residents of completing homework assignments the therapist will fully discuss the mechanics of doing the homework (break down the activity to simple steps) and delineate the times it is to be done. Inertia, apathy and negative cognitions reduce compliance with homework activities, therefore, the therapist will offer a rationale for completing homework assignments. The rationale is that they are learning new skills which require practice, and these skills need to be applied in the environment where the symptoms occur. It is explained that just the activity and short time spent in the group session cannot significantly reduce depression and change their life outside of group.

There are two types of homework assignments: general

homework and individualized homework. General homework stems from lecturette material and frequently involves monitoring and recording clients' emotional and cognitive reactions to events or to applied behavioral techniques. Individualized homework proceeds from the contact work and is designed to meet specific individual needs.

Homework review is essential because homework is an integral part of the group therapy. The homework review begins first with the successes, and members are encouraged to provide positive reinforcement for any achievement. Thereby, the therapist models the acceptance of realistic limited levels of success and is able to shift the focus from negative to positive aspects of events. Homework feedback is especially important. Clients must first learn to identify the relationships between thoughts and feelings, and then focus on the adequacy of the cognitive and behavioral strategies as related to their effectiveness.

Stage 3: Lecturette

The third stage lasts up to 40 minutes which consist of a short lecturette, feedback regarding comprehension of lecturette, discussion of personal application of the material discussed, general homework assignments,

possible contact work and individualized homework, and feedback on contact work.

The lecturette is used to present concepts of cognitive therapy in a brief lecture delivered in a somewhat formal manner, with the use of a blackboard to illustrate the material. Each lecturette is prepared before the start of the session, contains only one major point, and takes about five minutes to deliver. The lecturette is followed by a group discussion to ensure that the members understand the material and know how to apply the concepts to their own lives. Members are provided with a written summary of the lecturette to refer back to.

Eight lecturettes are provided to the group leaders. Each lecturette is to be handed out to participants at the end of the session. The lecturettes were drawn from the book, Group Cognitive Therapy by Yost, et al (1986). On the eighth session, in addition to the lecturette, the group leader conducts a review of the concepts covered, the progress made by the participants, and discuss the areas participants may want to continue working on.

Feedback

Feedback is an essential component of the therapy.

It enables the group leader to receive participants reactions to the lecturette, the homework assignments, other members' comments, and to keep the session active and integrative with participants involvement. Feedback by participants ensures that the material discussed is relevant, on target, and comprehended by all. When the therapist elicits feedback frequently and acts upon it quickly, it increases the clients perception that the theory and group is tailored to their own needs. This type of activity results in participants having a greater sense of control, collaboration and mastery over the material which in itself creates a dynamic therapeutic process.

Definition of Contact Work

A one-to-one encounter between a therapist and a client in a group setting is called contact work. When a client is struggling with a particular issue he or she is invited to focus on the problem with the therapist for "contact work." Individual contact work is designed to intensify the therapeutic experience and to engage the client in the problem-solving process. The encounter can take up to fifteen minutes while other members are asked to refrain from commenting until the end of the encounter

at which time they are asked to share their understanding of the work and its possible application in their lives. The process of doing contact work entails:

1. gaining permission to explore the problem
2. relating the problem to the event-thought-feeling (ABC) format
3. having the client examine the dysfunctional ideas, evaluate the significance of the dysfunctional beliefs, and create ideas which are more functional
4. designing an "experiment" (homework assignment) with the participant in order to test or further clarify what has been discovered during the contact work. The assignment should include reality testing of beliefs which the client is still evaluating and practicing a new belief derived from the contact work.

Stage 4: Concluding Activities

Stage four consist of concluding activities which last about 10 minutes. During this time the therapist reviews homework assignments to ensure tasks are understood, highlights concepts discussed, and obtains and provides feedback on the session, and comments on the topic of the lecturette for the next session.

Lecturette #1

Overgeneralization

Explanation. Depressed people tend to see a single incident as a sign that a great deal more is wrong. If one flower fails to bloom in the garden, this seems proof that nothing will bloom and that the person is a terrible gardener. This form of cognitive error, called overgeneralization, is responsible for much depression, because it paints the whole world black. For example, a man uses a new type of latch to fix his gate and puts it on wrong. He believes, as a result of this one failure, that he has lost all his handyman skills and tells himself. "I'm useless. I'll never be able to keep this place in shape." He feels worthless and incompetent. In another example, a woman feels very depressed one afternoon. She thinks, "My life is nothing but depression these days. I just feel so terrible all the time," and her depression increases. When a man sees a teenager throw garbage on his lawn, he thinks, "Kids nowadays are no good. This neighborhood isn't fit to live in any more." He feels angry and helpless.

In all these examples, the person was assuming that one unpleasant situation applied to all time and to all

similar situations and people. This generalization is almost always a distortion of the truth and can best be challenged by looking for exceptions to the overgeneralization. Ask the group members what sort of evidence might the people in the examples find to counteract their overgeneralization (place this evidence in a fourth column (alternative thoughts) on the board).

Table 7

Example of a 4 Column Record

---

1. Event: Forgotten wallet
   Thoughts: I'm getting senile
   Feelings: Frightened
   Alternative Thoughts: Everyone forgets things occasionally
2. Event: An empty mailbox
   Thoughts: I'm all along. Nobody cares.
   Feelings: Sad, isolated
   Alternative Thoughts: I can't expect a letter when I haven't called or written anyone in a month.
3. Event: Spouse in nursing home
   Thoughts: I've failed as a caretaker.

Feelings: Inadequate

Alternative Thoughts: I haven't failed since he or she is getting the best care available. Now I can help by visiting and calling.

Personal Application. Overgeneralization can often be detected in the use of words such as never, always, everyone, no one, all, nobody. Ask group members to think of a recent time when something bad happened and they thought it would keep on happening or that all people would behave the same way. If they have difficulty in doing this, suggest typical examples such as: "I'm always depressed nowadays" or "No one cares if I live or die." Write these statements and the accompanying dysphoric emotion on the board. Ask members to think of an exception to each overgeneralization and to rephrase their statement in the formula: "It is not true that (overgeneralization), because (exception)." For example, "It is not true that I can't do anything right, because yesterday I fixed the lamp." Write the corrected statements on the board.

Homework. As usual with cognitive errors, the homework is done in two stages, recognition (see table 4) and challenge. The stages can be combined or assigned on

successive weeks, according to the needs of the members.

For the recognition stage, members are provided with an ABC recording sheet (see table 5) and are asked to monitor single distressing incidents, looking in particular for the key words that indicate overgeneralization. Participants might find it helpful to post a list of keywords in a prominent place as a reminder.

The challenge stage requires members, either at home or during the group session (with or without the help of others) to look for evidence contradicting the overgeneralized conclusion. Members might wish to complete the sentence formula practiced in the group session or simple note the evidence. For this stage of the assignment, members should be asked to complete column D on a form provided (Table 6). They should also note any change in feelings as a result of the altered thoughts. The records can be shared at the next group session.

Table 8

Example of an ABC Recording Sheet

A Situation	B Thoughts	C Feelings/Mood
A sunny day	Life use to be fun, but no more.	Depressed
Doctor says my eyesight is worse.	There's nothing to live for if I can't see.	Hopeless, tired, want to give up
Feeling down	I should be able to snap out of this.	Guilty

Table 9

Participants' ABC Recording Sheet

A Situation	B Thoughts	C Feelings/Mood
1.		
2.		
3.		
4.		

Lecturette #2

Awfulizing

Explanation. In depression, people tend to attach a great deal of importance to unpleasant events in their lives. In fact, they give negative events the power to overshadow and even destroy anything good that might be happening. For example, a woman says, "My daughter was rude to me my whole day. " Another person complains. "I'm miserable all the time because of my son's marriage." A third person believes, "If I lose any more of my sight, there'll be nothing left for me in life." In all these cases, some unpleasantness really exits, but the people involved are concentrating their time and attention on the negative situation to the exclusion of most other things in life, including anything positive and pleasant. In this way, the negative aspect becomes dominant, with the power to obliterate anything pleasant. Citing these examples, ask group members to identify words that indicate the exaggerated power each person has given to a negative event.

Personal Application. Awfulizing uses words and phrases such as terrible, dreadful, awful, tragedy, catastrophe, my day/life etc. is ruined. Ask members to think of a

time, recently, when they felt bad for a while after some occurrence (don't include major events such as death). Write on the board what they say to themselves to exaggerate the importance of the event. Explain that there are several ways to counteract awfulizing:

1. Distract yourself from the negative by noticing something good or pleasant that is also happening: e.g., "My daughter was rude, but I got a nice letter from a friend."

2. See if there is anything good or pleasant in the situation, or any way that it could be made less negative. "At least if I go to a social event alone, I can come home whenever I please, without having to consult with someone else."

3. Decide that it is not your intention to let one negative occurrence ruin your whole day: "I was looking forward to planting my flowers today. I can't do anything about my son's marriage, and I refuse to let thinking about his problems spoil my plans."

4. Accept the negative aspects of the event, but minimize them: "Losing my sight is a very difficult thing for me to handle, but it doesn't mean life is over. I can still talk to people and hear music, and I'm learning how to

get around."

Use members' own statements and challenge them with the above techniques, or other techniques the group invents.

Homework. It is natural to be upset by unpleasant happenings, but they must not be allowed to assume an exaggerated importance if we want to avoid depression. Awfulizing thoughts, especially the small daily ones need to be challenged. Homework is the same as has been practiced in the Personal Application section of the lecturette. Records should be kept in four columns (see Table 7, p. 127):

A	B	C	D
Event	Awfulizing+Feeling	Corrective	Technique

Table 10

Participants' ABCD Recording Sheet

A	B	C	D
Event	Awfulizing + Thoughts	Feeling	Corrective Technique
1.			
2.			
3.			
4.			

Lecturette #3

Mind Reading

Explanation. Mind reading occurs when people assume they know what someone thinks or how someone feels without asking that person. While all people make assumptions about what others think in given situations, these assumptions become a problem when they make the people feel bad. By asking an individual what he or she is thinking or feeling about a situation, misunderstandings that originate in the assumptions can often be cleared up. For example, a man found out that a neighbor was having a party and had invited the whole neighborhood except him. He immediately concluded that the neighbor did not like him and felt rejected. Later, when he found out that the neighbor had tried to reach him, he was relieved and felt embarrassed that he had drawn such a quick conclusion.

To take another case, a woman who had just moved to a new city felt lonely. After several weeks, a neighbor called and invited her to a card party. She declined the invitation because she assumed that the woman only invited her because she was lonely and not because she liked her. Later, she found out that the neighbor really

did enjoy her company and she felt disappointed that her mind reading caused her to miss an interesting social occasion.

In these cases, both people mistakenly believed that they could guess what another person was thinking, and their error caused them some distress. Although sometimes, people correctly gauge others' reactions, often they cannot, and they upset themselves unnecessarily.

Suppose, for example, that on a first date Ralph was very quiet. What negative interpretation might Helen, his date, make of his reserved behavior? How might she feel? What other possible (neutral or even positive explanations might Ralph have for his silence?

Or, take the case of Henry, who had make plans with his wife to go shopping. When the time came for them to leave, she made no mention of the outing and seemed to be involved in an art project of her own. What negative mind reading could Henry do at this point? How would he feel as a result? What other possible explanations are there for the wife's behavior?

In a third example, a man arrives home late for dinner. When he enters the house, his wife frowns at

him. What might he believe she is feeling? How might he then feel? Is there any other way to interpret her frown?

Personal Application. Ask members to remember times in their lives when they engaged in negative mind reading, felt unhappy as a result, and discovered later that their interpretations were wrong? Ask them to think of any recent time when they succumbed to negative mind reading, so recent they have not as yet found out whether the suspicions were true? Ask them to think of a more positive mind reading. When people change from negative to positive mind reading, how to their feelings change? Discuss how to check the accuracy of mind reading.

Homework. Mind reading is often hard to detect because it happens so easily. If this type of error in thinking is producing depression, they first step is to gather examples of its occurrence. Ask clients to take a few minutes at the end of each day to look at their interpersonal interactions and at the assumptions they might have made about others' feelings and thoughts. Clients might reevaluate the evidence on which they based an assumption. For example, they could ask themselves, "What made me think he was angry?"

Once it is established that the client is, in fact, mind reading (i.e., drawing a conclusion about another person's feelings or thoughts from nonexistent or flimsy evidence), use the second stage of homework (determine the adequacy of cognitive and behavioral strategies) to challenge the mind reading. When possible, check out the mind reading assumption with the person whose mind was "read." When this is not possible, participants can look for evidence that a more positive assumption might be true. In the face of no evidence, they can imagine other possible explanations for the behavior of the person whose mind they are trying to read. These different steps can be presented as separate homework assignments or as one assignment, containing alternative ways to deal with mind reading.

Lecturette #4

Self Blame

Explanation. Self-blame is another type of dysfunctional thinking that poses a problem for people with depression. While most people want to see themselves at faulty as little as possible, depressed individuals are just the opposite; they try to blame themselves for just about everything. Usually self-blame causes depressed people to feel even more depressed.

Excessive self-blame can be challenged in at least two ways: One is to ask oneself whether this amount of blame would seem reasonable if someone else blamed himself or herself that much. Another way is to wonder if one is being greedy in claiming all the blame. In other words, was anyone else to blame in any way, and how big a share of the blame should one legitimately claim?

For example, a woman whose husband had a severely debilitating disease blamed herself for not having learned about nutritional approaches to the prevention of the disease. She told herself that it was her fault that her husband was so ill; she had been a terrible wife. She felt so guilty that she, too, became ill.

In another example, a man who prided himself on his

financial success lost a great deal of money in the stock market. He told himself that he should have foreseen the disaster; it was his fault that his family's financial situation had deteriorated. These thoughts made him feel so depressed that he was unable to work, and the situation got worse. In both of these cases, some self-blame might be legitimate, but both people increased their depression by blaming themselves and by dwelling on their faults.

Suppose a man were to find out that his wife was having an affair. How might he unreasonably blame himself? What would his feelings be if he accepted all the blame? Or suppose a woman finds out that she has been tricked out of her savings by a con man. She would naturally feel very upset by this. How might she make herself feel even worse by blaming herself?

Personal Application. Ask members to think of times when they blamed themselves and felt very bad as a result. One way to think of occasions is to complete the sentence, "It's my fault that ..." Ask them, "How large a share of the blame do you think is yours? Can you think of anyone else or any other factors that might

share the responsibility? How much blame would you apportion to someone else in a similar situation?"

During this discussion, group members can be asked to estimate how much blame should be allotted in each case. It is often enlightening to members to discover that almost everyone has different opinions on the subject.

Homework. Because it is so natural to look for a culprit when trouble arises it is sometimes hard to realize when people blame themselves too much, especially if others are happy to agree and let them have all the blame. If excessive self-blame is a hidden problem, one way to gain a better perspective on it is by exaggerating it. For the first level of homework, ask clients to list all the negative events of each day and find a way to blame themselves for each one. If there seem to be no problem, that can be a cause for self-blame, too, because clients can accuse themselves of not trying hard enough to do their homework.

A second level of homework is to ask clients to examine present and past incidents of self-blame, listing all other possible factors and people that could reasonably share the blame. The clients need not be

convinced of the contribution of these factors, but should bring in the list, so that the group can help the person sort out how much self-blame they are responsible for.

Lecturette #5

Demand on Others

Explanation. It is natural for all of us to anticipate things and to feel disappointed when our expectations are not met. This disappointment can turn to depression when we require, or demand, that things happen or people behave in a certain way. To prefer or wish that things go as we would like them is reasonable, but people set themselves up depression when they expect others to think or feel or act as they would prefer. When people feel let down by others, they often make the situation worse by the conclusions they draw. They might decide, for example, that the other person is in some way bad and, as a result, alienate themselves from that person. It is even more depressing if they conclude that the other person disappointed them because of their own failing. For example, a man raised his children to be Roman Catholics. When they left the Catholic Church he was so angry and disappointed that he refused to allow them in his house. This man made three errors in thinking that led to his depression. First, he expected his children to espouse his values rather than develop beliefs of their own. Second, he concluded that his children were

sinful. And third, he concluded that their lack of faith reflected on him and meant that he had done a poor job as a father.

A woman who prized books lent one to a friend who had little respect for books. The friend returned it with coffee stains on the cover. The lender made the same three types of mistakes in her thinking: "She should know better than to treat my property like that" (expecting her friend to have the same values as she had). "She's irresponsible and untrustworthy (drawing negative conclusions about the person's character). "She obviously doesn't think I'm worth having as a friend" (drawing negative conclusions about herself). These thoughts and the consequent feelings led to a permanent rift in the friendship. Demanding that others live by one's standard will almost always lead to depression because there are many different standards of behavior in the world and few people are likely to have exactly the same standards.

Several methods can counteract the "shoulds" that occur when people demand that others behave as they think they ought. One way is to realize that there are many different standards in the world and no way to prove which is right. This realization can be achieved by

asking others to discuss their rules and beliefs on various topics. Even the group often contains a considerable diversity of opinion, at least enough to counter the common belief that "everyone knows...(or) everyone believes..." Another way is to talk with others to examine their expectations to see if they are reasonable. For example, a widowed mother expected her busy married son to visit her daily. In what ways might this be too much to expect? Is there possibly a compromise that mother and son could agree on? Sometimes, the "rule" is quite reasonable but the other person chooses not to follow it. As there is no way to force others to follow one's own wishes, it can be helpful in these situations to examine the conclusions drawn. For example, a son expected his parents to pay for his college education, whereas they believed that he would value his education more if he had to work for it. The son risked depression and alienation if he concluded, "This proves that they don't think I'm worth their love. I must be unimportant to them. They are terrible people and I want nothing more to do with them." People can be helped to identify their conclusion and ask themselves: "Is there another way to explain the behavior?" " Does

just one act mean that the whole person is worthless?" "Even if the person is terrible, whey should that say anything bad about me?"

Personal Application. To recognize when one demands that others live by one's beliefs and rules, look for the words should, ought, must, or statements that tell others how to behave: for example, "If you loved me, you would..." or "If you were a good son to me you wouldn't... Explain to the members, "Another way to tell if you are demanding is by your reactions. When the person did not do as you expected, were you merely disappointed or did you feel angry, betrayed, hurt, helpless? If these were your reactions, you probably had an unreasonable expectation that the other person would comply with your wishes."

Ask them to think of a time when they were disappointed by someone else's behavior. "What belief or rule were you demanding that person follow? What assumption did you make about shared values or opinions? When the person did not do things as you expected, how strong were your reactions? What conclusions did you draw about the other person's character or about yourself?" Discussion on the rules underlying demands

can be valuable if group members are able to help a person to identify rules that are unreasonable or can suggest compromises.

Homework. During the coming week, ask members to monitor their feelings regarding how others treat them or behave in general, and notice if they are saying or implying a "should." Have them bring a record of those feelings to the next session. Second level homework concerns deciding whether to keep or discard a particular standard for the behavior of others. To make this decision, it can be helpful to consult others whom one respects. One possibility is to role play, in the group session, an interaction to be carried out for homework, in which someone negotiates a compromise with someone else or discusses a problematic behavior. It is also possible to break the intensity of an emotional reaction by reminding oneself, "I can't expect everyone else to think the way I do. People have a right to live their own way" (providing, of course, that the client endorsed this belief and arrived at it without undue persuasion by the therapist or other group members).

Lecturette #6

Unrealistic Expectations of Self

Explanation. As people mature, they develop standards for their own behavior and expectations of how they will and should behave in various situations. Those who fail to live up to these expectations often feel ashamed or guilty, and the uncomfortable feelings push them to make amends for any harm done or to try harder in the future. Thus, self-expectations are a good way to keep behavior in line. But, feeling upset about one's performance can become a problem. Depressed people tend to make two mistakes in the area of self-expectations: first, they often set up unrealistically high standards for themselves, and second, they are unforgiving toward themselves when they do not meet these standards.

For example, a man lost his job because of illness and could not provide for his family as well as before. His upset over his unemployment turned to depression because he kept telling himself, "I should be able to take care of my family. I shouldn't let my health stop me. If I were a strong person, I'd get over these problems." Similarly, a woman, unable to care at home for her husband who had a stroke, put him in a nursing

home. She became depressed by telling herself what a terrible wife she was because she should be able to look after him. In both examples, they made themselves depressed because of demanding the impossible from themselves.

Most unrealistic self-expectations are based on a set of rules about how one "should" behave as a good husband, wife, child, parent, employer, etc. Often these rules become an automatic part of thinking, and are rarely examined as to whether they make sense in a particular situation. In the examples just mentioned, the unemployed man had a rule that a man must always provide for his family or else he is a failure. The woman had a rule that a woman always takes care of her family's physical ailments, and she is a failure if she does not. Neither of these people allowed for exceptions to their rules, caused by uncontrollable circumstances.

Personal Application. Take the example of a woman who becomes depressed because her real estate company was doing badly during a severe slump in the housing market. What unrealistic self-expectations (that is, what "should" or "rules") might she be telling herself about her performance as a business woman? In another case, a

salesman could find no other job that paid as well as selling, although he had to spend most of his time away from home. His teenage son was arrested for drug dealing. What unrealistic rules might the father have about his role - rules that could lead to depression?

There are several ways to challenge rules that lead to depression. First, ask others if they have the same rule and if they allow any exceptions. Often, other people have very different rules, yet still manage to be decent, responsible human beings. This realization can help members feel free to choose a less harsh rule or to forgive themselves. Second, ask whether breaking one rule really means that one is a complete failure in that area. For example, is putting a sick husband in a nursing home proof that someone is a bad wife, or are there some other ways to be a good spouse? Third, ask if the same rule would apply to other people. Often people set higher standards for themselves than others, Almost as if they were, somehow, better than others to start with and can, therefore, be expected to reach higher. Members could ask themselves what reason they have to think they are so different from others.

In order for members to look at any of their own

rules - rules that might be contributing to their depression - have them think of a time when they were disappointed or upset with their own behavior and felt they should have acted differently. What "should" or "rule" did they have? Using one of the approaches just discussed, have them examine their rule and see if it was unrealistic or if they were being too hard on themselves. Homework. Like many other depressing thoughts, "should" and "oughts" are often automatic. The first step to eliminating these thoughts is to become aware of them. Ask clients to record each occasion on which they feel disappointed upset, angry, or frustrated with themselves and to identify the underlying demands they are making on themselves. Discuss these records with the group during the next session. If clients are unable to identify their underlying demands, they could be asked to list the various roles they play in life, together with a set of rules for each role by completing sentences such as "A good father..." "A Christian..." " A good citizen..."

The second level of homework is for clients to challenge their "shoulds". Since "shoulds" are often the product of a lifetime set of values, many older adults will not wish to abandon them even those that might

appear unrealistic. In these cases, therapists can reach a compromise by focusing on the idea of accepting the occasional failure, continuing to do one's best and perhaps trying to compensate for failure in other ways which is aided by endorsing the statement "I'm doing the best I can, even if I make mistakes."

Lecturette #7

Exaggerating Self-Importance

Explanation. A type of distorted thinking that increases depression is exaggerating one's self-importance. This usually occurs in social situations where the person thinks that others are watching or thinking about him or her. This type of error in thinking can be recognized in phrases such as "Everyone noticed..." "Everyone knows that I did that wrong..." "They are all thinking..." This error is based in the belief that one is the center of other people's attention and that they are all noticing and criticizing one's mistakes. Two ways to challenge the belief are to check out whether, in fact, everyone noticed and, even if they did, what importance should be given to their noticing.

For example, a man entered a crowded dining room, caught his heel on the step and fell. His immediate thought was, "Everyone say me fall. They must think I'm drunk." Feeling embarrassed and conspicuous, he at once left the room, not looking at anyone. In another example, a woman who was usually meticulous about her writing mailed out a christmas letter to her friends and only later noticed several misspellings. She thought,

"Everyone will think I'm losing my mind", and was so mortified and ashamed that she lost all pleasure at the prospect of talking with her friends over Christmas time.

Personal Application. In what ways might the following people upset themselves by exaggerating their self-importance? A man, usually a careful dresser, spills gravy on his tie before a business meeting; he has no time to change his tie. A woman loses her temper with her 2-year old in church and swats him because he won't stay seated.

Ask members to think of a recent social situation when they felt embarrassed or the object of everyone's attention for a mistake them made. What were their thoughts? Did they have any evidence that everyone noticed the mistake or did they just assume that? Even if everyone did notice, what negative conclusion could they draw about what happened? Did they have any evidence that these conclusions were indeed drawn? In a social situation, how much time do they spend looking at others and criticizing their behavior?

It can be particularly valuable to use the group to challenge this type of cognitive error. Members are often unwilling to discuss an aspect of themselves or

their behavior that they assume that other group members have noticed. One member, for example, had refused for some time to dine out because of an uncontrollable tremor in his hand. In group he apologized, under his breath, for the way the papers shook in his hand. When he checked with others, he was surprised to hear that most of them had neither heard his mutterings nor noticed the tremor. The discussion had a double benefit for him. He began to eat out without embarrassment, and he also stopped (in group at least) an annoying habit of pointing out mistakes that others made.

Homework. Often it is difficult to realize how concerned people are about what others think, so it takes careful monitoring of thoughts and feelings to find situations where this type of thinking interferes with one's life.

This week, after the group members have spend some time with other people, have them go back over the occasion and ask if at any time they were worried about negative thoughts others had about them, as a result of any faux pas they made. Have them record the thoughts and feelings they had; these will be discussed later.

A second level of homework involves two types of challenge. One is to learn to identify when members feel

that all eyes are upon them, to look for evidence that they are, indeed, the center of attention. They could also use a personalized self-statement to counter their discomfort; for example, "Most people are too busy with their own affairs to pay that much attention to me," " So what if they notice? Everyone makes mistakes occasionally. It's nothing to be ashamed of," or "Only critical people concern themselves about mistakes others make. I don't value such unkindness, so their opinion is unimportant to me."

Another type of challenge for this cognitive error involves exploration of situations where a person's behavior is constrained because of anticipated social disapproval. In these situations, the person is always on edge, afraid of doing the wrong thing, and as a result, does not relax or feel accepted in company. To identify these situations, members should look for social events that they avoid or leave early, and investigate any cognitions about self-importance.

Lecturette #8

Building Support Networks

Explanation. We all need the support of other human beings, not only in times of crisis, but also in our everyday lives. Unfortunately, the elderly are often without such support, as social networks tend to shrink when people get older. Friends and family die or move away, retirement brings with it an automatic loss of co-workers, and frequently the elderly, themselves, move to nearby retirement communities or even across the country to places with more hospitable climates. In addition, aging tends to increase social isolation because the physical effort to make social contacts becomes increasingly difficult, and many older adults think it takes too much effort.

Although, it is common for the elderly to have diminished social support networks, the situation need not stay that way; lack of social support is a problem to be solved like any other. Social networks can be restored, but to do so a person must make a systematic effort to both maintain old social contacts and establish new ones. This task is not as simple as it may seem, because dysfunctional cognitions often stop people from

taking action. They tell themselves that it takes too much effort to make social contacts ("I just don't have the energy any more to entertain") and that they shouldn't have to make such an effort ("If she wanted to see me she'd call me"). They compare new acquaintances with old friends and find the acquaintances wanting, and they fear rejection, believing that they have nothing to offer. For example, illness forced Shirley to move from Michigan to southern Arizona. Upon arrival, she joined several community groups and tried to make friends, but no one she met seemed as much fun as her old friends back home. She wondered, too, why her neighbors didn't drop by to visit. After all, in Michigan, she always welcomed newcomers to the neighborhood, but no one in her new community appeared to have any manners. She began to avoid going out and spent an increasing amount of time along, with frequent thoughts such as, "No one here cares about me," "They must think I'm not worth bothering with," and "I don't have anything in common with these people." The more she stayed home with these thoughts, the less she felt like going out, and the more isolated she became. Shirley became increasingly depressed and felt trapped, since she disliked the people in Arizona

yet could not afford to move back to Michigan.

In another example, family problems over several months took Joe's time away from his usual circle of golfing friends. When he finally had more time, he waited for someone to invite him to play golf and was hurt and angry when this did not happen. He thought, "They've all forgotten me. That's how much they care about me." When someone finally called, Joe was grumpy and brusque and refused the invitation. Like Shirley, Joe missed people and became increasingly depressed.

Personal Application. Therapists should initiate a brief discussion of members' social support networks, focusing mainly on whether the networks are perceived as adequate and on possible options for expansion. If networks have shrunk over the years, there is little point in encouraging much talk about reasons for the loss. Instead, therapists should investigate the barriers, especially cognitive ones, to increasing social support in the present time. Ask, "What is preventing you now from building a new circle of friends?" Usually, the group is very helpful in dealing with practical barriers, such as transportation, and knowledgeable about available activities. Dysfunctional thoughts can be addressed

within a cognitive framework (see Table 7).

Most of the personal application section of the lecturette should be focused on intervention; that is, on building social support networks. Therapists should assume that the participants already have the requisite skills to establish and maintain social relationships and do not need to be taught. In order to define and plan or expand the network, ask participants the following questions:

1. Who is in your social network now?
2. Do you feel you have enough people in your life?
3. What acquaintances do you have who could conceivably be friends?
4. How might you go about strengthening your relationships with these people?
5. Or, if there are no acquaintances who could be friends, how and where could you meet people?

Homework. In order to build a social support network, you must be active in initiating and maintaining friendships; you cannot build a support network by waiting for other people to come to you.

Identify two occasions over the next week in which you could either take the initiative to meet someone new

or extend an invitation to someone whom you already know but haven't seen recently. Specifically, how, when, and where will you take these steps.

Table 11

Cognitive Approach to Inadequate Social Support

A	B	C
Situation	Thoughts	Feelings
Inadequate social support network	No one will want to be my friend. I have nothing to offer.	Hopelessness Alone

Belief. "People only want to be friends with someone young, active, rich, attractive, etc."

Interventions

1. "You have had friends in the past. What qualities did they like you for that you still possess?"
2. "What is the evidence for your belief? Has everyone refused your friendship? How do you account for friendships among people who are not young, rich, etc.?"
3. "Are your expectations realistic? How quickly do you

expect a friendship to develop? Do you expect the relationship to develop without any problems?"

4. "How are you defining friend? Would you be more successful if you tried for acquaintances or causal friendships first."

Life Review Group Therapy Protocol

The life review group therapy protocol was derived from the work of Dr. Robert Butler (1963) and Dr. Barbara K. Haight (1988). The protocol consists of a series of group discussions focused on structured questions which reflect the life review. The questions are based on Barbara Haight's Life Review and Experiencing Form (Haight, 1989). Permission to reproduce the Life Review and Experiencing Form was granted by Barbara Haight (see Appendix C).

The life review group therapy protocol entails eight, weekly, one and a half hour group discussions on topics that pertain to the life review. Each session focuses on a particular developmental time and theme. The first six sessions examine childhood, adolescence, family and home, and adulthood. The last two sessions focus on group members summarizing their experience of the life review which includes integrating their life experiences, feelings, and new understandings in a meaningful manner.

To increase group discussion and interaction, the life review questions were presented in a variety of ways using techniques such as rounds and dyads, and activities

such as role playing a life experience. The techniques and activities were drawn from the book Group Counseling: Strategies and Skills by Jacobs, Harvill, and Masson (1988). Both group leaders had taken a course in group counseling with one of the author's of the book and are familiar with the content of the book.

Session 1

Overview: In the first session the group leader provides an overview of the discussion program and its focus. He describes what is a life review; the stages of a life review: childhood, adolescence, family and home, adulthood, retirement; and the benefits of a life review.

Childhood:

1. What is the very first thing you can remember in your life? Go as far back as you can.
2. What other things can you remember about when you were very young?
3. What was life like for you as a child?
4. What were your parents like? What were their weaknesses, strengths?
5. Did you have any brothers or sisters? What were they like. Who were you closest to and why?
6. What was your most memorable experience in school?
7. Did someone close to you die when you were growing up?
8. Did someone important to you go away?
9. Do you remember being very sick or having an accident?
10. Do you remember being in a very dangerous situation?
11. Was there anything that was important to you that was lost or destroyed?

12. Was religion a large part of your life?

13. Did you enjoy being a boy/girl?

Session 2

Adolescence:

1. When you think about yourself and your life as a teenager, what is the first thing you can remember about that time?
2. What other things stand out in your memory about being a teenager?
3. Who were the important people for you? Tell me about them. Parents, brothers, sisters, friends, teachers, those you were especially close to, those you admired, those you wanted to be like?
4. Did you attend church/synagogue and youth groups?
5. Did you go to school? What meaning did it have for you?
6. Were you involved with many after-school activities?
7. Did you work during these years?
8. Were there any hardships experienced at that time that are prominent in your mind?
9. Do you remember feeling that there wasn't enough food or necessities of life as a child or adolescent.
10. Do you remember feeling left alone, abandoned, not having enough love or care as a child or adolescent?

Session 3

Adolescence and Early Adulthood:

1. What were the pleasant things about your adolescence?
2. What were the most unpleasant things about your adolescence?
3. All things considered, would you say you were happy or unhappy as a teenager?
4. Do you remember your first attraction to another person?
5. How did you feel about sexual activities and your own sexual identity?
6. Who were your role models?
7. Who did you look up to and want to be like?
8. What were your dreams of the future?
9. What profession, line of work, or lifestyle did you want to have when you became an independent adult?
10. Did you feel you were able to accomplish your hopes and dreams in adolescence?

Session 4

Family and Home:

1. How did your parents get along?
2. How did other people in your home get along?
3. What was the atmosphere in your home?
4. Where you punished as a child? For what? Who did the punishing? Who was the "boss"?
5. In comparison with your brothers and sisters who was punished more?
6. When you wanted something from your parents, how did you go about getting it?
7. What kind of person did your parents like the most? The least?
8. Did you like your parents personality?
9. Who were you closest to in your family?
10. Who in your family were you most like? In what way?
11. In your family what was your position, age-wise, in respect to your brothers and sisters. Did you play a particular role in you family such as the nurturer, or the quiet one, the hero, or the joker.

Session 5 and 6

Adulthood:

1. What were some of the most important events.
2. What was it like in your 20's, 30's, 40's, & 50's.
3. What kind of person were you? What did you enjoy?
4. Tell us about your work? Did you enjoy your work? Did you earn an adequate living? Did you work hard during those years? Were you appreciated? If you were a homemaker rasing children and did not work a paid job, what are your feelings about that time.
5. Did you form significant relationships with others?
6. Did you marry? (Yes) What kind of person was your spouse? (No) Why not?
7. Did you have a happy or unhappy marriage and why ?
8. Did you have children, and if you did what was your relationship like with them?
9. What were some of the main difficulties you encountered during your adult years?
   a. Did someone close to you die? Go away?
   b. Were you every sick? Have an accident?
   c. Did you move often? Change jobs?
   d. Did you ever feel alone? Abandoned?
10. What do you regret about your adulthood and what

would you change if you could do it over again?

11. What were some of your major successes?

Session 7

Summary:

1. On the whole, what kind of life do you think you've had?
2. If everything were to be the same would you like to live your life over again?
3. If you were going to live your life over again, what would you change? Leave unchanged?
4. In discussing your over-all feelings and ideas about your life what would were three main satisfactions in your life? Why were they satisfying?
5. Everyone has had disappointments. What have been the main disappointments in your life?
6. Can you describe what was the hardest thing you had to face in your life?
7. What was the happiest period of your life? What about it made it the happiest period? Is your life less happy now and if so why?
8. What was the unhappiest period of your life? Why is your life more happy now?
9. What was the proudest moment in your life?

Session 8

Summary:

1. If you could stay the same age all your life, what age would you choose? Why?
2. How do you think you've made out in life? Better or worse than what you hoped for?
3. What are the best things about the age you are now?
4. What are the worst things about being the age you are now?
5. What are the most important things to you in your life today?
6. What do you hope will happen to you as you grow older?
7. What do you fear will happen to you as you grow older?
8. What would you like to give to future generations or to leave as a legacy to your family?
9. What would you like to give to a person or persons you are intimate with that would make you feel more complete in the relationship?
10. What would you like to receive from a friend or family member that would make you feel complete in the relationship?
11. Have you enjoyed participating in this life review?
12. What have you learned from this review of your life?

Appendix C

Page Number

"Seniors Speak Out" Discussion Group, Sept. 14 to Nov.4

Free to Residents of the Salem Personal Care Home

Do you worry?
Do you need help coping with your problems?
Would you like to feel better about yourself, your life?
Do you like to reminisce?
Would you like to get a better perspective on your life?
Would you like to feel support from others?

If the answer to any of these are yes, then
Join the "Senior's Speak Out" discussion group!

The "Senior's Speak Out" discussion groups offers:

* Confidential small group discussions (maximum of 12 residents per group), led by a professional, on the problems and challenges facing adults.
* Free coffee and cookies are provided to all participants in each session.
* Group discussions will be held one day per week from 3:30 to 5:00, for eight weeks, in the community meeting room.

To join the program speak to either Kayla Ash, Social Worker, Linda Ice, Activities Director, or Jules Weiss, "Senior' Speak Out" project director.

Mr. Weiss will be visiting you in August to sign-up residents to participate in the discussion groups.

Dear _____,

Thank you for joining the Senior's Speak Out program at the Salem Personal Care home. You have been assigned to group number _____ which meets on _____ from 3:30 to 5:00. The program will last for eight weeks, beginning the week of September 14 and ending the week of November 6.

We look forward to your participation.

Jules C. Weiss, MA, LPC, A.T.R.

Division of Clinical and Counseling Studies
West Virginia University
Department of Counseling, Rehabilitation Counseling and Counseling Psychology
College of Human Resources and Education

Jules C. Weiss, MA, LPC, A.T.R. August 1, 1992

Informed Consent Form

I understand that I am being asked to participate in a research study entitled "A Comparison of Cognitive Group Therapy to Life Review Group Therapy with Older Adults" at the Salem Personal Care home.

I understand that the purpose of the research study is to compare the effectiveness of two types of group therapies, cognitive group therapy and life review group therapy, in aiding older adults who reside in a personal care home.

I understand that the only requirement for participating in the program is that I am 50 years of age or older, live at the Salem Personal Care, and have no significant cognitive impairment that would prevent me from participating in group discussions. I understand that being a part of the program "Senior's Speak Out" does not imply that I am in need of therapy nor that I am signing up for therapy, but rather that I am signing up to participate in a discussion group focused on the issues of aging.

I understand that my participation will consist of being a member of a "Seniors' Speak Out" discussion group. The group will meet once a week for one and a half hours per session (3:30 to 5:00 p.m.) for eight weeks, September 14, to November 6. It has been explained that I will also be asked to fill out four brief questionnaires prior to the first session of the program (September 4-7, 1992), four brief questionnaires at the end of the 8 week program (November 7-8, 1992), and 3 questionnaires six weeks after the conclusion of the program (December 19-20, 1992). The time to complete the questionnaires should not exceed one hour per session. Jules C. Weiss, the primary investigator will be the sole test administrator.

I understand that there are no medical, psychological, or social hazards in connection with the activity. There will be no physical exercise or activity which would cause physical stress.

I understand that as a result of participating in the program I may receive psychological and social benefits in coping with aging, that would be to my advantage.

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Department of Counseling, Rehabilitation Counseling and Counseling Psychology
College of Human Resources and Education

I understand that I may be assigned to a specific discussion group or randomly chosen to be a part of a group in which I will not participate in a group discussions, but only be asked to complete four brief questionnaires on three occasions, around September 7, November 7, and December 19.

I understand that the discussions will not be taped nor photographed. I understand that all discussion within the group setting is confidential and participants will be asked not to discuss the information shared within the group, outside of the group.

I understand the discussions in the group, may at times, touch upon personal areas, but that they are not designed to be psychologically stressful and will be addressed in a manner sensitive to the participants feelings and concerns. I understand that I am free to not participate in any discussion I choose without harassment.

I understand that if I am assigned to a discussion group and I miss four sessions I will be asked to withdraw from the program. I understand that a male counselor who has a Master's degree in counseling will lead the group discussions.

I understand that I may withdraw from the discussion groups (and research study) at any time I choose, out of my own free will.

I understand that if by participation in the research program new knowledge becomes available to me about myself which might affect my willingness to continue participating in the study, I am free to terminate my participation in the group. Furthermore, if needed, the group counselor will assist me to integrate the information obtained in the group in an ethically responsible manner.

I understand that Mr. Weiss is a doctoral student at West Virginia University in the Counseling Psychology department and the research program is in partial fulfillment of his requirements for the degree of Doctor of Education.

I understand that the assessment tests which I complete will be confidential, and they will be stored at Mr. Weiss' home (105 West High Street, Salem, WV) only to be seen by Mr. Weiss. I understand that my assessment test records will be given a number, and only referred to by that number and only used in the analysis of the treatment effects of the discussion groups.

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West Virginia University

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College of Human Resources and Education

I understand that if I discontinue participating in my discussion group I will not be able to join the group at the designated discussion time for coffee and cookies.

I understand that there is no charge for participating in the program nor will I be paid for my participation in the program.

I understand that by participating in the discussion groups I will be provided with coffee and cookies during the weekly discussion group time to which I am assigned.

I understand that if I have any questions or I need to talk to someone concerning the program I can call Jules Weiss, the primary investigator, at 782-3662.

In meeting with Mr. Weiss I have been given an opportunity to ask questions about the research.

I understand that by participating in the research I may contact the Institutional Review Board at (304) 293-7073 concerning questions about my rights as subjects of research.

I understand that my research records will not become a part of Salem College Personal Care home's records, nor will any information about me gained through the research project be provided to the Salem College Personal Care. I understand that the only exception to this statement would be if I verbally state in group or in my assessment tests that I am about to do physical harm to myself or others, at which time the proper authorities and precautions would be taken.

I understand that any information about me obtained as a result of my participation in this research project will be kept as confidential as legally possible. I understand that my research records, just like hospital records, may be subpoenaed by court order or may be inspected by federal regulatory authorities.

I understand that my refusal to participate in the study involves no penalty or loss of benefits at the Salem Personal Care home to which I am entitled.

I understand that participation is voluntary, and out of my own free will do I volunteer to participate in the research program.

I have read and I understand all of the above explanations concerning the purpose and procedures of the study. I have voluntarily consented to participate in the study and have been given a signed copy of the informed consent form.

Subject's Signature _____ Date_____

Primary Investigator _____

SALEM COLLEGE
PERSONAL CARE CENTER

"WE CARE FOR YOU"

WEST VIRGINIA & HIGH STS.
SALEM, WV 26426
304-782-3650

May 27,1992

To whom it may concern:

I, **Robert Paugh,** administrator of the Salem College Personal Care home give **Jules C. Weiss** full permission to conduct his research program,**"A Comparison of Cognitive Group Therapy to Life Review Group Therapy With Older Adults,"** at the Salem College Personal Care Center. I understand that Mr. Weiss is a doctoral student at West Virginia University in the Counseling Psychology Dept. and the research program is in partial fulfillment of his requirements for the degree of Doctor of Education. I have been informed that the program will consist of 4 discussion groups, all named **"Senior's Speak Out"** to be held Monday to Thursday, 3:30 to 5:00 from September 14 to November 6, 1992.

Mr Weiss has met with me and my staff several times to describe the program. I understand that two therapists, Perry Cain and Robert Freedlander, will each conduct a life review group therapy and cognitive group therapy for one and a half hours per day, twice a week, for six weeks. I understand that a total of 54 residents can participate in the program. The program is totally voluntary, participants may quit at any time, and it is strictly confidential. I understand that participants will be required to complete pre, post and follow-up assessment questionaires.

I understand that the discussion program, "Senior's Speak Out" is free to residents and the facility. I have agreed to provide coffee or other drinks for each group discussion session and I understand that Mr. Weiss will provide cookies for the sessions.

I look forward to having Mr Weiss's research program at our facility and I feel that it will benefit the lives of our residents.

Robert R. Paugh

Robert R. Paugh
Administrator

ALLYN & BACON

Simon & Schuster Education Group
160 Gould Street
Needham Heights, MA 02194-2310
617-455-1250
Fax: 617-455-1220

May 21, 1992

Jules Weiss
105 West High Street
Salem, West Virginia 26426

Dear Mr. Weiss:

Allyn and Bacon is pleased to grant permission per your May 21, 1992 phone call to quote material (pages 83-94) from GROUP COGNITIVE THERAPY, by Yost for use in the doctoral dissertation you are preparing for West Virginia University.

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Best wishes for a successful paper.

Sincerely:

Barbara Tsantinis
Permissions Specialist

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Needham Heights, MA 02194-2310

October 8, 1992

Jules C. Weiss
105 West High Street
Salem, West Virginia 26426

Dear Professor Weiss:

Thank you for your letter of June 10. We will be happy to grant you permission to use material (pages 111-113) from COGNITIVE THERAPY, by Yost in your unpublished paper for the university.

Please provide a complete credit line on the first page where our material beings by citing the author, title, edition, copyright year date, and publisher.

If at a future date you decide to have your paper published, you must reapply for permission and indicate the exact passages and page numbers of the material you wish to use, the name of your publisher, and other pertinent information.

Best wishes for a successful paper.

Sincerely:

Barbara Tsantinis
Permissions Specialist

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Gerontological Nursing
Graduate Program
(803) 792-3108 or 4607
FAX (803) 792-2969

MEDICAL UNIVERSITY OF SOUTH CAROLINA
171 Ashley Avenue
Charleston, South Carolina 29425-2403

May 26, 1992

Mr. Jules Weiss
105 West High Street
Salem, WV 26426

Dear Mr. Weiss:

I am very pleased to hear of your interest in life review. I think your dissertation, A Comparison of Cognitive Group Therapy to Life Review Group Therapy with Older Adults, will add significant information to the existing body of knowledge. I caution you to be certain that what you are doing is life review and not reminiscing. Reminiscing is different and just as valuable, but your title should reflect your process.

You certainly have my permission to use the Life Review and Experiencing Form (LREF). I am eagerly looking forward to your outcomes. Please be sure to let me know and call if I can be of assistance.

Sincerely,

Barbara K. Haight

Barbara K. Haight, RNC, DrPH, FAAN
Professor of Nursing

BKH/kjb

Appendix D: Post-Test ANCOVA Tables

Page Number

Post-Test, Analysis of Covariance of the Beck Depression Inventory with Pre-Test Scores of the BDI as the Covariate

Source	SS	df	MS	F	p
Covariate (BDI1)	979.8	1	979.8	10.50	.004
Main Effects	530.9	4			
Age Grouping	16.9	1	16.9	.18	.675
Treatments	463.7	2	231.8	2.48	.107
Therapists	17.4	1	17.4	.19	.670
2-Way Interactions	232.4	5			
A.G. X Treatments	11.0	2	5.5	.06	.943
A.G. X Therapists	50.8	1	50.8	.55	.469
Treatments X Th.	166.6	2	83.3	.89	.424
3-Way Interaction	291.6				
A.G. X Tr. X Th.	291.6	2	145.8	1.56	.233
Residual	1958.8	21	93.2		
Total	3993.5	33			

Post-Test, Analysis of Covariance of the LSES Total Score with Pre-Test Scores of the LSES Total Score as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Tot.)	17577.4	1	17577.4	105.6	.000
Main Effects	1094.2	4			
Age Grouping	230.9	1	230.9	1.39	.252
Treatments	819.1	2	409.6	2.46	.110
Therapists	9.4	1	9.4	.06	.814
2-Way Interactions	16.1	5			
A.G. X Treatments	10.0	2	5.0	.03	.970
A.G. X Therapists	.1	1	.1	.00	.984
Treatments X Th.	5.7	2	2.9	.02	.983
3-Way Interaction	62.6	2			
A.G. X Tr. X Th.	62.6	2	31.3	.19	.830
Residual	3495.9	21	166.5		
Total	22246.3	33			

Post-Test, Analysis of Covariance of the LSES Scale 1 with Pre-Test Scores of the LSES Scale 1 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 1)	455.7	1	455.7	48.62	.000
Main Effects	46.7	4			
Age Grouping	17.5	1	17.5	1.87	.186
Treatments	26.1	2	13.1	1.39	.271
Therapists	1.0	1	1.0	.11	.745
2-Way Interactions	37.0	5			
A.G. X Treatments	20.9	2	10.5	1.12	.346
A.G. X Therapists	2.8	1	2.8	.30	.588
Treatments X Th.	15.3	2	7.6	.81	.457
3-Way Interaction	.9	2			
A.G. X Tr. X Th.	.9	2	.4	.05	.956
Residual	196.8	21	9.4		
Total	737.1	33			

Post-Test, Analysis of Covariance of the LSES Scale 2 with Pre-Test Scores of the LSES Scale 2 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 2)	420.8	1	420.8	87.46	.000
Main Effects	40.2	4			
Age Grouping	1.2	1	1.2	.24	.627
Treatments	26.0	2	13.0	2.70	.090
Therapists	17.9	1	17.9	3.72	.067
2-Way Interactions	14.7	5			
A.G. X Treatments	1.4	2	.7	.15	.862
A.G. X Therapists	.1	1	.1	.01	.914
Treatments X Th.	13.1	2	6.5	1.36	.279
3-Way Interaction	5.7	2			
A.G. X Tr. X Th.	5.7	2	2.9	.60	.561
Residual	101.0	21	4.8		
Total	582.5	33			

Post-Test, Analysis of Covariance of the LSES Scale 3 with Pre-Test Scores of the LSES Scale 3 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 3)	140.4	1	140.4	17.5	.000
Main Effects	32.7	4			
Age Grouping	3.7	1	3.7	.45	.508
Treatments	29.2	2	14.6	1.82	.187
Therapists	.4	1	.4	.05	.832
2-Way Interactions	50.1	5			
A.G. X Treatments	3.4	2	1.7	.21	.813
A.G. X Therapists	3.9	1	3.9	.49	.493
Treatments X Th.	39.0	2	19.5	2.43	.112
3-Way Interactions	7.6	2			
A.G. X Tr. X Th.	7.6	2	3.8	.48	.628
Residual	168.6	21	8.0		
Total	399.6	33			

Post-Test, Analysis of Covariance of the LSES Scale 4 with Pre-Test Scores of the LSES Scale 4 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 4)	216.6	1	216.6	21.1	.000
Main Effects	70.3	4			
Age Grouping	20.5	1	20.1	1.95	.177
Treatments	44.4	2	22.2	2.16	.140
Therapists	1.4	1	1.4	.14	.713
2-Way Interactions	62.1	5			
A.G. X Treatments	44.8	2	22.4	2.18	.138
A.G. X Therapists	4.1	1	4.1	.40	.534
Treatments X Th.	12.9	2	6.5	.63	.543
3-Way Interacton	8.1	2			
A.G. X Tr. X Th.	8.1	2	4.1	.40	.679
Residual	215.8	21	10.3		
Total	573.0	33			

Post-Test, Analysis of Covariance of the LSES Scale 5 with Pre-Test Scores of the LSES Scale 5 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 5)	148.8	1	148.8	22.44	.000
Main Effects	44.7	4			
Age Grouping	.1	1	.1	.02	.905
Treatments	25.8	2	12.9	1.94	.168
Therapists	15.8	1	15.8	2.38	.138
2-Way Interactions	25.9	5			
A.G. X Treatments	20.0	2	10.0	1.51	.244
A.G. X Therapists	1.1	1	1.1	.16	.689
Treatments X Th.	3.2	2	1.6	.25	.785
3-Way Interaction	2.9	2			
A.G. X Tr. X Th.	2.9	2	1.4	.22	.807
Residual	139.2	21	6.6		
Total	361.5	33			

Post-Test, Analysis of Covariance of the LSES Scale 6 with Pre-Test Scores of the LSES Scale 6 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 6)	225.5	1	225.5	55.76	.000
Main Effects	24.7	4			
Age Grouping	1.1	1	1.1	.28	.606
Treatments	23.4	2	11.7	2.94	.075
Therapists	1.1	1	1.1	.28	.603
2-Way Interactions	2.8	5			
A.G. X Treatments	1.9	2	1.0	.24	.786
A.G. X Therapists	.1	1	.1	.02	.894
Treatments X Th.	.9	2	.5	.12	.889
3-Way Interaction	5.8	2			
A.G. X Tr. X Th.	5.8	2	2.9	.73	.494
Residual	83.4	21	4.0		
Total	342.2	33			

Post-Test, Analysis of Covariance of the LSES Scale 7 with Pre-Test Scores of the LSES Scale 7 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 7)	685.2	1	685.2	150.43	.000
Main Effects	38.4	4			
Age Grouping	21.6	1	21.6	4.74	.041*
Treatments	5.2	2	2.6	.57	.573
Therapists	10.4	1	10.4	2.29	.145
2-Way Interactions	34.8	5			
A.G. X Treatments	18.6	2	9.3	2.04	.155
A.G. X Therapists	.2	1	.2	.04	.849
Treatments X Th.	15.1	2	7.6	1.66	.214
3-Way Interaction	8.1	2			
A.G. X Tr. X Th.	8.1	2	4.1	.89	.424
Residual	95.7	21	4.5		
Total	862.1	33			

*p<.05

Post-Test, Analysis of Covariance of the LSES Scale 8 with Pre-Test Scores of the LSES Scale 8 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 8)	158.6	1	158.6	16.77	.001
Main Effects	15.3	4			
Age Grouping	1.2	1	1.2	.13	.728
Treatments	13.0	2	6.5	.69	.513
Therapists	.0	1	.0	.00	.994
2-Way Interactions	71.9	5			
A.G. X Treatments	12.3	2	6.2	.65	.532
A.G. X Therapists	52.1	1	52.1	5.51	.029*
Treatments X Th.	.6	2	.3	.03	.970
3-Way Interaction	21.9	2			
A.G. X Tr. X Th.	21.9		11.0	1.16	.333
Residual	198.6	21	9.5		
Total	466.2	33			

*p<.05

Analysis of Variance of the Therapist Assessment Rating

Source	SS	df	MS	F	p
Main Effects	22.2	1	22.2	.18	.677
Therapists	22.2	1	22.2	.18	.677
Residual	2998.3	24	124.9		
Total	3020.5	25	120.8		

Appendix E: Follow-Up Test ANCOVA Tables

Follow-Up Test, Analysis of Covariance of the Beck Depression Inventory with Pre-Test Scores of the BDI as the Covariate

Source	SS	df	MS	F	p
Covariate (BDI1)	2000.5	1	2000.5	16.67	.001
Main Effects	525.0	4			
Age Grouping	253.4	1	253.4	2.11	.161
Treatments	253.0	2	126.5	1.05	.366
Therapists	7.4	1	7.4	.06	.807
2-Way Interactions	144.2	5			
A.G. X Treatments	96.6	2	48.3	.403	.674
A.G. X Therapists	5.8	1	5.8	.048	.829
Treatments X Th.	50.2	2	25.1	.209	.813
3-Way Interaction	25.1				
A.G. X Tr. X Th.	25.1	2	12.5	.104	.901
Residual	2519.8	21	120.0		
Total	5214.6	33			

Follow-Up Test, Analysis of Covariance of the LSES Total Score with Pre-Test Scores of the LSES Total Score as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Tot.)	9598.5	1	9598.5	28.94	.000
Main Effects	1423.8	4			
Age Grouping	936.6	1	936.6	2.82	.108
Treatments	454.9	2	227.5	.69	.515
Therapists	29.0	1	29.0	.09	.770
2-Way Interactions	353.8	5			
A.G. X Treatments	117.0	2	58.5	.18	.840
A.G. X Therapists	.0	1	.0	.00	.995
Treatments X Th.	229.1	2	114.5	.35	.712
3-Way Interaction	346.8	2			
A.G. X Tr. X Th.	346.8	2	173.4	.52	.600
Residual	6965.1	21	331.7		
Total	18688.0	33			

Follow-Up Test, Analysis of Covariance of the LSES Scale 1 with Pre-Test Scores of the LSES Scale 1 as the Covariate

Source	SS	df	MS	F	p
Covariate (BDI1)	416.8	1	416.8	34.90	.000
Main Effects	25.2	4			
Age Grouping	14.3	1	14.3	1.20	.286
Treatments	8.0	2	4.0	.34	.718
Therapists	3.3	1	3.3	.27	.606
2-Way Interactions	30.1	5			
A.G. X Treatments	13.9	2	6.9	.58	.568
A.G. X Therapists	.7	1	.7	.06	.814
Treatments X Th.	16.9	2	8.5	.71	.503
3-Way Interaction	1.7				
A.G. X Tr. X Th.	1.7	2	.9	.07	.930
Residual	250.6	21	11.9		
Total	724.38	33			

Follow-Up Test, Analysis of Covariance of the LSES Scale 2 with Pre-Test Scores of the LSES Scale 2 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 2)	287.9	1	287.9	45.44	.000
Main Effects	62.4	4			
Age Grouping	.0	1	.0	.00	.968
Treatments	57.2	2	28.6	4.51	.023*
Therapists	5.9	1	5.9	.93	.345
2-Way Interactions	29.0	5			
A.G. X Treatments	3.5	2	1.8	.28	.759
A.G. X Therapists	3.0	1	3.0	.47	.502
Treatments X Th.	23.5	2	11.8	1.85	.181
3-Way Interaction	4.7	2			
A.G. X Tr. X Th.	4.7	2	2.4	.37	.694
Residual	133.1	21	6.3		
Total	517.1	33			

*p<.05

Follow-Up Test, Analysis of Covariance of the LSES Scale 3 with Pre-Test Scores of the LSES Scale 3 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 3)	78.1	1	78.1	7.5	.012
Main Effects	41.7	4			
Age Grouping	18.9	1	18.9	1.82	.192
Treatments	22.4	2	11.2	1.08	.358
Therapists	.1	1	.1	.01	.921
2-Way Interactions	42.9	5			
A.G. X Treatments	1.4	2	.7	.07	.933
A.G. X Therapists	.8	1	.8	.08	.779
Treatments X Th.	39.5	2	19.8	1.91	.174
3-Way Interactions	7.8	2			
A.G. X Tr. X Th.	7.8	2	3.9	.38	.692
Residual	217.8	21	10.4		
Total	388.2	33			

Follow-Up Test, Analysis of Covariance of the LSES Scale 4 with Pre-Test Scores of the LSES Scale 4 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 4)	177.2	1	177.2	22.1	.000
Main Effects	40.5	4			
Age Grouping	15.0	1	15.0	1.87	.186
Treatments	26.6	2	13.3	1.66	.214
Therapists	.3	1	.3	.04	.841
2-Way Interactions	31.2	5			
A.G. X Treatments	26.8	2	13.4	1.67	.212
A.G. X Therapists	1.0	1	1.0	.123	.729
Treatments X Th.	4.2	2	2.1	.262	.772
3-Way Interacton	10.7	2			
A.G. X Tr. X Th.	10.7	2	5.4	.670	.522
Residual	168.3	21	8.0		
Total	427.9	33			

Follow-Up Test, Analysis of Covariance of the LSES Scale 5 with Pre-Test Scores of the LSES Scale 5 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 5)	89.3	1	89.3	8.41	.009
Main Effects	35.0	4			
Age Grouping	8.9	1	8.9	.84	.371
Treatments	17.3	2	8.6	.81	.457
Therapists	8.9	1	8.9	.84	.370
2-Way Interactions	26.3	5			
A.G. X Treatments	10.4	2	5.2	.49	.619
A.G. X Therapists	4.2	1	4.2	.40	.537
Treatments X Th.	10.7	2	5.4	.51	.611
3-Way Interaction	4.9	2			
A.G. X Tr. X Th.	4.9	2	2.4	.23	.798
Residual	223.0	21	10.6		
Total	378.5	33			

Follow-Up Test, Analysis of Covariance of the LSES Scale 6 with Pre-Test Scores of the LSES Scale 6 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 6)	84.9	1	84.9	9.67	.005
Main Effects	33.6	4			
Age Grouping	33.2	1	33.2	3.78	.065
Treatments	.9	2	.4	.05	.952
Therapists	.0	1	.0	.00	.958
2-Way Interactions	11.2	5			
A.G. X Treatments	2.5	2	1.3	.14	.868
A.G. X Therapists	6.4	1	6.4	.73	.403
Treatments X Th.	2.8	2	1.4	.16	.852
3-Way Interaction	24.1	2			
A.G. X Tr. X Th.	24.1	2	12.0	1.379	.276
Residual	184.4	21	8.8		
Total	338.3	33			

Follow-Up Test, Analysis of Covariance of the LSES Scale 7 with Pre-Test Scores of the LSES Scale 7 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 7)	288.7	1	288.7	26.64	.000
Main Effects	16.9	4			
Age Grouping	11.1	1	11.1	1.03	.322
Treatments	1.0	2	.5	.04	.957
Therapists	4.5	1	4.5	.41	.528
2-Way Interactions	18.5	5			
A.G. X Treatments	8.5	2	4.24	.39	.681
A.G. X Therapists	.0	1	.0	.00	.975
Treatments X Th.	9.6	2	4.8	.44	.647
3-Way Interaction	22.5	2			
A.G. X Tr. X Th.	22.5	2	11.2	1.04	.372
Residual	227.6	21	10.8		
Total	574.2	33			

Follow-Up Test, Analysis of Covariance of the LSES Scale 8 with Pre-Test Scores of the LSES Scale 8 as the Covariate

Source	SS	df	MS	F	p
Cov.(LSES Scale 8)	88.3	1	88.3	6.84	.016
Main Effects	59.9	4			
Age Grouping	35.3	1	35.3	2.73	.113
Treatments	19.2	2	9.6	.74	.488
Therapists	.2	1	.2	.02	.896
2-Way Interactions	29.7	5			
A.G. X Treatments	16.9	2	8.5	.65	.530
A.G. X Therapists	8.0	1	8.0	.62	.439
Treatments X Th.	7.4	2	3.7	.29	.753
3-Way Interaction	1.7	2			
A.G. X Tr. X Th.	1.7	2	.9	.07	.935
Residual	271.3	21	12.9		
Total	451.0	33			

Abstract

The study compared cognitive group therapy to life review group therapy with older adults who reside in a personal care facility. The study sought to find if there were differences in treatment gains between the two therapies based on subjects' level of depression (as noted on the Beck Depression Inventory) and life satisfaction (as cited on the Salamon-Conte Life Satisfaction in the Elderly Scale).

Subjects were pre-tested, post-tested and administered a follow-up test 6 weeks after the post-test. An analysis of covariance was conducted, using the pre-test as the baseline measure (covariate). At post-test, subjects assigned to a treatment group also completed a Therapist Assessment Rating to determine if outcome differences were significantly influenced by the therapist or if there was a therapist by treatment interaction.

Forty-eight residents were accepted into the study following a screening for dementia and speech and/or hearing problems. Subjects were randomly assigned to one of four treatment groups or a control group. Two masters level counselors, with a similar background and training,

each provided a life review and cognitive therapy program on alternate days. A standardized, 8 session (one and a half hour per session), group life review and group cognitive therapy program was offered to 40 residents, 10 residents per group. A standard control group with 8 residents was employed.

The results of the study showed that at the follow-up assessments (6 weeks after treatment ended), subjects in treatment groups had an increased feeling of purpose and usefulness in their life, $p=.04$. The study also provided insight into several crucial factors and dynamics related to group therapy with older adults in residential settings. Issues discussed are: the multiple psychosocial factors within the residential setting effecting residents and treatment; the length of time in treatment; subjects' varying cognitive abilities and psychosocial needs; the homogeneity of groups within a heterogeneous community; the need for multiple dependent measures; issues of denial and boundaries. Suggestions for future research in group therapy with older adults and a recommended protocol are provided.

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Ed.D. Counseling Psychology, expected 1994
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Lone Mountain College, S.F., CA
M.A. Creative Arts Therapy, 1979
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CERTIFICATION

Licensed Professional Counselor (LA) 1989
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HONORS

Who's Who Among Human Service Professionals 1992

SUMMARY OF PROFESSIONAL SKILLS

Teaching and Presentations

Over 15 years of experience instructing academic and professional training courses in colleges and in other settings.

- Five years of experience as Assistant Professor of Psychology, at Salem-Teikyo University. Served as the Chairperson of the Psychology Department, Director of the Art Therapy Department, and Director of the Counseling Center.
- Presented workshops and lectures on counseling, program development and therapeutic intervention at over 18 professional conferences, and led over 14 workshop/staff training presentations at colleges and for professional organizations.

Counseling and Social Service Administrative Positions

Over fifteen years of experience, in positions from therapist to administrator, working with a range of populations (children to elders) who have various psycho-social-physical needs and disabilities.

- Conducted group, individual, and family therapy in mental health clinics, psychiatric hospitals, long-term care settings, at a Children's Hospital, a college and in private practice.
- Performed administrative and supervisory functions for counseling and therapeutic social, educational, recreational, and creative arts programs.

Major Publications and Research

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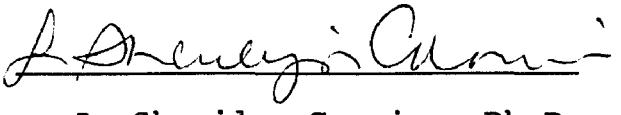

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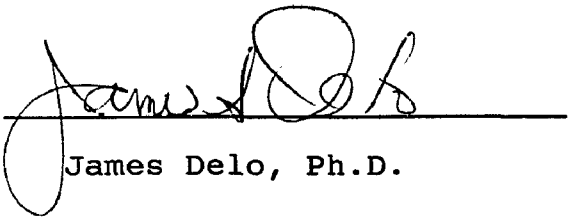

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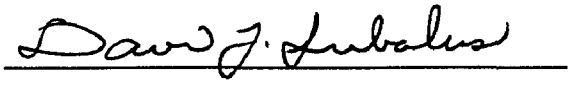

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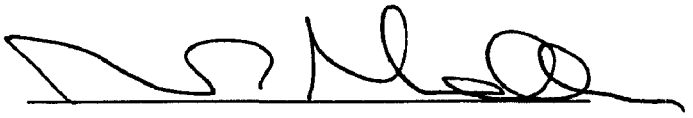

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