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AUTHOR Kahana, Boaz
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ABSTRACT

This paper presents a theoretical and clinical account of a psychotherapeutic approach to the aged. The approach is called "competent coping" therapy. It is oriented to helping older adults acquire and practice better adaptive strategies in handling problem situations. The author notes that unlike most work with older adults which is based largely on the principles of behavior modification, "competent coping" therapy takes a psychodynamic approach. The older person's adaptive style is seen as composed of both trait and dynamic components. Based on the assumption that awareness of a wide variety of coping strategies may facilitate the individual's own coping behavior, the therapy utilizes a group approach and focuses on sharing problem solving strategies and experiences. The author discusses several such groups and notes that his experience with "competent coping" therapy indicates that it is a fruitful approach to helping the aged adapt to their environment. (NG)

TRAINING THE AGED FOR "COMPETENT COPING"-- A PSYCHOTHERAPEUTIC STRATEGY

Boaz Kahana, PhD
Oakland University

In this paper I will present a theoretical and clinical account of an innovative approach to group psychotherapy with the aged. Conceptual underpinnings of the therapy will be presented as well as a clinical description for implementing the program.

Competent coping therapy is oriented to help older adults acquire and practice better adaptive strategies in handling problem situations. The therapeutic program may be geared to special groups such as institutionalized aged or widows and it focuses on general problem-solving strategies.

The effectiveness of group psychotherapy approaches has been increasingly documented with adults and even with children, yet this strategy has been only minimally utilized with older adults, both in the community and in institutional settings.

There has been a noticeable increase in attempts at therapy with deteriorated or senile older persons in institutional settings. Group programs of this type have typically used paraprofessionals to achieve at least minimal levels of orientation and responsiveness to the environment on the part of the aged participants. Remotivation and reality orientation and token economies have been the key approaches in this area. Typically these programs are based on principles of behavior modification rather than psychodynamics. By design they minimize or deemphasize emotional conflicts or "wounded areas of the personality."

In those clinically oriented papers discussing experiences in doing more traditional, dynamically oriented therapy with the aged,

brief goal-directed programs have been found to be especially useful.

Paradis (1974) has reported success in using brief supportive directive therapy with depressed aged outpatients who manifested age-related problems such as sleeplessness, loss of appetite, perceived problems with physical appearance and lack of socialization. Improvement was still present at a three month follow-up. In an outpatient group therapy program developed by Altholz (1973) advantages of the group are pointed out in providing an opportunity for exposure to problem situations and solutions developed by other elderly people. Berger and Berger (1937) pointed out another advantage of holistic, analytically-oriented group therapy in providing a degree of interpersonal activity and involvement with others which can reduce isolation, regression and low morale. Conrad (1974), who utilized group therapy with older adults in a public housing project, points to the function of the group in breaking through barriers of isolation by nonverbal and verbal expression of warmth and caring. Butler (1974) discusses the value of "life cycle group therapy" in helping the aged overcome myths of aging such as the assumption that old age is a time of failing productivity, disengagement and inflexibility.

The therapy program which I have developed is based on a conceptual framework for understanding strategies of adaptation which are helpful in enhancing the well being of older persons, especially in the context of institutional living. We are currently engaged in a study which describes strategies of adaptation and relates them to survival and morale among the institutionalized aged.

It has been argued that adaptive capacities of older people are diminished (Rosow, 1967). Yet there are frequent and major re-

adaptations required of older people through discontinuities posed by retirement, bereavement, impaired health and loss of social roles. Many older people are unable to cope, and succumb to these stresses. Yet others make successful adjustments and display great resourcefulness in coping with change.

Although the importance of adaptive strategies for psychosocial well-being is implicit in theories of personality (Hall & Lindsey, 1970), there has been relatively little specific research exploring adaptive strategies of older people. The emphasis in most investigations seeking to understand "outcome" such as adjustment or well-being has been either on the environment (Kahana & Kahana, 1970; Pincus, 1968) or on characteristics of the older person (Lieberman, 1969; Butler, 1968; Busse & Pfeiffer, 1969)

The assumptions about long-term effectiveness of certain "desirable" coping behaviors also bear examining. What appear to be effective short-term problem-resolutions may not necessarily be functional for long-term survival. Thus the energy expenditure involved in active coping in the face of a hostile environment may prove to be too much for an older person and despite an initial, apparently successful adjustment, rapid decline may set in.

The adaptive strategies marshalled by the older person may be seen on the one hand as rooted in earlier types of adaptation and coping, and, on the other hand as responsive to changing demands of the environment. Thus they may be viewed as having both traitlike and dynamic components. Individuals may thus be characterized by a given adaptive style. At the same time their adaptive strategies used in crisis situations may vary.

Based on the assumption that awareness of a wide array of coping strategies and recognition of situation-appropriate coping styles may be important factors in enabling older people to deal with their environment, a group therapy method has been developed. The method focuses on sharing problem-solving strategies and experiences among group members and sensitizes group members to labeling and identifying problems and developing appropriate solutions. The technique also focuses on overcoming resistances to tackling problem-solving situations and on marshalling resources of participants based on successful previous problem-solving strategies.

I would like to report to you, today, some initial data on implementing the above outlined conceptual framework to group therapy with both community-living and institutionalized aged.

Two groups each were conducted with volunteering participants in a community center program and among ambulatory residents in a home for the aged. The community groups volunteered in response to an announcement. Institutional groups were asked by staff if they were interested in participating in a discussion group of problem-solving and "how to deal with the world...". There were 7 to 8 participants in each group. Groups lasted for five sessions of about one hour for community groups and five sessions of 45-minutes each for the institutional groups. Participants were mostly of lower middle to middle socioeconomic class, about 70% were women. The community groups were predominantly Jewish. The institutional groups were predominantly Catholic.

Rather than focusing primarily on evaluations of outcome my interest today is in exploring the evolution of the therapeutic strategy and discussing the major problems in coping outlined by

participants as well as the specific techniques for handling them.

The therapist acted as a group leader, encouraging participants to share problem situations which they have experienced, and discuss their efforts in dealing with them as well as eventual problem resolutions. Group members were also encouraged to express their feelings and associations from their life experiences. Sessions were recorded and analyzed, listing the type of concerns voiced by each participant, their attempts to cope with them and their resolutions. During the initial two sessions participants raised issues as well as potential solutions. During sessions three and four, residents also discussed methods for resolving a common set of (hypothetical) problems, e.g., Mr. Green is told by his opthalmologist that he needs a cataract operation but is given no details regarding why or about the course of recovery. The final group session was open ended, allowing the group to develop its own discussion format and focusing primarily on the ability of group members to serve as resources to one another. There was a broad participation of group members especially in the community groups where there were no isolates in the group. Participation of institutional aged was more variable, suggesting possible advantages for combining group and individual therapy for this group.

There were marked similarities in themes discussed within the two community and two institutionalized samples, respectively with equally marked differences between community and institutional groups. Thus the institutional groups centered around basic needs while the community groups centered around interpersonal needs. Thus major themes for the community group included: family relationships, the generation gap, widowhood (loneliness, heterosexual relationships,

pros and cons of living with a mate) abandonment by children and relationships with service-providers, especially physicians. Major themes for the institutional group included: quality of food, bodily concerns (coping with impaired vision and hearing). These differential concerns may be fruitfully fitted into both a Maslow type conceptual framework of a hierarchy of needs and Lawton's scheme of differential functional levels among the aged. Coping strategies differed based on whether coping was seen as mandatory or optional. In the latter case, for example, heterosexual relationships, the community aged expressed anxiety or ambivalence over dealing with these problems whereas institutionalized aged turned toward avoidance, ie., withdrew and became uncommunicative.

Prevalent approaches to successful problem solving included such instrumental behaviors as seeking more information, asking for assistance, finding appropriate resources and organizing action groups. In addition expressive and escapist coping strategies were identified and discussed. Thus, given a situation where an aged person has to share living quarters with others, and has little of the privacy he wants he may employ varied coping strategies. Thus he may leave the field (e.g., go to the public library or visit his children as often as he can). He may change his location in the environment (e.g., stay out of his room and sit in the backyard). He might attempt to change the environment by having his children arrange for a private room or work out an arrangement with his roommate whereby each of them would be alone in the room on specified days. Or using expresive resolutions, our older subject may tell everyone that one cannot find privacy, he may generally be belligerent or cry about the lack of privacy. While not all of these resolutions may serve to change the noncongruent situation, they may be effective in

releasing tension or dealing with a reality which cannot be readily altered. A recognition of the variety of potential coping styles may be therapeutic.

The present paper could only provide some brief insights into the use of a dynamically oriented but brief and focused group therapy approach to dealing with shared problems and concerns of the aged. Nevertheless my own experiences in doing this type of therapy are sufficiently encouraging to warrant further refining the present approach. Thus similar groups will be started for participants who are sharing even more closely common experiences, e.g., widowhood and reaction to retirement.

In addition to sharing with you a technique which I feel is potentially very helpful I am especially pleased that others are doing work with a variety of new techniques which consider older people in more optimistic terms, as capable of being helped and of changing their behavior patterns. I feel that taking a holistic approach toward older people, taking into account their feelings, their cognitive strategies and their interpersonal contexts opens up new vistas in improving mental health among the aged.

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