An Age Old Problem:

Exploring Options for

Working with Older People

Literature Review

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June 2011

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The current perception of ageing is often characterised by negative images such as loneliness, helplessness, loss of mobility and ability and deterioration of cognitive ability. As a result of these perceptions it is also believed that the ability of the elderly to cope with emotionally difficult circumstances is also lessened. It is the purpose of this literature to determine whether this is indeed the case and to identify some strategies that are more effective in supporting the elderly in meeting the challenges of ageing. Four areas of research will be examined: Emotional Intelligence and the Elderly, Assisting the Elderly to Manage Loneliness, Group work and its use in Aged Care Work and Reminiscence Therapy in Aged Care.

Emotional Intelligence and Older People:

There is growing research to support the importance of emotional intelligence in ways of combating issues of loneliness and helplessness within the aged community.

Defining Emotional Intelligence

Shipley, Jackson and Segrest define emotional intelligence according to four main areas or 'branches':
- the ability to accurately perceive and express emotion
- to assimilate emotion into thought
- to understand emotion
- to regulate emotions in the self and others"
  (Shipley et. al, 2010, p.3)

They define "perceiving emotion" as the ability to identify one's emotions and the emotions experienced by others. Facilitating emotion relates to how the cognition and path of action is directed by a person's understanding of emotion. Understanding emotion focuses on how emotions function as a part of relationships and the various transitions we make between emotional states. Regulating emotion can be defined as the way a person controls and enacts their emotions (Shipley et. al, 2010, p.3).

Ageing and Emotional Memory

Susanne Scheibe and Laura Carstensen of the Department of Psychology at California's Stanford University suggest that, contrary to traditional thinking, as we age our emotional strategies change and that our emotional skills ***sharpen*** as we pass the age of 60. They argue that "…[through] selective and compensatory changes in emotional preferences and strategies, it is possible that learning and practice effects make older adults more competent at emotional regulation. Specifically, the long-term experience and practice in dealing with emotional situations should lead

older adults to acquire additional situational, strategic and procedural knowledge about emotional process" (Scheibe & Carstensen, 2009, p.136). Bucks, Garner, Tarrant, Bradley & Mogg discovered through studies of the elderly in interpersonal situations that "older adults…select more efficient strategies to solve interpersonal problems, and tailor their problem-solving strategies to contexts, using a combination of instrumental and emotion-regulation strategies" (Bucks, Garner, Tarrant, Bradley & Mogg in Schiebe & Carstensen, 2009, p.141). Their arguments highlight the importance of emotional intelligence in providing the tools for the elderly to be able to deal with emotional turmoil effectively as it relies on an elderly person's ability to employ a range of emotional coping strategies, a skill that remains firmly intact as a person ages.

Charles, Mather and Carstensen have identified the notion of emotional focus and refocussing. This refers to the idea of "a shifting ratio positive to negative information with advancing age" (Schiebe & Carstensen, 2009, p.138). Conducting a study to examine the differences between how younger and older age categories store memories of positive and negative images, they concluded that "while overall, older adults recalled fewer images than younger adults, they recalled a greater number of positive images as compared with negative images" (Schiebe & Carstensen, 2009, p.138). There has arisen significant debate concerning the theory's long term impact as to whether this method of dealing with emotions is a form of suppression that could result in future harmful side effects. Despite this, however, Scheibe and Carstensen believe that "it does not matter whether the effect is driven primarily by reducing focus on negative material or enhancing focus on positive material [as] selective cognitive processing that is really positive can benefit well-being" (Schiebe & Carstensen, 2009, p.139). This suggests that with further research this shift towards positive emotional focus is vital to providing the elderly with skills to enhance the ways in which they deal with emotional traumatic circumstances.

Emotional Reactivity and Older People

Of particular importance to the concept of emotional intelligence and the elderly is 'emotional reactivity' or the level at which a person reacts to a given emotional situation. There has been much research conducted into this field by academics such as Lumley, Levenson, Jain & Heinze to establish whether emotional reactivity increases or decreases with age. Their studies, primarily conducted through Neuro-imaging discovered that in certain situations elderly people experienced emotional reactions equivalent to or greater than that of younger generations – "When viewing films dealing with age-typical losses, such as loss of loved ones…older adults reported stronger feelings and have comparable physiological reaction to young adults. Moreover, cardiovascular reactivity in response to laboratory stressors such as challenging cognitive or speech tasks is actually increased in older adults" (Uchino et. al in Schiebe & Carstensen, 2009, p.140). The study also revealed that "accompanying physical arousal in older adults appears to be diminished in older

adults…[and] under conditions of comparable physical arousal, subjective feelings are increased in older adults" (Uchino et. al in Schiebe & Carstensen, 2009, p.140). Contrary to the belief that with age comes cognitive deterioration, these reports indicate an increase in cognitive activity in certain emotional situations, highlighting the opportunity to use the apparently enhanced emotional intelligence and maintained cognitive ability of the elderly in the healing process for victims of ageism and abuse.

Issues

These studies highlight three areas of future research to achieve best practice methods for the elderly to effectively deal with ageism and abuse. Firstly, there needs to be greater research into the implementation of healthy emotion regulation. The ability to shift focus between positive and negative emotion will prove highly useful in generating long-term well being for older adults. Furthermore, this skill of emotional regulation relies on cognitive functions that have ***not*** deteriorated with age allowing an older person to use strategies they are already fluent with to deal with emotional struggles. Secondly, further research is needed to establish the difference between the responses of emotional regulation and emotional reactivity. The lines between these two responses are often blurred as it is often unclear as to whether the subject is expressing emotional regulation or is simply unresponsive to a particular emotional situation. Finally, the emotional regulation and focus on positive emotion experienced readily by older adults may have negative effects. These particular emotional reactions can cause older adults to be poorer at detecting deceit and show greater emotional impairment after focusing on positive memories to alleviate negative emotions. Furthermore, they may also misjudge certain situations and engage in detrimental paths of action as a result of decision making that is guided by distorted emotional reactions. This can make them particularly vulnerable to issues such as financial fraud. Further research is required to enable older adults to 'emotionally right' themselves to avoid hardship as a result of these emotional coping strategies.

Assisting Older People to Manage Loneliness

A Definition of Loneliness

One of the more prevalent issues faced by the elderly is the incidence of loneliness and the impacts that experiencing loneliness may have on the individual. The term "loneliness" is often confused with social isolation and part of addressing the issues surrounding loneliness is providing a distinction between the two. Gardener argues that "often researchers, and practitioners alike, use the terms social isolation and loneliness interchangeably" (Gardener in Stanley, 2010, p.5) However, the terms are not the same, a notion supported by van Baarsen, Snijder, and Dahlberg who suggest that "not all people who live alone or have limited social contacts are lonely and

conversely people with many social contacts who live with others may still experience loneliness" (Baarsen, Snijder and Dahlberg in Stanley, 2010, p.5).

Loneliness is a highly important issue that needs examination in relation to ageism and abuse of the elderly as it has been linked to numerous physical and emotional health problems such as alcoholism, chronic health problems, anxiety, depression, suicidal ideation and suicide. An examination of research demonstrates a growing focus on the concept of loneliness, which is supported by Kirsten Thorsten and Sten-Erik Clausen who state that "demographic and social development with more and more people living alone in some phases of life, and the changing institution of the family with several unions resolutions, can result in social relations being less able to satisfy what scientists consider to be fundamental needs of human belonging and affiliation" (Thorsten, K. & Clausen, S. 2008, p.19).

Alleviating the effects of loneliness

There has been quite comprehensive research conducted by scholars Cattan, White, Bond and Learmouth into the effects of loneliness and the various types of methods employed to alleviate the negative effects of loneliness. They identify thirty studies that have been conducted on loneliness between 1972 – 2002. Through the review of these various pieces of literature they discovered that most commonly one to one interventions were the least effective means of aiding someone experiencing loneliness. They also discovered that effective interventions occurred when the person experiencing loneliness was consulted or included in the design of the program intended to aid them in alleviating the symptoms of loneliness. As part of this study they engaged in a three-stage project aimed at examining the causes and components of loneliness, the ways group interventions could be initiated in combating loneliness, and the most effective methods for guiding group intervention.

Stage 1:
Through the research examined Cattan, White, Bond and Learmouth discerned five dimensions of loneliness. Private loneliness was one of the dimensions they identified which they suggests relates to the loneliness a person feels when by themselves, that is often regarded as a stigmatised and personal experience. Another dimension they identified was 'Relational' loneliness which can be defined as whether people can maintain relationships and the loneliness they experience should they fail to do so. 'Connectedness' was also recognized and describes the way in which a person may have a wide social sphere and not live alone but will experience loneliness as a result of not feeling a strong connection with a particular person or group. 'Temporal' loneliness was another of the dimensions outlined which relates to how loneliness can be influenced by time of day or even time of life, i.e. the loneliness experienced when alone after a social interaction or the loneliness experienced as a result of the loss of a life partner. Finally Cattan, White, Bond and

Learmouth perceived 'Readjustment' to be a form of loneliness that can be experienced. This type of loneliness relates to the ability of an individual to respond to loss or change and the loneliness that may be experienced as a part of that.

External to this study but worthy of note, however, is the relationship between age and loneliness, examined by Tijhuis, De Jong-Gierveld, Feskens and Kromhout. There is a common perception that old age is something that leads to increased feelings of loneliness – "Elderly people appear to be more prone to loneliness possibly due to loss of close ties and increasing dependency" (Tijhuis, 1999, p. 491). This may not be the case, however. Tijhuis, De Jong-Gierveld, Feskens and Kromhout discovered through their study conducted over ten years that loneliness does not exponentially increase but rather only begins to increase after the ages of eighty and older. They found that loneliness is influenced by external factors such as lack of mobility due to physical ailments and is often tied to the health of a life partner, for example, whether a person's life partner is experiencing cognitive problems such as Alzheimer's.

Part 2:
Stage two of the study was directed to identifying the various techniques that could be employed to initiate group work therapy in regards to loneliness (See the next section on Group work and its use in Aged Care Work). The key areas identified in the study that needed consideration were:
- o Education
- o Building and Maintaining personal needs and connections with others
- o Maintaining meaning and purpose in every day life
- o Strengthening community capacity
- o Getting around: transport
- o Use of Media
- o Flexibility and diversity in service provision

The term education referred to the need to educate more aged care workers in the group work process and how it can be used as a therapeutic tool to manage loneliness. Cattan, White, Bond and Learmouth noted that there was limited research into how participants in group work could develop skills to build and maintain successful personal relationships and how these relationships could improve the meaning and purpose of everyday life. They also considered more practical elements such as the issue of mobility and transport that could pose a problem for the elderly. Also examined was the role of new media in the therapeutic process. They posited that more research needed to be conducted in regards to how technologies such as the internet and social media could be used in the therapeutic or group processes – "Utilising an internet social networking site and other communication mediums did have the potential to reduce loneliness; according to participant self-report" (Stanley et. al, 2010, p. 10). Their initial research revealed that there were difficulties in terms of access to the technology, the learning curve

that comes with new technologies and a general rejection of these new technologies. Perhaps most important to the group process, however, is the flexibility and diversity of service provision. They argue that as the feelings of loneliness, sadness and depression vary between each individual there needs to be a wide range of services offered by care staff to be able to cater to each individual's needs. Cattan, White, Bond and Learmouth outlined a series of principles that could be used to guide this group interaction:

- o Client centred practice – needs of the subject come first
- o Focus on the person is considered at multiple levels – individual, organisation and community
- o Person and their feelings are affirmed and valued
- o Activities (when used) are meaningful to the individual
- o Programs are individualised

These guidelines are essential to tailoring programs to the individual needs of each participant in group work or sufferer of loneliness.

Part 3:
The final stage of the study was used to summarise the best practice methods that Cattan, White, Bond and Learmouth discerned in regards to managing loneliness. Their final recommendations were:

- Loneliness is complex and more research is required to hopefully cover the full breadth of issue that are associated with loneliness
- Approaches to combating the issue must be tailored to the individual
- Education programs are needed to combat the stigma of loneliness, to empower the elderly, improve the services offered by age carers and to renew focus on social well being not words/programs targeted at loneliness
- Projects need to be sustainable as the termination of a project in its middle stages can be harmful to the person involved

<u>Issues</u>

Whilst these recommendations are somewhat general, they provide useful guidelines and direction as to where research into managing loneliness needs to be directed. For the purpose of this paper, the next focus will be on two programs, the group work and reminiscence therapy that potentially alleviate the symptoms of loneliness, empower the elderly as individuals and as part of a group, and renew focus on social collective well being.

Group work and its use in Aged Care Work:

<u>The role of group work among older people</u>

Current studies, aimed at improving aged care methods and outcomes have indicated the growing importance of group work. It is considered essential in working with the elderly, providing a way of alleviating the negative emotions experienced by the elderly as a result of loneliness, social isolation, and the perception that the person affected is alone in what they are feeling. Marianne Schneider Corey and Gerald Corey have conducted extensive research regarding benefits of group work with elderly people. They argue that group work provides a sense of community, which is a useful antidote to the isolation and impersonal nature that many elderly people may live. Furthermore, groups can demonstrate to participants that they are not alone and that there is hope for them to create a better life (Corey & Corey, 2002, p. 380). It is these key aspects that make group work so fundamental to combating the issues of ageism and abuse that elderly people may experience.

When conducting group work sessions there are ranges of factors that need to be considered. The perception that group work is a process in which a person's personal barriers are torn down by the group and then, through collaboration with the group, their personality is rebuilt, appears somewhat daunting and is one of the main points of resistance against engaging in group work. This perception needs to be considered, particularly in regards to work with the elderly. Marianne and Gerald Corey state that "group work [with the elderly] should not be aimed at personality reconstruction but toward making life in the present more meaningful and enjoyable" (Corey & Corey, 2002, p. 380).

In a positive light, group work, according to Marianne and Gerald Corey, offers the participants a way of observing the way they relate to others and how others react to their presence. This can allow an elderly person to develop their social skills and is essential to breaking down the social barriers they have. For example, an elderly person may say they experience social isolation or loneliness but through group work may come to the realisation that they are constructing social barriers themselves that prevent others from getting to know them more closely. This setting also offers a participant the opportunity to trial new social behaviours and then perhaps implement them in outside life. Furthermore, group settings can also offer "support for new behaviours" (Corey & Corey, 2002) as well as having the potential to enable participants to hear and observe how other people deal with many of the situations they may also experience. For example, an elderly person may experience certain abusive behaviours and will simply just tolerate them. Another person in the group, however, may see these behaviours as unacceptable and may tell the other person, providing possible strategies or solutions to deal with these experiences. This group setting offers an open forum in which coping strategies can be discussed and encouragement can be given to participants who may be experiencing abuse to stop tolerating these behaviours. These factors are quite useful in providing the elderly with methods to improve their social interactions and to deal with situations of abuse and ageism.

<u>Issues</u>

A wide range of factors may impact upon group work with elderly participants and should be considered for effective group sessions. One of the major factors that will affect successful group work is the health of the various participants. The physical and psychological ailments that some group members may experience could possibly hamper the progress of a group. As a result the pace of group work will need to be modified to accommodate for these members. Other health impairments that may be present include Alzheimer's, senile dementia and other memory dysfunctions that may cause members to forget about their group work. This, however, is easily countered through practical reminders such as telephone calls and letters in the mail. Group sessions may also conflict with appointments with medical professionals and other professionals. As a result, careful planning is required to ensure these sessions do not interrupt these appointments as routine and constant structure and continuity is required for maximised success in group work.

As with many studies involving group work for all ages, there is often reluctance within elderly participants to engage in any form of 'therapy' as it can be perceived by the person as an admission of psychological instability or weakness. Elderly people can often be sceptical of care workers and engagement in group work. Stone and Walters suggest that a possible solution to this problem is the implementation of peer counsellors in the group process. Peer counselling has the potential to be an effective way of getting older people to engage in the group process as they are more likely to communicate with someone they perceive as a friend than someone who they perceive as a health care professional. According to Patricia Sisco,

> "…peer counselling has many advantages to the client, the counsellor and the community. The clients are given the opportunity to model after someone whom they have reached out to. They are given the opportunity to develop coping skills that presumably work because they work with the peer counsellor they are relating to. They can learn to advocate on their own behalf…[and] their feelings of self-worth can be enhanced because they have a counsellor who truly understands" (Sisco, 1992).

One of the most discussed issues is the desire and need of the elderly to be listened to, 'conversation deprivation', (Corey & Corey, 2002) and is a common theme in the issues of loneliness and social isolation, which greatly contribute to feelings of depression, and low self esteem within the aged community. Ageing may limit opportunities for social interaction due to factors such as reduced mobility, which in turn enhances feelings of depression. Group work offers a practical, non-threatening way to allow each person to share their stories with others, engage with others in social situations and learn about the issues that other people face and the way that others cope with these issues – "To be encouraged to share and relate with others has therapeutic value in itself" (Burnside in Corey and Corey, 2002, p.388).

Reminiscence Therapy in Aged Care:

Work in the field of aged care surrounding group work has also indicated the importance of therapeutic practice known as reminiscence or 'reminiscence therapy'. Marianne and Gerald Corey argue that reminiscence therapy was "Once viewed as an unproductive escape into the past…It is now considered to be a useful therapeutic strategy in promoting psychological integration for elderly clients" (Corey & Corey, 2002, p. 390). Cynthia Stinson corroborates this view and she suggests that "reminiscing is a technique employed to help patients think and talk about their lives. This technique can be implemented in a structured group, in an unstructured group or even on an individual basis" (Stinson, 2009, p.521). Current research confirms the importance of reminiscence for the aged as it affords elderly people the opportunity to communicate with others and share similar concerns. This is essential to work with the elderly especially when dealing with issues such as loneliness and social isolation.

Studies have indicated a range of key areas regarding reminiscence therapy that should be included to improve the success of this kind of treatment.
Firstly, groups should be planned with attention to set goals, setting, the group's size, the group's format, and leaders. It should also be noted that members of the group may be experiencing strong physical and mental suffering or could simply be attending group sessions for the social interaction. Accordingly the way the group functions should be adjusted to allow for considerations such as these. Essential to successful group work is the establishment of a positive atmosphere. Other factors that influence a group's success include room size, lighting, locations, accessibility, temperature. The carers involved should lead the group and keep it intact – carers should not reframe, probe, or push for insight but serve as informal, supportive, ego-enhancing leaders. Props such as scents, foods, music, pictures, scrapbooks, magazines and old radio programs provide excellent stimulation for group interaction. Reminiscence should focus on positive memories – a 'favourite holiday' appeared effective in stimulating discussion in preliminary studies, followed by 'firsts', e.g. first job, first date, toy, pet, etc. Another issue to address is the cognitive abilities and difficulties experienced by members of the group. Should participants have cognitive memory deficiencies reminders about the group through phone calls or mail should be used. Implementation of group reminiscence requires prior knowledge about each member of the group which will allow for encouragement of discussion.

One possible framework that can be implemented to initiate reminiscence therapy is Molinari's life review. Molinari's life review schematic breaks up the reminiscence process into six separate phases or topics from which a participant can use to engage in reminiscence:

- Introduction – This part of the life review schematic allows a participant to introduce who they are, how they feel about themselves and possibly why they have chosen to participate in the group
- Family history – Molinari suggests that for the second stage the participant should describe their family history, taking time to analyse the important figures in their lives and both the positive and negative impacts these figures may have had
- Development stages – This stage requires the participant to try and divide their life into its significant stages. This may be categories such as early childhood, schooling, work life, marriage, etc.
- Life crises – This particular part of Molinari's life review requires the participant to discuss the various crises they have experienced throughout their life. This stage is unlikely to be discussed in isolation as many crises experienced by the participant could relate to family history, particular stages of their life or even how they currently feel about themselves
- Experiences of death – This stage will overlap largely with the life crises stage as many of the crises experienced by the participant may include death and mortality as a salient feature.
- Meaning of life – This final stage requires the participant to discuss the evolution of their life goals from past to present. As part of this they will need to discuss how their current goals provide meaning in their life today. This part of the reminiscence process is important as it can aid in identifying at what point in the participant's life cycle did they begin experiencing emotional turmoil and how this emotional turmoil may be affecting them in the present. (Molinari in Corey and Corey, 2002, p. 380)

Molinari's schematic for reminiscence is useful in reminiscence therapy for the elderly as it offers a useful way for the aged participant to frame their entire life. It is a targeted method which leads the participant to begin a process of self-reflection and possibly allows the participant to focus on the achievements they have made throughout their life cycle. Through discussion they can hopefully see how certain important events in their life have impacted upon their personal growth.

Issues

Nonetheless, although Molinari's life review provides an effective way in framing a person's life and initiating the process of reminiscence, there are some shortcomings to this particular approach. The task required of the aged participant to discuss their whole life story and to analyse key events within it is overwhelmingly large and as a result it presents a number of problems. A group session would simply be too long for each individual to go through this process. Breaking the sessions up so that the participant can cover different stages in different sessions is not beneficial either, defeating the purpose of providing a broad scope and review of the participant's life.

Furthermore at the start of each new session the participant will spend time trying to remember where they were up to in their life review.

Another issue to be considered whilst using Molinari's life review is its potential for negative focus. Recollections of episodes of pain and hardship within the person's life such as life crises, losses and experiences of death may negate any therapeutic benefit of reminiscence and contrast with the focus of reminiscence therapy which emphasises preserved abilities and positive memories and not what has been lost and what the individual can no longer do or experience.

Conclusion

A review of the literature demonstrates that providing the tools for the elderly to be able to deal with the challenges of ageing relies extensively on an elderly person's emotional intelligence and skills in employing a range of emotional coping strategies. Researchers have argued that these skills remain firmly intact as a person ages challenging the long-held perception that emotional intelligence, along with physical abilities, declines with ageing. Notwithstanding, particular support programs need to be instituted to empower the elderly to use these skills to their best advantage. Strategies such as group work and reminiscence therapy have been shown to promote social connectivity and a more positive world view among the elderly and must be viewed as important tools in the quest to promote best practice in the care of the aged.

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