Contemplating, Caring, Coping, Conversing : A Model for Promoting Mental Wellness in Later Life

KEYPOINTS : CONTEMPLATING, CARING, COPING, CONVERSING
1 Mental wellness for older adults can be promoted through communication that supports contemplating, caring, coping, and conversing.
2 Nurses working with older adults are especially challenged to develop an awareness of their own caregiving styles and communication processes, and to assist others such as family caregivers and care receivers to communicate and interact more effectively.
3 Nurses have many opportunities for unique and productive interactions with not only elderly individuals, but also their families.

ABSTRACT
This article is based on the premise that mental wellness for older adults can be promoted through communication and presents a model drawing on the constructs of contemplating, caring, coping, and conversing. The importance of interpersonal communication processes in the care of older adults and some barriers to communication and mental wellness are briefly reviewed. This article challenges nurses to develop awareness of their own caregiving styles and communication processes, and to assist others (e.g., family caregivers, care receivers) to communicate and interact more effectively to advance mental wellness for older adults.

Populations throughout the world are continuing to grow as life expectancy increases. The aging of the population has driven both governments and health professionals in many countries to recognize the need for care practices focusing on maintaining and promoting the health of older adults. Although cure and healing measures extend age, there is no cure for aging. However, various components of health, such as quality of life, personal growth, and healthy relationships, can and should be promoted and maintained throughout the aging process. These components of health are largely subjective and reflect an individual's mental wellness or mental health. In this article, mental wellness is understood to be a state of mind promoting a balanced, active, and social life through effective adjustment to life's physical, social, emotional, and spiritual challenges.

Driven by the premise that mental wellness for older adults can be promoted through communication, this article presents four dimensions of a model for a communication style promoting mental wellness in later life. The dimensions of the model comprise the constructs contemplating, caring, coping, and conversing. Brief dialogues are used to highlight the constructs and how they inform communication that advances mental wellness for older adults. Before examining the four constructs in terms of their relationship to communication, the importance of interpersonal communication processes in elder care and some current barriers are briefly reviewed.

IMPORTANCE OF COMMUNICATION IN ELDER CARE

The relationship between communication and the maintenance of health during aging has received much attention in the past two decades. It has been argued that the process of interpersonal communication is central to the aging process and provides the link between health and successful aging (Hummert & Nussbaum, 2001). Social interaction provides support for older adults, positively affects their self-esteem and ability to cope with stress and depression, and helps them maintain a societal role (Nelson, 1989). Essentially, "to be valued as a person implies being talked to and listened to" according to Erber (1994, p. 271). Giles, Coupland, and Wiemann (1990) contend that communication is crucial to understanding the interrelationships among social support, psychological well being, and physical health. Moreover, because interaction is necessary to assess needs, negotiate plans of action, and evaluate care, it provides an appropriate medium by which to examine processes of care (McIntosh, 1996).

Communication plays a significant, if not central, role in maintaining and promoting quality of life and quality health care for those of all ages. However, for many older adults, opportunity for interpersonal communication and interaction is limited by a number of barriers, such as ageism, limited quality contact with others, and the use of interpersonal control strategies by caregivers.

BARRIERS TO COMMUNICATION FOR THE OLDER ADULT
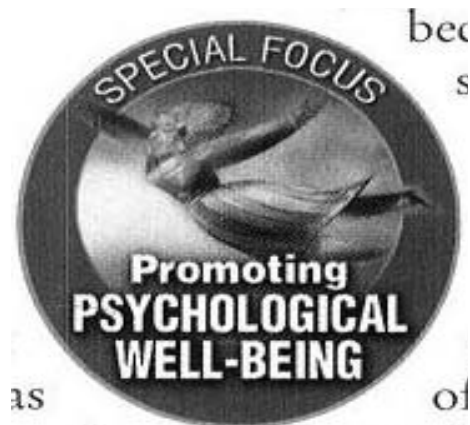
Many older adults find themselves more alone than ever before as long-standing friends and relatives die and family and friends relocate to different geographical areas (Martin, 1999). If entry into residential care is necessary, older adults may become even more isolated. For example, the move may create transport difficulties for family and friends who wish to visit and the ability to maintain relationships through reciprocal entertaining is threatened (Bear, 1990). Family and friends, the community, and residential care staff may assume that residents do not wish to maintain links with social networks or that they are too old and sick to continue this role. Life as it used to be ceases, and studies suggest that older adults in residential care have little opportunity for social interaction (Armstrong-Esther, Browne, & McAfee, 1994). Opportunity for social interaction by older adults in residential care may be limited to contact with staff members.

Research has shown that communication between nurses and their elderly clients is infrequent and of short duration (Edwards, Weir, Clinton, & Moyle, 1993;

MacDonald, Craign, & Warner, 1985; Oliver & Redfcrn, 1991). Studies also suggest that most interactions tend to focus on technical and physical aspects of care and that staff use of interpersonal control strategies, such as interrupting and directing, maintain the older adult's dependence (Edwards, Moyle, Clinton, Weir, & Eyeson-Annan, 1994; Gibb, 1990; Gibb & O'Brien, 1990).

Dependence-promoting behaviors block the adaptive processes necessary for mental wellness. It fosters processes of "learned helplessness" (Seligman, 1975), a state that occurs when events are perceived as uncontrollable. For example, when elderly adults enter residential care, their independence is surrendered as they become subject to the control of staff who, under the guise of the professional helping role, greatly influence their existence. Residents' lives become regulated by routines, rules, and practices often designed to meet the needs of staff. Residents arc relieved of responsibility, but in return lose freedom to make life decisions. They eventually learn to become passive, cooperative recipients of care. Under these circumstances, interactions between staff and residents can develop into a selffulfilling cycle with residents becoming increasingly dependent on staff, and staff becoming increasingly dissatisfied with their work.

Research, however, demonstrates that dependent behavior in older adults can be modified (Baltes, 1988; Mosher-Ashley, 1986). Baltes, Wahl, and Reichert (1991) argue that older adults have great latent reserves and

can continue to maintain or even grow in life domains that are important to them despite a reduction in biological, mental, and social reserves (p. 314).

Through the process known as selective optimization with compensation, individuals can adapt to the conditions of old age and achieve "mastery and progress despite an increasingly less positive balance between gains and losses" (Baltes, 1993, p. 592). That is, by selecting and concentrating on the important things in their lives, by engaging in constructive behaviors, and by using technical and psychological compensatory strategies and devices, individuals can age successfully, or age with mental wellness.

The principles of selective optimization with compensation do not fit comfortably with interpersonal control strategies and infrequent and brief communications with others. To age with mental wellness-to advance to a state of equilibrium and harmony-there has to be mutual valuing and respect between individuals and meaningful interaction must occur. Unfortunately, Western populations tend to hold negative attitudes toward old age and neither respect nor value elderly citizens. This form of intolerance has been termed "ageism" (Butler, 1969).

Ageism, or stereotyping and discriminating against individuals because they arc old, remains widespread throughout all Western societies, including the nursing profession. Studies since the 1950s have indicated that many nurses hold a negative attitude toward working in elder care. Elder care nursing is considered to be of lower status and appeal than more acute areas of nursing, it continues to be an undesirable career choice, and interest in elder care nursing as a career choice decreases during nurse education (Courtney, Tong, & Walsh, 2000; Stevens & Herbert, 1997).

The effects of ageism and the negative image of elder care are further compounded by the many false assumptions or myths that exist about older adults and the aging process. For example, it is widely assumed that old age must be accompanied by an irreversible decline in mental health (Darby, 1999). This assumption may lead to the further assumption that older adults are incapable of thinking or acting for themselves. Older adults increasingly have been looked upon as "useless and incapable of functioning in a rapidly changing society" (Jecker, 1999, p. 47). Ageist attitudes and assumptions such as these permeate interpersonal interactions and communications in gerontology, and by doing so ageism becomes a barrier to promoting mental wellness.
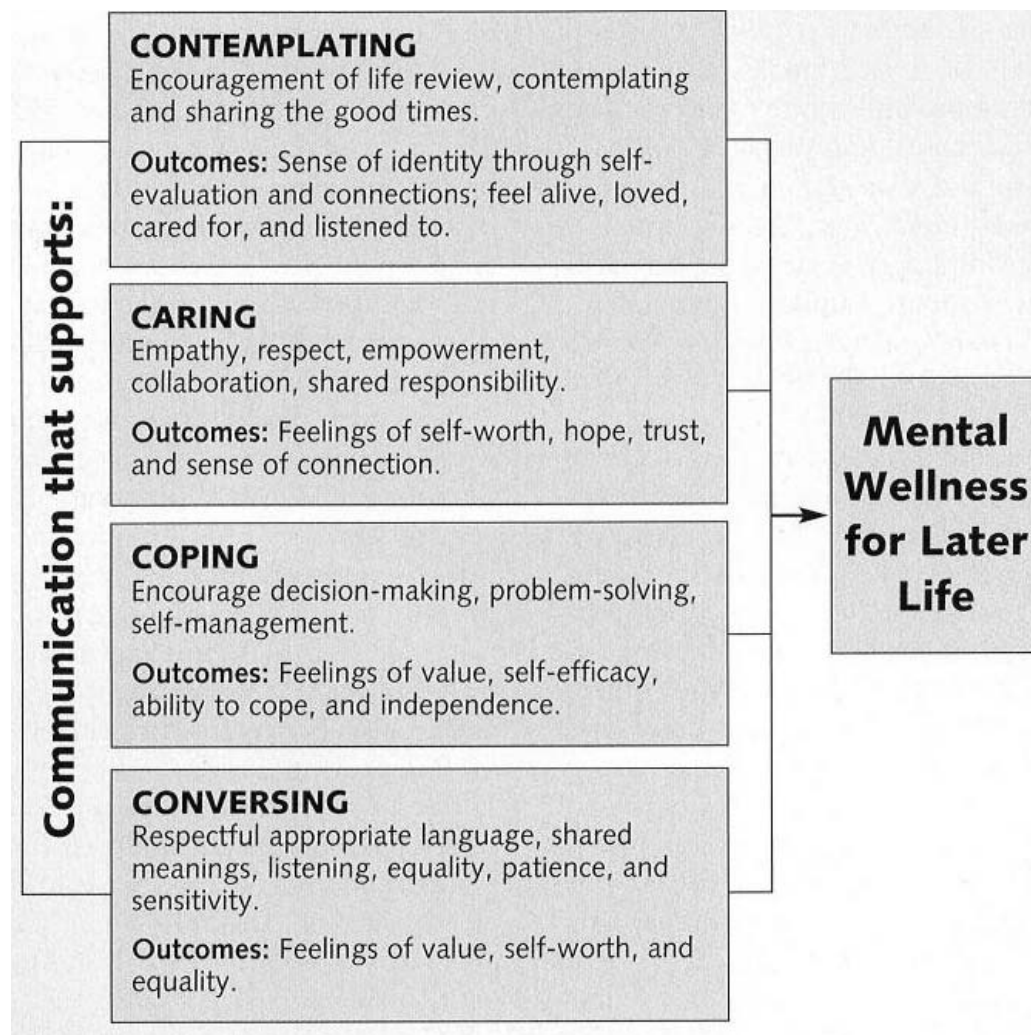
Communication that supports:

CONTEMPLATING
Encouragement of life review, contemplating and sharing the good times.

Outcomes: Sense of identity through self-evaluation and connections; feel alive, loved, cared for, and listened to.

CARING
Empathy, respect, empowerment, collaboration, shared responsibility.

Outcomes: Feelings of self-worth, hope, trust, and sense of connection.

COPING
Encourage decision-making, problem-solving, self-management.

Outcomes: Feelings of value, self-efficacy, ability to cope, and independence.

CONVERSING
Respectful appropriate language, shared meanings, listening, equality, patience, and sensitivity.

Outcomes: Feelings of value, self-worth, and equality.

Mental Wellness for Later Life

Figure. The ProMWell Model: A model for promoting mental wellness in later life.

These barriers to promoting mental wellness need to be confronted and overcome by all members of society because they exacerbate problems that eventually face us all. Nurses working with older adults are especially challenged not only to develop an awareness of their own caregivmg styles and communication processes, but also to assist others (e.g., family caregivers, care receivers) to communicate and interact more effectively. Poor quantity and quality communication processes do not occur only between nurses and elderly individuals in residential facilities. Other caregivers

within other contexts also use interpersonal control strategies and ineffective communication processes. For example, research indicates that power inequalities exist in family caregiver-care-receiver relationships, and that there is also a strong tendency to avoid issues of concern during interpersonal communication (Edwards & Forster, 1999).

A CONCEPTUAL MODEL

A conceptual model for promoting mental wellness in later life was developed by the authors and named the ProMWell model-a name deriving from the purpose (Figure). The model is driven by the contention that mental wellness for older adults can be promoted through communication that supports contemplating, caring, coping, and conversing.

The conceptual basis for the ProMWell model derives from mtegration of the principles of life-stage development and communication, aging, and health as depicted in the literature. The four constructs of the model were generated as the authors reflected and debated the purpose and meaning of communication, aging, and health for older adults. Various notions, such as caring being a communicative act, were related to the developmental task of integrity versus despair, the final or eighth stage of social growth and development as conceptualized by Erickson (1963). Although the four constructs are examined independently, in reality, they are interconnected, and inform and depend on each other.

Contemplating

According to Erickson (1963), life's last stage is a time of reckoning, of summing up. It is a time for reflection and reminiscing over one's life. Reflection is what individuals do when they "recapture their experience, think about it, mull over and evaluate it" (Boud, Keogh, & Walker, 1985, p. 19). Reflection enables individuals to engage in self-evaluation that may alter their own thinking and subsequent behavior (Bandura, 1986). Thus, old age can be considered the time for contemplating what has gone before, of reviewing one's life, and balancing the losses with the gains. Moreover, the activity of contemplating helps us to know and understand who we are. As Oliver Sacks (1985) says,

We have, each of us, a life-story, an inner narrative-whose continuity, whose sense, is our lives. It might be said that each of us constructs and lives, a 'narrative,' and that this narrative is us, our identities (p. 105, emphasis in original).

Although exploring and evaluating the past and maintaining a sense of identity is important for the mental wellness of all older adults, doing so can assume even greater importance for those elderly individuals who feel threatened by age-related changes, such as altered perception or cognition. Killick (2000) claims that when an individual's sense of coherence is threatened (i.e., when an individual doubts where they are, where they have been, and even who they are), the "autobiographical impulse is a crucial means for maintaining this sense of identity" (p. 8). Encouraging an individual with dementia to reflect and TCVIC-W life events is important for other reasons. For example, communicating with an individual with dementia is difficult, but according to Armstrong (2001), communication can be facilitated by stimulating

the individual's long-term memory and encouraging contemplation on what has gone before.

Hirst and Raffin (2001, p. 25) say, "Stories are the language that older adults use to talk about their lives." Most individuals enjoy contemplating the good times in their lives and, if encouraged, most will share the significant periods with others. It is through the sharing of life stories that individuals make connections across memories and between each other. It is these connections that "enable individuals to feel alive, loved, cared for, and listened to" (Haight, 2001, p. 90). However, older adults generally are not actively encouraged in contemplating and are given little, if any, encouragement or opportunity to tell their stories. Consider the following dialogue:

Elderly client: I wore a pink satin dress to a ball once...

Nurse: That must have been nice. Now, put this dress on or we'll be late.

Clearly, the older client was contemplating or reflecting on her life and personal history, looking back to a time when she had a special dress and was ready to share her experience. It is equally clear that the nurse's communication did not support further contemplating about pink satin dresses or balls. The story was cut off before it really began. Such an exchange contributes little to the elderly individual's feelings of mental wellness.

Caring

Traditionally, the constructs nursing and caring are closely associated. Although nurses are not the only health professionals who care, they are the only group to claim human caring per se as their central concern. Caring is investing oneself in the experience of another sufficiently enough to become a participant in that person's experience (Pearson, 1991, p. 199).

Caring docs not seek to control or master, but to facilitate and uncover possibilities. Essentially, caring provides empowerment (Benner, 1984). Caring makes recipients feel worthy and full of hope and, thus, promotes a feeling of trust and a sense of connection (Hirst & Raffin, 2001). To be effective, caring requires a collaborative partnership between caregiver and care receiver. For example, effective caring demands mutual respect and empathy. It entails mutual cooperation, sharing of responsibility, and joint decision-making. These requirements, in turn, call for communication practices that go beyond technical and physical aspects of care to a communication style that advances quality of life, personal growth, and healthy relationships. Such practices are evident in the following exchange:

Elderly client: I wore a pink satin dress to a ball once...

Nurse: You must have felt real pretty Mrs. Jones, I'd love to hear about it while you finish getting dressed! Was the dress long or short?

As before, the older client is contemplating her life and personal history, looking back to a time when she went to a dance in a special dress. This time the nurse's communication not only supports further contemplating but also demonstrates caring

in terms of respect and empathy. The response also actively encourages further communication. Such an exchange would contribute to the older person's feelings of mental wellness.

Coping

The vulnerability of older adults to illness and disability increases the stress associated with later life challenges and transitions, which arc largely associated with loss. Older adults can experience many different losses. For example:

* Loss of lifetime friends, work, independence, and control.

* Loss of perceptual, sexual, bodily, and cognitive function.

* Loss of opportunity or ability for valued action, such as fulfilling later life wishes or experiencing something one more time.

These changes can overwhelm an older adult to the point where they feel no longer able to cope. This self-judgment can cause further worry, distress, or even despair. Unless this cycle is interrupted, the elderly individual may surrender to despair and retreat into a state of passive dependency.

Essentially, "what people think, believe, and feel effects how they behave," according to Bandura (1986, p. 25). Actions and behaviors arc better predicted by beliefs about personal capabilities, perceived self-efficacy, than by what one is actually capable of accomplishing. Thus, the ability to cope effectively with later life challenges and transitions largely depends "not on the skills one has but with the judgments of what one can do with whatever skills one possesses" (Bandura, 1986, p. 391).

The ability of older adults to cope with later life challenges and transitions, therefore, depends largely on their perceived self-efficacy or confidence to do so. There are many opportunities for nurses and other caregivers to maintain and promote self-efficacy in older individuals. For example, nurses can engage older adults in decision-making and problem-solving whenever possible, and encourage them to self-manage the effects of their disabilities or illnesses as much as possible. Continued social interaction and the perceived social support of others also enhance the ability to cope in later life (Darby, 1999). Consider the following dialogue:

Elderly client: I wore a pink satin dress to a ball once...

Nurse: You must have felt real pretty Mrs. Jones, I'd love to hear about it while you finish getting dressed! Was the dress long or short?

Elderly client: It was what they called "ballerina" length and there were over 8 meters of tulle in the skirt. Which dress should I wear today?

Nurse: Which one do you want to wear? Don't forget you have visitors coming. Where will you meet them, Mrs. Jones? It is a cold day outside.

The nurse's communication in this exchange not only supports contemplating and caring, but also directly supports coping. The nurse has indicated to Mrs. Jones that she is capable of making the decision about what to wear, and she is also capable of solving the problem of where best to meet her visitors. Such an exchange would contribute to the elderly individual's feelings of mental wellness.

Conversing

Language (i.e., speech) shapes the social world, plays a crucial role in establishing ideas of ourselves and of society, and acts as a bridge between ourselves and others (Pugh, 1996). When one uses language to communicate or exchange ideas with someone else, this is conversing. For conversing to be effective, "the participants must be willing and able to share the meanings constructed in the process" (Pauwels, 1995, p. 11). However, this is often very difficult, especially in health care. For example, even when nurse and client appear to share the same language, the use of the jargon of the health field can lead to a range of problems including misunderstandings. Furthermore, effective conversing requires patience, sensitivity, treating each other with dignity, using respectful and appropriate language, and listening to and clarifying what is said.

Effective conversing also requires nurses' recognition of the likely inequality of the encounters in terms of health care knowledge, skills, and techniques, and also in terms of power and authority. In the elder care sector, power and authority behaviors may be hidden under the guise of maternal/paternal benevolence and manifest as helpful mother and father figures assisting a loved, but difficult, child. Under such circumstances, it is likely that the content of any conversation will be directive or controlling and delivered in words more suitable for a young child than for an older adult. This is demonstrated in the following dialogue:

Elderly client: I wore a pink satin dress to a ball once...

Nurse: That must have been nice, love. When we finish getting dressed you can tell me all about it!

Elderly client: There were over 8 meters of tulle in the skirt...

Nurse: Put this dress on today, it suits you best. That's a good girl! Now, I bet you forgot you have visitors coming. It's cold outside, so wait for them in the lounge. See you later, love.

This exchange does little if anything to promote mental wellness. The suggestion that the story could be continued after dressing was not carried through. Mrs. Jones was directed to the lounge. The nurse showed little respect or empathy toward the client, and the manner of address was patronizing at best. No attempt was made to involve Mrs. Jones in decision-making or problem-solving. The nurse was directive and controlling and the delivery was maternalistic/ paternalistic with Mrs. Jones being addressed like a loved, but difficult, child. This sort of communication is the antithesis of communication that supports the contemplating, caring, coping, or conversing actions of the ProMWell model.

SUMMARY AND IMPLICATIONS

Nurses play a major role in promoting mental wellness m older adults. The conceptualization of mental wellness as a state of mind promoting a balanced, active, and social life through effective adjustment to life's physical, social, emotional, and spiritual challenges indicates the importance of the concept in the overall health of older adults. The conceptual framework for promoting mental wellness through communication that supports contemplating, caring, coping, and conversing has profound implications for gerontological nurses. Nurses have many opportunities for unique and productive interactions with elderly individuals and their families. Nurses, therefore, are in an excellent position to assess and intervene with any maladaptive responses to later life challenges and transitions, or with inadequate communication processes between family dyads of caregiver-care-receiver.

Although discussion of strategics for achieving these changes is beyond the scope of this article, it is hoped that the article will generate further reflection and discussion about the importance of contemplating, caring, coping, or conversing in relation to communication with older adults. It is also hoped that gerontological nurses will accept the challenge to develop an awareness of their own caregiving styles and communication processes, and to assist others, such as family caregivers and care receivers, to communicate and interact more effectively with older adults. This would improve the mental wellness of older adults, and do much to ameliorate the burden of care for their families and loved ones.
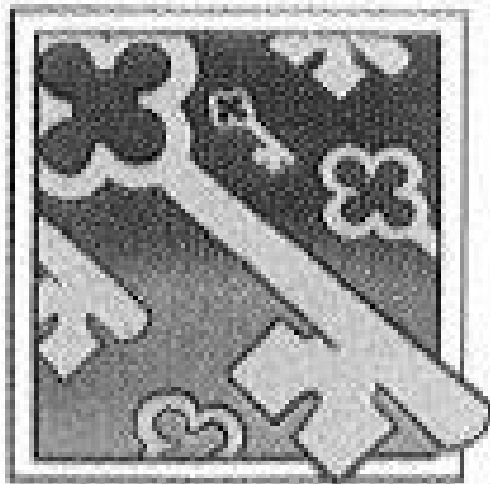
REFERENCES
Armstrong, M. (2001). The pressures felt by informal caregivers of people with dementia. Nursing Standard, 15(17), 47-53.

Armstrong-Esther, C., Browne, K., & McAfee, J. (1994). Elderly patients: Still clean and sitting quietly. Journal of Advanced Nursing, 19, 264-271.

Baltes, M.M. (1988). The etiology and maintenance of dependency in the elderly: Three phases of operant research. Behaviour Therapy, 79, 301-319.

Baltes, P.B. (1993). The aging mind: Potential and limits. The Gerontologist, 33(5), 580-581.

Baltes, M.M., Wahl, H.W., & Reichert, M. (1991). Institutions and successful aging for the elderly? Annual Review of Gerontology and Geriatrics, 11,331-337.

Bandura, A. (1986). Social foundations of thought and action: A social cognitive theory. Englewood Cliffs, NJ: Prentice Hall.

Bear, M. (1990). Social network characteristics and the duration of primary relationships after entry into long-term care. Journal of Gerontology, 45(4), S156-162.

Benner, P. (1984). From novice to expert. Menlo Park, CA: Addison Wesley.

Boud, D, Keogh, R, & Walker, D. (1985). Reflection: Turning experience into learning. London: Kogan Page.

Butler, R. (1969). Ageism: Another form of bigotry. The Gerontologist, 9, 243-246.

Courtney, M., Tong, S., & Walsh, A. (2000). Acute-care nurses' attitudes toward older patients: A literature review. International Journal of Nursing Practice, 6, 62-69.

Darby, S. (1999). Exploring the myths and stereotypes of mental health in old age. In S. Darby, J. Marr, A. Crump, & M. Scurfield (Eds.), Older people, nursing and mental health (pp. 1-24). Oxford: Butterworth Heinemann.

Edwards, H., & Forster, E. (1999). Avoidance of issues in family caregiving. Contemporary nurse, 8(2), 5-13.

Edwards, H, Moyle, W., Clinton, M., Weir, D., & Eyeson-Annan, M. (1994, May). Nurses talk in a dementia unit: What is said. Paper presented at the 2nd International Conference on Communication, Aging and Health, Hamilton, Canada.

Edwards, H., Weir, D., Clinton, M., & Moyle, W. (1993, May). Communication between residents and nurses in dementia facility: An issue of quality of life. Paper presented at the 3rd national Conference of the Alzheimer's Association of Australia, Melbourne, Australia.

Erber, N. (1994). Conversation as therapy for older adults in residential care: The case for intervention. European Journal of Disorders of Communication, 29, 269-278.

Erickson, E. (1963). Childhood and society (2nd ed.). New York: Norton.

Gibb, H. (1990). This is what we have to do-Are you OK? Nurses' speech with elderly nursing home residents. Unpublished manuscript, Deakin University, Victoria, Australia.

Gibb, H., & O'Brien, B. (1990). Jokes and reassurance are not enough: Ways in which nurses relate through conversation with elderly clients. Journal of Advanced Nursing, 15, 1389-1401.

Giles, H., Coupland, N., & Wiemann, J. (Eds.). (1990). Communication, health and the elderly. Manchester: Manchester University Press.

Haight, B. (2001). Sharing life stories: Acts of intimacy. Generations, 25(2), 90-92.

Hirst, S., & Raffin, S. (2001). "I hated those darn chickens...": The power in stories for older adults and nurses. Journal of Gerontological Nursing, 27(9), 24-29.

Hummert, M.L., & Nussbaum, J. (2001). Introduction. In M.L. Hummert, & J. Nussbaum (Eds.), Successful aging, communication and health (pp. xi-xix). Mahwah, NJ: Lawrence Erlbaum Associates.

Jecker, N. (1999). Ethical issues affecting older adults. In M. Stanley, & RG. Beare (Eds.), Gerontological Nursing (pp. 46-54). Philadelphia, PA: EA. Davis Company.

Killick, J. (2000). Storytelling and dementia. Elderly Care, 12(2), 8-10.

MacDonald, A., Craign, K., & Warner, L. (1985). The development of a short observation method for the study of the activity and contacts of older people in residential settings. Psychological Medicine, 15, 167-172.

Martin, J. (1999). Communication and interpersonal effectiveness: Skills training for older adults. Educational Gerontology, 25, 269-284.

McIntosh, I. (1996). Interaction between professionals and older people: Where docs the problem lie? Health Care in Later Life, 1(1), 29-38.

Mosher-Ashley, P.M. (1986). Procedural and methodological parameters in behavioural-gerontological research: A review. International Journal of Aging and Human Development, 24, 189-229.

Nelson, P. (1989). Social support, self-esteem and depression in the institutionalised elderly. Issues in Mental Health Nursing, 10, 55-68.

Oliver, S., & Redfern, S. (1991). Interpersonal communication between nurses and elderly patients: A refinement of an observational schedule. Journal of Advanced Nursing, 16(1), 30-38.

Pauwels, A. (1995). Cross-cultural communication in the health sciences. Melbourne: MacMillan Education Australia Pty Ltd.

Pearson, A. (1991). Taking up the challenge: The future for therapeutic nursing. In R. McMahon, & A. Pearson (Eds.), Nursing as therapy (pp. 192-210). London: Chapman and Hall.

Pugh, R. (1996). Effective language m health and social work. London: Chapman & Hall.

Sacks, O. (1985). The man who mistook his wife for a hat. London: Duckworth.

Seligman, M. (1975). Helplessness: On depression, development and death. San Francisco, CA: Freeman & Company.

Stevens, J., & Herbert, J. (1997). Ageism and nursing practice in Australia. Nursing Review, 17(1), 23-24.