

University of Massachusetts Amherst
ScholarWorks@UMass Amherst

Doctoral Dissertations

Dissertations and Theses

November 2017

**Group Process, Communication, and Relating as a Core
Phenomenon in an Older Adult Support and Learning Group on
Aging and Health**

Lisa Rose White

Follow this and additional works at: https://scholarworks.umass.edu/dissertations_2



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Rose White, Lisa, "Group Process, Communication, and Relating as a Core Phenomenon in an Older Adult Support and Learning Group on Aging and Health" (2017). *Doctoral Dissertations*. 1135.
https://scholarworks.umass.edu/dissertations_2/1135

This Open Access Dissertation is brought to you for free and open access by the Dissertations and Theses at ScholarWorks@UMass Amherst. It has been accepted for inclusion in Doctoral Dissertations by an authorized administrator of ScholarWorks@UMass Amherst. For more information, please contact scholarworks@library.umass.edu.

**Group Process, Communication, and Relating as a Core Phenomenon in an
Older Adult Support and Learning Group on Aging and Health**

A Dissertation Presented

by

LISA WHITE

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

September 2017

Nursing

© Copyright by Lisa White, 2017

All Rights Reserved

GROUP PROCESS, COMMUNICATION, AND RELATING AS A CORE PHENOMENON IN AN OLDER
ADULT SUPPORT AND LEARNING GROUP ON AGING AND HEALTH

A Dissertation Presented

by

LISA WHITE

Approved as to style and content by:

Cynthia S. Jacelon, Chair

Jeungok Choi, Member

Daniel S. Gerber, Member

Stephen Cavanagh, Dean
College of Nursing

DEDICATION

I dedicate this dissertation to every client I have had the pleasure and opportunity to work with over my experience as a nurse and to my parents, who helped me to go on in so many ways.

ACKNOWLEDGMENTS

I wish to thank the individual group members who participated in the support and learning group on aging and health that was the subject of this paper. This work is entirely indebted to your open sharing and commitment to being part of this project.

I wish to thank my committee chair and faculty supervisor Dr. Cynthia Jacelon for her mentorship and unyielding encouragement. Her scholarship and particular respect for the lived experience of older adults has been an inspiration to me and many other students. I entered graduate study because of her suggestion and could not have accomplished this goal without her support.

I wish to thank the associate members of my committee, Jeung Choi and Dan Gerber for their support and inspiration.

I wish to thank my partner Tom for his many acts of kindness over the course of this endeavor. The way he's cheered me on and shared proudly about the work I've done while creating no pressure for the work I haven't is so appreciated.

I wish to thank Nancy Pagano, Director and the members of the Council on Aging and Senior Health Advisory Group of the Amherst Senior Center for their enthusiastic support.

I wish to thank Linda Dunlavy, Executive Director of the Franklin Regional Council of Governments for making it feasible for me to go into nursing and Phoebe Walker Community Services Director for being supportive of this endeavor.

I wish to thank my friends Patty and Brenda who've encouraged me on early morning walks not to give up and offered strategies to keep me on track. I wish also to thank my friend Wendy, who served as reader, providing thoughtful comments and edits.

Finally, I wish to thank my family for their love and support. I'm so happy for the life stories that continue to develop for each of them.

ABSTRACT

GROUP PROCESS, COMMUNICATION, AND RELATING AS A CORE PHENOMENON IN AN OLDER ADULT SUPPORT AND LEARNING GROUP ON AGING AND HEALTH

SEPTEMBER 2017

LISA WHITE, B.A., B.S., UNIVERSITY OF MASSACHUSETTS AMHERST

Ph.D., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor Cynthia Jacelon

Supporting older adult clients to improve self-management of health is a focus of care for community-based nurses working with this population. The available literature on small group work indicates participation in a variety of group types has been shown to be beneficial for older adults. However, there is little research specifically on group work with adults over the age of 75 when individuals are at greater risk for actively facing illness and multiple personal losses and may need enhanced social supports to assist achievement of the psychosocial tasks of old age.

This research examined a support and learning group on aging and health involving seven community-dwelling older adults over the age of 75 using grounded theory research method. One male and six female subjects aged 76-84 years old participated in the study. To identify themes occurring in group and communication process, transcripts of the meetings, pre and post interviews with individual participants, and other data sources were analyzed using open, axial and selective coding. On the Group Process level, themes of group action/interaction were categorized by time phases of Before, Beginning, Middle, End, and Beyond the time the group met. On the Communication Process level, themes were abstracted under categories of Initiating, Responding, Relating, and Integrating. Group and Communication processes were then nested and conceptualized as a fractal occurring both over the course of

the eight weeks and in every group meeting. “Relating” was identified as a core phenomenon of the group and communication process, contributing to positive self-assessment regardless of whether the participant affirmed a similar or contrasting position in comparison with other participants.

Findings support the achievement of group type objectives for support and learning groups and delineate more clearly group participants’ experience leading to the outcomes of reinforcement of a positive self-assessment and the development of knowledge and skills related to aging and health. Findings may assist the design and implementation of similar groups and may direct further research on specific aspects of individual and group process in small group work with community-dwelling older adults.

TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS.....	v
ABSTRACT.....	vi
LIST OF FIGURES.....	xiv
CHAPTER	
1. INTRODUCTION.....	1
Background.....	1
Significance to Nursing.....	16
Problem Statement.....	16
Purpose and Aims.....	17
Research Questions.....	18
Definitions.....	19
Older Adults.....	19
Community-Dwelling.....	19
Health.....	19
Aging.....	20
Theoretical Frameworks: Psychosocial Development and Group Work.....	20
Research Base of Group Work with Older Adults.....	21
Research Methodology: Grounded Theory.....	22
Chapter Summary.....	23
2. LITERATURE REVIEW.....	25
Chapter Overview.....	25
Human Development and Aging.....	25
Aging as a Stage of Psychosocial Development.....	25
Selective Optimization with Compensation.....	26
Life Model.....	27
Self-Identity and Life Stories.....	28
Reminiscence and Life Review.....	28
Small Group Work.....	31
Systems Theory.....	31
Therapeutic Processes.....	31
Issues in Group Work.....	33
Patterns of Interaction.....	33

Group Size	34
Homogeneity/Heterogeneity Dimension	34
Exclusions.....	35
Group Leadership	36
Contracting	36
Group Phases	37
Database search literature review.....	38
Review Process	38
Classification of Therapeutic Group Types	39
Service/Advocacy Groups	40
Social/Recreational Groups	41
Support Groups.....	43
Psychoeducational/Learning Groups.....	44
Therapy Groups	46
Reminiscence/Life Review Groups	47
Cognitive Behavioral Therapy.....	49
Hybrid Group Type: Psychoeducational Support Group.....	50
Outcomes/Evaluation of Groups	57
Chapter Summary	58
3. METHODOLOGY	61
Introduction	61
Research Design.....	61
Study Aims	61
Research Questions	62
Units of Analysis.....	62
Setting.....	62
Recruitment of Participants.....	63
Pre-Screening Meeting	64
Protection of Human Subjects.....	65
Researcher Qualifications	66
Grounded Theory Research Method	67
Data Collection.....	68
Group Meetings	68
Discussion Prompts.....	69
Participant Diary	73
In Depth Interview	74

Memos and Field Notes	74
Data Analysis.....	75
Open Coding	75
Axial Coding	76
Selective Coding.....	76
Data Management.....	77
Symbolic Interactionism	77
Trustworthiness	79
Prolonged Engagement	79
Persistent Observation	80
Triangulation of Data	81
Member Checking.....	82
Audit Trail.....	83
Research Timeline.....	84
Summary	85
4. PARTICIPANT PROFILES	86
Introduction	86
Participant Profile Inputs to the Group and Communication Process.....	86
Mary.....	86
Patricia	88
Dorothy	90
Barbara	92
Robert	94
Betty.....	96
Shirley	97
Molly	99
Summary	100
5. FINDINGS.....	101
Introduction	101
Coded Themes of Group Process (Group Unit of Analysis)	102
Before	103
Envisioning.....	103
Asking Questions	104

Deciding to Join.....	104
Committing	104
Beginning	105
Coming Together	105
Identifying Concerns	105
Establishing Roles and Routines	106
Middle	106
Interacting in Patterns	106
Exploring Options.....	106
Developing New Directions	107
Managing Disruptions.....	107
End	107
Summarizing Experiences	107
Drawing Conclusions.....	108
Valuing Connections	108
Beyond	108
Incorporating Experiences	109
Moving On	109
Coded Themes of Communication Process (Participant Unit of Analysis)	109
Initiating.....	110
Seeking Information.....	110
Sharing Knowledge:	111
Telling Stories.....	111
Responding	112
Confiding Problems.....	113
Suggesting Solutions	114
Picking up Threads.....	115
Relating	116
Sympathizing/Empathizing	116
Making Comparison: Similar Position.....	118
Making Comparison: Contrasting Position	119
Integrating	120

Confirmation.....	120
New Information.....	121
Inspiration.....	121
Fractal Conceptualization of Group and Communication Process	123
Fractals in Social Science.....	123
Nested Patterns: Fractal Conceptualization of Findings.....	124
Fractal Patterns in Action/Interaction of Group Meetings.....	129
Participant Evaluation of the Support and Learning Group	133
Chapter Summary	136
6. THEORETICAL PROPOSITIONS: RELATING AS CORE PHENOMENON.....	138
Introduction	138
Story Line	139
Relating as Core Phenomenon.....	140
Exemplars of Relating From the Data	142
Similar Comparison: Shirley.....	143
Contrasting Comparison: Mary.....	144
Neutral Comparison: Dorothy.....	145
Summary.....	145
7. DISCUSSION.....	147
Introduction	147
Findings in Context of Literature on Group Work with Older Adults	147
Willingness to Share in Group Interactions	147
Relating and Integrity of Self Identity	150
Integrative and Instrumental Reminiscence in Group Interactions	152
Therapeutic Effect of Contrasting Comparison	153
Implications for Practice and Research	155
Older Adults Group Work Concept of Relating.....	155
Experiential Learning & Use of Didactic Tools	156
Member Direction of Topical Concerns	157
Outcome Measurement	159
Relevance to Nursing Education	161
Future Research	161
Limitations	162

Group Participant as Research Subject.....	162
Novice Leadership.....	162
Small Size of Group.....	163
Out-of-Group Contacts	163
Conclusion.....	164
APPENDICES	
A. RESEARCH ADVERTISEMENT.....	167
B. IRB CONSENT FORM.....	168
C. PRE-INTERVIEW GUIDE	172
D. PARTICIPANT DIARY	173
E. FINAL INTERVIEW GUIDE.....	174
F. MEETING ONE NOTES	175
G. MEETING TWO & THREE NOTES.....	177
H. MEETING FOUR & FIVE NOTES	179
I. MEETING 6 & 7 NOTES.....	181
J. DIAGRAMS OF FINDINGS	183
K. IRB APPROVAL LETTER	189
REFERENCES.....	190

LIST OF FIGURES

Figure	Page
Figure 1: Curative Factors of Therapy Groups (Yalom, 1985)	32
Figure 2: Literature Review Process.....	39
Figure 3: Group Types Commonly Used with Older Adults Organized by Interrelated Objectives and Outcomes Adapted from Loomis (1979) and Toseland (1990).	40
Figure 4: Structure of the Support and Learning Group on Aging and Health	63
Figure 5: Planned Conditions of the Health & Aging Support and Learning Group.....	69
Figure 6: Wellness Wheel (St. Peter’s University, 2014).....	70
Figure 7: Socio-Ecological Model Adapted from Bronfenbrenner (1977).	71
Figure 8: Problem Solving Cycle (Great Black Innovators, 2009).....	72
Figure 9: Unplanned Conditions of the Health & Aging Support and Learning Group	73
Figure 10: Time Engagement with Subjects.....	80
Figure 11: Sources Used in Triangulation of Data.....	82
Figure 12: Group Process Themes (Group Unit of Analysis).....	109
Figure 13: Communication Process (Individual Unit of Analysis)	123
Figure 14: Nested Group and Communication Processes (Before – Input).....	125
Figure 15: Nested Group and Communication Processes (Beginning – Initiating).....	126
Figure 16: Nested Group and Communication Process (Middle-Responding)	126
Figure 17: Nested Group and Communication Processes (End-Relating).....	127
Figure 18: Nested Group and Communication Process (Beyond-Integrating)	128
Figure 19: Fractal Description of Nested Group/Communication Processes	129

CHAPTER 1

INTRODUCTION

Background

The aging experience of older adults continues a life process requiring significant adaptation and the garnering of social resources (Rowe & Kahn, 1997). Increasing lifespan since the beginning of the 20th century and the aging of baby boomers will result in an unprecedented doubling of the American over age 65 population in the period between 2005 and 2030 (CDC, 2013). Community-dwelling older adults are at increased risk for chronic illnesses such as diabetes, arthritis, dementia and congestive heart failure which may contribute to decreased functioning and increased incidence of acute injury such as from falling (U.S. Dept. of Health and Human Services, 2016a). Chronic illness, decreased function and issues such as the loss of significant others which typically occur in older age can contribute to social isolation for which much research has found significant detrimental effects on health, including death (Stephens, Shankar, Demakakos & Wardle, 2013).

Persistent ageist bias and false stereotypes, for instance, the belief that older adults have a greater incidence of depression (they have less than younger cohorts), and the belief that older adults are suffering with physical difficulties (most report good, very good or excellent health) should be recognized (American Psychological Association [APA], 2004). Still, challenges associated with the experience of aging are real. In 2007, 26.8% of individuals in the United States over the age 65 rated their health to be fair or poor, compared to 9.5% of individuals overall (U.S. Dept. of Health and Human Services, 2016b). Depression and anxiety are among the most common mental health issues for older adults, respectively affecting 3-7% and 11% of the older adult population and symptoms of these disorders are much more prevalent

(SAMHSA/AoA, 2012). Individuals may have difficulty coping with losses of many types (persons, roles, health, and independence among them) that are commonly experienced in old age (APA, 2004). There is a great need for services that provide community-dwelling older adults with access to information relative to healthy aging, resources assisting self-management of health, and opportunities for social interaction with others, where the experience of aging can be expressed and explored.

Significance to Nursing

In addition to delivering appropriate clinical preventive and health promotion services, community-based nurses take a significant role in educating and empowering older adults to successfully cope with health challenges associated with aging. Community-based nurses regularly provide education and support in areas such as fall prevention, medication management, advance care planning, exercise, nutrition and chronic disease self-management in settings such as senior centers, senior housing complexes, churches, non-profit organizations, and other community spaces. These settings provide opportunities for older adults to come together with others sharing similar issues and concerns. Small groups led by community-based nurses are recognized as having the potential to address a significant health care need of community-dwelling older adults, providing information and support concerning issues of aging and health. Small group format is often chosen as an economical and effective treatment option having dual advantages of providing community-based nursing services to a greater number of persons and for maximizing the mutual aid benefits that come from older adults sharing with each other as experts of their own experience.

Problem Statement

Group work methodologies show promise as a short-term cost effective health care intervention with the potential for helping a large number of older adult clients to address individual needs

and forge beneficial social connections with others (Burnside & Schmidt, 1994; Campbell, 2004; Pandya, 2010). However, there is a scarcity of research on group work with community-dwelling older adults (Pandya, 2010). Existing research on older adult groups has been criticized for not identifying clearly the relationship between group type methodology and the outcomes of individual members and lacks information on how “group process, stages of group, and group interactions” create positive outcomes for individual participants (Pandya, 2010, p. 347). Put another way, why the experience of participating in groups is beneficial to individual participants and how the group process supports particular outcomes is less clear than it needs to be. A better understanding of the experience of older adults participating in therapeutic groups is needed to develop both theoretical and methodological foundations for continuing research in group work with older adults.

Purpose and Aims

This research set out to investigate the experience of older adult participants and the group process occurring in an 8 week support and learning group on aging and health for which I was researcher and facilitator. The group involved seven community-dwelling older adults over the age of 75. Each participant responded to an advertisement notice (Appendix A) and provided informed consent to participate in the group and be interviewed before and after the series of group meetings regarding their participation. Group meetings of two hours were held over eight Tuesday afternoons from November 2014 to January 2015 in the community Senior Center located in the Town of Amherst where most of the participants lived.

Though every group will be uniquely comprised of particular events in a particular time and place and every individual will experience a group uniquely, certain objectives for the group and expected outcomes for participants are considered with the selection of group type. A hybrid psychoeducational support group type was selected to be used in design of the research

group based on a categorization of individual group types presented by Loomis (1979) and Toseland (1990). A psychoeducational support group has two distinct purposes (or objectives) and two desired outcomes for participants. The objectives are learning new information and skills and sharing in mutual support with others who are in similar experience (in this case the older adult experience of aging and health). Outcomes are reinforcement of the individuals existing strengths and coping abilities and the development of knowledge and skills that may be drawn on to assist new and beneficial behaviors once the participant returns to daily life outside of the group. Further description of group types will be discussed within this paper.

Aims of the research were to describe and analyze the social processes occurring for the individual participants in the Support and Learning Group on Aging and Health and what specifically occurred in the group process that supported expected beneficial outcomes. As researcher, I wanted to understand how the interactions occurring in the group were experienced by the participants and to identify and describe how the group process either reinforced participants' existing strengths or supported their learning new information and skills.

Research Questions

The research questions used to guide this research were:

1. What group process or patterns occurred to support desired group outcomes?
2. What communication process or patterns occurred to support desired group outcomes?
3. What occurred in the group that positively or negatively affected participants' group experience?
4. What did participants value about being in the group?

Definitions

Definitions used to refine this research include:

Older Adults

Adults over the age of 75 were included in this study. A number of reference points were used to support this age distinction as a socially and psychophysically important demarcation of the aging process. Though individually this demarcation may be arbitrary, statistically there are distinct differences relative to risk for disease, decreased function and other health related concerns beyond age 75 (National Center for Health Statistics, 2015) that typically result in increased demands for coping and adaptation.

Community-Dwelling

All older adults participating at the time of this study were community-dwelling, that is living independently in a home environment with no at-home services addressing "activities of daily living," an assessment of functional status of the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring, commonly used as a measure of disability and quality of life (Weiner, Hanley, Clark & Van Nostrandus, 1990).

Health

The definition of health as established by the World Health Organization and unchanged since 1946 is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, n.d., para. 1). Health as discussed by the research group was defined further in context of our meetings with use of a multi-faceted "wellness wheel" comprised of Emotional, Environmental, Intellectual, Occupational, Physical, Social and Spiritual dimensions (St. Peter's University, 2014).

Aging

A stage of human developmental characterized by tasks independent of but commonly associated with old age and occurring at a point in the life course where a person is challenged to adapt or reconcile with 1) the finality of life, 2) the possibility or reality of physical and mental debilitation, 3) the continuous need to reframe social environment adapting to the loss of significant others, 4) coming to terms with life as it has been lived through a process of life review, 5) the possibility of precipitous decline that is a prelude to death (Baltes, Reese & Lipsett, 1980). All group members considered themselves to be in the experience of aging, and gave evidence of recognition during the course of the group of their lived experience facing most or all of the issues listed above.

Theoretical Frameworks: Psychosocial Development and Group Work

Psychologists theorize that throughout the lifespan, meaning and identity are developed and revised through our interaction with others (McAdams, 2001). According to Erikson's (1963) psychosocial model, ego identity emerges around the time of adolescence as the individual begins to autonomously interact in the world making individualized choices about the things they do and believe (McAdams, 2001). Self-understanding results from this process and continues to evolve over the remaining life course in the form of a life story (McAdams, 2001). Butler (1963) a geropsychiatrist was the first to identify how processes of life review and reminiscence are psychologically beneficial to older adults who have long established identities but have a continuing need to structure and review a life story (Young & Reed, 1995). Life stories, refined and reinforced in continuous social process occurring from adolescence through adult life, culminate in a total narrative connecting one's self-identity with meaning and purpose in the life they have lived (McAdams, 2001).

Life course theorists promote the power of small groups to assist the psychosocial development of persons coping with challenging circumstances and have identified small group work as helpful for older adults (Berman-Rossi, 1990; Gitterman & Shulman, 2005). Small groups provide well-recognized structures into which older adults may interact with others in ways that may, in Eriksonian terms, reinforce their self-identity and help them to address issues related to the life stage psychosocial developmental tasks of generativity and ego integrity (Gitterman & Shulman, 2005). Groups operate as open social systems in which members interact and influence each other in a unidirectional progressive process (Chambers Clark, 1994, Toseland & Rivas, 2017). Carefully designed and implemented groups provide opportunities for older adults to give and gain support from other members, learn new information, maintain existing coping abilities and consider new ways in which they may address, as attributed to Rossi-Berman, “problems in living” (Gitterman & Shulman, 2005, p. 544).

Research Base of Group Work with Older Adults

A literature review on group work with older adults indicates a variety of group types in use with older adults today. Broadly categorized by outcome objective they include service/advocacy, social/recreational, support, psychoeducational/learning and therapy. In practice, a combination of outcome objectives may be implemented in a group. A hybrid group type containing support and psychoeducational (also known as learning) group type features is commonly seen in group work with older adult groups. While few studies on support and learning groups have been conducted specifically with community-dwelling older adults over the age of 75, the research available indicates a number of positive outcomes occurring for older adult participants (Ruffing-Rahal & Wallace, 2000; Brownell & Heiser, 2006; Ingersoll-Dayton, Campbell & Ha, 2009; McInnis-Perry & Good, 2006; Palta et al., 2012).

Participants demonstrated the value of participating in a nurse facilitated health promotion intervention with support and learning objectives including member check-in, a formal program segment and discussion through their renewal of the group for more than seven years (Ruffing-Rahal & Wallace, 2000). Participants in an experimental pilot study of a psychoeducational support group for victims of family mistreatment identified the group as helping to increase their self-esteem and feelings of wellbeing (Brownell & Heiser, 2006). Participants in a forgiveness group intervention reported valuing the opportunity of reflecting on the impact a hurtful event had in their life and considering a model of forgiveness, journal writing assignments and sharing writing responses with other group members, and the support received from facilitators and other group members (Ingersoll-Dayton, Campbell & Ha, 2009). Members of a pilot psycho-educational co-dependency support group to help older adults coping with an addicted family member reported reinforcement of the importance self-care and the intention to live more fully as a result of participating in the group (McInnis-Perry & Good, 2006). Both experimental and control group participants evaluated their experience as positive in a mindfulness-based, stress reduction intervention study (Palta et al., 2012). Both groups included supportive and educative elements. A curriculum including meditation techniques was used in the experimental group, whose members had statistically significant lowered blood pressure measurements from baseline to post intervention (Palta et al., 2012).

Research Methodology: Grounded Theory

The qualitative research methodology of grounded theory as developed by Strauss and Corbin (1990) and Corbin and Strauss (2015) was used to conduct this study. Rooted philosophically in American pragmatism, grounded theory sees individuals engaged in an evolving process in which their reality is defined through social interaction with others (Strauss & Corbin, 1990). Grounded theory and its relationship with the social theory of symbolic

interactionism (Blumer, 1969), which posits meaning as arising from people in communicative interaction, provided an ideal approach for examining and constructing an explanation of what occurred in the group.

Grounded theory provides specific procedural steps and analytical techniques to develop findings derived not from hypothesis or theoretical assumptions made a priori, but from the data itself. Data in the case of this research study included close transcription of participant interactions within the group, interviews with individual participants, my observations as researcher documented in memos, and existing research and resources I have become familiar with throughout the course of my studies and the literature review conducted for and reported in this paper.

Consistent with the research method, transcribed data from the group interactions and individual participant responses were thematically coded to develop a content analysis. From data-generated codes, themes formed based on my observations of what was occurring for and between members of the group. Further abstraction of the themes, grounded within the data, were developed into theoretical findings examining the group process and communication process describing individual participant's experience in the group. Testing of findings was continuous in the research process and included a strategy of confirming my findings with group participants, going back to the data, and collecting further data as needed in order to challenge or confirm findings. More detail about the grounded theory method and its application in this study is presented in Chapter 3.

Chapter Summary

Community-dwelling older adults, particularly those over the age of 75, are at greater relative risk for experiencing age-associated problems such as loss and illness. Theoretical frameworks of human development and psychology identify how older adults maintain identity,

co-create meaning and solve problems in social interaction with others. Community-based nurses regularly conduct groups of a wide variety of topics assisting older adults to address concerns they share in common with others.

Research conducted on group work with older adults provides evidence of a therapeutic benefit for community-dwelling older adults participating in small groups but lacks description of the communication process and patterns that occur in groups and the group experience of individual participants. A better understanding of group process and communication process occurring in small group work with older adults is needed to increase understanding of what about groups is helpful to participants and may assist practitioners in the facilitation of similar groups.

This research uses grounded theory method (Strauss & Corbin, 1990; Corbin & Strauss, 2015) to conduct a qualitative description and analysis of the communication process and patterns occurring in a nurse-led support and learning group on aging and health for community-dwelling older adults over the age of 75. The techniques of grounded theory and the associated concepts of symbolic interactionism (Blumer, 1969) are appropriate for investigating social interaction including the communication processes occurring in small group work.

Data analysis conducted in this study identified themes describing the group process and how the communicative interaction of participants either reinforced existing strengths or supported their learning new information and skills. It is hoped that these findings may assist the developing knowledge base about group work with older adults assisting clinicians engaged in designing and implementing support and learning groups addressing the particular health needs of older adults.

CHAPTER 2

LITERATURE REVIEW

Chapter Overview

This chapter summarizes a literature review of group work with community-dwelling older adults utilizing published texts and articles about psychosocial development in old age, group work, and a database review locating peer-reviewed research conducted on group work with older adults. First, in order to orient the reader to a general framework for group work with older adults, aspects of the particular psychosocial developmental issues of older adults, group process, and issues particular to group work with older adults will be reviewed. Second, a model of group objectives and outcomes are presented, adapted from the group assessment model of Loomis (1979) and categorizations of group types in use with older adults identified by Toseland (1990). A discussion of five basic group types on a continuum of possible objectives, structure, process and expected outcomes for group work with older adults will be presented with examples of research from the literature review. Third, the available research regarding the hybrid psychoeducational support group type as it has been applied with community-dwelling older adults will be examined. Gaps in the literature relating to the questions of this study which used a psychoeducational support group type will be considered in the chapter summary.

Human Development and Aging

Aging as a Stage of Psychosocial Development

Erik Erikson's Stages of Human Development are foundational to the understanding of human psychosocial development across the life span. Group work with older adults is situated in this theoretical framework of human development, which identifies tasks of psychosocial development occurring with various stages of the life course and corresponding with a person's

age. Neugarten (1975) presented age-related classifications of “young-old” (55-75), “old” (75-85) and “very old” (85+) that are consistently recognized in the literature (Drown, 2008; Ersek, Turner, McCurry, Gibbons & Draybill, 2003; Toseland & Rizzo, 2004). Relating Erikson’s stages of human development to the age categorizations of Neugarten, the “young old” continue within the mature adult stage of generativity v. stagnation, challenged with the task of producing something that continues and perhaps improves things for the greater social sphere and the next generation (Erikson, 1963; McAdams, 1992); the “very old” are at the developmental stage of integrity v. despair, challenged with the task of coming to terms with their life as it has been lived, a final step in preparation for one’s own death (Erikson, 1963); and “old” adults, representative of the participants in this research study, are somewhere between, having psychosocial concerns of both stages of generativity and integrity.

There is great individual variation regarding age-related changes affecting health (Toseland & Rizzo, 2004). Baltes et al. (1980) consider that aging as a stage of development is not well characterized by chronological age alone, especially since old age may reasonably encompass a period of 40 or more years. Considering the inter-individual variability and heterogeneity that tends to increase with age (p. 74), these theorists and scientists propose life span development as a dialectical rather than a static process, formed more as the result of interaction and non-normative life experiences than by orderly patterned changes over time (Baltes, et al., 1980).

Selective Optimization with Compensation

With their concept of selective optimization with compensation (SOC), Baltes and Baltes (1990) also confirm the potential of experiencing old age as a time of growth, providing scientific evidence indicating that older adults who are aging successfully continue to use life management strategies in order to meet the challenges of aging (Baltes & Baltes, 1990; Baltes &

Carstensen, 1996). In the model, “selection” refers to choosing goals for functioning from a limited set of opportunities, “optimization” refers to the allocation of internal and external resources in order to achieve higher level of functioning in selected goals and “compensation” refers to the substitution of alternative processes in the face of loss or means in order to maintain a level of functioning (Freund & Baltes, 1998). Participants in the Berlin Aging Study using more SOC strategies scored higher than participants who did not for subjective well-being, positive emotion and absence of loneliness (Freund & Baltes, 1998).

Life Model

Consideration of the needs of human development over the life course is integral to planning group work with older adults (Berman-Rossi, 1990). Gitterman and Shulman (2005) developed their life model linking the continuous and cumulative evolution of human development in the framework of small group process. The life model views human beings in constant interchange with their environment. In these complex interchanges, disturbances often emerge as people experience an adaptive imbalance between a “perceived demand and the perceived capability to meet that demand through the use of internal and external forces” (Gitterman & Shulman, 2005, p. 5). The life model, which is applicable for human beings coping within a variety of circumstances at various life stages, identifies client “problems” as arising from three fundamental and interrelated areas: 1) life transitions and traumatic events, 2) environmental pressures, and 3) dysfunctional interpersonal processes (Gitterman & Shulman, 2005, p. 5).

The life model does not reject the life cycle conceptualizations of Erikson’s stages of development, but places greater importance on the unique pathways of development that each individual experiences from birth to death as shaped by biological, psychological, socioeconomic, and cultural forces (Gitterman & Shulman, 2005). Additionally, the life model

places even more focus on the development potential of group members, for instance, encouraging nontraditional techniques such as yoga and meditation that may be novel to group participants and may be incorporated to support self-actualization (Capuzzi, Gross & Friel, 1990). In their investigation of group work for vulnerable populations, Gitterman and Shulman (2005) specifically identify older adults as a vulnerable population for which group work methods utilizing life model theory are indicated.

Self-Identity and Life Stories

Relevance of the life cycle may be most apparent in therapeutic groups involving older adult participants because their conversation often obviously reaches back through their life history to provide context for their present. Erikson identified ways in which, beginning in adolescence and continuing through the lifespan, identity forms in a process mental functioning involving both reflection and observation (Erikson, 1963). With his life story model, McAdams (2001) furthered Erikson's idea that people create identities continually made and remade in social relationships with others. Through a lifetime of experiences, older adults have developed a trove of life stories they are often willing to share. In the sharing of these stories, they reinforce long established identities formed through chapters of childhood and adulthood. Coherent life stories are the medium through which individuals tell themselves and others how they've developed through life's events and find satisfaction and purpose in how life has been lived (McAdams 2001).

Reminiscence and Life Review

Cognitive psychologists theorize that the selection of self-defining memories provides our lives with the personal meaning needed in order to make sense of our present, review the past and make preparations for the future (McAdams, 2001). Butler (1963) is recognized as the first theorist to identify life review and reminiscence as specific activities assisting older adults to

achieve the vital task of ego integrity (Haight, 1992; McDougall, Graham, Blixen & Suen, 1997). Butler argued against the tendency of psychologists to view reminiscence as a pathological rather than beneficial phenomenon (Butler, 1963). He defined or hypothesized that older adults naturally and universally tend to a process of life review prompted by the realization that one is closer to death (Butler, 1963).

Several gerontologists went on to make clear distinctions between reminiscence and life review. A concept analysis on life review and reminiscence by Burnside and Haight (1992), defines reminiscence as verbal interaction between one or more persons eliciting memories recalling early life events or experiences and life review as a verbal interaction performed between a reviewer and a therapeutic listener one-on-one recalling the entire lifespan and always containing an evaluative component regarding elements of the self. Haight (2001) further defined life review as “the relatively systematic reflection upon one’s life and personal history – the twists and turns, ups and downs, successes and failures” (p.90). Haber (2006) defined reminiscence in simplest terms as the passive and spontaneous “recall of memories,” characterized by individual reflection or by storytelling, or nostalgia that may be a part of life review but is not synonymous with it.

Cappeliez, O’Rourke and Chaudhury (2004) identified both constructive and detrimental uses of reminiscence. The authors found reminiscence to be adaptive and predictive of life satisfaction when used constructively for death preparation or when used in social situations and non-adaptive when used to revive old problems and to reduce boredom, contributing to lower life satisfaction (Cappeliez et al., 2004). Wong and Watt (1991) attribute at least partial explanation for the discrepancies found in early studies intending to test hypotheses of protective factors of reminiscence to the unclear definition of reminiscence. From the results of a longitudinal study designed to test the relationship between certain kinds of reminiscence

and successful aging, the researchers proposed six types of reminiscence: integrative, instrumental, transmissive, narrative (referring to simple biographical recall, not presented in context of life story as discussed in this paper), escapist, and obsessive (Wong & Watt, 1991). Their taxonomy, in addition to providing specific guidelines for the classification of reminiscence, identifies productive and non-productive types of reminiscence and main functions of each type (Wong & Watt, 1991).

According to Wong and Watt's taxonomy, the main function of integrative reminiscence is to achieve a sense of self-worth, coherence, and reconciliation with regard to one's past. Integrative review does not always result in the achievement of integrity, but when successful, is hypothesized to contribute to successful aging (Wong & Watt, 1991). Instrumental reminiscence as defined in the taxonomy is also predicted to be related to successful aging when it achieves internal control (Wong & Watt, 1991). Instrumental reminiscence includes the process of using problem-focused strategies as a buffer against emotional distress and includes goal-directed activities, the attainment of goals, past attempts to overcome difficulties, and the use of past experience to solve present problems (Wong & Watt, 1991).

The longitudinal study through which Wong and Watt developed their taxonomy of reminiscence gathered data from 171 older adults aged 65-95, half living in the community and half in institutional settings. Subjects were pre-screened and judged against a wide array of measures of well-being and psychosocial factors to be either aging successful or unsuccessfully. Content analysis coding paragraphs of recorded and transcribed interviews identified the six reminiscence types, revealing a significant main effect for integrative, instrumental and obsessive reminiscence. Successful-agers showed higher rates of integrative and instrumental reminiscence and less obsessive reminiscence. These findings provided direct empirical support for Butlers' (1963) hypothesis regarding the integrative function of life review and importantly

suggest that reminiscence with specific integrative or instrumental functions are important for promoting successful aging (Wong & Watt, 1991). Further, the taxonomy of reminiscence provided by the study presents useful information for the development of research and therapeutic interventions using reminiscence to assist successful aging (Wong & Watt, 1991).

Small Group Work

Systems Theory

Systems theory, which originated in the fields of engineering and biology, is perhaps the most pervasive theory used to understand social processes (McDermott, 2002). Systems theory provides an overriding theoretical framework for understanding and working with groups (Chambers Clark, 1994; McDermott, 2002; Toseland & Rivas, 2017). Viewed as open systems, groups and their parts (members) take in and exchange matter, information and energy in unique patterns, creating outputs that feed into other systems, such as the agency that serves the group, family or community (Chambers Clark, 1994). As open systems, groups are not regressive and develop in a unidirectional pattern, but they may need the assistance of a skilled leader to progress (Chambers Clark, 1994). Shulman (1999) describes small groups as ‘microsystems’ in which group leaders must help to direct members to create conditions that are supportive of mutual aid (McDermott, 2002). Engaged in this process, the group leader influences the members and the group members influence each other and the leader. The group and all its parts exist as a “small social system whose influences can be guided in planned ways to modify client behaviors” (Vinter, 1974a, p. 5).

Therapeutic Processes

Yalom (1985) describes ‘therapeutic factors’ occurring in therapy groups and observes that the “front” of groups, that is the form, technique, specialized language, etc. of any school of therapy when disregarded, reveals ‘core’ similarities concerning the mechanisms of change in

group members of all group types. Originating from Yalom's work are eleven elemental therapeutic factors participants experience in the complex and intricate guided human experiences that occur in successful groups (Yalom, 1985). Yalom's curative factors (included as Figure 1) are a touchstone to many practitioners who have used them as a means to identify the components of group process, or to evaluate if the group process has been effective (Loomis, 1979; McDermott, 2002; McInnis-Perry & Good, 2006; Northen & Kurland, 2001; Ruffing-Rahal & Wallace, 2000).

Curative Factors of Therapy Groups (Yalom, 1985)

1. Instillation of hope
2. Universality
3. Imparting of information
4. Altruism
5. The corrective recapitulation of the primary family group
6. Development of socializing techniques
7. Imitative behavior
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis
11. Existential factors

Figure 1: Curative Factors of Therapy Groups (Yalom, 1985)

Yalom notes that these therapeutic factors are interdependent; some, like cohesiveness (the "we-ness" value in group work) and self-esteem are both facilitators of and prerequisites for successful treatment (Yalom, 1985).

Shulman (1999) identifies nine mutual aid processes that are possible to identify in an effective small group. They include: sharing data, the dialectical process, entering taboo areas, the "all-in-the-same-boat" phenomenon, mutual support, mutual demand, individual problem solving, rehearsal, and the strength in numbers phenomenon (Gitterman & Shulman, 2005). In

Shulman's mutual aid group model, the difficult work of being continuously present is needed from the participants and the group leader in order for the mutual processes to occur (Gitterman & Shulman, 2005). Group members may be challenged to address emotions in a taboo area such as anger, for example (Gitterman & Shulman, 2005). Group leaders may be challenged to appropriately address specific issues involving individual members and in doing so may neglect their central mediating role with the group (Gitterman & Shulman, 2005). There is fast moving activity and significant nuance in the life of groups. Functional clarity and an ability to act quickly and with skill is needed in order for the group leader to assist group members to achieve the processes of mutual-aid (Gitterman & Shulman, 2005).

Issues in Group Work

Patterns of Interaction

Communicative interaction in groups is facilitated by the group leader but importantly must also occur between its members (Burnside & Schmidt, 1994; Loomis, 1979; Yalom, 1985). During the initial phases of group interaction, the leader aware of this will implement communication techniques that discourage members from speaking directly to the leader, and instead encourage members to speak to each other (O'Leary, 1996). Depending on the group type, direction of the leader, and willingness of members to engage, groups will operate at different levels; subject matter and emotional content may be shallow or deep (Burnside & Schmidt, 1994). The stories members have created as part of their life histories, or stories members create in interaction with one another, may be of importance to explore. Sharing stories leads to the development of mutual support between group members, which reduces isolation regarding members concerns and enhances opportunities development of problem solving strategies and behaviors (Gitterman, 2005). The dynamics of communicative interaction

is the process through which groups develop intimacy, trust and eventually cohesiveness, which Yalom (1985) stresses is the sine qua non of successful group work.

Group Size

The size of the group will also affect patterns of interaction and the potential of the group to develop cohesiveness. A group that is too large promotes anonymity and decreases opportunities for engagement and may raise members' anxiety (Berman-Rossi, 1990; Northen & Kurland, 2001). A group that is too small may place too high a demand on individual members and may lack the stimulation necessary to promote positive change (Northen & Kurland, 2001). There is no set standard for group size, but Yalom (1985) suggests 7 or 8 members as ideal for an interactional therapy group and 5 to 10 members as an acceptable range. The lower limit is the minimum required to achieve a critical mass sufficient for the group to successfully interact (Yalom, 1985). Larger groups tend toward anonymity, less consensus, reduced participation, higher demands for leadership, and an increased ability to take on tasks requiring a complex division of effort. Small groups tend toward higher participation, greater individual involvement, consensus, increased restraint, and more intense relationships (Vinter, 1974b). Stability in the group's interaction is achieved by replacing members as they are lost in a group that is working successfully, and by allowing attrition when it is discovered that the group started with too many members (Yalom, 1985). A special issue for older adult groups is a greater incidence of loss of members to death which requires sensitive address (Burnside, 1994; Orr, 2005).

Homogeneity/Heterogeneity Dimension

Stability (homogeneity) and diversity (heterogeneity) are both needed in groups. A commonality of purpose binds members together (Gitterman & Shulman, 2005). As a general rule, the more intense the common interest, the greater the toleration for diversity; for

instance, limited life expectancy in a group of cancer patients made differences in age, class and ethnicity inconsequential (Gitterman & Shulman, 2005). Rice (2005, p. 153) recommends a “balancing rule” regarding issues of homogeneity and heterogeneity in developing groups, suggesting groups need to have both maximum homogeneity relative to degree of vulnerability and capacity to tolerate anxiety; and a maximum heterogeneity relative to conflict areas and patterns of coping. The group leader’s conscious attention to the homogeneity/heterogeneity dimension is important for assuring that group members will be able to find both the common ground necessary to empathize with one another and the diversity of perspectives and solutions needed to learn from one another.

Exclusions

Group work is not therapeutic or appropriate for everyone. One observation attributed to Waters (1964, 1984) is that group work is inappropriate for individuals who are so preoccupied with and overwhelmed by their own problems that they are unable to listen to or respond to other people (Burnside & Schmidt, 1994; O’Leary, 1996). Toseland (1990) notes practical barriers, certain personality attributes, and particular therapeutic needs as three broad categories of contraindications for group participation (Burnside & Schmidt, 1994). Groups may not meet expectations for learning or support and may even increase distress or depression (Golden & Lund, 2009). The uniqueness of life situations and perceived individuality may inhibit members from receiving help from the group (Golden & Lund, 2009). Privacy concerns are another issue that may prevent someone from working effectively within a group (O’Leary, 1996). Group facilitators are encouraged to take whatever steps necessary in order to ensure inclusion of older adults in therapeutic groups wherever possible, however (Berman-Rossi, 1990). Viewing such issues as potential problems instead of exclusionary criteria allows the

facilitator to seek solutions that support inclusion rather than ruling out participants (Gitterman & Shulman, 2005).

Group Leadership

A single group leader with substantive knowledge and practice skill is normative and may often provide the most efficient and effective leadership model; potential advantages to co-leadership should also be considered (Burnside & Schmidt, 1994). Co-leadership may be useful when roles are clearly delineated and interdisciplinary involvement is valued. Co-leadership is an important tool for training/mentoring inexperienced group leaders and can provide beneficial staff support, the opportunity for feedback, professional development and greater objectivity for the experienced leader (Gitterman & Shulman, 2005). Maintenance of democratic norms (everybody gets a chance to talk; the majority rules; participants take turns) is generally an objective in governing groups. Clear norms of group behavior provide a degree of stability and of knowing what to expect for all group members; on the other hand, a format that is too structured may hinder group members from fully expressing their individuality and frustrate the progress of the group (Toseland, 1990). It is recommended that ground rules for behavior be adopted by the membership early in group process and that the leadership throughout the group process work to “balance the needs of individuals and the group-as-a-whole” avoiding both excessive conformity and excessive diffusion (Toseland, 1990).

Contracting

Once formed, the group is empowered to make further decisions about activities and focus. However, issues such as criterion for inclusion, whether a group is “open” or “closed”, expectations for attendance and interaction, the objectives for the group, and the number of sessions need to be clearly established by the leader at the outset in a process of “contracting” (Loomis, 1979; Toseland, 1990; Toseland & Rivas, 2017; Yalom, 1985). Rice (2005) recommends

that informal contracting is appropriate in social support groups for older adults where the objective is to assist in adjustment to losses or changing life situations. Contracting is one in a series of planned steps involved in group facilitation including 1) intake assessment (client presents need and worker makes initial evaluation), 2) diagnosis and treatment planning, 3) group composition and formation, 4) group development and treatment, 5) evaluation and termination (Vinter, 1974;b). Each phase of these general practice principles need to be adapted for older adults (Rice, 2005). Intake assessment, diagnosis and treatment planning should also include consideration of the “declining potential” for development in older adults (Keller & Hughston, 1981). Reinforcement of existing strengths may be an appropriate objective for older adult group participants consistent with an outcome of Maintenance versus Behavior Change (Loomis, 1979).

Group Phases

Whether short-term or long-running, groups have a life span of their own and it is helpful to consider group development in stages, identifying patterns of behavior and typical characteristics of group process and structure (Northen & Kurland, 2001). One way the experience of groups may be reviewed is by the characteristics of the interactions occurring between members at different time-phases of the group process (Gitterman & Shulman, 2005; LeBarge, Von Dras & Wingbermuehle, 1998; Loomis, 1979; Toseland & Rivas, 2017). The pre-group time phase is previous to the first group meeting, where the individual is considering and then decides to join or at least try a group. The beginning time phase is where participants first meet and come to agreement on the purpose and plan of the group, and set norms for behavior and the rhythms of the group. The middle time phase is where individual participants’ role definitions are now established, performance of those roles and the “work” of the group is more

focused. The end time phase is where the knowledge meetings are coming to a close is understood and experienced by the members; steps are taken recognizing this closure.

At the end phase, facilitators assist group members to evaluate the experience of being in the group and sum up what the experience has meant to them. A concern is assisting individual participants to frame the end of the group positively, aware that some members may experience the end as another loss (Rice, 2005). Beyond is the time phase following the last meeting where the members continue to think about the experience of being in the group and what difference, if any, being in the group has made in their daily lives. Assisting participants similarly to summarize and plan steps they intend to take beyond meetings should be a prominent concern of the group leader (Lorig et al., 2012).

Database search literature review

Review Process

To locate relevant research, base searches in CINAHL, Academic Search Premier, Health & Psychosocial Instruments, Social Sciences Abstracts, PsychINFO and PsychARTICLES were conducted using keywords of: group work and older adults, older adults and support group, elderly and support group, generating more than 1300 articles. Abstracts were reviewed using inclusion criterion of English language research presented in scholarly journals discussing face-to-face therapeutic group work involving community-dwelling adults over the age of 60 (a review limited to age criterion of 75 and above generated no results). Several additional articles of interest were located using a snowball approach from the reference lists of articles reviewed. Following further review and elimination through application of the inclusion criteria above, a total 35 research studies on group work with community-dwelling older adults were identified. The literature review search process is indicated in Figure 2 below.

Review of Literature

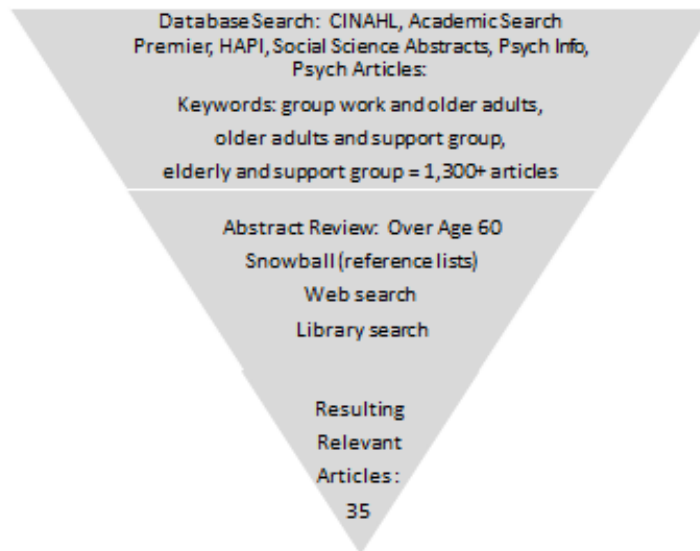


Figure 2: Literature Review Process

Classification of Therapeutic Group Types

A model for group assessment developed by Loomis (1979), a nurse researcher, was used to examine, evaluate and categorize the research that was reviewed according to group type. Group type in Loomis' conceptualization is based primarily on objective or purpose. The features of Loomis' model include objectives (group type), structure (theoretical framework, meeting structure, client characteristics, etc.), process (therapeutic factors promoted and naturally occurring in group interactions) and outcomes (broadly categorized as maintenance, learning and behavior change) (Loomis, 1979). Toseland (1990) identifies distinguishing characteristics among five related types of groups that are commonly used with older adults. By relating the research identified in the above described literature review on group work with

community-dwelling older adults to the categorization models of Loomis (1979) and Toseland (1990), five group types are identified: Service/Advocacy, Social/Recreational, Support, Psychoeducational/Learning, and Therapy. A model of group type, objectives and outcomes adapted from Loomis (1979) and Toseland (1990) is presented below in Figure 3.

	Objectives	Service/ Advocacy	Social/ Recreational	Support	Psychoeducational/ Learning	Therapy
Outcomes	Maintenance	<i>Low</i>	<i>High</i>	<i>High</i>	<i>Low</i>	<i>Low</i>
	Learning	<i>Med</i>	<i>Low</i>	<i>Med</i>	<i>High</i>	<i>Med</i>
	Behavior Change	<i>Med</i>	<i>Low</i>	<i>Low</i>	<i>High</i>	<i>High</i>

Figure 3: Group types commonly used with older adults organized by interrelated objectives and outcomes adapted from Loomis (1979) and Toseland (1990).

Service/Advocacy Groups

Also referred to as task groups (Loomis, 1979) the major objective of service/advocacy groups is the completion of some mission the group takes as their focus. Members come together in a structured process to pursue common interests and share individual skills (Toseland, 1990). Service groups such as friendly visitor programs and advocacy groups such as resident’s councils are representative of this type. Goal directed activities provide opportunities for group members to take on meaningful social roles and contribute to others; in Eriksonian life-cycle terms, to engage in tasks associated with the later-life stage of generativity (Toseland, 1990). Though members tend to be highly functional “young-old” adults, the structure, opportunities to socialize, and constructive activities of service/advocacy groups can also help isolated and impaired members to regain a sense of control and self-efficacy (Toseland, 1990).

In terms of structure, the role of a facilitator leading a service/advocacy group is to provide a core mediating function seeking the best fit between the members and their social environment, mobilizing available organizational and network resources, and helping the

members of the group to access available resources (Gitterman & Shulman, 2005). Members with diverse knowledge, skills and viewpoints are selected for their ability to contribute (Loomis, 1979; Toseland, 1990). Group process in service/advocacy groups is labor-focused, and is often formalized in procedures, bylaws, etc. Though the interpersonal needs of members must be attended to, accomplishment of goal-directed activities is the primary outcome of concern in the group (Loomis, 1979; Toseland, 1990).

Fisher and Gosselink (2008) present an example of a service/advocacy group in their qualitative study of efficacy and empowerment among members of an art guild for older adults. The group was organized with the stated objective “to showcase and promote the talents of artists age 55 and older, to offer opportunities to view the continued creativity of artists in later years, and to facilitate the interchange of ideas, information, motivation and fellowship to their members” and experienced both success and longevity (Fisher & Gosselink, 2008, p.6). In this example, empowerment and validation, occurring on an individual and group basis, was amplified by members joining with others with the intention of benefitting the community and shaping society’s view of older adults. The researchers found the group’s success in completing tasks also reinforced group members’ personal efficacy, instilling the sense that one can accomplish what one sets out to do (Fisher & Gosselink, 2008).

Social/Recreational Groups

Social and recreational groups are characterized by members’ active engagement with peers in activities promoting enjoyment, learning, growth and development (Toseland, 1990). A primary objective of social/recreational groups is to conduct an activity for social enjoyment, but another objective is to address the primary prevention and social support needs of members (Loomis, 1979; Toseland, 1990). A wide range of social/recreational group program activities occur in community settings such as senior centers. Discussion-oriented activities, reminiscence

and life review (though these are sometimes also recognized as therapy activities), physical activities, field trips and games are all social/recreational group activities (Toseland, 1990).

Leadership in social/recreational groups is facilitative and related to the program activity (Toseland, 1990). Members may be diverse in other ways but should be of similar skill level and ability to engage in the program (Loomis, 1979; Toseland, 1990). Despite the low level of self-disclosure required by members in social/recreational groups, the group process dynamics provide opportunities for developing socializing techniques and building social support (Loomis, 1979; Toseland, 1990). The outcomes for social/recreational groups are enjoyment in the activity and the maintenance of existing emotional and behavioral strengths (Loomis, 1979).

Cohen-Mansfield, et al. (2007) implemented and evaluated social and recreational groups with important biopsychosocial supportive functions in a study examining Self-Help Interest Groups (SHIGs). Member-defined activity groups involving 276 residents of three low-income elderly housing complexes were formed around interests of music, movies and bible study. The groups attracted members wanting to “meet new people that like similar things” and had a goal of promoting socialization and enhancing self-efficacy. Initially led by skilled leaders, the SHIG groups first focused on the topic of interest but then increasingly revolved around sharing of personal experiences. Leaders worked to facilitate empowerment, encouraging group members’ active decision making in how the groups developed. Based on member’s comments, the SHIG groups were found to enhance opportunities for socialization and to create an environment conducive to friendship. Some groups continued to meet long after professional leadership was withdrawn at the end of the project. Other groups did not continue, due in part to an inability to resolve conflicts occurring within the groups once the leadership (which had instituted mechanisms for conflict resolution) was removed (Cohen-Mansfield et al., 2007).

Support Groups

Support groups function to help older adult members cope and to enable them to grow as they proceed through difficult life events and transitions (Toseland, 1990). Group members develop support as they share experiences related to a common particular set of interests or problems (Gitterman, 2005). Widow/widower groups and cancer support groups are support group examples. The primary objective of the support group is emotional support and maintenance or revitalization of existing strengths and coping capacities (Loomis, 1979; Toseland, 1990). Support groups encourage a high level of social interaction and emotional self-disclosure as members work together to achieve the objective of overcoming isolation and identifying effective ways to cope with problematic life events and circumstances (Toseland, 1990). Support groups may be loosely or highly-structured and may or may not be reliant on strong leadership. Indeed, some support groups identified as self-help, are entirely member-run (Drown, 2008). The group leader role, where there is one, is facilitative and focused on developing mutual support among members. Members may be diverse in their backgrounds, but share a similar concern or traumatic event. Desired outcomes for support groups are the maintenance of existing emotional and behavioral strengths and improved coping mechanisms regarding the traumatic shared concern or event (Loomis, 1979; Toseland, 1990).

One variation of the support group is the mutual aid/reciprocal help group. The mutual aid concept, first attributed to Schwartz (1961), shifts the source of helping from the group's leader to the members themselves (Gitterman & Shulman, 2005). The group members provide the vehicle for transformation through the commonly-observed phenomena of "strength in numbers" and knowing one is not alone in their feelings. Members continue to need the help of the leader to activate the group's power and overcome obstacles that can frustrate effectiveness (Gitterman & Shulman, 2005). Mutual aid includes a number of identifiable

processes: sharing data, the dialectical process, entering taboo areas, the “all in the same boat” phenomenon, mutual support, mutual demand, individual problem solving, rehearsal, and the “strength in numbers” phenomenon (Gitterman & Shulman, 2005).

A research article examining a group with clear characteristics of the support group type was a longitudinal investigation of the main interactive effects of resources, competencies and the duration of a self-help group on depression levels and unresolved grief in a sample of older bereaved adults (Caserta & Lund, 1993). The bereavement support group participants in the study were reported to share grief-related feelings, to learn coping styles and skills from others to different degrees, and to recognize the commonality of grief experiences among group members. Interestingly, outcomes for individuals in the group were mixed. Group members with low resources and competencies reported the group as helpful, but group members who were not deficient in competency or resources at baseline reported less benefit and sometimes felt worse as a result of participating in the group (Caserta & Lund, 1993). These findings indicate instances in which group experiences intended to be therapeutic may potentially do harm, and highlight the importance of an evidence base for group work with older adults.

Psychoeducational/Learning Groups

Psychoeducational is a fairly recent group type designation that shares identical characteristics with what Loomis (1979) termed a learning group. Examples of psychoeducational groups are in abundant use in community group work with older adults today and include caregiver and chronic disease management groups (Drown, 2008). Psychoeducational groups share characteristics with support groups – indeed, many identify as support groups – including a shared condition or situation and the objective of sharing experiences and networking. What distinguishes psychoeducational groups from support

groups, however, is their clear educational objective. Group members have the goal of learning more about the issue they face together (Drown, 2008).

Psychoeducational groups also have a focused objective of supporting coping skills and facilitating behavioral change with regard to the issue of concern (Loomis, 1979). Meetings are structured to include a didactic portion, usually a presentation from the group leader or a visiting expert, followed by discussion among group members. Structure varies, with group leaders playing various roles of educator, supporter, enabler, broker and advocate, and members requiring more or less involvement in information sharing and self-disclosure (Toseland, 1990). Outcomes for psychoeducational groups include the acquisition of knowledge about coping and behavioral skills relevant to the shared issue, and the adoption of strategies for changing these skills to effect positive outcomes (Loomis, 1979).

A study by Ersek, et al. (2003) compared a chronic pain self-management group intervention with psychoeducational features with an educational booklet intervention involving 41 older adult residents from retirement facilities in the Seattle, Washington area. The experimental group included presentation, discussion, training and practice of relaxation exercises offered over 7 sessions. Group participants were older adults aged 65-94 (mean age of 81.9) reporting pain interfering with usual activities in the last 90 days. Participants in the experimental group worked over the course of meetings to set and act on individualized pain-management goals (Ersek et al., 2003). Experimental group members reported weekly on their effort to meet individualized goals and any barriers in their experience. Discussion aimed to assist members to deal with obstacles, suggesting potential solutions (Ersek et al., 2003). The educational booklet control group did not include individualized pain management goals or instruction and practice of problem-solving or relaxation techniques (Ersek et al., 2003).

Findings indicated significantly greater improvement relative to characteristics of pain intensity and physical role function for the self-management group compared with the control group from baseline to post-treatment (Ersek et al., 2003). Authors noted no difference was identified regarding depressive symptoms, activity interference and physical functioning as measured, and that on average participants had no depressive symptoms at baseline (Ersek et al., 2003). Despite noted shortcomings in measures and methodological limitations, authors noted positive implications from the study, including that older adults in the self-management intervention were highly motivated to participate and that a majority (77%) of participants reported at three months continuing use the relaxation techniques covered in the intervention rating them “somewhat” to “very” useful at managing pain (Ersek et al., 2003).

Therapy Groups

Principles of the theory and practice of group psychotherapy as described by Yalom (1985) are consistently noted in the literature as relevant to group work process (Burnside & Schmidt, 1994; Loomis, 1979; Toseland, 1990; Bains, 2014; Johnson, 1991; McInnis-Perry & Good, 2006; Ruffing-Rahal & Wallace, 2000). Though techniques and focus of each may differ, all therapy groups are concerned with assisting the participants to in some way to achieve new insight resolving some emotional or behavioral issue.

The objective of traditional psychotherapy, as distinct from various other therapeutic interventions, is to address some problematic behavior that is preventing a person from achieving successful interpersonal relationships (Yalom, 1985). Yalom’s group psychotherapy model, which is not specific to an older adult population, focuses the power of the group to create experiences that facilitate identification of the problematic behaviors of group members, and then to actively address and induce change in those behaviors. The “work” completed by members interacting in a psychotherapy group process is emotional and self-reflective, and

depends on a host of inbuilt tensions in the group (Yalom, 1985). The group must be experienced as a safe and secure environment, allowing the self-disclosure and exploration necessary for intrapersonal and interpersonal growth (Yalom, 1985). Interaction within the group, facilitated by a highly-skilled group leader, is directly confrontational, working at the level of “here and now” (Yalom, 1985). The desired outcome in psychotherapy groups is individual behavioral change and improved intrapersonal and interpersonal relationships (Loomis, 1979).

There is general agreement in the group work literature that older adults seek positive support and encouragement more than confrontation addressing problem behaviors (Burnside & Schmidt, 1994; Rice, 2005; Toseland, 1990, Toseland & Rizzo, 2004). Conflict, which is integral to developing beneficial intimacy in group psychotherapy, requires special attention in groups for older adults, where conflict may be viewed as threatening (Rice, 2005). Treatment goals in a therapy group for older adults may also be adjusted. For instance, outside-of-group contact (an undesirable “fractionalization” in traditional therapy groups) is generally waived in group work with older adults due to evidence in the literature that outside-of-group contacts fill important needs for friendship and mutual support (Caserta & Lund, 1996). Two distinct therapy group interventions that can be found in the literature on group work with community-dwelling older adults are Reminiscence/Life Review and Cognitive Behavioral Therapy.

Reminiscence/Life Review Groups

Reminiscence therapy approaches are noted in the literature as being commonly used with older adults (Burnside & Schmidt, 1994; Capuzzi et al, 1990; Pandya, 2005; Toseland,1990). Reminiscence groups (when approached at the level of therapy), require both a facilitator with specific training and experience and members that are appropriately screened and prepared for a high degree of intimacy and interaction in the group (Capuzzi et al., 1990). Based on the phenomenon of life review developed by Butler (1963), the objective of reminiscence group

therapy is to share memories, increase personal integration and increase understanding of the aging experience (DeLucia-Waack, Gerrity, Kalodner & Riva, 2004). Butler and Myrna Lewis, a social worker, provided clinical evidence for the effectiveness of group work with older adults based on Erikson's developmental stages and using life review techniques (Young & Reed, 1995).

Bohlmeijer et al. (2007) conducted a meta-analysis of reminiscence and life review groups with older adults finding moderate effects (mean effect size 0.54) on life satisfaction and emotional well-being. Interventions using life review, a more structured intervention reviewing significant life phases and events were shown to be more effective than interventions using simple reminiscence, which offers general cues to elicit response and discussion (Bohlmeijer et al., 2007).

Using techniques of reminiscence and life review, Johnson and Wilborn (1991) explored the link between depression and anger in a group of 17 older adult women (mean age of 76.2 in treatment group) participating in four separate treatment groups for six 60 minute therapy group counseling sessions designed to increase awareness and expression of anger. A semi structured format including presentation of topics and time for group members to respond and express thoughts and feelings. A control group of matching frequency responded to the same instrumentation as the intervention group, thus allowing comparison of those in the treatment group for depression and anger, expression of anger and guilt (Johnson & Wilborn, 1991).

Topics explored over the six weeks included personal anger experiences, anger experiences in family of origin and family constellation, and expression of and reaction to anger experiences. The authors found the older adult group participants took longer to develop rapport and comfort talking about their feelings than is generally expected in group process. Group members avoided at first talking directly about things that made them angry which the authors surmised may have reflected their discomfort with anger expression and may have

accounted for the length of time it took participants to share openly about personal experiences (Johnson & Wilborn, 1991). This finding on slower than expected rapport and comfort discussing anger experiences is not consistent with findings of Greenberg, Motenko, Roesch, and Embleton (1999) which noted faster than expected affiliation by older adult (sixty-five to seventy-eight years of age) female participants in a friendship support group. Greenberg, et al. (1999) found a high level of intimacy and active participation among members by meeting two.

A t-test showed significantly higher depression scores on the Beck Depression Inventory (BDI) for the group participants than for a control group, but no significant difference one month post-treatment, and no change in awareness or anger expression (Johnson & Wilborn, 1991). Authors concluded the significantly higher BDI scores might relate to increased anxiety related to problem identification and the review of painful memories occurring in the treatment group. Despite these findings, participants reported the therapy group experience as positive, especially enjoying discussion regarding family patterns of anger (Johnson & Wilborn, 1991). Evidence of the participants' enjoyment of the sessions was indicated by high attendance which continued throughout the sessions (Johnson & Wilborn, 1991).

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is an action and problem-focused intervention where the therapist works with individuals to better coping skills (Arean et al., 2005). CBT uses both cognitive therapy strategies, which have the goal of helping individuals learn to identify and monitor negative and distorted thinking, and behavioral strategies which have the goal of helping individuals learn to identify how their mood states are positively and negatively affected as they learn develop skills for problem solving, relaxation, and assertiveness (Gatz et al., 1998). Empirical validation through evaluation using criterion of the American Psychological

Association indicated CBT as “probably efficacious” when used in support groups for caregivers based on a psychosocial model (Gatz et al., 1998).

Bains et al. (2014) utilized Cognitive Behavioral training and role play exercises in a psychoeducative group running over a 6 week course for older adults experiencing anxiety and depression. Participants aged 65 and older (mean age 74.8, mostly women, all white British) had been patients of a secondary mental health service in a large northern city of the UK. Eight groups were conducted with 34 participants who completed the study. Participants were measured for anxiety and depression, psychological distress, aspects of mental and social health and group therapy alliance, a measure of relationship, evaluation of and overall view of the group (Baines et al., 2014). Measures indicated the psychoeducative CBT intervention was modestly effective for self-reported well-being. One surprising finding of the group was no change in alliance for attendees over the 6 weeks, counter to the prevailing understanding that group cohesion develops over time (Baines et al, 2014).

Hybrid Group Type: Psychoeducational Support Group

There are several examples in the literature of older adult group interventions combining psychoeducational and support group methodologies. This hybrid group type has apparent applicability for older adults who want to learn more about and be with others who are experiencing a shared issue. Among the benefits of this approach is it can help participants to gain understanding of their problems and empower them to take an active role in defining solutions to the problems they face (McInnis-Perry & Good, 2006). For the facilitator, a strategy is needed that both teaches specific information supporting improved knowledge and skills of self-care, and promotes opportunities for members to share experiences with one another. Five examples of short term older adult group interventions with psychoeducational and support objectives were isolated in the literature review: Ruffing-Rahal and Wallace (2000), Brownell

and Heiser (2006); Ingersoll-Dayton et al. (2009); McInnis-Perry and Good (2006); Palta, et al. (2012).

Ruffing-Rahal and Wallace (2000) described the evolution over seven years of the LifeCare Wellness Group, a weekly wellness group intervention conducted with a diverse group of older (mean age 77 at onset) mostly African American women living in urban Ohio. This long running group was facilitated by the authors, both nurses, using a psycho-educative and supportive structure (Ruffing-Rahal & Wallace, 2000). The community-based LifeCare Wellness, Group, involving up to 20 individuals and 14 core members over time, was originally provided in 1990 for ten weeks (Ruffing-Rahal & Wallace, 2000). At the time the article was written, the group had been successively renewed by the members for seven consecutive years (Ruffing-Rahal & Wallace, 2000). The group's wellness focus took various forms including the sharing of illness experiences and concerns, creative interests such as poetry and music, sharing of everyday experiences, and learning together about wellness topics such as fall prevention (Ruffing-Rahal & Wallace, 2000).

Group facilitators utilized an Ecological Well-Being theoretical framework developed by Ruffing-Rahal (1991) attending to strand core themes of Activity, Affirmation and Synthesis relating to the promotion of group participants self-care skills, social integration and qualitative well-being (Ruffing-Rahal & Wallace, 2000). Chinn's (1995) "Peace and Power" model delineating a "Speak Out, Play Havoc, Imagine Alternatives (SOPHIA)" strategy for the interaction of participants was also used (Ruffing-Rahal & Wallace, 2000, p.268-9). Regularly, the format of the meeting included member check-in, followed by a presentation of health information by the facilitators and a group discussion of that material, and ending with a movement and flexibility exercise. After the group meetings, members lingered for conversation and consultation (Ruffing-Rahal & Wallace, 2000).

The authors report that as the group evolved, members prioritized social interaction above the established group format of the meetings and took more autonomous roles, for example staying in contact with one another outside of group meetings and sending cards to ill members (Ruffing-Rahal & Wallace, 2000). The facilitators reported integrating six of Yalom's curative factors as described by Loomis (1979) into the format of the meetings: Instillation of hope, universality, imparting information, altruism, interpersonal learning, and group cohesiveness (Ruffing-Rahal & Wallace, 2000). Though the authors did not specifically identify their health promotion intervention as a psychoeducational support group, it clearly falls within the type, due to its "culture-specific and prevention-focused" programming with "robust educational and supportive dimensions" (Ruffing-Rahal & Wallace, 2000, p. 268).

Brownell and Heiser (2006) conducted an experimental pilot study comparing a psychoeducational support group of older women (average age 75) who were victims of family mistreatment with a control group. The study measured for external outcome objectives of increased social networks and efficacy and internal outcome objectives for increased self-esteem and decreased depression, anxiety, somatization, and guilt. Sixteen women age 69-83, most identifying either a son or spouse as their abuser, were randomly assigned to an intervention group that occurred at Fordham University or to the control group. Racial, socio-economic make up of both groups was similar. The intervention group was facilitated by trained social workers and met for 2 hour sessions over 8 weeks. Meetings were organized around a curriculum exploring domestic violence, family dynamics, and associated problems with a goal of increasing participants' social networks, efficacy and self-esteem and decreasing guilt, depression, anxiety and somatization. To determine whether changes occurred, pre-and-post interviews of approximately 1 hour were conducted and non-parametric statistical analysis was conducted comparing within and between groups.

Findings showed no significant differences between the intervention and control groups for the internal objectives on any of the hypothesized outcome measures before and after the elder mistreatment psycho-educational support group intervention (Brownell & Heiser, 2006). However, self-reports of all but one group participant identified the group as helping to increase their self-esteem and feelings of wellbeing (Brownell & Heiser, 2006). Researchers considered small sample size, sensitivity and appropriateness of measures, faulty assumptions about the population studied (e.g. that they would have in general lower scores for self-esteem) and a too short duration as possible alternative explanations (Brownell & Heiser, 2006).

Ingersoll-Dayton et al. (2009) conducted a descriptive study evaluating the effectiveness of a forgiveness group intervention with a group of older adult women, organizing sessions around Enright's four stages of Forgiveness. The model describes forgiveness as a phased process of uncovering, decision, work and deepening (Ingersoll-Dayton et al., 2009). Individuals ranging in age from 57-82, who had been emotionally hurt by someone, had something to forgive, and met psychiatric criterion, were recruited from postings and referrals from mental health professionals. Two groups of eight sessions were conducted in a private room within a senior center with ten participants participating in each group. Structure was mini-lecture presented by the facilitators, followed by a guided discussion.

After each meeting of the forgiveness group, participants were asked to write reactions to the sessions in a formatted participant journal provided at the first session which included an outline of the sessions with questions and space for responses. Participants were asked to share in the beginning of each meeting their writing from the journal which was used to help their exploration of feelings toward those who hurt them and develop skills related to forgiveness (Ingersoll-Dayton et al., 2009).

Quantitative assessment of the forgiveness group was assisted by measurement of biopsychosocial functioning (self-perceived health, social support, depression, and anxiety) and changes in forgiveness (affective, behavioral, cognitive, forgiveness progress, and degree of generalized forgiveness) administered before and after the intervention and at 4 months follow-up (Ingersoll-Dayton et al., 2009). Biopsychosocial findings indicated self-perceived health of participants was significantly improved at post-test but not sustained at 4-month follow up. Depression decreased at post-test and at the 4-month follow up. Quantitative assessment detected no change in the participants' anxiety or social supports. The ability of participants to forgive the persons who had hurt them was found to be improved relative to affective, behavioral and cognitive components of forgiveness at the end and at 4 months following the intervention. T-Test changes in outcome measures also supported the finding that participants made significant progress toward forgiving the person who had hurt them and generalizing forgiveness to others by the intervention's end and at 4-month follow up (Ingersoll-Dayton et al., 2009).

Qualitative assessment was assessed by asking open ended questions at post-test and 4-month follow up, addressing participants' general reactions to the group (Ingersoll-Dayton et al., 2009). Qualitative findings indicated participants found the forgiveness intervention generally helpful and that the journaling supported their re-examination of events and feelings in a positive way. A "key ingredient" noted by participants was the intervention's focus on forgiveness as a single critical issue (Ingersoll-Dayton et al., 2009). Members reported valuing the opportunity to reflect on the impact a hurtful event had in their life and to consider forgiveness of the person who hurt them in the multi-faceted framework of Enright's model. The participants reported highly valuing the in-between group writing and sharing responses to the journal questions with the group (Ingersoll-Dayton et al., 2009). The support provided by

facilitators and other group members was also favorably noted by participants (Ingersoll-Dayton et al., 2009).

McInnis-Perry and Good (2006) developed a pilot psycho-educational co-dependency support group to help older adults coping with an addicted family member. A convenience sample of 22 older adults were studied who had loved ones (82% with an adult child, 18% with a spouse) in treatment for a dependency on alcohol or drugs in an addiction treatment facility in Prince Edward Island, Canada. Participants, all older than 65 and mostly white women, attended six bi-weekly 90 minute group sessions led by the authors with senior volunteer co-facilitators. Three groups were conducted, providing curriculum developed by the facilitators (a family addictions counselor and clinical nurse specialist) that included topical sections discussing Chemical Dependency, Concepts of Codependency, Losses, Self-Esteem and Communication, Empowerment and Self-Love, and Moving On. The format of the meetings included brief presentation of the material with opportunities to discuss the information and share ideas, thoughts and feelings throughout the presentation.

A questionnaire of open questions evaluating the program, providing a Likert-like rating of feelings about self, self-coping and nurturing was administered pre and post intervention. The group process of the McInnis- Perry and Good (2006) study was described in phases, identifying tasks of the Beginning (establishing the purpose of the group and therapeutic relationship), Middle (working phase where the nature of the interactions between group members deepens) and End (consolidation of the work, summary and reflection). Yalom's 11 therapeutic factors were discussed as a guide for what was experienced, or intended, in the middle phase of the group. Group members were reported to bond quickly and share common themes regarding their loved ones. Many of the participants articulated their need to hear that

it was important to care for themselves, and their intention to live more fully (McInnis-Perry & Good, 2006).

Palta et al. (2012) conducted an experimental study with a sample of recruited residents of a housing facility in Baltimore City testing the use and effectiveness of a mindfulness-based, stress reduction (MBSR) psychoeducational support group intervention compared with a control group which was a social support group type. The participants were one male and 19 female African American low income residents aged 62 and over, most with hypertension. Prior to random assignment to group, participants participated in a baseline survey of demographic information, smoking status, perceived stress and current medications and assessment of blood pressure (Palta et al., 2012).

The intervention group (called ELDERSHINE) was conducted by a facilitator trained in MBSR through the Center for Mindfulness at the University of Massachusetts. Earlier evidence of the effectiveness of MBSR programs, founded in Buddhist tradition by Jon Kabat-Zinn in 1979, had been established for young adults with a variety of health concerns and older adults with lower chronic back pain. The ELDERSHINE curriculum presented material over eight 90 minute meetings with topics introducing the concept of Mindfulness, Non-Judgmental Attitude, Self-Awareness, Patience, Mindful Communication, Coping with Change, Realistic Expectations and Letting Be/Letting Go. Each session included an opening meditation, sharing of successes, review and lessons for the practice and application of mindfulness skills for self-care in the home environment and in interpersonal relationships (Palta et al., 2012).

The social support control group was led by two research assistants also convening for 90 minute sessions over 8 weeks in a similar senior center room with identical snacks. The same topics were introduced and pre-planned conversation starters were offered, but no mindfulness practices were taught. Both groups had attendance greater than 80% for all 8 weeks, supported

by a phone call reminding participants the evening before each session and \$25 gift card incentives at baseline and at end of the sessions (Palta et al., 2012).

Multivariate regression comparing blood pressure between post intervention and baseline measurements for the intervention group indicated a statistically significant 21.92-mmHg lower systolic blood pressure, and a 16.7-mmHg lower diastolic blood pressure compared to the social support group. Authors concluded finding evidence of effectiveness of mindfulness training for urban African American older adults. Participants in both groups responded to a short questionnaire asking about overall experience with positive comments about their experience in both groups. Comments including “ELDERSHINE is my safety net” and “I wait the whole week for ELDERSHINE” indicated the impact of the MBSR intervention in the lives of group members (Palta et al., 2012, p. 314).

Outcomes/Evaluation of Groups

Loomis (1979) identifies three potential outcomes for the group experience: maintenance, learning and behavior change. Each group type addresses all of these outcomes, but to differing degrees. Social and recreational groups, because they are focused on the therapeutic objective of developing socializing techniques, prioritize maintenance as an outcome. Therapy groups, because they are focused on the objective of interpersonal learning, prioritize behavior change as an outcome. The priority of outcomes should be considered when developing goals for the group and when evaluating outcomes.

Rubin and Babbie (2008) (as cited in Pandya, 2010, p. 325) indicates strong rigor may be claimed in surveys with a high response rate and neutral reviewers, such as may be obtained in research studies exploring the subjective opinions of group members in therapeutic supportive groups. Within the group, a useful assessment of group members’ experience can be written or spoken in a round-robin at the end of each group session, asking each group member to

respond to 1) what in the meeting was the most helpful thing that happened, 2) what was the least helpful thing and 3) suggested changes for next time (Rice, 2005). More formal evaluations can be done at intervals through the course of the group, asking about overall satisfaction, effectiveness of specific techniques or sessions and the success of the group in meeting desired goals (Rice, 2005). Individual members are typically the unit of analysis, thus evaluation of the success of the group is measured by whether or not individual members show change in the desired direction (Pandya, 2010).

Methods for evaluating the effectiveness of group work presented in the literature review conducted as part of this paper include measurement tools such as Rosenberg's Self Esteem Scale and Life Satisfaction Index (Caserta & Lund, 1993), Beck Depression Inventory and Anger Self-Report Scale (Johnson & Wilborn, 1991), Survey of Pain Attitudes (Ersek et al., 2003), the Hospital Anxiety and Depression Scale, Clinical Outcomes in Routine Evaluation-Outcome Measure, Health of the Nation Outcome Score and Group Session Rating Scale (Bains, et al., 2014), the subjective reports of group members and group leaders (Cohen-Mansfield et al., 2007; Fisher & Gosselink, 2008), blood pressure measurements (Palta, et al., 2012), and outcome measures developed by the researchers (Brownell & Heiser, 2006; Ersek et al., 2003; Ingersoll-Dayton et al., 2009; McInnis-Perry & Good, 2006; Ruffing-Rahal & Wallace, 2000).

Chapter Summary

The experience of old age may be very rewarding as the person both lives within the moments of daily life and also reflects on their past accomplishments and legacy. Being "old" is likely also to present assaults to a person's health and wellness and long held ways of being. Older adults, even if relatively healthy and active, must face change, loss, unpredictability and the eventual inevitability of the end of life (Berman-Rossi, 1990). As a stage of human development, aging presents dual challenges of continuing to find meaning while living in the

world and attending to the task of finding satisfaction in the life one has lived (Erikson, 1963). Life course approaches in group work for older adults seek to support older adults facing a variety of life circumstances and situations to maintain self-identity, interact with and exert control over their physical and social environments and engage in expression of their “ageless self” (Berman-Rossi, 1990, p. 144).

A taxonomy of therapeutic groups of a continuum of variety and type, including Service/Advocacy, Social/Recreational, Support, Psychoeducational/Learning and Therapy group types as presented here, can provide group facilitators with a systematic way to clearly delineate the methodological approaches that they with their group members choose, implement and evaluate. Pandya (2010) notes that a variety of group practice methodologies should be utilized without placing them in hierarchal order in order to support group work values of collective learning from diverse vantage points. Clear objectives, structure, process and outcomes can both clarify the expectations of a planned group and be responsive to members’ needs,

In practice, groups are often designed to meet more than one objective and commonly seek more than one outcome; many groups have characteristics of two or more group types. For instance, while changing behavior is not a desired outcome of a support group, its members may seek educational resources (a psychoeducational group type objective) in order to better cope with the issue of concern that brings the group together. A trained facilitator working with that group may also utilize therapy group strategies to address issues expressed or occurring within the group.

Similarities between all groups are also important to note. Berman-Rossi (1990) notes an unfortunate polarization between work associated with tasks and work associated with feelings may be observed and understood from group type conceptualizations. All group types

share the overarching goal of providing a helping activity responsive to human needs with the potential for enhancing lives and the intention of being therapeutic (Berman-Rossi, 1990, Loomis, 1979).

Understanding the experience of older adult group participants and what occurs within group process that is likely to contribute to the expected and desirable outcomes for those participants is a needed focus of research. There is limited research regarding older adult group work in general and a scarcity of research conducted on Psychoeducational/Support groups for community-dwelling adults over the age of 75. Where the existing research does often utilize several outcome measures to determine efficacy of group interventions, there are few examples where the discussion reflects back on the specific experience occurring for group participants and where there is an examination of group process beyond the format of the group meetings.

Overall, the experience of older adult group participants is under-reported and the existing research leaves a question of what occurs in group process of successful groups. A grounded theory study conducted with an older adult group over the age of 75 exploring individual and group process with this particular population may provide valuable information to practitioners who design and implement groups for older adults.

CHAPTER 3

METHODOLOGY

Introduction

This chapter is organized to provide the reader with detail about the methodology used to conduct research on the Support and Learning Group on Aging and Health that met during the fall and winter of 2014 and was the subject of this study. First, the research design including study aims, research questions, units of analysis, setting, recruitment of participants, pre-screening meeting, protection of human subjects and researcher qualifications are presented. Second, the chapter provides detail about grounded theory research methodology (Strauss & Corbin, 1990; Corbin & Strauss, 2015). Particular data sources and collection methods used in the study are discussed including group meetings, participant diary, in-depth interview and memos. Data analysis is discussed including the coding steps of grounded theory, data management and how each was applied in this research. The applicability of symbolic interactionism, which is congruent to grounded theory and provided a framework for the data analysis I conducted, is also discussed. Third, the chapter details qualitative research strategies defined by Lincoln & Guba (1985) which were used to assure trustworthiness, addressing credibility, transferability, dependability and confirmability. Fourth, the chapter identifies the research timeline that occurred for the basic steps of the research process including protocol submission, advertisement, pre-screening interview, the group meetings and data analysis before it concludes with a brief summary.

Research Design

Study Aims

The aims of this research study are to develop a group process and communication process model of the Support and Learning Group on Aging and Health, describing both what

occurred in the group meetings and the ways individual group participants experienced the group. Applicability of the research is to build on the understanding of small group work with older adults as may be useful to practitioners such as community-based nurses organizing and conducting similar groups.

Research Questions

Coding and analysis sought to answer the research questions guiding the study:

1. What group process or patterns occurred to support desired group outcomes?
2. What communication process or patterns occurred to support desired group outcomes?
3. What occurred in the group that positively or negatively affected participants' group experience?
4. What did participants value about being in the group?

Units of Analysis

Two units of analysis: group and participant are considered in the data. Over the course of the eight meetings, and in context of individual meetings, the research group's continuous process of communicative interaction was investigated at both the group and participant level.

Setting

The older adult group studied in this research was a hybrid group type psychoeducational/support group for community-dwelling participants that I conducted at the Senior Center in an academe rich "five college" area of Amherst, Massachusetts. It is a very active senior center directly serving older adults in the Town of Amherst (2016 U.S. Census population estimate 40,079) and welcoming of seniors of surrounding smaller communities to its activities. The Senior Center is situated adjacent to two low income elderly and disabled mixed service housing complexes of about 200 apartments in total and functions as a gathering

space and resource point offering social services, weekday meals, exercise classes, health seminars and activities provided by staff and volunteers, many of whom are seniors themselves. A group type taxonomy (Loomis, 1979) is used to present the structure that was used to organize the Support and Learning Group on Aging and Health that is the subject of this study in Figure 4.

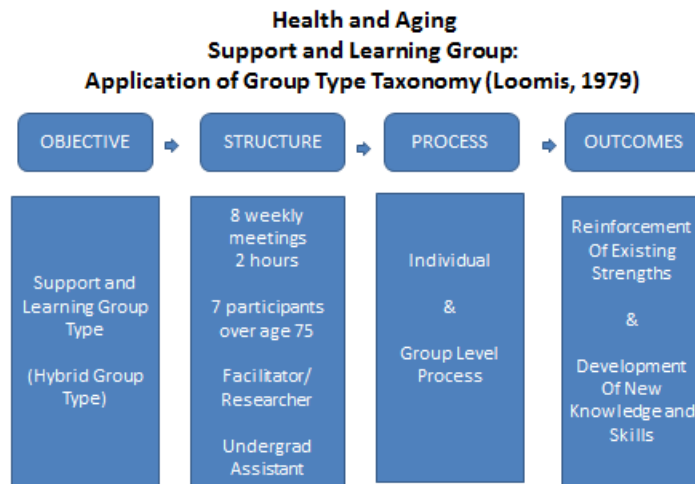


Figure 4: Structure of the Support and Learning Group on Aging and Health

Recruitment of Participants

Invitation to participate in the research study was advertised on flyers posted in the Senior Center and at the senior housing complexes adjacent to the Senior Center and at the public library located in the town center. It was also advertised in the Senior Center’s bi-monthly newsletter. The flyer utilized Loomis’ (1979) earlier terminology, identifying the group as a Support and Learning Group on Aging and Health to clearly identify for potential participants the purpose of the group type. The research advertisement, which is attached as Appendix A, sought individuals age 75 and older for the study and indicated what would be expected of participants including a 45 minute screening interview, regular attendance in 8

weekly meetings of the group and a 45 minute exit interview at the close of the group. Inclusion criterion for the study established through the University's Institutional Review Board (IRB) protocol were that participants must be 75 years of age or older; able to speak, read and write in English; and be appropriate for community-based group interaction relative to behavior, cognition and complexity of health issues. Exclusion criterion included mental health issues that would prevent participation or create significant disruption in the group.

Pre-Screening Meeting

I met with respondents to the advertisement for approximately 45 minutes in my office at the Senior Center to screen, collect basic demographic information (name, address, phone, email, preferred communication and age), review information about the project, and distribute the informed consent form. The objectives I identified for the group included sharing information and learning about a shared experience of aging and the common goal of staying healthy. The research objective I identified was learning about the experience of older adult participants in a support and learning group in my role as graduate student conducting research as part of doctoral education. I also shared information about the expected group format providing an outline of the 8 weekly sessions and plans for audio taping, transcription, custody and erasure of audio recordings at the end of the study. A copy of the participant diary that would be administered at most meetings and the expectation that participants would be interviewed after the group ending were also reviewed.

In addition to assuring the informed consent of participants in the study, the pre-group interview was designed to meet objectives of the group planning step of contracting by providing group participants with clear explanation of what they could expect from the experience of being a participant in the group and what specifically I would deliver as group leader. Once all items were reviewed, I asked each individual for their response to these plans

and if they had any questions. I then asked them what attracted them to the idea of participating in the group. This open-ended question provided an important data source as each individual shared a bit about their experience of health and aging as well as their expectations about participating in the group, including what they hoped to get out of it.

All of seven individuals, six female and one male, who responded to the study met screening criterion. At the end of the pre-screening meeting, I distributed an informed consent form in duplicate to be turned in before or at the first group meeting. All individuals who were screened agreed to participate in the study, signing and turning in consent at the end of the meeting or by the first meeting. Each of the seven individuals who responded to the research advertisement decided to join the group.

Though seven participants is a desirable group size, I had hoped to attract and include 10 participants. The assumption, which was born out in over eight weeks of meeting was that several less would actually attend all sessions, achieving an optimum size for interaction and saturation of data. All participants missed at least one and up to three meetings. None of the participants withdrew. However, one participant had a health issue (stroke) during the course of the study which prevented him from attending the 6th, 7th, and 8th meetings and postponed his final interview.

Protection of Human Subjects

The protection of human subjects was assured by following IRB requirements for informed consent, secure management of data, confidentiality and anonymity of the research findings. Safeguards for protection included providing participants with area social service agencies serving older adults in order to make appropriate referral if issues were revealed in group discussions which could not be addressed in the group. The IRB approved Informed Consent Form is included in Appendix B.

Researcher Qualifications

In addition to being the researcher, I have worked concurrently in several nursing roles with older adults since completing a second bachelor's degree and obtaining Registered Nurse licensure in 2006. As staff nurse and director of health services at the Senior Center where this research occurred, I work under a mission statement of "helping seniors to help themselves stay healthy", and operate several weekly-occurring walk-in wellness clinics that include blood pressure and other preventative screenings, assessment of health disruptions and assistance to clients with management of health care issues and personal health goals. As public health nurse for a health district serving 11 Massachusetts towns in an adjacent county, I take a similar role holding regular hours helping mostly senior residents at walk-in clinics held at four community sites. Together in these positions I serve approximately 400 seniors per year in 1,500 client contacts. Additionally, since 2006 I have worked part time as a bedside nurse at a skilled nursing facility and this position has supported the development of clinical knowledge with a gerontological focus.

Working with a number of older adult clients over a long period of time has provided intimate access to my clients' experiences with aging and health which has been a great privilege in my role as a nurse. Many meet aging with dignity, acceptance and grace. Some living with serious health issues are somehow able to transcend pitiful circumstances. In our nurse/client relationship, many have honestly shown their strengths and weaknesses, allowing me to be a part of their onward-moving life journey. These nursing relationships have imparted to me the message that life occurs in context of the fact of critical events: we are born, we live and we die. In between these events are the moments within which we experience our lives. The family we are given, the decisions we make, the company we keep and the perceptions we foster are the means by which we come to understand life. Moments of wonder in the

experience of living happen when they are shared, by a laugh, a tear or a hug, with others who are on the same journey.

During the course of my graduate study, I have been consistently interested in exploring the potential of the power of groups as a place to address important psychosocial needs of older adults. Early in my graduate coursework I wrote a practice proposal for a qualitative study examining the experience of a group of older adults involved in a community chorus. Also in coursework, I developed a concept analysis of aging exploring quality of life as a multi-faceted concept of health which was presented at scholarly meeting hosted by the College of Nursing. In 2008 and 2009, I co-facilitated two 8-week sessions of a learning and support group for older adults with the trained bereavement counselor of a local hospice. These group experiences were well received by participants and served as a pilot to this study. I obtained informed consent allowing me to report on one of these groups in coursework of an ethnographic exploration of the group and the experience of participants. The comprehensive examination of my doctoral studies focused on therapeutic group work with older adults and this research group was a natural extension of my interests.

Grounded Theory Research Method

The qualitative research method of grounded theory, originally developed by Glaser and Strauss and published in the 1967 text *The Discovery of Grounded Theory*, bifurcated as each of the two sociologists further developed distinct methodological approaches (Strauss & Corbin, 1990, Corbin & Strauss, 2015). For this study I utilized specific strategies for data analysis as defined by Strauss & Corbin (1990) of open coding, axial coding and selective coding. Through this multi-stepped methodological process, my interpretation of the data and the beginning of a theoretical proposition about the phenomenon under study emerged. Detailed transcriptions of the meetings, audio-recorded from set-up to close, were examined along with other data

sources used for the research including memos generated from my role as participant researcher, participant diaries completed each week and pre-screening and follow up interviews with participants, which were also audio-recorded.

Data Collection

Meetings of the research group occurred over eight sessions from November 2014 to January 2015. I transcribed the audio recordings from each meeting including conversation occurring during breaks. In addition to transcription of verbal exchanges, other data sources included pre-and-post interview, field memos documenting and expanding on the experience of the group and group members from my observations, scribed products from meeting activities and participant diaries. Participant diaries provided insight into the group participants' experience and were also used to conduct on-going evaluation of the sessions. Audio recordings of these interviews were also fully transcribed. All data sources were analyzed to identify themes answering research questions about the group process and communication process occurring for individual participants. The participant diary is included in Appendix D.

Group Meetings

The group met for two hours (1:30 p.m. to 3:30 p.m.) on Tuesday afternoons approximately weekly (due to one weather cancelation, the group missed a meeting in December and continued through early January) for a total of eight meetings. Group meetings consisted of participant check-ins generated from prompts, discussion and a group activity relevant to pre-planned and group determined topics on aging and health, and writing in the participant diary. The general format of the meeting was determined prior to the first session and submitted in IRB protocol. The Support and Learning Group on Aging and Health meeting format is presented, consistent with terminology of grounded theory, as planned conditions in Figure 5.

Planned Conditions

Meeting Format: 2 hours

- Participant check-in responding to prompt
 - a recent good day
 - a Thanksgiving tradition
 - a piece of good advice for getting through winter
 - a “must do” winter activity
- Introduction of topic/discussion/activity
- Break (Coffee, tea, water, fruit and baked snack every meeting)
- Continued discussion/activity
- Writing in participant diary

Figure 5: Planned Conditions of the Health & Aging Support and Learning Group

Discussion Prompts

In the meetings, I used prompts and evidence-based tools developed from nursing and chronic disease self-management literature to support the group format and discussions including a wellness wheel diagram (St. Peter’s University, 2014) identifying multi-faceted concepts of health and wellness including physical, environmental, intellectual, emotional, social, spiritual and occupational facets of health (included below as Figure 6.



Figure 6: Wellness Wheel (St. Peter's University, 2014)

The wellness wheel was presented to prompt discussion on the multiple dimensions of health and to encourage participant's consideration of health as more than just a bio-physical experience. The first through the third meetings of the research group included discussion of each dimension of health indicated on the wellness wheel. Definitions generated by the group were scribed onto poster sheets and displayed around the room and later written up in notes for the participants' future reference at our meetings. Meeting notes are included in Appendices F, G, H and I.

In meeting two a socio-ecological model adapted from Bronfenbrenner (1977) indicating multiple levels of experience affecting health status including individual, interpersonal, organizational, community and public policy dimensions was used to assist participants to consider how health is not only a personal experience but is also affected in a by larger cultural influences. The shared socio-ecological model is presented in Figure 7.

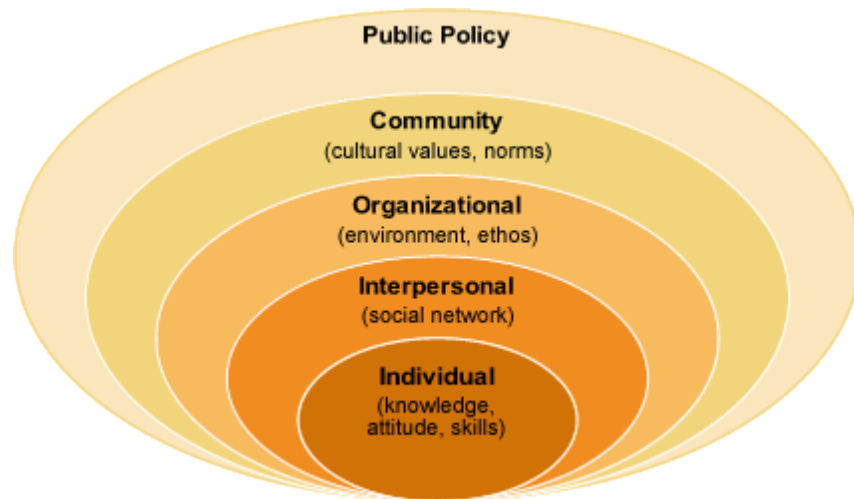
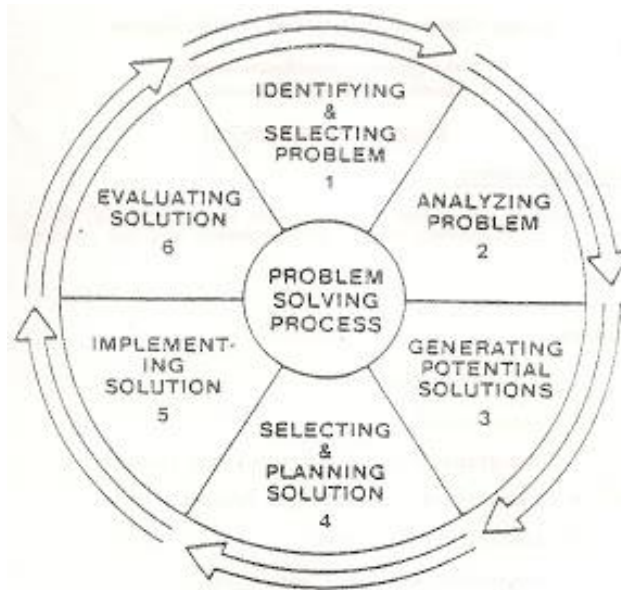


Figure 7: Socio-Ecological Model Adapted from Bronfenbrenner (1977).

In meeting three I shared a diagram of the problem solving cycle (Great Black Innovators, 2009) with the group which has steps similar to the Nursing Process (assessment, diagnosis, outcomes/planning, implementation and evaluation) promoted by the American Nurses Association as “the essential core of practice for the registered nurse to deliver holistic, patient-focused care” (ANA, 2017). The Problem Solving Cycle was used to assist participants to develop self-care skills needed to address problem solving in their own lives. The step-wise Problem Solving Cycle includes assessing problems, planning, implementing, and evaluating potential solutions (Great Black Innovators, 2009). Several problems presented by individual participants were considered by the group in facilitated exercises where members worked together to analyze the problem and generate solutions. In this way, participants practiced skills helpful to developing and implementing self-care interventions addressing problems. The Problem Solving Cycle is presented in Figure 8.



The Problem Solving Cycle

Figure 8: Problem Solving Cycle (Great Black Innovators, 2009)

Action-planning and decision making exercises from the Stanford Chronic Disease Self-Management Program (CDSMP) were also used in the research group (Lorig et al., 2012). Again participants worked together on particular issues suggested from the members to weigh options, rate possible solutions and move forward with solutions. The participant whose issue was discussed incorporated the planned actions between meetings in their day to day life and reported back to the group with their evaluation of implemented solution. The group continued to suggest adjustments to the action plan where the solution fell short of the goal. The decision making exercise was also attempted as a group exercise. The group worked to generate potential example problems. Through the activity of working on actual issues, participants took roles giving help to others in the group and participants in need of support received help on issues of concern to them. The format of the exercises for decision making (included in Appendix I) and action planning (included in Appendix H) are provided in Appendices.

While the planned conditions of the meeting and discussion prompts provided structure, each meeting included time for open discussion occurring in breaks, and allowed participant concerns to direct the focus of discussion in the time we had available. Discussion occurring during breaks and other unplanned conditions of the meetings were in some ways as important as planned conditions for generating the action-interaction of the group. Some examples of unplanned conditions are presented in Figure 9.

Unplanned Conditions

- Outside-of-Group Participant Relationships
- Discussion During Breaks
- Spontaneous Discussion Topics
- Illness
- Weather/Cancellations

Figure 9: Unplanned Conditions of the Health & Aging Support and Learning Group

Participant Diary

Participant Diary (Jacelon & Imperio, 2005) was used as a data collection strategy for this research. Unlike diaries that are kept by subjects and used to capture data when observation is not possible, this diary was intended to capture evaluative perceptions of the participants not be easily observed. Each week, participants were asked to complete a one page weekly writing assignment commenting on their experience in the group. Participants understood their responses would be shared with me as researcher. Participant diaries provided a summary of what occurred in the group, anything they would do differently as a result of the meeting, more they would like to learn about or discuss, and any other reflections. Diaries were collected at the end of the group meeting, reviewed and copied by me, and then

returned at the beginning of the next meeting. The content of the participant diaries were used to direct planning for the next meeting as well as providing a rich data source of what occurred for participants in the group. The participant diary form is included in Appendix D.

In Depth Interview

After the last group meeting, I conducted a 45 minute semi-structured exit interview with each individual participant asking about their reflections about being in the group (interview guide is included as Appendix E). This provided an opportunity to clarify each participant's experience and gave an opportunity for the participant to report on the experience of being in the group. The final interview was held at a time and location of the individual participant's choice. One occurred in a restaurant, two in the Senior Center, and four occurred at home. The four occurring at home, presented additional data for the research due to the intimate insight to the participant that this access provided. This final interview bookended with the pre-screening interview which revealed information about what each participant came with, expected, or hoped for from being in the group. This information could then be compared with information about what actually occurred for each participant and their evaluation of the experience.

Memos and Field Notes

Over the course of the weeks following first interview, after each group meeting, and continuing through the data analysis process, I wrote memos reflecting on the individual participants, the group experience, my impressions as they were forming, and additional influences on the group. Resulting were numerous memos and field notes that were included as data in the analysis of the group. These documents helped clarify and expand on the interactions that occurred between group participants, the outside-of-group experiences of participants and how those experiences affected the group. Data gathered from memos and

field notes were helpful for both organizing emerging themes and for describing what was occurring in group process.

Data Analysis

Data analysis began as soon as meetings started and has continued since the close of the group through the writing of this paper. The framework of grounded theory and its methodological steps of coding, concurrent with my reflections of the data, generated abstracted findings that were organized into a construct of what was occurring. Thematic coding proceeded in an iterative fashion identifying categories of action and interaction within the group and communication process. Prescribed methodological steps of grounded theory (Strauss & Corbin, 1990; Corbin & Strauss, 2015) of open coding, axial coding and selective coding, as each of these was used to develop my understandings of the group and communication process, are detailed below.

Open Coding

Open coding is the first step in the analytic process of grounded theory and involves examining and breaking down data in order to conceptualize it (Strauss & Corbin, 1990). By making comparisons and asking questions (also called the constant comparative method of analysis) discrete ideas or concepts identifiable in the data are labeled, and where multiple examples of these instances occur, the data is conceptualized (Strauss & Corbin, 1990). All meetings of the support and learning group and all interviews were fully transcribed in order to facilitate this process. Open coding identified themes directly from the statements of participants. Consistent with the method, themes were most often directly derived from the actual words used or by summarizing what the statement was about, for example: family. A qualitative analysis software was used to organize the coded themes.

Axial Coding

Axial coding is a further step in data analysis, where the many conceptual labels that form from the open coding process are further examined and grouped into categories and subcategories. The relationships between categories also begin to be considered in this phase of data analysis and the already identified concepts (phenomena) are organized more abstractly. The task of the researcher in axial coding is to refine their understanding of the phenomena in terms of properties (defined as attributes or characteristics) and dimensions (location of a property along continua of possibilities) (Strauss & Corbin, 1990). In order to test a developing hypothesis regarding the phenomenon under study, the researcher again returns to the data to validate relationships among thematic categories that they have interpreted to determine they are supported (Strauss & Corbin, 1990). During this phase of the analytic process, identified codes were further grouped and organized reflecting my developing impressions about what I saw occurring in the group and the relationships between the theme categories I was beginning to interpret. At this stage of analysis, as an example, I combined the conceptual labels of family, work, and home life under the code of “telling stories”, the self-narratives participants shared defining their lives and selves. At this stage of coding, data analysis had resulted in two diagrammatic representations of the data concerning the group process and communication process. These findings are discussed in detail in Chapter 4.

Selective Coding

Selective Coding proceeds from axial coding in order to fully develop grounded theory (Strauss & Corbin, 1990; Corbin & Strauss, 1996). Interpretations are fit to a story line and that story line is refined around a core category that is determined by the researcher to be the central phenomenon of the study (Strauss & Corbin, 1990; Corbin & Strauss, 1996). The relationship of the core category to other subsidiary categories is explicated with use of a

paradigm and the dimensions of the core category are defined (Strauss & Corbin, 1990). Theme categories regarding the action/ interaction of participants in the group were organized with consideration of the forward moving progression of the group process.

During the Selective Coding process, I considered at length what occurred in the group and how it was important. As a story line developed, the theme of Relating was identified as a core category within the communication process. These findings nested the core category and subsidiary categories of the communication process within the group process. A highly abstracted fractal conceptualization of the group and communication process developed. These findings are detailed in Chapter 4.

Data Management

Audio files were maintained on a digital recorder and on an iPad using the software application One Note. Password protected files including transcriptions of the meetings and interviews, memos and files maintained on the qualitative data analysis software QSR NVivo 10 were maintained on a laptop computer and thumb-drive back-up. As indicated in the approved IRB protocol, audio files are to be erased on completion of write-up of the study.

Symbolic Interactionism

My thinking about what was occurring in the group process and individual experience of group participants aligned at this point of the data analysis process with the sociological perspective of symbolic interactionism (Blumer, 1969). Blumer's work significantly influenced Strauss and is philosophically congruent with grounded theory (Strauss & Corbin, 1990). The framework of symbolic interactionism provided a fitting context in which to consider the action of the individual participants of the Support and Learning Group on Aging and Health.

The first premise of symbolic interactionism presented by Blumer (1969) is that people act toward other things, including other human beings, based on the meaning those things have

for them. The second is that meaning arises in process of the social interaction with one has with other human beings. The third is that meanings derived from interaction are handled in, and modified through, an interpretive process used by each person in dealing with the things s/he encounters (Blumer, 1969). Self-definition and shared meaning in this framework are symbolically generated within our social contexts.

Specifically, symbolic interactionism sees meaning arising not as a product of a person's psyche but from interaction occurring between two or more people (Blumer, 1969). Social interaction provides a formative process that is interpreted by each actor, first in their selection of what in the interaction is meaningful and second by process of interpretation in which a person "suspends, regroups and transforms meaning in the light of situation in which he is placed and in the direction of his action" (Blumer, 1969). I found the specific propositions of symbolic interactionism to be present as I considered how the words, interactions and dynamics of the social setting created by the Support and Learning Group on Aging and Health provided the context within which the experience of each participant was defined.

The forward moving evolution of human experience, generally proposed by pragmatism and patterns of interacting and reflecting embodied in symbolic interactionism, were also considered. Through the open, axial and selective coding analysis conducted in this study, I identified themes describing the group process and how the communicative interaction of participants either reinforced existing strengths or supported their learning new information and skills. Group and communication process were conceptualized using systems theory contexts of input, throughput, and output. Group process was organized by time phase of before themes (input), occurring before the first meeting of the group, beginning, middle, end themes (throughput), occurring in group meetings, and beyond themes (output). Time phase characteristics were found to occur in both each individual group meeting and over the course

of the 8 weeks. Conceptually, therefore, the group process of each meeting could be described as a fractal of all meetings occurring over the course of group. Detail about the thematic findings and the fractal conceptualization describing the group and communication process of the Support and Learning Group on Aging and Health are discussed in Chapters 4 and 5.

Trustworthiness

Evaluative criteria for qualitative research are intended to assure trustworthiness through the establishment of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). Prolonged engagement, persistent observation, triangulation of methods and member checking were employed in the conduct of this research in order to strengthen credibility and dependability; thick descriptions of participant and group experience were conducted, addressing transferability; and a retrievable audit trail of all materials developed in the course of this study was maintained addressing confirmability. Additional steps taken to strengthen trustworthiness of the study included accounting of researcher bias, sufficient development of evidential support achieving theoretical saturation, and keeping the conduct of the group and data analysis to a reasonable timeline, as detailed in the following sections.

Prolonged Engagement

Prolonged engagement means taking sufficient time to orient to the situation and the culture that the researcher is observing such that distortions introduced intentionally or unintentionally by researcher or subjects are dispelled (Lincoln & Guba, 1985). Prolonged engagement provides the dimension of scope so that all is observed, not just what the researcher expects to find (Lincoln & Guba, 1985). In the first meetings of the group, though unintentionally, I was affected by my assumptions of how group interactions would or should occur. Participants in the group at first participated tentatively, not sure of what was expected

of them or what to expect. Conducting eight group meetings and sitting with group participants in pre-screening and post interview provided me time enough to become familiar with the participants and the group, including opportunities to test the accuracy of my developing impressions. It also gave the time needed for trust to develop between the group participants such that their interactions with me and each other were comfortable and productive. Time engagement with each group participant varied somewhat due to missed meetings, but overall time engagement indicating hours of contact with the group is detailed in figure 10 below.

Engagement with Subjects 17.5 hours

- 45 minute pre-screening interview
- Week 1: Meet-and-greet, concepts of aging and health, identify topics for continued discussion (2 hours)
- Weeks 2 – 7: Discussion, presentation and activity, 1 page participant diary (12 hours)
- Week 8: Last meeting and group celebration (2 hours)
- 45 minute exit interview with the nurse reflecting on the group experience after the close of the group.

Figure 10: Time Engagement with Subjects

Persistent Observation

Persistent observation of what occurred in the group helped me identify and discern what was important for participants and to explore these areas in some depth. Identification of the salient is the object of persistent observation (Lincoln & Guba, 1985). At times important phenomena were easily identifiable in the group's interactions. At times important phenomena were experienced by the participants but were not discussed in the group. At times I did not 'see' what was occurring in the communication process or group process until further observing,

in the act of listening again and transcribing what occurred or until I saw more instances of it. Field notes were helpful for recording observations, questions that arose for me and issues that required further investigation, as well.

In my research process I utilized qualitative software to identify by category what seemed to be occurring within the group and for participants, following Lincoln and Guba's description of persistent observation as a process of tentative labeling and evaluation of this assessment (Lincoln & Guba, 1985). Memos noting what I observed in meetings and impressions of what seemed to be occurring were helpful for guiding further exploration of my findings in following weeks and provided an auditable data source.

Triangulation of Data

Triangulation of data from a variety of sources is another strategy suggested by Lincoln and Guba (1985) used to strengthen the probability that the interpretations developed in research are credible. Observation, participant diary, and participant interviews each provided different modes of data collection used in this study. Direct transcription of the group interactions, including set up, break-time, breakdown of each meeting, field notes transcribed after meetings, and memos written in between meetings provided more than my memory of what occurred. Participant interviews provided greater detail on participant thoughts about being in the group. This variety of sources could confirm or challenge my developing impressions and allowed me to cross reference my propositions as they were developing. A table outlining sources of triangulation is provided in Figure 11 below.

Triangulation of Data

- Transcriptions of Group Meetings
- Group-generated Materials (Flip Chart Record)
- Memos
- Field Notes
- Transcriptions of Participant Interviews
- Participant Diaries
- Data Generated from Member-checking

Figure 11: Sources Used in Triangulation of Data

Member Checking

Member checking, the practice of having participant's review the researcher's developing interpretations, served as external check on the inquiry process allowing a direct test of my findings. The participant diary and interviews were essential data sources and provided opportunity for me to check my impressions of what was occurring against the participants'. In order to test the group process and communication process models emerging from the data analysis, I shared group and communication process diagrams with several research group participants. Their feedback helped me ascertain the "truth value" (Lincoln & Guba, 1985, p. 290) of my findings as is consistent with suggested techniques used to assure trustworthiness in qualitative research (Strauss & Corbin 1990, Lincoln & Guba). Each participant's voluntary review and comment on the participant introduction drafted for the finding chapter of this dissertation also supported the trustworthiness of my findings. Comments received resulted in some corrections to some details on each participant. In general, each participant agreed with the accuracy of how their experience of being in the group was described.

Transferability of qualitative research depends on the degree of similarity between sending and receiving contexts (Lincoln & Guba, 1985). Thick Description or “an appropriate base of information” denotes a sufficient level of detail in the reporting of qualitative research such that it presents a rich data source of information about the particulars from which the findings were derived and from which other researchers may make judgements regarding how the findings may be used in other contexts (Lincoln & Guba, 1985, p.125). The findings of my research might be generalized in the context of a small support and learning group about aging and health including community-dwelling older adults of similar age, but that is not necessarily the case and cannot be assumed. The uniqueness of the participants, the format and content of the meetings, and the steps of data analysis are details that must be conveyed in the reporting of the research in order that any potential for transferability may be assessed.

Audit Trail

Lincoln and Guba (1985) cite strategies presented by Halpern (1983) addressing the importance of providing an audit trail where the steps of the research process may be retraced. In order to maintain a transparent audit trail presenting a clear description of the research process, all data and data products developed in the course of this research project including my process notes have been retained and are retrievable in an organized manner. During data analysis, tools used to keep information auditable included software for coding transcriptions of the meetings, use of a matrix to organize the literature review (Garrard, 2007) word processing files and paper files, which included printed and handwritten materials generated in the course of the research, and my analysis.

Research Timeline

Protocol submission was completed on March 27, 2014. The submitted protocol with requested clarifications was approved August 22, 2014. Extensions were approved July 30, 2015 and August 5, 2016 with a final expiration of August 2017.

Advertisement recruiting participants in the Support and Learning Group on Aging and Health was included on page 4 of the October-November 2014 Senior Spirit newsletter mailed to over 2,500 residents of Amherst and the surrounding communities. The advertisement was also posted at the Senior Center, two elderly housing apartment complexes in the neighborhood of the Senior Center and the main branch of the local public library.

Pre-screening interviews were held between October 2 and November 3, 2014 and were arranged by phone contact. Preferred mode of contact was established at the pre-screening interview and confirmations were made accordingly by phone or email.

Eight meetings of the group were held on Tuesdays from 1:30 – 3:30 p.m. in the period from November 18, 2014 – January 6, 2015.

Final interviews occurred with all group members. Five of the final interviews occurred within one month of the final meeting, two occurred further out in time. One meeting occurred three months after the last group meeting, due to the death of the participant's spouse just after close of the group. The other meeting occurred almost a full year later, due to the participant's significant health disruption (stroke) during the course of the research group and a long recovery period in the year thereafter.

Member checking occurred as findings were being established beginning with the first group meeting in November 2014 and during write up of the dissertation through early spring of 2017.

Summary

This chapter discussed the grounded theory methodology used to conduct my research on the Support and Learning Group on Aging and Health and the research itself as it was organized and conducted. Study aims of developing a group and communication process model were achieved through the investigation of research questions directed at two distinct units of analysis: the group and the individual participant. Setting, recruitment of participants, pre-screening meeting, protection of human subjects, and researcher qualifications were presented to give a sense of the organization of the support and learning group. Discussion about grounded theory research methodology (Strauss & Corbin, 1990; Corbin & Strauss, 2015) detailed the format of the meetings and data sources. Data analysis was discussed including how the coding steps of grounded theory (Strauss and Corbin, 1990, Corbin & Strauss, 2015) and the framework of symbolic interactionism (Blumer, 1969) were applied. Additionally, the chapter detailed the qualitative research strategies used to assure trustworthiness, addressing credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). Finally, a timeline identifying steps of the research from beginning to end was provided. The intent of this chapter was to give the reader some background and understanding of the research methodology undergirding this dissertation, and the manner in which the research was carried out.

CHAPTER 4

PARTICIPANT PROFILES

Introduction

An introduction to participants of the support and learning group on aging and health is provided from the data where group members shared information about life experience, prior group experience and their self-assessment of individual status regarding aging and health. In the data analysis, these features were conceptualized as inputs to the communication process. As required by the IRB approval for this study, each participant and any person identified in the study other than the researcher and assistant are identified by a pseudonym.

Participant Profile Inputs to the Group and Communication Process

Mary

Mary, 84 years old at the time of recruitment responded the day after the research notice was published, stopping me in the parking lot on the way into work and stating “I want to be in your group.” Mary’s interest, she explained in the second meeting, was simply to help me stating, “Well, ‘cause you wanted to be something like this, I thought well, all-right, I’ll do it. For you. That was all.” Mary’s speech is impaired as the result of two strokes. She speaks slowly, haltingly and often has difficulty selecting words. Additionally, writing is not easy for Mary. Given the inclusion/exclusion criterion of needing to speak and write I was truly concerned Mary would not be able to participate in the group and yet reasoned, I think fairly, that given time to respond and some assistance with writing (she could dictate answers) a reasonable accommodation could be made. Mary’s contribution to the group and the research was indeed very important and an essential piece of the communication process that made the group beneficial to every participant.

Mary grew up with her mother in her grandmother's Manhattan, NY household from the age of two after her father was killed in a subway accident. She thoroughly enjoyed her role as a single and adored child. Her family's experience as Hungarian Jewish refugees who left under threat and Nazi occupation shaped Mary's experience also. Mary was aware at a young age of her family's immigrant status and the acculturation attempted on people like her in the public school. In the second meeting of the research group when I introduced what I intended to be a safe icebreaker to share about a Thanksgiving tradition, Mary balked:

When I was growing up NY there were all these people from all other places in Europe, my family and others. And turkeys and thanksgiving was something that was brought to us in the schools from the teachers. Because it was all right for them, but for us it was different.

Shirley: Hmm.

Lisa: Do you think they were trying to acculturate?

Mary: Of course! Of course you were!

As well as providing an example of the diversity of older adult life experiences, Mary's experience as a member in a refugee immigrant family is significant for the differentness that she has always felt from the dominant culture and the context from which she interacts with others.

Mary was married once and has a son. Three years into the marriage, it was over. She explained in brief, "I was building a life and he wasn't. I told him not to come back." With her growing son, Mary lived for a time in California but eventually settled in Amherst, working as a school librarian in the public elementary school. Early in the morning one day when she was still working, the apartment building they lived in caught fire. No one was killed but almost everything in her household, including all of the pictures and documents of her family were a loss. She described how people helped her then, by donating everything she could need, and she has continued to use those items to this day as long as they've been serviceable. After the

experience of the fire, Mary has made a habit of the New Year to donate anything in her household that is not currently used. Among the few things she does collect and save are books.

Mary served for many years as town meeting member and on number of elected and appointed committees. At the time of the research group Mary continued to drive and kept active with activities including serving as a long-time elected member of the town's housing authority, serving as elected member of the town's democratic committee, participating in a research project conducted by the university's speech pathology department, regularly attending a long-meeting stroke support group coordinated by the hospital and getting together regularly with a group of friends to go out to eat or to other community events.

Mary says that while she knows she is "very old", she is feeling "just like myself." Despite being challenged by the effects of her strokes, she reports remarkably good health and never being sick with a cold or otherwise. Mary's simply-stated assessment of her health is accepting of her situation but positive in the overall: "My legs don't work....my speech is terrible. Otherwise I'm all right!"

Patricia

Patricia, age 82, saw the advertisement for the Support and Learning Group in the Senior Center's newsletter and contacted me by phone message. Patricia described her interest in being in the group from two perspectives. One is she feels an obligation to assist research when possible. Her own experience as a graduate student needing subjects has framed her view of giving back in this way. Also, she finds the subjects of health and aging to be personally of interest at this stage in her life. For ten years she cared for her husband, moving through major life changes including relocating from their single family home to an independent living retirement center, considering what was best for him. Since his death two years ago, she is

facing her own chronic health problems and challenges related to aging. The group study, she said in our screening interview, seemed to come at the right place and time.

Patricia worked as a speech therapist in the regional school district and her husband worked as a psychologist at the university. They lived in a residential area of town for years where they raised their three children.

Patricia was busy over the course of the group, as most participants were, with family events related to the holidays. The family gathered at Patricia's apartment for both Thanksgiving and Christmas Eve. Patricia reported driving to visit her younger sister and brother-in-law who live in New Hampshire, and being pleased about making the 220 mile round trip on her own. Patricia's son and his wife live in the house that once belonged to Patricia and her husband. They have three adult children of their own. Patricia also has another son living in Oregon and daughter living nearby to her.

Patricia is involved in a group that does fundraising for the retirement community where she lives and assists by collecting and filling bulb plantings for sale at the Annual Christmas fair. She also uses master gardener skills to volunteer time for a town conservation area arboretum and was co-chair on a committee collaborating with the town in support of the project. During the course of our research group's meetings, a storm with heavy snow occurred and Patricia walked the arboretum assessing the damage. Patricia's additional group experience includes participating in an on-going cancer support group run by a local non-profit, attending a Tai Chi group meeting at the Senior Center in which she has participated in for many years and recently participating in an eight- week mindfulness learning group that she found interesting but in which she had a very difficult time hearing the soft-spoken presenter.

Patricia wears hearing aids and uses a blue tooth microphone in order to participate as fully as possible, but sometimes finds it difficult to understand fast-paced talk. She noted how

this was the case at family events. Patricia used the blue tooth microphone at most of the research group meetings and noted some difficulty hearing all that went on.

Patricia considers her day-to-day health as generally good, but she is not without significant health concerns. One is her diagnosis of blood cancer, for which she receives experimental treatment at a Boston hospital. She is committed to the treatment and to her role as research participant, adhering to daily medication regimen and monthly appointments. However, she is ambivalent about some requirements of participation, including the hundreds of x-rays that have been taken of her torso and the priority of the research over the patient that exemplifies. In our first meeting of the research group, she explained how she is finding the experience of aging itself to be a challenge:

I think when one was younger (pause) like this morning, I made cookies and I was finished! When you were younger you would have made cookies and made breakfast and would have done 47 different things... I don't like it because you can't do so many things. Your energy resources disappear before you've done all the things you want to do. That's the way it affects me.

Dorothy

Dorothy, age 77, contacted me by phone to express her interest in participating in my research. When she came in for her screening interview, it was apparent her interest was in supporting my project whatever that would mean. After some explanation, Dorothy confirmed the idea of the group sounded fine and that she hoped to contribute in various ways to make the project a success. She had no questions for me but did note her daughter's recent surgery and how the priority of helping her daughter might require her to miss some sessions. I accepted these potential interruptions in Dorothy's attendance as may occur for all participants fitting meeting times into other obligations of daily life.

Dorothy and I first met when she moved to the area from New Jersey two years prior in order to be closer to her two daughters. At that time, she was seeking part time work as a

nurse. Dorothy is still settling in to a new phase of life. She has now transitioned to retirement and is taking an active role as grandmother to her one daughter's children who are three and six years old. The grandchildren are a delight to Dorothy and she is happy to help make their time happy and to assist her daughter and husband as they face a serious health issue. Dorothy's other daughter is also nearby and is available to support her sister and her mother.

As a young woman, Dorothy obtained masters level nursing training conducted at Mass General. Later, she married the business partner of her brother, a podiatrist. At the time of their marriage, her husband, who had lost his first wife to cancer, had three children, a married daughter and two teenage sons. Dorothy and he had two daughters of their own. Dorothy infers that their marriage, though 34 years long and lasting until her husband's death, had some problems, when she says with a humorous lilt in her voice "and I have very wonderful feet. I never needed anything! Ha-ha. Nothing! My feet were perfect!"

In New Jersey, Dorothy and her brother remained close to extended family, meeting regularly at "cousin's party" gatherings. A practicing Catholic, church life has always been important to Dorothy. Since moving here, she has met a group of new friends through church who take turns hosting supper parties. She has also been an active volunteer and participates in activities at the Senior Center. The day of our screening interview Dorothy was putting final touches on a presentation on wildlife of the Quabbin Reservoir that she was planning to give as a member of a "Learning in Retirement" group that meets locally. She had many pages of notes taken from her research on the subject, which was new to her before this assignment, and she was excited to be presenting soon.

Dorothy's assessment of her health is very good. She often expresses feeling blessed to have good health and to be able to do so much. While decisions like voluntarily surrendering her driving license show an awareness of changing abilities, Dorothy seems to have a boundless

energy and is always a flurry of movement and doing. One Tuesday on the way to the Senior Center for our group meeting, I found her briskly walking to a bus stop well over a mile away from her home. When I came to visit for our final interview, Dorothy unexpectedly served a delicious home-made meal of squash soup and stuffed shells at a table set with a white cloth. During our discussion she rose from the table at least ten times to go to the kitchen, or go to get a book to share, or to play her grandchildren's birthday phone message for me. Her daughters and granddaughters had slept over the night before and that evening she was hosting her supper group. Dorothy is a delight to be around and keeps a pace that would be dizzying for most people.

Barbara

Barbara, age 77, contacted me having seen notice of the group in the newsletter of the Senior Center. When we met together in my office for her screening interview, she indicated some cautiousness about her decision to join the group. Barbara reported her interest in joining the research group was her own experience of doing "just OK" with aging and health. She was interested in learning "what can be done in order to do the best I can." Barbara mentioned her husband was going through some health issues and spoke of the possibility of missing meetings in order to be available to him, which I accepted. After going through the materials, she left with the informed consent form, returning it signed on the first meeting of the group. When I contacted Barbara to set up our final interview, she shared that days after our last meeting, her husband had died. She also said she wanted to continue to be available to the research project and several weeks later set up a meeting time for our final interview.

Barbara's marriage of 47 years was her husband's second, and she entered the marriage assuming a parenting role to his five sons. Later, she and her husband had a daughter. At the time of the research group Barbara and her husband continued to live in the sprawling updated

home where they'd raised their children. Her husband, a skilled stonemason and contractor, ran a successful business that is now managed by his sons, one of which lives on a property next door. Barbara obtained a master's degree and worked as a substance abuse counselor assisting a number of people with addictions. Despite her advanced degree and professional status as well as her family's success and apparent wealth, Barbara spoke of an awareness of being a "local" among others who are part of the town's academic community, a reason she gave, when asked in the final interview, about being relatively quiet in the group.

Barbara has poor balance and difficulty walking and has sustained several falls with injury. She reported how her doctor warned her that without developing strength she would lose the ability to walk. This prompted joining a fitness club, where Barbara works with personal trainers to achieve fitness goals. She attends several times a week and loves the exercise and support. In years past, she was overweight and had success of losing 60 pounds working with a support group. She had also been a member of a swim group and a yoga group, both of which she enjoyed and had helped her health goals.

Barbara knew Betty and Mary from participating in the Senior Center's travel group. Several times over the course of the group, Barbara recalled some years ago responding to an advertisement inviting participants to a walking group and how she had contacted Betty to inquire. Betty had said no, noting Barbara was not fast enough to join the group and she would not be able to keep up. Barbara laughed about that now, but it was apparently a painful memory as she told of this rejection to Betty in the first meeting, to the entire group once in the course of our meetings and also in our post-interview.

Barbara's self-assessment of health is probably better than others would judge. While stating she feels "like an invalid" and is slower in her movements in comparison with others, Barbara independently meets the activities of her daily life. When it snows, her son plows but

Barbara may shovel. She cooks meals at home including meals for large family get-togethers, drives to appointments, and does most of her own housekeeping. Visiting Barbara at her home for our final interview I was astounded to see the stone steps or wooden second floor deck stairs she must navigate in order to get to her car each time she goes out. Barbara seems to take on each day with a quiet strength, willingness and determination to “just keep going.”

Robert

Robert, age 82, indicated his interest in the research group was as a means to learn information that may be helpful to his wife Margaret, considering her many health issues. Being a caregiver is a role Robert has accepted but finds challenging. Robert reports constant worry about his wife and of being frustrated by the symptoms of her dementia. Robert indicates he really likes being part of the caregiver group at the Senior Center which provides him positive activity and support. Robert thought this research group could be interesting and might give him information that he could bring back to Margaret at home.

When he was young, Robert played baseball well enough to tryout for a professional minor league. His parents felt he should have a fallback plan and instead Robert became a management trainee for a bank, a career he worked in forty years. His wife Margaret was an auditor working at the same bank when Robert and she first met. After their son was born, Margaret went back to school and eventually had a long career as a special education teacher. Robert’s son and daughter-in-law asked him and Margaret to move nearer to them after she’d experienced a stroke. Now, Margaret’s health problems which include epilepsy, mobility problems from a femur break, and dementia make it so she requires care, most of which Robert provides. While he misses some of his life in New Jersey, Robert is happy with the neighborhood where he walks his dog Barney several times each day and can be involved in his family’s activities, such as driving his grandchildren to events and school.

Robert shared in an early meeting how his youngest grandson, a senior in high school, plays on the soccer team where Robert's son is assistant coach. Robert loves going to his grandson's games and there socializing with the other families sharing in the experience. Robert also talked in the group about being a member in a group of church ushers back in New Jersey, meeting after services for breakfast and enjoying that togetherness. In addition to being an active member of the caregiver support group organized at the Senior Center, Robert recently attended a 12-week caregiver group facilitated by the region's elder service agency. Robert has some experience participating in other research groups, too. In his final interview Robert talked about being a participant in a study at the university, stating:

Three years ago I was in a class, you had to take a test, how strong you were with your arms and so forth, we went to UMASS, we went to Yale, MRIs. But that was a good group too. I enjoyed all groups, some large, some small. I enjoy them.

Robert's self-assessment of his own health is very good. Over the course of the research group meetings, I attempted a number of times to engage Robert in consideration of his own issues related to aging and health but besides caregiver stress, the only concerns he ever discussed were related to Margaret. Robert never identified his own experiences with health and aging as a source of distress even following the stroke he had after our fifth meeting, which caused his loss of speech and necessitated his going to a rehab facility for two months and having speech therapy for many months. Robert was back home and feeling well at the time of our final interview, but continued having significant difficulty with his speech. Still, Robert reported finding satisfaction in the life he's led, his son and family, and the marriage he's shared with his wife, despite the difficulties of her illnesses. Robert continues to show little concern and acceptance of his own issues:

I have no problems, I've been lucky, so I figure aging? I could be gone tomorrow, I've been lucky, I have no problems. But I meet other people, they have problems it's really scary. With Margaret, we don't go out, except to a doctor, but I know people who can't walk really, that's really sad. I'd rather not be able to speak than to walk.

Betty

Betty, age 83, had been a participant in two pilot support and learning groups I co-facilitated several years ago. She was interested in joining this new research group based on that experience and as a help to my scholarship. Her husband, John, whose Alzheimer's dementia eventually required around-the-clock care, died just last year. After a career as a Registered Nurse, Betty continues part time in the physical therapy department at a local rehab/nursing facility where she has worked for almost 30 years and also continues to volunteer at the local hospital providing set-up for endoscopy. Though she has let her nursing license lapse, Betty continues to be connected to others in a nursing role, helping friends, family and acquaintances consider and navigate health concerns and issues. She is a strong advocate of hospice and quality-of-life versus cure at the end of life.

Betty grew up in the Netherlands, the second oldest of nine children. Soon after training as a nurse, she traveled with a girlfriend to Switzerland where they both took jobs working with children displaced because of the war. She loved the work and the freedom, hiking and skiing regularly with her friend. In 1961 she met her husband, John, in Italy. They lived in Italy for a few years and then came to the US after her husband took a job as gymnasium manager at the university.

Betty extended her role as mother to her two children to numerous university students who lived with her, and her husband John, in international student housing just off campus. Years later, John and she bought the single family home in a residential area of town where Betty continues to live. In 1989 she was called back home to Holland to care for her father who had cancer and had become too ill for her mother to manage. It was a difficult time for Betty who knew she was needed at home but also knew she had to live her own life. Betty made a decision to place her father in a nursing facility withdrawing medical treatment where

he died in several weeks. Later, as her husband's illness went on and deepened for more than five years, Betty was creative about finding ways to work with his behaviors and memory loss. She also at times reached out for help from others, including her children, friends and service agencies in order to manage John's care.

For five years, Betty was a member of a caregiver support group facilitated by the hospital which she found very helpful to coping with challenges in caring for her husband. For many more years she has relied on a group of friends who she hikes with weekly, rain or shine, and a smaller group that she skis with weekly through the winter. She has continued her work helping international students, attending the university's female international scholars group which was meeting regularly through the course of our research group meetings.

Betty feels very lucky to consider her own health as excellent. She notices some changes, such as slowing responses that she considers part of the cycle of life. Except for insomnia, which she experiences on many nights, Betty considers the changes she is experiencing as normal aging. Betty is determined to be very active while she can and reports an uptick in travel now that her husband has passed. She traveled the last two summers, taking her grandchildren to visit back to the Netherlands where her sister and other family still live. At the time of our research group meetings, Betty was looking forward to Christmas holidays with her daughter's family in Utah. The week before starting the research group, she had spent a week in Florida with friends and for Memorial Day had recently visited New York City. Last spring, Betty traveled to Bhutan to visit with the family of a graduate student who was care aide to her husband John. She reported having a wonderful time.

Shirley

Shirley, age 76, was the last person to contact me with interest in participating in the group. She expressed being fearful about having the ability to do all that is necessary in order

care for herself and her husband, James, age 73. Shirley finds it challenging at times to do all that is needed in their current daily lives and says she sometimes feels overwhelmed. Shirley notices changes in James's health status and wonders how she will meet their care needs into the future when she has difficulty coping already. She stated she was interested in participating in the group for the opportunity of being with and learning from others who are coping with the challenges of aging. At the first meeting of the group Shirley expanded on that, responding to a prompt asking what brought her to the group:

The reason I'm here is I'm feeling a little desperate about this aging business. I have a wonderful husband who is ADD. He has an acquisition hoarding disorder which is really becoming really, really a problem. And I'm really concerned about his mind. He seems to be slipping a little bit and his mother had Alzheimer's. And I'm thinking, "How am I going to do this?" And I have multiple illnesses and it's just really scary. So I'm hoping I'll get some advice from other people on how to do this.

Shirley is still experiencing a busy and full life with her husband. A third marriage for both, they are now celebrating an Anniversary of 38 years. James and Shirley live in a nearby town where they maintain a residence with a full-time boarder in a separate section of the house. Their house also serves as home base for their large extended family which includes eight grown children and numerous grandchildren and great grandchildren, some of whom live in Washington and in Europe but stay with Shirley and James whenever they return to the area. Over the course of the holidays Shirley and James hosted a solstice party including about 80 guests dropping by through the day for food and song. They also hosted James's brother and their niece, who Shirley adores, to stay for the holiday. Shirley reported cooking an elaborate Indian meal. One of James's daughters and a granddaughter who live nearby helped Shirley to prepare for the party and host while family was in town, which was a help. The whole experience left Shirley both exhilarated and worn out.

Shirley and her husband James are regular participants in several of the ongoing programs of the Senior Center including a long-running group committed to learning about myriad topics under the heading of the noetic sciences where James is often a contributor. James is a virtuosic piano player and together they are active in the area's classical and jazz music scene. Shirley also enjoys being part of a luncheon group that has developed among their Unitarian/Universalist Church friendships.

Shirley's assessment of her health includes some difficult issues including joint pain in her hands, feet and body that she attributes to chronic Lyme and arthritis, for which she sees a homeopath and an acupuncturist. Because she cannot tolerate over-the-counter pain medications, Shirley also treats her pain with alcohol, often taken in the middle of the night when she is unable to sleep. This relieves the pain but leaves her groggy for the day and at times not up to the tasks of all she plans to do. Shirley also reports a history of seasonal affective disorder which she treats with plant lights. Shirley maintains her license to drive but most of the time James transports her due to episodes of vertigo she experiences. Just before the start of the research group, James had a surgery limiting his ability to be active during several weeks' recovery. In the research group Shirley expressed stress related to concerns for James's current and future health including how much she relies on him to do things for both of them.

Molly

Molly was not an older adult group participant but a senior baccalaureate nursing student who assisted with the group sessions and participated in the group. Molly helped with setup of refreshments, scribed group brainstorming onto easels, and shared as others did on conversational prompts. As planned with the researcher and with notice to the group, Molly attended meetings one through four and the very last, but was absent for the intersession break

in between while travelling with her family. Molly's presence left a positive mark for everyone in the research group. In final interview, Molly was mentioned by most of the participants in their reflection about what they liked about the sessions. They just delighted in her. During the meetings they would engage her in chat about her educational path and activities. For her part, Molly reported the group providing a new sensitivity to the experiences of aging that she related to concerns she has for her parents as they grow older. The interest the group took in Molly left an impression with me about the value of intergenerational groups as a rich opportunity benefitting both older and younger participants.

Summary

This chapter was organized to summarize data analysis about each of the participants in the Support and Learning Group on Aging and Health. Using the systems theory concept of input, a participant profile was developed introducing each participant through description of their life experience, prior group experience and their own self-assessment of individual status regarding aging and health.

CHAPTER 5

FINDINGS

Introduction

The findings discussed in this chapter resulted from my use of the methodologic strategies of grounded theory employed from the very beginning of the research group's formation and proceeding to a stage beyond the close of the group. Data collection began with the first received response to the research advertisement and the pre-screening meetings held with respondents. Analysis proceeded through the meetings of the Support and Learning Group on Aging and Health, as participant diaries were collected, as I composed memos to discussing what seemed important in the group and communication process, as the audio tapes of those meetings were transcribed, up to and including the final interviews conducted with participants.

Using coding strategies of grounded theory, I organized thematic categories of action/interaction within context of the group process and communication process. Analysis began with the concrete data and then through the steps of open, axial and selective coding abstracted understandings of the group and communication process emerged. Throughout the data analysis process, consistent with the method, I returned continually to the data sources to confirm and challenge my findings. The abstracted thematic categories were again checked against the data to confirm their grounding.

Data analysis was a long and iterative process that involved the drafting of conceptualizations and then contemplation of the schemes identified. Did they work? Did they truly capture the experience of the participants? Group participants reviewed and commented on diagrammatic representation of the group and communication process as well as paragraphs drafted to introduce each of them. Having the actual participants involved in the group review the work was a very important step in truth testing my analysis. Their review corrected some

details and helped direct the focus of and validate my findings. This chapter is organized to present to the reader steps through which data collection and analysis occurred, ending with my findings.

Thematic definitions of my findings are presented in this chapter with examples from the data which helped identify the thematic categories and theoretical arrangements chosen to describe the group process (group as unit of analysis) and communication process (individual participant as unit of analysis). Additionally presentation of a fractal conceptualization of the repeating and overlapping patterns of the group and communication process is included in this chapter, indicating how these patterns occurred over the course of 8 weekly meetings and in the course of each individual meeting. The chapter closes with a section on participant evaluation of the group and their experience in it, responding to the research question inquiring what participants valued about being in the group.

Coded Themes of Group Process (Group Unit of Analysis)

Group communication occurring in the research group was observed using a grounded theory approach and conceptualized through a philosophic lens of pragmatism. Pragmatism views communication as human inquiry, an evolutionary/biological process of temporal dimensions that continually points forward and continually undergoes change as two or more people converse with the result of developing shared understandings of meaning (Cronen & Chetro-Szivos, 2001). Pragmatism is consistent with many examples in the literature which identify group process as occurring in time and work phases (Gitterman & Shulman, 2005; LeBarge, Von Dras & Wingbermuehle, 1998; Loomis, 1979; Toseland & Rivas, 2017). Gitterman and Shulman (2005), for example, identify preliminary, beginning, work, ending, and transition phases of group development.

Time phases were used to organize the themes of group process occurring in the Support and Learning Group on Aging and Health. Doing so, each group meeting and the experience of the group over the course of eight meetings are segmented chronologically into phases of Before, Beginning, Middle, End and Beyond. The Before themes of group process identified through data analysis of the research group include Envisioning, Asking Questions, Deciding to Join and Committing. The Beginning themes of group process identified include Coming Together, Identifying Concerns and Establishing Roles and Routines. Identified Middle themes include Interacting in Patterns, Exploring Options, Developing New Directions and Managing Disruptions. Identified End themes include Summarizing Experiences, Drawing Conclusions and Valuing Connections. Beyond Themes include Incorporating Experiences and Moving On. Definitions for each of the identified group process themes are presented here below. Following the definitions given for each time phase is a brief example from the data demonstrating how the identified themes were in evidence within the communicative interaction of the group.

Before

Prior to actually joining, each participant moves through a process of considering, learning about, and deciding to join. Themes identified for the Before phase include Envisioning, Asking Questions, Deciding to Join, and Committing.

Envisioning

The theme of Envisioning reflects the participants' expectations of what participating in group will be like based on previous group experience and their interpretation of the information provided in the advertisement of the group and by the organizer. Expectations for the session include what the participant expects and hopes to gain from participation. In the pre-screening interview I sought to clarify what I envisioned for the research group and to

provide as much concrete information as possible to explain what it would be like to participate. As noted in the participant introductions above, I asked each individual what interested them about being in the group in order to gauge their expectations and what they hoped to experience in the group.

Asking Questions

The theme of Asking Questions refers to the participant actively seeking information about the planned activities of the group. As people responded to the advertisement for the project, they asked questions to clarify their understanding of what being in the group would be like. In the screening interview, I went over the format of the group, the participant diary form, and the informed consent form which was helpful to prompt questions and clarifications from the participants.

Deciding to Join

The theme of Deciding to Join marks that point in time where a person affirms to themselves the potential value of, and their intention to, participate in the group. For most of the participants, this occurred even before or during the screening interview. The group sounded interesting enough and they were motivated to join by their interest in the subject or in helping me with my research.

Committing

The theme of Committing is the act of confirming one's intention to participate in the group with the organizer, in this case formally, with signature on the Informed Consent Form. Committing is similar to the step of contracting which is identified in group work literature as a preliminary step in forming a group (Toseland & Rivas, 2017). Though participants retained the ability to withdraw from the research at any time, those that agreed to participate did so with their signature. All participated and none withdrew.

Beginning

Early in each meeting and in the course of 8 weekly sessions, group members found out about each other, identified the ways in which they would work together, and established, formally and informally, the roles and norms of the group. Themes identified for the Beginning Phase of the group include Coming Together, Identifying Concerns, and Establishing Roles and Routines.

Coming Together

The theme of Coming Together includes the physical actions of participants gathering together and settling into place around the table, the communicative actions of participants introducing or reintroducing to each other through informal communication and facilitated discussion, and the patterns of social interaction that entailed. Every meeting included a “check-in” where each participant shared something in response to a prompt I provided (e.g. a special day, a holiday tradition, a tip for getting through winter). This routine activity supported each participant to settle in and share creatively before the didactic portion of the meeting.

Identifying Concerns

The theme Identifying Concerns refers to instances occurring in the group process when topics of concern are initiated in discussion. The tools used to structure discussion in the sessions, e.g. the wellness wheel, assisted the participant’s to talk about the experience of health and aging in general or specific terms. Concerns identified in a generic sense might be further explored by the group. Specific concerns might be taken up by the group in order to assist a member, or if more than the group could address, referral to a source outside the group might be suggested or undertaken. For instance, a number of concerns were addressed with information from outside sources such as the National Institutes for Health.

Establishing Roles and Routines

The theme of Establishing Roles and Routines refers to the recurring ways in which members of the group interacted in discussion, occurring at numerous times in the course of group meetings. Roles of the participants were formed according to personality and experience relative to topical concerns of the group. Routines followed my imposed format (i.e. ice-breaker and check-in, presentation and discussion, breaks, participant diary) and the sequence and pattern of the discussion as it was formed by the group members usual manner of participation (i.e. long, short replies to prompt, interactions with me and each other).

Middle

The Middle is the working phase of the group where key topical concerns of the group are discussed. The content of the middle phase of the group is remembered by the participants as “what occurred in the group,” as identified by their weekly responses in the participant diary and in the final interview. Themes identified for the Middle phase of the group include Interacting in Patterns, Exploring Options, Developing New Directions, and Managing Disruptions.

Interacting in Patterns

The theme of Interacting in Patterns was identified from the communicative exchanges occurring between group members which followed repeating patterns reflecting the particular role of each participant and the norms that had developed for the group. By the middle phase of the group in both individual meetings and over the 8 weeks of meetings, these patterns more regularly occurred between participants rather than between participants and me.

Exploring Options

The theme of Exploring Options refers to portions of the group discussion where participants actively discussed problems, perspectives, and solutions related to issues of aging

and health. Exploring options is characterized by a high level of personal sharing and creativity, such as brainstorming potential solutions between group participants. At times discussion characterized by this theme was prompted and at other times it was generated by participants independently.

Developing New Directions

The theme of Developing New Directions reflects a circumstance in the group process where a new issue of concern is identified and taken up in the work of the group. New issues of concern may be introduced topically, for example when a new group exercise is introduced, or conversationally, for example when a participant identified as a new concern, or in response to a participant's sharing.

Managing Disruptions

The theme of Managing Disruptions refers to ways in which group participants responded to unforeseen occurrences affecting the meetings over the course of the 8 weeks. Examples include the illness of group members, weather, planned and unplanned absences.

End

At the end phase of the group process, participants prepare to finish the interaction with other group members, reflecting on and summarizing experience. The time phase of the End occurred both near the close of each meeting and at the end of 8 weeks of meeting in the group.

Summarizing Experiences

The theme of Summarizing Experiences was identified recognizing points where group participants developed conclusions about the group experience as they considered their own and other members' interactions occurring in meetings and over the group as a whole. The

meaning of the group experience to each participant was considered at this point in the group process.

Drawing Conclusions

The theme of Drawing Conclusions indicates where participants formed evaluative statements supported by their individual experience in the group and their interaction with other participants. Participants identified how the experiences of the group were meaningful in their thinking about aging and health.

Valuing Connections

The theme of Valuing Connections was indicated in instances when participants reported personally relating to or being affected by the experiences or position of another participant. These connections with others were in evidence at times when participants showed interest in continuing relationship with other individuals in the group at the end of the eight weeks.

Beyond

The theme Beyond identifies the time phase in which the participants have left the group and returned to their day to day lives. In this period, participants continued to think about and respond to the experience of being in the group. I held the final interview for most participants in the Beyond period just after or within the weeks following the close of the group. Their comments indicated some memories of being in the group were still fresh and that they had often thought of the other members in the group in the time since. One year later, at the time of Robert's final interview, and even two years later, when member checking of my findings was occurring, participants reported thinking of other members and the experience of being in the group.

Incorporating Experiences

The theme of Incorporating Experiences indicates occasions when participants reported thinking about their experience in the group and in instances where they used a skill or tried a new activity as a result of their experience of being in the group.

Moving On

The theme of Moving On indicates the phase after the group process when the individual participant's disengagement from the group is complete and the participant's experience of being in the group has moved from the present to the past. A Group Process Diagram of the Support and Learning Group on Aging and Health is provided in Figure 12 below.

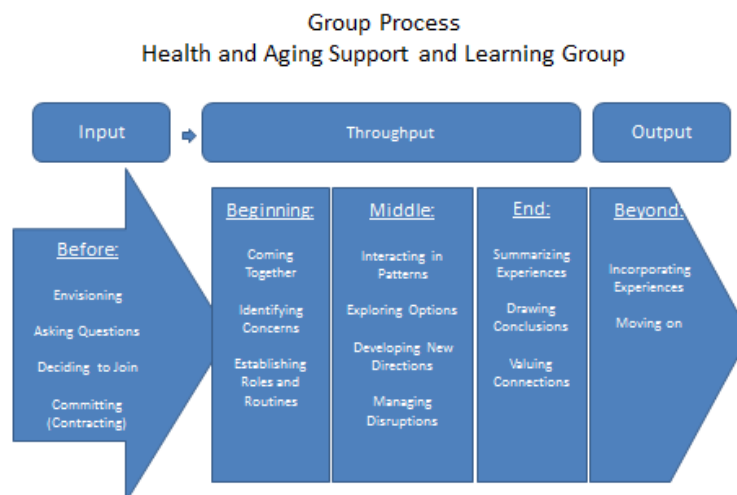


Figure 12: Group Process Themes (Group Unit of Analysis)

Coded Themes of Communication Process (Participant Unit of Analysis)

Analysis of the communication process was conducted considering the individual group participant as the unit of analysis. What each participant brought to the communication process was conceptualized as Input and thematically coded as Life Experience, Prior Group Experience, and Self-Assessment of Status regarding aging and health (described for each participant in the

above introduction). Communicative action/interaction occurring in the group was conceptualized as Throughput and thematically coded under categories of Initiating, Responding, and Relating. Participant outcomes were conceptualized as Output and thematically coded as Integrating. Sub themes were identified describing the types of communication in which participants engaged. Initiating themes included Seeking Information, Sharing Knowledge, and Telling Stories. Responding themes included Confiding Problems, Suggesting Solutions, and Picking-Up Threads. Relating themes included Empathizing/Sympathizing, Making Comparison: Similar Position, and Making Comparison: Contrasting Position. Integrating themes included Confirmations (Reinforcement), New Information, and Inspirations (Development).

Initiating

The thematic category of Initiating includes communicative actions generated by participants without prompting. Abstracted themes identified in the category of Initiating from the data include Seeking Information, Sharing Knowledge and Telling Stories.

Seeking Information

The theme of Seeking Information identifies instances where participants made direct requests for information from the leader and other members of the group. In the example below Patricia and Betty both initiated questions seeking information about my research with the group. The exchange marks their awareness of being subjects in research and wanting to know more of what it was about.

Patricia: Could I ask you for a question, in terms of your research what are you looking for?

Betty: Geriatric?

Lisa: I have to go in without expectations or a hypothesis I'm not saying that I'm looking for any particular thing.

Patricia: OK, alright.

Betty: Qualitative?

Sharing Knowledge:

The theme of Sharing Knowledge identifies instances where group participants willingly shared their knowledge and responded to others requests for information about topics of discussion. At times, the group revisited a topic that appeared earlier in discussion that day or over the course of meetings.

Patricia: I'm just going to add a bit to this having been a caregiver, sometimes you get to the point where this emotion's so strong that you feel like you are going to crack up. I mean that happened to me once in my life and I am a really very stable, very easy going person. But everything was coming at me so quickly in so many ways, it becomes really stressful and I think this becomes an emotional reaction, and you really do need help. Which point my family came in we made some changes, simplified life. But to me, the emotions are more sort of feelings and how do you respond to those feelings.

Lisa: Did you know this was happening?

Patricia: Oh, I knew my husband was in his last illness, pressures from here and here and here all saying do something different. You know it was resolved. It only was for a few hours but I could feel this stress that was almost bodily. Which you know, for me is under the heading of emotional response.

Lisa: Absolutely, it was a good indicator of what you needed to do at the time. But Thank goodness it happened, but how hard. How hard that must of been.

Patricia: Well, It was a good new experience for me, it never happened for me before like that. So, anyway....

Lisa: So let's just jot that down.

Molly: So, how.

Lisa: I'll let Patricia say.

Patricia: Say "Super Stress. "

Telling Stories

Personal narratives shared by group participants about their lives from the past to the present. At times participants told stories that were quite polished and apparently told over

many times, often prompting additional sharing by other group members. Participants also freely shared issues of concern related to aging and health as early as the first meeting. Our first exercise in meeting one was to break out into pairs to discuss, “a recent good day.” In this exchange, Betty shared with Barbara a bit about her concerns of daily life and a philosophy of taking things “day by day”:

Betty: My husband died last year. Everybody kept saying oh, Oma’s gonna live here. I said no, no. Because they’re working and I’d be alone! Here I have friends here and my own way of life. ... Up in Utah when it is beyond my control and I hope to be gone before that much. So, whatever, I’m still living in the house it’s ok. Take it day by day.

Robert shared this story about his wife and son with the whole group in meeting:

Robert: But she’s you know, really a sharp young lady. Photographic memory at one time. Went through college in three years. First married student taken at St. Elizabeth’s college in NJ, the best teaching college in NJ. She used to take, bring my son to class with her. When she got out of high school she had a scholarship to go to college, but her folks couldn’t afford it. So we got married, after three years, I put her through college. She took my son to school, all women’s school? You sit in the back of the classroom and you know, do things...

Well, he takes after, he’s pretty sharp. He’s a lawyer right now. But Margaret was really brilliant. She was teaching and she was about 10 years ahead of everybody else what she was doing with children. She ran a day care center. ‘Cause she had epilepsy she had walk to work or I would drive her to work, and people would come from NY to NJ to observe her teaching, she was that far advanced. She retired? They still came to our house...to still talk to her about teaching! (voice breaking) So, to see a brilliant woman, come down, it’s interesting.

Lisa: Difficult.

Robert: But it could be worse, that’s my philosophy, you know, I still have her.

Dorothy: That’s a good one to have, yes.

Responding

The theme of Responding includes communicative interaction in the group made in response to the initiations of other members, such as answering a request for information or suggesting a solution to a problem. Abstracted themes identified from the data in the category

of Responding include Confiding Problems, Suggesting Solutions, Picking up Threads and Giving Support.

Confiding Problems

The theme Confiding Problems refers to instances of problems related to aging and health experienced by the participants or their loved ones that were confided in the group. Problems were confided within the group as early as the first meeting and typically deepened in the middle to end phase of the session and over the course of the group.

Shirley: But uh, I don't know... The biggest issue is stuff, and um, I have a wonderful therapist who keeps me married. I love my husband very much, he's just absolutely wonderful, he's brilliant. But (pause) ...We have a big house and it's full and he has a nine bay barn that's

Betty: Full!

Shirley: and it's overflowing in front of the barn.

Mary: Ha Ha Ha.

Betty: And you can't throw anything away cause "you need it." I went through the same the room, the garage the basement... Yep, yep. Oh terrible. The room, the moment I'd take I'd take a thing, he needed it. In the garage he needed everything and it would be really terrible.

Lisa: This is your husband?

Betty: My son came and we tried to when he [John] was at lunch at the Senior Center, throw together. And you know the moment he used the truck you know put in the truck he would be furious! Hitting me and hitting my son. "I need it! I need it! I need it!" Ah, it was horrible, it was horrible, horrible. Nothing, I mean everything has to be saved. Took my kids after he died last year took them a full day to empty that.

Shirley: Yah.

Betty: I don't know how many...There was a couch and a table. I could not even see it. I had an empty room after that.

Shirley: Yeh.

Betty: Couldn't go. It would go in the room, just open the door, It would be right there. "No no no! I need all that stuff!"

Shirley: Fortunately, my husband has a very sweet disposition he just gets very sad when I try to take things away.

Betty: No you cannot. That's no, they really, I think losing (pause). "I need it! I need it!" You know really have to have it and doesn't do anything with it!

Shirley: Right, Right, right.

Betty: You know, never go in the room and take stuff out. It just has to be there. Oh yeh, I went through that. Big time!

Suggesting Solutions

Where participants suggested solutions to the challenges expressed by others or topics of concern discussed in the group, drawing from personal knowledge and experience. Members of the group regularly suggest ideas and possible solutions to help others and there were many examples in the group where a member showed a kindness or gave a word of encouragement. The week after Mary discussed difficulty holding a pen to write, Betty brought in a booklet showing a writing tool to help people who have difficulty holding pens. Mary said it could not help her as her fingers did not have the strength to hold. As we were going over the group's expansion of the wellness wheel, Mary shared that the cold affected her legs and speech. As the exchange followed, other participants tried to suggest solutions to Mary, which were rebuffed.

Robert: But maybe you could add a few of these to your, you know, daily life.

Mary: But I do.

Robert: You're doing them all now? Or?

Mary: Yeh, I don't need to, um, living, er, with loss. No. I mean some of these things don't bother me. So what?

Lisa: So that's you're coping well with living with loss, everybody's died, you said.

Mary: Sure!

Lisa: so you're dealing with that or if you've dealt with it. You're ok.

Mary: Sure! Doesn't matter.

Lisa: But, I think that's how these [wellness wheel domains] might interrelate. Let's take a concrete example. You have physical issues caused by your stroke.

Mary: Oh yes! Heheh.

Lisa: For instance, today you were saying you have difficulty walking.

Mary: Right.

Lisa: Because of the cold, specifically, you said. And that is phht [running finger from physical to environmental on the diagram]. The cold affects the condition.

Mary: That's right, but I can't do anything about the cold.

Lisa: Except?

Dorothy: Well, stay warm. Hahah.

Lisa: hahaha. Except, stay warm. Yeh, and I don't mean to be glib about it.

Mary: Yeh. Yah.

Lisa: But that's what the idea of the wellness wheel is. Yes, there are things you can't address, control.

Mary: That's right.

Dorothy: Control. You can't, you have no control. Many, many, issues.

Mary: That's right.

Picking up Threads

The theme Picking-Up Threads was used to identify instances where participants responded and developed on a topic initiated earlier by another member of the group within discussion or for example by returning to the topic in the following week. In other instances, participants recognized something shared by another participant as being meaningful to them within the meeting. Communication process developed from earlier discussion and flowed in new directions from this point guided by the action/interaction of the speakers.

Robert: But looking at these, dealing with stress is a tough one. Remember Patricia was saying that one time she was (pause)

Lisa: Super stressed?

Robert: Super stressed. And she got out of it? I guess she just asked for help. So I try to get out of the house walking my dog four times, I'm going to three basketball games, today, tomorrow and the next day...And that relieves my stress, you know, just getting away from everything and enjoying something.

Relating

The theme of Relating refers to an evaluation process occurring during and after group meetings in which participants considered their life experience in relationship to other members. Abstracted themes identified in the category of Relating from the data include Sympathizing/Empathizing, Making Comparison: Similar Position, and Making Comparison: Contrasting Position

Sympathizing/Empathizing

The theme of Sympathizing/Empathizing was chosen to mark the sympathetic and empathetic concerns expressed by participants made about other group members' life experience regarding issues of aging and health. Patricia shared in her final interview her sympathetic and empathetic relating to Robert's stroke:

Patricia: I feel very badly about Robert and what happened to him, and I feel it is an incredible lesson for all of us, that the caregiver needs to have anticipated the fact that sometimes something might happen to them

Lisa: Right.

Patricia: and then the house of cards just...

Lisa: Right.

Patricia: I mean his family stepped in I'm sure and took care of things I'm sure but... I'm sure he didn't expect it.

Patricia also spoke sympathetically and empathetically of other participant's, noting their strength in coping with difficulties:

Patricia: In spite um major challenges, you know of they weren't complaining or lying down or saying why does this happen to me, or, you know...

Lisa: Inspiring.

Patricia: OK, If this is what you've got for me, then I'm going to um you know like you know Mary, for instance, who had difficulty getting around. You know but somehow she always managed to come. And Um it must have been quite challenging to her, just getting in and out of the car probably....

Well, I think you know it creates a greater sympathy in one for what people are facing. And sometimes you don't know because they haven't told you. You know, and I think that, you know, you need to give people that recognition. I mean you don't have to say anything but you have to at least know that they may be having a hard time for one reason or another, either through their own health or a caregiver.

Betty also made comments directly reflecting on the experience of others and relating their experience to her own. Betty's comments are remarkable for the level of information she discerned about other participants, some of which she reported was obtained from outside-of-group interactions:

Betty: Well you know, at first I was really surprised how different we were all. I knew Mary. I knew she had a stroke when she was a librarian when

Lisa: Oh, you knew Mary from years ago?

Betty: Yah, she was the librarian from when my kids were at the elementary school. Not socially. But then I knew she had a stroke and I remember seeing her. And then Shirley, I know from the Options, the Wednesday group?

Lisa: Oh, Shirley, yeh?

Betty: Shirley. Yeah. Shirley and her husband, from the new options [group]. And he's wonderful too. And when John in the morning he was ok, and I left Cooley in the afternoon, so I said, "Well, I said I need something," I said, "I'm just joining" ...And then the woman over there, Betty sitting next to me, she was in Tai Chi and I couldn't do that and she's still there. And then Barbara.

Lisa: Yes, Barbara.

Betty: I've met on several trips, we'd been on several trips from Hadley [senior center in adjacent Town]. I think one we went to Canada and then on bus trips. So I met her several times. And then she talked about hiking, but she could never do that hike, because she kind of you know..

Lisa: Even back then, she.

Betty: No, no she couldn't, and then, now her husband, and I'm thinking now there's two. And so here you have Shirley has her own health problems and then as James, her husband is getting forgetful, she has to take care of her husband. And then Robert, he's amazing... he is upbeat. Enjoys his children. And you know his wife is not easy because she doesn't like that food and was a good cook and she still in her mind. Yah, he put up with a lot. And I think going to those games of his grandkids, and I think that keeps him going. Absolutely. And his dog. How he walks his dog. And I was impressed, you know for a man? For a man it's harder than women to live with Alzheimer's....

I just think, "Oh, my god," you know, and how strong women are, because look at Barbara. She goes very slow, she tries to do her own exercise. And now her husband has cancer, and has to go to chemo, and you really have to, you cannot let that drag you down. So then you really have to fight to keep that up. That's very....

Yah, I wrote down [refers to her notes] how we all deal with getting older, and somewhat difficult with the health when you can't take care of ourselves, and the other way, how strong we women are.

Yah. We fight it. We don't give up, most of the women don't, we keep fighting for it.

Making Comparison: Similar Position

The theme of Making Comparison: Similar Position is used to reflect where participants made comparison of their own lived experience with other members finding a similar self-assessment (my situation is like theirs).

Patricia: It's hard, and we can we can benefit from the strategies that other people have used and are using to kind of get through it. And I think the other thing is it's the commonality of the life period, they're not the only one. And that you know many people are dealing with all kinds of challenges they didn't ask for and somehow rising to the occasion and you know finding the strength to um cope. The other thing I felt was the people were pretty positive. You know, that were there.

Lisa: I agree. So are you saying that it heightened your sensitivity?

Patricia: I think it heightened my sense that you know.... that many people although they look like they are doing fine they're participating beautifully, under the surface they're really coping with challenges.

Lisa: Yeh, yeh.. And as a consequence of that, was that was a sensation of ...people are like me or people are different than me, or....

Patricia: No. People are like me. I think, you know I mean I think there's a there's a similarity amongst all of us. I mean I felt the people in the group, any of them could have been me. And, You know and they varied maybe with little blips but mostly I think were quite similar in terms of the way we coped with aging and health.

Making Comparison: Contrasting Position

The theme Making Comparison: Contrasting Position identifies time where group participants affirmed their position in regard to other group members finding a contrasting self-assessment (my situation is not like theirs). In her final interview Mary indicated her contrasting position:

Lisa: How did being in the group make you feel?

Mary: Um...(many seconds)... they didn't have um physical problems that I have, which is OK, I mean that's all. I just I couldn't do that, but that was all right.

Lisa: Hm. Hm.

Mary: But the kinds of things that worried, that worried them didn't worry me!

Lisa: But somehow that was helpful to you?

Mary: Um, well...well.

Lisa: Cause you said, I mean first I asked, "was being in the group helpful to you in any way?" and you said, "Oh, tremendously."

Mary: Hmhm.

Lisa: But I still don't understand how feeling outside of what they were experiencing was helpful to you...And I don't want to put words in your mouth.

Mary: No. The psychological things that were ah (cough) it didn't that didn't bother me, at all. ...Yah, I mean sure, my physical problems, sure they're awful, but it's all right. They don't... the other people didn't have them, that's good. But they had a lot of problems I didn't have.

Mary again stressed a contrasting position in comparison to others in the group in her response to the final interview question, "What do you think was the most important thing that happened in the group?"

Mary: That I don't have much to worry about and they have a whole lot. Really.

Lisa: Do you think they might think you do have things to worry about?

Mary: I don't know. I don't care, but I...just things that I want are here... Because um, they uh, worry about the same things that I don't worry about, it, it bothered me a little.

Lisa: It did?

Mary: Yeh, and then it occurred to me. Hmm: Most people are like those people, imagine that? I didn't... They thought that I needed a dog or something. I don't need things like that - no!

Mary found the concerns of other participants not relevant in her own life and her contrasting position was arrived at through a process of considering her experience against the others. Though she reported at first being "bothered a little" to not be concerned about the same issues, through the process of relating, Mary concluded that she herself was in a relatively better situation.

Integrating

The theme of Integrating occurred as participants indicated certain experiences of being in the group positively affecting their own thinking or behavioral actions related to issues of aging and health.

Confirmation

The theme of Confirmation denotes instances where participants reported the reinforcement of a positive assessment of their own status related to aging and health as a result of being in the group. In her final interview, when asked, "Was there anything, any way that being in the group was a help to your coping with aging and health?" Dorothy responded eagerly to confirm the benefit of the group:

Dorothy: Well, well, it was very, of course, I mean everything you do is a learning experience so.... It was good to talk about exercise it was good to talk about food and diet, the right foods to eat, and it was good to talk about church or faith or, it was good to talk about social, you know whatever all of the...[referring to the Wellness Wheel] in the realm of your circle all the um departments or the different sections, yes.

Lisa: I get you... all the different concepts of wellness or health. Or the social interactions and you need. It's true, you need other people. And that's very, very important, social, you know. Whether it's family or friends, or...

Dorothy: I had a birthday I told you just this month. Happy Birthday to you... And my daughter was sitting here and I had my friend sitting here and they sang happy birthday. We blew out the candles and they said OK, make a wish. My wish was that I'll always be surrounded by family and friends. So my daughter said, "Oh, Mom! That was so nice!" Hahah! She thought that was very nice. Well, it's true. I have two wonderful daughters. My husband's been dead for quite some time now. Fourteen years already. Fourteen years. But I have a wonderful family, and wonderful daughters and wonderful friends. Yes. So there!

New Information

The acquisition of new and helpful information related to aging and health that participants reported as an outcome of being in the group.

In response to my question in the final interview, "What do you think was the most important thing that happened in the group?" Betty talked about gaining a new perspective on health from the group's discussion of the wellness wheel:

Betty: I think when we did the wheel. That a lot of people came up with a lot of different things, but I didn't think about it. You know Like music, little things, how important that is. And when you take care of yourself, there are little things that you can enjoy. People came up... specially Shirley, spirit of music and all that stuff and I think that's true....

I always say to older people, "you will become smaller, but there still will be nice things."

Inspiration

The theme of Inspiration was identified where participants took a new notion presented in context of the group and reported forming a new and positive realization or perspective on the experience of aging and health. In her final interview Shirley's response to the question, "In what way, if any, has being in the group changed how you think about your health or aging?" indicated an example of inspiration.

Lisa: Do you think you'll do anything different in your day to day, by either by the tools, I'm not thinking so much as the tools. But I think I hear you saying that you'll use those tools, but by... anything that you learned from other people in that forum?

Shirley: Hm. I think I might be a little kinder to myself.

Lisa: Ohh. Well, when are you not kind to yourself, what do you mean by that?

Shirley: Well, I don't know, ah, when I was, when I was a child, when I was growing up, we weren't allowed to be sick. If we were ... if we said we were sick, we were trying to get attention. So I've always felt guilty about being sick, even though I tell myself I can't help it, things like that. But ahm, that's ahm what I need to do. When I said, be kinder to myself, is just to be more accepting of being ...ill. I mean I have chronic Lyme disease and it hurts! and arthritis! And I gotta cut myself some slack. That's my new year's resolution.

Lisa: Is it? Is it?

Shirley: Yes it is.

Lisa: To cut yourself some slack around that particular issue?

Shirley: Uh huh.

Lisa: Just let yourself be what you are and not harsh yourself for it?

Shirley: Yep.

Lisa: Well, How's it going so far?

Shirley: Pretty good! Hahaha!

Lisa Good! Hahaha. Good!

A diagram of the coded themes of the Communication Process (Participant Unit of Analysis) of the Support and Learning Group on Aging and Health are presented in Figure 13 below.

**Communication Process
Health and Aging Support and Learning Group**

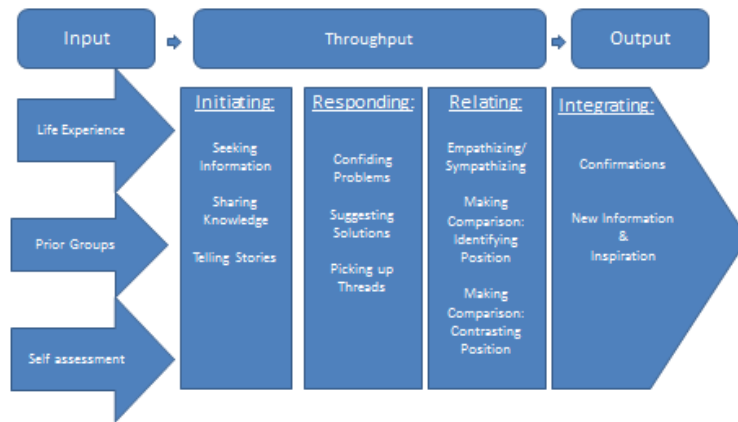


Figure 13: Communication Process (Individual Unit of Analysis)

Fractal Conceptualization of Group and Communication Process

The time-phased categorizations used to describe group process were first considered as occurring over the course of 8 weeks of group meetings. The communication process was also considered as it occurred over the 8 weeks. The idea of describing the group and communication process as a fractal came together at the suggestion of my faculty supervisor who encouraged me to consider if my findings over the course of the group were also occurring in each meeting. Doing so was an interesting exercise that resulted in a fractal conceptualization of the group and communication process occurring not just over the course of 8 weeks, but in each individual meeting and even in single communicative exchanges between group members.

Fractals in Social Science

Benoit Mandelbrot (1924-2010) is credited with coining the term “fractals” and inspiring in mathematics and the sciences a respect for the self-similar rough and complex patterns in abundant evidence in the natural world (Brown & Liebovitch, 2010; Prechter, 2003). A tree is

identifiable for its complexity in large or small scale from its trunk into branches, or down to its buds (Prechter, 2003). Wasserman, Clair & Wilson (2009) propose that fractals are helpful for describing the abstraction of concepts developed in grounded theory, recognizing, for instance, the branching relationships between particular structures (such as themes arising from coded data) and generalized structures (abstracted themes arising from consideration of dimensions of themes and the relationships between themes).

A fractal conceptualization of the communication and group process of the Support and Learning Group on Aging and Health leads to a configuration showing the structural relationships of the identified themes occurring in systematic stages and nesting one inside the other. Communication process steps of Initiating, Responding, Relating and Integrating occurred simultaneously and in step with the group process time phases of Before, Beginning, Middle, End and Beyond and the thematic categories of group interaction identified in each.

Nested Patterns: Fractal Conceptualization of Findings

Findings organizing a fractal conceptualization of the thematic categories of group and communication process of the Support and Learning Group on Aging and Health are presented hereunder:

Nested patterns occurring in the Before stage of group process are conceived as Inputs to the group and communication process. Before meeting in the group, patterns of Envisioning, Asking Questions, Deciding to Join and Committing are engaged in by each member. Each participant comes to the group with their own unique Life Experience, Prior Group Experience, and Self-Assessment of Status regarding aging and health. Nested themes of the Before - Input stage of group and communication process are presented in Figure 14 below.

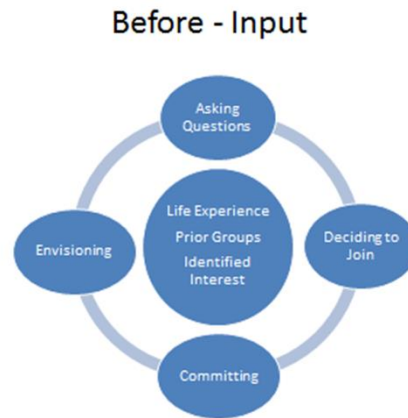


Figure 14: Nested Group and Communication Processes (Before – Input)

The action-interaction patterns occurring between group members are conceived as Throughputs in the group and communication process. Nested within the Beginning group process steps of Coming Together, Identifying Concerns and Establishing Roles and Routines are the Initiating communication process actions of Seeking Information, Sharing Knowledge and Telling Stories. Nested within the Middle group process steps of Interacting in Patterns, Exploring Options, Developing New Directions and Managing Disruptions are the Responding actions of participants of Confiding Problems Suggesting Solutions and Picking up Threads. Nested within the End group process steps of Summarizing Experiences, Drawing Conclusions and Valuing Connections are the Relating actions of the participants of Empathizing /Sympathizing and Making Comparison. Making Comparison occurs within the action-interaction of group meeting or following group meetings, as participants contemplate in conversation with others, or in conversation with themselves, a comparison of their own experience with that of the other group members. As a result of Making Comparison, participants identify in themselves a similar or contrasting position to others in the group. Nested patterns of throughputs (Beginning–Initiating, Middle–Responding, and End–Relating)

for the group and communication process of the Support and Learning Group on Aging and Health are presented in Figures 15, 16, and 17 below:

Beginning - Initiating

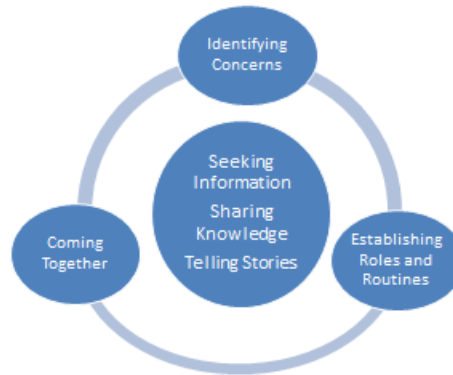


Figure 15: Nested Group and Communication Processes (Beginning – Initiating)

Middle - Responding

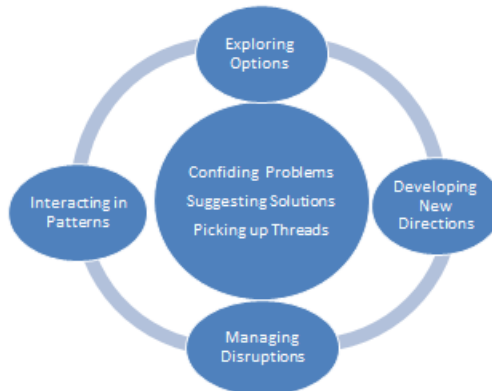


Figure 16: Nested Group and Communication Process (Middle-Responding)

End – Relating

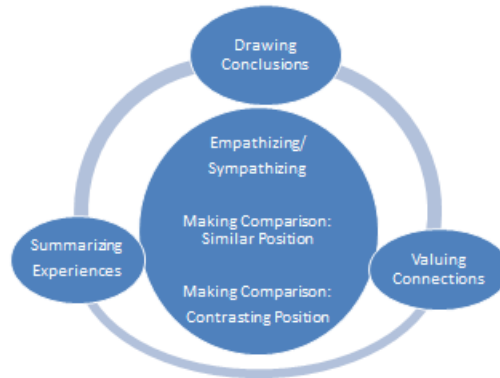


Figure 17: Nested Group and Communication Processes (End-Relating)

Nested patterns occurring in the Beyond stage of group experience are conceived as outputs of the group and communication process. Group process patterns of Incorporating Experiences and Moving On describe how participants break away from the group as each take Confirmations, New Information and Inspiration from the experience of being in the group. Nested themes of the Beyond-Integrating stage of group and communication process are presented in Figure 18

Beyond - Integrating

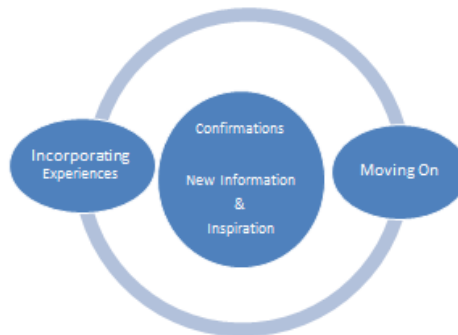


Figure 18: Nested Group and Communication Process (Beyond-Integrating)

The image of a branching tree provides a natural world example of a “V” generator, a fractal that provides a means to describe categories and the complex relationship between categories in non-linear data (Wasserman, Clair & Wilson, 2009). A tree image is used to represent the fractal levels of group and communication process occurring in the support and learning group in Figure 19. All diagrams of the findings of the research including the fractal conceptualization as it occurred over the course of meetings are also included in Appendix J.

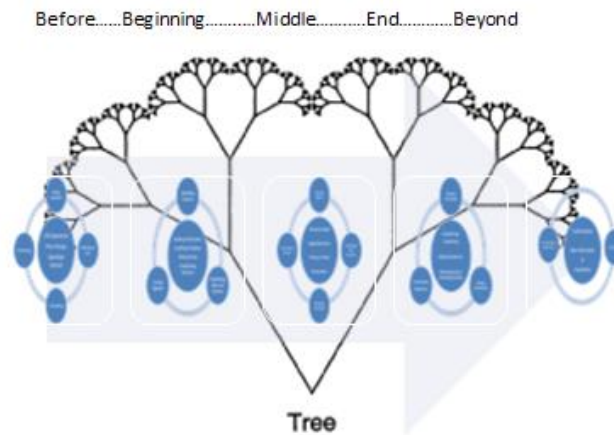


Figure 19: Fractal Description of Nested Group/Communication Processes
(Tree image: Prechter, 2003).

Fractal Patterns in Action/Interaction of Group Meetings

The phenomena identified in theme categorizations of the group and communication process were also identifiable in all meetings. Similar to group process over the eight weeks of meetings, each meeting began with tentative action/interaction that grew more comfortable through the course of the meeting. For example, in the Beginning phase of the first meeting, after the exercise of breaking into twos to discuss “a recent good day,” Shirley passed on being the first to speak. However, by the Middle of the meeting, the group’s interaction, including input from Shirley, was as dynamic as it was at any other time.

In the middle of first meeting during break, Robert asked Molly about her clinical placements as a nursing student and then talked about experiences he had in the Emergency Room, commenting on the long wait. After break, I introduced information about the human lifespan and an activity asking participants to consider differences between “what you find important to your daily living today when comparing younger stages to now.” My expectation

was that participants would respond, identifying in sequence, “When I was younger, that was important, now today this is important.”

Mary, who went first, did not respond to my prompt in that sequence. Instead, Mary picked up on Robert and Molly’s discussion occurring in our meeting break, and established a position regarding the culture of health care toward older adults she witnessed when she was a patient the Emergency Room and during her stay in a nursing home after a stroke. Other group members responded, sharing information and telling stories from personal experience. Each member’s response marked in some way their perspective of how to counter dissatisfaction with services of the community hospital and not all were in agreement. The conversation was remarkable for its frankness and confrontational content. Following is the transcription notable for how quickly members identified concerns and established their roles within the group aligned with personality tendencies: Mary politic and provocative, Patricia responsible and altruistic, Shirley open and pragmatic, Barbara calm but determined, Betty direct and action-oriented:

Mary: Well two things...Do the people? I was at Cooley Dick at the emergency room because I stroke ...I was eighty but why was that important because the hospital doesn’t have enough people? or didn’t enough people apply? Or well was it the... the um...they they thought perhaps that was OK? Because a lot of people go into the emergency room and they are like me... or you’re your about about about nurses.

Years ago, people, when you talked to people in the hospital the nurses would ha – though - as though you were five years old and they didn’t talk to you as though you were a patient. When I was, when I finally got into, somebody in the hospital, and the people, they they last they um um no the um the nursing home I went to for maybe two weeks and they all they thought I was ok. They wouldn’t talk to me, sometimes they even didn’t bring me breakfast or something. But other people, they talked [high pitched slow and loud voice] “Hi there! How are you?” These are people that are like me, but they could they could speak, and they could say something, but they didn’t say anything! And they used to, they, I don’t think the nur[ses], they noticed that people my age, like ah 84, are all right! I mean their brains are ok, but they’re all “Hi, there!” ...What!?

Lisa: So you’re reflecting on when you were in the emergency room and then in a long term care

Mary: That's right

Lisa: That people would speak, that nurses or other health care professionals would speak to you like you were a...baby?

Mary: Or I was, I was...oh, reading a book or ah ah walking around, just to make sure that I was ok. Well I was ok. And the way they talked to other people I don't know whether they did. You know what I mean? You know what I mean?...Another thing. Did they have a doctor or nurses in at the ah...the...the... where they put you into the hospital and you're...

Shirley: The Emergency Room?

Mary: Yeah. Did they have staff...Did they have staff? Or they just didn't .. I wonder that. I wonder about that.

Shirley: it's been my experience when I've been at the Emergency Room that it's been a long wait.

Mary: Why?

Shirley: Good question.

Mary: All right!

Shirley: But I've been in the Emergency Room many, many times ...and they're nice people but usually a good long wait.

Mary: Why?

Shirley: And that would be whether you are young or old. Everybody's getting equal treatment. They're, they're being triaged...They're doing x-ray or CT scan and you have to wait for somebody else to read it and that's the way it is....

Betty: I wrote a letter...I wrote them a letter, months ago, to [name of the CEO of local hospital]. And it was ridiculous there and I didn't get anything to eat! My daughter lives in Utah and you wait at Salt Lake City, and one at 10 minutes and the other at 50...

Lisa: So you wrote to the executive director?

Betty: Yeah, I wrote to [name of CEO]. No you get a nice letter, "We're sorry". We had a meeting and I told him, "You write and you get a nice letter and it's from the secretary!" And I said to him, "I wrote you! But you didn't read it! I wrote you!"

Barbara: It's better...[since the hospital reorganized] they seem more speedy.... on the ball yeh, on the ball, more speedy. My husband had on his back, blood, toxic blood I forget what you call it. And ah, we were sitting in the waiting room (to Robert) like your

wife. And they were taking little kids that were jumping around and bringing them in. And my husband, they took him finally and they were going to send him home. I said, "He can't come home he can't walk!" We thought he had a broken hip. But it wasn't that, it was an abscess in there and when they got the bloodwork back they said, oh, no you're not going...And they took him right in and they set him right up for an operation and gave him antibiotics. And they said "You would have been dead if they hadn't taken care of it right then." He would have been dead if the antibiotics didn't work. So in that case they acted appropriately and with speed. Well, they were going to send him home cuz and I said "He's got something wrong with his hip", so then they agreed and then the blood work came in... But they were going to take him home. ..

Patricia: I wanted to say Cooley Dickinson is where we go in an emergency and so we need to support the hospital, and it needs to be supported.

Mary: How?

Patricia: But like you (to Barbara) I'm very glad that they have a partnership with Mass General because it can only strengthen.

Lisa: Right. It is our community hospital. It's not 'us and them'. Right. (To Mary, who is scowling) No. (To Betty) That's why I really like to hear about your advocacy. And it was a conversation you were willing to have with the chief executive officer. They want to know that. Clearly, the challenges...

Mary: Harrumph!

Lisa: (to Mary) Ohh, No. Clearly, good to have.
(to all) OK, let's pick up the differences between the younger you and you now.

Patricia: I have something!

Lisa: Thank you!

In the example of this conversation, the action-interaction of group participants can be described as a whole sequence including group process themes occurring within time phases from Beginning through Beyond and including communication process themes of Initiating, Responding and Relating actions within the exchange. In this way, each meeting of the group, and even sequenced conversations within each meeting, may be seen as a fractal – a picture within a picture of the group and communication process overall.

Participant Evaluation of the Support and Learning Group

All participants in the health and aging support and learning research group experienced an outcome that was positive. Multiple data sources were used to gather participant evaluation including the participant diary that each attending member completed at the end of each meeting and the open ended questions and discussion occurring in the final interview. The format of the participant diary (Appendix D) and the questions guiding the final interview (Appendix E) are included in Appendices. In basics, the participant diary asked each participant to consider and report on what occurred in the meetings, how it affected them, how they would like to continue and any other comments. Participant diaries contained summary reflections drawing conclusions about the experience of participating in the group. Data from the participant diaries and from the final interview was analyzed to answer the research question asking what participants valued about being in the group.

Member evaluations of group experience reported in the participant diaries showed a breadth of responses. Patricia wrote about being positively affected by how upbeat participants were in the face of challenges. Barbara wrote of finding group members were different in ways but faced some of the same issues. Dorothy wrote how the group made her think more about the way attitudes, expressions, and religious beliefs can change how one thinks about health. Shirley wrote of finding the group informative and helpful and of expecting to miss the other members tremendously. Mary wrote of her intention to organize her life in the same way.

The final interview asked more probing questions about each participant's experience in the group, what occurred that was meaningful, and what they would want to do the same or differently if attending future groups. Responses indicated group members enjoyed participating, liked the structure and the learning tools provided, and valued interacting with others and hearing about other participant's experiences. In her final interview Shirley

confirmed valuing the information and tools that were shared and discussed and her enjoyment of being with the other group members:

Well I found the information very helpful. I like stuff I that you can use, you know, that you can figure out. I have a therapist and she's got very much stuff for me. And um, It helps me better able to cope with having to do with aging and that kind of thing. But I enjoy the people very much, they were very nice people. It was fun.

Betty spoke of wanting more content around end of life:

I wrote down, "I think we should talk more about palliative care, end of life, DNR, health proxy." You know some people, "oh no no no! My kids will take care of it!" No. You have to do that. Because when you have to make a decision when you have something big, that's harder... It's gonna happen, don't hide it. If I go somewhere, I have my DNR, my purple form I take it with me. If... I take the car I take it with me. So they know.

Patricia reported positively about interacting with others in the group. She noted how going to the Senior Center involved her with different people and reported that she particularly liked the structure of the meeting as compared with non-structured meetings she had attended in the past, where "things can flounder." She thought, however, that the decision making and other structured group-work examples may have at times limited rather than helped our discussion. Patricia recalled how the group had trouble coming up with an example to apply to the decision making model in meeting seven:

Well, you know, the structure is helpful. But once you've got it you can go on from there. It seemed to me we had a lot of difficulty coming up with, with goals... and there must be endless goals, you know as a caregiver, or as a person who's dealing with a health problem...beyond just medicine or...There just must be many, many things. One of the other things that I thought about your background is nursing and in some ways nursing is sort of scientific in its background, you know, and it's structured, it's a medical model. I don't know if there other approaches...I don't know, you know, that was just a question in my mind.

I was able to conduct a final interview with Robert and though it was almost a full year from the start date of our group and his difficulties with retrieving words were still very present, it was an informative talk. He came prepared with penciled responses to the questions and notes of the meetings, which he had reviewed and marked carefully. He felt the problem

solving materials were helpful that we had worked as a group using the example of his wife Margaret's weight loss, developing an action plan with strategies to increase her food and caloric intake.

Overall, participants evaluated their experience in the support and learning group positively. All members recognized the group as assisting them to assess how they were meeting their own experience of aging and health. Participants used the group to seek information and by their own report gained new information as a result of being in the group. Participants valued the evidence-based tools that I shared as facilitator (wellness wheel, problem solving, and decision-making model) but particularly valued and were affected by sharing their experiences and learning the experience of other group members. The group provided an opportunity for each participant to discuss issues of aging and health with others, gather new information that was personally relevant, and confirm through the group and communication process their own personal strengths given their relative position to others.

One more item I'd like to add here is a comment on what may not be easily located in the findings as presented in this chapter but I wish the reader to have some means to appreciate. Meetings of the research support and learning group were not a burden for the participants, but were mostly, and perhaps especially to me, a delight. Each of the participants brought to the meetings their interest and enthusiasm, and shared with others in ways that were positive and kind. They shared easily and honestly, discussing issues of their daily lives, and complied without hesitation to my directions for discussion and feedback. The meetings included laughter, easy-going conversation and at times the conversation deepened to reveal a deeper sentiment. From their reports, none of the participants shared that the experience of being in the group was life-changing to any degree. Rather, each in their own way did say being in the group was thought-provoking, and self-affirming. Additionally, final interviews with each

participant indicated most participants had a developed understanding of the situation of others in the group that assisted their positive self-assessment of how they were coping with issues of aging and health.

Chapter Summary

Within this chapter, findings including the coded themes of group process and communication process were presented with definitions for each and examples from the data, illustrating themes of the communication process. A fractal conceptualization nesting the themes of the group and communication process was provided. Patterns of the group and communication process were described as occurring over the course of the 8 weeks of meetings as well as in each individual meeting of the group. Finally, this chapter summarized the participants' evaluation of the group and their experience in it identifying what participants specifically valued about being in the group.

Findings did not support anything occurring in the group that negatively affected the existing strengths of participants or negatively affected their resources, new learning or behavior change. However, findings did indicate group participants were at times challenged in ways, particularly when they perceived themselves as having a difference from other members. Group participants' identification of differences between their own experiences in comparison with others is an interesting aspect of the findings emerging from the data analysis of the Support and Learning Group on Aging and Health. Group and communication process patterns worked to support positive self-assessment of aging and health regardless of whether the participant perceived other group members' experiences to be like or unlike their own.

The communication theme of "Relating" identified in the group and communication process emerged as a phenomenon of special interest, significant for its role in producing the desired outcomes of the support and learning group type and for including the unexpected

therapeutic factor of “Comparison: Contrasting Position.” More on the central phenomenon of “Relating” is discussed in the next chapter.

CHAPTER 6

THEORETICAL PROPOSITIONS: RELATING AS CORE PHENOMENON

Introduction

Data analysis of the group and communication process indicated themes producing outcomes associated with both support group and learning group types. While a number of themes emerged, this chapter will focus on the communication process theme of “Relating” identified in the data analysis conducted for this study, due to its importance relative to the achievement of the outcomes of reinforcement of existing strengths (a support group objective) and the development of knowledge and skills (a psychoeducational or learning group objective). Data analysis conducted using grounded theory methodology identifies the theme of “Relating” occurring in the communication process of the Support and Learning Group on Aging and Health as a core phenomenon in this study.

The process of “Relating” and its subthemes of “Sympathizing/Empathizing,” “Comparison: Similar Position,” and “Comparison: Contrasting Position,” were notable as key communication process steps affecting the objective outcomes for the support and learning group type. Through the process of “Relating” each participant first reflects on the experience of others in the group with sympathy (compassion for other’s unique experience) or empathy (understanding of other’s similar experience). Next, each participant considers their own experience in comparison with others in the group, identifying a similar or contrasting position in relationship to others. The communication process step of “Relating” was experienced by each participant as an internal process, characterized as a conversation with themselves, through which they arrived at a position that was personally affirming. Individual reports shared by the group members interviewed after the end of the group indicated in all cases a positive self-assessment of issues related to aging and health and achievement of the outcome

objectives for a support and learning group. In all cases, participants reported that being in the group had assisted their acquisition of new information and confirmed the adequacy of their current skills used to address life issues related to aging and health.

Grounded theory provided an exceptionally fitting methodological approach to conduct a qualitative investigation of the group and communication process of the Support and Learning Group on Aging and Health. Analytic coding of thematic categories and the framework of symbolic interactionism assisted the development of abstracted understandings of the communication and group process. The explication of a story line, a step in theory development in the grounded theory method, led to the identification of the coded theme category of “Relating” in the group communication process as a core category, important because whether participants related to others in the group as being the same or different from them, the comparison promoted a self-assessment that was positive.

At the close of the study, a theoretical proposition is made identifying “Relating” as an essential step occurring in the group and communication process of support and learning groups positively affecting support and learning group type outcome objectives of maintenance and learning.

Story Line

Grounded theory prescribes a research methodology that arrives at a story line, organized around the identification of a central phenomenon (Strauss & Corbin, 1990; Corbin & Strauss, 2015). The story line that develops through the grounded theory method presents the findings of the research in summary and tells the reader in some sense the import of the studied phenomenon (Strauss & Corbin, 1990; Corbin & Strauss, 2015). Findings of the Support and Learning Group on Aging and Health created a story line about the group process that occurred and how participating in the group was uniquely experienced by each member, supporting each

member to achieve the expected and desired outcomes of reinforcement and the acquisition of new information.

The theoretical preposition developed through this story line responds to the research questions of the study:

1. What group process or patterns occurred to support desired group outcomes?
2. What communication process or patterns occurred to support desired group outcomes?
3. What occurred in the group that positively or negatively affected participants' group experience?
4. What did participants value about being in the group?

Participants interacted in repeating patterns occurring in individual meetings and over the course of the 8 meetings of the support and learning group in ways that supported psychosocial development in the desired expected outcomes of maintenance and learning, reinforcing participants existing strengths and assisting participants to gain new knowledge and skills. Patterns related to the unit of analysis of the group (group process) and patterns related to the unit of analysis of the individual (communication process) were concurrent and overlapping. Group and communication process patterns moved forward in space and time, consistent with pragmatic understandings of the evolutionary nature of human inquiry (Cronen, 2001).

Relating as Core Phenomenon

“Relating”, the component of the communication process occurring at the End phase of group process in meetings and over the course of the research group, was identified as the central phenomenon in this study (Strauss & Corbin, 1990; Corbin & Strauss, 2015). Fit to the

developing story line, “Relating” action/interactions occurring within the group process were precedent to the expected outcomes for the support and learning group.

The term “Relating” was chosen as the thematic label of this step in the communication process for its indication of interaction with another or other individuals. Group participants engaged in “Relating” using an active stance as they considered the experience of others in comparison with themselves. All participants experienced “Relating” as an internal and external process during which they sympathized or empathized with other group members and made comparison of themselves against other members. As a result of their interaction with others, each member reported an interpretation of the experience of participating in the group that was self-affirming. Each participant reported how participating in the group upheld and strengthened their perspective, regardless of whether in the communication process of Relating they found their own position to be similar or contrasting in comparison with other participants.

Within the framework of symbolic interactionism, meaning arises from “the process of interaction between people” and through a step wherein the individual, simultaneous to being in joint action with others, engages in a “process of interpretation” (Blumer, 1969, p. 5). This step of interpretation requires the individual to be interacting and “communicating with himself,” first by indicating to himself what things have meaning, and then by considering the meaningfulness of the thing “in light of the situation in which he is placed and the direction of his action” (Blumer, 1969, p. 5). The theme of “Relating” identified in this study also contains an aspect of communication with the self. “Relating” themes occurred within the group in the form of conversational interaction between members and also as each participant reflected on the communication that occurred in meetings in the time phase beyond the meeting.

The reflective emergent process that undergirds the central phenomenon of “Relating” located in this research is similar to the subjective experience occurring in any learning process.

Kolb (1984) identified experience as the source of all learning and development. Kolb's experiential learning model, retracing origins of pragmatic theorists including Williams, Dewey, Lewin, Piaget and Freire among others, sees learning as a lifelong process where the individual adaptively responds to their environment, "thinking, feeling, perceiving and behaving" through time and space (Kolb, 1984, p. 31). The interplay that occurs through experiential learning is dialectical, positing both action and reflection (Kolb, 1984). Since experience can never be wholly anticipated, thus it creates tension and with it the opportunity for learning new knowledge, skills and attitudes (Kolb, 1984). The experiential learning model is similar to the process of interpretation and the handling of meaning described by Blumer (1969) in its suggestion that in order to be effective learners, individuals "must be able to reflect on and observe their experiences from many perspectives" (Kolb, 1984, p. 30).

Exemplars of Relating From the Data

The process of "Relating" within the Support and Learning Group on Aging and Health was relevant for the way in which the experience of being with others enabled participants to reinforce and expand on the skills they use to meet the challenges of daily life. Through repeating group and communication process patterns group members discussed issues relevant to their own lives related to aging and health. Through this continuous process, participants either identified a position that was similar or a position that contrasted with the other group members as they perceived them. Through the action of "Relating", all group participants, no matter if identifying a similar or contrasting experience when compared with others, achieved the acquisition of new and helpful information and individualized positive conclusions about their own management of health and aging.

As depicted in the fractal conceptualization and nesting of group and communication process themes presented in Chapter 5, the communication process of "Relating" was

experienced concurrently with the End group process themes of “Summarizing Experiences,” “Drawing Conclusions,” and “Valuing Connections.” These nested themes describe the importance of the group and communication process for achieving the outcome objectives of a support and learning group and indicate the value of the group as described by the participants themselves. Exemplars of Similar, Contrasting and Neutral Comparison are presented below showing how each variation worked to support positive outcomes for the Support and Learning Group on Aging and Health and for each of the group member participants.

Similar Comparison: Shirley

For a number of members, the group was experienced as a place to work through problems shared in common with others, described by Yalom (1985) as the therapeutic factor of universality and by Gitterman & Shulman (2005) as the “all-in-the-same-boat” phenomenon of mutual support. The phenomenon of “Relating” in this case resulted in the participant finding satisfaction in finding a similar position of their situation in comparison to others.

In her final interview, Shirley responded to the question “in what way if any has being in the group changed how you think about your health or aging?” with a statement about how the external (within group) and internal (beyond group) dialogic process occurred for her and the resulting positive self-assessment she arrived at comparing herself with others:

Shirley: Well, seeing how other people seem to be coping made me feel like maybe I’m coping OK too. I mean, It was surprising because although everybody had some kind of problem to deal with with aging, they seemed to be pretty together ... and, ah, that made me feel a little bit together.

Shirley’s experience making a similar comparison through the communication process step of “Relating” reflects her successful achievement of the support and learning group type outcome objective of reinforcement of her personal strengths. Shirley’s similar comparison also indicates how learning about the experience of other group members was one of the things she valued most about participating in the group. This was also evident in her report that she

enjoyed the group, finding it “fun,” and the wistful reply she gave when asked in her final interview if sharing was important. Shirley replied, “Yep. That was very helpful. I think about them a lot. All of them”. The stories were different for each, but the similarity of the other group members’ shared challenges struck Shirley and helped her feel more confidence about her own abilities to do the same.

Contrasting Comparison: Mary

Not all group participants indicated an experience that was similar to others. In certain instances members identified a contrasting position as they compared their personal experience to the experience of others in the group. Quite opposite from the curative factor of universality and “all-in-the-same-boat” phenomenon identified as helpful in group process (Gitterman and Shulman, 2005; Yalom, 1985), Mary’s expression of the meaningfulness of her experience was the difference she found in herself in comparison with others in the group.

The portion of Mary’s final interview transcribed in the presentation of the theme of “Relating” and definition for Making Comparison: Contrasting Position on pages 119-120 provides a strong exemplar of contrasting comparison. Mary’s statement, “people worry about those things I don’t worry about” marks the contrasting position she identified. Mary’s identification “that I don’t have much to worry about and they have a whole lot” and “things that I want are here” indicate how the differences she found in comparison with others provided a personally satisfactory understanding of her experience.

Mary described how she arrived at this contrasting comparison through the conversation with herself, where she was “bothered a little” that she did not have the same concerns shared by others regarding caregiving, family relationships and coping with daily living and then considered “ Hmm: Most people are like those people, imagine that?” This internal reflection and Mary’s finding of a contrasting position from others supported a high level of

satisfaction in her self-assessment related to aging and health and not having the problems that other people have.

Neutral Comparison: Dorothy

Dorothy provides an example of a neutral experience relative to the group communication process step of Relating and her comparison with others. Dorothy reported enjoying other group members and having sympathy or empathy for the experiences of others, but did not report or indicate evidence of deeply contemplating her experience relative to others. The experience of being in the group did seem to reinforce Dorothy's positive self-assessment concerning issues of aging and health and also did introduce her to new topics of learning, but did not result in her identification of a position in relationship to others that was either strongly similar or contrasting. Dorothy had no known previous contact with other members and attended the fewest meetings of any of the participants. It may be assumed this affected her experience in the group and may have restricted her ability to make comparison of her experience with other group members.

Summary

This chapter presented theoretical propositions arising from the identification of "Relating" as a core phenomenon in the communication process from grounded theory analysis of the Support and Learning Group on Aging and Health that was the subject of this study. Consistent with the framework of symbolic interactionism, the core phenomenon of "Relating" and its subthemes indicate an internal "process of interpretation" and conversation with oneself (Blumer, 1969, p. 5) through which meaning is made. This internal process is dependent on social interaction with others. The group provides a context for an experiential and reflective process, which is necessary to support individual learning and development (Kolb, 1984). The communicative action/interaction of the group affects each participant to consider the

experience of others empathetically or sympathetically and to make comparison of their own experience with others identifying either a similar or contrasting position.

CHAPTER 7

DISCUSSION

Introduction

This chapter is organized to present the findings of this research in context of the literature, to indicate implications for practice and research, and to discuss limitations of the research. First, the willingness of participants to share in group interactions, the relationship between the phenomenon of Relating and integrity of self-identity, integrative and instrumental reminiscence in group interactions, and the potentially therapeutic effect of a contrasting comparison with other group members in the process of Relating are discussed in context of the literature. Second, Implications of practice and research including experiential learning and the use of didactic tools, member direction of topical concerns, outcome measurement and possible directions of future research are discussed. Third, the primary role of group members as research participants, novice leadership, the small size of this group and out-of-group relationships are identified as potential limitations of this research. Finally, the chapter concludes the dissertation with a summary statement regarding the significance of the findings identified within this study of the group and communication process of the Support and Learning Group on Aging and Health.

Findings in Context of Literature on Group Work with Older Adults

Willingness to Share in Group Interactions

Similar to several examples found in the literature review conducted for this study, the aging and support group participants engaged in communication patterns that can be described in phases through which group members were found to share readily from their own experiences and bond quickly (Haight, 2003; McInnis-Perry and Good, 2006, Toseland & Rizzo, 2004). As early as the first meeting, participants in this study's support and learning group

shared deeply from their experiences given general prompts about health and aging, for instance telling about what it was like living with a spouse who has dementia and facing life with disability and disease that were part of day-to-day life. Participants quickly appeared to be comfortable sharing openly about the circumstances of their lives and aspects of their history and to come together sympathetically with other group members.

This finding of early-in-group-process open sharing is also similar to that of Greenberg et al. (1999) in which earlier than expected high risk sharing was identified. Greenberg et al. (1999) noted the affiliation among participants was maintained throughout the group meetings and surmised it may have been attributable to the familiarity group members had with one another from previously interacting in the Senior Center which was the setting for the group. A significant number of the Support and Learning Group on Aging and Health had previous interactions. Some of the relationships that I became aware of through the course of the Group included that Patricia and Robert were next door neighbors after Robert and Margaret moved to the area and before Patricia and her husband moved from the home they raised their family in before moving to assisted living about ten years before. Patricia also remembered Betty attending Tai Chi for a time and remembered Mary as colleague working in the same school system. Betty and Shirley were both members of a noetic sciences group meeting monthly at the Senior Center and recognized Mary from other activities. Betty and Barbara remembered each other from the Senior Center's travel group and from their interaction around Barbara's asking to join Betty's walking group. These outside-of-group contacts may have contributed both to their high level of sharing and the significant level of sympathetic and empathetic understanding some participants indicated concerning the circumstances of others in the group.

The finding of early sharing in this research contrasts with the slower than expected sharing among participants of Johnson and Wilborn (1991). Some explanation may be found in

the therapy group type of the Johnson and Wilborn (1991) study and its format and group process addressing the specific behavioral issue of lacking anger expression. The authors guessed anger expression may have been perceived as difficult territory for the research participants (Johnson & Wilborn, 1991).

It is unclear if Bains' (2014) finding of no change in alliance, indicated by patient's rating of the group, relationships, goals and topic and methodological approach, indicates a faster bonding or slower bonding than has been previously understood in the literature. Data analysis from this study of the Support and Learning Group on Aging and Health indicated the participants developed familiarity and esteem for one another over the course of the group, but their outward willingness to share also did not appear to be changed between the first to the last meetings.

The relatively accessible topic of health and aging used in the study of this support and learning group, similar to the topic of friendship used in the Greenberg et al. (1999) study, may have enhanced participants' comfort in discussing issues related to their own experience. A general topic allows group members to identify and discuss specific issues selected by them and therefore may have the greatest potential for engaging and addressing in a meaningful way the real concerns of participants. As noted in the literature review, a loose approach to common interest does risk an imbalance in the homogeneity/heterogeneity dimension by inviting too much diversity in a group than may potentially be tolerated (Gitterman & Shulman, 2005). However, the specific topics of concern that were chosen and discussed by participants in our group did not seem too particular for everyone's use.

Agreement in the literature stating that more support than confrontation is appropriate for older adult groups (Burnside & Schmidt, 1994; Rice, 2005; Toseland, 1990; Toseland & Rizzo, 2004) did seem to be accurate for the Support and Learning Group on Aging and Health, but not

in ways might be assumed. The literature could be interpreted to infer that older adults are less likely to accept new information and are less able to cope with challenges to long-held beliefs. The older adults participating in the research group readily brought to the discussion their interest in learning new information that might be applied in their own life. Early in the group process, participants initiated communication actively seeking information from others. Information was made both to check current understandings and in order to gain new insights. Also, there was no evidence of the avoidance of confrontation in the first meeting, when participants were ready to state and defend their positions when discussing care received in the Emergency Room and other health care environments.

One possible explanation for this group's early willingness to engage in higher risk sharing may be a difference in familiarity with group work of this current social cohort as compared to those discussed in the rather old literature on group work with older adults (Toseland & Rizzo, 2004). Each of the members of the Learning and Support Group on Aging and Health had previous and current experience in therapeutic groups. Familiarity to group work culture, small group structure, and the patterns of interactions within a support and/or learning group may have assisted these participants to interact more directly than previous generations might have.

Relating and Integrity of Self Identity

The communication process step of Relating occurring in the Support and Learning Group on Aging and Health was instrumental in assisting group members to address the psychosocial goal of integrity indicated in the literature as being a central task of old age and relevant to group work with older adults (Erikson, 1963; Gitterman & Shulman, 2005; McAdams, 2001). The goal of maintaining control and mastery of one's environment (Toseland & Rizzo, 2004) and reinforcement of self-identity (McAdams, 2001) understood to strengthen a sense of

integrity in the life span (Haight, 2001) was evident in the group. Through Relating, members used the group communication process to appreciate and check their experience against that of others. In all cases, individual group members' self-identity and favor of their relative position was reinforced. Their ability in the group process to interact with others both to share from their own experience and to understand the experience of others was significant in their coming to resolution with the issue of integrity.

Consistent with the literature indicating strong personality trait continuity in old age (Toseland & Rizzo, 2004) and the self-definition and achievement of life unity and purpose that is developed through life story (McAdams, 2001), a strong sense of self-identity in each of the participants of the Support and Learning Group on Aging and Health was consistently in evidence in the data gathered from my observation of the group meetings and in the final interviews. A remarkable example of the durability of self-identity was demonstrated by Robert. Despite even sustaining a stroke in between meetings four and five, which impacted Robert's speech dramatically and took him out of the group through the remaining weeks, data from the final interview with Robert supported a finding that his self-identity and even his self-assessment regarding aging and health remained consistent.

When we met for a final interview nearly a year after the end of the research group, Robert was still making progress in speech therapy. Throughout the interview, Robert had difficulty with words but was able to convey ideas well. Robert reported his concerns were unchanged with the stroke, his biggest problem being meeting Margaret's problems and caregiver stress. Responding to a question about his concerns regarding his own aging and health, Robert reported:

Big thing is my stress. Nothing bothers me really. I could die. I'm happy here. I have no problem at all. I'm stressed about her.

Lisa: But not you?

Robert: I don't think so. A couple of weeks ago I did not feel good. Margaret said, "are you sure you're OK?" I went to bed around 6. She thought I was [made a slitting throat motion, signifying death].

Lisa: Did you?

Robert: When we came here, I was never on medicine, now since stroke, two, and I do still feel pretty good. But Margaret, I worry about her all the time. But I'm lucky... I've been lucky. So I figure aging? I could be gone tomorrow. I've been lucky. I have no problems.

Robert's ability to continue to rate his own health so positively is a testament to the durability of his self-identity. Though recognizing significant health challenges of his own, Robert's focus continues to be Margaret and her health problems. At the end of our interview, he asked who among the other group members had been caregivers. When I confirmed that most were or had been, he responded with another affirmation of his self-identity: "That's what I am. I'm a care-keeper...a caregiver."

The implication arising from the data is that the life story and self-identity of all participants in the Support and Learning Group on Aging and Health remained much unchanged but importantly was upheld through the experience of being in the group. Being in the group provided each member an opportunity to once again share scenes from their life story, the self-narrative developed with thematic coherence over a lifetime (McAdams, 2001). The group provided a setting of social interaction supporting each participant to present themselves to others, to consider how what they shared was perceived by others, and to reflect on the meanings generated through the communicative interactions of the group.

Integrative and Instrumental Reminiscence in Group Interactions

Attributed to Tobin (1999) the task of earliest years is to become oneself, of the adult years is to fulfill oneself, and of the oldest years is to preserve oneself (Toseland & Rizzo, 2004).

Butler (1963) recognized reminiscence as a naturally occurring and developmentally beneficial review of the significance of days lying behind. Wong and Watt (1991) recognized different types of reminiscence and identified integrative and instrumental reminiscence as assisting self-identity to achieve coherence between the past and present. That reminiscence has an integrating function is clear, but as this group indicated, the benefit of reminiscence does not occur in isolation. Even recognizing an increased interiority in advanced age (Toseland & Rizzo, 2004), the positive effects of sharing and reflecting on experience in communicative interaction with others was apparent in the Support and Learning Group on Aging and Health. The interaction with other older adults specifically prompted reflection and comparison to others, confirming for each a positive self-assessment of their unique life position and their ability to navigate and problem solve within their experience of aging and health.

Therapeutic Effect of Contrasting Comparison

In distinct opposition to the curative factor of Universality noted for therapeutic groups (Yalom, 1985) or the “all in the same boat” phenomenon addressing the shared problems of group members in life model groups (Gitterman & Shulman, 2005), this study highlights how a group member’s identification of difference in comparison with others can also be therapeutic. The phenomenon of group members’ identification of difference through comparison of their experience to others, however, is little discussed in the literature on group work with older adults.

The literature review conducted for this study identifies only two studies discussing members’ making contrasting comparison of their experience with others. Toseland and Rizzo (2004) briefly presented the concept of downward social comparison as a psychologically beneficial strategy used by older adults confirming a relatively better position in their discussion of what is different in older adult groups. Golden and Lund (2009) Identified the individuality of

member concerns as a tension-causing theme related to outcomes for participants in their qualitative analysis of a mutual aid caregiver support group. Group members who perceived their experiences as different from others were shown to have difficulty accepting suggested options and finding the help they needed in the group (Golden & Lund, 2009).

The finding of Making Comparison: Contrasting Position within the communication process of Relating identified in the Support and Learning Group on Aging and Health may demonstrate the phenomenon of downward social comparison (Wills, 1981). The theory of downward social comparison posits that individuals enhance their sense of well-being by comparing themselves with less-fortunate others (Wills, 1981). Downward social comparison is understood to be a strategy used by older adults to identify a relatively better situation, as a means of controlling their environment in spite of losses (Toseland & Rizzo, 2004). In the Support Group on Health and Aging, most every other participant expressed sympathy for Mary's difficulties related to her strokes and compared a contrasting position from her. In relating their experience to Mary's they considered how hard it must be for her, and wasn't for each of them.

Mary's reflection that she was fortunate to not be like other group members since her life circumstance freed her from concerns for other family members was an unexpected variant of the phenomenon of Relating: Contrasting Comparison in this study but was not the only instance of such. There were several instances where other participants in the support and learning group identified their experience as different from others in ways that might have seemed a disadvantage but which they perceived as enhancing their position and their self-assessment related to aging and health. Betty, for example, compared her experience living with a spouse with advanced dementia as contrasting from others in the group. While she reported the experience as very difficult, she also has found it personally strengthening and

helpful in providing a high level of expertise about caregiving for people with dementia. Barbara also indicated an awareness of her physical limitations being different from others, but that contrasting comparison in no way deterred her indomitable belief in her ability to stay active and do all that is needed to meet the challenges of daily life.

Implications for Practice and Research

Older Adults Group Work Concept of Relating

The findings of this study indicate social interaction with others is a key element promoting the growth and development of small group participants, inferring the value of small group work for community-dwelling older adults. The advantages that a group has to one-on-one therapeutic modalities go far beyond efficiency of a mode of intervention delivery. Relating is more than the expression of the self that Rice (2005) suggests, may convey more benefits than can be obtained by working with a single practitioner or than affiliation with others in the group may provide. Action/interaction with other group participants generates new information and the opportunity for comparison of the self with others in a similar life-stage but different experience. This study indicates the differences found between members may be as supportive as findings of sameness. While groups benefit from experienced leadership, the diversity of experience of members produces the valued opportunity to hear how “others are doing it” and promotes unanticipated opportunities for experiential learning (Kolb, 1984).

In this Support and Learning Group, where unexpected tension was created in social interaction of the participants, it prompted participants in a process of internal reflection that was beneficial. Sympathetic and empathetic consideration of the experience of others and comparison of individual experience with others, promoted learning and development and reinforced a positive self-assessment regarding aging and health for each participant. Though more research is needed to confirm the applicability of these findings to community-dwelling

older adult groups in similar contexts, the implication from these findings is that the communication process of “Relating” that occurs through social interaction in a support and learning group for community-dwelling older adults provides opportunities for comparison with others that reinforces knowledge and skills and in some cases produces a contrasting comparison that serves a therapeutic purpose for group participants.

Experiential Learning & Use of Didactic Tools

The psychosocial support hybrid group type chosen for the research group demands the group facilitator has facility working between the two separate objectives for learning and support. The facilitator is required to be adept at movement between learning and support objectives and making connections within the group process linking to the outcomes for each. The research group participants of the Support and Learning Group on Aging and Health reported the planned group activities were valuable for the concepts they introduced and the development of skills they supported. However, Patricia’s sentiment that once introduced, we could have moved on, and the frustrating experience of trying to fit the scenario of a decision to be made within the tool during a didactic presentation provided a teaching moment.

Group facilitation that seeks to apply evidence based learning tools such as the decision –making model (Lorig et al., 2012) onto the real issues identified by participants as opposed to didactic teaching of the tools creates a preferable approach in group work. In a future group, for instance, an exercise using the decision making model (Lorig, et al., 2012) might be more meaningful if presented in response to a member’s initiated sharing of a problem for which no solution has been identified, rather than as a tool to use for the inevitable problems in life. This application of learning tools in this way is consistent with experiential learning (Kolb, 1984) and therefore is more apt to result in the acquisition of new knowledge and skills. Skilled facilitation should work to harness the communicative action-interaction created in both planned and

unplanned conditions within a group system recognizing participants as the source of the potential to further the objectives of the group.

As an example, the Emergency Room discussion participants had with each other in the Support and Learning Group on Aging and Health was initiated during problem sharing occurring in open discussion at break. The conversation presented a rich source of material that could have been used more to direct the activities of the group. Though I did not interpret it that way, Mary's identification of two issues: the lack of urgency concerning the needs of older adults in the ER and the phenomenon of 'baby talk' to older adults in a health care environment did respond directly to the prompt introduced for the facilitated discussion when our meeting resumed, "what you find important to your daily living today when comparing younger stages to now?"

I could have used Mary's contribution as the jumping off point to further probe the supportive functions of the group process to prompt learning, for instance by building on that discussion with questions such as, "Do others find they are treated differently in older age compared to younger age? What other experiences? How does this feel? What do you or can you do about it?" Leading the group in this way might have led to exploration of possible steps for self-advocacy, so rich was the exchange regarding the specific experiences of participants, recalled with emotion and strongly established positions.

Member Direction of Topical Concerns

Especially in a group that may continue beyond the first planned series, an approach similar to the one indicated by Ruffing-Rahal & Wallace (2000) where the format used over time develops to become member-directed may be considered beneficial. Ruffing-Rahal and Wallace (2000) consistently maintained the group's wellness focus grounded in a common concern of health while empowering participants to develop the group based on their concerns

and interests. As opposed to group formats that present information to older adults as passive receivers, a group-directed format supports meaningful individual development and group outcomes. The facilitator role continues to include delivery of evidence-based information, but in a manner that tailored to the group's particular needs and concerns.

Group facilitation guiding participants through a process of defining and prioritizing their own concerns for specific attention avoids the potential problem of a group leader assuming issues that may or may not be experienced by the group members as noted in Johnson & Wilborn (1991). The inability due to age of most group workers to draw upon the experience of older adults except vicariously (Toseland & Rizzo, 2004), and the difference between the needs of participants as compared with those anticipated by the facilitators (Brownell-Heiser, 2006) also speak to the importance of a group and communication process that address the actual concerns of its members.

Standing alone, the issues of aging and health are too broad a purpose to focus the concerns of a group. Issues of concern to group members of the Support and Learning Group on Aging and Health were incorporated into planned topical discussion as they arose. Notably, some concerns that were discussed, e.g. memory/Alzheimer's dementia and caregiving, were not applicable to all members. A group that comes together to discuss a single concern of interest to all members may be more effective in addressing needs for learning and growth. In comparison, Ingersoll –Dayton et al. (2009) found their intervention focus on one issue: forgiveness, which was important to the participants. Participants reported especially valuing the opportunity to reflect on the unresolved personal issue of the hurt experienced and the journaling and sharing journal entries with others in the group. Enright's forgiveness model provided not just new information but the context in which participants actively engaged in working on resolving their own issues (Ingersoll-Dayton et al. (2009).

In later iterations of the Support and Learning Group on Aging and Health, a keener approach to topical focus has been a goal. A portion of the first meeting of the group asks participants to specifically consider why they are interested in meeting together and what topics they'd like to discuss. Topical focus developed by consensus and revisited through the course of the meetings is intended to help assure clear group purpose and topical discussion reflecting the specific interests of the participants. Though it is still the case that not all topics reflect the specific concerns of all members at all times this does not seem problematic. As indicated in the literature and confirmed in the findings of this study, heterogeneity of group members is to some extent desirable and supports the achievement of positive outcomes for participants (Rice, 2005). The interest and compassionate response members show toward each other, and express as a result of participating in the group, revolve around both shared and differing concerns.

Outcome Measurement

Locating rigorous and appropriate outcome measures is a recognized challenge in group work with community-dwelling older adults and in other social science contexts where the diversity of experience and the progress of participants are individual and largely subjective (Pandya, 2010). Pre and post qualitative assessment such as surveys and in-depth interviews can provide useful evidence for the effectiveness of interventions (Pandya, 2010; Ingersoll-Dayton, 2009). This study's use of a screening interview provided data indicating something about each participant's self-assessment of health and aging as well as what they hoped to gain from participating in the group. Though the pre-screening meeting was not specifically intended to identify a baseline, the information obtained was useful for assessing the progress of participants within the group and communication process by its identification of each individual's self-perception of health.

Measures of global appraisal of subjective health such as life satisfaction and quality of life are commonly used to evaluate the effectiveness of groups (Bohlmeijer et al., 2007). In the literature review conducted as part of this study, only Palta et al. (2012) used the objective measure of blood pressure in addition to subjective assessment. Careful attention is required, however, to assure evaluative measures are well matched to the actual experience of group participants and that faulty assumptions are prevented (Brownell & Heiser, 2006). Use of a taxonomy providing clear delineation of group-type outcome objectives, such as was used in this study, may assist selection of measurement tools that are an appropriate match, resulting in effective outcome evaluation. Where learning objectives are clear, measurement of the acquisition of new knowledge and the development of skills may be appropriate. Maintenance and reinforcement of existing strengths in the specific areas of psychosocial development that are intended by the intervention may be well-captured in global subjective measures indicating change from baseline of degree and not kind.

Measures asking participants to directly evaluate the effectiveness of the group can confirm if outcome objectives of the group have been met and are useful for identifying what members value most about being in the group (Ingersoll-Dayton, 2009). Transferability of findings to future groups with similar characteristics will likely be improved with subjective input from participants evaluating the effectiveness of the group (Pandya, 2010). The final interview with participants used in this study was helpful for generating a data source of the group and communication process, for evaluating the effectiveness of the group for meeting the intended objectives of enhancing psychosocial development and building knowledge and skills, and for assuring trustworthiness of the findings through triangulation of the data.

Relevance to Nursing Education

The unprecedented growth of the older adult population and the directive that conveys to the nursing profession to meet the needs of community-dwelling older adults indicates the education of nurses needs to include a similarly enlarged geriatric focus. Service learning curriculum that includes meaningful interaction with community-dwelling older adults regarding psychosocial concerns is warranted. Pairing of student learners with skilled practitioners conducting small group work with older adults has the potential to promote experiential learning about the issues of aging and health, and to cultivate sensitivity regarding age bias. Group participant evaluations of the Support and Learning Group on Aging and Health were unanimously favorable to having the support of a nursing student in the group. Student involvement in group work interventions with community-dwelling older adults provide opportunities for intergenerational interaction that may be beneficial for both students and group members.

Future Research

Findings from data analysis of the Support and Learning Group on Aging and Health indicate the achievement of group type objectives for support and psychoeducational groups and delineate more clearly the group participants' experience leading to the outcomes of reinforcement of a positive self-assessment and the development of knowledge and skills. Findings may assist the design and implementation of similar groups and may direct further research on specific aspects of individual and group process in small group work with community-dwelling older adults. The finding of the core phenomenon of Relating in this study indicates how comparison of one's experience with others is a key ingredient in the action interaction of group contributing to beneficial outcomes for participants. More research is needed exploring the significance of comparison between members occurring in support and

learning groups, and the positive and negative consequences occurring when a contrasting position is identified.

Limitations

Group Participant as Research Subject

Several participants in the Support and Learning Group on Aging and Health: Mary, Betty and Dorothy, reported joining not because of inherent interest in participating in a support and learning group on aging and health but mainly to help me in my research. A fourth participant, Patricia also expressed that as a large factor. This must be recognized as a potential limitation of the research relative to the transferability of these findings to other support and learning groups recruiting older adults because of their interest in the group itself. However, findings confirm that the topical concerns of older adults that were discussed in the group were relevant in some way to all participants. Also, it has been my experience and may be common in other community practice settings that participants join groups based on an existing trust relationship with the group facilitator as well as from interest in the topic of the group.

Novice Leadership

Expertise in leading groups is developed over long practice and in practice there are always findings that point to opportunities for improvement. As a relatively novice group facilitator, I recognize several missed opportunities to address issues at the 'here and now' level (Yalom, 1985) in the group. A more seasoned facilitator may have helped the group to further explore, for example, the problems members identified regarding treatment received from the community hospital ED and other formal health care systems relative to the care of elders. Within that portion of the communication process, I moved on quickly and made a joke of my discomfort with having disagreement among participants and with Mary's criticism of the hospital. Additionally, my discomfort linked with a concern that the group was going 'off script'

from my lesson plan. A more experienced facilitator could have investigated further in that moment while sticking to the planned discussion.

After the meetings, listening to and having the task of transcribing all that was said, it is impossible for me not to notice that as group facilitator I talked too much and listened too little. Additionally, the data indicates information the group participants valued most came from their interactions with each other and not from the presented curriculum. While textbooks and articles do recommend a clearly planned curriculum it is with the suggestion that its importance is in providing a foundation or overarching theme used to help frame but not direct the group's work (Schneider & Cook, 2005). The group's objectives should remain clear to participants; however, flexibility should be prioritized by the facilitator in order to assure activities of the group address issues of concern that arise from its members. With experience it is expected my skills as a group facilitator will develop to include the ability to listen and to use more effectively the opportunities for therapeutic discussion arising from the group.

Small Size of Group

Though the size of the Support and Learning Group on Aging and Health of seven members (nine with Molly and I in attendance) is desirable (Yalom, 1985), planned and unplanned absences accounted for smaller size in actual group meetings. Every participant missed meetings at some time during the course of the 8 weeks. Dorothy, missing the most, came to 4 of the 8 meetings. These absences had some impacts, including unfamiliarity with other group members. For example, Dorothy and Barbara (who missed 3 meetings) never met one another until the eighth and last meeting.

Out-of-Group Contacts

Because meetings of the Support and Learning Group on Aging and Health occurred at the very active Senior Center of this relatively small community, it is not surprising that

participants knew one another. The previous out-of-group relationships of participants described in detail on page 125 and noted as perhaps contributing to a willingness to share, may also have been a limitation of the study. In addition to former familiarity, several group members interacted outside of the group over the course of the research group's meetings.

In one case Dorothy and Betty met at a farmers market and also interacted during shopping trips organized by the Senior Center. They reported these were pleasant exchanges. In another case, Barbara and Mary bumped into each other at a beauty shop. Barbara reported in her final interview that on seeing each other, Mary had not given her any sign of recognition. Mary reported how the hairdresser told a tale on Barbara about having a car accident in which she was at fault and seemed disoriented after. It certainly seemed an uncomfortable interaction and may have affected Barbara's interaction in the group and Mary's reflection and comparison of herself with Barbara. Though there was little indication in our group meetings, it is feasible that the comfort level of group members to divulge sensitive information with acquaintances may have been affected by out-of-group contacts, and thus may have an impact on the ability to build cohesion among members of a small support and learning group.

Conclusion

This study examining patterns of group and communication process in a support and learning group for community-dwelling older adults identified themes supporting individual participants' reinforcement of existing strengths and the acquisition of new knowledge and skills related to aging and health.

Qualitative analysis was conducted using the methodology of grounded theory and steps of open, axial and selective coding to investigate themes associated with group and communication process using various data sources. Transcriptions of the eight meetings of the support and learning group, pre and post interviews, participant diaries, and memos of the

researcher were coded to identify categorical themes. Themes were further abstracted to describe the group process and communication process within the group. Findings presented communicative action-interaction occurring within time phases of group process. A fractal conceptualization of the findings identify how the communication and group process patterns fitted to action-interaction sequences both within meetings and over the course of the eight weeks.

The theoretical framework of symbolic interactionism, consistent with grounded theory, assisted identification of the theme of “Relating” within the communication process as the central phenomenon of this study. Relative to group process, “Relating” nested within End phase group process steps of Summarizing Experiences, Drawing Conclusions and Valuing Connections. All participants engaged in “Relating” in joint communicative action occurring between each other in the group and in conversation with themselves as they considered the group communication. “Relating” as a step in group communication process involves the sympathetic or empathetic consideration of the experience of others and the comparison of one’s own experience in relationship to others. The position that each participant arrived at through the process of “Relating” was self-affirming whether they found their experience to be similar or contrasting to others in the group.

This study delineates more clearly the linkages between group and communication process and the outcome objectives in a support and learning group for community-dwelling older adults. Additionally, this research identifies “Relating” as a psychosocial feature of the therapeutic potential of group communication and identifies the sub theme of “Comparison: Contrasting Position,” a phenomenon of self-comparison with others, in need of further investigation but little discussed in the literature to date. The findings of this paper may assist community-based nurses and others planning and facilitating groups and offers suggestion for

maximizing the potential in groups of similar context for experiential learning, appropriate use of didactic tools, and member-directed topical concerns.

APPENDIX A

RESEARCH ADVERTISEMENT

**Participants wanted for Research Study:
Support and Learning Group on Aging and Health**

Individuals age 75 and older are sought for an 8 week group discussing issues of aging and health.

Meet with others to share experiences and learn new information about aging and health in a supportive interactive environment.

Nurse researcher will facilitate group discussion; present information on topics of interest to the group.

What will I be expected to do?

Meet for a 45 minute interview with the nurse for the purpose of providing demographic information and screening for participation in the group.

Regularly attend 8 weekly meetings of the Health and Aging Group held at the Senior Center Tuesday afternoons (1:30 – 3:30 p.m.) from November 18-January 6.

- Week 1: Meet-and-greet, concepts of aging and health, identify topics for continued discussion.
- Weeks 2 – 7: Discussion, presentation and activity: Complete 1 page weekly writing assignments reflecting on group experience
- Week 8: Last meeting and group celebration

Conduct a 45 minute exit interview with the nurse reflecting on the group experience after the close of the group.

This research study is being conducted by Lisa White, RN, PhD Candidate UMASS Amherst College of Nursing, who is exploring group process and the experience of group participants.

For more information please contact Lisa at 413 259-3257.

APPENDIX B

IRB CONSENT FORM

Consent Form for Participation in a Research Study
University of Massachusetts Amherst

Researcher(s): Lisa White, RN, Candidate Nursing PhD
Study Title: **Community-dwelling Support and Learning
Group on Aging and Health**

1. WHAT IS THIS FORM?

This form is called a Consent Form. It will give you information about the study so you can make an informed decision about participation in this research.

This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. We encourage you to take some time to think this over and ask questions now and at any other time. If you decide to participate, you will be asked to sign this form and you will be given a copy for your records.

2. WHO IS ELIGIBLE TO PARTICIPATE?

Subjects must be 75 years of age or older to participate. Subjects must be able to speak, write and read in English.

3. WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this research study is to understand how the group process and group interaction support individual members or members collectively to achieve shared goals.

4. WHERE WILL THE STUDY TAKE PLACE AND HOW LONG WILL IT LAST?

The research will be conducted at the Amherst Senior Center and will last 10 weeks.

5. WHAT WILL I BE ASKED TO DO?

If you agree to take part in this study, you will be asked to:

Meet one-on-one with the nurse researcher for 45 minutes for the purpose pre-screening. You may skip any question you feel uncomfortable answering. Individual nurse counseling or other appropriate services available at the senior center will be offered to any subject who screens out of the research group.

Attend 8 weekly meetings of the support and learning group. Group meetings will last approximately 1 and 1/2 hours each. Over the course of eight weeks members will work together to:

(Week 1) Define ground rules for interactions and identify topic headings for the next 6 weeks related to aging and health.

(Weeks 2 – 7) Participate in discussion group covering identified topics related to aging and health.

Complete weekly writing exercises (participant diary) reflecting on the group experience (weeks 2 – 7) to be shared as comfortable with group and handed in to researcher.

(Week 8) Group celebration. Group gathers to share experiences of knowing one another in this format.

Exit interview: approximately 45 minute interview with researcher reflecting on the group experience.

Group meetings and individual interviews will be audio recorded.

6. WHAT ARE MY BENEFITS OF BEING IN THIS STUDY?

Subjects participating in this study can reasonably expect the benefits of group participation including social interaction with others, and gaining information about aging and health.

7. WHAT ARE MY RISKS OF BEING IN THIS STUDY?

There are no more than minimal physical, emotional and social risks to being in this study. Physical risks are similar to participation in any Senior Center discussion activity. There are minimal emotional and social risks

sharing personal information in the format of a support and learning group. You will not be required to share any information that you wish to hold private. Conversational topics are designed to allow shallow or deep levels of discussion as may be comfortable to you. Although confidentiality cannot be guaranteed, ground rules of the group will be established to support it. If a subject demonstrates emotional distress at any time in the group, they will be provided an appropriate referral to seek additional help.

8. HOW WILL MY PERSONAL INFORMATION BE PROTECTED?

The following procedures will be used to protect the confidentiality of your study records:

Audio tapes of the sessions will be kept in a locked cabinet and destroyed after 3 years. The researchers will keep all study records, including any codes to your data, in a locked file cabinet. Research records will be labeled with a code. A master key that links names and codes will be maintained in a separate and secure location. The master key and audiotapes will be destroyed 3 years after the close of the study. All electronic files (transcriptions of audio tapes, observation notes, interview notes) containing identifiable information will be password protected. Any computer hosting such files will also have password protection to prevent access by unauthorized users. Only the members of the research staff will have access to the passwords. At the conclusion of this study, the researchers may publish their findings. Information will be presented in summary format and you will not be identified in any publications or presentations.

9. WHAT IF I HAVE QUESTIONS?

Take as long as you like before you make a decision. We will be happy to answer any question you have about this study. If you have further questions about this project or if you have a research-related problem, you may contact the researcher, Lisa White, RN (413) 259-3256. If you have any questions concerning your rights as a research subject, you may contact the University of Massachusetts Amherst Human Research Protection Office (HRPO) at (413) 545-3428 or humansubjects@ora.umass.edu.

10. CAN I STOP BEING IN THE STUDY?

You do not have to be in this study if you do not want to. If you agree to be in the study, but later change your mind, you may drop out at any time. There are

APPENDIX C

PRE-INTERVIEW GUIDE

Pre Screening Interview Guide:

Name: _____

Address: _____

Phone: _____

Email: _____

Researcher will review with potential participant:

Group objectives: Meeting for the purpose of sharing information and learning about a shared experience (aging) and common goal (staying healthy). Outcome objectives of support and learning groups are to reinforce existing strengths and develop knowledge and skills of participants.

Research objectives: To learn about the experience of older adult participants in a support and learning group. Role as graduate student conducting research as part of doctoral education.

Group format: Weekly for 8 weeks, closed group; format of each session.

Audio taping: transcription and analysis. Custody, erasure at end of study.

Participant diary

Participant interview after group ending

APPENDIX D

PARTICIPANT DIARY

WEEKLY DIARY Aging Together Group

Week # _____ Topic _____

Please write a few sentences about what happened in the group this week.

Is there anything you think you will do differently after this week's discussion?
Why?

Is there more about this week's topic that you would like the group to learn about
or to discuss?

Please write any other reflections on the topic or group experience this week.

APPENDIX E

FINAL INTERVIEW GUIDE

OUTLINE OF FINAL INTERVIEW

Nurse may use further prompts e.g. “could you say more about” to draw out responses of the subject and may ask clarifying questions (what, where, when, how and why) related to the responses of the subject.

What was it like for you to participate in the group?

Describe an interaction that occurred in the group that stands out in your memory.

In what way, if any, has being in the group helped you?

In what way, if any, has your being in the group helped others?

What do you think was the most important thing that happened in the group?

In what way, if any, has being the group changed how you think about your health?

In what way, if any, has being in the group changed the way you think about aging?

What if anything might you do differently now as a result of being in the group?

If you were to participate in a future group what would you like to do the same?

If you were to participate in a future group what would you like to do different?

Any other comments you'd like to share

APPENDIX F

MEETING ONE NOTES

Support and Learning Group on Aging and Health – Meeting 1 notes

Introductions

After settling in with an one on one discussion about a recent good day group members took turns introducing one another and for each, the “good day” described:

- ❖ Shirley shared her relief at her husband’s successful surgery - a day when two surgeons and all the coordination that required came together from planning that started in summer. He is now doing well and healing at home.
- ❖ Robert shared excitement that his youngest grandson’s team has a chance at winning the championship – a long term bucket list goal if it happens! He also shared how nice it is to be a part of the families and friends that enjoy the games together.
- ❖ Molly shared having a good time at her first New England Patriots home game. She and friends tailgated before the game, enjoying the energy of the scene. Though not sure who they played, it was a win for the home team!
- ❖ Patricia shared how visiting her sister and brother in law in NH is both a change from regular routine that brings her together with one she is most close to for talk about the people they know in common and to enjoy some time together.
- ❖ Barbara shared how her bi-weekly exercise class provides energy, improved strength and the support of others. Her health has been greatly improved by the class and she truly enjoys and looks forward to this activity each week.
- ❖ Betty shared her recent trip to stay in Disney World Florida at a gifted timeshare with a friend and a young one. Betty enjoyed playing grandmother to the young girl in the group. Betty noted how the circle of life from young to old age was evident on the trip.
- ❖ Mary shared a pleasant Friday when special neighbors came to visit in the morning with their six month old baby and loving dog, as they do every Tues and Friday and then she went with a friend to see an operella in the evening.
- ❖ Lisa shared enjoyment of a time home alone just doing as she liked while her husband was away for a week of hunting. While looking forward to his return it was a nice change of pace to eat whenever and enjoy some quiet time.

Considering Life Span Changes

The group looked at a timeline of life and was asked to consider how things are different in older age than younger.

Patricia reflected one difference is that you can't do as much multitasking as you used to and gave the example of being "done" after making cookies a recent morning.

Betty reflected that the world asks too much of people and that older people used not to need to keep up so much.

Shirley reflected that she still has much to do but not the energy to do it.

At this and other times in this meeting's discussion, the group talked about making adaptations such as driving instead of walking to enjoy sites and using technology to assist communication, for example.

APPENDIX G

MEETING TWO & THREE NOTES

Support and Learning Group on Aging and Health – Meeting 2 and 3 notes

Greetings and Icebreakers

Greetings and ice breakers of these two meetings included sharing a Thanksgiving tradition or memory and sharing good advice for getting through the winter months. Our plans for this holiday and many traditions and memories were shared (including new memories created by this year's snow and power outage!).

Some helpful ideas for staying healthy through winter included:

Avoiding contagious illness:

hand washing, flu shot, sani-wipes for handles, doorknobs, etc., avoiding crowds, eating and sleeping well.

Preventing falls:

ice melt, crampons with spikes, ski poles, eyeglass checks, medicine review

Staying warm:

wool, fleece, coat choice, microwave heated rice sock/bag, heated blanket, fleece sheets, not going out with wet hair

Wellness Wheel Mind Mapping Exercise

Over these two meetings the group reflected on the health concepts included in the wellness wheel representing health as a multi-faceted state of being. Molly scribed on a

large pad as the group came up with lists defining each concept more concretely. Lisa

shared a schematic similar to the one shown here, based on the widely used social ecological model, to illustrate the multiple contexts of health.

These were the Wellness Wheel Concepts mapped by the group:

Social

- Friends
- Community
- Sports, Music, Church (involvement)
- Family

Emotional

- Enjoyable activities
- Coping – moving on
- Being OK
- Living with loss
- Balance
- When to ask for help?
- Superstress

Intellectual

- Staying mentally active
- New experiences
- Success – accomplishment
- Book club, music, classes, Reading

Environmental

- Clean air, clean water
- Preservation of environment and resources
- Recycling
- Pleasant living environment
- Access to outside, sunlight
- Organization

Physical

- Good health
- Functioning at a certain level
- Exercise
- Regular check-ups – Annual physical
- Self advocacy
- Living with & managing chronic illness
- Eating well, sleeping well
- Immunization

Occupational

- Balance of work and enjoyable activities
- Importance of taking breaks from work
- Reading, films, writing... things you enjoy
- Journaling, record keeping
- Staying busy

Spiritual

- Praying
- Meditation
- Nature, serenity
- Poetry, reading, music
- Reflection
- Making time for important things
- Volunteering
- Good deeds

The group began to use these wellness wheel definitions using a problem solving activity that we will pick up on in our next meeting.

APPENDIX H

MEETING FOUR & FIVE NOTES

Support and Learning Group on Aging and Health Meetings 4 and 5: Problem Solving

In these meetings the group worked together on some problem solving examples using a commonly used 6- step model (in handouts) as a proactive way to address health issues.

Exercise Example #1

1. Identify Problem:
 - a. Not eating regularly
2. Analyze Problem:
 - a. Not remembering
 - b. Not initiating
 - c. Limited food likes
3. Identify Goal:
 - a. Maintain weight
4. Potential Solutions
 - a. Select favorite foods
 - b. Freeze portions of home-made foods
 - c. Frequent meals/snacks
 - d. Supplements
 - e. High protein/calorie dense foods
 - f. Take out foods/freeze meals
5. Implement Selected Solution(s)
6. Evaluate

When selecting from proposed solutions one or two to implement, a tool to assist your success is to be sure your proposed solutions are SMART:

- Specific (know what, where, when and how you will implement)
- Measurable (how will you know if they help?)
- Attainable (don't shoot for the moon, in your atmosphere is OK)

- Realistic (see above 😊)
- Time-bound (set a clear deadline for trying the solution out)

Exercise Example #2

1. Identify Problem:
 - a. Fatigue
2. Analyze Problem:
 - a. Sleeping too much or not enough
 - b. Irregular sleep pattern
 - c. Lack of physical energy to do the things you want
 - d. Tiring easily
 - e. Diet-blood sugar-medical issues
 - f. Physical and Mental fatigue (lack exercise and light)
 - g. Mood altering (frustration, sour mood)
3. Identify Goal
 - a. Improve energy/Feel less tired
4. Potential Solutions
 - a. Eat healthfully
 - b. Get a physical
 - c. Sleep hygiene – a healthy pattern
 - d. Exercise
 - e. Screen mental state – depression
 - f. Adjust tasks
 - g. Seek alternative ways to accomplish (buying instead of making bread, hiring a housekeeper service)
 - h. Take a break
 - i. Pace tasks
 - j. Allow yourself to cut back
5. Implement Selected Solution(s)
6. Evaluate

APPENDIX I

MEETING 6 & 7 NOTES

Notes: Decision Making.

Meeting 6 only a few of us attended due to weather and other appointments. We used the time to chat and catch up on any issues from earlier meetings. At meeting 7 we looked as a group at a process for decision making (see handout). The group made several attempts at using this model. An example of a decision to be made that Shirley suggested seemed to fit the model well:

Decision to be made: Should I hire help for house needs?

FORS	rating	AGAINSTS	rating
Get things done -Yard -Painting in the house	3	Expense \$\$	5
Reduce stress	2	Requires oversight	3
Create nice space	5	Having someone else in your space	5
Total	10		13

In this example, the “Againsts” scored higher than the “fors” but there’s one more step: “The Gut test”.

If Shirley is left still feeling like she really should consider hiring someone to help, there is more to think about here.

Decision making steps:

1. Identify the options: What are you trying to decide?
2. List the “fors” and the “againsts” related to each option. Don’t forget emotional reasons.
3. Score each statement from 1 (not important) to 5 (very important).
4. Add each column and compare the results to find the higher score.
5. In addition to score total, ask yourself how this option meets the “gut test”. In other words which decision feels “right” to you?

1. Write out decision to be made:

--

2. List “fors” and “againsts”

<u>FORS</u>	Score (1-5)	<u>AGAINSTS</u>	Score (1-5)
“Fors” Total:		“Againsts” Total:	

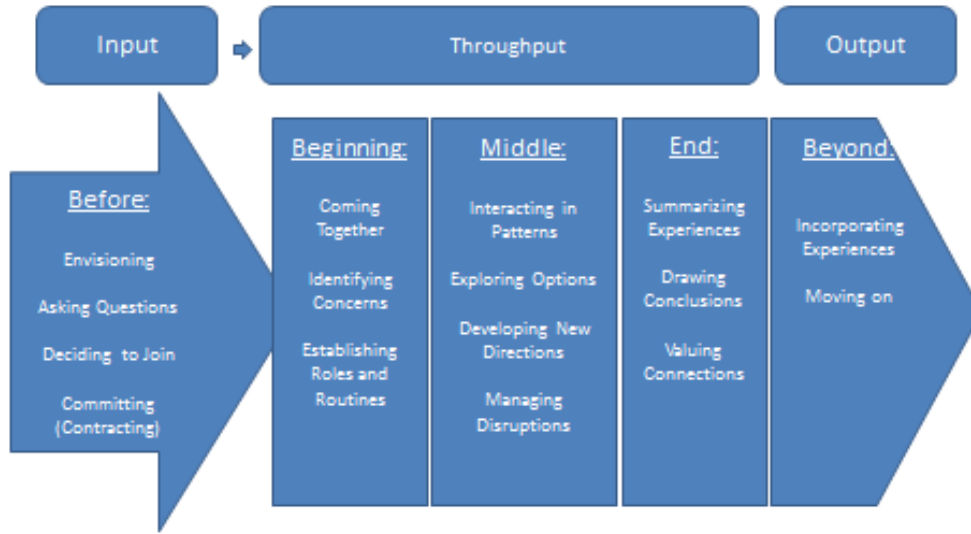
3. Score each statement “for” and each statement “against”.
4. What is total score?
5. Does the resulting higher score meet the “gut test”? If not, there’s more to think about...

Adapted from Chronic Disease Self-Management Program, Stanford University (2012)

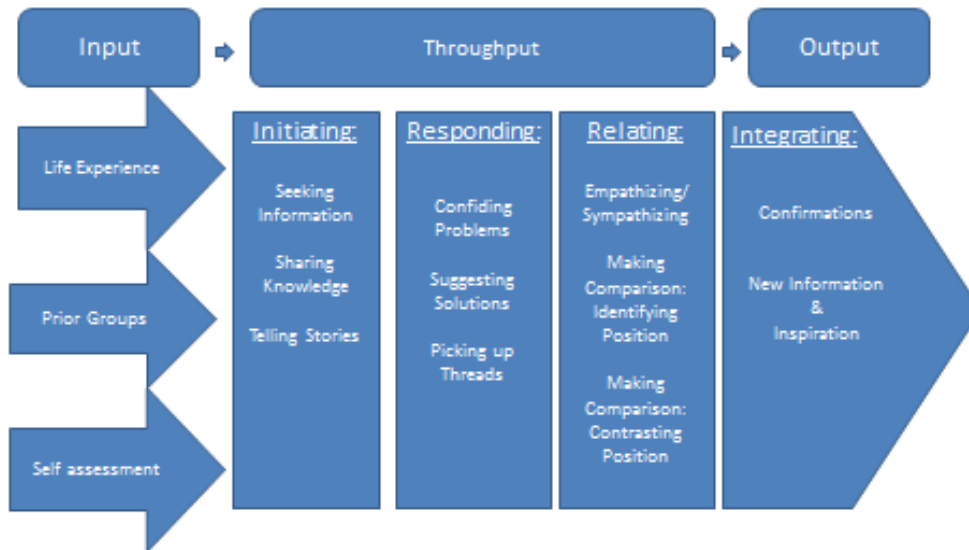
APPENDIX J

DIAGRAMS OF FINDINGS

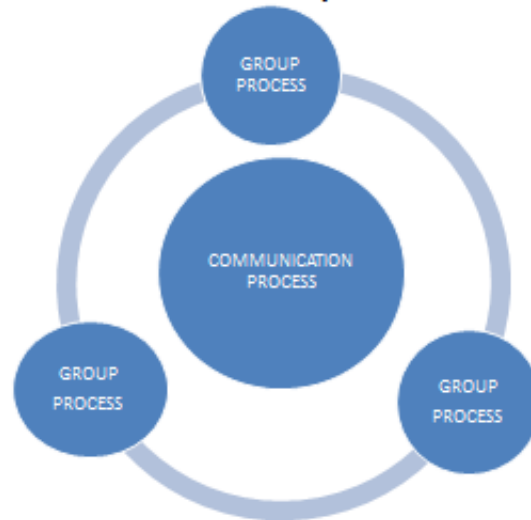
Group Process
Health and Aging Support and Learning Group



Communication Process
Health and Aging Support and Learning Group



Communication Process Nested in Group Process



Before - Input



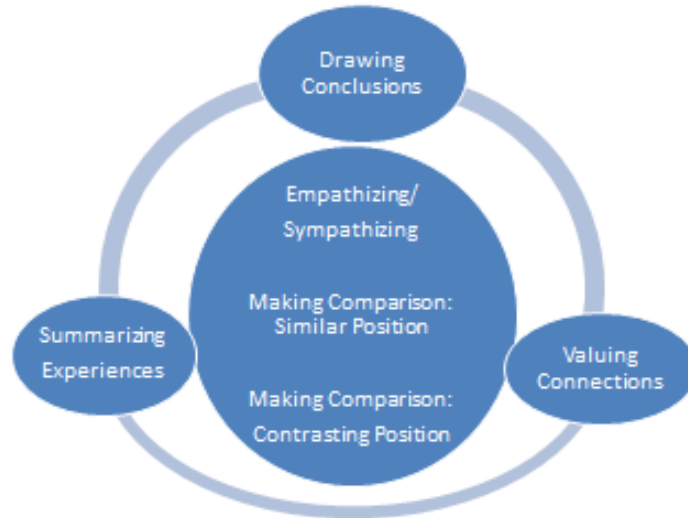
Beginning - Initiating



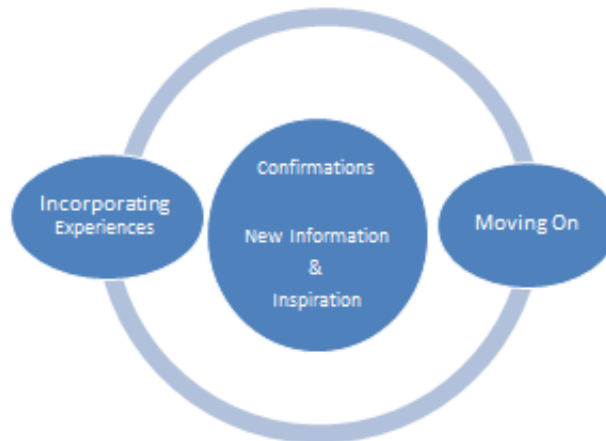
Middle - Responding



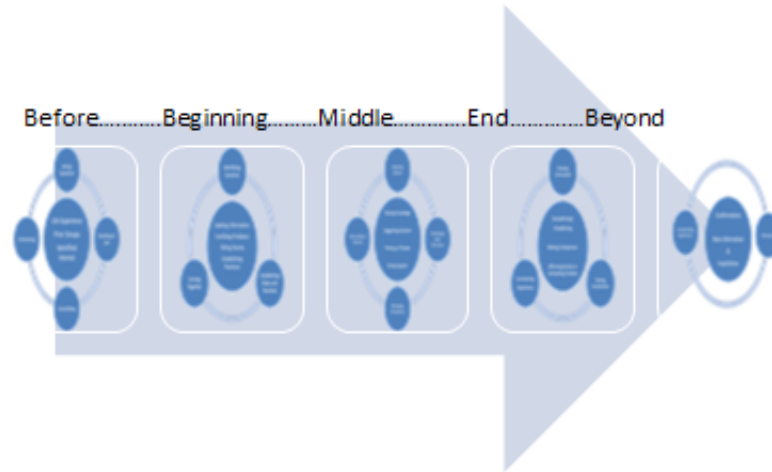
End – Relating



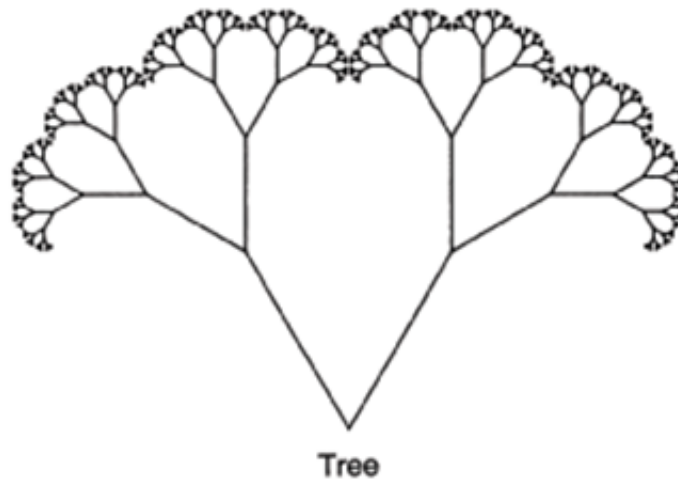
Beyond - Integrating



Putting it all Together—
Group Process and Communication Process Dimensions in
Eight Week Support and Learning Group



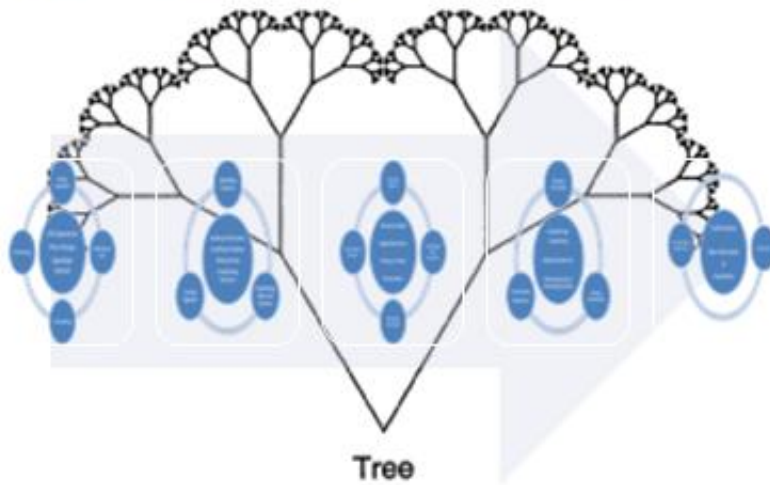
Fractal Conceptualization Group/Individual Process



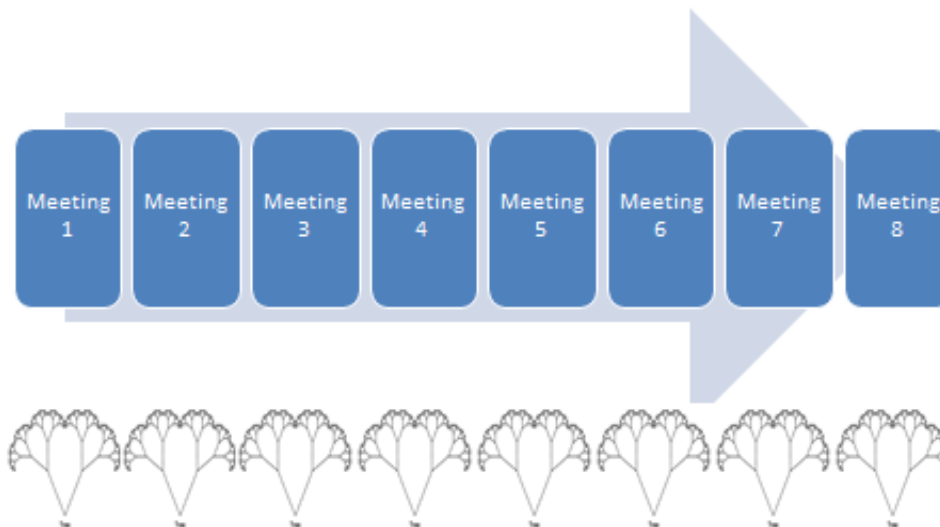
<http://www.socionomics.net/1986/05/the-fractal-design-of-social-progress/>

Group/Individual Process Described as Fractal

Before.....Beginning.....Middle.....End.....Beyond



Fractal Conceptualization of Group/Individual Process





APPENDIX K

IRB APPROVAL LETTER

University of Massachusetts Amherst

108 Research Administration Bldg.
70 Butterfield Terrace
Amherst, MA 01003-9242

Research Compliance**Human Research Protection Office (HRPO)**

Telephone: (413) 545-3428
FAX: (413) 577-1728

Certification of Human Subjects Approval

Date: August 5, 2016
To: Lisa White, Nursing
Other Investigator: Cynthia Jacelon, Nursing
From: Lynnette Leidy Sievert, Chair, UMASS IRB

Protocol Title: Health and Aging Support and Learning Group
Protocol ID: 2014-1969
Review Type: EXPEDITED - RENEWAL
Paragraph ID: 6,7
Approval Date: 08/05/2016
Expiration Date: 08/21/2017
OGCA #:

This study has been reviewed and approved by the University of Massachusetts Amherst IRB, Federal Wide Assurance # 00003909. Approval is granted with the understanding that investigator(s) are responsible for:

Modifications - All changes to the study (e.g. protocol, recruitment materials, consent form, additional key personnel), must be submitted for approval in e-protocol before instituting the changes. New personnel must have completed CITI training.

Consent forms - A copy of the approved, validated, consent form (with the IRB stamp) must be used to consent each subject. Investigators must retain copies of signed consent documents for six (6) years after close of the grant, or three (3) years if unfunded.

Adverse Event Reporting - Adverse events occurring in the course of the protocol must be reported in e-protocol as soon as possible, but no later than five (5) working days.

Continuing Review - Studies that received Full Board or Expedited approval must be reviewed three weeks prior to expiration, or six weeks for Full Board. Renewal Reports are submitted through e-protocol.

Completion Reports - Notify the IRB when your study is complete by submitting a Final Report Form in e-protocol.

Consent form (when applicable) will be stamped and sent in a separate e-mail. Use only IRB approved copies of the consent forms, questionnaires, letters, advertisements etc. in your research.

Please contact the Human Research Protection Office if you have any further questions. Best wishes for a successful project.

REFERENCES

- American Nurses Association (2017). The nursing process. Retrieved from <http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing/Tools-You-Need/Thenursingprocess.html> on February 20,2017.
- American Psychological Association (2004). Guidelines for psychological practice with older adults. *American Psychologist*, *59*(4), 236-260.
- Arean, P. A., Gum, A., McCulloch, C.E., Bostrom, A., Gallagher-Thompson, D., & Thompson, L. (2005). Treatment of depression in low-income older adults. *Psychology and Aging*, *20*(4), 601-609.
- Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the behavioral sciences* (pp. 1–34). New York: Cambridge University Press.
- Baltes, M. M., & Carstensen, L. L. (1996). The process of successful ageing. *Ageing and Society*, *16*, 397–422.
- Baltes, P. B., Reese, H. W., & Lipsitt, L. P. (1980). Life-span developmental psychology. *Annual Review of Psychology*, *Vol. 31*: 65-110 (Volume publication date February 1980) DOI: 10.1146/Bettyurev.ps.31.020180.000433
- Baines, M. K., Scott, S., Kellett, S., & Saxon, D. (2014). Group psychoeducative cognitive-behaviour therapy for mixed anxiety and depression with older adults. *Ageing & Mental Health*, *18*(8), 1057-1065.
- Berman-Rossi, T. (1990). Group work and older persons. In A. Monk (Ed.), *Handbook of Gerontological Services (2nd ed.)*. (pp 141-167). NY: Columbia University Press.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.
- Bohlmeijer, E., Roemer, M., Cuijpers, P. & Smit, F. (2007). The effects of reminiscence on psychological well-being on older adults: A meta-analysis. *Ageing & Mental Health*, *11*(3), 291-300.
- Brown, C., & Liebovitch, L. (2010). *Fractal Analysis: Quantitative applications in the social sciences*. USA: SAGE Publications, Inc.
- Brownell, P. , & Heiser, D. (2006). Psycho-educational support groups for older women victims of family mistreatment. *Journal of Gerontological Social Work*, *46*(3), 145-160.
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American*

Psychologist, 32(7), 513-531. Retrieved from <http://aegiscreative.com/how-we-help/our-theoretical-foundations/social-ecological-model/>

- Burnside, I., & Haight, B. K. (1992). Reminiscence and life review: Analyzing each concept. *Journal of Advanced Nursing*, 17(7), 855-862.
- Burnside, I. & Schmidt, M. G. (1994). *Working with older adults: Group process and techniques*, (3rd ed.). Boston: Jones and Bartlett.
- Butler, R. N. (1963). The life review: An interpretation of reminiscence in the aged. *Psychiatry* 26, 65-76.
- Cappeliez, P., O'Rourke, N., Chaudhury, H. (2005). Functions of reminiscence and mental health in later life. *Aging and Mental Health*, 9(4), 295-301.
- Capuzzi, D., Gross, D. R., & Friel, S. E. (1990). Recent trends in group work with elders. *Generations*, 14(1), 43-48.
- Campbell, R. (2004). Groups for older adults in C. Garvin, M. Glainsky and L. Gutierrez, (Eds.), *Handbook of social work with groups* (pp. 275-291). NY: The Guilford Press.
- Caserta, M. S., & Lund, D. A. (1993). Intrapersonal resources and the effectiveness of self-help groups for bereaved older adults. *The Gerontologist*, 33, 619-629.
- Caserta, M.S., & Lund, D. (1996). Beyond bereavement support group meetings: Exploring outside social contacts among the members. *Death Studies*, 20, 537- 556.
- Centers for Disease Control and Prevention (2013). The State of Aging and Health in America 2013. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services. Retrieved from <https://www.cdc.gov/aging/pdf/state-aging-health-in-america-2013.pdf>
- Centers for Disease Control and Prevention (2015). *Health, United States, 2015, with special feature on racial and ethnic health disparities*. Hyattsville, MD: National Center for Health Statistics. Retrieved from <https://www.cdc.gov/nchs/index.htm>
- Chambers Clark, C. (1994). *Springer series on the teaching of nursing (3rd edition): The nurse as group leader*. New York: Springer.
- Cohen-Mansfield, J., Parpura-Gill, A., Kotler, M., Vass, J., MacLennan, B., & Rosenberg, F. (2007). Shared interest groups (SHIGs) in low-income independent living facilities. *Clinical Gerontologist: The Journal of Aging and Mental Health*, 31(1), 101-112.
- Corbin, J. & Strauss, A. (2015) Basics of qualitative research techniques and procedures for developing grounded theory (fourth edition). Thousand Oaks, California: SAGE Publications

- Cronen, V. E. (2001). Practical theory and a naturalistic account of inquiry. *Communication Theory, 11*(1), 14-35.
- Cronen, V. E., & Chetro-Szivos, J. (2001). Pragmatism as a way of inquiring with special reference to a theory of communication and the general form of pragmatic social theory. In David K. Perry (ed.), *American Pragmatism and Communication Research* (pp. 27-65). Hillsdale, NJ: L. Erlbaum Associates.
- DeLucia-Waack, J. L., Gerrity, D. A., Kalodner, C. R., & Riva, M. T. (Eds.). (2004). *Handbook of group counseling and psychotherapy*. Thousand Oaks, CA: SAGE.
- Drown, E. C. (2008). Group work with older adults. In J. B. Allen (Ed.), *Innovations in clinical practice: Focus on group, couples, & family therapy* (pp. 61-70). Sarasota, FL US: Professional Resource Press/Professional Resource Exchange.
- Erikson, E.H. (1963). *Childhood and society* (2nd Edition). New York: Norton.
- Ersek, M., Turner, J.A., McCurry, S.M., Gibbons, L., & Draybill, B. (2003). Efficacy of a self-management group intervention for elderly persons with chronic pain. *The Clinical Journal of Pain, 19*, 156-167.
- Fisher, B. J., & Gosselink, C. A. (2008). Enhancing the efficacy and empowerment of older adults through group formation. *Journal of Gerontological Social Work, 51*(1), 2-18.
- Freund, A. M., & Baltes, P. B. (1998). Selection, optimization, and compensation as strategies of life management: Correlations with subjective indicators of successful aging. *Psychology and Aging, 13*(4), 531-543.
- Garrard J. (2007). *Health sciences literature review made easy: The matrix method* (2nd ed.). Sudbury MA: Jones and Bartlett.
- Gatz, M., Fiske, A., Fox, L. S., Kaskie, B., Kasl-Godley, J. E., McCallu, T. J., & Wetherell, J. L. (1998). Empirically validated psychological treatments for older adults (1998). *Journal of Mental Health and Aging, 4*(1), 9-46.
- Gitterman, A. (2005). Building mutual support in groups. *Social Work with Groups, 28*(3), 91-106.
- Gitterman, A., & Shulman, L. (2005). *Mutual aid groups, vulnerable & resilient populations, and the life cycle* (3rd ed.). NY: Columbia University Press.
- Great Black Innovators (2009). Problem Solving Cycle image obtained from <http://greatblackinnovators.blogspot.com/2009/10/to-begin-then-we-have-to-accept-basic.html>)

- Greenberg, S., Motenko, A. I., Roesch, C., & Embleton, N. (2000). Friendship across the life cycle: A support group for older women. *Journal of Gerontological Social Work, 32*(4), 7-23.
- Golden, M. A., & Lund, D. A. (2009). Identifying themes regarding the benefit and limitations of caregiver support group conversations. *Journal of Gerontological Social Work, 52*, 154-170.
- Haber, D. (2006). Life review: Implementation, theory, research, and therapy. *International Journal of Aging and Human Development, 63*(2), 153-171.
- Haight, B. K. (1992). Long-term effects of a structured life review process. *Journal of Gerontology: PSYCHOLOGICAL SCIENCES, 47*(5), 312-315.
- Haight, B. (2001). Sharing of life stories: Acts of intimacy. *Generations, 25*(2), 90-92.
- Ingersoll-Dayton, B., Campbell, R., & Ha, J. (2009). Enhancing forgiveness: A group intervention for the elderly. *Journal of Gerontological Social Work, 52*(1), 2-16.
- Jacelon, C. S., & Imperio, K. (2005). Participant diaries as a source of data in research with older adults. *Qualitative Health Research, 15*(7), 991-997.
- Johnson, W. Y., & Wilborn, B. (1991). Group counseling as an intervention in anger expression and depression in older adults. *Journal for Specialists in Group Work, 16*(3), 133-142.
- Keller, J., & Hughston, G. (1981). *Counseling the elderly: A systems approach*. NY: Harper & Row, Publishers.
- Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice Hall. Retrieved from <http://www.learningfromexperience.com/images/uploads/process-of-experimental-learning.pdf>.
- LeBarge, E., Von Dras, D., & Wingbermuehle, C. (1998). An analysis of themes and feelings from a support group for people with Alzheimer's disease. *Psychotherapy, 35*(4), 537-544.
- Lincoln Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: SAGE publications.
- Loomis, M. E. (1979). *Group process for nurses*. St. Louis, Missouri: C.V. Mosby Company.
- Lorig, K., Holman, H., Sobel, D., Laurent, D., González, V., & Minor, M. (2012). *Living a healthy life with chronic conditions (4th ed.): Self-management of heart disease, arthritis, diabetes, depression, asthma, bronchitis, emphysema & other physical & mental health conditions*. Boulder, CO: Bull Publishing.
- McAdams, D. (2001). The psychology of life stories. *Review of General Psychology, 3*(2), 100-122.

- McAdams, D. & de St. Aubin, E. (1992). A theory of generativity and its assessment through self-report, behavioral acts and narrative themes. *Journal of Personality and Social Psychology, 62*(6), 1003-1015.
- McDougall, G., Graham, J, Blixen, C. E., Suen, L. (1997). The process and outcome of life review psychotherapy with depressed homebound older adults. *Nursing Research, 46*(5), 277-283. ISSN: 0029-6562 Accession: 00006199-199709000-00006
- McDermott, F. (2002). *Inside group work: A guide to reflective practice*. Australia: Allen & Unwin.
- McInnis-Perry, G. J., & Good J. M. (2006). A psychoeducational codependency support group for older adults who reside in the community. *Journal of Gerontological Nursing, 32*(8), 32-41.
- Northern, H., & Kurland, R. (2001). *Social work with groups (3rd ed.)*. NY: Columbia University Press.
- O'Leary, E. (1996). *Counseling older adults: Perspectives, approaches and research*. London: Chapman & Hall.
- Orr, A. (2005). Dealing with the death of a group member: Visually impaired elderly in the community. In Gitterman and Shulman (Eds.), *Mutual aid groups, vulnerable and resilient populations, and the life cycle (3rd ed)* (pp.471-492). NY: Columbia University Press.
- Palta, P., Page, G., Piferi, R. L., Gill, J.M., Hayat, M.J., Connolly, A.B. & Szanton, S. L. (2012). Evaluation of a mindfulness-based intervention program to decrease blood pressure in low-income African-American older adults. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 89*(2), 308-316.
- Pandya, V. (2010). An evidence base for group work with older adults living in the community. *Social Work with Groups, 33*, 323-249.
- Prechter, R. R. (2003). *Pioneering Studies in Socionomics*. Gainesville, Georgia: New Classics Library, pp. 269-277. Retrieved from <http://www.socionomics.net/1986/05/the-fractal-design-of-social-progress>
- Rice, S. (2005). Group work with elderly persons. In G. L. Grief and P. H. Ephross (Eds.), *Group work with populations at risk (2nd ed.)*, (pp. 146-158). NY: Oxford University Press.
- Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist, 37*(4), 433-440.
- Ruffing-Rahal, M., Wallace, J. (2000). Successful aging in a wellness group for older women. *Health Care for Women International, 21*, 267-275

- Substance Abuse and Mental Health Services Administration & Administration on Aging (2012). *Older Americans behavioral health issue brief: Series overview*. Retrieved from: <https://www.ncoa.org/resources/issue-brief-older-americans-behavioral-health-series-overview/>
- Schneider, J. K., & Cook, J.H. (2005). Planning psychoeducational groups for older adults. *Journal of Gerontological Nursing*, August, 33-38.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: SAGE Publications, Inc.
- Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women *Proceedings from the National Academy of Sciences* 110 (15) 5797-5801; published ahead of print March 25, 2013, doi:10.1073/pnas.1219686110
- St. Peter's University (2014). Wellness Wheel [web graphic]. Retrieved from <http://testweb.saintpeters.edu/personal-development/2014/02/26/march-newsletter/>.
- Toseland, R. W. (1990). *Group work with older adults*. New York, NY US: New York University Press.
- Toseland, R. W., & Rizzo V. M. (2004). What's different about working with older people in groups? *Journal of Gerontological Social Work*, 44(1), 5-23.
- Toseland, R., & Rivas, R. (2017). *An introduction to group work practice (8th ed.)*. England: Pearson Education Limited.
- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2016)a. *Healthy People 2020*. Washington, DC. Retrieved from: <https://www.healthypeople.gov/2020/topics-objectives/topic/older-adults>
- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2016)b. *Healthy People 2020*. Washington, DC. Retrieved from: <https://www.healthypeople.gov/2020/about/foundation-health-measures/General-Health-Status#Physically>
- U. S. Census Bureau (2016). Quick facts: Amherst town, Hampshire County, MA, United States. Retrieved from: <https://www.census.gov/quickfacts/fact/table/amhersttownhampshirecountymassachusetts,US/PST045216>
- Vinter, R. D. (1974a). An approach to group work practice. In The essential components of social group work In P. Glasser, R. Sarri and Robert Vinter (Eds.), *Individual change through small groups* (pp.9-33). NY: The Free Press, A Division of Macmillan Publishing Co, Inc.
- Vinter, R. D. (1974b). The essential components of social group work practice. In The essential components of social group work In P. Glasser, R. Sarri and Robert Vinter (Eds.),

Individual change through small groups (pp.9-33). NY: The Free Press, A Division of Macmillan Publishing Co, Inc.

Wasserman, J. A., Clair, J. M. & Wilson, K. (2009). Problematics of grounded theory: Innovations for developing an increasingly rigorous qualitative method. *Qualitative Research* 9(3), 355-381.

Weiner, J. M., Hanley, R. J., Clark, R., & Van Nostrandus, J. F. (1990). *Measuring the activities of daily living: Comparisons across national surveys*. Brookings Institution and the U.S. Department of Health and Human Services. Retrieved from <https://aspe.hhs.gov/basic-report/measuring-activities-daily-living-comparisons-across-national-surveys>

Wills, T. A. (1981). Downward Comparison Principals in Social Psychology. *Psychological Bulletin*, 90(2), 245-271.

Wong, P., & Watt, L. (1991). What types of reminiscence are associated with successful aging? *Psychology and Aging*, Vol 6(2), 272-279.

Yalom, I. (1985). *Theory and Practice of Group Psychotherapy* (3rd ed.). NY: Basic Books.

Young, C.A., & Reed, P.G. (1995). Elders' perceptions of the role of group psychotherapy in fostering self-transcendence. *Archives of Psychiatric Nursing*, 9(6), 338-347.

World Health Organization (n.d.). *Frequently asked questions*. Retrieved from <http://www.who.int/suggestions/faq/en/>