A Group Approach to Improve the Well-Being of Elderly Residents in Long-Term Care

BY

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of

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This practicum is dedicated to the six residents of Deer Lodge Centre that participated in the "Well-Being" group who shared their wisdom and expertise as we explored the long-term care experience together.

The resiliency of the human being is truly inspiring!

Abstract

Relocation to long-term care is a stressful event for the elderly and may lead to depressive symptoms and a decreased sense of well-being. Eight residents were initially selected to participate in a "Well-being" group. Six residents completed the eight sessions. The Geriatric Depression Scale (15 item) and the Mini Mental State Examination was part of the screening process as they are included in the assessment process for the setting. Initially, a cognitive behavioural approach was used. To improve the effectiveness an empowerment model was incorporated. The group effectiveness was evaluated using qualitative data analysis: session observations and questionnaire results. Group members rated the group experience positively and suggested that the intervention addressed their needs. Findings suggest that it is more important to support people through the difficult transition to long-term care rather than treat depressive symptoms.

Table of Contents

Introduction

Canadian society has developed long-term care services in recognition of the complex care needs of our infirm elderly when their care needs are beyond the scope and abilities of community agencies and family caregivers (Forbes, Jackson & Kraus, 1987; Holosko, & Feit, 1996). People who come into long-term care may have difficulty adjusting to the environment and it can in fact be very traumatic for some individuals. Several studies link the transition to long-term care with the precipitation of depressive symptoms in individuals, symptoms that have an impact on the general health and quality of life of individuals in long-term care (Pablo, 1977; Amenta, Weiner & Amenta, 1984; Manion & Rantz, 1995). In addition, physical health has been found to impair the ability to maintain accustomed life-styles which often results in isolation, loneliness, and reduced life satisfaction (Connidis & McMullin, 1993; Duffy and MacDonald, 1990; Willis & Cider, 1988).

It was the intent of this practicum to implement a group intervention for long-term care residents experiencing depressive symptoms in order increase their well-being during the initial transition stage to long-term care. The design of the practicum was supported by a review of the relocation, well-being, depression, cognitive therapy, and group literature.

A cognitive behavioural group intervention was initially designed and implemented. The focus of the approach and style of intervention were questioned early on in the sessions. As a result an alternative approach was incorporated. An empowerment practice model was developed and guided an approach which was non-

directive and collaborative in nature. The model was adapted from the empowerment-oriented practice model (Cox & Parsons, 1994) and the strengths model (Tice & Perkins, 1996).

The learning objectives of this practicum were as follows: to design and implement a group intervention which decreases the depressive symptoms of elderly and as a result increases their sense of well-being; to discover what factors influence and are associated with depressive symptoms and well-being in long-term care; and to increase group work knowledge and skills with the elderly in long-term care.

The evaluation of the group process occurred in several stages. Group members completed the GDS pre and post intervention. Facilitators recorded observations of the group process in regards to emerging themes, climate, participant interaction, and concerns. Members were asked to evaluate the group process using a questionnaire. Learning objectives were evaluated through observations by the co-facilitator/practicum advisor, through self-observations and self-reflections, and through part of the questionnaire completed by participants.

Literature Review

Relocation

The literature suggests that relocation to long-term care is a major stressful life event. There are generally three phases to the relocation process: the events leading up to admission, the anticipated move, and the period of adjustment in the long-term care setting. The focus of research efforts on the impact of relocation to long -term

care has shifted from studying mortality (Aldrich & Mendkoff, 1963; Goldfarb, 1976; Killian, 1970; Markus, 1971; Schulz & Brenner, 1977; Pino, 1978) towards the effects on the cognitive, functional and social abilities, the amount and types of psychological distress, social-environmental factors and identification of populations at risk for experiencing negative effects (Pablo, 1977; Amenta, Weiner & Amenta 1984; Manion & Rantz, 1995).

Admission to long term care is a result of many factors both medical and social which in, and of, themselves are stressful. Most often it is a result of a person experiencing a deterioration in health, financial status or social support; hospitalization; inability to care for themselves; and families who are not able to provide care (Wilson, 1997; Glazebrook, Rockwood, & Stolee, 1994; Wingard, Jones, & Kaplan, 1987; Forbes, Jackson, & Kraus 1987).

The anticipation of a move to long term care can be a source of anxiety in later life (Stokes & Gordon, 1988; Biedenharn & Normoyle, 1991) . Schienle and Eiler, (1984); and Solomon, (1988) appear to capture the essence of this anxiety and note that the actual decision to enter a nursing home is often viewed as an option of last resort. When the specifics of an anticipated relocation are identified, the reality of relocation as a stressful event becomes more apparent. For example, the event of relocation to long term care is associated with a threat to quality of life and loss of independence (Starck, 1992); as well as loss of home, loss of family, belongings, freedom and privacy (Crosbey, 1994). Solomon (1993), and Joiner (1991) describe several stresses unique to long-term care residents: adjustment to group living, loss of

health, disruption of personal space, loss of self esteem, a sense of separation from family, friends and the immediate community and decreased opportunities to retain a sense of meaning in life.

Wilson (1997) describes fear, loneliness, sadness, and crying as typical relocation reactions to long-term care of new residents in the initial adjustment phase. To the extent that individuals are aware of the anticipated losses, the whole idea of relocation can be an overwhelming one. A number of authors discuss both physiological and psychological adjustment issues of the relocated elderly (Anthony, Proctor, Silvermand, & Murphy, 1987; Elwell, 1986; Mirotznik & Ruskin, 1984; Stein, Linn & Stein, 1985); Wilson (1997). Chick and Meleis (1986) sum up the psychosocial adjustment problems by describing the properties of transition which individuals experience: as a sense of disconnectedness from social support; a loss of familiar reference points; and a sense of old expectations no longer current in the new situation. A model of stress helps to illustrate the relationship between relocation and stress (see Appendix 1).

Gatz (1992) constructs an amalgamated model of stress based on the work of Lazarus and Folkman (1984); Maddi, (1989); and Pearlin, (1989). This model illustrates quite simply that the impact of relocation on the elderly is stressful. Life events lead to stress which may lead to negative outcomes such as poor mental and physical health. Stress may be associated with a variety of cognitive affective phenomena such as fear, worry, anxiety, and depressed mood: all of which are symptoms of depression. Several authors support the connection between stress and

depressive symptoms (Antony, Proctor, Silverman & Murphy, 1987; Elwell, 1986; Morotznik & Ruskin, 1984; Stein, Linn & Stein, 1985). Furthermore, the presence of depressive symptoms threatens an individual's sense of well-being. Therefore it is important to consider the effects of relocation of the elderly from the perspective of well-being and depression literature.

Well-Being

The World Health Organization (1996) states that health is a state of complete physical, mental, and social well-being, and not merely the absence of disease of infirmity"(p.1). Achieving a sense of well-being throughout the ageing process can be difficult in that the task of sustaining the contentment of continuous growth in the face of accumulated loss and deterioration can be daunting for some individuals. Nevertheless, it appears that people are motivated to do so. Shmotkin (1998) characterizes this dilemma in stating ". . . that even if happiness becomes less and less tangible, the pursuit of happiness may never be over" (p.15).

As Kahneman, Diener and Scwartz (1999) point out, the nature of well-being is one of the most enduring and elusive subjects of human inquiry. None the less, the elusiveness does not preclude attempts to define and study the construct of well-being.

The study of Subjective Well-being (SWB) according to Shmotkin (1998) can be divided into three stages. During the 1960s and 1970s, the concept of subjective well-being was defined and operationalized, epidemiological surveys were conducted, interest in gerontological research was undertaken, and the basic dimensions of SWB

emerged. During the 1980s, research was characterized by studies that looked at the correlates of personality and adjustment, the relationship between positive and negative affect, and models, which incorporated SWB with physical and mental health. During the 1990's, studies considered subjective well-being from the viewpoints of major psychological and sociological processes including cognitive functions of judgement and memory, emotionality and mood, stress and coping, communication and social relations.

A look at several definitions of well-being illustrates the multidimensional and interrelated conditions of well-being. Subjective well-being has been defined by a number of authors as a broad concept that includes a wide range of distinct dimensions such as life satisfaction, positive affect, happiness, personal growth, satisfying social relationships, and autonomy (Deiner, 1994; George, 1981; Lawton 1975, 1983; Neugarten, Havighurst & Tobin, 1961; Ryff, 1989).

Filipp (1995) discusses a variety of theoretical conceptions of subjective well-being that attempt to explain contentment and positive affect in the face of the losses of old age: social emotional selectivity theory; social integration theory; social comparison; dual process of development; and control theory. Social emotional selectivity theory (Carstensen, 1993) contends that older people seem to conserve emotions in a way that they afford fewer and fewer persons the power to affect them profoundly and thus limit the experience of negative emotions. This theory comes out of social integration theory (Antonucci & Jackson, 1987) which posits that social networks serve as effective buffers against the detriments of aging (Suls and Mullen

1982). Social comparison theory contends that individuals compare themselves to others to provide feeling of self-worth. Filipp and Buch-Bartos, (1994) indicate that Social comparison is less salient in the elderly. A temporal comparison seems to be a more pertinent aspect of the comparison theory for the elderly. Here the comparisons are between past and present self, along with a shift from social demand toward a focus on inner self. Furthermore, the dual process model of development (Brandstädter and Greve, 1990) says that elderly shift from an assimilative to a more accommodative coping style. For example, people adjust their expectations and reappraise their goals. The control theory (Heckhausen and Schulz, 1995) explains that in primary control individuals have clear preferences for engaging in behaviours that shape their environment to fit their needs and potentials. Aging forces individuals to adopt secondary control strategies that mirror a more accommodating mode of coping.

Filipp (1995) concludes "...that research has been dominated too long by the presumed problems among the aged of 'long-term' affective states, like emotional adjustment, suicidal state, or depression." It appears that it is necessary to refocus the concept of well-being from a disease model to one which appreciates the resiliency of the individual in later life.

The dynamic equilibrium model (Headey and Wearing, 1989) proposes that each person has an equilibrium or normal level of subjective well-being which is predictable on the basis of stable personality characteristics. Deviations from normal levels occur in response to negative events. The deviation is temporary, and a person

is likely to revert to normal levels of subjective well-being because of personality traits. This model supports the concept that people have an inherent resiliency to deal with exogenous shocks.

In developing a wellness index, Slivinske, Fitch, and Morawski, (1996), define well-being as a composite construct involving six components: physical health, morale, economic resources, ability to carry out activities of daily living (physical and instrumental), religiosity, and social resources. For example, Revecki and Mitchell (1990) found that physical health was the most important life strain among the elderly. Connidis and McMullin, (1993); Duffy and MacDonald (1990); Willits & Crider, (1988) found that isolation, loneliness, and reduced life satisfaction resulted from an inability to maintain accustomed life styles due to a decline in physical health. Furthermore, Bishop, Epstein, Baldwin, Miller, and Keitner (1988) found that poor health, family functioning and adjustment to retirement resulted in deficits in morale. Finally, an absence of satisfying social relationships corresponded to feelings of loneliness and depression (Mullins & Dugan, 1990). People with close friends, tend to be more active and experience greater life satisfaction (Hong & Duff, 1994). Social support acts as a buffer against stress and negative life events (George, 1989; Larson, 1993; Okun, Melichar, & Hill, 1990). Long-term care has a direct impact on these components of well-being. Admission to long-term care is a result of a physical decline for individuals. People experience isolation and loneliness in institutionalization. Many social ties have been severed and social supports have diminished. In addition, institutions encourage residents to internalize a sick role

definition of self, because it is primarily a nursing medical model (Goffman, 1961, Freidson, 1970 cited in Donnenwerth & Peterson, 1992). If people perceive themselves as "sick" in order to cope, they tend to have a low level of well-being.

Furthermore, the overall impact of institutionalization on well-being is negative (Donnenwerth & Peterson, 1992; Kirchbaum, Ryden, Snyder, Pearson, Hanscom, Lee, & Savik, 1999). Admission into long-term care demands people to conform to the organizational demands of the institutions. Institutions expect residents to behave sensibly, in an orderly fashion, to tone down their individual traits, to socialize with each other, not complain, and to be understanding if their wishes cannot be granted (Pink, 1992; Stephens, Kinney, & Ogrocki, 1991).

Depression

The purpose of examining the literature on depression is to gain a clear understanding of the depressive symptoms associated with a stressful event such as relocation to long-term care, as opposed to diagnostic purposes. The literature suggests that depression in some form is pervasive and undertreated in long-term care. As well, the contributing factors to depression in the elderly are unique. It is apparent that the definition of "depression" is varied and complex. Tice and Perkins (1996) describe the characteristics of depression as a range from the "blues" to loss of interest or pleasure in usual activities to thoughts of suicide. Ensel (1986) in discussing depression refers to the states of mental health as mood, symptoms, syndrome or illness. Meador and Blazer (1998) attribute the variability of the word

depression according to the context and the predisposing biases of the speaker. Shuchter, Downs, and Zisook (1996), state that:

> . . . the term depression has been employed to describe many forms of human experience . . . as an acute state of upset, as a pervasive and persistent mood that is abnormal and is associated with numerous psychiatric, medical and toxic disorders; and as an autonomous syndrome (p. 42).

Weinstein's (1953) fluid understanding of the term depression, is one which does not conceptualize depression according to any particular definition or assessment strategy, rather as a class of symptom pictures that demonstrate a "family resemblance". This supports the focus on depressive symptoms rather than depression as a diagnosis. The adoption of this family resemblance of symptom pictures of depression in the elderly is functional in that it points to a way of thinking about depression that encompasses the variety of depressive syndromes and associated depressive symptoms in the elderly in long-term care settings. The variety of depressive symptoms whether it is due to loss, grief, dysthymia, or major depressive episodes appear to have commonalties such as, functional disturbances, cognitive distortions, affective experiences, sleep disturbance, risks factors and to some extent treatment response.

One of the problems in adopting such a fluid understanding of the term "depression" and symptoms of depression is that prevalence rates become unclear. However, looking at the prevalence rates of depression is one way of looking at the prevalence rates of depressive symptoms. The prevalence rates for depression vary depending on the definition, method of assessment, and particular sample used. For

example, using DSM III criteria for major depression, Robins, Helzer, Croughan, and Ratcliff (1981) and Heithoff, (1995) cite a one-year prevalence rate of .9% of adults age 65 and older living in the community. When the construct of depression is not restricted to the DSM criteria, the prevalence rate rises to 10 - 15% (Gurland, Copeland, & Curiawsky, 1983; Blazer & Williams, 1980); or 20 - 31% (Klerman 1985; Gurland, Dean, Cross & Golden, 1980). Within the population of elderly living in a long-term care setting, the variability in the incidence rate of depression is even greater than that of elderly in the community. For example Masand, (1995) reports a prevalence range from 3.6 to 85% of both major and subsyndromal types of depression in 22 different studies of elderly residing in long-term care settings. Burrows, Satlin, Saltzman, Nobel, & Lepsitz (1995); and Gerety, Williams, Murlow, Cornell, Kadri, Rosenberg, Chiodo & Long (1994) estimate the prevalence rate of major depression of elderly residents in long-term care between 12 - 15 %. Kim and Rovner (1995) estimate the prevalence of minor depression in long-term care between 30 - 50%. The literature supports the deduction that the prevalence of depressive syndromes within the elderly appears to be variably high which could account for high rates of depressive symptoms within the elderly population.

With this wide range of prevalence rates, the treatment of depressive symptoms in the elderly becomes challenging. The extent of the problem becomes unclear and most likely results in the undertreatment of depressive symptoms. Studies by Rovner, German and Brand, (1991); Heston, Garrard, Makris, Kane, Cooper, Dunham and Zelterman, (1992); and Burrows et al., (1995), support the idea that

depression in the elderly in long-term care is often misdiagnosed and subsequently undertreated. This is of concern for it has a significant influence on health, cognition, behavior, and social relations of the elderly in long-term care (Keller, Shapiro, Lavori, & Wolfe, 1982; Lewinsohn, Zeiss, & Duncan, 1989; Phifer & Murrell, 1986; Katona & Watkin, 1995).

The connection between relocation and depressive symptoms in long-term care settings can be seen by examining the contributing factors of depression in the elderly. Several studies suggest reasons that account for depression in long-term care residents (Chenitz, 1983; Moody, 1992; Masand 1995). These studies focus on the loss of autonomy and social support, greater co-morbid physical illnesses, increasing awareness of ones own mortality, and institutional demands for increased passivity. It appears that loss is so much a part of old age that individuals tend to think of life only in terms of loss. Murrell and Meeks, (1992) see the variety of studies on depression in the elderly divided into those focusing on the internal and external onset factors and those studies which look at the impact of depression. Internal onset factors include genetic factors, age related changes in neurochemistry and geriatric depression, neuroanatomical and neurochemical changes associated with late life depression and dementia, physical illness and pain; sleep disturbance and geriatric depression; personality factors. External onset factors include psychosocial stress and coping; bereavement and depression in later life; social support and geriatric depression; ethnic background and birth-cohort effects.

It may be that the strongest connection between relocation and depressive symptoms in the elderly is found in the concept of loss. Taking this further, it may be that any change at this stage of life is enough to be potentially overwhelming for the elderly in long-term care settings. Change in, and of, itself then has an impact on mood resulting in adjustment/reactive depression (Mosher-Ashley, Barrett, 1997). A number of studies support this concept by suggesting that a change in social situation influences the psychological condition resulting in the development of a depressive stupor (Blazer and Williams, 1980; Murphy, 1982). The transition to a long- term care facility represents a major change in social condition that may contribute to the presence of depressive symptoms in the elderly.

The various treatments for depression point to strategies for treating depressive symptoms. Treatment for depression appears to fall into four categories: pharmacotherapy, electroconvulsive therapy, psychotherapy, and psychosocial therapies (Blazer, 1993; Futterman, Thompson, Gallagher-Thompson & Ferris, 1995; Mosher-Ashley & Barrett, 1997; Rush, 1994). Of the numerous therapies for depression, the cognitive-behavioral approach is suited for the elderly in long-term care settings (Abraham, Currie & Neundorfer, 1992; Heston et al., 1992; Hyer & Blazer, 1982;Manion & Rantz, 1995; Masand, 1995; Roth & Coviu, 1984; Rovner & Rabkins, 1985; Rovner, German & Brant, 1991; Solomon, 1993; Zeiss & Steffen, 1996).

Cognitive Model and Cognitive-Behavioral Therapy

The cognitive model hypothesizes that people's emotions and behaviors are influenced by their perceptions of events (Beck, 1964; Ellis, 1962). Simply put, the way a person feels is associated with the way in which they interpret and think about a situation (see Appendix 2). The way a person feels is related to a person's sense of well-being. Cognitive-behavioral approaches are based on the cognitive model. Beck, (1995) describes Cognitive therapy as a directive, time limited, structured treatment approach that emphasizes recognizing and changing negative thoughts and maladaptive beliefs known as schemata.

The goal of Cognitive-behavioral approaches, according to Beck (1995), is to change the individual's reaction to the upsetting event or stream of thoughts. Clients are helped to gain insight into "cognitive distortions" (distorted thinking or dysfunctional thinking) which are common to all psychological disturbances. Realistic evaluation and modification of thinking produces an improvement in mood and behaviour through techniques including: socratic dialogue, homework assignments, discussion and formation of alternative interpretations, and the development of problems solving skills and coping skills. Aaron T. Beck, (1979) outlines a basic procedural sequence of cognitive therapy guides the direction of intervention: 1) preparing the client by providing a cognitive rationale for treatment and demystifying treatment; 2) assisting the client to monitor thoughts that accompany distress; 3) implementing behavioral and cognitive techniques; (4) identifying and challenging cognitions through the process of being in problematic situations that evoke such

thoughts; 5) examining beliefs and assumptions by testing them in reality; 6) preparing clients by teaching them coping skills that will work against relapse.

Cognitive therapy has been used effectively in treating a wide variety of disorders: depression (Beck, 1991); phobias, psychosomatic disorders, eating disorders, anger, panic disorders, substance abuse (Beck, Wright, Newman, & Liese, 1993; chronic pain (Beck, 1987) and in crisis intervention (Dattilio & Freeman, 1994).

A significant amount of research for treatment of depression in the elderly has been conducted using cognitive-behavioral approaches (Futterman, Thompson, Thompson & Ferris, 1995; Morris & Morris 1991; Thompson, Davies & Gallagher 1986; Scogin, Jamison & Gochnauer, 1989). More recently, two sources in particular support the efficacy of the cognitive-behavioral approach for depression in the elderly: Gatz, Fiske, and Fox, (1998); Engels and Vermey, (1997). The former source suggests that a cognitive-behavioral approach is probably an effective treatment for depressed community-residing older adults who are cognitively intact, have minimal co-morbid psychopathology, and are not suicidal. The latter source suggests that cognitive-behavioral approaches produce a larger effect size than a combination of other therapies.

The above noted sources support Beck's (1979) landmark study that showed that cognitive therapy works faster than most traditional forms of therapy. In addition, studies show that outcomes of cognitive-behavioral approaches with the elderly in a group mode are as effective as those in individual therapy (Abraham et al., 1992;

Beck, 1979; Covi & Lipman, 1987; Roth & Covi, 1984; Solomon & Zinke, 1991; Yost, Beutler, Corbishley & Allender, 1986; Zerhusen, Boyle & Wilson, 1991).

There is considerable criticism of cognitive-behavioral approaches. Corey, (1996) cites a number of concerns. One concern centres around the little use of the unconscious dynamic, free association, dream work and transference in the cognitive-behavioral approach. Another is that people may feel that they are not being listened to or cared about because of the confrontational nature of cognitive-behavioral approaches. Yet another concern is of inexperienced therapists using cognitive therapy as a quick cure procedure by wearing down client's resistance with persuasion, indoctrination, logic and advice (Corey, 1996).

Freeman and Dattilio,(1992) and Weishaar,(1993) focus their concerns on the assumed simplicity of the cognitive behavioral approaches. They contend the cognitive- behavioral approaches rely on the power of positive thinking; being too technique oriented; failing to use the therapeutic relationship, neglecting the role of feelings, and working on elimination of symptoms while ignoring underlying causes.

Patterson, (1986) appears to focus concerns on broader issues and questions the best way to change a client's internal dialogue:

> Is directly teaching the client the most effective approach? Is the client's failure to think rationally or logically always due to the lack of understanding, reasoning or problem solving? Is learning by self-discovery more effective and long lasting than being taught by a therapist?

Dattilio and Freeman(1992) and Ellis (1994) put forth a concern from a multicultural perspective. Cognitive-behavioral approaches can challenge client's

values and beliefs. There may be some hesitation on the part of some clients to question their basic cultural values.

In spite of these concerns there appears to be sound rationalization to refute the above mentioned criticisms. For example Zeis and Steffen, (1996) appear to address some of the general criticisms of cognitive-behavioral approaches indicating that because of the collaborative psychoeducational feature and non-pathologizing nature of cognitive-behavioral approaches, there is opportunity for therapists to communicate their respect for clients experiences and strengths.

With regards to simplicity and lack of depth to therapy, a general comment can be made. Cognitive-behavioral approaches do have simplistic principles however, the actual procedures to bring about change are sophisticated, complex and require a lot of hard work (Burns, 1990). Glantz (1989) addresses the criticism of lack of depth and points out that the elderly, in general, require special considerations in psychotherapy related to development/life stage problems. Physical, psychological, financial, social and familial changes require practical solutions. Psychodynamic techniques are unrealistic if there is less likelihood to have resolution. In many cases with the elderly in long-term care, there is not a lot of time left nor is it particularly useful to re-traumatize individuals.

With regards to the multicultural concerns, there is an absolute need for sensitivity on the part of the therapist in order to accommodate cultural diversity. Social Workers have a long tradition in attempting to understand the cultural differences of clients. Additionally, the cognitive-behavioral approach has a flexibility

that allows for the incorporation of techniques form other therapies to achieve the desired goal of the client. The multicultural concerns then become one of therapist sensitivity and training.

Groups

Toseland (1991) defines group work as ". . . Goal-directed activity with small groups of people aimed at meeting socio-emotional needs and accomplishing tasks. This activity is directed to individual members of a group and to the group as a whole within a system of service delivery" (p.12).

Goal directed activity includes support, education, socialization, personal growth and treatment for problems and concerns. Groups may focus on techniques for individual change (Rose & LeCroy, 1991; Sarri, 1974; Vinter, 1967, 1985) or person-in-situation where members are encouraged to gain greater control over their organizations and communities (Klein, 1972; Pincus & Minahan, 1973; Schwartz & Zalba, 1971; Siporin, 1975).

The use of small groups allows for sufficient interaction among members. This promotes the identification of members within the group, and exchange of thoughts and feelings among members through verbal and nonverbal communication. The role of the group worker has a dual purpose of goal directed activity with individuals members and with the group as a whole (Toseland, 1995). It should be recognized that the sponsoring organization's resources, policies, goals and mandates influence groups. This is important to consider when setting goals for the group.

The purpose of group work can be classified as either task or treatment oriented. Treatment oriented groups meet the socio-emotional needs of members and offer support, education, therapy, growth and socialization. The purpose of the task oriented group is to accomplish a predefined mandate (Toseland, 1991).

Toseland (1995) discusses the characteristics of treatment groups. Members of treatment groups are bonded together by their common need and situation. Roles develop through interaction among members. Communications patterns are open and members are encouraged to interact with one another. There are flexible procedures for meetings. Members are encourages to disclose their own concerns and problems within the agreed upon format of confidentiality. Criteria for evaluation is based on the extent to which the group has helped members meet their treatment goals.

There are several advantages to treatment groups. Groups can help with most anything that individual therapy can (Levine, 1979). Groups help members realize they are not alone (Shulman, 1992; Yalom, 1985). Group can also help members in reality testing (Gilbert, Miller & Sprecht; Rose, 1989) role play, testing of new skills, and rehearsal of new behaviors (Rose, 1989). These advantages make group work particularly suited for therapy with the elderly (Glantz, 1986).

Toseland (1995) notes several disadvantages to using group work in treatment. Groups can encourage member conformity (Corey & Corey, 1992) and dependency (Klein, 1972). Vulnerability and harmful responses during self-disclosure may be problematic for some individuals making it difficult for open communication (Corey & Corey, 1992). Divergent interests of each group members can bring about a

different urgency to issues that may be unique and unrelated (Shulman, 1992). Groups may also develop as a complex system (microsociety) with rules and procedures operating beneath the surface. These can be counterproductive to the therapeutic process (Shulman, 1992). These obstacles can be minimized through the process of group member selection and skills of group facilitation (Toseland & Rivas 1995).

A major factor of relocation is learning to live in a group environment. A threat to independence within a communal environment may lead to depressive symptoms and a decreased sense of well-being. With regards to treating depression, group therapy is an effective intervention in the elderly (MacLennan, 1993). Group therapy has been shown to relieve depressive symptoms, improve personal and social functioning, and increase self-esteem (Leszcz, 1990). It appears that the group process can positively effect depressive symptoms by reinforcing existing coping skills and learning new skills through modeling and rehearsal. The group process can also empower individuals through normalization and mutual support. Furthermore, a greater awareness of others and their needs can lead to higher tolerance levels.

Within the current climate of conservative ideals, a group approach appears to be well suited for helping older adults in long-term care because it addresses staffing shortages, and economic viability serving the combined need for therapeutic intervention, socialization, activity and purpose for individual in long-term care.

Preplanning

The initial intervention was planned using the Cognitive-Behavioral Approach (Beck, 1995; Gallagher & Thompson, 1981; Miranda, Schreckengost & Heine, 1992;) with the goal to decrease depressive symptoms in elderly residents in a long-term care setting. This is important because a decrease in depressive symptoms has a direct impact on the general health and quality of life of individuals in long-term care and thus improve well-being (Pablo, 1977; Amenta, et al., 1984; Manion & Rantz, 1995). The group intervention was modelled after a number studies which incorporate cognitive-behavioral principles for individual and group therapy for the treatment of depression (Abraham et al., 1992; Beck, 1979; Covi & Lipman, 1987; Gallagher & Thompson, 1981; Glantz, 1989; Lewinsohn, 1974; Miranda et al., 1992; Mosher-Ashley, 1997; Roth & Covi, 1984; Schuchter, Downs & Zisook, 1996; Solomon & Zinke, 1991; Yost, et al., 1986; Zerhusen, et al., 1991).

Practicum Questions

The practicum questions are as follows: 1) Is the cognitive behavioural therapy an effective intervention to decrease the depressive symptoms and increase subjective well-being of elderly in a long-term care setting?; 2) What factors influence and are associated with depressive symptoms and well-being in long-term care?

Procedure

Sample of Population

Participants were identified from the personal care population of Deer Lodge Centre, a 497 bed long-term care facility. Participants were relatively new residents with an admission date at or after January 1, 2000.

Selection Criteria

The following selection criteria was used:

- Depressive symptoms indicated by ≥ 5 on the GDS
- Cognitive ability determined by ≥ 25 on the MMSE
- Informed consent to participate.

For the purpose of this practicum, the presence of depressive symptoms was defined by a number of criteria. Participants had a Geriatric Depression Score (GDS) of ≥ 5. A score of ≥ 5 indicates the presence of depressive symptoms (Burke, Roccaforte & Wengel, 1991). In order to determine that the depressive symptoms were related to transition to long-term care, only those who had not been diagnosed and treated for depression within a two-year period were included. The transition period began on the date individuals were admitted to acute care with consequential application to long-term care or on the date that the application was made for those living in the community. A score of 25 or higher on the Mini Mental State Examination (MMSE) determined the cognitive suitability for group participation

(Crum, Anthony, Basset &Folstein, 1993; Folstein et al., 1975; Malloy & Clarnette, 1999).

Selection Process and Procedure

The selection process was divided into three stages: identification of potential group participants and screening, final selection. The procedure was the group intervention.

Identification of Group Participants

Residents who were exhibiting various depressive symptoms identified in the pre-admission, admission and post admission process received a clinical interview by a social worker for further assessment. Depressive symptoms included: depressed mood, tearfulness, loss of interest and pleasure inmost activities, sleep disturbance, weight loss/gain, diminished appetite, diminished concentration, diminished energy, psychomotor agitation/ retardation, hopelessness, diurnal variation of symptoms, suicidal ideation, guilt ridden or self deprecatory thoughts, delusions/hallucinations.

As part of regular intake system at Deer Lodge Centre, there are three opportunities to initially identify individuals for adaptation and adjustment difficulties to long-term care: pre-admission, admission period, and post admission conferences. As part of the pre-admission to Deer Lodge Centre, future residents are assessed by a pre-admission team for potential adaptation and adjustment difficulties based on application information and/or medical records. This team consists of the Social Work Department and Unit Co-ordinators (unit nurse managers). Individual applications are discussed and concerns are raised based on the information presented.

Upon admission, the unit physician, unit staff nurses, and nurse's aides are in a position to identify individuals who they assess as experiencing difficulties in the transition to long-term care. Identifying information may come from clinical observation, residents themselves or families and friends.

Between six to eight weeks after admission, residents and family members are involved in a post admission conference with an interdisciplinary team to address concerns related to care or adaptation and adjustment to Deer Lodge Centre. This team consists of the unit co-ordinator, social worker, registered nurse, physiotherapist, occupational therapist, pharmacist, pastoral care worker, and recreational worker. Any concerns regarding the adjustment and adaptation to long-term care are discussed with the resident and family.

New residents who were experiencing depressive symptoms were asked if they wanted to receive help with these concerns either the usual one to one intervention options with their health care team members or by the proposed group intervention. These options included music therapy, recreational activities, pastoral care one-on-one support, and social work one-on-one intervention. If residents were interested in the group, potential group participants proceeded to Stage B – Screening and Final Selection.

Screening and Final Selection

Residents who wished to pursue resources to help with adjustment to long-term care were asked to complete a consent for measuring the depressive symptoms

(see Appendix 3). Residents were then asked to complete a GDS and MMSE for screening purposes. They were informed that the completion of the GDS and MMSE were completely voluntary.

If residents had a GDS score of ≥ 5 and a MMSE score of ≥ 25, residents would be informed that the scores obtained on the GDS and MMSE indicate they could participate in group intervention along with the choice of no involvement or a variety of other options. If residents scored lower than the proposed cut-off scores on the GDS or MMSE, they were given the choice of no involvement or one of the above mentioned options excluding the proposed group intervention. The decision not to participate in the proposed group intervention did not influence or limit opportunities for adequate care and treatment at Deer Lodge Centre.

Those interested in participating in the proposed group intervention were informed that group participation was voluntary. If residents had concerns or reservations that would have prevented them from participating in the proposed intervention, other potential participants would have been interviewed.

Those who wished to participate in the group intervention were informed about the type, purpose, duration, and expectations of the group. If they agreed to participate, they were asked to sign a consent form which described the duration of the intervention, the purpose of the program, the potential benefits, study procedure, alternative treatments, confidentiality, and participant's rights (see Appendix 4).

The expectations of the group were discussed with residents in the initial screening stage. Expectations included: commitment to regular attendance; members

are to be supportive, caring, and willing to give everyone an equal chance to participate; members are encouraged to give constructive and practical feedback to one another; criticizing, confronting, pressuring, or telling others what they should do is discouraged; confidentiality of session activity is to be maintained; completion of homework is encouraged to practice what is learned in the group. Those residents that gave their informed consent proceeded to the group intervention phase.

Group Intervention

As a result of this process eight residents were chosen. Toseland and Rivas (1995) suggest that a group should ideally consist of six to ten residents. It was intended that participants proceed through the intervention stage that involved eight one-hour sessions.

The group intervention consisted of eight weekly sessions. The sessions were facilitated by a social worker and supervized by faculty advisor. The broader concepts of the group sessions included: a) How mood is affected by thoughts; b) How mood is affected by activities; c) How mood is affected by people (Miranda et al., 1992; Gallagher & Thompson, 1981) (see Appendix 5 for expanded contents).

Ethical Concerns

There were potential ethical concerns of the dual responsibilities as the facilitator and as the social worker employed at the site of the group intervention. Information obtained prior to the consent for treatment could be used in a manner harmful to the resident. There is, however, an expectation of Deer Lodge Centre employees to uphold at all times the confidentiality of any resident information

obtained. The Manitoba Institute of Registered Social Workers and the Social Work Code of Ethics also demand that social workers uphold the ethical use of client information at all times. In addition, the process of identifying potential group participants and the subsequent clinical interview places the researcher in a position to influence the participation of residents in the group intervention. This is controlled by the use of psychometric testing (GDS and MMSE) and consent of the participants. Only those residents who have consented and meet the criteria of the proposed cut-off scores on the GDS and MMSE will be asked to participate. Influence is also controlled by the use of other social workers in the screening process.

There may be an additional ethical concern that the use of psychometric testing for cognitive impairment and depression could implicate a diagnosis. Residents were informed that the routine use of these instruments was to assess for symptoms and that scores provided a baseline to determine if there was a change in mental status or a change/presence of depressive symptoms. The results of the testing did not implicate diagnosis.

Instruments Used

Three instruments were used throughout the process, Geriatric Depression Scale (GDS) (Sheik & Yesavage, 1986), Mini Mental State Examination (Folstein et al., 1975), and a questionnaire designed by the facilitator (see Appendix 6).

Geriatric Depression Scale (GDS)

The GDS was used to measure depressive symptoms as a pre and post test instrument (see Appendix 7). The GDS is a reliable and valuable screening device to

assess depressive symptoms in the elderly. It exists in both short and long forms. The original form had thirty items and was designed for self-administration (Yesavage, Brink & Rose, 1983). Questions are in a yes/no format and correlate well with the clinical diagnosis of depression in cognitively intact subjects. A lower the score corresponds to low presence of depressive symptoms. The test relies on self-report of depressive symptoms over the past week. A shorter version was developed by Sheik and Yesavage (1986) and consists of fifteen items that shortens the administration time considerably. Only the items that had the highest correlation with depressive symptoms were included in this shorter version. Burke, Roccaforte, and Wengel (1991) compared the thirty to the fifteen-item scale and found that the fifteen-item test was comparable to the sensitivity and specificity of the thirty-item test.

Mini Mental State Examination (MMSE)

The MMSE was used as a screening tool to determine the cognitive status in order to assess the suitability of potential group members (Appendix 8). The MMSE is one of a number of brief mental status assessment tools that is widely used to assess mental status in both clinical and research settings. While the MMSE cannot identify specific disorders, it can alert the practitioner to cognitive disturbances which may potentially hinder success within a cognitive behavioral group setting (Fosltein et al., 1975).

The Mini Mental State Examination samples a wide range of cognitive abilities and provides a good indicator of general cognitive status. The MMSE is a

short standardized form devised for serial testing of cognitive function and separates clients with cognitive disturbance from those without such disturbance.

A general cutoff score of 25 has been established by Folstein et al. (1975). The cutoff score separates people into dichotomous categories of those individuals with cognitive impairments and those who are not cognitively impaired. Scoring of individual items is done while the test is administered to the client. An overall score is obtained by simply adding the scores for the individual items.

The MMSE is used by psychologists, social workers, occupational therapists, physical therapists, physicians and psychiatrists. It is one of the most widely used brief mental status assessment tools and is considered to be user friendly. The original article provides a copy of the test plus detailed administration and scoring instructions (Folstein, et al., 1975).

Questionnaire

A questionnaire was designed by the facilitator to evaluate the following: 1) the facilitator, 2) the group sessions, 3) client satisfaction. The questionnaire also had four opened-ended questions to determine what was beneficial and what was not beneficial to the group sessions. This questionnaire was adapted from the Client Satisfaction Questionnaire (CSQ) (Attkisson & Larsen, 1989).

Methods

Data Collection

The evaluation of the group process occurred in several stages. Group members completed the GDS pre and post intervention. Facilitators recorded

observations of the group process in regards to emerging themes, climate, participant interaction, and concerns (Dimock, 1993) (see Appendix 9). Members were asked to evaluate the group process after the last session. They completed the post GDS and the questionnaire.

The facilitator's learning objectives were evaluated in four ways: through observations by the co-facilitator/faculty advisor, through self-observations and self-reflections, and through part of the short questionnaire completed by participants.

Analysis

An analysis was performed with the data collected throughout the group intervention and from the two clinical interviews. The data was examined visually for changes in scores on the GDS. A content analysis of patterns and emerging themes was completed (Marshall & Rossman, 1989). The intention was to analyse the responses as they relate to the outcome of the intervention. Information was gathered within the group sessions during the intervention process. Data is displayed in graphs to show the following: the change in the GDS scores, how group members rated the facilitator, how group members rated the group, and group member's satisfaction levels.

Supporting Factors of Practicum

There were several factors that supported the group intervention. Appropriate space was available at Deer Lodge Centre. A review of the resident records indicated that there was an appropriate sample within Deer Lodge Centre. Duration time of the group intervention appeared to be manageable both for residents involved and for the

facilitator. Deer Lodge Centre administration was supportive of the intervention and a variety of onsite resources were available. Interdisciplinary team members assisted in identifying potential participants and medical personnel were available to address medical concerns that potentially could have arisen during or between group session. On site supervision by faculty advisor was available as part of clinical supervision requirements. As well, clinical psychological and psychogeriatric resources were available for consultation as part of resources available to residents of Deer Lodge Centre.

Observation of Group Sessions

Group Session One

Introduction

The focus of session one was to introduce members to each other, review purpose of group and to establish ground rules (see Appendix 10). In addition the purpose was to discuss member's depressive symptoms, highlight benefits of group work and self-monitoring of mood for group members.

Preparation involved a pre-group visit to each group member. Participants were reminded of the location of the group session and asked if transportation was needed. Out of the original eight participants four group members attended the first session. Four members were ill and unable to attend.

Observations

A number of themes related to residents in a long-term care facility emerged throughout the session. These included a threat to freedom and independence, increased sense of dependency, commonality of mood concerns and depressive symptoms, and the importance of support networks.

The general climate of the first session was accepting and friendly, although members appeared to be guarded in their comments. The cohesion of the group was high because of the established commonalties of mood concerns, family networks, and loss of freedom and independence.

Group members were hesitant to engage spontaneously and most interactions were done through the facilitators. Two of the members have potential to become leaders within the group. They appear to have a sense of confidence that allows them to feel they can express themselves. Most people were shy about disclosing information. The facilitators encouraged people to talk to each other through the suggestion " Why don't you tell so and so about ...". Throughout the presentation it appeared that people lost interest. Their eyes glazed over and they became sleepy and some members made an effort to leave early. People appeared to be uninterested in the presentation.

Reflections

The strict agenda for group procedure was perhaps wishful thinking and counter productive. The importance of establishing a sense of group precludes any set agenda. This was due to the impatience of the facilitator and the perception that there

were specific goals that had to be achieved during the first group. It appeared that the facilitator expectations were too rigid. More focus was needed in establishing the therapeutic milieu.

The presentation style and didactic approach to introduce topics appeared to be ineffective and resulted in the decreased attention span of group members. It was also noted that the didactic approach could minimize the value of people's experience and knowledge. The participants have much to contribute about their own lives and experiences. A suggestion was made to adopt a more collaborative approach to impart information. There was some concern as to the appropriateness of a psycho educational group approach with this population.

The indirect style ("beating around the bush") that was used to introduce the topic of depressive symptoms was not clear and therefore not effective. The reality is that everybody in the group was familiar with depression and their depressive symptoms. Therefore the topic should have been discussed directly, without couching it in terms such as "feeling low", "feeling blue", and "feeling down".

Group Session Two

Introduction

The focus of session to was to provide information about thoughts that cause and maintain a depressed mood; to identify errors in thinking, to discuss increasing positive thoughts that improve mood, and identify pleasant events. The homework for this session was to track daily moods for one week (see Appendix 11) and identify pleasant events (see Appendix 12).

Preparation involved a pre-group visit to each group. Out of the eight group members, five were present. Three of these five had been part of the first session. Two members who had been previously ill joined the group. One of the members who was present during the first session was distracted on her way to the session and did not attend. The two remaining members could not attend because of illness.

Observations

An increased number of themes emerged during session two: visitations drop off after the initial admission period; there is loss of independence within a nursing home; plans or life is disrupted by the routines of the institution; for some, medications and illness dictate what people can do; weekends and holidays are the most difficult because regular staff are not available and replacement staff is unfamiliar with residents; the dilemma of needing to be involved in activities and not having meaningful activities available; meaningful activities are often interrupted by schedules of daily care.

People who attended the previous group sat in the same place, new members found a place around the table without incident. People continued to be respectful of each other. The climate was informal with people addressing each other on first name basis. There was a feeling of acceptance of each other within in the group.

The level of interaction increased from session one. Members were beginning to share personal information more freely. This may have been due in part to the two members with strong social skills. Members may also have felt more comfortable. Using the more collaborative approach combining the expertise of group members

with the information from the facilitator appeared to generate more interaction and participation. A conflict arose between two strong members who had definite ideas about the origins of depressed mood, but was contained and resolved due to the positive and respectful climate of the group.

Reflections

The facilitator was able to implement a more direct approach and was able to articulate the purpose of the group more clearly. As well, the more collegial approach seemed to initiate more participation and interaction among group members when they are asked to share their experiences and expertise. It allowed them the freedom to participate, it bolstered self-confidence, and it reconnected them with past achievements. Questions facilitated more lively interaction than the lecture style. When the facilitator was trying to seek information rather than being the expert more helpful ideas to manage depressive symptoms emerged.

People also seemed to respond to introduction of humour. One member stated that he hadn't laughed like this since he arrived. Generally, people appear to have gained something from the group.

Group Session Three

Introduction

The focus of session three was to attempt to establish an understanding among participants about the relationship between engaging in pleasant events and the resultant effects on mood. As well, three additional techniques were intended to be

introduced: increasing pleasant activities, pleasure predicting, and setting goals (Miranda et al. 1992).

Preparation involved a pre-group visit to each group members. Six people attended. Three members have consistently attended. The two that came last session were there. Two members remain ill.

Observations

The emerging themes for this session included: the need for elderly to be with young people, not just seniors; the difficulty and fear of consequences in expressing anger or frustration to the people who provide care; venting anger results in retaliation from care givers; the benefits of venting anger and frustration; physical response to frustration and anger and the impact on mood; identifying the cycle of stress and how this impacts on mood; strategies to stop this cycle; and group is a welcome activity.

The general climate of the group was challenged with the increase in attendance and the need to accommodate the dynamics of the larger group. Several members arrived late, so there was some interruption. People expressed their anticipation of that day's group. There was an increase in the group's solidarity as members acknowledged their own experiences and related to other's experience. Two strong members injected humourous anecdotes that increased levels of comfort and ease. A strong sense of group seemed to be established characterized by trust, openness, realization, and interdependence.

The two strong members frequently initiated conversation and directed comments to other group members. The larger group size seemed to increase group

interaction, because the burden to participate was diminished with more participation from others.

Group members did not do the assigned homework of tracking mood and identifying pleasant events. An attempt was made to relate emerging themes to the original focus of the group session. Very little response was forthcoming and it appeared to be an imposition. With less directed agenda the themes appeared to have evolved naturally. Occasionally people turned to each other and talked about the symptoms of depression and general feeling of disappointment in being in a long-term care setting. Interaction was generally spontaneous. One of the members appeared to be lost in thought and therefore some cueing was required to get back on track with the topic at hand.

Reflections

The homework assignments, which required keeping records (mood graph or pleasant activities) were not completed. They may have forgotten the assignments, they may have been ill, or they may have felt that it was unnecessary. It is apparent that the lecture presentation style intended for this group is ineffective. With this population, there appears to be a tendency to react negatively to a lecture format. It may be that a lecture style negates the experience and expertise of people. It was suggested to try a less directive approach that would introduce the concepts as a point for discussion inviting responses which either support or refute the concept. This may be more effective and perhaps more appropriate technique for this population. Members may have completed the homework assignment identifying pleasant

activities, but not because of instructions given, but because of daily living. Therefore it is the act of identifying and labeling an activity that may be routinely done that represents the homework completion. For example one member was planning a trip to visit family.

There appears to be a difference between the research about group work with this population and the current group. The literature supports the use of the cognitive-behavioral approach with elderly long-term care residents. However individuals appear to have difficulty accepting the highly structured aspect of this intervention. Cognitive functioning of individuals and the realities of dependency and illness appear to be barriers to this form of group intervention in long-term care. There is a concern that the targets of the cognitive behavioural approach negate what people are currently experiencing. Living in long-term care is challenging for people and the inference that faulty thinking and apathy are the source of depressed mood places the responsibility on people that may feel a decreased sense of control and therefore powerless to affect change in their lives. The losses are ongoing and cumulative for these people and targets of intervention of a cognitive-behavioral approach may be unrealistic. However group members appear to identify with the concept of increasing pleasant activities. The dilemma is that old age, illness, dependency and institutionalization constrict the pursuit of activities. The guided approach of a psycho educational model seems to require a cognitive awareness level different from present group members in which to explore the various topics.

Group Session Four

Introduction

The focus of session four was develop strategies to bolster mood as directed by group members. As before, preparation involved a pre-group visit to each group member. Three members were present. These members have attended all group sessions thus far. Three members did not attend because one had another commitment, one forgot, and one was ill. It was decided that the two members who have not attended any sessions because of illness would no longer be part of the group.

Observations

The emerging themes for session for include: interacting with others, listening to music, letter writing improve mood; the limitations old age create dilemmas in improving mood (decreased manual dexterity, decreased mobility and dependency on others, decreased hearing); difficulties adapting to communal living in long-term care; maintaining core values in communal living; strategies for dealing with conflict.

Members present seemed to be disappointed that there were only three group participants. Nevertheless there continued to be a cooperative and friendly climate in the group. There was good cohesion in the group, because there were fewer interruptions with fewer people.

Interaction within the group seemed to be limited and much of the communication was through the facilitators. Were they uncomfortable with the situation? People were not into discussing mood. Although there were no conflicts,

the strained interaction is indicative of something. It may be that members appreciate the activity of group more than the actual content of the group sessions. For example one of the members appeared to be enthusiastic about sharing pictures from a recent trip to visit his son. Others seemed to take interest in what he had to say and may have experienced the trip vicariously. The trip generated some spontaneous discussion about what was seen, the fall colours and activities during the trip. This provided a good example of the benefits of engaging in a pleasant activity. However it also reminded people that their choice of activities was limited. This individual was enjoying a measure of independence that allowed him the option to experience activities outside the long-term care setting (an option very few residents have).

Reflections

The two members who are no longer part of the group paradoxically have identified themselves as too depressed and too anxious to attend group sessions. The group approach may not be an appropriate setting to address their mood. Appropriate referrals were made to provide alternative support. The limited number of participants in session four highlights the difficulties of group work in long-term care with the elderly. Cognitive behavioural therapy requires regular attendance, because consecutive sessions are built on topics covered in previous sessions. In addition, members may not have the ability to remember what happened in previous sessions. Short-term memory loss has an impact on the gaining of insight. Furthermore, the group participants have survived to this point in spite of their depressed mood and current situation. The presentation style of the cognitive behavioural group approach

may have little useful information that can be incorporated by group participants to manage their depressive symptoms and enhance well-being.

Members discussed strategies to improve mood, but with little enthusiasm. The primary focus and interest was on a group member's trip outside of the setting, providing an escape from the current situation and identification with independence. This may have been more beneficial in improving mood than gaining insight into one's situation. Once again the ongoing concern about the appropriateness of the cognitive behavioural approach is questioned.

It was noted that one member did not discuss the challenges of the living in a long-term care setting. The reasons for this may vary and may remain unknown. This may reflect coping abilities, an absence of difficulties, fear of admitting weaknesses, acceptance of situation, or anticipation of events (e.g. planning a trip). Regardless of the reasons for his reluctance, this member provides an excellent example of the concept of how planning and participating in pleasant events effects mood. His adventures have had a motivating effect on himself and on the other group participants.

Group Session Five

Introduction

The focus of session five was to use a non-directed format and to allow issues to freely evolve. Preparation involved a pre-group visit to each group member to remind them of the group session and to ensure that group members knew where the group was to be held and that they had a means of transportation to the group. Three

people attended the group initially (core members), one was late and two were ill. People who could not attend the groups expressed their genuine regret and disappointment to the facilitator during the previsit.

Observations

The range and number of topics the participants discussed increased dramatically. The emerging themes included: loss of family members; coping with loss; death of loved ones reminding people of own mortality; "sense of possession" is decreased in long-term care; finding comfort in long-term care is a function of care; difficult not being depressed in long-term care; cycle of stress; support networks; acceptance of living in long-term care; gender differences in activities; spirituality and religion; guilt and regret.

Even though the attendance was low, participants were more energetic than during the previous session. There appeared to be a good sense of group cohesion. Interaction between group members was lively with many ideas being expressed and discussed. People appeared to feel free to talk about deeper issues.

Reflections

The lateness of an individual attending group sessions highlights the subtleties of cognitive impairment. It was curious to note that this individual scored almost perfectly on the MMSE. This has implications for the appropriateness of using the MMSE as a screening instrument for the original planned intervention.

The non-directed approach that was used during this session seemed to stimulate much more participation than the more directed approach in previous

sessions. People appeared to feel free to comment on topics that arose and contribute their own stories. The increased participation may also have been a normal part of group process that develops as a function of time together and discovering the commonality among each other. In addition, advice was sought from group members. This appeared to motivate people to participate as a consultant and opened the dialogue up to more involvement. This reduced the perception of the expert versus the group member and equalized the relationship of all involved. Asking for feedback from the group seems to be an excellent way to introduce topics that need to be discussed. For example, the schedule of pleasant events for older adults (Appendix 12) was introduced as a topic that required their feedback. People were open to this and maybe even a little excited about having a role in discovering a way to think about planning activities and in what activities they could participate.

During the session it was evident that people benefited from talking about difficult issues even though they couldn't be resolved. This supports the utility of group sessions. Furthermore, listening to people interact with each other during the session, there was an impression that they have come to terms with the difficulties of a long-term care setting, despite some of the depressive symptoms they may still display.

The expectations of the original design of the group sessions appear to have been too detailed. A more realistic expectation for this population would have been to limit the number of prescribed topics and skill development. It may be sufficient to discover the link between mood and activity. For example, if opportunities to

participate in an activity were limited, the goal would be to find ways to increase the opportunities.

Group Session Six

Introduction

The focus of session six was to continue the non-directed format and to allow issues to freely evolve. As in all previous group sessions preparation involved a pre-group visit to each group member to remind them of the group session and to ensure that group members knew where the group was to be held and that they had a means of transportation to the group. Five people attended the group. One person forgot, in spite of the reminder.

Observations

As in the previous session, many themes arose. These included: living in long-term care is depressing; pleasant events are plentiful; engaging in events and activities is beneficial; difficulties identifying positive things in long-term care; living in long-term care is a necessity for people who require help; there are good and bad staff; unpleasant events and unpleasant people influence moods; problem solving about inappropriate treatment of residents by staff; helpless people in long-term care are victimized by some staff; group sessions are perceived as a safe place.

Climate continues to be informal, respectful, and cooperative. Members are interjecting more humour into their discussions. This signifies that people are becoming more relaxed, trusting, and comfortable with each other. When five people attend, there is a stronger sense of group than with only three. Interaction between

group members has increased. Group members are beginning to respond to each other's comments. People feel free to disagree with each other and disagreements are resolved respectfully.

Members who attended group session five brought the pleasant event schedule assigned in session three for discussion. Members appeared eager to discuss the list. One member had even written a page of information about how a depressed person thinks. Other members reported various activities in which they participated. In discussing the pleasant events schedule, participants seemed to grasp the connection between experiencing pleasant events and mood. In long-term care pleasant events can be ordinary every day things. When an effort is made to appreciate the ordinary events, mood can be elevated. Therefore, the schedule can be used to gain some control over how one is feeling by doing something that one can control.

Reflections

The non-directive approach continued to be effective in soliciting responses and engaging people in discussion. It allowed members to perceive themselves in collaboration with the group facilitators. It recognized their authority from the perspective of their experience and wisdom. It was possible to introduce the cognitive behavioural technique of identifying pleasant events in an indirect way.

Throughout the group sessions, group members identified the setting as "depressing". Even though members recognize their need to be in long-term care, the setting represents a loss of independence and remains a threat to whatever independence is left. They are told what to wear, when they eat, what events to go to,

what would be good for them, etc. etc. They are even told what certain events are supposed to mean to them and how they will be affected by them. The loss of independence becomes a threat to a state of being. One group member characterized this state of being as a "sense of possession" in that everything a person owns becomes an integral part of their being. The act of coming into long-term care requires the relinquishing of possessions that have taken a lifetime to accumulate. People seem to accept that it is a difficult environment to live in. Members stated that nothing could be done about the setting, but they recognized that engaging in activities helped to decrease some of their negative feelings.

Group Session Seven

Introduction

The focus of session seven was once again non-directed and to review pleasant events of the past week. As per usual preparation involved a pre-group visit to each group member to remind them of the group session and to ensure that group members knew where the group was to be held and that they had a means of transportation to the group. Five members were present. One member was ill.

Observations

This session's emerging themes included: the importance of humour in general; noise in the setting created by staff; benefits of happy staff on residents in long-term care; benefits of the recreation program; goals of getting better and improving health; lack of meaningful activity; individual recreation programs; transition to long-term care setting; mixed feelings about loosing control; the need to

"keep fighting", because when you quit it is time to die; the right to die("pack it up"); requiring help yet holding on to independence; a reminder that next week would be the last session.

Overall the group climate remained respectful. There was more use of humour. Individuals were beginning to challenge each other respectfully. The larger number of people in attendance seemed to have a positive impact on the climate and cohesion of the group. It was observed that group participants require approximately twenty minutes for group members to address each other directly.

Group participants had trouble spontaneously recalling what they did throughout the week. When asked if they did any thing today, some members were unable to recall or did not make the connection between the activities in which they participated and assignment of identifying pleasant activities. However, there was animated discussion as members brought up the various topics that emerged.

Reflections

It is difficult to discern what it is about Cognitive Behavioural Therapy model that does not work. The prescriptive and directive nature of the model appears to turn people off. It can be perceived as somewhat demeaning and paternalistic. Do people actually like the mini lecture style (didactic style) of a psycho educational group? People want to get away from being stereotyped and categorized by symptoms. People in long-term care are more open and freer without the prescriptive aspects of the Cognitive Behavioural approach.

A technique that appeared to work is to introduce a general concept or topic and then ask for their personal reflection on that topic. For example, people in long term care often experience adjustment difficulties to long term care. Moving to the smaller context or bringing it to the members of the group is characterized by the question "What do you think?" This allows people to consider the larger picture and evaluate their experience in terms of the larger picture. It appears that people participate more with this type of approach. The prescriptive nature of Cognitive Behavioural Therapy tends to put a lot of information to the members of the group inferring that they do not have any information about the topic that is being discussed. When people identify with the topic and their own expertise is solicited, the chances for meaningful participation increase.

Another issue that is becoming apparent is that people want to maintain the hope that things will get better. Participants appear to hold on to hope because that is what keeps them going. Maybe it is unrealistic but it is functional. As one member said, "Once you realize there is nothing left then it is time to pack it in"(client B). However, even this is not one's choice. This comment is indicative of the dilemma residents face in long-term care. On one hand people realize, want and accept help but on the other they want to maintain the independence they have if not regain some that has been lost. It is within this context that the Cognitive Behavioural approach is presumptuous. What is the goal of the intervention? It is as if symptoms are imposed on people by telling them that the reaction they are having to this situation is abnormal and requires treatment. In fact, they may have accepted the reality of living

in long-term care. People in long-term care do not like it, it is sad, it is a loss, it is a threat to independence, but they have accepted it. People are entitled to feel and react to situation they do not like without being labeled as abnormal. It was evident is this session people are experts of their own situation to an extent.

The length of sessions poses a problem in that sessions cannot be long due to attention span and fatigue. However members require a period of time to socialize which leaves very little time for therapeutic intervention.

Group Session Eight

Introduction

The focus of session eight was to continue the non-directive approach and process group termination. Session preparation involved a pre-group visit to each group member to remind them of the group session and to ensure that group members knew where the group was to be held and that they had a means of transportation to the group. Five group members were present. One participant was involved in another activity.

Observations

The emerging themes for the final session included: "shrinking horizons" in old age; a group is a good place to discuss issues related to mood; doctors do not understand depression; the effects of co-resident's death; it is depressing to think about "loosing it" (cognitive decline); reviewed key themes of group sessions; loss of an important activity as a result of ending the Well-Being Group; dilemmas of long-term care; commonalties of people in the group; euthanasia (including Health Care

Directives); death, the right to die; continuation of the group; perception that people with cognitive impairment may have an easier time with mood; future plan to continue some form of the present group with additional members.

Group members were respectful and cooperative. They seemed to have developed close relationships within the group. Members appeared to work hard at respecting each other's comments, even when there was disagreement. It may be that it was more important to maintain a relationship rather than win an argument. People appeared to be bright and alert, eager to begin. Humour was prevalent. The general atmosphere was relaxed and informal.

Members were reluctant to engage in the discussion about pleasant activities of the past week as part of the homework review for the previous session. However, when the expectation of recalling pleasant events as part of homework was removed, group discussion became animated and lively. In this session participants began interacting with each other much earlier than in the previous sessions. Serious topics were raised. It appeared that group participants were motivated by the threat of the last group and thus tried to touch upon issues that they may have wanted to talk about in previous groups. Several members talked openly about depression rather than mood and well being.

Reflections

It was interesting to see the group participants with an anticipatory attitude. Members of the group appeared to be energized. They appeared to be alert and eager to participate. Perhaps it was a sense of accomplishment that they experienced with

the completion of the project. People said they enjoyed the group sessions. They unanimously supported the continuation of the group.

People seemed very interested in what the facilitator thought of the group and the themes that emerged. They were intrigued by the fact that the facilitator would have learned something. Is this indicative of the power of the professional?

It is interesting to note that during this enthusiastic session, the only time members were reluctant to participate was when they were asked to take part in structured activity of discussing pleasant activities. One wonders about the usefulness of imposing this concept and skill development.

Group Observation Summary

The plan, techniques used, and observations are summarized in Table 1.

Table 1: Group Observation Summary

Session	Plan	Techniques Used	Observations
1.	-Introduction of members -Review purpose of group -Establish ground rules -Define depressive symptoms -Highlight benefits of group work -Homework: Tracking daily mood	-Didactic presentation -Socratic dialogue -Guided communication -Homework	-Members appeared uninterested in the presentation -Didactic presentation seemed to minimize experience -Members depended on facilitator communication -Members seemed more involved during guided communication -Illness decreased attendance
2.	-Thoughts that cause and maintain a depressed mood -Identification of errors in thinking -Increasing positive thoughts that improve mood -Homework: Mood graph & pleasant events schedule	-Didactic presentation -Socratic dialog -Guided communication -Collegial approach to engage members -Open-ended questions -Humour -Homework	-Didactic presentation appears to be ineffective (members were inattentive) -It seemed to minimize member's expertise and experience -More participation and interaction with collegial increasing self-confidence by reconnecting with past achievements -Members responded to humour with increased interaction -Members forgot homework assignment

3.	-Establish relationship between pleasant events and mood -Pleasure predicting -Setting goals	-Free interaction as warm-up activity -Didactic approach -Guided communication -Collegial approach to engage members -Open-ended questions -Soliciting information from members -Humour	-Allowing members to freely interact in beginning fostered group development -Homework was not completed -Limited response during homework review -Better to track moods through discussion rather than written homework -Members responded more to collegial approach than didactic approach -Member's memory deficits and illness limited the effectiveness of a highly structured approach and requires modification -Ongoing losses challenge the concept that depressed mood is the result of faulty thinking and apathy
4.	-Establish connection between pleasant activities and mood -Develop strategies to bolster mood -Discuss issues presented by members	-Free interaction as warm-up activity -Discuss past week events and moods -Guided communication -Collegial approach to engage members -Open-ended questions -Soliciting information from members -Humour	-Small group size impacts interaction between members -Members benefited from engaging in pleasant activities -Short-term memory loss has an impact on the gaining of insight. -Members have survived to this point in spite of their depressed mood and current situation -Review of past experience and successes promotes well-being -Communication between members has increased and requires less guided communication
5.	-Discuss issues presented by members -Identify pleasant activities --Continue to establish connection between pleasant events and mood	-Free interaction as warm-up activity -Discuss past week events and moods -Collegial approach to engage members -Open-ended questions Soliciting information from members with "general to specific" technique -Humour	-Non-directive approach stimulates more participation than the directed approach Difficult issues were raised and discussed -There was an impression that members have come to terms with the difficulties of relocation -The resilience of members was evident -Asking group members for advice motivated members to participate as consultants -This reduced the perception of facilitator as expert -It is important to limit the number of prescribed topics and skill development within group sessions
6.	-Discuss issues presented by members -Identify pleasant activities -Continue to establish connection between pleasant events and mood	-Free interaction as warm-up activity -Discuss past week events and moods -Collegial approach to engage members -Open-ended questions -Soliciting information from members with "general to specific" technique -Humour	-Non-directive approach continues to stimulates more participation than the directed approach -Additional difficult issues were raised and discussed -The collaborative approach is more effective to help members acquire understanding, insight, skills, and develop strategies

7.	-Discuss issues presented by members -Identify pleasant activities -Continue to establish connection between pleasant events and mood -Prepare members for final group	-Free interaction as warm-up activity -Discuss past week events and moods -Collegial approach to engage members -Open-ended questions -Soliciting information from members with "general to specific" technique -Humour	-Non-directive approach continues to stimulates more participation than the directed approach -Additional difficult issues were raised and discussed -Despite many losses members remain hopeful -Members want to remain some sense of independence -Members are experts of their experience -Symptoms may not necessarily require treatment -Symptoms may reflect a normal reaction to an abnormal situation
8.	-Discuss issues presented by members -Identify pleasant activities -Continue to establish connection between pleasant events and mood -Process group termination	-same as session 7	-Modifying the originally planned cognitive behavioural approach to include a more collaborative style was effective -Final sessions elicited serious topics which previously had not emerged -Sense of accomplishment was evident -Members wanted the group to continue

The above summary of observations traces the development of the Well-Being Group. Toseland and Rivas (1995) discuss a variety of group development models. The development of the Well-Being Group corresponds to Trecker's (1972) model. In this model the beginning stage of the group is characterized by the emergence of some group feeling. The middle stage of development is characterized by the development of bonds, purpose and cohesion. There is a strong group feeling. The end stage of group development is characterized by personal evaluation of the group experience, highlighting accomplishments, identification of further needs and processing feelings around termination.

A number of skills were learned and employed by the facilitator during the group sessions. These skills correspond to the three categories of skill development necessary for group leadership as outlined by Toseland and Rivas (1995): group

facilitation, data gathering and assessment, and action. In the category of group facilitation, skills acquired include involving group members, attending to members, expressing self, responding to others, focusing on group communication, making group processes explicit, clarifying content, and guiding group interactions. In the category of data gathering and assessment, the skills acquired included identifying and describing thoughts feelings and behavior of group members; requesting information; questioning and probing; summarizing and partializing information; synthesizing thoughts, feelings, and action; and analyzing information. In the category of action, acquired skills include supporting; reframing and redefining; linking members communication; direction, giving advice, suggestions or instruction; providing resources; modeling; role playing; rehearsing and coaching; confronting; and resolving conflicts.

Data Review

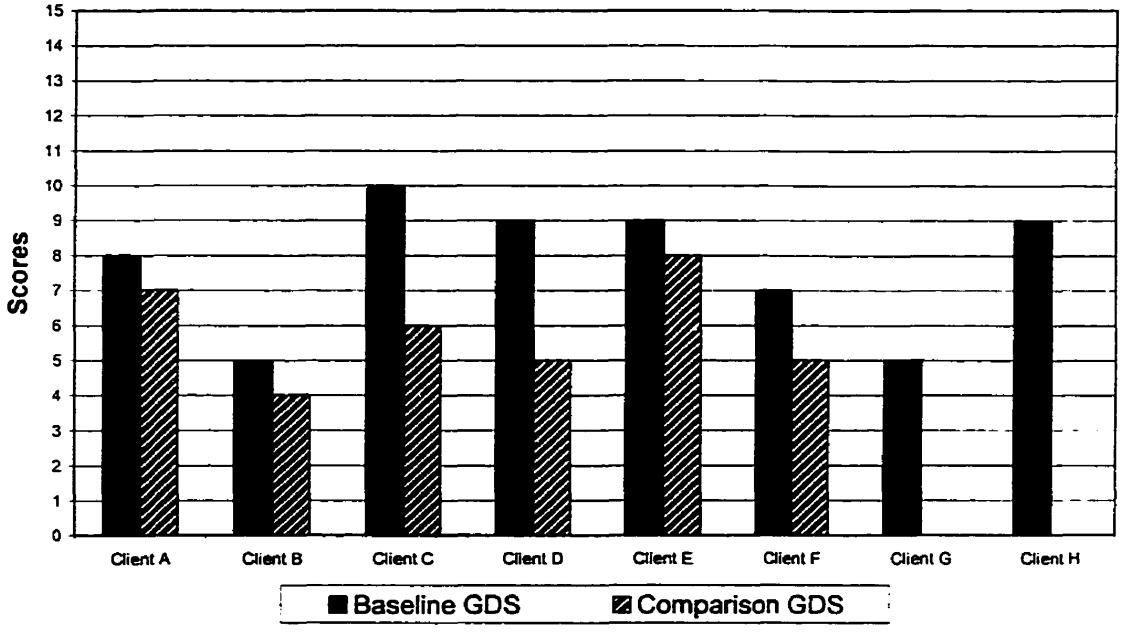
GDS Results

Originally there were eight people who consented to participate in the Well-Being Group. Two original members were unable to participate due to health reasons. The data of the baseline and comparison GDS scores are from the six group participants who completed eight group sessions of a closed group. The GDS baseline was obtained as part of the screening process. For comparison purposes a GDS was administered one week after the final session along with the questionnaire. No tests of

significance were performed on the data. Of the six participants screened, five individuals had significantly high levels of depressive symptoms according to GDS items. The visual inspection of the data shows a slight decrease in individual GDS scores indicating a slight decrease in depressive symptoms. Two individuals showed a decrease of four points on the GDS.

Figure 1 shows the individual raw scores of both baseline and comparison GDS measures. The figure indicates that the baseline scores range from five to ten. The comparison scores range from four to eight. The difference in scores indicates the intervention decreased the depressive symptoms of group participants.

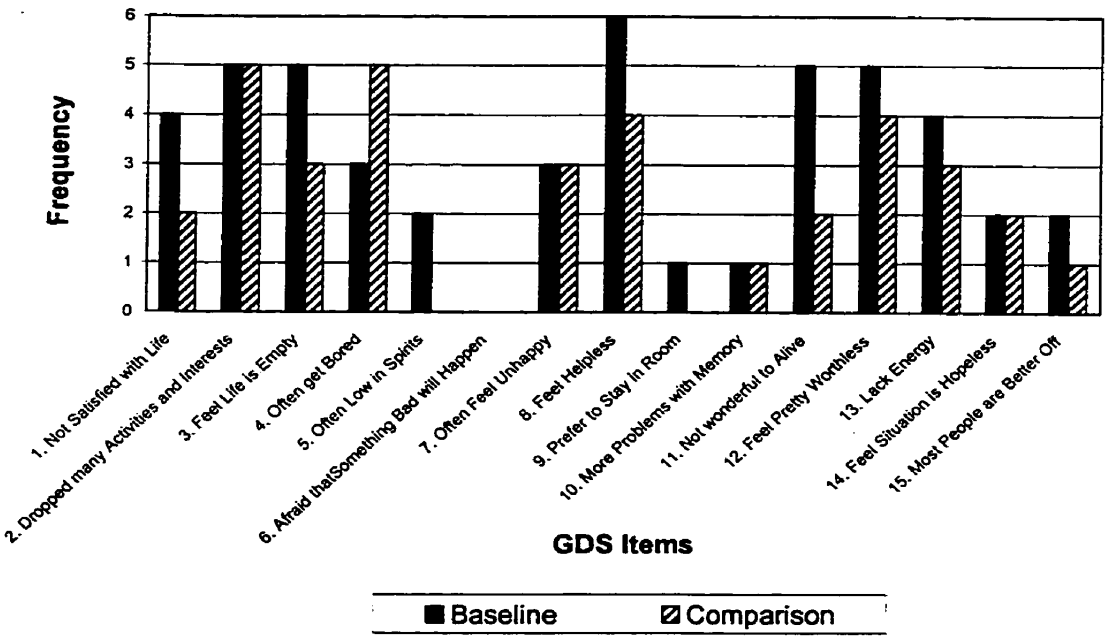
Figure 1: Baseline and Comparison GDS



The baseline and comparison GDS items were compared to explain changes in GDS scores as illustrated in Figure 2. The biggest changes (two or more people)

occurred in item number one (not satisfied with life), number three (feel life is empty), number four (often get bored), number eight (feeling helpless), and eleven (not wonderful to be alive). These changes could be attributable to several reasons. For items one and three (not satisfied and life is empty), involvement in the group may explain the decrease in the feelings of emptiness and an increase of satisfaction with life. Item four shows an increase in feelings of boredom that could be attributable to identifying pleasant events. Members may have realized that they were participating in very few pleasant activities and this is reflected in the higher negative

Figure 2: Baseline and Comparison GDS Items



rating for this item on the GDS. For item number eight (feeling helpless), the act of choosing to participate, contributing something meaningful during group sessions as experts, and interacting with others may have restored members with a sense of

control. For item number eleven (not wonderful to be alive) involvement in the group process may have contributed to the increase in the impression that "It is wonderful to be alive".

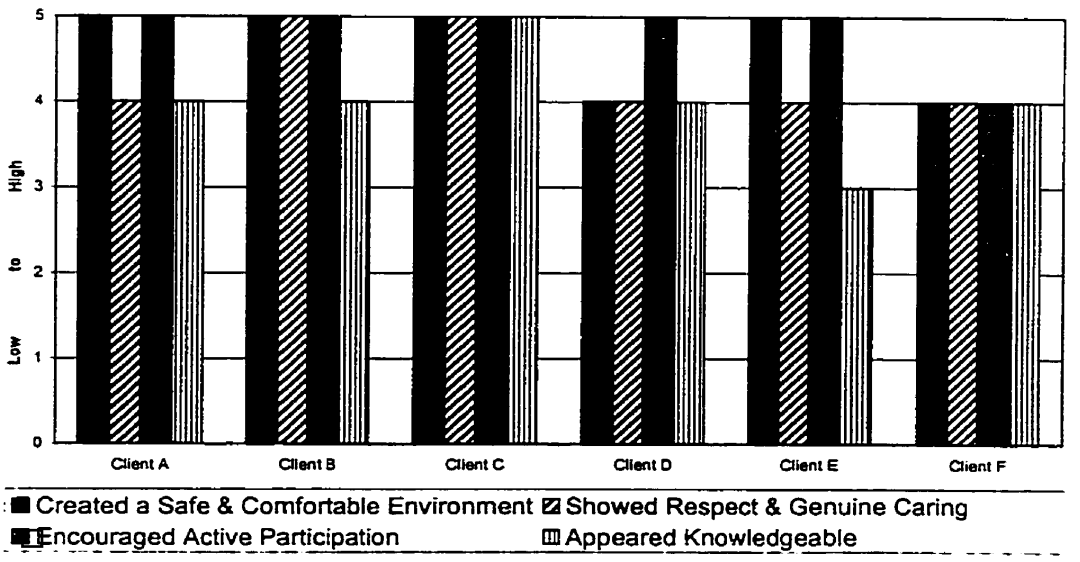
Questionnaire

The results of the questionnaire helped to evaluate the facilitator, the group sessions and client satisfaction. The questionnaire also had opened ended questions to determine what was beneficial and what was not beneficial of the group sessions.

With regards to the facilitator, group members completed four Likert style questions. The questions asked members to rate the facilitator on the following items: creating a safe and comfortable environment; showing respect and genuine care; encouraging active participation; and knowledge about areas of concern.

Figure 3 illustrates the how clients rated the facilitator on a continuum of five points: 1 = definitely not, 2 = no I don't think so, 3 = maybe, 4 = yes I think so, 5 = definitely.

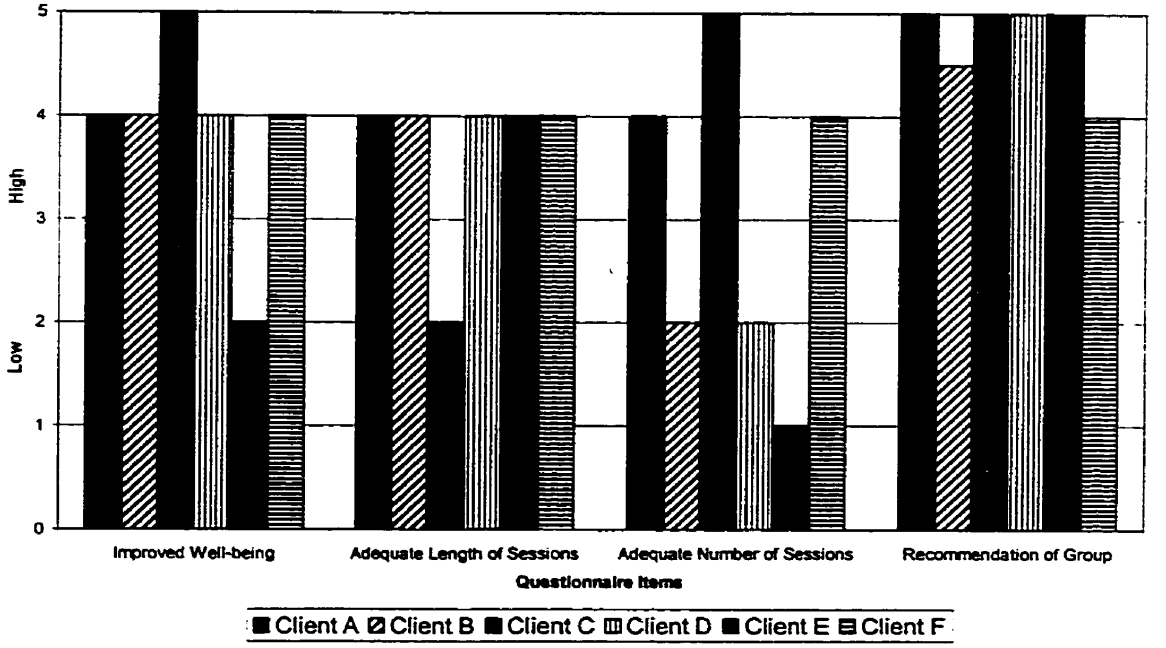
Figure 3: Facilitator Evaluation



A visual examination of the data shows that the group members rated the facilitator positively. The range of scores for creating a safe and comfortable environment was four to five. The mean score was 4.6. The range of scores for showing respect and genuine caring was also four to five. The mean was 4.3. The range of scores for encouraging active participation was four to five. The mean was 4.83. The range of scores for rating facilitator knowledge was three to five. The mean was 4.0.

With regards to member's perception of the group experience, group members completed five Likert style questions. Members were asked to rate the group on the following items: improved emotional well-being, adequate length of sessions, adequate number of sessions, and recommendation of group to others. Figure 4

Figure 4: Perception of Group Experience



illustrates summarizes how group members rated the group experience along the same continuum as above.

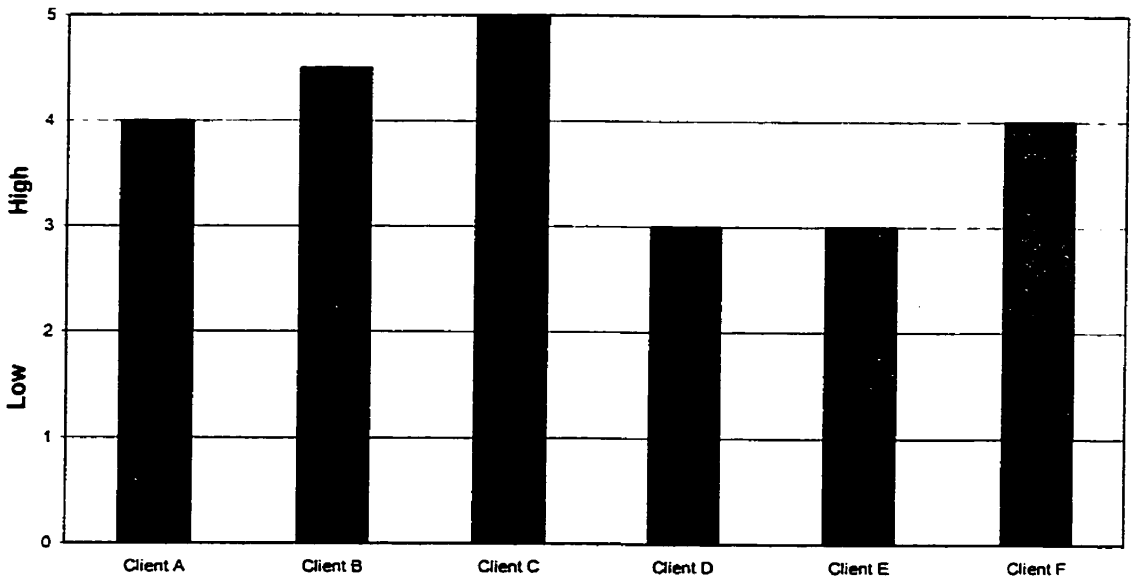
A visual examination of the data showed the group members rated the group experience positively. The overall mean score for improvement was 3.8. The range was two to five. The mean score for length of individual sessions was 3.7. The range was again from two to five. The mean score for number of sessions was 2.3 and scores ranged from one to five. The mean score for group recommendation to others was 4.75. The scores ranged from four to five. The variability in the rating score for the group experience can be partially explained. For example, Client E's low rating of improvement corresponds with her personal statement that she's chronically depressed and does not expect to improve. At the same time, Client E thought that the length of individual session were adequate and highly recommended the group to others. Client E was disappointed in the number of sessions and wished that there were more. Client C had high rating for all categories accept for the length of session which was rated low indicating that longer sessions would have been preferable. This corresponds with Client C's perception that the group provided a welcome and anticipated activity. Similarly Client D rated the overall experience positively, but rated the number of sessions low, corresponding with the expressed desire to participate in a meaningful and stimulating activity.

Group satisfaction was measured by a single Likert style question. Members were asked to rate their satisfaction with the group experience on a continuum scale

of five points: 1 = very unsatisfied; 2 = unsatisfied; 3 = satisfied; 4 = very satisfied; 5 = extremely satisfied.

Visual inspection of the data illustrated in Figure 5 shows that members were satisfied with the group experience. Scores range from three to five. The mean score was 3.25. During exist interviews several members expressed their disappointment

Figure 5: Satisfaction of Experience



that their experience has come to an end. This may explain the variability in some scores. For example, Client C who was disappointed that there were not enough sessions, was less satisfied because the group was coming to an end.

The final section of the questionnaire asked group members to answer four opened-ended questions and to add any other comments regarding their experience.

The first question asked whether things changed for group members since they participated in the group sessions. The responses included:

"No, however group was welcome activity and I met new people in the group who were similar to me." (Client A)

"Nothing changed, except, I was involved in a weekly activity. I was interested in how group members were thinking. I met new people. It was an activity." (Client B)

"Yes, the group offered me enjoyment." (Client C)

"Yes, I learned a lot. It was a place to bring subjects up safely." (Client D)

"No, but group provided a welcome activity." (Client E)

"Not particularly." (Client F)

The second question asked what members found helpful in the group sessions. Responses included:

"It was good to sit around the table. There were no gag orders on the comments. I felt free to talk about anything." (Client A)

"Discussion brought up topics of interest and made you think about how you feel about things. It was thought provoking. I was impressed with the dedication of other group members." (Client B)

"I found that the group brought happiness, enjoyment, and humour. It brightened my life. I enjoyed the variety of topics. I like to hear what others think about things." (Client C)

"All members contributed to topics. We're all in the same boat." (Client D)

"People with depression are similar. I liked that commonality." (Client E)

"I realized everybody is in the same boat. Some can handle the situation better than others can. I liked the humour. I liked the two men." (Client F)

The third question asked members what they did not find helpful in the group sessions. Four out of the six people did not have a comment. Responses included:

"Would have liked a bigger group. There are a variety of people. Each case is different, some people are depressed with what happened them and some are depressed because of where they are." (Client E)

"The location was hard to get to and worried you. I found it was too early in the day." (Group was at 2:00 p.m.) (Client F)

The final question asked what if anything needed to be added, deleted or changed in future groups. The responses included:

"No lectures." (Client A)

"Continue to have water and juice." (Client B)

"Have a more central location. I have short term memory problems." (Client C)

"We need more time to adjust to a new group." (Client D)

"I wish there were more people in the group. That way more people get involved." (Client E)

"It would have been better if group session were at 3:00 p.m. Generally, it was a good experience." (Client F)

When members were asked if they wanted to add any additional comments the following responses were given:

"I always used to plan things. Now I'm just existing in a cocoon. I used to live. I prefer an interaction style rather than a lecture. I didn't sign up for the lecture nor did I pay for it. I prefer to read. I'm an adult. When is the group going to start again?" (Client A)

"If I had control, I'd like to run out of life all at once. Memory is fluid. It's like a book; it does come to an end. I consider I'm better off because of my outside influences. I enjoy the to opportunity to discuss things. I appreciated you sharing your information. Each person is affected differently by old age. It is an individual journey. If started up again, I would be interested." (Client B)

"I would be interested in more group sessions. It brightened up my life. There is no one to talk to. I've been here almost two years and there is only one

person who I speak to. I don't want to talk about the war. I hate being read to and lectured. I enjoyed the group very much. I'm very sorry it didn't continue." (Client C)

"I preferred sharing information rather than listening to a lecture. There are some real practical reasons why I don't feel great about being here. I'm getting used to interm (temporary placement in long-term care), but Holy Dinah, I can't believe the bathrooms." (Client D)

"Nobody likes to be lectured. You can't fix me. As you grow old you grow smarter. I want respect. Most people would be dead if they couldn't deal with things." (Client E)

"I would be interested in another group in the New Year. I felt down at end of group." (Client F)

The open-ended questions gave a clear impression that people prefer the interactive, non-directed approach versus a didactic presentation and discussion. As well, it appeared that the act of belonging to and attending group sessions was meaningful as illustrated by the responses to the second question: it was interesting, thought provoking, brought happiness, humour, enjoyment, commonality, and

socialization. Four members also expressed an interest for the group sessions to continue.

Discussion

The learning objectives of this practicum were to design and implement a group intervention which decreases the depressive symptoms of elderly and as a result increases their sense of well-being; to discover what factors influence and are associated with depressive symptoms and well-being in long-term care; and to increase group work knowledge with the elderly in long-term care. Much was learned in the process of preparation, implementation, and evaluation.

With regards to the first learning objective, the initial design of the group was an adaptation of a cognitive behavioural approach (Gallagher & Thompson, 1981; Miranda, et al., 1992). Early in the intervention it became evident that the planned cognitive behavioural approach was not working and the empowerment approach was incorporated. Four reasons have been identified.

First of all, the duration of the session presented a problem. Basic procedural sequence of cognitive behavioural therapy requires more than fifty to sixty minutes per session (Miranda, et. al.,1992). The basic procedural sequence that Beck (1979) outlines appears to require considerably more time. Ideally one would want to have enough time to socialize (warm up), present a topic, discuss reactions, review previous homework, talk about new homework, and allow for discussion of issues that arise. In reality, the need for socialization, group member fatigue, and pressures

of appointments within the institution limited the amount of time available to employ the original intervention approach.

Secondly, it needs to be recognized that over 85% of the people in long-term care have some form of cognitive impairment including short term memory deficits (Graham, Rockwood, Beattie, Eastwood, Gauthier, Tuokko, & McDowell, 1997). Group members expressed a common concern about their memory deficits. This had a direct impact on the implementation of the approach. Members were unable to recall previous session topics, they forgot the simple homework assignments, and when binders were used to collect information they were forgotten. Some members needed to be reminded about the time of sessions at least one our in advance. It was assumed that the cut off score of 25 on the MMSE (Folstein, et. al., (1975) indicated that people were relatively cognitively intact and thus the cognitive behavioural approach would be effective (Gatz, et al., 1998). It appeared that the assumption was not well founded within this group. The subtleties of short term memory deficits have an implication on the ability to process the concepts, to develop new skills, to remember homework, and to gain insight in the manner that is prescribed by the cognitive behavioural approach.

Thirdly, it was clearly evident that members did not accept the lecture presentation style adopted to teach skill concepts and skill development, and process homework assignments in an attempt to provide a guided experience. (Gallagher & Thompson, 1981; Miranda et al., 1992). During attempts to present information, members appeared to be disinterested, bored, and fatigued. When the less directive

approach was used group members interacted significantly more. Members expressed their dislike for lectures in their response to the questionnaire. For example, "I didn't sign up for a lecture, nor did I pay for it. I prefer to read. I'm an adult"; "I prefer sharing information than a lecture"; "Nobody likes to be lectured." It appeared that group members reacted to the condescending style of presentation and the imposition of information. A possible explanation could be that it devalued their own wisdom and did not consider their own personal experiences and expertise. They already had a wealth of knowledge and skills that they preferred sharing with each other.

From observations of group sessions, the concerns of the cognitive behavioural approach as expressed by the literature were experienced in this group. If the emphasis is on teaching people, rather than listening to them as experts of their own lives, it is understandable why people feel detached from the process and not interested. Corey (1996) identified that people may not feel listened to or cared about because of the nature of the approach. Freeman and Dattilio (1992) and Weishaar (1993) highlighted concerns regarding an emphasis on techniques and working on the elimination of symptoms. Patterson (1986) raises concerns that learning by self-discovery is more important than teaching by an "expert".

A fourth consideration for questioning the validity of the cognitive behavioural approach is a tendency to pathologize a negative event such as relocation resulting in depressive symptoms. Contrary to Zeis and Stephen's (1996) claim that collaborative psycho educational feature is non-pathologizing in nature, the cognitive behavioural therapy model seems to suggest that "faulty thinking" effects mood and

that individuals are responsible. Freeman and Dattilio (1992) and Weishaar (1993) support the notion that cognitive behavioural approaches focus on the elimination of the symptoms while ignoring underlying causes. This minimizes the effect that the long-term care experience has on mood (Manion & Rantz, 1995). Furthermore, Fillip (1995) supports the refocus from a disease model to one that appreciates the resiliency of the individual in later life.

In response to the perceived ineffectiveness of the highly structured aspects of the cognitive behavioural approach, an empowerment model and philosophy was incorporated in the early stages of the group intervention (see Appendix 13). This model was adapted from the empowerment-oriented practice model (Cox & Parsons, 1994) and the strengths model (Tice & Perkins, 1996). Both models rely on the collaborative assessment of the problem to conceptualize components of the problem and formulate strategies for action and reflection. The blended approach was more collaborative, non-directive and saw the reaction to relocation as a normal rather than a pathological response. This is in contrast to Beck's (1995) emphasized goal of cognitive behavioural approach as changing an individual's reaction to an upsetting event implying reaction is abnormal. In addition, the process became a shared gathering of information, consciousness raising, an exploration of strategies, and learning. The new goal then of the group was not to treat depressive symptoms, but to offer support through the transition period of relocation to long-term care. It was the collaborative and supportive atmosphere created by using the empowerment model that offered the therapeutic intervention.

A technique that appeared to work well in the group sessions was either for the facilitator or group member to introduce a general topic and then ask for personal reflections on that topic. For example, "People in long term care often experience a adjustment difficulties to long term care". Moving to the smaller context or bringing it to the members of the group was characterized by the question "What do you think?" This allowed people to consider the larger context and evaluate their experience in terms of that context. Once people responded to the larger context, they found it easier to personalize the issue and started to respond from their own experience. Other group members followed with their expertise. Thus the wisdom and experience of group members was utilized and valued. This is in direct contrast to the psycho educational style of the original intervention. Group members reflected on the skills they already had and learned from other members. The collaborative nature restored a sense of control to group members. Control Theory, (Heckhausen & Schulz, 1995) explains that having some form of control contributes to a sense of well-being. Because group members were more in control they felt more involved and part of the process. The blended approach appeared to reduce passivity and perhaps addressed the paternalistic nature of the cognitive behavioural approach. In addition it fostered a non-threatening atmosphere. Within this context it was still possible to explore issues, exchange information, learn from each other, and discuss strategies.

It was evident that the blended approach was effective. Members immediately participated more during sessions. They brought up more issues, the discussion was more animated, more personal issues were discussed, people shared more of

themselves, and there was more interaction between members. There was also open discussion about helpful coping strategies. In addition, the final group evaluation was rated high supporting the use of the non-directive approach. There also was a high rating of group satisfaction, recommendation, and a desire to continue the group sessions.

The second learning objective was to discover what factors influence and are associated with depressive symptoms and well-being in long-term care. The major factors that emerged in the group sessions were loss, relocation, socialization/activity, life history, personality traits, and the setting of long-term care.

There is no doubt from discussions within group that the many losses that accompany the transition into the long-term care have a profound effect on individuals. The losses that were identified by group members include the following: loss of independence; loss of freedom; deterioration in health; loss of home; sense of separation from family, friends and immediate community; "sense of possessions"; and loss of privacy. A number of studies corroborate the many losses identified by the group members (Crosby, 1994; Joiner, 1991; Solomon, 1993; Starck, 1992).

Socialization appeared to be associated with depressive symptoms and well-being. Several members commented on the limited number of individuals with which to socialize. Several other members admitted to remaining in their rooms and isolating themselves because of the lack of meaningful interactions with people. Studies support member's sentiments that the opportunities for socialization are reduced as a result of relocation and have an impact on well-being (Solomon, 1993;

Joiner, 1991; and Chick & Meleis,1986; Mullins & Dugan, 1990). In addition, Blazer and Williams (1980) see the development of a depressive stupor as the result of a change in social condition. Attending the group seemed to address the need for socialization. Group members frequently commented on the benefits of interacting with people in similar circumstances, for example: "I haven't laughed like this since I got here" (Session 3, Client C); "It's good to be with people you can talk to" (Session 2, Client D); " It brought me happiness, enjoyment, and humour" (Questionaire, Client C); "I like to hear what others think about things" (Session 7, Client B). This appeared to have a positive effect on the mood of group members. This positive effect appears to correspond with the Social Integration Theory (Antonucci & Jackson,1987) where social networks serve as a buffer against negative events. Several studies support this theory (George, 1989; Larson, 1993; Okun et al., 1990).

It appears that the life events that people have experienced prior to relocation may have an impact on their mood, general well-being, and ability to adapt to the long-term care setting. It is beyond the scope of this practicum to discern the magnitude these life events may have. However, members alluded to various events that influenced their mood states in the past and continue to do so in the present. This is supported by Murrell and Meeks (1992) who state that external factors influence mood in later life.

In regards to personality traits, several people in the group who were more outgoing and who had a more positive out look on life, appeared to be more sociable, more involved in activities, and interpreted events in a more positive light. They said

this helped them maintain a more positive mood during the transition to long-term care. This is supported by Headey and Wearing (1989) who proposed that the level of subjective well-being is predictable on the basis of stable personality traits.

Throughout the group sessions, group members identified the setting as "depressing". People seemed to accept that it is a difficult environment to live in. One member described the setting as a threat to a state of being. Research has shown that admission into long-term care requires people to conform to the organizational demands of the institutions, to behave sensibly, orderly, and tone down their individual traits (Pink, 1992; Stephen et al., 1991). Nevertheless, group members seem to have accepted that nothing can be done about the setting. They have accepted that they can engage in activities to ameliorate some of the depressive feelings. In fact, they may have accepted the reality of living in long-term care. They do not like it, it is sad, it is a loss, it is a threat to independence, but they have accepted it. The acceptance may be in part due to the shift from an assimilative to a more accommodative coping style (Brandstädter & Greve, 1990). For example, elderly people adjust their expectations and reappraise their goals. They are experiencing a normal reaction to this abnormal event and are relying on the skills and knowledge gained from past experiences.

The third learning objective was to increase group work knowledge with the elderly in long-term care. Group work with this population is effective, but has limitations. As discussed earlier, group members rated the group highly in the group evaluation portion of the questionnaire and the variety of emerging themes showed

high levels of interaction. The characteristics and process of the group sessions were similar to what Toseland and Rivas(1995), and Shulman (1992) have discussed: groups help members realize they are not alone; groups help in reality testing; groups help establish commonalities; groups provide a safe setting to discuss taboo topics; and groups provide a social outlet. Similarly members in the group liked to share their knowledge and views to help other members in the group. Members found commonalities in their situation and gained a reassurance that they were not alone in their feelings. Members felt the support of the group providing a safe environment to express their feelings and viewpoints. Within the group participants felt free to challenge viewpoints providing a means of testing reality. The members came to an understanding that the admission to long-term care was inevitable. Some individual problem solving was met with different opinions and options for solving problems. Comments that the group was a welcome activity, something to look forward to, indicated group sessions provided improved opportunities for social interaction.

The major limitations that were discovered working with this group of elderly individuals in long-term care were chronic illness, dependency, and cognitive impairment. People are admitted to long-term care because their health is compromised and they no longer can manage in the community (Wilson, 1997; Glazebrook, et al, 1994; Wingard, et al, 1987; Forbes, et al., 1987). It is understandable then that members would not be able to attend all sessions. This has an impact on the cohesiveness of the group. Therefore session contents need to be modified constantly. This is a compelling reason to question the use of the highly

structured aspects of a pure cognitive behavioural approach as it requires a continuity of sessions (Beck, 1995).

The organizational demands of a long-term care institution limits the independence of individuals (Pink, 1992; Stephens et al., 1991). It was difficult for members to exercise their own schedules. Groups members were dependent on others for care. Members relied on staff to get them ready for appointments and to assist them to the group setting.

The issue of cognitive impairment using the cognitive behavioural approach has far reaching implications for group work. Group members need to be cognitively intact in order for the highly structured aspects of cognitive behavioural approach to be effective (Gatz et al., 1998). Some group members had difficulties remembering group times, where the group was being held, and what was discussed in previous group sessions. As well, cognitive processes in acquiring insight into one's situation appear to be compromised by subtle levels of cognitive impairment.

In addition to the learning objectives, a number of dilemmas became apparent throughout the group sessions that underlined the difficulties of living in a long-term care setting. These dilemmas are related to the factors that influence and are associated with depressive symptoms and well-being in long-term care: losses, relocation, limited socialization opportunities, and the setting of long-term care. Four dilemmas became apparent that deal with the recognition that activities are beneficial in regulating mood: wanting to be involved, but not having meaningful activities; wanting to be involved, but participation being limited due to decreased health;

wanting to be involved, but having no control as to the type of activity and when the activity is available; wanting to have increased activities, but not having opportunities for meaningful activities. Two dilemmas relate to independence: recognition of the need for help, but wanting to be independent; needing privacy, but living in a communal setting. The final set of dilemmas relate to a sense of control: the need to express frustration, but fearing retaliation by care givers on whom they are dependent; needing some form of control, but having very little.

Conclusion and Recommendations

The admission to a long-term care facility is stressful for some. Relocation to long-term care can have implications for quality of life of residents in the adaptation and adjustment phase. The literature reviewed supports the contentions that depressive symptoms are prevalent and under treated in residents of long-term care. In a number of instances these symptoms can be linked to the stress of relocation to long-term care. These depressive symptoms have an impact on physical and emotional well-being and can effect the quality of life and provision of care of elderly residents.

The learning objectives of this practicum were to design and implement a group intervention which attempts to decrease the depressive symptoms of elderly and as a result increase their sense of well-being; to discover what factors influence and are associated with depressive symptoms and well-being in long-term care; and to increase group work knowledge with the elderly in long-term care.

A cognitive behavioural therapy group attempted to mitigate the depressive symptoms of six to ten residents of Deer Lodge Centre, a long-term care facility in Winnipeg, Manitoba. Individuals were selected on the basis of depressive symptoms and cognitive suitability using two reliable and valid screening instruments; the Geriatric Depression Scale-15 item (GDS) and the Mini Mental State Examination (MMSE). Individuals gave written consent. Duration of the group was eight one-hour sessions. A clinical supervisor was used for facilitator support and guidance.

During the initial sessions it was apparent that the psycho educational approach of the cognitive behavioural therapy was not working. Group members appeared to be tired, disinterested, bored and several members attempted to leave the group early. A number of factors may have contributed to the perceived necessity of changing the intervention model: lack of facilitator experience with the cognitive model; the population that was screened may have been inappropriate for the model; the number of sessions may have been inadequate; and the content of the program may have been too ambitious and detailed. Through clinical supervision, it was decided that a more collaborative approach should be adopted. An empowerment model was developed and implemented for the remaining group sessions. Within this new model it was not feasible to maintain the originally planned intervention schedule. Group members responded much better to the new model and approach.

The evaluation revealed that the group sessions were successful as a whole, however, not necessarily in reducing depressive symptoms. The difference in the baseline and comparison GDS scores indicates that depressive symptoms decreased

for all members over the eight group sessions. Caution must be exercised in interpreting the scores because the difference was minimal and most likely was not statistically significant. However, the group members highly rated the facilitator, group sessions, and level of satisfaction. Comments from the open-ended questions showed that members supported the change in the group intervention style, appreciated the group experience and expressed a desire to continue. It is noted that members stated that their situation had not changed and because they identified long-term care as a depressing place, this could be interpreted to mean that their depressive symptoms remain unchanged.

Throughout the eight group sessions valuable information came forth which addressed the learning objectives of the author. It may be that any intervention style for elderly long-term care residents requires modification to incorporate a more non-directive and collaborative approach. The emerging themes of the session content centred around loss and the attempts to maintain some independence. The group members reassured the author that it was acceptable to feel depressed about long-term care. The group members stated that feeling depressed in a long-term care setting was a normal reaction to an abnormal situation, as opposed to symptoms that need to addressed therapeutically. Symptoms provide a label that is helpful to focus and guide treatment. However, if those symptoms are not really part of a pathology or syndrome then it is nothing more than a convenience to obtain outcome measures and may not necessarily help people. People are entitled to feel and react to situations they do not like without being labelled as abnormal. Individuals in this group indicated during

the group sessions that one could have a sense of well-being while experiencing depressive symptoms.

It was inspiring to see group members holding on to a sense of hope in the face of accumulated losses and admission to long-term care, a situation which is often labelled as hopeless. It may be unrealistic, but it is functional. To help elderly residents in long-term care maintain a sense of hope may be the most compelling reason for abandoning the cognitive behavioural therapy and adopting a more collaborative therapeutic style guided by an empowerment model.

In light of the results, several recommendations can be made. Long-term care institutions need to continue to recognize the impact that relocation to the setting has on individuals. Therefore it is important to provide adequate support for people during this transition period rather than view it as a syndrome or a collection of symptoms requiring treatment. A group intervention appears to be a highly supportive environment in which to address issues that arise as a result of the relocation. It appeared that a non-directive collaborative approach incorporating a cognitive behavioural approach and an empowerment model was effective. The nature of the blended model focuses on collaboration and therefore requires more than eight sessions.

The hallmark of long term care is a fusion (sometimes a confusion) of health care and social care. Finding the efficient, accurate way of assessing and providing intervention a formidable challenge (Kane & Kane, 1988). The blended model supports dignity, autonomy, independence, and a regained sense of control addressing

a need for providing a resource for living rather than mere survival or existence for elderly in long-term care.

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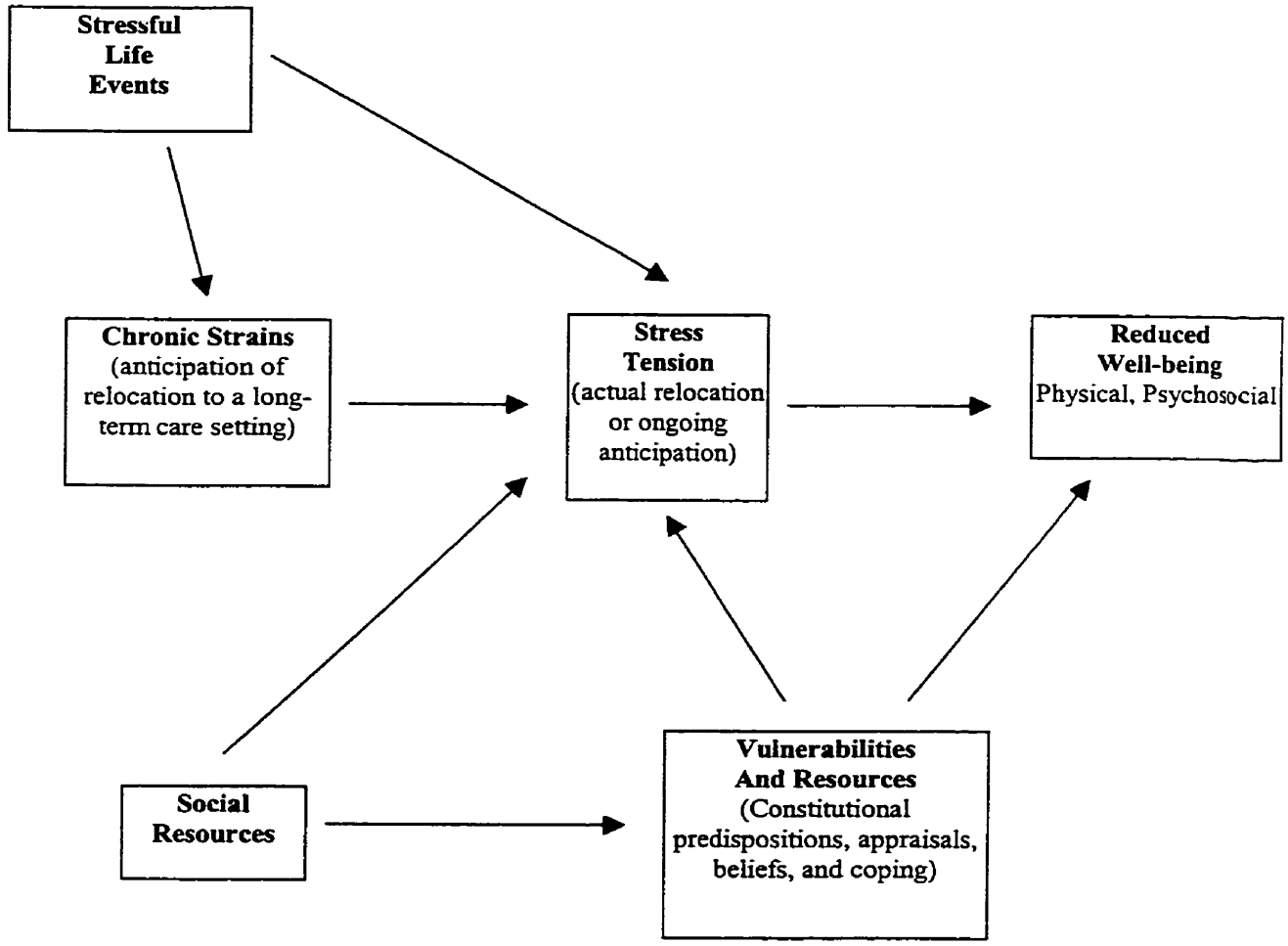
Appendices

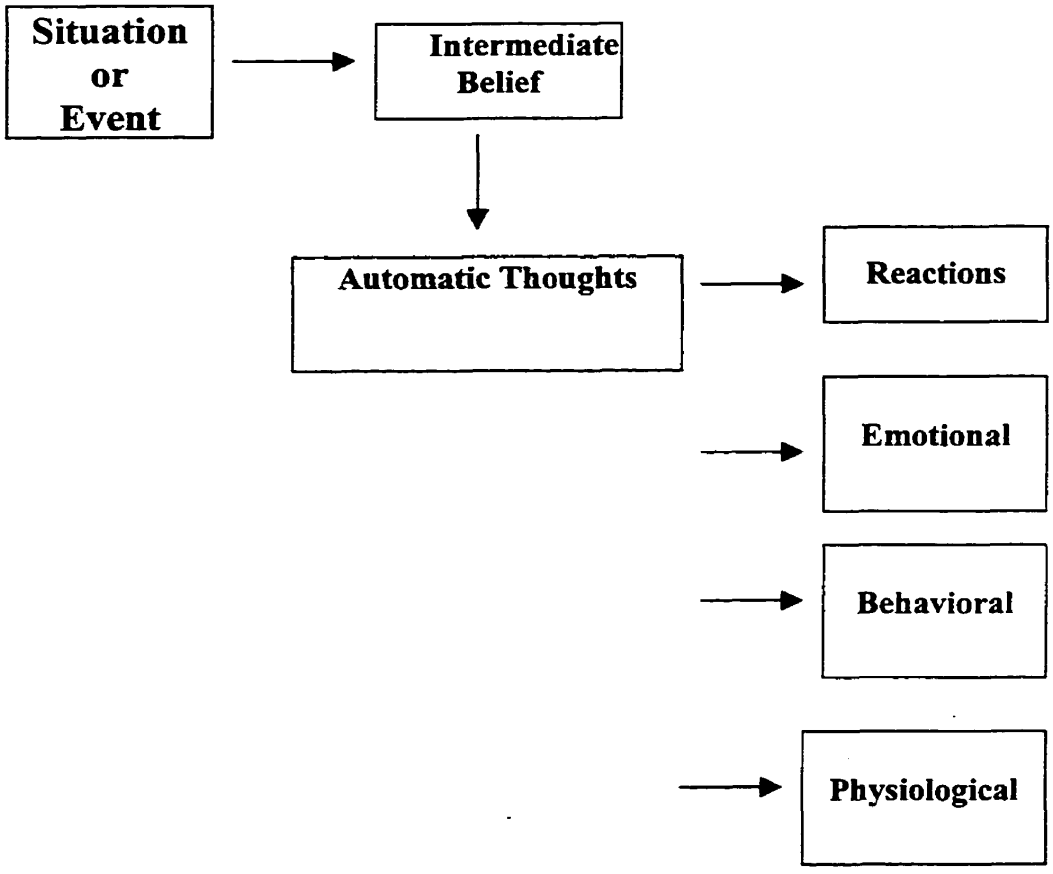
Appendix 1



Amalgamated Model of Stress

(Lazarus & Folkman, 1984; Maddi, 1989, Pearlin, 1989)

Appendix 2



The Cognitive Model

(Beck, 1995)

Appendix 3

Consent for Screening

You are asked to take two screening tests, the GDS (Geriatric Depression Scale) and the MMSE (Mini-Mental State Examination) to determine your suitability for a group intervention at Deer Lodge Centre. Before you give consent, please read the following information and ask as many questions as you wish:

The GDS is a screening instrument to determine the presence of depressive symptoms. **The results do not represent a diagnosis of depression.**

The MMSE is a test for the cognitive mental state of residents. **The results do not represent a diagnosis of cognitive impairment.**

You are free to withdraw from the testing at anytime. Your withdrawal will not influence your care and treatment at Deer Lodge Centre.

I have read the above information and understand the purpose of this testing, as well as the potential benefits and risks of my participation. I have had an opportunity to ask questions and all my questions have been answered. I hereby give my informed consent to be a participant in this testing. I have been given a copy of this consent.

Name of Resident _____

Signature of Resident _____ **Date** _____

Name of Facilitator _____

Signature of Facilitator _____ **Date** _____

Appendix 4

Consent to Participate

You are being invited to participate in a group to be conducted at Deer Lodge Centre by **Chris Enns, Master of Social Work (MSW) student.** The group will be co-facilitated by Pam Robb, Director of Social Work. Sharon Taylor Henley (assistant professor of Social Work at the University of Manitoba) is the faculty advisor and she can be reached at 474-6669. Before you give your consent to participate, please read the following and ask as many questions as you wish:

1. The objectives of this project are to improve the well being of individuals by decreasing depressive symptoms and to teach skills that will prevent the relapse of depressive symptoms in the future. This program will take place at Deer Lodge Centre and will involve 6-10 other residents within Deer Lodge Centre.

2. If you agree to participate you will participate in two clinical interviews and 8 group sessions (8 weeks, 1 session per week, 1 hour in length). During the sessions you will be asked to rate your mood, listen to a presentation about mood, participate in discussion of topics presented, take part in simple homework assignments, and adhere to the group rules. You may discontinue this project at any time and be assured that members of your health care team will always be available to help you if you so choose.

3. The possible benefit of the program is as follows:
   a) Your well-being may increase and your depressive symptoms may decrease.
   b) You may acquire a set of skills that will help you to overcome depressive symptoms in the future.
   c) You may find participation a welcome social activity.
   d) You may establish valuable friendships through you participation in the group process.
   e) This group may help to establish a treatment program at Deer Lodge Centre for people who are experiencing similar symptoms.

4. There is no financial compensation for your participation in this study.

5. The information obtained in the group will be kept confidential and will be used for the purposes of determining the effectiveness of the group.

6. Your participation in this program is purely voluntary. You will receive a signed copy of this form. You have the right to withdraw from the study at any time.

7. You can contact me between our group sessions at XXX-XXXX during workdays, XXX-XXXX during evenings, weekends and holidays.

Thank you for agreeing to participate in this group. If you have any questions regarding this group, please feel to call me at XXX-XXXX.

I have read the above information and understand the purpose of the group. I have had an opportunity to ask questions about the group and my participation. I feel I am in a position to make a decision regarding participating in the group.

Name of Resident _____

Signature _____ **Date** _____

Group Facilitator Name _____

Signature _____ **Date** _____

Appendix 5

Expanded Session Content

Clients will attend a group intervention based on principles of cognitive therapy. There will be one 60-minute session per week for 8 consecutive weeks. The sessions will be facilitated and co-facilitated by social workers.

1. Program Content
    a. How mood is affected by thoughts
    b. How mood is affected by activities
    c. How mood is affected by people
2. Session Format
    a. Introduction - first session to introduce members and explain reason for participation (members will be informed that the purpose of the group is to reduce the depressive symptoms they are experiencing), subsequent sessions to review homework and material from previous sessions; and to discuss issues that may arise
    b. Didactic presentations
        1) Defining depression
        2) Cognitive-behavioral therapy
        3) Monitoring your mood
        4) Thoughts that cause and maintain depression
        5) Identifying errors in thinking
        6) Increasing thoughts that improve mood
        7) Decreasing thoughts that lower mood
        8) The ABCD method

9) Modifying errors in thinking

10) Increasing pleasant activities

c. Skill development

1) Identifying pleasant activities

2) Pleasure predicting

3) Setting goals

4) Improving interpersonal relationships

5) Increasing social activities

6) Increasing assertiveness

7) Enhancing social skills

8) Dysfunctional thoughts about people

9) Maintaining relationships

d. Group participation/discussion of presentation and skills

e. Simple homework assignments

1) Mood graphs

2) Take part in recreational activities

3) Goal setting

4) Initiative contact with others outside the group

f. Session closure

1) Brief review of session content

2) Feedback regarding group progress

Appendix 6
Evaluation Questionnaire

	Rate from low to high See scale on reverse
1). The facilitator helped to create a comfortable and safe environment.	1 2 3 4 5
2). The facilitator showed respect and genuine caring for group members.	1 2 3 4 5
3). The facilitator encouraged active participation from all members.	1 2 3 4 5
4). The facilitator appeared knowledgeable about areas of concern.	1 2 3 4 5
5). The group sessions helped improve my emotional well being.	1 2 3 4 5
6). Were the length of sessions adequate.	1 2 3 4 5
7). Was the number of sessions adequate.	1 2 3 4 5
8). Would you recommend this type of group to others.	1 2 3 4 5
9). How satisfied are you with your experience in the group sessions.	1 2 3 4 5

10). Have things changed for you since you participated in the group sessions? If so how?

11). What did you find helpful in the group sessions? (I liked . . .)

12). What did you not find helpful in the group sessions? (I didn't like . . .)

13). What if anything would you suggest we add, subtract, or change in future groups.

Scale 1: ***for use with question 1 through 8)***

No definitely not	*No, I do not think so*	*Maybe*	*Yes, I think so*	*Yes definitely*
1	**2**	**3**	**4**	**5**

Scale 2: ***for use with question 9***

Very Unsatisfied	*Unsatisfied*	*Satisfied*	*Very Satisfied*	*Extremely Satisfied*
1	**2**	**3**	**4**	**5**

Additional Notes:

Appendix 7

Geriatric Depression Scale (GDS) – skip if MMSE <20

("During the last week" Check √ if same answer; — if different)

1. Are you basically satisfied with your life?	No
2. Have you dropped many of your activities and interests?	Yes
3. Do you feel that your life is empty?	Yes
4. Do you often get bored?	Yes
5. Are you in good spirits most of the time?	No
6. Are you afraid that something bad is going to happen to you?	Yes
7. Do you feel happy most of the time?	No
8. Do you often feel helpless?	Yes
9. Do you prefer to stay in your room, rather than going out and doing new things?	Yes
10. Do you feel you have more problems with memory that most?	Yes
11. Do you think it is wonderful to be alive now?	No
12. Do you feel pretty worthless the way you are now?	Yes
13. Do you feel full of energy?	No
14. Do you feel the situation is hopeless?	Yes
15. Do you think that most people are better off than you are?	Yes

Score:_____/15 (n<5)

I. Depressed Mood		II. Anxiety		**Comments/ Thought Content**
Cry Easily		Anxiety/Fear		
Feel Empty		Panic Spells		
Feel Guilty		Behavior at interview		
Anhedonia		Insomnia		
Negative Self Image		Depressed Mood		
Negative About Others		Gastrointestinal Symptoms		
Passive Suicidal Ideas		Concentrations		
Active Suicidal Ideas		Somatic Sensory		
Insomnia (Initial,Middle,Terminal)		Cardiovascular Symptoms		
Hypersomnia		Respiratory Symptoms		
Appetite		Autonomic Symptoms		
Concentration + or -		Somatic Muscular		
Agitation/Retardation (anxious or slowed down)		Genitourinary Symptoms		
Fatigue				

(Sheik & Yesavage, 1986)

(Public Domain)

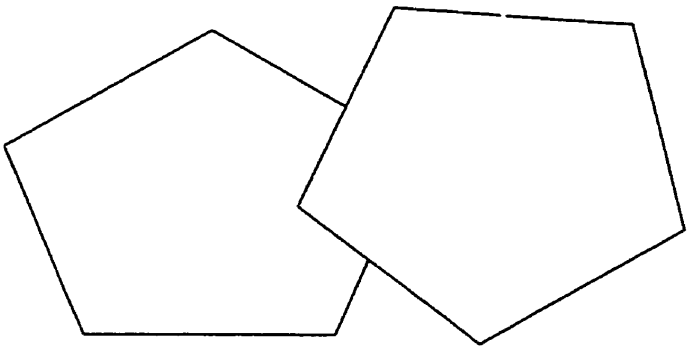
Appendix 8

FOLSTEIN MIN MENTAL STATE EXAMINATION

Max Score	Score	
5	[ ]	**Orientation to Time** What is the : Month _____ date _____ year _____ day of week _____ season _____
5	[ ]	**Orientation to Place** Where do you live? Address ____ street ____ city ____ province ____ country ____
5	[ ]	**Registration** Name 3 objects (apple, penny, table); I second to say each. Ask the client to repeat all 3 after you have said them. Give 1 point for each correct answer, then repeat them (up to 6 times) until client learns all 3. Count trials. Trials: ____
5	[ ]	**Attention and Calculation** Spell "WORLD" backwards. (Spell forward & correct errors first) _ _ _ _ _ Alternatively, do serial 7s. 1 point for each correct. Stop after 5 answers. 93 ___ 86 ___ 79 ___ 72 ___ 65 ___ Record best score.
3	[ ]	**Recall** Ask for the 3 objects repeated above. Give 1 point for each correct. _____ _____ _____
8	[ ]	**Language** Name a pencil _____ and a watch _____ (2 points) Repeat the following: "No ifs, ands, or buts" _____ (1point) Follow a 3-stage command. "Take this paper in your right hand _____, fold it in half _____, and put it on the floor/bed _____." (3 points) Read and obey: "CLOSE YOUR EYES" _____(on next page). (1 point) Write a sentence _____ (on next page). (1point)
1	[ ]	**Visual Construction** Copy design (on next page).
__/30		**Total Score**

CLOSE YOUR EYES

WRITE A SENTENCE



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Appendix 9

GROUP WORK PROCESS

Date: _____ Time: _____

Participants	Emerging Themes	Climate/Cohesion	Participation/ Interaction	Concerns/Conflicts	Plans/Comments

(Dimock, 1993)

Appendix 10

Group Rules

1. **Members are asked to commit to regular attendance of group sessions.**

2. **Members are to be supportive, caring, and willing to give everyone an equal chance to participate.**

3. **Members are encouraged to give constructive and practical feedback to one another.**

4. **Members are to refrain from criticizing, confronting, pressuring or telling others what they should do.**

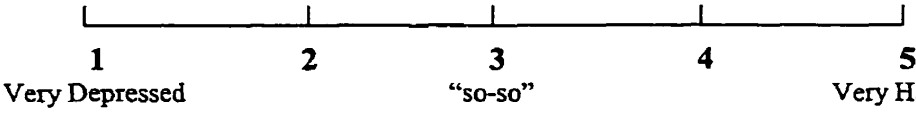
5. **Members are to respect the confidentiality of session activity.**

6. **Members are encouraged to participate in homework activities as defined within the group sessions.**

Appendix 11

DAILY MOOD RATING FORM

1. **Rate your mood for this day (i.e., how good or bad you felt) using the 5-point scale shown below. If you felt good, put a high number on the chart below. If you felt "so-so" mark 3, and if you felt down or depressed mark a number lower than 3.**



2. **Try to identify why you felt that way and record the reason in the space provided.**

Date	Mood Score	Why I think I felt this way

(Adapted from Gallagher & Thompson, 1981, p. 124.)

Appendix 12

PLEASANT EVENTS SCHEDULE

Identify the pleasant events for you.

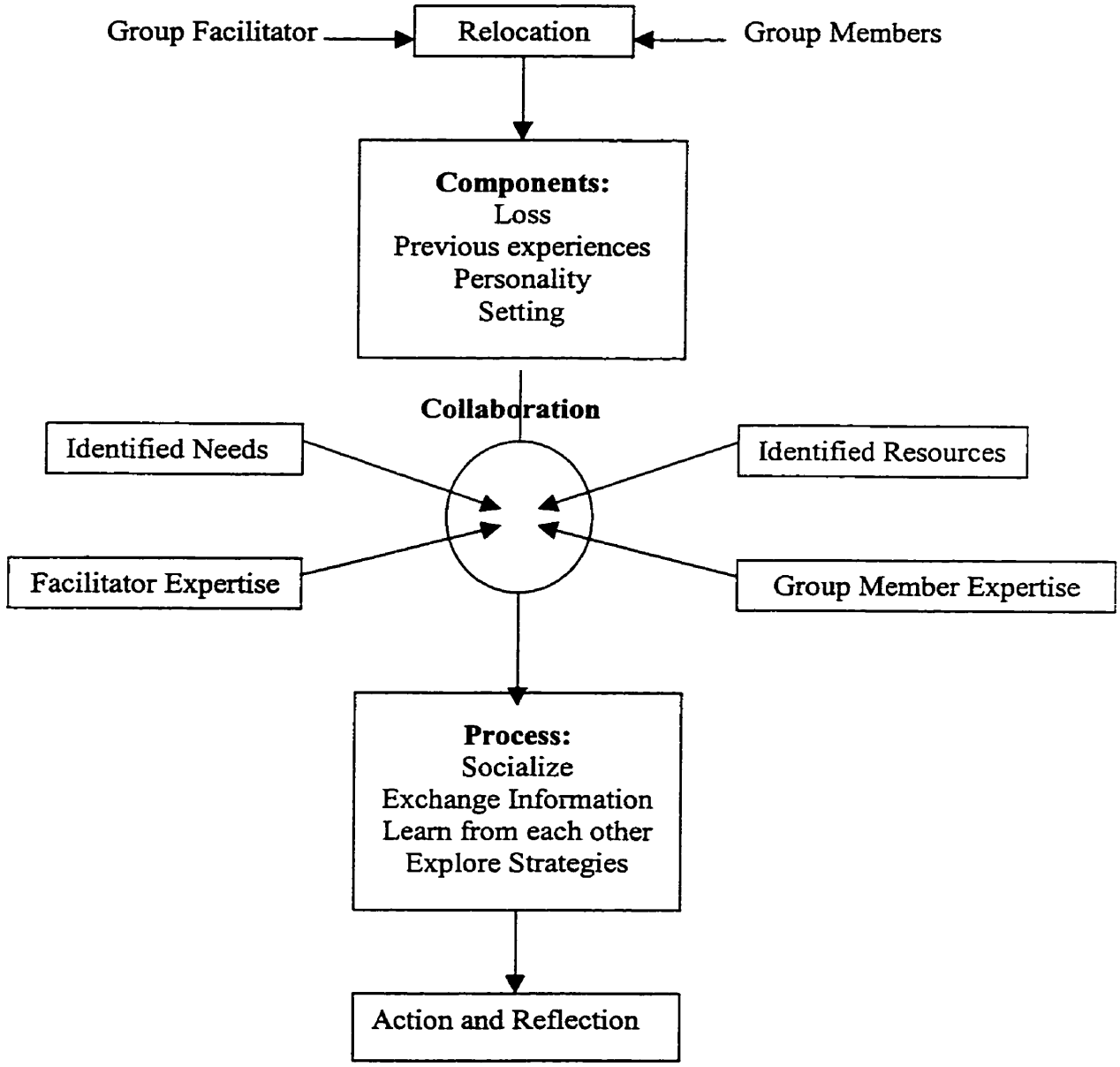
Pleasant Events	Check to Identify √
1. Look at clouds	
2. Being with friends	
3. Having people show an interest in what I say	
4. Seeing beautiful scenery	
5. Having a frank and open conversation	
6. Having coffee, tea, etc. with friends	
7. Thinking about pleasant memories	
8. Showing affection	
9. Seeing good things happen to family and friends	
10. Saying something clearly	
11. Complimenting/praising someone	
12. Amusing people	
13. Making a new friend	
14. Helping someone	
15. Being complimented	
16. Listening to the sounds of nature	
17. Being told I'm needed	
18. Listening to music	
19. Seeing or smelling a flower	
20. Being asked for help or advice	

21. Thinking about myself	
22. Being with happy people	
23. Looking at the stars or moon	
24. Giving advice to other based on past experience.	
25. Watching a sunset	
26. Reading literature	
27. Listening to the birds sing	
28. Reading magazines	
29. Being needed	
30. Having a daily plan	
31. Smiling at people	
32. Meditating	
33. Solving a problem, puzzle, or crossword	
34. Getting out of the centre	
35. Attending a recreational activity	
36. Thinking about something good in the future.	
37. Thinking about people I like	
38. Having peace and quiet	
39. Feeling a divine presence	
40. Going outside	
41. Going to place of worship	
42. Taking inventory of my life	

(Adapted from Gallagher & Thompson, 1981, p. 119)

Appendix 13

Empowerment Practice Model



(Adapted from Cox & Parsons, 1994, p. 147)