

# Journal

of AGING (ife CARE™  
Resilience in the Elderly



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FALL 2015

Resilience

Carol Hoare, EdD

## Introduction

When an explorer on an unknown river finds the current quickening under his boat, hears a faint but increasing roar, and sees above the farthest treetops a mist of spray, he knows that he is nearing a cataract. Yet if he is bold, if his craft is strong, and if on a prosperous voyage he has already shot other foaming rapids with success he may push blithely into the unknown, confident that he can override all dangers. (Nevins, 1950, p.3)

In this introduction to his two volume history of Abraham Lincoln's political emergence, Nevins described the spirited mettle and positive outlook of this country at the middle of the nineteenth century. We might use his metaphor to capture the meaning of resilience during adulthood. In this, the craft and its occupant represent physical and psychological readiness, respectively, just as the explorer's confidence conveys a history of prior success in similar circumstances. The sustaining current indicates a supportive society and relationship network. All of these characteristics are important to resilience.

## Definition and Personal Correlates of Resilience

The attribute of resilience has a lengthy history, with its study flourishing in the nineteenth and twentieth centuries. Theories of human adaptation have ranged from natural selection to ego psychology (Masten & Reed, 2002). With respect to the latter, Freud (1928) held that the ability to flourish in the face of calamity is a remarkable human attribute. After Freud's era, the construct of resilience found its way into theories of motivation and self-efficacy (Masten & Reed, 2002). Recently, resilience has been employed to describe attributes that have been found to support healthy outcomes in children who had been imperiled by environmental hazards or detrimental caregiving circumstances. (Garmezy, 1991; Luthar, Cicchetti, & Becker, 2000; Masten, 2001; Rutter, 1999). Thus, the notions of childhood protection and illness prevention have surrendered to resilience indicators. That is, given that many children will experience trauma, what qualities are seen in resilient children compared to those who are less resilient?

In the last decade the theoretical and research literatures reveal certain common characteristics of the resilience phenomenon. All who write on the topic include the ability to manage trauma such that long term negative consequences are diminished. In this, personal resources and a history of

## ABOUT THE AUTHOR

Dr. Carol Hoare is Professor of Human Development and Human and Organizational Learning in the Department of Counseling/Human and Organizational Studies at The George Washington University. An alumna of Carlow University and the University of North Carolina at Chapel Hill, she earned her doctorate in Adult Learning and Human Development at The George Washington University. She has served as a university trustee, provided consultation to national and international organizations and, at The George Washington University, has served as department chair, Acting Assistant Dean, and co-director of the University Office for Community Services. She has studied, taught, and published on topics in adult development and learning for twenty-five years and is the author of more than fifty original research articles, paper presentations, book chapters, and invited addresses. Her recent book, *Erikson on Development in Adulthood: New Insights from the Unpublished Papers* (Oxford University Press, 2002), has received wide-ranging acclaim in the United States and abroad. Her recent edited volume, *the Handbook of Adult Development and Learning* (Oxford University Press, 2006), is the first

effective coping are paramount. The capacity to “bounce back” after adversity has been emphasized by a number of theorists (e.g., Gucciardi, Jackson, Hodge, Anthony, & Brooke, 2015; Southwick, S., & Watson, 2015). This is the “ability to bend but not break in recovering from threatening challenges” (Southwick & Wilson, 2015, p.21). The American Psychological Association (2010) concurs by defining resilience as the “process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of threat.”

publication to show the reciprocal relationship between development and its compatriot, learning, during the adult years.

Positive adaptation is a clear marker of resilience, yet the literature holds no uniform definition of the resilience phenomenon. Furthermore, resilience is sometimes seen as a process and in other instances as an outcome (Hu, Zhang, & Wang, (2015) Some authors consider resilience a trait or inborn capability (Hu, Zhang, & Wang, 2015), while others hold to a more fluid attribute that comes into play as one equilibrates after the traumas of life (Gucciardi, Jackson, Hodge, Anthony, & Brooke, 2015). A number of authors question whether the resilience phenomenon stands on its own or is the same as positive emotionality (Bonanno, 2004; Robinson, Larson, & Cahill, 2014). Unknown is whether the resilient individual “sustains” or “regains” psychological and physical health after adversity (Masten, 2011). Despite definition variance, however, it is clear that the findings support the belief that resilience is common in healthy adults and is not nearly as rare as was once believed to be the case (Bonanno, 2004; Masten, 2001).

Recently, the theoretical and research literatures on resilience have increased immensely and, in the last decade in particular, resilience has informed the psychosocial literature on adulthood. In adulthood, resilience refers to the ability of adults who have experienced a life altering experience, such as the loss of a loved one or some other personally shattering event, to remain comparatively stable or to return to healthy psychological functioning after the incident. Resilience has been studied with respect to Post Traumatic Stress Disorder (PTSD) and related maladies, largely in young and middle-aged persons.

Unfortunately, the resilience concept has been only sparsely studied with respect to the older years of life. This is unfortunate in that, as common experience and the literature on aging show, the later years include a variety of losses and traumas that challenge and often diminish physical and mental health. Largely due to ageist stereotypes, the expectation often exists that elderly persons have limited resilience, and that they have negative views about themselves, their peers, and their ability to remain in personal control of their existence (Baltes & Baltes, 1990). This bias is countered by a literature providing evidence that most elders are similar to younger persons in their reports of self-efficacy and personal control (Baltes & Baltes, 1990). Baltes and Baltes (1990) claim that alterations in aims, desires, and ambitions may account for this similarity. The older adult revises prior views to account for a new experience of life. Furthermore, the elder’s comparison group often changes, with the senior now comparing the self with persons in like circumstances. This permits the person to find him or herself advantaged when compared with many other elders who are similarly situated.

In the remainder of this article we consider the meaning and characteristics of resilience that are important to the elderly. We first consider data with respect to successful aging and then look to resilience indicators found in the research literature. The article concludes with a section on some interventions that may augment resilience among elders.

## Successful Aging

In 1987, Rowe and Kahn published an exceptional article that changed the way many developmental theorists and gerontologists think about the aging process. Historically, perspectives about the later years of life had held a decrement mentality. Decline charted elders’ advancing years, and the old were seen as burdens due to physical illness, cognitive loss, isolation, and, often, depression. In their article Rowe and Kahn stated that what we had previously considered normal aging was actually a “gerontology of the usual” (p. 143), and the typical pattern seen was not normal aging but usual aging. Rather, the authors held, we should subscribe to a

rendition of successful aging. Successful aging is characterized by maintenance or expansion of intellectual powers and autonomy, and by superior physiological functioning. These lead to enhanced health and ability, and the avoidance or even reversal of functional losses. The authors demonstrated that physical fitness, good nutrition, and normal weight are moderators of the aging process. In the absence of disease cognitive decline is preventable and often countered when elders engage in active cognitive processes or training. On the other hand, typical or usual aging often shows deteriorating cognitive powers, curtailed autonomy, poor physiological functioning, and limited longevity. Hsu and Jones (2012) found that only 29% of their sample clustered in the successful-aging group.

In the psychological realm, Rowe and Kahn showed the positive effects of autonomy, personal control, and good social support, and the negative effects of bereavement and forced geographic relocation. Positive psychosocial factors promote health-enhancing and risk-limiting behaviors, and reduce vulnerability to infections processes and immunological depletion. Adequate social support counters stresses and depression, and is associated with self-reported well-being. Under conditions described as those that promote successful aging, elders show reduced morbidity and mortality.

Related to Rowe and Kahn's findings, studies have shown that when middle-aged and older adults participate in cognition-promoting exercises such as playing word puzzles, Sudoku, chess, and musical instruments, cognitive decline is forestalled. When such activities typify everyday life, openness to experience and learning are enhanced, cognitive flexibility is maintained, and persons are inclined to engage in additional learning. These findings have been demonstrated by data from the Seattle Longitudinal Study (SLS). In the SLS, Schaie (2005) showed that, for those who continue to learn, who live in resource rich environments, and who do not suffer from cardiovascular or cerebrovascular disorders, cognitive prowess is maintained and expanded into the seventh decade of life (see also Fillit, et al, 2002; Knoop et al., 2004) Schaie (2005) holds that extensive reading, travel, and attendance at cultural and professional meetings decrease cognitive decline significantly (see Lachman, Rosnick, & Rocke, 2009).

Adults who are characterized by limited cognitive undertakings have about 2.5 times the probability of developing dementia compared with those who show extensive cognitive engagement (Hoare, 2011). In studying 500 elders over 75 years of age, extensive cognitive immersion was associated with a decreased risk of dementia over the subsequent two decades. Based on 20 years of longitudinal data, Schooler and Mulato (2001) found that elaborate cognitive activities expanded intellectual performance in the far years of life. Complementing these findings, in studying data from 48,537 online subjects, combined with findings from memory and intelligence tests, Hartshorne and Germine (2015) found considerable heterogeneity in cognitive peaks and declines for various abilities. Although working memory and digit span peaked around 30 years of age, emotion-recognition abilities remained stable between 40 and 60 years of age, and vocabularies crested in the eighth decade of life.

Without using the actual term, many of the authors cited above have described resilience in adulthood. Resilience does not just appear when one needs it most. Rather it is engendered by mentally engaged lifestyles, physical fitness, social support, and a sense of active agency in controlling one's life.

Finally, although it is beyond the scope of this article, it is important to note that a number of theorists have implicated physiological factors in an individual's response to stress and coping. For example, in an extensive review of psychobiological markers of resilience and vulnerability, Charney (2004) cited evidence that genetic factors play important roles in one's behavioral response. He found that brain regions, neural mechanisms, and neurochemicals intersect with traits that are associated with resilience and vulnerability (see also Elliott, Sahakian, & Charney, 2010). Synthesizing macro (societal) and personal (family, individual psychosocial, physiological, cellular) factors in vulnerability and resilience, Szanton, Gill and Thorpe (2010) examined the

potential intersection between contextual and physiological factors. The authors contended that under challenging conditions resilience can be linked to neurochemical activity and related cellular functioning.

## Psychosocial Resilience in the Elderly

Research that has specifically addressed resilience in older adults is meager and tilts toward examining such qualities among those who can be considered as resilient to begin with, that is, those who are community dwelling (non-institutionalized), have lived into their later years, and can function as research subjects (Thorp & Blazer, 2012). However, several studies are worthy of mention. One study found that mortality rates were reduced by six percent among elders who were more self-accepting, non-isolated, and less anxious than their peers (Shen & Zeng, 2010). Two studies have shown that resilience foreshadows good mental health (Nygren, et al., 2005; Mehta, et al., 2008), and one study found that resilience buffered the effects of poor health (Windle, Woods, & Markland, 2010). Resilience has often been seen under conditions of social support and ample socioeconomic resources (Kwong, Du, & Xu, 2015). However, among minority and immigrant populations, the effects of structural discrimination auger against healthy personal behaviors and adequate resources in education, social services, and health care (Kwong, Du, & Xu, 2015). Thus, resilience should be treated as a multifaceted construct with different cultural, racial, and social class ramifications.

Studies with respect to the harbingers of resilience have found that optimism, strong social networks, self-rated successful aging, emotional health, cognitive success, and the absence of depression foreshadow resilience. Comparing young adults (under 26 years of age) with older adults (over 64 years of age), Gooding, Hurst, Johnson, and Tarrier (2012) found that older adults were more resilient than young adults, particularly with regard to problem solving and the ability to regulate emotions. This should not be surprising since most older adults have had many years of experience in solving problems and controlling their feelings.

Based on their research and literature reviews, Aldwin and Igarashi (2015) found that while the essence of resilience connotes a person's ability to adapt flexibly, resilience should be thought of as an individual attribute, as a process, and as an end result. These are contingent on resources at the personal (e.g., intellectual) and contextual (e.g., social support) levels. And, in their meta-analysis of 60 studies on resilience and mental health, Hu, Zhang, and Wang (2015) agreed that resilience is both process and outcome in that it mobilizes the ability to grapple with adversity and leads to positive outcomes. In the Hu, Zhang and Wang (2015) study resilience was positively associated with good mental health such as positive affect and life satisfaction. Negative correlations were found for depression, anxiety, and pessimistic affect.

In reading the resilience literature one comes away with a veritable laundry list of factors that are correlated with, and result in, resilience. In part, this is a function of multiple definitions of resilience. Nonetheless, "flourishing under fire" is one positive predictor of positive aging (Ryff & Singer, 2003, p. 15).

## Interventions

Aging adults may or may not have the capacity to improve their own resilience. Thus interventions may be useful in this respect. A wide range of interventions permeate the literature. Here we look to three types that are emphasized by a number of writers on the topic: 1. mindfulness meditation, 2. cognitive reframing, and 3. mastery development.

However, first it is necessary to avoid a scattergun approach. Those who intervene must identify the attributes that are most in need of improvement. In doing so, one must observe and listen carefully to elders. Their descriptions of their own experiences of resilience are fundamental to the work that follows. Elders are the ones who are experts on their own life histories and their knowledge, beliefs, and opinions, conscious or less so, must prefigure any attempt to adjust their behavior. Second, a plan should be developed with the client that extends their positive experiences of resilience (Wagnild & Collins, 2009).

## MINDFULNESS MEDITATION: ASSISTS POSITIVE COPING

As is indicated by a number of authors, mindfulness meditation (MM) training has been shown to improve a person's ability to cope, to enhance a sense of well-being, and to augment positive emotions (Davidson & McEwen, 2012; Kabat-Zinn, 1990; Southwick & Watson, 2015). In MM, the elder practices skills that assist in focusing attention on the current moment, developing acceptance and tolerance, and regulating emotions. (Baer, 2003; Kent & Davis, 2010). Thus, rumination about potential future stresses is avoided and elders learn to reconcile themselves to exigencies that cannot be altered.

## COGNITIVE REFRAMING CAN ALTER NEGATIVE PERCEPTIONS

Cognitive reframing or reappraisal is a useful tool that helps persons to alter their perceptions of events such that their negative emotional impact is diminished. Research has shown that those who report using reappraisal tend to be more flexibly adaptive and have better social outcomes. Through training elders can learn the skills of reinterpretation or distancing as they reframe meanings. In reinterpretation, persons psychologically alter the meaning of events, contexts, or outcomes such that more positive effects can be envisaged. In distancing, one alters the perceived closeness of an occurrence by seeing it through the lens of an uninvolved third-person. Distancing tends to show greater long term benefits, although both skills are important to elders.

## MASTERY DEVELOPMENT: ENHANCING SENSE OF ACHIEVEMENT

Finally, personal mastery can be developed. In mastery development programs elders develop the skills that enhance self-agency. Elders develop active, positive coping abilities, learn to understand the role of their actions on consequences, and develop abilities in responding effectively to challenges. According to Masten (2011) mastery leads to five key results:

1. improved mastery and ability to cope well,
2. improved relationships with others,
3. enhanced self-awareness and knowledge,
4. movement away from materialism,
5. and, in some, enhanced spirituality.

A number of studies have implicated protective attributes that sustain healthy functioning in spite of trauma, loss, and adversity. These include positive adaptability, a sense of good self-esteem, and an achievement mentality (Bookwala, 2014; Kishida & Elavsky, 2015; Robinson, Larson, & Cahill, 2014). These qualities are also correlated with positive emotions and affect and a feeling of well-being (Robinson, Larson, & Cahill, 2014; Ryff, 1995). All of these qualities implicate personal hardiness (Robinson, Larson, & Cahill, 2014) and a history of low vulnerability (Bonanno, 2004; Connor & Davidson, 2003).

## Conclusions


Resilience is multifaceted and complex. It is wrought by a number of individual psychosocial and physiological attributes and resources, and tends to develop best in the context of a supportive environment. The literature reveals a variety of definitions, a broad array of human characteristics that correlate with resilience, and a host of potential interventions. Research on resilience in the elderly is limited, partly in response to still-prevalent ageist stereotypes. There remains much to be learned from resilient elders themselves, particularly from those who are aging successfully.

## References

### Article references

## Topics: Resilience

### One thought on “Resilience in the Elderly”

1.  F. Groves says:

February 28, 2018 at 7:59 am

Excellent article. This information has reinforced all the things I have felt about aging and health and resilience to cope with the challenges of aging.

[Reply](#)

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FALL 2015

Resilience

## The Baltes' model of successful aging and its considerations for Aging Life Care™ / geriatric care management

Claire Donnellan, PhD

Foreword by Jennifer E. Voorlas MSG CMC

I originally became aware of the Baltes theory of successful aging – usually referred to as the SOC (selection, optimization, compensation) model — in my Master’s program studying the psychology of aging. A particular interest of mine was why some people age “successfully” and some don’t. When I learned about this theory I was immediately struck by the concrete way it explained how the inner resources of an individual can be utilized to transform a negative situation into something positive. This model seemed to say that the old school of thought – disengagement – could be replaced by actively pursuing the means to make any specific situation better.

Dr. Donnellan’s article discusses in depth the SOC theory of selection, optimization, and compensation, and she suggests that one of the main difficulties in implementing SOC in practice is that this theory has remained rooted in adult development psychology. She proposes that studies have shown the beneficial impact of this model in the health care setting, particularly in rehabilitation, and she suggests that its potential in Aging Life Care™ / geriatric care management remains largely unexplored.

As Aging Life Care Professionals™ we consciously assist the elderly and their family members to cope with loss: disability, death of loved ones, and weathering the aches and pains of the aging process. Care managers already intuitively help their clients select, optimize, and compensate for losses, but can we do this in a more organized and systematic way through using this model?

Our clients are often unable to appreciate their own resources due to personality issues, depression, physical and / or mental impairment. The care manager can play a key role in assessing their resources (financial, emotional, physical) and understanding how they have weathered previous losses. It can be helpful to remind the client that their losses are legitimate and must be validated, but asserting the importance of focusing on their unique abilities and inner resources may be helpful.

Donnellan’s article may bring forth less concrete ways we can explore this but upon closer examination, the SOC model theory provides a way to understand what appears to be an intuitive approach in the Aging Life Care / care management and we as care managers are in a unique position to use the core insights of this model and put them to practice.

### ABOUT THE AUTHOR

Claire Donnellan, PhD<sup>1,2</sup>

<sup>1</sup>School of Nursing and Midwifery, Faculty of Health Sciences, Trinity College Dublin, Ireland

<sup>2</sup> Royal College of Surgeons in Ireland – Bahrain, Kingdom of Bahrain

Correspondence to: Dr Claire Donnellan, Trinity College Dublin, School of Nursing and Midwifery, 24 D’Olier Street, Dublin 2, Ireland

Tel +353 1 896 4109 email [cdonnel@tcd.ie](mailto:cdonnel@tcd.ie)

Care managers can use the SOC model as an assessment tool to understand:

- What are the client's strengths?
- What resources do they have?
- What strategies/insights do they need to access their strengths and resources?
- How can that assessment lead to setting achievable goals?
- How to use positive reinforcement and investigate alternative strategies when one is not working
- Focus on action based problem solving, setting the context for change
- Working with the family systems to build a "culture of resiliency"
- Working with staff / caregivers to foster resiliency (using creative modalities, outings, thinking "outside the box")
- Training caregivers/facility staff to foster adaptive strategies

The Baltes' model of successful aging and its considerations for geriatric care management

## Abstract

This article aims to present the description and explanation regarding the application of the Baltes successful aging model of selection, optimization, and compensation (SOC) in the context of Aging Life Care / geriatric care. The SOC model is reviewed in terms of its theoretical aim and efforts to explain successful aging and also its application within healthcare research and practical settings. A brief overview of its theoretical background i.e. the concepts of successful aging and life span developmental psychology, are described including how healthy aging individuals adapt to everyday life situations using SOC strategies. The model is then discussed further in relation to any potential declines and losses imposed by illness or disease e.g. the consequences of health-related conditions.

## Introduction

The substantial increases in life expectancy at birth achieved over the previous century, combined with medical advances, escalating health and social care costs, and higher expectations for older age, have led to international interest in how to promote a healthier old age and how to age "successfully" (Bowling & Dieppe, 2005). The concept of successful aging dates back to the 1960s (Havighurst, 1963) and included the elements life satisfaction and active engagement with life. The goal of successful aging is now more realistic in today's aging society as a result of more effective interventions to control and reduce disability and health risks. It has recently been proposed as a field of interest in gerontological research and as a challenge for the design of social policy (P. B. Baltes & Baltes, 1990). According to Rowe and Kahn (1997)(Rowe & Kahn, 1997), successful aging is multidimensional encompassing the avoidance of disease and disability, the maintenance of high physical and cognitive function, and sustained engagement in social and productive activities. Bowling and Dieppe (2005)(Bowling & Dieppe, 2005) outline the main theoretical approaches that define successful aging: psychosocial and biomedical and also include additional lay definitions.

The biomedical model focuses on the absence of disease and the maintenance of physical and mental functioning, whereas psychosocial models focus on life satisfaction, social participation, functioning, and psychological resources, including personal growth. Psychological resources are required for successful aging and according to Bowling (2005), these include a positive outlook and self-worth, self-efficacy or sense of control over life, autonomy and independence, and effective coping and adaptive strategies in the face of changing circumstances. Psychosocial researchers generally agree on defining successful aging as subjective well-being, life satisfaction, and longevity (Freund & Riediger, 2003; Jopp & Smith, 2006). As a result of



longevity, people are now living longer with physical impairments whether acquired for the first time in old age or at a younger stage in life.

In the context of Aging Life Care / care management, the use of theories or theoretical frameworks for guidance or to establish guidelines on how to care for older people and how to support them in adapting to aging processes remains limited. Wadensten (2006) has described and considered how psychosocial theories of aging e.g. Activity Theory, Disengagement Theory of Aging, Continuity Theory, Erikson's Psychodynamic Theory, and the Theory of Gero-transcendence are applicable and/or relevant to practical gerontological nursing and concludes that there is a need to translate the aging theories into guidelines (Wadensten, 2006). She argues that the use of theories explaining aging do not provide guidance on how to care for older people and how to support them in the aging process. It is of significant interest that the developmental lifespan theories of aging including the Baltes SOC model (P. B. Baltes & Baltes, 1990) were not considered and included as part of the psychosocial theories of aging.

Out of the vast amount of articles conducted on theories used to inform Aging Life Care management, one article does describe integrating behavior change theory into geriatric care management practice (Enguidanos, 2001). Overall, this work attempted to describe the theory and practice gap in geriatric care management emphasizing the limited empirical evidence of theoretical or conceptual models in terms of their efficacy and effectiveness. Given the limited evidence available in the literature to support Aging Life Care Management programs using theoretical frameworks and models, the adaptational challenges for older people should be taking into consideration through these programs. For example, health-related events such as chronic illness and disability are key challenges that have been reported to account for increased distress in older people (Ensel, 1991; Murrell & Norris, 1984; Pearlin & Skaff, 1996). However, the specific type and severity of the health-related event must be taken into account (e.g. a stroke vs angina). A life course framework may serve as a background for observing and making sense of the kinds of stressors to which people are likely to be exposed, particularly a major life event such as an abrupt onset of an illness that is considered an extreme stressor during middle to later life.

Another consideration for application to Aging Life Care Management are developmental changes that occur across the lifespan in that ontogenetic development is a life-long process where no age period holds supremacy in regulating the nature of development. During development, and at all stages of the lifespan, both continuous and discontinuous processes are at work. Developmental change involves gains and losses in different functional and life domains, and efforts to keep this balance favorable represent an essential aspect of human action and the momentum of personal development over the life span (Brandtstadter & Renner, 1990). The developmental dynamic of positive (gains) and negative (losses) change led to Baltes and colleagues' life span work on specifying a general process of adaptation that would represent the life-long nature of development as a gain/loss relation. This dynamic relation between gain and loss in development has been outlined in a theoretical framework describing successful aging known as the Selection, Optimization and Compensation (SOC) model (P. B. Baltes & Baltes, 1990).

## Baltes SOC model of Successful Aging

The selection, optimization and compensation (SOC) model, first presented by Baltes and Baltes (1990), provides a general theory for conceptualizing processes of successful development generally and in aging in particular (S.-C. Li & Freund, 2005). The meta-model of SOC evaluates cognitive-motivational processes regulating human development across the life span and was originally designed and developed as an explanatory framework for adaptation to aging.

The key concept of SOC describes a general process of adaptation that individuals are likely to engage in throughout life and is essential for the achievement of higher levels of functioning (P. B. Baltes & Baltes, 1990). The model takes the global view that at all stages of human development individuals manage their lives

successfully through the developmental regulation processes of selection, optimization, and compensation. Successful development involves the orchestration of these three processes (selection, optimization, and compensation) which in turn, regulate the maximization of gains and minimization of losses over time. Selection, optimization, and compensation can be conceived of as one single “integrative” process of adaptive mastery and also on a lower or more micro level of aggregation, the facets of SOC can be viewed as separate processes, each contributing to successful development (Freund & Baltes, 1998b).

Selection refers to an individual focusing attention on fewer, more important goals e.g. rescaling/reconstructing goals. Optimization involves engaging in goal-directed actions and means; examples include investing time and energy into the acquisition, refinement and application of goal-relevant means, seizing the right moment, persistence, acquisition of new skills/resources, and practice of skills.

Compensation maintains a given level of functioning in the face of loss and decline in goal-relevant means by individuals investing in compensatory means.

These strategies acknowledge and address the declines and losses which occur; examples include modifying behaviors, the use of external aids (zimmer frame, tripod), and activating unused resources (e.g. help from others). Selection, optimization, and compensation can occur at various levels of analysis or integration ranging from the macro-level (e.g. societies) to the micro-level (e.g. biological cells) (P. B. Baltes & Freund, 2002). Overall, the theory posits that across the life span, individuals further their development adaptively by maximizing their potential gains and minimizing losses.

SOC strategies have been measured experimentally in studies that involved dual-task performance (patterns of task priority) (K. Z. H. Li, Lindenberger, Freund, & Baltes, 2001), qualitatively using content analysis (behavioral adaptation interview responses categorized as selection, optimization and compensation (Gignac, Cott, & Badley, 2002) and quantitatively using SOC measures: the SOC-12 (P. B. Baltes, Baltes, Freund, & Lang, 1995) and the SOC-48 (P. B. Baltes, Baltes, Freund, & Lang, 1999). Other quantitative versions of SOC measures also exist within the literature e.g. SOC-15 (Donnellan, Hevey, Hickey, & O'Neill, 2012), SOC-36 (Chou & Chi, 2001) and SOC-9 (Gestsdottir & Lerner, 2007).

## Operationalization of SOC

The empirical evidence for the use of the SOC model has mainly been applied in life-span developmental psychology, e.g., life management strategies in a general aging context (Freund & Baltes, 1998a, 2002) and in industrial-organizational psychology, e.g., life management strategies and human performance in a work place setting (Abraham & Hansson, 1995; Bajor & Baltes, 2003; Wiese, Freund, & Baltes, 2000, 2002). There is currently less empirical evidence of the use of SOC within the context of health-related conditions although the use of SOC as a theoretical framework has been applied in some instances (Collins & Smyer, 2006; Donnellan & O'Neill, 2014; Ireland & Arthur, 2006; Volicer & Simard, 2006).

### SOC and age-related differences

Age-related decline in resources may place a constraint on engaging in SOC-related behaviors. The execution of SOC-related behaviors require resources such as effort, skills, organizational meta-strategies and these resources can be more limited in advancing old age. Theoretically the argument has been that because of aging-related adaptive pressures and reduced plasticity there should be more involvement of SOC-related behaviors (P. B. Baltes, 1997). However, the empirical evidence has shown that decline in resources is associated with reduced endorsement of SOC-related behaviors.

There are two different hypotheses regarding the age trajectory of SOC beyond adulthood into old age (Freund & Baltes, 2002). The first of these is that adults, as they age, become better at the use of SOC because of accumulated life experiences (P. B. Baltes & Baltes, 1990). The other argument is that the use of SOC itself is

resource dependent and because of age-related losses in resources and plasticity, the physical, social, and cognitive resources available to individuals in old age may not be sufficient for them to engage in SOC resulting in a decline in SOC-related behaviors. Despite this decline in the frequency of use of self-reported SOC, it is expected that older people continue to use SOC and that if they succeed in doing so, they display better states of functioning (M. M. Baltes & Lang, 1997).

### SOC and wellbeing

Freund and Baltes (1998) reported that those who used SOC-related behaviors had higher scores on subjective well-being, positive emotions, and absence of feelings of loneliness (Freund & Baltes, 1998a). In a later study (Freund & Baltes, 2002) (Freund & Baltes, 2002), they also found similar associations in that SOC-related behaviors were associated with subjective wellbeing and positive emotions. Each of the SOC components was significantly and positively related to these subjective indicators of successful management even after other rival constructs such as assimilative and accommodative coping, action versus state orientation, personality variables, social desirability, intellectual functioning, and cognitive style were statistically controlled separately. However, elective selection had the lowest correlations with outcomes of wellbeing. The rationale given for this is that elective selection focuses on the most important goals and domains of functioning thereby implying some loss aspect. This would exclude alternative options and pathways that would be more associated with subjective feelings of wellbeing.

Wiese, Freund, and Baltes (2000) investigated if the use of SOC related positively to satisfaction with function in the two domains of partnership and work as well as to satisfaction with life in general (Wiese et al., 2000). They found that individuals who reported using SOC behaviors scored higher on multiple subjective indicators of global and domain-specific success. There were significant positive associations between overall SOC scores and the three categories of well-being (general, work, and partnership). The SOC construct optimization had the greater association compared to the other SOC constructs with general and work-related wellbeing whereas compensation had greater association regarding well-being in the partnership domain. In their follow-up longitudinal study (Wiese et al., 2002), they investigated whether the use of SOC predicted general well-being as well as satisfaction and subjective attainment in the work domain over an interval of three years. Results were consistent with the previous cross-sectional findings in that SOC behaviors did predict global and work-specific subjective well-being.

### Application of SOC in health-related conditions

The SOC model was developed by Baltes and colleagues in search for a general process of systemic functioning (use of selection, optimization and compensation) that would serve as an effective strategy for the basic life span architectural frame. The model formulated is considered highly general, hence it has been described as a meta-theory of development. Because it does not designate the specific content and mechanisms of developmental processes and outcomes, it is applicable to a large range of variations in goals and means (Baltes, 1997). Therefore it may well be applicable within the context of adaptation to health-related conditions although the empirical evidence in relation to SOC use in health-related conditions is limited to date. SOC has been theorized to explain changes over time and this may explain why the model has not been operationalized in many acute conditions or illness to date. However, SOC may be applicable to measure changes in an acute condition that becomes chronic over a period of time i.e. in studies that use longitudinal methodologies.

One study has examined whether SOC may be of value in measuring adaptation after stroke quantitatively (Donnellan & O'Neill, 2014). There were clearly no age or disability related differences regarding the endorsement of SOC strategies by stroke patients. This study also informs the theory from the perspective that a generic self-rated tool does not measure physical (functional ability) or psychosocial adaptation (HRQOL, depression levels) after stroke. A self-report SOC measure may be too generic to deal with the onset of acute disability.

SOC has been applied as a framework in some studies that have aimed to explain adaptive behaviors qualitatively in certain health-related conditions (Gignac et al., 2002; Ryan, Anas, Beamer, & Bajorek, 2003; Wilhite, Keller, Hodges, & Caldwell, 2004). The use of SOC in a health-related condition was first applied by Gignac et al. (2002) to investigate the adaptation of individuals with osteoarthritis to disability (Gignac et al., 2002). Their findings were that compensation adaptive behaviors were the most frequently reported by older adults to manage disability followed by optimization adaptive behaviors[1]. Hamilton and colleagues found that activity-modifying behaviors (representative of SOC strategies) mediated the relationship knee pain and physical function in participants with no diagnosis of knee osteoarthritis (Hamilton et al., 2013). Janke and colleagues (2012) explored how adults with arthritis use self-care strategies in their valued leisure activities and themes of self-management that emerged were based on the SOC processes (Janke, Jones, Payne, & Son, 2012). They concluded that SOC processes may be useful to help individuals maintain their valued leisure activities when faced with functional limitations. Hutchinson and Warner (2014) investigated the SOC theory from the perspective of examining ways rural community dwelling older adults were able to continue valued activities after an acute health event (Hutchinson & Warner, 2014). In the same vein, they concluded that helping people learn SOC strategies may help those individuals who lack knowledge, skills, or confidence to participate independently.

Ryan, Anas, Beamer and Bajorek (2003) aimed to analyze the specific strategies that older adults with macular degeneration used to cope with reading-related barriers in terms of the SOC framework (Ryan et al., 2003). In fact the results reported the use of the SOC framework when describing the adaptive behaviors this sample used for coping with instrumental activities of daily living. Selection was referred to when participants were faced with continuing decisions about when to maintain goals and when to modify them and appropriate goal selection was evident in that most participants aimed for challenging and potentially achievable goals. Optimization was referred to when participants relied more on new learning and memory and for compensation there was effective use of devices and reliance on others to be as independent as possible. Wilhite et al. (2004) used the SOC framework to explain the adaptive processes individuals with multiple sclerosis use to achieve optimal health and well-being (Wilhite et al., 2004). The sample size involved in the study was small (n=13) but the translation of adaptive behaviors into the SOC framework were described for each individual participant and no summarized or consistent explanations of selection, optimization or compensation were reported.

Rapp, Krampe, and Baltes (2006) conducted the only experimental study investigating the SOC model that has included a patient population (Rapp, Krampe, & Baltes, 2006). Young and older adults and patients with Alzheimer's disease were assessed for their performance on a dual-task paradigm that combined working memory with a postural control task. The older adults, especially those with Alzheimer's disease, maintained a higher level of functioning in postural control i.e. allocate resources towards the task of higher immediate value, as compared to working memory. The SOC model posits that older adults will allocate resources towards tasks of higher immediate value and the findings from this study extends one of the assumptions of the theory to pathological aging (Rapp et al., 2006).

The SOC model has been suggested as a framework for the delivery of care in patients with advanced dementia (Volicer & Simard, 2006) and to implement behavioral risk-reduction programs for patients in secondary stroke prevention clinics (Ireland & Arthur, 2006). Volicer and Simard (2006) describe how dementia care can be improved by the appropriate use of the SOC constructs. For example, the selection of appropriate strategies for management of medical issues is necessary for maintaining quality of life of individuals with dementia. The care should be optimized according to the remaining functional abilities of the individual with dementia. Compensation is required in two areas: functional deficit and executive dysfunction. Ireland and Arthur (2006) state that an understanding of the SOC process at the collective (for a client group assessment) and individual (for an individual assessment) level has potential to create an age-sensitive environment for effective and supportive behavioral risk-reduction care within current resources (Ireland & Arthur, 2006). However, there is

no evidence in the literature to support the integration of SOC and self-efficacy models to inform the development of behavioral risk-reduction intervention programs.

In a more recent paper, the SOC model has been suggested as a rehabilitation framework especially in the context of neurological conditions such as acquired brain injury e.g. post stroke (Donnellan & O'Neill, 2014). Because there is a scarcity of theoretical frameworks that can facilitate and be inclusive for all the necessary complexities of adjustment, required in stroke rehabilitation and that rehabilitation intervention frameworks should be goal orientated; address self-regulatory processes; be person-centered and use a common language for goal planning, setting, and attainment. Donnellan and O'Neill (2014) recommend that the Baltes' SOC model is one such framework that may address some of the considerations for stroke rehabilitation, including motor recovery and other life management aspects.

Another recent inclusion in the literature regarding the use of the SOC framework is for an intervention to make respite care and services more effective for family caregivers (Lund et al., 2014). This family caregiver intervention called Time for Living and Caring (TLC) was developed according to the theoretical principles of SOC – selective optimization with compensation. The TLC intervention will aim to address what caregivers do during their respite time, thereby getting caregivers to spend time focusing on their own personal lives as well as their caregiving responsibilities.

In an overview by Collins and Smyer (2006), they describe the ecology of disability and long-term care as being consistent with the SOC model in that the ecological approach removes the full burden of responsibility of successful aging from the individual while illuminating the tools that individuals and their social structures can use to manage and optimize opportunities for successful aging (Collins & Smyer, 2006). They reviewed the individual aspects and differences for older Americans aged 50 years and older at risk for disability and consequent need for long-term care. Examining the tools that individuals and their social structure can use helps to manage and optimize opportunities for successful aging.

The empirical evidence and other additional interpretations regarding the use of the SOC model in health-related conditions provides some support regarding SOC's potential to serve as an explanatory model for understanding adaptation in relation to illness.

## Summary

This article has attempted to describe the SOC model in some detail and has outlined its uses in the context of successful aging in terms of managing everyday life stressors and in circumstances when resources are limited. However, there has been limited use of the SOC model and its individual components in Aging Life Care / care management generally and for specific health-related conditions, although its potential use has been widely emphasized. While the theoretical model remains, the uncertainty in how to apply it may still exist. Here is where the creativity of the Aging Life Care Professional™ / care manager to apply the core principles is needed for better patient outcomes and quality of life measures.

In summary, the endorsement of SOC processes in general aging populations have been associated with better physical functioning (Baltes & Lang, 1997), subjective wellbeing and positive emotions (Freund & Baltes, 1998, 2002), and aging satisfaction (Jopp & Smith, 2006). In health-related conditions, behavioral adaptations of individuals with osteoarthritis, visual impairments and multiple sclerosis have been demonstrated to be conceptually integrated in the SOC theoretical framework (Gignac et al., 2002; Ryan et al., 2003; Wilhite et al., 2004). Other researchers are stressing the potential use of SOC for example in terms of a framework of care (Collins & Smyer, 2006; Ireland & Arthur, 2006; Volicer & Simard, 2006) however its potential use has yet to be assessed empirically in health-related conditions. Some potential uses of SOC may be to examine its association with depression as the evidence to date supports that SOC is associated with improving well-being and has correlated negatively with depression in one study (Chou & Chi, 2001). Another potential use of SOC

may be in relation to age-related rehabilitation as rehabilitation is a process of retraining and education, where older people must have the capacity to learn new ways of doing things (Kelly-Hayes & Paige, 1995). The use of SOC strategies would be of an imperative value in a rehabilitation setting where goal pursuit and attainment are of primary importance.

The potential validation as to why use the SOC model to explain adaptation outcomes in older people may be in line with the core assumptions of the model. The SOC model has major emphasis on the notion of development in that development evolves when individuals with their specific abilities and temperaments, proactively and reactively respond and interact with whatever given contexts come their way. The SOC model has been shown to be a framework used for explaining the challenges to successful aging (Baltes & Lang, 1997; Freund & Baltes, 1998, 2002). However, whether SOC is a useful framework in predicting successful adaptation to the challenges of health-related conditions in older people remains inconclusive.

## References and Tables

[1] In Gignac et al's (2001) study, 85% of the study sample were women

Article references and tables

Topics: Baltes' SOC-Model, Goal Attainment, Resilience, Successful Aging

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Aging Life Care Association™  
3275 West Ina Road, Suite 130 | Tucson, AZ 85741-  
2198  
520.881.8008 | 520.325.7925 Fax

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# Journal

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## Notes from the Family Classroom



FIND AN AGING LIFE  
CARE EXPERT

FALL 2015

Resilience

Rosemary De Cuir

Life without purpose is colorless and without cheer

I recently visited my 92-year-old father, a bright, vital senior whom I've watched struggle in his life with challenges of his own, including diabetes, macular degeneration, raising a daughter with a developmental disability, overseeing the care of a needy mother and most recently, coping with watching his spouse of 60 years deal with short-term memory deficits. Dad has always been known for his optimistic, roll-up-your-sleeves-and-attack-it perspective towards tackling the difficulties that arise for all of us from time to time. I asked him once the secret of how he manages to bend and flex ("shift gears" in car parlance) and he answered that he made a conscious decision as a young man to always work with a problem and not against it – thus demystifying a sobering or frightening prospect and facing it head on.

However, Dad was different on the day of my visit. He was sitting somberly at his desk, staring into space and looking at a file of papers that contained information about his car. Dad had very reluctantly renounced his driving privilege about five years earlier, when it had become apparent that the combination of his visual limitations and slower reflexes were endangering his ability to drive safely. He'd had a few near misses that had frightened the family. After much discussion and a follow-up consultation with the DMV, all agreed that he should no longer operate a motor vehicle. This was a blow to someone who had (like all of us) loved the independence one has when "mobile." Dad had driven nearly seventy years; an intelligent, thoughtful person, he realized that there would be many repercussions and adjustments as a result of this decision.

As always, he deliberately and quietly assimilated the unhappy thoughts and feelings (so typical of the stoicism of that generation) and respected the ruling of the department and the wishes of his family. Consistent with his lifetime of disciplined practices, he would rise early for private time of prayer and reflection, exercise, then retreat to his little art studio to play his beloved music from the big band era and work on an oil painting. Of late, his vision impairment demanded that stronger lighting be set up (along with a magnifying glass for closeup evaluation of his work) and some fatigue required the use of a stool that he could perch on when needed. His skill at producing beautiful oil paintings – particularly portraits – remained intact despite the need to pause for periodic rest breaks. Dad would lose himself in the pleasure of creating.

Fully five years after he had given up the car, it was apparent that Dad was still very troubled by this occurrence – to the point that he simply couldn't marshal his usual disciplined approach to the problem. He was stuck. I initiated a conversation about finding meaning in our lives. We talked about shifting our focus from what we've lost to what we still have. The trick was to figure out how to do it and the rest would be taken care of.

### ABOUT THE AUTHOR

Rosemary De Cuir received her Bachelor of Arts degree in Sociology from California State University, Fullerton in 1986 and began her multifaceted career in senior services in 1987. Her path included positions as supervisor of a senior center, sales and marketing director/corporate trainer for several national assisted living companies, developer of an RCFE dementia care program in Los Angeles, in addition to accepting speaking engagements for a wide variety of audiences – her favorites of which include students of gerontology and nursing. She founded Alliance Family Advocates in 2005 as a geriatric care consultant and family mediation specialist.



Providentially, I had just had a conversation with a friend about a sad story of a 12-year-old girl struggling with Pick's Disease (the juvenile cousin to Alzheimer Disease). She had been declining since first diagnosed at age of 5 and was bed bound, cared for by 'round-the-clock nurses. Her parents were financially strapped due to the exorbitant costs of care. The tale of woe included the father losing his job along with the extreme pressure of being "on" all the time due to fear that their precious child could die at any time.

A thought had popped into my head when speaking with my friend. "Have your friends any portraits of their little girl?" "No way," she said, "they've been so busy the last seven years that I don't think they even have any photos." Right then I knew this could become an important window of opportunity for both my Dad and the little girl's family. I approached my father about painting Jessica (the little girl). After hearing the details of the case, he was intrigued, sympathetic, and agreed immediately. I asked my friend to say nothing to Jessica's parents but to find a photograph. She produced a beautiful one of a five-year-old in a woodland fairy costume (taken the last Halloween before she became ill). Her infectious smile, impish expression, and sweet little face were adorable.

A week or so later, Dad called me to come over and view the finished results. "Your mom and I fell in love with her during this week," he said with a broad smile. Dad matted and framed the painting (figuring that was something that the parents would hardly have the time or money to do) and we presented it to my friend, who would deliver the likeness to the family (who lived many miles away and weren't up to having visitors). When she called me the next day, she said that the little girl's parents had cried upon seeing it, and Jessica, who is largely non-verbal at this point, smiled and said, "That's ME!"

My father is one of many seniors that I encounter in my work as a geriatric care consultant. Retirement, ill health, decline or death of a spouse, financial downturns – these are all situations which can slide from the "problematic" category into a catastrophic one if not addressed aggressively. I was concerned that my dad, like so many of my clients, could drift into a depressive state that would only worsen if not handled soon. My father was blessed with the realization that he might be limited in terms of physical mobility; he is still capable of making an impact on people's lives in a meaningful and powerful way. This privilege is one he need never worry about having revoked or taken away. He just needed me to remind him that he can "take it on the road" anywhere, to anyone, anytime his heart desires.

## Topics: Resilience

## One thought on "Notes from the Family Classroom"



1. Patricia Sanborn says:

September 20, 2016 at 11:51 am

Lovely story with a useful moral. When listening better and longer, we often do not realize the impact we might make on people and how they make use of our words.

[Reply](#)





# Journal

of AGING (life CARE)™



FALL 2015

Resilience

## Meaningful, Enjoyable, and Doable: Optimizing Older Adults' Activity Engagement at Home

Susan L. Hutchinson, PhD and Grace Warner, PhD

### Abstract

In addition to being able to live safely at home, when facing declining physical or cognitive abilities it remains important to all people to have a sense of purpose—something to do—in their everyday lives. Meaningful and enjoyable leisure pursuits can fulfill this need. This article reviews some of the benefits associated with home-based leisure pursuits for community dwelling older adults living with chronic health conditions. Selective Optimization with Compensation (SOC) theory and the Needs Driven Dementia Compromised Behavior (NDB) model are reviewed to provide a framework for Aging Life Care Professionals™ / geriatric care managers to support continued activity engagement in the face of declining abilities associated with dementia. Practical suggestions are provided to guide processes of assessment, planning, and implementation related to optimizing older adults' activity engagement at home.

### Introduction

Just over six months ago my brothers and I moved my mother into an independent living facility because she could no longer manage to live alone in her home. Mom was devastated (“I’ve lived here for the last 26 years”), confused, and scared. While much of the confusion was because of progressing cognitive decline associated with dementia, some of her confusion was also because things were happening around her that she couldn’t fully understand. In the year leading to this move and in the months since, I have reflected at length on what I — as someone who studies successful aging — could have done differently to have prevented (or at least prolonged) this move. Unfortunately I live fully across Canada, over 4500 kilometers away from my mom. Yet, had I had the right understanding or information, my hunch is that a different trajectory may have been possible. As I’ve come to learn more about the role of an Aging Life Care Professional / care manager (a role I was unaware of until recently) I can see how intervention “early enough” by an Aging Life Care Professional™ / care manager could have mitigated many of the risks that led to mom’s unwanted move from her home. Hindsight is wonderful.

The above story, written by the first author, is intended to illustrate the point that people who are experiencing cognitive decline will be unable to manage on their own without appropriate care and support. But what should the nature of this care and support be? While much of the focus is necessarily on the medical management of

### ABOUT THE AUTHORS

Dr. Susan Hutchinson is an Associate Professor in the School of Health and Human Performance at Dalhousie University in Nova Scotia, Canada. In a previous life she worked as a Recreation Therapist in a long term care residential facility and in neurorehabilitation. Currently she teaches in a 4-year undergraduate Therapeutic Recreation program and her research focuses on the role of personally meaningful and enjoyable (and doable!) activity in living well with a chronic health condition.

Dr. Grace Warner, is an Associate Professor at the School of Occupational Therapy at Dalhousie University in Halifax. She conducts applied health services research focused on community-based services that enable older adults to live well at home. This includes empowering older adults and their family/friend caregivers through programs that maximize their physical and mental health.

frail older adults living at home, we believe it is also equally important to focus on supporting engagement in personally meaningful and enjoyable leisure pursuits.

The purpose of this paper is to examine, both theoretically and practically, why and how to help older adults to “stay engaged” at home when experiencing cognitive and physical decline associated with dementia. Although care managers work with clients other than those living with dementia, for this paper we are focusing on theories and approaches to amplify activity engagement by persons with dementia because this is a population at risk for increasing decline resulting from lack of meaningful activity engagement. According to Buettner and Kolanoswki (2003), “[a]ctivity is a basic human need expressed in leisure....pursuits. Unfortunately, people with dementia have a low rate of activity participation because of associated physical and cognitive constraints. The boredom and isolation resulting from inactivity leads to many of the agitated and passive behaviors exhibited by this population” (p. 19). Drawing on evidence of the role of activity engagement in coping and successful aging and the theoretical lens of Selective Optimization with Compensation (SOC) and Needs Driven Behavior (NDB), we aim to outline practical ways to support older adults living with dementia to remain engaged in ways that optimize their remaining interests and resources. We begin by briefly reviewing the concept of aging in place and, within this, argue for the centrality of meaningful activity in aging in place.

## Aging in Place and Activity

Despite declines in health and social networks it seems an almost universal reality that most adults have a desire to remain in their own homes as they age (Farber, Shinkle, Lynott, Fox-Grage, & Harrell, 2011), often referred to as “aging in place.” Aging in place has been defined as “[t]he ability to live in one’s own home and community safely, independently, and comfortably” (The Centers for Disease Control and Prevention, 2010) with the emphasis on remaining in one’s own home rather than residential care (Pynoos & Nishita, 2007). For the most part, the emphasis within the aging in place literature is on strategies or resources to support independent functioning in everyday activities associated with being at home. From household modifications like grab bars and non-skid mats to remote monitoring devices and home meal delivery there is a plethora of resources (some of them very costly) for supporting people’s safety and independence at home.

Yet, it is also somewhat of a universal truth that all people, regardless of age or ability, want to feel what they do has purpose or value. And this sense of purpose or value is beyond having access to adaptive technologies; it is met by being engaged in meaningful and purposeful activity or interactions. Wilcox (2006), an occupational sciences researcher, suggested that participation (or meaningful activity engagement) reflects four fundamental needs we have as humans: to do, to be, to become, and to belong. Participating in activities (or, what Wilcox describes as tasks) gives us a chance to express who we are through what we do. Interestingly, doing, being, belonging, and becoming are also essential elements of psychological wellbeing or happiness.

While much of the focus of the successful aging literature is on people’s “out-of-home” participation in their communities (e.g., van Dijk, Cramm, van Exel, & Nieboer, 2015) there is a need to understand ways to support people to remain actively engaged at home. This is especially important for people who are not social or who lack access to transportation or other supports for community-based activity participation. Drawing primarily on our own research with community dwelling older adults, the next section briefly outlines some evidence of the importance of leisure—personally meaningful and enjoyable activity—as a resource for ‘living well’ with a chronic health condition.

## Activity Engagement, Coping, and “Successful Aging”

In research with community-dwelling older adults living with some form of physical or cognitive impairment we have accumulated evidence that meaningful and enjoyable leisure-related pursuits, whether done alone or with others, afford several immediate and enduring benefits for health, wellbeing, and successful aging. Specifically, it seems leisure-related activity participation can:

- provide opportunities for people to prevent declines in their health;
- serve as a positive distraction, resulting in improved mood, enhanced coping efficacy, and hope for the future; and
- contribute to wellbeing and successful aging when the participation is personally meaningful, or affirming of valued self-attributes.

Examples from our research illustrating how these benefits can be obtained through home-based activity engagement follow. It is important to note that these activities were undertaken by community-dwelling older adults who were able to be relatively self-determined (i.e., independent in their activity pursuits, and in the strategies they adopted to adapt to changed abilities). However, we believe that: (1) remaining engaged can be an important strategy for promoting health and preventing decline, and (2) when faced with declining abilities people can continue to experience these beneficial outcomes when they are able to continue to be self-determined in their activity pursuits with appropriate supports. This is where family members and care providers, like Aging Life Care Professionals / care managers, come to play an important role in facilitating continued engagement.

Leisure-based activities can be a resource for preventing declines in health. The older adults we interviewed reported a myriad of home-based activities as important to taking care of themselves both mentally and physically, from baking, to playing music, doing puzzles, and brain games (like Sudoku) to more physically active leisure such as gardening, walking, and following an at-home exercise DVD (Hutchinson, LeBlanc & Booth, 2006; Hutchinson & Nimrod, 2012; Hutchinson & Warner, 2014). As noted above, the people we interviewed were either able to select activities that they could continue to do, or were able to modify what they did or how they did it in order to accommodate changes in their functional abilities. However, it is when people do not know how to go about making necessary modifications or have lost the cognitive abilities to problem-solve accordingly that supports from health professionals, like Aging Life Care Experts, are often needed.

Helping community-dwelling older adults to remain physically and cognitively active is essential for maintaining independence and reducing the risks of falls and cognitive decline in later life (e.g., Centers for Disease Control and Prevention, 2015; Public Health Agency of Canada, 2011). However, for physical activity to be perceived as beneficial for self-care by older adults it needs to be both familiar and enjoyable; for the most part, activities done with others are most enjoyed and preferred (Graham & Connelly, 2013). The challenge is often in helping older adults to overcome barriers to participation, like fear of falling, lack of confidence, and transportation to physical activity programs in the community.

As one example of an innovative approach to addressing these barriers the Victorian Order of Nurses (VON) Canada has developed an innovative in-home physical activity program—named the SMART program (Seniors Maintaining Active Roles Together). The program is designed to improve strength, flexibility, mobility, and balance in seniors who may not be able to participate in traditional exercise because of barriers such as cost, limited transportation, chronic health conditions, or a lack of programming to meet their ability levels. Most importantly, the program is delivered by trained peer volunteers. Speaking with a local SMART program organizer in Atlantic Canada, she explained that because they promote the program as a program to “stay independent” they’ve had a lot of interest from older adults who would not traditionally participate in physical activity programs. She also emphasized how important the social connections are to both the senior volunteers and program participants. Participants in a multi-site evaluation of the SMART program identified multiple physical benefits associated with participation, including improved strength, flexibility, endurance and coordination, as well as mental health benefits such as improved energy, concentration, and mood (Connelly & Mersich, 2007).

Looking beyond physical activity to other forms of leisure participation, social leisure activities have been found to be associated with good physical and mental health in later life. In a Canadian study of social participation and health, older adults were more likely to report having lower self-perceived health, greater dissatisfaction with life when they experienced greater disability, and loneliness and when they experienced low social support (Gilmour, 2012). The study also found that greater frequency of social participation (with family, friends, at their church, or in their community) was associated with positive self-perceived health. In fact, social isolation is viewed as a significant risk factor for increased vulnerability in later life, including cognitive impairment. We found that lack of companionship or someone with whom to participate in activities was viewed by some of our study participants as the most difficult part of living with a disability that restricted them to home; some also explained they felt guilty over-relying on family members to visit and didn't feel comfortable to ask them to take them to activities that may have been considered non-essential (such as going to a coffee shop) and preferred to stay at home rather than ask for help (Hutchinson & Nimrod, 2012; Hutchinson & Warner, 2014).

Leisure-based activities can be a coping resource. As we previously noted “[w]hether done alone or with others, leisure engagement that was relatively enjoyable and not emotionally, cognitively, or physically taxing was most valued for its ability to give people some distance or a temporary break from the stressor” (Hutchinson & Kleiber, 2005, p. 9). In the face of persistently stressful life circumstances we found that ‘positive distractions’ can serve to either reduce distress (e.g., frustration, anxiety) or enhance positive affect or mood and in so doing become important resources for coping (e.g., Hutchinson, Loy, Kleiber, & Dattilo, 2003; Kleiber, Hutchinson, & Williams, 2002). While not quite as dramatic as “laughing in the face of danger”, we found that being able to experience pleasure in the face of adversity provided people with a sense that they were capable of handling challenges in their lives (Hutchinson et al., 2003). Having something to look forward to (e.g., a visit from a friend, or an outing) also sustained people's hope for their future and ongoing coping efforts (Hutchinson, Yarnal, Son, & Kerstetter, 2008; Kleiber et al., 2002; Kleiber, Reel, & Hutchinson, 2008). We found these benefits are available from moments of enjoyment experienced at during valued leisure activities or infused within obligatory activities, such as cooking a favourite recipe or listening to music while preparing food. Playing cards, listening to music, watching birds at a birdfeeder, enjoying a cup of tea, or talking on the phone with friends, were only a few of the many examples of relatively casual leisure activities that participants in our studies described doing that were both pleasurable and meaningful for helping them cope with the ongoing challenges in their lives (Hutchinson et al., 2008; Hutchinson & Warner, 2014).

Leisure-based activities contribute to well-being and successful aging when they are personally meaningful. It is obvious that activities that are too easy can lead to boredom (and be perceived as too childish) whereas activities that are too difficult may result in frustration, so striking the right balance is important (Buettner & Kolanowski, 2003). However we have also found that it is the “meaningfulness” of activities that can amplify any potential benefits associated with leisure-based participation (Hutchinson & Kleiber, 2005). In particular, it is when activities allow for affirming or expressing one's personal values (e.g., importance of family time) or valued self-attributes (e.g., as a caring or fun-loving person) that they are potent resources for successful aging. When the adults we interviewed (who had all experienced significant life changes as a result of ongoing physical or cognitive limitations) were able to engage in personally meaningful activities they were able to experience a sense of normalcy (e.g., able to feel like one's old self, despite changes in abilities or living situation). Retaining social connections and a sense of purpose (having something personally meaningful to do) were central to their views of successful aging (Hutchinson & Nimrod, 2012; Hutchinson & Warner, 2014; Warner, Hutchinson & Doble, 2012) with personally meaningful leisure pursuits often fulfilling both these goals.

Taken together, we believe that for older adults living at home it is essential to their coping, adaption, and successful aging that they retain engagement in personally meaningful and enjoyable leisure-related pursuits. As noted, while our research has primarily been conducted with older adults who were living independently,

and thus able to be relatively self-determined in their leisure activity pursuits, we speculate that these same benefits can be afforded individuals living with more significant impairments when they are able to be self-determined with supports; in other words when they are supported by health providers or families who can help compensate for declining abilities in order to optimize remaining interests and strengths. In the next sections are two theories that seem relevant for guiding care planning related to activity engagement.

## Selective Optimization with Compensation (SOC)

For a more comprehensive overview of Selective Optimization with Compensation (SOC) theory see Donnellan's article in this issue on the application of the SOC model in clinical practice. SOC is a useful theory to help us think about how to support optimal development in the face of losses and change across the lifespan (e.g., Baltes & Baltes, 1990; Baltes & Carstensen, 1996, 1999; Freund & Baltes, 1998). As such it is a theory not only of development but of adaptation. Selection refers to focusing on, developing, and committing to goals or tasks. Sometimes this selection will be chosen (or elective), such as when people decide they are no longer interested in an activity or goal, or "loss-based" when goals or activities have to be abandoned or changed because of anticipated or actual restrictions or losses. Optimization involves drawing on personal or social resources or using strategies to maximize remaining resources and abilities in order to pursue one's goals (Boerner & Jopp, 2007). Compensation involves finding and using alternative means to keep doing what one wants to do in the face of real or anticipated losses. This is most often where environmental modifications or adaptive tools come into play. This theory can be a framework for guiding examination of clients' access to personal, social, or psychological resources and for supporting the selection (or reorientation) of goals and efforts to compensate for lack of abilities or resources (Baltes & Lang, 1997). For example, in the context of declines in health that result in ongoing functional limitations it may be more adaptive to support clients to alter or change their goals related to activity participation in order to make best use of their remaining abilities and resources.

An important factor in being able to adapt to negative changes in health status is finding ways to cope with the emotional consequences of ongoing health challenges and to learn how to manage losses or changes in valued roles. In fact, the extent to which people can identify and use strategies that allow them to maximize their remaining physical and mental abilities and to pursue their interests can determine whether they experience a sense of personal control in the face of such losses and changes. An inability to reformulate meaningful life goals or maintain a valued sense of self (e.g., sense of mastery, personal competence) in the face of ongoing limitations had been identified as "pathological aging" (Atchley, 1999). We have found that when people are unable to use strategies and access resources (e.g., help, energy) that are needed to overcome barriers to preferred activities they can also experience pathological aging (Hutchinson & Nimrod, 2012; Nimrod & Hutchinson, 2010).

## Model of Needs Driven Behaviour

While SOC is a theory of optimal development (and adaptation) across the lifespan, the Needs-Driven Dementia Compromised Behavior (NDB) Model (Algase et al., 1996; Kolanowski, 1999) is specific to supporting adaptation in the context of living with dementia. As Aging Life Care Professionals / care managers you are likely familiar with this model, which suggests that all behaviour is a result of unmet needs (e.g., for companionship, purpose, food) arising from the interactions between people's functional abilities (e.g., physical/cognitive) and their immediate personal (e.g., fatigue, hunger, pain) state and their physical (e.g., light, noise, temperature) or social (e.g., social contacts) environment. This model overlaps substantially with the SOC theory in its emphasis on understanding people's functional abilities and resources and its focus on people's responses (emotionally and behaviourally) to their environments. Focusing on elements within the individual and within his/her immediate environments provides a framework to access strengths that can be improved, weakness that can be circumvented, and adaption patterns that can be supported (Buettner & Kolanowski, 2003).

Interestingly, Kolanowski and Buettner (2008) have found that activities tailored to both functional abilities and prominent aspects of personality result in higher levels of engagement and less passivity than do non-tailored activities (Kolanowski, Litaker, & Buettner, 2005). Kolanowski and Buettner (2008) looked at personality types of older adults in residential care to match up these preferred approaches with potential activity interests. From their perspective, “The extraversion facet of gregariousness directly affects the context in which activities are delivered (i.e., group versus one-on-one), and the trait of openness affects the content of those activities (i.e., creative, oriented toward feelings and exploration versus the routine, more familiar, and conventional)” (p. 16). Buettner and colleagues have outlined a host of activity ideas that they have named “Simple Pleasures” to support individuals with dementia-compromised abilities in their efforts to meet their needs (Buettner, 1999; Colling & Buettner, 2002).

## A MED Approach to Planning Successful Activity Engagement at Home

We have developed a simple approach to planning for successful activity engagement by individuals experiencing physical or cognitive declines. This approach draws on the SOC and NDB models as well as evidence presented earlier on leisure as a resource for coping, adaptation and successful aging. The approach involves helping clients and their families to identify and take action on MED goals (in describing this idea to clients and families we liken the idea of MED goals to a prescription for wellbeing). The M stands for meaningful, the E stands for enjoyable, and the D is for doable. As with most health professionals, we anticipate that the processes of assessment, planning, implementation, and evaluation guide the work of care managers. With the above theories, models, and principles in mind the following strengths-based practice-related recommendations are provided:

**Assessment.** We anticipate that functional abilities are assessed when first meeting with a new client and family and completing an intake history (or when access to existing health records is obtained). In addition to assessing people’s physical, cognitive, and social functional abilities, there is a need to assess clients’: (a) activity interests, talents, and preferences and (b) abilities to function within their social and physical environments. Given that, with some clients such as those with dementia, it can be challenging to generate ideas regarding interests and preferences, providing clients with checklists or card sort pictures that allow them to indicate preferences may be useful.

This assessment information is crucial for supporting activity-based goals. In addition to identify remaining leisure-based skills and knowledge that can be strengths to build on when developing care plans, taking time to identify clients’ values and beliefs, including their views about themselves and what’s important to living a life of meaning, is essential. As noted earlier, it may be necessary to guide clients toward abandoning previously enjoyed activities if there is a significant mismatch between the cognitive/physical demands of the activity and their remaining abilities and resources. In this context it would be useful to understand what needs were met by previous activity participation in order to facilitate identification of potential activities that could be substituted but still meet similar needs. For example a client may have liked to keep her hands busy but no longer be able to follow a knitting pattern; understanding this will assist in identifying potential alternative activities that require using one’s hands but may be less cognitively demanding.

In addition, in order to plan ways to optimize and/or compensate for remaining abilities it is also important to understand the resources and barriers in clients’ social and physical environments, and how they are able to function or interact within them. Shank and Coyle (2002) explain that all care environments can be described in terms of their physical attributes, the level and complexity of social interaction, and the organizational structure (e.g., overall care philosophy, policies and procedures that regulate what, when, and how things occur), with each having the potential to positively or negatively impact emotions, comfort, and behaviour. There would be merit in assessing each of these, with the emphasis on client’s social and physical environments in the home and immediate neighbourhood (e.g., if a client is living in an apartment building, to

know where there might be common facilities/resources such as an exercise room, pool, or book exchange location, and how to access them). Observing clients as they interact within their environment, especially spaces where they may engage in activities may illuminate remaining abilities and challenges. Problem-solving tasks (Can you make me some tea?) can be useful to assess functional abilities in ways that open-ended interview questions cannot (e.g., someone may be a “good talker” but a care manager would likely be able to quickly identify discrepancies in what is said and done).

Although standardized assessments of functioning abound there is one tool—the Farrington Comprehensive Therapeutic Recreation Assessment (Buettner & Martin, 1995)—that has been recommended for evaluating and planning for the background factors identified within the NDB model, including measures of physical strength, flexibility, cognitive functioning, leisure history, and style of interest (activity preferences based on personality). In Donnellan's article in this issue she reviews the development and validation of tools to assess individuals' use of SOC processes. Alternatively, interview-based questions can be developed to reflect aspects of the SOC process. For example, selection-oriented questions could focus on helping people to identify their goals and the importance of these goals (including which of the goals may be most important), as well as helping with restructuring goals or searching for new goals. Notably, it is through this assessment process that the meaningfulness of a selected goal should be clear. Optimization-oriented processes will be reflected in the planning and implementation that follows goal selection (addressed below). Within the physical environment there would be value in observing the temperature, lighting, and air quality, as well as the built environment (e.g., the objects, both supportive and hazards). Assessment of the social environment would focus on both oral and written ways in which information is communicated, social traditions or mores, as well as the opportunities for social interaction and support.

**Planning and Implementation.** Beyond ensuring the meaningfulness of a potential activity-related goal, planning for activity engagement involves ensuring that the selected goal and supporting activities and interactions are enjoyable and doable. As noted previously, experiences that are likely to reduce distress and generate positive emotions are more likely to result in enhanced coping efficacy and perceived wellbeing. Even if someone can complete an activity, if it is not enjoyable for him or her then much of the inherent therapeutic benefit of it is lost. If clients have reduced communication abilities, observing for signs of enjoyment or disinterest will be important in the implementation and evaluation phases. An additional factor to consider in the planning and implementation phases is to identify shared activities that are mutually enjoyable for clients and their families (Roach & Drummond, 2014). Shared activities can make visits by family members and friends more comfortable, and takes the pressure off clients having to respond in conversations, especially if clients are experiencing difficulties with expressive communication. If shared activities are part of the care plan, it is especially important to provide education to families on how to facilitate/structure and support more self-determined engagement rather than doing for the person.

Planning for successful and relatively self-determined activity engagement (its do-ability), especially in the face of declining abilities, is complex. It involves understanding: (1) the nature and diversity of possible leisure and recreation activities, (2) how to select activities that help clients achieve their goals and match their interests and needs, (3) how to analyze and modify activities to fit clients' abilities, and (4) how to use techniques to foster client enjoyment and engagement. As it relates to the first two points above, given the myriad of activity opportunities that exist it is important to support clients in selecting activities that will address their goal(s) and interests, not those of the care provider. As Shank and Coyle (2002) noted: “A critical factor in facilitating clients' learning, adaptation, and growth is being able to evaluate the potential therapeutic value of activities and then being able to match therapeutic potential with client needs” (p. 148). If clients with declining abilities become overwhelmed with choices then providing two different options to choose from may be sufficient.

In general, modifications to the physical and/or social environment within the home can include: (1) establishing environmental cues (e.g., to identify spaces, cues to assist in locating information, calendars to



structure daily activities), (2) environmental stimulation (e.g., promoting use of senses, appropriate uses of challenge), and (3) environmental supports (e.g., providing opportunities for control, choice, competence through instrumental assistance and/or guidance; Shank & Coyle, 2002).

Understanding the inherent physical, cognitive, social, or emotional requirements of specific activities allows the care manager to more appropriately plan for activity modifications or adaptations, including adaptations to the time, equipment, and, often most importantly, the processes or instructing or supporting/guiding participation. Optimization of remaining abilities may include a diversity of strategies depending on clients' personal and social resources (e.g., planning the best time for specific activities to maximize physical or mental energy, reducing the time devoted to specific activities, facilitating skill or strategy development and practice, or helping people to acquire new resources [e.g., an activity partner]). Further compensatory strategies include using external aids or the help of others, breaking down of tasks to procedural steps, altering the time, space, or materials required to complete the activity, and at times, guided (step-by-step) actions. For example, in the face of declining abilities a client may still be able to play a game of cribbage (a previously enjoyed and preferred activity) if: the game play is broken down step-by-step (e.g., shuffling, dealing, turn taking, counting), each step is described or explained with a verbal or visual cue (e.g., "now can you deal us each 6 cards?"), and both players work together to complete some tasks (e.g., counting as the client is dealing the cards).

Planning ways to ensure the focus of activity engagement is on the process of engagement rather than the outcome or completion of a project/activity is often critical. This may mean focusing on the characteristics of the physical and social environment rather than on the activity. Will the radio or music be distracting or calming? Is the lighting sufficient for the tasks? Ensuring that staff and volunteers have adequate training to be calm and so they can be "role models for enjoyment" (e.g., laughing with clients, expressing pleasure) is important. Table 1 summarizes a number of principles outlined by Buettner and Kolonoswki (2003) to follow when supporting activity engagement by persons living with dementia.

Evaluation. In addition to evaluating the completion of specific activity-related tasks there would be value in determining if the activity or participation was meaningful (and why) and enjoyable for clients. Although the former almost always involves asking clients to respond to open-ended questions, use of pictures to reflect core needs/motivations (e.g., to have a sense of purpose, accomplishment, connect with others) may merit exploration, especially for clients with difficulties communicating. Asking visiting volunteers or staff to involve clients in writing a journal entry which summarizes what they did together, what the client liked about it, and if he/she would like to do it again, may be a way to track participation and whether it remains meaningful, enjoyable, and doable.

## Conclusion

Returning to my (SH's) mother, unfortunately she did not have an Aging Life Care Professional / care manager who could have done all the things we've just described. She did have a family doctor who assessed her cognition (MMSE) but who offered limited guidance to her family in terms of the types of activities she should and could still do to try to retain her remaining abilities. With almost no social interaction with either family or friends, she had virtually no social stimulation, except for every-other-day calls from me, who lived across the

**Table 1: Strategies to Support Activity Engagement in the Context of Dementia-**

**Compromised Abilities**

Take advantage of **Strengths**.

**Encourage Independent Participation** as much as possible.

**Approach** slowly, calmly, and with relaxed smile. Do a 3-second assessment – what information are you receiving from the individual? What mood are they displaying?

What is their posture like? What are they doing with their hands? This information can alter how to approach and interact with that individual.

Pay attention to **Body Language**, ensuring that facial expression, tone, and posture/body language all match.

Focus on **Communicating** effectively, supporting use of reminders or cues if people are experiencing memory loss, providing written cues or physical demonstration of the task if people are unable to understand or use words.

When people experience **Agnosia**, or inability to recognize familiar objects or faces, gestures & demonstrations can be effective but they may need direct assistance to start the activity and when people experience **Apraxia**, and are unable to perform familiar motor tasks, staff will need to perform hand over hand assistance to help the client engage in the task.

country. Although she used no mobility aids, her eye sight was significantly impaired. As a result she was nervous to go for walks. She also became unable to knit—an activity that had provided her with enormous enjoyment throughout her adult life—partly due to her eyesight, but likely, in hindsight, more likely due to her declining memory. Since she had never walked in her building for physical activity, nor tried other alternative craft activities, or even used memory aids (like notebooks) to help her remember, all these would have required someone to help her create and practice routines until she became comfortable and confident with them. Moreover, providing a structured calendar of activities (which ideally would have been responsive to times when she is most able to concentrate) for her to engage in each day would have enabled her to experience a sense of purpose within her day. As it was, with limited opportunities for enjoyable self-determined activity, she increasingly turned to smoking (likely out of boredom, but also because it was something she could do and enjoyed); in the end it was when she started smoking in her apartment and not eating that my brother intervened. By then she had declined so far physically and cognitively the best and safest option for her seemed to be a care facility even though this was not what she wanted. If we had engaged an Aging Life Care Professional / care manager my hunch is that this story would have had a much different ending.

One of the morals of the story for us both is that, with appropriate supports and guidance, it is possible for older adults to experience a sense of accomplishment, meaning, and purpose through engagement in enjoyable and meaningful leisure-based activities, even when faced with declining physical and cognitive abilities. And that these activities are important for health and well-being, for coping with stressors and challenges, for experiencing a sense of continuity or normalcy in the face of change, and for living a life of meaning. In order to amplify these potential benefits of activity engagement for older adults living with dementia there is merit in basing care planning on either the SOC and NDB models (or, ideally, a combination of both). Setting 'MED' activity-based goals and care (action) plans that optimize people's remaining strengths and interests (and that focus on creating environmental conditions that support successful engagement and enjoyment) will ensure that clients and their families are addressing, as Wilcox (2006) suggested, their fundamental needs as humans to do, to be, to become, and to belong. While Aging Life Care Experts / care managers can clearly play a pivotal role in supporting continued activity engagement at home, other health professionals, such as occupational therapists or recreation therapists, can also be valuable resources as part of a team to support clients with complex care needs to remain in their homes.

## References

### Article references and tables

Topics: [Aging in Place](#), [Compensation Theory](#), [Leisure](#), [Needs Driven Behaviour Model](#), [Resilience](#), [Selective Optimization](#)

## One thought on “Meaningful, Enjoyable, and Doable: Optimizing Older Adults’ Activity Engagement at Home”

1.  Edita Diamante says:

September 2, 2018 at 6:47 pm

This is a very enlightening information about ageing in place. I am 70 years old, a business educator by professional background, immersed in the arts and physically as well as socially active. Many of the facts you mentioned are familiar to me and have witnessed the hardship experienced by friends and colleagues when their only sons or daughters are burdened by costly distance across interstate. Australia is a vast island-continent. My friend who at 90 was teaching jazz and exercise in our school for seniors, died of pneumonia alone in her apartment. Her only child, a son, had been travelling to Sydney

6/8/2021

Meaningful, Enjoyable, and Doable: Optimizing Older Adults' Activity Engagement at Home – Aging Life Care Association™

and back to Melbourne for her on weekends. It was as much a burden to her son as it was for his mother (my friend). This is only one of thousand cases, I'm sure. Economic survival being the core of ageing people and their children's problems. I am looking into more articles/essays from different countries just to find ways of how to reduce the cost of living for the elderly so they can afford home care and so on.

Thank you for your article, Dr Susan L. Hutchinson and Dr Grace Warner.

Best regards,  
ECD

Reply

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Aging Life Care Association™  
3275 West Ina Road, Suite 130 | Tucson, AZ 85741-  
2198  
520.881.8008 | 520.325.7925 Fax

Website Design by IlluminAge



## Building Resilience: Strategies for Aging Life Care Professionals™ / Care Managers

Paula Davis-Laack, JD, MAPP

A career in Aging Life Care™ / care management with disabled adults and the elderly can be both rewarding and stressful. Helping aging and disabled adults, and their families, navigate a new and complex world of healthcare issues and develop appropriate goals for care can provide a great deal of meaning, but the challenges are many. Aging Life Care Professionals™ (ALCP) need to be able to quickly develop trust with their clients and their client's family, which often involves managing difficult, even unreasonable, expectations. An older client may struggle with losing his or her independence while a family member may simply want their loved one to be safe, and balancing those competing demands can be difficult. Some clients may be verbally abusive to care managers as they struggle to process a life that looks different from what they used to know. As a result, resilience is an important skill set for every ALCP to have.

### What is Resilience?

Resilience is a person's capacity for stress-related growth. Contrary to early research findings that resilience was wholly a genetic trait, we now know that resilience is largely a learned set of skills (Masten, 2001). Resilience skills provide the tools ALCPs need to successfully cope with the stressors outlined above. Resilience is built through a set of core competencies that enable mental toughness and mental strength, optimal performance, strong leadership, and tenacity. The four core competencies that drive resilience are:

1. Being a flexible, accurate, and thorough thinker under stress (turning your inner critic into your inner coach);
2. Practicing safe stress (being more mindful, incorporating more positive emotions into your day, and practicing self-care);
3. Increasing your meaning quotient (identifying what gives you meaning during your day and having bigger-than-self goals); and
4. Developing high-quality connections with others (being able to draw on support networks when you need them).

Aging Life Professionals / care managers who develop a resilience practice gain many of the following benefits (Skodol, 2010):

- They can tolerate change, stress, uncertainty, and other types of adversity more effectively than low resilience ALCPs do. They have developed healthy coping strategies and are therefore more likely to mitigate the impact of stress and adversity.
- They are more self-efficacious; meaning, they believe that they can produce results in their life. They have a sense of agency, are able to develop more of a growth mindset, and believe that problems can be solved as a result of their own efforts. This helps to buffer against developing a "giving up" mentality and learned helplessness.
- They are more motivated to achieve in many different areas of their lives and are flexible in their ability to adapt to challenges, adversity, and changing life circumstances.
- They not only move from "negative to zero," but go from "zero to plus." In other words, resilience skills bring out the best qualities in a person and activate specific behaviors and qualities that are desirable at work and in life.

### About the Author

Paula Davis-Laack, JD, MAPP, is a former practicing lawyer, an internationally-published writer, media contributor, and a burnout prevention and stress resilience expert who has taught and coached burnout prevention and resiliency skills to thousands of professionals around the world.

Her articles on stress, burnout prevention, resilience, and thriving at work are prominently featured on her blogs in The Huffington Post, U.S. News & World Report, and Psychology Today. She is the author of two e-books, the latest one titled, *Addicted to Busy: Your Blueprint for Burnout Prevention*.

Paula works with brands such as American Express and NIVEA to help them craft messages around what it means to have success, health, and happiness today. Her expertise has been featured in and on O, The Oprah Magazine, Redbook, Time.com, Fast Company, Forbes.com, The Steve Harvey TV show, Huffington Post Live, and a variety of radio programs and podcasts. She was also named a Top 10 Online Influencer in the area of Stress by Sharecare, which is a Dr. Oz website.

She is the Founder and CEO of the Davis Laack Stress & Resilience Institute, a practice devoted to helping companies and busy professionals create sustainable success by helping them prevent burnout and build stress resilience. Her website is [www.pauladavislaack.com](http://www.pauladavislaack.com), and you can contact her at [paula@pauladavislaack.com](mailto:paula@pauladavislaack.com).

As individuals and organizations become more aware of the benefits of resilience, more are engaging in opportunities for formal resilience training. Here are three examples:

1. Psychological resilience has been associated with a lower prevalence of burnout in intensive care unit nurses (Mealer, et al., 2012), and incorporating formal resilience training has been shown to be both feasible and acceptable within the nursing profession (Mealer, et al., 2014);
2. The American Medical Association recently developed an online course module to help physicians improve their resiliency (AMA, 2015); and
3. The US Army has been teaching and training resilience skills to its soldiers for more than five years. Soldiers receiving resilience training reported higher overall emotional fitness, good coping (when I get stressed out, I problem solve), engagement (I would choose my current work again if I had the chance), friendship (I have someone to talk to when I'm down), and lower levels of catastrophizing (when bad things happen to me, I expect more bad things to happen) (Lester et al., 2011). Units with resilience trainers had significantly lower rates of substance abuse diagnoses and diagnoses for mental health issues, such as depression and anxiety (in some cases the reduction in these diagnoses was as high as 60%) (Harms, et al., 2013). To build on the program's success, the Army has developed additional resilience training programs for spouses and teens and an executive course for Army leaders.

For more tips on building your stress resilience, please sign up for Paula's monthly newsletter at <https://www.pauladavislaack.com> or download the Addicted to Busy e-book at <https://www.pauladavislaack.com>

## Resilience Building Strategies for Aging Life Care Professionals

While formal resilience training is one pathway to building personal resilience, another is to incorporate more informal practices or skills on a day-to-day basis. Here are three examples of skills that can boost your resilience:

Become more of an "otherish" giver. Every professional caregiver I know has a strong tendency to put others first. My cousin, a critical care nurse, has completed entire 12-hour shifts without taking a bathroom break, and I know you have had similar experiences. In his book Give and Take, Dr. Adam Grant discusses the difference between givers, takers, and matchers and their success at work. He found different sub-sets of givers, two of which are "selfless" givers and "otherish" givers. Selfless givers give their time and energy without regard to their own needs (hey - it's 3pm and I haven't eaten yet today!). Paying attention to your own self-care is critical to preventing burnout, and selfless giving, in the absence of self-care, drives burnout. The trick is to become more of an otherish giver. Otherish givers find a way to balance giving with their own self-interest and self-care. This might be difficult at first, and you may need to identify core beliefs standing in your way; such as, "Good care managers must always put the client first," or "I have to be a people pleaser." You can determine how strong your giver tendencies are at Dr. Grant's website, [www.giveandtake.com](http://www.giveandtake.com).

STOP stress. Mindfulness techniques are a great way to build resilience. Mindfulness is simply becoming aware of what's happening in the present moment. Constant connection to technology, lack of sleep, and experiencing intense emotions and stress make it hard to be mindful in our always-on, 24/7 world. This simple mindfulness technique, called STOP, can help you re-balance your thinking when stress is high (Stahl & Goldstein, 2010). The steps are as follows:

S: Stop. Literally, stop what you are doing and pay attention to how you're feeling and what you're thinking.

T: Take a breath. Take several deep breaths to help you to re-center and re-focus.

O: Observe. Take a mental note of where you feel tension in your muscles. Are your shoulders tight? Is your jaw clenched? What are you thinking, and are those thoughts productive or counterproductive?

P: Proceed. Now that you have a little additional information about the sources of stress in your environment, proceed with what you were doing. The goal is to go about your merry way, but in a more intentional and balanced way.

Note the sacred moments: Dr. Ken Pargament is a psychologist and noted researcher on the connection between spirituality and health. I recently heard him speak at a conference. He defines spirituality as the search for the sacred and notes that sacred moments are not rare occurrences. He detailed his latest research showing that sacred moments were often reported by care providers and when identified, increased resilience and positive change for both the care provider and the client/patient. Sacred moments led to stronger relationships with the client/patient, a greater reported sense of meaning in one's work, and a greater sense of well-being. Keep a journal of sacred moments and review it often.

I developed my own resilience practice after I burned out from practicing law for seven years and have since taught resilience skills to thousands of professionals. These skills have changed my life in numerous ways, and I want that for you too.

## References

Article references

Topics: Resilience

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Aging Life Care Association™

3275 West Ina Road, Suite 130 | Tucson, AZ 85741-2198

520.881.8008 | 520.325.7925 Fax

# Journal

of AGING (ife CARE™



FALL 2015

Resilience

## What Do We Feed? Mindfulness and Resilience in Successful Aging

Lucia McBee, LCSW, MPH, CYI

What do we feed?

One evening an old Cherokee told his grandson about a battle that goes on inside people. He said, “My son, the battle is between two wolves inside us all. One is Evil. It is anger, envy, jealousy, sorrow, regret, greed, arrogance, self-pity, guilt, resentment, inferiority, lies, false pride, superiority, and ego. The other is Good. It is joy, peace, love, hope, serenity, humility, kindness, benevolence, empathy, generosity, truth, compassion and faith.” The grandson thought about it for a minute and then asked his grandfather: “Which wolf wins?” The old Cherokee simply replied, “The one you feed.” — A Native American Tale

No matter what our circumstances, we will experience the good and bad, and there will be circumstances outside our control. This is increasingly apparent as we age and face losses of friends and family, physical health, and even living environments. Aging Life Care Professionals™ / care managers face these losses both personally and professionally. We cannot change this fact, but we can change how we respond to it. Our innate capacity to face and handle life’s challenges—resilience— is an important factor in living a satisfactory life.

Mindfulness, the ancient art of paying attention non-judgmentally, can be an important key to cultivating resilience. We may be born with a greater or lesser capacity for it, but we can also nurture this quality through our behaviors. Human survival is based on our hypersensitivity to negative and intense situations or, as Rick Hanson says, “The brain is like Velcro for negative experiences, but Teflon for positive experiences.” (quoted in Bergeisen, 2010). We also know, however, that we can change our brains by our thoughts and behaviors, and that intentionally focusing on the positive can create new habits that will increase resilience. In other words, we get better at what we practice.

Consider this: Imagine something unexpected, unwanted, and unfortunate happens to you. It could be a client who fires you; an argument with someone in your own family; a higher than expected tax bill; or any other event. What are your thoughts? What are your feelings? Do you notice physical sensations? If you are aware of them, it is a great start to noticing your habits. The next step might be to consider if these responses are helping you or not. Is your first thought, “I am a loser”? Do you clench your fists? Is it helpful? Since you have learned and practiced these habits over many years, it may be challenging to change. But mindfulness practice brings awareness of our habits, teaches us that we have choices, and nurtures our natural capacity for resilience.

### What is mindfulness and mindfulness practice?

#### ABOUT THE AUTHOR

Lucia McBee, LCSW, MPH, CYI, is a geriatric social worker and certified yoga teacher who integrated mindfulness and complementary therapies with elders and their caregivers for more than 30 years. She is adjunct faculty at the Columbia School of Social Work, and a freelance speaker and consultant in New York City. She is the author of *Mindfulness-Based Elder Care* (New York: Springer Publishing Company, 2008).

Mindfulness–Based Interventions (MBIs) offer a mind/body approach to health and healing that teaches coping skills for physical and emotional trials. It offers a shift from the conventional emphasis on curing to living with what cannot be changed. Jon Kabat–Zinn, the pioneering creator of Mindfulness–Based Stress Reduction (MBSR), describes mindfulness as:

Moment–to–moment, non–judgmental awareness, cultivated by paying attention in a specific way, that is, in the present moment, as non–reactively, and as open–heartedly as possible.

Bringing awareness and compassion to our moment–to–moment experience is challenging when the experiences are unpleasant or uncomfortable. Mindfulness teaches us to increase our comfort with this discomfort. There are skills, like deep breathing, that we can use at critical moments, so that when distress or disaster arrives unexpectedly we are better prepared to cope with it.

Mindfulness is learned through personal practice, the same way we learn to play an instrument or ride a bike. There are many classes, books, and online apps to learn mindfulness. The most widely used and researched program for teaching mindfulness, is MBSR. It was introduced in 1979 by Kabat–Zinn at the University of Massachusetts Medical Center. MBSR is an intensive 8–week class that teaches participants to connect with and encourage their innate capacity to find balance, reduce stress, and heal using daily assignments of secular, yet often deeply transformative, practices. Practices include formal exercises such as meditation and yoga, and informal exercises that integrate self–compassion, and invite you to pay attention to all aspects of your life.

## How do we know it works?

Initially created to help people with chronic pain, MBSR has been shown, in multiple evidence based research studies, to improve mood, sleep, and stress levels, as well as reduce inflammation, impacting multiple chronic conditions ([www.goamra.org](http://www.goamra.org)). Mindfulness has been taught to all ages and in a wide variety of settings such as yoga studios, hospitals, schools, and prisons. Groundbreaking studies of participants following an 8–week MBSR class include:

- Strengthened immune systems (Davidson, et al, 2003)
- Increased brain grey matter (related to intelligence, skill, memory and emotion) (Holtzel, et al, 2011)
- Slowing of cellular aging (Epel, et al, 2009)

Mindfulness interventions have also shown the following benefits for older adults:

- Improvements in memory and attention (Meta–analysis by Marciniak, et al, 2014)
- Reductions in anxiety and depression (Young & Baime, 2010)
- Reduction in pain (Marone, et al, 2008)

## What are the practices and where can we learn these?

Mindfulness courses (MBSR or similar ones) are taught in most major cities in the US and around the world. These courses are a great way to begin a regular practice. The courses traditionally begin with awareness of the body and breath. Students are asked to spend time each day paying attention, moment–by–moment, to their breath and physical sensations. This focus can be challenging, but helps participants stay in the present moment. Most notice that their attention is attracted to thoughts, and thoughts reflect the past or the future.

Mindful movement is another important way of bringing awareness to the present via body experience. Yoga, Tai Chi, and Qui Gong are all mindful movement practices, as well as mindful slow walking. In fact, informal mindfulness is available at every moment, just by paying attention. Cultivating a non– judgmental attitude is another important aspect of mindfulness. When learning to pay attention, many people begin noticing harsh, critical thoughts. Letting these thoughts go, and returning to physical awareness, begins to shift habitual



negative thinking patterns. An intentional practice of lovingkindness can also be helpful as an antidote to self-criticism and judgment.

The brilliant aspect of mindfulness practices is that they benefit both the professional and the client. In addition to personal stress, Aging Life Care Professionals / care managers may absorb the stress of their clients. Interestingly, stress is contagious. Remember the last time you were around someone who was highly stressed? Did you feel more stressed? If you are stressed, you may find it impacts your clients. Consider the opposite. Would it be possible to de-escalate a stressful circumstance just by using mindfulness practices to calm yourself?

Despite the powerful historical and scientific evidence supporting the benefits of mindfulness and meditation, the final evidence is personal. We can participate in our own healing. Try the exercise described below throughout the day. Notice what you feel immediately following this practice, and after practicing for several days. There is no right or wrong answer—become the scientist of your own life!

## Basic Breathing Exercise

The following three-minute breathing exercise is from Mindfulness-Based Cognitive Therapy:

First minute: Awareness

Observe—bring the focus of awareness to your inner experience and notice what is happening in your thoughts, feelings and bodily sensations. Describe, acknowledge, identify—put experiences into words.

Second minute: Redirecting attention

Gently redirect your full attention to your breath. Follow your breath all the way in and all the way out.

Third minute: Expanding attention

Allow your attention to expand to the whole body—especially to any sense of discomfort, tension, or resistance.

As best you can, bring this expanded awareness to the next moments of your day.

Remember, as the song writer Roger Miller said: “Some people feel the rain, others just get wet”.

## References

Article references

Topics: Resilience

## The Role of Behavior Management in Reducing Distress and Improving Coping in Caregivers of Dementia Patients

Suma Chand, PhD and George Grossberg, MD

Foreword by Phyllis Brostoff

Chand and Grossberg have done a rather thorough review of the recent literature of how the behavioral and psychological symptoms of dementia challenge those who provide care to people with dementia. They provide an in-depth analysis of studies of the efficacy of a variety of non-pharmacological behavior management approaches. Aging Life Care Professionals™ / care managers who seek to improve their understanding of behavior management will find this literature review by Chand and Grossberg useful. In their conclusion, Chand and Grossberg suggest that care managers can play a useful role by providing training in behavior management to family caregivers as well as to facility staff.

### Introduction

Behavioral and psychological symptoms of dementia (BPSD) affects up to 90% of all patients with dementia at some point in their illness (Cerejeira J et al., 2012). These symptoms include agitation, depression, apathy, repetitive questioning, aggression, sleep problems, wandering, psychosis, and a variety of socially inappropriate behaviors (Lyketsos et al., 2011). The behavioral and psychological symptoms of dementia lead to an increase in caregiver distress and burden as there is also greater functional impairment in the individual (Black and Almeida, 2004; Kales et al., 2005; Van Den Wijngaart et al., 2007). This paper outlines and examines the efficacy of behavior management strategies in reducing caregiver burden and improving caregiver resiliency as they cope with the care of dementia patients.

Management of behavior problems in dementia patients has become more complicated by the fact that risk and safety factors have been found to be associated with pharmacotherapy which has resulted in their use being limited (Steinberg & Lyketsos, 2012). Non-pharmacological treatments have been recommended as the preferred first line treatment for BPSD except in emergency situations where there are imminent danger or safety concerns (American Geriatric Society, 2013; National Institute for Health and Care Excellence, 2012). The non-pharmacological approach of behavior management has involved training caregivers in the application of behavioral strategies so that they are able to manage these behaviors more effectively. It has also involved strategies to assist caregivers in improving their coping and resilience to face the stress of caring for individuals with dementia. Behavior management techniques include a variety of

### ABOUT THE AUTHORS

Suma P Chand PhD, is an Associate Professor and Director of the Cognitive Behavior Therapy program, Department of Psychiatry, St Louis University School of Medicine. She is a certified diplomate and fellow of the Academy of Cognitive Therapy.

George T Grossberg MD, is Samuel W Fordyce Professor and Director of the Geriatric Psychiatry in the Department of Psychiatry, St Louis University School of Medicine. He currently serves as medical editor of CNS Senior Care; Section Editor, Geriatric Psychiatry of Current Psychiatry and Geriatric Psychiatry for Current Geriatric Reports. He is also on the editorial boards of Demencia Hoy, the International Journal of Alzheimer’s Disease, and the Journal of the American Medical Directors Association.

behavioral interventions such as functional analysis of specific behaviors, token economies, habit training, progressive muscle relaxation, communication training, cognitive behavior therapy, and various individualized behavioral reinforcement strategies (O’Neil et al., 2011). Randomized controlled trials have been carried out which investigated the impact of multi-component interventional programs utilizing behavioral management strategies.

## Behavior Management Studies

A number of randomized controlled trials (RCT) have been carried out in community settings which have involved training caregivers in the application of behavioral treatment strategies. Teri et al developed the community based Seattle protocol which involves training caregivers in the behavioral approach in problem solving using the ABC (antecedent-behavior-consequences) paradigm and the application of strategies to increase behavioral activation (exercise, pleasant events). The intervention was evaluated for efficacy in three different randomized controlled trials and in all three trials treatment was found to lead to significantly better function and fewer behavioral disturbances than did the usual treatment or wait-list control conditions (Teri et al., 1997, 2003, and 2005). The first study also evaluated the impact of the behavioral program on mood and found that depression was found to be significantly lower in the caregivers as well as the dementia patients, with improvement being maintained at the six month follow up (Teri et al., 1997). In the third study, which was carried out in an assisted living facility, the caregiving staff who received the training also reported less adverse impact and reaction to the problem behaviors displayed by the dementia patients and more job satisfaction (Teri et al., 2005).

Huang et al carried out a RTC on 59 family based caregivers in the community utilizing an intervention program which involved functional analysis to help identify negative environmental stressors that could be triggering problem behaviors and provision of appropriate environmental support (Huang et al., 2003). The intervention based on the Progressively Lowered Stress Threshold Model (Gerdner et al., 1996; Hall et al., 1987; Hall et al., 1995) was tailored to the individual needs of the caregivers in the community. The intervention consisted of two in-home caregiving training sessions carried out over two weeks, followed by telephone consultations every two weeks for the experimental group. The control group received only written educational materials and social telephone follow-ups every two weeks. Follow-up evaluations carried out at the third and fourth month indicated that in the case of the experimental group there was significant improvement in caregivers’ self-efficacy in managing behavior problems and in a number of the problem behaviors in the subjects with dementia.

In a RCT with a smaller sample size of 31 caregivers two psycho educational interventions directed at the caregivers were compared. One was a cognitive behavioral intervention aimed at modifying dysfunctional thinking in the caregivers and the second was a problem solving intervention aimed at improving caregiver efficacy in modifying problem behaviors in their relative with dementia.

Following the intervention, the caregivers who received the cognitive behavioral intervention showed significantly less perceived stress with a trend towards reduced stress associated with the problem behaviors as compared to the control and the problem solving intervention group. The group that received the cognitive behavioral intervention also reported significantly less behavior problems than the other two groups (Losada et al., 2004). Burgio et al., (2003) developed a manualized intervention involving functional analysis, problem solving, and cognitive restructuring which was delivered to 70 caregivers in the experimental group through workshops and in home training sessions. Another 70 caregivers were placed in a minimal support control condition involving brief supportive phone calls and written instructions. Results indicated that both interventions had a significant impact on caregiver distress since both groups of caregivers reported being less distressed by the problem behaviors and also increased satisfaction with their leisure activities. Both interventions also resulted in reduced problem behaviors in the two groups. The investigators took into

consideration the race of the subjects and found that the Caucasians responded better to the minimal support condition and the African Americans responded better to the skills training condition. Differential responses were also linked to whether the caregivers were spouses or not.

In another multi-center RCT 158 caregivers were randomized to the treatment and control groups in 12 successive waves. While the control group attended the traditional support groups the treatment group attended the psycho educative program developed by Folkman et al., (1991) extended over 15 two-hourly weekly group sessions. The program consisted of two main components. The first component targeted improving cognitive appraisal of the problem situations they face in the care of the dementia patient and the second component involved acquiring effective coping skills in dealing with the problem situations.

The cognitive appraisal component of the program focused on breaking down global situations into specific elements in order to clarify the problem and distinguish between changeable and unchangeable aspects of the stressor, leading to a better choice of coping strategies. The coping component focused on the strategies of problem solving, reframing, and seeking social support. With regards to problem solving, caregivers were taught the steps that have to be taken to clarify a target behavior that was changeable, utilizing behavioral techniques and finding an appropriate solution to help reduce the frequency and intensity of the problem behavior.

The reframing strategy was based on the cognitive approach in which dysfunctional thinking is viewed as generating dysfunctional mood states (Beck et al., 1979). Caregivers were trained to recognize dysfunctional thinking and modifying them so that the emotions associated with the dysfunctional thinking is modified and improves as rational ways of thinking replaces the dysfunctional thinking. The third coping strategy consisted of seeking social support. The results indicated that the intervention resulted in a significant reduction in the frequency and severity of the caregiver reactions to disruptive behaviors. There was also a reduction of behavior problems reported by the caregivers in the treatment group with the difference between the study and control group approaching significance (Hebert et al., 2003).

Gonyea et al., (2006) carried out a RCT with 80 caregivers which involved group training sessions for caregivers in the experimental group in a multi-component behavioral intervention extending over 5 weeks. The intervention was based on behavior therapy principles and involved functional analysis and behavioral activation. It was aimed at reducing the problem behaviors, caregiver distress, and burden. The control group received a similar period of group psycho education.

The results of the study indicated that the training resulted in significant reduction in caregiver distress and also problem behaviors in the dementia patients. A RCT was carried out with 54 experimental and 59 control families who provided care to dementia individuals living at home over a period of 18 months (Moniz-Cook et al., 2008). The caregivers in the experimental group were given guidance by trained community mental health nurses in managing the problem behaviors manifested by the dementia patient by applying the intervention which involved functional behavior analysis, problem solving, and stress-coping. The control group received care as usual from the community mental health nurses. Results indicated that while cognition declined in the dementia subjects in both groups the problem behaviors were reported as having reduced in the experimental group and the mood of the caregivers showed improvement at 12 months and 18 months. The control group on the other hand reported reduced coping resources, increased problem behaviors, and worsening of depression.

Gitlin et al., (2011) carried out a RCT on 272 caregivers and dementia patients where the caregivers in the experimental group received advanced caregiving training which conceptualized problem behaviors as being a consequence of interacting factors which could be patient based (unmet needs, discomfort/pain, incipient medical condition), caregiver-based (stress, communication style) and environment-based (clutter, hazards).

The training helped caregivers to develop the skills to identify and eliminate, reduce, or prevent the problem behaviors. The control group received no intervention. The study results indicated improved caregiver well-being and skills in managing the problem behaviors as well as significant reduction of problem behaviors in the dementia patients at the end of the intervention at 16 weeks and again at 24 weeks.

In one RCT carried out in a residential care setting (Burgio et al., 2002) a four week comprehensive behavior management training program was provided for nursing assistants. The training included training the nurses in identifying factors in the environment that could impact the resident and behavior management skills training, such as application of specific behavior management techniques and effective communication. The staff was also taught to increase the use of effective antecedent and consequent behavioral techniques and to decrease the use of ineffective techniques. The supervisory staff in the treatment group was provided with training based on the author's behavioral supervision model in order to apply supervision that would help the nursing assistants maintain the skills acquired during training. The control group nursing assistants received the conventional supervision. In the case of both groups it was found that the behavior management training program improved the nursing assistants' ability to interact with behaviorally disturbed nursing home residents and produced sustained reductions in agitation. The supervision provided in the treatment group led to more effective maintenance of learnt skills as indicated by the follow up assessment at six months.

## Discussion

The randomized controlled studies on behavior management have typically involved multi-component programs with caregivers receiving training in the application of behavior management strategies. Studies have described training programs involving one or more behavioral strategies such as application of functional analysis in problem solving, behavioral activation, individualized contingency management, or communication skills. In many of these studies, the primary goal of the training has been to train the caregivers in application of the behavior management strategies that will help reduce the problem behaviors in the dementia patient. However, these studies found that it also resulted in positive changes in the caregivers, such as, improved skill in interacting with the behaviorally disturbed patient, improved mood, reduced distress, and less adverse reactions to the problem behaviors.

In some studies the training programs also incorporated training directed at building skills of the caregivers which would enable them to help themselves with regards to stress reduction, depression, and the burden associated with caregiving. These studies incorporated strategies such as cognitive reframing, stress management, and seeking of social support which resulted in improvement in the area of caregiver wellbeing. The length of the period of training, number of training sessions, and follow up support varied from study to study. The studies also differed in the targeted behaviors and outcome measures utilized.

Although the studies have used different combinations of strategies in their multi-component programs, in the length of the training, follow up support, and also in the outcome measures used, the end result has indicated significant reductions in caregiver distress, improvement in caregiver coping, and also in the BPSD. The research in the area has limitations but shows promise in improving the coping skills and resilience of the caregivers along with managing the difficult problem behaviors that are part of this progressive disorder.

Many of the authors who have carried out research on the efficacy of behavior management programs have developed manuals for their programs and they are good educational resources for Aging Life Care / geriatric care managers (Teri, et al, 2005; Burgio et al., 2003; Folkman et al., 1991). The Alzheimer's Association is an excellent resource for education and training in the area of behavior management directed at dementia patients. They provide online and classroom training programs and also specific training programs that will lead to certification. They also provide details about training programs provided by other organizations that meet the recommended care practices for patients with dementia. The website provides detailed information about educational and training resources for professionals which also include books and DVDs in addition to

information about training programs

([https://www.alz.org/professionals\\_and\\_researchers\\_professional\\_care\\_providers.asp](https://www.alz.org/professionals_and_researchers_professional_care_providers.asp)).

## Conclusion

Effective non-pharmacological strategies like behavior management have not been translated well into clinical management and standard care (Molinari V, et al. 2010). One of the reasons that have been suggested for the continued limited use of non-pharmacological strategies has been the lack of awareness of their efficacy, and more importantly, lack of training in the application of the strategies (Cohen-Mansfield J, et al. 2013). In the application of behavior management strategies the caregivers would benefit from being trained in the application of the strategies. Individuals with dementia are cared for in a variety of settings such as their own homes, adult day care centers, assisted living, nursing homes, and psychiatric hospitals.

The people involved in the care of the persons with dementia have diverse trainings and back ground since they range from family members, nurses or nurses' aides, activity staff, occupational therapists, to teams that include a combination of providers. This would be where Aging Life Care Professionals / care managers could play an important role. In the case of dementia patients being cared for in their homes it would be beneficial for care managers to provide training programs in behavior management themselves or assist the caregivers in getting guidance and training in the application of behavior management strategies from other suitable professional sources.

In the case of dementia patients who are being cared for in residential settings it would be helpful for Aging Life Care Professionals / care managers to work with the institution to ensure that the caregiving staff receive training in the application of behavioral strategies. An interdisciplinary team approach becomes imperative in applying behavior management interventions in residential settings and the Aging Life Care Professional / care manager could play an important role in ensuring that the team functions cohesively with the support of the institution.

## References

Article references

Topics: Resilience

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Aging Life Care Association™

3275 West Ina Road, Suite 130 | Tucson, AZ 85741-  
2198

520.881.8008 | 520.325.7925 Fax

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# Journal

of AGING (ife CARE™

## Promoting Resilience through Creative Engagement



FIND AN AGING LIFE  
CARE EXPERT

FALL 2015

Resilience

Promoting Resilience through Creative Engagement[i]

Susan H. McFadden, PhD and Anne D. Basting, PhD

Over the past 15 years we have collaborated on the research and development of programs for people with dementia that use creative engagement as a means of shifting the paradigm of care from managing behaviors to engaging individuals and building community.

Engaging in creative activities – storytelling, painting songwriting, dance, drama – enables people with memory loss to express their strengths. These activities not only reflect resilience; they may also reinforce it, biologically, psychologically, and socially. After all, the brain is a social organ and we have based our research and interventions on the belief that resilience and creative engagement are nurtured best in supportive, accepting communities.

Research demonstrates that this approach improves the lives of persons with dementia. (Fritsch, et al., Feb. 2009)

By “creative engagement” we mean programs designed for older persons aimed at encouraging individual expression and strengthening social connections. We distinguish these programs from art, music, or dance therapy because the goal is not to ameliorate psychological or physical symptoms, nor do these programs rely on the presence of a professional therapist. Resilience in broad terms includes the recognition that we cannot control all aspects of our life; a feeling of commitment to people important to us and to our ideas; believing we can manage our life and have some close and positive relationships with other people; having a sense of purpose; not giving up or becoming overly discouraged in the face of failure; and the ability to feel some pride in our achievements.

In developing and working with a wide range of programs aimed at creative engagement (Table 1), we have found that focusing on people’s ability to thrive and flourish, rather than on their pathology or negative behaviors, provides a broader way to think about the complexity of human behavior. We have seen severely impaired individuals participate in complex creative activities that their caregivers did not believe they would be able to manage.

In addition, we have focused our work on helping individuals to maintain their sense of their own selfhood, which is formed and flourishes in relationship with other people. One foundational concept of our creative engagement programming is that it occurs in a social context, one-on-one or in a group. This is supported by research that shows there is a strong connection between meaningful relationship in a diverse social network

### ABOUT THE AUTHORS

Anne Basting, PhD., (anne@timeslips.org) is Professor of Theatre at University of Wisconsin Milwaukee’s Peck School of the Arts. She is founder and President of TimeSlips Creative Storytelling, and author of three books, including *Forget Memory: Creating Better Lives for People with Dementia*.

Susan H. McFadden, Ph.D., (susan.h.mcfadden@gmail.com) is Professor Emerita of Psychology, University of Wisconsin Oshkosh, where she taught a variety of courses for undergraduate and graduate students, including several seminars on dementia studies. Susan retired from the University in June, 2012, now works as a research consultant for the Fox Valley Memory Project ([www.foxvalleymemoryproject.org](http://www.foxvalleymemoryproject.org)) which aims to create a “dementia-friendly community” in northeast Wisconsin. She has been a trainer in the TimeSlips storytelling method for persons with dementia for many years and serves on the Board of Directors of TimeSlips, Inc. Currently, she is directing a study of personalized music for people with dementia living at home.

and less cognitive decline in old age, greater resistance to infection, and a better prognosis in the face of life-threatening illnesses.

The mission statement of TimeSlips Creative Storytelling ([www.timeslips.org](http://www.timeslips.org)) is “improving the lives of people with memory loss through creative engagement.” It is a multi-sensory, sustainable, evidence-based approach to positively engaging people with dementia which founder Anne Basting began to develop in 1998 (Phillips, Reid-Arndt, & Park, Nov/Dec 2010). The TimeSlips method provides individual and group activities that are teachable, sustainable, low-cost, and allow for individualization. It has been successfully used in facilities to demonstrate what person-centered care feels like for staff and residents and offers a way to creatively envision deeper shifts toward meaningful relationships and person-centered care.

## References

[i] See “Health Aging Persons and Their Brains: Promoting Resilience Through Creative Engagement,” *Clinical Geriatric Medicine* 26 (2010), pages 149–161.

### Article references

## Tables

Table 1: Sampling of Programs for Creative Engagement with People Living with Dementia

IMPROV, DANCE, MUSIC, POETRY

### Alzheimer’s Poetry Project

The Alzheimer’s Poetry Project is based on a simple idea, to read classic poems to people living with Alzheimer’s disease that they might have learned as children.

Background: During a period of ten years a new approach to engage participants with Alzheimer’s disease and related dementia in the performative aspects of poetry and to create new poems was developed.

Results: Data indicates that a significant number of people in mid to late stage dementia remember words and lines from poems they learned in childhood. Moreover, the participants show a high level of positive facial expressions, laughter, verbalizing memories, and robust social interactions. Of interest is the use of call and response, where the session leader recites a line from a well-known poem and the group echoes the line. Coupling this performance technique with a simple prompt or opened ended question enables a group poem to be composed, based on the participant’s responses.

Conclusion: The findings led to the development of a training system for artists, family members, and healthcare workers in using poetry with dementia.

Mission: Our goal is to facilitate the creativity of people living with Alzheimer’s disease and related dementia. We strive to advocate for cultural change in the healthcare industry and for the daily inclusion of arts in assisted living and adult day care. Further, we do not set boundaries in our beliefs in what possible for people with memory impairment to create.

By saying to people with dementia, we value you; we are saying we value all members of our community. By working with health care professionals and giving them a tool to have fun with and stimulate the people they serve, we are saying we value your work. By working with family members who have a loved one with dementia, we are saying you are not alone in your struggle to treat your loved one with dignity.

Artz: Artists for Alzheimer’s & I’m Still Here Foundation

ARTZ has three primary programs:



1. The Artists Network: ARTZ recruits and trains volunteer artists to perform and work side by side with people living with dementia
2. The Museums Network: ARTZ trains museum staff and implements educational museum tours for people living with dementia and their care partners.
3. The Cultural Events Network: ARTZ develops annually recurring community-based programs for people living with dementia and their care partners, which have led to increased accessibility and opportunity.

### Kairos Alive (dance and story)

Mission: Our mission is to support the artistic work of Maria Genné and promote her vision of sharing the joy of intergenerational interactive participatory dance and story, and to liberate its power to nurture and heal.

Vision: KAIROS alive! uses dance and storytelling to create a sense of community and well-being in participants of all ages and walks of life.

Work: Our work draws upon modern dance, movement improvisation, folk dance, and oral history traditions from around the world, and the lives of inspiring people. Artistic Director Maria Genné is recognized for her ability to highlight the beauty of human experience through movement and story, skillfully weaving together the gifts of each performer. KAIROS Dance™ is the only intergenerational modern dance company in Minnesota, and one of only a handful in the US.

We are an unusual and unique dance company of all different ages (7–98 years). We have created an award winning program called KAIROS Dancing Heart™ which vitally engages frail elders, including those with mid-to-late stage Alzheimer's, in a weekly dance and storytelling playshop that has shown to positively improve the health of participants. We have won three national awards: The 2011 Rosalinde Gilbert Innovations in Alzheimer's Disease Caregiver Legacy Award, The Archstone Award for Excellence in Program Innovation from The American Public Health Association and the 2008 Mind Alert Award from the American Society on Aging.

### Songwriting Works

Songwriting Works™ fulfills its mission to restore joy, hope, health and community by bringing interactive musical adventures, skills building workshops and inclusive events to elders, youth, and families in neighborhoods, care centers, and schools. Also offering training and consulting to health, arts, and social service providers internationally.

### TimeSlips Creative Storytelling

TimeSlips offers an elegantly simple revolution in long-term care – a clear shift from “managing behaviors” toward using the arts to engage and build community. In an age when medicine offers few treatments for dementia, TimeSlips provides hope through meaningful communication and connection. While started back in 1998, TimeSlips became an independent non-profit in 2013. Providing:

- Online Certification to Individuals in our improvisational storytelling method
- Training for Organizations on how to building a creative community of care, engaging elders, staff, families, and volunteers
- A Creativity Journal for one-on-one use (available through Attainment Co.). Ideal for families, home care, and hospice
- Online Trainings that support student (high school and higher education) service learning

- FREE online storytelling software that lets you create together and share your stories with others around the world. Come and play today! Start a story!

## MUSEUM-BASED

### Arts & Minds (New York City)

Arts & Minds is a non-profit organization committed to improving quality of life for people living with Alzheimer's disease and other dementias. Partnering with museums to provide meaningful art-centered activities that create positive cognitive experiences, enhance communication, and reduce isolation. Their programs empower people with dementia, family members, professional caregivers, and educators to strengthen social, emotional, and spiritual bonds by engaging with art.

### Meet Me at MOMA (New York City)

The MoMA Alzheimer's Project was a special initiative in the Museum's Department of Education. The initiative took place from 2007 to 2014 and was generously funded by MetLife Foundation. During this time, MoMA staff expanded on the success of the Museum's existing education programs for individuals with Alzheimer's disease and their care partners through the development of training resources intended for use by arts and health professionals on how to make art accessible to people with dementia using MoMA's teaching methodologies and approach.

MoMA remains as committed as ever to providing programming for individuals living with dementia and their care partners and to supporting the development and success of this type of programming around the world. To that end, the Museum will continue to offer engaging programming and resources for this key constituency. For more information on MoMA's ongoing education programs for individuals with Alzheimer's disease or dementia and their care partners, visit the [Programs page](#).

In addition, MoMA staff will continue to provide resources, information, and advice to other organizations and to facilitate training workshops locally, nationally, and abroad. We are poised to maintain our role as a connector in this field– to serve as a hub for conversations on aging and creativity and to provide a vital link for colleagues around the world who are interested in making art accessible to people with dementia. For more information on these continued efforts please write to [accessprograms@moma.org](mailto:accessprograms@moma.org).

### Spark Alliance (Wisconsin)

Spark brings cultural programming to families with memory loss. The Alliance shares training and scheduling information to act as a resource for the families we serve and other cultural organizations that wish to open themselves to older adults regardless of disability.

### Here: Now at the Frye Museum (Seattle)

here:now is an arts-engagement program for individuals living with dementia and their care partners to enjoy a creative and relaxing time together. The only museum-based arts program of its kind in Washington State, here:now offers gallery tours and art-making classes designed for individuals with young-onset or early to mid-stage dementia and their care partners.

Over the next two years the Frye is piloting new program components to serve individuals as their disease progresses. The museum will also convene a professional development conference and workshop on art, creativity and dementia care; establish a student internship in creative aging with a local university; and publish a report and present the results of the program pilot at conferences. An advisory committee of community advocates and leaders in gerontology, neuropsychology, creative aging, and memory care guides the expansion.

## Topics: Resilience

### 2 thoughts on “Promoting Resilience through Creative Engagement”



1. Steve White says:

January 7, 2018 at 3:24 pm

Persons with dementia actually need this type of non-judgemental environment in terms of engagement and expression of mind skills.

Reply



1. Steve White says:

January 7, 2018 at 3:36 pm

Healing of dementia goes well with artistic activities.

Reply

# Journal

of AGING (ife CARE™  
One Size Does Not Fit All!



FALL 2015

Resilience

Laurie Bachner

In collaboration with Aging Life Care Professional™ / care manager Helene Bergman, my dementia specialist mentor, I have been able to assist clients with dementia build and maintain resilience through the use of what I have come to call Chair Yogacise. Chair Yoga was developed to fill a void for those who loved Yoga but were unable to practice it for many reasons including disability, obesity, or just being unable to get on and off a mat. Adults recovering from cancer or those suffering chronic neurological disorders gravitated to it for exercise, serenity, and self-esteem. Chair yoga is a safe method for stretching, strengthening, and meditating.

Chair Yogacise is Yoga without the mat, including ballet balancing techniques without the bar, and a series of upper and lower body flexibility and strengthening exercises on and off the chair. I have developed successful approaches to work with individuals with dementia, using a variety of methods to overcome the many challenges this condition presents. Since the disease doesn't stand still, neither can I. What might have worked in the first six months with an individual client might not work any longer. My client who always followed my movement by simply watching with some verbal cues along the way now can't. When I say, "let's do some shoulder rolls", and I realize she no longer knows what the word "shoulder" means or where it is, I know to switch gears.

From the start, it has been clear that actions, and objects, speak louder than words. With that in mind, I integrated bands and balls into sessions. The bands are used by each of us holding one in each hand and as I initiate lateral movements, we stretch and flow to the music. And who doesn't like to throw a ball? Using two size balls (soft of course), one small and one beach ball size, we throw and catch– reinforcing large and small motor skills and hand-eye coordination. Actions such as trying to pick up the ball as well as reaching for it as you bend down without falling backwards requires balance. These movements are also strengthening. They demand the quads to kick in as if one were doing squats, especially when it's repeated several times over. Sometimes my client understands, "throw it back to me." When she doesn't, I can model the action desired.

Connecting with a client with dementia is integral to an effective working relationship and music opens the door. Tailoring the music list to each client's past history and preference is imperative. Finding the right music, songs they know, that they can sing to or even dance to, is sometimes all you need to get the session up and running. Culture and ethnicity is often a guide. One of my clients, who grew up in Puerto Rico as a child, explained how she and her six sisters would dance around the living room while her mother clapped. I made a Latin play list for her and when I played it for the first time and we began, her eyes lit up, her stance straightened and she began to dance in my arms. And we both clapped!

## ABOUT THE AUTHOR

Laurie Bachner is a certified Chair Yoga Instructor in NYC with a background in dance from Juilliard, Martha Graham, and Merce Cunningham. Following a career in sales and marketing, Laurie channeled her passion for fitness into her version of chair yoga. She initially worked with individuals and groups in the corporate world (SOS–Stretch Out Stress) and with cancer survivors at Mt. Sinai hospital. With encouragement from an Aging Life Care Professional / Care Manager, she adapted her protocol for seniors with dementia. Her sessions are private, individualized, and includes caregivers.

The oldies but goodies (i.e. Take Me Out to the Ball Game, and Comin' Around the Mountain) are real crowd pleasers with the older generation. The familiar tunes peak their memories and help the exercise become more aerobic. Clients move and sing at the same time and as this promotes breathing, more oxygen flows throughout the body and to the brain. Not all clients respond to these old standards. Some enjoy opera and classical music. Others enjoy Ella and Frank, show tunes by Cole Porter and Gershwin. It's up to the therapist to identify what they love– what music will inspire their movement. One of my clients sings the arias in Italian along with Pavarotti. The music was so inspirational, he just moved instinctively. I let him lead the way, with arms out stretched, head back, the music filling him up with joy, with passion.

Often, clients surprise me! One very slim 92 year old with advanced Alzheimer's moved so well, I offered her modern dance movements I learned while studying with Martha Graham. Forget overhead arm reaches, we were doing four part sequences of contract and release. I asked her if she was ever a dancer and she thought for a moment and said, "Maybe." I later found out that she was a tap dancer in her youth and although her brain might have forgotten she had danced, her body didn't. To my surprise, she also liked the ball but not for a simple game of catch. Buying into her competitive nature, we had a rigorous one on one, two handed basketball game from the chair, batting the ball back and forth to each other at rapid speed. Here was a woman who barely smiled, now she was laughing saying, "don't stop, I'm not tired yet".....though I was.

The caregiver (family or professional) should be an integral part of the process. Family and friends feel a sense of relief and joy when they observe their loved one partaking in life, laughing, smiling, and being engaged on any level they can. With family permission, I take photos or a quick video so they can see firsthand that the client is not only getting the physical and mental benefits of a workout but is truly enjoying themselves. I engage the direct caregivers as well, explaining why exercise and good diet is so important not only for the client but for them as well. Sometimes it's as simple as the more the merrier! My goal is multi-faceted: if they are engaged and feel a part of what you are doing they might incorporate some of the exercises and activities into their daily routine, when I'm NOT there. When the caregiver is there day in and day out, having some plain fun, laughing, dancing, partaking in joy together, it is beneficial for all. It's energizing, rejuvenating, and, I believe, builds resilience in both the client/patient and the caregiver by strengthening the bond between them.

Although each of my clients has some degree of dementia, the disease never presents itself in the same way, not physically or psychologically. Each client brings a unique personality with his/her own personal memories and psychosocial background to the present. Individuality persists despite the dementia. Understanding who one was and is now is step one; knowing how to switch gears and responding to all the constant changes is next. You do whatever is working on that particular day, with that particular client. Always showing them the respect they deserve; understanding they are a work in progress, as you are, every time you walk through that door. One size does not fit all. It never did. And how great is that!

## Topics: Resilience

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Aging Life Care Association™  
3275 West Ina Road, Suite 130 | Tucson, AZ 85741-  
2198  
520.881.8008 | 520.325.7925 Fax

Website Design by IlluminAge

# Journal

of AGING (ife CARE™

## Success Counseling: A Tool for Aging Life Care Professionals™ / Care Managers



FALL 2015

Resilience

D. Barnes Boffey, EdD & Jennifer Pilcher Warren, PhD, CMC

### Introduction

Success Counseling is an approach to working with our clients which focuses on the individual's ability to evaluate themselves. It is a process that assists the client to ask hard questions and increases awareness of how he/she feels, how these feelings effect decisions they make, and the results of these decisions. The goal is to improve the client's ability to be an independent problem solver. This article discusses how the principles of Success Counseling can be applied by Aging Life Care Professionals™ / care managers as a practical approach to helping our clients. We believe that by using the Success Counseling approach, care managers can help clients uncover their strengths and foster increased feelings of effectiveness, happiness and well-being. Success Counseling can create a "resiliency perspective" which changes how clients see the world and their own behavior, leading to more effective action and a greater degree of self-worth and hope.

Success Counseling is based on the theories of Dr. William Glasser (Choice Theory) and William Powers (Perceptual Control Theory). Both of these theories posit that people who believe that their happiness and well-being are a function of external factors will focus on trying to change those external factors to achieve happiness. In contrast, people who believe that a variety of factors are within their own ability to change (expectations, perceptions, and actions) can maintain their balance and improve their situations even when they previously felt powerless. Success Counseling also posits that behavior is not a matter of linear causality (stimulus leads to feeling which leads to action) but circular causality (expectations affect emotions which affect perceptions which affect expectations) – that we actually create our emotions rather than emotions simply happening to us. One of the fundamental aspects of this type of counseling is that it uses the process of self-evaluation to help the individual consider how effective their approach is to dealing with common losses and challenges associated with aging. This is the essence of resilience: positive adaptation in the face of loss and change.

As Aging Life Care™/ care managers, when we are faced with a cognitively intact client who is struggling with the common issues of aging such as

### ABOUT THE AUTHORS

D. Barnes Boffey, EdD has been working in the field of Internal Control Psychology since 1977. He was a Senior Faculty member at both the William Glasser Institute and the International Association for Applied Control Theory and has taught at the University of Cincinnati, Dartmouth College, and in many other adjunct roles. Dr. Boffey is currently the Director of Training of the Aloha Foundation, an organization whose total philosophy is based on Success Counseling. Dr. Boffey has written two books ([Reinventing Yourself](#) and [My Gift in Return](#)) and multiple articles regarding Success Counseling

Jennifer Pilcher Warren, PhD, CMC was awarded her doctoral degree in Gerontology from the University of Massachusetts in Boston. Her professional experience has focused primarily on care and housing arrangements for elders with Alzheimer's disease and related dementias, including policy and fundraising work for the Alzheimer's Association of Eastern Massachusetts, the Alzheimer's Association of Utah, and the Massachusetts Association of Older Americans. She currently sits on the board of the New England Chapter of the Aging Life Care Association™ and the

death and dying, resisting accepting needed care, driving cessation or difficult family dynamics, what do we have to offer? Can we help that client regain a sense of control and promote good decisions even when choices are limited? Widening the lens from which our clients view the world may open up several new possibilities that may replace loss with potential gains.

## Theoretical Foundations of Success Counseling

### Internal vs. External Control Theory

External control psychology underlies most thinking about human behavior in our major societal institutions: school, family, marriage, corrections, and management. A major belief in these institutions is that we do what we do because of how we feel (“I felt depressed so I’m sitting here doing nothing!” or “I felt angry and that’s why I yelled at him.”). We tend to believe that our feelings drive our behaviors.

A second major belief of external control psychology is that I feel the way I do because some person, place, or thing makes me feel that way. (“My aide made me angry,” or “Other residents make me feel stupid.”) These two beliefs create a “victim” mentality: others cause both our happiness and sadness, and therefore we try to control the behavior of others so we can feel the way we want to. (“If I can just get her to stop doing that, then I wouldn’t be so upset all the time.”) A typical question you hear based on an external control perspective is “How are we going to make this client do....?”

Internal control psychology is based on the belief that what goes on around us is simply information, which we can choose to perceive as positive, negative, or neutral. If someone calls me a name, I can choose to feel angry, sad, or sorry for that person’s lack of understanding, grateful I am not them, or any of a number of other emotions based on my perception. Internal control psychology tells us that our emotional pain comes not from the circumstances of our lives, but primarily from the way we deal with those circumstances.

Gaining skill in choosing our feelings and thoughts is not an easy process; it takes time, energy, and good role models. Aging Life Care Professionals / care managers who use this approach can help clients learn to face life through asking a new set of questions. When we are having difficulty, the question isn’t “What is making me feel bad?” but “How do I feel in this situation?” and then “How would I like to be feeling?” As the question changes, the responsibility shifts to how we deal with the information we are receiving rather than feeling like a victim of that information.

This approach consciously rejects victimizing others or ourselves, and supports learning to be responsible (response-able) for how we act, think, and feel. The Success Counseling approach allows our clients to realize their potential in choosing their perceptions and emotions, rather than feeling victimized by their circumstances.

EXAMPLE: Questions based on the external control or the internal control model

Your client is unhappy after moving to a facility. In an external control model, the questions are “Why are you unhappy here?” and “What’s making you feel unhappy?” In an internal control model the questions are framed differently: “Do you want to be unhappy?”, “Can you imagine being happy even though you are not in your house?”, “Do you want to be enjoying living here rather than feeling sad all the time?”

Publications Committee for the Aging Life Care Association™. For seven years, Ms. Warren was affiliated with Hearthstone Alzheimer Care Assisted Living programs in Massachusetts and New York, where she held a number of management positions. For 8 years, Ms. Warren worked both as a Geriatric Care Manager and as the Director of Operations for AZA Care Management of Boston. She currently holds the position of Executive Director of Care Management for Overlook C.A.R.E., a non-profit Geriatric Care Management practice with offices located in Hingham, Dedham, Plymouth and Charlton, MA.



The internal model questions are based on the assumption that our emotions are coming from the inside out (internal), not from the outside in (external). If we treat our clients as if they have more control over their emotions than they believed possible, we can help them learn to exercise that control to increase their choices.

### Internal Instructions

Another aspect of Dr. Glasser's model of choice theory, is that human beings are born with basic psychological/spiritual instructions.

As human beings, internal biological instructions to eat, sleep, and maintain a certain level of liquid in our bodies are built into our physiology. If we follow these instructions by eating good foods, sleeping a reasonable amount, and varying our liquid intake to match our activities, we feel healthy and in balance. But if we don't follow them — eating the wrong foods, not sleeping enough, or drinking too much or too little liquid — we experience an "internal signal" of hunger, nausea, fatigue or thirst which lets us know we are out of balance. We do not choose these signals; they are a physiological consequence of not following our internal instructions.

Choice theory posits that we also have internal psychological/spiritual instructions and we also experience painful signals if they are not followed. In our Success Counseling model these basic internal instructions are to be loving, to be powerful, to be playful, and to be free. In an external control model these would be expressed as the need for love, power, fun, and freedom. Viewed this way, these qualities become something we need to get or have, like commodities. External motivation drives people to search outside themselves to "have more freedom," or "get more love" in their lives, or "have more fun," or "search for power and recognition."

Examples of the expression of needs when based on the external control model

"My son doesn't give me enough freedom."

"I'm feeling lonely; I need people to love me more!"

"That's not fun — I need to have more fun things to do in my life."

"If I could just go back to work, that would make me feel more important and powerful."

By viewing love, power, fun, and freedom as instructions "to be," we spend less time looking outward and more time looking inward at who we are and how we can be the people our instructions urge us to be. When we are able to follow our internal instructions, even in difficult situations, we begin to esteem ourselves and sense a new freedom and power in our lives.

The instruction to "Be Loving" is an urge to connect, to belong, to feel compassion for others, and to forgive. Being loving is easy in situations others are doing what you want and giving you the attention and love you desire. But being loving is more difficult if someone is mad at you, lets you down, treats you poorly, or does not do what you want them to do. In an external motivation model, we blame the people who are doing these things and see them as the cause of our pain.

The internal motivation model says that our pain is created because we are having difficulty being loving when others are acting this way. To wait for others to change so that we can love them is be a source of endless frustration and disappointing relationships.

For example, after an argument with an adult child, we could ask a client, "Do you want to be mad at your daughter or do you want to figure out a way that you can feel calmer and less angry?" We are inviting the client to consider the alternative of changing his/her way of perceiving the situation.

"Being Powerful" means having a voice, staying strong in difficult situations, being worthy, having self-respect, and having impact on the world. It is easy to feel powerful if everyone is listening to you and giving you what you want. It is harder when others do not value you as much as you think you deserve. In the external model,



we might say, “That person makes me feel worthless,” or “How can I feel good? I can’t do anything anymore.” Using Success Counseling, we would invite the client to create his/her perception by asking, “Would you like to spend your time feeling good about what you can do or bad about what you can’t do so well?”

“Being Playful” is the ability to have fun regardless of your surroundings. Little children can have fun with a stick and a juice can. They create their play; they don’t wait for it to happen. Too often as we get older, we wait for external circumstances to create pleasure. Internally motivated playfulness comes from viewing each situation with curiosity, whimsy, and an openness to new perceptions. Hiking is fun for some people and for others it is not, but it is not the hiking that is fun or not fun; it is the attitude with which we hike that creates the pleasure.

Finally, “Being Free” is our ability to maintain a sense of autonomy and choice. People following their internal instruction to be free are able to see choices, to see the glass half full, and to think about “freedom to” and “freedom in.” People who are trapped in the external mind-set are always worried about “freedom from” and ask themselves, “How is this making me feel?” People who are being free are more likely to ask, “How do I feel about this situation?” and even more importantly, “How do I want to feel about this situation?”

If we don’t follow our psychological/spiritual instructions, we feel internal signals — loneliness, powerlessness, boredom, or feeling trapped — that inform us of that fact. When people who understand their internal instructions feel lonely, for example, they do not wait for others to love them. They look for others to love. They call a friend, they pat the dog, or they give a gift. As they take these actions, they begin again to be loving, and the loneliness disappears. When they feel bored, they don’t wait for something to entertain them, they create their fun by beginning to be playful in the situation at hand.

## “Quality World” and Pictures

Success Counseling also uses Dr. Glasser’s concept of the “Quality World”. This is a metaphorical way of saying that, throughout our lifetime, we select what we believe to be the best pictures from our life and store them as our Quality World. These pictures are how we attempt to actualize how we are loving, powerful, playful, and free. We may not always be able to attain our desires or measure up to our ideals, and over time, we may adjust our pictures to be more realistic or effective. But, at any given time, our pictures of what we believe get us what we want and provide the day to day foundation for our behavior.

These pictures of our Quality World are very personal to us and in some instances may have little to do with reason or rationality. For example, our picture of a holiday dinner together with our extended family may include everyone getting along, very specific foods, a specific length of time, a specific feeling, and specific people. Our ideal picture may have little or nothing to do with what actually occurs at that meal, but we continue to carry that picture anyway. This attachment to our pictures can be a barrier to flexibility and therefore resiliency.

Our Quality World contains the knowledge that is most important to us as individuals, the things that define how we wish to be. Anytime we succeed in satisfying a picture in our Quality World, it is enjoyable. On the other hand, if we fail to satisfy a picture in our Quality world, it is painful. People define reality in the way that works best for them. We see the world, not as it is, but the way we want to see it. The discrepancies between our Quality World picture of what we want and who we want to be with the picture of what we actually have and who we actually are creates the stress in our lives. When the pictures don’t match, we experience various degrees of frustration and upset. How we deal with the tension between what we want and what we get will for the most part determine the quality of our happiness.

In Success Counseling we recognize that when we can’t change the conditions within which we find ourselves, our happiness and freedom become contingent on our ability to change ourselves. If we are unable or unwilling

to make that change, we inevitably become victims of our own pictures. It is frequently the case that our clients have outdated pictures in their Quality World that is making them miserable because the picture is so different from their current reality. For example, an older gentleman could be unhappy because driving a car is a picture in his Quality World long after he has the physical or visual capacity to do so safely. However, it is painful for him to let go of this picture as it represents freedom and independence. Further, as you age, most people experience continual losses of people, independence, occupations, roles and abilities – in other words, a constant death of the idealized pictures you have of yourself throughout your lifetime.

## Success Counseling: Putting the theory into action

As care managers, it may be difficult to envision how to help your clients who are experiencing stress or unhappiness due to obsolete pictures in their Quality Worlds. Based on Dr. Glasser's theory, the way to help people to be happy and make change in their lives is to identify what is in their Quality World and then try to support it. However, it may be difficult to gain the trust necessary to have a client share their Quality World because they are afraid that others may not support their picture of the world. As care managers your goal should not be to force a client to change their picture of their world but rather to help our clients create new pictures of a Quality World that can be achieved.

### Example: Past Pictures/Current Life

An elderly male client may believe that power and recognition primarily come from status and career accomplishment, while at this point in his life his working career is over and his power in the marketplace is severely diminished. Another client's pictures of fun include being able to run a half marathon, or her picture of freedom is built on the idea of doing anything she wants, anytime she wants. Using the Success Counseling approach, your role as a care manager is to challenge your clients to grow and redefine what they believe to be quality through creating new pictures for their life with instructions that are viable today.

Success Counseling uses a process of self-evaluation to guide the client through choosing how they want to experience the world. Success Counseling is focused on helping the client do the work, assisting through the thought process that allows her to arrive at a next step and to move forward. The basic rule of Success Counseling is "Ask, don't tell". In Success Counseling asking the right questions makes the client an active participant in the problem solving process and therefore in control over her life.

## The Essential Questions

Success Counseling uses a series of questions, rather than statements, throughout the counseling process, in concert with building a relationship of trust with the client so they can be honest and feel safe. The relationship we build with the client rests on a foundation of being loving, powerful, playful and free. We don't just talk about those qualities; we put them in action in the relationship. When the relationship has the strength to handle honest interaction, we can then begin to ask a series of questions to build resilience and the ability to change that is the goal of Success Counseling.

1st question: What do you want?

Alternative Questions: What do you want to do? What do you want to feel? Who do you want to be?

You start by asking the client: What is your picture? What is your idea of where you would like to be? With these questions you are trying to understand the client's Quality World and where the discrepancies lie that may be at the foundation of their unhappiness. The pictures that are in the client's Quality World are what drive their behavior on a daily basis and what leads them in their lives. The question: "What do you want" is a powerful way to begin to understand the client's pictures. Too often we offer suggestions, judgments, or solutions rather than starting with understanding what is most important to the client.

With many traditional approaches this is where the client’s contribution to the conversation ends. Once we have found out what the client wants, we utilize our many resources and strategic approaches to apply solutions we believe are likely to work. For example, you may respond by:

Traditional External Approach	Internal Approach
What is making you feel so bad?	What do you want?
Who made you feel bad?	How did you hope things would be turning out at this point in your life?
What’s wrong?	What do you want to feel?
Why do you think you’re feeling so unhappy?	What do you want to be in this difficult situation?
	What is important to you?

- Validating the client’s feelings and redirect the conversation
- Saying “Well, then why don’t you just \_\_\_\_\_”
- Giving advice and guidance to the client’s caregivers and family members about which approaches should be used to improve the client’s quality of life

While this is a worthwhile, sometimes effective and seemingly efficient approach to problem solving, what it doesn’t do is engage the client in the process of identifying their own needs and working collaboratively on solutions. Moreover, it does not leave the client feeling empowered and free.

2nd Question: What are you doing to get what you want?

Alternative Questions: What have you tried? What behaviors have you tried to get what you want?

Success Counseling suggests that in order to engage the client in evaluating themselves and generating their own solutions to problems, the self-evaluative process needs to go deeper. For this reason, the second question involves asking the client what they have done so far to try and solve the problem or to try and feel better. The focus on self is what carries you through the questioning process. Sometimes the answer to the second questions is “nothing” or sometimes the client will tell you what they have done.

3rd Question: Is it working? Has it been as effective as you hoped it would be?

This next question is not one of right or wrong, but rather a question of effectiveness. There is an old Hawaiian saying, “effectiveness is the measure of truth”. What we are essentially doing is holding the mirror up to the client and saying, “Ok, you have tried to do this, is what you are doing working?” This is the self-reflective and self-evaluative part of the process.

At this point, it is important to help the client look at the overall picture of what he wants. If a client thinks what they are doing is working, she will not change their behavior.

4th Question: What do you see as your choices now?

Again, you may be tempted to begin pointing out what you see as the choices for resolution. In Success Counseling, however, we ask the client to come up with the answers. Once the client offers their ideas, then you can follow up by asking “If I had some other choices you hadn’t thought of, would you like to hear them?”

“What do you see as your choices now?” is not the same as asking, “Ok, what are you going to do?” “What do you see as your choices now?” is a divergent question looking for options; “Ok, what are you going to do?” is a convergent question looking for a decision. Using this method is respectful, thoughtful, and it allows your client to be in charge during the process. Most of the time, your client will want to hear your choices. Once you have a list of his ideas and your ideas, you are ready for the next question.

5th Question: Would any of these choices be better than what you are doing now?

Typically we might ask, “Would any of those work?” By “work” we are asking the client to solve, finish, or resolve the problem. Rather, we want to ask our client a comparative question – “Here’s where you are, here’s where you want to be, my job is to help you get closer to where you want to be. If one of those choices would be better – are you willing to take the next step?” If the answer is yes, you are ready for the last question in the process.

6th Question: What’s your next step?

Notice you are not asking the client “What is your resolution?” You are not asking for the whole solution, just the next step.

These questions are not necessarily linear, this is not a one stop question process, but should be used in a circular manner. Some of the questions you may have to ask over and over if you have a resistant client. You may have to come back to “Is it working?” over and over again until you can get a client to admit the ineffectiveness of what they are doing or break through an alibi or excuse.

However, like adolescents, older adults may choose to continue to be miserable or continue their behavior. Sometimes there are payoffs of sympathy, help, closeness and resources that we receive if we stay in the victim role. If your client wants to be unhappy, you will not be successful in getting them to change. In this case, you will need to find a way to help them improve their lives while staying as unhappy as they want to be. Paradoxical, but effective.

## Success Counseling Example: Mr. Smith

Description: Mr. Smith has been refusing to accept care in his home. His adult daughter has been hounding him to accept care as he has fallen several times. He agrees to accept care and then fires the home health aides that his daughter sends to the house. In desperation, the daughter has hired you to try and work with her father to see if you can uncover what is going on and help him to accept assistance.

### Question 1

Mr. Smith: Who are you and why are you here? Did my daughter send you?

Care Manager: I am an advocate that works with older folks to help them meet their goals.

Mr. Smith: Oh, I bet you do. I know, you are just one of my daughter’s henchmen.

Care Manager: Mr. Smith what is it that you want?

Mr. Smith: What do you I want? No one asks me that question, they just tell me what to do. Let’s see..... I want to stay in my home until I die. I want my daughter and everyone else to stop pestering me.

Care Manager: Is there anything else?

Mr. Smith: Well, yes, I would like to visit with my daughter like we used to.....watch the baseball game together.....not argue...

### Question 2

Care Manager: So what have you tried so far to get what you want?

Mr. Smith: Well, I have sent everyone away and told everyone to stop bothering me.

Care Manager: Anything else?

Mr. Smith: I have been trying harder to do everything myself so I can show my daughter I can do it.

### Question 3

Care Manager: And how has that been working? Are you getting the independence and relationship you said you wanted?

Mr. Smith: Well, yes and no. I mean I have been able to get everyone to go away....and I have been able to manage by myself most of the time, except when I fell and broke my arm....., now I have someone here every damn minute...

Care Manager: So it sounds like you were able to fire the home health aides, but you aren't alone at home and things aren't so good with your daughter, so did this work?

Mr. Smith: Well, no.

### Question 4

Care Manager: So, what do you think your choices are now?

Mr. Smith: Well, I don't know, maybe I will have to try harder to do things on my own.

Care Manager: That is one choice.

Mr. Smith: Or maybe I should just give up and die in this awful place.

Care Manager: That is another choice.

Care Manager: Ok, any other choices?

Mr. Smith: I don't know. I could talk to my daughter. I could call the agency we were using before.

Case Manager: Or you could just keep doing what you're doing.....

Mr. Smith: no, that's not working.

Care Manager: If I had some other choices you hadn't thought of, would you like to hear them?

Mr. Smith: I guess so.

Care Manager: One choice would be to come up with a plan so that someone could check on you during the day, and help you with certain things, but they wouldn't have to be there all day.

Another would be to tell your daughter how grateful you are for her help and that you want to watch the game with her rather than fight.

Another choice would be to ask your daughter if there is a way she would feel that you are safe without having people here all the time... maybe one of those house monitoring systems.

Another would be to check in with your daughter a few times a day.

Another would be to ask her over for dinner or ice cream so it's more festive and less confrontational.

### Question 5

Care Manager: Ok, now we have a list. Would any of these choices work better than what you are doing now?

Mr. Smith: I guess I could check on those camera things where they show the house but I don't know how expensive they are?

Care Manager: Well, one step could be to check on that and ask your daughter for help checking on it. Would that feel like a step in the right direction?

Mr. Smith: Yes, and I like the idea about ice cream too. We always used to put lots of stuff on our ice cream and laugh like kids when we ate it.

Care Manager: And can I ask you if you think the three of us talking together might be a good idea too?

Mr. Smith: Sure, I think she thinks I'm fighting her. I just don't want to feel like I'm 10 years old with my mom hounding me all the time.

## Question 6

Care Manager: Ok, are you ready to make that your next step?

At this point in the counseling session, you should get very specific about how to get the ice cream and what toppings, when the conversation might happen with his daughter, and how to get information about a home monitoring system. You will not have solved the problem fully, but you will have headed down the road in the direction of his wants.

## Conclusion

In Success Counseling, self-evaluation is much more important than the evaluation of others, because it is self-evaluation that leads to change. Success Counseling shifts the responsibility and the thinking to the client. This process forces the client to ask himself hard questions and makes him aware that he can influence how he feels and the results of his decisions. With repetition, Aging Life Care / care managers can get their client to utilize this process themselves for independent problem solving. By participating in Success Counseling, your clients will become more confident in solving problems with you or independently, which will have a significant impact on his resilience, confidence, self-esteem and ability to handle change.

## Topics: Resilience

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Aging Life Care Association™  
3275 West Ina Road, Suite 130 | Tucson, AZ 85741-  
2198  
520.881.8008 | 520.325.7925 Fax

Website Design by IlluminAge



FALL 2015

Resilience

# Journal

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## Caregiver Coaching: Fostering Resilience in Older Adult Spousal Caregivers

Frank Fee, PhD, CCM

### Introduction

Older adult spouses who are caregivers are an overlooked group that deserves our attention. A recent study by the AARP Public Policy Institute and the United Hospital Fund (2014) found that spouses account for approximately 20% of family caregivers, and 49% are aged 65 or older. 58% of spousal caregivers received no help from family or friends. A full 70% of spousal caregivers indicated that they felt they had no choice but to take on the responsibility of performing complex medical/nursing tasks. A small, but significant, literature is emerging regarding the impact of caregiving on spouses, with recent studies providing potential guidance to inform the provision of services to this special group. Bookwala (2014) found that the psychological resources of mastery and self-esteem are particularly effective in improving adaptation to the stress of an ill spouse. The emerging field of professional coaching appears well suited to play a key role in addressing the needs of the caregiving spouse.

Over the past dozen years, I have received numerous referrals of older adult spouse caregivers who are already active participants in a support group for a period of time, but still experiencing problems making the necessary adaptations to their caregiving role. Although I have been a Geropsychologist since the early 1980's, due to the nature of the presenting problems I found myself using the formal coach training I completed in 2003 to a greater extent than my training as a psychologist. A coaching approach helped many of these spouses engage in a process of adaptation and development of a sense of mastery with improved self-esteem, thereby meeting their goals without having to be treated as if they had a mental disorder.

My coach training might best be considered Holistic, Values-Based Action Coaching (Auerbach, 2001), which rests on a foundation of the client's most important values. Coaches who work with clients in transition help them clarify their personal identity, integrate a new sense of purpose, and experience increased confidence. A key characteristic of coaching is the orientation to help clients "forward their actions." By this I mean that rather than exploring pain or trauma, the coach helps the client maintain focus on their ideal vision of their future.

It is important to understand that coaching is not psychotherapy – emotional healing is not the focus of coaching. Although coaching can be used concurrently with psychotherapeutic work, it is not used as a

### ABOUT THE AUTHOR

Frank Fee, PhD, CCM

Dr. Fee is a Geropsychologist and Advanced Aging Life Care Professional. He has been a Licensed Psychologist for over 30 years and has practiced in many settings that serve the aging population. He has been a trained Coach for over 12 years. He has worked in Long Term Care settings, rehabilitation hospitals, and community-based programs. He currently has a private practice in Houston, Texas and provides geropsychological services and Aging Life Care services, including caregiver coaching. He also consults with various organizations serving the aging population.

Dr. Frank Fee & Associates,  
PLLC

9801 Westheimer Suite 302  
Houston, TX 77042

substitute for psychotherapy (Auerbach, 2001). Coaching concentrates primarily on the present and the future. Coaching does not focus on the resolution of past trauma as a precursor to move forward. The coach helps the client through the coaching conversation in developing a coaching agenda, incorporating values clarification, identification of strengths, and articulation of the client's current life and career/life purpose. The coach supports the client's efforts to engage in lifelong learning, navigate any obstacles, delegate or let go of energy-draining situations, honor challenges, and celebrate successes.

In my practice as an Aging Life Care Professional™, I have observed that many Aging Life Care Professionals / care managers rely on referrals to support groups as the primary way to address the issues that spousal caregivers experience in adjusting to the stresses and insecurities related to their caregiving role. When spouses' needs are not fully met in the support group, a referral to a mental health professional for psychotherapy often follows. I would like to encourage my care manager colleagues to consider referrals to appropriately trained and credentialed coaches with experience working with caregiving spouses as an alternative to referring these clients for psychotherapy. The following case study demonstrates how coaching can assist a caregiving spouse to become more resilient and able to manage the challenges he faced.

## Case Study of Rob D

The facilitator of a support group for spouses of individuals with Alzheimer's disease referred Rob D. to me. Rob was 75 years old at the time of referral and his wife was 77. She had been diagnosed with Alzheimer's disease about 4 years ago, and was progressively requiring more care and supervision. He was very knowledgeable about the stages of dementia and the progression that typically occurs. However, he realized that his wife's condition was changing and his life was about to change more than it already had since becoming the primary caregiver.

The reason for the initial referral was the challenges Rob was experiencing and his difficulty in envisioning his future life, both as a caregiver and a person in his own right. He was experiencing a general lack of support from other family members with his wife's care, and the support group was not helping him address issues that were important to him at this stage of the caregiving role. Rob had been a successful businessman and originally had no intentions of retiring simply because he reached retirement age, and was actively working past the age of 70. However, because of his wife's care needs, he discontinued his business travel and started working mostly from home. By the time coaching began, he had gradually reduced his work to the point that it was no longer a reliable source of income.

He had two children, a daughter on disability due to psychiatric problems, and a son who was divorced and spent all of his time working in a stressful job. Rob allowed his daughter to move back into the family home a year earlier after she ended a bad relationship. He had expected her to provide some relief to him, and companionship and supervision for her mother when he would go to the gym or out to eat with friends. Rob had experienced previous health scares in his life due to cardiac issues and had established an exercise routine that was beginning to suffer. The arrangement with his daughter had worked for a time until his wife's behavior triggered negative behavioral responses from his daughter to the extent that she experienced another psychiatric hospitalization about the same time the coaching started.

His wife's condition had deteriorated to the point that she only ate if someone sat and encouraged her to eat. She resisted bathing to the point that she would become combative. She increasingly wandered through the house and began saying that she wanted to go home and attempted to leave the property. She was not consistently recognizing Rob as her husband.

Prior to the first coaching session Rob completed a "new-client" questionnaire and identified his general goals for entering into the coaching relationship. He also provided a written summary of what he considered important for me to know about his family situation, caregiver role, personal life, and future vision. This



information was carefully reviewed to clarify that Rob was appropriate for coaching instead of entering psychotherapy for treatment of a mental health disorder.

The initial coaching session was spent identifying and defining what Rob hoped to gain from the coaching relationship and to further clarify that coaching, rather than psychotherapy, was appropriate. Questions about mental health history, previous therapy, use of psychotropic medications, suicidal ideation, and substance misuse/abuse were asked to address this potential area of concern. It became clear early on that Rob did not have a mental health disorder. He did not meet criteria for a depressive disorder or anxiety disorder diagnosis. He simply reached the point where he needed a thinking partner to help him tap into his resilience reservoir and develop some new skills and strategies for moving forward.

Questions were asked to clarify key forces in Rob's life by elaborating on his answers in the "new-client" questionnaire, e.g., "Tell me more about what you are hoping to get from the coaching relationship." "Tell me about a time in your life when you felt particularly focused and energized—a period of high personal satisfaction. What was going on in your life and who was involved?" Before the end of the initial session the scope of the coaching relationship was outlined and an agreement made that if an issue arose that should be treated in a psychotherapy context, an appropriate referral would be made. In addition to establishing rapport and trust in the initial session, we conjointly began to clarify the focus of the coaching agenda.

The next few sessions were spent in the process of creating the coaching plan that would guide the rest of the coaching relationship. Additionally, energy was spent on the development of the coaching alliance. Rob indicated that he wanted to explore his future role as a caregiver and to clarify and weigh possible alternatives that he knew he would have to address in the not too distant future. He also wanted to develop an action plan for engaging in meaningful activities, including some professional and work-related ones. He also expressed motivation for increasing social contact with others who have similar interests. During the second session we discussed Rob's most important values, his "passion areas," to ensure that the coaching agenda was resting on a foundation of what was most important to him in his emerging life chapter. For Rob this included a strong spirituality component, mutually satisfying relationships, and a sense of meaningfulness in his activities. The latter two had suffered tremendously over the past several years.

At the beginning of each coaching session there was a focus on identifying and committing to specific actions that would move Rob forward toward his most important goals. The entire coaching process was action oriented, which was a good fit for Rob. During the early sessions it became apparent that Rob was approaching his caregiver role in much the same way that he previously addressed his work. He was attempting to explore all of the available options, look at the pros and cons, and select the one(s) that appeared best. However, at the initiation of coaching he was having trouble seeing that he had options. He experienced a breakthrough during a coaching-exercise that helped him identify steps in his reasoning that were leading to unintended consequences. He was able to realize that he was making some faulty assumptions and had been drawing conclusions based on his assumptions that were keeping him stuck. When he corrected his assumptions, he was able to see many more options than before. Rob went from seeing his only options as placing his wife in a memory care unit versus continuing to enduring the burden of caregiving on his own, to exploring in-home options that would take over some of his caregiver responsibilities.

Midway through this process the sessions focused on trying out new strategies and the development of new skills and enhancement of existing skills. For example, Rob explored having paid in-home caregivers to allow him the time to engage in more activities outside the home. This was a big step for Rob. After exploring the various options for securing in-home caregivers, Rob decided to try an alternative before hiring a home health agency for services. In keeping with his core values, he sought and found two female caregivers through referrals from his faith community. He decided to hire them for the right temperament, and believed that he could teach them about Alzheimer's and his wife's specific care needs. It turned out that the caregiver who

worked in the mid afternoon through dinnertime was skilled in getting his wife to bathe and even enjoy the activity. She had a history of caring for her own grandmother and mother as they aged. Rob described her as a “natural” at caregiving. Rob also took the step to confide in his son that there would be times that he may need his help. This too was a big step for Rob, but he reasoned that his own health would suffer if he did not get respite, and then he would become an even greater burden on his son.

Rob planned and took a long-weekend trip to visit an old friend out-of-state. He left his son in charge to oversee the caregivers and spend the nights at the family home since caregivers were only scheduled from 8 AM–7 PM. Although his son did not volunteer before he was asked, Rob became more comfortable asking for respite when needed or if he wanted to take a trip. Rob developed a routine that provided him with both alone time and opportunities to spend time with old colleagues and friends. He quickly increased contact with acquaintances and friends. On several occasions during coaching he attempted to take his wife to church, out to eat, or to previously enjoyed activities such as theater and symphony, but realized that her cognitive status had deteriorated to the point that she was no longer able to tolerate these settings for more than a few minutes. This reality testing was part of the process of Rob letting go of the notion that things they formerly enjoyed as a couple could still bring positive experiences to them both. Although he already knew this in his heart, the act of “experimenting” was helpful in helping him get his head and his heart aligned.

As a homework assignment, Rob reduced to writing his own criteria that would indicate that he was no longer able to care for his wife at home with the added caregivers that he hired. Once he had a clear understanding of all of the care options in the home, as well as local facilities with memory care programs, he was able to factor in his personal feelings and values and write out the observable criteria that would lead him to make the decision to place his wife into a full time care environment. This accomplishment was huge for Rob as he had struggled with this issue in the support group for quite some time. The group’s feedback was “You’ll know when it’s time.” Rob now felt comfortable that he would “know,” but it was no longer based primarily on emotional factors, but a holistic perspective and a checklist based in reality.

Rob was seen for a total of sixteen coaching sessions over a six month time period. The first twelve sessions were weekly, then bi-weekly for a month, then monthly for the last two months. Contact was made three months after the final coaching session and then a year later. At a follow-up conversation three months following the end of the formal coaching sessions, Rob had checked off another criterion on his list that indicated another step closer to out-of-home placement. He had become more self-confident in his ability to be a caregiver as well as maintaining a meaningful life. And his self-esteem was much higher. A year later his wife had been placed in a memory care program and he visited her daily when he was in town. He had not reclaimed his old life, but had created a new one. Coaching met Rob’s needs in a way that surpassed what a support group could provide, and there was no need to seek psychotherapy since there was no mental disorder present.

## Conclusion

Aging Life Care Managers should, of course, consider the individual circumstances of the spouse/caregiver and make appropriate referrals as part of the overall care plan. I suggest that you consider referring spousal caregivers to a coach with the appropriate background and experience. Getting to know local qualified coaches with expertise in caregiving and aging issues is highly recommended. Virtually no states license coaches, so it’s important to engage in due diligence before adding a professional coach to your roster of referral sources. Many experienced coaches do not have certifications from national or international organizations since the coaching profession is an emerging one, although many have already been credentialed in a related profession. Additionally, there is no recognized organization that specifically credentials caregiver coaching or coaching for older adult care needs. However, there are organizations which are similar to the credentialing process for care

managers: requiring passing a standardized examination, adhering to a code of ethics, and completing a minimum amount of continuing education before recertification.

The International Coach Federation (ICF), and the Center for Credentialing & Education are two such organizations. The ICF was founded in 1995 and is the oldest and leading global body that credentials coaches. They have some 17,000 credentialed coaches in more than 130 countries worldwide. In addition to demonstrating completion of formal coach training, passing a written examination, submitting evidence of paid coaching experience, and providing evidence of formal coaching by a mentor, ICF requires candidates to submit two recorded coaching sessions with verbatim transcriptions that are reviewed by trained “reviewers” as part of the credentialing process. Credentialed coaches must adhere to the ICF code of ethics and obtain a designated minimum amount of continuing education between recertification periods (<https://coachfederation.org>).

The Center for Credentialing & Education (CCE) is a nonprofit organization that provides practitioners and organizations with credentialing in six specialties, most recently adding the BCC credential (Board Certified Coach). Created in 1995, CCE credentials more than 25,000 practitioners globally in a variety of fields. The BCC is the newest credential (established in 2012) and demonstrates that the BCC has met professional coaching competency standards established by CCE and subject matter experts. The BCC certification also requires demonstration that the coach has met educational and training (coaching specific) requirements, passed a psychometrically sound coach-specific examination, obtained experience in the field of coaching, provided professional peer references (coaching specific), is accountable to an enforceable ethics code, and makes a commitment to continuing education between recertification periods (<https://www.cce-global.org/Credentialing/BCC>).

## References

### Article references

## Topics: Resilience

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Aging Life Care Association™  
3275 West Ina Road, Suite 130 | Tucson, AZ 85741 –  
2198  
520.881.8008 | 520.325.7925 Fax

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## Case Study: Identifying Resilience in Families

Phyllis Mensh Brostoff, CISW, CMC

In my Aging Life Care™ / care management practice, I often have identified resilience in families that they did not know they had. By resilience I mean responding to stress and adversity positively, coping well when change is needed rather than disintegrating. These family histories illustrate how an Aging Life Care Professional™ / care manager can assist families in identifying resilience within the families they assist. The care manager can provide a unique point of view by looking at the whole family system, improving the family's resilience when they come to you driven by that crisis which provides the opening for the family to change.

Ingrid W contacted me because her widowed mother seemed to be experiencing significant memory loss. Mrs. W lived in the family home with Ingrid's brother, Joe. Joe had been diagnosed with schizophrenia in his early 20s and was 48 when I met him. He spent most days walking to the local library around 9am, having lunch at a nearby McDonalds, and then coming home around 5pm. He had no friends, but mother and he got along well and enjoyed each other's company. Now Ingrid wanted Joe out of the house because she wanted someone to come in and take care of their mother. I visited the home and found a lovely well cared for home in a suburban village, close to a mall and within walking distance of stores and the library. Mrs. W was in the mid-stage of an Alzheimer's type dementia, but she appeared to be doing very well in her home, even though she really could no longer safely prepare food or remember to take her medication. Joe managed his own room and laundry and was mild mannered and polite, although hard to engage in conversation. He could comprehend the need to call for help if something happened to his mother and had, in fact, called Ingrid when Mrs. W. had a fall in the home. While on the surface it may have appeared that Joe was a hindrance to the care that his mom needed, my recommendation to Ingrid was to preserve his role in the home. Joe was an asset, providing Mrs. W with continuity in the home and a measure of safety. Since he was gone for most of the day, Ingrid could hire a caregiver to come from 9am to 5pm, cook all of the meals, help her mother with a bath and dressing, take her to any appointments, and do the housework. Joe would be the second and third shift helper. This plan did work for several years and Ingrid and Joe now had a changed relationship.

A similar scenario occurred with the H family. Mr. H had dementia and a stroke. He lived in the family home with his wife and mentally ill adult son,

### ABOUT THE AUTHOR

Phyllis Mensh Brostoff CISW, CMC, is the CEO and co-founder of Stowell Associates in Milwaukee, Wisconsin, providing geriatric care management and care managed home care services to the elderly, disabled adults, and their families since 1983. She received her master's degree in social work from the University of Maryland in 1970, and immediately began working with the elderly. Phyllis is certified by the state of Wisconsin as a Certified Independent Social Worker (CISW), the National Association of Social Workers Academy of Certified Social Workers (ACSW) and the National Academy of Certified Care Managers (CMC). She taught at the University of Wisconsin–Milwaukee School of Social Welfare from 1971–1977. She was a founding member of the NAPGCM and was the President of the National Board in 2009 and President of the Midwest Chapter Board 2006–2008. She has given numerous speeches, workshops, and presentations throughout the country on care management, assessment, ethical issues, the care of the chronically ill, and how to grow a business to social workers, nurses, attorneys, trust officers, financial planners, and the general public.

George. George had been in the Navy for 10 years but something happened and he left with a duty disability. George was very handy and lived in the basement of the family home surrounded by tools. Friends and family brought over TVs and other small appliances for him to fix which he then donated to shelters for homeless families. Three days a week he biked over to the Habitat for Humanity building and worked on whatever project they had for him. He sometimes prepared a simple dinner, but mostly Mrs. H cooked and cleaned the home. George helped transfer his father from the bed to the wheelchair, but the two H daughters felt that their father was too much of a burden on their mother and eventually he was moved to a nursing facility close to where daughter Deb lived. The daughters thought that George should find his own apartment, sell the home, and mother should move into the home of daughter Gail about 100 miles from the family home. Mrs. H refused this plan and George and she continued to live together for another 3 years until she went into a residential hospice.

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3275 West Ina Road, Suite 130 | Tucson, AZ 85741-

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520.881.8008 | 520.325.7925 Fax

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