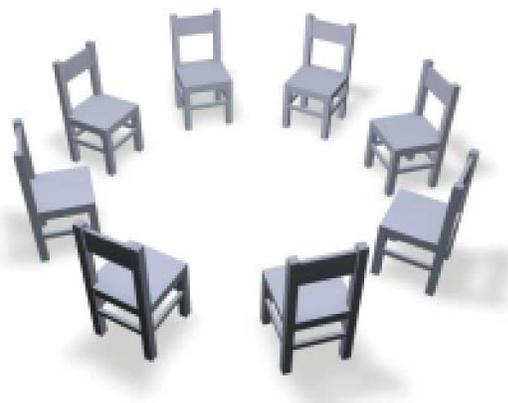


PSYCHOTHERAPY GROUPS for Long-Term Care Residents



Intervention Training Manual
November 2011

Psychotherapy Groups for Long-Term Care Residents

Intervention Training Manual

Acknowledgements

Funding for the Intervention Training Manual was provided by the Ontario Ministry of Health and Long-Term Care AHSC AFP funds for the years 2008-2009 and 2009-2010. I would also like to thank the Baycrest Research Ethics Board for its approval of the project.

I would like first to extend a special thanks to my Research Assistant, Carly Goodman for her significant contribution to the evaluation and analysis of the model of intervention. I would also like to extend a special thanks to Elsa Marziali for all of her valuable advice and encouragement to keep the project going.

Thank you to Illia Tchernikov for help in getting the Ethics approval. A thank you also goes to Isobel Coelho and Einat Vinokur for their early work on the project. In addition, my sincere appreciation to Melyn Leszcz, Anthony Joyce, Jan Malat, Paul Katz and Linda Jackson for their kind words and encouragement in reviewing the manual.

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CHAPTER 1 – OVERVIEW OF TRAINING MANUAL

Introduction

The purpose of the training manual is three-fold:

- 1) To discuss the challenges that physically frail and more cognitively intact (though often still with mild cognitive impairment or symptoms of early mild dementia) individuals face upon entry into a long-term care home.
- 2) To describe a model of an interactive and integrated group psychotherapy intervention that addresses the mental health and psychosocial needs of newly admitted residents within a long-term care context.
- 3) To undertake a naturalistic study of the suitability of the Transtheoretical Stages-of-Change Model (Prochaska & DiClemente, 1982) in facilitating the adjustment of newly admitted long-term care residents.

Upon a move into a long-term care setting, an individual is initially confronted with the loss of one's personal home at the same time as having to adjust to the larger and more impersonal institutional setting (Firstenberg, 2009). Few studies address the anticipation and relocation experience of new residents to long-term care facilities (Heliker & Scholler-Jaquish, 2006). Research questions typically involve asking an open-ended question such as "moving to a nursing home is sometimes a big change in one's life. How did you handle the change when you first came to this nursing home?" (Porter & Clinton, 1992). Such phenomenological studies using newly admitted residents' own points of view increase the understanding of their experiences. The focus of the innovative project described in this manual adds to the literature in evaluating the benefits of a group therapy intervention to help these residents in their adjustment to conditions within a long-term care facility. The aim of the group psychotherapy intervention is to understand and assist residents' management of a major life transition while also facilitating adjustment to declining health and significant interpersonal losses. The intervention model replicates a group therapy approach used by Schwartz (2007) to address the often forgotten mental health and psychosocial needs of both newly admitted and long-term nursing home residents.

The initial section describes the challenges new residents face in adjusting to the long-term care home and that long-term care settings face in providing optimal psychosocial care. The role of group psychotherapy in dealing with these challenges is outlined.

Subsequent sections support the premise that groups designed exclusively for these residents provide a therapeutic setting that helps them adapt, adjust and accept their new residence. The formation of the group, member selection, group preparation, the group

model, and the proposed Transtheoretical Model (TTM) of Adjustment to a Long-Term Care Home for Newly Admitted Residents are described. Qualitative data, from audiotaped recordings of sessions, illustrate individual stages of change, major group themes and group process throughout the intervention. A focus group to demonstrate the impact of the intervention serves as another form of program evaluation. The difficulty and limitations of using quantitative measures such as pre- and post-psychological and functional self-assessment questionnaires with this population is also discussed.

Background

Long-Term Care Homes and the Adjustment Process

Transition occurs throughout the life cycle and marks the stages of an individual's life. For older adults, moving to a nursing home is an example of transition (Brandburg, 2007). When individuals find themselves in the position of requiring long-term care admission, they arrive under some of the most vulnerable circumstances of their lives (Kao, Travis & Acton, 2004). With time, most new residents work through the initial feelings of loss and alienation and become members of the long-term care community. Erikson et al., (1986) suggest that failure to achieve renewed integration in the face of disintegration leads to despair and increased decline. Brooke (1989) suggests the more health professionals know about the process of adjustment, the smoother the adjustment for the newly admitted residents.

Based on 32 interviews with 10 residents during the first three months of admission, Heliker and Scholler-Jaquish (2006) identify three patterns of transition to long-term care: becoming homeless, getting settled and learning the ropes, and creating a place.

In the first stage of admission, there is an initial one-month period of almost disbelief and chaos where some new residents enter the unfamiliar and are unknown, a feeling of becoming homeless (Heliker & Scholler-Jaquish, 2006). Story after story describes the decision to leave home as associated with the loss of self, friends, and neighbourhood. Residents are often left with a sense of profound sadness. Cutchin (2001) observes that homes contribute to an individual's sense of identity, familiarity, security and control. New residents enter a situation where familiar ways no longer work and new experiences have not yet been started (Heliker & Scholler-Jaquish, 2006).

In the stage of getting settled and learning the ropes, approximately one to two months after admission, residents are surrounded by individuals not of their choosing and not necessarily to their liking. Residents begin to negotiate the environment and begin new stories after spending the first few weeks mostly in their rooms (Heliker & Scholler-

Jaquish, 2006). These authors acknowledge residents in this stage beginning to move from feeling unknown and invisible to becoming known and knowing others, as well as learning new routines, boundaries and rules leading to new possibilities for adjusting.

Creating a place usually occurs after two to three months and involves residents developing new meanings, new memories, new friends and new neighbours as they try to make the best of their new place, a new neighbourhood, if not a new home (Heliker & Scholler-Jaquish, 2006).

Based on open-ended questions about adjustment conducted over a one-year period with 42 newly admitted residents, Brooke (1989) similarly describes transfer to the nursing home as the key event and discusses adjustment in relation to the transfer. Four major phases in the process of adjusting to residing in a nursing home are outlined: disorganization, reorganization, relationship building and stabilization (Brooke, 1989). Within eight months, 93 percent of those studied progress through these stages, but if an emotional or physical stress occurs, they regress, at least briefly, to an earlier stage (Brooke, 1989). Wilson (1997) points out that acceptance can be adaptive or maladaptive. With adaptive acceptance, residents find meaning in their new life. Maladaptive acceptance can lead to withdrawal, helplessness and resignation to one's fate.

Porter and Clinton (1992) also employ a phenomenological method to analyze the responses of 243 individuals to an open-ended question regarding the changes they initially experience as nursing home residents. However, these authors listen to residents describe their adjustment in terms of interaction with others rather than as a reaction to the crisis of moving into a nursing home. In other words, they describe everyday difficulties (such as getting along with roommates and staff) and daily satisfactions (such as meeting new persons with whom to talk) (Porter & Clinton, 1992). These authors note that residents generally use more passive than active approaches to adjustment, which means modifying their needs in accord with nursing home requirements.

Long-Term Care Homes and Mental Health Care

Long-term care settings have the potential to be an important component in the provision of mental health care to elderly persons who have unique characteristics that make them susceptible to mental health problems (Stelmach & Konnert, 2005). Factors contributing to the psychological difficulties of long-term care (LTC) residents that are potentially responsive to non-pharmacological interventions include: being institutionalized against one's will or with ambivalence; the novelty or strangeness of the environment; rooming with a stranger; loss of relationships, possessions, pets and personal freedom; fear of

other residents with poor impulse control; boredom; limited visitation from family members; and finally, an awareness that the LTC setting is likely the last place of abode before dying (Bharucha et al., 2006). Unfortunately, in North America, the narrow focus of federally-funded research efforts and the inclination of psychiatry to emphasize neurobiological determinations of mental illness and clinical practice reimbursement constraints are not serving the nursing home population adequately (Reichman & Conn, 2010). Consequently, the psychotherapeutic needs of long-term care residents are underserved and poorly studied (Bharucha et al., 2006).

Nursing homes must cope with limited budgets, low staff to resident ratios, low morale amongst staff, poorly designed and aging facilities, and difficulty in attracting qualified professional staff (Conn, 2007). Such pressures make it challenging to be a resident, staff or administrator. It is especially difficult for more cognitively intact and physically frail residents to access psychological help or interpersonal connectedness with others. For example, long-term care homes offer some social and activity groups which residents are expected to attend even though they experience some of these groups as demeaning or unfulfilling (Schwartz, 2007). Both the type of group and the lack of homogeneity that exists among group members with respect to cognitive impairment and psychological concerns do not serve them well in addressing their unique circumstances.

Long-Term Care Homes and Group Therapy

An integrated group psychotherapy model incorporating developmental, cognitive-behavioural, interpersonal and psychodynamic approaches is designed exclusively for more cognitively intact long-term care home residents (Schwartz, 2007). Why group psychotherapy? To begin with, group psychotherapy is considered as effective as individual psychotherapy (McRoberts et al., 1998). As it can treat several individuals concurrently, it is cost efficient for both the health-care system and the individual.

Group therapy provides opportunities to deal with the imposed changes in the life situation and accompanying feelings of decreased autonomy that long-term care residents experience (Leszcz, 1996). It provides members opportunities to express feelings of loss, deal more effectively with interpersonal problems and provide affirmation of one another (Capuzzi & Fillion, 1980). When understood within the framework of potential serious complications of pharmacotherapy for frail elders, there becomes a need for psychotherapy trials in long-term care settings (Bharucha et al., 2006). This idea is especially relevant in an era when psychopharmacology seems the be-all and end-all of geriatric psychiatry or mental health care, including in long-term homes (Agronin, 2009). Indeed, group psychotherapy is an important treatment modality that should be used more frequently in nursing home facilities because it permits more residents to be in

psychotherapy treatment, counteracts the isolation that many residents experience in this setting, and promotes individual and relational growth (Firstenberg, 2009).

Despite the many and obvious benefits of group therapy (Burlingame et al., 2004), this clinical intervention remains underutilized because of the challenges involved in working with this unique population (Schwartz, 2007). Not surprisingly, the literature regarding psychotherapy groups for older adults is sparse (Saiger, 2001). Greater clarity is especially needed regarding treatment, group process, patient and leader characteristics (Burlingame et al., 2004).

CHAPTER 2 – ASSESSMENT OF NEWLY ADMITTED LONG-TERM CARE RESIDENTS

A Long-Term Care Home Group Psychotherapy Model for Newly Admitted Residents

The Goals of the Group

Atchley (1982) has stated “it is not merely a matter of what aging does to people, but also what people do with aging.” Similarly, “it is not merely a matter of what a long-term care facility does to aged residents, but also what aging residents do with long-term care facilities” (Schwartz, 2007). With this in mind, the premise of this manual is that groups designed exclusively to meet the needs of the more cognitively intact frail newly admitted long-term care home residents will provide a therapeutic setting in which the frustrations and demoralization related to the challenge of entry into a long-term care home can be addressed. Members will be assisted in mourning what was and accepting their new realities (Pollock, 1980). For example, they have left not only a home, but a part of who they are, and benefit from help in grieving their losses, albeit each in their own way and in their own time (Heliker & Scholler-Jaquish, 2006). The group will, therefore, aim to assist members gain an increased understanding of their personal situations by encouraging reflections on the emotional impact of the move, reflecting on their past coping styles, assisting them in processing emotions associated with the move, and reflecting on their interpersonal styles with respect to receiving help.

Design and Methods

Recent concerns about the lack of uptake and application of quantitative research have shifted the focus of medical research to the study of knowledge translation (Graham et al., 2006). As a result, research in the field of psychiatry has moved away from the use of quantitative research methods marked by large sample size, more objective methods, and more reliance on statistics towards incorporating qualitative approaches in answering questions (Streiner, 2008).

The use of qualitative approaches in geriatric mental health has become more common and has been shown to be more effective in the formation of intervention programs (Hinton, 2010). Program evaluations using qualitative methods reveal what helps, for whom, and with what consequences. Such programs allow health professionals to implement appropriate care in real-world contexts (Goering et al., 2008).

As such, in the present study, a naturalistic study method is undertaken to follow the adjustment behaviours of six newly admitted residents over the course of a three-month period in a long-term care facility located in Toronto, Ontario. Implementation of the intervention model begins with gaining Research Ethics Board approval and administrative support.

All prospective members complete the Mini-Mental State Examination (Folstein, Folstein & McHugh, 1975) to assess their cognitive status for entry into the group. As a service component to the study, pre-post questionnaires are administered to qualifying participants (all with scores of 23 or greater) with the intention of using the information to develop a database for future program evaluation post admission. These questionnaires, which are administered with assistance from the Research Assistant pre-post the intervention include: Health Status Questionnaire (HSQ-12) (Ware & Sherbourne, 1992); Geriatric Depression Scale (GDS) (Yesavage et al., 1983); Rosenberg Self-Esteem Scale (SES) (Rosenberg, 1986); Enriched Social Support Instrument (ESSI) (Mitchell et al., 2003); Nursing Home Adjustment Scale (Lee, 2007); Nursing Home Adjustment Question (Lee, 2010); Quality of Life Scale (Gerritsen et al., 2007). The Group Climate Questionnaire – Short Form (GCQ-S) (MacKenzie, 1983) is completed after each session. Throughout the study, sessions 1 through 12 are audio recorded, transcribed, coded and analyzed using interpretive phenomenology qualitative methods (Tanner et al., 1993; Van Manen, 1990).

Sample Selection

Group members are referred by the attending physician, nursing staff, or social workers who are familiar with newly admitted residents and their problems and needs. ‘Newly admitted’ as defined in the present study, refers to residents admitted to the facility within the previous four months. ‘More cognitively intact’ refers to those residents who are cognitively intact, have mild cognitive impairment, or demonstrate symptoms of early and mild dementia. To facilitate the referral process, long-term care home staff are informed beforehand by the clinician-researcher and co-therapist social worker of the purposes of the study and potential benefits for the residents.

Other inclusion criteria are: 1) residents with an adjustment disorder and depressed or anxious moods; 2) residents with mild to moderate major depressive disorder; 3) dysthymic disorders; 4) residents experiencing bereavement issues; 5) residents struggling with interpersonal difficulties or physical decline; and 6) residents’ ability to tolerate dysphoric affect.

Exclusion criteria are: 1) residents with moderate or severe cognitive impairment; 2) residents who are overly paranoid or aggressive; 3) residents with severe personality disorder; 4) residents with severe hearing problems; and 5) residents who are physically ill and unable to participate actively in group sessions.

The initial sample size is comprised of six residents who have resided in the facility at least 10 days to four months prior. With respect to attendance, three out of six group members have a non-compliance rate attending the group therapy sessions of about 60% (7/12 sessions attended). In addition, three of the same six members (A, B, C) are non-compliant with answering the Group Climate Questionnaire (GCQ) on a weekly basis and are missing more than 50% of the total possible GCQ scores. Barriers to attendance relate to health concerns, initial ambivalence about joining the group and difficulty tolerating dysphoric affect. Thus, only three residents (D, E, F) who are consistent in completing the weekly GCQ and in attending the group sessions on a regular basis are included in the individual and focus group qualitative analyses of the present study. The active group residents' ages range from the 60s to the 90s and include both men and women. To further preserve confidentiality, both the actual ages and sex of the resident are not revealed in these analyses.

Pre-Group Assessment

Following referral, each prospective resident is screened by the therapists in an unstructured interview to assess for cognitive, physical, psychological and mood problems. For those who meet inclusion criteria, the goals of the study and potential benefits of group participation are explained to each resident by the research assistant of the study. The use of audiotaping for study purposes is explained. The importance of confidentiality is stressed and a pseudonym and numerical code is assigned to each member. The use of pre- and post-intervention questionnaires and participation in a post-intervention focus group interview is also discussed in detail with the group members. Written informed consent is obtained and all members are given the opportunity to address any concerns about joining the group, and ask questions pertaining to the study goals. During the intake process, often rapport is beginning to be established, though in some cases ambivalence about not only the long-term care home but about entry into the group is noted.

Intervention Group

The intervention is structured in the following manner: Each 75-minute weekly group session is conducted in a small meeting room located at the long-term care home, in close vicinity to the residents' private rooms to maximize accessible participation. There are 12

group sessions in total. No new members are allowed, making it a closed type of group. Initially, the group was to have been co-facilitated by the facility social worker and clinician-researcher with time for debriefing between the co-facilitators following each session to help optimize the clinical benefits for each resident member of the group. However, due to medical reasons, the group sessions are facilitated solely by the clinician-researcher. Each session is audiotaped and transcribed for theme analysis, stages of change and group process.

Intervention Model

A common approach recommended in the field of group therapy involves the identification of a clinical population, establishment of treatment goals, adaptation of therapeutic models and the evaluation of the intervention (Yalom & Leszcz, 2005). This approach has led to the treatment of previously unidentified clinical populations for which, at one time, intervention was viewed to be ineffective or even futile (Leszcz, 2011). In keeping with this concept, this section will outline the key elements of an integrated group psychotherapy model (Schwartz, 2007) used in this manual for newly admitted residents to a long-term care facility. This model features increased therapist activity and utilizes psychodynamic, interpersonal, developmental and cognitive-behavioural approaches to best address the psychological, social and emotional needs of long-term care home group members.

Group members are helped to understand that improved emotional processing is possible at any age or setting and that members are agents of their own lives and not just passive victims of the attitudes and behaviours of others (Schwartz, 2004). They are also encouraged to examine their relationships with other residents, staff and family members. Cognitive-behavioural techniques address group members' dysfunctional beliefs about themselves and long-term care homes. Past accomplishments and areas of competence and pride are highlighted through the articulation of past successes to help restore feelings of worth and status (Leszcz, 1997). Caring, empathic interactions among group members in the group reinforce their sense of worth and well-being.

Certain technical modifications help promote the development of cohesive group work with elderly group members. Saiger (2001) suggests the use of cognitive reframing, general supportive resources, use of humour and accommodations for problems in mobility, hearing and other disabilities. There is a need for therapists to be active, supportive and to invite members to talk and to give and take feedback, thereby setting the stage for an interactive group and fostering group cohesion (Leszcz, 1987). To this end, therapists may need to clarify members' comments in order to safeguard members

from being hurt by others, or to focus empathically on members' discouragement and the self-protective function of their withdrawal or projections (Leszcz, 1987).

Proposal for a Long-Term Care Home Transtheoretical Model (TTM) of Adjustment for Newly Admitted Residents

The nature of change is at the heart of research on psychotherapy (Joyce et al., 2002). The problem, as such, is defining the structure of change in a model that explains how people intentionally change their behaviours. The Transtheoretical Model (TTM) is one such model in psychotherapy research that provides clinicians with a useful tool for predicting 'the nature of change.' Comprised to outline, explain and predict the process of intentional change over a period of time, this model has been successfully applied to track behaviours of diverse clinical populations and to discern processes of change that are present in the psychotherapy process (DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1982; McConaughy, Prochaska & Velicer, 1983; Prochaska & DiClemente, 1983; Prochaska & Norcross, 2001). Beginning with smoking cessation (DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1983), TTM models have since been used to enhance treatment outcomes of other mental health disorders, such as drug dependence (Prochaska, DiClemente & Norcross, 1992).

According to the literature, there are six stages in the process of change of behaviour in the TTM model: precontemplation, contemplation, preparation, action, maintenance and termination (Prochaska & Norcross, 2001). In this manual, group members are classified into various stages of change as they move through the 12 session intervention. This model offers a unique perspective into the underlying behaviours of change and helps identify barriers to achieve change in a group therapy setting. Stages of change typically involve some levels of oscillation, as individuals are likely to progress and regress into different stages throughout their behavioural transitions. As the time an individual spends in each stage varies, therapists encourage and guide such individuals in the process of successful change.

A need to identify the phases residents pass through in the process of adjusting to a nursing home has been identified (Brooke, 1989). The phenomenological approach underlying the study in this manual allows for the close examination of phases residents pass through during the process of adjusting to a long-term care facility within the first few months of admission. Based on the analysis and review of some of the existing literature (Prochaska & DiClemente, 1982); (Prochaska, DiClemente & Norcross, 1992); (Prochaska & Norcross, 2001); (Heliker & Scholler-Jaquish, 2006); (Porter & Clinton, 1992); (Brooke, 1989), a model was developed to reflect empirical insight into the defining criteria of stages of transition in a long-term care home and in group therapy

sessions. This model provides a unique opportunity to understand how resident group members in their own words experience and adjust to their new environment. There are six components to the Model of Stages of Adjustment to a Long-Term Care Home and Group (modified from DiClemente & Prochaska, 1982; Prochaska & DiClemente, 1982; McConaughy, Prochaska & Velicer, 1983; Prochaska & DiClemente, 1983; Prochaska & Norcross, 2001) as proposed in the study: preappraisal, appraisal, adaptation, adjustment, acceptance, and approval (see Table 1).

Resident group members who are in the Preappraisal or Precontemplation Stage have no intention to change their behaviour in the foreseeable future. They may continue to minimize or deny their need to live in a long-term care home. For these residents, staff and family encouragement to be in a group whose main focus is on adjustment may instead contribute to these residents experiencing pressure or coercion to attend. Such members have difficulty tolerating dysphoric affect associated with the move, or in some cases, with their initial attempts at adjustment. Unless they are able to be assisted with this, they become impatient with the other group members and therapists. These residents may be more comfortable attending social and recreational groups and, therefore, may stop attending an adjustment group.

The Appraisal or Contemplation Stage is when residents are aware of their struggle to adjust, but remain ambivalent about doing something about it. In the early group sessions, these residents are assisted in the challenge of finding meaning in the experience of their living in a long-term care home. In so doing, these residents overcome their ambivalent feelings of attending an adjustment group and with time prepare to make a commitment to take action to adjust to their new surroundings.

Residents in the Adaptation or Preparation Stage intend to and have begun to both contemplate and take action to adjust, but have not yet successfully reached criterion for effective change. They are committed group members who discuss the everyday challenges of adjusting to new rules, staff and other residents while dealing with feelings of both hope and hopelessness. They benefit from the support of other group members as they begin trying out new behaviours in the facility, such as approaching others and attending various activities, in an effort to create new relationships and a new, albeit different, lifestyle.

The Adjustment or Action Stage features residents beginning to successfully adjust to the long-term care home. With the help of the group, residents build relationships with group members, other residents and staff. In some cases, residents rebuild relationships with family and friends. Where initially the long-term care setting is experienced as unfamiliar

and they feel like a “nobody,” residents in this stage now feel more known and more valued, and again feel like a “somebody.”

The Acceptance or Maintenance Stage occurs during admission to the long-term care home and is continuing with the help of the group and time. Residents may choose to carry on in a group beyond the time-limited adjustment group as they anticipate the ongoing challenges of residing in a long-term care setting in the context of declining health and aging. In any event, the challenge for these residents, with or without the help of the group, is to remain active, social and to accept the good and bad of themselves, other residents, staff and the facility, thereby creating as good a quality of life as possible.

In the Approval or Termination Stage, residents have come to terms with living in a long-term care home and approve of how the group has assisted them in accomplishing this challenge. No matter the stage of adjustment, depending on residents’ responses to the vicissitudes of health and potential problems with staff, other residents or the long-term care home environment that may arise, some residents may experience oscillations in their adjustment. In other words, with stress, these residents may regress to an earlier stage but within a supportive long-term care home or group environment coupled with personal growth they have been able to achieve in the group, they can be helped to counteract this regression and return again to their healthier stage of adjustment.

Table 1. Model of Stages of Adjustment to a Long-Term Care Home and Group

Stages of Adjustment (Proposed in study)	Stages of Adjustment as cited in literature (Refer to page 10)	Defining Criteria/Long-Term Care Home	Defining Criteria/Group
Preappraisal	Precontemplation	<p>Little or no interest in considering change or <i>adjusting</i> to LTC facility.</p> <p>Def’n: Little or no current intention to accept <i>adjustment</i> and often speak about moving out. Typically feels pressured by others to be in LTC facility. May lack confidence in their ability to <i>adjust</i> and can interpret attempts to change as overwhelming and retreat back into this stage. Challenge is to accept change and deal with multiple losses, both associated with the move and aggravated by it.</p>	<p>Not planning to attend an <i>Adjustment Group</i> and may feel pressured by others to be in a group whose main focus is on <i>adjustment</i>.</p>

Appraisal	Contemplation	<p>Considering <i>adjusting</i> to LTC facility</p> <p>Def'n: Concerned about change in life situation i.e. with respect to losses of health and residence and actively thinking about accepting new residence, but remains ambivalent about staying as has not yet made a commitment to make <i>adjustment</i>; often involves the weighing of pros and cons of problem and solution. Challenge is to find meaning behind why change of residence has occurred. Often involves an attempt to resolve or justify living in LTC facility.</p>	<p>Considering <i>adjusting</i> to life situation and LTC facility with help of group.</p>
Adaptation	Preparation	<p>Intending or starting to make <i>adjustment</i> and has unsuccessfully <i>adjusted</i> to LTC facility so far.</p> <p>Def'n: Combines commitment to change, considering new possibilities about how to <i>adjust</i>, not yet reached criterion for effective change. Challenge is to create new relationships with others, new memories and new life within LTC facility.</p>	<p>Involves intending to make effective changes in adapting to life situation and <i>adjusting</i> to LTC facility with help of group.</p>

Adjustment	Action	<p>Resident has been successfully <i>adjusting</i> to LTC facility.</p> <p>Def'n: Combines commitment to change and active modification of attitude, behaviour, or environment in order to overcome <i>adjustment</i> difficulties. Residents relate better to other residents and staff, both in knowing others and being known. They move from being a "nobody" to a "somebody." They learn the rules and routines of the LTC facility. The challenge in this phase is to feel settled and familiar with the LTC facility.</p>	<p><i>Adjusting</i> to LTC facility by applying skills gained in group to modify emotions, attitudes, behaviour or environment resulting in improved interpersonal relationships and sense of commitment to group.</p>
Acceptance	Maintenance	<p><i>Adjustment</i> occurs during admission to LTC and is continuing.</p> <p>Def'n: Residents work to accept change/situation at hand and consolidate gains attained during <i>Adjustment</i> phase. Continuation of <i>adjustment</i>, not an absence of <i>adjustment</i>. Challenge is to remain active and social and to accept the good and the bad of other residents, staff and LTC facility, thereby creating a place for them to live, not die.</p>	<p>Maintaining <i>adjustment</i> to LTC facility by continually working in group on challenges at hand and accepting life situation.</p>

Approval	Termination	<p><i>Adjustment</i> process to LTC facility (or group) is completed and residents no longer have to work to <i>adjust</i> to LTC facility. They have come to terms with living in a LTC facility.</p> <p>Def'n: Much confidence in LTC facility without temptation to resist <i>adjustment</i>. Challenge is to maintain <i>adjustment</i> and sense of self and integrity so are not overwhelmed by inevitable problems that may arise with health, staff or LTC environment.</p>	<p><i>Adjustment</i> process is completed and resident approves of how group has assisted in moving on with life.</p>
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CHAPTER 3 – THE GROUP PSYCHOTHERAPY INTERVENTION (OUTCOMES AND PROFILES)

Qualitative Data Analysis

Throughout the study, sessions 1 through 12 are audio-recorded, transcribed and analyzed using interpretive phenomenology qualitative methods (Porter & Clinton, 1992). The research assistant, along with the clinician-researcher identity salient individual group member stages of change and group themes across the phases of the intervention. Quotes are categorized according to the stages proposed in the Table 1 Model of Stages of Adjustment to a Long-Term Care Home and Group. In this way, overall benefits of the group psychotherapy across the sessions for each individual member can be evaluated.

Individual Group Member Profiles of Stages of Adjustment to a Long-Term Care Home and Group

Porter and Clinton (1992) suggest new residents experience the changes associated with living in a nursing home by trying to balance their own needs and preferences with the perceived requirements of life in a nursing home setting. Adjustment approaches most used are reframing the idea that the nursing home is a bad place to live, getting used to living there and going along with what takes place there. These resident individual adjustment approaches are influenced by the circumstances of the move, unique aspects of the individual's life history, the fit experienced between the individuals and the environment and the belief by some that the nursing home is their only option (Porter & Clinton, 1992). The individual adjustment approaches and influences for three members (D, E, F) who become active participants in the group will now follow.

Group Member D: Sessions Attended: Sessions 1-12

Coping with deteriorating mobility due to a chronic and progressive medical illness, D is by the first session, (fourth-month post-admission) already in the Adjustment Stage of change. For example, in session 1, D comments "I really got into here on my doing because this is a place for people who aren't mobile. Nobody is going to look after you. Some will, family will, but really it is going to have to be you. I've been doing that for a long time and you just heard before I am willing to tell other people why I am still around and still plan to be around for a while." To which another group member points out "You've had a chronic illness for many years. You are already a long liver." In turn, D comments "No, I am a doer. Because as soon as you shy away from life, you are thinking of other things that aren't so positive." In keeping with this, throughout the sessions D deals with dysphoric affect by accentuating the positive. For example, in session 2, D

tells another group member “It’s also up to you to pick up the phone and call your friends. You’re new, but so am I. All I’m saying to you is there is nobody restricting you. You’re the one that is restricting yourself. But your reactions are normal because you are in a new facility. They (staff) are going to do that as there is a hierarchy. It’s called getting used to a new environment.”

D’s attitude from session 1 is predictive of a successful adjustment to the facility. For example, D states, “This is another facet of my life. So I would consider this day one of the final chapter. I am not going to be moving into a condo anytime soon. So I look at it this way. This is the final place so no I don’t want to go back into history. I have to start up a new history.”

D’s commitment to the group is in evidence from session 1 when D states the group is an opportunity “to share feelings. I’ve been doing that for a long time with my (illness) organization.” In the second session, D encourages another member with the comment “You want to learn. You want to meet new people. You are in control of what you want to do and this group takes a while to get together, but you are here and that shows it’s working. You are getting out. You are speaking what you want to speak. You are telling people about you. Others are telling things about themselves, so you are learning and communicating with people who you never met until the last time.”

D’s commitment to the group is further shown in session 6 when D states “What happens after the next six weeks? Are we done and go back to our cubbyholes or is there another step that we could be taking and if the step is there what is it? Six weeks could go by very quickly.”

D, in middle sessions, continues to speak up and encourages others to do the same in order to adjust better. For example, with respect to displeasure voiced by others about the food, D remarks “But you can open your mouth and write to them and say I am sick of this crap. That’s what I end up doing.” D later acknowledges another way of adjusting to things that are bothersome, like noisy residents, “Like I cope with anything else, I blank it out of my system...I just knew I had to adapt how I live. I’ll ignore things because I knew the policies and all the stuff that goes on here before I got here. It is strange for me in the sense of meals but I know how to get around that corner too because I can go outside. I’m not confined to just here.”

A more difficult challenge for D is to acknowledge feelings of upset, loss and vulnerability that are experienced in the disruption of family relationships because of chronic illness and the move. For example, D states “Well, my spouse still makes plans and we still meet with friends, too, the only thing is I can’t do things like I used to, like

travel.” Similarly, D only briefly mentions disappointment about infrequent visits from children. But D did share other feelings, as in session 8, “I have always looked ahead with respect to illness and business as I knew I had to find something that will aid me as I grew older. One of my strengths was to do that.”

By the end of the group, D is doing as best as possible for as long as possible to adjust to future life in the facility. For example, when in session 10, in response to a comment made by a group member that it seems “You are looking to continue your life here. Most people come here know that life will continue and end here,” D responds “Yes, I moved here to live, but I also agree about dying here.”

Upon completion of the group, D observes that “Communication and friendship isn’t something instant. It takes time as it did with the growth of the group.” On an emotional level, D expresses both acceptance of the situation and wish for better health stating “I would rather walk. Yes, everybody does. Maybe someday. Yeah, I go do my exercises and I will continue doing that.” D also chooses to continue in the newly-formed adjustment group that will include residents admitted during the course of the original group. D believes this will facilitate further self-development and adjustment.

In summary, several factors have a positive effect on D’s adjustment approaches and influences. D anticipates the need for the move and plays an active role in arranging it. Being a “doer” helps D handle dysphoric affect associated with illness and a new environment. D’s personality and life history contribute to an ability to accept the good and to try to modify the negatives improving D’s fit with the environment, enabling D to leave the group in the Acceptance Stage.

Group Member E: Sessions Attended: Sessions 2, 5, 6, 8, 9, 10, 11, 12

E enters both the LTC and Adjustment Group (one month post-admission) in the Appraisal Stage with ambivalent feelings of feeling “lucky,” but also “angry.” E did not attend the first session due to a time conflict with another group. With respect to the facility, E comments in session 2, “I reserved a place on the waiting list years ago. I lived just up the street and always thought when the time came I would be ready...but oh no, I didn’t want to come. I fought with everybody. I quarreled with the person who examines you and decides which floor you go on, with my son and daughter and granddaughter. I said I don’t need three mothers. You know I’m the mother. You’re the children. Get off my back. I’m not going. I’m very angry, but look at me, I have all my faculties...Every once in a while I’ll say accept it, be quiet, it’s fine. I’ll get mad again, but then I’m good again.” Further evidence of E’s weighing the pros and cons of adjusting are shown in the remark “This is a marvelous place and we are very lucky to have it, but I would love to

have a little apartment where I did my own cleaning and I did my own things and I have a longing to be there but it's impossible. I am still angry about losing my personal things...but I feel lucky that anybody wants me and they look after me. I have no argument with that at all, so why am I still angry?" However, E's preparation for change and modification of attitude and behaviour is shown when E states "I do a lot of things and it helps me deal with adversity when I'm feeling blue or mad or upset. As far as activity is concerned I already have too much and I am going to have more because that is my style. I have a big appetite for activity and for living."

E did not attend the next two group sessions (3 and 4). Frustrated and embarrassed by difficulty hearing the others, E did not want to burden the other group members. E only returns after arranging to get a new hearing aid.

Upon E's return to the group in session 5, E enthusiastically identifies with the writing of a group member, as E also uses creativity to help cope with challenging situations and the processing of emotions. For example, E remarks "This is one of the best places, but it ain't mine. Yes, now I have a bed and live here, but I have a lot of complaints. But I have a good habit of laughing at myself and I do this in writing so that helps me." However, E's ongoing struggle with adjusting is shown in session 6 when E states, "I don't think anybody ever accepts and adjusts. You adjust a tiny little bit then you go back. Then you adjust again and then go back and eventually you say to yourself I have no choice. I'd better make the best of it or you make yourself miserable by repeating where do I go from here? It's a help to find a space for yourself that you're comfortable in. Another person can't do that for you. You have to do that for yourself." E's challenge with adjustment is also shown when E states "The fact is you may have left behind a life that had its difficulties, but you forget all that. You're looking at the new difficulties and you can't solve them because it's an institution. It's got to have rules you can't possibly agree with, but you try to do your best. I have so many interests that I don't have the time or health to do them. So it isn't that this isn't a good place. It's one of the best places, but it ain't my place."

In the last part of the group, E continues to actively strive to achieve a successful adjustment stating in session 9, "I feel that this is my destiny regardless of what my head or heart wants. There is a reason that I am here. It just takes time and if you don't feel, then you're nothing." E's struggles with reconciling life are also shown by a remark in session 10, "Well, we all have the same emotional hurt. We are not looking at the future. We are too busy looking at the past. I keep thinking about my old couch which wasn't worth 20 cents, but I think about it and that's the problem you see. It wasn't just an old couch, but it was my comfy couch and I loved it." So E's grieving continues for both this loss and a very significant past personal loss, one which E has shared with very few, but

in session 11, E confides to the group about this very painful time in her life. However, E also focuses on the present and is moving forward. For example, E is now thankful for the support of family, and states “My family has been so helpful in reorganizing my room. They can momentarily help me out and they don’t have to worry about me. Somebody else is worrying about me.”

E demonstrates a successful adjustment and acceptance to both the facility and group when in session 11 E states that coming to the group “made me more determined. Instead of calling up my son and complaining, the group allows me to simmer down and I didn’t realize that was happening. It was only afterwards you begin to think. So I want to thank all of you for having patience with me because I kept saying that I did not want to come, that I wanted to go to the other group at the same time and now I really feel that I can manage and that is a good feeling.” A group member responds saying “I think the group has accomplished that for E because this is a feeling that E didn’t have before but has now.” E then states “I am going to certainly miss the group, but I have accepted in my head. My heart gives me a little bit of trouble once in a while, but it is my decision to not join a possible ongoing group though I feel I benefited greatly.” E suggests the group can continue on in another way by commenting “If we who are the graduates of the group could help other people who are just coming in, this is another way for the group to carry on.” With respect to the group, E attains the Approval Stage as E accepts self-responsibility, while at the same time, is able to review and acknowledge the group’s importance.

In summary, E’s adjustment approaches and influences are affected by several factors, positive and negative. The initial circumstances of the move are negative for E who is angry with family members for wanting E to move into the long-term care home. Although E tries to prepare emotionally, E is not ready for the change. However, E’s creativity, appetite to be active and social skills contribute to eventually fitting in it with both the nursing home and group. E leaves in the Acceptance Stage, despite retaining longings for the old home and belongings.

Group Member F: Sessions Attended: Sessions 1-12

F enters the nursing home (10 weeks post-admission) in the Appraisal Stage. For example, in the first two sessions F speaks ambivalently, but clearly, about life changes, stating “I moved because I had an accident. I couldn’t look after myself where I was and once more my wife was a resident here (on another floor because of dementia). I find the organization a beautiful place. It’s got a terrific reputation, but I also find that I am restricted in my activities and friendships. When I was in business, I met people of different walks of life and I don’t find that here. It’s only about one thing. I’m not

interested in that.” F goes on to comment “I think this is a marvelous place, but is it a marvelous place for me? That is the question. I must face the facts. I have no alternative. I can’t go back to where I was. I’m not so sure I’m going to be happy in this place.”

With respect to the group, F states “I know what I am signing up for. I don’t know what I will get. It’s early.” However, F’s commitment to the group is in evidence with the comment “Well, I would like to participate in the group, perhaps learn how to get along with people more and to forget some of the things I learned in my life. I don’t feel comfortable in expressing my feelings to others. You need to keep a stiff upper lip. I learned that early.” However, F soon talks about life being “suffocating” and is pleased that others recognize F’s expression of feelings. F comments “It is only the beginning and it is going to take time for change and I don’t have that much time. That is what I am trying to say.” However, F is appreciative of the therapist for “planting a seed” that allows the opportunity to share feelings.

After sharing many feelings in session 3, F remains anxious about doing so and is not sure whether it is a sign of strength or weakness, but in session 4, F tells the group “Well, I calmed down after a couple of days and I guess I am beginning to think maybe there is something to this. I was looking forward to coming back.”

In the middle sessions, beginning in session 5, F shows resolve to adjust stating “So far, I’m coping. I’m making do. I am making do with my life here. I see no other way.” F’s preparation for a new way of life is certainly a challenge as F remarks in session 7, “I don’t think I could come to terms with this establishment here. The care is excellent. Everything is great, but I don’t know if I can adjust to these two things, the attitude of the facility and food. I can (at best) live and tolerate.” In session 8, F continues with “Expressing my feelings is hard for me. I was never able to express my feelings and I never did.” Nonetheless, F is certainly attempting to do this and talks about a book of poems F wrote 50 years previously relating to “middle of life feelings, a time when I embarked upon the change in my career to allow for more creativity.” The group enthusiastically welcomes F revealing “inner feelings,” although F, himself, struggles with being “uncomfortable” with private feelings becoming more “public.”

In terms of overall adjustment at this point, F in session 7 comments “Well, being in the home is a new experience. One learns as time goes on what it is like to be in the home, what you’re getting and what you are losing and you gain more and more knowledge as time goes on. You want me to say something whether I am adjusting to it. In some ways it doesn’t feel strange and in some ways it feels more strange.”

Displaying comfort with sharing personal feelings with the remaining group members in session 10, F communicates “I have something to share. I was having a talk with my spouse yesterday who came out with an expressive statement. The statement was ‘a broken bottle cast away; it was once full of beer.’ I thought it was a very profound statement. My spouse had a full life in the past and doesn’t have it in here. I was wondering whether my spouse was talking about this individually or whether my spouse is talking about all of you people who come here to spend the rest of your lives and who might have the same thought. Because not everyone is living the full life they had before. I didn’t follow through on asking. I didn’t want to open up a can of worms.” A lively discussion ensues about F’s emotional reaction and response to the spouse and the meaning it holds in view of the spouse’s cognitive impairment. Another group member then remarks “It is a fact of life that we pass through the stages of life. You can’t change it now. You come to think I forgot to do all these other things along the way and you keep saying why can I not come back to the things that I missed? You can’t. So I understand 100% what you said and what your spouse was saying to you. It is something called living. Your spouse is saying something that everybody goes through not just in the dementia stage, but at any stage of life. Your spouse may not realize it, but you do, and it is really strong words that come out which must make you scratch your head about who has the dementia. Something has come to life.” This group interaction perhaps signifies not only the challenge of coming to terms with the end of life, but likely by way of a parallel process, the approach of the end of the group itself. The theme of this particular group session seems to confirm this as members speak of achieving a balance between looking at the past, living in the present and planning for the future as they talk about giving up valued possessions upon moving into the home and the present bond that F still has with the spouse and the need/wish/fear of creating new relationships and memories through remaining active and social in their new environment.

With respect to the facility, F shows a wish in later group sessions to maintain acceptance stating, “I have made peace with the fact that I am going to live here for the rest of my life even though I am limited in my sight and my hearing. I can’t read, but there are other things that I can do and I’ll find my way to do it. I have no alternative but I’m up to the challenge.” With respect to the group, F comments that “I like the group because it gives us a chance to talk to each other and learn about each other. I find that very helpful. I think this experience adds to my life. My purpose in coming to the group in the first place was to get help to adjust to the new life here. I think this small group has helped me do that. I must say I do not feel as strange as when I came here. I have become accustomed to it and other things I detest and I am prepared to go along and see what happens in the future. I made my peace with certain things. With others I haven’t, but I am prepared to continue on in the group if it continues.”

In summary, F's adjustment approaches and influences are multi-determined. In several ways, F feels no other option with respect to where to reside due to an accident and a spouse with dementia already in the nursing home. The main challenge for F is the lack of fit between F's personality which enjoys meeting people of various backgrounds and interests, but being in an environment that F experiences as "suffocating." Nonetheless, due to taking advantage of an opportunity to express feelings coupled with a serious commitment to change, F leaves the group in the Acceptance Stage.

Group Adjustment Themes

Certain themes and issues are identified early on in the life of the group and continue to be prominent throughout the 12 sessions, as for example: a) themes related to an individual's sense of connection with one's previous home; b) themes related to being known and knowing others; c) themes related to changes in oneself; and d) themes related to the long-term care environment.

a) Sense of Connection with One's Previous Home – Coping with Loss

Feelings of loss and mourning of one's previous home is an early focus of the group. For some, angry feelings about being encouraged to move changes to making the best of it. An example of this is a member accepting help from family to make the room as comfortable and functional as possible. Nonetheless, though this member tries to focus on the future, it becomes a struggle as "I keep thinking about my old couch which wasn't worth 20 cents, but I think about it...it wasn't just an old couch, but it was my comfy couch and I loved it." Another member decides to accept the move stating "Well, my feeling is...that it is the right place for me because I have no alternative." Others agree with the response of one member who states "We all don't have another alternative. We aren't made of money that we could live in a castle with servants." One member's early departure from the group and inability to mourn the loss of her previous home and adjust to the long-term care home is demonstrated by another member who points out "This person made it clear she was not going to try everything she could to see if she could stay here." Another member, initially wanting to go home to a spouse still living at home, struggles with loneliness, but tries with the encouragement of one group member who previously faced a similar life circumstance, to accept living in the facility, realizing returning home would only add to the spouse's physical burden.

b) Being Known and Knowing Others – Expressing Feelings

An important therapeutic task is to instill a group culture that the group is a place for individuals of various backgrounds to share feelings about their move and present

situation. The group members, as to be expected from any group, respond in different ways. One expresses a willingness “to participate in this group. I’d like to learn perhaps how to get along with people more and learn to forget some of the things that I learned in my long life.” Later on in the first session, this same member acknowledges that “I think it is hard to talk about inner feelings.” A quieter member encourages others to continue talking about their feelings, but indicates discomfort with doing the same. Another member at the end of the same session states “We’re all getting to know each other, which makes the second meeting more meaningful.”

Members in this stage are reluctant to having their life known prior to the nursing home. One member emphasizes the importance of starting over and creating new memories stating “This is the final place, if anything, so I don’t want to go back into history. History was made. I am not going to go through that. I gotta start up a new history.”

The following is an example from the third session where feelings are able to be expressed.

F: “Music appreciation is every week now. My spouse (on the other floor) was brought to me by my grandson. The musician started playing music by Chopin and my spouse started singing it.”

Therapist: “It brings you to tears as you tell us that. It must have been touching and powerful.”

D: “Ok, how to keep the memory. That’s important.”

F: “I was feeling, wow my spouse remembers it.” (crying)

Therapist: “This is the place where you can cry.”

D: “It’s human.”

F: “I don’t generally show my feelings. Did you read the first poem I wrote? ‘The things I see and hear and know and feel. Stored up in my brain and heart, aching for release. Overflowing in spasmodic rushes of joy and tears. Silent and unsaid.’ I didn’t expect this to happen.” (crying)

Another member: “Silent and unsaid. It really did come out. I am very impressed by what you wrote and that you have these feelings. I have more respect because I know more about you.”

F: "It will take more than this conversation, but maybe you (the therapist) have planted a seed there somewhere."

Therapist: "You have taken another step in this group and there has already been a change in you. You are changed from the first day when you said I am not going to be able to talk about my feelings."

D: "You held things back, but there was a time previously when you began to open up and be yourself. Those thoughts were still with you and today was the right place at the right time. You won the lottery."

F: "I haven't won yet. I hope you are right that I am not too old to change. But I am not afraid. I know that we come and we live and then we go."

Therapist: "We come, we live, we go. D, you put it slightly different last time when you said we are here, we are starting a new history and we build the history."

D: "Yes, a new dimension."

Indeed, the theme of moving into the long-term care to live and not die no matter what age, has been described elsewhere with respect to ongoing groups in long-term care homes (Schwartz, 2007). Residents want more, not less, social interaction. This is shown by a group member wanting to start "an after-dinner supper club" to cope with the lack of socializing in the evening. At the completion of the group, this member "was pleased to come to the group to meet other people because it takes a long time to get acquainted."

Getting to know staff is also important. For example, one member expresses displeasure with the health-care system for burdening the nurses with so much paperwork and states "How could they possibly know anything about me when she doesn't have time to chat with me. You see, I need sometimes to talk to somebody who is interested in my emotional and physical health. At times, I don't want to tell my family or friends. I admit the group has recognized this need. I admire that very much." Another member refers to frustration with staff's frequent changes and comments "We don't have a steady one for a length of time, so how can they get to know you? You can't create a relationship with professional people in this institution. Talking to the person is a lost art."

c) Changes in the Newly Admitted Resident's Sense of Self and Autonomy

The importance of retaining a sense of control over decisions in one's life and being heard is repeatedly expressed. Indeed, three features of nursing homes particularly inhibit personal autonomy: routine, regulation and restricted opportunity, so-called "the three

R's" (Kane, 1990). One group member who, in particular, takes great pride on retaining autonomy, both in the decision to reside in the home and to improve the services of the home, encourages others to voice their complaints.

Family members may restrict or influence a resident's right to choose. For example, one group member states "I should be the first person who is asked regarding my medical treatment. I listen to them and they should listen to me." Another member struggling with reconciling residing in the home remarks "I don't feel dumped...I gave up my apartment because my daughter stated if you aren't happy here, I'll get you another apartment." This allows the member to hold on to some sense of control. Similarly, this member holds onto a sense of control with respect to the group by never fully committing to attending. Finally, this member stops coming as this member is primarily attending because of the initial commitment made to the research-clinician, instead of attending for the purpose of being assisted with adjustment.

Appropriate acceptance of dependency, or loss of independence relating to declining health, is a prominent challenge and theme. One member, on occasion, newly needing a wheelchair, readily accepts this. Another member, affected for many years with a chronic deteriorating illness, plans ahead and adjusts to the use of an electric wheelchair. This is in contrast to another member who is also dealing with chronic illness, but could only admire the other member and exclaims "I am ready to pull out my hair at times."

d) Difficulties in Adjusting to the Long-Term Care Home Environment – The Development of Trust and Acceptance of Good and Bad

In the first meeting, a task of the therapist is to encourage members "that the group will be not just to get to know each other, but also getting to know what the nursing home is about." Not surprisingly, the fit individuals perceive between themselves and the long-term care environment is an important theme. For example, a member who finds the social, cultural and religious milieu much different from what this member is comfortable with, experiences the limited interests of other residents and the focus of the long-term care home "suffocating." Another resident experiences the move to a large facility as "a loss of intimacy." This resident is also distressed by the "loss of privacy because they (the staff) walk into your room without announcing themselves or knocking." The dining room ambience and the quality of the food are also hard for most to adjust to. Other members struggle with long waits for staff, even when the call bell is used. Frustration is also expressed regarding limited access to the physician. One member encourages the others to cope by actively trying to improve things or to "blank" things out and instead focus on the more positive things. The therapist responds by encouraging the members "to attempt to accept both the good and bad in the long-term care home, as well in

themselves and others. Then it becomes possible to be more accepting of the life situation you are now in.”

At the same time, the therapist remains mindful of the possibility that focusing on the external aspects of the facility may serve as a resistance from exploring and expressing feelings about being “strongly encouraged by others” to move into the facility. For example, in session 5, the therapist remarks “When what upsets you is more personal and leads to an increase of vulnerability, sadness and fear, it’s hard to talk about. I think that’s where the group is at today with all the recent talk focusing on food and staff. The group is an opportunity, but I am aware it is very hard to talk about your feelings about being here when your heart in part may be elsewhere.” In this session, the therapist is addressing members in the Preappraisal and Appraisal Stages in an effort to help them move into the Adaptation and Adjustment Stages.

In response, a member asks, “What is your motivation in organizing a group in this manner?” After listening to the therapist’s response “that there are many things you are saying goodbye to. I hope the group can help you settle in here, learn the ropes and ultimately make the best of it.” F then questions, “Why don’t you let us suffer?” This questioning perhaps addresses the nature of the group serving both clinical and research purposes and is similar to what happens early in the development of ongoing long-term care home groups when members question the loyalty of therapists – are they more interested in the members, or are they there as advocates of the long-term care home administration? (Schwartz, 2007). In a parallel process, this question may also unconsciously reflect some members’ uncertainty whether their entry into the long-term care setting, which is encouraged by family members, is in their own or their relatives’ best interests.

As is often the case, it is best for the group members to get themselves back on track. In this case, another member wisely, and with much wit, responds to F and exclaims, “The doctor wants to know why we are so full of woe. Oh, it just ain’t so. Maybe I have to grow. That is what the doctor is saying.”

Group Process Questionnaires

Group Climate Questionnaire (GCQ-S)

The Group Climate Questionnaire – Short Form (GCQ-S) contains 12 items (see Table 2) rated on a seven-point Likert-type scale (e.g., 1 = not at all; and 7 = extremely) (MacKenzie, 1983). Completed independently in just five minutes by members (with assistance from the research assistant) after every session, the results can be recorded as

an individual member's impression of the group or averaged into a group score based on the perceptions of all members. The GCQ-S has proven to be a source of information with which to understand group process and shifts in group climate from one session to the next and to formulate appropriate interventions – an example of applied clinical research, which is what this study also tries to entail.

Table 2. Items on Group Climate Questionnaire

1. The members liked and cared about each other.
 2. The members tried to understand why they do the things they do, tried to reason it out.
 3. The members avoided looking at important issues going on between themselves.
 4. The members felt what was happening was important and there was a sense of participation.
 5. The members depended on the group leader(s) for direction.
 6. There was friction and anger between the members.
 7. The members were distant and withdrawn from each other.
 8. The members challenged and confronted each other in their efforts to sort things out.
 9. The members appeared to do things the way they thought would be acceptable to the group.
 10. The members distrusted and rejected each other.
 11. The members revealed sensitive personal information or feelings.
 12. The members appeared tense and anxious.
-

Note: Mean group scores are calculated for each sub-scale independently (e.g., Engagement: Items 1+ 2 + 4 + 8 + 11 / 5; Conflict: Items 6 + 7 + 10 +12 / 4; Avoiding: Items 3 + 5 + 9 /3). (MacKenzie,1983).

In order to track and conceptualize group climate in the present study, GCQ-S scores are collected in successive sessions from three group members (D, E, F) throughout the 12 group therapy sessions. Scores are quantified by calculating mean group scores on the three GCQ-S subscales (i.e., engagement, avoiding, conflict) for each session (see Figure 1). MacKenzie (1983) suggests GCQ-S scores can track specific behaviours and events in group therapy over time. However, the results in the present study are greatly impacted by the small sample size. Hence, the results that follow are kept brief in nature and must be seen as very preliminary. They are used only to augment the understanding of the clinical process of individual adjustment to the group, rather than to guide clinical judgment.

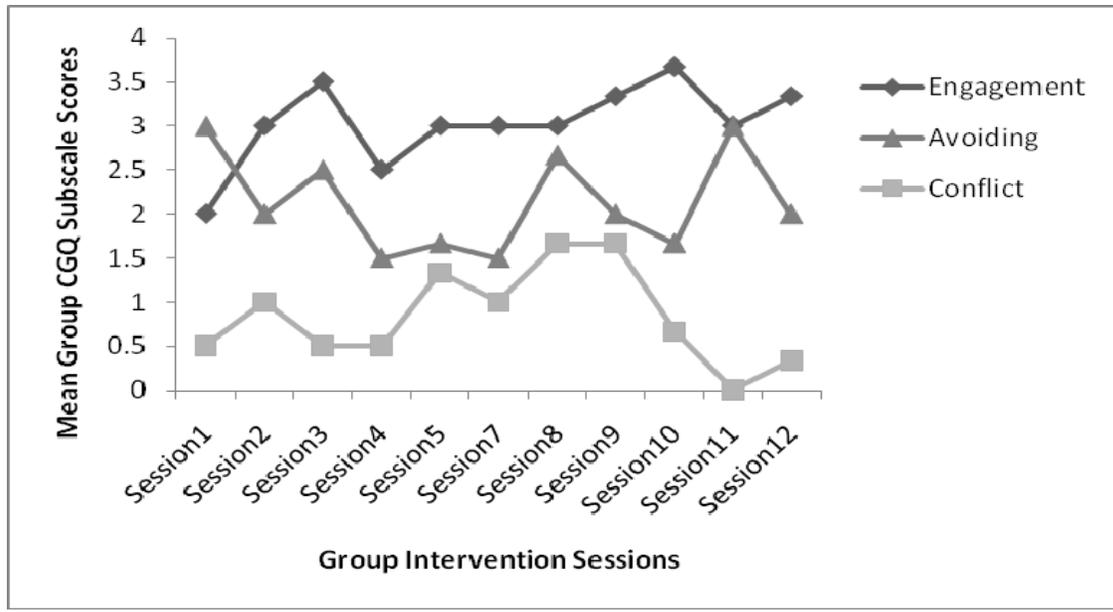


Figure 1. Group Climate Questionnaire (GCQ) Engagement, Avoiding, and Conflict subscale mean group scores for group members D, E, F throughout 11 sessions ($n = 3$). *Note:* Session 6 is excluded as scores were not obtained.

Although all the members lived in the same facility for periods of two weeks to four months, most remain unfamiliar with one other. As a result (as is typical for any psychotherapy group), members are initially asked by the group leader to share personal experiences regarding the circumstances of their lives, in this case, the move, something they all share in common. Subsequently, all the members agree with one member who states “We are all here, but not necessarily by choice.” This sense of universality, “We’re all in the same boat,” helps overcome the initial basic social anxiety found in groups, thereby creating an atmosphere for constructive work to occur. In this manual’s proposed Stages of Adjustment to a Long-Term Care Home and Group Model (see Table 1.), newly admitted residents in the Preappraisal and Appraisal Stages share the universal challenge of engaging in a group with the primary purpose of helping them adjust to the long-term care home.

In session 8, a disconnect in the group occurs when E suggests, “Maybe we should talk about having fun.” What follows, are members talking about the preponderance of females in the facility and the possibility of meeting someone new. F finally displays dismay with the discussion exclaiming, “I don’t know what I’m doing in this room...What are we talking about? What does this have to do with anything if people get along better with men than with women?” The clinical material interfaces well with F’s individual experience of the group’s engagement, avoiding and conflict scores for session 8 (see Figures 2, 3 and 4). F’s rating of the avoiding scale as high suggests that E is

avoiding the important process of self-introspection and is leading others to do the same. In rating the conflict session as high, F is displaying displeasure with the focus of other members. The score can also be interpreted as an attempt to direct E back to working on more difficult personal themes. The positive correlation between the engaged and conflict scales indicates that group members do not necessarily view these behaviours as incompatible (MacKenzie, 1983).

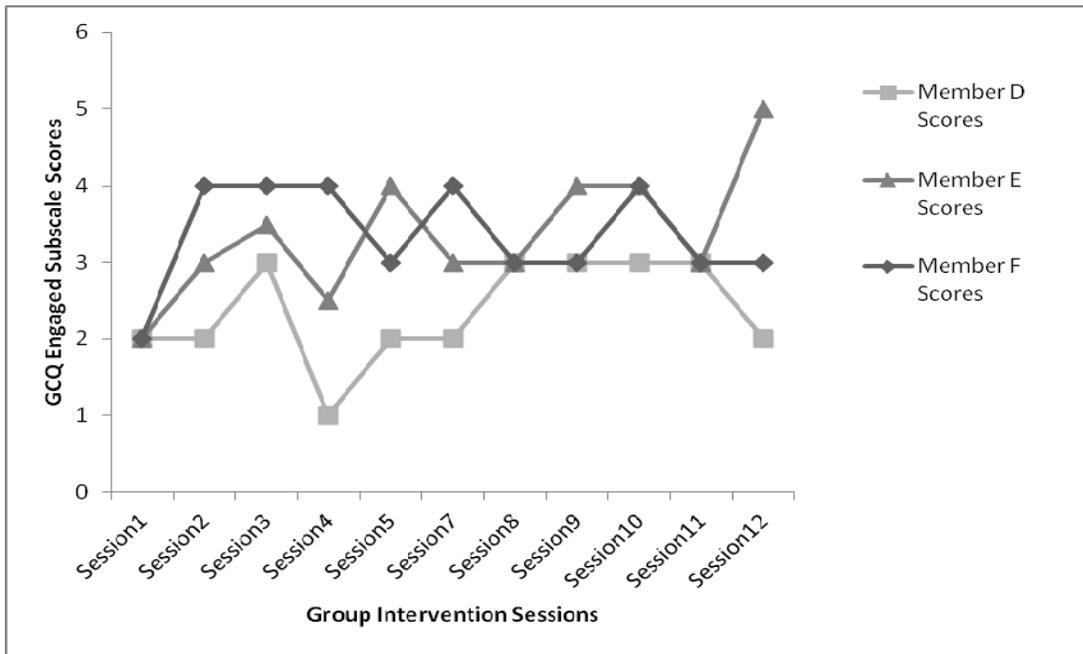


Figure 2. Group Climate Questionnaire (GCQ) Engaged sub-scale scores of group members D, E, F ($n = 3$) throughout 11 sessions. Note: Session 6 is excluded as scores were not obtained.

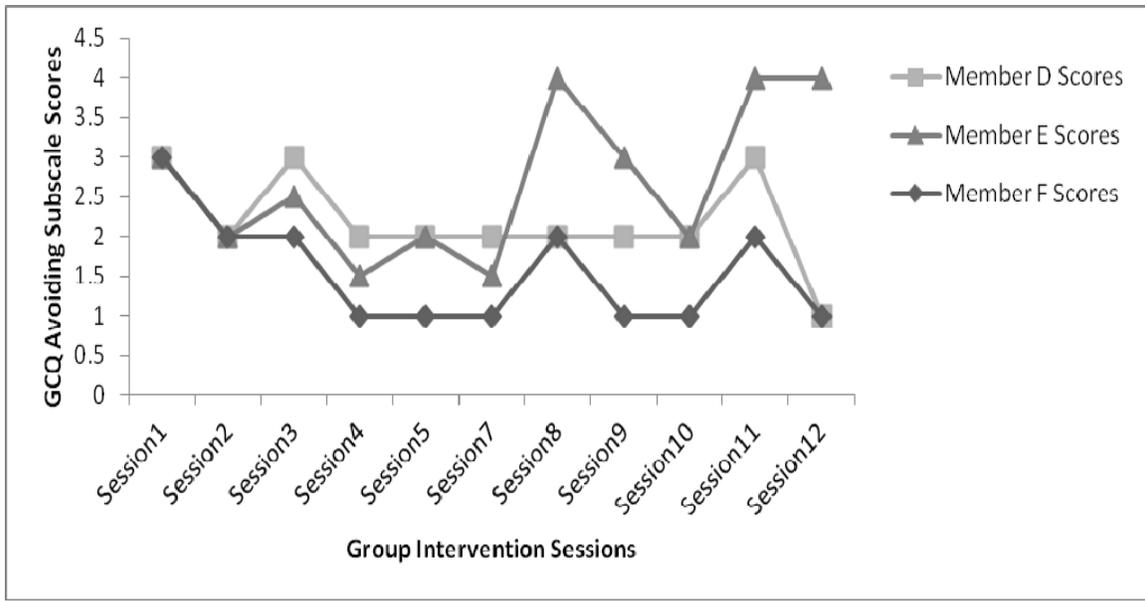


Figure 3. Group Climate Questionnaire (GCQ) Avoiding sub-scale scores of group members D, E, F ($n = 3$) throughout 11 sessions. Note: Session 6 is excluded as scores were not obtained.

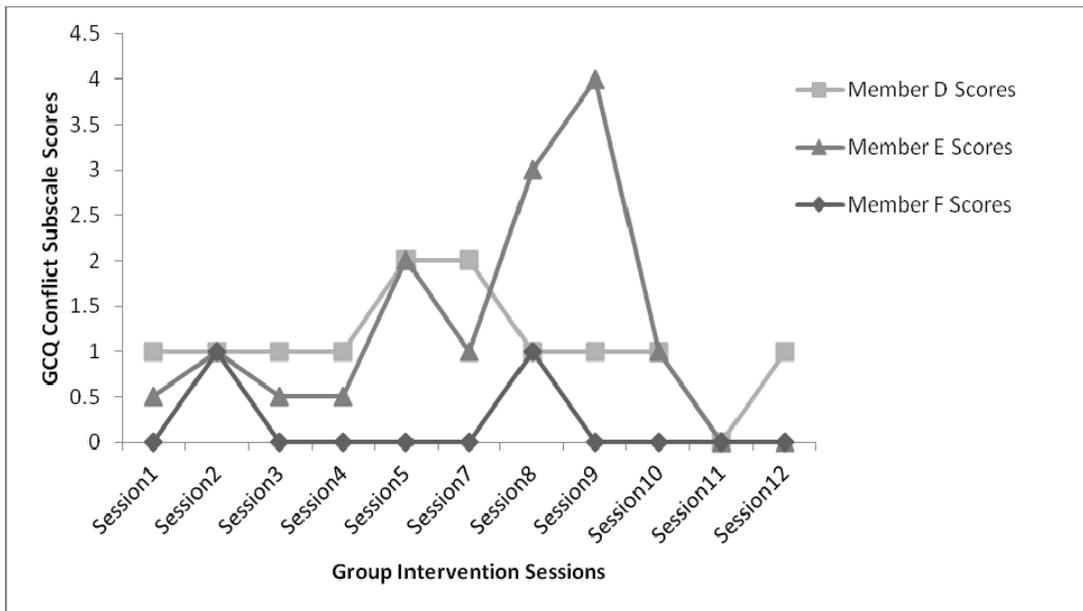


Figure 4. Group Climate Questionnaire (GCQ) Conflict sub-scale scores of group members D, E, F ($n = 3$) throughout 11 sessions. Note: Session 6 is excluded as scores were not obtained.

Focus Group Questions

A semi-structured 45-minute audio recorded focus group session was held by the research assistant with three active group members (D, E, F) at the end of the 12 intervention sessions. The session's goal is to obtain their subjective responses on 18 open-ended questions as to whether the group influences adjustment challenges and aids transition to the LTC facility (e.g., What were your expectations of the group before you came to the first meeting?; What was it like for you to engage with others in the group?). Responses are qualitatively analyzed to affirm key stages of change and adjustment themes. The individual responses for three members (D, E, F) are as follows:

Individual Group Member Summaries of Focus Group Questions

(D) Focus Group Summary

D responds to early thoughts and expectations of the group sessions stating "It was different than what I expected from the beginning...I didn't know what it was about." Actively involved with setting up "that kind of work" for other group therapy initiatives, D acknowledges the group is "unique" in allowing him to see what it is like to be in an older group with different perspectives. He relays "for my purposes, I needed to know what people were feeling and how they felt with being with other people because I was also going through that."

Throughout the focus group, D denies encountering any threatening topics in the group discussions. When asked about the overall effectiveness of the group, D observes "we really didn't get into any discussions between all the people in the group." D identifies a primary concern with the group as the lack of consistent member participation throughout the 12 sessions. D relates hesitation with the group continuing in the future due to "lack of numbers" (but D has become an active participant in the new adjustment group that has eight members, including D and F).

D acknowledges having improved relationships with the other residents because of the group, due to talking to group members who did not show up and engaging them in conversations. D claims "What difference is anything going to be?" when asked to comment on the inclusion/exclusion group criteria, stating that it did not make a difference if the group is opened to long-time residents "unless you are only going into specifics (of helping new members adjust)."

D declares that "adjusting to the nursing home depends on the person." D initially did research on the nursing home and was thereby "adjusting to the home before I got here."

Nevertheless, D acknowledges that the most enjoyment derived from the group meetings is new people and “getting to know what was on their minds.” When asked about the overall picture and how the group has shaped D’s future adjustment to the LTC facility, D indicates a wish still to meet people, commenting that “If I look into the future, yes we are continuing what we started here.”

(E) Focus Group Summary

E indicates being “very pleased and interested” when first told about the group. E acknowledges the therapist’s consideration of E’s hearing issues that made participation difficult in the early group sessions. Nevertheless, in admitting that the group is a “positive experience,” E identifies enjoying mostly the unique forum of discussion about challenges involved with aging and illness.

On further inquiry, E declares an admiration for one group member’s ability to cope with progressive illness as E acknowledges “not thinking about that before.” This proves helpful in stimulating a reflection of E’s life situation and health concerns. As a result, E believes that the group definitely improves relationships with staff members, as E got a “better understanding” of problems they face, such as those experienced by the therapist in the group sessions.

E identifies a fear of self-disclosure and topics involving “the past about E’s family.” E’s primary concerns with the group are that “people weren’t coming” and expresses a frustration that certain group members could not take the initiative to attend the group sessions. E acknowledges that the group is a safe place to discuss issues related to adjustment at the LTC facility. When asked if the group should carry on longer than 12 weeks, E replies “it is enough.” E commends the idea of limiting the group to residents who are newly admitted, as it ensures “evenness, and a common bond with a lot of same issues.” When asked about the overall experience in the group, E declares “I want to start doing as well as just talk about problems and to continue living my life to the fullest here.”

(F) Focus Group Summary

F reflects upon early thoughts and expectation of the group by claiming to be “excited about anything new.” F recalls an early indifference to the group stating “I didn’t know what I was going to get out of it. I didn’t know exactly what the group was about. I knew it was led by a psychiatrist and a social worker, but I really had no idea what to expect. I didn’t expect anything. I didn’t have any expectations.”

Throughout the focus group, F is encouraged to share thoughts on how the sessions attended to and facilitated thoughts and feelings related to the LTC facility adjustment. When asked if there is anything about the group F would change, F suggests avoiding “extenuating issues” to improve the quality of group discussions. In regard to the study’s duration, F comments that the group “could have carried on for longer than 12 weeks.” When asked about what should be future exclusion/inclusion group criteria, F states that “we should include everybody.”

When asked to elaborate on this opinion, F declares “I don’t think that would make a difference as long as we carry on with the group the way we have been doing.” On numerous occasions, F alludes to the fact that “this has been a very good experience for me” acknowledging that the group is “a learning experience” and that “I went along with it.” When asked how the group has positively impacted him, F expresses “I don’t know how and I don’t know why and I really don’t care to know how and why, but I think if this carries on the way it has I should grow with it.”

As an active member in group discussions, F reflects upon the effectiveness of the group, describing how “We had a lot of differences. We had a lot of revelations, personal revelations from people. It proved to be a worthwhile effort.” F identifies “the experience of listening to people talk” about adjusting to life in LTC allows the development of “positive feelings” in the group therapy setting. When asked if the group is helpful in his adjustment to the LTC facility and his current situation, F affirms “It helped me along with my experience here and the time I was here I experienced various things that I adjusted or tried to adjust to, so along with that experience I think I may answer that question in the affirmative, that it has helped me to adjust.”

Limitations/Future Suggestions

There are a number of limitations within the present study which may have influenced our findings. With respect to the literature, meaningful empirical study of an individual’s adjustment to the long-term care setting has been hindered by the wide range of research perspectives on the construct of adjustment and its attributes (Porter & Kruzich, 1999). As a result, the administration of reliable and valid questionnaires in the present study design, specifically for a long-term care population, proves problematic.

A larger sample size could allow a more thorough examination of the overall benefits of the group intervention, as small sample sizes restrict the ability to make stronger statements about the evaluation and results. Nevertheless, perhaps the results provide enough information from resident group members to warrant this kind of intervention in the form of a randomized controlled trial. Researchers such as Porter & Clinton (1992)

have suggested the utility of a phenomenological qualitative approach, as opposed to using the more traditional quantitative pre-post questionnaire method. In the present study, change is based on context and environmental factors, as every individual change is different and thus difficult to track using quantitative scores. Prochaska and DiClemente (1983) suggest there is a need to collect longitudinal data to determine the predictive validity of the transtheoretical model of stages of change as individuals move from one stage of change to another. Residents in the present study are tracked over a period of 12 group psychotherapy sessions which take place on a weekly basis for about three months. Future studies might want to evaluate change behaviours over a longer period of time, such as a year post-admission to a long-term care home as adjustment can continue for up to a year (Melrose, 2004).

Salient themes available for study of newly admitted long-term care residents include adjustment approaches and influences of residents through their own words, while they are actually living the adjustment experience. This is what the group psychotherapy approach is able to do. Although small group intervention sizes are necessary to be most clinically effective, group members are very knowledgeable about the research topic.

In a study conducted by Soler et al. (2008) the suitability of applying TTM stage-of-change construct to treatment with Dialectical Behaviour Therapy (DBT) of Borderline Personality Disorder (BPD) is assessed following eight to ten BPD patients over 13 psychotherapy sessions in the span of three months. Although the population and group intervention are very different, the study by Soler et al. (2008) features a similar attempt to correlate stages of change with evaluations of outcome.

In regard to intake measures and attendance, it may be beneficial to conduct more stringent intake screens to increase compliance with the study. For example, which personality types would most benefit from the group and which health problems of potential members would negatively influence their overall participation in the group. Due to health issues in the present study (e.g., dizziness, pain, radiation treatment for cancer) and a member in the Preappraisal Stage who is also inconsistent in attendance due to difficulty tolerating dysphoric affect and having more comfort with recreational groups, the group declines from six to three members who are able to attend regularly. In turn, effects of group processes are not as clear. Nevertheless, the non-compliance of three members in the present study suggests the need for different kinds of group approaches and/or type of group. For example, more attention to the member's readiness for change could lead to a modification of therapeutic approach and technique resulting in improved engagement of members uncomfortable with a group or the idea of adjusting to a long-term care home. For example, the application of Motivation Interviewing Principles in a Modified Interpersonal Group Therapy was able to successfully treat non-

abstinent, addicted patients who are in the Pre-contemplative and Contemplative Stages of change (Malat et al., 2011). Other less cognitively-intact or less psychologically-minded newly admitted residents may benefit more from participation in forms of therapeutic recreation such as music or art groups that could cultivate social ties to the facility and other residents.

Due to the study design (absence of control groups), the possibility exists that adjustment behaviours and progress through stages of change are due to other factors in member environments (e.g., time itself, social engagement) versus the group psychotherapy intervention (Porter & Clinton, 1992). Use of a control group in future research would help to evaluate patterns of change with and without intervention. Future studies could take other perspectives into consideration to isolate the effects of the group therapy. For instance, the Multi-dimensional Observation Scale for Elderly Subjects (MOSES) could be administered with long-term care home staff and family members to provide a perspective on a member's depressed/anxious mood, irritable behavior and withdrawn behaviour. The MOSES has been demonstrated to provide reliable valid staff ratings of the major areas of clinical concern to health-care staff and researchers (Helmes et al., 1987).

During the administration of the GCQ after every session, it is observed that some participants have difficulty understanding the nature of the questions in their entirety. Thus, there is the possibility that some participants become easily confused when self-reporting on the questionnaire. Other factors, such as optimism, might influence the validity of the responses (Soler et al., 2008).

A number of challenges limit the popularity of psychotherapy groups in long-term care homes, assisted living facilities and retirement homes. Difficulties can arise in forming and conducting these groups including residents' resistance to accepting mental health help, therapists' countertransference and obstacles imposed by the institution (Ronch & Crispi, 1997). Denial and avoidance of therapists' fears and anxieties regarding dependency, illness and death can be projected onto older members and often preclude these therapists from working with this population (Schwartz & Schwartzberg, 2011). Logistical problems related to other competing activities and schedule conflicts, as well as soft voices and hearing problems of residents, are other challenges (Speer & O'Sullivan, 1994). A unique countertransference issue related to working within a long-term care facility stems from the competing wishes to provide therapeutic support, on one hand, and to serve as patient advocates vis-à-vis staff, on the other hand (Schwartz, 2007).

Nonetheless, the multitude of struggles faced by newly admitted residents is so great that it is incumbent on nursing homes and similar facilities, such as assisted living facilities and retirement homes to find the will and resources to both address the needs of these residents, not only in the first few months, but in the first years. For example, retirement homes have a larger population of more cognitively intact residents who also face similar challenges in adjusting to the move from their homes. As has been shown elsewhere, the positive effect for members continues well past the first year (Schwartz, 2007). For example, in ongoing cohesive long-term care home groups, time permits members further opportunity for accepting late-life challenges relating to deteriorating health and other losses without experiencing undue despair or bitterness (Erickson, 1950), even while living in a long-term care home (Schwartz, 2007).

Summary

Group psychotherapy in long-term care settings remains undervalued and underutilized. This is unfortunate as many newly admitted residents experience a difficult adjustment period. A majority of residents appraise the long-term care facility negatively, especially after three months (Iwasiw et al., 2003). Although clinical symptoms diminish over time, some may continue to struggle throughout the first year (Melrose, 2004) and even for longer periods (Schwartz, 2007). Iwasiw et al., (2003) emphasizes that listening and providing residents' opportunities to talk about their feelings helps meet their needs to maintain their identity and dignity. Adjustment to a nursing home is a unique experience for each individual (Porter & Kruzich, 1999). A brief interactive and integrated group psychotherapy that emphasizes therapeutic factors such as cohesion, universality and interpersonal learning (Yalom & Leszcz, 2005) is described in this intervention manual. Weekly ongoing groups can provide long-term resident group members who are struggling with multiple losses and changes in themselves and their environment with a sense of consistency and stability (Ruckdeschel, 2000). This approach eases the stress of transition through the encouragement of individuals to retain their sense of autonomy by expressing their unique thoughts and feelings.

The present study provides the first empirical insight into the suitability of the TTM stages-of-change construct in facilitating adjustment and continued development through the difficult transition to a long-term care home. Brooke (1989) cautions the description of phases may lead them to be regarded as real points in time through which all residents must pass. Nonetheless, the adjustment approaches and six stages-of-change identified in this study should be explored and clarified in future studies in nursing homes, assisted living facilities and retirement homes to establish clinical outcome measures. Understanding the unique adjustment difficulties facing newly admitted residents during this critical transition period through the use of group therapy, focus groups and perhaps

questionnaires can help health professionals to better recognize this important process and to shape their own clinical psychotherapeutic and social interventions in a way that is most helpful to the individual. Furthermore, understanding the experiences and expectations of residents will help lay the foundation for various program strategies and supportive interventions in the long-term care home (Heliker & Scholler-Jaquish, 2006).

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