Shifting gears: A workshop to increase well being in older adults residing in congregate housing

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SHIFTING GEARS: A WORKSHOP TO INCREASE WELL BEING
IN OLDER ADULTS RESIDING IN CONGREGATE HOUSING

by

Amanda Haboush

Bachelor of Arts
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ABSTRACT

Shifting Gears:  
A Workshop to Increase Well Being in Older Adults Residing in Congregate Housing

by

Amanda Haboush

Dr. Jeffery Kern, Examination Committee Chair  
Professor of Psychology  
University of Nevada, Las Vegas

Many adults who are moving into the later stages of life have difficulties transitioning into a new lifestyle including the move into congregate housing. This lack of a well-adjusted mental transition could lead to mental disorders or health problems, if not addressed. To attend to this concern, the current program was designed to educate older adults residing in congregate housing about basic coping strategies for common stressors.

Results of the study indicated that there were no significant changes from pre to post treatment measures. These results may be explained by an insufficient sample size and to overall pre-treatments scores indicating good mental health. Even though results were non-significant, participant feedback was positive and indicated a desire to participate in future workshops. Future research should replicate this study with suggested changes to a clinical population to better detect treatment effects.
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CHAPTER 1

INTRODUCTION

In the past 10 years, the population of Nevadans 60 years of age and older has grown three times faster than the national rate of growth in that age group (State of Nevada Department of Human Resources, 2002). Since many who moved to Nevada during earlier points in the life course are aging in place here, and Nevada tops the country in attracting in-migrants 55 and older, the number of older residents is projected to continue its upward trajectory. Nevada’s older residents contribute to the community by remaining in the local labor force, volunteering, and providing informal care to family members and friends (State of Nevada Department of Human Resources, 2002). Recent survey research on the particular needs of older adults, demonstrate that they desire to remain active in the community, maintain a social network, and retain their health and independence, therefore it is important that services are provided to enable them to continue living in this lifestyle (State of Nevada Department of Human Resources, 2002; Tinsley & Bigler, 2001). Although some Nevadans, 60 and older, accept transitions from previous lifestyles, roles and tasks to new ones, others find such changes more of a personal challenge, which may effect their health and well being negatively (Karel, Ogland-Hand, Gatz, & Unutzer, 2002). A particularly difficult emotional move, for some, accompanies the physical move into congregate housing (Tinsley & Bigler, 2001).
Common Transition Problems Associated with Aging

There are many unavoidable milestones that occur in late life. A survey was conducted in nursing homes and assisted living facilities to discover some of the key issues involving older adults in these locations. It was found that social isolation, a reduced social network, decreased income, limited mobility and declining physical strength and stamina, frustration with medical facilities, worry or anger about past events and a sense of powerlessness over one's life were the main factors (Lee & Carr, 1994). These are common problems that are seen in the older adult population at large as well (Diego & Diekstra, 1990). Being that congregate housing is a bridge between independent living and assisted living (Congregate Housing for Seniors, 2005), these conflicts may not only apply to residents in nursing homes, but may also be common for older adults residing in congregate housing.

Congregate housing facilities offer independent living in separate apartments as well as opportunities to share activities of daily living with other residents, as one chooses. They may be rental or ownership units or include a buy-in. Today, congregate communities are sometimes hard to tell apart from senior apartments that offer many services and opportunities to do activities together. In communities where differences are minimal, the main difference may be in additional levels of care that are available within the same community as congregate housing. These levels may include assisted living, skilled nursing or Alzheimer care. Active senior apartments offering meals, services, transportation and planned activities will generally not include additional levels of care within the same community (Seniorresource.com, 1996).
Often congregate housing residents must grapple with stressful personal challenges related to changes in one’s physical context (such as moving out of a long-time former residence), relational changes (such as dealing with the loss of a spouse or other close relative with who one shared a residence), and status changes (such as moving out of the labor force or relinquishing a heavy duty care-giving role) (Neiderehe & Schneider, 1998).

Although many older adults function fine with regards to physical health and cognitive state, older adults may fear that these areas will progressively deteriorate (Jacobs & Adams, 2001). The stress that accompanies these fears may actually enhance the further deterioration of physical and mental states and induce mental illness (Blazer, 1998; Palmore, 1980). It has been documented that the diagnosis of a major illness is linked to deterioration in health and is extremely stressful for an older individual (Rentoul, 1997). The following describes some additional situations that older adults may encounter which may cause them distress.

As we age there are certain roles that may have dominated our lives that no longer exist. These may include the parental role, work role, or wife/husband role. Being void of these responsibilities can produce feelings of loneliness, isolation, uselessness or meaninglessness. Losing a spouse can be one of the major changes that occur in a person’s life that can contribute to loneliness, isolation, and financial difficulties (Rentoul, 1997). Although it is better handled in late life and the adjustment period is shorter than that of younger adults, when compounded with the other stressors mentioned, it is likely to result in deterioration in mental and physical health (Palmore, 1980).
With the loss of a spouse, along with other concurrent losses, sometimes people may also feel a loss of status role in the community (Lindsey, 1997). Previously, they may have felt like contributing members of society through work, volunteering, or other organizations. Certain present factors in life may make these roles impossible to continue. For example, transportation becomes more of an issue as one grows older as a result of losing the ability to drive. Alternative forms of transportation (e.g. bus, taxi, subway) are not always readily available, inexpensive or safe. This may hinder the ability to participate in activities around the city. Elderly individuals located in rural areas, or older sections of town, may not have medical facilities available nearby and cannot easily attend regularly scheduled medical visits (Palmore, 1980). This would again promote feelings of uselessness and social isolation.

Many older adults face a dramatic income loss when moving into the later stages of life. This may be due to retirement, loss of a spouse (who may have provided additional income), or forced retirement due to a physical disability (Jacobs & Adams, 2001). This loss may cause reductions in nutrition, clothing, recreation, and in the ability to cover medical services and/or other activities (Palmore, 1980). Financial strain may also force some individuals into congregate housing facilities. As people continue to live longer, financial burdens of relying on social security and inevitable failing health will fall on more and more individuals. Increasing financial strains cause great distress for many elderly people (Glasscote, Gudeman, & Miles, 1977; Jacobs & Adams, 2001).

Growing up in the early 1900’s was a very different experience compared to today’s technologically based world. Older adults of today also experienced events such as the Great Depression, World War II, and may have had a very different home setting.
(e.g. lower divorce rates, traditional all American family concept). One emerging issue involves life long education. As the world grows, job descriptions and education needs change with it. Education is a cycle, and providing and encouraging this process will promote independence in the elderly and prolonged contribution to the societal workforce (Tice & Perkins, 1996).

A different perspective of loss is the psychosocial theory, which looks at the loss of independence and control over ones life as well as coping strategies. A fundamental characteristic of being human is their primary control over their surrounding environment. Primary control deals with the perceived ability to control the external world, allowing individuals to shape their environment to fit their needs. This involves behavioral action. Secondary control is directed towards changing the inner self through cognitive actions (Schulz, Heckhausen, & O'Brian, 2000). In old age it becomes a challenge to maintain primary control as the body functions begin to fail. This causes frustration, wasted effort and failure. When secondary control strategies fail to supplement for primary loss, individuals can become depressed (Jacobs & Adams, 2001). Older adults are in need of the coping resources to maintain secondary control in their life.

Indeed, it is a misconception that, because older adults have accepted that they must reside in congregate housing, they have mentally adjusted to the change (Erwin, 1996). Although congregate housing offers independent living and opportunities to socialize, many older adults move into this new stage of life without making the necessary emotional adjustments. This lack of a smooth mental transition may lead to
emotional problems and health status challenges, if not dealt with. Indeed, these problems may escalate to the point where independent living is no longer an option.

**Related Health Problems**

If left unaddressed, many of these "transition" issues can have a major affect on mental and physical well-being. Mental health issues that are common in older adults include, but are not limited to suicide, alcohol use and misuse, and dementias (Blazer, 1998).

Two predominant mental health issues include anxiety and depression. Anxiety is "the distressing affect which is subjectively experienced as worry similar to fear of a real danger or the anticipating of danger" (Verwoerdt, 1980). As people age, effective coping strategies that deal with anxiety may become more vulnerable. This may be caused by a decline in health or overall energy. Also accompanying aging is a decline in the restoration of the body to a normal state after experiencing anxiety (Bonder & Wagner, 1994). These two combined situations may leave the person in a prolonged state of anxiety without any effective coping resources. Older adults typically worry about: finances, loss of physical vigor, loss and loneliness, which are all transitional issues that were previously discussed (Stanford & Du Bois, 1992). Anxiety can arise due to constant reflection upon life and feelings that one's life was and is insignificant (Blazer, 1998). Individuals may tend to view aging as a negative process essentially viewed as a bad thing or a problem to be solved rather than another stage of life. With this perspective, the aging process itself can be seen as a stressful event and invoke anxiety in older adults (Tice & Perkins, 1996). Anxiety can also be coupled with depression for many individuals (Blazer, 1998; Verwoerdt, 1980). This may come from an individual fear of
additional misfortunes that brought on the depression or it may come from a fear and
disappointment that life goals may not be completed. Identifying and treating anxiety in
older adults can prove to be a difficult task as well. Older adults are less likely to know
where their anxiety comes from so it may present to be harder to treat. Also symptoms
are more likely to present in the form of physical complaints, which would cause the
person to seek medical assistance versus psychological assistance (Tice & Perkins, 1996).

A depressive disorder is an illness that involves the body, mood and thoughts. If
untreated, this disorder can last for weeks, months, or years (National Institute of Mental
Health, 2000). The most important indicators for depression in older adults include
sadness, frequent tearfulness, recurrent thoughts of death and suicide, diminished interest
in pleasurable activities, avoidance of social interactions, difficulty initiating new tasks,
and a family history of mood disorder (Reynolds, Alexdopoulos, & Katz, 2002).

Depression is the most common mental health complaint made by older adults.
The number of individuals who are depressed has increased due to the growing
population of older adults in the 20th Century. In 1960, elders comprised 9% of the
population while today it has grown to 13% (Powers, Thompson, Futterman, &
Gallagher-Thompson, 2002). Depressive symptoms can be as high as 20-31% in the
elderly (Blazer, 1998). Even though effects of old age can seem to mimic symptoms of
depression (e.g. loss of appetite, low energy, reduction in pleasurable activities), it is very
important to note that depression is not a normal part of aging (Blazer, 1998). It is
important to treat mild cases of depression to prevent dysthymia or major depressive
episodes. (Tice & Perkins, 1996)
The major type of depression experienced is secondary or reactive depression due to significant life events in which a person may have problems coping (Zarit & Zarit, 1998). One of the reasons older adults might have these problems may be that the environment is not set up to assist older adults. People use to be valued for their age and wisdom and now they are hardly respected or cherished. With the advancements society is making and the lack of education being transferred to older adults, a gap is created between the generations. This also fosters ageism and prejudice against older adults. An additional cause for reactive depression in older adults is that as one ages, one may encounter more losses in a shorter period of time such as loss of spouse, children, friends, personal control, jobs, finances, power, etc. (Tice & Perkins, 1996). Life may become empty and meaningless. Being that these losses are not controllable, one may feel helplessness and fall into a depressive state. Diminished participation in the community due to physical disabilities, depressed state or lack of resources may increase loneliness (Mehta, Simonsick, Pennix, Schulz, Rubin, Satterfield, & Yaffe, 2003; Tice & Perkins, 1996).

Learned helplessness also plays a major role in developing and maintaining depression. Learned helplessness is the “inability to recognize available choices or to make constructive changes in our lives” (Seligman, 1990). The cause of depression is the expectation that participating in the social environment will be unsuccessful. Because many uncontrollable events are occurring in such a short time period, it has been reinforced that they may feel no control exists over what will happen next (Blazer, 2002).

Recent research has shown that if left untreated, depression can have severe negative effects on the individual, their family, and the community (Williamson &
Schulz, 1995). One of the reasons that depression has gone untreated is under diagnosis. This can be the cause of caregiver’s lack of confidence in identifying depression. Physicians don’t focus on depression when there are more severe illnesses at hand (Reynolds, et al, 2002). Physicians have inadequate psychiatric diagnostic training so they do not recognize symptoms as psychologically based (Reynolds, et al., 2002). Older adults tend to visit a physician rather than a psychologist, being that their main symptoms are somatic complaints. Older adults may also experience depressive symptoms but not at a clinical level (Reynolds, et al., 2002). Depression is one of the most prevalent mental health disorders that affect the elderly and is the most treatable (Blazer, 2002; Chaisson-Stewart, 1985). Treating depression can alleviate other co morbidities including other health or other mental disorders (Ernst, Rand, & Stevinson, 1998).

Treatment

There are many challenges that accompany treatment of mental health issues with older adults. Although there are many techniques that may provide comfort to the individual once they are in individual therapy, one still must get the person into therapy. One of these challenges is the stigma that is related to receiving treatment (Knight, 2004). Although we are moving into an age where it may appear that society has become more accepting of individuals who seek psychological counseling, older adults were not brought up in such an atmosphere. The elderly may still hold beliefs and doubts of the benefits of psychotherapy and are often reluctant to be evaluated by a mental health professional (Tice & Perkins, 1996). A common view of the older adult may be to attribute difficulties to physical illness versus a mental health problem and may be uncomfortable discussing the connection between the two states (Tice & Perkins, 1996).
The central goal of therapy with the elderly individuals, according to Zarit, is restitution (Yost, Beutler, Corbishley, & Allender, 1986). According to Merriam Webster’s Collegiate Dictionary (1997), restitution is “an act of restoring or a condition of being restored, making good of or giving an equivalent for some injury.” Within therapy, one should aim to develop insight, provide symptom relief and relief of strained relations, delay deterioration through adaptation skills, develop skills that will enable the older adult to remain or become active in the community, increase activity by overcoming resistance to new experiences, and increase independence (Blazer, 2002). Therapy is for all ages and can benefit the old as well as the young with the primary objective being to maintain and enhance quality of life (Scrutton, 1997). In the past, some believed that therapy with older adults would not be beneficial being that their behavior patterns are too rigid to constitute change (Knight, 2004). This theory has been tested in several different realms of psychology such as psychoanalytic, psychodynamic, and behavioral approaches (Laidlaw, 2001; Qualls, Segal, Norman, Miederehe, & Gallagher-Thompson, 2002; Rechtschaffen, 1959; Wisocki, 1991). Findings concluded that psychotherapy can have positive results when dealing with the elderly in a variety of mental health issues including depression, insomnia, substance abuse, and improving life satisfaction (Gatz, et al., 1998). Studies have also concluded that psychological interventions are equally if not more effective than psychopharmological interventions. This information is based on self-reports of mood and lower drop out rates in psychologically based treatments (Beutler, et al.; Knight, 1998).

One of the problems with individual therapy is the interaction is limited to the therapist and the client. It does not give many opportunities for direct generation of
activity, companionship or demonstrate the normalness of the problems that may exist (Scrutton, 1997). When therapy is in a group setting, the support within the group can establish credibility to the treatment (Yost, et al., 1986). Group therapy has many additional benefits including lifting morale, receiving the opportunity to learn and share attitudes and behaviors with a larger society. Waters (1990) discusses how group therapy provides an opportunity to find common experiences and/or shared feelings among the group members. This provides the group the opportunity to see the universality of their problems. Group psychotherapy is well suited for elderly due to its opportunity to develop relationships and provides a chance to use problem-solving strategies that will utilize effort to work out life’s complications (Breher, 2001). As well as a means of social support, group therapy allows individuals to directly address stigmas society creates and allows older adults to negate those social stereotypes (Brody & Semel, 1993). It is suggested that smaller groups are formed when working with older adults in order to provide a safe, non-threatening environment. This will also allow individuals with impairments to participate with greater ease (Johnson, 1996).

One particular type of group therapy that might be especially effective for older adults have coping problems with retirement, is brief group psychotherapy. Factors associated with this include isolation, physical illness, financial worries and anhedonia. The brief therapy approach is similar to cognitive therapy, but has additional benefits for the elderly. Brief therapy takes into account the finitude of the older person’s life, conveys an expectation that the patient can master current stress in a short time period, reduces patient’s fear of dependency on therapist, and brings into focus the inevitable termination which may alleviate financial worries (Blazer, 2002).
Although psychologists and advocates feel that psychotherapy in a group environment is beneficial for older adults, many of these older adults may still not see this process as the answer for them. This may be due to the fear of vulnerability within a group of strangers, having to share personal information with people you have never met (Tice & Perkins, 1996). As people age, this fear is thought to become more intense and unlike the younger generations, older adults may have little knowledge about therapy in general. The generation of older adults that exists today were raised to be independent and taught that sharing your problems with others, especially strangers, was very undignified and wrong (Tice & Perkins, 1996). Stereotypes still exist about old age and about therapy that may present a challenge. Some of these may include believing that only crazy people go into therapy, therapy will brainwash me, I am weak if I admit I need help, and/or I am too old to change my ways (Yost, et al., 1986). These maladaptive beliefs may be altered if the person decides to participate in group therapy, but we arrive at the same problem, how does one convince an older adult to participate?

Offering a workshop to older adults who reside in congregate housing enables them to be active participants in a process where they acquire the skills necessary to overcome transition-related challenges. An additional benefit of utilizing a workshop format is that the stigma associated with receiving “mental health treatment” is eliminated, as are the costly bills that sometimes accompany individual psychotherapy. Groups that are designed to increase feelings of self-efficacy can assist older adults in learning and practicing individualized self-care and independence. One benefit of conducting a workshop versus group therapy is that the workshop will be held over a six-week period whereas group therapy can be an ongoing process meeting for any length of
time. This may be a barrier for some older adults who do not want to commit their time to a lengthy process. By advertising a brief workshop, participants will know that they will receive the necessary information in a certain time period versus attending ongoing group therapy where they may perceive that benefits will take longer to obtain.

**Purpose of Study**

The “Shifting Gears” workshop focuses on three strategies that can provide the coping skills associated with transitions common to those who have moved into congregate housing. First, a brief psycho-education portion will be introduced in order to provide information on normal aging processes, myths about aging and facts related to aging and mental health. It was found by the State of Nevada Human Resources Department (2002), that older adults are generally uninformed about “normal aging” subjects. Workshops with a psycho-educational component, such as this one, will decrease ignorance and may increase action taken to maintain health and prevent serious health problems due to neglect and misinformation. This perception can lead to many problems when dealing with transitioning into late life and into new housing arrangements such as congregate housing facilities. By educating older adults about normal aging, physical and mental health, participants’ will begin to learn the connection between mental and physical health and understand that having a mental illness can directly effect a person’s physical health or having a physical illness can directly effect a person’s mental condition.

The second strategy will include adapting assertiveness behavior styles. Assertiveness is the ability to express yourself and your rights without violating the rights of others (Ballou, 1995). Assertiveness training educates people on the difference
between assertive and aggressive behavior, and accepting their own rights as well as the rights of others, as well as, works to reduce cognitive distortions that may inhibit assertive behavior (Lange & Jakubowski, 1976). By strengthening the acquisition of assertiveness techniques in the older adult population, personal competency and effectiveness in dealing with stress should increase.

The third strategy, reminiscence training, is a technique that can compliment assertiveness training by acting as a deterrent to the practice of “learned helplessness.” This process involves reflecting upon one’s personal history, accepting events that occurred in the past, and taking responsibility for past events. It is thought to establish a connection between the events and emotions that are in the past that are currently affecting the individual. The main goal of this process is to integrate acceptance of the past with acceptance of the current self, unifying the person (Rentoul, 1997).

The intent of this project is to design a workshop that combines psycho-education, assertiveness training and reminiscence exercises to maximize the benefits of the three coping strategies. Psycho-education will give participants accurate knowledge about themselves in order to discard irrational beliefs that might have existed regarding their present state. Reminiscence exercises are provided to increase understanding and acceptance of events that have taken place in one’s life, and assertiveness training provides techniques to make the appropriate changes one may need to ensure survival and happiness (Johnson, 1996). Percell (1973) stated that there is a positive correlation between assertiveness and acceptance; in order to obtain an assertive behavioral style, self-acceptance is necessary which will be provided through reminiscence exercises. Both assertiveness training and reminiscence training have been shown to enhance well-being,
improve self-esteem, and alleviate symptoms related to depression and anxiety (see
Chapter 2: Literature Review for citations). This workshop will work to enable residents
to cope with challenges and learn how to make the appropriate changes in their lives,
leading them to greater satisfaction with their current life situation. The workshop also
will strive to improve participants’ mental health, thus increasing internal resources
needed to remain in a community-based setting over an extended period of one’s later
years.
CHAPTER 2

LITERATURE REVIEW

Psycho-education

Misconceptions can trigger several problems that are faced by the elderly, especially concerning health and their control over their environment. As people age, there are a number of myths that exist about aging that need to be corrected. These myths instill fear and loathing of the aging process, which may prevent individuals from experiencing this stage of existence.

The first myth that is important to change is that older people are unhealthy individuals who depend on other people. Most older adults live independently and healthy and value this independence. Along with this myth is the misconception that older adults loose their mental capacity. Although there may be a decline in some areas of intellect, the majority of older adults are able to maintain their daily activities and duties (Cooley, et al., 2004). Mental health issues, such as depression, are also thought to accompany aging as a natural course. It is true that older adults may experience more life situations that may lead to a depressed state, but it is naïve of us to believe that this is a normal part of aging and that nothing should be done to correct this mental state. Older adults can be assisted through therapy and medication and tend to have the same rate of recovery as younger adults (Older Adults Consumers’ Mental Health Alliance, 2004).
The idea that older adults are not interested in sex is another common thought of many individuals; just the opposite is true. In a survey conducted by the Consumers Union of over 4,000 people (ages 50-93), about 75% of men and women responded that they are interested in sex, lead sexual lives and/or enjoy sexual activity (Brecher, 1984). Other common misconceptions include that older adults are rigid, unproductive members of society and growing old just leads us closer to death (Tice & Perkins, 1996).

Our society tends to value youth over old age and it is easy to understand how these common misconceptions continue to grow and are maintained. Until corrections are made in our way of thinking, growing old is going to continue to be a negative aspect of life that is unavoidable instead of realizing that aging is another stage of life that can be a wonderful opportunity to expand and grow as individuals. Many of these myths can lead into learned helplessness. This suggest that older adults are taught that they cannot function normally in society, they are to depend on others and no matter what, their health can only get worse (Blazer, 2002).

Psycho-educational approaches to treatment can be an important addition to any treatment modality being that psycho-education is based on the concept that maladaptive beliefs and behaviors are present due to incorrect or nonexistent information. Therefore, one of the goals of psycho-educational therapy is normalizing the problem at hand (Wilson & Fairburn, 1998). This technique normally consists of providing adequate information about the nature of the problem at hand, methods for treating the problem and promoting attitude and behavior change. These programs tend to be provided to people in a group format in order to facilitate interaction and support (Foreyt, Poston, Winebarger, & McGavin, 1998).
This treatment modality has been shown to reduce binging and purging with mild cases of bulimia in adolescents and adults (Connors, Johnson, & Stuckey, 1984; Davis, McVey, Heinman, Rockert, & Kennedy, 1999; Johnson, Conners, & Stuckey, 1983). It was suggested that psycho-education yielded better results when combined with other treatment modalities such as cognitive-behavioral therapy (Davis, et al., 1999).

McArt, Shulman and Gajary (1999) developed an educational workshop on teen depression and suicide as a proactive, prevention, community intervention. This workshop focused on providing facts about adolescent depression and suicide to parents, children and other adults who work with children. This approach was thought to teach participants about help-seeking behaviors and available community resources. The workshop was developed by a community planning team who met regularly for several months in order to decide on the pertinent information that should be included in the workshop. A pilot workshop was conducted in two high school classrooms. The students in this pilot workshop provided feedback about the content, format and presentation style of the workshop. The workshop was then refined and distributed in the community. The researchers believe that the project was well received in the distribution area and they are pushing for more primary and secondary intervention models for the future. This study, however, fails to provide any statistical data on the effectiveness of the workshop provided and relies solely on comments and direct experience with the population participating in the workshops. This makes it difficult to report whether or not the intervention was actually effective in reducing teen depression and suicide.

A psycho-educational workshop was created for depressed patients, their family and friends by Jacob, Frank, Kupfer, Cornes and Carpenter (1987). This study had two
primary objectives. The first objective was to increase the family’s ability to help the patient and to personally cope with the problem. The second goal was to normalize depression and present depression as a valid illness in which an individual cannot control. In order to achieve these goals, the workshop consisted of material about depression and its management as well as a rationale and designs of various treatments. Basic coping skills were provided to the family of the depressed individual, as was an opportunity to interact with others who have had similar experiences with the disorder. The workshop was divided into a morning and afternoon session and was conducted by staff members at the University of Pittsburg.

The morning session was attended by patients, family, and friends and consisted primarily of general information. In the afternoon, the patients where separated from their family and friends and each group attended a workshop that combined lecture and discussion. The afternoon session for the patients focused on discussing personal experience with depression and how outsiders react when they are depressed. The family and friends afternoon session focused on participants’ experience with depression and the depressed person, how they react to the depression and coping with the patient’s illness. Both groups were conducted in an informal discussion manner with a group facilitator to maintain continuity and provide answers to any questions group members may have.

The workshop was evaluated using a form that contained 16-question on a five point Likert-scale that rates the usefulness of the workshop, workshop presentation and how easy the information was to understand. Responses varied from 1 indicating “nothing” and 5 indicating “a great deal.” The mean age of participants was not reported in this paper. The majority of the family members and friends found the workshop to be
moderately to extremely helpful and believed that the information was presented clearly. They also reported that the interaction with other people was valuable and provided emotional support and a new insight into their present situation. Although this workshop appears to have met the primary objective of the study, it lacks quantitative measure of attitudes, beliefs, and distress prior to and after the intervention. This study also failed to measure the impact the workshop had on the participants with depression and only concentrated on the family, friends, and others in direct contact with the patients (e.g. Co-workers). The study would also be improved by an adequate follow-up data collection in order to detect the ongoing effects of the process.

A similar study was conducted on elderly patients with recurrent major depression. The idea of the workshop and the workshop design was based off the previously discussed study conducted by Jacob et al (1987). Subjects for this study consisted of 161 patients, aged 60 and over, with non-psychotic major depressive episodes. Each workshop consisted of 8-12 people. Participants were simultaneously involved in additional treatments such as individual psychotherapy and pharmacology interventions. The goals of this workshop seem relatively unclear although they report that post workshop, medication adherence and outcomes of continuous individual treatment were improved compared to individuals who did not participate in the workshop. Dropout rate was also more than three times greater in individual treatment in people who did not attend the workshop. One of the problems with this comparison is that people were not randomly assigned to either participate in the workshop or not. The comparison group was formed by using statistics on people who refused to attend the workshop in which one could assume they might be aversive to therapy altogether.
Family members who participated in the workshop filled out the same 16 item Likert-scale utilized in the previous study discussed and it was noted that several family members were interested in more support group meetings and additional workshops. The results of this study do indicate that families and friends of elderly people with depression feel that they benefit from psycho-educational workshops, but all other claims seem to need additional research to support their assumed results (Sherrill, Frank, Geary, Stack, & Reynolds, 1997).

Rokke, Tomhave, and Jocic (2000) compared the effects of self-management therapy, educational group therapy and a wait list group for depressed elders. Forty participants were included in this study and were at least 60 years or older. Participants were randomly assigned to one of the three groups. Self-management therapy was conducted in a group format with only three-five participants in a group. This weekly treatment was one and a half hours in duration and continued for 10 weeks. Sessions consisted of rational for self-management therapy, introduction to techniques (e.g. self-monitoring, pleasant events scheduling), identifying cognitions that contribute to depressive symptoms, homework and goal setting. The educational support group met that same as the self-management group and also consisted on only three-five participants. Content of the sessions began with information about the definition of depression, common treatments and provided reading material on the topics. The sessions moved on to discuss the four main treatment modalities of depression (psychodynamic, interpersonal, learning, and cognitive). The second half of each session was dedicated to group discussion, which was managed by the facilitator. The results of this study indicated that people in both treatment groups significantly improved (89% no longer
meeting criteria for depression) when compared to the wait list group (59%). There was no significant difference between treatment modalities and both maintained improvement at a one-year follow-up. The results of this study, although positive, should still be taken cautiously due to small sample size. The benefits of the treatment cannot be specifically noted to one type of treatment, but may be due to similar components such as a supportive group atmosphere and general education on depression. Further studies are needed to conclusively support the results obtained in this study.

Psycho-educational components to therapy seem to be beneficial although more concrete data needs to be established to learn their true significance to treatment modalities. However, even though benefits are not accurately measured, providing education regarding illness, treatment and removing myths can hardly seem damaging to a population and may lay the groundwork for being accepting new behavior and cognitive changes to improve self-esteem and life satisfaction.

Assertiveness Training

A forum was created to allow seniors to be major decision makers in plans for implementing different programs in their community. This workshop was successful, and many programs run by the seniors have been implemented and maintained since the workshop. The group also decided that they enjoyed the process and wanted to continue to meet and pursue new projects. The purpose of this Forum was about seniors keeping their rights and responsibilities. The impact of this forum shows that being independent and taking charge of their lives and activities in their community has an impact on their quality of life and independence (Pilpel, 1995). Given this information, an important aspect of the workshop will focus on the seniors taking control of their own lives.
Implementing goals and activities and believing that one has a certain amount of control over their lives during this time period. The main training used to obtain this goal will be assertiveness training.

The term assertiveness training was created in 1958 when Wolpe considered assertiveness responses would be beneficial in relieving social anxiety (Temple & Robson, 1991). Assertiveness is the ability to express yourself and your rights without violating the rights of others. It is appropriately direct, open, and honest communication that is self-enhancing and expressive. Believing that one is important and having the ability to communicate effectively is important to an individual’s mental health and success in daily life situations (Ballou, 1995). Assertiveness training provides individuals with the opportunity to learn and enhance these techniques through role-play, modeling, rehearsing, and homework (Ballou, 1995). Assertiveness training was found to be most effective in a group format due to the social support, feedback, and the ability to practice with others (Cormier & Hackney, 1993).

Assertiveness training is appropriate for older adults for several reasons. Older adults are often characterized by a sense of “learned helplessness,” and this is a contributing factor in lacking assertiveness skills. It has been well documented that an older adult’s sense of control can have a direct effect on their well-being. It is suggested that older individuals who feel that they have some degree of control of their lives are more active, alert and have lower mortality rates than do individuals who feel that they have no control over what takes place (Johnson, Stone, Altmaier, & Berdahl, 1998). Assertion problems can stem from mood disturbances, hypochondria, low self-esteem
and complaints of dominance by others. Since these are common problems among older adults, assertion training would seem an optimal approach to enhancing well-being.

Assertiveness training has two major goals. One is to reduce anxiety and the other is to increase related skills. Assertiveness training works to educate people on the difference of being assertive verses being aggressive. It also assists people in accepting their own rights and the rights of others, aids people in reducing cognitive distortions that may inhibit assertion, and works to enhance assertive skills through practice (Lange & Jakubowski, 1976). This training can be helpful for people who are unable to assert their rights or feelings, who are too aggressive, and/or for individuals who experience depression and/or anxiety.

Assertiveness training has been found to be effective in alleviating and preventing relapses of mild depression (Sanchez, Lewinsohn, & Larson, 1980). Ball, Kearney, William, Dewhurst-Saveellis, & Barton (2000) conducted a longitudinal study on sixty-one participants (mean age 41) that had been diagnosed with major depression or dysthymia and had comorbid personality disorders. This sample was divided into two groups. One group received only cognitive behavioral therapy and the other received both cognitive behavioral therapy and assertiveness training. In this study, participants were not randomly assigned to one of the two groups. Participants whose primary need was to develop mood control techniques were placed in the CBT group, and those who had a range of mood and interpersonal problems were assigned to the combined group program. No significant difference between these two groups was found at pretreatment. Both the cognitive behavioral therapy group and the combined group met over a five-week period. Sessions were held twice a week and were two hours long. Each group had
a minimum of four participants and a maximum of eight participants in order to maintain a small group. Cognitive Behavioral Therapy treatment was based from Beck’s therapy manual and consisted of education in the cognitive model, thought monitoring and evaluation, verbal challenging skills, behavior hypothesis testing, pleasant event scheduling and goal setting. Meanwhile the groups with added assertiveness training therapy participated in education concerning the association between social skills, relationship satisfaction and mood; monitoring of problematic interactions; body language skills; anxiety control training which consisted of breathing and muscle relaxation exercises; training in assertive script preparation, request, refusal and conflict resolution skills. Findings showed that the cognitive behavioral therapy group improved from severely depressed pretest and mildly depressed at posttest and follow-up. In the assertiveness training group, depression scores changed from moderate depression at pretreatment to mild at post treatment. There was also a decrease in the level of depression at the follow-up, but it was still higher than those of those of reported control groups.

Since older adults are often characterized by a sense a learned helplessness, assertiveness training would seem to have an impact on co-occurring depressive systems (Dobia & McMurray, 1985). It has been well documented that an older adult’s sense of control can have a direct effect on their well-being. It is suggested that elderly individuals with internal locus of control beliefs are more active, alert and have lower mortality rates than individuals with an external locus of control (Johnson, et al., 1998). Locus of control can specifically be related to life satisfaction and effective coping styles in older adults. Older adults tend to have a greater tendency towards possessing external locus of control
beliefs when compared to a younger population. Although, this is currently under debate in the research, the myth that a decline of personal control exists with regards to aging (Rhee & Gatz, 1993). Krouse (1987) found that older adults with internal locus of control beliefs are less likely to experience psychological distress in relation to financial strain. This in turn, has a great training chance at improving depressive symptoms among the elderly related to financial strain. Given this information, assertiveness training may be able to reaffirm an existing sense of internal locus of control or instill a greater sense of internal control if one is lacking.

McKibbin, Guarnaccia, Hayslip, & Murdock (1997) suggested in their research that changes of locus of control are more influential when looking at Domain-Specific State Locus of Control versus Trait Locus of Control. Uncontrollable life events that are common in the elderly could impact Domain Specific beliefs, but a person's overall Locus of Control appears to remain relatively stable. This conclusions stems from sampling community dwelling older adult widows participating in a widow support group over a six week time span (McKibbin et al., 1997). A stronger intervention may result in a change in both Trait and Domain-Specific Locus of Control.

In a study conducted by Lazarus (1981), after implementing assertiveness training, the subjects' sense of control and communications skills both improved. However, it was suggested that assertiveness training should be conducted along with other techniques such as cognitive-behavioral therapy, for maximum effectiveness of relieving depression. Riedel, Fenwick and Jilling (1986) also found significant improvements in depression, but noticed that it is better maintained when utilizing
booster sessions. They concluded that learning assertiveness techniques is a continuing process.

Temple and Robson examined the relationship between self-esteem and assertiveness in 1991. They wanted to determine the effectiveness of assertiveness training on individuals with poor self-esteem in a hospital setting and community dwelling individuals. The patients in the hospital setting (mean age of 30) attended a two-day workshop (two days were divided, with one day per week- number of hours were not provided), while the community classes (mean age of 40) were held for one and a half hours once a week for eight weeks. The curriculum was consistent for both groups and the same person conducted all workshops. Material covered included personal rights, the four modes of communication, use of body language, saying “no”, coping with criticism and put-downs, expressing feelings and anger effectively, strategies on particular situations and role-play situations relevant to participants. This study did find that self-esteem significantly increased with assertiveness training and the results were maintained for several months. The improvement of the community sample and the hospital sample were similar, although improvement in the hospital sample could be attributed to several factors (i.e. additional medical and/or psychological treatments). The researches noted that, to their knowledge, the community sample participants were not receiving additional treatment so success could be attributed to the classes.

Corby (1975) mentioned that assertion training has been very successful with a variety of populations such as juvenile delinquents, women, college students, etc., although it has not been thoroughly researched with regards to older adults. Being that it is a problem-solving oriented treatment, it should generalize across population and may
be well suited for older adults. Assertion problems can tend to stem from mood
disturbances, hypochondria, low self-esteem and complaints of domination by others.
Being that these problems occur often among older adults, assertion training would seem
an optimal approach to enhance well-being. Even when placed in a congregate
environment, where one may assume that excellent staff and many activities provide care
and support systems are available, residents may often have concerns that are not being
expressed. Assertiveness training may be able to provide older adults with the tools
necessary to effectively change their environment and improve their current life situation.
While unassertiveness may not cause depression in older adults, deficits in assertion have
been associated with depression in many populations. In many cases, the cause of
depression, however, can be linked to a lack of social support. If an individual does not
possess assertiveness skills to seek out necessary social support, depressive symptoms
can occur (Kogan, Van Hasselt, Hersen, & Kabacoff, 1995).

Few studies have been conducted that look at the direct effects of assertiveness
training in older adults. Alice Franzke (1987) conducted research on the effects of
assertiveness training on non-clinical older adults (over the age of 65). Participants were
given a 6-week course in assertiveness training. Sessions began by administering pre-test
instruments and providing participants with an explanation of assertiveness training.
Following sessions included discussion of the different types of behavior, modeling and
role-playing assertive behavior techniques, and discussion on forces blocking
assertiveness behaviors. Participants were given homework assignments to practice their
learned behaviors and engaged in many scenarios within the workshop that directly
pertained to their lives. By reviewing the scores of the Assertiveness Inventory and the
Express Acceptance of Self scale, this study found that assertiveness training is an effective method for improving individual empowerment for older adults and can increase their quality of life. One factor that might influence results was socioeconomic levels. Participants who had a lower SES were less affected by the treatment. It is suggested that these individuals have been exposed to a long history of negative self-image due to their economic situation, and this treatment may be effective if conducted over a longer period of time. Franzke suggested that there is a need to evaluate long-term effectiveness of assertiveness training, especially when dealing with short-term group training. Another research venue that should be considered is the effect of religious beliefs on assertiveness. Franzke suggested that some might adapt a passive role in problem situations being that their attitude is that the situation is “God’s Will.” Upon further investigation, research on theology and assertiveness training, Sanders and Malony (1982) suggested that many believe that assertiveness conflicts with Christian teachings that emphasize self sacrifice and by being assertive is seen as going against the teachings of the bible. Several authors, Sanders and Malony included, have researched the bible for examples of how Jesus promotes assertion and was assertive himself (Sanders & Malony, 1982; Moy, 1980; and Jones, 1984). Many would still agree that assertiveness is a proper attitude to have when dealing with promotion of faith, but should still not be used for personal gain. Examples of how Jesus used assertiveness in his personal endeavors were also cited to cease this myth. Assertiveness skills can all people of faith to negotiate in their business and personal life in a manner that will allow solutions to be reached where all parties involved are satisfied and foster good, healthy relationships (Sanders and Malony, 1982) Currently, workshops do exist that specifically
address assertiveness in a religious community in an attempt to dispel the myth that it is going against one’s faith to act assertively whether it be on behalf of God or for personal situations. This study will examine the implications level of religiosity has on current assertive behaviors as well as its influence on change in behaviors with regard to assertiveness.

**Late Life Review**

Reminiscence therapy uses past stories to remember the good old days and to find coping strategies used then that might be applicable today. There are three different types of reminiscence: (a) informative— which is a pleasurable recollection of favorite stories; (b) evaluative—structured personal history to explore strengths and weaknesses to achieve resolution, and (c) self-acceptance and obsessive—stuck in counterproductive activity of retreating to the past to escape present (Erwin, 1996).

In 1963, Butler wrote a paper on the Life Review Process. This article demonstrated Butler’s interpretation of reminiscence. This process involves reflecting upon one’s personal history and accepting what has happened in the past, and being able to take responsibility for those actions. This process is thought to establish a connection between the events and emotions that are in the past with their current person. The main goal of this process is to integrate acceptance of the past with acceptance of the current self, unifying the person (Rentoul, 1997).

Previously reminiscence was seen as an escape for older adults to better times where they were comfortable, desirable and youthful. That image has changed; it is just the opposite. Done correctly, reminiscence can be viewed as the final adjustment to late adulthood. We all go through stages in life and part of moving into the later adulthood is
life review. This will assist in adjusting to loss, retirement, and the other transitional problems that were previously discussed. By reviewing life’s positive and negative achievements and events, each individual will be able to understand the true value of their life as it is to them. Butler (1963) believed that without this process, older adults are susceptible to fall in to despair and depression.

Butler’s ideas of life review are parallel to Erikson’s work on development. Erickson believed that adjustment in late life was dependent on one’s ability to adapt to the wins and losses in one’s current situation and previous life experiences (Erikson, 1950). As people move into the later stages of life, they experience an identity crisis that can be eased by looking back on life with acceptance and respect (Bornat, 1997). If this does not occur, they may look back on their life full of regret and remorse (Tinsely & Bigler, 2001). However, both Butler and Erikson have recognized that this behavior can become pathological. The outcome of life review should be to “accept one’s one and only life and to find some meaning in it” (Rentoul, 1997).

Due to these components, life review seems a good strategic therapy for use with older adults to alleviate depression and enhance self-esteem throughout their later years. Life review is beneficial in many ways for older adults. Elders frequency rely on their past to help them cope with current stressors. This form of therapy can promote self-esteem and self-worth in an individual (Magee, 1988).

Havighurst and Glaser (1972) suggest that remembering enhances adjustment, self-acceptance and ego strength, although, a review done by Coleman (1986) demonstrates there is a fair amount of variability in the research on the benefits this therapy. Boylin, Gordon, and Nehrke (1976) discovered, in their research, that
reminiscing is positively correlated with life satisfaction and present adjustment. In a literature review conducted by Bucchel (1986), it was discovered that people who engaged in this therapy were found to be less depressed and had higher self-esteem. From these studies, one can conclude that life review has contents that induce self-esteem and reduce depression though discovering and acknowledging self-worth. Research has shown that reminiscence exercises can be used successfully as coping strategies with older adults and also can be administered with great success in a group setting and is positively correlated with life satisfaction and present adjustment in older adults (Boylin, et al., 1976).

Cognitive-behavioral therapy, reminiscence and activity treatments were conducted in a group format with the elderly (65+) to determine effects on life satisfaction and anxiety (Scates, Randolph, Gutsch, & Knight, 1986). This study consisted of equal division of participants into one of three treatment groups listed above. Each group met for six one-hour sessions that were held twice a week. The reminiscence groups consisted of didactic lecture, discussion, and homework. The activities (lecture, discussion and homework) in the reminiscence group emphasized integration of the past with the present. The results of this study were non-significant regarding improvement in life satisfaction and anxiety in all three group therapies. However, they did find a trend that appeared to favor the reminiscence group for anxiety at the follow-up. This could be attributed to lower stat anxiety scores at initial testing or that reminiscence has a positive effect on state-anxiety. The latter theory supports the belief that reminiscence offers a pleasant experience that has a positive effect on mental health. In order to obtain more significant results in future studies, the authors suggested that future research should
include elderly individuals who do and do not have confidents and/or who do not have a high level of community support in order to review the effects on treatment outcome. This will provide an opportunity to see if reminiscence is more pertinent for people with less of a social network. Participants may also want to be prescreened for levels of anxiety and life satisfaction being that reminiscence may have more of an immediate and direct effect for those who are currently distressed. Highly anxious individuals or individuals who are highly dissatisfied with life have a higher range for improvement and would serve as a better gauge of treatment effectiveness.

In a study that reviewed reminiscence therapy with depressed older adults, reminiscence therapy was compared to Social Problem-Solving Therapy (Arean, Nezu, Schein, Christopher, & Joseph, 1993). Participants included 75 individuals who were over the age of 55. Treatments were conducted in a group format and implemented over a 12-week period, one session per week lasting approximately one and a half hours. Reminscence therapy focused on participants reviewing their life histories in order to gain perspective of their past, acceptance of their past, and utilization of past experiences to assist with current dilemmas. Weekly topics were discussed that worked towards acceptance of one’s life, enhancing resolution of unresolved conflicts and encouragement to pursue future goals to enhance meaning in life. Problems solving group sessions focused sessions on better defining nature of problems, generating a range of alternative solutions, evaluating consequences of solutions, and monitoring outcomes of implemented solutions.

Results indicated significant improvements in depression symptoms for both treatment modalities when compared to a wait list group. Furthermore, 64% were
considered to be in remission at post-treatment. This study did find that the problem-solving group reported significantly less depression as measured by the Hamilton Rating Scale for Depression and the Geriatric Depression Scale when compared to reminiscence therapy. Participants in the problem-solving group also maintained their levels significantly more than those in the reminiscence group. The authors mentioned the examination of allegiance to a particular form of therapy should be assessed in future research and may have had influences in this particular study. Three therapists conducted both forms of treatment, but they each had a supervisor for each modality and were thought to have had equal influence of the effectiveness of that modality. Although it was not believed to affect this research study, it should be examined in future studies in order to assure this has no impact on outcome.

Weiss (1994) was interested in comparing the effects of cognitive group therapy with life review group therapy in a group of older adults (age not specified) residing in a long-term care setting with regards to levels of depression and life satisfaction. Forty-eight members of a personal care home volunteered to participate in the project. The participants were randomly divided into five groups, all of which had the same title, “Senior’s Speak Out.” Each group consisted of approximately 10 members. Two groups received cognitive therapy, two received life review therapy and one group was utilized as a control group. Groups met weekly for eight weeks with each session lasting approximately one and a half hours. Materials in both treatment groups were used from published manuals. These published manuals included Group Cognitive Therapy: A Treatment Approach for Depressed Older Adults by Yost et al., and Life Review and Experiencing Form by Haight. Two therapists with equal education lead one cognitive
therapy group and one life review group. The results indicated that the treatment groups all had a significant increase in perception of meaning and purpose in their life when compared to the control group, however the groups did not significantly differ from each other. Suggestions from the author to improve results of the study include increasing facilitators' awareness of the therapy program by having them participate in a similar weekly group therapy program. It was also suggested that cognitive group therapy and life review should be combined in order for the participants to review their lives, re-evaluate dysfunctional conceptions and utilize other cognitive techniques. Older adults may feel more comfortable with their past and see it as a time where they had more control over their lives whereas, cognitive therapy tends to concentrate more on the present. A combination of these therapeutic techniques would allow them to do both and may provide a more comfortable experience during the group process.

Stevens-Ratchford (1992) researched the effects of life review reminiscence activities in a group of well older adults (mean age 79.75 years). The participants went through 6 sessions of life review therapy, doing two sessions a week. These activities consisted of persons engaging in past-oriented thinking and discussion after being presented with nostalgic materials. The materials would be shown, and then the participants would have time to think about their reactions. The remainder to of the hour was left for discussion. No significant differences were found between pre and post-test self-esteem and depression scores. This may be due to the fact that both groups had relatively high self-esteem and did not present with depression at the onset of the treatment. Participation in this study did not negatively affect the group of well older adults.
adults and is still thought to be a worthwhile experience. Limitations of this study included a small sample size.

Hypothesis

The intent of this project is to design and evaluate the effectiveness of a workshop that combines psycho-education, assertiveness training, and reminiscence exercise in order to maximize benefits of the coping strategies utilized. Shifting Gears was designed to educate older adults residing in congregate housing about basic coping strategies for common stressors in their lives in order to meet the following objectives: (a) learning assertive behavior styles; (b) increasing life satisfaction; and (c) enhancing self-esteem.

Secondary objectives include: (a) relieving depressive and anxious symptoms in individuals where symptoms exist, and (b) examining the influence of religiosity on adapting assertive behaviors from this workshop (Rohrbaugh & Jessor, 1974); and (c) determining the impact this workshop has over locus of control.
CHAPTER 3

METHODS

Participants

A power analysis was conducted using the G-Power computer program. To detect a large effect size of 40, with a power level of .80 and an alpha of .05, the number of participants needed for the analysis planned was 52, thus 60 participants were recruited. Participants included older adults (60 years and older) who resided in congregate housing facilities in the Las Vegas Valley.

Properties

Participants were recruited from six different senior housing complexes in Clark County. Originally, only properties managed by Nevada HAND were to be selected, but recruitment proved to be challenging at these properties. Management was contacted to determine which properties could be solicited. Only four properties received enough responses to signify a workshop. These properties included Sierra Pines, Rochelle Pines, Capistrano Pines and Bonanza Pines. All properties were rent subsidized at about 60% of mean area income. Once recruitment was determined to be problematic at the Nevada HAND facilities, other senior housing complexes were contacted that was similar to the Nevada HAND housing structures. The properties that were selected were run by the City of Las Vegas, income graded, and offered similar activities as the Nevada HAND
properties (group games, shuttle services, and the presence of an activities coordinator).

Two properties elicited a response to conduct a workshop, James Down Towers and Sartini Plaza. One workshop was offered at each of the six properties listed above.

Measures

Demographic Information

Demographic information assessed included age, gender, race, religion, marital status, living arrangements, education, health status, current psychological treatment, and current psychotropic medications. To access race, individuals were asked to circle whether they affiliated themselves with being Caucasian, African American, Hispanic, Asian/Pacific Islander, American Indian or Other. For religion, options included Christian, catholic, Jewish, Muslim, Buddhist, or Other. Asking participants to circle whether they were single/never married, married, widowed, or divorced on the form provided assessed marital status. Living arrangements assessed whether individuals were living alone, with a spouse or with others. Having participants indicate what level of schooling they had completed assessed level of education. If respondents indicated some college, it was coded as 14 years of education. If they indicated that they had completed college it was coded as having completed 16 years of education. This questionnaire also assessed personal perceptions of current health status. This was assessed by having participants self rate their health status on a scale ranging from 0-10, with 0 being poor health and 10 being excellent health. Lastly, an assessment was done to inquire about current mental health treatment and/or current psychotropic medications. This information was asked in a yes or no format.
Self-Efficacy

The Self-Efficacy Scale (SES; Sherer & Maddux, 1982) is a 30-item instrument developed to assess generalized self-efficacy. This measure asks respondents to endorse questions on a 5-point scale stating the extent to which they agreed with the statement presented. The scale has two sub-scales, General Self Efficacy (17 items) and Social Self-Efficacy (6 items). The seven remaining items on this scale are filler questions. Validation of this scale was conducted using college students in introductory psychology classes. Construct validation showed a moderate positive relationship with the Rosenberg Self-Esteem scale (.51) and a small positive correlation with Rotter’s Internal-External Locus of Control measure (.28). To demonstrate criterion validity, 150 inpatients, which were being treated for alcoholism, were given a vocational history assessment and the SES. It was determined that high scorers on the subscales of the SES were more likely to be employed, quit fewer jobs, and have been fired less frequently. It seemed that in both studies, the General Self Efficacy scale was more highly correlated the Rosenberg’s Self-Esteem scale and the Rotter’s Internal-External Locus of Control scale than the Social Self Efficacy subscale. Therefore, only the General Self Efficacy Scale was utilized in this study’s analyses. Smits, Deeg, & Bosscher (1995) researched well-being and control in 90 Dutch older adults (ages 55-89) utilizing the General Self-Efficacy scale. They reported means of 47.35 (SD = 6.90) in this population of normal older adults. Their study indicated that this measure had acceptable reliability and validity and may be useful in determining treatment efficacy Cut-off scores were not indicated, but it was suggested that higher scores are indicative of higher self-efficacy. The SES has been used to measure generalized self-efficacy beliefs in adults aged 55 and older (e.g. Bourland,
Self-Esteem

Rosenberg's Self Esteem Scale is simple to administer and is a valid and reliable measure of self-esteem (Rosenberg, 1965). It has been utilized with older populations in several studies (George and Bearon, 1980). It was reported that its test/retest reliability is \( r = 0.85 \) and correlations with other self esteem measures range from \( r = 0.56 - 0.83 \). This scale contains 10 items that are responded to via a rating scale ranging from strongly agree to strongly disagree. The scores on this scale range from 10-40, with higher scores indicating a higher level of self esteem and lower scores indicating a low level of self esteem (Crandal, 1973). Cut-off scores were not provided for this measure and no normative data is available. Gilbert and Meyer (2005) reported means of 19.3 (SD = 4.71) for college age women. Means were not available for this population. This scale is easy to administer, brief, and evidence suggest that it is appropriate to use with older adults populations (George & Bearon, 1980).

Quality of Life

Participants completed two quality of life scales, the Quality of Life Inventory (QOLI; Frisch, 1994) and the Life Satisfaction Index-Z (LSI-Z; Wood, Wylie, & Shea, 1969). Two measures were administered due to the domain-specific nature of the Quality of Life Inventory and due to the fact that the LSI was designed specifically for use with older adults to assess successful aging, whereas the QOLI was designed for ages 17 and older.
The Quality of Life Inventory is a 16-item scale that assesses satisfaction with 16 life domains (e.g. self esteem, money, work; Frisch, 1994). The importance of each domain is judged by the participant on a 3-point scale (0 = not at all important, 3 = very important) and satisfaction within each domain on a 6-point scale (-3=very dissatisfied; 3=very satisfied). Scores on this measure range from -6 to 6 and are divided into four categories: very low (-6-.8), low (.9-1.6), average (1.6-3.5) and high (3.6-6). The psychometric properties of the measure indicate that it is a valid and reliable measure of life satisfaction (Frisch, 1999). To obtain psychometric properties, this scale was distributed to a non-clinical population that was sampled from 12 states from all areas of the country. The average age of the participants in this sample was 38.8 (SD=12.0). Means scores for the standardization sample (n = 520) are available for White (2.5; SD = 1.3), African American (2.4; SD = 1.5), Hispanic (2.8; SD = 1.3), and Other (3.4; SD = .8) females. Mean scores for the standardization sample (n = 278) are available for White (2.4; SD = 1.2), African American (2.4; SD = 1.3), Hispanic (3.0; SD = 1.0), and Other (2.6; SD = .1) males. The average mean for the female sample was 2.6 (SD = 1.3), 2.5 (SD = 1.2) for the male sample, and 2.6 (SD = 1.3) for the total sample. Statistical analysis revealed high internal consistency (.79). Other measures were given simultaneously to evaluate convergent and discriminant validity. Analysis determined that the QOLI was significantly and positively correlated with both measures (r = .56 with Satisfaction with Life Scale; r = .75 with the Quality of Life Index).

The Life Satisfaction Index-Z is a shorter version of the Life Satisfaction Index-A, which assesses contentment and satisfaction in life in an older adult population. This scale contains 13 statements in which each item is rated on a 0-2 point scale, with higher
scores indicating greater life satisfaction; specific cut-off scores were not suggested. One hundred older adults from Kansas were mailed this measure to determine its reliability and validity with an older adult population. The mean score on this scale was 11.6 (SD = 4.4). No normative data was available for this group (George & Bearon, 1980). This measure demonstrated adequate internal consistency (coefficient alpha = .79) and discriminant validity ($r = 57$) among old adults (Wood, Wylie, & Shea, 1969).

**Depression Scale**

The Geriatric Depression Scale is a 30-item measure of depression that utilizes a yes-no answer format. The initial validation study indicated high internal consistency, with alpha of .94, and high convergent validity as indicated by a correlation of .83 with the HRSD. Mean scores of 5.75 were reported for a normal population, 15.05 for mildly depressed persons, and 22.85 for severely depressed older adults (Yesavage, et al., 1983). It was suggested that a cutoff score of 10 be used, with scores of 11 or higher indicating depression. This cutoff score has been determined to be extremely accurate for outpatient older adults with a sensitivity of .96 (Olin, Schneider, Eaton, & Pollock, 1992).

**Anxiety Scale**

The State-Trait Anxiety Inventory (STAI; Gaudry, Vagg, & Spielberger, 1975) is a 40-item scale that measures both A-State anxiety (20 items) and A-Trait anxiety (20 items). This measure requires individuals to indicate the intensity of their feelings at the moment they are completing the measure (A-State Scale) and the intensity of how they generally feel (A-Trait Scale) on a four-point scale ranging from Not at all (1) to Very much so (4). Higher scores indicate higher levels of anxiety. This measure of anxiety has been acclaimed to be a carefully developed instrument, from both the theoretical and
methodological standpoints. Normative data is available for working adults. This group is further divided into three age categories and separated by sex. The age groups consist of 19-39, 40-49, and 50-69. The means for the most relevant group to the current study, ages 50-69, for State anxiety are 34.51 (SD = 10.34) for males and 32.20 (SD = 8.67) for females. For Trait Anxiety the mean scores were 33.8 (SD = 8.86) for males and 31.79 (SD = 7.78) for females. It was noted that mean anxiety score for ages 50-69 were lower than the other two age groups. Both scales have demonstrated a high degree of internal consistency, however, the A-Trait scale has been found to have moderate test-retest reliability (.73-.86), while the A-State scale reliability has been found to be in the low to moderate range (.16-.54). The original statistics were developed from college students. Measures from college students were correlated with an adult sample and demonstrated (r = .75) that reliability and validity would be consistent across these age groups.

**General Psychopathology**

The Brief Symptom Inventory (BSI; Derogatis, 1983) served as an overall measure of psychopathology for the participants in this study. The BSI contains nine primary symptom dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and three global indices (global severity index, positive symptom distress index, and positive symptom total). The BSI has four distinct normative samples, which include adult psychiatric outpatients, adult non-patients, adult psychiatric inpatients, and adolescent non-patients. The adult non-patients sample is most appropriate for the current study. The normative data for the Global Severity Index indicates a mean score of .25
(SD = .24) for males, a mean score of .35 (SD = .37) for females, and a mean score of .30 (SD = .31) for the total population (Derogatis, 1993).

This measure is a short-form of the SCL-90-R containing 53-items that are rated on a five-point scale. This instrument is estimated to take 8-10 minutes to complete. This measure is often used in measuring patient progress in treatment or in assessing treatment outcomes.

**Assertiveness**

The Rathus Assertiveness Schedule (RAS; Rathus, 1973) was utilized to measure pre and post levels of assertiveness in the participants of the workshop. The RAS is widely used in Assertiveness Training Research and has been shown to have a moderate to high test-retest reliability and satisfactory validity in terms of indicating how a person would behave in specific situations. Subjects indicate on a 6-point scale (ranging from 3= very characteristic of me to -3= not at all characteristic of me) the extent to which they consider each of 30 statements presented to be characteristic of themselves (Rathus, 1973). Janda (1996) suggested that people with a score below -29 might benefit from Assertiveness Training. RAS scores, based on this suggestion, were divided into three categories: high (+29 or over), average (-28 to +28) and low (-29 or below).

**Locus of Control**

Rotter's Internal and External Locus of Control Scale asks participants to choose one of two statements presented, determining which one best describes them. It was developed to measure general locus of control beliefs. A high score on this measure is indicative of an internal locus of control whereas a low score would indicate an external locus of control (Rotter, 1966). This measure was given to middle-aged and older adults.
in a study looking at death anxiety, life satisfaction, and locus of control. The mean for this population was 12.42, indicating relatively high internal locus of control (Trent, Glass, & McGee, 1981). No standard deviations were provided.

Religiosity

The measure of religiosity was developed to cover various aspects of the four dimensions of religiosity conceptualized by Glock (Rohrbaugh & Jessor, 1974). These four components are ritual, consequential, ideological, and experiential. Each subscale contains two-items that compose an eight-item composite religiosity measure. Each item is scored on a 0-4 scale resulting in subscale scores ranging from 0-8 and a composite score ranging from 0-32. Higher scores indicate greater religiosity. In developing this measure, special attention was given the language presented in order to minimize any reference to a specific religion. There is converging support for the measure’s internal reliability and validity. Since this has been shown to be one-dimensional with regard to religiosity, the four subscales were combined into a single, eight-item scale (Rohrbaugh & Jessor, 1974). No normative data is available for this measure. However, it was indicated that college males had a mean score of 12.5 and college females had a mean score of 12.7 on this measure. No standard deviations were available Measure.

Program Evaluation

A program evaluation was designed to solicit participants’ feedback regarding the workshop. Areas assessed included materials, presenters, and the information in the program. Samples of questions included: to what extent did this program increase your understanding of the subjects, knowledge of the subject by the presenter, and overall quality of the materials. For these questions, participants indicated their assessment by
rating these items as being poor (1), fair (2), good (3) or excellent (4). Scores ranged from 13-52, with higher score indicating a better program. Questions were also asked whereby participant provided free responses such as: “Would you recommend the program to anyone else?” and “What did you like most and least about the program?” These recommendations were considered for program revisions.

Procedure

Three graduate students from the UNLV Clinical Psychology graduate program and two staff members from Nevada HAND committed to facilitate at least two workshops. All facilitators attended a mandatory training session that reviewed in depth, the implementation details of the workshop, the topics to be discussed, and provided the opportunity to role-play exercises included in the manual with other facilitators.

A series of workshops was then administered to residents of congregate housing properties in the Las Vegas valley. Participants were recruited through flyers around the complex, flyers delivered to the resident’s apartments, a monthly news article provided by the apartment complex, and a general announcement made at other activities provided by the complex. Participants were able to sign up for the workshop at designated areas in their facility. Each workshop was limited to 14 participants. The properties were randomly assigned to either begin the workshop immediately or to have a six-week delay from the time the participants filled out their first set of paperwork. The delay group completed measures after the six-week delay, prior to the start of the workshop, and at the other designated data collection times. Data was collected at the facilities during scheduled times one week prior to the first session and at the end of the last scheduled session for some properties. Due to difficulties explained in more detail in the discussion
section, some post-workshop data was collected after session 5. A three-month follow-up data collection was conducted at each property. At the last session, participants were informed that they would be contacted in three months to fill out the paperwork one last time. At this time, they were also be given information with the specific date and time that they would be asked to complete the paperwork at their property. Approximately two weeks prior to the three-month follow-up, participants were reminded by a flyer of this date and time.

**Manual Development**

The main ideas and concepts for the majority of the workshop, which is assertiveness training, was obtained from Paterson’s (2000) book entitled, “The Assertiveness Workbook: How to Express Your Ideas and Stand Up for Yourself at Work and In Relationships”. Reminiscence activities were included every week that were related to the current discussion topics. Information from the psycho-education portion of the workshop was selected based upon primary misinformation topics identified previously in this paper, which included basic transitioning (e.g., health and loss) and current myths about aging. The participants’ workbook was designed to augment the participants’ understanding of the material by having a written guide to follow along with the facilitator. The information was similar to that of the manual minus the extensive detail regarding discussions and directions for the facilitators. The participants’ workbook had room for the participants to make their own notes and comments regarding the material and served as a resource after the workshop was completed. The workbook also included exercises for the participants to engage in.
Treatment Description

This program was designed to educate older adults residing in congregate housing about basic coping strategies for common stressors in later life. Problems that were focused on included roles transition, loss, and isolation. Coping strategies used included psycho-education about transition issues and related mental health issues, assertiveness training, and reminiscence exercises.

This information was dispersed via a workshop that included lecture, handouts, and group discussion. The workshop was divided into six, two-hour sessions that ran consecutively for six weeks. Each individual session was as follows:

Session 1:
- Review Group procedures and what will transpire over next 5 sessions
- Review transition issues
- Educate participants about negative effects of these issues
- Briefly go over some normal aging effects
- Discuss common Myths about aging and therapy

Session 2:
- Review what was discussed in session 1
- Questions or comments about last session
- Why we are doing Assertiveness training
- What is Assertiveness and types of behaviour
- Inserting new behavior into your life

Session 3:
- Review what was discussed in session 2 and review homework
- Questions or comments about last session
- Begin to learn how to become more assertive
  - Non verbal behavior, Opinions, Positive Feedback
- Emphasize as we learn more behavior skills, very important to practice in order to remember them and become part of daily habit.

Session 4:
- Review what was discussed in session 3 and review homework
- Questions or comments about last session
- Begin to learn how to become more assertive
  - Saying No, Asking for help
- How Stress Relates to Assertiveness
- Key Points
• Emphasize as we learn more behavior skills, very important to practice in order to remember them and become part of daily habit.

Session 5:
• Review what was discussed in session 4 and review homework
• Questions or comments about last session
• Reminiscing
  o Discuss what reminiscence is and how it is helpful
  o How it fits in with what we are doing
• Conduct exercises

Session 6:
• Review what was discussed in session 5 and review homework
• Questions or comments about last session
• Conduct review of past 4/5 sessions
• Fill out paperwork
• Congratulate all individuals for all they have accomplished
  o Certificates of Completion
• Any last questions or comments that anyone would like to share
• Explain what will happen next
  o Review that everything that happened in the group stays in the group. Confidentiality remains the same
  o Schedule to conduct post test
  o Will be contacted in 3 months to redo test and explain why
    • Want to know if workshop has lasting effects. If it does we will offer it again.
CHAPTER 4

RESULTS

During the beginning stages of recruitment, eight properties advertised the workshop through posted flyers. The initial sign-up yielded approximately 10-20 participants per property. Seventy participants filled out the initial paperwork to participate in the workshop. Prior to the start of the workshops, 21 individuals declined further participation. This caused the cancellation of two workshops due to the small number of group members (i.e., 3) remaining at each of the two properties. An attempt was made to combine individuals from these canceled groups into one workshop, however transportation obstacles obviated that possibility. Many of these cancellations occurred in the control groups during the 6-week waiting period. Therefore, none of the control groups had a sufficient number of participants. In workshops that did proceed, participants discontinued the workshop at various points. An additional 14 participants declined participation at some point given that they attended three or fewer sessions.

For analysis, participants who attended less than four sessions were excluded due to inadequate access to the information provided throughout the workshop. Ten people attended four sessions, 10 people attended five sessions, and 15 people attended the workshop in its entirety. Six individuals attended the minimum number of sessions required for analysis, however, they did not complete the packet of measures at either the pre or post workshop assessments. Therefore, their data was not included in the analyses.
Thirty-five participants completed a minimum of four workshop sessions and completed the pre and post-workshop measures. Table 1 provides a listing of the 35 participants’ demographic characteristics. The participants’ average age was 71 years (SD = 11.44) and 95% of participants were female. Ethnic diversity was limited in this population, with 83% being Caucasian, 14% African American, and 3% Asian/Pacific Islander. The dominating religious preference was Christian (60%), followed by Catholicism (14%). The remaining participants were Jewish (6%), other (3%), or unreported (17%). The participants’ average level of education was 12.74 years (SD = 1.86). Approximately 20% of the participants were married, 20% were divorced, 20% were single, and 40% were widowed and. The majority (70%) of the participants were currently living alone at the time of the study. The average participant rated 7 out of 10 (SD = 2.5) on a self-rated health assessment. Fourteen percent of the participants were currently being treated for mental health problems and 11% were currently on psychoactive medication for depression. The average number of sessions attended by participants was 5 (SD = .84).

Location and Facilitator Effects

A one-way multivariate analysis of variance (MANOVA) was conducted to determine pre-treatment differences across locations on the demographic information (age, gender, education, self-rated health, current psychological treatment, and current psychotropic medications). Analysis was not feasible for the workshop conducted at Capistrano due to the limited usable data. Therefore, differences across five locations were analyzed. No significant differences were obtained between the five workshop groups on the demographic information, Pillai’s Trace =1.687, F(36, 56)=1.134, p=.330.
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A MANOVA was also conducted to determine the effect of the four facilitators on the nine dependent variables (i.e., Rathus Assertiveness Scale (RAS), Quality of Life Inventory (QOLI), Life Satisfaction Scale –Z (LSI-Z), Self Efficacy Scale (SES), Rosenberg Self Esteem Scale (RSES), Geriatric Depression Scale (GDS), State-Trait Anxiety Inventory (STAI-1andSTAI-2), Brief Symptom Inventory (BSI), and Rotter’s Locus of Control Scale (RLOC). Four different facilitators conducted workshops. However, one facilitator only had two participants with usable data. Therefore, the analysis only examined differences between the outcomes obtained by the remaining three facilitators. No significant differences were found between the three facilitators on the dependent measures, Pillai’s Trace = .56, F(18, 46) = .994, p = .483.

Treatment Outcome

In order to determine whether the QOLI and the LSI-Z should be evaluated as a single measure of life satisfaction, a Pearson product-moment correlation coefficient was calculated to examine the relationship between these two measures. A moderate relationship was obtained, r (33) = .55, p < .001, at pre-treatment. Given that this was a moderate correlation (Cohen, 1988), it was decided that this did not indicate the relationship was strong enough to average scores of the two measures into a single assessment of life satisfaction. Therefore, each of these measures were analyzed separately.

Pre and post treatment scores for participants are provided in Table 2. Pre-treatment measures demonstrated that as a group, scores on the primary five measures indicated that participants’ scores of assertiveness, quality of life, self-efficacy, and self-esteem were all within normal limits. No deficits or signs of mental distress were noted.
Table 2: Pre and Post Treatment Scores on Primary and Secondary Measures

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<th>Post</th>
<th></th>
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<td>X</td>
<td>SD</td>
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<td>LSI-Z</td>
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<td>20.91</td>
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<tr>
<td>SESGS</td>
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<td>.77</td>
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Note: RAS = Rathus Assertiveness Scale, QOLI = Quality of Life Inventory, LSI-Z = the Life Satisfaction Inventory-Z, SESGS = Self-Efficacy Scale Global Scale, RSES = Rosenberg Self-Esteem Scale, GDS = Geriatric Depression Scale, STAI-1 = State-Trait Anxiety Inventory-1, STAI-2 = State Trait Anxiety Inventory 2, BSIGS = Brief Symptom Inventory Global Scale, and the RLOC = Rotter’s Locus of Control Scale. N=35 for all measures except for the QOLI Pre and Post (N=30) and the BSIGS Pre and Post (N=33).
This was true for the secondary measures as well. The group presented as normal in regards to depression, anxiety and overall mental health status. Pre-treatments score did, however, suggest that as a group, participants’ locus of control tended to be externally-oriented.

Five repeated measures univariate analyses of variance (ANOVAs) were conducted to test the primary hypotheses that there would be significant differences in pre-treatment and post-treatment scores on the measures of assertiveness, life satisfaction, self-efficacy, and self-esteem. The analyses indicated that there were no significant pre-post treatment changes on the RAS, $F(1, 34) = .32, p > .05$, QOLI, $F(1, 29) = 2.49, p > .05$, LSI-Z, $F(1, 34) = 1.12, p > .05$, SESGS, $F(1, 34) = .08, p > .05$, and the RSES, $F(1, 34) = .35, p > .05$.

Five repeated measures univariate ANOVAs were conducted to test the secondary hypotheses that there would be significant differences between pretreatment and post-treatment scores on the measures of depression, anxiety, overall mental health, and locus of control. The GDS, $F(1, 34) = .78, p > .05$, the STAI-2, $F(1, 34) = .53, p > .05$, the BSI, $F(1, 32) = 2.10, p > .05$, and the RLOC, $F(1, 34) = .54, p > .05$, all yielded non-significant changes from pre to post-treatment.

The STAI1 yielded a statistically significant pre to post-treatment change, $F(1, 34) = 5.80, p < .05$. Participants’ state anxiety scores increased significantly after participation in the workshop. However, both pre and post-treatment mean scores were within normal limits.

To determine lasting effects, repeated measures univariate ANOVAs were conducted to examine if there were significant differences between post-treatment scores
and 3-month follow-up treatment scores on both the primary and secondary measures.

Post treatment and follow-up scores for participants are provided in Table 3. For the primary measures of assertiveness, life satisfaction, self-efficacy, and self-esteem, analyses indicated that there were no significant post to three-month follow-up treatment changes on the RAS, $F(1, 25) = .31, \ p > .05$, QUOL, $F(1, 22) = .24, \ p > .05$, and LSI-Z $F(1, 29) = .38, \ p > .05$. Two of the primary measures yielded significant results, the SESGS $F(1, 31) = 5.58, \ p < .05$ and the RSES $F(1, 31) = 5.71, \ p < .05$. Scores on these measures indicated a significant decrease in self-efficacy and self esteem.

For the secondary measures of depression, anxiety, overall mental health and locus of control, analyses indicated that there were no significant post to three-month follow-up treatment changes on the BSIGS $F(1, 27) = 1.87, \ p > .05$ and the RLOC $F(1, 31) = 2.75, \ p > .05$. The GDS, STAI-1, and the STAI-2 all yielded significant results. The GDS $F(1, 25) = 5.01, \ p < .05$, indicated a significant increase in depression at the follow-up, however the mean score of individuals was still within normal limits. The STAI-1 $F(1, 29) = 9.20, \ p < .01$ and the STAI-2 $F(1, 31) = 8.10, \ p < .01$ both indicated a significant decrease in anxiety.

**Predictors of Outcome**

A Pearson product-moment correlation coefficient was calculated to examine the relationship between religiosity and the pre to post-treatment differences scores (i.e., pre minus post treatment; higher difference scores represent less assertive behaviors) on the measure of assertiveness. This analysis was conducted to examine the predictability of religiosity on changes in assertive behavior.
Table 3: Post Treatment and Follow-Up Scores on Primary and Secondary Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>Post X</th>
<th>SD</th>
<th>3-Month Follow X</th>
<th>SD</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAS</td>
<td>26</td>
<td>5.02</td>
<td>21.53</td>
<td>- 3.11</td>
<td>25.63</td>
<td>1.07</td>
<td>.31</td>
</tr>
<tr>
<td>QOLI</td>
<td>23</td>
<td>2.37</td>
<td>1.62</td>
<td>2.64</td>
<td>1.57</td>
<td>1.45</td>
<td>.24</td>
</tr>
<tr>
<td>LSI-Z</td>
<td>30</td>
<td>20.91</td>
<td>3.35</td>
<td>19.4</td>
<td>7.5</td>
<td>.77</td>
<td>.38</td>
</tr>
<tr>
<td>SESGS</td>
<td>32</td>
<td>47.31</td>
<td>10.83</td>
<td>38.15</td>
<td>17.89</td>
<td>5.58</td>
<td>.02</td>
</tr>
<tr>
<td>RSES</td>
<td>32</td>
<td>32.08</td>
<td>6.99</td>
<td>25.62</td>
<td>12.55</td>
<td>5.71</td>
<td>.02</td>
</tr>
<tr>
<td>Secondary Measures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GDS</td>
<td>26</td>
<td>6.00</td>
<td>4.93</td>
<td>8.03</td>
<td>5.53</td>
<td>5.01</td>
<td>.03</td>
</tr>
<tr>
<td>STAI-1</td>
<td>30</td>
<td>35.82</td>
<td>11.36</td>
<td>27.60</td>
<td>19.09</td>
<td>9.20</td>
<td>.00</td>
</tr>
<tr>
<td>STAI-2</td>
<td>32</td>
<td>36.00</td>
<td>11.55</td>
<td>25.81</td>
<td>17.35</td>
<td>8.10</td>
<td>.00</td>
</tr>
<tr>
<td>BSIGS</td>
<td>28</td>
<td>.56</td>
<td>.53</td>
<td>.48</td>
<td>.58</td>
<td>1.87</td>
<td>.18</td>
</tr>
<tr>
<td>RLOC</td>
<td>32</td>
<td>9.57</td>
<td>4.57</td>
<td>8.18</td>
<td>4.78</td>
<td>2.75</td>
<td>.10</td>
</tr>
</tbody>
</table>

Note: RAS = Rathus Assertiveness Scale, QOLI = Quality of Life Inventory, LSI-Z = the Life Satisfaction Inventory-Z, SESGS = Self-Efficacy Scale Global Scale, RSES = Rosenberg Self-Esteem Scale, GDS = Geriatric Depression Scale, STAI-1 = State-Trait Anxiety Inventory-1, STAI-2 = State Trait Anxiety Inventory 2, BSIGS = Brief Symptom Inventory Global Scale, and the RLOC = Rotter’s Locus of Control Scale.
The correlation coefficient was significant, \( r(33) = -.391, p < .01 \). The scatter-plot for the two variables, as shown in Figure 1, indicated that there was a trend for the two variables to be linearly related such that as the level of religiosity increased, changes to a more assertive behavior style increased.

**Exploratory Analysis**

Parametric correlation coefficients were computed between the pre-treatment scores on the 11 dependent variables. Table 4 provides the correlation matrix. Using the conservative Bonferoni approach (Harris, 1975) to control for Type I error across the 11 correlations, a p-value of less than .001 was required for significance. Given that this is a conservative approach, correlations that were significant at the .01 and .05 level will be reported as well so as to identify correlational trends among the measures. The correlation matrix indicated that 13 of the 55 correlations were statistically significant at the .001 level and were greater than or equal to .54.

Correlations with the GDS that were significant at the .001 level included the LSI-Z, \( r(32) = -.60, p < .001 \), STAI-1, \( r(33) = .63, p < .001 \), and the BSIGS, \( r(33) = .77, p < .001 \). This indicated that higher depression scores were associated with lower life satisfaction, higher state anxiety, and more indications of mental health concerns. Correlational trends included the RLOC, \( r(33) = .49, p < .01 \), QOLI, \( r(30) = -.46, p < .01 \), and the STAI-2, \( r(33) = .40, p < .01 \). This indicated that higher depression scores were associated with a higher internal locus of control, lower life satisfaction, and higher trait anxiety.
Figure 1.1 Plot graph of Change in Assertiveness vs. Level of Religiosity
Table 4 Pearson Correlation Matrix of Pretreatment Scores of Dependent Variables

<table>
<thead>
<tr>
<th></th>
<th>RAS</th>
<th>LSI-Z</th>
<th>Religion</th>
<th>RLOC</th>
<th>RSES</th>
<th>QOLI</th>
<th>STAI-1</th>
<th>STAI-2</th>
<th>SESGS</th>
<th>BSIGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSD</td>
<td>-.215</td>
<td>.155</td>
<td>-.137</td>
<td>.485(**)</td>
<td>-.240</td>
<td>-.459(**)</td>
<td>.632(**)</td>
<td>.402(*)</td>
<td>-.210</td>
<td>.772(**)</td>
</tr>
<tr>
<td>RAS</td>
<td></td>
<td></td>
<td></td>
<td>-.282</td>
<td>-.068</td>
<td>.177</td>
<td>-.111</td>
<td>-.134</td>
<td>.107</td>
<td>-.147</td>
</tr>
<tr>
<td>LSI-Z</td>
<td></td>
<td></td>
<td></td>
<td>-.641(**)</td>
<td>.203</td>
<td>.554(**)</td>
<td>-.542(**)</td>
<td>-.541(**)</td>
<td>.190</td>
<td>-.675(**)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td></td>
<td>-.455(**)</td>
<td>.330</td>
<td>.523(**)</td>
<td>.516(**)</td>
<td>-.197</td>
<td>.689(**)</td>
<td></td>
</tr>
<tr>
<td>RLOC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.267</td>
<td></td>
<td>-.205</td>
<td>-.212</td>
<td></td>
<td>-.176</td>
</tr>
<tr>
<td>RSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.568(**)</td>
<td></td>
<td>-.599(**)</td>
<td></td>
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<tr>
<td>QOLI</td>
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<tr>
<td>STAI-1</td>
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<td>STAI-2</td>
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<td></td>
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<tr>
<td>SESGS</td>
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</table>

Note: *p < .05. **p < .01. Items in Bold indicate p < .001. N is 35 for all measures with the exception of the RSES and QOLI in which the N is 32.
No measures were significantly correlated with the RAS. Significant correlations with the LSI-Z included the RLOC, r(33) = -.64, p < .001, STAI-1, r(32) = -.54, p < .001, STAI-2, r(33) = -.54, p < .001, BSIGS, r(33) = -.68, p < .001, and the QOLI, r(30) = .55, p < .001. This indicated that as life satisfaction increased, locus of control became more external, state and trait anxiety decreased, overall mental health increased, and quality of life increased.

Trending correlations with the Religiosity Scale only included one measure, the RLOC r(35) = -.455, p < .01. This indicated that as religiosity increased, locus of control became more externalized.

Significant correlations with the RLOC included the QOLI, r(30) = -.57, p < .001, STAI-1, r(33) = .52, p < .001, and the BSIGS, r(33) = .69, p < .001. This indicated that as locus of control became more internalized, quality of life decreased, state anxiety decreased, and overall mental health improved. Trending correlations only included one measure, the STAI2, r(33) = .52, p < .01. This indicated that as locus of control became more internalized, trait anxiety decreased.

There was one significant correlation with the RSES, the SESGS, r(33) = .87, p < .001. This indicated that as self-esteem increased, self-efficacy increased.

Significant correlations with the QOLI included the STAI-1, r(33) = -.60, p < .001 and the BSIGS, r(33) = -.55, p < .001. This indicated that as quality of life increased, state anxiety decreased and overall mental health improved. Trending correlations with the QOLI only included one measure, the STAI-2, r(30) = -.36, p < .05. This indicated that as quality of life increased, trait anxiety decreased.
Significant correlations with the included the STAI-1, $r (33) = .79$, $p < .001$ and the STAI-2, $r (33) = .62$, $p < .001$. This indicated that as overall mental health improved, state and trait anxiety decreased.

Utilizing Cohen’s strength of relationship indicator ($r > .3$ low; $r > .5$ medium, and $r > .7$ high; Cohen, 1988), the correlation matrix indicated that the majority of the correlations listed above were moderately correlated. High correlations within the matrix included BSI & GDS, RSES & SESGS, and BSI & STAIT1.

Participant Feedback

During the last session, participants had the opportunity to fill out program evaluations forms. These forms were done anonymously. Twenty-eight evaluations were received and had a mean score of 44.5 (SD=6.55) for the overall rating of the workshop. Given that this form had a possible score of 52, the mean for these evaluations in the good to excellent rating for the workshop. On the open-ended questions, all 28 participants indicated that they would recommend this program to someone else. When asked what they liked most about the program, eight people commented that they liked meeting people in their building and sharing experiences, four people commented the have better self understanding, and nine individual wrote they liked learning how to be more assertive. When asked what they liked least about the program, six participants indicated nothing, and individual responses varied from one person commenting that it was upsetting to have people leave the “quit the program”, another commented that the program was too short, and one person suggested that there should be more crafts in the workshop. It was also asked what other types of programs they would like to have offered
and single responses included exercise programs, arts and crafts projects, budgeting skills, and six people asked more workshops that are similar to this one.

Session by Session Analysis

Six Shifting Gears workshops were conducted at six different locations in the Las Vegas Valley. Sessions by session suggestions were made to improve the manual and the workshop by the facilitator. Major suggestions for each session are provided.

Session 1:
- In the workshop, participants were asked to sign a confidentiality agreement and it was suggested that each person is given a copy of this agreement for their personal records. It was also noted that the confidentiality form has participants agree to several different group rules. It was suggested that participants should agree to each item, one by one, rather than signing the whole document at once. Rules and guidelines should also be established for individuals who do not agree to sign the confidentiality form.

- It was mentioned several times that the section describing depression and anxiety needs more elaboration on the purpose of the information as well as how to recognize if a person has this disorder.

- Given that the group is based highly on discussion, more exercises may need to be established during the first session to introduce group members. This may ease participants into more discussion throughout the sessions.

Session 2:
- It was felt by the facilitators that the first information regarding assertiveness was hard to follow and should be revised for facilitators to ease through the information with the group members.

- More examples are needed to help members grasp the concepts of the different types of assertive behavior. These examples should also relate to older adults.

- More emphasis may be needed on aggressive behavior styles for this population. It was mentioned that members often thought if someone wasn’t assertive they were passive. All four behaviors should be discussed in each concept to clarify.

- There were several individuals who did express an interest in improving their assertiveness skills. The manual should include discussion about the desire to remain the same and resistance to change.
• It was suggested that the Self-Assessment of Assertiveness page might need clearer instructions.

Session 3:
• This section is the first time when participants were asked to pair off and to practice certain exercises. It was noted that many would just talk about various topics rather than perform the exercise. Maybe continuing to practice as a group would have been more beneficial. Strategies need to be detailed for facilitators on what to do if no one is participating in the exercises.

• It may need to be added in the manual to point out that even if someone is already adequate at a certain behavior or concept, the benefits of bringing these discussing these concepts so everyone is aware how they affect their own behavior and the effects it may have on others.

Session 4:
• Many individuals endorsed feelings of guilt in the first part of session four, which was discussion the ability to say no. It was suggested to add this specifically to the misconceptions about saying no.

• It was also suggested that prior to the activity for this section to add a discussion exercise. The exercise could have participants share experiences about people in their own life who tend to ask a lot from others. It may also be helpful bring up the situation in which no one directly asks for help, but mentions a problem and they feel obligated to offer assistance.

• The next session on stress, participants had a hard time with Assessing situations. It was suggested to add more examples so they are more familiar with what is being asked of them.

• Many group members had difficulty with the concept of saying no, especially regarding family members. Many felt family was too persistent or they didn’t want to say no. Overall, it was noted that the group didn’t believe change their notions about their ability to say no. This may have occurred for several reasons, some being associated with guilt especially with regard to family or their desire which is not really to say no because they do not mind the intrusion. It should be emphasized there is nothing wrong with doing things for people as long as it is ok with person. This only pertains to situations in which they do not want to say yes. The facilitator repeated this, but the group still did not see the difference in scenarios.

Session 5:
• In order to create a comfortable atmosphere regarding sharing experiences in the reminiscence exercises, it was suggested that the facilitator first demonstrate the activity by sharing a personal memory or a provided example.
Session 6:

- It was suggested to have the group talk about what they learned, liked or disliked as a result of the workshop. This was a discussion that had gone on prior to beginning these workshops. Group discussion was decided against as to not to skew the results of the paperwork, which is suppose to be done after the 6th session. It was believed that if people discussed the workshop it might skew the results from the paperwork depending on how the discussion went. However, after seeing the evaluations, it appears that no one really made written comments so a discussion may provide more information on how they directly felt about the workshop.

- It was also mentioned that paperwork can be done after the 5th session since that is the end of learning new information and the 6th session is just a wrap up. Also paperwork can be checked at this session to see if there was anything missing and can be fixed while they are still present.

- It is crucial that the packets are checked because some forms were not filled out completely.

- Through the review of the sessions, some participants seemed to be confused; they tended to look for some form can follow along.

- While passing out the supplemental materials, this group had commented on the political affiliation of the Senator Reid book. It was explained that this workshop did to follow so it was suggested that a review paper be put in the participant workbook so that they not endorse any specific political party or person and seemed to accept this explanation.
CHAPTER 5

DISCUSSION

This study examined the effectiveness of a program designed to educate older adults residing in congregate housing about basic coping strategies for common stressors in their lives in order to meet the following primary objectives: (a) learn assertive behavior styles, (b) increase life satisfaction, (c) enhance self-esteem, and (d) enhance self-efficacy. Secondary objectives included: (a) decreasing depressive symptoms, (b) decreasing anxiety; (c) improving overall mental health; (d) establishing an internal locus of control, and (e) evaluating the degree to which religiosity is a predictor of changes in assertiveness.

Overall Discussion of Results

At the start of this project staff at the housing facilities provided information suggesting that recruitment would not be a problem. It was also suggested by staff that participants would have some mental health deficits. However, these two expectations were not met. This caused complications with the dissemination of the workshop and may have contributed to insignificant results as well as several limitations that will be discussed in detail. The proposed research plan was to recruit approximately 100 residents for this program. This number would allow for the inclusion of a delayed-
treatment group as well as robust statistical analyses. Furthermore, it was anticipated that this group of lower income elders living in congregate housing would have mental health needs in the areas of assertiveness, self-esteem, depression, and anxiety. Unfortunately, the analyzable population obtained was limited to 35 participants and they were, on average, mentally healthy based on pre-treatment assessment measures. Due to lack of enrollment, the proposed control group could not be implemented. Furthermore, participants’ lack of mental health problems may have lead to non-significant mental health improvements from pre to post-treatment.

The analyses conducted (MANOVAs) determined that the different workshop facilitators did not have a significant effect on the dependent variables. It was hoped that this analysis would demonstrate that staff at congregate housing facilities would be able to administer this workshop as effectively as someone with more training in psychology (i.e., graduate students in a Clinical Psychology doctoral program). The results of this analysis would have supported the idea that this program could be administered with standardized training and a workshop manual; however, only one facilitator from the congregate housing facility was able to conduct a workshop. Given that his workshop had extremely low attendance, analysis was restricted to the remaining three facilitators who were all graduate students in the Clinical Psychology program at the University of Nevada - Las Vegas. One of these student facilitators had not begun the program so her education level was comparable to that of the staff member, however, being a psychology major, she may have been exposed to more treatment manuals, which may have had an effect.
When looking at group differences between workshops on demographic characteristics, all groups appeared to be similar at the start of the workshops. Given the design of the study, the option to randomly assign participants to group was not available. However, this analysis demonstrated that this was not an issue because there were no significant between group differences. This suggested that effects obtained in subsequent analyses could be stated, with some degree of confidence, as being attributable to the effects of the workshop.

It was an assumption prior to the study that residents at these housing facilities would have scores on the measures administered that would be indicative of mental health problems. However, reviewing pre-treatment scores, very few individual's scores indicated a need for concern about their mental health in the areas assessed. It is difficult to assess change in a population that is already mentally healthy in all areas that are being assessed. For future research, it may be beneficial to pre-screen subjects for low assertiveness or high depression so as to look at the effects of the workshop with a more specific clinical population.

ANOVA's on pre and post-treatment measures of primary and secondary hypotheses yielded non-significant results with one exception, the State-Trait Anxiety Inventory-1 (STAI-1). This form measures state anxiety, which indicates how a person is feeling at the exact moment the participant is completing the measure. When examining pre and post-treatment means, state anxiety significantly increased after the workshop, indicating that participants had more state anxiety while filling out the measure after the completion of the workshop than before the workshop. However, the means for the post-workshop measure of state anxiety still indicated that anxiety levels were within the
normal range even though they were statistically higher than the pre-treatment measure. State anxiety can fluctuate over time and can vary in intensity (Gaudry, Vagg, & Spielberger, 1975). This finding could be due to the fact that participants completed the post-treatment measures at home for the first time or that information was brought up during the workshop that participants had not previously been contemplating, especially given that they were a healthy group of individuals. This effect did not seem to be permanent given levels of state anxiety significantly decreased at the three month follow-up.

The three-month follow-up analyses yielded inconsistent results. Although self-efficacy and self esteem decreased while depressive symptoms increased, both state and trait anxiety levels significantly decreased and no significant effect was obtained on overall mental health, life satisfaction or quality of life.

In this study, a secondary analysis was conducted to examine the relationship between religiosity and changes in assertive behaviors. It was expected that higher levels of religiosity would predict increases in assertiveness because prior research has shown that religious teachings promote submissive behavioral styles (Malony, 1982). However, the trend found in the current analysis demonstrated that higher religiosity scores were slightly associated with the tendency to change to a more assertive behavior style. It is important to note that this finding only indicated a possible trend; significant results were not found. Also, pre-treatment scores on the measure of assertiveness demonstrated that as a group, participants' assertiveness fell within the normal range.

An exploratory analysis was conducted to determined relationships between the pre-treatment dependent measures. It would be expected that all measures indicative of
good mental health would be positively correlated with each other and negatively correlated with measures indicative of poor mental health. Similarly, it would be expected that measures of poor mental health would be positively related to one another and negatively related to measures indicative of good mental health. Most of the correlations yielded this pattern. The following section will discuss those correlations that were aberrant from the anticipated directional relationships.

One of the main measures of this study, the RAS, did not yield any significant relationship with any of the other 10 measures. Correlations between the RAS and other measures ranged from .068 to .282, with none of the relationships yielding significant results or being high enough to suggest even a small relationship by Cohen's standards (Cohen, 1988). Given that one of the main goals of this program was to increase assertive behaviors, it is very important to note that this particular measure of assertiveness yielded results that were incongruent with the extant literature. Prior research has found that assertiveness is positively related to self-esteem and negatively related to depression (Sanchez, Lewinsohn, & Larson, 1980; Temple and Robson, 1991). The current findings suggested that the RAS should be reconsidered for use with older adults and may not be measuring assertiveness in this population. Given that the other correlations between pre-workshop measures did produce significant correlations, mostly small to moderate relationships in the expected directions, it did not appear that the test battery was invalid. Rather there appeared to be something specific about the RAS that is problematic. This could either mean that the RAS is invalid for use with older adults or that assertiveness does not have a relationship with these other characteristics as previously stated. Given the literature on the latter subject, the first explanation would be more likely. This may
also be the primary reason why the few other studies that have been conducted looking at assertiveness in an older adult population have reported non-significant results (e.g. Alice Franzkel, 1987). Perhaps a new assertiveness scale needs to be developed specifically for this population in order to capture the truth about current assertive behavior styles among the elderly and to measure change in behaviors over time.

During the administration of the pre-workshop measures it was noted that there were some concerns with the RAS. One problem reported by several participants indicated that the questions were not applicable to them. One major assumption of the scale that is that the situations presented should be handled in an assertive manner. Assertiveness training strives to give individuals the ability to stand up for themselves on issues that cause discomfort or where it is believed that one’s rights are being violated. If feelings of violation are not felt in the situation that is presented, then this scale may not be indicative of unassertive behavior. So it may be better to include a statement assessing how a person would want to act in the situation presented as well as how they currently act. Overall results on this measure only establish parameters for behavior that is assertive or unassertive. Future scales may be more useful if other behavior styles are also assessed (such as passive, aggressive, or passive aggressive), therefore allowing a group leader or the participant more knowledge about what exactly needs to be worked on to adapt to an assertive behavior style. Another complaint about this measure dealt with the response key. The RAS provides participants with six different responses that range from −3 to 3 and contain a lengthy explanation for each response. This appeared to be a cumbersome task for the elderly. They experienced difficulties remembering the response scale and the misunderstanding of this scale could be a critical problem for
measurement. Future assertiveness research with older adults populations may want to use a measure that assesses perceptions of feelings in the situations described, situations that are often encountered by this population, and a measure with a simplistic response scale that is easily understandable by the population responding to the questionnaire.

Another measure that may need to be reconsidered in any replication of this study or in future assessments with older adult populations is the Rotter’s Locus of Control Scale (RLOC). The RLOC is a global measure of locus of control. For the purpose of this study, it may be more indicative of changes in behaviors to receive an assessment of domain specific locus of control. Domain specific locus of control would allow assessment of personal control across situations that participants face on a daily basis rather examining worldly beliefs to determine internal vs. external control (McKibbin, Guarnaccia, Hayslip, & Murdock, 1997). McKibbin et al (1997) suggested that locus of control pertaining to general situations is unlikely to change over one’s lifetime, however, locus of control concerning personal day-to-day matters may be more likely to change.

It was also noticed that several participants had a difficult time deciding between answers and were inclined to put question marks in the margin rather than choosing a response. It was also apparent by questions that were asked by several participants, that they did not understand why they were being asked about the situations described in the scale. Some stated that they did not know how to answer, being that the situation was not relevant to their life. One final dilemma that was noted regarding this scale was the complexity of the questions asked and the language of the questions. It appeared that it was difficult for participants to process each statement, thereby making comparisons between two statements particularly challenging for the participants. Several participants asked for an
explanation of statements on this measure. It may be beneficial in future studies to utilize a measure with a more simplistic writing style.

Further notations of the measures utilized in this study included the length of time that it took to complete measures and participants' comments while completing measures. While administering the measures prior to the workshop, it appeared that the paperwork proved to be too dense, and confounding variables such as fatigue may have begun to influence responses on the questionnaires. The average time to complete the paperwork was 1.5 hours. A short time after the paperwork had begun (one-half hour), some participants began to make comments referring to how much longer it would take to complete the measures as well as stating that they may not be able to stay and finish, even though it was requested that participants block off two hours for paperwork completion. Although very few people decided not to participate and did not finish the measures during this initial data collection, the cumbersome amount of paperwork may have affected the results obtained.

Overall Summary of Workshops

Program evaluation forms indicated that the workshop was well received and enjoyed by the participants. Overall scores on the evaluation yielded an excellent rating and participants indicated that they would refer other people to the workshop. Comments made by participants indicated that they felt the assertiveness training was “helpful” and “needed” and they also enjoyed “meeting neighbors” and having the opportunity to express themselves. Several also reported that the workshop was too short and that they would participate again if given the opportunity.
An overall analysis of participants' comments and facilitator remarks determined several areas in which the workshop could be improved to enhance its effectiveness. Suggestions for improvement began with expressing the need to clarify the instructions for the participants and for the facilitators in various sections of the workbook and the manual. It was also repeatedly mentioned that many participants did not engage in the role-plays after they had been divided into practice pairs. It would seem that conducting role-play exercises as a group would insure higher participation rates. It was also noted that some of the situations used in the role-plays did not appear to be pertinent to the older adult population and should be adjusted to represent situations that would be familiar to the group. Towards the end of each workshop, it seemed that many participants expressed a desire for a lengthier workshop. This would have allowed more time to process concepts and to have additional materials on assertiveness training that were excluded from the manual due to time limitations.

One of the major issues of the workshop was deciding on the best timing for participants to complete the post-workshop measures. In the original research design, assessment measures were to be completed during the sixth session. However, many individuals complained about this process. Facilitators mentioned that participants wanted to enjoy the last session and did not want to spend it filling out paperwork. To compensate for this, participants were allowed to take the paperwork home and it was retrieved one week later. This was done to accommodate participants; it was thought that by allowing them to take the paperwork home, more accurate responses would be received since they were able to fill out the paperwork at their leisure. If the participants had to fill out the paperwork while agitated or apathetic, these feelings could interfere...
with detecting true change as a result of the workshop. This occurred at Bonanza Pines, Sierra Pines, and Capistrano Pines facilities. Once this was recognized, an adjustment was made that allowed participants to take home the paperwork after the fifth session and return the completed forms during the sixth session. Facilitators were instructed to check the packets for completion of the questionnaires. This method seemed to be favored by participants. It would perhaps be beneficial to review the instructions prior to participants’ filling out the measures at home to refresh their knowledge of the instructions for the measures and to address any misunderstandings. Participants were also invited to phone the project manager with any questions regarding the measures. Even though the participants preferred this method, this design had its flaws.

The sixth session consisted of a presentation of completed collages, review of workshop information, and a small celebration, which included food, raffle prizes, and presentation of certificates of completion. It was originally perceived as a problem if participants completed paperwork immediately following a celebration because the celebration might artificially affect their responses in a positive manner. Having the participants fill out the paperwork after the review, but prior to the celebration may have yielded more accurate results; however, given that people completed the paperwork at different rates, it would be challenging to finish the session without having some individuals waiting for others to finish their paperwork. This may not be ideal and may have taken longer than the allotted time. A better method may be to allow participants to complete paperwork at home after the 6th session and to collect the paperwork a week later. However, this may increase the chance that paperwork is not returned, but may in turn provide more accurate results.
There are a few other limitations to the current study as well as problems encountered throughout the course of the program. Each of these areas, along with future recommendations, will be discussed separately.

The project was originally developed from a need expressed by staff at Nevada HAND, a local development company that specializes in income-based congregant housing for older adults. They offer several services to their residents, including computer classes, monthly potlucks, bingo, and various other activities. While conducting another project with the organization, several staff members mentioned that there seemed to be a number of individuals that were experiencing difficulty adjusting to this new living environment. This was determined through both a standard annual evaluation of the residents and through ongoing relationships with the residents. Staff commented that the adjustment issues had left residents feeling lonely, isolated, and depressed. From this perception, Shifting Gears was developed as an adjustment tool to enhance these individuals’ well-being. However, when recruitment began, the residents demonstrated very little interest for the workshop. The workshop was advertised via the delivery of flyers to each apartment indicating that interested parties were to sign up for the workshop at a designated location on the property. Staff who developed other property events commonly used this method. This procedure, however, yielded little response from the residents. To enhance interest, an information session about the workshop was given at each property. Although interest increased, there was still significantly less interest than anticipated. This made the design of the study, (especially having a control group and a treatment group at each site) nearly impossible, as there were barely enough participants to run one workshop at each property. It seemed that although this service
was perceived by the staff to be needed, either the residents didn’t feel that this service was needed, that the residents in need were too depressed and/or isolated to seek needed services, or that the residents did not want to admit that they would find this group helpful. During the information sessions, some residents inquired about activities during the workshop and commented that they did not want to sit and talk every week but rather, that they wanted to engage in activities that are more physical. For future workshops, it may be beneficial to add a component that involves some physical movement throughout, such as minimal exercise activities and/or stretching exercises that can accompany breathing for relaxation purposes. It also appeared that the population that did participate in the workshop primarily consisted of individuals who were already active in programs offered by their property and a few even participated in the workshop from a fear that if participation was low, other activities would be eliminated from their facility. A promotional method that captures the attention of those residents most in need of this workshop would provide a better evaluation of the effectiveness of this program.

Prior to recruitment, housing staff stated that they would promote the workshop specifically to targeted residents exhibiting characteristics that indicated mental health difficulties and/or adjustment challenges, as determined through observation and an annual evaluation. However, when recruitment began, housing staff expressed that it was inappropriate to promote the workshop to some individuals and not to others. By and large, the analyses indicated, that residents exhibiting mental health difficulties and/or adjustment problems did not enroll. Although the workshop needs to be open to enrollment for all residents, for future program implementation at congregate housing sites, staff promotion of the program to targeted individuals may demonstrate the true
effectiveness of this program to increase assertiveness and improve mental health. Recent research focusing on the recruitment of older adults supports this theory. It was noted in several studies with older adults (Dibrartolo & McCrone, 2003) that individuals are more likely to participate if solicited by a trusted patron such as a favored doctor, family member, friend, or church organization. It would seem that this may be extended to a resident service coordinator in congregate housing facilities; however, this assumes that the resident coordinator at the properties has a good relationship with the residents and is well received. Given this information, another alternative recruitment strategy would be to rely on word of mouth after the workshop has been introduced and is to be repeated. Other recruitment strategies that were noted that may be useful include advertisements through newspaper articles, church newsletters, television advertisements or brochures in business offices where older adults frequent (Dibrartolo & McCrone, 2003; Marx; Cohen-Mansfield, Jiska, Guralnik, 2003).

Unfortunately, due to recruitment difficulties, it was not possible to run a control group in this study. The one attempt at a control group was thwarted, as the attrition rate was so high that the workshops for the control group were being canceled. Establishing a control was attempted by utilizing two different strategies. First, it was thought that 20 people would sign up at each property, and half would be randomly assigned to a control group. Being that on average, only 10 people signed-up for the program per property, a control group was not able to be established. Then certain properties were designated as the control group, where they would have a six-week delay prior to starting the workshop. But this yielded a very high attrition rate and the groups had to be cancelled. Working with a limited population is part of the struggle with this approach. Holding the
workshop at the properties solves transportation issues, but it leaves a limited number of individuals to pool from when holding a group. If repeated at similar facilities, more incentives may need to be offered to the designated control groups.

For those who did participate in the workshop, group dynamics proved to be an interesting component. When running a group workshop or holding group therapy, groups frequently develop unique dynamic characteristics (Johnson, 1996). For the current study, this included the interactions and social history between the participants. The workshop participants all resided in the same facility and many of the group members had prior interactions with one another that may have been positive and/or negative. A few individuals who did not get along outside of the group setting were not able to put their differences aside and decided not to continue with the workshop. In such circumstances, it seems that having a group that is open to the community may assist with this problem, as less people are likely to know each other in such an intimate way. Although this does bring about the issue of transportation problems, it may provide a healthier group experience and not prevent people from speaking freely due to constraints from relationships with other members in the past.

In any group setting, whether or not the individuals are familiar with each other, dynamics are still a factor. There may be individuals who tend to dominate the group discussion in which other follows in their path, or those who are timid and will not express an opinion opposite from someone who has already spoken. Although guidelines are established to try to limit such occurrences, it is still possible that awkward group dynamics will manifest. It is hoped this dynamic will not hinder participants from obtaining the information from the workshop.
Conclusion Summary

The current workshop was administered to congregate housing facilities in the Las Vegas area and data from 35 participants were analyzed to test for program effectiveness. Only one significant difference was discovered through analysis which demonstrated an increase in state anxiety from pre-post workshop measures which could be attributed to discussion of issues that were previously not thought about that may have caused an increase in anxiety. Even though significant differences were not obtained in the remaining domains assessed, this may have been due to the small sample size available for analysis, as well as ceiling effects given that this population did not show mental health deficits prior to the start of the workshop. Through participant evaluation and facilitator remarks, it appeared that participants did enjoy the workshop, it provided benefits to participants, and participants desired similar workshops in the future.

Limitations in the current study that should be readjusted in subsequent projects included picking an optimal time for the completion of post workshop measures, an addition of a control group to establish concrete treatment effects, more effective recruitment strategies (especially in targeting at-risk individuals), a briefer battery of assessment measures, and measures that were more applicable to the target population and desired outcome information. Future research should also utilize a revised version of this workshop on clinical populations in order to assess its effectiveness in changing domains such as assertiveness, self-esteem, and depression.

Assertiveness in older adults is an under-researched area that has many facets that need exploration, including current assertiveness strategies of older adults, the effect of
these current strategies on mental health, and desires to adapt those strategies to increase well being.
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