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Old Is an Attitude - Age Is a Concept: A Qualitative Study on Aging and Ageism with Guidelines for Expressive Therapies Literature

Steven Durost
Lesley University

Old Is an Attitude - Age Is a Concept:
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with Guidelines for Expressive Therapies Literature

A DISSERTATION

(submitted by)

STEVEN DUROST

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Dissertation Committee Chair:

_____ 3/11/11
(signature)   (date)

Dissertation Committee Member:

_____ 3/11/11
(signature)   (date)

Dissertation Committee Member:

_____ 3/11/11
(signature)   (date)

Director of the Ph.D. Program:

_____ 3/11/11
(signature)   (date)

Dean, Graduate School of Arts & Social Sciences:

_____ 3.11.11
(signature)   (date)

_____ 3.11.11

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SIGNED: _Steven William Durost_

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TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

Mental health professionals who work with people over 65 have been shown to exhibit subtle and overt ageist attitudes. Many of these misconceptions were based on societal perceptions and ageism stereotypes arising from contemporary research performed on a non-representative portion of people over 65. Nursing home residents representing only 4.2% of the older adult population have been studied and the results of those studies have been generalized to represent all older adults. Few studies have given voice to the 95.8% of well older adults living independently. It was held if older adults were listened to, guiding information could be gained which could help professionals working with older adults to become more aware of the trappings of ageism and age stereotypes. A qualitative study was employed to explore the lived experience of aging through the analysis and coding of interviews with ten independent people over 65 years old living in diverse locations around the world. Though some of the findings supported old age stereotypes, it was found that the participants held an "inner age" that was 30-40 years younger than their physical age, that the participants did not see themselves as "old," that "old" meant physical disability or poor attitude, and that "connectedness" was important in life fulfillment. The findings were used to develop a set of guidelines for critiquing expressive therapies literature about working with older adults. Applications of the guidelines to a selection of expressive therapies literature was performed and presented.

Keywords: Aging; Ageism; Phenomenology; Qualitative; Expressive therapies

CHAPTER 1

Introduction

People with a positive attitude about aging have been shown to live seven years longer than those whose attitudes were less favorable (Levy, Slade, Kunkel, & Kasl, 2002). Stereotypes about older adults have contributed to negative attitudes about aging. Ageism stereotypes have included the idea that older adults were senile, more mentally ill, frail, sick, inefficient, isolative, inflexible, stubborn and lacking interest in sex (Edelstein & Kalish, 1999). Belief in these stereotypes have lead older adults to perform less well than younger counterparts in research tests (Chasteen, Bhattacharyya, Horhota, Tam, & Hasher, 2005; Hess, Hinson & Hodges, 2009) and also increased dependency among the older adults in the study (Coudin & Alexopoulos, 2010). Psychologist, mental health counselors and social worker were found to have age-related biases (Danzinger & Welfel, 2000; Helmes & Gee, 2003; Kane, 2004; Kane 2008; Lee, Volans, & Gregory, 2003; Roberts, 2008).   Mental health professionals misdiagnosed depression in older adults due to age bias (Lasser, Siegel, Dukoff, & Sunderland, 1998). According to a review of studies, mental health professionals were less likely to offer psychotherapy to treat older adults with depression than to offer drugs and were more likely to offer a poorer prognosis for older patients (Gatz & Pearson, 1988). Internalized ageism was shown to prevent older adults from seeking help if they believed the symptoms (like depression) were just part of growing older (Sarkisian, Lee-Henderson, & Mangione, 2003).

Many age-based misconceptions, biases, and ageism stereotypes were based on contemporary research performed on a non-representative portion of people over 65,

namely older adults in nursing homes (Butler, 1969; 1998b). Nursing home residents were studied and the findings were incorrectly generalized to represent the entire older adult population. Since 95.8% of people over 65 were not in nursing home and since research on aging was performed on older adults in nursing homes, information on aging lacked a proportional representation of well elders (Woolf, 1998b, para. 6).

Misconceptions of older adults and age-based biases permeated the literature on counseling older adults. From Freud (1905/1953) to the National Institute on Health (Scogin & McElreath, 1994, p. 69), ageism was found in all areas of counseling and care of older adults. Thus, ageist thinking influenced mental health counselors and their work with older adults. Danzinger & Welfel (2000) "found that mental health professionals judged older clients significantly less competent and less likely to improve than younger clients" (p. 135). Helmes & Gee (2003) found that when presented with two vignettes in which only the client's age had been changed, mental health professionals rated the older client as being less able to connect with the counselor, less able to get well, and less appropriate for counseling. The counselors were also less willing to accept the older adult as a client. When Kane (2004) presented Bachelor and Master level Social Workers with two vignettes in which only the age of the client had been change the participants statically showed that they thought the older client was less likely to recover, had "lived long enough" and the best way to counsel her was to help her "prepare for death." The client in one the vignette was 72 and in the other was 38. In addition, a significantly less percentage of participants felt the client should be referred to psychotherapy (92.9% versus 79.3%).

It has been shown that mental health professionals misdiagnosed depression in older adults due to age bias (Lasser, et al., 1998). According to a review of studies, mental health professionals were less likely to offer psychotherapy to treat older adults with depression than to offer drugs and were more likely to offer a poorer prognosis for older patients (Gatz & Pearson, 1988). Ivey, Wieling, & Harris (2000) showed marriage and family therapists did not perceive elder couple issues "as seriously as are identical concerns presented by younger couples" (p. 163). By 2030, the older adult population has been expected to be twice as large as it was in 2000, growing from 35 million to an estimated 72 million, thereby representing 20% of the total population of America (Federal Interagency Forum on Aging-Related Studies, 2010).

Emerging research discounted the previously believed age-based stereotypes. For example, when creative lives were analyzed by "career age" and not physical age, no difference was found in late life potential for creative output in older adults (Simonton, 1998). Although changes in creative resources (intellectual processes, knowledge, personality, intellectual style, motivation, and environmental context) over the lifespan were observed, creative performance averaged out to the same (Lubart & Sternberg, 1998). The aging process which involves the development of postformal thought was shown to allow greater creativity in problem solving (Sinnott, 1996; Sinnott, 1998).

With regards to creativity and the arts, it was written that it might be the challenges of aging that deepens and enriches the artistic process (Lindauer, 1998; Ravin & Kenyon, 1998). Lindauer (1998) stated "the substantial number [of artists] who have remained creative into old ages suggests that involvement in the arts may have a positive,

healthy and therapeutic effect on those who become involved with the arts late in life" (p. 248).

Though there has been research on aging, the studies mentioned did not look at the lived experience of aging as reported by older adults. Older adults were studied but not listened to in the research. By contrast, this dissertation explored the lived experience of aging through the analysis and coding of interviews with ten independent people over 65 years old living in diverse locations around the world. The researcher was an active listener and diligent reporter, striving not to promote or isolate the more prevalent, diverse, or sensational. With a desire to minimize bias data were presented as found even when it reinforced existing stereotypes as well as when it presented otherwise unseen angles of the aging experience.

Though some of the findings supported aging stereotypes, it was found that the participants held an "inner age" that was 30-40 years younger than their physical age, that the participants did not see themselves as "old," that "old" meant physical disability or poor attitude, and that "connectedness" was important in life fulfillment. These findings were used to develop guidelines for critiquing expressive therapies literature which discussed working with older adults (Appendix A). Expressive therapies was chosen for the sample literature because of its wider therapy reach, dealing with both verbal and non-verbal therapy interventions. Both positive and negative examples of the guideline applications were chosen from expressive therapies literature (Appendix B).

CHAPTER 2

Literature Review

Old Age and Older Adults: Statistics, Research and Reality

The Administration on Aging (2009) reported people turning 65 could expect to live another 18.6 years. Thus, a person born in 2007 could expect to live 30 years longer than someone born in 1900. Advances in medicine, health and healthcare have extended the lives of elders by 4.2 years since 1960. With longevity increasing and the baby boomer generation (people born between 1946 and 1964) turning 65 as of 2011, the population of older adults (people 65 years or older) has been on the increase. As of 2008, older adults were 12.8% of the population or one in eight Americans (Administration on Aging, 2009). By 2030, the number of people 65 years of age and older has been expected to be twice as large as it was in 2000, growing from 35 million to an estimated 72 million and representing 20% (or 1 in 5) of the total population of America (Federal Interagency Forum on Aging-Related Studies, 2010).

However, the large portion of current research in psychology and similar fields was performed by universities with college students as research subjects. Not only did this bring generalizability into question but it also negated the ability to use the research to explore developmental processes as it excludes other age groups (Hess & Blanchard-Fields, 1999, p. xviii). In addition, the majority of research originally done on aging was poorly controlled. Researchers went to where "the aging" were easily accessible, long-term care facilities. Thus, the research done on aging and on older adults has been done on "non-well, institutionalized older individuals" (Woolf, 1998b, para. 6). Since, "only 5 percent of the older adult population is institutionalized…poorly controlled

gerontological studies have reinforced the negative image of the older adult" (para. 6)

without broadening the research to include the other 95% of well, active older adults.

Current research, limited though growing, countered the preconceived notions of older adults and aging. Dr. Gene Cohen in *The Creative Age: Awakening Human Potential in the Second Half of Life* (2000) and *The Mature Mind: The Positive Power of the Aging Brain* (2005) presented that older adults were just as creative in their later years as at any other time in their life. It has been shown through neurological scans that emotional well-being (defined as emotional stability) improved over the human lifespan (Williams, Brown, Liddell, Kemp, Olivieri, Peduto, & Gordon, 2006). Dr. Bill Thomas in answering the title of his book *What Are Old People for?: How Elders Will Save the World* (2004) argued it was a necessary evolutionary function that older adults existed because through them the perpetuation of the species occurs. Thomas proposed that evolution favored older adults as they carried the stories of survival, interacted with youth freeing parents to hunt, and imparted to the youth and adults needed information for the continuation of the species. Thomas put forth that without older adults, the human species dies.

Old Age Stereotypes and the Perpetuation of Ageism

Research in the area of aging has failed to take in the experience of all older adults, thereby limiting society's understanding of older adults and their abilities (Woolf, 1998b). These narrow concepts have led to stereotypes, and a formalized prejudice against older adults named ageism. Gerontologist, Robert N. Butler (1969) has been given credit for coining the term "ageism." However, the definition Butler originated was strictly in relationship to prejudices against older adults. Only later was the term

expanded by others to include discrimination against any group based on age (Robinson, 1994).

Woolf (1998a) acknowledged the broader definition of ageism but used Butler's definition when she stated there were two fundamental differences between prejudices towards older adults and prejudices towards other types of people. First, Woolf stated whereas "race and gender remain constant" (para. 3), age continually changes. Second, unless one died early, one would become old. Thus, everyone (no matter what race, gender, sexuality, ability, disability, etc) had the potential of experiencing prejudice based on their age and thus also had the potential to internalize that prejudice lowering their self-concept.

In discussing the basis for ageism in America, Woolf (1998b) reviewed four possible contributing factors (a) fear of death, (b) a youth-based culture, (c) America's evaluation of value based on productivity and (d) a dominant amount of research conducted on aging was conducted in long-term care institutions. Moller (2000) commented that America's fear of death could be seen in the movement of society to care for the dying in one's house to placing the dying in a hospital. By this movement from home to hospital, "dying is removed from the social and moral fabric of the culture" (Moller, 2000, para. 3). In an interesting commentary on American society, Wilson (2007) stated Americans spent thousands of dollars on miracle medicines but did not seem willing to exercise and eat healthy. America's fear of death was so strong that "in essence, many of us would rather live long, stretched out and possibly mediocre lives rather than amazing yet short ones" (para. 11).

America's prejudice towards the elderly was also linked to its emphasis on the youth-based culture. "For example, the media, ranging from television to novels, place an emphasis on youth, physical beauty, and sexuality…The emphasis on youth not only affects how older individuals are perceived but also how older individuals perceive themselves" (Woolf, 1998b, para. 4). Another factor contributing to ageism was found to be America's evaluation of worth based on economic productivity. Elders and children were considered a drain on society. Children, however, were seen as the future and thus carry a redeeming value for economic investment. The aged, on the other hand, though not considered "unproductive" per se, were devalued as economic liabilities. (Woolf, 1998b)

The final contributing factor in Woolf's (1998b) review of the research on ageism was the bulk of research originally done on aging was poorly controlled. Researchers went to were the aging were easily accessible, long-term care facilities. Thus, the research done on aging and the aged had been done on "non-well, institutionalized older individuals" (para. 6). Since, "only 5 percent of the older population is institutionalized…poorly controlled gerontological studies have reinforced the negative image of the older adult" (para. 6) without broadening the research to include the other 95% of well, active older adults.

The impact of ageism on society and on older adult's view of themselves was found to be significant. For example, older adults given tests for recall performed statistically poorer when indications were made the tests were harder for elders (Hess, Hinson, & Hodges, 2009). Additionally, elders performed less well on tests when told the research was to test "how good their memory is" as opposed to testing "their ability to

learn facts" (Chasteen, et al., 2005). In both studies, control groups of elders mixed with younger people revealed no difference between the elders' and younger people's abilities to learn, remember and recall. The indication was that internalized stereotype beliefs about aging (in this case memory being affected by age) was more a factor in poor performance than a person's age itself. The internalizing of age stereotypes was found to be insidious, beginning up to 23 years prior to one being old (Levy, Slade, Kunkel & Kasl, 2002). Additionally, a positive self-perceptions of aging has been linked to a 7.5 year increase in life expectancy (Levy, et al., 2002). The same study pointed out by contrast that lowering cholesterol added only 3-4 years to a person's life.

Old Age and Older Adults: Words and Definitions

Old age has been a topic not comfortably discussed. Even groups trying to establish unbiased guidelines for writing about age found it difficult to strike the right tone. Whether caution and courtesy on one hand or societal fears and ageism on the other hand, adequate and non-offensive words have been hard to obtain. The American Psychological Association's Publications Manual (2010) seemed to struggle with the wording in its section on "Reducing Bias by Topic." On the topic of "Age," the manual read as follows:

> Age should be reported as part of the description of participants in the Method
> section. Be specific in providing age ranges; avoid open-ended definitions such
> as "under 18 years" or "over 65 years." *Girl* and *boy* are correct terms for
> referring to individuals under the age of 12 years. *Young man* and *young woman*
> and *female adolescent* and *male adolescent* may be used for individuals aged 13
> to 17 years. For persons 18 years and older, use *women* and *men*. The terms

elderly and senior are not acceptable as nouns; some may consider their use as

adjectives pejorative. Generational descriptors such as *boomer* or *baby boomer*

should not be used unless they are related to the study on this topic. The term

older adults is preferred. Age groups may also be described with adjectives.

Gerontologists may prefer to use combinations terms for older age groups (*young-*

old, *old-old*, *very old*, *oldest old*, and *centenarians*); provide the specific age of

these groups and use them only as adjectives. (p. 76)

The only noun the manual offered in this passage was "older adults" but exactly who the

population being referred to was not clear. The sentence might have been linked to the

one before in which "boomer" and "baby boomer" were mentioned, but the majority of

the baby boomer population (generally those born between 1946 and 1964) were still

within what was considered middle age (40-60 years old) when the manual was written.

Thus, the term "older adult" was a person 46 years old or older at that time. The same

passage referred to "elderly" and "seniors" which proceeded the statement about baby

boomers and the terms "young-old," "old-old," "very old," "oldest old" and

"centenarian" which followed the statement. The reader had to question if the APA thus

allocated 46 year old people to the same over all category as centenarians.

In the quoted APA passage, there were no guidelines or definitions for terms

(unless one was a gerontologist) to use with "persons 18 years and older" except for

"women," "men" and "older adults." Whereas, there were clear definitions and age

ranges given for the use of "girl" and "boy" (under the age of 12 years) and "young

man," "young woman," "female adolescent" and "male adolescent" (for individuals aged

13 to 17 years). There were six words offered to describe people in the first 18 years of

life but only three offered to describe people in the last 80+ years of life. Thus, a stated

time was established by the APA when a "young" woman could be referred to as a

"woman" or a "young" man could be called a "man" but no time at which a person was

referred to as an "old" woman or an "old" man.

The APA's reserve on defining the "older adult" population by a numerical age

might have been sensitivity to bias-laden words and a caution to avoid being seen as

pejorative. The APA did allow gerontologist, schooled in terminology, more options for

words to describe later life (young-old, old-old, very old, oldest old and centenarian) but

the gerontologist still needed to define the parameters of the usage by age. For the non-

gerontologist, the only term offered was "older adults." There was no reference point

offered for "adult" except through the supposition that "adult" was a person over the age

of 18, leaving a large range of age that could be considered "older." The APA clearly

defined "youth" by a numerical age but offered no definition of old age by the number of

years lived. The APA might have been reflecting the fear of aging and death Woolf

(1998b) discussed or might have been so sensitive to the issue as to avoid taking a

position.

It was found that this hesitancy to define "old" by a number of years was not just

the APA's. Webster's New Collegiate Dictionary (1977) had an entry for "middle age"

which it defined as between "40-60" years old (p. 728) but had no entry for "old age."

No term was offered for someone over 60 years old. "Older adult" did not have an entry

either. "Old" was defined as someone or something "advanced in years" (p. 798), but the

dictionary did not specify the number of years. The Concise Oxford American

Dictionary (2006) described "middle age" as "the period between early adulthood and old

age, usually considered as the years from about 45-65" (p. 560). In that passage, "middle age" was been redefined in the 29 years between these two dictionaries. The lower end had increased from 40 to 45 and the upper end from 60 to 65. With this in mind, "old age" was seen as starting at 65. However, the entry for "old age" read "the later part of normal life" and "the state of being old" (p. 616). "Old" was "having lived for a long time; no longer young" (p. 615). The best the Concise Oxford American Dictionary (2006) offered was an inference of when old age begins but did not define it by numbers as it does with middle age.

A person who lived to be 100 years old or older was defined as a "centenarian" (Webster's New Collegiate Dictionary, 1977, p. 180; Concise Oxford American Dictionary, 2006, p. 142). This definition incorporated the number of years lived into the description, "cent" referring to 100. On the other hand, "antique" was defined as "a work of art, piece of furniture, or decorative object made at an earlier period and according to various customs laws at least 100 years ago" (Webster's New Collegiate Dictionary, 1977, p. 50). The Concise Oxford American Dictionary (2006) stated an "antique" was "a collectible object such as a piece of furniture or work of art that has a high value because of its considerable age" (p. 34). In these definitions, objects that were 100 years old or of considerable age were seen as valuable. However, the term used to describe people of age equal to the object's age were given a term coined from the number of years lived with no mention of their worth.

Whether the hesitancy of the dictionaries and APA to define old age was ageism or just caution, they reflected society's dislike and fear of the topic of aging. At some undefined age the wonder of being young and growing up was replaced by a code of

silence about being old. This dissertation did not shy away from defining its terms. By doing so it was not trying to point out who was old, but rather to help society incorporate all the realities that are found in aging for a greater comprehensive understanding of the phenomenon.

Older Adults and Elders

With regards to the discussion above and taking parts of each definition, this paper used the term "older adults" to describe people 65 years of age and older. In addition, this paper sought to incorporate a sense of worth and value into the definition of "older adult." Thus, the term "elder" was chosen as an interchangeable term. An "elder" was described as someone "advanced in age" as well as a "leader" in a "tribe or group" (Concise Oxford American Dictionary 2006, p. 289). Additionally, the term "elder" referred to someone "having authority by virtue of age and experience" (Webster's New Collegiate Dictionary, 1977, p. 365). The APA Publication Manual (2010) stated the use of "elderly" as possibly "pejorative" (p. 76) when used as an adjective. With respect to that, this paper used the term "elder" only as a noun. Thus, "older adult" and "elder" were used interchangeably in this dissertation to refer to people 65 years of age or older, connoting at the same time value and honor.

Ageism

Webster's New Collegiate Dictionary (1977) defined ageism as "prejudice or discrimination against a particular age-group and especially against the elderly" (p. 22). Concise Oxford American Dictionary (2006) stated ageism as "prejudice or discrimination on the basis of a person's age" (p. 16). It left out any reference to prejudice against "older adults." This omitting kept with the modern reference to ageism

which has been expanded to encompass any prejudice or stereotyping due to age, not just with regards to older adults (Robinson, 1994). The predisposition to one age over another was not in itself ageism, but rather ageism happened when one age excluded, demeaned or ignored another individual or group because of their age. As has been mentioned, Gerontologist, Robert N. Butler (1969) has been given credit for coining the term "ageism." However, the definition Butler originated was strictly in relationship to prejudices against elders. Since this dissertation specifically focused on people 65 year of age and older, the term "ageism" was used according to Butler's original definition being prejudices against older adults.

Therapy Versus Therapeutic

In counseling older adults, ageism and misconceptions of old age and older adults have found their way into the words used to describe approaches to working with elders. In a review of counseling terms, it was found the words "therapy" and "therapeutic" were often used interchangeably and incorrectly. The repercussions of this misuse have been subtle yet profound. The obvious difference between the two words was found to be therapy was a noun and therapeutic was an adjective. Therapy was "the treatment of mental or psychological disorders by psychological means" also a "treatment intended to relieve or heal a disorder" (Concise Oxford American Dictionary, 2006, p. 943). Therapeutic was defined as "having a good effect on the body or mind; contributing to a sense of well-being" (p. 943).

The lines have blurred between these two terms as was found in an online article called "Therapeutic Group Activities for the Elderly" (Jones, 2010). The preliminary part

of the article stated, "as people age, their bodies and minds may get slower…" (para. 1),

revealing ageism stereotypes from the start. It continued by stating this slowing down…

> can limit the type of activities that they can do. However, there are still many
>
> options that provide much needed stimulation. Exercise classes, dancing and
>
> outdoor adventures can be practiced individually or in group settings and offer
>
> many therapeutic benefits for the elderly. (para. 1).

It was agreed that these activities have benefit for participants. However, exercise

classes, dancing and outdoor adventures, though beneficial, could not be seen as therapy.

The article talked about exercises such as hiking, yoga, tai chi and swimming.

Jones stated that yoga could be modified for older adults. Then, Jones quoted Dr. Zelter

as saying yoga was "highly therapeutic and safe for people with medical conditions,

including chronic pain." Jones did not make mention of any training a leader of these

activities might need. In fact, the presentation that yoga was "safe" might imply to the

reader he could lead a yoga group for older adults without training even though Yoga

instructors should be trained and certified.

Even with these nuances, the article does not cross the therapeutic-therapy line

until it started to discuss dancing.

> Dancing provides the elderly with an alternative way of expressing themselves
>
> and can be a group therapy activity. According to the Health Professions
>
> Network, dancing can be a tool used in managing stress, improving self-esteem
>
> and confidence, and building relationships. (para. 5).

When Jones used the term "group therapy," he started to blur the line between the "therapeutic group activities" in his title and "group therapy." The article went on to state,

> There are many ways to incorporate group dancing, such as dance nights, partner dancing, group-led dancing and team dancing. The American Dance Therapy Association defines dance therapy as "the psycho-therapeutic use of movement to promote emotional, cognitive, physical and social integration of individuals."
> (para. 6)

The quote within the quote above showed the author was familiar with the American Dance Therapy Association's (ADTA) description of dance as therapy. However, the author's use of the description was misleading. Though it was true the ADTA defined the psychological benefits of dance therapy as described, the ADTA did not propone that "dance nights, partner dancing, group-led dancing and team dancing" (para. 6) though potentially therapeutic, were therapy. The use of the ADTA statement by the author and the use of the term therapy in the paragraph prior misrepresented therapy as something anyone could perform just by doing these activities.

The next section of the article described outside adventures and Jones finished the article with the following statement. "Fishing, nature walks, gardening, bird and wildlife watching, outdoor community service such as trash clean-up, and helping with outdoor animal adoption events can all be used as group therapy" (para. 8) The last words of the article clearly stated the "therapeutic activities" in the title were synonymous with "group therapy" (para. 8).

If the term therapy was seen as a "treatment" and treatment was defined as "medical care given to a patient for an illness or injury" (Concise Oxford American Dictionary, 2006, p. 970), one could not imagine a casual walk or picking up garbage as "group therapy" as the article proponed. It was understood that under the right medical professional, such activities could be utilized for therapy as could art making, dancing, playing music, writing, acting, as well as talking. Also understood was that in talk therapy or psychotherapy, a client who talked to a trained professional in a therapy session could make greater and more direct progress than simply talking to a friend. This proactive interaction was seen as true for the beneficial use of art supplies, movement, instruments, paper and pens, and one's body and voice when employed by a trained professional.

Thus, the differentiation for this dissertation between the words therapy and therapeutic was defined as follows. Therapeutic: an adjective to describe the beneficial side effects of an activity, which promote a sense of health or well-being. Therapy: the proactive use of beneficial activities combined with psychotherapy to promote health, to gain sense of well-being and work towards resolution performed by a trained professional. In other words, therapeutic was used to describe activities with non-directive tangential gain whereas therapy was used to describe active approaches to those gains.

Counseling Older Adults

Counseling Older Adults: Ageism.

Since the inception of psychotherapy, ageism has been integrated into the

literature of counseling older adults. Sigmund Freud (1905/1953) ageist belief was seen

in his comparison between younger and older clients.

> The age of the patients has this much importance in determining their fitness for
>
> psycho-analytic treatment, that, on the one hand, near or above the age of fifty,
>
> the elasticity of mental processes, on which treatment depends, is as a rule lacking
>
> – old people are no longer educable – and, on the other hand, the mass of material
>
> to be dealt with would prolong the duration of the treatment indefinitely. In the
>
> other direction the age limit can be determined only individually; youthful
>
> persons under the age of adolescence are often exceedingly amenable to
>
> influence. (p. 264).

In addition to the ageist division of fitness for counseling between young people and

older adults, Freud made two clear statements concerning older adults and counseling.

First, older adults were unfit for psychotherapy because they were unable to learn due to

their lack of mental elasticity. And second, older adults had so much "material to be

dealt with" that treatment could be indefinite.

From Freud till now the belief that people over a certain age could not benefit

from psychotherapy continued.

> The National Institute of Health (NIH) Consensus Development Conference on
>
> Diagnosis and Treatment of Depression in Late Life (Washington, DC) concluded
>
> that psychosocial interventions for older adults experiencing depressive symptoms
>
> were only "moderately effective" and were listed third in a hierarchy of

recommended treatments behind pharmacotherapy and electroconvulsive therapy.

(Scogin & McElreath, 1994, p. 69).

In other words, the NIH stated medication and electroconvulsive therapy were more effective and preferred treatments for depression in late life than counseling.

The NIH's position was reverberated in this story from Dr. Bill Thomas (1996).

Often I ask the medical students who study at my facility to choose which causes more suffering in a typical nursing home: congestive heart failure or loneliness. They nearly always answer that loneliness is the worse of the two. Then I ask, "What is the most effective treatment for loneliness?" Usually, there is a moment of painful thought before a student suggests that a course of haloperidol or desipramine may do the trick. When I answer that providing companionship is the most fitting response, a small smile of relief spread across their faces.

"Ah, it was just one of those funny nonmedical questions that Dr. Thomas is always asking" (p. 23-24).

Just as the student in this example discounted the question because was nonmedical, mental health professionals who work with people over 65 exhibited subtle and overt ageist attitudes. Research studies on ageism among psychologist, mental health counselors and social worker revealed age bias among all the mental health practitioners (Danzinger & Welfel, 2000; Helmes & Gee, 2003; Kane, 2004; Kane, 2008; Lee, Volans, & Gregory, 2003; Roberts, 2008). Danzinger & Welfel (2000) "found that mental health professionals judged older clients significantly less competent and less likely to improve than younger clients" (p. 135). Helmes & Gee (2003) found that mental health professionals rated the older clients in two vignettes where only the age had been

changed as being less able to connect with the counselor, less able to get well, and less

appropriate for counseling. The counselors were also less willing to accept the older

adult as a client. When Kane (2004) presented Bachelor and Master level Social Workers

with two vignettes in which only the age had been changed the participants statically

showed that they thought the older client was less likely to recover, had "live long

enough" and the best way to counsel her was to help her "prepare for death." The client

in the vignette was 72 as opposed to the younger client in the other vignette who was 38.

A significantly less percentage of participants felt the client should be referred to

psychotherapy (92.9% versus 79.3%).

Mental health professionals misdiagnosed depression in older adults due to age

bias (Lasser, et al., 1998). And, according to a review of studies, mental health

professionals were less likely to offer psychotherapy to treat older adults with depression

than to offer drugs and were more likely to offer a poorer prognosis for older patients

(Gatz & Pearson, 1988). Ivey, Wieling and Harris (2000) showed marriage and family

therapists did not perceive elder couple issues "as seriously as are identical concerns

presented by younger couples" (p. 163).

Counseling Older Adults: Research.

In contrast to Freud (1905/1953), the NIH report and Thomas' medical students,

there have been studies which showed psychotherapy was beneficial for older

participants suffering with major depressive disorders (Kennedy & Tanenbaum, 2000;

Knight, 1993; Knight, 1999; Knight & McCallum, 1998; Leszcz, Feigenbaum, Sadavoy,

& Robinson, 1985; Scogin & McElreath, 1994). In addition,

- *Behavioral Therapy* was shown to provide an equal recovery rate for older

adults suffering from a major depressive disorder when compared to research on recovery rates of similar therapies with younger depressed people (Thompson, Gallagher, & Breckenridge, 1987).

- *Bibliotherapy* (the use of reading assignments in conjunction to therapy sessions), though needing more research, was found in a small study to "be a useful adjunct to psychotherapy for depressed older adults," and might "facilitate more rapid improvement and compensate for any limitations in the number of psychotherapy sessions" (Floyd, 2003, p. 194).

- *Brief Psychodynamic Therapy* matched recovery rates of younger people with depression to that of elders with major depressive disorder (Thompson, et al., 1987).

- *Cognitive Therapy* was found to produce similar recovery rates for older participants with a major depressive disorder as those found in the research about Cognitive Therapy recovery rates for depressed younger people (Thompson, et al., 1987).

- *Interpersonal Psychotherapy* (a goal-directed application of Brief Therapy) was shown to produced similar results in a case study with an older adult encumbered by major depressive disorder as in larger trials with young people with various mental health issues (Hinrichsen, 1999).

- *Reminiscence Therapy* (an approach which utilized the natural developmental aging process of retelling life stories) has been shown to reduce depressive symptoms and increase life satisfaction in older adults (Arean, Perri, Nezu, Schein, Christopher, & Joseph, 1993; Cook, 1998; Jones & Beck-Little, 2002;

Pasupathi & Carstensen, 2003; Watt & Cappeliez, 2000).

- *Social Problem-Solving Therapy* (a skill-oriented Cognitive-behavioral approach) was found to be effective in reducing symptoms and depression in older adults (Arean, et al., 1993).

In some cases, the research actually showed the therapy worked better with elders, countering Freud's (1905/1953) assertion that older adults needed indefinite amount of time to get well. Contributing factors to these findings might have been in the study of Cognitive Behavioral Psychotherapy (Walker & Clarke, 2001), the elder's attendance was better and, in the study of Short-term Psychotherapy (Gorsuch, 1998), the researchers remarked that elders had a greater commitment to the work of psychotherapy knowing their "time" on earth was limited (p. 201).

Counseling Older Adults: Reminiscence and Life Review Therapy.

Knight (1999) has written that some adjustments might be needed when using a therapy with an older adult but "not because they are older" (p. 931). Rather Knight (1999) remarked the adjustments were needed because of the elder's context (where they live: retirement centers, nursing homes, etc), because of the elder's cohort (having different values, skills and life experiences), and/or because of the different therapeutic skills and specific knowledge needed to work with older adults, but "not because of the client's age" (p. 932). Laidlaw (2001) stated "there is no evidence of therapeutic necessity to adapt cognitive therapy in order to make it suitable and accessible for older adults without cognitive impairment or in the absence of frailty" (p. 11). The aforementioned studies listed above made no mention of age-based adaptations for the counseling approaches that were researched. "There is no justification for arbitrary age

cut-offs in making decisions about the appropriateness of psychological treatment, and

good practice with younger adults is just as applicable in later life" (Wood, 2003, p. 129).

Knight (1993) stated "psychotherapist who have worked with older adults, describe the

experience as valuable for the client and rewarding for the therapist, whereas those who

have not argue that the aged cannot benefit from psychotherapy" (para. 1).

Reminiscence therapy arose as particularly geared for work with elders for it has

been observed that people over the age of 65 naturally partake in the act of reminiscing.

Butler (1963), who was the first to make this observation, defined reminiscing as follows:

A naturally occurring, universal mental process characterized by the progressive

return to consciousness of past experience, and particularly, the resurgence of

unresolved conflicts; simultaneously, and normally, these revived experiences and

conflicts can be surveyed and reintegrated. Presumably this process is prompted

by the realization of approaching dissolution and death, and the inability to

maintain one's sense of personal invulnerability. It is further shaped by

contemporaneous experiences and its nature and outcome are affected by the

lifelong unfolding of character. (p. 66).

This naturally occurring act has been shown to benefit elders. Wong and Watt

(1991) summarized their research stating reminiscences increase self-understanding,

increase self-esteem, increase personal meaning, increase life satisfaction, help in

acceptance of one's past, aid in the reconciliation of differences between ideal and

reality, help in acceptance of negative events, and increases resolution of past conflicts

(para. 11). Wong and Watt identified six forms of reminiscing: integrative, instrumental,

transmissive, escapist, obsessive, and narrative. Integrative reminiscence's function was

"to achieve a sense of self-worth, coherence, and reconciliation with regard to one's past" (para. 11). Instrumental reminiscence used "memories for providing evidence of past successful coping and for identifying appropriate coping strategies" (para. 12). Transmissive reminiscences helped to pass on one's personal legacy and cultural heritage (para. 13-14). Escapist reminiscence tended to down play the present and glorify the past (para. 15-16). Obsessive reminiscence emerged from one's guilt of one's past or ruminations over disturbing past experiences (para. 17). Finally, narrative reminiscences primarily described rather than interpret recollections (para. 18-19). Wong and Watt stated that successful agers had a greater occurrence of integrative and instrumental reminiscences (para. 63). Reminiscence therapy provided an environment in which these two forms of beneficial reminiscences were encouraged.

In practice, the therapist presented a topic and facilitated a discussion among the participants. For example, a picture of a cast iron stove was shown and a conversation about stoves, cooking, mealtimes, or baking bread might ensue. This approach aimed at encouraging instrumental and integrative reminiscences. The benefits of reminiscence therapy emerged from the natural healing by-products of a positive story-telling environment. According to the definition of therapy versus therapeutic earlier in this dissertation, this type of reminiscing activity could be considered therapeutic rather than therapy in that the benefit was a by-product not the goal itself.

Life review therapy arose as distinct from reminiscence therapy as it focused on purposeful resolution of life issues. As the name implies, life review therapy aided a client through their life remembrances, stopping to deal with problematic time periods. Through this process the synthesis and integration of the good and bad of a person's life

occurred and the person embraced their life as their "one and only life cycle" (Erikson, 1963, p. 269). When and if this happened, the participant was considered to have resolved the Integrity vs. Despair stage of Erikson's developmental model. In an attempt to help facilitate the life cycle resolution, life review therapy had been adapted into various formats and uses such as: guided autobiography (Malde, 1988) in which clients record their life story and spiritual life review (Lewis, 2001) in which clients revisit spiritually significant chapters of their life story. Life review therapy and its derivatives sequentially called forth both positive and negative reminiscences and proactively sought to integrate these recollections into the client's larger life narrative.

Reminiscence and life review therapy were seen as different yet often referred to interchangeably. Reminiscence was the act of recalling past life events whereas life review was the act of recalling life events with an evaluation of those events (Burnside & Haight, 1992; Staudigner, 2001). Though reminiscence was used in the life review process, life review could not have been done through simple reminiscing.

Burnside & Haight (1992) differentiated between the two activities further by insisting that life review therapy was done one-on-one with a "therapeutic listener" and that a group format for life review therapy was at best a borderline use. In contrast, Garland's (1994) chapter on life review therapy noted group applications of the life review process and their benefits (p. 28). In addition, other authors have referred to life review therapy as group work (Aday & Aday, 1997; Toseland, 1995). Burlingame (1995) stated that participants of life review therapy were "often in groups" (p.160). Burnside and Haight (1992) also differentiated the two activities by listing the benefits of reminiscence as mostly relating to social interaction (i.e. increased positive behavioral

responses, increased communication skills, etc.) whereas the benefits of life review

therapy were listed as being more psychological in nature (i.e. increased life satisfaction,

decreased depression, increased sense of self, etc.) (p. 860). However, the delineation of

these benefits of reminiscing and life review were not as clear cut as Burnside and Haight

portrayed as there has been research which showed that reminiscing also increases life

satisfaction and decreases depressive symptoms (Cook, 1998; Pasupathi & Carstensen,

2003; Watt & Cappeliez, 2000). Thus the difference between reminiscence therapy and

life review therapy was not in their benefits (which overlap), nor in their application

(group vs. individual), but rather in their approach to reminiscences (casual vs.

proactive). Because they utilize at their foundation the beneficial advantages of

reminiscences, life review and reminiscence therapy seemed particularly suited for work

with older adults.

When one employed life review and reminiscence therapy, one needed to be

attentive to the potential uncovering of negative painful reminiscences. Regrettably,

reminiscence therapy has often been advertised to Recreation Directors of nursing homes

or adult day programs as a benign "therapeutic" activity geared to enhance participant's

natural development process. Through group discussions on various topics like

memories of cooking, vacations, family houses, etc, staffs have been encouraged to

facilitate memory stimulating sessions. Caution needed to be taken against a blanket

application of this practice (and of the ageism such a blanket application represented).

The natural unprompted process of reminiscing could uncover both positive and negative

events which could amplify if proactively probed by group memory activities. Knowing

how to bear witness to an elder's pain has been an important skill for those who engage

in reminiscence-based work with older adults. Most recreation directors in a nursing

facility have not been trained nor hold proper credentials in counseling and, thus, when

participants become unduly agitated the leader has been unequipped with how to properly

respond.

Counseling Older Adults: Trauma Work.

One of the areas least looked at in counseling older adults has been trauma work.

It was proposed that people who work with older adults needed to be aware that an

elder's behaviors and symptoms could have been the result of past trauma and not

necessarily connected to current activities. Many older adults have been reluctant to

discuss the past event, thus the connection of behavior to past trauma has not been

obvious. In a review of PTSD in elderly, Weintraub and Ruskin (1999) reported finding

up to 25% of heavy combat war veterans experienced symptoms of PTSD 45 years after

their return (p. 145). Holocaust survivors, people from war torn countries, displaced

South Africans, victims of torture and abuse survivors have existed, often unknown,

among the geriatric population. Thus, there has been a need for people working with

elders, no matter what the therapy approach or staff position, to be trained in trauma,

trauma symptoms and trauma recovery.

In the section on Posttraumatic Stress Disorder, the Diagnostic and Statistical

Manual of Mental Disorder IV-Text Revision (DSM-IV-TR) defined "extreme traumatic

stressors" as those that "involved actual or threatened death or serious injury, or a threat

to the physical integrity of self or others" (American Psychiatric Association, Diagnostic

and Statistics Manual IV Text Revision, 2000, p. 467). A person could either experience,

witness or be confronted with the event and their response could involve "intense fear,

helplessness, or horror" (DSM-IV-TR, 2000, p. 467). In a less specific definition, Webster's New Collegiate Dictionary (1977) defined trauma as "a disordered psychic or behavioral state resulting from mental or emotional stress or physical injury" (p. 1243). In recent times, the term trauma had become overused to mean "a deeply distressing or disturbing experience" (Concise Oxford American Dictionary, 2006, p. 969). Though it might be remiss to include any distressing experience to the realm of trauma, it has been thought the DSM-IV-TR's definition has been too restrictive. In terms of counseling, it seemed more appropriate to look at trauma by the effect the event had on the person rather than to focus on the event itself. For, there has been a difference existed between experiencing a traumatic event as opposed to being traumatized by the event. Some people have been devastated by one instance of molestation whereas others have walked away from years of sexual abuse relatively unscathed. Thus, the broader definition found in the Oxford Dictionary of Psychology was employed here, which stated trauma as "a powerful psychological shock that has damaging effects" (Colman, 2001, p. 755).

DSM-IV-TR's description of Posttraumatic Stress Disorder included the following list of potential symptoms of traumatic events: re-experiencing of the event, avoidance of stimuli connected with the event, numbing of responsiveness, increased arousal, and social functioning impairment (DSM-IV-TR, 2000, p. 468). Triggers for these symptoms (whether active or previously latent) included media, people, environmental, losses, and life changes (Murray, 2005). Though events which surfaced during therapy with older adults might not have met the standard for clinical diagnosis according to the DSM-IV-TR, the isolated symptoms have been viewed as still

distressing to the older person involved. Attention needed to be paid to the effects of trauma at whatever level they occurred not just when they were clinically significant.

Little has been written or researched on the application of present theories of trauma recovery as they apply to elders (Busuttil, 2004). However, modern literature has been divided into two categories: psychological approaches as with Dr. Judith Herman's work (1997) or psychobiological approaches as with Dr. Bessel A. van der Kolk's work (van der Kolk, McFarlane, & Weisaeth, 1996). The difference between these approaches was seen in how they list the effect of trauma on the client. Herman listed the psychological effects, such as alteration in affect regulation, consciousness, self-perception, perception of perpetrator, relations with others and systems of meaning (1997, p.121). On the other hand, van der Kolk (van der Kolk, et al., 1996) listed the abnormalities as being related to the psychophysiological functioning, neurotransmitters, hypothalamus-pituitary-adrenal axis, memory, neuroanatomical, and pyschoimmunologic functioning (2001, p. S51). Thus, one approach focused on the psychological and emotional effects of traumatic events and the other focused on the biological. Because of their emphasis, the authors viewed the recovery process from different angles.

Herman (1997) proposed a three stage approach to working with trauma survivors which employed "talk therapy." In the first stage, the client was empowered to establish safety, power and control in their lives. This process started with the client's body and eventually moved outward to the environment (pp. 155-174). Once the client had gained some psychological integrity, the second stage of recovery began. Here telling the story in detail and mourning the loss occurred (pp. 175-195). The third stage focused on reconnecting with the world at large, first through one's own being and then through

others. In this stage, the traumatic event was integrated into the client's larger personal narrative. Though the symptoms could return from time to time, the client had been empowered to no longer be a victim to them (pp. 196-213). Other writers such as Briere (1996) and Chu (1998) aligned with the talk therapy approach. Chu (1998) even presented a three stage recovery process that referenced Herman's work (p. 86).

Van der Kolk (2002), on the other hand, approached trauma from the field of Neuroscience detailing the effects of traumatic events on the brain. Through advanced brain imaging, it was possible to view which areas of the brain were involved in which function. Neuroscientists have noticed during traumatic events there was a deactivation of the prefrontal cortex (the brain's area of analysis and language) and an interference of Broca's area (the brain's processing place which turns feelings into words). "Thus, traumatized people are ill equipped to talk about their traumas in rational or analytical fashion" (p. 385). Further, traumatic experiences were found to be stored in the subcortical areas of the brain that "are not under conscious control and possess no language" (p. 384). Trauma imprinted sensory information into the amygdala which then acted as an alarm when trauma related stimuli was near (p. 385). The amygdala's position in the subcortical region of the brain explained why "when people with PTSD relive their trauma, they have a great difficulty putting that experience into words" and why "they tend to talk 'around' trauma rather than facing it" (p. 387).

When approaching recovery from trauma, van der Kolk (2002) stated that traditional therapies, including Herman's (p. 388), which involved discussing the event in detail, had a high drop out rate "probably because patients feel too overstimulated re-experiencing the trauma without immediate relief" (p. 389). Van der Kolk further stated

that these therapies paid little attention to the body's chemical processing of the trauma. He made clients aware of the somatic states trauma produces and instructed them not to avoid them. Clients were to allow feelings rather than see them as threats. Through this process, clients were able to envision new solutions not merely react (p.389). Van der Kolk offered Eye Movement and Desensitization and Reprocessing (EMDR) as an example of a successful approach to trauma recovery that involved people remembering events but not just talking about them (p. 390).

Earlier in this dissertation, it was discussed that Wong and Watt (1991) revealed that two types of reminiscences were beneficial (instrumental and integrative). In the same research, they found obsessive reminisces, those dealing with unresolved "disturbing past events" (para. 17), were linked more frequently to "the unsuccessful elderly" (para. 63). Thus, recollections, remembrances and naturally occurring reminiscences were seen as negative and even detrimental. The frequency of each type of reminiscence varied based on the person and their ability to synthesize the meaning of these unresolved events. Thus, not all that has been recalled in old age could be seen as positive.

Linking van der Kolk's research which stated that trauma (disturbing past events) were held in a non-verbal part of the brain and the knowledge that as one aged the occurrence of reminiscing increase, it was proposed that reminiscences could also be non-verbal and these non-verbal reminiscences could increase with age. Positive example of reminiscences were memories stimulated by the smell of bread baking, the feel of a child's skin or the sound of a well-loved song. It was postulated that if there were positive non-verbal recollections, then there were also negative non-verbal ones.

The obsessive reminiscences that Wong and Watt (1991) discussed as being unadaptive forms of reminiscences (para. 63), were thought to also occur non-verbally. Negative non-verbal recalls happening to an adult below 60 are considered "flashbacks" and dealt with as part of a post-traumatic stress disorder. Yet, the person over 60 who had flashbacks was often medicated rather than offered psychotherapy. To complicate this matter, one needed only to look at the possible dual diagnoses that occur in some elderly people. Alzheimer's, stroke, and aphasia could lead to an inability to express one's self verbally, let alone to present non-verbal recollections.

Nursing homes had used restraints to keep clients from wandering, falling out of bed or harming themselves. Being restrained against one's will was seen as traumatic and thankfully many nursing homes have moved away from this practice. However for the aphasic elder who was forcefully raped in childhood, restraints could augment non-verbal reminiscences (flashbacks) and the elder would be unable to advocate for herself. Her thrashing could appear as resistance and medication would have been applied. The last years of this person's life would have been lived in fear and sedation with the staff believing they were acting with care and compassion.

The example above was one of many in which well-meaning yet myopic medical-model staff lost sight of a more global view of an older person. Applying an expansive holistic view of elder care with an understanding of the possible surge of non-verbal traumatic reminiscences, a need was seen to approach older clients with an appreciation of the client's entire life story if one was to provide true "health care." An understanding of the role of reminiscences was seen as crucial and education on the impact of both verbal and non-verbal negative recollections as essential.

If one identified that an elder was experiencing psychological pain from non-verbal reminiscences, one might attend to her. But how? As mentioned, van der Kolk (2002, p. 385-389) did not propone that trauma-based memories have been fully relieved through talk-based therapies. Thus, some thing more than talk-based therapies was sought to help elders integrate all the possible range of verbal and non-verbal reminiscences.

Expressive Therapies with Older Adults

Expressive therapies was seen to engage the symbolic and generally non-verbal expression of the inner psyche through an intermodal application of art-based therapies. These body-involved therapies, such as dance, music, art, drama, poetry and story-telling, provided environments through which a client could explore non-verbal personal narratives. At the foundation of expressive therapies theory was the belief that the mere act of self-expression was healing in and of itself (Blatner, 1996, p. 12). Ellen Levine wrote that "the imagination is implicitly therapeutic" (1999, p. 272). The imagination was "…the bridge from the internal to the external world" (Meyers, 1999, p. 244) allowing inner images to emerge from non-verbal hiding places.

"People require physical experiences that directly contradict the helplessness and the inevitability of defeat associated with the trauma" (van der Kolk, 2002, p. 388). Natalie Rogers, Carl Rogers' daughter, added "when trauma is too great for words, people may find that symbols, colors, movement, and sound provide acceptable paths for expression" (1993, p.145). For "imagery can speak when there are no words" (p.143). Art was seen as the documentation of imagery and imagery was the language of the non-verbal parts of the brain. The expression of that language was seen as being healing and

"often more expedient at revealing the psyche than talking" (Newham, 1999, p.90). Van der Kolk (2002) mentioned as an example of the societal need for art-based healing that theater had been used throughout history as a ritual for dealing with communal trauma. In his own clinic, theater was employed as an action-oriented approach aimed at transforming the participant's traumatic experiences (p. 388).

The writers of the theory went on to say that art was also the sustainer of the soul with a direct connection to one's emotional, psychological and physical well-being. Paolo Knill (1999) stipulated the regular practice of art might be part of a healthy diet (p. 50). Knill stated, "It would be reasonable to stipulate that dreams, imaginative thinking and play may belong to the psychic substances that when not available or not metabolized correctly may cause disturbances" (Knill, 1999, p. 50). Thus, providing environments of creative exploration was important not only for elders who have experienced trauma but for the well-being of all older adults. Limited access to creative output was seen to drain a person's imaginative energies. Yet, society has provided little opportunity to explore, express and learn through art-based activities beyond a certain age.

It has been observed the aging process deepened and enriched the artistic process and product (Ravin & Kenyon, 1998). Through the combined application of life review and expressive therapies, the elder could be aided in a sequential retelling of life stories while exploring those stories creatively. In this approach, reminiscences of the verbal and non-verbal types could be given environments in which they were presented, interacted with, integrated, ignored and/or discarded.

These art-based therapy opportunities could be important because "the body is full of information about who we are, how we feel and what we think - a living body

anthology" (Halprin, 1999, p. 133). For elders with no creative or therapeutic outlet, their

bodies could hold a life of stories and "what the soul cannot express, the body will

express" (Meyer, 1999, p. 242). The stories could find their way out through physical,

emotional and mental distress (Halprin, 1999, p. 133, 134). It was considered possible

that some of the symptoms that were currently being medicated could be relieved if

elders were given the opportunity to explore their non-verbal narratives through art-based

therapy.

The "work" of the expressive therapist was to create an environment in which the

client explored these inner images, worked with them in various forms and gave external

shape to them. Annette Brederode (1999) remarked, "My work with psychiatric patients

made me aware of how important it is to express and make visible with the help of

images that which cannot, or not yet, be verbalized..." (p.151). She stated,

> Strangely enough, the internal images, as well as the images on the paper or in the
>
> clay, are usually so primary and swift that they are far ahead of their meaning.
>
> The images can always be trusted; it usually just takes time to realize and accept
>
> this. (pp. 161-162)

"These images are the carriers of memory. They transport experiences from the past to

the here and now...The imaginative process becomes a healing process…" (p. 157). This

was not art in therapy; this was art as therapy.

Important to note, "it is the process, rather than the product, that heals..." (Rogers,

1993, p. 70). For many older adults (and people in general) there was a resistance to

creating art because they were afraid that the end result would not "look good." It has

been stated it was important to provide quality materials that could contribute to an

aesthetically pleasing result (Wald, 2003). However, the goal was not to produce "art." Art was the symbolic documentation of the process, the by-product of the therapy. Helping participants overcome their focus on the product could lead to greater exploration of their verbal and non-verbal reminiscences.

In applying expressive therapies to trauma work, especially as it applies to older adults, Meyer's (1999) description of people in transitional war-type camps was viewed as interesting and applicable.

> People who live in exile have often lost everything. They have lost the "house of the family," "the house of the community." The only house they have left is "the house of the body." Because this house often contains so much pain and "bad memories," the owner "moves out" in order to save his soul....Being exile from the body as a method to avoid the pain of trauma will, over time, give an individual the experience of belonging to the "living dead," a state where one feels totally isolated from life (p. 241-242).

The theory writers would urge for the inclusion of expressive therapies in work with traumatized elders with further research focused on the use of expressive therapies as a viable conduit for naturally occurring non-verbal reminiscences, such as traumatic memories, to be uncovered, processed, and integrated. The writers offered that expressive therapies helped clients circumvent their protective layers of emotional defenses, process events they could not give words to, find healing despite their inability to verbalize their pain, contact their inner self, integrate their being and re-enter the "house" of their bodies.

In a study on the use of drama therapy with older adults, Johnson (1985) stated that "by creating a playful and metaphorical atmosphere, conflictual material is expressed more easily since, if necessary, it can be more easily disowned" (p, 124). Through the process of disowning, the conflictual material was allowed to leave the body. As evidence of the potential physical benefits of the use of expressive therapies with elders, Johnson concluded by stating "the death rate in this group, which is in its fifth year, is one-third that of the nursing home at large…" (p. 125). This study testified to the power of inner symbols, of creative processing and of imaginative expression to stimulate healing resolutions even for lifelong issues.

In another study that utilized theater as a healing modality, 122 older adults in subsidized retirement homes participated in eight bi-weekly "theatrically based" interventions in which "cognitive-affective-physiological" trainings were used as "typically employed in college acting classes" (Noice & Noice, 2009, p. 56). A no-treatment control group and a singing group were used for comparisons. The study found using pre-test and post-test of "a battery of 11 cognitive/affective test measures" that "gains were achieved despite the fact that no aspects of the intervention supplied specific training or practice on the test measures" (p. 56). This study was a replication of a previous study done with community-dwelling adults yet revealed similar results.

These studies showed the benefit of expressive therapies for trauma resolution and other mental health concerns for older adults. Yet because the expressive therapies literature, counseling literature, society and research has proponed stereotypes of older adults, it was important to first ask older adults who were not in nursing homes, who were well, and who were in the community, what their experience of aging has been and

how they saw themselves as older adults. Then, it was important to take that information, develop guidelines for evaluating literature on counseling older adults and apply those guidelines. The rest of this dissertation followed these steps.

CHAPTER 3

Method

Participants

The ten participants for this study were chosen from a group of 12 older adults

interviewed in four countries (America, Israel, New Zealand and Australia). These ten

participants represented a wide diversity of people living in these various countries. They

represented diversities in socioeconomics, marital status, ethnicity, spirituality, gender,

age and, obviously, location. Diversity was sought to provide perspective. Two

interviews were not included due to the quality of the audio recordings.

Each participant had to be 65 years or older, willing to be interviewed, their own

power of attorney, and sign the consent forms. Nine participants were female, one male.

All participants were Caucasian. Two participants were married to each other. Two were

close friends. Six were widowed. One never married and one was married to someone

12 ½ years younger than she. The average age of the participants was 79.7 and the

median age was 84. Other breakdowns were as follows in Table 1.

Table 1

Chara*cteristics of Participants*

Participant	Age	Gender	Marital Status	Economic Background	Career	Spiritual Orientation	Place of Interview
Bernice	82	Female	Widow	Middle Class	Store Owner	Jewish Nationalistic	Jerusalem, Israel
Ceil	74	Female	Married	Upper Middle Class	Model Store Owner Mother	Jewish Conservative with spiritual mysticism	Marblehead, Massachusetts, United States
Herb	81	Male	Married	Upper Middle	Optometrist	Jewish Nationalistic	Marblehead, Massachusetts,

				Class			United States
Irene	71	Female	Widow	Upper Middle Class	Business Owner	Jewish Moderate	Jerusalem, Israel Lives in Florida, United States
Janet	80	Female	Single	Lower Class	Catholic Nun	Catholic Devote	Sydney, Australia
June	83	Female	Widow	Middle Class	Red Cross Agent	None Mentioned	Wellington, New Zealand
Lorna	72	Female	Married	Middle Class	Psychodramatist Counselor	Christian	Wellington, New Zealand Lives in Perth, Australia
Marguerite	84	Female	Widow	Lower Middle Class	Created School Counseling in New Zealand	Spiritual Non-specific	Auckland, New Zealand
Mena	75	Female	Widow	Lower Class	Housewife and Hospital Billing	Raised "very Catholic" no current orientation	Manchester, New Hampshire, United States
Nancy	94	Female	Widow	Lower Middle Class	Speech Therapist and Theater Instructor	Spiritual Non-specific	Wellington, New Zealand

Data Collection

A digital recorder captured the interviews. A video recorder, not aimed at the participants, provided audio backup. Recordings began as soon as participants gave verbal permission. Thus, all but the initial 10 minutes of each visit was preserved for analysis.

It was understood that interviews with older adults needed to develop at their own pace and not be forced (Butler, 1963; Bornat, 1994; Knight, 1996; Warnick, 1995). Thus, participants were allowed to pace the interview with the interviewer being attuned to cues the participant might be tiring. A balance between pace and length allowed the interview

questions to be explored while allowing a conversational pace. Participants were

interviewed up to three times for varying lengths of time from 60 to 150 minutes. The

breakdown of the interviews was as follows in Table 2.

Table 2.

Length and Number of Interviews

Participant	Number of Interviews	Total Length of Interviews Combined
Ceil	1 w/Herb	02:25:25 or 145:25 minutes
Herb	1 w/Ceil	02:25:25 or 145:25 minutes
Mena	1	02:04:07 or 124:07 minutes
Bernice	1 w/Irene	02:35:56 or 156 minutes
Irene	1 w/Bernice	02:35:56 or 156 minutes
Lorna	2	02:19:44 or 139:44 minutes
June	2	04:32:05 or 272:05 minutes
Janet	3	05:07:06 or 307:06 minutes
Marguerite	2	04:11:32 or 251:32 minutes
Nancy	2	04:11:55 or 251:55 minutes

Totals: 10 participants, 14 interviews, totaling 27 hours: 27 minutes: 50 seconds or

1647:50 minutes.

An hour or more of the total interview time was informal and focused on rapport

building with tours of the house and apartment, offers of hospitality, and "hellos" and

"goodbyes." The formal parts of the interview contained three distinct sections: the

signing of the informed consent, life and background questions, and thoughts on aging.

During the informed consent signing, all participants were given the opportunity to remain anonymous for any or all disclosures of information. Each participant expressed excitement to participate in the study and wanted to be connected to it through full name disclosure. The participants felt transparency was a virtue. "I don't have anything to hide." A decision was made during the writing of the report to use only the participants' first names to allow a personal connection to the study while maintaining confidential distance.

The second part of the formal interview focused on the participant's background. It was held that perspectives on aging were not found in a vacuum, but connected to the life of a person. Life experiences needed to be taken in context. Comments made on the meaning of aging needed to be viewed through the lens of the whole lived experience (Creswell, 1998, p. 51), not just the present phenomenon. Relevant parts of the participant's historical data were woven into the study when appropriate to deepen the perspective of the resulting data.

The third part of the interview focused on the meaning of aging itself, inviting the participants to discuss the aging process from different angles. All questions were open ended and aimed at creating a conversational tone, fostering safety and developing openness. Reflexive listening was employed to encourage elaboration. Whereas self-disclosure has not been the norm in research interviews, self-disclosure when interviewing older adults has been seen as important if appropriately used to build comfort and rapport. Such disclosures were used sparingly and with discrimination.

Each interview began with the following research statement:

You are invited to participate in a research project titled Cross-Cultural Analysis of the Meaning of Aging for Seniors. The purpose of this study is to explore the meaning of aging for seniors from different cultures. The researcher seeks, through interviews with people over 65 years old in various countries, to understand the meaning elders of different cultures give to the experience of aging.

The following questions provided the general outline of information to be gathered. The questions were used to stimulate conversation and direction, but the researcher was not limited to nor bound by these questions.

Introductory, background and rapport building questions:

1. Tell me about your family when you were a child. For instance, describe your parents, your siblings and other relatives.

2. Tell me about your ethnic background.

3. Tell me about your socioeconomic background.

4. Tell me about your religious background.

5. Tell me about your education.

6. Tell me about your work life.

7. Tell me about your adult family life.

8. Tell me about a significant life experience.

9. Tell me about a typical day in your present life.

10. Do you consider yourself a spiritual person? Tell me about that.

11. How do you experience this spirituality in your life?

Questions specifically on aging:

12. Tell me about getting older. Tell me more.

13. What is your experience of being older?

14. How old are you?

15. Tell me a story about being your age.

16. What would you like to say about growing older?

17. Have you experienced any benefits of growing older? Tell me about them.

18. Do you think there is a part of aging that everyone experiences?

19. How do you think you are perceived by your culture as an older person?

20. How do you feel about being what some would call "old"?

21. How would you describe your age?

22. How old is "too old"?

23. Is there something you would do differently in relation to growing older? If so, what would it have been?

Ending questions:

24. If you could live forever just as you are now, would you want to?

25. If you had one gift to give the world, what would it be?

The first set of questions were to build rapport and gather historical information. The next set of questions were on the topic of aging itself. The two end questions were developed to ease out of the interview.

Data analysis

Important information was sometimes exchanged in the non-specific discussions before and after a formal interview. Even though the participants answered research questions for 1 to 1 ½ hours, analysis was performed on the entirety of the recorded

information, including the informed consent, salutations, "small talk" and rapport building sections. The interviews were approached from a narrative therapy-informed stance viewing the entire "visit" as a narrative on the subject of aging. The stories being told as well as the environment in which the interviews were performed were observed with care.

All recorded information was transcribed by the interviewer-researcher to increase familiarity with the data. This approach allowed a third person stance when analyzing the data which aided in the analysis and coding. The transcribing of the 27+ hours of interviews produced 275 pages of single spaced transcription.

After the initial transcription was complete, a second and third review of the transcripts was performed to check precision and increase familiarity. Final copies of the transcriptions were produced and then loaded into Atlas.ti, a qualitative software analysis program. Atlas.ti did not analyze the data but rather allows for data to be read, coded, and studied in a digital environment. Atlas.ti simplified the viewing of linkages between salient passages and coded materials. Being able to manipulate the data in various ways allowed more options for observing the data by various grouping outputs. The steps in the analysis process were as follows.

First and second coding cycles followed guideline for *initial coding* described in Saldana (2009, pp 81-85) and final coding cycle followed *focused coding* methods (pp. 155-159). *Initial coding* worked well for these interviews in that it dissected the text into parts and examined them, looking for comparisons and differences. During f*ocus coding*, the data was mined for themes and categories.

Transcriptions of all the interviews were read as presented in Atlas.ti and codes were methodically assigned based on the content of the passages (*initial coding* cycle). Passages which seemed to hold content salient to the research or to the overall structures of the interview were given a name which was used over and over when and if that content arose again in the transcript. Multiple codes could be assigned to the same passage if appropriate. During the second reading of all the transcripts, data were mined for additional content-driven codes, while listening for passages whose content and meaning might need additional coding (*initial coding* cycle). Also during the second reading, the search function and the word count capabilities of Atlas.ti were used to capture all connections to certain emerging key codes or themes. During the third coding reading, emphasis was placed on eliciting references specifically concerned with the topic of aging and all its auxiliaries *(focused coding cycle)*.

Similar extensive coding was performed on three participant interviews in a pilot study called *Three on Aging: A Qualitative Study on Aging as Viewed by Three Elders.* In that study 180 codes were discovered, explored, analyzed and condensed into greater themes. With the understanding produced through the pilot study, the three readings of all the interviews for this study produced a list of 85 codes, leaving out topics not specifically on aging, which had been included in the pilot study. Example of those topics not coded as in the pilot study were *questions about the interview process*, *dialogue while explaining and signing the informed consent, rapport building, and hospitality [towards the interviewer]*. The codes split into two categories: information based (i.e. age of participants, length of interview, etc.) and theme codes (aging, benefits,

retirement, fears of aging, connectedness, etc). A complete alphabetical list was

produced and presented as Table 3.

Table 3

Data Analysis Codes

_____

Adaptation	Info - Marguerite
Address - Bernice	Info - Mena
Address - Janet	Info - Nancy
Address - Nancy	Inner Life
Age - Bernice	Inner age
Age - Ceil	Interview Date - June
Age - Herb	Length of Interview - Bernice and Irene
Age - Irene	Length of Interview - Ceil and Herb
Age - Janet	Length of Interview - Janet
Age - June	Length of Interview - June
Age - Lorna	Length of Interview - Lorna
Age - Mary	Length of Interview - Marguerite
Age - Mena	Length of Interviews - Additional
Age - Nancy	Length of Interview - Nancy Live Forever
Age is a Concept	Marguerite's Conference Experiential
Aging	Meaning/Purpose
Aging and Society	Not Feeling Useful
Aging that everyone experiences	Perceptions of you as old by others
Aging Well	Physical Ailments
Benefits	Retirement
Challenges	Self Description - Janet
Changes - Career	Self description - Mena
Changes - Family	Spirituality - Ceil
Changes - Mental	Spirituality - Herb
Changes - Physical	Spirituality - Janet
Changes - Social	Spirituality - Lorna
Children - Ceil and Herb	Spirituality - Marguerite
Children - Nancy	Spirituality - Mena
Connectedness	Spirituality - Nancy
Cultural perception of being older	Tell the world about aging
Date of Interview - Bernice and Irene	Time being precious
Date of interview - Ceil and Herb	Time Speeding Up
Date of Interview - Janet	Tolerence
Date of Interview - Lorna	Too Old
Death	What would you change
Describe your age	
Determination	
Fears of Aging	
Gift to the world	
How feel about being called old	
Importance of Affection	
Increased sense that time is short	
Info - Bernice	
info - Ceil	
Info - Herb	
Info - Irene	
Info - Janet	
Info - June	
Info - Lorna	

_____

Atlas.ti was then used to produce two documents. The first was a report showing

each code and all co-occurring codes listed under it. For each code, the report showed all

other codes using the same passages as it did. This document aided in linking some

subjects together whose connections were not initially apparent. This document was 9

font and 27 pages long. From this document, themes like *aging* were seen to be linked to

20 other topics. Many of the other codes linked to *aging* were *adaptation*, *benefits*,

challenges and *death*. Atlas.ti presented all the quotes for each code connected to the

code *aging* and listed all the quotations under each co-occurring theme for easier

referencing. A partial presentation of the codes for the topic "Aging" was included as

Table 4.

Table 4

Atlas.ti's Presentation of Co-occurring Codes
_____

Aging {27-0} [20]

Adaptation {11-0} [4]
2:29 S: ...that's going (referring to.. (1232:1242):
2:30 C: How do you transition? S: Y.. (1234:1242):
6:27 Even quite much people very ol.. (352:364):
8:22 N: No age...you're bring it up a.. (415:423):
Aging and Society {5-0} [4]
8:8 N: Two years ago, I was not ex.. (131:193):
8:16 N: I told you Saturday and I w.. (355:363):
8:23 S: And then this whole other p.. (481:491):
8:32 S: Final thoughts...I'm thinking.. (717:719):
Aging Well {21-0} [8]
5:12 P: Well it's hard to age grace.. (121:121):
5:13 P: Ah yes. Yes it's um quite a.. (119:119):
6:33 I don't like talking about mys.. (376:376):
7:19 So you've been kind of talking.. (767:773):
7:21 And granted if you take better.. (769:769):
7:35 S: Yeah. So I'm hearing you sa.. (1069:1103):
8:8 N: Two years ago, I was not ex.. (131:193):
8:11 N: Can I ask you how old you a.. (251:277):
Benefits {23-0} [3]
3:15 S: So being who you are as you.. (132:137):
3:18 I don't find anything else muc.. (135:135):
8:11 N: Can I ask you how old you a.. (251:277):
Challenges {1-0} [1]
7:33 M: You know, there's a disadva.. (993:993):
Changes - Family {4-0} [3]

7:33 M: You know, there's a disadva.. (993:993):
8:22 N: No age...you're bring it up a.. (415:423):
8:23 S: And then this whole other p.. (481:491):
Changes - Mental {20-0} [5]
3:15 S: So being who you are as you.. (132:137):
3:16 P: It's frustrating because th.. (135:135):
3:19 I feel...but um...getting old .. (137:137):
5:11 S: So you're talking about slo.. (116:119):
5:13 P: Ah yes. Yes it's um quite a.. (119:119):
Changes - Physical {40-0} [16]
2:29 S: ...that's going (referring to.. (1232:1242):
2:30 C: How do you transition? S: Y.. (1234:1242):
3:15 S: So being who you are as you.. (132:137):
3:17 So but that's one of the thing.. (135:135):
5:11 S: So you're talking about slo.. (116:119):
5:13 P: Ah yes. Yes it's um quite a.. (119:119):
6:26 M: (Reading from her homework .. (348:352):
6:43 S: So how would you describe y.. (470:498):
7:19 So you've been kind of talking.. (767:773):
7:20 And of course, you don't how l.. (769:769):
7:30 M: Really. Yeah. My kids even .. (955:955):
7:33 M: You know, there's a disadva.. (993:993):
8:7 N: Two years ago, I was not ex.. (131:139):
8:8 N: Two years ago, I was not ex.. (131:193):
8:22 N: No age...you're bring it up a.. (415:423):
8:23 S: And then this whole other p.. (481:491):
Changes - Social {8-0} [1]
8:22 N: No age...you're bring it up a.. (415:423):
Connectedness {38-0} [4]
2:29 S: ...that's going (referring to.. (1232:1242):
2:30 C: How do you transition? S: Y.. (1234:1242):
5:12 P: Well it's hard to age grace.. (121:121):
7:35 S: Yeah. So I'm hearing you sa.. (1069:1103):
Cultural perception of being older {19-0} [5]
7:27 S: Yup. Yup. So you're experie.. (881:887):
7:30 M: Really. Yeah. My kids even .. (955:955):
8:7 N: Two years ago, I was not ex.. (131:139):
8:8 N: Two years ago, I was not ex.. (131:193):
8:32 S: Final thoughts...I'm thinking.. (717:719):
Death {9-0} [3]
8:8 N: Two years ago, I was not ex.. (131:193):
8:16 N: I told you Saturday and I w.. (355:363):
8:31 he second world war began, she.. (651:681):

The second document produced contained all the quotations listed under each

code. This document was 9 font and 263 pages. This document allowed a re-reading of

the interviews in dissected format, rechecking if each passage was appropriate for the

coding assigned. In this format, the grouped quotations were searched for key passages

on a stated theme. Atlas.ti bolded the passage information first stating what document

the passage came from, the first words of the passage, the line numbers of the passage,

the code it was under and the other codes to which it was linked. Table 5 was a partial

printout for the code *adaptation*.

Table 5

Atlas.ti's Presentation of Quotations Linked to a Code
_____

Code: Adaptation {11-0}

P 2: Ceil Transcription 001-A-004-
Steven Interview to End with
Reflection I and II - Final.doc -
2:30 [C: How do you transition? S:
Y..] (1234:1242) (Super)
Codes: [Adaptation] [Changes -
Physical] [Connectedness] [Inner
Life]
C: How do you transition?
S: Yeah, yeah…
C: You sort of…
H: It creeps up on you.
C: …play it play it as it lays. I
mean it isn't it isn't a planned
thing that today I decide that I'm
not going to be able to do all of
those other things that I love to do
so now I'll have to go on a
different path. It's just that it
happens. Whatever happens let's say
physically that changes my ability
to get a phone call from New York
saying be here tomorrow morning at
5:00 to see the first ??? you know
the first client we have. It's it's
like that. It's, it's not difficult
it just really it just happens. I I
think no matter how much physically
I may be impaired, I still have an
inner life that very wonderfully
working all the time. And and in my
mind I am everywhere. You know I
just can mentally transport myself.
Am I fed by being at a piano bar,
yes because it to me it's like I'm
at the symphony. I mean I am in
heaven when I am there. I'm
singing. I'm with my friends. I'm
meeting new people. We have that
common bond of whether it be a life
style or whether it be the fact that
they are musicians. We we are
there. We sing and we ask questions
later…or not. Really, I mean I I
might say, "gee, do you know who
that person was who had that
wonderful voice?" But it doesn't
ever get heavy. You know, there's
none of this, none of this well
what's that person's inner life…what

is he? Nothing like that. We
expect nothing and just go with the
flow. That's all.

P 3: Janet - Australia -
Transcription - 2010-11-28
Final.doc - 3:21 [S: So at what age
were you whe..] (140:141) (Super)
Codes: [Adaptation] [Changes -
Physical] [Meaning/Purpose]
[Retirement]
S: So at what age were you when you
retired from all those duties?
P: Seventy. Yeah well I'd been
looking after another nun three
times a week and I just wore out. I
just gradually got less and less
energy and when she died I was
really completely spent because of
the trauma of going up and seeing
her getting lower and lower. I
hadn't been in my, I had a magic
number in my head when I knew I was
going to be again but when I was
seventy and she died and I had been
going up there and taking public
transport which took an hour to go
up there and an hour to get home.
I'd get there and she'd say, "I
think it's gonna rain you'd better
go home. Don't stay too long." I'd
get there and she'd have ten minutes
and then I'd come home again so it
was a big strain and stress for me
but I think I don't know, I think
what I'd have is, I'd come home from
there, I'd get home about two-o-
clock in the afternoon and then I'd
have to go down there to visit
somebody and I would be completely
done. I'd walk down and I'd ring the
doorbell and I didn't want to go in
there and listen to anyone's
problems. I hadn't got anything left
to give them. So I just had to come
to terms with sort of stopping
gradually. I didn't stop altogether
I just volunteered now to go to
(50:30 unintelligible) a building
down here you might have heard of
(unintelligible) but it's a big
building and there are people there

with mental illness and drugs and elderly people. It's a big building you can see it from there it's just (unintelligible). Well I had volunteered to go there once a week. Just now decided. I saw it on television and they were looking for volunteers so I went down and said to them, "I'll volunteer once a week and I'll give you my time to look after the community center," and these people come in all the time and you talk to them and be with them sort of visit them. It's something extraordinary to do this year. I just decided I'd like to do that because I'm not frightened, I'm not afraid of psychiatricly ill people. I had a course about twenty-one years ago in Melbourne and worked in the psychiatric hospital and did a course there to become accustomed to people that were psychiatricly ill because I was meeting a lot of them at (51:40 unintelligible) and I didn't know how to handle it very well so I went there and did that. So I'm really not afraid of people who are strange or not overly managed. So I just though and I said to the lady down there, "I'd like to volunteer," and she said, "Oh we'd just love somebody to come." You know. They were just (52 unintelligible) but I'll be quite happy to go for a day and do some work down there. Just be with them for the day. Have cups of coffee and just listen to them and just be around for them. So that's a little spark of extra life that I'm going to do.

Coded themes were grouped together to create larger "families" on a main theme. These "families" of meanings were reread and analyzed as they related to the topic of aging and with the insight gained from the pilot study. The results were presented in the chapter entitled Results.

CHAPTER 4

Results

The umbrella categories from the data directly relating to the topic of aging were

the *Lived Experience of Aging*, *Benefits of Aging and Aging Well*, *Societal Perceptions*

vs. Personal Perceptions of Being Old, and *Connectedness*. The sub-categories were

listed below under the major themes. Each theme and sub-category was discussed in its

own section below.

Lived Experience of Aging

Ceil reported on an experience she had one day prior to the interview, which

reflected and was echoed in the interviews with other participants on their lived

experience of aging. Ceil was trying to recall exactly how old she was,

> Well it's funny because I was I was in the bedroom the other day and I don't
>
> know what made me think of it. And I thought of it [her age] and I said to myself,
>
> "no, that couldn't be right." And then I thought again and I said, "my God, that's
>
> right." It doesn't seem possible to me. I don't know what we thought people in
>
> their seventies were going to be like because when we were growing up there
>
> weren't a lot of people that got to that stage and were still living their life so to
>
> speak.

Herb confirmed Ceils surprise adding, "It creeps up on you." When asked to

expand on this, Herb states, "Yeah, like it took me 14 years to put this place together.

And uh as I think back, I said if I had to do it today, no way. I would not be able to do

what I did then." Herb then told how he would get up at 6 a.m., leave his home office in

Lynn, work on the house in Marblehead until noon, "drop the tools, go back to Lynn, take

a shower, and see my first patient at one o'clock." After his last patient, he would change

his clothes, go back to Marblehead and stay until he was so tired he "missed the nail and

hit my finger." The next day he would do it all over again. He said, now "you're aware

of your limitations. There are things that I want to do and I stop and I think about it.

Whereas before, I would just go ahead and do it."

When Mena talked about being older, she said,

I can't vision myself. I mean, I don't know how other people see me. If other

people pass me on the street, am I an old lady when they look at me? This is what

I wonder sometimes. When I look at myself in the mirror, I say, "Yeah, that's an

old lady in there."

Mena did not like the idea of being older. She commented, it "is not fun…not at

all…my three kids, 'specially since I've been sick, they treat me like an old lady. And I

tell them, 'I'm fine. I'm fine.'" Mena told the story of being at her granddaughter's

wedding recently. She was dancing and enjoying herself all night. When it came time to

leave everyone became overly attentive while she was going down the steps outside the

building.

Peter's mother's on this arm, one of the daughters is on this arm…you're fine if

people want to help you, but I feel more secure if I've got something to hang on

to. So I said, "Dianne, I need to hang on to the railing." So, she said, "Okay." I

get down the stairs and there's another guy there with his hand out…helping me

to the car. I said, "God, I mean I was up dancing." And they're treating me like a

helpless invalid.

Mena said that time passed quickly. "It's just that you know…it goes by so fast. It's unreal. You turn 30 and the next one's 31 and the next one…and all of a sudden you're 40. And it goes so fast…and you wonder where it went."

Aging

All the participants had something to say about aging and unless specifically prompted for a positive, they tended to lead the conversation to physical changes they experience. Janet, who described herself as a very positive person, found it frustrating to not be able to do all she liked to do.

> It's frustrating because there's a lot of things I want to do. I keep losing things. I lost my barrette before you came and I spent twenty minutes looking for it. I thought, "this is a waste of time. Where did I put it?" And then I found it next to the phone in there with a book on top of it…I find it limiting not to be able to do what I used to do. I can't. I get very tired in the afternoons. I used to go out in the morning but I find I haven't got the energy I used to have…I want to go and do things and I can't do them. I run out of energy.

Janet told the story of how she was invited by a friend twenty years younger than she to go to the town hall and other such places. Janet, who was 80 years old, had been unable at times because she no longer had the energy of a 60 year old.

Marguerite concurred with what Janet said and added that people "not only slow down with their energy but they seem to slow down with their interest." She explained because older adults are not able to "keep up," they lose interest in doing the thing altogether. Along with slowing down, June stated, "after you're 70 most people seem to collect a few disabilities…You're very lucky if you don't get some."

These physical changes as well as age itself came on slow. Marguerite commented, "Well, I didn't really feel getting older." Nancy stated, "I have never every thought of people's ages….So, I have never thought 'I'm old.' Or I am reaching old." Even though it came on slow, Lorna added, "Yes it's um quite a perceptible difference between late sixties, seventy, and seventy-one…Not worse really but you have to change your perceptions and how you think you want to be or you always will lie." The "lie" that Lorna mentioned was the lie one tells one's self so as not to have to face the grief which came with not being able to do what one had done in the past. Even when one has aged, it was still hard to accept the reality stated June. "I still can't think of myself as really old, even though I know I am. It is very difficult. Your mind is not telling you you're old but you're body sometimes tells you."

Marguerite laughed when telling of the story of an ocean swim she took the year before when she was 83 years old.

> I went last summer…went swimming in the sea and it was lovely and I was enjoying it and then I had to go back. I put my feet down and I couldn't keep my balance. I had a friend who had not gone swimming and I had to call her to have her get me out. In the end, she tried to carry me out. So I couldn't get out. I love this story. So, I got down with my bottom out and she pulls me out. And I got out and I look up and there are all sort of tourists and they are all taking pictures. See what a sense of humor does. And you know how these Japanese are rich people and they all got their photos. And I didn't think at all except jeeze this is funny. We laugh a lot about that. I am really lucky to have that sort of attitude.

Marguerite was glad to have a sense of humor to get her through her later years. She

reiterated a statement attributed to Betty Davis, "Old age is no place for whimps."

Changes Associated with Aging

All the participants described changes they had experienced as they aged. These

changes included retirement, family, mental processing, and social interactions. Along

with these external changes, participants had noticed a change in their perception and

concept of time. Predominately though, it was the physical changes that were most

discussed and disconcerting for the participants.

Career and retirement. Each of the participants was employed during their lives

though their careers varied. Mena was a housewife until her husband died. After that,

she went from cleaning the rooms in a hospital to working in the administration office in

the hospital. She was 65 when she chose to retire. She then got bored and started

volunteering at the hospital in the same office even though they offered to hire her part-

time. Mena declined their offer because she did not want to be tied to a job. She liked

the freedom that volunteering offered.

Herb, at 81, was still covering for vacationing optometrists. He had not ever

stated he was retired until the interview. His admission came as quite a surprise to his

wife, Ceil.

Herb: I'm retired.

Researcher: Retired.

Ceil: Semi-retired. You are still going in and filling in for other doctors.

Herb: I haven't worked since January. So I think I'm retired.

Ceil: That's the first time I've heard him say that. This is news to me. You

consider yourself retired.

Herb: When the reality hits you, you go along.

Janet was a nun who had worked 15 years as a teacher and 15 years as a school principal.

Then into her 70s, she had done community work and eventually took care of an aging

nun. When the nun died, Janet decided it was enough and moved to doing more

volunteer work and resting more.

Lorna was a gifted group therapist who had taken a backseat to the other group

therapists she had trained, supervising now more than doing. Ceil no longer flew to New

York on a moment's notice to help with trade and fashion shows. Marguerite created the

field of school psychology in New Zealand and longed for the days when she spoke in

front of audiences and did trainings. Nancy taught speech and theater but could not walk

well anymore and needed to leave teaching. She proudly stated many of her student still

kept in touch. June retired from her work with the Red Cross when her husband retired

due to his failing health. Irene worked in hospital and did some extra roles in movies.

Bernice worked with her husband in the store they set up in Jerusalem. All the

participants were retired. Though they enjoyed the time and freedom they had, they

looked back fondly remembering a time when there was more activity in their lives.

Family. Ceil saw the changes in her family through the loss of the traditional

Jewish celebrations she enjoyed. Her daughter and son-in-law attended the Unitarian

Universalist church. Ceil observed the changes in her family through the ending of the

spiritual tradition. "I think it will end with Herb and I as far as the family is concerned.

And I feel a loss about that….But you can't direct the music in everybody's life."

Mena discussed the changes in family roles more pragmatically.

You know, there's a disadvantage in, in my case, because I don't drive. So, I am

limited to doing a lot of things. And sometimes my kids get together and I

wonder why they didn't ask me to go with them and do with them.

Mena stated her children have been doing a lot to get her to her appointments, refill

medication and get food. She had "no doubt at all in the world though that that my kids

love me." Irene added,

I think the hardest part about getting old is that you can't do anything and your

family doesn't have time for you. So, I see how these people were in Florida and

I think that's what frightened me more about getting old. To see these people

sitting around talking about their children and not hear from them.

Nancy had seen the shift in family from her giving the care to her receiving care

especially since she was brought back to her apartment to die, three years prior. Nancy

jokingly said she was quite a "disappointment" to the doctor in that she did not die.

Hospice had to be removed and she playfully said the doctor was quite upset to be wrong.

Her daughters arranged for an in-home agency to take care of Nancy and one of her

daughters flew in every three months to make sure all was well. Nancy stated, "I don't

want to feel like a burden. I have been an independent person, very independent all my

life. All my life." It was not the independence Nancy reacted to but rather the strain she

saw her "living" was on her family, even though they had not said anything of the sort.

Mental processing. Most participants made mention of the mental processes

which changed as they aged. Most notably were changes in memory. Bernice stated her

memory had changed "much." She used to be able to remember names, addresses and

phone numbers when meeting a person even one time. "But now if you're not where I met you and your face is familiar, it takes me a long time to remember a person's name and that frustrates me." Indeed, during the interview, Bernice had trouble with finding the work "incentive." "You see, that's what…I can't remember words."

Ceil's experience of losing words was linked to her recent physical ailment. "Sometimes, I find myself having hesitation about…it will be in my head and it's not coming as quickly as it would before I had the stroke." Lorna had noticed she was "slow to learn things." June noticed,

> my memory is just beginning to slip a little bit not…but not too badly yet. I find I
> can think better now about the past and now really concentrating on that. And it
> is the day to day things that I have to read up about all the time…to make sure I
> am getting them right.

June enjoyed being able to remember the past well as she was writing her memoirs. Janet simply stated, "I find I am forgetting things. I think that I've got a short term memory at the moment."

There were evidences in the interviews that the self-observations about memory loss were justified. June had a hard time finding a file on the computer which she accessed regularly. Several participants had trouble finding specific words or recalling certain events. Marguerite's thoughts wandered and she was unable to recall the town in which she was born. Marguerite stated about her memory lapses that she got "flustered," "it irritates me," "it's frightening" and "it is a real norsen, norsen, norse..." The researcher offered, "nuisance." "Yeah," Marguerite said, "it feels like you are losing

yourself." She added, "It is just that I am losing some parts of my brain, brain I guess. It's a nasty funny feeling."

Janet did offer one consolation,

I tell you one advantage of getting old, if you've got a bad memory, five years after you've read one book you go back and read it again. That's an advantage! It's true! It's true! I used to read a lot of mysteries. I picked one up and read it the other day and I went to the library to get books, and I picked this one up and it was a mystery and I thought, "Have I read this before?" If I read the first paragraph I'd know. So I read the first paragraph or so and I thought, "No I don't remember reading this so that's alright." I bring it home, I'm half way through it and I thought, "Hmm some of this rings a bell." Anyway I kept on going and I kept on reading it and I got to the end and I found out who done it and I knew yes I did read it…I've been going through all the books in the library and now I can start again because it was five years ago and I've forgotten what they were. That's something good.

Social interactions. The participants noted social interactions, even with their families, had decreased. Bernice was not sorry in some ways for this. "The good thing about having a small apartment is that I don't have the space for 20 people." She stated it tires her out to have a large group over. "When I go to cook, it's a big thing for me to cook a meal. So, I am glad the kids can't come all at one time." Though she did still enjoy her family and wanted them to connect more. Herb did not wait for his family to come to him. He had been known to drive over to his son or daughter's house and call them from their driveway to see if they would enjoy a visitor.

Marguerite, Nancy, Lorna, and Janet noted in various ways that as they had aged their friends had become younger, well at least the median age of their friends had become younger because there were less people in their generation. Marguerite stated,

> I don't know many people of my age and most of my friends are at the end of the line. And a lot of people I know have died…towards the very end…you might find yourself in a world which didn't have anything else around you of your age that knew you or know you or knew that life, that time.

They had noticed there were not as many people their age around, so they ended up socializing with people 10 and 20 years younger. Socializing though became harder because, as Marguerite pointed out, it became increasingly more difficult to go out. Mena stated there are some days "I don't even bother to get dressed, if I am not going anywhere…It's dull." Marguerite seemed to sum up the sentiment for everyone,

> I have got some good friends. But a lot of people who are my friends are still working and probably quite a little bit younger than I am and haven't got a lot of time. I've got a lot of time but not a lot of people to spend it with.

Time. One of the perceptual changes the participants mentioned was in their relationship to time. Lorna, Janet, Mena and Marguerite all mention that time seemed to speed up the older they became. Janet stated, "Believe me. Yes. Before you sort of realize that January's come and gone, you're up to November. Every year it speeds up more and more as you get older." She remarked she sees this a lot with appointments. "'I was only there last year' and they say, 'no you weren't, it was two years ago.'" Mena added, "It goes by so fast. It's unreal. You turn 30 and the next one's 31 and the next one…and all of a sudden you're 40. And it goes so fast."

Marguerite concurred but thinks that young people were experiencing this too in today's fast paced society. She postulated that it was not age that speeds time up but being active and having things to do that affects time.

> Yes it [time] seems, when you're young it does seem quite long. Now I find it going very fast…Yes I feel it is going very fast, very fast. But I have heard people of much younger than I am saying the very same thing….so I don't think it is just the old age people. And some old age people don't see it that way because they don't do anything…They just sit around all the time. It seems like, you know, you know, a long time. But if you're active then I think you feel it the other way. I can't believe it. I remember saying, "I wonder if I will get to the millennium?" Well, we are well over it and passed it now!

Janet believed time speeds up as one ages "because you can get less done. You have to slow down bodily, therefore you can't achieve as much as you did before." For Janet, however, this shift in her perceptive and her advancing years came with an increased sense of the preciousness of time.

> I've never got enough time to do what I want to do. I just run out of time because the day goes too quickly. It's very precious. That's the sense that I have. The older I get, the more precious time is…I've got this real sense of not having much time left and I need to spend it well. I need to make the most of it, enjoy it and use it to the fullest. And that's important to me. Not to sort of squander the time that's left. That time's too precious to be wasted.

Janet's focus on the preciousness of time had got her to laugh at herself over the years.

I drove into town to get a traveling blanket for somebody and there were two girls talking behind the counter. It was Monday morning and they were exchanging their weekend escapades. They looked at me and kept on talking and I was standing there and I was just doing this [taps] on the top of the desk. One of them turned round and I said, "Would you mind serving me because I haven't got much time left." I said, "Time's running out for me and I haven't got much time. So I can't afford to waste it." Such a startled look on their face she walked over and said, "What can I get for you?" I said, "I just want that blanket there. That's all I'd like. I'd like that." So I bought it and then I was telling the others about it I said, "The poor girl probably had a break down and went home and told her mother, 'There was some woman that was dying in the shop.'" I said, "No I didn't mean it that way. I just meant that I was wasting time standing there. I was just wasting time." I mean she's talking about the weather or something and here's me. I could have been downstairs and doing something else and I could have been doing things instead of wasting time but that's a true story and that's what happened and I can still see the look on the girls' face. I think she thought I was going to drop dead on the floor. I didn't mean it that way. I just meant that life's precious.

Physical concerns. Among the physical concerns the ten participants mentioned were: difficulty walking, exhaustion, fatigue, underneath of teeth infected, hands losing their dexterity, harder to stand, pain in legs, generally aches and pains in body, could not walk as fast, balance was off, intermittent claudication, strokes, dystonia, gall stones, stomach pains, circulatory issues, heart issues, stiffness, and slowness. Of all of them, the one most mentioned by the participants was their lower energy level. This change in

physical well-being was the one that prevented them from doing all they wanted more than other concerns.

Ceil commented that when it comes to aging, one needed to "play it as it lays." Ceil stated,

> It's very difficult to find your path in another way. You don't want people to think of you as being sick all the time. And you're helpless to help it when it happens. I mean I was floored when the doctor said to them that I had a stroke. I just had a little incident to me. I just had a little incident.

Ceil said that it was difficult to adjust to health concerns that did not go away like a cold went away.

> That is what is a difficult thing for me to adjust to because I want to be fine. I want to get up in the morning and say to Herb, "it's such a beautiful day. Let's just go to Ogunquit and..." And I'm upset with myself and when my body won't cooperate.

Still in all, Ceil said about the adjustment to aging that "it's not difficult. It just really, it just happens."

Herb noticed when he was moving stones and working outside that he got stiff and started to "huff and puff." It was then he had to take a break until his breathing returned to normal. Mena said,

> It seems like the body is falling apart sometimes. And granted if you take better care of yourself before your older age you might be in better shape…I mean…I eat well, but you don't exercise. You know. You put that off…I'll start that

tomorrow. Right? But no matter what, nobody's going to be Jack LaLane." [a

fitness guru who lived until he was 97]

Mena commented that along with physical concerns, "You end up on pills galore

because… I tell my kids, 'I feel like I have a pharmacy here.'"

The ailments that bothered the participants most was anything that limited their

ability to get around. Ceil had dystonia which was "where the brain misfires and the

extremities are cramped. So the big toe is 90 degrees…across the top. The bottom toes

are crimped underneath" making it very painful to walk. Marguerite still drove but

remarked the driving was easy, it was getting to the car that was the real issue. Bernice

reported where she used to go climbing, she could not even walk fast now. It was

particularly hard this year as she was not able to attend the memorial anniversary picnic

of her daughter's murder which was held in the field of flowers her daughter and son-in-

law visited just before being shot by terrorist in their home. She has attended every year

for the last four years but she could not go this year "because there was too much

climbing." Bernice lived in Jerusalem and stated, "I like to travel. It's getting a little

harder. I mean America seemed further away this last trip then it did before."

It was these physical symptoms that alerted the participants to their age. June

remarked, "…some days when the aches and pains get at me I begin to think, 'gosh, I

must be old.' I never would have thought that before." Janet added,

the body tells me I'm not but the head tells me I'm about 50 or 60. That's what I

feel. I feel the same as I was when I was 50 or 60 but I know I'm not because I

get stiff and can't walk quickly and get indigestion.

The participants desired more independence. The independence sought was not from societal restriction but rather from their body limitations. Ceil stated in regard to her body not doing what she wanted it to do, "It's that lack of control. [Control] would be the one thing that I miss most about my life today."

Though there was substantial talk about their physical ailments, the participants did not want to be identified by these concerns. Ceil had spent many joyful times at a Piano Bar in Ogunquit, Maine, USA. Over the years since the 70s, Ceil had drawn great enjoyment from singing around the piano and making friends. She had experienced the pain of losing some of those friends to AIDS and she had set up an AIDS Support Network in her area. At an hour and fifteen minutes away, the piano bar which use to give her such enjoyment was many times too far for her to travel. But when she was there it had a new meaning for her. She felt "normal."

> The reason I love sitting at the piano bar, and I said this much earlier. Is that at the piano bar, to me, and I hope to the people there, I look normal. They can't see that I can't open my hand at all. This right hand, I can, I can't open at all. And the same thing with what's going on you know with my other extremity [her tangled toes]. And I forget it when I'm there…that's one of the reasons that I am so happy at the Porch. Because I am only seen at the piano bar from here up. No one knows anything else.

It was important to Ceil that she had a place where she could be seen for whom she was and not her physical ailment.

Descriptions of What is "Too Old"

There was a concurrence among the participants as to what was considered "too old." Herb started off by stating "old" was "not being able to do what you did when you were 20." Ceil added, "I don't know if I would have put it at 20 but, yes, being physically unable to do the things that you wish to do." If that was "old," then "too old" for Herb and Ceil was:

Herb: When you can't take care of yourself…

Ceil: I was going to say the exact same thing.

Herb: …and you're a burden to other people.

Ceil: I was going to say the exact same thing.

Physical and mental symptoms as indicators of being "too old" were contained in most of the interviews. Bernice described and gave an example of "too old."

Too old is when you can't get up and you can't go out and do things. And you're house bond and you have to have a Pilipino aid or something like that. Then then you have no life you have no quality of life. As long as I can get up and go and do things I am not old…I mean like I have a friend Sarah. I knew her when she was driving a car going here and there. Now she is homebound. She goes from her bed to her chase lounge and she can't go any further. She has a Pilipino full time and she has a hard time going from the bed to the chair. I mean that's too old. She just sits in her chair all day and watches television.

June stated, "'too old' is when your mind was not working anymore, I think. 'Cause we've got people like that down the corridor and I really feel sorry for them." Lorna stated it was when one had "fading health."

Marguerite and Mena both give approximate ages as to when one was "too old." Marguerite answered that someone she knew had people helping her, lived virtually in one room, never went out, was always tired and was "103 nearly 104." Mena placed a rough age on being "too old," "probably 80, 90, 100." However when Mena started to describe what it was like to be "too old," she provided the following details:

> There was a woman…celebrated her 102nd birthday…I don't want my kids to remember me that old. I want them to see me as the pretty lady that I am…or was. I don't want them seeing me all stooped over…and walking with a walker…my mother was like that…my mother was always old…me, I was not old and I am trying not to get there now.

Particularly important to Mena was that people remembered her as "the pretty lady that I am."

Janet, Marguerite and Nancy answered the question of "too old" not with a specific number of years but rather with a concept. For them, "too old" was more about being on the earth for "too long." Marguerite, "Don't go too soon…but don't hang on too." Nancy, "I think I'm falling into ruin here…I'm going to be a hundred…and that would horrify me…I think you can be in the world long enough." For Janet, "too old" was when a person has a negative attitude. "They start to grow old quickly and of course by the time they reach this age they're really old." When asked to elaborate on what "too old" was, Janet told this story:

> My mother was ninety-three when she died and for the last six months of her life she was bed ridden and she was sad because she wasn't able to do what she needed to do and she was in a nursing home and she felt she wasn't being looked

after very well and I felt she was too and she said to me, "I've been too long." She said, "This is too long to be here." When the quality of life goes, when you can no longer enjoy each day and like you can't, you can't be part of what's going on around you, that's too long.

Thoughts on Death and Dying

The topic of death came up during the interviews. Ceil, Mena and Janet discussed their respective mother's deaths. Ceil and Herb mentioned several people they knew who had died due to AIDS-related complications. Ceil, Herb, Nancy and Mena all mentioned people who were now dead. Ceil, Nancy and Mena mentioned the death of relatives. Whereas Ceil and Herb talked about other's death, they only made mention of their deaths in relation to getting their wills in order.

On the other hand, Mena made mention of her own death and stated exactly what she thought about it.

Like I tell one of my kids, I says, "Okay my mother had her turn, she'd died. My father, he died." I said, "Now I'm the oldest one in our little family clan. And now it's my turn." And of course, you don't [know] how long you have. You can be gone just like that, and I hate it.

Mena stated, "I think if I am going to die, I'd rather not have my mind. So, I don't know I'm dead or going to die, you know."

Bernice mentioned that when one was not having a good day, death might not be a bad alternative. When questioned by Irene, Bernice stated she did not support Dr. Kevorkian (a doctor known for euthanasia). Thus, even though the day was bad, a proactive approach to death was not the option. Nancy stated euthanasia was to be

"recommended." She stated she saw no reason why someone who had lived a full life should not be able to choose the time of her death. "That little blue pill. I wish I had one. Not that I would want to take it now." Nancy was emphatic that this approach was not playing God. "That's rubbish. That's rubbish." Her thinking was that people are more compassionate to animals than to our humans. People had the dog "put down because he was in such pain. And the vet said there was nothing that could be done." Nancy postulated, "we should feel as much about our human relatives as we do about our pet animals…but that we don't. We let them suffer. Some for years. Some poor souls for years."

> Nancy stated she has "been here long enough" and she "has no fear of dying."
> Why would you be afraid of dying for goodness sakes?...I have no fear of
> dying…I am not a religious person who is frightened of going to hell or I
> certainly would not want to have wings and fly around in Heaven. I think it
> would be very boring. And I know that all plants die. All things that live die.
> And are replaced by others. An that is how it is for human beings. And why
> shouldn't it be? Why should we be more special than the useful creatures in the
> wild? Or a tree...everything dies. But we are so egotistical. We human beings.

Janet was a Catholic nun and spiritually on the opposite side of the spectrum of beliefs from Marguerite, yet there was a similar quality to her response about death found in the story she told about her Catholic order of nuns, the Sisters of Mercy, dying out. "I really believe we just live in an age where we were able to do what we had to do and the church needed us at that time. But I think the whole thing has moved on now." She stated the lay people had taken up what the sisters were doing. Janet was not saddened

by this. In fact, she saw it in a historical perspective. "Most religious orders only last for two or three hundred years." With regards to aging, Janet's story about the fading of the Sisters of Mercy seemed to hold the sentiment for all the participants whether they like the aging process or not.

> And we just gradually fading out and going off. So, I think we are losing our usefulness. So, I think we were there when we were needed and we are gradually going out. And I don't feel sad about that. I feel we did what we had to and we were there at the right time. And now it's time for us to fade back and fade away and a new era will begin.

Staying One's Present Age

When asked if the participants would choose to live forever at their present age, Ceil recognized her own dodging of the question. "This is a cop out, but if my soul could continue on, without being constricted by my body, I would live endlessly. Life to me is very exciting." Herb said, "I could tolerate it as it is right now. I wish it were earlier, but I could manage." Mena also responded similarly, "Yeah, if I don't go any further this wouldn't be too bad. Yeah, I could stop here." Irene stated, "it depends on the wrinkles," but then said with some good plastic surgery it might not be too bad. Bernice was noncommittal saying it might be "okay." Lorna responded she would live on just so she could continue to make a difference. As a Catholic nun, Janet was remiss to stay for she wanted to move on to her life with God. Both Marguerite and June were concerned that they would get bored after a while if they stayed. Marguerite was not sure what she would choose. However, June stated she would not want to stay unless "I could live with all my eyesight and faculties." Their present ages were no so bad when, as Bernice

pointed out, "compared to the alternative." Mena also offered this statement to help understand her wanting to live on, "life to me is like a book. You want to keep reading it and reading it, reading it, reading it, reading it. You ever think of it that way? I never want to get to the end of it."

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Aging Well and Benefits of Age

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Through the interview process, the participants revealed that, despite all the changes expressed which could make one scared of aging, there were many benefits especially if one did what they could to age well.

Aging Well

Though none of the participants spoke directly about aging well, most of the information was given in response to other topics. Those topics included *making more out of the time one has*, *taking care of one's body*, *being determined not to give in* and *having a positive attitude*. Janet thought,

> the ordinary things that are everyday, you haven't got to do them in a boring way. You can do them creatively, interestingly and some new life out of them because they give you life…that's what I get my energy from, doing new things. I feel energized by, always doing something different.

June at 83 and legally blind continued to go to the gym. She said she needed to stay active or "your mind gets so sluggish." She recommended eating well also. Marguerite's key was almost a mantra, "I don't give up." Lorna found she was best when she adapted her abilities to her age though she admitted she was not doing so gracefully. Mena stated that reducing the stress in one's life was a good way to "live longer." And, Nancy recommended, with tongue in cheek, that if you were at a good age, "hang on to it."

Different Actions the Participants Would Take with Regards to Aging

Tough Ceil mentioned that she would not have changed her life one iota. Yet, she also wished that they had been in a better financial position to travel more. Herb did not enjoy traveling as much as Ceil. Ceil stated, "I thought, 'it's endless.' I can't do it now, but when we work very very hard and earn the money to do it, we'll be able to do it. And that time never came." Herb did not see how he would have done anything differently. Except maybe to have moved to New York and lived on Long Island when an opportunity in optometry had come his way. Yet even now he could not stand the thought of being near to New York City. Marguerite echoed Ceils desire to have traveled more and added that she wished she had saved more money.

Mena stated humorously that she would have invented a stopwatch to pause time. After her joke, she stated very practical actions she would have done if given the opportunity again. "You might take better care of yourself. You might exercise more. And you might not say, 'Oh, I don't want to go. I've got this to do.'" She then paraphrased a poem that she had read over the internet.

> She would have used that…sexy nightgown had she known and not saved it. And
> not saved the china for a special day because sometimes that special day never
> comes…she would have gone with her friends…and the heck with the dishes.

Mena added, "We think we have all the time in the world…and we don't."

If she could do something differently, Irene stated she would have "liked more schooling." In this way she could have been able to work earlier in her life, been more independent and then she could have "been freer to say, 'go to hell' if I had to. I wish I had had the ability to be more independent during my marriage." Lorna was less reserve

with the number of things she would do different. "Yes, there's always things you could have done differently. Anytime wasting time, over sleeping too much or opting out" of doing things as well as keeping in better physical shape. Bernice, June, Nancy and Janet stated they would not have done anything different in regards to aging. Janet stated, "I think I've prepared for it very well by having a lot of interests. That's the secret."

Tell the World about Aging

Lorna liked to tell people in regards to aging to "take heart." She said it was hard even for her sometimes as she aged. Marguerite said that people needed to recognize early that they were aging so it did not suddenly surprise them. June offered this advice, "take every possible opportunity to do anything differently that comes along…not just getting into a grove." Janet would have everyone "live life to the fullest…enjoy every minute of it…just love everyone."

One of the keys to maneuvering old age was adaptability. Ceil stated when things change one had "to go on a different path." Janet changed occupations when it was too much for her to continue to care give. June had to learn how to use a computer for the blind. She commented, "change happens all the time really…it doesn't come smoothly. It comes suddenly into your life and you have to adapt to it somehow." Marguerite stated "people really go to pieces" when they were not able to be adaptable to the changes associated with aging. Bernice and Irene wanted people to know when it comes to aging, "it ain't too bad."

Aging as a Concept or Attitude.

Two of the participants specifically pointed to age as a concept or attitude rather than a chronological number. June said, "don't think you're old…You are not old until

you jump in a hole you might say…until you feel you're old….it is all in how you relate in your mind. How you think of yourself." Janet said, "That's what it's all about is your attitude. That's that's for sure. I'm positive of that…the way you live life as a result of the way you look at things." Janet told the story of a friend who complained about everything. "She's ten years younger than me and she's really old."

Inner age. Even though the other participants did not comment directly on aging as an attitude, all but one stated the age they thought of themselves (their inner age) was different from their external (chronological) age. Ceil (74) reported an age that was the youngest amongst the participants by stating, "my spirit is probably in its 20s. I don't feel spiritually any sense of aging. I feel constricted and confined by the outer part of me. My body that won't cooperate." Ceil also stated, "I think no matter how much physically I may be impaired, I still have an inner life that's very wonderfully working all the time. And in my mind I am everywhere. You know, I just can mentally transport myself."

Bernice stated, "I can't believe I am 82," then reported she feels "60, 65." It was a time in her life when she was taking courses and was very active. Irene quipped that her inner age "depends on the day it is." Bernice elaborated in jest, "depends on how the arthritis is." Irene (71) agreed that her inner age was around 60-65. Janet (80) stated she feels about "60 or 50. That's how I feel but I know I'm not. The body tells me I'm not, but the head tells me I'm about 50 or 60." Marguerite (84 ½) stated she felt almost 35 years younger then she was. "I have a young heart." She placed her inner age at "40. 43." Nancy (94) never thought about her age until she had to go to the hospital where they were inconsiderate enough to ask a person their age "every ten minutes." June (83)

felt "not spry but middle age." She continued, "Yes…I am feeling quite young inside.

About 40-50, I'd say." June said that was the best time for her, the "very best age to be."

Herb (81) felt his internal and external age were in sync but the discrepancy

between his aging process and other people's was not lost on him.

Herb: I remember when I first started practice and I would see someone who was

65…

Ceil: You thought they were ancient…

Herb: Ahhh, my God…and then when I turned 65 I was still in full practice. And

I'd see some guy come in….ahh…barely walk in, sit down. I'd look at him and

I'd says, "God, this guy has got one foot in the grave." I says, "how old are you?"

And he says, "oh, God, over sixty years old." I says, "I'll keep my mouth shut."

And when I got to be 70 and 75 and still working and this people would come in

their sixties and complain me about their age and all. It's funny, and when I read

in the paper and I see people dying at 55 and 48, I look. It's amazing. How the

hell did I get this far?

Mena (75) reported that she felt 40-43. "I tell my doctor, you know, the mind and

body don't work together. Mind you're thinking young, but because you are not in the

best of shape sometimes…your body isn't working or doing what your mind is telling."

Mena added, "We always think younger. I still look at the good looking guys. I might

flirt a little bit."

Lorna (72) did not specifically state an inner age but felt she related well to

people of all ages. She did acknowledge the idea of an inner age but framed it this way,

Well the truth is from the time of your own conscious awareness of yourself, it is

the same person all the way through, you know? And I know other older people

say, "I'm so young inside," and of course it doesn't mean young physically in

body it means I'm still the same being that I became aware of when I was three

year old and I remember being five and starting school. I'm still that person.

Lorna saw the discussion of inner age as more of a discussion of a person's inner

conscious awareness of herself, an inner self that was different from one's chronological

age.

Benefits of Aging

The difference between one's inner and outer age was seen as a benefit of aging

or at least a clue to aging well. The participants reported other benefits to being older

including freedom. Irene enjoyed "freedom from responsibilities. You know, you don't

have to take care of children." Bernice added, "she doesn't have to take care of her

husband anymore. He was very demanding." Irene continued,

There are a lot of benefits. You can sleep when you want to. You can wake up

when you want to. You can go to the…I have a lot of advantages where I am

living because I have a club house and a swimming pool and a spa with all the

equipment. So you can do all these things and if you can get into a couple of card

games at night. And, watch television what you want to watch or read a book all

night if you wanted to. There are a lot of pluses. Nobody says, "Irene go to

sleep." I use to hear that from my husband all the time.

Bernice added, "she found herself." It was unclear if Irene's self-discovery was related to

her husband's death or to Irene's aging process but likely it was some of both. Janet

enjoyed the freedom to make her own plans for the day. Upon reflecting, she acknowledged her "tremendous freedom" and remarked, "I just take it for granted I think."

Other advantages mentioned by the participants were getting a seat on the bus, buying clothes they wanted, "spending my children's inheritance" (mentioned in jest), going to the movies or theater as one wanted, doing activities within one's budget, having the time to do new projects and to start new interests, being able to pay more attention to nature, having a richer spiritual life, having more appreciation for sports, being in contact with different people (namely doctors and nurses) and dressing as you like. Janet saw an additional spiritual benefit in old age. "I think old age is a gift from God to have time before we meet him. I think we should use it well."

Wisdom was mentioned several times as a benefit of aging though sometimes it was mentioned as a shift in perspective leading to greater practical understanding of the world, less anxiety, and increased self-confidence. Ceil and Herb related that when one was younger, one could take chances but as an older person one saw how unrealistic some things were. June referred to wisdom as having a "width of experience." Janet reported being less anxious. "I don't worry about things as much as I used to. I've been a glad worrier all my life. I used to worry a good bit but then I thought I have got less things to worry about." Marguerite agreed, "We realize that we don't need to be always hollowed up and anxious and you can let go and have fun."

Lorna stated she had gained self-confidence as she had aged and reflected, "If you've got enough self confidence in the deepest sense, if you have enough knowledge of who you are and you keep good heart, you can come to terms with the fact that we live

life in our amount of time and that's about it." June stated she "used to be very shy when I was younger believe it or not. But not now….you just do what you want and say what you want." Janet then related these thoughts to her age,

> Yes, I've got confidence in myself, even though I must look frightfully old…but it doesn't worry me anymore because you know who cares when you are that old you might as well be who you are and not what someone thinks you should be.

In addition to the other benefits mentioned, Janet and Mena enjoyed blaming their action on their age. Janet remarked,

> I can do what I like. If you do something peculiar or funny, people think, "oh she's old. She doesn't know any better." And, you can wear funny things and people think, "She's peculiar." I don't care. I feel I can do what I want to do.

Mena enjoyed being "a little more outspoken" now that she was older. She told the story of being in an elevator when a construction worker using the same elevator rolled in a palette jack. To conserve space, Mena stood on the jack. She then turned to the worker and asked, "Is this what you call 'getting forked?'" Mena finished by saying, when you were outspoken "You get to blame it to old age. 'That's what us old people do.'"

Societal Perceptions and the Impact on Older Adults

None of the participants were isolated but rather a part of a larger society in which they had to function and interact. When asked about how they felt they are perceived by the society around them, there were no differences defined by the different cultures of the participants. Rather, the answers given crossed cultural and societal lines and were unified by the experience of aging itself. This held true with one exception. Two of the

three participants from New Zealand mentioned the number of older adults in the

population was a societal issue. Marguerite stated,

> It's a funny time now. Probably everywhere. Because there are so many older
>
> people who don't die and fewer babies being born. Therefore there's a lot of
>
> people going on in life or doing more in life than they would have done. And
>
> there are not enough younger ones to hold it together. I mean it is very difficult to
>
> get people to look after the older people.

Nancy said,

> I haven't been trying to think that people are living too long. And the lastest
>
> census that there are more and more people in New Zealand living beyond a 100
>
> years. That's too long. I don't think society is arranged…to accommodate
>
> messes and messes of people of that age. They have to make way for the next
>
> generation. We must. And let them get on with it.

Nancy reinforced Marguerite's statement about how hard it was to get proper and even

non-abusive care for older adults.

Perceptions of the Participants as Old by Others

Ceil did not see herself as being treated any differently or perceived differently by

society. Even with her cane, she did not feel she was treated any way but normal. Herb

echoed Ceil adding a story about being discriminated against in the Navy and not

receiving job advances because he was Jewish. The story indicated Herb felt more

discrimination as a Jew in the Navy in his 20s than he did as an 81 year old man. Mena

also felt like "just one of the crowd…Just another older lady walking around." However,

Mena later told a story about dancing at her granddaughter's wedding. When she was

ready to leave, four people helped her down the stairs to her car. It upset her because it was more of a hassle than needed. She remarked, "God, I mean I was up dancing. And they're treating me like a helpless invalid." So even though she did not mind being seen as "another older lady" it did bother her to be seen as an "invalid" because of her age.

Janet felt she got along well with younger people, better than older adults most of the time. However, she thought people in their 20s probably, "just see an old person and they just put you in a category…they categorize you as being uninteresting and set [in your ways] and all those things. I think that's how young people see you." Lorna agreed, "The people in the culture, people who don't know me, when I'm not crossing the road or going up steps will see me as an older, an older lady." She believed that society probably did not want older adults. However, Lorna acknowledged people who got to know her probably saw her "as a withered person who can make meaning." As Lorna was a counselor, being seen as a "person who can make meaning" was equivalent to being seen for who she really was.

How Participant Feels about Being Seen as Old

Irene realized she was being seen, not as she really was, but as "old" when someone gave her a seat on the bus. "It's demoralizing." Bernice was not offended as she knew she needed the seat on the bus and even asked for it sometimes. June stated when it comes to being seen as old "I don't mind because I can't see myself. I can't see what young people see. So in my mind, I am the same as when I was young to look at. But, I know I am not really but (since I cannot see in a mirror) I don't know what I am looking at."

In regards to how she felt about being viewed as old, Marguerite stated it was most obvious when "some people look down on older people…They even know they do, but they say, 'well how are you dear? How's it going…Oh, well done.'" She stated it was "condescending" and "patronizing." She added, "It's not vicious. It's not bad. But it's not at all that they're aware." Marguerites stated, older adults felt "squashed." She did not like it when people came in and "immediately start doing thing for you." She knew she could not do some things but this did not mean she wanted everything done for her. "What I am able to do I want to go on and be able doing." Marguerite said when people "come in who sweep right over you and do it and do it and decide all for you…and skip past [you]," it made "you feel light," "rather silly, rather lonely, a bit stupid," and "feeling perhaps they're right. Perhaps, I should just give up."

<div align="center">**Connectedness**</div>

Though the word "connectedness" was only used once by Ceil, it was a theme that prevailed through much of the data. It was talked about in connection to family, to friends, to people in the community, to humanity and to something larger than one's self was important to all participants. Further, it was this feeling of connectedness that added meaning to the lives of the participants and helped during the aging process.

Ceil's commented early in her interview,

I think my love of people, *my connectedness* [author's emphasis] with people of

all ages stems from that experience of so young being in the mix of all, you know,

all these people that would come into the store and go out.

Ceil's "connectedness" continued through her life. She continued to go out to eat every month with a group of people who graduated from Salem State College with her almost

50 years before. Once a year since college, they have spent a weekend together on Cape

Cod. Over the years, Ceil had made friends with priests, outcasts, homosexual men,

AIDS victims, families of the victims, and people singing around a piano bar to name a

few. Ceil felt connected still to the mother of the AIDS victim who wrote her on

holidays. "I know that I am the only link she has to her son that has passed." Ceil said

she was the only one that understood what was happening at a time when this lady could

not tell her neighbors her son died of AIDS. "That wouldn't have, you know, gone well."

Ceil mentioned fondly the priest she worked with on AIDS Project North.

> I gained a wonderful life time friend. I mean to this day, you know, when we see
> each other, there is that special special connection. He's such a fantastic guy. But
> he can't be himself in the community. He has to conduct himself in a certain way.
> So even though he's beloved by his congregation, it's not the same as when you
> want to hang out and just be.

Ceil delighted when singing with others at The Front Porch (a piano bar in Ogunquit,

Maine that Ceil and Herb frequented). Though she did not do it purposely, she was

connecting even there.

> I'm singing and I see other people and it just happens. It's not that I put my sites
> out on one person or anything like that. It just is a spontaneity that comes and a
> feeling of joy that is better than any med…I am just in heaven. I am just in my
> happiest place to be at that time. So when my time does come, we are gonna have
> to change the orthodox rules because we are not supposed to have music at a
> funeral. But I want singing.

Ceil had met "the most wonderful people" at the Front Porch. Every season there were one or two people she ended up "chatting" with and "finding out more about them." Though these serendipitous meetings might have seemed random and by chance, Ceil believed there was something greater going on. "I choose to believe that's not by accident. That's what I believe. It is not by accident." Whether the meeting with the person turned out favorably or not Ceil said, "I believe it is ordained."

> I believe people come into your life…at a certain time in the course of a lifetime. And you have a commonality. You have something that clicks. And now sometimes you learn from the situation where you gave your all and at the end there's great disappointment. That happens. There are people that you meet that are then life time friends and there are many many more of the latter. Many more.

Ceil felt connected by friendship, spiritual awareness, community and humanity to the world around her. Music and her inner spirit were firm connectors to the outer world. "I'm very content and feel very good about the friends I have made. And I have learned so much about humanity. We are kindred."

Herb stated they had a lot of friends whom they have met, "Years will pass and when we meet again, it's like we were there yesterday." Yet, Herb was more pragmatic in his view of friendship and connection. "I think also that, instead of coincidence, it's if you have your eyes open to what you're looking for. The antennae are up and you're aware." Herb then told a story of when they were furnishing their home. After the house was completed, he happened across a renovation site down the road and saw four legs sticking up from the piles of debris. He asked the workman and they were throwing it out. As it turned out, it was a Victorian style chair which Herb had reupholstered and put

in his living room. In much the same way, he told of a captain's desk which he also found and refined. Herb used these stories of items discarded by other which become treasures to show how one person saw things that were barely visible to others. One just needs to look with one's "antennae up." Herb stated they had acquired many friends this way. Herb said they know so many people that they have actually met people who know the same people. "So now we got friends who know friends."

Mena also enjoyed people. "You know, you need someone to talk to." Mena stated later, "I think that's why, one reason I went to work too. So I'd have somebody to talk to, because you need adult companionship. Whether it's constantly or just now and then, you know." Mena added, "I like volunteering. I like going in seeing the people I use to work with…I get all kinds of hugs when they haven't seen me for a while. It, it's just nice." Besides, "I'm going to be without people when I'm dead. I'm with people now. I want to be with people. I'm a people person."

Bernice stated her "grandson calls once a day or so. My door is never locked. She [Irene] just walks in." Bernice wanted more connection with her grandchildren. "They still love me so much. They don't keep in touch that much. But, you know, they have their own lives." Marguerite enjoyed and desired more connections in her life. Nancy very much enjoyed people and talked proudly about her theater and speech students whom visit her even 12 years after their classes.

Janet remarked, "I love having a party. I love that. Luckily we have celebrations. That's the best thing. Having a good party and everyone coming and enjoying themselves. I love doing things really for people." Janet liked to stay connected to

people whether through parties or sending cards or making phone calls. "I'm a good communicator."

Part of connectedness that was mentioned was connecting through touch. Nancy stated that physical contact had increased in importance as she has aged. Her mother was keen not to give any physical affection or verbal praise so Nancy would not become "swollen headed." Now that there were less people around, the desire for meaningful hugs had increased. June stated affection had changed "in a way because you don't get as much of it, especially when you are a widow or widower. People don't seem to touch you much." Besides, "you don't seem to have as many contemporaries as you had before. You've got practically none by the time you get to my age."

Meaning and Purpose

Under the umbrella of *connectedness* came the sub-category of *meaning*. The need for connectedness in aging was fueled by a desire to have purpose in one's life and to be meaningful to others. Bernice explained it this way,

> The problem when you get old is you have a tendency not to be wanted, not to feel wanted. Like you have no purpose in life. And in Florida, I found that because older people sat around and played cards all day and to me it's a waste of life….I just keep going as long as I know I am helping.

When her daughter, living in Israel, was killed by terrorists, Bernice moved from Florida to Jerusalem so she could be more present in her grandchildren's lives. Bernice painted a grim picture of older adults who did not have meaning in their life, "when you're older, most people have nothing to do. A lot of seniors commit suicide you know." Bernice did not know of any personally though. "So it's good to feel that you're wanted. And it's

good to be busy. I can't stay at home because there is nothing to do in the house except clean."

Irene carried the need for meaning into her discussion about daily living, "I think you have to have a reason for getting up in the morning, too." Irene saw the need for meaning to be prevalent everyday.

I could lie in bed sometimes…if I don't have any plans, if I don't go to class…I can lie in bed until 9 o'clock. And then I figure what am I going to do when I get up? So that's why I make sure Ollie and them lots of times go to the museum on Tuesdays so I get up and go some place. But you have to have a reason for getting out of bed in the morning. And that's why I am going to classes not because I want to be studious or something…I am going because it's a way to get me up and out. Once I'm out I'm out. I go to class. I meet somebody for lunch. We do something. But otherwise if you get up in the morning and you have nothing to do…I mean clean house, forget it.

Herb loved to be over his son-in-law's Ceil noted, "the more projects that Frank does, he loves it. He's over there. You know, instead of being here, he's doing it over there." Janet kept meaning in her life after retiring by volunteering as did Mena. Mena continued to volunteer at the hospital she did administration work. Janet volunteered to look after a community center once a week, along with babysitting for the people next door, baking scones once a month. Lorna stated she will never be ready to do nothing and her continued work as a group counselor was very meaningful to her.

Gift to the World

In closing off the interviews, the question was asked, "If you could give a gift to the world, what would you give?" The participants reflected and then responded with answers that reflected their continued "connectedness" to the world.

Ceil wanted to give the gift of "tolerance for every man. Tolerance." Herb wanted the world to have "people accepting other people in spite of their differences." Mena wanted to give "just the advice to keep peace. Try to get along. Treat others as you want to be treated. Be nice to everyone because you never know whose relative you're going to run into." Bernice wanted to "shoot all the leaders" and then she softened her answer by stating she would just "get rid of the stupid leaders." Irene wanted to "wipe out poverty." Lorna wanted everyone to learn "to love themselves in a very real way, accept the love of the universe, live every moment and look after yourself. Go for it." Marguerite wanted to give unity, understanding and openness. Nancy wanted to settle things (between countries and superpowers) verbally rather than physically.

Of all the participants, June was the only one actively working to make her gift happen. She wanted to give the world a charitable trust to research the retina "so people don't have to go blind." She continued to edit an on-line newsletter to create awareness for macular degeneration, blindness due to genetics and retinal damage. "So I am trying to do a little bit."

Janet summed up the offerings to the world by stating she would give "Love, I think. I think love's the most important thing in the whole world. I think love is what makes the world go round because without love we have nothing."

CHAPTER 5

Discussion

As the literature review pointed out, many factors contributed to stereotypes on aging (Woolf, 1998b). The basis of these stereotypes have been external (imposed by society) rather than informed by the lived experience of elders themselves (Hess & Blanchard-Fields, 1999; Woolf, 1998b). Yet when reviewing the participants' stories on aging, many topics discussed aligned with the stereotypes that were discussed by Edelstein and Kalish (1999). For example, aging was awful (Mena "hates" aging, Marguerite said it was not for "whimps," Janet found it "frustrating"). There were physical disabilities and ailments associated with aging (Ceil had two strokes in eight months and suffered with dsytonia, Herb had intermittent claudication, Bernice's teeth were infected, Nancy was sent home to die). Older adults were slower (Herb needed to stop more while working, Janet noted a lack of energy, Bernice had days she could not walk to the bus stop). Older adults talked about death and associated aging with death (Mena saw herself as the next to die, Herb and Ceil recounted many stories of people who were dead, Nancy welcomed death). Older adults were depressed and lonely (Mena spent much time alone in her apartment, Bernice and Irene desired their children to contact them more, Lorna lied to herself so as not to have to grieve about her age). Of course, none of the participants stated that aging was wonderful, but they did say there were benefits: wisdom, the ability to speak one's mind, freedom to do what one wanted, the freedom to make one's own choices, having time to appreciate things and go to events, decreased anxiety, increased confidence and a greater perspective. So though old age had its challenges, as Irene said, "it ain't too bad." Though elements that contributed

to stereotypes about aging were contained in the experiences of the participants, two topics emerged and were looked at further, *connectedness* and *old was an attitude - age was a concept*.

Connectedness

Connectedness or feeling connected to others and to society was a theme that surfaced in many forms. When "listening with different ears" (Warnick, 1995) and being vulnerable observers (Behar,1996), a possible connection was seen between how intensely these participants talked about being connected to the people in their life, past and present, and their attitude towards the aging experience. Ceil talked a great deal about the people she knew and still felt very connected to many of them even though they were separated by distance or death. This connectedness filled Ceil and allowed for her to be "content." Herb also felt connected to the people he had met and to his family. He was at ease with his present age and continued to be active in his early 80's. Janet was always looking for reasons to connect with people and saw her present life in the positive. Bernice knew her family loved her but wanted them to connect more with her. She was ambivalent about her present age, enjoying what she could but also stated, "Well the alternative [death] they say is bad…but sometimes when you don't feel so good, the alternative is good." Nancy enjoyed her past students who still visited her but felt her daughter had to do too much for her. She felt she had lived "too long." Mena reported having limited friends throughout her life and having distanced herself from a friend over the past several years. Mena stated she "hates" aging. To say that there was a direct correlation between connectedness and participants' attitude on aging was not totally

accurate, but there was evidence in the data that *feeling* connected played a role in these participants' ability to be content with their present status.

Death and Connectedness

Death was not seen with fear. It was just another topic of conversation. Bernice mentioned it off-handedly as "the alternative" which on some days did not seem so bad. Nancy approached it directly when she stated she felt she had been alive "too long" and "I don't feel a loss for dying. Why would you be afraid of dying for goodness sakes?" She elaborated, "I mean all plants die, trees die, everything dies." Janet's statement about her order "fading out and going off" paralleled Nancy's thought on aging. Janet stated, "I don't feel sad about that. I feel we did what we had to and we were there at the right time. And now it's time for us to fade away and a new era will begin." Marguerite stated there were too many older adults for the young people to take care of properly. Of the participants who mentioned death, only Mena mentioned she did not want to die. She wanted to be around to see all the generations coming after her. For the other participants, death was represented as a relief, a transition and a time of moving on so the next group could move forward. Death was even considered socially responsible by two New Zealand participants.

The fact that death was mentioned was not surprising as societal conception was that older adults talk about death because it probably was the next significant event in their life. What arose from the data was the casual nature in which death was mentioned. Fear of death generally caused many people in society to avoid the topic, to use euphemisms, and to avoid situations that brought them in contact with death or dying unless absolutely necessary. By contrast, the participants who talked about death did so

without hesitancy. It was matter of fact. The participants seemed to have an acceptance of death as part of their lives.

In people younger than the participants, it might have been considered depressive thinking to engage in thoughts about death. But as the next major life event, death for these older adults was a reality. Some of the participants had resolved this and were not afraid to die. These statements appeared without depression, sadness or depressive thinking. Having the ability and freedom to engage healthily in the thoughts of death, some of the participants had added meaning such as: social duty, being with God and being one with the cycle of nature.

Being comfortable with death as a natural life process was seen as different from being comfortable with death as a wish or desire. Nancy believed she had lived too long and anticipated her death. One could easily see signs of depression in Nancy's statement and there were certainly evidences that she might have been. However, the belief that discussing one's death was a natural part of aging and/or that depression was a natural part of being older lead to misdiagnosing (Lasser, et al., 1998). Thus, it was observed that a counselor must look at each older adult individually to work towards proper assessment.

Another point was the distinct difference between the data and the concept proposed by Cumming and Henry (1961) as summed up in the title of their work *Growing Old: The Process of Disengagement*. At first look, the focus on and acceptance of death by the participants might have been seen as withdrawal from life and from society on a whole. This movement away from society would be the disengagement which Cumming and Henry stated was a natural part of the aging process. This point was

especially present in the two New Zealand participants who believed they were doing society a favor by dying. Cumming and Henry (1961) could have used this belief as proof of their theory. For, Cumming and Henry stated death was the ultimate form of disengagement from society and life. In the accepting of death, one was making room for other people. When one was settled with that fact, one was "free to die" (p. 227). "The ability to disengage" increased the emotional state of the older person (p. 209).

Though the discussion on death by the participants might have seemed to correspond to Cumming and Henry's (1961) work, an essential difference existed. In Cumming and Henry's work "morale" was achieved by the older adult who disengaged well. In other words, older adults who accepted the role of disengaging from society had a better sense of self. By contrast, the participants in this dissertation found their sense of self (their morale) in their connectedness to others. Even when they talked about their deaths, they talked about the connection it had to the society, to the universe, and to God. Unlike the disengagement views proponed by Cumming and Henry, the participants of this dissertation ultimately showed the acceptance of their death coincided with a sense of their societal, natural, and universal *connectedness.*

Purpose and Connectedness

Dr. Bill Thomas (1996) stated older adults did not die from old age. They died from loneliness, helplessness and boredom (p. 23). Loneliness was described as not feeling connected to other people (*connectedness*). Boredom was a lack of spontaneity in a person's life. (Mena described her life as boring.) Helplessness was not the feeling of being helpless, but rather it was the feeling one had when one was unable to help others.

It was not *having a purpose*. Bernice: "I think the hardest part about getting old is that you can't do anything and your family doesn't have time for you."

> The reason loneliness, helplessness, and boredom rage out of control is that they
>
> are difficult to define in medical terms. Although they cause the bulk of
>
> suffering, their roots cannot be traced back to an imbalance of the metabolism or
>
> of the psyche. A survey of leading geriatric textbooks reveals that loneliness is
>
> accorded less than a paragraph at best. Helplessness and boredom are not
>
> mentioned at all." (Thomas, 1996, p. 24).

Thomas and the participants of this study coincided. Being connected to other people was important; being useful (having purpose and meaning) heightened the experience of *connectedness*.

Old Was an Attitude - Age Was a Concept

In the pilot study for this dissertation called *Three on Aging: A Qualitative Study on Aging as Viewed by Three Elders*, it was discussed that the data concerning *influences on aging well* pointed to the following possible connections: (a) *socio-economic levels*, (b) *spiritual backgrounds and practice*, (c) *regions of one's birth, childhood, adulthood and elderhood*, (d) *positive and/or negative life experiences*, (e) *concepts of life and/or death*, (f) *freedom of movement* and (g) *gender*. "Aging well" in this case was considered to be having a better experience with aging. The discussion section from the pilot study on this topic read as follows:

> Each of these areas seemed to correlate to a better or worse experience with aging
>
> for each participant. Ceil and Herb were upper middle class and had a more
>
> favorable view of aging. Mena self-described as poor and disliked the aging

process. Ceil and Herb were more connected to their Jewish heritage. Mena was

not connected to her spiritual and/or religious background. Ceil and Herb lived in

larger wealthier towns. Mena lived in smaller, poorer towns. Ceil and Herb had

many stories of positive life affirming experiences, whereas Mena talked about

the harshness of her life and her marriage. Ceil and Mena discussed the death of

their mothers but only Mena mentioned the potential nearness of her own death.

Ceil and Mena were restricted in their present movement as they did not drive.

However, Ceil had had a lifetime of free movement, going to New York City

whenever she wanted to or was called to go for work. Mena had had limited

movement during her life and at the time of the interview. Ceil and Mena,

(females) both identified themselves as having different inner ages than physical

age. Herb (male) had an internal and physical age that matched.

Adding the research from the additional seven participants in this study to the three

participants who were also part of the pilot study, the data did not clearly support any of

the factors mentioned as a possible determining factor in aging well above except

freedom of movement. A variety of answers and attitudes were expressed which did not

favor one *socio-economic level*, *spiritual backgrounds or practice*, *concept of life and/or

death*, or *positive and/or negative life experiences*. As the participants were from four

different countries yet expressing the same thoughts on aging, *regions of one's birth,

childhood, adulthood and/or elderhood* did not seem to influence one's concept of aging

more than another. As Herb was the only male participant, no additional data was

gathered to inform the impact of *gender* on aging well. The new information did not

mean these topics were not influences but rather that they were not as clearly defined factors as were observed in the pilot study.

Freedom of movement was the exception. This topic had a great impact on the participant's attitude on their present situations. Whether the limitation were physical, transportation related or both, the ability to move around freely impacted the participants and their attitudes about aging. Ceil's dsytonia made it painful for her to walk around. Janet found the lack of energy "frustrating." Bernice had days when she tired getting to the bus stop. So even though there was good public transportation, she was unable to access it at times. Nancy had a help aid who drove her around and did errands for her. Being attended to made Nancy feel like a burden. Mena did not drive and relied on others to take her to her appointments and out for shopping. This had been a factor through her whole life but particularly harder now that she was not able to walk as far. Marguerite was able to drive but had a hard time walking to the car. Restriction of movement impacted all the participants' concept of aging.

The participant's experiences corresponded to research done on the impact of decreased mobility on elders. Social integration was negatively impacted by driving cessation (Mezuk & Rebok, 2008). Physical limitations affected the distance from home an older adult traveled while cognitive abilities did not (Bendixen, Mann, & Tomita, 2005). Increase in interpersonal dependency correlated to an increase in depression and mobility problems (Gardner & Helmes, 2006). Meaning, the more one needed other people because of physical limitations, the more likely one was to develop more physical limitations. Thus, a frustrating vicious circle was observed.

Though most of the topics of *influences on aging well* from the pilot study did not coincide with the results of this study, a greater theme grew out of the combined data. It was not so much economic or physical abilities or life experience that created a better or worse old age. It was the participant's *attitudes* about those factors that impacted their aging experience. It was the *meaning* they gave to their lives that supported or drained their present experience.

Meaning and Attitude

Ultimately, it was the meaning the participant had about life in general and about their present situation that aided in their feelings about their present age. Janet stated, "that's what it's all about is your attitude." Janet recalled when her father was dying.

> He was lying there for weeks and it was very difficult to watch him. He was only seventy-four and I remember back in the day I thought he was really old. He wasn't really old at all, he was quite young. I don't think anyone's old now unless they're ninety. That's the age of being really old now you know? Someone says they're really old and I say, "How old?" then you find out and I say, "That's not old." They say, "They're sixty," and I say, "No!" So you've got to be over ninety now for me to say you're old but if I get there I might still feel that's not old either.

Janet's perception of her father's age was he was "really old." He was dying. Now that she was 80 years old, 74 was not old at all. In fact, 90 was "old." But, she acknowledges that when she arrives at her 90th year she "might still feel that's not old either." Old age was a concept that was fluid and changed. One was as old as one thinks. This concept was very apparent when the participants discussed their *inner age*.

Inner Age

Inner age was defined in this study as the age one perceived one's self and *physical age* was the actual number of years one had been alive. The concept of an "inner age" surfaced in one of the early interviews and was followed up on in subsequent interviews with other participants. Though the term "inner age" was not familiar to the participants, they understood what was meant with minimal explanation. Ceil (74) stated she felt 20 inside. Mena (75), Marguerite (84 ½) and June (83), all stated they were in their 40's internally. Janet (80) said she felt 50-60. Bernice (82) and Irene (71) said their inner age was in their early 60s. Neither Lorna (72) nor Nancy (94) gave a specific age. Herb (81) was the only participant who felt internally in sync with his physical age. Thus, seven of the ten participants perceived themselves as being anywhere from a seventh to a quarter of their actual age. The average age of all the participants was 79.7 years. The average inner age of those who responded (using 20 for Ceil, 43 for Mena, Marguerite and June, 55 for Janet, 63 for Bernice and Irene and 81 for Herb) was 51.4 years. If one removes Herb as the male from the equation, then the average inner age of the respondents was 47.1 years. Meaning, the participants felt about 30 years younger than they were.

A search in Academic Search Premiere under "inner age," "inner age and older adults," "external age," "external age and older adults," "psychological age" and "psychological age and older adults" turned up studies about the "inner ear," "inner-city," and "internal tibial torsia." A search on the internet pulled up a quiz to find out what was one's internal "physical" age (or rather the health of one's body). No research or articles were found on this topic. The phenomenon of inner age as described in this study has not been well studied (or studied at all). Yet, the implications of inner age on societal

treatment of older adults could be dramatic. If instead of treating elders like they were decades older then they were, society treated elders according to their inner age, then there could be a shift which could have major implications for the societal reintegration of older adults. This studied understood it might seem out of sync to treat an 80 year old as the 40 years old they feel inside. However, society has already exhibited a disconnection between an elder's age and the age they were treated. For example, many elders were treated as if they were 120 years old at one end or mere children at the other end, too old to do anything and too childlike to make their own decisions. Since treating elders as a different age has already been a societal reality, then treating elders according to their self-declared inner age could be potentially positive for elders and society alike.

Self-perception of Being an Older Adult

Since the participants did not see themselves as being as old as they were, none of the participants spent time ruminating about being old. Additionally, they did not spend time thinking if others see them as old. The only time they reported thinking they were old was if there was a physical challenge present. Even then the thoughts were that the ache or pain was from a physical ailment, not from being old. For example, Ceil in commenting about her stroke could have said she did not want to be seen as "old." Rather, she stated she did not want to be seen as "being sick all the time." Even though a stroke could be considered linked to her age, Ceil's consideration was not to be seen as "sick." Being seen as "old," was not part of her thinking because she did not see herself as old. This held true for all the participants. They were not old. Old was the person down the hall.

Old Was Someone Else

When asked what was "too old," Ceil and Herb stated it was when "you can't take care of yourself…and you're a burden to other people." Mena agreed "too old" was having physical limitations, being "stooped over" and "walking with a walker." Ceil and Mena did not see themselves as "too old." Herb at 81, whose inner and physical age he reported as being the same, did not consider himself "too old." June had sympathy for the others down the hall from her whose minds were "not working anymore." They were "too old." Even Nancy at 94 years old and who felt she had lived "long enough," still placed "too old" as an age beyond her present one. She stated if she reached 100 years old "that would horrify me." For all the participants, old was someone else. The idea did not seem to be a disconnect between the participants and reality, but rather a viewing of "oldness" as linked to one's physical well-being instead of one's physical age. Herb stated that there were people coming to his practice that considered themselves old at 65 while Herb himself was 81.

The heightened self-concept expressed by the participants was in line with Pinquart (2002) who observed older adults, when given information containing negative old age stereotypes, exhibited a lowering of their perception of older adults while showing a heightening of their own self-concept. Pinquart postulated older adults used the negative stereotype as a baseline by which they were vastly better. In the same way, the ten elders in this dissertation study did not self-identify as old. They understood they were getting older, but did not see themselves as old yet. Their inner age and the physical condition informed their concept of old and it was clearly someone else.

Attitude and Concept

Attitude was defined as "a settled way of thinking or feeling about someone or something, typically one that is reflected in a person's behavior" (Concise Oxford American Dictionary, 2006, p. 51). The following example from Janet linked this definition of attitude to being old.

> It's all about your attitude. That's, that's for sure. I'm positive of that. It's the way you look at things and the way you, the way you carry out that looking at things. The way you live life as a result of the way you look at things. If you look at things in a negative way and you look at things in a non positive way that's what life is for you. It's just negative. I've got a friend who'll be completely nameless who is, for who nothing is right. We'll meet and go to town and she says, "It's too windy here, there's a draft here." So we move over here and she says, "It's too glaring." We move over somewhere else and it's something else and I think, "My God, how can you live like this?" You know? Or if we go away together nothing is right. You know? Nothing is right. There's something wrong with the window and there's something wrong with the door. Now no wonder you get old. She's ten years younger than me and she's really old.

Janet's friend whose attitude made her old gave evidence to Ron's (2007) study, which found there was a correlation between an older adult's attitude towards old age and their subjective description of having bad health. Blazer (2008) reviewed 30 years of studies searching for the impact of self-perception on older adults. He concluded "we have yet to learn in what ways unfavorable comparisons contribute to health outcomes, but I believe that we have accumulated enough evidence from studies…that we should explore the possibilities further" (p. 421). Negative attitudes toward aging impacted

older adult's overall sense of well-being (Lai, 2009). Thus, Janet's friend's negative attitude lead to poorer concept of her health which potentially lead to poorer health which lead to a poorer overall sense of well-being which lead to intensified negative attitude. Janet's friend was thereby caught in a vicious circle and had become old.

Concept was defined as "an abstract idea; a general notion" (Concise Oxford American Dictionary, 2006, p. 186). It has been discussed that one's age could be internally influenced by one's sense of self rather than the number of years one has lived. This inner age was understood to be "an abstract idea," "a general notion," a "concept." June agreed that age was a "concept…now a days people much younger than 60 or even 50, they can start getting old. Depends on what happens to them." She continued, "don't think you're old…You are not old until you jump in a hole you might say…until you feel you're old….it is all in how you relate in your mind. How you think of yourself."

For the participants, old was an attitude - age was a concept.

Limitations of the Study

This study was not seen to be generalizable but rather was seen as a snapshot of the experience of these ten people ranging in age from 71 to 94. It told only of their lived experience. It started the process of context-driven inquiry which could give voice to a growing population of older adults with concerns, experiences, and diversity.

The snowball method of finding participants for this study contributed to the homogeneity of the participants. Even though participants lived in diverse parts of the world, they were all Caucasians from European descent. People contacted to help find participants referred to people of like backgrounds who then referred to others of like backgrounds. Though a cultural diversity of participants was sought, the snowball

method limited the potential multiplicity of cultural representation that a proactive approach might have achieved. The study could be strengthened and deepened by the addition of the voices of elders from African, American Indian, Maori, and Aborigine tribes.

This study was limited by the lengths of the interviews. Two to six hours was hardly enough time to mine the richness of a life. This study was only a snapshot of their lives. Expanding the study to include several interviews with the same participants at different ages, pre and post physical ailments and pre and post nursing home admissions could provide a three-dimensional view on age and aging.

Even with the adjustments made above, the fact was the participants in this study had not spent a lot of time thinking about their aging process. Though they spent time during their lives thinking about "getting old," they did not spend a lot of time reflecting on "being old." They were no more or less self-reflective now than they had been in their lives. The information they presented was spontaneous. Thus, the data might not have been as rich as it could have been if the participants had agreed to meditate and journal about their age and aging process.

In addition, there was also no way to factor out the impact of ageism, self-prejudice due to age, and the influence of negative old age stereotypes. Though the study listened to the lived experience of older adults, none of the elders interviewed existed in a bell jar in which ageism had been removed. The experiences reported were, thus, contained within a society full of negative and positive ageist beliefs. Thus, the participants reported what they think they knew about aging rather than the actual experience. It was most likely the participants allowed their own aging process to be

influenced by society's negative stereotype patterns. By doing so, realities other than those influenced by ageist beliefs were hard to uncover as older adults uninfluenced by society are hard to find. With this in mind, it was thought that research performed with older adults in cultures where elders were honored might prove to hold important counterpoint information.

Suggestions for Further Research

Instead of denying the process of aging or accepting as truth the stereotypes proposed by ageism, this dissertation sought to explore what age and aging was for those who were older in order to provide potentially important developmental, societal and, possibly, policy-making information. This dissertation understood that as the baby boomer generation becomes older adults, the concept of aging could change and alter. Research that looked at what the experience of aging was for older adults could be imperative to our understanding of how to relate to the growing, aging percentage of the population.

An example of society's disconnect in research and reality about age and aging was found in the National Center for Health Statistics (with funding from the National Institute on Aging and the Centers for Disease Control and Prevention) three wave longitudinal "Study of Aging." The entirety of the survey dealt with the living arrangements, family situation, medical care, benefits used, healthcare assistance, impairments, cognitive functioning, insurance, and final services provided to an elder *prior to the elder's death* (National Center for Health Statistics, 2002). The study surveyed elders' families <u>after</u> the death of the elder as the method to carrying out their "study on aging." Aging and death seemed synonymous in the make up of this

questionnaire and no older adults were interviewed or surveyed. Data was obviously slanted in the direction of the stereotypes as all the information concerned ailing and dead older adults, not well elders. In fact, there was no place in the survey that offered opportunity to discuss positives in the older adult's life. Though it was true the elders in this study were part of Wave 1 and Wave 2 which emphasized other parts of their lives, the focus on just the elders who had died during Wave 3 slanted the data on aging and presented a biased perspective. With other research stating longevity was increased by positive self-perception of aging (Levy, et al., 2002), the CDC might consider a better service to older adults, society and the concept of age and aging would be to focus on how elders do live and can live better, rather than how they die.

In addition, further research based on this study could explore the definitions of "connectedness" and its potential factor in healthy aging. Did people who had deeper and more meaningful relationships throughout their lives age better? Were there ways of increasing one's feeling of connectedness?

An expanded investigation of "inner age" could reveal insights into the internal human landscape. What percentage of people, especially elders, identified with a different inner age than physical age? What was the impact of having an inner age that differed from one's physical age? What did elders in the general population believe was "too old"? Was "too old" always linked with physical ability or disability? What were the ramifications of inner age on how society works with, defines, treats, and interacts with elders?

Further research could look to discover any correlations between attitudes on aging and socio-economic levels, spiritual backgrounds and practices, regions of one's

birth, childhood, adulthood and elderhood, positive and/or negative life experiences, concepts of life and/or death, and/or freedom of movement. What was the impact of a positive attitude on age and aging on older adults? In addition, further studies could look at the potential correlation between how one lived one's life and the attitude one had about aging. Did a good, healthy and exciting life lead to a better attitude towards aging? To what extent did the emotional, physical, social, mental life one lived determine the experience one had with aging?

Referring back to the research in the literature review, there was evidence that older adults were impacted by implied and overt ageism when given memory tests which implied age discrimination (Hess, Hinson & Hodges, 2009). Also, older adults did statistically less well on test when even just the wording was changed to less ageim-ladened phrases (Chasteen, et al., 2005). Follow-up research could test if older adults performed better if they thought tests were skewed in their direction. In other words, could there be "positive ageism," stereotypes of older adults which helped elders to perform and live better? These stereotypes could be as equally unfounded as the negative ones. However, if a positive attitude on aging increased the length of one's life by seven years (Levy, Slade, Kunkel, & Kasl, 2002), then it could be important to explore the impact and perpetuation of positive concepts of age and aging.

Further research could work with a larger sample and not be limited to Caucasian elders of European descent as in this study. The research could extend to elders of all ethnic backgrounds in all countries. What was the meaning of aging for people of different ethnic backgrounds, or different geopolitical stresses? Was there some connecting human experience found in the experience of aging? Were there differences?

How did this information inform, challenge, alter, and instruct our concepts, approaches, policies, and opinions of the elders we might be one day?

A curious study could be to ask older adults how they would like others to refer to them. One older adult offered "experienced adult." She thought the current term "older adult" offered by the APA was pejorative. Thus, it would be interesting to survey elders for terms they would like used to be referred to and to self-refer.

A possible response to this study could be to apply the literature review, data and discussion to literature written about working with older adults. With a greater understanding of the lived experience of older adults, their self-concept, and their inner age, a set of guidelines could be developed by which literature on working with older adults could be evaluated for overt and covert ageism as well sensitivity to the lived experience of all elders. Such guidelines and applications were done and follow in Appendix A and B.

Conclusion

People born today could expect to live years longer than those born even a few decades ago (Levy, et al., 2002). Medical advances have been increasing exponentially and every day one lives there has been a greater chance of living longer. Thus, a better understanding of the concept of age and aging itself has been vitally important. Rather than relying of society's preconceived notions of aging, riddled with old age stereotypes, this dissertation focused on the actual lived experience of ten elders as a starting point for understanding. The participants in this study supported some of the stereotypes about old age being harsh, debilitating, and reductionistic. However, the participants also mentioned benefits to aging: wisdom, ability to speak one's mind, and freedom.

The participants in this study revealed that connectedness was very important to them and to their sense of well-being. In this aspect, this study refuted the myth presented by Cumming and Henry (1961) who proposed the role of the older adults was to disengage from society and the role of society was to disengage from the elder. This process was slow, lengthy, and ended with the ultimate disengagement, death. The older adults in the qualitative part of this dissertation stated in various manners that connectedness was an important part of their life and essential for meaning and purpose. Even when the participants talked about death, it was in relation to being connected to society, the universe, and/or God. So, though their present life involved disengagement at some level, continued connectedness, even when thinking about death, provided meaning and purpose. No meaning and purpose was found in disengaging from society as Cumming and Henry proposed.

The disengagement Cumming and Henry observed might have been a result of ageism, which they proceeded to perpetuate. Maybe it was not the elders who need to accept disengagement from society but society who needed to re-engage with older adults. Perhaps, the evolutionary and natural role of the older adult was, as Thomas (1996) suggested, to engage meaningfully with society for the perpetuation of the race. Maybe, the role of the older adult was, as the participants of this study naturally felt, to stay connected. Maybe, the internal desire of the participants to increase connectedness was their instinctual societal role calling from within. For if what Thomas (1996) proposed was true, then society would do well to re-connect with its elder and in doing so the "elders will save the world" (title).

The participants reported having an inner age that was different from their physical age. Many reported feeling internally like they were 30-40 years younger than they were. The implication was that these elders felt viable, alive and willing to connect and contribute. Leventhal (1988) suggested that physical deterioration was not inevitable but rather occurred because of inactivity <u>not</u> because of aging itself.

> While all these changes of ageing are well known, we do not really know how much is due to the ageing process itself and how much results from our sedentary lifestyle…physical inactivity can make a body age prematurely (p.70).

If we understood what Leventhal was saying here, we might begin to understand the concept of inner age and be able to bring the inner and outer concept of age together. An understanding of the phenomenon of inner age could help those who work with elders understand the frustration of an older adult who is 80, saw herself as 40 but was being treated like a 2 year old by her family and like a 200 year old by society.

Since older years have been seen as the creative years (Cohen, 2000), this dissertation proposed that expressive therapist could hold a unique position in helping older adults with mental health concerns to work through their issues. Arts-based therapies could engage the client in a variety of ways and with various modalities in order to help the client get what was inside out. Expressive therapies could help give voice to needs and concerns when words were not enough.

In order to create the environment where older adults could feel safe, revive and thrive, the expressive therapist needed to be active in neutralizing ageism wherever it was found. For though Pinquart (2002) found that negative stereotypes might boost self-concept because elders might gage themselves against the bad stereotype knowing they

were doing better, it was still important to create bias-free literature and work towards an ageism-free society. These guidelines, based on this dissertation, with an application using expressive therapies literature were created and placed in Appendix A and B.

The lived experiences of the ten elders in this study helped gain insight into the meaning of aging for these elders, while also giving direction for further research and guidelines for expressive therapies literature about working with older adults. During the study, many of elders stated that they could accept living eternally just as they were even with limitations, ailments and irritations. Though it would be better to have life without aging, they could accept aging if it meant life. Mena stated, "Life is to me is like a book. You want to keep reading it and reading it, reading it, reading it, reading it…I never want to get to the end of it." It was seen that with proper research, it might not be possible to perpetuate Mena's book forever, but it could be possible to provide useful and insightful information on the process for all who are aging…and thus help each person's book be fuller, longer and more enriched.

Appendix A

Guidelines for Ageism Awareness When Reviewing Literature and Research about

Expressive Therapies with Older Adults

Appendix A

Guidelines for Ageism Awareness When Reviewing Literature and Research about

Expressive Therapies with Older Adults

Whereas, ageism and age stereotypes have been shown to:

- impact the performance of older adults (Chasteen, et al., 2005; Hess, et al., 2009),

- affect the diagnosing, interactions and treatment by the older adult's health professionals (Danzinger & Welfel, 2000; Gatz & Pearson, 1988; Helmes & Gee, 2003; Kane, 2004; Kane 2008; Lasser, et al., 1998; Lee, et al., 2003; Roberts, 2008),

- prevent older adults from seeking help (Sarikisian, et al., 2003), and

- increase dependency (Coudin & Alexopoulos, 2010)

and whereas age has been shown

- not to affect and possibly to improve creativity (Lindauer, 1998; Lubart & Sternberg, 1998; Ravin & Kenyon, 1998; Simonton, 1998; Sinnott, 1996; Sinnott, 1998),

and whereas it has also been shown that

- emotional stability improves with age (Williams, et al., 2006)

and whereas older adults in counseling were

- equally as able if not better able to improve (Arean, et al., 1993; Cook, 1998; Floyd, 2003; Gorsuch, 1998; Hinrichsen, 1999; Jones & Beck-Little, 2002; Kennedy & Tanenbaum, 2000; Knight, 1993; Knight, 1999; Knight & McCallum, 1998; Leszcz, et al., 1985; Pasupathi & Carstensen, 2003; Scogin

& McElreath, 1994; Thompson, et al., 1987; Walker & Clark, 2001; Watt &

Cappeliez, 2000; Wood, 2003),

and whereas it has been shown that

- people with positive attitudes on aging lived seven years longer (Levy, et al.,

    2003)

it was seen as important that ageism, ageist belief, age stereotypes and misconceptions

about aging were found, reduced and eliminated wherever they arose. As health

professionals were many times the first people an older adult came in contact with when

they had concerns about physical or mental health, it was also seen as important that

health professionals were aware of their age bias (whether positive or negative) and its

potential damage.

With elders, words might not be the easiest or most comfortable form of

expression, especially in the counseling process. Since there was increasing research on

the potential for creativity in older adults (Labert & Sternberg, 1998; Lindauer, 1998;

Ravin & Kenyon, 1998, Simonton, 1998, Sinnott, 1996, Sinnott, 1998), there was a need

for mental health professionals who have an understanding of creativity to be involved in

the elder's therapy process. Expressive therapists could provide just that service. Thus,

it was seen as important that expressive therapists were aware of the impact of ageism on

their literature, research and work. Because of this need and based on the qualitative

study on aging above, a set of guidelines was developed and presented here.

Eliminate Age Bias and Ageism Stereotypes

Articles about working with older adults sought to eliminate age bias and ageism

stereotypes in their language, content and/or omissions.

Ageism has been shown to have an impact on older adults (Woolf, 1998b) and on therapists (Danzinger & Welfel, 2000; Helmes & Gee, 2003; Kane, 2004; Kane 2008; Lee, et al., 2003; Roberts, 2008). This awareness was important as it has been proponed that people could internalized ageism stereotypes which then could turn into self-loathing as one grew older (Woolf, 1998a). In addition, those internalized ageist beliefs could negate the effects of therapy (Goodstein, 1985; Perlick & Atkins, 1984; Settin, 1982). Thus, it was seen as important to eliminate ageism's influence in the wording and semantics of any article whether on aging or not.

Eliminate Both Positive and Negative Biases and Stereotypes

Articles about working with older adults sought to eliminate both positive and negative age biases and stereotypes.

Positive and negative biases about aging and older adults impacted elders (Roberts, 2008). Both were shown to lead to condescension and patronization (Nussbaum, Pitts, Huber, Raup Krieger & Ohs, 2005) as well as misdiagnosises (Lasser, et al., 1998). Acceptance of both positive and negative age stereotypes were shown to be detrimental to interactions, treatment and planning (Danzinger & Welfel, 2000; Gatz & Pearson, 1988; Helmes & Gee, 2003; Kane, 2004; Kane 2008; Lasser, et al., 1998; Lee, et al., 2003; Roberts, 2008). Thus, it was seen as important to eliminate both negative and positive stereotypes in the literature.

Promote Counseling as Effective with Older Adults

Articles about working with older adults expected elders were just as able to work through their issues as anyone.

Counseling for older adults was just as effective as counseling for other age populations (Arean, et al., 1993; Cook, 1998; Floyd, 2003; Hinrichsen, 1999; Jones & Beck-Little, 2002; Kennedy & Tanenbaum, 2000; Knight, 1993; Knight, 1999; Knight & McCallum, 1998; Leszcz, et al., 1985; Pasupathi & Carstensen, 2003; Scogin & McElreath, 1994; Thompson, et al., 1987; Watt & Cappeliez, 2000; Wood, 2003) and in some cases more effective (Gorsuch, 1998; Walker & Clark, 2001). Thus, it was seen as important to ask what goals the article sought for the older adult. Were the results and/or goals aimed towards resolution (as in regular counseling) or were the goals lowered based on ageist beliefs that resolution was not possible?

Differentiate Arts-based Therapy from Arts-based Therapeutic Programs

Articles about working with older adults differentiated arts-based therapy from arts-based therapeutic programs.

As just noted, counseling for older adults was just as effective as counseling for other age populations (Arean, et al., 1993; Cook, 1998; Floyd, 2003; Hinrichsen, 1999; Jones & Beck-Little, 2002; Kennedy & Tanenbaum, 2000; Knight, 1993; Knight, 1999; Knight & McCallum, 1998; Leszcz, et al., 1985; Pasupathi & Carstensen, 2003; Scogin & McElreath, 1994; Thompson, et al., 1987; Watt & Cappeliez, 2000; Wood, 2003) and in some cases more effective (Gorsuch, 1998; Walker & Clark, 2001). Thus, it was seen as important that an article did not reduce therapy to "therapeutic programs" as was described in the "therapy verus therapeutic" section of this dissertation. This semantic nuance could effectively minimize the role of expressive therapies by presenting the benefits as tangential rather than direct.

Represent the Expressive Therapist as a Therapist

Articles about working with older adults were aware of the representation of the expressive therapist.

Expressive therapists were seen as mental health professionals and not just creative activity coordinators. Thus, it was seen as important that the expressive therapies literature reflected this fact. Expressive therapist should be presented in the literature as having all the rights and responsibilities of other mental health professionals, exhibiting all the same ethics and following all the same ethical standards. The expressive therapist should be represented in the literature as a therapist not a kind of "recreation director" with little to no boundaries, confidentiality or therapy goals.

Though not a guideline specifically dealing with ageism, this guideline arose out of the research performed to create these guidelines. In the same fashion that ageism could create prejudice against one's self as one ages (Woolf, 1998b), expressive therapists reflected themselves in the literature as less than or different from other healthcare professionals. This image stereotyped expressive therapists as different. Thus, it was seen as important that expressive therapists presented themselves as the professionals they were and not as alternatives. If either the client or the therapist had lower expectations for improvement, the therapy could move towards what some have termed "therapeutic nihilism" (American Psychological Association, 2004; Goodstein, 1985; Perlick & Atkins, 1984; Settin, 1982).

Adjustments Made Are Based on Client's Needs Not on Client's Age

Articles about working with older adults made adjustments to counseling techniques based on the client's actual need not on the client's age.

It has been shown that older adults might need adjustments to the setting of the counseling but do not need adjustment to their therapy because they were older (Knight, 1999; Laidlaw, 2001). Thus, it was seen that adjustments to counseling approaches should be based on client's needs and therapy goals and not based on preconceived notions of the needs of an older adult.

Aim to Increase Older Adult's Connectedness, Purpose and Meaning

Articles about working with older adults aimed to increase the older adult's level of connectedness, purpose and meaning.

Connection, purpose and meaning were shown to be important aspects of successful living for the older adults interviewed in this dissertation. Though not the only reasons for counseling, an understanding of the importance of connection purpose and meaning was seen as important for a thorough assessment of an older client's needs and for the enriching of the counseling experience.

Honor Client as a Person Who is Older Not as an Old Person

Articles about working with older adults treated the client as a person who is older not as an old person.

Internalized ageist beliefs adversely affected older adults (Woolf, 1998a) and impacted health professionals' attitudes and diagnoses of an older adult (Danzinger & Welfel, 2000; Gatz & Pearson, 1988; Helmes & Gee, 2003; Kane, 2004; Kane 2008; Lasser, et al., 1998; Lee, et al., 2003; Roberts, 2008). The qualitative part of this dissertation revealed that the participants did not see themselves as old. Old was the person with physical disabilities or who had a poor attitude. Thus, it was seen as important that articles about working with older adults showed an understanding of the

concept that perceptions of age were linked to physical disability and attitude more than physical age.

Show an Understanding of the Inner Age of the Client

Articles about working with older adults sought to honor the inner age of the client.

The participants in this dissertation stated their inner age was 30-40 years less than their physical age. Thus, potential, goals and prognosis for older adults could be more accurately created if this concept of inner age was taken into account. Professionals could reflect this observation by asking about a person's inner age and their attitude on aging during assessments. Even if an article was not dealing with inner age directly, acknowledging the inner age concept could enrich the content of the material.

Encourage the Creative Potential of Older Adults

Articles about working with older adults reflected an understanding of what older adults have to offer in their creative stage of life.

Emerging research showed that though the brain changes, problem solving abilities stayed in tact as one age (Sinnott, 1996; Sinnott, 1998). Creativity remained the same and possibly increased as one aged (Lubart & Sternberg, 1998). Creative output from any field were not bound by physical age but rather "career age," thus older adults starting a new career or having a resurgence in their old career were just as capable of producing the same number of creative outputs as those who started their creative careers earlier in their lives (Simonton, 1998). Creative output was deepened and enriched by the aging process (Lindauer, 1998; Ravin & Kenyon, 1998). Thus, it was seen as important

for articles to contain an understanding of the creative potential of older adults even if that was not the focus of the article.

Appendix B

Applications of Guidelines for Ageism Awareness When Reviewing Literature and

Research about Expressive Therapies with Older Adults

Appendix B

Applications of Guidelines for Ageism Awareness When Reviewing Literature and

Research about Expressive Therapies with Older Adults

Books and articles were sought for this section with the intent to include at least

two articles and/or books from each of different arts-based therapy modalities: art, music,

dance/movement, and psychodrama/drama. Though several books were looked at under

the heading of "expressive therapies," the author or editor(s) often broke the topic into

chapters dedicated to each of the modalities individually and not to the intermodal use of

the arts as therapy. Thus, the chapters from the intermodal books (Weisberg & Wilder,

2001) or the book itself (Weiss, 1984) were placed under the appropriate modality

heading it best fit. All the chapters, books and articles were not chosen as an overall

representation of a modality itself but rather to show that no modality was without its

biases. Thus, selections were made based on illustrative merit not to promote one

modality over another. The texts were also selected to represent writings from the 1980s,

1990s and 2000s to show that ageist beliefs have not changed much. Because the texts

were from different times and because the politically correct words for older adults have

changed, no observations were offered on the use of terms that were period specific such

as "elderly," "old person" or others. An annotated bibliography follows for each of the

selected books and articles. Abstracts or self-descriptions were presented if available.

Expressive Therapies Literature

Art Therapy

Wald, J. (2003). Clinical art therapy with older adults. In C. A. Malchiodi (Ed.),

Handbook of art therapy (pp. 294-307). New York: Guilford. Wald's chapter

discussed "age-related changes and losses that the elderly suffer" so "therapists

can help them to maintain hope despite physical, psychological, and/or cognitive

losses" (p. 295). The use of the word "losses" twice in the same sentence relating

to older adults showed the focus of this chapter to be on the negative of aging.

Wald did widen her scope while talking about treatment considerations stating

there were three types of older adult clients but then immediately refocused on the

worse case scenarios, "the frail and debilitated" (p. 298). Wald reviewed art

therapy goals with older adults, presented three case examples and outlined group

work with older adults.

Weiss, J. C. (1984). *Expressive therapy with elders and the disabled: Touching the heart*

of life. New York: Haworth. Weiss focused on arts-based therapy approaches in

long term care settings where he intermingled the approaches for older adults and

people with disabilities as if they were the same. Weiss presented many of the

standard arts-based therapy exercises and was obviously compassionate for the

older adults with whom he worked. However, the book was more subjective than

objective, especially demonstrated by the inclusion of two chapters spanning 58

pages which contained mostly pictures. Though title had the words "expressive

therapy" in it, the book itself was heavily art therapy based.

Dance/Movement Therapy.

Sandal, S. L., & Hollander, A. S. (1995). Dance/movement therapy with aging

populations. In F. J. Levy, Fried, J. P., & Leventhal, F. (Eds.), *Dance and other*

expressive art therapies: When words are not enough (pp. 133-143). New York:

Routledge. This compact chapter clearly defined the differences between

"physical therapy, 'fitness' programs, creative movement, and dance/movement therapy" (p. 133). It also defined the different types of older adult populations with which one might use dance/movement therapy. It then offered many examples of how dance/movement therapy could be used with older adults and finished with a case study.

Stockley, S. (1992). Older lives, older dances: Dance movement therapy with older people. In Payne, H. (Ed.), *Dance movement therapy: theory and practice* (pp. 81-101). New York: Routledge. Stockley presented an overview of the history of dance/movement therapy with older adults along with models and approaches. The author then described techniques and issues one should keep in mind when using dance/movement therapy with an older adult. The chapter finished with a sample group outline and three case illustrations.

Music Therapy

Palmer, M. (2001). Older adults are total people. In Weisberg, N., & Wilder, R. (Eds.), *Expressive arts with elders: A resource, 2nd ed*. (pp. 179-187). Philadelphia: Jessica Kingsley. This chapter first appeared in the 1985 edition of this book whose original title was "Creative Arts with Older Adults: A Sourcebook" (Weisberg & Wilder, 1985). Though much had changed in the world of therapy in the intervening 16 years between editions, not much was changed in the updated chapter. The chapter urged music therapist to consider and create sessions around the physical, mental and psychosocial needs of the client, and to see the older adult as a whole person. Palmer described the concerns the music therapist should have when heading towards the goal of helping the client to be as

independent as possible. Current research could have strengthened the valid

points in this chapter.

Wigram, T., Pedersen, I. N., & Bonde, L. O. (2002). *A comprehensive guide to music*

therapy: Theory, clinical practice, research and training. Philadelpia: Jessica

Kingsley. "This book is structured to follow a path starting in history and leading

the reader through to current research and clinical practice" (p. 12). The book had

a particular format for the presentation of material which made it easy to follow.

The small section (8 pages out of 380) which dealt with older adults seemed to

have been written by Hanne Mette Oshsner Ridder who was given only

parenthetical credit. The chapter contained two case study vignettes, a list of the

ways music could be used, the results of a review of studies dealing with people

with dementia, and a list of how therapy could be employed. Music therapy with

elders was a very short section of an otherwise detailed book.

Psychodrama/Drama Therapy

Horvatin, T., & Schreiber, E. (Eds.). (2006). *The quintessential Zerka: Writings by*

Zerka Toeman Moreno on psychodrama, sociometry and group psychotherapy.

New York: Routledge. This book:

Documents the origins and development of the theory and practice of

psychodrama, sociometry and group psychotherapy through the work and

innovation of its co-creator, Zerka Toeman Moreno. The comprehensive

handbook brings together history, philosophy, methodology and application. It

shows the pioneering role that Zerka, along with her husband J. L. Moreno,

played in the development not only of the methods of psychodrama and sociometry, but of the entire group psychotherapy movement worldwide. (p. i)

Johnson, D. R. (1985). Expressive group psychotherapy with the elderly: A drama therapy approach. *International Journal of Group Psychotherapy, 35*(1), 109-127.

This article describes group psychotherapy with nursing home residents, ages 64-96, which utilizes the nonverbal and symbolic activities of drama therapy to facilitate an orientation to insight and transference phenomena, in contrast to the purely supportive techniques often used with the elderly. A case study of a long-term therapy group is described with examples of how the patients confronted their physical limitations, the death of their parents and of themselves, and transferences to the therapist. The media of creative drama, by concretizing and symbolizing difficult feeling states, and thus encouraging verbalization, may be a useful aid in extending the benefits of expressive psychotherapy to the impaired elderly. (Abstract, p. 109)

Selections chosen for examples did not reflect the treatment of older adults by the whole of the modality used. Society, therapists and individuals all exhibited age-based stereotypes. None of the writers of these books, chapters and articles set out to perpetuate ageism and stereotypes. In fact, it has been assumed the writers chose to work with the older adults because they liked the population and were passionate about their work. Positive examples were also included below to reflect that passion. In the end, these selections have been chosen as learning examples so all might benefit.

Application

Eliminate Age Bias and Ageism Stereotypes

Articles about working with older adults sought to eliminate age bias and ageism stereotypes in their language, content and/or omissions.

The subtle, yet clearest when understood, examples of articles promoting age stereotypes came through word associations. Often the title of an article stated it was about therapy with older adults and then the text was about work done with people in nursing homes. Older adults were associated with nursing home residents through the omission of description which continued by also ascribing them similar physical attributes.

Several examples of this type of ageism were found in "A Comprehensive Guide to Music Therapy: Theory, Clinical Practice, Research and Training" in the chapter called "Music Therapy with Older Adults" (Wigram et al., 2002, pp 188-196). The book stated it was "comprehensive" yet dedicated only eight pages (2%) to music therapy with older adults. Of these eight pages, only two sentences mentioned older adults as anything but "weak and dependent," "needing 100 percent help and care," "suffering with dementia," and "with severe memory, communication and functional deficits" (p. 188). Those opening two lines of the chapter (representing 2.5% of the chapter and but .05% of the entire book) contained the only positive remarks about older adults. They were as follows:

> Working with older adults in music therapy means working with a very non-homogeneous group. At one end of the spectrum of differences there is the group of wise, serene elderly, representing big resources for younger generations. At the opposite end of the spectrum are the weak and dependent, needing 100 per

cent help and care, with severe memory, communication and functional deficits.

This group includes amongst others, older adults suffering from dementia. (p.188)
The positive words connected to older adults were "wise, serene elderly," "a very non-homogenous group," and "a big resource for younger generations." "Wise, serene elderly" was an obvious positive stereotype as "weak and dependent" were obvious negative stereotypes. Though presented as opposite extremes, it could be seen as pejorative to some older adults to be placed in-between those ends. The value of elders was subtly addressed in the sentence which placed older adults as a "big resource for younger generations." The statement implied that the value of older adults was through their usefulness to the younger generation. This submission of value to youth was a subtle example of ageism in a culture that values youth (Woolf , 1998b). Though the statement mentioned that older adults represented a "very non-homogenous group," the statements after that and the rest of the chapter discussed older adults in "old people's home." Both of the case studies were about people with Alzheimer's Disease and/or dementia. The chapter was not comprehensive, equated older adults to people in nursing facilities and was not as "non-homogenous" as it stated the elder population to be.

Other misrepresentation of older adults found between the title of a text and the content of the text itself were as follows:

Palmer's "Older Adults are Total People" (2001) had a great title but the content of the chapter was on music therapy with "elderly adults…in a health care facility or in a community-living situation" (p. 180). The inference was that older adults lived in nursing facilities.

Johnson's "Expressive Group Psychotherapy with the Elderly: A Drama Therapy Approach" (1985) stated in the abstract "this article describes group psychotherapy with nursing home residents" (p. 109). As the article was solely about the work done in a nursing home, a more accurate title was thought to be "Expressive Group Psychotherapy with Older Adults in a Nursing Home: A Drama Therapy Approach."

Wald's "Clinical Art Therapy with Older Adults" (2003) had a few mentions of well elders but the bulk of the chapter rested on her work at a day treatment program. The opening poem under the title was by "clients at a geriatric day treatment program" (294). The four case studies were taken from day treatment programs. Though the chapter acknowledged other older adults in the community, its focused was on work with older adults in a geriatric program setting.

Weiss' "Expressive Therapy with Elders and the Disabled: Touching the Heart of Life" (1984) reflected the most grievous example in that the title itself equated elders to disabled. The chapters, the examples and the case studies were about people in care facilities. Chapter 2 was titled "Creative Arts Therapy for Various Elder Populations: Techniques and Processes" (pp. 25-44). Though the title had "various elder populations" in it, the chapter did not mention working with an elder who was not incapacitated in some form. In fact, the chapter talked only of residents in care facilities and grouped them into "minimally handicapped," "moderately handicapped," and "severely handicapped (pp. 26-27). Weiss (1984) did mention in his introduction that the book was a compilation of his years of work with "elders and disabled at various facilities (hospital, institutions, senior citizens centers, adult day care programs, and mental health clinics)" (p. xix). Knowing his work was with elders at facilities, the author could have avoided

linking the concept of older adults to people with handicaps or in need of assistance through a more accurate title.

Not directly related to the examples above, Sandel and Hollander's (1995) chapter titled "Dance/Movement Therapy with Aging Populations" showed a very subtle semantic example of ageism. The term used to refer to older adults in the title was "aging populations." It was understood that all were aging. Thus, linking the aging process only to older adults was a subtle, yet powerful form of ageism.

Ageism was also observed in omissions. Wigram et al. (2002), as was discussed, limited their information on aging to 8 pages of a 381 page book or just 2%. In their book which was self-described as "comprehensive," most of the chapter on older adults dealt with people with dementia. This representation of older adults did not accurately reflect the elder population. Though the authors did not acknowledge their less than "comprehensive" chapter on working with elders, they interestingly pointed out that the major music therapy journals had minimized articles about music therapy with older adults to a non-representational percentage of overall articles printed. Wigram et al. (2002) presented a table which showed that between the years of 1998 and 2001 the percentage in three major music therapy journals of article on working with older adults was as follows:

Journal of Music Therapy – 0%

British Journal of Music Therapy – 4.1%

Nordic Journal of Music Therapy – 3.1%

(p. 231)

As elders in America represent 12.8% of the population or one in eight Americans (Administration on Aging, 2009), the percentage of time devoted to working with older adults by these music therapy journals did not reflect the reality of the population itself.

The next was an unfair example in that the author of the text did not set out to work with older adults nor write about older adults. Zerka Moreno was a co-creator in the form of action therapy called psychodrama. Horvatin and Schreiber (2006) collected all Moreno's writing into a "quintessential" compilation. In 328 pages of article, Moreno did not address applying psychodrama to work with older adults. With due respect, it was noted that there were no articles about working with adolescents either. The one reference to older adults stated, "Not only the aged are severely affected by death" (p. 241). The article continued by talking about adolescence who have contemplated or attempted suicide. It was hard to differentiate if Moreno did not include elders in any of her articles because she saw no need to alter the psychodrama process with different populations or if older adults were simply in her blind spot. The reason this example was included was because of all the arts-based therapy modalities, psychodrama was the one with the least representation of articles dealing with elders in expressive therapies literature. The absence seen in Moreno's work was echoed in the modality itself.

Eliminate Both Positive and Negative Biases and Stereotypes

Articles about working with older adults sought to eliminate both positive and negative age biases and stereotypes.

Wigram et el. (2002) used the phrase "wise, serene elderly" (p. 188). Though a positive view of older adults, the phrase revealed a stereotype just the same. In this case, the stereotypes was that older adults are wise. Several of the participants in this

dissertation stated one of the benefits of aging was wisdom. However, realistically, it was understood that age alone did not make one wise.

Weiss (1984) used the following definition for "elder":

An Elder is a person who is still growing, still a learner, still with potential and whose life continues to have within it promise for, and connection to the future. An Elder is still in pursuit of happiness, joy, and pleasure, and her or his birthright to these remain intact. Moreover, an Elder is a person who deserves respect and honor and those whose work it is to synthesize wisdom form long-life experience and formulate this into a legacy for future generations. (pp xix-xx)

Weiss stated the term was "used in a dignifying manner, to note a person who deserves to have a sense of self-esteem, respect and opportunities for a fulfilling life" (p. xix). This definition of an elder created a positive and even rosy picture of older adults. Weiss, though passionate, worked with an overly positive definition created on overly positive stereotypes.

Promote Counseling as Effective with Older Adults

Articles about working with older adults expected elders were just as able to work through their issues as anyone.

A good example of the knowledge that older adults could work toward resolution through arts-based therapies was presented by Wigram et al. (2002). The authors were describing a music therapy session in which one of the participants

tried to join in the first lines, but every time he burst into tears, and cried while the therapist sang the song. He was not able to put into words what was going on in the music therapy. However, the fact that he, in this period, was searching for a

way to express some very strong feelings can be construed as his way of handling

essential conflict-ridden themes without being badly affected by it (p. 191).

The passage showed positive and negative feelings handled in the therapy process and

older adults being able to do the work of therapy.

Wigram et al. (2002) further stated "the elderly individual will benefit from co-

ordinated activities and therapeutic interventions where a trained professional is able to

set up a safe structure that enables the participants to enter a dialogue" (p. 195). Though

the statement referred to "activities," it was understood the authors were doing the work

of therapy in creating a safe space and entering into dialogue with the elder. These

statements were made with the knowledge that the effort would not be lost because older

adults could indeed work towards resolution and change.

Differentiate Arts-based Therapy from Arts-based Therapeutic Programs

Articles about working with older adults differentiated arts-based therapy from

arts-based therapeutic programs.

In the literature review of this dissertation, definitions were offered for the

difference between arts-based therapy and arts-based therapeutic programs. The

difference was that emotional well-being was a tangential result of therapeutic programs

whereas it was the primary goal of therapy. With this in mind, it was important to talk

about expressive therapies in the literature in a manner which reflected its equality as a

therapy. Weiss (1984) referred to his work as "creative arts programs" (p. 25) and

"creative arts therapy activities" (p. 27). Neither of these gave the impression that Weiss

was doing anything more than creating activity programs.

This image of therapeutic programming continued in Wigram et al. (2002) who employed these statements in examples of music therapy: "sing-a-long," "music and movement activity," and "simple exercises" (p. 189). One of the groups referenced in the text was called the "'Friday coffee singing' where residents, staff and relatives listened to music in a calm and warm atmosphere, and sang, chatted and drank coffee" (p. 190). In addition to music therapy described as a program, this example also revealed another dramatic difference between programs and therapy. In this music activity, families and staff were welcomed to share coffee with the participants during the program. Doubtful a psychotherapy group would allow such activity.

The above example was not isolated. Palmer (2001) stated the following,

One of the interesting sidelights to music therapy programs with the elderly is the reaction of the families involved. Attending a program where their family member is involved or seeing them in new roles can help the family also to accept the new living situation. There is improved communication, and visits become more enjoyable. Frequently the families then become more involved within the facility, and when this happens, *everyone* benefits" (p. 187).

Several issues surfaced in this statement. First, the benefit mentioned was for the family (not the client). Second, if the family were present when they wanted, then where were the boundaries for the therapy? Where was the safety for the other members? And most importantly, where was the informed consent? The program described above was a needed program and was therapeutic. But, it was not therapy and did not present itself as therapy, otherwise it should have attended to boundaries and consent.

Carrying this one step further, in this example not only was informed consent not gathered, the therapist essentially tricked older adults into attending the group. Weiss (1984) remarked, "I have seen a better response by elders to creative arts therapy sessions when it is called 'creativity in self-development' to avoid the stigma of the term therapy" (p. 26). Changing the name of the group in order to lure participants into therapy negated their right to informed consent. Even if the group was beneficial, informed consent was needed to treat a client. Some assumptions could be made about Weiss' willingness to alter the group title including: he did not view his work as therapy in the same manner as talk therapist did, and he did not value the older adults with whom he worked in that he did not see them as able to make proper informed decisions on their own. Though Weiss assuredly believed he was acting in the best interest of the client, his actions might have undermined his role as therapist and his participants sense of respect and self-worth.

Good examples of differentiating the differences between therapeutic programming and expressive therapies were found in Sandel and Hollander (1995) and Stockley (1992). The wording in both was almost identical but only Stockley referenced the Association of Dance Movement Therapy which one had to assume Sandel and Hollander are drawing from without reference. Despite this, the following example used the Sandel and Hollander text as it was clearer and longer.

Right from the beginning of the chapter, Sandel and Hollander (1995) defined the role of a dance/movement therapist. "Movement is a meaningful part of many different treatment modalities for the aged. Although physical therapy, 'fitness' programs, creative movement, and dance/movement therapy all use movement, each modality has its own goals" (p. 133). The next three paragraphs defined the goals of each. Of note,

the authors stated the goal of a fitness program were physically related and "emotional well-being, if it comes, is a by-product of better physical functioning" (p. 133). The comment that emotional well-being was a by-product demonstrates the authors had an understanding of the difference between therapy and therapeutic programs as discussed in the literature review section of this dissertation.

The next paragraph in the chapter discussed the goals of creative movement in a nursing home or senior center. The authors acknowledged that creative movement had some of the same physically-oriented goals as fitness programs with the additional goals being "to encourage creativity, spontaneity, body awareness, increased self-esteem, and social interaction" (p. 134).

Finally Sandel and Hollander (1995) discussed how the goals of dance/movement therapy were broader than the other movement modalities in that it integrated physiology, sociology and psychology. "Dance/movement therapy gives meaning to movement through the development of images, encourages emotional responses and the processing of the responses both positive and negative, and it facilitates and supports social interaction" (p. 134). Importantly the authors noted, "movement activities are not the primary goal of the group experience, but rather the tool for creating a therapeutic environment" (p. 134). Sandel and Hollander (1995) displayed an understanding that the arts-based activity (in this case dance/movement) was the setting for the therapy process and resolution of positive <u>and</u> negative emotions was the therapy goal. This example was art as therapy and not just as therapeutic activity.

Represent the Expressive Therapist as a Therapist

Articles about working with older adults were aware of the representation of the expressive therapist.

In the same manner that therapist misrepresented expressive therapies as programs not therapy, they also misrepresented themselves as less than a therapist through the language used and roles performed. Patricia A. Kinsella in the foreward of Weiss' (1984) book said about older adults, "he is still a living soul with a story" (p. xv). Weiss's book was subtitled "Touching the Heart of Life." Terms like "soul" and "heart of life" could lead readers to wonder if they could take the writer seriously as they approach the metaphysical.

The therapist understanding of their role as somehow less than a mental health counselor or other health care staff was reflected in Wald's (2003) statement,

> Most art therapists working in geriatric programs are required to lead other groups besides art. This can serve an integrative function by combining art with gardening, cooking, music, dance, and writing. For example, planting seeds, watering them, and watching them grow into flowering plants can be nurturing and reparative (p. 305).

Though gardening might be therapeutic, it was not therapy. The role here was less of a therapist and more of a recreation director.

In the following examples, the therapist was reduced from recreation director to the role of entertainer playing background music. "A music therapist accompanied the songs on the piano and entertained with quiet, easy-listening music in a coffee break halfway through" (Wigram et al., 2002, p. 189). One might imagine a talented doctor or

administrator playing the piano on a rare occasion but this was not what was happening here. For later in the chapter Wigram et al. described the work of the music therapist.

> Working as a music therapist function in gerontology is an all-round job. You will often see the music therapist function as a piano entertainer, leading very different groups where music is integrated in some way, as well as carrying out individual music therapy sessions" (p. 194).

A mental health counselor or social worker would not double as a piano entertainer as a normal part of their job.

Downplaying the role of art as therapy by talking about creating "activities" and "programs" as well as reducing the role of the expressive therapist to anything less than a mental health professional could be seen to weaken the therapy in the minds of the therapists, staff, family and, especially, the older adult clients themselves.

Adjustments Made Are Based on Client's Needs Not on Client's Age

Articles about working with older adults made adjustments to counseling techniques based on the client's actual need not on the client's age.

Some articles on older adults included long lists of issues with which older adults might be dealing. One example stated, "elderly people may cling to their grown-up children, or become almost autistic and unable to respond to help or stimulation, so that helping them to find a balance between dependence and autonomy seems to be an important issue" (Stockley, 1992, p. 89). The text also listed these issues: stroke, loss of physical health, loss of mental faculties, sensory impairments, deafness, blindness, loss of speech, loss of skin sensation, cataracts, tinnitus, strokes, multiple sclerosis, Parkinson's disease, and so on (Stockley, 1992, p. 89). What was important to note about this list was

there are no mention of common concerns that any adult might have had: finances, sexual frustrations, relational issues, sexuality concerns, grief, etc. Listing potential concerns found at times among older adult clients was important but neglecting to also list common concerns that everyone dealt with did not reflect the reality. Most of the texts examined failed to acknowledge a need to view the older person first as a person and then build the therapy from there.

One adjustment that respected the older adult was to "be sure to provide good-quality art materials, which help promote respect and dignity" (Wald, 2003, p. 299). Because of budgets and financial constraints, many expressive therapists had to be creative about the supplies they used. One needed only flash forward in her life 50 years and imagine how invested one would be in making a popsicle stick craft to understand the need for quality art materials when doing arts-based therapy.

As far as activities go, Stockley (1992) pointed out,

teachers often adopt a "Simon Says" style which reinforce their power as experts and essentially invalidates the students themselves as individuals with specific contributions to make, effectively keeping them at a distance. A dance movement therapist will take a more creative and empathic stance, which empowers and validates the participants' individual experiences" (p. 84-85).

Doing "Simon Says" type activities was the dance/movement equivalent to making the popsicle stick crafts mentioned above. The childishness of the activity (though fun, spontaneous and playful at times) could be thought to be demeaning. Playing childlike games with elders on a regular basis could encourage stereotypes and reduced expectation of the older adults in the mind of the therapist and the participants. Stockley

understood her role was as therapist not as leader. Her role was to empower not to dictate.

Aim to Increase Older Adult's Connectedness, Purpose and Meaning

Articles about working with older adults aimed to increase the older adult's level of connectedness, purpose and meaning.

The expressive therapies texts that were examined did a good job in presenting connectedness as a goal of therapy. As expressive therapies was often done in group format, it was not surprising the goal of connection was often mentioned. Providing or helping a client find purpose and meaning was not directly presented but could be found in the literature in the shadow of the goal of connectedness. Here were examples from the texts that highlighted the goal of connectedness:

Weiss (1984) stated, "through a therapeutic creative arts program, individuals may experience a closer communication with themselves and others, work through problems and issues, and find channels for their feelings, thoughts, and creative inspirations" (p. 25).

Wald (2003) stated the expressive therapies work can "bring clients out of personal isolation and despair by encouraging socialization and group support in creative therapy groups" (p. 300).

Wigram et al. (2002) presented a case study in which they reported, "Mrs. F was one example of a person to whom the 'being together with others' in a musical situation was essential to her quality of life" (p. 190).

Sandel and Hollander (1995) discussed several times that "social interaction" was an important part of expressive therapies (p. 134).

Stockley (1992) remarked, "the need to experience warm, loving contact continues throughout life; it is not a prerogative of babies and young lovers," (p. 90).

Palmer (2001) stated, "one of the great needs for all persons is recognition," (p. 186).

Expressive therapist seemed to understand the need for connectedness which could help in making expressive therapies a good fit for work with older adults.

Honor Client as a Person Who is Older Not as an Old Person

Articles about working with older adults treated the client as a person who is older not as an old person.

Treating an older person as a person first could be seen as imperative to creating a healthy and realistic therapy relation. One of the first places to start was with the image of older adults as presented in the literature. Blanket statement were to be avoided as the image of elders presented could be unrealistically negative as in these examples. Weiss (1984) stated "often elders and the disabled feel their lives as impoverished. While trying to cope with their changing life circumstances, they inadvertently neglect and lose meaning of their inner feelings" (p. 117) and "verbal psychotherapy is often a difficult modality of therapy for elders because the discussion of feelings and problems may seem taboo to them" (p. 25). In the first example, the reader received a dreary picture of what elders "often" experience. And even if there was truth in the second example (though it might not be the case with the Baby Boomer generation who might be more counseling-savvy), a blanket statement of this nature could establish blocks in the mind of the therapist before they ever get to assess the client.

Another example of an unrealistic blanket view of older adults was presented by Palmer (2001) who stated, "the first goal [of the music therapist] is simply to counteract the contracture which develops when the resident sits with fists clenched and arms folded" (p. 180). Palmer added that this stance was "a common posture of residents in nursing homes" (p. 180), effectively painting the vision of hallways of older adults with "fists clenched and arms folded" (p. 180).

Another way in which the texts did not view the older person first as a person was seen in the previously discussed issue of informed consent. Johnson (1985) stated he told the drama therapy group participants that the goal was "to get to know each other and share your feelings with the group" (p. 113). This statement did not provide proper informed consent, especially when he stated,

> For the therapist, the purposes of the group are (1) to serve as an orienting and socializing environment, (2) to be an arena for sharing reminiscences about important life events, and (3) to aid in the acceptance of one's physical limitations, interpersonal losses, and eventual death (p. 113).

These goals differed from the ones Johnson told the participants and these goals were therapy goals. Thus, an informed consent with disclosure was needed. Anything less removed the rights of the client as a person first. If the purpose of expressive therapies (or any therapy) was to empower, then one could not start out a positive relationship with an act of disempowerment.

Show an Understanding of the Inner Age of the Client

Articles about working with older adults sought to honor the inner age of the client.

No specific references were made in the texts to the concept of inner age. This occurrence was not surprising in that the concept was one being put forth in this dissertation. That said, expressive therapies' "emphasis is on the inner life" (Weiss, 1984, p. 117). With that as the focus, expressive therapists were in some manner always working with the older adult's inner age and the inner concept the person had herself.

Statements like the following by Wald (2003) worked against the therapist's understanding of the concept of inner age and its usefulness in therapy. "The older adult must cope with major life losses, physical decline, sexual changes, changes in dependency status, role as receiver, and reduction in social contacts…" (p. 295). That statement alone was not too concerning, but Wald (2003) continued by quoting Blau and Berezin's (1975) report which stated that the older adult was "expected to sustain mild feelings of depression, anxiety, and grief, and one needs to reduce somewhat one's aspirations" (p. 226). The concept of inner age as revealed in this dissertation pushed against the idea of a reduction in "one's aspirations" while still acknowledging physical age.

Encourage the Creative Potential of Older Adults

Articles about working with older adults reflected an understanding of what older adults have to offer in their creative stage of life.

As has been mentioned, good quality materials was suggested to be provided to older adults partaking in expressive therapies (Wald, 2003, p. 299) for creativity was fostered in an environment of possibilities not one focused on issues. Because a wide range of older adults existed, it was seen as important to make sure their diversity was reflected in the writings rather than the group of elders being seen as one collective.

Sandel and Hollander (1995) defined the wide range of elders one might work with by describing how "aging populations differ" (p. 134). In their description they included sections on "well-elderly," "physically challenged," "psychiatric disorders," "cognitively impaired," and "frail elderly" (p. 134-136). By providing quality materials, being in the role of therapist, and being open to the wide range of elder populations, one could work with older adults to achieve their creative best.

Finishing Comment

"An important aspect of the work done by a dance movement therapist will lie in combating ageism, particularly at the level at which older people have themselves internalized it" (Stockley, 1992, p, 82). Combating internalized and external evidences of ageism was seen in this dissertation not just the work of the dance/movement therapist but of all expressive therapists working with older adults. One of the first places expressive therapists begin learning about their future work was through expressive therapies literature. The literature was also the place where practicing expressive therapist learned new skills and practices. Thus, it was seen as important in combating ageism and its influences that expressive therapies literature reflected the reality of aging. Basing the articles on solid research, being attuned to overt and subtle ageist statements, and incorporating the guidelines spelled out above, writers and researcher could help expressive therapist enter the work with older adults not focusing on limitations but envisioning possibilities.

References

Aday, R. H., & Aday, K. L. (1997). *Group work with the elderly: An annotated bibliography* (Vol. 33). Westport, CT: Greenwood.

Administration on Aging: U. S. Department of Health and Human Services. (2009). *A profile of older Americans: 2009.*

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorder* (4th ed. text revision ed.). Washington, DC: Author.

American Psychological Association. (2004). Guidelines for psychological practice with older adults. American Psychologist, 59(4), pp. 236-260.

American Psychological Association. (2010). *Publication Manual of the American Psychological Association* (6th ed.). Washington, D.C.: American Psychological Association.

Arean, P., Perri, M. G., Nezu, A. M., Schein, R. L., Christopher, F., & Joseph, T. X. (1993). Comparative effectiveness of social problem-solving therapy and reminiscence therapy treatment for depression in older adults. *Journal of Consulting and Clinical Psychology*, *61*(6), 1003-1010. Retrieved May 1, 2004, from PsycARTICLES database.

Bendixen, R. M., Mann, W. C., & Tomita, M. (2005). The relationship of home range to functional status and cognitive status of frail elders. *Physical & Occupational Therapy in Geriatrics*, 23(2/3), pp. 43-62, 20.

Behar, R. (1996). *The vulnerable observer: Anthropology that breaks your heart*. Beacon: Boston.

Blatner, A. (1996). *Acting-in: practical applications of psychodramatic method* (3rd ed.). New York: Springer.

Blau, D., & Berezin, M. (1975). Neurosis and character disorders. In J. Howells (Ed.), Modern perspectives in psychiatry of old age (pp. 201-233). New York: Brunner/Mazel.

Bornat, J. (Eds.). (1994). *Reminiscence reviewed: Evaluation, achievement, perspectives*. Open University: Philadelphia.

Brederode, A. (1999). Layer upon layer: A healing experience in the art studio. In S. K. Levine & E. G. Levine (Eds.), *Foundations of expressive arts therapy: Theoretical and clinical perspectives* (pp. 151-170). Philadelphia, PA: Jessica Kingsley.

Briere, J. (1996). *Therapy for adults molested as children: Beyond survival* (Revised and expanded ed.). New York: Springer.

Burlingame, V. S. (1995). *Gerocounseling: counseling elders and their families*. New York: Springer.

Burnside, I., & Haight, B. (1992). Reminiscence and life review: analyzing each concept. *Journal of Advanced Nursing*, *17*, 855-862. Retrieved March 16, 2004, from Academic Search Premier database.

Busuttil, W. (2004). Presentations and management of post traumatic stress disorder and the elderly: a need for investigation. *International Journal of Geriatric Psychiatry*, *19*(5), 429-439. Retrieved January 28, 2006, from Academic Search Premier database.

Butler, R. N. (1963). The life review: an interpretation of reminiscence in the aged. *Psychiatry, 26*, 65-76.

Butler, R. N. (1969). Age-ism: Another form of bigotry. *The Gerontologist, 9,* 243-246.

Chasteen, A. L., Bhattacharyya, S., Horhota, M., Tam, R. & Hasher, L. (2005). How feelings of stereotype threat influence older adult's memory performance. *Experimental Aging Research*, 31, 235-260.

Chu, J. A. (1998). *Rebuilding shattered lives: The responsible treatment of complex post-traumatic and dissociative disorders*. New York: John Wiley & Sons.

Cohen, G. D. (2000). *The creative age: awakening human potential in the second half of life*. HarperCollins: New York.

Cohen, G. D. (2005). *The mature mind: The power of the aging brain*. Perseus: New York.

Colman, A. M. (2001). *A dictionary of psychology*. Oxford: Oxford University.

Concise Oxford American Dictionary (2006). Oxford University Press: New York.

Cook, E. A. (1998). Effects of reminiscence on life satifaction of elderly female nursing home residents. *Health Care for Women International*, *19*(2), 109-118. Retrieved April 4, 2006, from Academic Search Premier database.

Coudin, G., & Alexopoulos, T. (2010). "Help me! I'm old!" How negative aging stereotypes create dependency among older adults. *Aging & Mental Health*, 14(5), pp. 516-523.

Cresswell, J. W. (1998). Qualitative inquiry and research design: Choosing among five traditions. SAGE: Thousand Oaks, CA.

Cumming, E. & Henry, W. E. (1961). *Growing old: The process of disengagement*. New York: Basic Books.

Danzinger, P. R. & Welfel, E. R. (2000). Age, gender and health bias in counselors: An empirical analysis. *Journal of Mental Health Counseling*, 22(2), 135-149.

Edelstein, B., & Kalish. K. (1999). Clinical assessment of older adults. In J. C. Cavanaugh & S. Whitbourne (Eds.), *Gerontology: An interdisciplinary persceptive* (pp. 269-304). New York: Oxford University Press.

Erikson, E. (1963). *Childhood and society*. New York: Norton.

Federal Interagency Forum on Aging-Related Statistics. (2010). *Older Americans 2010: Key indicators of well-being*.

Floyd, M. (2003). Bibliotherapy as an adjunct to psychotherapy for depression in older adults. *Journal of Clinical Psychology, 59*(187-195).

Freud, s. (1953). On psychotherapy. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 7, pp. 257-268). London: Hogarth Press. (Original work published 1905).

Gardner, D. K., & Helmes, E. (2006). Interpersonal dependency in older adults and the risks of developing mood and mobility problems when receiving care at home. *Aging & Mental Health*, 10(1), 63–68

Garland, J. (1994). What a splendor, it all coheres: life-review therapy with older people. In J. Bornat (Ed.), *Reminiscence reviewed:evaluation, achievements, perspectives* (pp. 21-31). Buckingham: Open University.

Gatz, M., & Pearson, C. (1988). Ageism revised and the provision of psychological services. *American Psychologist*, 43:3, 184-188.

Goodstein, R. K. (1985). Common clinical problems in the elderly: Camouflaged by

    ageism and atypical presentation. *Psychiatric Annals, 15*, 299-312.

Gorsuch, N. (1998). Time's winged chariot: short-term psychotherapy in later life.

    Psychodynamic Counseling, 4, 191-202.

Halprin, D. (1999). Living artfully: Movement as an integrative process. In S. K. Levine

    & E. G. Levine (Eds.), *Foundations of expressive arts therapy: Theoretical and*

    clinical perspectives (pp. 133-150). Philadelphia, PA: Jessica Kingsley.

Helmes, E. & Gee, S. (2003). Attitudes of Australian therapists towards older clients:

    Educational and training imperatives. *Educational Gerontology*, 29, 657-670.

Herman, J. L. (1997). *Trauma and recovery: the aftermath of violence - from domestic*

    abuse to political terror. New York: Basic Books.

Hess, T. M. & Blanchard-Fields, F. (Eds.). (1999). *Social Cognition and Aging.*

    Academic: NY.

Hess, T. M., Hinson, J. T. & Hodges, E. A. (2009). Moderators of and mechanisms

    underlying stereotype threat effects on older adults' memory performance.

    Experimental Aging Research, 35, 153-177.

Hinrichsen, G. A. (1999). Treating older adults with interpersonal psychotherapy for

    depression. *Journal of Clinical Psychology*, *55* (8), 949-960. Retrieved March 16,

    2004, from Academic Search Premier database.

Horvatin, T., & Schreiber, E. (Eds.). (2006). *The quintessential Zerka: Writings by*

    Zerka Toeman Moreno on psychodrama, sociometry and group psychotherapy.

    New York: Routledge.

Ivey, D. C., Wieling, E., & Harris, S. M. (2000). Save the young – the elderly have lived their lives: Ageism in marriage and family therapy. Family Process, 39(2), 163-175.

Johnson, D. R. (1985). Expressive group psychotherapy with the elderly: a drama therapy approach. *International Journal of Group Psychotherapy, 35*(1), 109-127.

Jones, E. D., & Beck-Little, R. (2002). The use of reminiscence therapy for the treatment of depression in rural-dwelling older adults. *Issues in Mental Health Nursing*, *23*, 279-290. Retrieved March 16, 2004, from Academic Search Premier database.

Jones, K. (2010). Therapeutic Group Activities for the Elderly. *eHow*. Retrieved January 2, 2011, from http://www.ehow.com/list_7217152_therapeutic-group-activities-elderly.html

Kane, M. N. (2004). Ageism and intervention: What social work students believe about treating people differently because of age. *Educational Gerontology*, 30, 767-784.

Kane, M. N. (2008). Imagining recovery, resilience, and vulnerability at 75: Perceptions of social work students. *Educational Gerontology*, 34, 30-50.

Kennedy, G. J., & Tanenbaum, S. (2000). Psychotherapy with older adults. *American Journal of Psychotherapy*, *54*(3), 386-407. Retrieved April 4, 2004, from Academic Search Premier database.

Knight, B. G. (1993). Psychotherapy as applied gerontology: a contextual, cohort-based maturity-specific challenge model. *Generations*, *17*(1), 61-64. Retrieved April 4, 2004, from Academic Search Premier database.

Knight, B. G. (1996). *Psychotherapy with older adults, second edition*. Sage: Thousand Oaks, CA.

Knight, B. G. (1999). The scientific basis for psychotherapeutic interventions with older adults: an overview. *Journal of Clinical Psychology*, *55*(8), 927-934. Retrieved March 16, 2004, from Academic Search Premier database.

Knight, B. G., & McCallum, T. J. (1998). Adapting psychotherapeutic practice for older clients: implications of contextual, cohort-based, maturity specific challenge model. *Professional Psychology: Research and Practice*, *29*(1), 15-22. Retrieved April 4, 2004, from PsycARTICLES database.

Knill, P. J. (1999). Soul nourishment, or the intermodal language of imagination. In S. K. Levine & E. G. Levine (Eds.), *Foundations of expressive arts therapy: Theoretical and clinical perspectives* (pp. 37-52). Philadelphia: Jessica Kingsley.

Lai, D. W. L. (2009). Older Chinese' attitude toward aging and the relationship to mental health: An international comparison. Social Work in Health Care, 48, 243-259.

Lasser, R., Seigel, E., Dukoff, R., & Sunderland, T. (1998). Diagnosis and treatment of geriatric depression. *CNS Drugs*, 9, 17-30.

Laidlaw, K. (2001). An empirical review of cognitive therapy for late life depression: does research evidence suggest adaptations are necessary for cognitive therapy with older adults? [Invited essay]. *Clinical Psychology and Psychotherapy*, *8*, 1-14. Retrieved March 16, 2004, from Academic Search Premier database.

Lee, K. M., Volans, P. J., & Gregory, N. (2003). Attitudes towards psychotherapy with older people among trainee clinical psychologists. *Aging & Mental Health*, 7(2), 133-141.

Leszcz, M., Feigenbaum, E., Sadavoy, J., & Robinson, A. (1985). A men's group: psychotherapy of elderly men. *International Journal of Group Psychotherapy, 35*(2), 177-196.

Leventhal, M. B. (1988). The dance of life: Dance and movement therapy for the older adult. *Topics in Geriatric Rehabilitation*, 4(4), 67-74.

Levine, E. G. (1999). On the playground: child psychology and expressive arts therapy. In S. K. Levine & E. G. Levine (Eds.), *Foundations of expressive arts therapy: theoretical and clinical perspectives* (pp. 257-273). Philadelphia, PA: Jessica Kingsley.

Levy, B. R., Slade, M. D., Kunkel, S. R. & Kasl, S. V. (2002). Longevity increased by positive self-perceptions of aging, 83 (2), 261-270.

Lewis, M. M. (2001). spirituality , counseling, and elderly: An introduction to the spiritual life review. *Journal of Adult Development*, *8*(4), 231-240. Retrieved March 16, 2004, from Academic Search Premier database.

Lindauer, M. S. (1998). Artists, art, and arts activities: What do they tell us about aging? In C. E. Adams-Price (Ed.), *Creativity & successful aging: Theoretical and empirical approaches* (pp. 237-250). New York: Springer Publishing.

Lubart, T. I., & Sternberg, R. J. (1998). Life span creativity: An investment theory approach. In C. E. Adams-Price (Ed.), *Creativity & successful aging: Theoretical and empirical approaches* (pp. 21-41). New York: Springer Publishing.

Malde, S. (1988). Guided autobiography: a counseling tool for older adults. *Journal of Counseling and Development, 66*, 290-293.

Meyers, M. A. (1999). In exile from the body: Creating a 'play room' in the 'waiting room'. In S. K. Levine & E. G. Levine (Eds.), *Foundations of expessive arts therapy: Theoretical and clinical perspectives* (pp. 241-256). Philadelphia, PA: Jessica Kingsley.

Mezuk, B., & Rebok, G. W. (2008). Social integration and social support among older adults following driving cessation. *Journals of Gerontology Series B: Psychological Sciences & Social Sciences*, 63B(5), pp. S298-S303.

Moller, D. W. (2000). Fear and denial of death. *InnerSelf Magazine*. Retrieved June 7, 2007, from http://www.innerself.com/Miscellaneous/moller09113.htm

Murray, A. (2005). Recurrance of post traumatic stress disorder. *Nursing Older People, 17*(6), 24-29.

National Center for Health Statistics. (2002). Second longitudinal study of aging, wave 3: Decedent questionnaire (computer assisted telephone interview). Retrieved September 19, 2010, from http://www.cdc.gov/nchs/lsoa/w3df.htm

Newham, P. (1999). Voicework as therapy: The artistic use of singing and vocal sound to heal mind and body. In S. K. Levine & E. G. Levine (Eds.), *Foundations of expressive arts therapy: Theoretical and clinical perspectives* (pp. 89-112). Philadelphia, PA: Jessica Kingsley.

Noice, H., & Noice, T. (2009). An arts intervention for older adults living in subsidized retirement homes. *Aging, Neuropsychology, and Cognition*, 16, 56-79.

Nussbaum, J. F., Pitts, M. J., Huber, F. N., Raup Krieger, J. L., & Ohs, J. E. (2005). Ageism and ageist language across the life span: Intimate relationships and non-intimate interactions. *Journal of Social Issues*, 61(2), 287-305.

163

Palmer, M. (2001). Older adults are total people. In Weisberg, N., & Wilder, R. (Eds.),
Expressive arts with elders: A resource, 2nd ed. (pp. 179-187). Philadelphia:
Jessica Kingsley.

Pasupathi, M., & Carstensen, L. L. (2003). Age and emotional experience during mutual
reminiscing. *Psychology and Aging*, *18*(3), 430-442. Retrieved March 9, 2004,
from PsycARTICLES database.

Perlick, D., & Atkins, A. (1984). Variations in the reported age of a patient: A source of
bias in the diagnosis of depression and dementia. *Journal of Consulting and
Clinical Psychology, 52*, 812-820.

Pinquart, M. (2002). Good news about the effects of bad old-age stereotypes.
Experimental Aging Research, 28, 317-336.

Ravin. J. G., & Kenyon, C. A. (1998). Artistic vision in old age: Claude Monet and
Edgar Degas. In C. E. Adams-Price (Ed.), *Creativity & successful aging:
Theoretical and empirical approaches* (pp. 251-267). New York: Springer
Publishing.

Roberts, J. M. (2008). The parameters of prejudices: Knowledge of ethics and age bias.
Journal of Gerontological Social Work, 50(3/4), pp. 65-79.

Robinson, B. (1994). *Ageism*. University of California at Berkeley. Retrieved June 7,
2007, from http://socrates.berkeley.edu/~aging/ModuleAgeism.html

Rogers, N. (1993). *The creative connection: Expressive arts as healing*. Palo Alto, CA:
Science & Behavior Books.

Ron, P. (2007). Elderly people's attitudes and perceptions of aging and old age: the role

   of cognitive dissonance? International Journal of Geriatiric Psychiatry, 22, 656-

   662.

Saldana, J. (2009). *The coding manual for qualitative researchers*. Los Angeles: Sage.

Sandal, S. L., & Hollander, A. S. (1995). Dance/movement therapy with aging

   populations.   In F. J. Levy, Fried, J. P., & Leventhal, F. (Eds.), *Dance and other*

   expressive art therapies: When words are not enough (pp. 133-143). New York:

   Routledge.

Sarkisian, C. A., Lee-Henderson, M. H., & Mangione, C. M. (2003). Do depressed older

   adults who attribute depression to "old age" believe it is important to seek care?

   Journal of General Internal Medicine 18(12), 1001-1005.

Scogin, F., & McElreath, L. (1994). Efficacy of psychosocial treatments for geriatric

   depression: a quantitative review. *Journal of Consulting and Clinical Psychology*,

   62(1), 69-74. Retrieved March 16, 2004, from Academic Search Premier

   database.

Settin, J. M. (1982). Clinical judgment in geropsychology practice. *Psychotherapy:*

   Theory, Research, and Practice, 19, 397-404.

Simonton, D. K. (1998). Career paths and creative lives: A theoretical perspective on late

   life potential. In C. E. Adams-Price (Ed.), *Creativity & successful aging:*

   Theoretical and empirical approaches (pp. 3-18). New York: Springer

   Publishing.

Sinnott, J. D. (1996). The developmental approach: Postformal thought as adaptive

   intelligence. In F. Blanchard-Fields & T. M. Hess (Eds.), Perspectives on

cognitive change in adulthood and aging (pp. 358-383). New York: McGraw-Hill.

Sinnott, J. D. (1998). Creativity and postformal thought: Why the last stage is the creative stage. In C. E. Adams-Price (Ed.), *Creativity & successful aging: Theoretical and empirical approaches* (pp. 43-72). New York: Springer Publishing.

Staudigner, U. M. (2001). Life reflection: a social-cognitive analysis of life reveiw. *Review of General Psychology*, *5*(2). Retrieved March 9, 2004, from PsycARTICLES database.

Stockley, S. (1992). Older lives, older dances: Dance movement therapy with older people. In Payne, H. (Ed.), *Dance movement therapy: theory and practice* (pp. 81-101). New York: Routledge.

Thomas, W. H. (1996). *Life worth living: how someone you love can still enjoy life in a nursing home: the eden alternative in action*. Acton, MA: VanderWyk & Burnham.

Thomas, W. H. (2004). *What are old people for?: How elders will save the world*. Acton, MA: VanderWyk & Burnham.

Thompson, L. W., Gallagher, D., & Breckenridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. *Journal of Consulting and Clinical Psychology*, *55*(3), 385-390. Retrieved May 1, 2004, from PsycARTICLES database.

Toseland, R. W. (1995). *Group work with elderly and family caregivers*. New York: Springer.

van der Kolk, B. (2001). The psychobiology and psychopharmacology of PTSD. *Human Psychopharmacology Clinical Experience, Supplement 1*, *16*, S49-S64. Retrieved January 28, 2006, from Academic Search Premier database.

van der Kolk, B. (2002). Posttraumatic therapy in the age of neuroscience. *Psychoanalytic Dialogues*, *12*(3), 381-392. Retrieved January 28, 2006, from Academic Search Premier database.

van der Kolk, B., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic stress: the effects of overwhelming experience on mind, body and society*. New York: Guilford.

Wald, J. (2003). Clinical art therapy with older adults. In C. A. Malchiodi (Ed.), *Handbook of art therapy* (pp. 294-307). New York: Guilford.

Walker, D. A., & Clarke, M. (2001). Cognitive behavioral psychotherapy: a comparison between younger and older adults in two inner city mental health teams. *Aging & Mental Health*, *5*(2), 197-199. Retrieved March 16, 2004, from Academic Search Premier database.

Warnick, J. (1995). *Listening with different ears: Counseling people over 60*. QED: Fort Bragg, CA.

Watt, L. M., & Cappeliez, P. (2000). Integrative and instrumental reminiscence therapies for depression in older adults: interventions strategies and treatment effectiveness. *Aging & Mental Health*, *4*(2), 166-177. Retrieved April 4, 2006, from Academic Search Premier database.

Webster's New Collegiate Dictionary. (1977). Merriam-Webster: Springfield, MA.

Weintraub, D., & Ruskin, P. E. (1999). Posttraumatic stress disorder in the elderly: A review. *Harvard Review of Psychiatry*, *7*(3), 144-152. Retrieved January 28, 2006, from Academic Search Premier database.

Weisberg, N., & Wilder, r. (Eds). (1985). *Creative arts with older adults: A sourcebook.* New York: Human Sciences.

Weisberg, N., & Wilder, R. (Eds). (2001). *Expressive arts with elders: A resource, 2ⁿᵈ ed.* Philadelphia: Jessica Kingsley.

Weiss, J. C. (1984). *Expressive therapy with elders and the disabled: Touching the heart of life.* New York: Haworth.

Wigram, T., Pedersen, I. N., & Bonde, L. O. (2002). *A comprehensive guide to music therapy: Theory, clinical practice, research and training*. Philadelpia: Jessica Kingsley.

Williams, L. M., Brown, K. J., Palmer, D., Liddell, B. J., Kemp, A. H., Olivieri, G., Peduto, A. & Gordon, E. (2006). The mellow years?: Neural basis of improving emotional stability over age. *Journal of Neuroscience*, 26 (24), 6422-6430.

Wilson, S. (March 6, 2007). America's greatest fear. *The Daily: Opinion*. Retrieved June 7, 2007, from

http://www.thedaily.washington.edu/article/2007/3/6/americasGreatestFear

Wong, P. T. P., & Watt, L. M. (1991). What types of reminiscence are associated with successful aging? *Psychology and Aging*, *6*(2), 272-279. Retrieved May 1, 2004, from PsycARTICLES database.

Wood, B. T. (2003). What's so different about older people? *Clinical Psychology and Psychotherapy*, *10*, 129-132. Retrieved March 16, 2004, from Academic Search Premier database.

Woolf, L. M. (1998a). Ageism: An introduction. *Ageism.* Retrieved May 30, 2007, from http://www.webster.edu/~woolflm/ageism.html

Woolf, L. M. (1998b). The theoretical basis of ageism. *Ageism*. Retreived May 30, 2007, from http://www.webster.edu/~woolflm/ageism.html