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Using Common Factors Outcome Research to Guide a Strength Based Counseling Approach with Nursing Home Residents

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Abstract

This article explores how outcome research findings can be used to guide strength based counseling with nursing home residents. The problems nursing home residents face are identified. The four common factors of client strengths, the counseling relationship, hope/expectancy, and model techniques are presented and guide the case illustrations. The need for research with this population is underlined.

*Keywords:* common factors, strength based counseling, case illustrations

Lambert and Bergin (1994) indicated there have been more than 40 years of empirical evidence supporting the effectiveness of psychotherapy and counseling. Luborsky, McClellan, Woody, O'Brien and Auerbach (1985) and later comprehensive reviews (Lambert & Bergin, 1994; Miller, Taylor, & West, 1980; Stubbs & Bozarth, 1994), highlighted the conclusion that studies comparing differences between specific therapy approaches found little significant differences in outcome. Meta-analytic studies (Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997) confirmed this conclusion, but it is still not accepted as a fact about psychotherapy (Tallman & Bohart, 2003). In contrast, the available evidence on common factors present in diverse counseling models makes different therapy approaches equally effective.

Hubble, Duncan, and Miller (2003), citing Lambert (1992), identified four common factors accounting for improvement in therapy: 1) 40% due to the clients' strengths, supportive environmental elements and chance events; 2) 30% due to relationship factors; 3) 15% due to placebo, hope and expectancy, both the client and therapists' belief in the counseling; and 4) 15% due to model/technique factors. Based on Lambert's (1992) research Tallman and Bohart

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## **The Aging Population**

In 1900, persons 65 years of age represented only 4% (3 million) of people in the country (Wilmouth & Longino, 2006). Currently the approximate number of older United States' residents is 35 million, and by 2030 the number is projected to be approximately 70 million (U.S. Census Bureau, 2006). The census bureau predicts one in nine baby boomers will survive into their late 90's (Crowley, 1999). Unfortunately, a number of these older persons become impaired and require care the family is unable to provide, and which necessitates nursing home placement.

Butler (1975) perceived the lives of older persons as a tragedy marked by despair, deprivation and anger. In contrast, Fries (1980) underlined the American Gerontological Society's motto that modern medicine was adding life to years and not just more years to life. The recent literature on health in late life indicates 'successful aging' is not an oxymoron. Valliant and Mukamal (2001) demonstrate aging not only means decline but also communicates development and maturation. These comments can reduce the negative perception and stereotyping of older persons.

## **Nursing Home Residents**

The older impaired, dependent population that needs 24-hour residential nursing care is still hidden away, with minimal expectations and hopes. Thomas and Martin (1997), counselor educators, point out the losses of aging are intensified for the institutionalized older adult. They represent a disenfranchised group that still does not receive adequate mental health care. Persons in nursing homes often have a combination of serious medical and psychological disorders which underline biological, psychological, and social factors in aging (Litchenberg et al., 1998). Many are weak, frail and bedridden. Most use walkers and/or wheelchairs. They require the medical assistance of doctors, nurses, physical and occupational therapists, and other specialists. Depression and anxiety are the characteristics that most often accompany older adults in nursing homes (Mazza & Vinson, 1999).

Counseling experts have identified more than a dozen typical losses associated with living in a nursing home setting: 1) significant other, 2) home, 3) independence, 4) contact with family/friends, 5) mobility, 6) finances, 7) personal possessions, 8) health, 9) identity, 10) personal power, 11) purposeful activity, and 12) life meaning (Marshall & Mackenzie, 2007; Dykstra, van Tilburg, & de Jong Gierveld, 2005; Myers & Harper, 2004). A loss that has not been mentioned, but observed is the drastic change of life space, i.e., sharing a room and bathroom with one or more other residents. The medical setting and serious physical and mental health problems of nursing home residents has resulted in an emphasis on pathology rather than the healthy, positive characteristics of this population. The challenge for counselors is how to identify and maximize the power still present in older impaired persons in nursing homes.

The research demonstration of common factors can be the guide for strength based interventions in counseling older persons in nursing homes. This model of using common factors can be applied to identify and increase; 1) older resident's strengths, positive characteristics and emotions; 2) power of the therapeutic relationship; 3) hope and expectancy of both the counselor and client; and 4) the process and techniques used in the counseling encounter.

In the following four sections this approach of applying these common factors and strength based counseling with older persons in nursing homes is presented. First, maximizing resident strengths are illustrated. Next, strengthening the relationship between counselor and nursing home residents is demonstrated. Then methods to increase nursing home residents' hope and expectancy are outlined. Lastly a counseling model maximizing techniques is suggested.

### **Maximizing Resident's Strengths: Illustrations**

Psychological impairment can be created by the trauma of nursing home placement and the daily life in a nursing home (Castle, 2001). Older persons in this environment need recognition of their strengths, and ways to enhance them to get their needs met. Unfortunately, the administration of medical care and assistance with daily personal needs does not amplify older persons' strengths (Baltes, 1996; Myers & Harper, 2003; Schwiebert & Myers, 1996). Counselors emphasize psychological health, not impairment or patholo-

gy (Seligman, 1999; Walsh, 2004). Counselors can be skillful in helping shape and increase the strengths of older impaired persons (Nordhus & VandenBos, 1998).

### **Identifying Strengths: Courage**

A positive approach can focus on older clients' successful past history and identifying how these strengths can be applied in the present. During a group counseling session, a frail, self-effacing, reserved older woman shared traveling around the country with her husband riding Harley Davidson motorcycles. Another female resident, who had suffered a stroke and used a wheelchair, and talked in a hoarse and weak voice, related her travels to Egypt and touching a pharaoh's tomb. The group members applauded them as "dare devils". The counselor underlined the strength of courage these group members showed in the past, which was now being demonstrated by their risk of sharing in the group.

### **Identifying Strengths: Empowering Skills, Assertiveness, and Self-Healing**

Another resident had experienced a major stroke, which severely impaired his speaking ability, besides his mobility. His typical routine was to sit in the corridor, adjacent to the nurses' station and dining/activities room with full visual access to all these areas. He would observe and listen to all the ongoing action. This man had been a minor league ballplayer, which required excellent hand-eye skills and coordination. The therapist verbally identified and praised his perceptual acuity and active mental ability in knowing the current events in the world, thus underlining his strengths and living in the here and now. Another resident asked the counselor why he did not understand the meaning of "no", after she rejected counseling twice. Unfortunately the counselor failed to seize the opportunity to reinforce the person's strength of self determination and highlight her strength of self healing.

### **Identifying Strengths: Boundaries**

One of the more humorous counseling moments occurred when a male resident with Alzheimer's observed the counselor interacting in a flirtatious manner with the nurse and activity director. He objected by yelling out "those are my women". Despite his expressive aphasia, making it difficult for him to communicate in verbal interaction, he was oriented in the here and now and the perception of his territory, which reflected strength in declaring his boundaries.

### **Identifying Strengths: Recognizing Self Determination**

Another illustration demonstrated the complexity of mental abilities. The counselor was assisting a 90-year old woman who was disoriented about her placement in the nursing home setting. The counselor presented the cues of 'rest, convalescing, and nursing'. Her quick response was "I am not tired and thus not resting, I have not been ill and thus not convalescing", and pointing to her chest stated, "I am obviously not nursing an infant". Clearly her dementia was not all encompassing because she demonstrated the strength of maintaining her ability to define her present here and now awareness. This resident progressively improved and once her confusion dissipated, she chose to move to an assisted living facility.

## **Identifying Strengths: Empowering Verbal Abilities and Interpersonal Skills**

Potential strengths of older persons that could be capitalized upon were prominent in group counseling sessions. Several residents' verbal abilities and helping personal qualities were so outstanding the therapist suggested they visit isolated residents and assume the role of peer counselors. They enthusiastically accepted the job and tried interacting with two lonely residents. They reported the encounters were successful in providing contact and support and appeared to lift the mood of these isolated residents. These older impaired persons showed their interpersonal strengths and ability to befriend others. A recent study by Freesman and Lester (2000) found that social relationships with other nursing home residents was negatively correlated with depressed mood.

## **Maximizing Strengths of the Relationship: Illustrations Fostering Relationship Conditions and Alliance Characteristics**

Following this focus on increasing clients' strengths the enhancing of the therapeutic relationship is addressed. The relationship in the therapy change process represents a common factor determining beneficial outcomes (30%) across diverse therapeutic models (Beutler, Machado & Neufeldt, 1994). Rogers (1951) identified empathy, genuineness, and unconditional positive regard as the necessary and sufficient conditions that activate a person's self healing processes. Heppner, Rosenberg, and Hedgespeth (1993) emphasized the client's attributions of the therapist's expertness, trustworthiness and attractiveness as central to the success of therapy. The alliance concept focuses on the collaborative and interactive elements in the relationship (Norcross, 2002; Lubrosky, 1976; Bordin, 1989, 1994). Luborsky (1979) identified mutual liking and client perceived support as basic to the alliance and identified it as a characteristic of successful helping.

## **Counselor Presence and Client Autonomy Enhancement**

The older impaired person's world is severely constricted. There is less stimulation, interaction, and activity occurring in their lives. The counselor needs to establish a strong presence, bringing his/her energy, liveliness and current experiential reality to the encounter. The older person's relationship repertoire can be explored to enable him/her to join the counselor in developing a collaborative relationship. As previously stated, due to the older person's chronic health issues, they often become accustomed to being administered to and cared for by the nursing staff. Baltes (1996) identifies this as learned dependency. Now, the counselor is challenging them to assume a greater role in the relationship, which hopefully will encourage their self responsibility.

## **Self-Disclosure and Empathy**

One approach is for the counselor to disclose his/her triumphs and losses, and present life demands. It is recommended that counselors identify the strengths and techniques he/she uses in self-healing. The goal in sharing personal life and history is not only to encourage older persons' self explorations and life stories but to communicate they are important enough to know the counselor which can promote relationship equality. The senior author is able to relate to older, impaired persons age-wise and experiencing of illness (two open

heart surgeries), but not the major losses they have faced. One 85-year old resident was a pilot in the Second World War. He protected the country from attacks by submarines and bombers along the California coast. He regretted not being in a combat zone, and the therapist understood (empathy) because it was embarrassing not to serve in the military or a war zone during this time.

### **Achievement, Recognition, and Validation**

The counselor introduced Judy to the group as a former teacher and foster mother of 107 children. She appreciated this identity recognition, which helped others to know her. Eileen was introduced to another counseling psychologist as a woman of Italian descent. Her cultural and ethnic background was significant in the life connection to her father who came from Italy. She lost her only son and child in a motor vehicle accident when he was 20. The counselor's identification of her history and major loss brought an unexpected smile to her face, as isolation and aloneness contributed to her feelings of being unnoticed and unknown. In amplifying these clients' identities, the counselor was communicating empathy and positive regard for their accomplishments (Weick & Chamberlain, 2002).

Heather has difficulty remembering what was said two minutes ago. Statements have to be repeated two or three times, which became annoying to other group members. Yet, she remembered events in the group from two months ago. The counselor underlined this recall pointing out how she remembered events that happened relatively recently. This improved the reactions of other group members and contradicted her negative self-perception. Other residents also experienced difficulty with memory recall. However residents did not experience this memory problem when confronting the counselor about missing two sessions, which did not fit their relationship expectations.

### **Confrontation and Self-Healing**

For younger and older counselors working with nursing home groups, it is challenging to see life from older persons' historical and present life positions. The pilot voiced his wish to die because of his major life losses and present inability to see well enough to read. Another group member pointed to his negativity and suggested he be more positive. Later in the session, he was able to see some aspects of his life that were meaningful, and laughed at some of the group members' interactions. The members were able to experience his, and the confronting member's, self healing strengths. Although Bordin (1994) was referring to the counselor/client relationship, the alliance between the older group members is critical and needs to be emphasized more in nursing homes.

### **Death and Bonding**

Finally, collaboration with older persons is enhanced when the counselor is present during a resident's death. Jim, a tool and die maker, was a history and anthropological buff, picking up Indian artifacts on weekend excursions. During crossword puzzle contests, he was able to excel, which bolstered his diminished self esteem due to his inability to walk after several major strokes. The counselor was able to positively reinforce his mental ability, fulfilling Rogers' relationship tenet of positive regard. When he died, the counselor was able to mourn and reminisce with his friends and the care staff. This

highlighted the counselor's bonding with the group of older persons.

## **Maximizing Strengths of Hopeful Expectancies: Illustrations**

### **Encouraging and Instilling Hope**

In the following paragraphs attention to the common factors of hope and positive expectancy are highlighted. Experts in positive psychology define hope as optimism directed towards the future, and more specifically expecting positive outcomes, and working to achieve them, believing they can be brought about (Peterson & Seligman, 2004). Many experts indicate counselors must have the hope clients can change. Frank and Frank (1991) believe an open relationship with a therapist who is hopeful and committed to help, works to re-stimulate clients who are depressed and hopeless. Hope mobilizes the individual and functions as positive reinforcement for behavioral and attitudinal changes (Snyder, 2000). Older impaired persons frequently are unable to remember their previous successes and skills when confronting their impairment and isolation of nursing home placement. Typically, they feel a sense of futility or doom regarding the future. They perceive themselves as helpless and powerless and believe they cannot attain what most people want and need. Counselors are faced with these obstacles in eliciting hope and positive strengths of older persons to increase their life hope.

### **Emphasis on Past Competence**

An initial counseling step would be to provide illustrations of nursing home residents who made effective life transitions in this setting. For example, Rose, lonely in her apartment, used her social skills, to make many friends in the nursing home. John, a nursing home resident for five years, used his abundant energy to attend all the nursing home activities and was an active member of the resident's council. Sue, who reveled in competition, keeps winning and losing in Bingo; while Fran loves reading books and listening to classical music. Another female resident encouraged her more reserved roommate to join the counseling group. The counselor was able to reinforce the residents' social skills, in the present, and how it made their life meaningful now. Using these examples the counselor can then explore with residents their prior success repertoire and how the strengths used in these achievements can be employed in the nursing home.

This is the residents' last home, and symbolizes life ending. This reality is in addition to their multiple significant losses. The typical assumption is that counselors need to provide the opportunity for the residents to confront the reality of death. The counselor asked a 97-year old resident if she wanted to talk about dying. She emphatically rejected this suggestion declaring, "I plan to live till 110". Similarly, in two groups, the members' responses were "I don't think about dying" and "I accept it". Possibly, more than the fear of death is the struggle with how to meet their needs now. Thus the counselor's role is to encourage residents' hope that they can obtain present life satisfaction.

## **Maximizing Counseling Models and Techniques: Illustrations**

Specific techniques for identified populations of clients are becoming the standard of care. The assumption is that the therapist's techniques are mainly responsible for client improvement, which conflicts with the common



factors approach and the research findings that models and techniques only account for 15% of the outcome variance. Ogles, Anderson & Lunnen, (2003) point out that a correlation between therapist techniques and client outcome are insufficient to rule out common factors as the primary influences of change. Strupp (1986) demonstrates it may not be possible to separate the techniques of a model from the common factors because they are embedded in the complex therapeutic interaction. Miller, Duncan and Hubble (1997) indicate when clients are asked by researchers about helpful therapeutic actions, they rarely mention specific interventions. They do identify similar variables of being respected, understood, and cared for.

Identifying specific counseling techniques which have the potential to increase client resources, enhance the counseling relationship and maximize the hope factor is the challenge. The person-centered attitudes of unconditional positive regard, congruence and empathy are needed with these clients in this environment. Yalom's (2005) therapeutic factors appear to have potential for maximizing strengths as resident's readiness to give (altruism), their need to not feel alone (universality) and family reconstruction are requisites for improving the personal strengths of residents.

The therapeutic factors of interpersonal learning and cohesiveness (Yalom, 2005) are most critical as the loss of relationships and ability of how to relate to others is severely compromised when older persons are faced with major physical and social losses. They have difficulty beginning and making interpersonal contact, and developing emotional closeness with new people who are less attractive physically and mentally. It is suggested by these authors that the counselor explore the social strengths residents used in past successful relationships and help them implement these interpersonal skills in this setting.

The residents commonly perceive themselves as less important, not needed or wanted, and/or requiring too much care and assistance. Their self-worth has not only been threatened but seriously diminished, as has their self-identity. A prime example is residents asking one another "who did you use to be?" An example of lost identity was Janice, a former teacher, who now has trouble seeing and remembering things said a minute ago. The counselor continues to ask about her educational and career history, emphasizing her success and competence which Duffy and Karlin (2006) indicate improves self-esteem through the recognition of past accomplishments. With John, the therapist emphasized exercising and participating in many nursing home activities to reduce his persistent depression. The counselor also reminisces with him about his past successes as a high school basketball player and navigator in the air force during World War II. Thus his positive strengths, past and present, are brought into the foreground. It is hoped these techniques of encouragement and praise will serve as models this resident can incorporate internally and use for self healing.

One of the major losses that confront older persons is an absence of future goals. One technique is that of approximation and small steps. Frank, an avid golfer, dreams and fantasizes about recovering from his stroke and playing again. The counselor has suggested a small putting green in his room where he can practice putting strokes with his unaffected arm. Nursing home residents cannot look too far in the future, and need small, more immediate goals that can

be achieved today, which will provide them with a sense of achievement and enjoyment. For example, Donna, a new resident, smiles and laughs easily, although suffering some dementia. The counselor has pointed out how her optimistic mood has reduced her family's anxiety, in addition to her being a pleasure to interact with.

## Conclusion

Research on how to increase the strengths and self efficacy of the older impaired person in nursing homes is critically needed with the projected increase in this population. Although research (Lambert, 1992) has found 40% of therapy outcome variance is due to the client, it is unknown whether this can be generalized to the population of older impaired persons in nursing home. It is possible the variance contributed by the counselor and the relationship would be greater for persons in this environment and at this life stage. The suggestions made in this article are tentative and limited by the scarcity of research with this population and setting

Lambert's (1992) research findings on common factors outcome variance can be one guideline in directing research and practice. Another can be the positive psychology approach focused on increasing strengths. A third guideline can be consultation with the older residents about what is helpful to them. The love, shown by the care and hugging of residents by the care staff, stood out for this counselor and highlights the importance of appropriate touching and is an essential fourth guideline.

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