

USING AN INTEGRATED COMPETENCY-BASED GROUP THERAPY APPROACH  
IN BUILDING ADULT CAREGIVER STRENGTHS

by

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(ABSTRACT)

The purpose of this project was two-fold. First the intent was to learn about the strengths of caregivers and bring the more latent view of caregivers as “strengthened” rather than stressed to the forefront. Second, the study explored the usefulness of applying a competency-based therapy approach to caregiver issues and experiences. Specifically, 12 caregivers of adults were self-referred and participated in a weekly group over the course of a 6 week time frame. The study addressed a gap of a strength discourse in the literature on adult caregivers, and also provides important information about the breadth of the applicability of a competency-based therapy approach with older adults in a group setting.

A qualitative research design was employed, the approaches of ethnography and action research were the specific types of qualitative methods for this project. An analysis was performed of qualitative data that consisted of transcripts of fieldnotes and audiotaped focus group interviews. Six major themes that emerged from the analysis of the data included: self-care, guidance, togetherness, separation, relationships with family members, and caregivers as experts. These themes are discussed as they relate to caregiver strengths. Suggestions for future research and for practitioners are considered in conjunction with the need to provide valuable information about family enrichment with caregivers, and new interventions that build on a strength discourse.

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## **CHAPTER I: INTRODUCTION**

### **Statement of the Problem**

It is projected that over the next fifty years, the number of people age 65 or older will more than double (US Bureau of Census, 1989). The aging of the population is a social and demographic change that affects the family in numerous ways.

One of the more prevalent ways that the family is affected involves the enduring ties of family relationships into old age, and the need to negotiate the provision of care for persons who experience physical and cognitive impairments. As the proportion of older adults in the population increases, the likelihood increases that more older people will need long term care and assistance (Brody, 1985; Smith & Longino, 1994). Although some of the care will come from institutions and skilled nurses, most of the caregiving of adults who need assistance in daily living will be provided within the home by family, particularly spouses and adult children (Smith & Longino, 1994).

The involvement of the family in caregiving creates changes in the family system. The family faces new tasks, such as organizing personal care for the care receiver, financially managing care receiver needs, linking up to formal care networks, and obtaining emotional support for the caregiver (Gatz, Bengtson, & Blum, 1990). Also, chronic illnesses and conditions such as Alzheimer's disease create demands and changes in family and other close relationships (Blieszner & Shifflett, 1990; Chesla, Martinson, & Muwaswes, 1994). Even though intrafamily caregiving has become so prevalent that it has been called a "normative experience" (Brody, 1985), there is general consensus that this new relationship within the family is stressful (Gatz et al., 1990).

Much has been learned and reported about the stress of caregiving. Some of the sources of stress that have been investigated include (a) conflict between obligations to and among family members (Pratt, Small, & Wright, 1987; Strawbridge & Wallhagen, 1991), (b) impaired physical and mental health of caregivers (Hooker, Monahan, Shifren, & Hutchinson, 1992; George & Gwyther, 1986), (c) role engulfment and loss of self (Skaff & Pearlin, 1992), and (d) adjustments in family roles (Bengtson & Kuypers, 1986). The understanding and portrayal of caregivers as stressed has been made clear. The problem is that this dominant paradigm of caregiver stress has kept hidden an equally valid and important view of caregivers, that being the paradigm of caregiver strength.

The purpose of this study is two-fold. First the intent is to learn about the strengths of caregivers and bring the more latent paradigm of caregivers as "strengthened" (rather than stressed) to the forefront. Second, the study explores the usefulness of applying an integrated competency-based group therapy approach to caregiver issues and experiences. This effort is designed to assess and identify some of the valuable ingredients of a competency-based approach as it is applied to caregivers. The qualitative nature of this study provides a rich and in-depth description of caregiver strengths and of the process of using solution-focused techniques with caregivers.

### **Significance of the Study**

Much of the previous research on caregiving families has been based on a stress model of coping. This research has tended to focus on the negative outcomes of caregiving. Terms such as burden, depression, and conflict are frequently used in this literature. The dearth of positive terms suggests that researchers may be biased in their expectations and perceptions of the effects

of caregiving on family members and thus overexaggerating negative outcomes. The term "caregiver stress" is a common buzzword that carries with it assumptions that have gone largely unexamined in the literature.

Recently, investigators of family caregiving have advocated exploration of positive aspects of caregiving. Walker, Pratt, and Eddy (1995) have argued for the need for study of the benefits and rewards that abide within the contextual relationship of caregiving families. They clearly make the point that investigators of caregiving need to pay attention to the positive dimensions of caregiving. In addition, in their seminal chapter on caregiving in The Handbook of the Psychology of Aging, Gatz and colleagues (1990) contended that the stress framework for caregiving research has limited the exploration of positive outcomes.

Even though prior research on caregiving has focused on stress and burden, this study addressed and explored the strengths and resources of caregivers' experiences. This was done by using a therapy approach that is based on the notion of strengths. The predominant framework for the competency approach was based on solution-focused therapy.

The solution-focused approach to problems is based on the assumption that clients already possess strengths and resources for dealing with their dilemmas (de Shazer, 1985, 1989, 1991). Unlike traditional therapy approaches that are oriented to the past, especially childhood roots of problems, a solution-focused approach concentrates on the present and future (O'Hanlon & Weiner-Davis, 1989). This "here and now" perspective is likely to fit with caregivers who are probably more concerned about present caregiving struggles than about past psychosocial functioning. In a study of caregivers of relatives with schizophrenia, one theme that emerged was that caregivers were often unaware of their strengths or of how well they had coped (Bloch,

Szmukler, Herrman, Benson, & Colussa, 1995). It is reasonable to believe that solution-focused strategies will also work in helping caregivers of other needy family members, such as frail elders, to become more aware of their strengths.

The research has important implications for theories and interventions with caregivers. The pervasiveness of the stress discourse in caregiver investigations needed to be informed by a strength discourse. The general use of the "stress" label for caregivers is limiting. Most caregiver experiences include more than stress, and to see them through that one lens is partial at best. The objective of the study was to take a closer look at the caregiver experience and explore what may be there in regards to "strength". The intent was to learn about the presence of caregiver strengths, and perhaps be surprised by how "strengthened" caregivers really are!

In addition, I intended to take a discovery oriented, exploratory approach to the usefulness of competency-based group therapy with adult caregivers. The competency-based intervention was primarily developed from the solution-focused therapy model. The aim was to obtain rich descriptive data about the effectiveness of the solution-focused model. The study was significant in that it offered some assessment of the feasibility of the usage of solution-focused techniques with caregivers. The study provided information about how the participants viewed the intervention. This was important for gathering findings about how to adapt the model to a group setting. It also gives guidance for practitioners who work with caregivers or who utilize solution-focused perspectives in their general practice.

### **Research Questions**

The aim was to do an investigation of an integrated competency-based group intervention with caregivers, and to build a framework for learning about caregiver strengths. This inquiry

examined the following questions as they helped to guide the process:

1) Does an integrated competency-based group approach provide an effective means of enhancing a sense of self-perceived strength in the caregiver?

2) How can solution-focused strategies be adapted so that they are useful with caregivers meeting in a group setting?

3) What has participating in a competency-based group been like for them as caregivers? What has been helpful or not helpful?

4) What changes did caregivers experience for themselves as group members? What were the ingredients of these changes?

5) What/who do caregivers view as their resources and strengths? How/when do they use these resources and strengths?

6) In what ways does a theory of caregiver strength emerge out of this research process?

## **Chapter II: Review of the Literature**

### **Introduction**

During the 1980s there was such growth in the research dealing with caregiver burden and stress that by the end of the decade a leading researcher questioned the need for the same old studies of caregiver stress (Zarit, 1989). The dawning of a new decade along with a new stress and coping model as a theoretical framework for understanding caregiver burden (Pearlin et al., 1990) brought a resurgence in the study of caregivers and a continuing focus on their stress. However, the 1990s have also brought forth researchers interested in pursuing avenues beyond the caregiver stress discourse (Rapp, 1996; Burack-Weiss, 1995; Walker, Pratt, & Eddy, 1995; Allen & Walker, 1992; Gatz, Bengtson, & Blum, 1990). These researchers have pointed the caregiver dialogue in the direction of a new vision for caregiver studies. Walker and colleagues stated, “Researchers and practitioners must embrace the notion that caregiving may have positive as well as negative outcomes. It is critical not to assume that strain and burden are the essential, or sole, outcomes of the caregiving experience” (1995, p. 407). Based on my past experience with caregivers I concur strongly with this notion. In an attempt to build on the path of researchers who have started to question the overwhelmingly negative portrayal of caregiving, this study of caregivers as possessing significant strengths can explore a heretofore underutilized perspective for conceptualizing the caregiver’s experience. First of all, as a way of locating myself in the field of caregiver research, I want to review some of the theory and intervention studies that have given prevalence to a stress discourse before turning to my elaboration of a conceptual framework as a development of a strength discourse.

## Exploring Caregivers as Stressed

According to Beigel and Blum (1990), the growth and interest in caregiving as a research, practice, and policy issue has been affected by demographic, economic, and social changes. Some of these trends include the following: a growing older adult population and longer life expectancy; the increase in multigenerational families, many of which include adult caregivers; the influence of divorce and remarriage on caregiving; the increased prevalence of women in the paid labor force; the high costs of institutionalization of older adults; and changes in medical technologies (Biegel & Blum, 1990). These changes and issues are aspects of the normative place caregiving has found in society.

### A Preview of the Stress Paradigm

Along with the view of caregiving as a normative family experience has come a normative paradigm of caregivers as stressed. As early as 1984 at the annual meeting of the Gerontological Society of America, Elaine Brody's Donald P. Kent Memorial Lecture was entitled "Parent Care as a Normative Family Stress," and published the following year in the Society's premier journal, The Gerontologist (Brody, 1985). Surely such a highly respected and central figure in the field of gerontology significantly influenced the thinking and subsequent research of scholars interested in caregiving. Brody clearly exploded the myth that older adults are abandoned by their families, and she also highlighted the stressful side of parental care. Brody stated, "...study after study has identified the most pervasive and most severe consequences as being in the realm of emotional strains," and "...filial care of the elderly has become normative but stressful..." (1985, p.22). Brody's remarks leave little doubt as to the burden that is placed on the family, especially women, by the need for parental caregiving.

It is important to see Brody's 1984 lecture and subsequent article as a reflection of the direction in which caregiving research was then moving and would continue to move in the next ten years. This interest in the stresses of caregiving came to fruition in numerous studies. Large portions of the research on adult caregivers have been concerned with stress and burden (Montgomery, Gonyea, & Hooyman, 1985; Quayhagen & Quayhagen, 1988; Pearlin, Mullen, Semple, & Skaff, 1990; Williamson & Schulz, 1993). It has been stated that the stress framework is one of the more prominent orientations in current caregiver research (Pearlin et al., 1990). Some of the more prevalent demands of the caregiving role that have been identified in the literature include the impact of caregiving on work, lifestyle, relationships, and finances; the emotional strains and stresses; and the mental and physical health of caregivers.

The connection of caregiving to emotional strains and stresses is made very clear in research done by Montgomery and her colleagues. A central concept to her research is the experience of caregiver burden (Montgomery, 1989). Caregiver burden is the concept she used to refer to the stress or costs of taking on the demands of caregiving.

A distinction has been made between objective and subjective burden in a study by Montgomery, Gonyea, and Hooyman (1985). The distinction between these terms is aimed at separating the concrete events, happenings, and activities of caregiving (objective) from the emotions and attitudes about the caregiving experience (subjective). In interviews with 80 caregivers of older relatives the researchers found that the age and income of the caregiver were the best predictors of subjective burden, while tasks that confined the caregiver's time or place were associated with objective burden. The findings of Montgomery and colleagues suggest that intervention programs and services can alter the level of objective burden, whereas factors such

as age and income associated with subjective burden cannot be altered by interventions.

A study that focused on understanding caregivers' coping strategies and how these strategies were related to subjective burden found that caregivers' sex, age, income, and education did not affect burden scores (Pratt, Schmall, Wright, & Cleland, 1985). Rather, burden scores were related to caregiver health status and to specific coping strategies. The researchers found that internal coping strategies of reframing, confidence in problem solving, and passivity and external coping strategies of seeking spiritual support and social support from extended family were correlated with lower burden. Thus, the findings by Pratt and colleagues (1985) suggest that interventions to help caregivers reframe their situations and increase their sense of confidence can be effective in altering the caregivers' sense of burden.

Research on caregivers of family members who have Alzheimer's disease has also been a prominent aspect of the paradigm of the caregiver as stressed. Specific caregiving stressors and coping strategies were identified in interviews with 170 caregivers of persons with Alzheimer's disease (Williamson & Schulz, 1993). Common caregiver stressors were related to the memory loss, loss of communication ability, and gradual decline of the care recipient. Coping strategies that related to less depressed affect of the caregiver included relaxation, acceptance, and seeking social support.

In another study on Alzheimer's stress, Quayhagen and Quayhagen (1988) looked at the coping patterns, management strategies, and support factors that were associated with well-being in three different caregiver groupings, female spouses, male spouses, and offspring. Their research identified the most stressful types of behaviors and found that female spouse caregivers were more stressed by the husband's dangerous behavior and embarrassing sexual acts than were

male spouse caregivers and offspring. Offspring caregivers were more stressed by the inability of the parent to stay alone or bathe him or herself. Also stressful for all caregivers were care recipient behaviors such as incontinence, difficulty cooking and handling money, and asking repetitive questions. Caregivers in all groups used similar coping strategies such as seeking help, problem-solving, exercise, and dining out, but these varied in association with well-being for male, female, and offspring caregivers (Quayhagen & Quayhagen, 1988).

### Conceptual Ambiguity of the Stress Paradigm

One of the aspects of the stress discourse in caregiver research that stands out is the ambiguity around the concept of stress itself. This is evident from the need to distinguish between objective and subjective burden as seen in the work of Montgomery. While “caregiver burden” and “caregiver stress” are often used interchangeably in the literature, Montgomery (1989) made the point that “burden” is a more sensitive measure of the effects of caregiving, as opposed to the more global concept of “stress.” She argued that the qualifier “caregiver” needs to be used with the term “stress” when the research is focusing on the caregiver role. This is necessary in order to provide a clear distinction between the two constructs of burden and stress, since there are many existing definitions of stress in a variety of literatures.

In a discussion of issues surrounding the definitions of caregiver stress, Chiriboga, Weiler, and Nielsen (1990) considered how the concept, stress, takes its roots from a medical model first espoused by Hans Selye in 1956 and moves to broader components of environment, internal demands, and adaptive resources of the body, individual, or social network (Monat & Lazarus, 1985). The variety in conceptual views of caregiver stress have been costly in that the growth of knowledge in the field may seem inconsistent (Pearlin et al., 1990). There is yet a

different example of the stress concept and of how the paradigm of caregiver stress is elaborated in the work of Pearlin and associates.

Pearlin and associates (1990) referred to the stress process of caregiving involving the following four domains: (a) the background and context of stress, (b) the stressors, (c) the mediators of stress, and (d) the outcomes of stress. Each of these domains of the stress process have multiple components within them. Pearlin and associates are concerned with conceptualizing the caregiver's stress not as the result of a singular event or happening, but as a set of relationships and conditions that develop and change over time, so they concentrate more on the notion of process and the dynamic character of caregiver stress.

The stressors are at the heart of the conceptual scheme, and these are divided into primary and secondary categories. Primary stressors are subdivided into objective and subjective indicators of stress. Objective indicators include cognitive status, problematic behaviors, and daily dependencies of the care receiver, and subjective indicators of primary stress include the overload or burnout felt by caregivers as well as their relational deprivation (Pearlin et al., 1990). The secondary categories of stress in the Pearlin and associates model are made up of role strains and intrapsychic strains. Role strains include family, work, economics, and social activities. Intrapsychic strains involve dimensions of self-concept such as self-esteem, mastery, role captivity, loss of self, competence, and gain. There is much detail and differentiation in this conceptual model of stress. According to the researchers this specificity is important in order to know how and where to intervene in the stress process of caregiving families.

Thus far an attempt has been made to highlight several different studies in the area of caregiver stress to tell a story of the stress paradigm as a very dominant way of thinking about

family caregiving. Many other researchers have promoted the use of a stress framework to support caregiver investigations (Stephens & Zarit, 1989; Haley, Levine, Brown, & Bartolucci, 1987; Kinney & Stephens, 1989; Vitaliano, Russo, Young, Teri, & Maiuro, 1991). Gatz and colleagues stated that, “Most research on caregiver burden appears to operate on some sort of stress and coping model, whether explicit or--more often--implicit” (1990, p. 411). They saw the rare recognition and exploration of positive outcomes of caregiving as one of the limitations of these frameworks (Gatz et al., 1990).

### Beyond the Stress Paradigm

Although this is a short coverage of a vast amount of literature on caregiver stress, it gives a legitimate expression of what could be traced in deep detail throughout the caregiver research of the past fifteen years. The overall tendency in most of the caregiver researchers is to assume an overarching medical mindset that views caregiving as a form of pathology that needs to be fixed.

This trend does not appear to be declining as is shown in a review of three recently published books on families in later life with an emphasis on caregiving (Pillemer, 1996). “As research studies have proliferated,” stated Pillemer, “there has been a persistent sense that in this area we have furious effort with relatively little to show for it” (1996, p. 269). A topic that Pillemer discussed as a theme of the books he reviewed is the lack of interest from caregivers in the services that are offered to them. He mentioned how this may be telling caregiver researchers that they need to examine their assumptions about caregivers. A possibility for consideration is “that many people may be reluctant to use services because they generally feel okay about their caregiving experience, and because for them, *the services don’t work*”[emphasis in original]

(1996, p. 271). I believe that my research is a move in the direction of questioning assumptions about caregiving as it has been portrayed from much of the research thus far. This project offers an alternative from the dominant stress view and provides a different conceptual basis from which to enter into dialogue and research with caregivers. Before doing this it is appropriate to elaborate on how the stress discourse has been prominent in the research on interventions for caregivers.

### **Mapping the Stress Discourse in Caregiver Intervention Research**

Most of what has been described about the stress paradigm in the previous pages could be applied to the intervention studies done with caregivers. Monahan commented in a review of the literature on support group interventions that "...there has been a proliferation of research describing caregivers as hidden victims and associating caregiving responsibility with stress, depression, anger, increased risk of nursing home placement for the care recipient, and deteriorating physical and mental health for the caregiver" (1994, p. 699). Here again, this statement is an indication of the strong connections that are often made between caregiving and negative outcomes, or caregiving and "victimization," in the minds of researchers and in the literature on caregiving families. Gatz and associates saw this theme of exclusive focus on the caregiver's stresses and lack of attention paid to the care recipient's perspective as a revictimization of the care recipient (Gatz et al., 1990).

By and large the models for interventions are aimed at changing caregiver stress and are stress based models themselves. This issue has been attributed to how many samples used in this domain of research are often made up of caregivers who are acutely stressed by the cumulative and extended demands of caregiving, and so only participants who are in serious need of

interventions are seeking them out (Malonebeach & Zarit, 1991). According to Malonebeach and Zarit, “Since sampling to date has focused more on relatively distressed caregivers, the extent to which caregiving is not stressful is unknown,” (1991, p. 105).

Sampling may certainly be a limitation of most studies on family caregiving and the pivotal reason for largely stress-based intervention models. However, it can be argued that the undercurrent of the stress framework and researchers’ general assumptions about caregivers as stressed is also a major contributor to the lack of knowledge about caregivers who are doing quite well. If this is the case, one place to begin is not simply to look at the sample, but look at the sampler and her or his assumptive views about the lives of caregivers. The sampler does not stand objectively outside the research process but knowingly or unknowingly shapes that process and the story or results she ends up with.

In light of the stress paradigm previously discussed in this review, it is clear that researchers and practitioners alike would see older persons and their caregivers in need of intervention programs. But what have previous researchers perceived as the kinds of interventions that are needed? This question can be answered by looking at some of the intervention studies that have been done. It will be shown that most of the focus has been on stress based models of intervention.

### Interventions and Excerpts of the Stress Paradigm

In a review article about interventions, Knight, Lutzky, and Macofsky-Urban (1993) looked at 20 studies published in peer-reviewed journals from 1985 to 1990. The criteria for studies reviewed was that each measured caregiver distress (burden, anxiety, depression, hostility, negative affect) and also included a comparison group that did not receive the

intervention. This meta-analytic review combined the results from different studies using differing statistical analyses into a common measure, the effect size. Knight and associates found a rather strong effect for individual psychosocial interventions and respite interventions, whereas group psychosocial interventions showed a small but positive effect on caregiver distress. They also noted that the theoretical groundwork for the choice of intervention methods often was not clearly stated. This finding is in agreement with Sutor and Pillemer's statement that much of the research on caregivers has had an atheoretical nature (1990). The field of research on interventions to aid family caregivers would be enhanced by increased conceptual rigor (Gatz, Bengtson, & Blum, 1990).

The interesting aspect of the review article by Knight, Lutzky, and Macofsky-Urban is that it did pay attention to interventions for negative outcomes of caregiving as opposed to positive outcome intervention studies. Is this because there have been so few studies that concentrated on caregiver strengths and the benefits of caregiving that these have been ignored in review investigation? Or is it due to the dominant stress paradigm that is so influential among researchers on caregiving, that such studies are the majority and, therefore, most available for review? Both questions can be answered in the affirmative. The intervention studies submitted for publication and those that are getting published in some leading journals specific to gerontology (The Gerontologist, Journal of the American Geriatrics Society, Psychology and Aging, Gerontological Social Work, Journal of Applied Gerontology) and therefore available for review are for the most part studies that characteristically reflect the field on caregiver research. I am arguing that this research is dominated by a stress discourse.

Examples of the stress discourse in the caregiver intervention literature are available from

excerpts taken from this literature. The first two of the following excerpts are from discussions of the format and content of group interventions, and the latter two are from details of the recruitment procedures from two separate studies.

The primary focus on negative outcomes is obvious in a discussion about a particular treatment session of a support group for family caregivers of persons with dementia:

The sixth session was focused specifically on caregivers' psychological reactions to being caregivers and ways to manage the stress of their role. Emotions of depression, guilt, anxiety, anger, and resentment, among other reactions, were included.  
(Haley, Brown, & Levine, 1987, p. 378)

The emotional impact of caregiving was one of seven major themes identified by Toseland and Rossiter in a review of 29 group intervention studies. Their discussion of how this theme formed the basis of group interaction is another example of interest:

Participants were encouraged to express and learn how to better cope with the highly emotional task of caregiving. Emotions acknowledged and dealt with in the group included guilt about not doing a good enough job at caregiving, anger at the situation and at fellow family members for not helping out, loneliness and isolation resulting from not having anyone to share feelings with and from a curtailed social and recreational life, and anxiety resulting from the stress of caregiving. (Toseland & Rossiter, 1989, p. 439)

Sometimes the criteria for inclusion in a caregiver group and the methods of recruitment give evidence of the assumptions of focusing on stress:

Group participants were recruited primarily through referrals from community agencies whose activities made them aware of situations in which primary caregivers were experiencing significant stress. The referral criteria given to the agencies stipulated that referred individuals be primary caregivers experiencing substantial stress in their caregiving roles, be significantly at risk of having to place their care receiver into an institution, and be interested in participating in a support group.  
(Monahan, Green, & Coleman, 1992, p. 255)

In this example the criteria of caregiver stress is a prerequisite for group attendance. This is not

the only study in which this prerequisite is viewed as important to the study. In an investigation of the effectiveness of individual counseling by professional and peer helpers, the participant recruitment involved the certainty of the presence of caregiver stress:

Potential clients were screened to ensure that each was the primary caregiver for an elderly family member with two or more chronic disabilities, was residing in the community, was experiencing an above-average degree of stress, and was free of major psychiatric disorders. Participants rated their level of caregiving stress on a 5-point Likert-type scale, with a score of 3 or more used as criterion for inclusion in the study. (Toseland & Smith, 1990, p. 257)

It is logical to think that in the event of a self perceived stress score of 2 or less the caregiver would not be eligible for participation in the Toseland and Smith research project, and in the research by Monahan and associates the caregiver would not be eligible to participate without being deemed “substantially stressed” according to a referring agency’s subjective appraisal of the caregiver’s experience.

Do such approaches to caregiving persons and their treatment as described above bespeak a rather restricted and one dimensional perspective from which the researcher enters a relationship with the caregiver? Is a respect and appreciation for the caregiving person lacking so that the caregiver is viewed with limited and stereotypical assumptions about her or his life and relational connections? These questions raise the danger inherent within approaches that de-contextualize caregiving by a perspective and language that is strongly influenced by stress discourses. Walker, Pratt, and Eddy commented that, “An exclusive focus on stress, ... ignores the authentic connections between people, thus removing caregiving from its relational context,” and they went on to state, “Perspectives that reflect the complexity of family caregiving in its broader relational and sociohistorical context are necessary to provide this view” (1995, p. 407).

There is a clear need for more well rounded and wholistic perspectives of caregiving than what a majority of the literature provides thus far.

A mapping of the stress discourse in caregiver research has taken place through an investigation of the presence of this discourse in conceptual models and intervention studies. After considering moral and ethical implications of a stress discourse, the next section will look at studies in the caregiver literature that have focused more on the positive aspects of caregiving.

### **Exploring Caregivers as “Strengthened”**

“Strengthened” is a term I have coined as a counter-part to the word “stressed.” The idea behind the term is that if a caregiver can be described as stressed, he or she could also be described as “strengthened.”

Thus far, the stress paradigm in caregiver research was explored by reviewing existing conceptual frameworks and specific intervention studies. Ample indicators are available for the case that caregiving is problematized when viewed solely as a stressor. Rather than problematize caregiving by an exclusive focus on it as stressful and negative, my position is one of problematizing the notion of caregiver stress itself. A recognition of a strength discourse is available in a small, yet perhaps growing portion of the caregiver literature. First, the discussion turns to a consideration of some possible ethical implications of the dominance of a stress discourse in our thinking about and practice among caregivers.

#### Ethical Implications

Is the primary tendency to see the negative influence of caregiving in people’s lives an ethical problem? The focus on caregiver stress leaves numerous other aspects of the caregiving experience unstudied. It is important to ask how the acceptance of one dominant means of

viewing and understanding caregivers fringes on unethical practice due to a diminishment of a more wholistic view of caregiving. Is the field of caregiver research in danger of creating a pathological view, and a research agenda which is only interested in the “minuses” of caregiving? A caution flag must be raised in this regard. Consonant with feminist perspectives on research is a wise consideration drawn from the guidelines of the Canadian Sociology and Anthropology Association:

Researchers must guard against the uncritical acceptance of research, which in design, execution, or results, furthers the power of states, corporations, churches, or other institutions, over the lives and cultures of research subjects, even when ostensibly warranted by professional, therapeutic, or social control reasons. The first responsibility of researchers is to those whose lives and cultures they study. Should conflicts of interest arise, the interests of these people take precedence over other considerations (CSAA, 1.3).

My study is an attempt to begin a process whereby the positive dimensions of caregiving are brought to the foreground. The issue of caregiving needs to be understood from perspectives that allow opportunities for the voicing of alternative caregiving experiences.

A failure to engage in an uncritical posture toward the fundamental beliefs and values of any research domain can prevent the change that is necessary for future development. We engage in questionable ethical practices which maintain the status quo without what is referred to as “critical praxis”:

*Critical praxis* is a shorthand way of saying that we need to examine ourselves, examine our own actions, beliefs and values to see how they connect up to the larger patterns and process of the system of which we are part, to understand how we are part of the problem in order to have any hope of becoming part of the solution. . . . *Critical praxis* practices the hermeneutic of suspicion (Ricoeur, 1970); it assumes that we *are* part of the problem, that even our most basic beliefs and values should be suspect. Critical praxis should lead to changes in these beliefs and values as well as to changes in our actions (Lemke, 1995, p. 131).

The maintenance of a stress discourse at the center of caregiver research poses a threat of becoming a status quo belief about caregiving which keeps other relevant beliefs on the margins of our practice and research.

What happens when researchers and practitioners from the fields of gerontology, family studies, therapy, and their respective professional organizations, view one group or population of persons as primarily stressed, burdened, and depressed? Do we not verge on the dehumanizing practice of social control? A discussion of some forms of social control are presented for consideration:

Domestic violence, spouse abuse, marital rape, date rape, sexual abuse and harrassment; 'fag-bashing' of gays; 'nigger-bashing' of African-Americans; . . . elder abuse, police brutality and prison rape are all routine, common, frequent practices of social control. They help maintain the domination of some social categories of people over others in our social system (Lemke, 1995, p.134).

Unless care is taken, 'stress-bashing' of caregivers could become a very routine and common practice. Vigilance is necessary to prevent the production of patterns of practice that can be viewed by those who are the recipients of that practice as limiting, or worse, unjust and inequitable. Put yourself in the place of a caregiver, would you like the majority of the research literature and professional discourse about you to portray only the negative side of your experience?

Another ethical issue is raised by the awareness that the majority of caregiver research is with white females. Though this domain of research does give voice to a minority (women), it can at the same time be a form of subjugation if the continual voice that is ascribed to these women caregivers is one that is problematized. In a discussion of the definitions of caregiving, Walker, Pratt, and Eddy speak about this gendered nature of caregiving:

As wives and/or mothers, women perform many tasks, such as laundry, meal preparation, house cleaning, and so on, that are included in measures of instrumental activities of daily living (IADLs; e.g., laundry, meal preparation). Because IADLs are consistent with everyday household work (Sankar, 1993), wives may not consider such tasks to be caregiving activities, but husbands, who are less often involved in household work, and who take on these tasks primarily because their wives are unable to do them, see dusting and vacuuming as caregiving. In the same way, daughters may distinguish the tasks they do in their own households from those they do in the homes of their mothers and fathers. Cleaning house is typically a responsibility of wives in their own homes, but having to do so in another house is caregiving (1995, p. 402).

The awareness that women do most of the caregiving in this culture and it is largely invisible caring labor (DeVault, 1991), and that they often do so with little or no financial reimbursement, is a larger ethical and socio-political consideration that is in danger of being forgotten in much caregiver research.

Also, few researchers have studied the caregiving relationships of minority groups as identified by race, sex, or sexual orientation. The field can grow and benefit by giving expression to the perspectives of various racial, ethnic, and sexual minorities. In the case of caregiving research, sexual minorities would include male caregivers, since most samples are largely of females. In addition, studies of gay and lesbian caregiver relationships would provide a more diverse and well rounded comprehension of caregiving.

Finally, there are ethical implications in regards to informed consent. Of course there is always a responsibility to research participants in the area of consent. Informed consent is a central feature and necessity in relations with people studied. The code of ethics of the American Association for Marriage and Family Therapy (AAMFT) includes a section that discusses the need for investigators to respect the dignity and protect the welfare of participants in research:

Investigators requesting participants' involvement in research inform them of all aspects of the research that might reasonably be expected to influence willingness to participate.

Investigators are especially sensitive to the possibility of diminished consent when participants are also receiving clinical services, have impairments which limit understanding and/or communication, or when participants are children. Investigators respect participants' freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid dual relationship with research participants that could impair professional judgement or increase the risk of exploitation (AAMFT, 5.2, 5.3).

My study is not intended to involve people in research without their consent or willing participation. The nature of the research is not being withheld from them nor are the participants being deceived to conceal the true purpose of the research. With this said, it is still a project that invades their time and privacy to some extent. Personal questions that are asked of them about their caregiving experiences may not seem threatening to me, but could be perceived that way by some persons.

Most likely there is a human cost that is part and parcel of any research that invades even minimally, one's privacy, and so could be questionable on that basis. Therefore the importance of respect and appreciation for the lives and dignity of participants must be kept foremost in mind in doing this study. The researcher must be mindful of the human sensitivities of those who participate and not treat them as research objects. In a subtle way, this means fulfilling commitments to participants by being on time at appointments, and being considerate of the situational and relational contexts of the research interactions. It also includes an acknowledgement of the expertise of those who participate in the study by making them partners in the research process.

The previous consideration of possible moral and ethical implications of the dominant stress discourse is a way to open up the dialogue about caregiver research, and leads to the need

to bring heretofore marginalized topics to the foreground. Next it is appropriate to review some studies that have given voice to a strength discourse.

### Building a Strength Paradigm

The case for a paradigm of caregivers as “strengthened” is difficult to make due to the dearth of studies that have focused on positive aspects of caregiving. However, researchers have started to investigate ways in which to view caregiving as more than stress and burden.

Some studies have shown interest in positive outcomes of caregiving by paying attention to both negative and positive outcomes. Although these studies were not exclusively dedicated to the benefits of caregiving, they add to knowledge in this arena. Three examples of studies that fit this category are mentioned here.

First, research with 80 wife caregivers of frail elderly veterans investigated both satisfaction and strain (Dorfman, Holmes, & Berlin, 1996). In their research report, Dorfman and colleagues made an observation that is the focus of this proposal, “Less attention has been given in the literature to the satisfactions of caregiving than to the strains of caregiving” (1996, p.46). They went on to state, “By examining satisfaction and strain, the present study was able to assess positive as well as negative outcomes of the caregiving experience” (1996, p. 46). A range of variables related to both satisfaction and strain were investigated, these were organized as three primary sets that included background and context of stress, stressors, and self-efficacy and support. The researchers found that support from spouse was a predictor of both caregiver satisfaction and strain, and that support from friends and neighbors were negative predictors of strain. Also, a sense of caregiver self-efficacy was the strongest positive predictor of satisfaction (Dorfman et al., 1996).

A second study that focused on both negative and positive outcomes was done with caregivers of depressed older adults (Hinrichsen, Hernandez, & Pollack, 1992). The researchers asked 150 spouse or adult-child caregivers what were the most difficult and rewarding aspects of caring. Content analysis of the responses showed seven areas of difficulty and three areas of reward. Difficulties included affective, behavioral, and cognitive symptoms of the illness, as well as interpersonal, practical, emotional, and family problems. Rewards were identified as enhancement in the relationship with the patient, self, and others. These included such areas as satisfaction in seeing the patient improve, or feeling that one discovered new strengths as a result of caregiving (Hinrichsen et al., 1992). By focusing on both difficulties and rewards this study offered a more well-rounded understanding of how illness and adversity can be seen.

A third study examined the role of both caregiving stress and satisfaction in the well-being of 60 family caregivers of persons with dementia (Kinney & Stephens, 1989). The researchers conceptualized caregiver stress as “hassles” and satisfaction as “uplifts,” and measured events that typically occur in caregiving with a 110 item Caregiving Hassles and Uplifts Scale (Kinney & Stephens, 1987). They found more hassle with the care of behaviorally inappropriate care recipients. Intensely involved caregivers reported more uplifts, with most satisfaction reported by younger caregivers who spent more time per day providing care. The authors stated, “In general, care-recipient characteristics were stronger predictors of hassles, and caregiver characteristics were stronger predictors of uplifts” (1989, p. 405). A portion of the discussion of how caregivers appraise events as uplifts is interesting:

It is possible that appraisal of events as uplifts reflects a form of coping with an inescapable and chronic stressful situation. Perhaps caregivers attended to the more positive aspects of giving care, which allowed them to minimize the negative. For

example, caregivers might have acknowledged the good feelings that resulted from being helpful, whereas at the same time deemphasizing the physical exhaustion that often accompanies such aid. On the other hand, some caregivers might initially have regarded an event as stressful, but found the negative emotions that followed to be too painful and, thus, reevaluated these events to be more positive in order to make the losses more psychologically tolerable. (Kinney & Stephens, 1989, p. 406)

The attention to uplifts in this study, and to satisfactions in the previous two studies cited in this subheading, offer examples of a strength discourse in the literature. This discourse continues in studies of caregivers of Alzheimer's disease patients.

Rather than focusing on the negative aspects of caring for a parent with Alzheimer's disease, Blieszner and Shifflett (1989) used a qualitative methodology to explore the effects of the disease on more positive relationship aspects. Four interviews were done with the adult-child caregiver to learn about affection, communication, and commitment. The choice of these aspects as the primary focus of investigation stands in stark contrast to much of the literature on Alzheimer's caregiving that focuses on stress and burden. The researchers found that affection and communication declined with most participants. Interview excerpts from the study were provided as examples to illustrate the strength of personal commitments in the caregiving role (Blieszner & Shifflett, 1989).

Another study of caregivers of persons with Alzheimer's disease examined the concept of mastery as a positive outcome (Skaff, Pearlin, and Mullan, 1996). Skaff and associates used longitudinal data from 456 spouses and adult children who cared for a relative with Alzheimer's disease. The study looked at mastery as it related to transitions in the career of the caregiver. Transitions in this case were viewed as markers that brought about change in the daily life, in this case those transitions were continuing care provided by the family member, placement of the

patient into a care facility, and death of the care receiver. They found that mastery declines for those who continue to care for the family member, mastery is unchanged for those who place the relative in a care facility, and mastery increases for those who experience the death of their family member. They also found that younger caregivers are higher in mastery than older caregivers, and that adult-child caregivers are higher than spouse caregivers (Skaff et al., 1996).

The development of perceived benefits in caregiving was the focus of an investigation with 64 caregivers of dementia patients (Rapp, 1996). A range of benefits perceived in the caregiver role include positive self-perceptions, positive perceptions of life in general, opportunities for skill development, and a strengthening of social relationships. The social resourcefulness of the caregiver was found to be the strongest predictor of perceived benefits. This study is important because it contributes to the much needed research that includes positive aspects of the caregiving experience.

The intent to look for the positive aspects of caregiving is openly stated in two studies of a qualitative nature. In a report of a narrative analysis of the memoirs written by caregivers, the author states in the abstract:

The dominant professional paradigm, that family caregiving equals stress, is reductive. Memoirs written by people who have cared for severely ill and disabled parents, mates, and children suggest that there are multiple meanings -- many of them positive and life enhancing -- inherent in the experience. (Burack-Weiss, 1995, p. 391)

In a separate study, Allen and Walker stated that one of the purposes of their feminist analysis of interviews with daughters who cared for elderly mothers is to address the underlying assumption “that the outcomes of caregiving for the caregiver are overwhelmingly negative” (1992, p. 198).

In the article about caregiving memoirs the focus is on recognizing the value that

memoirs hold in providing multiple meanings of caregiving. These meanings go far beyond the stress and burden discourse, and allow for alternate understandings of the caregiving experience. Examples of the diversity that can be found included the strategies caregivers use to make their loved ones real to professional staff caregivers in a hospital setting, and the ways that caregivers work at allowing the care receiver to live his or her own life (Burack-Weiss, 1995). These are instances of narratives that can be identified as drawing on the strengths of the caregiver.

Likewise, in their inquiry Allen and Walker (1992) draw on the strengths and positive aspects of the relationship between aging mothers and their caregiving daughters. Through an analysis of field notes and caregiver responses to semistructured questions they identified three positive themes that emerged from the data; companionship, concern and caring, and appreciation and gratitude. This study found much evidence for positive caregiving outcomes and raises questions about the focus on the burdens and stresses of caregiving found in the literature (Allen & Walker, 1992).

Though there are few studies available to reference in regards to building a paradigm of caregiver strength, this review highlights the presence of this avenue of discourse in the literature. This research project will build on this small, but growing development of knowledge in this area.

The field of family therapy offers an approach that is consistent with the strength paradigm. A solution focused model of therapy builds on strengths to focus on what works for the client. After a consideration of aging issues in the family therapy literature, the discussion will turn to therapy process research, and research on the solution focused model in particular.

## **Family Therapy, Gerontology, and Therapy Process Research**

### A Gerontological Discourse in Family Therapy Literature?

There is a growing interest in the application of family therapy theory and technique to families of later life. Some of this interest is expressed by clinicians and researchers outside of the field of family therapy. A licensed psychologist with research focuses on family therapy with later life families stated, "Family therapy theories offer rich frameworks for viewing and studying later-life families (Qualls, 1995, p. 478). Qualls went on to say, "The family therapy literature can build on the descriptive research on families that is already available and can proceed to focus on how to design and evaluate interventions with later-life families" (1995, p. 484). Also, leading researchers from the field of gerontology discussed the importance of family therapy for interventions to aid caregivers, "Two theoretical perspectives do have obvious relevance to conceptualizing this area: family therapy literature and writings in community psychology about preventive interventions..."(Gatz, Bengtson, & Blum, 1990, p. 418). Add to this another threesome of authors' who commented in a review of the literature on caregiver groups:

Specialized techniques and structured approaches to assist caregivers need to be explored. The focus of group interventions to date seems to be on relieving feelings of stress and burden. Beyond the remedial aspects of group work, the possibility of proactive interventions to facilitate more effective family relationships needs to be explored. Family counseling with older family members is a fertile area for group research.  
(Myers, Poidevant, & Dean, 1991, p. 203)

The field of family therapy itself has been slow to incorporate its theory and practice into the lives of older adults when gerontological content in the family therapy literature is used as a gauge. Evidence of this is expressed in a review of the literature on the prevalence of aging issues in the marital and family therapy literature (Amburg, Barber, Zimmerman, 1996). The

researchers did a content analysis of articles published in the Journal of Marital and Family Therapy, Family Process, Family Systems Medicine, and the Journal of Family Psychotherapy, and of the proceedings of the annual national conferences of the American Association for Marriage and Family Therapy (AAMFT) from 1986 to 1993. They found that out of 873 published articles in the above journals, only 28, (3.2%) contained explicit emphasis on aging issues, and only 37 (2.3%) of the regular AAMFT conference sessions had an aging focus. This primary finding is in accord with that of Flori (1989) who did a similar review of two marriage and family therapy journals from the years 1976 to 1985.

Gerontological issues in family therapy are addressed in several books and book chapters. In the late 1970s Herr and Weakland wrote a book that applied a problem focused approach to the families of older adults (Herr & Weakland, 1979). Shortly thereafter a book that applied a Bowenian family systems framework to aging families appeared on the scene (Keller & Hughston, 1981). More recently two books have appeared that focus on the application of family therapy to later life concerns; these include Aging and Family Therapy and Family Therapy with the Elderly (Hughston, Christopherson, & Bonjean, 1989; Neidhardt & Allen, 1993). Also, family therapy theory and techniques are applied to life cycle events and particular treatment issues, and are addressed in book chapters by leading names in the family therapy field (Walsh, 1989; Minuchin & Nichols, 1993).

A recent review of research in the October 1995 issue of the Journal of Marital and Family Therapy included a section on family interventions in adult physical illness (Campbell & Patterson, 1995). They found that there are no controlled trials of family therapy for chronic adult physical illnesses or for family caregivers of elderly patients. Another interesting finding of

this review is that most caregiver interventions involve group sessions led by a trained professional such as a nurse or social worker, however no family therapists!

A distant but growing relationship between family therapy and older adult issues does exist. It is likely to be far more evident in the everyday practice of therapists than what is garnered from the minimal literature on this topic in family therapy publications. This study will add to this literature as it features a particular therapy model associated with family therapy that is applied to adult caregiver issues of later life. In addition, this study conducted by a family therapist, will offer much needed ethnographic research about the therapy process when using that model. A discussion of therapy process research in general, and of research with the solution focused model follows next.

#### Family Therapy and Process Research

Research on therapy outcome has confirmed the conclusion that psychotherapy works and has positive effects. The efficacy of psychotherapy in general is clearly established by previous outcome research that compares a variety of treatment modalities to a control group (Bergin & Garfield, 1994; Lipsey & Wilson, 1993). The positive conclusion about the effectiveness of psychotherapy drawn from empirical research was reconfirmed by the consumers' experience in a study published recently by Consumer Reports magazine (1995). The outcome of psychotherapy is a well-researched topic dating from the early 1950s (VandenBos, 1995).

Scholars have raised the issue of the gap between therapy outcome research and practice, and the need for studies that address this gap. More studies are needed that reflect the actual process of therapy and therapeutic techniques (Wynne, 1988; Alexander, Holtzworth-Munroe, & Jameson, 1994; Goldfried & Wolfe, 1995). It is believed that investigations into the processes

of therapy will provide better understandings of the client-therapist relationship and of aspects of change within sessions and over the course of treatment. Findings from this type of research are likely to provide more meaningful information to the practicing clinician and narrow the gap between research and practice. Jacobsen & Christensen stated that "...single-participant designs and qualitative research methods will play a role in providing findings that are especially relevant to practicing clinicians, and it is in this area that clinicians themselves can play major roles in the shaping of both the design and the execution of studies" (1995, p. 1038). Methodologies derived from qualitative designs are helpful in the pursuit of understanding therapeutic processes.

Qualitative research strategies and ethnographic studies have come forth in the marital and family therapy literature (Moon, Dillon & Sprenkle, 1990, 1991). Researchers have called for more qualitative studies in the field of family therapy as a way to bridge the gap between clinicians and researchers:

Qualitative research could help reunite clinicians and researchers because qualitative methods are close to the world of the clinician. Qualitative researchers tend to ask the kinds of questions that clinicians are asking and to explore these questions in ways that are clinically meaningful. (Moon, Dillon, & Sprenkle, 1990, p. 367).

These research approaches are especially useful for gaining more descriptive information about the clients' and therapists' perceptions of therapy and of the therapy process.

There are several recent studies from the field of family therapy that lessen the divide between researchers and clinicians and at the same time incorporate qualitative or ethnographic methodologies (Newfield, Joanning, Kuehl, & Quinn, 1991; Stamp, 1991; Stith, Rosen, McCollum, Coleman, & Herman, 1996; Smith, Jenkins, & Sells, 1995). One example of inquiry that bridges the gap between researcher and clinicians is in the work of Sells, Smith, and Moon

(1996). These researchers evaluated therapy using an ethnographic approach. Clients and therapists were interviewed to obtain their perceptions of the therapy process. Six categories were found that highlight similarities and differences between the respective perceptions, including: changes associated with counseling, important practitioner qualities, effective interventions or techniques, ineffective interventions or techniques, recommendations for future sessions, and strengths and limitations of ethnographic practice evaluation (Sells, Smith, & Moon, 1996, p. 327). Implications are drawn from this study for practice, training, and research. They discussed the importance of an ethnographic approach in learning more about developing a therapeutic alliance. Also, the ethnographic methods provided opportunity to make adjustments in the treatment as it progressed from session to session:

However, therapists in this study overwhelmingly reported that these research methods were invaluable because findings could be used in providing better treatment. Although study findings could not be generalized to a clinical population, therapists may find them useful with particular client(s) in similar settings. For therapists, this direct feedback was extremely beneficial. For example, in one case the therapists received feedback from clients that they were “dissatisfied with counseling because no clear goals had been established.” The therapist used this information in the next session to establish clear treatment goals. (Sells, Smith, & Moon, 1996, p. 338).

The proposed research project will combine the need to make therapy research relevant to practice with the need to learn more about a particular therapy intervention. To date, few studies have explored the helpfulness of solution-focused therapy, and even fewer have explored the model from the client’s perspective, or its use in a group setting.

One study used conversation analysis to examine a solution-focused therapy session in order to see how the therapist accomplished his agenda (Gale & Newfield, 1992). In a separate study, Metcalf and Thomas employed qualitative methods to gain insight into client and therapist

perceptions of solution-focused brief therapy (1994). However, in my reading of the Metcalf and Thomas article it doesn't appear that the study really focused on client and therapist perceptions about solution-focused brief therapy (SFBT), but rather dealt with more general themes of the therapeutic process like role of the therapist, or reasons for seeking therapy. These issues of therapy are not specific to SFBT, and it would have been more helpful to get information specific to SFBT techniques and strategies.

A third study did acquire some valuable information about how clients perceive solution-focused therapy in a group setting (Zimmerman & Prest, 1995). The researchers provided an empirical study of the solution-focused model with heterosexual couples in group therapy. They found greater pre-test to post-test change on all scales in the experimental group. Even though an experimental design guided the study, the research report lists participant responses about how the solution-focused group brought about changes in themselves or their relationship (Zimmerman & Prest, 1995). Some of the group participants' reports included the following:

I learned what I can do to solve problems  
I'm more willing to work on solutions  
I think of little steps to achieve a goal  
We brainstorm options for change  
We have shorter, less intense arguments  
(Zimmerman & Prest, 1995, p. 7).

Another study utilized an experimental design to assess the effects of a specific solution-focused technique on treatment outcome (Adams, Piercy, & Jurich, 1991). The researchers investigated the impact of assigning the formula first session task (FFST) and compared it with a problem-focused task assignment. The three treatment conditions included the FFST followed by problem-focused therapy, the FFST followed by solution-focused therapy, and a problem-

focused intervention followed by problem-focused treatment. The study found that the FFST was an effective technique in the initial stages of treatment for obtaining clearer goals, gaining family compliance, and initiating improvement in the presenting problem. The FFST was not effective in increasing optimism about treatment outcome (Adams et al., 1991).

The proposed inquiry attained new impressions about solution-focused techniques as a treatment approach with a new client population. It offers rich description of research participants' perceptions of the application of these techniques in a group setting. This led to gaining useful information for family therapy training, practice, and research.

### **Theoretical Framework**

One way to provide an alternative to the dominant stress perspective is to utilize a different conceptual framework and intervention approach. Such a framework and intervention incorporates ideas that promote an awareness and exploration of strengths, and does not begin with the assumptions of caregivers as people who are described with terms such as stressed, burdened, and victimized. The purpose of the next section of this review is to elaborate on the solution focused intervention model and life span principles that will serve as a dynamic framework for an approach that focuses on caregiver strengths.

Researchers have agreed that investigations of group interventions for caregivers are in an early, yet maturing, stage of development (Toseland & Rossiter, 1989; Haley, 1991). Perhaps an important ingredient to that maturation process involves inquiry that is not founded upon the dominant stress paradigm. A major area of need in future research on group interventions is to explore the effectiveness of different group approaches and specialized techniques with caregivers (Myers, Poidevant, & Dean, 1991; Toseland and Rossiter, 1989). Toseland and

Rossiter stated, “Almost no information is available about the relative efficacy of different approaches or whether particular approaches are more effective with certain types of caregivers” (Toseland & Rossiter, 1989, p. 447). The proposed study will address this research need by challenging the stereotypes of caregivers as stressed and giving voice to their strengths.

As a practicing clinician in the field of marriage and family therapy I am interested in looking at how the caregiving experience can be viewed from a perspective different from one dominated by stress and burden. Family therapists can make many choices about how to view client situations and experiences. One way for me to view the caregiving experience and not assume that stress and burden are the essential ingredients is to adopt a conceptual framework that draws on a variety of theoretical perspectives. Rather than choosing one theoretical perspective and swearing allegiance to it (such as a stress model), I want to approach this inquiry with a conceptual framework that draws on different theoretical perspectives. I see this as consistent with an ethnographic methodology that seeks to generate theory in order to identify and explore the positive aspects of caregiver experiences.

My exploration of the strengths of caregivers will be informed by specific aspects of life span theory and the solution-focused model of therapy. These perspectives offer the possibility of developing a more positive approach to caregivers, and thereby challenge the generally accepted paradigm of caregiver as stressed.

#### Life Span Theory and Solution-Focused Therapy

A life span developmental perspective takes into account the change and constancy in behavior throughout life, and emphasizes themes of life-long development. Baltes (1987) set out a “family of perspectives” that help to characterize the life span model. Among this family of

perspectives is the notion that processes of change and growth occur throughout life and not only during childhood. Change is viewed as multidirectional and growth involves both gains and losses as people age. Another important aspect of life span thinking is that people are adaptable and possess a plasticity that offers the potential for different forms of behavior and development.

These principles of life span development offer a foundation from which to understand the caregiver's experience in a more positive way. Caregiving can be seen as one aspect of a process of life long development, and not the only aspect of that process. So often the stress of caregiving comes from its power over all other aspects of one's life, it becomes all encompassing. The life span perspective can aid in normalizing the dependencies and obligations of caregiving by allowing for a more contextual understanding of caregiving. This is done by seeing caregiving as one part of life and not all of it, by an awareness that there are gains and losses, not just losses involved in caregiving, and in believing in the adaptability and plasticity of the caregiver and her or his experience.

My study will draw on the life span perspective and use the principles and intervention techniques of solution-focused therapy. The core principles of the life span model are consonant with brief therapy approaches such as the solution-focused approach. In a review article on research on brief therapy, the focus on life span changes is listed as a core principle of brief approaches to therapy (Koss & Shiang, 1994). The authors' discussion of the relationship between life span changes and brief therapy is instructive:

Therapeutic goals are based on the view that patients are capable of making changes throughout their life span. The belief system that guides the practice of brief therapy is that people continue to grow throughout their life span and that carefully honed interventions, based on the environmental context, can contribute to growth and adaptive functioning. (Koss & Shiang, 1994, p. 668).

This is the first instance that I have found any semblance of a connection between life span perspectives and brief therapy. As a brief therapy model, my view is that solution-focused and competency-based approaches are in strong agreement to the life span view. The life span principles incorporate the developmental, as well as cultural and sociohistorical context of the person, and combine this with the belief in adaptability and change, a belief shared by the solution-focused model. This developmental aspect of the life span view of change adds a useful dimension to the more immediate and existential focus of solution-focused therapy.

The solution-focused model emphasizes an awareness of client resources by focusing on their strengths, goals, and solutions (DeShazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986). Like the life span approach, a solution-focused approach is undergirded by several guiding principles. These principles emphasize the empowerment of clients and enhancement of cooperation between client and therapist. The principle of the possibility for change is a major component of solution-focused therapy. The assumption is that change is constant so people's situations are always in flux. Also, change can happen quickly and it can be amplified, so small change can lead to big change. Another important principle of the model is the importance of developing a cooperative relationship with the client, one aspect of this is the need to work with clients to define their own goals (O'Hanlon & Weiner-Davis, 1989). The approach is based on the idea that clients already possess strengths and resources for dealing with their dilemmas (DeShazer, 1988).

Techniques such as re-framing and complimenting, will aid in the process of looking for the signs of adaptability and gain in the caregiver's life and personhood, and offer that to her or him as feedback for thought and discussion. Also, caregivers will be asked to formulate personal

goals that will move them in the direction of improvement and strength building. These goals can come from any aspect of the participant's life, for the setting of a goal is the beginning of movement toward change, however small that change may be.

The competency-based group therapy approach will be aided by ideas from the life span perspective. The solution-focused approach does not take a life span view, and it is helpful to be mindful of this when working with older adults, and with caregivers and their family members in particular.

### **Conclusion**

Rather than support those paradigms of thinking that dwell on the pathology of caregiving, by that I mean stress, burden, and depression, I have argued for a new way of organizing thinking on this topic. Sometimes it is necessary to take early conceptions of what could be and follow through with exploration in order to break through the barriers of unquestioned ways of thinking and doing. Hopefully this inquiry is a step in that new direction. The stress discourse in caregiving literature is very clear, as I have shown in this review. A strength discourse is less obvious, though growing. New interventions with caregivers may help to find ways to build on that strength discourse, and in the case of this study, provide valuable information about the therapy process with caregivers in a group setting.

## **Chapter III: Methods**

### **Design of the Study**

A qualitative research design was used to explore the usefulness of an integrated competency-based group approach with adult caregivers, and to build a theory of caregiver strength. A qualitative strategy was valuable for this study because it offered exploration of little known phenomena (Marshall & Rossman, 1995).

The approaches of ethnography (Hammersley & Atkinson, 1995) and action research (Stringer, 1996; Reason, 1994) served as the specific types of qualitative methods for this project. My role as group leader placed me in the traditions of both ethnographer and action researcher. The term “ethnography” takes on a variety of definitions depending on the user. For the purpose of this study it is a method that is characterized by participant observation and places an emphasis on exploration rather than on hypothesis testing (Atkinson & Hammersley, 1994). I was involved in the domain of ethnography by being a participant in the group process and observer of the research participants. First hand involvement in the group allowed me to gather data and record it in the form of field notes. Some of the strengths of participant observation are that it provides face to face encounters and facilitates cooperation with participants, obtains large amounts of contextual data quickly in a naturalistic setting, offers discovery of complex interconnections in relationships, and utilizes the subjective side of processes (Marshall & Rossman, 1995). These strengths of the ethnographic approach are compatible with the focus of this inquiry.

Also, this inquiry took on some of the components of action research. Like the term ethnography, action research has had varied interpretations (Kemmis & McTaggart, 1988;

Reason, 1994; Stringer, 1996). Common themes of most interpretations of action research are that it is reflective, engages people as active participants in the research process, and results in a practical outcome for the participants (Stringer, 1996). This project incorporated all three of these themes, and added another component of action research by having the principal investigator in the role of group leader, and the inquiry took place during the action of clinical practice. In this regard the study can be viewed within the tradition of practitioner research, in which the practitioner researcher provides leadership and direction to other participants in the process. Ethnography and action research approaches offered a good fit between the nature of the phenomena being explored and the purpose of the study.

### **Participants**

Participants for this study were caregivers of adults with mental or physical impairments. Caregivers were both male or female, and at least 21 years of age or over. The caregiver's relationship to the care receiver was as a family member, with the exception of one caregiver who was a friend and paid carer. Caregivers did not need to live in the same household as the care receiver, but had to identify themselves as a person who had responsibility for providing care. These criteria were broad to include spousal and adult child caregivers, as well as those who are not married or biological kin. A total of 13 caregivers showed up for the group meeting, but the paid carer dropped out after the first group session. Two groups were formed between these twelve caregivers, five in Group 1 and seven in Group 2. Group 1 met in Blacksburg, Virginia at the Adult Day Services location on the campus of Virginia Tech. Group 2 met in Salem, Virginia at the Adult Day Care of Roanoke Valley location on the campus of the Veteran's Administration Hospital. There was only one male participant in this study and he

was involved in the Salem group. A description of the participants in each group is included as Appendix A.

Participants were recruited through mailings and phone calls to community service and senior agencies, nursing homes, churches, adult day care centers, and other community organizations. Also, newspaper advertisements and informational flyers were used to recruit subjects and announce the dates, time, and locations of the group meetings. I purposefully avoided negative assumptions about caregiving in the wording of the advertisement flyers (see Appendix B). The flyers presented a “strength-based” language about caregiving. A contact with the director of the New River Valley Area Agency on Aging led to the agreement for the Agency to distribute the flyer to over 300 households through the agency’s home care and meals on wheels programs. Although there were some phone inquiries about the group as a result of this effort through the Agency on Aging, no one was able to attend the group planned for the Pulaski location due to lack of interest. Flyers were also provided to the Departments of Social Services in Radford, Virginia; and in Montgomery and Pulaski counties, and to the Geriatric Assessment unit of Carilion Roanoke Memorial Hospital in Roanoke, Virginia. The director of the Retired Senior Volunteer Program (RSVP) in Christiansburg, Virginia was also contacted and informational flyers were made available to that agency for distribution to their clientele.

Two caregivers who attended the Blacksburg group came as a result of hearing about the group through a friend who had called and signed up. She had heard about the group through her attendance at a monthly caregiver group in Giles County, Virginia. At that particular meeting a nurse from Carilion St. Albans Hospital was the featured speaker and he had information about my upcoming group that he passed along to the caregivers. I had contacted Carilion’s Home

Health agency and provided them with flyers, and also contacted Connect, Carilion's 24 hour referral and assessment service in the area. One of the caregivers heard about the group through Connect, and another of the caregivers in the Blacksburg group was informed through a direct mailing of flyers that I sent to family members of persons who attended the Adult Day Services site at Virginia Tech.

With the exception of one caregiver, all of the caregivers for the Salem group responded as a result of my contact with the Adult Day Care Center of Roanoke, Virginia. I went to the meetings of their monthly caregiver groups and spoke to them about my group and handed out flyers. The one exception heard about my group through the newspaper, and although she lived in closer proximity to the Blacksburg location, chose to attend the Salem group due to the time schedule of the group meetings. This was a volunteer sample residing in either the New River valley or Roanoke valley areas.

### **Procedures**

Recruitment efforts began in May 1997 and continued until there were a minimum of eight and maximum of sixteen caregivers recruited as participants for this study, allowing for no fewer than four and no more than eight participants in each group. The first contact with potential participants was made by telephone when they called and inquired about the group. The purpose and procedure of the study was described to callers, and the name, address, and phone numbers were taken from potential participants. Participants were assigned to one of the two groups based upon their ability to attend or their interest in attending at a particular site. The intention was to accumulate a pool of enough participants to offer two solution-focused groups. Group 1 began meeting mid June 1997, and Group 2 began meeting in August 1997. Group 1

met for six 90 minute sessions, one session per week. Group 2 met for six 105 minute sessions, with one session per week. I learned from Group 1 that more time was needed and this was extended in Group 2. The time was extended in Group 2 for 15 minutes after it was discovered in Group 1 that more time was needed to deal with consent forms and orientation to the research in the first session. This time extension in Group 2 also allowed for more time for the intervention process, so in Group 2 there were 75 minutes for the group therapy intervention conducted by me, a 10 minute break, and 20 minute focus group interview conducted by a research assistant trained in ethnographic methodology. In Group 1 the 90 minutes were divided with the first 60 minutes being the group therapy intervention conducted by me, a 10 minute break, and the final 20 minute focus group.

Another change made in Group 2 based on what I learned in the experience with Group 1 had to do with the way in which I had caregivers introduce themselves. In Group 1 I asked the caregiver to imagine she was the person she cared for, and to introduce herself as that care receiver might talk about her. My evaluation was that caregivers had some difficulty with this method of introducing themselves in the very first session. This may have been a more useful exercise to incorporate into a later session after the caregivers had become more acquainted with each other. In Group 2 I changed the way initial introductions happened in the group as a result of my perception that caregivers in Group 1 had some difficulty with this method of introduction. In Group 2 I used a list of questions that I posed to the group and members were invited to respond to these questions. Members were also told that they did not have to respond to any of the questions and could simply say “pass” if they did not want to answer. A sample of some of those questions/requests follows:

Give your name and a compliment you have commonly received in your life.  
Who do you care for and why do they need care?  
How long have you cared for that person and are you his/her only caregiver?  
What kind of care do you provide and does the person you care for live with you?  
Who do you talk to about caregiving?  
What advantage does being a caregiver give you over other people?  
What is most difficult for you as a caregiver?  
When have you noticed things going better for you as a caregiver?

The intervention emphasized caregiver strengths, and had as a goal the development of ways to help overcome caregiver struggles. Group sessions helped to formulate individual goals and promote the presence and building of caregivers strengths. Homework assignments were given at the conclusion of each session. Four of these assignments were in the form of a handouts given to participants to take home, complete, and bring back to the next scheduled group meeting, one assignment was made verbally. A description of the contents of the six sessions follows, with homework assignments labeled and included in the appendix:

### **Session 1: Clear Goals and New Vision**

*Assumption: Goals contain small steps toward change*

- \*Welcome and purpose of group
- \*Discuss confidentiality and ground rules, sign consent forms (Appendix C)
- \*Introductions -- by introducing self as if they were the care receiver introducing them (Group 1), or by responding to questions asked by the group leader (Group 2)
- \*Discussion of session assumption, qualities of well formed goals, guidelines for goal setting, and the miracle question
- \*Homework assignment -- establish a goal(s) in writing, handout (Appendix D)

### **Session 2: Caregiver Windows**

*Assumption: Strengths exist in every perspective*

- \*Homework followup
- \*Assisting members to clarify goals and discuss any changes from goal setting
- \*Discussion of session assumption, importance of our individual perspectives, what it may be like to be in care receiver's shoes
- \*Homework assignment -- list phrases that describe perspectives, handout (Appendix E)

### **Session 3: Strengths and Resources for Change**

*Assumption: Caregivers have strengths*

- \*Homework followup
- \*Check back on goal setting and follow through, achievements
- \*Discussion of strengths noticed in caregivers, and caregivers as “experts,” growth happens over life span
- \*Homework -- complete sentence strips in handout (Appendix F)

### **Session 4: Common Patterns/Problems of Caregiving**

*Assumption: There are exceptions to every pattern, no problem happens all the time*

- \*Homework followup
- \*Reading of sentence strips and externalizing disease
- \*Discussion of session assumption, common patterns/problems of caregiving
- \*Homework -- recognize patterns, continue to work on goals

### **Session 5: Cooperation, Time Out, and Triangles**

*Assumption: Solutions may be in the simple and obvious*

- \*Homework followup
- \*Discussion of session assumption, stress as a triangled position, visualizing cooperation with care recipients, time out from \_\_\_\_\_, time out for \_\_\_\_\_
- \*Homework -- handout on triangles and 4 C's of caregiving (Appendix G)

### **Session 6: New Windows to Look Through**

*Assumption: Expect change, it is already well under way*

- \*Homework followup
- \*Discussion of change as a process they have started, how to continue it
- \*Celebration ritual, certificates with lists of strengths awarded (Appendix H and I)
- \*Closure

Techniques such as re-framing and complimenting were used to view caregiver experiences as unique resources. The intervention sessions were videotaped in order to aid in the data analysis.

These tapes were not transcribed, but I viewed and listened to them to discover strengths that emerged. The tape provided the ability to make direct quotes of participants' views and experiences from the intervention sessions. This also offered a more an avenue for a more precise description of the use of strategies employed during the six sessions.

The assistant researcher observed the intervention sessions from behind a one way mirror

in Group 1, and she sat in the room and observed in Group 2 since a one way mirror was not available at that site. While observing, the assistant took notes from which focus group questions were developed. I met briefly with the research assistant after each intervention session to discuss and decide on questions to pursue during the focus group interview.

A focus group interview was held with the participants following each solution-focused session. Focus groups have been used as part of program evaluation (Krueger, 1994) and as an extension of group therapy methods (Bellenger, Barnhardt, & Goldstucker, 1976). The focus group interviews were audiotaped in order to be transcribed and also videotaped. The purpose of these interviews was to elicit the participants' perceptions about the strengths and weaknesses of the techniques used in the previous session, and to get feedback on the various components of the intervention sessions. The focus group meetings often started with a more general question about where participants were, for instance, "What was meaningful to you in the previous sessions?" Then the questioning took on a more specific tack in order to learn about the various components and techniques used in the previous intervention. The focus group interviews for this project were the "informal, natural group" type, such that they were moderately structured with several open-ended, yet purposive questions (see Appendix J).

The focus groups provided a means of exploratory investigation of previously gathered data and also served as a confirmability check. Focus groups offer a useful way to triangulate the data by adding the element of multiple participant voices, and they lend methodological rigor to the interpretive nature of ethnographic reports (Frey & Fontana, 1993). Thus, as Huberman and Miles point out:

But triangulation has also come to mean convergence among researchers (agreement between field notes of one investigator and observations of another) and convergence among theories. . . . Beyond this, triangulation is less a tactic than a mode of inquiry. By self-consciously setting out to collect and double-check findings, using multiple sources and modes of evidence, the researcher will build the triangulation process into ongoing data collection. It will be the way he or she got to the finding in the first place--by seeing or hearing multiple instances of it from different sources, using different methods, and by squaring the finding with others with which it should coincide (Huberman & Miles, 1994, p. 438).

In this project the focus groups increased credibility by providing feedback to and from the participants. I met with my research assistant prior to the next week's session in order to compare notes about the previous session and focus group process. The information gleaned from the focus group was used to modify subsequent intervention sessions based upon participant feedback about techniques that were most or least helpful. At the beginning of the next intervention session I sometimes asked participants about their opinions of the previous week's focus group.

According to Emerson, Fretz, and Shaw (1995, p. 2), "First hand participation in some initially unfamiliar social world and the production of written accounts of that world by drawing upon such participation" are activities that form the core of ethnographic research. I recorded fieldnotes immediately following each session. "Writing fieldnotes as soon and as fully as possible after events of interest have occurred encourages detailed descriptions of the processes of interaction through which members of social settings create and sustain specific, local social realities" (Emerson et al., 1995, p. 14). Fieldnotes included observations, interpretive comments, new learnings, key events, and questions that arose from the previous session. Notes also helped to document my activities, circumstances, and emotional responses as factors that shaped the processes of observing and recording others' lives. The fieldnotes also attended to the

indigenous meanings and concerns of the people studied, thereby becoming responsive to what others were concerned about in their own terms, and sensitive to what the participants experienced and reacted to as important (Emerson, Fretz, & Shaw, 1995).

### **Data Analysis**

The data for this study consisted of the transcripts of fieldnotes and audiotaped focus group interviews. The employment of multiple analytical perspectives provided the advantage of theoretical triangulation (Denzin, 1978). In regard to multiple perspectives, Coffey and Atkinson state, “One fruitful way of thinking about the production of ‘thick’ analysis is to recognize the value of multiple analytic strategies” (1996, p. 16). The analysis of the data for this project was based on Strauss and Corbin’s framework of constant comparison (1990), but this framework was expanded.

I read the transcripts three times and made marginal notes of emergent themes or sensitizing concepts. Then I coded these themes and concepts for linkages according to contrasts and comparisons. This involved the discovery and naming of categories. I used file folders to label the category and hold transcript sections with corresponding themes and concepts.

I read and re-read each file in order to allow for the emergence of a data display or diagram that portrayed the interconnections and relationships of themes and concepts within each file and between files. I made changes among and within files as necessary. The connections among categories were then used as a basis for the introduction of other analytic frames upon the data. For example, one framework was to analyze the data in regards to conversations of participants around specific interventions used in the group. Another analytic perspective was to explore how the caregiver constructs agency in the story. For example, does the caregiver do

things, or are things done to him/her? This focus related to the concept of strength. I wanted to analyze the emergent folk themes with a particular focus on the language used to describe strengths, or positive aspects of caregiving. These are examples of approaches that related the large formal issues (theoretical constructs) to the substantive issues (concrete entities) that are aspects of the constant comparative method (Strauss & Corbin, 1990). I also reviewed the videotapes and made notes of pertinent quotes or significant moments to include in the final report.

My approach was to use the process of writing to interweave the fieldwork and analysis. It was important to view writing as a way to begin analysis and theory generation. This writing was preliminary to coding in order to help figure out the phenomena. Paul Atkinson discussed the need for this integration of writing and fieldwork:

The conventional models of the research process which imply clearly demarcated phases (e.g., design, data collection, analysis) and treat writing up not only as separate but a relatively straightforward phase, do not fit. The writing up of qualitative research is a much more extensive and pervasive feature of the process. . . . The “writing up” of a qualitative study is not merely a major and lengthy task, it is *intrinsic* to the “analysis,” the “theory,” and the “findings.” The success or failure of the entire project can depend on the felicity of the writing. (Atkinson, 1992, p. 162-163, 164).

Writing took place in keeping a journal that included analytical reflections, memoing, and recording of how I was making decisions. This is referred to as a reflexivity journal by Carney (1990). This need for reflexive writing is discussed by Huberman and Miles as “a reflexive stance to the conduct of the study that assumes regular, ongoing, self-conscious documentation--of successive versions of coding schemes, of conceptual arguments among project staff, of analysis episodes--both successful ones and dead ends” (1994, p. 439). This approach to qualitative research also provides a check for bias as the journal serves as an ethnographer’s path,

trace, or audit.

The journal also offered a means whereby initial analysis of early field notes was recorded, providing a kind of summary sheet. Huberman and Miles (1994) offer a list of 13 tactics for initial analysis of early fieldwork. Some of the tactics that were useful for this study included noting patterns and themes; seeing plausibility by making initial, intuitive sense; clustering concepts; making metaphors; and making contrasts and comparisons.

### **Conclusion**

The aim of this project was to learn about the strengths of adult caregivers and provide the possibility for the emergence of a story about caregiver strengths. It was expected that a plotline would emerge out of an integration of the coding process, entries and passages from fieldnotes and transcripts, and from the relevant literature.

It was expected that the project would give voice to previously hidden stories of caregiver strengths and thereby challenge the predominant caregiver stress paradigm. It was also expected that new information about the feasibility of taking a competency-based approach with adult caregivers would be cultivated from this research. In conjunction with this information, I received feedback on the adaptation of specific solution-focused techniques with adult caregivers in a group setting.

## **CHAPTER IV: RESULTS AND DISCUSSION**

### **Introduction**

There are a number of possibilities for presenting and discussing the results of any research endeavor and my study is no exception. I have chosen a format that is congruent with my research questions, literature review, methodology, and the research experience itself. As I analyzed the data and mulled over the many possibilities for writing it up, I decided it is best to organize and communicate what this study offers in a three part structure. The three piece conceptual format is reflected in the framework of my earlier chapters through my delineation of the literature and statements of prior research in the field. So, my remarks for this chapter and the presentation and discussion of results will be set within the major headings as follows:

- (1) Group Beginning: Hearing a Stress Discourse
- (2) Group Learning: Pacing Stress and Leading to Strengths
- (3) Group Changing: Building a Strength Discourse

The components emerge out of the integration of the previous chapters, the literature, the experience with caregivers in the groups, and the data. This offers a story in three parts about the stresses and strengths of caregiving, and about the feasibility of using a competency-based group approach with adult caregivers. All of the quotes of participants' comments come from the focus group interviews.

It is necessary to keep in mind that the themes and findings I present in the following 3 major headings were co-constructed results. The results do not come out of a vacuum, they come from the context of my group interventions with the caregivers. Even though I will discuss the results and themes as "emerging" from the participants, it is important to know that there is often

a relationship between “emergent” findings and the topics or interventions that I presented in the groups. In this sense the results are co-constructed themes of that relationship.

### **Group Beginning: Hearing a Stress Discourse**

#### The Researcher’s Interest

I can trace my interest in taking a competency-based or solution-focused approach to problems back to a 1991 graduate course that covered various types of strategic therapies. One of the major strategic models is the solution-focused approach. The unique and different way of looking for solutions and exceptions to the problem resonated with me on a deep level. I liked the idea of taking a less pathological stance toward human struggle, difficulty, and pain. I think this was consistent with my previous career as a minister, theologian, church pastor, and preacher of the Good News! In my training as a marriage and family therapist I sought ways to incorporate the competency-based approach to problems with many of the clients who presented themselves for counseling.

In 1995-1996, one of my duties as a graduate assistant with Virginia Tech Adult Day Services involved leadership of the monthly caregiver support group. Although I had never worked with that population, I was swiftly made aware by colleagues and staff that caregivers of adults would benefit from a support group due to the stresses and burdens they experience on an ongoing and often daily basis. The language of stress and caregiving seemed to go together, and that was the introduction to the expressed need for a support group.

At some point that is not clearly demarcated in my experience I started to wonder whether there might be other ways to view the caregiver situation beyond the focus on stress and burden. I had applied competency-based ideas to the stresses of people with a variety of presenting

problems, so why not take a solution-focused approach with caregivers! I thought to myself, “Any person who provides and offers caring practices on a regular basis to a family member must draw on a wellspring of their own inner resources and strengths.” I wanted to find out something about that from the caregiver’s perspective and develop a group setting that might enhance and empower the caregiver’s sense of competence. It is this interest and willingness to learn from caregivers, not only about their stress but also about their strengths, that set me on the journey of this research project.

### The Caregivers’ Interests

Tom is a male caregiver in his 70s who describes himself in good health. He has cared for his wife in their home for the past five years. Although he no longer works outside the home he has adequate income to meet the financial needs of caregiving. We can begin to get a clear indication of one of the aspects of his motivation for attending the caregiver group:

I’ve learned how to do everything else, I’ve learned how to cook, I’ve learned how to wash clothes, I’ve learned how to take care of the house, I’ve learned how to take care of my wife’s incontinence, I’ve learned how to catheterize a person, I’ve learned to take care of transfers, I’ve learned how to take care of her in all those aspects, but I haven’t learned how to deal with the frustration.

Tom is unique as a caregiver by virtue of being a male, and perhaps by the length and level of care he has provided for his spouse. However, he comes to the group sharing similar frustrations, hopes, and the need to vent and belong with the other caregivers. Another excerpt from his comments is instructive at this point:

So you see it (referring to his nightly responsibility of turning his wife in bed to keep her comfortable) goes on until it starts to wear a little bit thin, but I’ve learned how to do that, that is not my biggest problem. My problem is dealing with the stressful part, dealing with the frustration and the anger that I have, I have a lot of anger that’s in me and I don’t know how to deal with it and that’s why I’ve come here. I’ve come here so maybe I can

learn something about how to deal with it, 'cause I'm not going to get any other information from anybody else. I can't read about it, no one can tell me, I've got to learn it myself and I have to learn how to deal with it so I can overcome it.

Tom's words remind us of the daily changes and tasks of caregiving for him. Tom was the only male voice in the study. It is possible that some aspects of caring that were learning processes for him as a male (cleaning house, cooking, washing clothes) may have been long time responsibilities for the female caregivers and not even mentioned as caring tasks by them at all. Walker, Pratt, and Eddy (1995) spoke of these gender differences in the perceptions of caregiving. However, his words and experience sound real to other caregivers.

Something in Tom's perspective is reflected in the comments and interactions of the female group members. Like Tom, the women clearly arrived for the group with an awareness and ability to enunciate indications of their own difficulties in caregiving. For instance, a confusion and sense of unknowing were expressed by the words of Deb when she talked about a recent feeling she had one night:

Last Monday night I called my brother three times and I knew he needed to be in bed asleep, but I was like "I don't know what to do." Lynn called the next day and I think it was a blessing, I thought, "Oh somebody has called and we can talk and it will be a comfort." I could feel tears run down my face because you really don't know what to do, and this, you know, I feel like there is someone I can talk to that understands what it is like, and it is so hard, and I don't know what to do.

Add to Deb's words the following phrases from other caregivers that indicate more of this common caregiver discourse:

It is so frustrating after you have answered the same question twelve times.

I go in the bathroom, shut the door and just cry, that will help.

I just feel when I have to deal with mother that I have just been there 15 minutes and it is almost worse than a 10 hour work day, the stress involved in it. I feel like there has got to

be something, and I guess you take it personally like there is something I have to be doing wrong.

He does not remember asking me the same thing over and over.

The ways in which these caregivers defined themselves was usually as stressed, confused, and tearful. The dominance of a stress discourse that I identified in the literature on caregiving was obviously present in the lives of the caregivers in this study.

It was common to discover this mindset among the caregivers as they entered the group and research process. A problem focus and desire to get some kind of help in dealing with the stressful aspects of caregiving were interests the caregivers brought with them to the group. The problematized view of caregiving as solely a stressful and negative experience was the prominent paradigm.

#### The Function of a Stress Discourse

One of the well known stressors related to caregiving is the lack of social supports in the care deliverer's life. Contacts with an outside community and the ability to seek social connections are aids in coping with the negative side effects of caregiving (Williamson & Schulz, 1993). It is in this sense that the prevalence of a stress talk and a problem focus can be viewed as a way to create belonging in the group setting. I saw this as a continuing theme within the data.

My interest and purpose for the group was to make it more than a traditional support group where people simply come and share and hear information. It is clear that in many ways the group took on the flavor of a traditional support group and naturally created that kind of nurturing environment. This is not unlike other types of support groups that meet for a variety of issues such as alcoholism, breast cancer, attention deficit disorder, sexual abuse, and grief.

Given that caregiving can be so isolating, the caregiver's presence in a group is a way to attach herself to a social community of persons who, it is often assumed, have nearly immediate comradery and empathy for her because of shared experiences as carers. The stress talk is a function of the need to belong and caregivers quickly formed a sense of solidarity in the group and drew circles of inclusion. There were many examples of this in the data and Mae is a clear one:

So what, it's easier to talk to this group rather than family other than my sister who still takes care of a lady from time to time, but it's kind of hard to talk to the people that do not understand. So it's so much easier being in the group because people are going through the same thing I am going through.

This group solidarity is also expressed in the comments that show a kind of knowledge boundary that is formed and distinguished between the caregiver who has attended a group and those who have never done so:

No, even caregivers who haven't gone through a group support still don't know what we're talking about because they're giving care and they're going through all these different problems and not knowing that there is a balance here some place, and not knowing that maybe to a perspective that they can see that their problem might be diminished, made smaller than what you think it is. So they need help, and I guess that's why we're here, I came here because I thought I needed help.

Again, the understanding and knowledge boundaries between caregivers and the outside world are expressed by another caregiver:

It's good to share, I think it makes you feel better when it's all over, because these people understand and you can share your feelings with other people and they don't understand. They say they do and they try to, but they don't understand.

These words show how the caregivers seek a group to find support, and their stress language and problem focus becomes a way to create and reinforce belonging, commonality, and empathy.

When seen in this context the stress discourse serves a meaningful function for caregiving

and much of the awareness and perception of caregiving can remain there unless new strategies and approaches challenge that paradigm. This project was involved with finding a way to broaden and challenge the stress discourse of caregiving by providing opportunities to make steps toward new perceptions of the caregiving experience. Although the caregivers themselves would likely be content with a more traditional support group approach, they also came with motivation toward making movement beyond stress in themselves and their own perceptions about caregiving.

### Moving Beyond a Stress Discourse

Another caregiver interest became evident as the groups developed. Perhaps this interest was piqued by the advertising flyers about the group that many of the caregivers had seen and responded to in order to participate in the group (see Appendix B). I purposefully avoided negative connotations of caregiving in the flyers. The title of the group and catch phrases on the flyers offered an alternative of hope. Whether it was from their initial perceptions of the group or not, caregivers provided statements that indicate an interest in viewing caregiving from a strengths perspective as is evidenced in these quotes:

I think the very fact that this is not a support group as such, it is building our strengths, it's a different approach. This is trying to build our strengths from what we have already, and it's a whole different approach.

I came here with certain expectations, I came here with the idea that at the end of six weeks I am going to be able to do a better job.

We have got to make it through and that's why we're here. We wouldn't be here if we didn't want to make it through.

It was this budding interest of the caregivers about their strengths that matched with my interest to provide an environment where their self-definition and discourse about caregiving could grow,

expand, or change. My purpose was to help bring about a small shift in the prominent paradigm of caregiver stress to a view that added something new. In order for that to happen it was necessary to begin with the caregivers where they were in the stress discourse, and slowly lead to awareness of their strengths.

The next section is an account of attempting to introduce a new caregiver discourse through six sessions of competency-based group interventions. It is a story of some of the highlights of particular sessions, specific techniques utilized, and process aspects of the research experience.

### **Group Learning: Pacing Stress and Leading to Strengths**

It is common to find two types of caregiver group formats in the research literature and in applied practice. One is the non-directive supportive type of group that can be peer-led or professionally-led, with the primary focus for group members on sharing concerns and finding support. A second group format is a more structured psychoeducational approach that presents a variety of information relevant to caregivers. For the most part these interventions address care from the standpoint of a stress-based framework and assume the presence of a predominantly problem-focused paradigm of caregiving. Much of the research on group interventions with caregivers has been dominated by investigations that measure burden and stress among caregivers (Knight, Lutzky, & Macofsky-Urban, 1993), and has been notably lacking in theoretical rigor (Suitor & Pillemer, 1990; Gatz, Bengtson, & Blum, 1990).

The Ericksonian psychotherapeutic practice of pacing and leading the client was important in the group work with these caregivers. Milton Erickson used the technique of pacing with the client in both verbal and nonverbal ways in order to build rapport (Erickson & Rossi,

1979; Bandler & Grinder, 1981). This technique is a way of utilizing the client's experience in order to lead him or her to change. It was important to keep this practice in mind with caregivers. In order to lead the caregivers to strengths it was necessary to pace with their need to talk about stresses.

### Caregivers as Central

Although the group intervention I offered contained elements of the two previously mentioned group formats (support and psychoeducation), it aimed to move beyond the stress-based discourse that was typical of caregivers coming into the group by incorporating an approach based on concepts of competency-based therapy and life span developmental theory. The specific emphasis in this group intervention was the caregiver, not information about the medical aspects of particular disease processes, not legal issues related to wills and estates, and not how-to lectures on overcoming stress. A competency-based approach that elevated the caregiver's perceptions, participation, and resources over an assumed problem paradigm of stress made this research process and group intervention unique.

It is not easy to capture the full essence of how caregivers' views, participation, and potential were explored in this study, but some excerpts of comments made at a halfway mark provide clues to this dynamic. The interviewer asked, "That also brings another question to my mind in terms of we are nearly halfway through and in what way has this group been what you expected and how has it been different or similar?" A couple of caregiver responses from the Blacksburg group are significant here:

I think it has been different that he's (Alan) focusing on us or we're focusing on us. I think I came here thinking the focus would be my mother and her problems, and they are my problems and I've got to deal with them, and I think that's a little different from what

I expected.

I think I expected him to take charge more and not involve us like he is doing, for example I thought maybe he would be giving us more lecture, book type facts. Instead he is, he has gotten us to exchange our thoughts and our problems and really started us thinking about how we can solve these, you know he has been a motivator there. He involves us more than I thought he would. I thought we would be listening more but he definitely makes us all part of the group and makes us feel as though we're important to each other, and uh will ultimately help us all, our relationship with our care person.

Likewise in the Salem group statements were made that coincide with these comments and help to show how caregivers felt their perceptions were highlighted and valued. Here is an example of an interchange between Jan and Tom:

Jan: I don't think we are talking about the patient part, I think what we have been talking about is us.

Tom: We have been talking about the caregivers, it is the caregivers and no matter what you are dealing with, it's immaterial.

Jan: We just bring that up.

Tom: It is introspective, you have to look within yourself and we are looking within to see how we are dealing and what we are dealing and whether we can be helped and what strength we can get for dealing whether it is physical incapability or mental deficiencies, makes no difference.

I am highlighting here what seems to be an important aspect of this group process in that the members slowly started to notice that their position and views were important aspects of the caregiving experience. In this setting they were able to look at their experience and begin to notice it from a perspective that took them outside of the dominant stress focus. This was a way to subtly interrupt the problem pattern.

Most importantly the caregiver herself emerges as central, her perspectives and goals become the focus of attention, rather than a theory about caregiving or therapy. With this in

mind it makes sense to turn to a discussion of the first three group sessions. These sessions were designed to elicit the caregiver's perspective and work with her to set and accomplish goals.

The next section will draw on the group sessions and content. However, rather than examine each individual group meeting in itself, I am presenting the data from the groups in two major parts by dividing the groups at the mid-point (between sessions 3 and 4) for the purposes of discussion. Major themes within each of these parts of the group process will be viewed as the building blocks of the strength discourse. This organization of the data from the group sessions into these two parts with a transition from one to the other at the midway point in the group meetings also fits with an element of the group process. In both groups (Blacksburg and Salem), an obvious transition took place between sessions three and four so that by the end of session four members spoke of being more involved, in rapport, and going deeper emotionally. The shift in the groups may have been due to the specific intervention used in the fourth session, discussed later, or it could have resulted from the fact that it was the fourth meeting and group members were becoming more comfortable with each other. Yalom (1995) referred to this process as group cohesiveness and wrote:

It is not the sheer process of ventilation that is important; it is not only the discovery of others' problems similar to one's own and the ensuing disconfirmation of one's wretched uniqueness that are important. It is the affective sharing of one's inner world and then the acceptance by others that seem of paramount importance. (Yalom, 1995, p. 49)

### Strength Building Blocks (Themes)

#### Sessions 1-3 -- Self-Care, Guidance, Togetherness

The pre-flight instructions given by the flight attendant of a major airline as the plane taxis down the runway provide a metaphor for strength based caregiving. Among the

instructions to passengers concerning smoking and seat belts, the flight attendant adds words similar to these regarding the use of oxygen masks, “If you are traveling with a small child always remember to put the oxygen mask on **yourself first**, then place the mask on your child.”

The importance of **caring for oneself** is an especially relevant aspect of adult caregiving and emerged as a basic building block in the data of early group sessions. Caregivers who are often isolated face the challenge of finding ways to take care of themselves. The theme of self care was interspersed in both groups in a variety of ways. The novel and mundane approaches to self care are expressed in the following words of Esther and Pat. Pat simply wanted to have some alone time to talk to a friend on the phone, and Esther just needed to get out of the house for a brief while. Their examples are noteworthy. First is Pat:

I have a friend in Florida and she was here in the Spring and I needed to talk with her and I knew it was impossible. I had something on television for him (her spouse for whom she cares) to watch and I went in the bedroom and locked the door and I’ve never locked the door. I thought I want to talk and I don’t want him to come in and interrupt me, maybe that sounds bad, but I just wanted a few minutes to talk on the phone. He did, he knocked on the door and he shook it a little bit but then he went, he left. About a few minutes he came and he did it again and he left so I just continued on with my conversation until I finished, otherwise I couldn’t have carried on a conversation.

When Pat said “maybe that sounds bad” there is evidence of the inner struggle she has with caring for herself in this way and at the same time knowing that she very much needs to be able to talk in a private and uninterrupted manner. In her next comment in the interview she went on to say, “that’s something I needed that I owed that much to myself and I needed it for myself.”

Likewise, Esther found a break to take care of herself in a novel way:

Well I was thinking about what the doctor told me. If I get sick none of my children live here so who is going to take care of him (her husband)? My sister lives with me and she has been a big help. There’s been times when I say to my sister, “Are you gonna be here?” and she will say sure. I say “I’m gone” and she will say “where you going?” I say

I don't know. One time I went to Hill's parking lot and parked my car and sit there and watched people going in and out of the store. Eventually I went in and got me a hot dog and come back and sit in the car.

An event as simple as Pat's talking to a friend on the phone becomes a means of self care, as does

the experience of Esther sitting in her car in a department store parking lot.

The airplane metaphor along with other ideas and concepts that assumed the presence of strengths and inner resources of caregivers were presented in the course of the first 2 group sessions. Self-care became one of the themes of this discussion. In the focus group interview following the second group session this need and intent to learn about self-care is heard in Jan's comments:

From what I understand about support groups you learn more about the patient and how to deal with them. Here I thought our goal was to learn what our inner resources are, we need to help one another to build our resources, we're not really focused on who we're working with (the care receiver), we're focused on ourselves. My understanding of the goal of this group is to help us identify our own resources.

Jan was a new caregiver in that she recently moved back into her mother's home in southwestern Virginia after living in the Chesapeake Bay area of Virginia. Her mother was diagnosed with Alzheimer's disease and this was Jan's first participation in a support group. As a new caregiver she showed interest in starting off as a resourced carer.

**Guidance** is a second theme that surfaced in sessions one through three. It was common to hear the caregivers talk about getting information and wanting advice. They came to the group seeking guidance from each other and from me. I see this as a strength in itself. They came as people who are motivated learners and open to suggestion.

Caregivers sought guidance from each other as noticed in these statements of Lynn and

Mae in the Blacksburg group. Lynn referred to another group member and Mae responded.

Lynn: I think we all want so much information and we're just trying so desperately to get information, that's the way I feel. I just want all the help and suggestions and anything she might say that might help me.

Mae: If a person went into a little more depth about what they were facing with their care person then that would give us a little more material with which to ask questions. Say, "Well, when you went through such and such, how did you handle it?" Or, "What finally happened to give you some peace as far as the way you were handling things?" for example.

These caregivers imply that there is so much to learn from each other simply by knowing the experience of the other.

Professional guidance or academic expertise was sought after as well by the caregivers.

Although other caregivers expressed a desire to receive this, Tom was most direct and outspoken in asking for formal instruction. At least once in each of the first three sessions he stated he wanted direct advice to take with him:

I like the idea of goals, to work for a goal because if we don't have a goal you're gonna be, all you do is pass time away, but it's gotta mean something. I want to be able to take something back home, want to be able to do that knowing that there is someone here that has the academic background to be able to interject something, can be a big help.

In session two Tom was looking for this group to provide something different than previous groups he had attended had not offered, and that difference for him would come in the form of formal learning. He said:

Well there is a difference because I attend a group that you're talking about the support group, they develop their own little situation and maybe it is not a program. I'm here differently with this group because I think there is something there that we can learn because it has been learned before. Some sort of program available that we might latch on to, that we can catch an idea or a thought.

In the next quote taken from the beginning of the third focus group interview he stated very

clearly what he wanted. This statement is followed by a quote taken from the end of the same interview where he voiced a question.

I'm looking for more than what we are getting out of this. I know it's great and it's progressive, but in a way I'm thinking that if we're gonna meet six different times that we will be getting some constructive points to consider being a caregiver in our situation. I would look for Alan to be able to say as a caregiver there are certain things you should keep in mind, there are certain things perhaps you ought to do, and be more instructive I suppose.

Is there more of a formal application of directing a group of caregivers, a formal way of presenting facts? I don't know, I'm asking the question myself, thinking about maybe there is, maybe that is what I'm looking for.

Throughout the data of these first three interviews are other references to how the caregivers were seeking guidance, advice, or strategies that worked in caring. They mentioned several sources they had already sought for getting this direct instruction including health care professionals, books, family members, and most importantly other caregivers. Although it is reported that most group members in retrospect do not highly value didactic information or advice (Yalom, 1995), it is clear that these caregivers wanted it during the course of the group work.

A third building block throughout these initial sessions was **togetherness**. The perception of togetherness or mutual cooperation held by the caregivers was expressed by them in metaphors that Yalom (1995) said are often used in group therapy settings. What he referred to as "universality" and I am calling "togetherness," is a therapeutic factor in the feeling of relief that comes as a person finds she is not alone in her experience of caregiving. These caregiver metaphors included the phrases "being in the same boat" and "sharing a common thread."

Tom, who spoke of wanting expert knowledge and formal didactic instruction, also found

strength in the sense of togetherness as expressed in these words:

It is nice to be able to vent it out and be able to talk to others, even the people who come to the house to help, but we don't discuss situations as intimate as we would with a group like this. We all bear responsibility, we all, well, we're in the same boat here, we're all trying to overcome this big problem that we have to deal with every day. It is not every other day it's every day, and so yes this helps, my being able to discuss and talk about it, it does help.

While Tom used the "same boat" metaphor, Mae spoke of sharing a common thread. Her choice of words was fitting knowing that she used to design sweaters and was a seamstress:

I would say that it's the benefit of sharing experiences and finding out that other people are going through the same thing you are, because if you're just by yourself caregiving and you don't have anyone to commiserate with you get the feeling that you're alone and handling things all wrong. You know, it's the exchange of ideas, the common thread that we are all doing this and we're not alone is the outstanding thing to get from a group like this.

This theme was so prevalent that nearly every group member at some point stated it in her own words. Here are two more examples from Esther first and then from Deb.

Well just listening to the questions and answers and just being with people that's going through the same things that I'm going through because at one time I got so sad, and I'm like Wilma she said she had a pity party. I had one last week and then I stopped and said you are not the only one going through this. But I enjoy being with people that's having the same problems, it gives me strength to go on to know that I'm not alone.

All of a sudden it was like, well gee there's someone else that's going through some stuff that I am. When Lynn was talking about her mother who thought she could do everything, I thought that's just like mom, you know. And when you said your sister was belligerent I thought, gee you know. And you listen to this and it, it's kind of even though it's sad but is comforting to know there is someone else that's experiencing this that you can share and learn from because last week I was at my wits' end.

It seems to come as a surprise for the caregivers to learn that others have similar feelings and experiences. The opportunity to confide in the group and find common ground with other carers was a powerful source of self-acceptance and validation.

The phenomenon of togetherness, along with the need for self-care and the search for guidance, surfaced as the leading themes of the first three group meetings. A triad of different themes are the focus of the next section that presents the results from the latter three group sessions.

#### Sessions 4-6 -- Separation, Family, Experts

The fourth group meeting proved to be an emotionally moving and powerful session as is evidenced by the caregivers' reports. It is from this session that the **separation** theme actualized. In order to make clear the impact of the session it is important to provide more depth and detail about the intervention employed.

The intervention I presented in the fourth group meeting was conceived from the idea of externalizing the problem. Externalization was a technique discussed by White and Epston in their narrative therapy approach (1990), but I think it also shares a likeness to concepts about getting objectivity from the problem in the works of Milton Erickson (1979) and Murray Bowen (1988). Though the terms used to refer to the therapy process are different (externalization, objectivity, differentiation) in these various approaches, the intention is to help the client gain distance from the problem in order to bring about clearer thinking or less negative emotional response.

The fourth session intervention involved a prior homework handout that was explained at the end of the third session (see Appendix F). Group members were given the homework assignment and told to complete it and bring it back to the next session. The caregiver would fill it out according to the particular disease they were dealing with in the person for whom they cared.

The intervention began by asking each group member to take scissors and cut off each of their completed sentences into sentence strips. An example of a completed sentence strip follows, although the caregivers' sentences were completed in hand writing, not typed: I am "The PLS," and I am like a slave master who will take away your independence and your self esteem and make you fully dependent on others for any fulfillment of your expectations of a normal life. Those are the words that Tom used to complete one of his sentence strips that described his wife's disease, primary lateral sclerosis (PLS). I brought three empty flower pots of different sizes, small, medium, and large. I explained to the group members that the medium-sized pot would represent the physical or mental impairment of their care receiver. So for Tom it was known as the PLS pot, for other group members it was known as the Alzheimer's pot, deriving the name from the disease of their respective family member. Group members were invited to read each of their completed sentence strips to the group and then place them into the pot. As each member shared there was time for other group members to respond or comment. During this process emotion was evident either in the expression of tears, watery eyes, or change in voice or facial tone. After each group member completed the process I then brought out the smaller and larger pots. I talked about how the disease and problem can seem bigger and smaller from day to day depending on circumstances. I also queried as to ways that the caregivers might be able to notice when the task of caregiving or the disease (problem) seemed smaller or larger than usual in their lives.

The theme of **separation** came forth in connection to this intervention. The intervention proved to be influential in setting some distance or objectivity in caregiving. Pat was in the Salem group and for the past eight years has provided care for her husband. She said:

When the demented side is not showing then there is a little bit of that person and that's the way I could say the disease could be separate from the person. You never know when the real person is going to leave and the demented one comes out. When the dementia comes out with him it's totally opposite from the person he has always been. And when I say I'm angry it's not my anger at him it's at the dementia and what it's done to my life and his, because everything has changed.

In this example Pat gave three ways separation was expressed. First there is separation between her husband as the real person and the demented person. Second there is separation between the present husband and the past husband ("the person he has always been"). Third there is separation between Pat's feeling of anger directed at the dementia as opposed to her spouse as a person. This is not unlike the important distinction that happens when a parent is able to separate the inappropriate behavior of a child from the selfhood or person of the child, so that both the child and parent learn to uphold the person while making change in unwanted behavior. Pat expressed how she can still hold something of her husband as a person even while she dislikes the disease.

In the Blacksburg group Mae and Lynn reported how separation was experienced for them when Mae stated first:

Well you know Alan said this is the first time he had ever done that, this was interesting to him from the standpoint of not knowing what to expect. But I think what we did tonight is we put names on the Alzheimers, and the pot was the significance of where the names we were bringing up were going.

And Lynn followed by saying:

Actually taking it from us and putting it in there, it was like separating it from me and putting it somewhere else for a while, identifying it.

Not only do they speak of separating the disease but also naming it in some way through the process of writing and reading the sentence strips and placing them in the pot. The pot metaphor

was picked up and used by the caregivers in ways that showed a changing/dynamic quality to the disease or to themselves as caregivers. Lynn spoke of going to her mother's home when she said "I think it is different for me because I haven't seen my mother for a week, so I think it is easier in a way to deal with it (the Alzheimer's) when I don't see her. But then when I get a phone call or call then the pot gets big again." And in talking about Lynn's father as a caregiver for her mother it was said that "his flower pot must be pretty big just about every day."

In all of these discourses different levels of separation were expressed. The disease was separated from the person who has it and from the caregiver. The caregiver was separated from the care receiver and from other family members. Also, manifestations of the separation of the disease or caregiving task were varied in size and scope. Separation became a way for caregivers to find some acceptance and gain distance and in that sense it was a building block of the strength paradigm.

Another prominent theme of these latter three group sessions was **relationships with family members**. There is a need for group interventions that are responsive to caregiver family relationships (Myers, Poidevant, and Dean, 1991). Although this study did not have family relationships as a primary focus of inquiry, the awareness of family systems processes guided my thinking. Since a review of caregiver groups in an article in the Journal of Marital and Family Therapy made the point that none of those groups was led by a family therapist (Campbell & Patterson, 1995), it is important to claim that aspect of this study as well. My training as a marriage and family therapist was underlying various interventions and the discussion of triangles in relationships during the fifth group meeting. The presence of the family theme was evident in the caregiver conversations.

All of the data analyzed were from family caregivers, not paid carers. However there was a paid caregiver who attended the first meeting of the Salem group who dropped out after that first session. My conclusion is that she dropped out because of a felt difference between herself and the other caregivers. This difference was highlighted in a couple of comments made by the family caregivers that could have been interpreted as downplaying or minimizing her as a caregiver, and that identified her as an “outsider” to the group. One example of this is the comment made by Tom when he realized this paid caregiver had nights off:

So you are free at nights? It would be nice to have nights off. See I take my wife and she goes to bed and then of course it takes her a long time before she gets to sleep and then she wakes up and has to be turned every two hours, maybe every hour some times. I have to get up, wake up and turn her over and set her comfortably, then go back to sleep. Wait for the next turn, so from left, to right, to left, to right, this goes on every night.

Another example of the group’s excluding this paid caregiver was Wilma’s comment later in the same conversation when she directed these words to the paid carer, “but this is just a job for you.” The distinction made between paid and family caregivers is noted in order to emphasize not only the distinctions that can be found in the literature, but those that play out existentially in the lives of carers. This distinction brings focus to the family theme.

Of the 12 caregivers in this study, 6 cared for a spouse and 1 of the 6 was a male caring for his wife. One of the five female spousal caregivers did not live with her husband because his stroke had made it necessary to place him in a nursing home a year earlier. This woman, Sarah, had cared for him in her home for 11 years prior to his nursing home placement. Three caregivers were daughters caring for their mothers with Alzheimer’s disease, and only 1 of those 3 lived with her mother. One caregiver helped with her brother-in-law, one cared for a sister-in-law, and one cared for her sister who lived in another state.

The differences in familial relationships brought variations and unique situations in caregiving. Some of these are reflected in the following comments by caregivers. Family gatherings around holidays were affected by the presence of more people in the care receiver's life. Caregivers were attuned to this and three of them mentioned this experience. One example is Sarah when she said:

We get together every Memorial day in Hickory, North Carolina at my youngest boy's place on the lake and I took my husband as long as I possibly could, but he wasn't happy and it was hard for the rest of the family. There were about 20 or 25 of us together and we were just all concerned that he be taken care of and he just endured it. So one year I decided I'm just not going to do this, I'm going to bring somebody into the house to take care of him and I'm going to go and I did. It was the best thing for the family as well as for him. He was just fine and he didn't know what was going on and didn't miss it at all and I was able to enjoy it too.

The caregiver becomes a person who manages and monitors the relationship between the larger extended family, outside social networks, and the care receiver. This triangle of relationships consists of the caregiver, care receiver, and some other family member or social context. Hansson and Carpenter (1994) mentioned this aspect of caregiving and how the family depends on this case management type of service from the caregiver to determine the degree of integration of the older adult into social contexts. Caregivers spoke as though they had to be the responsible person or gatekeepers of these relationships. In one conversation Deb labeled herself as the bad person and black sheep in the family for assuming this role.

Then you know the rest of the family they want these folks to visit two and three times a year and I said that's fine, you all ask them, but they are not staying at mother's any more. So when I learned that my dear beloved cousin had called them last October and asked them to come, I called him and his mother and I said I certainly hope you have made arrangements for them to stay somewhere because they are not staying with mother, and I'm telling you that you need to find a place. And of course I was the black sheep of the family, they were real upset with me but I had to do it for mother's safety.

Caregiver and care receiver relationships can become intense. Caregivers often function and are perceived by others as the only person in the family who can provide the care. The next excerpt of a few conversational exchanges between two women who each cared for their mothers with Alzheimer's disease shows this dynamic.

Lynn: I think my sisters call me the warden (laughter).

Deb: Well somebody's got to do it.

Lynn: I'm the oldest so I can wear the hat.

Deb: Well see my brother should wear that hat, he's the oldest but he won't do it.

Lynn: That's why you are going to have to start calling on him more. It's difficult though.

Deb: Well I know his wife's sister has been very sick and I know that they try to help out there too. When you are a small family, you be thankful for the size, it is hard.

Lynn: Well I know the minister told Daddy when he was in the hospital that he had these children and they are willing to help and you have to accept it now.

A popular myth about older adults is that they are cut off from family members and live alone. These caregivers show how family is a very real and ongoing part of the care receiver's life. The caregivers' comments also show some of the struggles in maintaining those connections. Finding a balance between family and self-care was a continuing aspect of the caregivers' experiences.

A final theme that surfaced from these group meetings had to do with the caregivers as **experts**. I presented this concept to the caregivers in the third group session in order to facilitate their reflection upon their own skills, competence, and know-how as caregivers. One of my observations from previous work with caregivers involved an awareness that they were often

capable and coping well with their caring practices. Despite this caring ability they often minimized themselves and seemed to present themselves as lacking what was needed. My thought was that of all people in the care receiver's life, these carers were most closely involved and were intimately aware concerning the relationship. They were positioned to think about caregiving and had acquired knowledge and skill by virtue of being in that relationship. I thought this was a strength to be enhanced with the caregivers.

Caregivers did not necessarily share this viewpoint with me, especially in the initial meetings. A statement made by Mae in the very first focus group interview shows how she was expecting to receive expert advice from outside of herself:

I know we would like some guidance from you (talking to Saliha) or from Alan as the experts. Surely you have studied much more than any of us put together, you can come up with some suggestions.

Also, the initial responses of the group to my introduction of the concept of the caregivers as experts showed their reluctance to claim or accept any expert status for themselves. This reluctance was illustrated by the words of Deb which were representative of both groups at that point:

I don't see myself as any kind of expert, if I was an expert I might not be here (laughter). I'm not an expert...and I feel like I could be doing something different but I don't know what it is.

Several sessions later though, the expert idea changed somewhat for them. This was expressed by a confirmation of that concept in another support group that Lynn attended on a monthly basis in a different location, and by the direct acceptance of the expert status by Tom in the Salem group. Here are the quotes of their respective viewpoints, with Lynn's comment first:

Well last week we were here and he (Alan) told each one of us that we were our expert,

was it last week? The very next night I went to Giles to the support group and at the group the same word came out there. Each of you know what you are going through better than the next person, that you are your own best expert, both the groups.

I just think that we as caregivers in our own situation are best to know that situation. You (Saliha) don't understand my situation well enough to tell me how to behave, and Alan would like to think that he could, but we are, we know best I think somewhere along in that, in one of those papers he gave out that we know best about our own situation, and that's true, we do know best. So people around us don't know as well as we do of what's going on in dealing with our day to day problems, that's why I take one day at a time.

Most caregivers were not as forthright as Tom. Although she was not fully convinced, some difference was present when Deb said in the focus group interview following the fifth session that she was still not an expert, yet a shift had taken place for her as evidenced by the following comment:

It's just really hard but this has been really, really helpful. I think I handle it better and I think that's the whole idea of this class, is that I can now handle it. Not an expert, won't ever be, but I think I am handling it better.

I think these small yet significant changes were evident in the overall experiences of the caregivers in both groups. My introduction of the expert concept and their consideration of it offered another possible lens for viewing themselves beyond the stress label. Words from the introduction of Caregiving: Readings in Knowledge, Practice, Ethics, and Politics, a book with the thoughts of a variety of scholars, researchers, practitioners, and feminists, are relevant:

Caring practices always involve receptivity, engrossment, attunement, engagement, intelligence, skill, shrewdness, and knowledge. All these elements have, unfortunately, been made invisible in our society. Leery of any rigorous discussion and exploration of caregiving, we fear that it may invite subservience, oppression, and dependence. Obsessed with theoretical knowledge and abstract reasoning, we do not recognize the practical knowledge, skilled know-how, and relational expertise of caregivers *as* knowledge, skill, and expertise. But caregiving in fact demands an intricate combination not only of abstract learning and reasoning but of relational intelligence, social learning, and skilled knowledge as well. (Gordon, Benner, & Noddings, 1996, p. xiii)

Different levels of separation in caregiving, family relationships in caring, and openness to viewing caregivers as experts developed as the pre-eminent themes of the last 3 group sessions. These themes combined, with those from the earlier group sessions (self-care, guidance, and togetherness), stood out as some of the building blocks toward caregivers' competencies.

Thus far in this chapter, two parts of the three part narrative have been discussed, the beginning and the middle. The third part follows, and is a reflection on change and the end.

### **Group Changing: Building a Strength Discourse**

If caregivers came into the group and talked in a familiar stress discourse at the beginning of their interactions, and then participated in six group sessions that intended to lead them toward a strength discourse, how did they talk at the end? What changed for them or for me?

I found in being with two separate groups of caregivers over a three month period of time that a sense of caregiver strength was varied and not obviously visible. There were not explicit discourses of caregivers' new found awarenesses of strength or competence. Caregivers did not speak forthrightly about glittering or distinctive new strengths gained as a result of being in the group. Rather, the data suggested that there are intimations of strength and competence in the languaging about themselves by the end of the group meetings. I chose to present this languaging in the next two sections. Some of the strength discourses were in conjunction with specific homework activities, and others were simply non-specific articulations of strength.

#### Homework Activities and Strengths

The homework assignments offered occasions for group members to express views that can be understood as aspects of a strength discourse. Again, the comments by caregivers

provided in an indirect way a sharing about caring that is not solely stress and burden focused:

I like the homework, it makes me wonder if after we finish the caregiving group and all of that, if it would be helpful to have our friends and our families help us to set little goals for ourselves, because if it's been helpful to have a homework assignment why do we have to stop just because we're not going to be in this group? I think I'd like to on my own give myself a homework assignment each month, just to motivate me to do things that will help me, strengthen my resolve, to be a good caregiver.

Here are some quotes that spoke of homework having a focusing purpose, first by Jan:

Focus, everything seems so big sometimes and if just one little thing you can think about and accomplish. I've heard the way to eat an elephant is one bite at a time, you know you get it to one thing and do it and you feel good about that, I do. Actually this is what this is about, helping us to feel good about what we're doing and how we're doing it.

And Tom, a co-member of the group with Jan, talked about being focused, in the context of a discussion on relationship triangles and the homework assignment that coincided with that topic:

So, how do you deal with that kind of stress...but to visualize it to the extent that a normal situation that might develop during the day, some problem of some kind, to know that there's a way out. Maybe that's the way out, is looking at it a little differently than I looked at it before. I'll do a lot more thinking about it, I wasn't aware of focusing in like that.

Then in the last focus group interview, Tom questioned and Jan immediately responded. They spoke of a rewarding aspect of homework as it enabled them to make some form of movement in themselves as caregivers:

Tom: Yea, there's a reward there some place isn't it?

Jan: Yea, even if I accomplish just one thing today.

### Non-specific Articulations of Strength

Most examples showed how caregivers talked about strengths in a manner that was not clear cut. For instance, earlier I quoted the words of Deb when she said, "I think I am handling it better." And in the final focus group interview she said:

...but I know I feel like I'm doing a better job since I've been here. I feel better about me, I don't know if that's a true statement or not (laughs), but I feel better, so yea I feel better.

Lynn, in the Blacksburg group with Deb, also commented in the last interview:

I think it's showed us, or has me, the things that I can do that maybe I didn't realize I could or I didn't feel like I was doing the right thing and maybe it, it was okay.

Likewise, there were statements like these from the Salem group:

I think he gave us a lot of information to make us aware of what to do and work to build our strengths.

I think it had a positive effect as far as the entire session was concerned.

So you have, it's introspective, you have to look within yourself and we're looking within ourselves to see how we're dealing and what we're dealing or whether we can be helped and what strength we can get for dealing with the problem we're dealing with, whether it's physical incapability or mental deficiencies makes no difference. A caregiver is a caregiver, right?

In these qualified ways people talked differently about themselves and about their change or strengths in caregiving. I think the best example of a strength-based discourse in all of the transcribed data came from the following excerpt from the fifth focus group interview with the Salem group. All of the group members who were present for that session were contributing to this dialogue and this makes the discussion even more poignant.

Jan: And I saw Alzheimer's as an animal, I saw it as an ocean, big and powerful, and those are just feeling reactions. Then when I thought about it I realized this is what we're looking at, something that has these characteristics is what we're facing.

Pat: It's so powerful we can't handle it, and the care receiver can't handle it.

Jan: But we can handle us.

Pat: We can try (chuckle).

[  
Jan: We can handle ourselves.

Sarah: Can we?

[  
Pat: But we can't handle the disease, we try to handle ourselves.

Tom: We're not always successful in handling it ourselves, we lose control sometimes.

Jan: I haven't heard anybody in here that seemed like they weren't going to make it through, I've heard people say they have hard times.

Sarah: We've got to make it through and that's why we're here, we wouldn't be here if we didn't want to make it through.

Tom: Sure. Jan: Yea.

Pat: I was fixing to say sometimes I wonder and sometimes I think well have I gone as far as I can, can I make it on? The next day comes and I make another day.

Wilma: And then situations may change but we have to accept them too.

Pat: But we know they are not going to get better.

Wilma: Sometimes the situation will be a different situation.

Jan: Our lives have always been like that haven't they, circumstances change in a day sometimes. Something happens in a day and our lives are changed.

Wilma: Yea we change our life.

The caregivers themselves offered competency-based reframes of caregiver stress statements so that perhaps the solution-focus of previous sessions had become infectious somehow!

During the last group session each caregiver was awarded a certificate of strengths (see Appendix H) accompanied with a list of 5 specific strengths (see Appendix I) I had observed in each of them in our group interactions and discussions over the 6 week period. Examples of some of my observations of strengths in various caregivers were these:

She has developed an approach that draws on her calm and patient self.

She learns from the past and builds that learning into the future.

She knows what it is to go through many transitions of caregiving and survive.

She is willing to accept help and cooperate with others in caring.

She can talk about her experiences of caregiving and thereby help others to understand their own situations.

He can speak about his needs, reveal his emotions, and set goals that lead him into action.

She is an investigator who seeks out caregiving information.

Thus far in this section I delineated two categories of strength discourse in this study, those linked to specific homework activities, and those more non-specific articulations of strength. These are the types of strengths that I think caregivers, researchers, and practitioners with caregivers need to expand and make more visible to one another. A strength discourse in caregiving is available for learning and information, but caregivers, scholars, and practitioners will need to look for it. Such a perspective can question the assumptions that lie behind the overarching stress paradigm so dominant in research, practice, and in caring.

Next, some of the data from the last focus group interviews provided information about differences between this group experience and other support groups that they had attended prior to this one, and about caregivers' views of me as a group leader or therapist. This information is included under the following two subheadings of group distinctiveness and group views of therapist.

### Group Distinctiveness

A number of previous investigators have described the factors that group members selected as most important to them as a result of being in the group (Bloch & Crouch, 1985; Bednar & Kaul, 1994). The most common factors included catharsis, self-awareness, and

interpersonal input (Yalom, 1995). So in this study, did the incorporation of certain competency-based interventions make the groups different? The answer is yes and no. No, in that this study showed agreement with prior studies in regards to how catharsis, self-awareness, and interpersonal input were important factors to the members as expressed in the following data. But yes, in that members reported how this caregiver group experience was different for them as they compared it to other caregiver groups previously attended by them.

One difference noted by Lynn in the Blacksburg group resulted from her comparison of this group to a monthly group she attended in another location. She liked the once per week meeting schedule of the Blacksburg group as well as the group composition that included the same people each week:

I think it (meeting weekly) was better for me because I've tried to be in a support group in Pearisburg too, but a month is a long time and they are not the same people each time. Here all of us sort of know each other and know what we're going through and I'll know if she's (referring to another member) had a bad week or if she's (referring to still another member) had a good week.

Also, a brief excerpt from the Blacksburg group that involved some dialogue with verbal contributions from all members except one showed how the group size and home-like atmosphere of the meeting location made it distinct from other caregiver groups.

Saliha: Now that you've completed this group you must have come with some expectations you had, experience with some other caregiver groups. So looking back what do you see as being different here in this group?

Hanna: I say the fellowship.

Mae: Yea we were small and got close. I think if you're in a big support group where there are 15 or 20 you are a little bit timid to speak out.

Lynn: Here we didn't have that problem.

Deb: And it's relaxed, you know you've got your recliners, it's almost like sitting at home talking, so it is relaxed.

A longer excerpt from the interview with the Salem group also demonstrated how catharsis, self-awareness, and interpersonal input were important to the members. At the same time this excerpt made evident the distinctions caregivers noticed between other groups that were more support oriented in nature and this group that provided "depth."

Saliha: Here we are last session and it's gone fast. When you go from here today, when you leave, there will be times when you may talk to other caregivers and when you talk about this group I was wondering what would you tell them about the group?

Tom: Well I'm gonna tell them if they have a chance to go, then go, attend something and just let it be able to identify themselves with other people who have the same kind of problems, or you know, be aware.

Wilma: Learn how to cope.

Tom: Learn how to cope, try to gain some kind of strength, and just be willing to share I guess.

Pat: Sharing with other people means a whole lot.

Sarah: I think those care support groups, have you been to the other support groups, they are so helpful, they really are.

Wilma: They have one here, it's at 1:30 on Tuesday.

Sarah: And my support group where I attend is at Liberty and that's the 4th Tuesday.

Tom: How do you compare that with this? Wilma, how do you compare that with being at this group meeting?

Wilma: I think this was more in depth than the other group, it meets as a support group most of the time.

Sarah: This one was instruction where as that...

Wilma: Yea and he has this diagram, you know he has something to work, where it's just sort of to share and talk to each other there.

Tom: More of the sharing and just being there.

Sarah: Just interacting with each other whereas this does more instruction.

Pat: This one goes deeper than the support group. It went deeper into your emotions and therefore you were able to get more of your problems out and interact with other people's problems.

Wilma: See he talked about the triangles, the windows.

Sarah: And the goals, and it's been very helpful, where we don't do that in the support group.

Caregivers linked some of the competency-based interventions and group exercises to a felt difference in this group that was expressed as depth, therefore making it distinct from other caregiver groups they were familiar with and had attended in the past.

One of the findings from this study that was not supported by prior research on groups had to do with the issue of guidance. Yalom stated that prior research has shown that guidance was one of the least valued factors in the group experience according to participants' reports (1995). As I showed in the previous discussion of the guidance theme (p. 61), group members from both locations valued the acquisition of new knowledge and skills related to caregiving and at times were direct in asking for it.

#### Group Views of Therapist

It was not surprising to find that the participants' views about their relationship to me as a therapist were supported by prior research. Studies have shown that clients perceived warmth, acceptance, and genuineness as vital ingredients of successful therapeutic relationships (Bergin & Garfield, 1994; Truax & Carkhuff, 1967). Over 30 years of research has demonstrated that it is not the superiority of one therapeutic model over another that clients value most, but the client's

perception of being heard and understood.

The participants for this study valued the personal elements of the relationship with me and the accepting, relaxed style. Here are several comments from Lynn and Mae of the Blacksburg group, and lastly Jan from the Salem group:

His mannerism, you know like she said he was a leader but he didn't take over. Relaxed, I guess casual. If he had come in here with a shirt and tie and stood up do you think any of us would have said a word (laughter).

Yea, he's laid back. Alan has the ability to ask questions that make you stop and think, you know he has a quality to bring out what's on your mind.

I think he's an excellent counselor in the sense that he is good, he draws each person into the group and he's interested in what people had to say, very willing to listen and direct conversation. Sometimes I was impatient, I wanted to get through a little bit faster. Especially the start, I wanted to get on with it. I went through a lot of trouble to get here and I know everybody has a style, I was really impatient to get on.

I really did not expect group members to offer negative feedback on their relationship to me since they knew the information would be reported back to me. However I do think a positive and accepting connection was present in my relationship with both groups.

### **Conclusion**

Findings of this exploratory research were presented in a three part narrative. I attempted to deploy the data and organize it in a way that wove a story line about the experiences of the caregivers so that it attended to an emerging strength discourse. Theoretical notions and previous research provided a heuristic value that allowed me to reframe the study of adult caregiving from my own unique perspective. I made connections in the data across both groups and group settings by looking at it as a whole, rather than making the contrasts and differences between the group more prominent.

## CHAPTER V: SUMMARY

### Reflections

I find it difficult to think about this research without connecting the experience to other aspects of myself. The project incorporated parts of me as a person with family relationships and personal history, and as a professional with career development and changes.

The study started from a very personal place. While growing up as a child I had a younger brother (Artie) who at the age of 18 months was diagnosed with an incurable blood disease known as aplastic anemia. Our mother served as his primary caregiver for 17 years, a caregiving career that ended only by his death. Artie required various levels of care for those 17 years that were demanding both physically and emotionally.

Yogi Berra, the famous New York Yankee baseball catcher was known to have said, “You can observe a lot by watching.” Throughout those 17 years I watched and observed my mother in her caring, and noticed that the experience contained more than a problem orientation. Often it was very stressful for her and I could see that in her mood, attitude, and emotions. Her worry would show in her face and eyes at times. Yet her experience was not only stress focused. I also observed her strength. I saw how she handled herself and situations in caring with a power and fight, a tenacity simply to do what had to be done. I saw how she went on living and allowed the family to do the same in as normal a way as possible. My experience of being reared in a family with illness and caring was a large part of how this research endeavor got started.

Caregiving of a child certainly has differences from caring for an adult family member. However the differences should not negate the potential for finding commonality. The sense of strength I observed in a parent caring for her child is available in adult caregivers as well. This

study was designed to learn about adult caregivers strengths.

Situations can be viewed from alternative perspectives. Stress and burden are words most familiarly used to conceptualize caregiving. This is true in everyday lived experience as well as in the scholarly research, trade books, and articles on the subject of caregiving. Most caregivers can talk about how difficult and stressful it is for them to care for another adult person who has physical or mental impairments. I have noticed in various settings that fewer caregivers are asked to talk about the competence, strength, or growth components of their experiences. This lack of inquiry into caregiver strength is reflected in the literature. The focus of professional researchers and practitioners in the field has largely been engulfed in a problem/pathology mindset when it comes to the issues related to caring activities of adults.

The same caregivers who can inform researchers and practitioners of the stressful aspects of what they experience, also have much to teach themselves and others about their ability to care with some measure of competence and strength. Usually this under-prized piece of their conversation about caring stays hidden and neglected. In this study I set out to explore caregiver strengths.

My desire was to find new ways of looking at familiar experiences of caregiving in order to bring about change in those experiences and how caregivers and professionals perceive them. I observed these experiences in a context of group support and therapy for caregivers. The aim was to learn about their strengths with a competency-based therapeutic approach at the helm of my interactions with them. My hope was to engage people's interests about a less visible aspect of caregiving and open up new thinking and possibilities for action.

This research was in relation to practice, and although it did not have to be practical it

turned out to be that way. I hope it provides a contribution that will make a difference in how people work with caregivers, and in how they think and relate to them. In addition, my hope is that this study enhanced the participants' perceptions about themselves as caregivers. I know that for me the research has been a significant learning experience. A glimpse of how I felt about my group interactions with the caregivers was recorded in my field notes. On August 20, 1997, at the conclusion of the last caregiver group meeting I wrote these words:

I am feeling very positive about my work in doing these groups this Summer. As I look back on it I think I have put together a program that is beneficial and unique for caregivers. I do think I should continue to develop and use my ideas and expand it further.

### **Nature of Findings**

I presented the findings with a narrative style that is more conversational than empirical in some ways. At the same time, in reading the findings I think it is possible to overhear the theoretical implications when I have not presented them straightforwardly or directly. The caregivers and their voices were given priority. In my view this presentation was consistent with the fact that I had multiple meetings with the same group members over an extended period of time, and the relationship between us developed some "depth" as several of the group members described it. Therefore the participants, in their words (transcripts) through my observations of them, became the teachers.

Representative quotes were chosen in interpreting the data. My research assistant read this report and thereby added a form of triangulation of the data and findings. It is important to note that how people interacted in the groups was an influence on the nature of the findings. People who are more comfortable speaking out in groups can receive more "air time." Although

representative quotes were chosen and an attempt was consciously made to allow all voices to be heard, some voices still dominated. Tom, Pat, Lynn, Mae, and Deb were often quoted and this was because they were the most verbal people in their groups.

### **Clinical Implications**

The six co-constructed themes (self-care, guidance, togetherness, separation, relationships to family members, caregivers as experts) that emerged from this study offer a helpful foundation for building caregiving from a strength perspective. The qualitative and ethnographic approaches utilized made ostentatious interpretations of the findings inappropriate, but they do provide a rich description of caregiver experiences in two separate group settings.

Though limitations exist in regards to the generalizability of the results, some implications for practitioners are warranted. First, this was the first study by a family therapist that used ethnographic methods to understand competency-based techniques in a group setting with adult caregivers better. It is important to note that although caregivers were receptive to the idea of building their strengths, the need to talk and express the stressful aspects of caregiving continued to be ongoing for them. This need on the part of caregivers to talk about their stress was stronger than I anticipated and a somewhat surprising finding for me. The solution-focused principle that “you need not know a lot about the problem to solve it” must be tempered with adult carers. It was important for them to have the opportunities to express their problems in caring, and then make movement toward other ways of thinking and feeling about them. The Ericksonian style of pacing the complaint and leading to competence seemed to fit well in this context (Erickson & Rossi, 1979; Grinder & Bandler, 1981). It is useful for practitioners to continually stay in pace with the caregiver’s stress talk. It is this pacing ability to build rapport

that can offer opportunities for leading to strength. So an awareness on the part of the therapist to be flexible with the application of competency-based techniques with caregivers is necessary.

In connection with this is another significant implication to be mindful of as practitioners work with caregivers. Caregivers may have prior experiences in support groups. Often support group settings perpetuate the familiar stress discourse and victimized status of caregivers. Their background in groups may appoint them as passive recipients of knowledge and they can bring that stance to a solution-focused group. This is an impediment to recognizing their own resources and strengths. Group leaders will benefit by being cognizant of this fact and making adjustments accordingly. This study helps to show that caregivers benefit not only from the two common types of caregiver formats that include the non-directive, supportive type and the fact-giving, psychoeducational type of groups, but also need a focus on developing a sense of caregiver competence or strength. The combination of these three legs of the group structure, (1)time to ventilate and experience shared belonging, (2)factual information and guidance, and (3)strength awareness and development, are each vital aspects to include in a caregiver group. Prior to this study, the third leg of developing caregiver strength obviously was missing from group work with caregivers.

A third implication relates to the homework assignments made to group members. Though caregivers are often perceived as already overburdened, the group members were surprisingly responsive to the homework activities. They found homework to be a helpful means to get them thinking differently about their situations. Here were comments made by some of the caregivers:

I like having a homework assignment because I thought about this group during the week and I thought about what we talked about, that's important.

I find it interesting to know that we have an assignment, gets you thinking about what you can bring back as input that will help the group, and establish in your own mind that you're working towards a goal, working towards something, thinking about it.

Well I think it's very thought provoking for me, especially tonight and then well I enjoyed the homework assignment that we had last week too.

Solution-focused family therapy models have emphasized the value of homework between sessions (de Shazer, 1988, 1991). It turned out that the homework assignments for these groups was a central aspect of the content of each subsequent group session.

The establishment of personal goals for each of them to focus on during the six sessions helped to maintain progress and momentum in the group. Examples of their goals included areas such as:

I want to stop being so angry.

My goal is to learn how to be more patient.

I want help with what to do when I get so frustrated at my husband.

I am concerned with how belligerent I get and need to work on that.

These goals were recorded by the caregiver on the goal setting handout (Appendix D), and the caregivers brought them back to the next session and we discussed the goals. As seen by the examples listed above, often the goals caregivers came back with were not very clear or specific. I worked with one or two caregiver goals in the session in order to make it more clear and clean according to the 5 P's outlined in the handout. This process allowed other caregivers to observe how to make their own goal more specific and behaviorally measurable. In subsequent sessions the caregivers were asked about their movement toward goal accomplishment and discussions were held about their progress as needed. Practitioners need to be aware that caregivers may

need additional help in clarifying their goals.

As reported in the findings chapter under the theme of **separation**, the strategy of externalizing the problem contributed to an especially powerful group process. The unexpected impact of this technique is worth further exploration. It means that clinicians and clients can benefit from expanding or adapting various competency-based ideas to a group setting. In addition, for therapists who work with mentally or physically impaired persons and their families it implies that such clients may benefit from some technique that helps them to obtain distance from the illness or disease.

Finally, with the dearth of articles on issues related to aging in the leading marital and family therapy literature (Amburg, Barber, & Zimmerman, 1996), it is important that clinicians share their knowledge and experience about how various approaches were received by older adults and their families. Also, since most professionals who have led group interventions have been nurses or social workers (Campbell & Patterson, 1995), family therapists are urged to consider how their skills are needed and can be useful with this client population.

### **Research Implications**

The qualitative design employed in this study offered a good fit for me in my roles as both therapist and researcher. The specific approaches of ethnography and action research were methods that fostered engagement of participants in the research process and likewise resulted in practical outcomes for them. I did not experience major tension in my roles of both therapist and researcher. I think it was easier for me to be in the role of therapist because the researcher role was newer to me. I recall experiencing some anxiousness in the very first group meeting when it was necessary to explain the research consent form and have participants sign it. Although I had

much prior experience obtaining consent from people as a therapist, it somehow seemed new and different to me as a researcher acquiring consent for research. Future researchers in group settings may want to consider the option of getting consent from participants on an individual basis before the first group meeting. There were not any problems doing it as a group, but I am simply aware of my anxiousness in the first meeting of the Blacksburg group. This was not the case with the first meeting of the Salem group three weeks later, when by then my anxiety about this piece of the process had subsided.

More studies are needed that explore the usefulness of competency-based therapy approaches in groups and with different client populations. In the current practice environment within the United States more and more clinicians are relating to managed care networks. Often these networks are very receptive to competency-based treatment plans as well as to group interventions. Future studies can continue to make therapy research relevant to practice while learning more about particular interventions with certain niches of clientele.

There is a need to conduct studies that are more quantitative and experimental in nature to test the effectiveness of particular interventions. This study was limited in its scope by the nature of sample size and purpose in order to obtain thick description of caregivers' experiences. Future researchers could develop methods that measure the effectiveness of solution-focused approaches with caregivers as compared to the traditional psychoeducational format often employed with caregivers in a group setting.

Finally, another point to consider for future research is related to focus group interviews. An outside person (as opposed to myself) conducted the interviews for this study and this was easily incorporated into the therapy and research processes. Future researchers may consider the

option of being the therapist and focus group interviewer as well. Interviews for this study were conducted following each therapy session and were 20 to 30 minutes in length. In subsequent studies consideration can be given to the frequency and length of focus group interviews. There was value in having the interviews after each group therapy session as an ongoing and immediate feedback device. There can also be value in less frequent and immediate interviews that may provide a more reflective stance for participants and move toward obtaining their views in a less immediate context. I am sure such an approach would access a different kind of data and feedback from respondents.

### **Conclusion**

A discovery oriented, exploratory method was taken to learn about the use of a competency-based group approach with adult caregivers. My role as a practitioner/researcher placed me in the traditions of ethnography and action research. The participants' roles as group members/co-researchers placed them in those same traditions.

New impressions and experiences about caregivers and competency-based group therapy were attained and presented in a three part narrative that described under-utilized and non-stereotypical aspects of adult caregiving. Two spheres of discourse were noted in the literature and in group interactions, a stress discourse and a strength discourse. While mindful of the paradigms of thinking that dwell on caregiver stress, I have explored new options that build on a strength paradigm of caregiving.

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## Appendix A

### Blacksburg Group

Hanna is a 71-year-old black female and considered as the “patient” caregiver in her group. Although she describes her own health as poor, she cared for her husband for the past three years. Two days of the week she enjoys a break from caregiving while her husband participates in the Virginia Tech Adult Day Services program. She was the only person who cared for a spouse in the Blacksburg group.

Mae is a long distance caregiver of her sister who has Alzheimer’s disease and lives in Arizona. She is a 67-year-old married white female, and the newest caregiver in this group. Mae is a very verbal contributor to the group and has the ability to be open and encourage others to be open.

Lynn is a 52-year-old white married female. She is employed as a bank teller and has been caring for her mother with Alzheimer’s disease for one year. Her mother continues to live with her father in their own residence separate from Lynn.

At 45 years of age Deb is the youngest of all the caregivers. She has cared for her mother for the past 3 years but maintains a separate residence from her, though she lives in the same town. Deb is a divorced white female and works full time as a human resource manager.

Mary, Deb’s sister-in-law, is a 51-year-old married white female. She works full time as a secretary/bookkeeper and also lives in the same town as Deb. She is married to Deb’s brother and sees herself as a caregiver to her mother-in-law as well as to her own sister.

### Salem Group

At 77 years of age Wilma was the oldest caregiver of both groups. She considers her own health to be poor and cares for her husband for the past 2 years. She is a married white female and does not work outside the home.

Tom is the only male caregiver in either group, and the next oldest member. He is a 76-year-old married white male who, like Wilma, cares for his spouse. He provides more physical care than any other caregiver and much of it is very demanding. He has been a caregiver for the past 5 years.

Esther is a 66-year-old married black female. She is not employed outside the home and holds this in common with all the other caregivers in her group. She has cared for her husband for the past 3 years.

Eileen is a 61-year-old single black female. She lives with Esther, her sister, and helps in caring for Esther's husband, her brother-in-law. Eileen and Jan are the only 2 caregivers in this group who are not caring for a spouse.

The youngest and newest caregiver in this group is Jan who at the age of 55 has been caring for her mother for the past 6 months. She is a single white female and has recently relocated and moved in with her mother after living 6 hours away from her.

Pat is a 69-year-old married white female. She lives with her husband and has cared for him for the past 8 years. Her husband has Alzheimer's disease.

Sarah is a caregiver for her husband who is in a nursing home at the time. She is a 73-year-old married white female, and the only spousal caregiver who does not live with the spouse. She has been a caregiver for 12 years, more years than any of the other caregivers.

# BUILDING YOUR STRENGTHS AS A CAREGIVER

Do you have responsibility for care of an older person or an adult with disabilities, dementia, illness?

Is it time for you to focus on your strengths and inner resources rather than be limited by your stress?

**A GROUP IS BEING FORMED JUST FOR YOU!**

**A FREE 6 WEEK PROGRAM OF GROWTH AND SUPPORT  
IS BEING OFFERED BY DR. ALAN WILLARD, A LICENSED  
PROFESSIONAL COUNSELOR AND ORDAINED MINISTER**

**IN PULASKI**

Time is 1:30 - 3:00pm

Dates: On Fridays

July 25, August 1,8,15,22,29

Where: Area Agency on  
Pulaski

Call 639-9677 or 980-7720

to sign up or for more info

**IN BLACKSBURG**

Time is 6:30 - 8:00pm

Dates: On Wednesdays

June 25, July 2,9,16,23,30

Where: Adult Day Services Aging in  
of Virginia Tech

Call 231-3160 or 552-8048

to sign up or for more info

Reservation is required, spaces are limited so sign up early

**TAKE ADVANTAGE OF  
THIS EXCELLENT OPPORTUNITY!**

# **BUILDING YOUR STRENGTHS AS A CAREGIVER**

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WHERE: ADULT DAY CARE CENTER AT THE  
VETERANS MEDICAL CENTER IN SALEM

WHEN: ON WEDNESDAYS -- JULY 16, 23, 30  
AUGUST 6, 13, 20 10:30AM - NOON

Call 552-8048 or 983-1026 to sign up or get more info  
Reservation is required, spaces are limited so sign up early

**TAKE ADVANTAGE OF  
THIS EXCELLENT OPPORTUNITY!**

Appendix C  
**VIRGINIA POLYTECHNIC INSTITUTE  
AND STATE UNIVERSITY**

**Informed Consent of Participants of Investigative Projects**

Title of Project: Building Adult Caregiver Strengths

Principal Investigator: Alan Willard and Rosemary Blieszner

**I. THE PURPOSE OF THE PROJECT**

The purpose of this study is two-fold. First you can help me learn about the strengths of caregivers. Second, I want to learn about what works in building your strengths. Specifically, I ask you to participate in a support group for caregivers that will focus on strengths and solutions rather than on stress. There will be no fewer than four and no more than eight members in the group.

**II. PROCEDURES**

You are among a group of caregivers who will meet to discuss the positive aspects of caregiving. The group will meet one time per week for six weeks. Each group will last 90 minutes. I will conduct the support group for the first 60 minutes. We will work on ways to overcome caregiver struggles and build strengths. The group sessions will be audiotaped. A research assistant will sit in, observe, and take notes on the group sessions.

After a 10 minute break, the final 20 minutes will be an interview. My research assistant, Saliha Bava, will interview you as a group. She will ask you questions about the session I had with you. Of course, you may refuse to answer any questions. This group interview will be audiotaped, and I will transcribe it later. All tapes will be stored in a locked file cabinet in my home and will be destroyed upon successful defense of the dissertation.

**III. RISKS**

The risks from your participation in this project are minimal because you will answer only those questions you wish to answer and discuss only those issues you wish to discuss.

**IV. BENEFITS**

No promise or guarantee of benefits are being made to encourage you to take part in this project. You may learn something about yourself as a caregiver, and about the strengths that you bring to the caregiving experience. Your views will help other caregivers and professionals have a better awareness of how caregiver experiences are different.

## **V. EXTENT OF ANONYMITY AND CONFIDENTIALITY**

Every measure will be made to keep your name anonymous. Your name will not be included in the interview transcripts or in any publications that might result from this research. Instead, you will be assigned a fake name or code number. Your signature below indicates that you are aware that the sessions are being audio taped. All tapes will be secured in a locked file cabinet in my home and will be destroyed upon successful defense of the dissertation.

## **VI. COMPENSATION**

Other than by my sincere appreciation you understand that you are not being compensated for your participation.

## **VII. FREEDOM TO WITHDRAW**

You can refuse to answer any question, and you may withdraw without penalty from this research at any time by simply informing me at 540-552-8048 or my e-mail(gwillard@vt.edu).

## **VIII. APPROVAL OF RESEARCH**

This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University, and by the Department of Family and Child Development.

## **IX. PARTICIPANT'S RESPONSIBILITIES**

I voluntarily agree to participate in this study. I have the following responsibilities:

\*Attend all six sessions and the group interviews

## **X. PARTICIPANT'S PERMISSION**

I have read and understand this form and agree to the conditions of this project. I have had all my questions answered and acknowledge the above and give my voluntary consent for participation in this project. I understand that I may withdraw at any time without penalty.

---

Signature of Participant

---

Date

Should I have any questions about this research or its conduct, I should contact:

Alan Willard, Principle Investigator	552-8048
Rosemary Blieszner, Faculty Advisor	231-5437
H. Thomas Hurd, Chair IRB Research Division	231-5281

**INFORMED CONSENT FORM**

I \_\_\_\_\_ am aware that the Caregivers Strengths Group is being video-taped for educational and training purposes. I give permission to the group facilitator to show/screen parts of the sessions in which I appear for education and consultative purposes, including but not limited to professional conferences and scholarly publications.

I have read or had explained to me all the above terms and have signed below to indicate my voluntary consent to these terms.

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of facilitator

\_\_\_\_\_  
Date

## Appendix D

### HOMEWORK ASSIGNMENT

Develop a goal(s) for yourself. Here are the 5 P's for your goals:

- ◆ Make it *Particular*. Your goal is for **you**, so make it individual and specialized for you. Not vague, but easy to recognize. Concrete behavior that can be observed by yourself or others.
- ◆ State it *Personally*. In your language and within your control. Identify a goal you can start and maintain by yourself right now. The goal can not depend on someone else or some condition changing first.
- ◆ Make it *Puny*. Small rather than large, it is achievable and easy to do.
- ◆ State it *Positively*. What you will be doing, thinking, or feeling rather than what you will not be doing, thinking, or feeling.
- ◆ State it *Presently*. In the here and now, not way out in the far, remote future.

Example:

A shy person's goal without the 5 P's:

I want to become completely carefree and uninhibited in social settings.

A shy person's goal using the 5 P's:

I want to look at a stranger and say "Hello."

Now, write below your particular, personal, puny, positive, and present goal or goals. Please bring this with you to our next session. Thank you.

Goal #1--

Goal #2--

Goal #3--

***Alan Willard, LPC, Carestrengths 302 Hemlock Dr. SE Blacksburg, VA 24060  
540-552-8048, gwillard@vt.edu***

## Appendix E

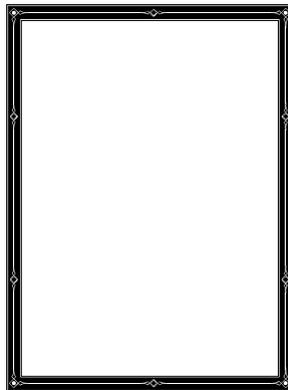
### HOMEWORK ASSIGNMENT

Part 1-- Do something that will show some action or movement toward your goal this week.

Part 2-- Each of us has a window through which we view ourselves, others, the world. The windows we look through tend to frame how we see things. You have your own unique window from which you view your life and caregiving. **YOU** know more about your situation than anyone else. Your views provide powerful strengths and contain inner resources that will help you deal with problems.

Teach me what it is like for you. Around the window below I would like you to write out four words, phrases, or sentences that give glimpses into your view of things. These can be feeling or thoughts you often have, values or beliefs you hold, ideas or attitudes. There are no right or perfect answers, this is **your** personal window.

Please bring this with you to our next session.



Alan Willard, LPC, CareStrengths, 302 Hemlock Dr. SE Blacksburg, VA 24060  
540-552-8048

Appendix F

HOMEWORK ASSIGNMENT

Part 1-- Continue to do something that shows some action or movement toward your goals this week.

Part 2-- Next week I will talk with you about stress as a triangle in our relationships and how dementia, PLS, or Alzheimer's can be a part of that triangle. I will also bring "The Alzheimer's," "the PLS," and "the dementia" to our next session.

In preparation for our next session I want you to think of some ideas, concepts, and behaviors that make up "The Alzheimer's, dementia, or PLS" as you notice it in your own experience this week. As a way to get you started, fill in the following incomplete sentence:

I am "The Dementia," and I am like \_\_\_\_\_

\_\_\_\_\_.

I am "The Dementia," and I am like \_\_\_\_\_

\_\_\_\_\_.

I am "The Dementia," and I am like \_\_\_\_\_

\_\_\_\_\_.

I am "The Dementia," and I am like \_\_\_\_\_

\_\_\_\_\_.

*Alan Willard, LPC CareStrengths 302 Hemlock Dr. SE Blacksburg, VA 24060  
540-552-8048, gwillard@vt.edu*

## Appendix G

### HOMEWORK ASSIGNMENT

#### Part 1 -- “Triangles”

Notice the triangles that you are in, and be aware of times when you get into or stay out of a “triangled” position. How did you get triangled? How did you keep from becoming triangled?

List below some of the common relationship triangles that you have been involved in this past week?

#### Part 2 -- “The 4 C’s of Caregiving”

Caregiving might be described in one of the following four ways:

Cooperation -- willingness to act or work together.

Competence -- capable, adequate, fit and able.

Compliance -- yielding to another, giving in to a rule, request, or demand.

Competition -- to vie with another, to contend as in a rivalry.

**Especially notice** those times in the coming week when **cooperation** and **competence** best describes you or the care receiver. Make a note of those times below:

**Alan Willard, CareStrengths, 302 Hemlock Dr. SE Blacksburg, VA 24060  
540-552-8048**

## ***CareStrengths Program -- 1997***

**Tom** possesses the following strengths as a caregiver:

1. He is committed to reaching out for support and getting the help he needs.
2. He can identify his anger and is taking steps to change in relationship to it.
3. He knows “The PLS” very well, and can describe it with detail and creativity.
4. He is able to view himself as a person who gives good care.
5. He can speak about his needs, reveal his emotions, and set goals that lead him into action.

## ***CareStrengths Program -- 1997***

**Jan** possesses the following strengths as a caregiver:

1. She can think with creativity and offers ideas and questions to help others.
2. She begins a new process with hope and determination.
3. She is open to new ideas and can incorporate them to be meaningful to her needs and situation.
4. She is able to set concrete goals and act on them.
5. She finds ways to chart a new course and adapt through change and stress.

## VITA

**G. ALAN WILLARD**  
302 Hemlock Dr. SE  
Blacksburg, Virginia 24060  
540-552-4608

### EDUCATION

Doctor of Philosophy (1998) Marriage and Family Therapy	Virginia Polytechnic Institute & State University Department of Family and Child Development Blacksburg, Virginia
Doctor of Ministry (1987) Pastoral Care and Counseling	Southeastern Baptist Theological Seminary Wake Forest, North Carolina
Master of Divinity (1980) Pastoral Care and Counseling	Southern Baptist Theological Seminary Louisville, Kentucky
Bachelor of Arts (1977) Religion and Philosophy	Bluefield College Bluefield, Virginia

### PROFESSIONAL EXPERIENCE

Marriage and Family Therapist March 1998 - present	Carilion Behavioral Health Roanoke, Virginia
Marriage and Family Therapist January 1997 - April 1998	The Family Place Roanoke, Virginia
Marriage and Family Therapist August 1996 - present	Pastoral Counseling Center Roanoke, Virginia
Marriage and Family Therapist May 1995 - June 1996	Center for Family Services Blacksburg, Virginia
Adjunct Instructor, Counseling Dept. January 1995 - June 1996	West Virginia Graduate College Institute, West Virginia
Caregiver Group Therapist August 1995 - January 1997	Adult Day Services Center, VPI Blacksburg, Virginia

## **Professional Experience (continued)**

Marriage and Family Therapist  
May 1994 - August 1995

The Family Institute  
Beckley, West Virginia

Pastor  
October 1986 - July 1993

Mechanicsville Baptist Church  
Gordonsville, Virginia

Chaplain/Counselor  
September 1985 - August 1986

Medical College of Virginia Hospital  
Richmond, Virginia

## **LICENSURE**

Licensed Marriage and Family Therapist (#0717), Virginia Board of Professional Counselors and Marriage and Family Therapists.

Licensed Professional Counselor (#2324), Virginia Board of Professional Counselors and Marriage and Family Therapists.

## **RESEARCH GRANTS**

Fahs-Beck Fund for Research and Experimentation, 1997 - 1998.

James D. Moran Memorial Dissertation Award, Virginia Tech, 1996 - 1997.

Graduate Research Development Award, Virginia Tech, 1996 - 1997.

## **HONORS AND AWARDS**

Sigma Phi Omega Professional and Academic Honor Society in Gerontology.

## **PROFESSIONAL TRAINING**

Art and Science of Clinical Hypnosis, 1997 - 1998. American Hypnosis Training Academy, Silver Spring, Maryland.

Post Graduate Program in Family Emotional Process with Dr. Edwin Friedman, 1991 - 1992. The Center for Family Process, Bethesda, Maryland.

Clinical Pastoral Education, 1985 - 1986. Medical College of Virginia Hospital, Richmond, Virginia.

Post-Master's Certificate in Pastoral Counseling, 1981 - 1983. The School of Pastoral Care, Virginia Baptist Hospital, Lynchburg, Virginia.

## **PUBLICATIONS**

Willard, A. (1998). Seeing change when clients don't. In T. Nelson & T. Trepper (Eds.), *101 Interventions in Family Therapy, Vol. II*. NY: Haworth Press.

Willard, A. (1991). When we work too much. *Pulpit Digest*, 72, 39-41.

Willard, A. (1989). Review of Behind the masks: Personality disorders in religious behavior. *Search*, 19(4), 60.

## **THESES**

Willard, A. Using an integrated competency-based group approach in building adult caregiver strengths. Unpublished Doctoral Dissertation, Virginia Polytechnic Institute and State University, (Rosemary Blieszner, Ph.D., Advisor), 1998.

Willard, A. The use of the genogram in the pastoral care of patients coping with chronic or terminal illness. Unpublished Doctoral Project in Ministry Report, Southeastern Baptist Theological Seminary, (Robert D. Dale, Ph. D., Advisor), 1987.

## **PROFESSIONAL PAPERS, WORKSHOPS**

Willard, A. (1996). The Effectiveness of Solution Focused Group Therapy in Building Adult Caregivers' Strengths. Roundtable discussion presentation at the Gerontological Society of America annual conference. Washington, D.C.

Willard, A. (1996). Strength-Based Caregivers' Group. Workshop presented at the Southeastern Symposium on Child and Family Development. Greensboro, NC.

Willard, A. (1995). Successful Aging and Nonnormative Parenting. Paper presented at the Fall Institute on Aging annual meeting. Richmond, VA.

Willard, A. (1994). Therapeutic Letters: Effects on Clients' Perception of Therapy. Paper presented at the Southeastern Symposium on Child and Family Development. Knoxville, TN.

## **PROFESSIONAL MEMBERSHIPS AND AFFILIATIONS**

American Association for Marriage and Family Therapy (Clinical Member and approved Supervisor in training)

Association of Clinical Pastoral Education (Advanced Standing)

Mental Health Association of New River Valley

## **PROFESSIONAL PRESENTATIONS - Local**

Willard, A. (1998). Solution focused parenting. In-service training for medical staff of Giles Memorial Hospital. Pearisburg, VA.

Willard, A. (1997). Depression education for clergy. Four part series presented for the Mental Health Association of New River Valley. Blacksburg, VA.

Willard, A. (1996). Building strengths and managing stress: A solution focused approach. Workshop presented for the Area Agency on Aging. Pulaski, VA.

Willard, A. (1996). Stress: How to recognize and reduce it. Workshop presented for the Postal Service Executive Conference. Roanoke, VA.

Willard, A. (1996). Spirituality and the pastor. Seminar presented for the Ministerial Association of Giles County. Pearisburg, VA.

Willard, A. (1995). The role of the hospital chaplain. Chaplaincy training for Giles Memorial Hospital Chaplains Program. Pearisburg, VA.

Willard, A. (1995). Pastoral care in the brief hospital visit. Chaplaincy training for Giles Memorial Hospital Chaplains Program. Pearisburg, VA.

Willard, A. (1994). Grief, dying patients, and their families. In-service training for Home Health Department, Giles Memorial Hospital. Pearisburg, VA.