Counseling the Younger Elderly—A Responsive Approach*

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The Freda Mohr Center of Jewish Family Service of Los Angeles is a storefront, walk-in counseling service for the elderly. This paper describes the work of the Center and discusses the emphasis placed on responsiveness in program planning. Three specific Center programs are outlined as methods of counseling particularly appropriate for use with many of the "younger elderly" clients who come to family service agencies.

As the Coordinator of the Freda Mohr Center, a storefront walk-in counseling service for the elderly, I am frequently asked how we are different—that is, how the counseling and other services we offer differ from those a client might receive in a more traditional setting. My reply, as indicated by the title of this paper, is that we attempt to deliver our services responsively, and to adapt as quickly as possible to the needs we are seeing at a particular time. By this I suggest more than the responsiveness of the worker to the individual client, which is inherent in all social work practice. I am referring, rather, to the responsiveness of the agency, at a program planning level, to the kinds of needs being presented. For a number of reasons—among them our neighborhood setting and our extensive use of volunteers— we are more able to be flexible and therefore to offer this kind of responsiveness than might be possible in a conventional program.

The Setting

The Center was, in fact, begun responsively. It was created in an attempt to answer the needs of the aged people living in the "old Jewish" Beverly-Fairfax area of Los Angeles who were not effectively or easily served by the more traditional programs offered through the district offices of Jewish Family Service. The hope was that the visibility and accessibility of the Center, located in the group of stores which comprise the shopping area of the neighborhood, would encourage people to come in for help with their problems. The openness of the setting was designed to diminish feelings of humiliation at the prospect of asking for help—a characteristic response of the poor, first-generation, Yiddish-speaking, unassimilated elderly people for whom the Center was originally designed. It was the aim of "The Storefront" (its original name) to help clients deal with the problems of aging as normal and natural concerns, rather than as functions of disease or personal inadequacy for which they might feel embarrassment and shame.

The Setting—Seven Years Later

In the seven years since the program began, many changes have taken place. The original drop-in neighborhood center has developed into a kind of community mental health center for the Jewish aged. The number of clients and the demand for counseling have increased daily. There are more and more referrals from other agencies and from psychiatrists, internists and other physicians in private practice who are looking to programs such as ours for their aged patients. We are seeing more severely disturbed elderly who, in another time, might have been in long-term care facilities or state hospitals. Of more relevance to this particular discussion is the fact that we are also seeing increasing numbers of younger elderly people whose needs are often different from those of our older clients.

* Presented at The Annual Meeting of The National Conference of Jewish Communal Service, Washington, D.C., June 6, 1977.

The "Young Elderly"

The "young elderly" are a new group to be recognized. In 1933, the Social Security Administration determined that one is old at 65. Regardless of changes in life expectancy, or in average age of population, or in life styles or quality of life, that definition of aged has remained intact.[1] What has changed, however, is the number of people to whom that definition applies. With ten percent of the population now fitting into this category, further distinctions are necessary. If 65 is "old," then how does one describe the increasing number of people who are over 75? The term, "young elderly," therefore, has begun to be used to refer generally to the individual in his or her 60's or early 70's.[2]

This younger aged person often has very different characteristics and needs from the individual who is in his late 70's or 80's or 90's. The "younger elderly" may even represent a different generation within the same family. At the Center, we are more and more frequently seeing individuals or couples in their sixties who have very elderly parents in their 80's or 90's. Most often this younger group are less in need of the supportive concrete services we offer to the older group and more in search of counseling as they face inter-generational problems with both parents and children, problems associated with retirement, and the need to adjust to the many changes and losses which they are beginning to experience.[3]

Levels of Treatment

In describing a number of the methods of treatment which we have found to be most successful in our work with this "young elderly" population, I will focus primarily on Freda Mohr Center programs, but will draw from work done throughout the agency in staff development sessions and training programs.

The traditional kinds of counseling generally offered in a family service agency are available at the Center. Clients are seen individually or as couples, and in intergenerational family sessions. A recent emphasis, however, has been working more with clients in groups. We have used a variety of models and have instituted a number of creative programs in response to specific needs being presented at a particular time. The groups were designed on a continuum—from prevention, to "coping," to insight-oriented therapy.

Groups for Older Clients

Two types of groups, a group for severely disturbed paranoid clients and some groups created for purposes of reminiscing were directed toward helping the older, more limited client cope with serious problems. The co-leader for the former group was a psychiatrist from Cedars-Sinai Medical Center, who was able to offer badly needed medication to a number of group members once they had developed a relationship with him. These clients did not see their problem as emotional and would not ordinarily go to a psychiatrist for "treatment." They were willing, however, to participate in a group at the Center. The Reminiscing Groups were held in Board and Care Homes for residents who seemed to need this kind of stimulation and support to keep them from becoming more withdrawn and less functioning.

Groups for the "Young Elderly"

With the younger population, other models of groups have been used at each of the three levels of intervention. First, as a preventive approach, Jewish Family Life Development Groups led by volunteer paraprofessionals have offered help to individuals dealing with the normal crises of aging. On a second level, a

1 John Hendricks and C. Davis Hendricks, *Aging in Mass Society*. Cambridge: Wintrop Publishers, Inc., 1977, pp. 51-73.

2 Neal E. Cutler, "The Aging Population and Social Policy" in Richard H. Davis, ed., *Aging: Prospects and Issues*. Los Angeles: The University of Southern California Press, 1977, pp. 122-124.

3 Alida G. Silverman, Beatrice H. Kahn, and Gary Anderson, "A Model for Working with Multigenerational Families," *Social Casework*, Vol. 58, No. 3 (March 1977), pp. 131-135.

"Coping Group" helped to develop peer relationships and as much peer leadership as possible, with the goal of supportive maintenance. Finally, an insight-oriented therapy group, led by professionals, was begun for clients who were interested in examining their behavior and who seemed to be capable of change. I would like to describe briefly our experiences in these three programs.[4]

Jewish Family Life Development Groups

Jewish Family Life Development Groups are being offered more and more frequently by family agencies interested in offering service at a preventive level. These groups help clients deal with stresses typical to particular life stages.[5] Our program offered this experience to five groups of approximately ten clients each, who were facing the "normal" problems of the aging.

The unique feature of our particular program was that the JFLD groups were led by volunteer paraprofessionals who concurrently participated in a training program which was, itself, both experiential and didactic. The goal of the training program was to help the volunteers develop the skills necessary to successfully lead JFLD groups around the issues of aging. Our purpose in devising this type of training program was to enable the agency to meet the increased demand for services to elderly clients at a time when funds were not available to increase professional staff time.

In designing the training program, the agency's Supervisor of Volunteers and I began with a semi-structured format which the JFLD aged groups would follow. From our experiences with other groups, we were able to predict the topics which would be of concern to the elderly group members. We outlined the suggested topics likely to be covered in the eight JFLD aged group meetings and planned our training sessions with the leaders to conform to this outline. A large part of each training session was a group experience for the volunteers, themselves, in which we participated as co-leaders. The sessions were designed to offer both theory and practical experience in dealing with group dynamics and group process, leadership skills, and methods of reporting and evaluation. Modeling of co-leadership roles was an important element of the experiential part of the training.

The training program lasted for twelve weeks and had two stages. The first consisted of four preliminary weekly sessions which dealt with group theory and introduced the concerns related to recruitment of group members. The second stage, which ran concurrently for eight weeks along with the actual JFLD group meetings, prepared the trainees for each following meeting of their own groups and offered supervision and discussion of individual experiences.

The first meeting of each JFLD aged group was devoted to introductions and a survey of interests. Since the lists of group members' concerns in each group were very much what we had anticipated, we were able to suggest that all of the groups use the following outline:

Week #2: Retirement Problems: Structured experiences recalling preretirement life. Expectations of own aging, including factors of health, economics, activities and social and family relationships.

Week #3: Loss and Deprivation: Reminiscing sharing, leading to discussion of methods of coping with loss.

Week #4: Intergenerational Relationships: Exploration of different life styles of aged, children, grandchildren. Importance of each to each other. Family stories.

Week #5: Peer Relationships: Possible activities, interests which may be shared with peers. How to make new friends. Issues of male and female relationships.

Week #6: Work and Leisure: Meaning of work. How to feel useful to self, to family, to other senior citizens. Possible projects.

Week #7: Jewish Identity: Jewish life styles. Inter-generational differences in this regard. Holidays. A Jewish group? Possible transition to a Havurah group. Other alternatives.

In most cases, the final session of the JFLD group was a social event of some sort, during which the future of the group was discussed. Members of two groups expressed the desire for a kind of "cultural" discussion group. These individuals formed a new group which meets weekly under the direction of two of the volunteer group leaders, and discusses books, movies and other topics of interest. Another group was helped to become a Havurah, under the leadership of a retired professional social worker. The other two groups terminated after the scheduled eight-week series.

While a number of clients who participated in these groups were suffering from some degree of depression, the treatment offered was generally preventive. Group leaders reported that, in almost every case, even depressed group members participated in the discussions. While some members, at times, talked of not wanting to "hear others' troubles," they were overwhelmingly positive in their final evaluation of the group experience. This response is corroborated by the JFLD literature which stresses the value of sharing common experiences at times of developmental crises.[6] Thus, with the support and socialization that this kind of group experience offers, many of the younger elderly clients who come to family service agencies can be appropriately helped in the early stages of adjustment to retirement and aging. By providing the client with such help at the time it is needed, more serious future problems may be averted.

It was generally agreed, moreover, that the success of this particular program could not be measured merely by the achievement of its original purpose—that is, the offering of service of a preventive nature to large numbers of elderly clients who could not otherwise have been seen. While the program clearly accomplished this, other benefits resulted from the training of the volunteer leaders. Although group skills were emphasized, for almost every leader effectiveness in working with individual clients was also increased. The added group skills are continuing to be valuable as these volunteers are again serving as leaders of other groups. Most importantly, this type of training offers volunteers an opportunity for self-growth, for the development of new skills, and for new roles. It is thus an incentive for their continued participation in agency programs that need them.

In addition, by employing a number of volunteers, as paraprofessional staff, who are "young elderly" themselves, we are responding to another need. We are satisfying the needs of this group for meaningful activity, for help with their own adjustment to aging, and for a way of feeling truly productive at a time in life when productivity is often "retired."[7]

The "Coping Group"

The second level of intervention which we have used at the Center is a way of offering support and socialization called the "Coping Group." This model was designed by the first director of the Center when it became apparent that many of the people who were coming in for counseling might be most appropriately helped in a particular kind of group setting. These clients, though frequently

4 Other JFS staff were involved in designing these programs and co-leading the groups; Phoebe Sharaf, the agency's Supervisor of Volunteers, worked with the JFLD program, and Stella Kleinrock, a Freda Mohr Center caseworker, was involved in the therapy group. Dr. Rosalyn Benitez, Associate Director of JFS, participated in the planning of both programs and offered supervision. Barbara Kaplan, the first director of the Center, designed the "Coping Group."

5 Joseph Bronstein, "An Experience in Training Staff for Jewish Family Life Education," *Journal of Jewish Communal Service,* Vol. LII, No. 2 (1975), p. 210.

6 Gertrude K. Pollak, *Leadership of Discussion Groups.* New York: Spectrum Publishers Inc., 1975. pp. 9-13.

7 George L. Maddox, "Retirement as a Social Event in the United States" in Bernice L. Neugarten, ed., *Middle Age and Aging.* Chicago: University of Chicago Press, 1973. pp. 357-365.

among the younger group in age, had low self-esteem and were generally individuals who, at that point in their lives, were having difficulty finding supports elsewhere. They suffered from a variety of the losses associated with the aging and, for the most part, did not expect that their situations would significantly improve. The group experience was directed toward helping them, in a protected setting, to find others with similar problems with whom they could form mutual self-help relationships.[8]

The group was designed to be a place where feelings were to be discussed, but also where alternative coping styles would be shared. A large group was formed initially to allow for choices in the development of friendships and for the formation of subgroups. Four facilitators (three volunteers and one professional staff member) began with sixteen group members.

The early meetings provided an opportunity for ventilation of feelings, for the discovery of the commonality of problems, and for the gratification of supportive responses. Facilitators shared some of their own experiences but also, as leaders, were models—setting limits when necessary, encouraging positive and supportive interaction when possible. Friendships did emerge gradually between a number of the group members. Some members remained isolated but did continue to come to meetings.

After an initial twelve-week period, the group assessed its situation and suggested some changes. This involved a mutual agreement to continue as an ongoing group of twelve members and one leader. (The other group members had dropped or were not interested in continuing. Only one staff person was available to continue working with the group.) The format changed over time, and the group became a discussion and social action group which managed to maintain a good many of the supportive bonds that had been established among group members during the initial phase of the group experience.

An Insight-oriented Therapy Group

The third group which I would like to mention represents the most traditional approach we use in group treatment at the Center. This is an insight-oriented therapy group which is co-led, as mentioned above, by professional staff. The group is small, long-term, and open-ended, and is psychoanalytically based. It offers the participants the opportunity, within a protected setting, to examine their patterns of behavior and to risk change.

While this is very much a conventional treatment modality, we find that many professionals are surprised at the use of this kind of group treatment in a program such as ours. Our group members are very different from what has been traditionally considered to be the "ideal" participant in such a group.[9] They currently range in age from 61 to 73. They are almost all European born, primarily low income, without higher education (in every case but one). With two exceptions, they came to us having had no prior treatment, and were generally psychologically unsophisticated.

They are, however, remarkably able to deal with feelings and with relationships. After the initial phase of developing into a group, they have become able to use the group in dealing with feelings of envy, of anger, and of guilt. By examining interpersonal responses within the group, they have been able to develop insight into some of their intrapsychic patterns. What we have found most rewarding, moreover, in working with this group, is that they have shown themselves, in a number of cases, to be capable of change.

In short, they have responded to this type of treatment very much the same as we would expect a much younger group to respond.[10]

[8] Barbara Kaplan, "Recruiting, Training and Retaining Volunteers" in Louise M. Foley, ed., *Stand Close to the Door*. Sacramento: California State University Press. 1976, pp. 61-62.

[9] Robert N. Butter and Myrna I. Lewis, *Aging and Mental Health*. St. Louis: The C.V. Mosby Co., 1973, pp. 231-238.

[10] Irvin D. Yalom, *The Theory and Practice of Group Psychotherapy*. New York: Basic Books, Inc., 1970, pp. 60-81.

Of course, we were selective in recruiting for this group. But, in order to benefit from such a group, clients of any age must be of sufficient intelligence and must not be so well-defended that they cannot examine their behavior. It is certainly true that many people who come to us cannot meet these requirements. What is important for us as professionals to recognize, however, is that many do. Thus, for some elderly, and particularly the "younger elderly," this type of group approach can be most effective.

The Role of Staff Development

In the program I have mentioned, and in all of our work with this population, a number of agency staff development sessions were particularly helpful. A series of seminars on the use of psychotropic medication, given by a psychiatrist with a speciality in this field, helped staff to offer clients a coordinated approach to treatment. Since many elderly people can be helped by medication—often along with counseling—our increased knowledge in this area has made us more aware of the need for referrals, of the possibility of side effects, and of ways of helping clients take medication properly. Other staff development sessions on working with holocaust survivors, and on survivor guilt, were also relevant. In all of our work with the aged, we have been able to draw upon the expertise of the agency's Associate Director, who has worked extensively in this field.

Summary

I have mentioned a number of approaches used at our Center with clients in the early stages of aging. While each of the programs was directed toward individuals of a similar age group, there were differences in level of intervention, in type of staff used, and in expectation of how the client might participate. These differences reflect, of course, the wide variety of needs which clients bring to the Center. I have attempted to describe three specific ways in which we respond. What I have tried to emphasize is this responsive element, both in planning and in offering services.