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Structuring reminiscence group interventions for older adults using a framework of mattering to promote wellness.

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STRUCTURING REMINISCENCE GROUP INTERVENTIONS FOR OLDER ADULTS USING A FRAMEWORK OF MATTERING TO PROMOTE WELLNESS

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Herman R. Lukow II

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DEDICATION

"Watching the trapeze artist soar through the air with the greatest of ease, we grasp that this is the most thrilling part of his act. This is where he defies gravity. This is where he flies. We understand that the moment between trapezes is a magical time, the time when anything can happen, the time there is no past, no future, only the present. Though we may sense that this magical midair suspension is all part of the thrill, few of us ever permit ourselves to savor such sweet moments in our own lives."

Gail Blanke
Between Trapezes

This dissertation is dedicated to my fellow fliers who may be beginning to wonder when the other bar will swing close enough to grasp. Your times will come my friends...

the hardest part was letting go.

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There are so many people that assisted and supported me during the doctoral process that I am unable to acknowledge them all adequately. I owe enormous thanks to the entire faculty and staff of the School of Education and the members of my dissertation committee: Dr. McAdams, Dr. Foster, Dr. Bracken, and Dr. Jensen. As I was flailing about in mid flight and doubting that the other bar would ever come, your patience and guidance steadied me, gave me confidence, and convinced me that I belonged in this new life.

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Finally to my mother, you've always been there for me and I know you always will be. You will never know how valuable those daily e-mails were in keeping me feeling connected. Your blessing before the defense removed all fear and replaced it with peace. I will never take you for granted, love you dearly, and hope to make you proud ma.

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ABSTRACT

This study examined if the wellness of older adult residents of a continuing care retirement community was enhanced through the promotion of a sense of mattering to others. A ten-session reminiscence therapy protocol (REM) was developed as a treatment baseline for this study and four tenets of mattering promotion were developed as an additive to the baseline protocol (REMAIR). The hypotheses that drove this study posed that wellness would be enhanced for all participants and that those participants in the REMAIR group would demonstrate significantly greater gains in wellness and mattering than participants in the REM group. It was further hypothesized that females would demonstrate greater gains in wellness and mattering than did males but there were not a sufficient number of males in the sample to permit meaningful statistical analysis. Nineteen independent living residents with a mean age of 83.26 years (SD = 4.99) participated and were randomly assigned to either the baseline REM group (n = 10) or to the REMAIR group (n = 9). Two instruments were administered using a pre- and post-test design to compute gains in wellness and mattering and Chi square tests, Pearson correlations, and independent and dependent sample t-tests were used to analyze the data. Results failed to support the hypotheses however, additional analysis of within group gains indicated that members of the REM group and females as a whole achieved significant positive gains in wellness. Despite the lack of significant findings indicating that wellness can be enhanced through the promotion of mattering or that the mattering promotion tenets produced an increased sense of mattering to others and wellness, the study is the first attempt at translating the strong

positive relationship between wellness and mattering established in the research literature into a specific tenets that can be used in clinical settings. The results at least partially support the body of literature that establishes the usefulness of employing reminiscence groups for enhancing older adult wellness and suggests that the constructs of wellness and a sense of mattering to others differ by gender.

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STRUCTURING REMINISCENCE GROUP INTERVENTIONS FOR OLDER ADULTS USING A FRAMEWORK OF MATTERING TO PROMOTE WELLNESS

CHAPTER ONE: INTRODUCTION

This study examined the usefulness and implications of promoting a sense of mattering to others as a vehicle for enhancing wellness in older adults living independently in continuing care retirement communities (CCRCs). Specifically, the study determined the effectiveness of structuring and processing group reminiscence according to four tenets of mattering. This chapter provides an overview of the issues and challenges that accompany increased age and the need for developing newly structured interventions to meet the demand caused by rising numbers of older adults. An introduction to wellness, mattering, and group reminiscence therapy are provided. Chapter Two contains a detailed review of selected literature that is relevant to the study.

Statement of the Problem

Whether United States society is ready or not, the population is growing older. Aging of the massive baby boomer generational cohort and unprecedented life expectancies will, by the year 2030, produce a doubling in the numbers of adults 65 years and older and a quadrupling of those over the age of 85. In the next 20 years, this swelling number of older adults will grow to comprise almost 20 percent of the U.S. population (U.S. Census Bureau, 2010). Because the labor pool to care for these older adults is projected to remain relatively constant from now until 2030 (U.S. Department of Labor, Bureau of Labor Statistics, 2010), social structures that support older adults will be challenged as never before, requiring innovative ways to support our most senior cohort of adults. Therapists must understand the influence of society's prevailing attitudes on age, ageism, and treatment of the aged as first steps in attempting to develop counseling efforts that remain responsive to the unique characteristics and expectations of aging baby boomers (Maples & Abney, 2009).

Age and Role Expectancies

Age is more than a label denoting chronological years of life; it also serves as a powerful source of personal and social identity for individuals. Family, educational, and work identities are central facets of the human experience. As people engage in different roles over the life course, they develop a sense of their own place and worth within the structural arrangements of daily life and age-graded role expectations imparted by society, while attendant status changes influence an individual's acceptance of age-based roles and behaviors (Moody, 2010). This socially ingrained process of age differentiation ensures that, from an early age, people know how to "act their age" according to the expectations of behavior that accompany roles such as toddler, adolescent, or elderly person (Moody, 2010). However, age grading (i.e., the assignment of roles based upon chronological age alone) ignores unique individual needs such as health status, financial position, or family structure, resulting in a process of age stratification, whereby individuals voluntarily modify their behaviors and attitudes to fit the expectations of age-graded roles (Moody, 2010). Institutionalized age-graded social policies combine with an individual's own beliefs about aging to create a "personal clock" denoting an expected progression of milestones and associated roles throughout one's life cycle (Moody, 2010; Neugarten, 1979). Individuals use these clocks in educational, employment, and family settings to compare themselves to others of the same age in an effort to determine how they relate to a larger social clock (Neugarten, 1979). Neugarten, an early leader in aging studies, offered that questions of timing are "central to the individual's self-concept" (p. 889) throughout the lifespan.

Role identity theory addresses the concepts of age grading and stratification by supporting the notion that, throughout life, one organizes his or her reality by categorizing people according to the social positions and roles those others hold (Siebert, Mutran, & Reitzes, 1999).

A personally constructed hierarchy of age-graded and stratified role expectations emerges, based on the observed behaviors of others in various positions, which then drives the creation of one's own role identity and motivates one to seek social exchanges that legitimize this imagined view of self (Siebert, Mutran, & Reitzes, 1999). Kite, Stockdale, Whitley, and Johnson (2005) found that individual bias associated with personal evaluations of role-driven behaviors leads to the development of negative stereotypic beliefs about the aged. Without additional contextual information such as work history and health status ratings, older adults are seen in a more stereotypically negative light than younger adults occupying the same roles (Kite et al., 2005).

Aging and Ageism

Ageism is "the belief in the intrinsic superiority of people within a certain range, often accompanied by prejudice, stereotyping, and discrimination on the basis of age, usually against old people" (Coleman, 2001, p. 17). Sue and Sue (2009) add "negative attitudes towards the process of aging" (p. 455) to that definition. Ageism is a unique phenomenon, because it impacts all people that live long enough to be considered 'old'. The literature indicates that ageism is not only as damaging as other social diseases such as racism and sexism, but also magnifies negative aspects of race, class, and gender based stereotypes and oppressions (Packer & Chasteen, 2006; Palmore, 2001).

In studies of the pervasiveness of ageism in Canada and the United State, over 75 percent of the adult respondents aged 60 or older had reported experiencing at least one instance of ageism such as being ignored, talked down to, or being the subject of an age-related joke (Palmore, 2001; 2004). Older adults are subjected to effects from both positive and negative stereotypes based on perceptions of their competence and warmth by members of the youthful majority in group (Fiske, Cuddy, Glick, & Xu, 2002). In one study, older adult's perceived as

competent by the younger in-group were also perceived to be greedy or uncaring evoking emotions of envy and contempt (Fiske et al. 2002). Cuddy and Fiske (2002) proposed that many older people may remove themselves from social roles that require competence to avoid being treated negatively. Other research supporting these studies of stereotype content indicated that older adults are likely to be the victims of a "paternalistic prejudice" that rewards older adults with positive feelings of warmth and compassion as long as they conform to the role of incompetent (Packer & Chasteen, 2006). Packer and Chasteen's studies provide insight into how negative attitudes towards aging may originate or be triggered not so much by personal experiences with the aged, but as individuals contemplate movement from the in-group majority to what is anticipated to be a less than valued social identity as an older person.

Longitudinal research indicates that attitudes on aging also directly affect one's length of life. Levy, Slade, Kunkle and Kasl (2002) found that individuals with "positive self-perceptions of aging, measured up to 23 years earlier, lived 7.5 years longer than those with less positive self-perceptions of aging" (p. 261). Yet, negative attitudes towards aging and the aging process developed over a lifetime are hard to change, and the booming cosmetic and "anti-aging" industries promote the denial of aging instead of supporting efforts to enhance adaption or development. Sociologist Erdman Palmore's (2007) studies, found that one-third of respondents 50 or older reported engaging in some type of age denying behavior, that women did so more frequently than men, and that individuals may become more accepting of their age as they mature and develop. Palmore's results indicated that age denying behaviors were maintained as an effort to avoid negative stereotypes and associated prejudicial treatment rather than as an expression of the individual's negative response to the aging process. Some question if engaging in age denying behaviors are harmful since they are evidence that older adults are able to

maintain control over their lives by adaptation to the environment (Palmore, 2007). However, Palmore likens seemingly benign age denying activities to "passing" by members of mixed ethnic heritage who deny their out-group membership by representing the dress, mannerisms, and attitudes of an in-group of higher status (Elam, 2007; Palmore, 2007). Just as passing exerts a negative effect on the formation of an individual's racial identity formation (Elam, 2007), age denying behaviors may be conceptualized as developmental roadblocks to the formation of an integrated self-concept as an older person and to successful entry into and negotiation of the generativity versus despair stage of Erikson's (1997) psychosocial model.

The Aged and Cohort Characteristics

When developing counseling efforts to counter threats to the psychological and emotional well being of older adults resulting from the loss of familial and occupational roles that accompany older age, it is essential to account for and understand the influence of distinctive social and cultural environments on the development of entire generational cohorts of adults. A generation is defined as a kin relationship and genealogical lineage such as grandparent or child, whereas a cohort is defined as a specific age group that has shared historical experiences; both must be accounted for when considering older adult wellness (Hareven, 1994; Vander Zanden, Crandell, & Crandell, 2007). Shared historical circumstances such as war, migration, and collapse of local economies pose common developmental challenges and impart a personality on generational cohorts as do the educational, medical, and governmental social structures that provide support to members as they negotiate the life course (Alwin, 1998; Hareven, 1994). Adaptation to social and economic conditions in the later years of life is contingent on specific pathways followed to old age and must be accounted for by the diversity competent counselor attempting to understand an older adult's world view.

There are approximately 30 million adults remaining of the "the silent generation," those adults born roughly between 1925 and 1945. Vander Zanden et al. (2007) maintain that the defining historical events influencing this generational cohort included the Great Depression and World War II. Hardworking, economically conservative, and patriotic, the members of this cohort worked long hours after the Second World War in hopes their offspring would never suffer as they had. They hold strong values, and worked to ensure that their children received a college education, and are now becoming involved in child rearing and maintaining close relationships with grandchildren.

The "baby boomers," often referred to simply as "boomers," were born between 1946 and 1964, and their members began turning 65 in 2011. Maples and Abney (2006) cite general differences of this cohort from its predecessors, noting that they are physically healthier; have vastly different quality of life expectations given higher education levels; possess expanded worldviews because of technological advances in media, communications and travel; and have not experienced the global challenges of previous generations (e.g., Great Depression, World War II). However, aging boomers face a unique set of life stresses that their parents have not faced, such as the need for working into later age because of economic downturns, the delay in being able to collect Social Security, the doubt that Social Security will even be solvent when they are ready to retire, and the rising costs of health care (Maples & Abney, 2006). Maples and Abney also noted boomers are experiencing more relational difficulties as the result of divorces and blended family issues, are reporting higher rates of lifetime drug use, and are much more willing to utilize counseling to assist with personal growth and wellness. Roszak (2009) offers the hypothesis that boomers, freed from familial and occupational roles and responsibilities, will not age quietly as their parents have but will engage in a renewed social activism, placed on hold

during the years of middle age, that will impact U. S. culture as their prior efforts did in the 1960s and 70s. However, more aging boomers find themselves sandwiched between responsibilities for taking care of both parents and children, which causes stress by taxing reservoirs of emotional and material resources (Maples & Abney, 2006; Riley & Bowen, 2005). Consequently, the increased size of the older adult population will naturally manifest in an increased demand for a wide range of health and wellness supporting services tailored for aging boomers and their families.

Theoretical Rationale

Theories of Aging and Adult Development

Society has contemplated the developmental changes associated with aging since the time of Plato. Historically, the central question revolves around activity; namely, whether disengagement and withdrawal (rather than seeking to remain active and engaged) are normal and natural parts of the aging process (Blando, 2011). Biological, psychological, and social challenges accompanying maturation in childhood have long been a subject of study, but adult development and aging and the significance of social roles in later life only began to warrant attention from social science researchers after the Second World War (Settersten, 2006).

In 1961, Cummings and Henry proposed their disengagement theory, maintaining that as people age, it is natural for them to turn inward and reject previous roles, relationships, and activities, and disengage from society (Blando, 2011; Moody, 2010; Schroots, 1996). This theory maintains that disengagement is beneficial to individuals, since being freed from employment and familial responsibilities allows time and opportunity to turn inward and prepare for the inevitable end. The theory also maintains disengagement is beneficial to society as the retirement of the eldest generational cohort enables members of younger, more productive

cohorts to fill vacated roles of status, power, and prestige in all areas of society (Quadagno, 2002). Robert Havinghurst proposed activity theory as an alternative since he, and others, found disengagement theory to be too generalizing of older adult experiences and a threat for justifying withholding resources from adults as they age (Blando, 2011; Moody, 2010). Building on his earlier work on developmental tasks and activity according to a lifespan perspective, activity theory maintains that older adults attempt to remain engaged in activities of mid-life as they age, and that they must substitute new roles for those lost in old age in order to maintain a positive sense of self (Schroots, 1998).

However, Erikson's model of psychosocial development (1997) is still considered as "the first and oldest tradition in the personality-and-aging field" (Schroots, 1998, p. 746) and rang-in what is considered the modern era of aging theories. Unique at the time, the model framed individual development as a series of eight stages from infancy through old age, each marked by a pair of clearly defined and opposing psychosocial tasks; a desired ego-syntonic (i.e., emotionally harmonic) element of development at one pole, and an ego-dystonic dimension (i.e., a state of emotional discord) at the other. Erikson proposed the degree to which an individual internalizes the ego-syntonic element of each stage affects negotiation of later tasks towards ego expansion and an expanded view and sense of self (Erikson, 1997; Schroots, 1998). In this progression of stages, the tasks of middle-to-late adulthood, the seventh stage, involve rectifying issues of generativity versus stagnation. During the negotiation of this stage, individuals either shift their focus to caring for and guiding following generations by passing along lessons learned from life or stagnate in a self-focused perspective with reduced connections to people and institutions and sense of accomplishment. The eighth and final stage, beginning around age 65, involves rectifying the challenges of attaining ego integrity versus living in despair. At this stage

of later life development, an individual is challenged to integrate all past life experiences, both good and bad, into a complete sense of self, which the model suggests would lead to a sense of acceptance. If unable to achieve this ego integration, Erikson's model holds an individual will develop a distain for life and despair caused by not being able to accept the life led to that point.

Joan Erikson (1997) extended her distinguished husband Erik's work after his death, noting that adults display markedly different characteristics at age 85 or 90 than at age 65. Herself past age 91 at the time, she combined her personal experiences with those obtained in research with adults over 85 years old, and proposed that a new ninth stage be added to account for a final dimension of development in the life cycle. This underpublicized stage proposes that although the oldest of older adults may have attained ego integrity, they are then challenged to come to terms with the daily despair of living at an advanced age marked by disintegration. She wrote:

> Despair, which haunts the eighth stage, is a close companion in the ninth because it is almost impossible to know what emergencies and losses of physical ability are imminent. As independence and self-control are challenged, self-esteem and confidence weaken... To face down despair with faith and appropriate humility is perhaps the wisest course (pp. 105-106).

Those adults who are able to accept this daily despair transcend worldly concerns and enter into a more cosmic and spiritual realm of development.

The hypothesis that adults negotiate a ninth stage has been extended by Tornstam's (1997) research on gerotranscendence. Tornstam defines gerotranscendence as "a shift in meta-perspective, from a materialistic and pragmatic view of the world to a more cosmic and transcendent one, normally accompanied by an increase in life satisfaction" (p. 143). Tornstam

noted gerotranscendence is a process of not just reviewing a life lived, but a qualitative redefinition of reality that challenges many conceptualizations of development in older age.

Rowe and Kahn (1997), working on a new framework for conceptualizing the aging process, were concerned that a focus on stage theories such as Erikson's did not account enough for individual differences and created the formation of a "gerontology of the usual" (p.143). Rowe and Kahn developed the concept of successful aging, defined as maintaining an active engagement with life free of chronic cognitive and physical challenges. With this concept Rowe & Kahn did not discount the importance of Erikson's model, but they did move the discussion of aging beyond physical and pathological disease by adding the maintenance of functional mental capacities and active engagement with life in their definition.

The Role of Wellness

The models of aging and development, above all, acknowledge that changes occur in multiple domains as people age. Wellness is defined as a lifestyle focused on maintaining optimal health and well-being that integrates the domains of body, mind, and spirit in such a way that an individual can participate more fully in life (Myers, Sweeney, & Witmer, 2000). Although not identified as such, Maslow's hierarchy of needs can be seen as a progression through domains of wellness from the basic security needs through those associated with belonging and self-actualization (Maslow, 1970). The shift in the medical community towards accepting a wellness model began in the 1970's with Dr. Bill Hettler, considered by many to be the father of the wellness movement. Dr. Hettler was the first to propose a holistic wellness model that conceptualized social, occupational, spiritual, physical, intellectual, and emotional domains of wellness to account for these changes (Hettler, 1984). His model proposed a broader

framework of human experience that challenged the medical profession's primary focus on physical health.

The entire counseling profession has since grown around the construct of wellness. When the American Association of Counseling and Development changed its name to the American Counseling Association in 1992, Myers (1992) emphasized that wellness, prevention, and development represent foundational foci which serve to differentiate counseling from other human services and helping professions. Leading proponents of wellness counseling, Myers and Sweeney (2008) maintain that wellness is *the* strength-based paradigm for assessing clients, conceptualizing treatment issues, and planning and developing interventions for remediating mental health issues and promoting growth.

There are numerous studies into the common domains of wellness and how they can be measured; but five common components of emotional, intellectual, physical, social, and spiritual wellness have emerged (Roscoe, 2009). Much of the existing research appears focused on validating specific instruments to measure the construct quantitatively but can also be used for planning and tracking therapeutic wellness-promoting activities (Roscoe, 2009). Nevertheless, increased wellness has been found to be positively correlated with a sense of mattering to others and with life satisfaction in a variety of studies (Degges-White & Myers, 2006; Dixon, 2007; Myers & Degges-White, 2007; Rayle, 2005).

An Introduction to Mattering

In its simplest form, mattering can be defined as being noticed and needed by others, or the extent to which an individual perceives that he or she makes a difference in the world (Elliot, Kao, & Grant, 2004). Rosenberg and McCullough (1981) differentiated between general (societal) and interpersonal (personal) forms of mattering that originate from significant others,

groups, and institutions. Elliot et al. empirically validated mattering to consist of awareness, importance, and reliance (AIR). Awareness, or attention, is the feeling that others are aware and acknowledge an individual's existence; importance is the perception that an individual's actions are relevant to others; and reliance is the perception that significant others are emotionally invested and rely upon the individual for promoting their welfare (Elliot et al., 2004).

A sense of mattering was found to accurately predict an individual's level of wellness (Rayle & Myers, 2004), and is affected by a number of social and cultural factors such as marital status and employment setting throughout the life course. Fazio (2007) found that shifts in perceived mattering accompany differences in social roles an individual occupies. For example, children provide a significant source of perceived mattering for parents, and the derived sense of mattering in parents decreases as their children age (Marshall & Lambert, 2006). Other research found that the strength of the perception of mattering to romantic partners versus mattering to others influences the length and quality of young adult romantic relationships (Mak & Marshall, 2006).

Mattering pioneers Rosenberg and McCullough offered that: "the reward of retirement, involving the surcease of labor, can be the punishment of not mattering" (1981, pp. 179-180). Myers and Degges-White (2007) collected data from adults living in a retirement community in the southwestern United States and found that a sense of mattering may play a large part in an older adult's desire to become involved with others and participate in health-promoting activities. Another study found a significant positive relationship between mattering to others, purpose in life, and overall wellness, and found a significant negative relationship between mattering to others and depression among older adult participants (Dixon, 2007).

Losses of mattering sources accompany increased age either because of deaths of friends and loved ones, removal from employment settings, or departure of children from the home; and many individuals attempt to fill these voids with volunteer activities. Piliavin and Siegel (2007) studied longitudinal data of 4000 individuals, and found that an individual's level of volunteering was positively related to psychological wellbeing but was moderated by both the levels of social integration and the perceived mattering the activity provided. For those working with older adults it is important to remember that the purposeful and meaningful nature of the activities that allow older individuals to retain a sense of mattering and remain socially integrated is far more significant than the activity the volunteering itself may provide (Piliavin & Siegl, 2007).

Rayle (2006) proposed that counselors want to matter just as all other people do, and suggested that counselors can adopt a mattering focus to enhance the therapeutic environment. She provides a number of strategies counselors can use to demonstrate awareness, importance and reliance (AIR) when interacting with clients that strengthen the relationship. Rayle's suggestions provide examples of how easily the components of AIR can be integrated into therapeutic efforts, and although the benefits of mattering have been clearly established with a variety of populations, no specific research has been conducted to measure if mattering can be promoted through specifically targeted interventions.

Group Reminiscence

In their review of evidenced-based practices for counseling older adults, Myers and Harper (2004) found that group counseling and life review therapies have become the most common strategies to emerge for assisting older adults with common life transitions and age-related developmental challenges. Reminiscing in structured group, unstructured group, or individual settings helps older clients think and talk about their lives, and has been long

recognized in the nursing profession as an effective, empirically-based, practice for assisting older adults with coping with life transitions as well as reducing depression, increasing self-esteem, self-care, and life satisfaction, and building social relationships (Jones & Beck-Little, 2002; Myers & Harper, 2004).

The two essential elements of reminiscence therapies are the recalling of past pleasant memories and the sharing of the memories in a verbal exchange with others (Burnside & Haight, 1992). Most instructional research focuses on the group modality for older adults, not only because of its cost effectiveness, but also because the group modality is a good vehicle for reducing isolation and enhancing social connectedness, communication skills, self-care, quality of life, and validating of participant's life experiences (Burnside & Haight, 1992). Although there is not a consensus on the selection and sequencing the topical themes that guide reminiscence interventions, Stinson (2009) notes the growing evidence that structured protocols provide better outcomes than unstructured group reminiscence in terms of reducing depression in older adult populations. She suggests a six-week group intervention for older adults aimed at reducing depression that can be used as a basis for constructing the protocol for the proposed study.

Justification for the Study

Older adults are less often referred for specialty services to deal with mental health issues than are younger adults, and are less likely to utilize mental health services when referred (Klap, Unroe, & Unutzer, 2003; Substance Abuse and Mental Health Services Administration, 2010). Lower utilization rates may be explained, at least in part, by unique cohort attitudes and characteristics of the current oldest generational cohort, but lower referral rates may also be attributable to ageist attitudes and ratings of competency by referral sources as well as a lack of

tailored programs to refer older adults to (Klap et al., 2003). Reminiscence therapies have been found to be effective for assisting older adults with a variety of challenges to well being such as depression, but have been used primarily as an activity for older adults with various forms of dementia and cognitive challenges in long term care and adult day care settings (Bohlmeijer, Roemer, Cuijpers, & Smit, 2007). Little research has been conducted to examine the benefits of reminiscence for older adults not challenged by mental health issues. The reminiscence group framework was selected as a basis for the study, since this intervention has been found to promote a sense of social connectedness and interaction and enhance participant global wellness by the activation of pleasant then-and-there memories. Most reminiscence outcome research has also focused on reminiscence therapies conducted by paraprofessionals and volunteers, leaving this mode of therapy virtually unexplored by the counseling profession (Myers & Harper, 2004). Although the benefits of higher levels of perceived mattering have been established in a variety of contexts; and the positive relationship between mattering and self-esteem, wellness, and purpose in life are clear; no specific interventions have been developed to directly address the promotion or rejuvenation of the universal human need of mattering. Research on adult development and aging, wellness, and reminiscence therapies has been gaining momentum as the number of older adults associated with the aging baby boomer cohort continues to rise. As noted earlier, professional counselors in the next 20 years can anticipate delivering more services to older adults both because of the rapidly growing cohort of older adult boomers that generally possess less stigmatized views of counseling and because the workforce to care for and deliver services to older adults remains relatively constant. Further research is needed to explore the impact of mattering-specific interventions, and to determine how best to support wellness and development for older adult populations.

Purpose of the Study

The purpose of this study was to investigate the effects on wellness of a reminiscence group protocol structured to promote perceived mattering for older adult residents of a continuing care retirement community (CCRC). The study aimed to enhance perceived mattering by developing a group counseling curriculum that required group leader modeling of AIR with group members, integrating AIR into the organization and processing of the group members shared memories, and in constructing a group constellation to provide group members with temporary sources of mattering to sustain the therapeutic effort. Outcomes were measured to explore the direct effect of an AIR-specific intervention on global wellness and the development of perceived mattering in older adults. Analysis was performed by comparing gain scores from pre- and post-tests of comparison groups, examining the effects of demographic variables on results, and examining the correlation between wellness and mattering.

The researcher hypothesized all participants would benefit from participating in group reminiscence, but that those participating in the AIR structured groups would demonstrate larger gains in wellness and perceived mattering. Specifically, the purpose of the current study was to answer the following research questions:

1. What is the effect of structured reminiscence interventions on the global wellness of older adult participants?

2. What is the effect of a mattering structured intervention on the global wellness and perceived mattering to others of older adult participants?

3. What influence do other demographic variables such as age and gender exert on participant wellness and perceived mattering?

4. How are the measures of wellness and mattering correlated with this population?

Definition of Terms

For the purposes of this study, the following terms and definitions are used:

Cohort: A specific age group or generational group marked by shared historical experiences.

Mattering: A psychosocial construct first posed by Rosenberg and McCullough as the perception that one is noticed by, important to, and relied upon by others. The three dimensions of global mattering are awareness, importance, and reliance (AIR).

Awareness mattering: The most basic and cognitive form of mattering; it is the perception that others know that one exists that "flows" from others to the self.

Importance mattering: A relational form of mattering; it is the perception that others are emotionally vested in sharing ones successes and failures that "flows" from others to the self.

Reliance mattering: A relational form of mattering that "flows" from the individual to others; it is the accepted obligation to be relied upon to further another's best interest

Reminiscence group therapy: Recalling of past pleasant memories shared in a verbal exchange with others (Burnside & Haight, 1992).

Wellness: Defined as a lifestyle that is directed towards maintaining optimal health and well being "in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving" (Myers, Sweeney & Witmer, 2000, p. 252).

General Research Hypotheses

This study was undertaken to understand whether wellness could be enhanced through the promotion of mattering. As a result of the intervention, it was expected that all individuals

participating in reminiscence groups would experience gains in global wellness scores. Further, it was expected that individuals in reminiscence groups structured to attend to the components of AIR would obtain significantly higher gain scores for both global wellness and perceived mattering than those participants in the traditional reminiscence groups. The study also examined the relationships between perceived mattering, global wellness, and other demographic variables.

Research Hypotheses

H1. Older adults participating in group reminiscence therapy will demonstrate significant gains in global wellness as measured by the Five Factor Wellness Inventory (5F-WEL).

H2. Older adults participating in group reminiscence therapy structured around an awareness, importance, and reliance (AIR) mattering framework will demonstrate significantly greater gains in global wellness, as measured by the 5F-WEL, than participants of traditionally structured group reminiscence.

H3. Older adults participating in group reminiscence therapy structured around an AIR mattering framework will demonstrate significantly greater gains in mattering as measured by the Mattering Index, than the participants of traditionally structured group reminiscence.

H4. Women will demonstrate greater gains in wellness, as measured by the 5F-WEL, and mattering as measured by the Mattering Index.

Sample Description and Data Gathering Procedures

The sample for this study consisted of older adult residents of a continuing care retirement community (CCRC) in the Southeastern United States. Twenty volunteers, 15 women and five men, who were not receiving assistance for a diagnosed cognitive challenge and did not

have medical procedures that precluded participation in the study were randomly assigned either to a traditionally structured reminiscence group of ten members or an AIR structured reminiscence group of ten members. All 20 participants conducted pre-testing in May 2012; biographical and demographic data were obtained during pre-testing. One male participant in the AIR structured reminiscence group withdrew after the first week resulting in 19 participants completing the post-test assessments at the conclusion of the five-week, ten session intervention.

Limitations of the Study

The most significant limitation of the current study was the small, select, sample size, resulting in a limited geographical and diversity representation. The study also focuses solely on residents of a CCRC limiting an ability to draw any conclusions regarding the effectiveness of interventions with older adults residing in other community settings. Subject effects also pose a limitation for this study since volunteers are likely to be regular participants in other programs and activities offered by the CCRC and are of a high-end or privileged social economic status when compared to residents of other long term care environments or facilities. A final limitation is the threat that participants may have responded to the assessments in a perceived socially desirable manner, particularly when accounting for generational cohort characteristics that honor autonomy and self-reliance.

Summary

The numbers of older adults in our population will double in size by the year 2030, whereas the size of the workforce charged with caring for them remains relatively constant. This makes it an almost certainty that counselors will be delivering services to larger numbers of older adults in the future. In order to do so, counselors need to understand the differing requirements of older adults. Unique shared life experiences may differentiate generational

cohorts, but older adults become more diverse as they age, since they continue encounter decision points along the life course. Negative views of age, aging, and the aged prevail that have resulted in generalizations around the course of older adult development; however, current models of aging and development are beginning to address development of the oldest old. Efforts to support older adult psychological and emotional health focus on promoting wellness but do not fully account for threats to wellbeing resulting from the loss of familial and occupational roles that accompanies older age. Research indicates the positive relationship between mattering and global wellness and mattering's contribution to enhanced life satisfaction, but research has been lagging in the area of examining how mattering might be promoted as a means of enhancing wellness through specific interventions. Current research establishes the usefulness of reminiscence therapy conducted by paraprofessionals and nurses in a group modality to promote social interaction and reduce the effects of depression.

This chapter presented an overview of the current issues and problems relevant to issues of age, aging, and the aged that impact the delivery of mental health services to support successful aging. Theories of aging and adult development, wellness, mattering, and reminiscence therapies serve as the rationale for this investigation. An overview of how these theories were integrated in the study was also provided. Chapter Two presents a more detailed review of the literature relevant to this study.

CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter presents a review of available literature and relevance of the constructs of older adult development, wellness, the use of reminiscence group work with older adult populations, and mattering. The following section is a critical analysis of a selected body of scholarly and empirical research that led to the development of four tenets for mattering promotion that are used in the present study.

Age, Aging, and the Aged

By the year 2030 the numbers of adults over the age of 60 years old will double and comprise more than 20% of the United States population (U.S. Census Bureau, 2010). As a natural consequence, those involved with providing services to older adults, to include those in the counseling profession, can expect to experience increased contact with older adults (U.S. Department of Labor, Bureau of Labor Statistics, 2010). A lack of knowledge of the aging process and older adult issues hampers efforts to serve older adults, but more damaging are society's negative prevailing attitudes towards age, aging, and the aged.

Educational gerontologist Erwin Palmore (2001) conducted a 20-item ageism survey of 84 older adults over the age of 60. The sample was comprised of 65% women and 35% men, and 77 percent of respondents reported having experienced at least one instance of ageism. Half of those reported that the specific form of ageist behavior occurred more than once. Being told a joke that pokes fun at older people was reported by 58 percent of respondents, and 43 percent agreed that "a doctor or nurse assumed my ailments were caused by my age" (Palmore, 2001, p.573). Almost a third of the sample reported that people both assumed they could not hear or understand because of their age (Palmore, 2001).

Although the sample was small for this original study, a later study of 375 Canadians over age 50 and 152 Americans over age 60 yielded similar rates of ageist incidents in both countries (Palmore, 2004). These studies highlight the need for counselors to monitor their attitudes towards age while working with older adults. Many seemingly benign actions such as raising one's voice when speaking to an older person may be seen as generalizing and stereotyping behavior from the older adult's perspectives. If issues of age are not included in addition to issues of race, class, and gender in counselor preparation programs, additional training may be required

The emotional content that underlies the formation of stereotypes was conducted by Fiske, Cuddy, Glick, & Xu (2002) using a stereotype content model (SCM) that assess how ratings of warmth and competence result in positive and negative stereotypes. Of interest to these researchers was examining the content members of any majority in-group (whites, males, native English speakers, etc.) use in the formation and assignment or flattering and unflattering stereotypes to different, definable, minority out-groups (the poor, elderly, housewives, etc.). The researchers hypothesized that cultural stereotypes are carried forward by social structures and the general public's perceptions of any subgroup's power and status resulting in evaluations of competence and competition to the majority in-group. Fiske et al. note that evaluations of competence translate into ratings of personal warmth (content); out-groups perceived to be highly competent, and thereby a threat to the majority's in-group status, are generalized as cold and uncaring while compliant groups that pose no threat relate in ratings of high personal warmth. A matrix constructed along the dimensions of competence and warmth yielded four possible clusters of ratings for groups of any category: high perceived competence and high warmth; high perceived competence and low warmth; low perceived competence and high

warmth; or low perceived competence and low warmth. Fiske, et al. tracked specific emotional responses from members of in-groups that lead to their assigning ratings for members of groups that fell in each quadrant. Stereotypes were accompanied by emotions of admiration for members of high/high rated out-groups, contempt for low/low groups, envy for groups perceived as high competence and low warmth; and pity for groups rated as high in warmth but low in competence (Fiske, et al., 2002).

Specifically, Fiske, et al. asked a sample of 73 undergraduate students and 38 nonstudents to rate 23 pre-defined out-groups along the dimensions of competence and warmth using five-point Likert scales. No additional information was offered other than the descriptors of the out-groups such as "blue collar", "educated", "poor" or "elderly". Using cluster analysis, the researchers found that respondents rated the "elderly" significantly higher on warmth than competence placing them in the same mixed cluster of low competence and high warmth as only two other groups, the "retarded" and "disabled". Fiske et al. then relied on participants to define the numbers and types of groups perceived to be low status before asking a different sample of 148 undergraduates to complete the same warmth and competency ratings. As before, ratings confirmed a significant relationship between the dimensions and the ratings of "elderly" to be similar to other low status and non-competitive out-groups.

Cuddy, Norton, and Fiske (2005) employed the SCM and cluster analysis in a study with 55 college student participants who were asked to rate a number of personality traits for an imaginary 71-year-old adult. The purpose of the study was to determine the interaction between ratings of the older adult's perceived competency to positive emotions of warmth felt toward the older adult by the participants. All participants were first provided with a standardized vignette to describe a fictional 71-year-old man and his wife that was used as the control condition for the

study. Cuddy, et al. then provided additional information to indicate high incompetence (could not find car keys without the assistance of his wife) and low incompetence (misplaced keys but remembered where they were on his own) as two experimental conditions. Results from a one-way ANOVA indicated a main effect of competency on warmth; higher ratings of warmth were assigned for the older person in the high incompetence condition than for the person in the low incompetence or control scenarios. Perception of the imaginary adult's competency obviously impacted their evaluations of warmth placing the subjects of all scenarios in mixed cluster of incompetent but warm which was accompanied by the emotions of pity and sympathy. These series of studies employing the SCM are limited by their small sample sizes, but samples from both student and nonstudent populations indicated that stereotype content (i.e. ratings of warmth and competence) were the same in both settings.

Packer and Chasteen (2006) used a social identity approach to examine youthful in-group views of the aged and aging from the perspective of transitioning between the youthful in-group to an aged out-group. In two different studies, these researchers evaluated younger adult identification with their current age group and prejudicial attitudes held towards both older adults as a group and the process of aging. In the first comparative study, 88 undergraduate students between the ages of 17 and 23 years old ($M = 18.56$ years) participated. Members of the randomly assigned control group ($n = 38$) were asked to imagine and write about how their lives will be different in one year. The members of the future self condition ($n = 50$) were asked to imagine and write about how their lives would be different when they are at age 70. In the second study, 75 undergraduates were asked to imagine a "day in the life" of someone they knew over age 70 (instead of imagining themselves at age 70) in order to examine if perceptions of older adults and aging are dependent on a "self" or "other" perspectives. In both studies Packer

and Chasteen found that the strength of age group identification did not have a negative impact on attitudes towards *specifically identified* older adults, but when rating *themselves* as aged, those identifying strongly with their age group also reported more negative, prejudicial attitudes and perceptions of older adults and aging.

Negative attitudes towards aging drives many adults to engage in age denying behaviors. Palmore (2007) constructed and distributed a health behavior inventory consisting of ten healthy behaviors such as engaging in exercise and taking multi vitamins, and ten common age denying behaviors such as coloring hair or undergoing cosmetic surgery. Results from the 222 respondents over age 50 indicated that health-promoting activities were reported more frequently than were age denying behaviors, but almost one-third of the respondents reported engaging in some form of age denying behavior. There was a difference in results by age and gender, with respondents between the ages of 55 and 75 reporting significantly more age denying behaviors than those 76 years and older, and more women engaging in denying behaviors than men (Palmore, 2007). These results indicate that individuals may become more accepting of their age as they mature and develop, and that women are particularly susceptible to the double effects of ageism combined with sexism.

Palmore noted that these findings support assertions about older adult denial of the negative stereotypes and associated prejudicial treatment that accompany age rather than the aging process. Palmore likens seemingly benign age denying activities by aging individuals to "passing" by members of mixed ethnic heritage who deny their out-group membership by representing the dress, mannerisms, and attitudes of an in-group of higher status (Elam, 2007; Palmore, 2007). Age denying behaviors may be conceptualized as developmental roadblocks for the formation of an integrated self-concept as an older person and for successful entry into and

negotiation of the generativity versus despair stage of Erikson's (1997) psychosocial model. Longitudinal research indicates that attitudes on aging also directly affect one's length of life. A study by Levy, Slade, Kunkel and Kasl (2002) examined the impact of individual self-stereotypes and negative attitudes towards aging on longevity. Results were obtained from 660 adults who were ages 50 and older in 1975 and had participated in the Ohio Longitudinal Study of Aging and Retirement, a study originally conducted by Robert Atchley and associates at Miami University to examine the determinants of the unprecedented increase in life expectancies at that time (Levy, et al., 2002). Levy and colleagues found that those with "positive self-perceptions of aging, measured up to 23 years earlier, lived 7.5 years longer than those with less positive self-perceptions of aging" (p. 261).

An Expanded View of Older Adult Development

The question of what psychological changes accompany increased age has been contemplated by society since the time of Plato. Theorists and researchers attempting to understand the aging process have traditionally wrestled with whether it is normal for adults in older age to withdraw and disengage from society, or if it is more likely that in the normal process of aging older adults prefer to maintain an active lifestyle as they age (Blando, 2011). The former view was extended in 1961 with the release of Cummings and Henry's disengagement theory that proposed that older adults voluntarily withdraw and disengage from society (Blando, 2011; Moody, 2010; Schroots, 1996). It was thought that this natural disengagement not only allowed older persons to turn inward and prepare for death, but also provided opportunities for younger members of society to fill positions of power and status as older adults vacate those positions (Quadagno, 2002). In direct opposition to disengagement theory was Robert Havinghurst's activity theory, which posed that older adults will attempt to

maintain the activities of middle adulthood as long as possible as they age. Activity theory noted that older adults engage in activities to find new roles to replace those lost with old age in order to maintain a positive self image and sense of being (Schroots, 1998). Since the time of these two early theories, the concept of successful aging has become popularized by Rowe and Kahn (1997).

Rowe and Kahn (1997) expressed concern that attempting to define a normal life course in older adulthood according to a concept of disengagement or activity unnecessarily generalized older adult experiences. They conceptualized successful aging in physical, mental, and social realms which provided a new lens for viewing aging beyond merely pathological considerations. In this theory, success in aging equates to a low probability of disease and disease-related disability, the maintenance of cognitive and functional mental capacity, and the maintenance of active, social engagement with life (Rowe & Kahn, 1997). They emphasized the hierarchal and relational nature of these three components, noting that physical health supports cognitive functioning, which in turn, supports social engagement. Successful aging remains one of the most valuable concepts of aging because it moved the discussion past stage and other theories which Rowe and Kahn felt were being used to the point of perceiving a "gerontology of the usual" (p.143). The successful aging concept takes a whole person approach and accounts for diversity in the aging experience.

Probably the most well known model relied upon as a guide for conceptualizing and tracking development through the life cycle is Erikson's stage model of psychosocial development. Erikson's model rang in the modern era of theories aging and development (Schroots, 1998) and was unique because it proposed stages of development from infancy through older adulthood. The model consists of eight stages described in Table 1. Each of his

eight stages is defined by a pair of developmental tasks; an ego-syntonic or harmonic element at one pole, and an ego-dystonic or element of discord at the other. This model tied an individual's developmental path to the degree that each ego syntonic element had been accomplished in the negotiation of stages; Erikson proposed that incomplete or insufficient task accomplishment carries forward and impacts the negotiation of the future developmental dilemmas (Erikson, 1997).

Table 1.

Erikson's Stages of Psychosocial Development

Stage	**Developmental period/age**	**Favored outcome**
Trust v. mistrust	Infancy	Trust in self, parents, and world
Autonomy v. shame and doubt	2-3 years old	Sense of control without a loss of self-esteem
Initiative v. Guilt	4-5 years old	Direction and purpose in activities
Industry v. inferiority	6 to puberty	A sense of mastery and competence
Identity v. confusion	Adolescence	Coherent sense of self and identity
Intimacy v. isolation	Early adulthood	Become intimate with another and work on career
Generativity v. stagnation	Middle adulthood	Build family, develop concern for others
Integrity v. despair	Late adulthood 65 years old +	Integrating the good and the bad from a life lived

Note. Adapted from "The Lifecycle Completed," by J. Erikson. Copyright 1997 by Norton.

The two final stages of the psychosocial developmental model (seven and eight) deal with developmental challenges of older adults. The seventh stage outlines the tasks of middle adulthood as rectifying issues relating to generativity versus stagnation. It can span 30 years or more from the time one rectifies the intimacy versus isolation stage of young adulthood until children leave the home. During this stage, many adults may enjoy raising a family and attaining positions of power associated with middle adulthood. Successful negotiation of this stage involves caring for others and a displaying a concern for future generations; failure to adequately do so may leave the adult relationally stagnant and socially isolated (Erikson, 1997). Near the end of this phase, uncertainty about status and roles develops as an individual is removed from positions of power associated with middle adulthood (Erikson, 1997).

The tasks of stage eight, which begins around age 65, involve issues of ego-integration versus despair. In this stage, individuals integrate all of their past life's experiences, good and bad, and accept their existential journey or continue to live in a state of dissatisfaction and distain for the present (Erikson, 1997). Life reviews, facilitated reflections of an entire life to rectify unresolved conflicts, are commonly conducted to assist older individuals at this seemingly final stage of the life cycle (Butler, 1974; Burnside, 1994). However, the aging member of the boomer cohort that turned 65 this year is expected to live an average of another 17.3 years (U.S. Census Bureau, 2010), so it is now entirely possible that individuals may spend more time in this phase than in stage seven, an unexpected occurrence when the model was first constructed.

After her husband's death at age 91, Joan Erikson (1997) extended his work noting that her and Erik's personal experiences highlighted how markedly different their lives were at 85 or 90 than they were at 65. She combined her personal experiences as an older adult with those obtained in research with adults over 85 years old and proposed that a new ninth stage might

exist to account for a final dimension of development in the lifecycle. This underpublicized stage notes that the oldest of older adults who are able to accept and embrace the despair of daily living transcend worldly concerns and enter into a more cosmic and spiritual realm of reality (Erikson, 1997). Although the challenge of the eighth stage is to integrate all the despair caused by decisions of the past to improve current quality of life (ego-integration versus despair), despair at the ninth stage concerns transcending daily despair associated with losses of independence, dignity, health, and status leading to a qualitatively different reality (Erikson, 1997).

The hypothesis that adults negotiate a 9th stage has been extended by Tornstam's (1997) work on gerotranscendence. Analyzing data from a qualitative study of 50 men and women between the ages of 57 and 92 Tornstam (1997) found that subjects desired and took pleasure from contemplating past positive experiences in life and were more selective in personal and social relationships as they aged. Tornstam noted that adults in the latest years of life experience changes in three domains as gerotranscendence is attained: the cosmic, the self, and social. The cosmic domain includes a shift from a linear view of time to a more circular view that is accompanied by increased interest in revived childhood memories and feelings of kinship with ancestors. Subjects also reported that other forms of expression such as art or music became more important for generating insights and understanding, and that small daily interactions with nature provided a sense of oneness with the universe. Discovery of hidden aspects of one's personality was the major theme of the self domain. Subjects reported that they redefined the personal qualities, both positive and negative, that they used to identify themselves throughout life, jettisoning some aspects of personality from earlier and integrating new interests and talents. Changes in the social domain included a preference for fewer but deeper relationships with

others, an increased need for positive solitude, delight in breaking away from the role expectations of others, and increased tolerance and acceptance of other views despite one's sense of possessing increased wisdom. Although more studies are needed to fully investigate this notion of a qualitatively different reality, Tornstam's work offers another explanation for the same types of behaviors that led Cummings and Henry to propose their disengagement theory (Moody, 2010; Schroots, 1996).

Summary of Aging and Older Adult Developmental Models

Regardless of the model of aging used to conceptualize older adult development, respecting the diversity of life courses that individuals follow is of primary importance. The theory of successful aging posed by Rowe and Kahn (1997) provides a good framework for conceptualizing age and driving efforts to support an older adults. Incorporating physical and cognitive status with activity level provides a more comprehensive view of the individual's functioning. Erikson's model of psychosocial development remains as one of the most highly respected models of conceptualizing development across the lifespan as noted previously (Schroots, 1998). The underpublicized ninth stage of this model (despair versus transcendence) was theorized as the result of Erik and Joan Erikson's personal experiences as adults over the age of 90. Tornstam's (1997) investigation into gerotranscendence opens the door for expanding the definition of development at the far end of the lifecycle, and counselors should be alert for possible signs of gerotranscendence when developing or matching activities for older adult populations.

Wellness

Dr. Bill Hettler (1984), considered by many to be the father of the wellness movement, was the first to propose a holistic wellness model that conceptualized social, occupational,

spiritual, physical, intellectual, and emotional domains of wellness. Hettler defined wellness as "an active process through which individuals become aware of and make choices towards a more successful existence" (p. 13). The concept challenged the emphasis on physical health and crisis intervention that drove the medical health community at that time. Hettler challenged medical educators to adopt a proactive, Hygiean approach to health care that stresses education and prevention to support wellbeing rather than remaining grounded in a reactive, Panacean approach. Although this early model was developed to conceptualize the role of wellness in the development of medical college students, his work spurred interest in wellness across disciplines and lead to the exploration of a counseling-based model of wellness.

Wellness and Counseling

Soon after the American Association of Counseling and Development changed its name to the American Counseling Association in 1992, Myers (1992) opined that wellness, prevention, and developmental perspectives provide counseling with a unique professional identity. In her review of the state of the profession to that point she, like Hettler, confronted the traditional and widely held medical model of treating psychological issues. She established the primary role of wellness in defining counselor identity, but acknowledged that integrating treatment that takes a preventative, wellness-based approach may be more of an aspiration for many in the counseling field, since the world of insurance reimbursement relies on a medical model and focuses on remediation of illness or pathology in order to gain insurance reimbursement.

Measuring Wellness

Myers, Sweeny, and Witmer (2000) defined wellness as a lifestyle that is directed towards maintaining optimal health and well being "in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community.

Ideally, it is the optimum state of health and well-being that each individual is capable of achieving" (p. 252). This holistic definition was the basis for conceptualizing a "wheel of wellness" (p. 251) model that considered five life tasks of global wellness including spirituality, self-direction, work and leisure, friendship, and love (Sweeney & Witmer, 1991; Witmer & Sweeney, 1992). The original intent of the model was to identify correlates of health, quality of life, and longevity based on reviews of cross-disciplinary studies at the time. Spirituality, as the central construct to wellness in this early model, was conceptualized to occupy the center of the wheel with self-direction radiating as spokes to connect it to the remaining three domains of work and leisure, friendship, and love composing the outer rim of the wheel.

To assess wellness according to this model, Myers, Sweeney, and Witmer (2000) developed the Wellness Evaluation of Lifestyle (WEL) to support the planning and conduct of wellness counseling and clarify the relationship of the five domains. The intent was to develop an accurate and empirically-based model of wellness, and there was no attention directed to developing specific clinical interventions (Myers et al., 2000). Seventeen sub-components of wellness were identified under the five domains that, when combined, comprised a measure of global wellness. Results of more than 5000 people who completed the WEL were analyzed, and structural equation modeling confirmed that the 17 sub-components provided a sound measure of global wellness even though they did not group under the five domains as hypothesized.

Myers and Sweeny (2005) supported the Adlerian belief that the self and associated life tasks cannot be divided as simply as Myers et al. (2000) had attempted in the previous model, so they redefined domains of the creative, coping, social, essential, and physical selves and distributed the 17 sub-components among them. This led to the creation of a new assessment instrument, the Indivisible Self: An Evidenced-Based Model of Wellness (IS-WEL; Myers &

Sweeny, 2005), the empirical data obtained from research using the WEL was combined with structural equation modeling that once again confirmed that the original 17 third-order factors are discreet variables which, when combined, support a single higher order factor of global wellness. In order to assess wellness according to the IS-WEL, the 72-item Five Factor Wellness Inventory (5F-Wel; Myers, Sweeney, & Witmer, 1998; Myers & Sweeney, 2005) was created. In addition to assessing the status and impact of any of the 17 wellness sub-components, items were included to assess the influence of local, institutional, global, and chronometrical contexts on the self.

The WEL (Myers ea al., 2000) and 5F-WEL (Myers, Sweeney, & Witmer, 1998; Myers & Sweeney, 2005) have been used to investigate the role of holistic factors in job satisfaction (Connolly & Myers, 2003), stress, wellness, and mattering among cadets at West Point (Myers & Bechtel, 2004); adolescent gender differences in adolescent minority wellness (Rayle, 2005); and life satisfaction and wellness of mid-life women (Degges-White & Meyers, 2006). Relationships between perceived stress, mattering, and wellness were also studied to develop a profile of older adults living in upscale retirement communities (Myers & Degges-White, 2007). In this latter study, mean scores on the 5F-WEL scales were significantly higher for 142 adults with a mean age of 83 (SD=4.86 years) than comparative scores of adults between the ages of 18 to 59 years old (M = 31.25 years, SD = 12.78). Although the results indicate that older individuals reported higher levels of wellness than younger respondents, results are limited by the sample population's context of an upscale retirement community. An upscale retirement setting provides a level of support and social networking activities and planned by a wellness committee or panel of residents that other settings may not be able to afford or support; thus, it is important to consider the potential impact of these contextual differences when organizing treatment and

comparison groups. The researchers suggested that higher levels of spiritual wellness in this sample of older adults might result from a greater senses of identity developed during ego-integration and from the contemplation of end-of-life issues that accompanies increased age.

Roscoe's (2009) meta review of nine models of wellness theory published between 1979 and 2000 revealed that five common components of emotional, intellectual, physical, social, and spiritual wellness were evident in most of the theories. Roscoe also examined five different assessment instruments, and found that each measured the psychometric model it was created to represent using quantitative designs, but did little to explain the true nature of wellness. Roscoe reported that: "most of the current research is not exploring the nature of wellness because exploring properties of the instruments is not analogous to exploring the dimensions of wellness. Research needs to emphasize integrating wellness theory and defining the dimensional structure" (p.223). Despite the lack of an integrated definition and emphasis on reducing the wellness construct into quantitative data, Roscoe noted that all of the models he studied are appropriate in individual or group counseling settings to assist participants with goal setting and for focusing the treatment or educational efforts on those areas of wellness that were identified as goals. None of the models or assessments he studied was were developed with samples from older adult populations, and the focus on defining and measuring wellness has detracted from research into the design and effectiveness of specific interventions to promote it.

A Summary of Wellness

Promoting holistic wellness is a defining feature of the counseling profession and differentiates it from many of the other helping professions. Although research has focused more on validating instruments to measure a particular model of wellness rather than examining the true nature of wellness, emotional, intellectual, physical, social, and spiritual wellness have

emerged as five common components. Despite the focus on measurement, researchers have established a positive relationship between wellness and various constructs, such as life satisfaction and mattering, noting that current theoretical frameworks are useful in identifying potential areas for growth, goal setting, and assessing the effectiveness of counseling efforts.

The Significance of Mattering

Rosenberg and McCullough (1981) were the first to suggest that mattering to others was a reciprocal counterpart to the construct of interpersonal significance. In its simplest form, mattering can be defined as being noticed and needed by others, or the extent to which a person feels he or she makes a difference in the world. Rosenberg and McCullough theorized that commanding the attention of others is the most fundamental sense of mattering to an individual, followed by the feeling that others consider the individual to be important, and, lastly, the belief that others depend on the individual (Rosenberg & McCullough, 1981). They studied four large-scale samples of adolescents, finding that mattering to others is important for not just the individual but for society, highlighting the differences between general (societal) and interpersonal (personal) forms of mattering. Although their study was restricted to perceptions of parental mattering, results indicated that perceived mattering is likely higher for young children than adolescents because of the intense attention and concern about children received from parents and society. Similarly Rosenberg and McCullough noted that middle-aged adults perceive that they matter more than older adults due to the increased sources of mattering that accompany primary child rearing occupational roles responsibilities. In this study, Rosenberg and McCullough clearly communicated the changes to mattering that accompany age-graded roles stating, "the reward of retirement, involving the surcease of labor, can be the punishment of not mattering" (1981, pp. 179-180).

The loss of many sources of interpersonal mattering accompanies increased age as friends, family members, and loved ones die. Other identity-related mattering sources that accompany employment and parental status also disappear with retirement and the departure of children from home. Many older adults, and individuals of all ages, attempt to fill voids in perceived mattering by engaging in volunteer activities. Piliavin and Siegel (2007) studied longitudinal data from more than 4000 respondents that graduated from Wisconsin high schools in 1957. They examined data obtained from four waves of follow-up surveys conducted in 1964, 1975, 1992, and 2004 to examine the relationship between other-oriented volunteering and self-reported health and psychological wellbeing. They found that the background factors that predict involvement in volunteer activities (age marital status, income, etc.) differ over time, but there was a significant positive relationship between present volunteering and present psychological wellbeing in each group of data collected. Their finding revealed that the activity associated with volunteering by itself did not result in the positive outcomes, but that activities that allow individuals to perceive they are making a meaningful contribution (i.e. that they matter to others) produced better outcomes in terms of psychological wellbeing. The authors noted that although their research showed that volunteer activities are useful for making social connections and remaining actively involved with organizations and individuals, it is much more useful in promoting the idea of one's "doing well by doing good " (p. 462).

Mattering and Counseling

A growing body of research published in counseling literature indicates that the psychosocial construct of mattering is gaining interest across counseling specialties. Much of this research has focused on adolescents just as Rosenberg and McCullough's early work had. Studies have been conducted to examine how mattering moderates suicide ideation for youth

ages 11 to 18 years old (Elliot, Colangelo, & Gelles, 2005); how it impacts adolescent mental health and behavior in school based on relationships to stepfathers and non-resident fathers (Schenck, et al., 2009); how it varies in relation to the race and gender of adolescents (Dixon, Scheidegger & McWhirter (2009) and how it effects young adult romantic relationships (Mak & Marshall, 2004).

Rayle (2005) conducted a study to determine adolescent gender differences in mattering with a sample of 462 high school students (49.5% male, 50.5% female) in the southwestern United States. Respondents completed two different mattering scales, one to measure general mattering and the other to assess interpersonal mattering, and a teenage version of the 5F-WEL, the 5F-WEL-T (Myers & Sweeney, 2001). An independent sample t-test indicated significant differences in interpersonal mattering [$t(460) = 2.89$, $p = <.05$] with females reporting higher levels($M = 3.56$, S.D. = .65) than did males ($M = 3.01$, S.D. = .7) with no significant differences in general mattering and wellness between the groups. When inter-correlations between mattering and wellness were examined for the entire sample, general and interpersonal mattering were significantly related ($r = .29$, $p = .001$) as were each form of mattering with wellness (both $r = .17$, $p = .001$). Significant differences between groups emerged; with results indicating that interpersonal mattering, general mattering, and wellness were all significantly related for females; but only general mattering and wellness were significantly related for males. These results indicated that there are gender-based differences in perceived mattering in adolescents and that females feel they mean more to their families than males making interpersonal mattering a more important component to female adolescent wellness than it is to male wellness. These findings do not address the questions of how mattering may differ by gender throughout the life course, with different adult populations, or how it is influenced by changing family and

employment roles held. It does, however, through the use of a large sample and two different mattering instruments, establish the differences in perceived mattering based on gender early in the life cycle. The developmental influences of these differences in mattering make it possible that gender differences in mattering would exist with older adult populations.

Other existing studies have contributed to an understanding of the effects of perceived mattering and wellness in the contexts of job satisfaction (Connolly & Myers, 2003), college student perceptions (France & Finney, 2010), and parent and child interactions (Marshall & Lambert, 2006). Taylor and Turner (2001) examined the relevance of mattering in the context of mental health by evaluating the relationship of mattering to depression. They employed a sample of 3,415 Canadians between the ages of 18 and 55 years old to collect two rounds of assessments that were 12 months apart, of general mattering, emotional reliance and autonomy, social support, and depressive symptoms. Correlation analyses yielded significant negative relationships between mattering and depression in the total sample (r = -.23), males (r = -.24) and females (r = -.28) alike. Other findings included: (a) that changes in mattering corresponded negatively to changes in depression throughout life, with mattering generally increasing until age 45 and then slightly decreasing with depression significantly trending in the opposite direction ($p < .001$); (b) that married respondents reported significantly higher levels of mattering than single respondents ($n = 719$, $p < .05$); and (c) that women in the study reported significantly higher levels of mattering than men ($n = 760$, $p < .001$), and (d) that women reported significantly more depressive symptoms than did men ($n = 760$, $p < .001$)

Although this study does indicate gender-based differences in mattering past adolescence, the sample for this study were between the ages of 18 and 55 years old so it is not possible to generalize the findings to older adult populations. This study was also confounded by women

reporting significantly higher depressive symptoms and perceived mattering than men which indicates that mattering alone is not a valid predictor of depression among women. The researchers acknowledge that they did not include a control to determine the variations of social support provided by spouses commenting that the experience of mattering to an intimate other that involves love, trust, and reliance is distinctly different than the social support received from friends, family, and coworkers that was measured. In addition to providing additional evidence of gender-based differences in mattering past adolescence, this study indicated that mattering is a relevant to the treatment of mental health issues, depression in this case, and may be a viable avenue for promoting mental health with other populations.

Measuring Mattering

Mattering research was extended by Elliot, Kao, and Grant's (2004) construction and validation of an instrument for measuring mattering as a social-psychological concept. Building upon Rosenberg and McCullough's (1981) model, they operationalized mattering into the three dimensions of awareness, importance, and reliance (AIR). The cognitive process of knowing that others are aware of our presence is the most fundamental type mattering, and although most individuals prefer that others recognize them for positive reasons, Elliot et al. noted that negative behaviors serve the same purpose in terms of gaining awareness from others. Importance and reliance are relational forms of mattering, in that they directly result from interpersonal relationships. Importance mattering occurs when a person feels that he or she is the object of another person's interest and concern and that other person shares in successes and failures (Elliot, et al., 2004). Rosenberg and McCullough identified this interest in sharing in another person's successes and failures as serving an ego extension function that flows from the other person to the individual. The flow of the second form of relational mattering, reliance, is

reversed; it flows from the individual to the other, and is the sense that one is relied upon to fulfill the needs or wants of one or more others and society at large (Rosenberg & McCullough, 1981).

Elliot, et al. (2004) developed a 47 item pilot assessment of mattering and administered it to 508 college students. These researchers were interested in validating the distinctions between three subtypes of mattering as well as determining if mattering was a distinct psychological construct from self-consciousness, self-monitoring, self-esteem, alienation, and perceived social support. Twenty-six total items emerged that supported the distinct nature of each dimension. The number of items was reduced to 24 because two items cross-loaded on multiple subtypes of mattering. Exploratory factor analysis indicated that global mattering was positively related to self-esteem and perceived social support, and that it was negatively associated with self-consciousness and alienation. However, strong correlations between awareness and self-esteem (.691), importance and self-esteem (.795), and importance and social support (.748) indicated that awareness and importance forms of mattering may not be distinctly different from self-esteem and social support (as Elliot, et al. originally hypothesized). Confirmatory factor analysis using the three-factor AIR model demonstrated the internal discriminant validity of each of the three types of mattering as being distinct (CFI= .950 and RMR= .027). Although additional research is needed to further clarify the relationship of these three closely related subtypes of mattering, the research endorses the validity of the AIR model as a valid conceptualization of mattering. Furthermore, this research establishes the components of AIR as an operational definition of mattering and validated the 24-item scale as an instrument for assessing AIR.

Mattering and Wellness

There is also a growing body of literature that notes the positive relationship between mattering and wellness. Utilizing a sample of 142 adults older than 72 years old (M= 83, SD = 4.86), Myers and Degges-White (2007) conducted a quantitative study of the relationships between 23 first, second and third order factors conceptualized by the 5F-Wel (Myers, Sweeney, & Witmer, 2000; Myers & Sweeney, 2005), mattering, and stress . Results indicated a significantly positive relationship ($p < .002$) between mattering and global wellness, four of the five second-order, and six of the sixteen third-order factors ($p < .002$; Myers & Degges-White, 2007). This study is limited by the nature of the sample which was comprised of predominantly white (81%) females (64.5%) who were all were residents of an "upscale" retirement community but the significant relationship between mattering to wellness is evidence that promotion of mattering is a viable avenue to improving wellness.

Another study focusing primarily on mattering as a psychosocial construct with an older adult population was conducted by Dixon (2007). In this study Dixon utilized a sample of 167 adults aged 70 years old or older ($M = 83.5$, $SD = 4.40$) and living in a retirement community in order to determine the relationship between mattering, purpose in life, depression, and wellness. There was a significant difference [$X^2(1) = 47.43$, $p = .000$] between the number of men (23.4 %, $n = 39$) and women (76.6%, $n = 128$) in the sample, and 68.3% reported being of European American heritage ($n = 114$). Dixon administered the 25-item Interpersonal Mattering Scale (IMS; Dixon Rayle, 2005), 20-item Purpose in Life Test (PIL; Crumbaugh, 1968), the Short version of the Geriatric Depression Rating Scale (GDRS; Yesavage, et al., 1983), and the 43-item Older Adult Wellness Evaluation (OSWE; Dixon Rayle, 2006). The IMS and OSWE were constructed specifically for this study. Analysis revealed that 78 percent of the variance in wellness was shared by the three constructs of mattering, purpose in life, and depression. Using

Pearson product-moment correlations, a significant positive relationships emerged between mattering and purpose in life ($r = .58$, $p < .001$) and overall wellness ($r = .62$, $p < .001$). A significantly negative relationship also emerged between mattering and depression ($r = -.64$, $p < .001$). A one-way repeated measures analysis of variance was also conducted to determine to whom the participants felt they mattered the most among the choices of others in general, friends, children, grandchildren, and/or significant others. Respondents indicated that they mattered most to their children, followed by their friends, grandchildren, significant others, and others in general.

Limitations of Dixon's (2007) study include the voluntary nature of participants, since it is impossible to know what common traits or motivations, beyond living in a retirement community, participants may have shared that may have influenced the outcomes. Additionally, the study was conducted in the southwestern region of the United States, an area influenced by a distinct and unique Hispanic culture and a preferred destination for many older adults who choose to reside in a warm and dry climate for health reasons and can afford membership in a retirement community. The unique ethnic composition of the population and common health issues for residents thus limit generalizability to populations influenced by other ethnic cultures who do not experience health challenges that require a specific climate associated with the southwestern United States, or who reside in community based, long term care, or other institutionalized settings. The use of instruments specifically constructed for this study were not available for review, so it is also difficult to determine the validity of the assessment.

Mattering Summarized

Despite some limitations, the research indicates the positive relationship between mattering, purpose in life, and wellness and the negative relationship between mattering and

depression. As with the research by Myers and Degges-White (2007), the homogenous nature of the sample not withstanding, there is evidence that the two constructs of wellness and mattering are significantly and positively related, thus supporting the development of empirically-based interventions to promote mattering as a means of enhancing wellness. Overall, "it appears that the current results offer legitimacy to a new area of research and practice in counseling with older adults: mattering to others (Dixon, 2007, p. 90)".

The expanding body of research across a widening diversity of contexts confirms the usefulness of an awareness, importance, and reliance (AIR) definition from which to investigate the effects of efforts aimed at enhancing perceived mattering. However, although mattering has been empirically linked to enhanced wellness, no specific interventions have been developed or tested to determine if wellness can be increased by systematically promoting a sense of mattering to others.

Reminiscence Therapies

Reminiscence is the process of calling to mind long forgotten or memorable experiences (Burnside & Haight, 1992). The origins of using reminiscence in a therapeutic setting can be traced to Butler's (1974) work on life-cycle group therapy. Butler conducted a study of group process utilizing age-integrated groups and believed that segregating groups by age detracts from the richness of the group experience. During his study, Butler noted that older-aged participants' engagement in reminiscence aided in "ameliorating suffering, overcoming disability, and facilitating opportunity for new experiences of intimacy and self-fulfillment (1974, p.14)" which was keeping with the purpose for the groups in his study. Since Butler's early work, reminiscence has now become recognized by the nursing profession as effective, empirically-based, intervention employed both on a one-to-one basis to enhance daily nurse-patient

interactions or with individuals and in groups over a sustained period to promote wellness and development (Burnside, 1994). Two distinctly different forms of these therapies have evolved over the last 20 years; life reviews and simple reminiscence therapies.

Reminiscence Defined

Burnside and Haight (1992) note that a life review is most commonly facilitated through an individual counseling relationship, because its purpose is to assist with ego-integration and consideration of the self as one prepares for death, makes an important decision, or responds to a crisis. Life reviews encompass the entire lifespan, and involve the client's use of recall to process both recent and remote as well as pleasant and disturbing memories. The critical attributes of the life review as outlined by Burnside and Haight are that it must: (a) contain an evaluative function, (b) encompass the entire lifespan, (c) be performed on a one-to-one basis between an individual and a therapeutic listener, (d) use memory for recall of past and present events, (e) address both happy and sad periods, (f) include a willing participant who wishes to share his or her past, (g) last between four to six weeks, and (h) contain the element of self in evaluations. Since troubling and painful events of the past may resurface during the life review, higher order facilitator skill and finesse is required to recognize and treat early symptoms of the onset of depression and anxiety that the life review may trigger (Burnside, 1994). Simple reminiscence groups with older adults are intended to "build relationships based on present, successful experiences" (Burnside, 1994, p. 54), and are most often accomplished in the group modality. Burnside notes that verbal interaction and the discussion of remote memories are two critical attributes of reminiscence that differentiate it from life review. The facilitator's role in the reminiscence process is to keep the focus on the sharing of pleasant, then and there experiences, and adding themes to guide session content (Burnside & Haight, 1992). Burnside

and Haight (1992) reported that most instructional research focuses on the group modality for older adults, not only because of its cost effectiveness, but also because groups are a good vehicle for reducing isolation and enhancing social connectedness, enhancing communication skills, self-care, and quality of life, and validating participants' life experiences.

Reminiscence and Counseling

In their literature review and recommendations for using evidenced-based practices for counseling older adults, Myers and Harper (2004) highlighted special considerations "related to the more numerous life experiences of older adults and frequent co-morbidity requiring a complex array of interventions for the older adult and his or her family" (p. 209). Their examination revealed that life review and reminiscence group counseling modalities have emerged as viable tools for assisting older adults with common life transitions and age-related developmental challenges. Reminiscing in structured group, unstructured group, or individual settings helps older clients think and talk about their lives, assists them in coping with life transitions, reduces depression, and increases self-esteem, self-care, life satisfaction, and the building of social relationships (Jones & Beck-Little, 2002; Myers & Harper, 2004).

Empirical study demonstrates the effectiveness of reminiscence therapies and their promise for use by counselors with older adults. Bohlmeijer, Roemer, Cuijpers, and Smit (2007) conducted a meta-analysis of standardized effect sizes of seven studies that employed life reviews and eight studies that utilized simple reminiscence to determine their effect on older adult psychological wellbeing and life satisfaction. They examined designs that utilized both no treatment and placebo treatment controls; and despite differences in sample sizes, living arrangements, levels of care of participants, and individual study objectives, reminiscence interventions produced a significant ($Z = 4.98$, $p < 0.001$) standardized mean effect size of 0.54

(95% CI = 0.33 – 0.75) across all studies (Bohlmeijer, et al., 2007). Life review interventions were found to be significantly more effective (d = 1.04; 95% CI = 0.74 – 1.34) than simple group reminiscence (d = 0.40; 95% CI = 0.17 – 0.64), and community dwelling adults benefitted more from interventions (d = 1.04; 95% CI = 0.72 – 1.37) than did residents of residential care settings (d = 0.44; 95% CI = 0.22 – 0.67); there were no differences in results for "younger older adults" (Bohlmeijer, et al., 2007, p. 298) and older adults over age 80 years old. Bohlmeijer, et al. note that the apparent effectiveness of these interventions supports the call for standardized protocols that would allow more effective treatment and research, but also cautions that the differences in effects may be accountable to reduced opportunities for social interaction by nursing home residents as well as to the increased use of simple reminiscence with adults experiencing dementia and their limited ability to self-evaluate wellbeing and life satisfaction.

Other research compared the effectiveness of reminiscence therapies to other forms of psychotherapies in treating of specific, clinically diagnosed, mental health issues. Pinquart, Duberstein, and Lyness (2007) analyzed 57 controlled intervention studies focused at treating depression, eight of which employed reminiscence against a control group. Their findings indicated that reminiscence interventions delivered over seven to 12 sessions produced a large effect size (d = 1.0, 95% CI = 0.73 – 1.27) for both self-rated and clinician-rated depression that was exceeded only by interventions utilizing cognitive behavioral therapy (d = 1.06, 95% CI = 0.87 – 1.26). The findings provided empirical evidence for the use of reminiscence therapies by counselors working with older adults.

Structuring Reminiscence

Stinson's (2009) meta analysis of the qualitative and quantitative research on group reminiscence as an independent nursing intervention revealed that structured protocols, using a

series of themes to focus reminiscence in group settings, produce better outcomes in terms of reducing depression and promoting wellness among older adults than groups with no guiding themes or structure. She noted that there was no consensus among the researchers as to the nature of structure or themes needed, but themes that emerged most frequently included significant firsts, such as first house, first toy, and first job, and favorites such as favorite holiday, favorite food, etc. Stinson noted the growing evidence that structured protocols provide better outcomes, and suggested that a six-week, 12 session group curriculum that might be useful as a guide for any reminiscence group of older adults in order to fill this gap. She also highlighted the need for additional research to develop evidence-based interventions, since the majority of reminiscence therapies are completed by paraprofessionals, and "most outcome research has included mental health providers other than professional counselors" (Stinson, 2009, p. 82). Stinson (2009) highlighted the need for providing education concerning organizing, facilitating, and evaluating reminiscence groups to those contemplating leading such groups. She recommended that a two-hour class or practicum would be appropriate for educating facilitators on reminiscence strategies and techniques.

Pitkala, et al. (2004) also highlighted the need for professionals to be specifically educated to lead groups of older adults but found a paucity of studies that proposed specific training requirements. Pitkala and colleagues noted: "the central issue in older people's groups is empowering its members. In this respect, group leaders need knowledge about group dynamics and special kills to develop their own role as group leaders" (p. 822). They conducted a total of twelve educational sessions spread over an 18 month span to prepare a group of eight healthcare related professionals for leading groups of adults ages 75 years and older. The goals of their program were, in part, to enhance participants' understanding of older adult feelings of

loneliness; to motivate them to internalize the aims of enhancing interaction and relieving loneliness; to augment their current group leading skills in terms of managing dominating, withdrawn, or impaired members; and to promote reflective thinking. Vignettes were used to examine difficult or challenging group situations, and role-playing of group sessions was used to build and practice skills and strategies needed to expand participant knowledge. The researchers relied upon participant self-reports of learning; positive and specific statements made by participants were used to highlight and document the favorable outcomes. The qualitative nature of the study by Pitkala et al. limits it's generalizability, as does the unique training setting and sequence. Regardless, it highlights the need for providing specific education about age-related changes and unique group processing and functioning for those working with older adults and reminiscence.

The process of reminiscence has also been shown to benefit those that lead others in the process of recalling positive memories. Shellman (2007) investigated the effect that reminiscence education had on Baccalaureate nursing student participants' levels of cultural self-efficacy and sensitivity to cultural differences. This qualitative survey of 41 nursing students (98 % female, 84 % white, mean age = 25.7) was conducted after the students had received two hours of reminiscence education and completed a 13-week community health clinical experience. The educational program included an introduction to reminiscence therapies and adult development; preparation for conducting reminiscence therapy to include specific group skills such as active listening, linking, rectifying challenges, and addressing inappropriate reminiscing and other difficult situations; the use of role playing to practice group facilitation skills and; recognizing the signs and symptoms of depression, grief, and anxiety. Using a survey of open ended questions, the three themes of "making a connection", "seeing the world through their

eyes", and "benefits of reminiscence" (p. 499) emerged. Students repeatedly noted how the shared reminiscence led to increased comfort with the patients and triggered instances of introspection about their own lives. The increased insight into other perspectives and world views was noted, as was the positive benefit the students experienced as the result of seeing their older adult subjects enjoying and benefitting from the protocol.

Although the qualitative nature of this study limits generalizability, Shellman's study supports reminiscence as a powerful tool that promotes cultural assessment and bridges differences between nurses and patients. Analysis of the nursing students' results supports the hypothesis that "incorporating reminiscence education programs into clinical practicum's may be an example of an educational intervention that increases students' confidence levels in caring for elders and influence them to view caring for elders as positive instead of experiences to avoid" (p. 50). Despite the results of this study being limited by a homogeneous sample and lack of ethnic minority representation, it offers useful evidence that educational efforts that focus on group skills for working with older adults can enhance group leader sensitivity to older adults cultures. When combined with Stinson's (2009) study, the need for structured training for those leading reminiscence groups is clear.

Summarizing Reminiscence Groups

In summary, reminiscing in structured group, unstructured group, or individual settings helps older clients think and talk about their lives. Reminisce and life review therapies are distinctly different modalities according to their intended outcomes, frame of reference, and other attributes as highlighted by Burnside and Haight (1994). Although structured protocols have been found to produce better outcomes than those that are non-structured in terms of positive participant experiences, few standardized themes to guide programs have been offered.

Stinson (2009) offered a standardized and sequenced protocol to overcome these limitations. Specifically structured educational programs for leaders of reminiscence groups were also posed by Pinquart (2004) and Shellman (2007), with both offering evidence that reminiscence education enhances cultural self-efficacy, as the process allows facilitator and client to close any cultural divide through the reminiscence process. Reminiscence therapies, thus, seem to support the efforts of professional counselors seeking to encourage wellness and a positive state of well-being through developmental, preventive, and wellness-enhancing interventions.

Hettler (1984) expanded the consideration of wellness beyond matters of physical health alone resulting in a holistic view of wellness that exists today. Researchers have now begun to address wellness issues for older adults in institutional communities and have established the positive relationship between mattering and wellness. Group reminiscence therapies have emerged as effective vehicles for providing opportunities for engagement and social interaction, but such therapies are often unstructured and have relied on untrained professionals to lead them.

A New Approach

Previous research has documented the variety of challenges older adults face from the effects of aging, which include negotiating age-graded role expectations and instances of ageism and expectations of development that omit the latter portion of the life course. The concept of successful aging and its focus on active engagement with life currently drives many wellness efforts for older adults. However, current efforts do not fully account for a loss of perceived mattering that accompanies role loss in older age. Schieman and Taylor (2001) noted that variations in mattering might be importantly connected to the entry and exit of specific social roles such as when older adults vacate occupational and familial roles and enter the role of

"retired" or "old person". Research outlined previously indicates the positive relationship between the understudied psychosocial construct of mattering and wellness in a variety of contexts, but no research has examined the structure of therapeutic interventions designed to promote a sense of mattering. Exploring conceptual tenets for the promotion of mattering holds both scholarly and practical significance for those designing and conducting therapeutic groups and wellness programs for older adults.

Attachment theory informs the conceptualization and utility of utilizing AIR to guide the structure and processing of reminiscence groups. Attachment theory maintains "interactions with a primary caregiver in childhood result in episodic memories that form secure or insecure working models of relationships in adulthood (Shorey & Snyder, 2006, p. 7). Individuals rely on a progression of attachment figures as they age and develop working models of attachment that are, in turn, consulted and influence the formation of new relationships (Shorey & Snyder, 2006). Shorey and Snyder maintain that by activating an individual's episodic memories of past working models of secure and comfortable attachments, these memories become a more salient basis on which the individual can evaluate current relational experiences in the present.

As they mature, individuals develop new working models of mattering just as they do new working models of attachment (Marshall & Lambert, 2006). The intent of the AIR structured reminiscence is, therefore, to assist clients in activating past working models of mattering in order that memories of secure and comfortable mattering relationships in the past may assist in the assessment and formation of current mattering relationships.

Tenets of Mattering Promotion Counseling

Rayle (2006) proposed that attending to awareness, importance, and reliance (AIR, the three sub-types of mattering) in the therapeutic relationship strengthens that relationship, and that

concerns for promoting AIR should overlay all engagements with all clients. She urges practitioners to incorporate a mattering focus into their methods of counseling, and provides examples of small interventions such as telephoning clients before appointments, noting the importance of the client' role to the therapeutic process, and communicating reliance on their participation in the counseling process as essential to the promotion of mattering.

Maintaining a mattering oriented approach by the counselor is, therefore, the first tenet of any mattering promotion intervention. Counselors desiring to enhance a client's wellness by promoting a sense of mattering must adopt a truly genuine orientation towards demonstrating to others that they matter; modeling mattering behavior is a natural requirement of this tenet. The challenge is for counselors to recognize and perform their role as a secure mattering base or temporary mattering source just as counselors maintaining an attachment orientation acknowledge their role as a secure base of attachment from which clients are able to explore thoughts, actions, and feelings as they develop new internal working models (Bolen, 2002; Erdman, 1998). Whether in individual or group settings, a counselor's demonstrating awareness of the client's existence, investment in the client's successes and failures, and reliance upon the client as essential for the entire therapeutic process are essential first steps to promoting mattering.

The second tenet that guides this approach is that clients must first have lower order basic human needs met before mattering can be promoted. According to Maslow, a hierarchy of human needs exists which drives human behavior (Vander Zanden, Crandell, & Crandell, 2007). Most often depicted as a pyramid, the most fundamental and basic of human needs, shelter and safety, lie at the base of Maslow's ranking of needs. When fundamental needs are satisfied, individuals then seek to fulfill higher order psychological needs of belonging and building

esteem on the journey to self-actualization which occupies the pinnacle of Maslow's model (Vander Zanden et al., 2007). Table 2 outlines the relationships between the categories and types of need on this hierarchy. As can be inferred from the table, mattering most closely aligns with an individual's desire to fulfill self-esteem needs, which include the desires for achievement, recognition, status, and responsibility.

Table 2

Maslow's Hierarchy of Needs

Category	Type of Need	Examples
Fundamental	Physiological	Satisfy hunger, thirst, and sex
	Safety	Secure shelter and protection from danger
Psychological	Belonging and love	Affiliate and belong
	Esteem	Achieve, be competent, win approval and recognition
Self-actualization	Fulfill potential	Continue self-directed change

Note. Adapted from "Human Development by J.Vander Zanden, T. Crandell, & C. Crandell. Copyright 2007 by McGraw Hill

These needs emerge only after biological and physiological, safety, and belonging needs are satisfied, so promoting a sense of mattering would be premature for an individual facing immanent physical danger or a lack of basic shelter.

A third tenet for a mattering framework would be the need to attend to the hierarchal nature of AIR. Similar to Maslow's hierarchy, a hierarchy of mattering needs must be acknowledged and properly sequenced into interventions. For persons to matter, not only must their presence in the group be acknowledged, but they must also feel as though they are important and that they make significant contributions to the group; mere membership in a group

is not sufficient by itself to elicit a perception of mattering, and a sense of belonging is essential for mattering to develop (France & Finney, 2009). The feeling that specific others or social institutions rely on an individual to further the other person's or organization's best interests is a defining facet of relational mattering. It is doubtful that individuals will feel relied upon, however, if they do not have another person who is vested in sharing their failures and triumphs. Finally, if a person's existence and contributions are ignored and does not receive indications that others are aware of his or her existence, it is doubtful that a sense of importance can develop. Therefore, it is important to tend to the hierarchal relationship of the types of mattering just as it is important to tend to Maslow's hierarchy of human needs. Mattering interventions should first ensure that clients perceive the counselor or group members are aware of their presence before implementing interventions aimed at promoting a sense of being important to others. It is only after individuals sense that others are aware of them and that they are important to others that relationships of reliance can be explored or facilitated.

The fourth tenet of a mattering-focused framework is that the counselor must create an environment that utilizes the structure of the group to promote mattering relationships. In addition to acting as a temporary mattering source for members, the counselor transforms the group into a mattering constellation by assigning group members as mattering buddies or partners for one another. The counselor must also take advantage of new sources of AIR presented by the group modality by assigning members jobs necessary for group functioning such as unlocking and setting-up the meeting space.

To summarize, the nature of this new approach for promoting psychological health in older adults relies on a growing body of literature that establishes the positive benefits of mattering in promoting wellness, particularly in regards to ameliorating the effects of changing

social roles with age. It offers opportunities to broaden the focus of current reminiscence therapies in order to incorporate and revitalize a sense of mattering for older adults by activating memories of specific past events. There has not been a formalized framework offered for the promotion of mattering; however, the research literature detailed above suggests that any framework to promote mattering should include the following tenets:

1. The counselor must provide clients with a sense that they matter to strengthen the therapeutic relationship.
2. Before mattering can be promoted, biological and physiological, safety, and belonging needs must be satisfied.
3. The hierarchal nature of AIR must be considered; awareness mattering must be promoted before importance mattering, and reliance may not be promoted until clients perceive they are important.
4. Group structure and processing must provide sources of AIR to support the participant's formation of new working models and the reactivation of memories associated with secure mattering relationships.

Conclusions and Implications

The positive relationship between mattering and wellness has been clearly established with a variety of populations and in a variety of contexts. The positive effects that mattering exerts on other psychological constructs such as self-esteem and life satisfaction have also been demonstrated, as have the negative relationships between mattering and depression, suicidality, and anxiety. Despite the growing body of literature that supports mattering as a viable psychosocial construct, no research has examined how mattering might be promoted as a path to improving wellness.

Attending to the components of AIR in interactions with individuals and groups is a unique way to strengthen the therapeutic relationship no matter what the population. As individuals age they confront normative developmental challenges and transitions, which are accompanied by shifting mattering dynamics. By adopting a mattering-focused practice, counselors can establish themselves as temporary, or transient, mattering sources and secure bases of mattering to support a client's needs for AIR until other sources are developed or discovered. Linking the shifting mattering sources and relationships that individuals experience during their normal life course adds a new dimension of development for counselors to pursue with clients who may be experiencing difficulty adjusting to new roles and associated changes in mattering relationships. As an example, some clients may experience difficulties by losing mattering sources while others may become overburdened by performing as a mattering source for too many other people such as the caregiver who is sandwiched between responsibilities for child and parent.

Reminiscence therapy is a popular intervention for promoting social connectedness and psychosocial health, and for reducing loneliness through the sharing of memories by participants and is an excellent vehicle for studying whether structuring and conducting groups according to a framework of AIR can promote mattering. Older adults are particularly affected by losses of mattering sources and exploring past working models of mattering, facilitated during reminiscence, may be an effective way for assisting older adults in negotiating the developmental stage of ego integration versus despair or achieving gerotranscendence. Reviving past working models of mattering may facilitate the creation of new mattering sources and relationships. The group modality also allows group leaders model mattering activities and to construct a

constellation of mattering among group members so that the group provides a supply of AIR until other sources are developed.

The amount of research that establishes the positive relationship between wellness and mattering indicates that wellness may be increased through the promotion of mattering. Attending to the four tenets of the mattering promotion framework proposed above in the design and conduct of interventions may prove to be an effective way to enhance wellness in a wide variety of contexts and populations.

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

This chapter describes the research design and methodology, which includes: a description of the population and sample, data collection procedures, instrumentation, the research design of the study, hypotheses, data analysis, and a brief description of the intervention. Ethical considerations and limitations are also provided. A detailed outline of the intervention follows in Chapter Four.

Target Population and Sample

The target population for this study was adults 60 years old or older residing in continuing care retirement communities (CCRCs) in the greater Williamsburg, James City County, and Upper York County areas. The participants resided in an area that is ethnically 82.5 percent White, 14 percent African American and 3.5 percent "other," reflecting less ethnic diversity than national rates of 75 percent White, 12 percent African American, and 9 percent "other" (U.S. Census, 2010). A popular retirement destination, over 20 percent of the local population in Williamsburg is aged 60-years-old or older compared to 11.8 percent in that age group at the state level and 12.6 percent nationally (U.S. Census Bureau, 2010). This target population of older adult residents was selected because it encompasses older adults who have undergone transitions associated with the removal of primary parenting and work roles.

Random sampling was prohibitive in terms of time and cost, so convenience sampling was employed, with the understanding that results from this study may not be generalizable to other older adult settings. The principal investigator (PI) first contacted the Executive Director of the only CCRC accredited by the Commission on Accreditation of Rehabilitation Facilities in the Williamsburg, James City County, Upper York County area and presented an outline of the

study to gain approval and support in recruiting 60 participants. The Executive Director approved and facilitated PI contact with a small support cell, which included the Directors of Resident Services, Community Relations, Medical Services, Ambulatory Home Health Care, and the Activities Coordinator. Feedback on the feasibility and scope of the study was also obtained from members of the Resident's Council and the Chair of the residents' wellness committee.

An initial round of flyers outlining the study and asking for volunteers was placed in the mailboxes of 359 independent living residents (female = 228, male = 131) by the Director of Resident Services. A question and answer session hosted by the PI followed two days later. A second round of flyers was mailed two weeks after the first, and was followed by the PI's staffing of an information table during a Sunday brunch event the following weekend. Members of the support cell also referred residents that they thought would benefit from participating in reminiscence activities.

Recruiting efforts fell short of the desired 60 participants with only 17 women and five men volunteering for the study. The staff recommended that two volunteers not participate due to concerns about their cognitive and mental health status, resulting in a final group of 20 participants (female = 16, male = 4) being randomly assigned to one of two treatment groups with the knowledge that attrition could threaten the ability to perform meaningful statistical analysis of variance. In addition to completing an Informed Consent and Confidentiality Agreement, all participants completed the Five Factor Wellness Inventory (5F-WEL) and the Mattering Index during pre-testing. One male participant withdrew from the reminiscence with AIR treatment group during the study resulting in 19 participants completing the 5F-WEL and Mattering Index during post-testing.

Data Collection

The Directors of Medical Services and Ambulatory Health Care screened all participants to ensure that cognitive or mental health issues would not interfere with regular group participation. Participants were randomly assigned to one of two treatment groups and were informed during the first session of the purpose of the study and their right to terminate their participation in the study at any time without penalty. Participants were given an opportunity to ask questions before being asked to sign and date the informed consent and confidentiality statement. A doctoral-level proctor assisted in setting-up the testing room and distributing packets that contained the instruments and answer sheets. The proctor was also required to assist one participant who was legally blind with completing the assessments.

All participants (n = 20) completed the 5F-WEL and Mattering Index during pre-testing. Demographic information was captured from fields contained on the 5F-WEL. In order to determine and counter the presence of any possible ordering effect, half of each treatment group completed the 5F-WEL before the Mattering Index, and the order of administration was reversed for the remaining half of each group. The sequence of tests was similarly reversed for all participants on the posttest. The same doctoral-level proctor assisted with distributing and collecting materials, as well as with assisting the visually impaired participant with completing the two instruments (N = 19). To ensure privacy, a unique code was assigned to each participant, and the PI maintained sole access to a master cross-indexed list of identities in order to determine the sequencing of the instruments for pre- and post-testing. After post-testing was complete, participants were also asked to provide comments relating to their favorite and least favorite topics and general impressions and suggestions for similar programs.

Instrumentation

Four instruments were used to collect data during this study. They include an informed consent form (Appendix A), the Five Factor Wellness Inventory (Appendix B), Elliot, et al.'s Mattering Index (Appendix C), and a participant feedback form (Appendix D).

Informed Consent

The informed consent form outlined the purpose of the study, described participant and researcher expectations, and identified how results would be used. Procedures for assuring security and confidentiality of data were outlined, as were the participants' rights to leave the study at any time. Supervisory contact information was provided, in the event that a participant wished to contact the researcher's supervisors or the human subjects committee to address concerns. Participants signified their agreement to participate by signing and dating the Informed Consent form. The researcher kept one copy for the researcher files and provided a copy to participants for their records.

Five Factor Wellness Inventory

The Five Factor Wellness Inventory (5F-WEL-A; Myers & Sweeney, 2005) was selected for this study, because it measures multiple domains of adult perceived wellness. The 5F-WEL-A is an 89-item assessment based on an earlier measure of wellness, the Wellness Evaluation of Lifestyles (WEL, Myers, Sweeny & Witmer, 1994, 2004). Seventy-nine questions assess a single higher order factor of global wellness by combining scores of 17 factors of wellness. Ten items collect demographic data related to age, gender, relationship status, employment and student status, years of education and educational level, advanced degree held, sexual orientation, and ethnicity.

Items are written at the ninth-grade level, and respondents are directed to ask themselves if each statement is true most of the time before choosing from among the four Likert-type responses for each item: strongly agree, agree, disagree, or strongly disagree- (DeMauro & Lonborg, 2005). Possible responses range from (1) for strongly disagree to (4) for strongly agree. They are then converted into a total score by multiplying by 25, so that final scores on the scale range from a minimum of 25 to a maximum score of 100, with higher scores equating to higher perceptions of wellness. It took respondents fifteen to twenty minutes to complete this assessment. Minimal training was required for administration of the instrument, and completed assessments were required to be mailed to one of the authors of the instrument, Dr. Jane Myers, for scoring.

The test manual indicates that validation data includes a combined sample of scores from 3343 adults that had taken the Wellness Evaluation of Lifestyle (WEL, Myers, Sweeny & Witmer, 1994, 2004), the precursor to the 5F-WEL. The creators of the 5F-WEL note that validation based specifically on the WEL is valid, since both models share the same 17 wellness factors that were identified through structural equation modeling as accurate measures of global wellness (DeMauro & Lonborg 2005). Males comprised 35 percent of this sample, and African American's comprised 27 percent, reflecting an under and over representation from national averages respectively. The alpha coefficient of internal consistency for the five factors ranged from .89 to .96, and for total wellness the alpha coefficient was .94. There is no test-retest reliability data reported that is specific to the 5F-WEL, although the two-week test-retest reliability for the WEL exceeded .68 (DeMauro & Lonborg 2005). The global wellness scale was used for the current study since it provides the most accurate assessment of wellness given the small sample size.

The Mattering Index

Elliot, Kao, and Grant (2004) constructed a 24-item instrument to measure perceived mattering and its three sub-types of awareness, importance, and reliance as originally proposed by Rosenberg and McCullough (1981). The 24 items are structured to measure how much of one of the three types of mattering are reflected by each statement. Respondents are asked to not focus on specific individuals but to consider interpersonal relationships in general when responding using a four-point Likert scale to how much they agree or disagree with each of the 24 statements. Response options range from 1 (strongly disagree) to 4 (strongly agree). Twelve items (item numbers 1, 2, 3, 5, 8, 9, 13, 15, 16, 17, 19, 20) are reverse scored resulting in a final score of between 24 and 96. Higher scores indicate higher perceptions of mattering to others.

Elliot, et al (2004), using a sample of 508 college students, reported internal construct validity between the three components of mattering: awareness, importance, and reliance. Awareness factor loadings ranged from between .307 and .753 (median = .692); importance coefficients ranged between .408 and .705 (median = .587); and the range for the reliance factor was between .520 and .772 (median = .722), indicating that each item accurately reflects a distinct facet of the components of mattering. Chronbach's alphas for all 24 items with three different samples were .904, .922, and .886, respectively.

Participant Feedback Form

At the completion of post-testing, participants were given an opportunity to provide feedback on their satisfaction with the reminiscence protocol. Participants responded to eight questions using a five-point Likert scale ranging from one (low satisfaction) to five (high satisfaction). These questions asked for ratings of: (a) overall satisfaction, (b) adequacy of time and space provided, (c) the group's composition, (d) the group leader, (e) communication

procedures, (f) topics selected, (g) and usefulness of the program. Space was provided for participants to comment on the topics and aspects of the program they felt to be most and least beneficial, as well as providing suggestions for improvement and general comments. Responses to the items on this form were not statistically examined; rather, the responses provide participant insight on specific aspects of reminiscence protocols to aid in analysis and replication studies.

Research Design

This study was designed as a quasi-experimental, pre-test/post-test, 2 (gender) X 3 (treatment) between group design utilizing gain scores obtained from the two different instruments. It was anticipated that members of treatment groups would demonstrate significant gains in wellness, and that participants in groups structured and around the tenets of the AIR framework described in the previous chapter will demonstrate the largest gains in both wellness and mattering. It was also anticipated that gender would impact the results, with women recording larger gains in wellness and mattering than men. The lines of research outlined in the previous chapters have established the positive relationship between perceived mattering and wellness. This study aimed to build upon that research by investigating whether perceived mattering can be promoted, thus potentially enhancing wellness, by incorporating tenets of mattering into the structure of therapeutic interventions.

Research Questions

This study intended to address the following research questions:

1. What is the effect of structured reminiscence interventions on the global wellness of older adult participants?

2. What is the effect of a mattering structured intervention on the global wellness and perceived mattering to others of older adult participants?

3. What influence do other demographic variables such as age and gender exert on participant wellness and perceived mattering?

4. How are the measures of wellness and mattering correlated with older adult residents of CCRCs?

Hypotheses

The four directional research hypotheses for this study are:

H1. Older adults participating in-group reminiscence therapy will demonstrate significant gains in global wellness as measured by the Five Factor Wellness Inventory (5F-WEL).

H2. Older adults participating in group reminiscence therapy structured around a awareness, importance, and reliance (AIR) mattering framework will demonstrate significantly greater gains in global wellness as measured by the 5F-WEL, than participants of traditionally structured group reminiscence.

H3. Older adults participating in group reminiscence therapy structured around an AIR mattering framework will demonstrate significantly greater gains in mattering as measured by the Mattering Index, than older adults participating in traditionally structured group reminiscence.

H4. Women will demonstrate greatest gains in wellness as measured by the 5F-WEL and mattering as measured by the Mattering Index than men.

Data Analysis

Mean gain scores were computed using pre- and post-test scores from the 5F-WEL and Mattering Index. PASW Statistics GradPack 18 (formerly SPSS statistics) software was used to perform statistical analysis. Descriptive statistics used to present a profile of the study participants are presented in Chapter Five (see Table 5). Since the number of total participants in this study fell far short of the 60 desired, the control group condition was omitted. Additionally, because not enough males volunteered for this study to conduct a statistically meaningful two (gender) X two (treatment) multivariate analysis of data (MANOVA) hypothesis four remained untested but was retained in the study to highlight the need for examining gender variations in wellness and mattering promotion in replication studies. A Chi square analysis for independence was performed to determine the equivalency of groups in the categorical variables of gender, age, educational level, marital status, employment status, ethnic heritage, and affective/sexual orientation. Chronbach's alpha was computed to determine internal consistency and reliability of each scale. Dependent t-tests were performed to compare pre- and post-test means of both instruments in order to determine the presence and impact of any ordering effect imparted by the sequence of instruments completed by participants. Results from dependent t-tests were also used to determine the impact on wellness of reminiscence for all participants. Independent t-tests were performed to determine the significance of wellness and mattering gain scores between treatment groups. Pearson-product correlation (*r)* was computed to determine the relationship between the two measured constructs of wellness and mattering. Given the small total sample size and small numbers within each treatment group, a significance level of $p < .1$ was used to increase the sensitivity for detecting significant change and to reduce potential for Type II errors.

Brief Description of the Intervention

The intervention used a specialized curriculum of topics to guide discussion and processing of shared reminiscence. Originally intended to include a control and two treatment groups, a limited sample size resulted in only two differing types of treatment groups being used for this study; those that processed memories and experiences in the context of "traditional" reminiscence protocol similar to that proposed by Stinson (2009), and those that incorporated the elements of AIR while executing the structured reminiscence protocol. A more detailed review of the intervention is provided in Chapter Four. Both groups met once a week for five consecutive weeks beginning in May 2012. Each meeting was 90-minutes in length and consisted of two differently themed 45-minute sessions separated by a 15-minute intermission. During each session, participants were encouraged to share and discuss past pleasant memories that were appropriate and relevant to the session's theme. An intervention and session guide for the counselors leading the groups provided timing, themes, and topical stems for sessions. Counselors accessed and displayed images from the Internet and encouraged participants to bring artifacts such as printed materials and photographs to aid in sharing memories. Counselors recorded general and clinical impressions on session logs contained in the intervention guide.

Counselor Credentials

Two second-year doctoral-level counselors who had completed course work in advanced group processing from the College of William & Mary Counselor Education Program led the treatment groups. Both counselors received training on older adults and aging, working with older adult groups, and the structure and sequence of the experimental (AIR) protocol. The counselor assigned to lead the AIR structured groups had previously attended two professional presentations on the theoretical underpinnings of mattering and had received additional training

on the tenets of mattering promotion from the PI before the study began. During and after each session the counselors completed a session log that served as a basis for discussion with the PI following each session. Weekly group supervision was conducted by Dr. Charles R. McAdams III, Co-PI.

Reminiscence Treatment Group

Reminiscence groups promote social connectedness and engagement for older adults. The leader of this treatment groups attended to the critical attributes of reminiscence by facilitating verbal interactions between at least two people in the group as they recalled and told of memories focused on past events or experiences. The role for the counselor leading this group included introducing topics and themes as outlined in the treatment and session guide, ensuring participant discussions remained on pleasant then and there experiences, and protecting members from over talkative or intrusive group members.

Mattering Promotion Group

The intent of the AIR structured reminiscence was to assist clients in activating past working models of mattering using the framework of reminiscence therapy so that memories of secure and comfortable mattering relationships might assist in the assessment and formation of an improved sense of mattering to others. Activating past working models of mattering required a more active stance by the counselor in this treatment group. Not only did the counselor attend to the basic attributes for conducting reminiscence groups, she also facilitated discussions among group members about changing perceptions of AIR that resulted from the events shared with the group. Both groups used the same intervention and treatment guide to standardize the schedule and sequence of themes and topics. However, the leader of the mattering promotion group also attended to four tenets of mattering promotion:

1. The counselor must provide the client or clients with a sense that they matter to strengthen the therapeutic relationship (Burnside, 1994; Dixon, 2006)
2. Before mattering can be promoted, biological and physiological, safety, and belonging needs must be satisfied (as cited by Vander Zanden, et al., 2007).
3. The hierarchal nature of AIR must be considered; awareness mattering must be promoted before importance mattering and reliance may not be promoted until clients perceive they are important (Rosenberg & McCullough, 1981).
4. Group structure and processing must provide sources of AIR to support the participant's formation of new working models and the reactivation of memories associated with secure mattering relationships (Burnside, 1994).

Ethical Considerations

This study posed minimal risk to group leaders and participants. All participants in this study were treated with the utmost respect and care. Participants were informed that the purpose of the study was to examine the effects of the structure of reminiscence groups on older adult wellness. Group leaders expressed heightened anxiety because of unfamiliarity in working with older adults; however, this was ameliorated before the intervention began by providing them with an educational session on older adult development and aging, special considerations for counseling groups of older adults, and the structure and processing of reminiscence groups. Although not as great as the risk posed by more intensive life review modalities discussed in Chapter 2, there was a risk of participants experiencing transitory emotions of depression, unresolved grief, or anxiety associated with the memories shared during sessions. To address this risk, appropriate actions for monitoring and assessing mood disorders, cognitive challenges, and harmful substance interactions were included during the counselor training session. Group

counselors were prepared to conduct brief interventions with individual group members displaying emotional distress and in such cases, were directed to notify the Director of Medical Services and the PI of intervention efforts taken, their assessment of the distressed participant's condition, and their recommendations for additional services as needed. Counselors were required to call their group members each week with reminders for the next session and to maintain awareness of any issues that might impact a member's participation. As it turned out, no participants experienced emotional distress that could not be rectified through conversations in-person and during these required weekly telephone calls by the counselor.

Ethical guidelines established by the American Counseling Association and The College of William & Mary's Internal Review Board relating to the treatment and protection of research participants were strictly followed. The proposed study was reviewed and approved by the College of William and Mary, School of Education Human Subjects Review Committee. After screening, participants were, as noted previously, presented with an informed consent agreement for review and signature. In addition, doctoral level counselor who did not participate as group leader for the study acted as a test proctor during pre- and post-testing to answer any questions, explain the provisions contained in the informed consent agreement, and read and record responses for one participant who was visually impaired. Personal information was kept confidential and protected at all times. The PI assigned codes to participant's identities to ensure anonymity, and maintained the only access to the cross-referenced index of codes and names. Study participants were assured that their living arrangements and residential status would not be impacted in any way through their participation in this study.

Informed Critique

It was critical to control for the effect of extraneous variables that could influence the outcomes of the proposed study to the maximum extent possible. Common threats to the internal validity of experimental and quasi-experimental studies include subject characteristics, mortality, location, instrumentation, testing, history, maturation, subject attitudes, regression, and implementation (Fraenkel & Wallen, 2006). Following are explanations of the identified threats to the internal validity of the proposed study and how they were accounted for and controlled for in the study design.

Subject Characteristics

Specific individual differences among participants may adversely impact any study. Although participants in the study varied in terms of many important personal factors, the small sample size limited the potential variability of these factors but also may have magnified their effects. Random assignment of participants to also minimized this threat by ensuring that any possible unobserved systematic characteristics were evenly distributed between the groups (Gall, Gall, & Borg, 2007). The nature of the intervention decreased this threat by relying on personal reminiscence that carries unique meaning for the individual who reminisces. The process of sharing was more important to outcomes than the content of the memories and did not require other subjects to comment or validate these experiences beyond sharing them.

Mortality

The mortality threat is associated with losing subjects during a study. Because participants in this study were older adults, there was a heightened risk that illness, hospitalization, or death could impact participation and results. As noted previously, participants were screened for any serious medical conditions or medical procedures which might have impacted on their ability to regularly attend sessions. Limiting this study to five weeks also

reduced the chance that a participant was unable to participate for the full duration of the study.

Location

The location in which the study is conducted and data collected may impart a threat to validity, particularly if different groups are conducted at different locations. To reduce this location threat, all testing and group counseling was conducted in the same two rooms at the CCRC's health club and spa, thereby reducing the potential for having to account for differences in lighting, environmental control, accessibility, etc..

Instrumentation

The manner in which instruments are used in a study can confound results. Instrument decay, data collector characteristics, and data collector bias must be accounted for and controlled. Overall these threats were controlled by using instruments that are reliable and valid. Only the global wellness and total mattering scores were used to determine gains because the small sample size and attendant restricted variability precluded a meaningful investigation into the 17 subcomponents of mattering. Although the wellness and mattering assessments partially counter the threat of instrument decay by using Likert-type scales that restrict the range of possible responses, the older adults of this study were unfamiliar with bubble response sheets. In anticipation of this, additional time was allocated for explaining and demonstrating the proper way to cross index questions and answers and a large print copy of the bubble response sheets was provided to reduce fatigue. Threats caused by characteristics and bias of data collectors were minimal, since the graduate-level student counselors running groups and collecting data received standardized education on instruments, aging issues, and reminiscence therapies prior to groups beginning.

Testing

Internal validity is threatened any time pre- and post-testing is conducted, because it is plausible that study participants may determine the nature of the intervention from the instruments used for the pre-test. Administering identical pre- and post-tests 5-weeks apart ensured that respondents could not track the purpose of the study based on their completing different assessments.

History

Whenever an experimental study is conducted over time, there is always the threat that other unforeseen events may occur which could impact participants. Limiting the study to five weeks reduced the opportunity for events to occur which might have impacted participants. Conducting sessions on the same day of the week, at the same time of day, and in almost identical rooms helped to ensure that any historical events would have a similar effect on each group. The counselors were reminded to be continually alert to the influences of events, such as unpredictable spring weather and ongoing construction at the CCRC, and to record any such events and their influence on group members and group processing so the PI could take them into account during analysis. No unanticipated events occurred during the course of the study to impact either the continuity of the study or responses of subjects.

Subject Attitude

Another threat that could confound the study is that participants in different groups may share their experiences and change the nature of the study by developing attitudes of superiority, inferiority, or competition among group members. Participants in a treatment group may feel special and react more positively to the unique aspects of the treatment and other members may feel that they are being denied desirable intervention and react negatively. This threat was minimized by standardizing the instruments administered to participants and through the use of a

standardized reminiscence protocol so that both groups were discussing the same topics and in the same sequence. The addition of the AIR agenda simply supplemented the reminiscence protocol rather than denying any specific treatment.

Statistical Regression

This threat is present when using pre-test/post-test designs and is defined as the "tendency for research participants whose scores fall at either extreme on a measure to score nearer the mean when the variable is measured a second time (Gall, Gall & Borg, 2007, p. 385). With a larger sample, extreme scores can be identified and excluded to control for this threat but because of the small sample size for this study, no scores were excluded.

Implementation

Variances in implementation pose a major threat, because the nature of mental health group counseling is fluid and allows group leaders great freedom in terms of personal style and interventions employed. For this study, however, the role of group leaders were constrained by the necessary attributes of reminiscence group therapy that include a less active group leader role and a significant level of structure in the treatment protocol. A detailed intervention guide with detailed session guides reduced this threat along with meetings between counselors and the PI before and after all sessions to discuss implementation issues. The fact that the efforts of only two counselors had to be coordinated also would seem to have reduced this treat.

In summary, the strengths and potential usefulness of this study would seem to counterbalance its limitations. The threats discussed above were carefully considered and controlled for in the design and implementation of the study. Participants were selected from the same population, randomly assigned to treatment groups, and completed the same pre- and post-

test instruments. Groups met concurrently in almost identical environments and followed the same base five-week protocol facilitated by trained doctoral-level counselors.

Chapter Summary

This chapter described the research design and methodology that was used for this study. It includes a detailed description of the target population and sample, counselor credentials, and the data collection process. Information on the validity and applicability of the instruments used was presented as were the research questions and hypotheses that drove the data analysis process that was also outlined. The chapter concluded with an examination of ethical considerations and the threats to internal validity that were considered in the design of the study. The results of the study are detailed in chapter five.

CHAPTER FOUR: INTERVENTION DESIGN AND METHODOLOGY

This chapter describes the design of the intervention used in this study. A detailed description and purpose are followed by the participant and counselor requirements. The chapter concludes with an outline of the session objectives and a discussion of the researcher and session logs which the lead researcher used to surface any challenges and guide the intervention.

Description of the Intervention

The intervention consisted of ten, 45-minute structured sessions conducted over a five-week period and involved implementing a specialized curriculum of topics to guide discussion and processing of shared reminiscence among groups of residents of a continuing care retirement community (CCRC). The 20 participants were assigned to one of two types of treatment groups for this study; one that involved shared memories and experiences in the context of a structured reminiscence protocol (reminiscence only), and one that incorporated the mattering tenets into group function and processing of the same structured reminiscence protocol (reminiscence with AIR).

Both groups met in multi-purpose meeting rooms of their CCRC's health club beginning in May 2012. Groups met simultaneously and on the same day of the week and time of the day for the course of the study. Each weekly meeting consisted of two 45-minute topically-themed sessions separated by a 15-minute intermission with refreshments. Counselors trained on issues of aging, counseling older adults, and the sequence and structure of the intervention introduced topics and discussion stems and searched for Internet images to project on a screen in the front of each room to assist with the generation of memories. Participants discussed pleasant past memories according to topical cues introduced by the group counselor and provided artifacts as aids to reminiscence when called for in the session guides. Individual session guides were

constructed to be used as working logs by counselors to capture impressions, comments, and concerns.

Purpose of the Intervention

Supporting Wellness With Reminiscence

One purpose of the intervention was to improve the global wellness of all participants by facilitating an environment that allows the verbal exchange of pleasant past memories in a group setting. Empirical evidence establishes reminiscence as a viable practice for assisting older adults with coping with life transitions, reducing depression, increasing self-esteem, self-care, and life satisfaction, and building social relationships (Bohlmeijer, Roemer, Cuijpers, and Smit, 2007; Jones & Beck-Little, 2002; Myers & Harper, 2004). The group modality for older adult reminiscence is not only cost effective, but by its nature is a good vehicle for reducing isolation and enhancing social connectedness, communication skills, self-care, quality of life, and validation of life experiences (Burnside & Haight, 1992).

Adding Mattering to Reminiscence

A second purpose of the intervention was to assist those participants in the reminiscence with AIR group to activate past working models of secure and comfortable mattering relationships which might assist in the assessment and formation of satisfying mattering relationships in the present. The same protocol of topics and sequencing was used for both reminiscence groups but the elements of AIR were used as the framework for processing shared memories in the reminiscence with AIR group. Constructs related to attachment theory informed the conceptualization of using AIR in guiding this group's functioning and processing.

Attachment theory accounts for the impact of early childhood experiences with primary caregivers and the development of internal working models that convey an individual's sense of

value and worthiness of care throughout life (Raque-Bogdan, Ericson, Jackson, Martin, & Bryan, 2011). Shorey and Snyder (2006) maintain "interactions with a primary caregiver in childhood result in episodic memories that form secure or insecure working models of relationships in adulthood (p. 7)". Individuals rely on a progression of attachment figures and working models as they age which are, in turn, consulted and influence the formation of new relationships (Shorey & Snyder, 2006). Shorey and Snyder maintain that by activating an individual's episodic memories of past working models of secure and comfortable attachments, these memories become a more salient basis on which the individual can evaluate current relational experiences in the present.

Mattering and attachment are theoretically linked, in that a secure adult attachment style tends to be indicative of consistent, internalized experiences of being nurtured and seems to include a feeling of mattering to caregivers (Raque-Bogdan et al., 2011). The expectation that emotional support will be available in times of need implies that there are others who are aware of the individual's existence, who are emotionally vested and interested in sharing in that person's successes and failures, and who rely upon the individual to further the other's best interest's (Raque-Bogdan et al., 2011).

Objectives of the Intervention

Improving Wellness

The overarching objective of the intervention was to provide an environment that encouraged participants to verbally share and discuss pleasant remote memories in the group setting, thereby enhancing wellness. Stinson (2009) provides growing evidence that structured group reminiscence protocols provide better outcomes than unstructured group reminiscence and that older adult participants most enjoy sharing about "firsts", "favorites", and "bests" (p. 525).

Therefore, the topics selected, their sequencing, and the stems used in the current study to promote sharing were standardized for both types of groups as indicated in Table 3. Overall guiding objectives of the baseline reminiscence intervention were to:

- Provide a safe and trusting group environment that promoted the sharing and processing of personal memories.
- Reduce isolation among participants by providing an enjoyable, interactive, and regularly scheduled group program.
- Enhance social connectedness by providing topics that are engaging and relevant to the specific generational cohort of the participants.
- Link participants' memories to validate personal life experiences.
- Allow for the exercise and improvement of communication skills as participants share.

Promoting Mattering

In addition to designing an intervention that capitalizes on the positive relationship between reminiscence and wellness, the study also aimed to promote a sense of mattering in participants of the reminiscence with AIR group. Group content and process for this group were consistent with the tenets of mattering promotion, and the elements of AIR were used as a framework for supporting the participant's formation of new working models and the reactivation of memories associated with secure mattering relationships. Overall objectives for the reminiscence with AIR treatment group were to:

- Ensure that all members of the group feel that they matter to their counselor through the application of AIR during all interactions.
- Introduce mattering and the components of AIR as a method for participants to evaluate past working models of mattering and when evaluating current relational experiences.

- Ensure group processing provides sources of awareness and importance mattering for participants.
- Use the group constellation to structure reliance relationships among members.

Table 3

Overview of reminiscence themes and sequencing

Session/week	Theme	Stem examples
Session 1, week 1	Pretest	n/a
Session 2, week 1	Introductions	Birth place; proudest accomplishment
Session 3, week 2	School days	First days of school/college; favorite clothes; best classes and teachers
Session 4, week 2	Fun and Games	Favorite toys; favorite outdoor games; favorite adult activities
Session 5, week 3	Work and Home	Best job; favorite position or activity; first home
Session 6, week 3	Family and Pets	Favorite relative; remembering children; favorite pets
Session 7, week 4	Romance	Favorite first dates; best dates; wedding proposals
Session 8, week 4	Holidays and Traditions	First and favorite holidays; favorite traditions
Session 9, week 5	Old and New Friends	First best friend; new best friends
Session 10, week 5	Post-test	n/a

Requirements of the Intervention

Before the intervention began the lead researcher provided the two second-year doctoral counselors with a 90-minute training session that encompassed: (a) the demographics, myths,

theories, and developmental challenges of aging; (b) the principles of reminiscence therapy; (c) a review of group theory and modifications for older adults; (d) the role of the counselor in handling challenges and monitoring members; and (e) a review of the intervention protocol to include the timeline, activities, and use of the session guidelines and log. The counselor leading the reminiscence with AIR group had previously attended presentations on the AIR model and also received an additional half hour of training on the mattering tenets and using AIR as a framework to compliment the reminiscence protocol. Counselors were required to review the session guides in order to be familiar with stems and topics. They called each of their group members 24-hours in advance of sessions with a courtesy reminder of the session times, themes, and special requirements such as providing an artifact or memento for discussion. Counselors met with the lead researcher before each session and provided notes on session logs after each session. Participants were expected to attend sessions prepared to share their memories and to limit discussions, and artifacts, to the topics introduced.

Intervention Design

Reminiscence Groups

As noted earlier, group reminiscence therapy requires a verbal interaction between at least two people during the sharing of past memories (Burnside & Haight, 1992). The counselor's role in this group was limited to the introduction of session themes, insurance that the discussion remained on pertinent and pleasant "then and there" experiences, and protection of members from intrusive probing by others in the group. The lead researcher provided counselors with treatment guides that identified the sequence of topics for each session, provided topic-specific stems to initiate sessions, and also functioned as a researcher log. Table 3 provides an

overview of the sequencing of themes and stems that guided the reminiscence-only group intervention.

Individual session guides included space for counselors to record administrative comments relating to the facilities and other support issues that impacted group functioning and to capture clinical impressions of the group functioning and concerns about any group member. In this way the session guides doubled as a therapist log and were used during a weekly meeting with the lead researcher to address concerns before the next week's reminiscence sessions were conducted

Reminiscence With AIR

Using the same baseline curriculum as the reminiscence group, the design of the reminiscence group used the counselor as well as the group dynamic to promote perceived mattering. The counselor's role capitalized on the universal human need to matter while the group provided the counselor with an opportunity to structure a mattering constellation or community for group members. Table 4 outlines the role of AIR that guided the counselor in both individual and group settings and includes examples of questions intended to stimulate memories that specifically relate to AIR during group processing.

The design of the reminiscence with AIR group incorporated the four tenets of mattering promotion:

1. The therapist must provide the client or clients with a sense that they matter to strengthen the therapeutic relationship (Burnside, 1994; Dixon, 2006)
2. Before mattering can be promoted, physiological and safety needs must be satisfied (as cited by Vander Zanden, et al., 2007).

3. The hierarchal nature of AIR must be considered; awareness mattering must be promoted before importance mattering and reliance may not be promoted until clients perceive they are important (Rosenberg & McCullough, 1981).

Table 4

The role of AIR in individual and group contexts and examples of questions for AIR promotion.

Component	Individual: building the counseling relationship	Group: guiding shared group reminiscence.
Awareness	• Attend to clients. • Note differences of appearance from previous sessions. • Call the client immediately to follow-up on missed appointments. • Focus more on nonverbal cues.	• Processing awareness by others to group member's shared memories. • "How did getting that first car cause people to take notice of you?" • "What other things did people put on their bicycles when they were children to get them to stand out from the crowd?"
Importance	• Demonstrate how important clients are to the counselor and the counseling process. • Send notes or cards that mark significant life events and accomplishments. • Employ nonverbal gestures of empathy. • Slow the pace of counseling; show patience.	• Processing experiences of importance • Begin group with recognition of significant life events and accomplishments of members. • "How did getting a new vehicle impact your importance to others?" • "In which ways did that make you feel as though you were important to others?"
Reliance	• Illustrate that the counselor relies on the client for success. • Remind the client that the counseling process (the counselor's job) relies on the client's efforts.	• Assign rotating duties among group members that are critical to group functioning. • Remind the group that successful outcome relies on each member's participation. • Pairing members as "mattering buddies" to foster reliance.

4. Temporary mattering sources and group constellations must be provide as sources of AIR to support the formation of new working models and the reactivation of memories

associated with secure mattering relationships (Shorey & Snyder, 2006).

The intent behind the first tenet is to strengthen the therapeutic relationship and to assist in the formation of the counselor as a temporary mattering source for each participant. To do so, the protocol required that the counselor make personal connections with each participant before, during and after each session. The counselor was also required to contact each participant by telephone each week and to make a personal one-on-one contact with each participant either before each session or during the 15-minute intermission between each week's two group sessions to promote awareness. To promote importance, the counselor was required to remain alert to and highlight any group member's achievements, awards, special accomplishments, or personal milestones. Reliance mattering was be demonstrated by the counselor stressing appreciation to participants for continued participation and reminding them how the group relies on each individual to attend sessions and share in the conversations and activities for survival.

The second tenet is actualized by ensuring participants have basic physiological and safety needs satisfied before promoting the satisfaction of the higher order needs of belonging and mattering. The CCRC environment provides a high level of secure housing, housing support, nutrition, and activities and wellness programs that support the fulfillment of lower order needs of residents. Although the counselors in this study had little to no ability to directly influence a participant's lower order physiological and safety needs, she was nonetheless charged with maintaining vigilance for participants' comments, outward behaviors, and affect which might indicate unmet lower order needs. The lead researcher coordinated with the Directors of Resident Services, Medical Services, and Ambulatory Home Health Care during recruitment to ensure no participants were knowingly dealing with basic need issues at the outset of the study. Session guides provide subsequent opportunity for the counselor to make any notes

or clinical impressions regarding unmet lower order needs that might appear once the study was underway. Any such issues observed by the counselor were to be brought to the attention of the lead researcher and the above-named members of the resident support staff.

The hierarchal nature of the components (i.e., tenet three) of mattering was established in a number of ways, beginning with the lead researcher emphasizing this hierarchal order during the additional training for the counselor of the reminiscence with AIR group as outlined earlier. Armed with this knowledge, the counselor was ultimately responsible for maintaining this hierarchal relationship during all client contacts and when processing memories with the group. The counselor provided each group member with personal attention through phone calls and other personal contact before, during, and after sessions to ensure that all group members received a baseline level of awareness mattering. Tending to the relationship of the AIR components while participants activated past working models of mattering required that the counselor maintain a more active stance of questioning and prompting to ensure issues of awareness were examined before issues of importance, and that reliance issues were examined only when participants felt that they were important to others. Table 4 provides examples of the sequential nature of questions used by the counselor to aid in AIR processing. As an additional measure, the counselor explained the AIR model and the hierarchal relationship of the components to the members of her group during the second session to reinforce the hierarchal AIR relationship.

The final tenet for mattering promotion requires the counselor to transform the group into a mattering community as a source of mattering for participants. The counselor linked participant experiences and encouraged group members to demonstrate awareness of one another and mutual interest in each others' shared stories. Reliance was fostered by assigning group

members responsibilities for various group functions such as setting up the meeting space, procuring refreshments, and calling each other with reminders. The group modality also allowed the counselor to promote reliance by assigning participants as temporary mattering partners for one another. In these roles participants were encouraged to rely upon one another, as opposed to relying solely on the counselor, for answering questions about topics or administrative details of the upcoming sessions, sharing rides to and from sessions, and continuing to reminisce about past topics.

Activating past working models of mattering in this way required a more active stance by the counselor of this treatment group. The counselor not only had to attend to the basic requirements for conducting the baseline group reminiscence protocol, but also had to do so while facilitating exchanges among group members that focus on past perceptions of AIR. The counselor of this group demonstrated AIR in all interactions with clients at the individual level, monitored group members to ensure lower order needs were being met, facilitated group processing while honoring the hierarchal relationship of AIR, and looked for opportunities to structure mattering relationships using the group structure.

Specific Session Objectives

General Considerations

As noted previously, individual session guides consisting of themes, stems, and objectives guided each session of the intervention. Room was provided on each form to record comments on administrative and clinical observations and comments that were addressed before the next week's sessions. The forms were also used to guide meetings and discussions between the lead researcher and the counselors following each week's sessions. Counselors explained the role of the session guides and note taking in maintaining sequencing of topics and activities as

well as in capturing participant or counselor concerns. It was anticipated that note taking during session might distract the participants and negatively impact trust and communication, so counselors maintained an attitude of transparency by showing participants the session guides and explaining how the notes would be used to focus and guide the intervention as well as track the popularity of the topics. As also noted earlier, a common protocol of reminiscence topics and sequencing guided both groups (Table 3). The session objectives outlined below were created to be consistent with the conduct of group counseling and reminiscence therapy for both groups. Additional objectives consistent with the tenets of mattering promotion are identified for the reminiscence with AIR group.

Session One

- Explain and have participants sign the Informed Consent Agreement and Confidentiality Statement and administer the two assessments (5F-WEL and Mattering Scale).
- Introduce the counselors and, during intermission, distinguish the main points and purpose of reminiscence groups versus life reviews.
- Complete the common goals of collecting baseline data and providing brief educational support as the new groups prepare to form for the first time.

Session Two

- Counselor introduces self and facilitates the opening activity for member introductions (participants were asked to bring an artifact of personal significance to this session at the time the lead researcher called to confirm the time of the initial group meeting.).
- Counselors emphasize the purpose of the group, highlight procedures, and lead the group in establishing group norms.

- Common goals include establishing norms, building trust, and encouraging communication.
- In addition, the counselor of the reminiscence with AIR group defines mattering, the AIR components, and the use of AIR in processing memories.
- Complete the AIR goals of encouraging participant reflection of mattering using the AIR model.

Session Three

- Sharing memories of first, favorite, and best school memories.
- Work towards accomplishing the common goals of building trust and verbally exchanging past pleasant memories.
- AIR groups will become more comfortable using the AIR framework when reflecting the context of shared memories.
- The counselor provides opportunities for dyads of mattering partners to accomplish group functions (setting up room, arranging refreshments, calling group members with reminders, etc.) aimed at promoting reliance mattering.

Session Four

- Sharing memories of first, favorite, and best toys, games, and adult leisure activities.
- Further the common goals of continuing to build trust and improving personal interactions and communication.
- Linking participant memories of secure working models of AIR in the past to the present is an additional goal for the AIR group.

Session Five

- Sharing memories of first, favorite, and best places to work and live.

- Members bring an artifact from current/former career to facilitate memories.
- Increasing social interaction, improving communication skills, and promoting an enjoyable experience are common goals.
- Members of the AIR group continue accessing past working models of mattering through shared reminiscence and processing the changing dynamics of AIR that were unique to the context of the shared memory.

Session Six

- Sharing memories of first, favorite, and best experiences shared with family and pets.
- Continuing to improve participants' sense of wellness is the common goal of the session.
- Members of the AIR group continue evaluating past working models of mattering in the context of the social, familial, and occupational roles held at the time of the memory, and evaluating the changing nature of mattering related to these roles.

Session Seven

- Sharing memories of first, favorite, and best friends, mates, and lovers.
- Continuing to improve participants' sense of wellness is the common goal of the session.
- Members of the AIR group continue evaluating past working models of mattering in the context of the social, familial, and occupational roles held at the time of the memory, and evaluating the changing nature of mattering related to entering and exiting these roles.

Session Eight

- Sharing memories of first, favorite, and best holidays and traditions

- Continuing to improve participants' sense of psychological wellbeing and moving to closing are common goals for both groups.
- An additional goal for the AIR group is encouraging participants to review their current life experiences and mattering relationships against those shared in past sessions in order to facilitate participants' accessing new sources of mattering as they desire.

Session Nine

- Counselor leads a discussion of memories of friends in the past, new friends made during the group, and lessons learned; closes the groups with a memorable experience.
- After members have shared, counselors distribute "thank you" cards to each participant with a personal note to each acknowledging the significance of their roll in helping others process their shared memories.
- Recapping the process of the previous five weeks and closing the group process with a memorable and meaningful event are goals common to both groups.
- Recapping the fluctuating nature of mattering, how AIR components change over time, and how AIR might be used to foster new mattering relationships are the additional goals for the AIR group.

Session Ten (post testing).

- Explain and administer the two assessments (5F-WEL and Mattering Scale).
- After completing the assessments, ask participants to provide feedback with the participant feedback form.
- Common goals are to collect post intervention data for statistical analysis and participant feedback for use in replication studies; there are no AIR specific goals for post-testing.

The Researcher's Log

Throughout the planning and implementation of this study, the researcher kept a record to detail challenges to the study. Comments captured from the counselor's logs were also used to track the direction and fidelity of the intervention. Conversations between the counselors and researcher before and after each week's sessions provided opportunities for answering questions, providing feedback, and otherwise supporting the counselors as they implemented the intervention.

The counselors selected for the study initially indicated uncertainty about counseling groups of older adults. Although both had completed advanced work in group design and leadership as a part of their doctoral education, neither counselor had worked with, nor received counselor education specifically focused on, older adults and aging issues. The pre-intervention training session reduced counselor anxiety and increased their anticipation of working with this special population. The lead researcher also conducted an additional training session with the counselor that was selected to lead the reminiscence with AIR group. In this meeting, the specifics of the AIR protocol were outlined and the counselor was provided with an opportunity for role-playing and practicing "AIR talk" with the lead researcher. Counselors reported that receiving the treatment and session guides before the intervention began helped them to prepare more effectively.

The pre- and post-test design appeared to induce a heightened level of suspicion and curiosity in participants regarding the purpose of the study. Despite being advised that this study was concerned with evaluating the impact of the structure of reminiscence groups on wellness during the recruitment and screening process, counselors of both groups reported that participants' repeatedly asked for specific details about which personal attributes or factors were

of interest to the study. Participants also queried counselors about specific outcomes being assessed during the intervention and if they, the participants, would get to see the results. The lead researcher advised the counselors to remind participants that no one other than the lead researcher knew the specific factors under examination in an effort to protect the validity of the study. Furthermore, counselors were advised to remind participants that groups were the basis of comparison, that no individual results were being tracked or would be reported, and that results would be provided to those interested participants when the study was completed in accordance with the informed consent and confidentiality agreement.

In earlier sessions, counselors also reported that participants were interested in many details of the counselor's personal and professional lives and pressed the counselors to self-disclose their own memories. The counselors expressed concerned that not self-disclosing, while asking participants' to share very personal and salient memories, might have a negative effect on the trust level in the groups. The lead researcher reminded the counselors that some self-disclosure was certainly appropriate for starting or reenergizing discussions, but that any such self-disclosure must be brief and pointed to ensure group members had adequate time for sharing their own memories. The lead researcher also emphasized that the counselors must ensure that any self-disclosures they elected to make must ultimately focus attention back on the participants' issues and the group process.

In early sessions, participants also tended to consider reminiscence exclusively as the recalling of memories from childhood. The lead researcher suggested that the counselors stress to the participants that the reminiscence protocol targets pleasant memories from throughout the lifespan. Additionally, the counselors and lead researcher expanded the discussion stems to prompt memories of other developmental periods (e.g., memories from the first day of college as

opposed to asking for memories of the first day of school). As participants developed trust in the group and sharing memories became more natural, counselors reported that their group members expressed a desire to share on themes they selected themselves or to continue discussions of interesting themes from past sessions. The lead researcher advised the counselors that although this is acceptable in some reminiscence groups, the design of this study relies on a specific protocol of both groups following the same sequencing of topics. The lead researcher advised the counselors to emphasize this to their group members in order that they remain on track with the protocol as designed.

Interestingly, participants of the reminiscence with AIR group failed to comply with the opportunities to accept responsibilities for calling each other, setting up refreshments, or performing other functions necessary for the functioning of the group that were intended to provide sources of reliance mattering. All but one group member declined the counselor's requests for volunteers to fill the reliance building positions. The issue was not addressed however, due to concerns for minimizing mortality by reducing resistance and maintaining a positive and uplifting group environment.

Chapter Summary

This chapter provided a detailed description of the five-week, ten session intervention designed for this study and the methodology for implementing it. The purpose for the intervention and requirements that influenced the design were outlined followed by specific details of the common reminiscence protocol as well as the additional elements included for the reminiscence with AIR treatment groups. Specific objectives were provided for each session, and the chapter concluded with comments from the researcher's logs that guided the implementation of the intervention. The following chapters will detail and discuss the results.

CHAPTER FIVE: RESULTS

This chapter details the statistical analysis performed to determine the outcomes of this study. Gains in wellness and mattering were compared between individuals who had participated in a standardized group reminiscence protocol (REM) and those who participated in an identical reminiscence protocol that also incorporated the examination of awareness, importance, and reliance into group function and process (REMAIR). This chapter reviews the sampling procedures, describes the demographic data of the sample, provides descriptive statistics of the demographics and measurement results, and concludes with a formal analysis of each of the hypotheses and a summary of results.

Sampling Procedures

The sample was recruited from a target population of 359 independent older adult residents of an accredited continuing care retirement community (CCRC) in Williamsburg, Virginia. Recruitment efforts included conducting two rounds of mailings to residents of the independent living community (N = 359) followed by informational sessions hosted by the lead researcher two days after each mailing. Details of the sampling procedures are outlined in chapter three. The study required that participants were capable and willing to recall and communicate past memories, did not require any medical assistance as the result of diagnosed mood or memory issues, and were willing to complete instruments assessing wellness (5F-WEL) and mattering to others (The Mattering Index) once before the study began and again after it ended. After five weeks of recruiting, twenty individuals (n = 20) comprised the initial sample, were randomly assigned to one of the two ten member treatment groups, and completed pre-testing. One male participant of the REMAIR group withdrew from the study after the second session resulting in a final sample of 19 participants (n = 19).

Descriptive Statistics

Demographics

Initial demographic data were obtained from each participant during screening, and additional demographic data was collected during pre-testing. All 19 participants of the final sample identified themselves as white, heterosexual, and not currently working or attending school. Analysis of the variables of age, gender, relational status, years of education, and highest level of education and type of advanced degree by treatment group are recapped in Table 5 and detailed below. Chi Square tests were performed to determined the equivalency of groups using a 95% confidence interval indicated no significant differences between the groups for the variables; results are included in the analysis of each variable below.

Age. Measures of central tendency for the total sample indicated that participant ages were normally distributed and ranged between 76 and 95 years with a mean age of 83.26 years (N = 19, SD = 4.99 years). Ages in the REM group ranged between 76 and 95 years with a mean age of 85.40 years (n = 10, SD = 5.72) and ages in the REMAIR group ranged between 77 and 86 years with a mean of 80.89 years (n = 9, SD = 2.67). The Chi Square test performed to detect differences between the mean ages of the treatment groups failed to detect any significant difference [$X^2(13) = 12.98$, p = .45] indicating that the groups were equivalent in terms of age.

Gender. Fifteen females (n = 15) accounted for 78.9 % of the sample, and four males (n = 4) comprised the remaining 21.1 % of the sample. The REM group was comprised of nine females (90%) and one male (10%). The REMAIR group was comprised of six females (66.7%) and 3 males (33.3%). Although the number of females is disproportionate to the number of males between groups, Chi Square testing performed to determine if the groups were equivalent

in terms of gender failed to detect any significant difference [$X^2(1) = 1.55$, $p = .213$], thus indicating that the groups were equivalent in terms of gender.

Table 5

Summary of Demographics by Treatment Group

	REM (n = 10)		REMAIR (n = 9)	
Variable	Percentage	N	Percentage	N
Gender				
Female	90%	9	66.7%	6
Male	10%	1	33.3%	3
Relational Status				
Married	30%	3	66.7%	6
Widowed	50%	5	33.3%	3
Divorced	10%	1	0%	0
Single	10%	1	0%	0
Years of Education				
12	10%	1	0%	0
13	0%	0	11.1%	1
14	0%	0	11.1%	1
15	0%	0	11.1%	1
16	90%	9	66.7%	6
Education Level				
High school	10%	1	0%	0
Trade/Technical	0%	0	22.2%	2
Bachelor's	20%	2	55.6%	5
Master's	30%	3	22.2%	2
Professional	30%	3	0%	0
PhD	10%	1	0%	0

Relational status. Of the 19 participants, nine (47.4%) reported being married, eight were widowed (42.1%), and one each reported being single (5.3%) or divorced (5.3%). The REM group was comprised of three members who were married (30%), five who were widowed

(50%), and the remaining two participants were single (10%) or divorced (10%). Six members (66.7%) of the REMAIR group reported being married and three (33.3%) were widowed. Although the only single and divorced participants were in the same treatment group, the Chi Square test performed to detect differences between treatment groups in terms of relational status failed to detect any significant difference [$X^2(3) = 3.46$, $p = .326$], thus indicating that the groups were equivalent in terms of the relational status of group members.

Years of education. Years of education ranged between 12 and 16 years with a mean of 15.47 years ($n = 19$, $SD = 1.17$ years). Measures of central tendency indicated that the distribution of years of education for the sample is negatively skewed (-2.24) and leptokurtic (4.19), indicating that the sample is concentrated around a high level of years of education. The median is usually a better indicator of central tendency when presented with a skewed distribution such as this. However, there is so little variability in years of education for this sample that both the median and mode were computed to be 16.00 years which only differ from the mean by .53 years. These measurements of central tendency reflect a sample that is almost homogeneous in terms of its high level of education. One member of the REM group (10%) reported 12 years while the remaining nine members (90%) reported at least 16 years of education. In the REMAIR group, one member each reported 13, 14, or 15 years of education, each representing 11.1% of the group respectively, and the remaining six members (66.7%) had attained at least16 years of education. The Chi Square test performed to detect differences in the mean years of education between the treatment groups failed to detect any significant difference [$X^2(4) = 4.56$, $p = .335$], indicating that the groups were equivalent in terms of the number of years of education.

Level of education and type of advanced degree. One member (n = 1) of the sample reported high school as the highest level of education achieved and comprised 5.3% of the sample. Two others (n = 2) reported possessing trade, technical or Associates degrees, and another seven (n = 7) reported possessing Bachelor's degrees accounting for 10.5% and 36.8% of the sample respectively. The modal educational level was the Advanced degree reported by nine participants (n = 9, 47.4%) of the sample. Of these nine, five (n = 5) reported having earned a Master's degree, three (n = 3) reported earning a professional degree, and one (n = 1) participant had earned a PhD. Seven of the participants possessing advanced degrees (n = 7) were randomly assigned to the REM group while the remaining two participants (n = 2) were members of the REMAIR group. The Chi Square test performed to detect differences in the highest level of education between treatment groups failed to detect any significant difference [$X^2(3) = 7.03$, p = .071], indicating that the groups were equivalent in terms of educational level. The Chi Square test performed to detect if the groups were different in terms of the numbers of advanced degrees held likewise failed to detect any significant difference [$X^2(3) = 5.76$, p = .124], indicating that the groups were equivalent in terms of advanced degrees held.

Measurement Results

This section presents the mean and gain scores participants achieved on the measures of global wellness (the 5F-WEL) and mattering (the Mattering Index). In addition to the descriptions of the instruments and scores for the total sample, descriptive statistics are also included for each instrument by group.

The Five-Factor Wellness Inventory (5F-WEL)

As detailed in chapter three, the 5F-WEL was administered to assess participants' gains in global wellness by comparing pre- and post-test scores. Instruments were computer scored,

and they produced a single standardized score of global wellness for each participant that ranged between 25 and 100. Higher scores indicate higher levels of global wellness and higher gain scores (computed by subtracting post-test scores of global wellness from the pre-test scores) reflect greater gains in wellness.

Table 6 presents the minimum and maximum pre-test, post-test, and gain scores, the means, and the standard deviations for the entire sample on the 5F-WEL. Measures of central tendency indicate that pre-test, post-test, and gain scores were normally distributed. Reliability statistics indicate an alpha coefficient of .89 for the instrument, indicating a high level of reliability that is consistent with the strong alpha coefficient of .94 published in the 5F-WEL manual. Correlational analysis identified a significant positive relationship between pre-and post-test wellness scores ($n=19$, $r = .68$, $p < .01$). Because the scores co-vary significantly, higher pretest wellness scores serve as strong indicators of higher wellness post-test scores. A significant negative relationship was found between pre-test wellness and wellness gain scores ($n = 19$, $r = -.416$, $p < .01$). Although it is not as strong a relationship as the pre- and post-test relationship, higher pre-test scores are significant indicators of lower wellness gain scores. No relationship of significance was reported between the post-test wellness and gain scores.

Table 6

Total Sample Mean Wellness and Gain Scores and Standard Deviations

Scale	Min	Max	Mean	SD	n
PreWel	68.00	94.00	82.79	6.79	19
PostWel	73.00	95.00	84.47	6.66	19
WelGain	-10.00	12.00	1.68	5.31	19

Pre-test, post-test, and gain scores for global wellness on the 5F-WEL are presented by treatment group in Table 7. The REMAIR group pre-test mean (85.33) is more than five points higher than the REM group's pre-test mean wellness score (80.50) and the REMAIR group's post-test mean score of 85 is one point higher than the REM group's mean score of 84. Independent t-tests indicate no significant differences between each group pre- or post-test mean scores [$t(17) = -1.62$, $p = .124$; $t(17) = -.32$, $p = .754$]. From the wellness gain scores in table seven, it can be seen that individual members demonstrated losses as well as gains in wellness during the study. Results from the REM group indicate an overall net gain in global wellness ($M = 3.5$, $SD = 5.48$), while the REMAIR group results reflect a small but, nonetheless, negative net loss ($M = -.34$, $SD = 4.58$). Although the independent sample t-tests did not detect a significant difference between the wellness gain scores of the groups [$t(17) = 1.64$, $p = .119$], paired-sample t-tests indicated that the 3.50 point increase ($SD = 5.48$) in mean wellness gain score the REM group experienced was significant [$t(9) = 2.02$, $p = .074$].

Table 7
Mean Wellness and Gain Scores and Standard Deviations by Treatment Group

	REM (n = 10)				REMAIR (n = 9)			
Scale	Min	Max	Mean	SD	Min	Max	Mean	SD
PreWel	68.00	93.00	80.50	6.82	74.00	94.00	85.33	6.12
PostWel	73.00	92.00	84.00	6.58	75.00	95.00	85.00	7.09
WelGain	-4.00	12.00	3.50*	5.48	-10.00	5.00	-.33	4.58

Note. *p < .10

The Mattering Index

As detailed in chapter three, the Mattering Index was administered to assess participants' gains in perceived mattering to others by comparing their pre- and post-test scores. The

instrument produced a single score of mattering for each participant that ranged between 24 and 96. Higher scores indicate higher levels of perceived mattering to others, and higher gain scores, computed by subtracting post-test scores from the pre-test scores, reflect greater gains in mattering than lower scores.

Table 8 presents the minimum and maximum pre-test, post-test, and gain scores; the means; and the standard deviations for the entire sample on the Mattering Index. Measures of central tendency indicate that the pre-test, post-test, and gain scores are normally distributed. The pre- and post-test mean scores varied by less than one point resulting in a small overall negative gain in mattering ($M = -.16$, $SD = 3.53$) for the total sample. There is no normative data for this instrument, but reliability statistics revealed an alpha coefficient of .849 for the 24-item scale on pre-test and .907 on post-test. These statistics indicate a high level of stability and reliability and are consistent with the alpha coefficients of .904 ($n = 388$) and .922 ($n = 544$) that Elliot, Kao, and Grant (2004) attained when validating the instrument. Correlational analysis revealed a significant positive relationship between pre-and post-test mattering scores ($n=19$, $r = .89$, $p < .000$), suggesting that higher pre-test mattering scores serve as strong indicators of higher post-test mattering scores. No relationship of significance was reported between the post-test mattering and gain scores.

Table 8

Total Sample Mean Mattering and Gain Scores and Standard Deviations

Scale	Min	Max	Mean	SD	N
PreMat	66.00	91.00	75.32	6.08	19
PostMat	62.00	90.00	75.16	7.58	19
MatGain	-8.00	6.00	-.16	3.53	19

Pre-test, post-test, and gain scores for The Mattering Index by treatment group are presented in Table 9. The mean pre-test score for the REMAIR group was computed to be 76.22 (SD = 6.4), less than two points higher than that of the REM group mean of 74.50 (SD = 6.0). The REMAIR post-test mean score decreased slightly, however, to 75.56 (SD = 6.19) and the REM post-test mean increased slightly to 74.80 (SD = 8.98). Independent t-tests indicated that there were no significant differences between the treatment groups' mean mattering pre-test scores '[t(17) = -.61, p = .762] or post-test scores [t(17) = -.211, p = .145]. Mean mattering gain scores for participants of the REMAIR group indicated a slight decrease in mattering (M = -.67, SD = 3.54), and the mean mattering gain score increased for members of the REM group (M = .30, SD = 3.65; these differences were not significant between groups [t(17) = .59, p = .566], and paired sample t-tests also failed to detect significance of the within group gains.

Table 9
Mean Mattering and Gain Scores and Standard Deviations by Treatment Group

	REM (n = 10)				REMAIR (n = 9)			
Scale	Min	Max	Mean	SD	Min	Max	Mean	SD
PreMat	66.00	83.00	74.50	6.00	71.00	91.00	76.22	6.40
PostMat	62.00	89.00	74.80	8.98	69.00	90.00	75.56	6.19
MatGain	-5.00	6.00	.30	3.65	-8.00	2.00	-.67	3.54

Analysis of Research Hypotheses

Hypothesis I

Older adults participating in group reminiscence therapy will demonstrate significant gains in global wellness as measured by the Five Factor Wellness Inventory (5F-WEL).

Results. The findings did not support this hypothesis. Paired sample t-tests indicated that mean gain scores of global wellness for participants increased but this increase was not statistically significant [M = 1.68, SD = 5.31; t(18) = 1.38, p = .184]. Despite the absence of significant findings, further analysis of Hypothesis I revealed that the mean wellness gain score of participants in the REM group (M = 3.50, SD = 5.48) were significantly greater than the mean wellness gain scores for members of the REMAIR group [M = -.33, SD = 4.58; t(9) = 2.02, p < .10].

Hypothesis II

Older adults participating in group reminiscence therapy structured around an awareness, importance, and reliance (AIR) mattering framework will demonstrate significantly greater gains in global wellness as measured by the 5F-WEL, than participants of traditionally structured group reminiscence.

Results. The findings did not support this hypothesis. Mean wellness gain scores decreased slightly for participants of the REMAIR group. Independent sample t-tests indicate that mean gain scores of global wellness (M = -.33, SD = 4.58) did not differ significantly from the mean gain scores of global wellness for participants of the REM group [M = 3.50, SD = 5.48; t(17) = 1.64, p = .119].

Hypothesis III

Older adults participating in group reminiscence therapy structured around an AIR mattering framework will demonstrate significantly greater gains in mattering as measured by the Mattering Index, than older adults participating in traditionally structured group reminiscence.

Results. The findings did not support this hypothesis. Mean mattering gain scores

decreased for members of the REMAIR group. Independent sample t-tests indicate that mean mattering gain scores for participants of the REMAIR group indicated a slight decrease in mattering (M = -.67, SD = 3.54) and did not differ significantly than the mean mattering gain scores for participants of the REM group who demonstrated a slight increase in mattering [M = .30, SD = 3.65; t(17) = .585, p = .566].

Hypothesis IV

Women will demonstrate greatest gains in wellness as measured by the 5F-WEL and mattering as measured by the Mattering Index than men.

Results. An insufficient number of men responded to recruitment efforts resulting in an inability to perform a statistically meaningful 2 (gender) x 2 (treatment) MANOVA to determine main effects and interactions between gender and treatment condition. Despite not achieving a sample size large enough to permit a comparison of gender and other cultural factors, additional one sample *t*-tests indicated that the fifteen female participants demonstrated a significant gain in wellness scores [t(14)= 2.52, p = .024] although changes in mattering gain scores were non-significant ($p < .10$).

Summary

This chapter presented the statistical analysis and findings that resulted from this study. Descriptive statistics were used to describe individual participants' demographics and the measurement scales and scores and Chi Squared analysis were performed and determined that the two treatment groups were equivalent in terms of age, gender, relational status, years of education, and level of education. Pre- and post-test measurements from each instrument were analyzed for the total sample and each treatment group, and reliability statistics indicated high alpha coefficients for both instruments and strong correlations between pre- and post-test scores,

thus confirming the reliability of the instruments for measuring global wellness and mattering. Three of the four directional hypotheses were tested and all were rejected because hypothesized changes in gain scores lacked statistical significance. Hypothesis four was not tested because there were not enough males ($n = 4$) in the sample to permit a meaningful examination of the main effects or interactions between gender and treatment. A detailed discussion of the results, their meaning, and implications are presented in the following chapter.

CHAPTER 6: DISCUSSION

Introduction

By 2030 the number of adults over the age of 65 years old will constitute an unprecedented 20 percent of the U.S. population (U.S. Census Bureau, 2010). This growth of the older adult segment of the U.S. population is attributable to a combination of increased life expectancies and the aging of the 76 million-member "baby boomer" cohort. It is accompanied by projections that the labor pool to serve older adults during this time of growth will remain relatively constant (U.S. Department of Labor, Bureau of Labor Statistics, 2010). The logical result of these phenomena is that social structures and services that support older adult wellness will be challenged to develop and implement innovative ways to support the older adult population; ready or not, counselors will be working with more older adults in the future.

In addition to defining the problem outlined above, Chapter One outlined issues related to age, aging, and the aged that counselors must consider as a starting point for developing therapeutic efforts with older adults. A discussion of theories of aging and adult development, the role of wellness in supporting development, an introduction to mattering as a means of enhancing wellness, and the use of reminiscence groups as a framework upon which to structure wellness and mattering promotion programs was provided as a rationale for the current study. In Chapter Two an in-depth review of selected literature of older adult development, holistic wellness, mattering to others, and the use of reminiscence with older adults supported the creation of four tenets of mattering promotion. The research methodology, which included four directional hypotheses and an informed critique, were included in Chapter Three, and a detailed outline and discussion of the intervention were provided in Chapter Four. Chapter Five reported the results of the statistical analysis that was completed for each of the hypotheses of the study to

determine the effectiveness of the experimental intervention; none of the hypotheses were supported by statistical analysis. This final chapter will discuss these results in detail to include how the findings relate to the current state of research and literature. In addition this chapter will address the implications of the study, its limitations, and recommendations for future research.

Overview of the Current Study

This experimental study was intended to determine if older adult wellness is enhanced through the promotion of a sense of mattering to others. Over the past 20 years supporting holistic wellness and promoting personal development have been defining concepts of the counseling profession (Myers, 1992, Myers, Sweeney, & Witmer, 2000). Rowe and Kahn's (1997) concept of successful aging emphasizing the maintenance of active engagement with life currently drives many wellness efforts for older adults. However, these wellness efforts do not tend to account for the loss of perceived mattering to others resulting from changes in vocational, social, and familial roles that occur with advanced age. A strong positive relationship between wellness and mattering has been established in the literature (Degges-White & Myers, 2006; Dixon, 2007; Myers & Degges-White, 2007; Rayle, 2005), and this study aimed to build on that research by examining the effects of employing four tenets of mattering promotion during the conduct of a standardized protocol of older adult group reminiscence created for this study.

Nineteen older adults with a mean age of 83.26 years (SD = 4.99) participated in the study and were randomly assigned to one of two reminiscence treatment groups. One group (n = 10) completed ten sessions of traditional reminiscence (REM), while the other (n = 9) completed ten sessions of reminiscence that incorporated the tenets of mattering into group function and processing (REMAIR). All participants completed pre-tests and post-tests of the Five-Factor Wellness Inventory and the Mattering Index to determine possible gains in global wellness and

perceived mattering to others. Since members of both groups participated in the same baseline reminiscence therapy protocol, it was anticipated that wellness would be enhanced for all participants. It was also anticipated that members of the REMAIR would demonstrate greater gains in both wellness and perceived mattering as a result of their recall and examination of past working models of mattering and their application of those models in assessing current relationships and building new ones. A final hypothesis proposed that females would experience greater gains in both wellness and mattering than their male counterparts.

Results were analyzed using dependent and independent t-tests, Chi Square, and Pearson correlation coefficients as detailed in Chapter Five. Statistical analysis indicated both gains and losses among participant wellness and mattering gain scores, but results indicated the changes to be of little or no statistical significance. A lack of males in the sample prohibited a meaningful statistical examination of gender by treatment main effects or interactions. In the following paragraphs, the implications of the findings with regard to the research hypotheses will be discussed in detail. Strengths and limitations of the study and recommendations for research in the future will also be provided.

Discussion of Major Research Findings

Hypothesis I

It was hypothesized that all members of the sample would demonstrate increased wellness gains scores as obtained from 5F-WEL pre- and post-tests, since all were participating in identically structured reminiscence group therapy protocols. This hypothesis was based on evidence of positive psychosocial and mental health benefits for older adults participating in reminiscence groups (Bohlmeijer, Roemer, Cuijpers, & Smit, 2007; Jones & Beck-Little, 2002; Myers & Harper, 2004). Following Stinson's (2009) recommendations, it was expected that

adding a standardized sequence of topics focused on favorites, firsts, and bests to guide both groups would further promote a baseline of gains in wellness.

Results from paired sample t-tests did not detect significant wellness gain scores for the entire sample to support this hypothesis. However, further analysis of wellness gain scores by treatment group using an independent sample t-test (see Table 7) indicated significant gains in wellness for the REM group and a slight non-significant negative gain (loss) in wellness for the REMAIR group. Despite the significance of REM group's gains, these findings may indicate that there is not the stable or predictable relationship between older adult participation with group reminiscence therapy and wellness as hypothesized. However other factors are worthy of consideration when examining these results.

One possible explanation is that the selected definition of wellness used to formulate this hypothesis is inaccurate. Although the definitions offered by Hettler (1984), Myers (1992), and others account for the holistic nature of wellness, the specific sub-factors and components of wellness tend to vary according to the particular model of wellness under consideration. As Roscoe (2009) reported, much of the existing research on wellness is quantitative and aimed at validating specific instruments that support a particular researcher's theoretical definition rather than exploring the nature of wellness from a contextual or qualitative paradigm. Such may be the case with the definition that drove the selection of the 5F-WEL as an appropriate scale for measuring wellness for older adult populations in this study. Myers, Sweeny, and Witmer's (2000) definition of wellness as achieving optimal physical, intellectual, and spiritual health "within the human and natural community" (p. 252) ultimately drove the development of the 5F-WEL. Although this definition may be appropriate for the vast majority of the general population, it may not account for the effects of redefinition of time, self, and relations with

others that mark the shift to gerotranscendence as found by Tornstam (1997) in his qualitative studies with adults up to 97 years old. According to Roscoe (2009) no research has been specifically conducted to determine the exact nature of wellness for older adult populations. Of the 3,343 adults in the norming sample for the 5F-WEL, only 115 (3.4%) were age 70 or older, and results are not reported by age group, thus making it entirely possible that the 89 items used to access wellness do not accurately represent wellness from an older adult's perspective.

High wellness pre-test scores indicate that there was a greater sense of wellness among the older adults of the sample that left little room for them to improve on the post-test. An upscale retirement environment that provides a multitude of social support and activity programs and is populated by residents with higher levels of education and income might account for these higher wellness scores. As Table 6 indicates, the mean pre-test wellness score for the current study was 82.79 (SD = 6.79) on a scale ranging from 25 - 100. These higher older adult wellness scores are consistent with those Myers and Degges-White (2007) obtained from a sample of 142 adults over the age of 73 (mean = 85.05, SD = 6.69). Both these mean scores are more than ten points higher than the mean wellness score of 71.63 (SD = 15.87) reported from 3,343 adults of the 5F-WEL norming sample, indicating that older adults may generally have a higher range of wellness scores. Six participants in the current study demonstrated pre-test wellness scores above 87.50, placing them in the region of two standard deviations or more above the norming mean, and all but one of the participants' scores fell one positive standard deviation above the mean of the norming sample. It is plausible, therefore, that higher pre-test levels of wellness in the older adults contributed to the lack of improvement that was reflected on the post-test.

Given that additional analysis indicated the REM group demonstrated a significant within group gain in wellness, and the REMAIR group demonstrated a small but non-significant loss of

wellness, it is possible that processing reminiscence using AIR actually changed the nature of the reminiscence intervention that confounded its utility in promoting gains in wellness. Pinquart and Sorenson (2001) conducted a meta-analysis of 122 studies and reported that psychosocial interventions such as self-help groups and social activity programs were not as effective for decreasing depression and increasing psychological wellbeing as are psychotherapeutic interventions such as cognitive behavioral and reminiscence therapies. Both group and individual reminiscence therapies are by definition psychological, in that they focus on improving an individual's mental health status and functioning through the use of a therapist (Coleman, 2001). Psychosocial interventions focus on enhancing the functioning of the individual in society without identifying specific psychopathology, and they take the form of self-help and social activity programs. Pinquart and Sorensen (2001) attributed the advantage of psychological approaches to the greater levels of support that a foundational body of theory and the use of trained therapists provide to the process. As outlined in earlier chapters the normal roles for the leader of a reminiscence group are limited to introducing topics, ensuring discussions remain focused on pleasant past memories, and to prevent members from probing shared memories too deeply which might cause discomfort for the person sharing (Burnside, 1994). Paraprofessionals lead many of these groups because their roles as are primarily concerned with maintaining a pleasant and engaging social atmosphere. However the REMAIR group processed shared memories using the AIR framework requiring the counselor of this group to take a more active stance than is normally required of reminiscence group leaders by prompting participants to examine and probe shared memories for themes of AIR and encouraging others to share in the same manner. Therefore it is plausible that asking questions about the shared memories and directing group processing to access the working models of

mattering that accompanied the memories may have changed the therapeutic benefit of the reminiscence group, thereby negating the outcome of increased wellness as hypothesized.

Hypotheses II

It was hypothesized that members of the REMAIR group would experience greater gains in wellness than the members of the REM group. This relationship was expected to occur based on the literature suggesting that mattering and wellness are independent but closely related and complimentary constructs (Dixon, 2007, Myers & Degges-White, 2007). Results from independent sample *t*-tests did not support this relationship and indicated that wellness gain scores for REMAIR participants actually decreased slightly (-.33) by the conclusion of the intervention. As with the first hypothesis, these findings suggest that there is not a stable or predictable relationship between older adult participation in group reminiscence therapy that incorporates the tenets of mattering promotion and AIR as hypothesized. However, because this hypothesis, like the first hypothesis, focused on wellness gain scores, the results could be attributable to the same three extraneous factors presented above for Hypothesis 1: (a) use of an inadequate definition of wellness upon which to base the hypothesis (b) attainment of higher pre-test wellness scores by participants leaving little room for demonstrating gains, and (c) implementation of the REMAIR protocol confounding the effectiveness of the reminiscence group process.

Hypothesis III

Results from independent *t*-tests failed to support the third directional hypothesis of this study that proposed members of the REMAIR group would experience greater gains in mattering than the members of the REM group. This hypothesis was informed by attachment theory, and as such, carried the expectation that creating a therapeutic group environment that incorporated

the mattering tenets would provide participants with the three sub-types of mattering and a safe base of temporary mattering sources from which to explore the formation of new mattering relationships. It was also anticipated that processing the shared memories by examining the changing nature of AIR associated with specific memories would serve to activate past working models of mattering and result in an increased sense of mattering to others in the present. The non-significant findings suggest that the anticipated positive relationship between older adult participation in group reminiscence incorporating tenets of mattering promotion and AIR and increased sense of mattering to others does not exist. However, there are other factors that must also be considered when reviewing these results.

As with hypothesis I, it is possible that the mattering Index used for this study relies upon a definition of mattering that was not applicable to this older adult population. The original definition of the construct presented by Rosenberg and McCullough (1981) emerged from their work examining the mattering dynamic between parents and adolescents. Since that time other models of mattering have been proposed, but none have examined the role of mattering for older adults, particularly those in the latest stages of the lifecycle. Roscoe (2006) noted that most wellness research was concerned with validating models that support a particular researcher's definition of wellness and it appears that mattering researchers are similarly focused on validating their particular models of mattering as opposed to qualitatively exploring the true nature of mattering (France & Finney, 2009).

Another explanation for the lack of gain scores is that mattering to others simply may not be the concern to older adults that was anticipated, particularly to the oldest of older adults who may be negotiating late adulthood gerotranscendence. Jane Erikson (1997) wrote that it was one thing for her and her husband Erik to look forward 20 or 30 years and propose theoretically what

the tasks of the final (eighth) stage of late adulthood development would involve; however, it took their actual experiences as 90-year-old adults to convince them that a final (ninth) stage of development was needed to account for the redefined reality (gerotranscendence) experienced by that age group. Tornstam and Tornqvist's (2000) investigation into gerotranscendence found that a qualitative redefinition of reality takes place for those persons moving towards transcendence which is "marked by new understanding of existential questions, a feeling of cosmic communion with the universe, a redefinition of time and space, life and death, and a redefinition of self and relations with others" (p. 15). Given that participants' ages in the study sample ranged between 76 and 95 years (M = 83.26, SD = 4.99), it is plausible that mattering to others did not carry for them the same significance as it did in earlier stages life.

A final factor that may have confounded the results involves the possibility that the unfamiliar nature of mattering impacted the participants' willingness to fully participate in the intervention as intended. Multiple researchers have established that the members of our most senior generational cohort value self-sufficiency and negatively stigmatize mental health issues and the role of counseling to health (Blando, 2011; Klapp, Unroe, & Unutzer, 2003; Maples & Abney, 2006; SAMSHA, 2010). The older adults of this sample represent an affluent population of oldest older adults that is provided with opportunities to participate in a wide range of wellness enhancing activities provided by the staff of the prominent retirement community (CCRC) they resided in. Participants of the REMAIR group were resistant to participate in group activities intended to foster reliance mattering such as arranging for refreshments, calling each other with reminders of sessions, or entering into a temporary mattering partnership with another group member. Session logs and discussions with the REMAIR counselor confirmed that the group members did not wish to comply, because they simply could not understand the

utility of the reliance promotion activities given their long and rich life experiences in family, business, government, and educational settings.

Finally, as with the first two hypotheses and the findings by Pinquart and Sorensen (2001) highlighted previously, it is possible that adhering to the REMAIR protocol effectively transformed the nature of the intervention from a psychological to a psychosocial intervention which decreased it's effectiveness. Although this study did not target any specific pathology, a psychological intervention was selected because of the multidimensional nature of wellness and the positive impact of mattering on psychological health in a number of clinical studies (Elliot, Colangelo, & Gelles, 2005; Rayle & Myers, 2004; Taylor &Turner, 2001). The counselor of the REMAIR group reported that when broaching termination, the group members began a discussion of continuing the reminiscence group on their own. This lends evidence to support the notion that the participants may have viewed the group as a social activity rather than a psychotherapeutic process thereby accounting for reduced gain scores that might have otherwise been produced.

Hypothesis IV

The final hypothesis of this study posed that women would demonstrate larger gains in wellness and mattering than men; however, men did not volunteer for the study in sufficient numbers to allow for meaningful statistical analysis of possible treatment by gender effects. The original hypothesis was based on research that the gender composition of groups influences the level of participation derived from the females in the group (Tolbert, Graham, & Andrews, 1999). It was anticipated that the gender bound social roles and norms held by this oldest generational cohort of adults would influence their examination of differing mattering sources associated with familial and occupational roles that males and females of that cohort have

historically filled. In this study the existence of these different role expectations was indicated by many of the female participants sharing memories originating from milestones of their partners' and children's lives and relating those memories to their roles of wife, mother, and homemaker, while males, on the other hand, tended to share memories related primarily to past career roles. Even though the comparative aspect of the hypothesis could not be tested, the findings were useful in illuminating specific differences in the ways that men and women in the older adult cohort construct a sense of mattering and wellness within the therapeutic process.

The primary reason a sufficient number of males did not volunteer for this study could be accountable to attitudes among older adult males who, as a group, stigmatize and avoid participating in self help or therapeutic activities (Blando, 2011; Klapp, Unroe, & Unutzer, 2003; Maples & Abney, 2006; Moody, 2010). During recruitment efforts, the PI made a conscious effort to avoid using language in mailings or when answering questions that might activate negative attitudes towards group participation in the male participants. Men generally expressed satisfaction with their achievements that led to their being able to afford residence in the CCRC and questioned how sharing memories would benefit them. The counselors for both groups also reported in session logs and during post-session meetings that the men took more prompting to share experiences other than those relating to career. Wellness and security were one in the same for many men the PI spoke with during recruitment, and though not formally tracked and analyzed, it seems that most of the men in the current study were prompted to participate by their wives, female acquaintances, or staff members.

As shown above there were numerous alternative explanations for the finding of no relationship between participation in reminiscence groups that incorporated tenets of mattering promotion and improved wellness, and further research providing controls for those alternatives

is recommended in advance of any final conclusions about the proposed relationship. In spite of the inconclusive findings, the study offers some new and potentially useful information to the counseling profession on issues related to counseling practice, counselor education, and counseling research with the population of older adults.

Contributions of the Study

Contributions to Counseling Practice

One noted strength of this study is that it established the positive benefits of wellness and mattering as identified in research into a viable and operational clinical goal for professional counselors. Although the results on wellness as an outcome of the reminiscence programs were mixed, the study provided evidence that reminiscence therapies may have benefits beyond use in the nursing profession with adults challenged by dementia. Maples and Abney (2006) forecast that the aging members of the baby boomer generational cohort will seek opportunities to engage in the group reminiscence process because of their familiarity and comfort with counseling and a more holistic view of health and wellness. As the numbers of these older adults continues to rise, counselors can use the relatively simple format of reminiscence groups to achieve an economy of scale by using the group modality to serve multiple clients with limited time resources.

This study also attempted to cross the gap between mattering theory and clinical application by proposing four tenets of mattering promotion that can be structured into existing counseling interventions in multiple contexts. Although the results did not indicate that these tenets are viable as hypothesized, they provide an initial baseline on which continued efforts to promote the identified benefits of mattering through clinical intervention can be structured.

Finally, this study opened a heretofore unstudied area of research into mattering and AIR as new frameworks for counselors to use in establishing and building the therapeutic relationship with older adults. Sharing in older adult client's past and present mattering using AIR may help to determine the older client's worldview, values and beliefs, and concerns about the treatment process (Dixon, 2007). Intertwining mattering into existing interventions supports older adult clients by encouraging an exploration of: (a) past and present meaningful relationships, (b) life purpose and spirituality, (c) activities that provide enjoyment, (d) plans and options for the future, and (e) other domains of wellness may prove to be a way that counselors t can help to enhance life satisfaction in this growing client population (Dixon, 2007).

Contributions to Counselor Education

This study highlighted the need for increased training on older adult developmental issues and the unique aspects of working with older adults in counselor education programs. The counselors for this study reported that they had not received any specialized training or emphasis on counseling older adults in any Master's or Doctoral coursework or in clinical settings. Both reported being appreciative of receiving two hours of theoretical background information on older adult development as well as on specific clinical considerations and techniques when working with older adults that had not been provided earlier in their academic careers. The experience of the two counselors used in the study serves as evidence that providing education in gerontological counseling has been neglected in many counselor preparation programs. The challenge for providing counselors competent at working with older adults is complicated, since the National Board of Certified Counselors no longer offers a Nationally Certified Gerontological Counselor credential, and gerontological counseling competencies were removed from the Council for Accreditation of Counseling and Related Educational Programs standards

beginning in 2009. Because these specific certifications and competencies no longer exist, it becomes questionable as to whether counselor education programs will devote limited resources to adequately prepare counselors for meeting the known increased demand for counseling older adults that will accompany the rising tide of aging boomers. In the absence of mandates for gerontological competency there now greater reliance on individual counselor educators and supervisors to evaluate their personal perceptions of older adult needs and to develop their competencies and abilities for teaching and supervising students wishing to work in older adult settings.

Contributions to Counseling Research

This study provides supporting evidence that existing counseling interventions require a specialized set of unique planning considerations and skills when applied to older adult populations. Although reminiscence therapy as an evidence-based clinical intervention is not well-known, beyond the nursing profession, this study adds to a currently scant but growing base of counseling research that supports its use by counselors. Since most reminiscence outcome research has also focused on reminiscence therapies conducted by paraprofessionals and volunteers, this study initiates needed inquiry into the outcomes that might be anticipated by counselors (Myers & Harper, 2004).

A number of practical lessons learned also presented themselves for consideration by those wishing to replicate this study or conduct similar studies. One of these is the need to ensure that the roles and responsibilities of administration and resident organizations are coordinated during initial planning meetings to discuss the purpose, nature, scope, and level of support required. The Executive Director of the CCRC used in this study was very supportive but withheld his formal approval until the PI was able to brief and gain the support of the

Resident's Council. As noted in Chapter Four the Executive Director formed a small support cell of key staff and tasked them to support the study after the resident's concurred with the study. However confusion arose between which group was responsible for the approval of the design of recruitment flyers, scheduling question and answer sessions, sequencing the program with existing activities, and finding adequate space for the groups. When members of both organizations began duplicating effort, providing input, and asking for updates, the PI formalized the relationship by establishing the support cell (administration) as being primarily responsible for all logistic issues and establishing the resident Chair for the resident's wellness committee as the liaison to provide resident input. Formalized letters of agreement outlining the roles and responsibilities of the PI, the administration, and the resident's council will prevent this confusion for future researchers.

Another lesson learned during this study involves the nature and length of the recruitment process. The program was advertised as an opportunity to share memories, and the purpose was described as investigating the impact of sharing memories on wellness. It quickly became apparent during the first question and answer session that potential participants believed they were being asked to share only interesting childhood memories, and that could not see the relationship to their current lives. Clarification by the PI that the study was interested in memories from throughout the lifespan and providing examples of stems such as "what has been your favorite car to drive" clarified the scope and led to some residents reevaluating their participation and ultimately volunteering. However, many residents still voiced that they did not feel the need or see the usefulness of "living in the past". In future studies two to four additional weeks of recruitment will permit more opportunities to engage resident's concerns and allow them additional time to contemplate participation.

Chapter Two highlighted unique aspects of the most senior generational cohort that included the stigmatization of mental health counseling as a sign of personal weakness, and the presence of the stigma was apparent in this study. Significant thought was devoted to the language and images used on flyers and when explaining the nature of the study to potential participants to ensure that they did not feel that they were being pathologized. In spite of these efforts, the PI's affiliation as a Doctoral student in *counselor* education activated a negative stigma that was voiced by many residents during personal contacts; they were suspicious of counselors and noted that they were not in need of counseling. Additionally tying the sharing of memories to *wellness* produced mixed participant responses. Despite the existence of a wellness committee and specifically planned wellness activities at the CCRC, many residents felt that they were "well" already and that wellness enhancing program such as this are for those that are "not well". Advertising for volunteers willing to share past memories and linking the study to wellness may have exerted a major negative influence on the number of male volunteers for the study, particularly given the tendency of men in this generational cohort to negatively stigmatize anything that can be seen as displaying weakness or a lack of competency. Future researchers are encouraged to remain aware of the unique aspects of this most senior generational cohort when selecting words and phrases for advertising and explaining their intended research to older adults.

Those conducting research with older adults are also encouraged to pay particular attention to age related sensory limitations and to account for them early in the research process. In the current study there was one participant who was legally blind, one who required the use of a wheel chair, and multiple participants who were challenged by eyesight and hearing deficits of varying degrees. These conditions required that a proctor be dedicated solely for assisting the

blind participant with the pre- and post-tests, that the wheelchair-bound participant had adequate space and a placement that did not interfere with others' movement in and out of the meeting rooms, and that group counselors slowed their rate and increased the volume of their speech to ensure that all participants understood the directions. Participants stressed that counselors should look at the residents while speaking to allow for lip reading, that increasing the volume of speech does not mean that the counselor should shout or "shriek" at residents, and that slowing the rate of speech should not transform into an infantile pattern of speech.

Researchers studying older adults should remember that large print versions of assessment instruments are easier for older adult's to read and complete. The use of a bubble sheet for recording answers confused some participants and required additional time for explaining how to cross reference answers on the test sheet to the bubble sheet. As an alternative providing large print versions of the instruments and allowing respondents to mark their responses directly onto the test would reduce the amount of time, confusion, and fatigue for the respondents during testing sessions. The researcher would then transfer responses to bubble sheets for the respondents which would require additional time for the researcher to transfer responses and the development of procedures for ensuring that the responses were accurately transferred.

Finally, future researchers are encouraged to take potential gender differences into account when determining the composition of groups or selecting outcomes of interest. The study current did not detect significant differences gender differences in participant responses; however, it did suggest that women may construct wellness and mattering differently than men do. Degges-White and Myers (2006) noted that age norms for life events are uniquely

changing for women of the baby boomer generational cohort , so care must be taken to account for these unique changes.

Limitations of the Study

Research Design

The current study was developed to compare outcomes in wellness and mattering between two different groups using an experimental pre-test post-test design. Such a quantitative design is tied to post-positivist claims to knowledge as reflected by the use of scales constructed by researchers according to their definitions of wellness and mattering (Creswell, 2011). Predetermined scales and numeric data serve to confirm or deny a construct's congruence or incongruence with those scales, but they have limited capability to extend understanding into new areas such as how older adults in their last decade of life consider wellness and mattering.

In addition, questions asked by participants during testing sessions and annotations on session logs indicated that the pre-test post-test design aroused suspicion in the participants. As noted in the discussion of the researcher logs in Chapter four, participants repeatedly asked for specific details of the intended outcomes and constructs under review. Despite being assured that individual results were not being analyzed or reported as indication of pathology, it is conceivable that this concern may have had a negative effect on some of the participants' level of participation.

Sampling

Five weeks of recruitment efforts resulted in a final sample of 19 older adults for this study (female = 15, male = 4). Difficulties in securing a larger sample may be attributable in part to several unique characteristics of the CCRC setting. CCRCs, such a the one in this study, offer older adult residents with opportunities to enjoy a variety of ongoing and regularly

scheduled services and programs that may not be available to older adults not residing in such a facility. As a result potential participants had to balance participation in the study with participation in a host of other popular activities such as bridge and bible studies. Because of the plethora of activities and wellness programs already offered at the CCRC, it was difficult to spur interest in a new and unfamiliar activity such as the reminiscence groups.

The possibility must also be considered that the participants in the study varied in a significant degree from the CCRC population they were intended to represent. During early coordination meetings, the Executive Director and other staff members predicted that there were a large number of residents who did not participate in activities and programs; they suggested that those who volunteered for the study could be among a somewhat unique group who were involved in multiple activities. Research corroborates this prediction, with findings that females and those with higher levels of educational attainment tended to volunteer at higher rates than males and those with lower educational attainment (Gall, Gall, & Borg, 2007; Piliavin & Siegl, 2007). The well-educated, largely female, sample in this study seems to have been no exception and, thus, may have constituted a unique subset rather than a truly representative sample of the target population.

The small sample size ($n = 19$) imposed limits to this study in a number of ways. First, because a minimum of ten participants per group are required for making any between group comparisons, the use of a control group was not possible, thus eliminating the ability to analyze changes in the treatment groups against a no treatment condition. The small sample size also limited the variability of the sample in many factors that might have affected the outcomes. Specifically, this sample was homogeneous in race and sexual orientation and demonstrated little variability in years of education and relational status. Because men did not volunteer in

sufficient numbers, there was not an opportunity to examine treatment by gender effects; nor were there enough participants to fulfill the minimum cell numbers needed to conduct examinations of the effect of other variables such as race, economic status, or relational status. Despite use of a significance level of $p < .10$ (to increase the chances of detecting change) and the use of global wellness and mattering scales rather than the 17 subscales of wellness or the three mattering subscales, there were simply not enough participants to permit an accurate analysis of second or third order factors of wellness and mattering. It could be that this intervention produced changes in the sub types of wellness or mattering, but the restricted variability within a small sample did not permit a statistically meaningful examination.

Instrumentation

As noted in the previous discussion of the major findings, limitations of the instruments used to measure wellness and mattering may have rendered them inadequate for this population. Although participants' wellness scores reflected levels of reliability consistent with the norming data, and mattering scores were consistent with the data used to validate the Mattering Index, the definitions that serve as the foundations for the creation of the scales may not have been accurate for a sample of older adults such as those involved in this study. The nature of the questions on both instruments may have led participants to select answers to reflect what they perceived to be socially desirable responses, coupled with the pre-test post-test design which may have instilled suspicion among participants that they were being pathologized.

Intervention Content and Process Requirements

This study may also have been limited by the scope of the content and processes called for in the reminiscence protocol developed for both groups. As Stinson (2009) recommended, topics for each session were themed to evoke memories of firsts, favorites, and bests; and three

conversation stems were provided on the session guides. It quickly became apparent from the meetings with the counselors and their comments on session logs that three stems were too much to cover in the course of a 45-minute session. Despite reducing the number of stems from three to two , the need to change topics while the participants were still enjoying the discussion of the previous topic continued and may have caused frustration among participants thus confounding the effectiveness of the intervention.

Internal Validity

Threats to internal validity and attempts to control them in the design of this study were introduced in Chapter Three, and a more detailed discussion of each threat and its intended controls is provided below.

Implementation. The largest threat to the internal validity of this study may have resulted from a difference between counselors in implementing the group reminiscence protocol. The nature of mental health group counseling allows counselors great latitude and freedom to interject personal style and their theoretical orientation into the process. In an effort to counter this threat, both counselors received the same training on older adult issues and the conduct of group reminiscence, and a standardized set of guides for each session were provided to each in order to assist in attaining standardized implementation. As discussed in the major findings, the requirement for the counselor for the REMAIR group to take a more active role in exploring memories according to AIR may have actually changed the nature of the therapeutic process. An additional threat involves possible counselor bias. Although issues of ageism and its effects on researcher objectivity were addressed during training, there is no guarantee that both counselors possessed the same level of comfort working with older adults in the reminiscence protocol.

Subject characteristics. Even among the homogeneously white, heterosexual sample that participated in this study, there are any number of different personal characteristics that could have confounded the validity of the findings. In addition, the impact of such personal differences would likely be magnified due to the small sample size. Random assignment of the participants was employed to ensure any unobserved or unmeasured personal characteristics were distributed equitably between groups, but there is no guarantee that unique subject characteristics did not impart an influence on outcomes. It was also not possible to determine if the members of the sample possessed any special characteristics that were different from those who did not volunteer.

Mortality. There was a concern from the outset that mortality could threaten results, because some of the participants were of advanced age and might experience normal age- related sensory and cognitive processing challenges. Telephone calls reminding participants of sessions and personal counselor attention to each were aimed at reducing the likelihood of this threat and, except for the voluntary withdrawal of one male participant following the second session, no other participants withdrew from the study.

Location. There was little to no location threat, since both groups were conducted on the same day, at the same time, and in almost identical rooms of the CCRC.

Instrumentation. In addition to limitations imposed by instrumentation that were discussed previously, it is possible that the respective versions of two of the instruments used presented and additional threat. The pencil and paper versions of the 5F-WEL (89 items) and the Mattering Index (24 items) were used in this study. Although the two instruments account for only 113 total items addressed in the research, the small (12 c.p.i.) fonts and the need to record responses on a white bubble sheet with red print may have induced fatigue in participants that

may have resulted in less concentration and, thus, less accurate responses to questions falling later on the instruments Otherwise, the potential threats of instrument decay, data collector characteristics, and data collector bias were not considered to be threats for the two standardized instruments, because they both used Likert scales for participants to record responses.

Testing. Any time a pre-test/ post-test design is used, there is the threat that the participant scores on the post-test will be influenced by subjects having "practiced" on the pre-test (Fraenkel & Wallen, 2007). Modest positive as well as negative gain scores in wellness and mattering obtained from the pre-post administration of instruments in the current study would seem to indicate that there was not a practice effect that would have been indicated by inflated scores. The testing threat also refers to participants being able to determine the nature of the study from the instruments administered and to modify their behaviors to reflect either success or failure of the treatment condition. This phenomenon does not appear to have been a threat to this study. Although participants expressed curiosity about the exact variables being measured, the counselors reinforced that the study was intended to measure impacts on wellness of sharing memories in a structured manner. This threat was also minimized because both groups adhered to the same sequence of topics and were similarly configured.

History. No known events occurred across the duration of the study that would have impacted the participants' objectivity.

Subject attitude. Hawthorne effect, or the tendency for participants to intentionally perform better or worse because of the novelty of the treatment rather than the nature of the treatment, presented a threat to validity of this study (Fraenkel & Wallen, 2007). Although there was no indication that members of either group felt that they were either privileged or disadvantaged by their assignment to one treatment group over another, many of the participants

expressed enthusiasm and excitement for being able to participate in a unique research study such as this. It is suspected that participants of both groups may have responded in a manner that was socially desirable in order to cast a positive light on the wellness and mattering profile of the sample.

Statistical regression. Given the high pre-test wellness and mattering scores, there is the possibility that post-test scores regressed towards the group mean thus accounting for the lack of significant gain scores. The use of a control group would have countered this threat to some extent; however, the small size of the available sample precluded the formation of a control group as initially planned.

External Validity

External validity refers to the extent to which the results of this study may be generalized to both: (a) the population from which the sample was drawn and (b) other settings of independent living older adult residents of CCRCs (Fraenkel & Wallen, 2007). Because random sampling was prohibitive in terms of time and cost, a convenience sample of volunteers was used with random assignment. The risk associated with this sampling method is that the participants may not be representative of the larger population. In this study the 20 original participants of the study accounted for just 5.7% of the 359 independent living residents of the CCRC, indicating that caution should be exercised before attempting to generalize these results. As discussed previously under sample limitations, administrators, staff, and residents assessed that most independent living residents of the CCRC do not participate in planned activities and programs, and those that do tend to be involved in multiple programs. Based on that assessment, the results could most likely be generalized to those independent living residents who regularly participate in the planned activities and programs hosted by the CCRC.

Ecologically the results of this study may not be generalizable to older adult residents living independently at other CCRCs. The use of a structured and standardized protocol was intended to limit the differences in processing and functioning between the counselors of this study and for counselors that may replicate this study. However, although the PI was able to ensure treatment fidelity by reviewing the protocol in meetings with each of the counselors twice a week, individual differences of personal counseling style, theoretical orientation, schedule, staffing, etc. may differ in research projects conducted among various CCRC programs and may pose a major threat to generalizing the current studies results across CCRCs. Another threat to ecological generalizability concerns the unique aspects of the current study's population that consisted of predominantly white, heterosexual, highly educated, and female members residing in a federally accredited CCRC. It is also plausible that cultural factors associated with the geographical region of other facilities could impart differential effects on research outcomes, as could differing treatment and living conditions within CCRCs, especially those that are not federally accredited and able to offer the level of services and activities that attract more affluent and privileged residents.

Recommendations for Future Research

Despite its lack of significant findings and stated limitations, this study began to bridge the gap between theory and clinical application through the formation and testing of proposed mattering tenets. The study raises important issues for the counseling profession and suggests multiple opportunities for further research.

As noted previously, research into the constructs of wellness and mattering have been centered in a quantitative paradigm aimed towards validating various models of wellness as opposed to understanding the true nature of the constructs across contexts (Roscoe, 2009).

Because variations in wellness and mattering may be connected to the entry and exit of social roles throughout the lifespan, it is impractical to think that 20-year-old, 40-year-old, and 80-year old persons would construct wellness and mattering in the same way. As such, there is great need and unlimited potential for the qualitative examination of differences in personal definitions of mattering among different populations of older adults such as those residing in public housing settings or those diagnosed with chronic health conditions.

Additional research opportunities exist in the area of examining gender and culture-based differences among populations of older adults such as sexual orientation and social economic status as well as the differences attributable to unique characteristics between generational cohorts. Although it is tempting to generalize the members of the baby boomer cohort as being better educated, more mobile, and open to counseling it is important that researchers remain sensitive to differences in access to resources and long standing systems of inequality and oppression that may have changed in past decades but are still present in society. Qualitative research seems especially warranted in light of the budding knowledge that older adults negotiating gerotranscendence experience a shift in reality that moves them away from worldly and relational concerns towards the cosmic realm. For example, such research might include interviews to examine the hypothesis that adults in gerotranscendence place reduced importance on relationships and increased importance on contemplative solitude and its role in their reconceptualizing of time and space.

Even though this study did not provide evidence that mattering could be promoted by attending to the proposed tenets, it did not change the fact that a strong positive relationship between wellness and mattering has been found to exist and, thus, it did not convincingly dispel the hypothesis that wellness may be enhanced by the promotion of mattering. It may be that

replications studies conducted in contexts other than the unique CCRC context of the current study will produce more positive results, and as such replication studies are recommended. Similarly, studies of interventions incorporating the AIR tenets into delivery models other than reminiscence therapy (e.g., cognitive behavioral, reality therapy, etc.) could potentially yield different findings and are likewise recommended.

Additional research is also needed to investigate the possible uses and outcomes of reminiscence therapies conducted by trained counselors. Myers and Harper (2004) noted that most of the present outcome research on reminiscence therapy has involved reminiscence groups conducted by paraprofessionals and volunteers, thereby leaving this potentially valuable mode of therapy virtually unexplored by the counseling profession. Research focusing on outcomes produced by professional counselors leading such groups could add to the clinical significance of this mode of therapy. In addition, because most reminiscence groups are conducted with older adults challenged by dementia, most outcome research omits the examination of possible benefits of reminiscence for healthy and functional older adults, and this is another promising area for continued study.

Conclusion

As the numbers of older adults in U.S. society continues to grow to unprecedented levels over the next 20 years, counselors will have more opportunities to interact with older adults. Current models of aging and development are beginning to consider development in the later stages of life, and efforts to support older adults are focusing on promoting notions of holistic wellness. However, these efforts do not fully account for threats to wellbeing resulting from the loss mattering sources accompanying losses of familial and occupational roles that come with older age. Research indicates a positive relationship between a sense of mattering to others and

both wellness and enhanced life satisfaction, but research has lagged in the area of examining how mattering might be promoted through clinical intervention.

This study represented an initial effort to transform mattering theory into a clinical application for older adults. Despite its mixed results, it is anticipated that mattering to others and the AIR framework will ultimately provide a useful new way of conceptualizing human interactions and relationships for counselors of all specialties. Above all, the study has alerted counselors and the counseling profession to growing needs for better understanding of aging and the aged, and it has provided a model for future efforts to develop wellness enhancing counseling intervention to support a rapidly growing population of older adults.

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Appendix A

Informed Consent

I, (print name here) _____, am willing to participate in a study of the benefits of participating in reminiscence groups. I understand that this study is being conducted by Herman R. Lukow II, a doctoral candidate in counseling at the College of William and Mary.

As a participant, I am aware that I will be asked to complete research instruments at the beginning and again at the end of my participation in the group experience. The research instruments are: The Five Factor Assessment of Wellness- Adult Version; a scale to measure perceived mattering developed by Elliot and colleagues (2004); and a brief demographic questionnaire.

I am aware that my participation is voluntary and that I may withdraw from this study at any time without penalty. The assessments and demographic questionnaire will be confidential and identified by a code that only the lead researcher will know. Results will be combined and reported in the aggregate and no identifying information will be reported in the study results. I also understand that a copy of the results of the study will be given to me upon request.

By participating in this study, I understand that there are no obvious risks to my physical or mental health.

Confidentiality Statement

As a participant in this study, I am aware that all records will be kept confidential and my name will not be associated with any of the results of this study. If I have any questions that arise in connection with my participation in this study, I should contact Dr. Rip McAdams, the chair of Mr. Lukow's Doctoral Committee at (757) 221-2321 or crmcad@wm.edu. I understand that I may report any problems or dissatisfaction to Dr. Thomas Ward, chair of the School of Education Internal Review Committee at (757) 221-2358 or tjward@wm.edu or Dr. _____, chair of the Protection of Human Subjects Committee at the College of William and Mary at (757) 221-2778.

The investigator in this study may be reached by contacting Herman Lukow at 757-876-4649.

Participant's Signature **Date**

THIS PROJECT WAS FOUND TO COMPLY WITH APPROPRIATE ETHICAL STANDARDS AND WAS EXEMPTED FROM THE NEED FOR FORMAL REVIEW BY THE COLLEGE OF WILLIAM AND MARY PROTECTION OF HUMAN SUBJECTS COMMITTEE (PHONE: 757-221-3901) ON_____ AND EXPIRES ON _____

Appendix B

Five Factor Wel Inventory
Form A (5F-Wel-A)

The purpose of this inventory is to help you make healthy lifestyle choices. The items are statements that describe you. Answer each item in a way that is true for you most of the time. Think about how you most often see yourself, feel, or behave. Answer all the items. Do not spend too much time on any one item. Your honest answers will make your scores more useful.

INSTRUCTIONS

Mark your answers on the bubble sheet. Use a number two lead pencil. Begin by filling in the following information:

your name	(last name, first name)
sex	(male or female)
highest grade completed	
birth date	(be sure to bubble in your month, date, and year)
identification number	(ID number if you were given one)
special codes, columns K, L, M	(1st three digits of your zip code)
columns N, O, P	(code from test administrator, if provided)

Mark only one answer for each item using this scale:

Answer **Strongly Agree**	if it is true for you most of the time.
Answer **Agree**	if it is true for you some of the time.
Answer **Disagree**	if it is mostly not true for you.
Answer **Strongly Disagree**	if it is never true for you.

EXAMPLE

If you "like to meet new people" some of the time, mark "agree" as shown here.

	Strongly Agree	Agree	Disagree	Strongly Disagree
I like meeting new people.	(A)	(B)	(C)	(D)

1. I engage in a leisure activity in which I lose myself and feel like time stands still.

2. I am satisfied with how I cope with stress.

3. I eat a healthy amount of vitamins, minerals, and fiber each day.

4. I often see humor even when doing a serious task.

5. I am satisfied with the quality and quantity of foods in my diet.

6. Being a male/female is a source of satisfaction and pride to me.

7. When I have a problem, I study my choices and possible outcomes before acting.

8. I do not drink alcohol or drink less than two drinks per day.

9. I get some form of exercise for 20 minutes at least three times a week.

10. I value myself as a unique person.

11. I have friends who would do most anything for me if I were in need.

12. I feel like I need to keep other people happy.

13. I can express both my good and bad feelings appropriately.

14. I eat a healthy diet.

15. I do not use tobacco.

16. My cultural background enhances the quality of my life.

17. I have a lot of control over conditions affecting the work or schoolwork I do.

18. I am able to manage my stress.

19. Most nights I get enough sleep.

20. I can take charge and manage a situation when it is appropriate.

21. I can laugh at myself.

22. Being male/female has a positive affect on my life.

23. My free time activities are an important part of my life.

24. My work or schoolwork allows me to use my abilities and skills.

25. I have friends and/or relatives who would provide help for me if I were in need.

26. I have at least one close relationship that is secure and lasting.

27. I seek ways to stimulate my thinking and increase my learning.

28. I am often unhappy because my expectations are not met.

29. I look forward to the work or schoolwork I do each day.

30. I usually achieve the goals I set for myself.

31. I have sources of support with respect to my race, color, or culture.

32. I can find creative solutions to hard problems.

33. I think I am an active person.

34. I take part in leisure activities that satisfy me.

35. Prayer or spiritual study is a regular part of my life.

36. I accept how I look even though I am not perfect.

37. I take part in organized religious or spiritual practices.

38. I am usually aware of how I feel about things.

39. I jump to conclusions that affect me negatively, and that turn out to be untrue.

40. I can show my feelings anytime.

41. I make time for leisure activities that I enjoy.

42. Others say I have a good sense of humor.

43. I make it a point to seek the views of others in a variety of ways.

44. I believe that I am a worthwhile person.

45. I feel support from others for being a male/female.

46. It is important for me to be liked or loved by everyone I meet.

47. I have at least one person who is interested in my growth and well being.

48. I am good at using my imagination, knowledge, and skills to solve problems.

49. I can start and keep relationships that are satisfying to me.

50. I can cope with the thoughts that cause me stress.

51. I have spiritual beliefs that guide me in my daily life.

52. I have at least one person with whom I am close emotionally.

53. I am physically active most of the time.

54. I use humor to gain new insights on the problems in my life.

55. I can put my work or schoolwork aside for leisure without feeling guilty.

56. I have to do all things well in order to feel worthwhile.

57. I feel a positive identity with others of my gender.

58. I am appreciated by those around me at work or school.

59. I plan ahead to achieve the goals in my life.

60. I like myself even through I am not perfect.

61. I am satisfied with my free time activities.

62. I do some form of stretching activity at least three times a week.

63. I eat at least three meals a day including breakfast.

64. I do not use illegal drugs.

65. I believe in God or a spiritual being greater than myself.

66. I can experience a full range of emotions, both positive and negative.

67. I am able to relax when I need to do so to relieve my stress.

68. I eat fruits, vegetables, and whole grains daily.

69. My spiritual growth is essential to me.

70. When I need information, I have friends whom I can ask for help.

71. I am proud of my cultural heritage.

72. I like to be physically fit.

73. I have at least one person in whom I can confide my thoughts and feelings.

74. I am satisfied with my life.

75. I have enough money to do the things I need to do.

76 I feel safe in my home.

77. I feel safe in my workplace or school.

78. I feel safe in my neighborhood.

79. I feel safe in my daily life.

80. I am afraid that I or my family will be hurt by terrorists.

81. What is your current marital status?
A. married/partnered
B. single
C. separated
D. divorced
E. widowed

82. What is your current employment status?
A. employed full time
B. employed part time
C. retired, not working
D. retired, working part time
E. not working

83. Are you currently a student?
A. yes, in high school
B. yes, working on undergraduate degree
C. yes, working on graduate degree
D. yes, taking courses for fun
E. no, not currently a student

84. What is the highest level of education you have completed?
A. less than high school
B. high school graduate
C.. trade/technical school/A.A. Degree
D. Bachelor's Degree
E. Advanced Degree

85. If you have an advanced degree, please specify your highest degree.
A. Master's degree
B. Specialist degree
C. Professional degree (DDS, JD, MD)
D. Doctorate degree (Ph.D., Ed.D.)

86. What is your biological sex?
A. Male B. Female

87. Are you biracial?
A. Yes B. No

88. What is the primary cultural background with which you most closely identify?
A. Native American
B. Asian or Pacific Islander
C. African American
D. Caucasian
E. Hispanic/Latino/Latina

89. What is your sexual/affectional orientation?
A. gay
B. lesbian
C. bisexual
D. heterosexual

Please check to be sure your birth date has been included in the proper space on the bubble answer sheet (lower left corner).

Thank you!

Appendix C

Elliott, G.C., Kao, S., & Grant, A. (2004). Mattering: Empirical validation of a social-psychological concept. *Self and Identity, 3*, 339-354.

1. Most people do not notice when I come or when I go.
2. In a social gathering, no one recognizes me
3. Sometimes when I am with others, I feel almost as if I were invisible.
4. People are usually aware of my presence.
5. For whatever reason, it I hard to get other people's attention.
6. Whatever else may happen, people do not ignore me.
7. For better or worse, people generally know when I am around.
8. People tend not to remember my name.
9. People do not care what happens to me.
10. There are people in my life who react to what happens to me in the same way they would if it had happened to them.
11. My successes are a source of pride to people in my life.
12. I have noticed that people will sometimes inconvenience themselves to help me.
13. When I have a problem, people usually don't want to hear about it.
14. Much of the time, other people are indifferent to my needs.
15. There are people in my life who care enough about me to criticize me when I need it.
16. There is no one who really takes pride in my accomplishments.
17. No one would notice if one day I disappeared.
18. If the truth be known, no one really needs me.
19. Quite a few people look to me for advice on issues of importance.
20. I am not someone people turn to when they need something.

21. People tend to rely on me for support.

22. When people need help, they come to me.

23. People count on me to be there in times of need.

24. Often people trust me with things that are important to them.

Appendix D

Participant Feedback Form

Thank you for you participation in the research study on reminiscence conducted over the last five weeks. In addition to the information obtained from the assessments you completed before and after the groups, your likes, dislikes, and suggestions are very important for understanding the usefulness of these types of groups with older adults. If you could take five minutes to provide your feedback below, I would greatly appreciate it.

On a scale of 1 to 5, with 1 being low and 5 being high, how would you rate:

	Low				High
1. Your overall satisfaction with this five-week program?	1	2	3	4	5
2. The time allotted for sessions?	1	2	3	4	5
3. The adequacy of the meeting space in general?	1	2	3	4	5
4. The composition of your group?	1	2	3	4	5
5. Your group leader?	1	2	3	4	5
6. Communication of important dates and times?	1	2	3	4	5
7. The topics and themes selected for reminiscing?	1	2	3	4	5
8. The usefulness of this program for others?	1	2	3	4	5

Please comment:

Which topic or topics did you find to be the most and least useful?

What did you enjoy the most and least while participating?

What would you do to make this a better program?

What other comments do you wish to make?

Appendix E

Protocol for structured reminiscence

The overarching goals of all reminiscence group sessions are to enhance psychological health, increase socialization, reduce isolation, and build relationships through a group process that involves the verbal exchange of pleasant then and there memories. Additional goals for specific sessions are included. In addition, common goals for AIR structured groups is to activate past working models of mattering by exploring shared memories through the AIR "lens" and changes to AIR that occurred in the "then and there".

Session 1 (Week 1)

Pretest: Proctors will administer the pretest

Session 2 (Week 1)

Theme: Introductions

Activity: Members provide an artifact from the past to facilitate introduction of members and leaders to each other.

Goals: Introduce group members to each other; emphasize the purpose of the group; establish procedures and group norms; concentrate on personal backgrounds in order to build trust, foster communication.

Session 3 (Week 2) School days

Theme: School Days

Activity: Members share memories of clothing styles worn to school while counselor finds images to project from the Internet.

Remembering the first day (s) of school

Discussing favorite classes, teachers, and activities

Goals: Build trust among group members; encourage communication

Session 4 (Week 2)

Theme: Fun and Games Through the Years

Activity: Remembering first toys while the counselor finds images to project from the Internet

Remembering toys made at home

Discussing favorite games, sports, and activities

Goals: Continue to improve psychosocial skills.

Session 5 (Week 3)

Theme: Jobs to Do, Places to Live

Activity: Members bring in an artifact from current/former career to facilitate memories; counselor finds and projects images of occupations from the Internet.

Remembering the first job and home

Discuss favorite job or volunteer activity

Goals: Continue to improve psychosocial skills.

Session 6 (Week 3)

Theme: Family and pets

Activity: Members provide photos of family, friends, and pets to facilitate discussion.

Remembering favorite siblings, aunts, uncles, etc.

Remembering children

Discussing favorite pets

Goals: Continue to improve social connections, strengthen new relationships

Session 7 (Week 4)

Theme: Romance is in the air

Activity: participants share photos, cards, or mementos

Remembering first dates

Discuss courting, proposals, and weddings

Goals: Continue to improve social connections and new support relationships; begin to move to closing.

Session 8 (Week 4)

Theme: Holidays & Traditions!

Remembering firsts for the holidays

Remembering favorite holidays

Discussing traditions for the holidays

Goals: Continue to improve social connections and new support relationships; begin to move to closing.

Session 9 (Week 5)

Theme: Old friends, new friends/closing

Activity: Group counselor distributes thank you cards as part of closing

Goals: consolidate lessons learned; end the groups with a memorable experience.

Session 10 (Week 5)

Posttest: Proctors will administer the posttest