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# The effects of a focus group discussion on elderly worriers.

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# THE EFFECTS OF A FOCUS GROUP DISCUSSION ON ELDERLY WORRIERS

A Thesis Presented

by

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**ABSTRACT**

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Recently the focus group interview, or discussion, has become more commonly used in social science research as a data collection technique (Lederman, 1990), which could lead to improved theory and practice in the social sciences (Basch, 1987; Morgan, 1988). Further, the focus group has been used by researchers to collect data from elderly subjects on various psychological issues such as adjusting to widowhood (Morgan, 1989), quality of life (Wolkenstein & Butler, 1992), and the impact of life events on widows and caregivers (Morgan & March, 1992). The emerging literature about focus groups, however, has only begun to explore the effects of participating in these groups. This study examines the effects on elderly worriers of six focus group discussions, centered on the topic of worry (Wisocki, Hunt, & Souza, 1993).

Subjects for this study consisted of two groups: (1) Non-focus group participants (N=20); and (2) Focus group participants (N=21). All subjects were self-designated

worriers, were at least 70 years of age, and had agreed to participate in the focus groups.

All subjects were given questionnaires before the focus groups began and then one-year after the groups ended.

Results suggest that while there were no significant differences between groups on the measures of worry, anxiety, and life satisfaction, psychological symptom domains unrelated to the focus group topic, the focus group participants reported benefitting from the experience. No adverse effects were determined.

The therapeutic implications of using focus groups with the elderly are discussed. Also discussed are the implications of using focus groups as a data collection technique to explore psychological issues in the elderly.

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# CHAPTER I

## INTRODUCTION

Recently the focus group interview, or discussion, has become more commonly used in social science research as a data collection technique (Lederman, 1990), which could lead to improved theory and practice in the social sciences (Basch, 1987; Morgan, 1988). This technique appears to be at least as effective as the survey technique in gathering data, and better because it provides for additional detail not acquired by surveys (Ward, Bertrand, & Brown, 1991).

The focus group technique has been used by researchers to collect data from elderly subjects on various psychological issues such as adjusting to widowhood (Morgan, 1989), quality of life (Wolkenstein & Butler, 1992), the impact of life events on widows and caregivers (Morgan & March, 1992), and worry in the elderly (Wisocki, Hunt, & Souza, 1993). There are many potential benefits of focus group participation, which may be considered therapeutic. Focus groups allow participants to discuss the various aspects of a specific problem area in their lives. It may provide them with an understanding of the nature of, and remedies for, the particular problem. This understanding comes from peer group members who share similar concerns, and a moderator who ensures that certain relevant and potentially therapeutically useful questions are discussed.

The focus group may provide an alternative therapeutic milieu for these hard to reach individuals because the cost is minimal to the client, the time commitment is brief, and the stigma of being perceived as severely disturbed is curtailed by designating the activity a "discussion group" in which there is intense focus on a particular problem area. This study explores the effects of a focus group discussion on self-identified elderly worriers. These focus groups were not initially designed as therapeutic groups, but were used to gather data about worry among elderly citizens (Wisocki, Hunt, & Souza, 1993).

Worry, a prominent feature of anxiety disorders, is prevalent in about 15% to 17% of the older population (Brody & Kleban, 1983) and has been identified as a salient feature in the psychological lives of many elderly (Carstensen, 1988; Powers, Wisocki, & Whitbourne, 1992; Wisocki, 1988; Wisocki & Handen, 1983; Wisocki, Handen, & Morse, 1986). The health consequences of chronic stress, anxiety, and worry may be especially dire for the elderly (Kahana & Kahana, 1983; Sallis & Lichstein, 1982). In fact, many diseases common to the elderly, such as hypertension, hypoglycemia, hypertriglycemia, and coronary heart disease, can be worsened dramatically by stress, anxiety, and worry (Hersen & Van Hasselt, 1992).

There is currently no treatment literature on chronic worry in the elderly, and the treatment literature on

anxiety is based predominately on psychopharmacological methods (Allen, 1986; Palmore, 1973; Parry, Baltes, Mellinger, Cisin, & Manheimer, 1973; Salzman, 1991; Waxman & Carner, 1984), which pose complicated problems as they interact with biological age-related changes in the human organism. The prevalence of psychopharmacological treatment may be due to the lack of participation by the elderly in traditional psychological services (MacDonald & Schnur, 1987) and their greater reliance on physicians (Lewinsohn & Teri, 1983; McCarthy, Katz, & Foa, 1991; Waxman & Carner, 1984). In fact, for many elderly the utilization of mental health services is akin to the acknowledgement of severe pathology and they are frightened by the prospects of psychiatric hospitalization (Butler & Lewis, 1982).

One useful way of addressing the unique mental health needs of the elderly, which include stigma, age compatibility, and affordability, is by peer facilitated group therapy (Finkel, 1990; Lieberman & Gourash-Bliwise, 1985). Numerous authors have reviewed the use of group methods in meeting the psychological needs of the aged (Edinberg, 1985; Hartford, 1980; MacLennan, Saul, & Weiner, 1988; Schneider, Corey & Corey, 1992; Thorman, 1989). According to Edinberg (1985), group methods appear especially useful for the elderly for seven reasons: First, the elderly are often unwilling or financially unable to seek out individual treatment. Second, the group format

provides mutual emotional support derived from members of the group, which might be especially useful for elderly if the group leader is much younger than the group members.[1] Third, the group experience gives group members a chance to express aspects of themselves and their thinking that they may not normally express in their everyday environments. Participants can use the group discussion as a form of catharsis or as a way to explore ideas which may not be acceptable in another format.[2] Fourth, the group allows for the development of relationships between group members, a feature especially important for those elderly who are socially isolated and are otherwise unable to develop relationships of mutual understanding and support. Fifth, modeling, in which group members learn more adaptive coping behaviors from each other, may occur. Through discussion and interaction in a small group, participants may be better

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[1]The importance of the peer aspect of the focus group is supported by the research on indigenous helpers which indicates that therapeutic benefits are more likely if the helping agent is similar in terms of background, life-style, and social characteristics (Brown & Myers, 1975; Hall, 1972; Lamb & Clack, 1974; Russell & Wise, 1976; Zunker & Brown, 1966). It is believed that reductions in psychological distance between the helper and client will lead to greater role modeling and openness to change (Durlak, 1979; Sobey, 1970).

[2]In a study on the suppression of emotional material, including anxious material, Roemer (1991) found that if subjects allowed themselves to talk about an emotional situation, they talk about it less than subjects who expressed neutral material. Roemer concluded that "suppression of emotional material is not an effective way to reduce negative emotion and in fact may increase it, whereas expression seems at least to decrease the focus on the emotional material." (p. 4).

able to understand the ideas presented, and learning may occur more efficiently. Sixth, in a group the older individual can choose to participate actively or just take information in without having to speak. No such choices are possible in an individual format. Finally, the group format allows for downward and upward social comparison, which is a common coping strategy in all age groups.

In a study on anxiety and depression management classes for groups of elderly, Sallis, Lichstein, Clarkson, Stalgatis, and Campbell (1983) found that none of their treatment conditions (which included an anxiety treatment condition and depression treatment condition in which subjects were taught cognitive-behavioral methods for reducing either anxiety or depression) were more effective than the placebo condition (which was designed to foster expectations of success without providing the structured cognitive-behavioral techniques of the treatment conditions) on any measure, and that only the subjects in the placebo condition made marginal improvements on anxiety. Each group met for ten 1-hour sessions. In rating the effective components of the process, two of the three groups rated the two "nonspecific" components (i.e., group discussion and information from leader) as most helpful. The authors concluded that the elderly subjects in their study were "highly reactive to and benefitted from the social contact and varied forms of social influence to which they were

exposed," (pp. 10-11). Levy, Derogatis, Gallagher, and Gatz (1980), have speculated that the elderly may be more responsive than younger adults to the nonspecific factors inherent in group treatments, although no comparative studies support such a differentiation.

MacDonald and Schnur (1987) point out that one of the most effective and simplest cognitive interventions for treating worry and anxiety in the elderly is education. They use the example of the elderly's excessive fear of crime, which Hahn and Miller (1980) report was the single most salient concern for elders in their sample and the fact that the rate of victimization among the elderly was lower than that in any other age group (U.S. Department of Justice, 1979). Education about the reality or feasibility of the fear may reduce the fear. Education can be useful in treating elders who experience anxiety because they misattribute normal aspects of aging such as mild forgetfulness, to incipient Alzheimers disease (Sluss, Gruenberg, Reedman, & Rabins, 1983; Sparacino, 1978; Zarit, 1982) and side effects from medication to mental or physical decline (Hussian, 1981).

A creative and affordable group approach to counseling severely disabled elders involved cognitive group therapy by telephone conferencing, which had an effect of reducing feelings of loneliness and increased goal attainment in a sample of homebound elders (Evans, Smith, Werkhoven, Fox, &

Pritzl, 1986). Further examples of effective groups for the elderly include support groups in the community (Petty, Moeller, & Campbell, 1976), feelings groups for adult day care patients (Van Wylen, Dykema-Lamse, 1990), and integrative outpatient group therapy for discharged psychiatric patients (Schmid & Rouslin, 1992). All of these groups showed some effectiveness in reducing symptoms and/or enhancing mental health.

The focus group approach is similar to the psychoeducational model proposed by Lewinsohn (1978) for the treatment of depression in which clients are solicited through advertising a "course" on "how to control depression". The psychoeducational approach, with some modification, has been found to be effective in treating major depression in elders (Hedlund & Thompson, 1980). Thompson, Gallagher, Nies, and Epstein (1983) found that older depressive patients who participated in a psychoeducational group reported fewer symptoms of depression, and a more positive outlook on their future in post-test evaluations. These group meetings met once a week for 6 weeks with sessions lasting 2-hours.

In a focus group the psychoeducation occurs mostly through intense focused discussion with other group members who share similar problems. With a group of 4 to 8 individuals there will be a number of potentially useful coping ideas generated in one 2-hour focus group that

individuals may not have thought of on their own. Thus there is heavy reliance on peer facilitated learning in the focus group model. In one of the few studies looking at the effects of focus group participation, Swenson, Griswold, and Kleiber (1992) found that 67% of the subjects in their sample reported that they continued to think about the topics raised in the focus group and that the discussion generated during the focus group had an impact on their thinking. Also 57% of the subjects reported that they discussed the focus group issues with others outside of the group, and 43% said they had followed up on ideas generated during the discussion. Eighty-six percent of the subjects reported that they were planning more involvement in the topic area, and that participating in the focus group was the motivating factor. Swenson et al., (1992) concluded that:

> All problems are not solved by getting a small group of people to sit down and talk about them. With the group dynamics of a focused interview, conflicts are articulated, diverse points of view are solicited, and a tolerance for differences is fostered. The impact of focus group participation may be relatively short term, in that participants focus on talking and thinking about a focused problem. But as part of a campaign in community development, focus groups were extremely useful because they organized the attention of participants toward certain issues and their role in addressing those issues. (Swenson et al., 1992, p. 468).

While this study did not deal with emotional problems in the lives of individuals, the nonspecific, short-term effects of a focused discussion with peers and a professional moderator

are encouraging. Whether there are any long-term effects of a focused discussion and whether there is a difference in effect when the focused discussion topic is of great personal psychological relevance to the group members are unknown.

Focus group discussions have been shown to induce certain collective group norm effects, such as polarization, which might bias the data collected (Sussman, Burton, Dent, Stacy, & Flay, 1991). The brainstorming effect, one of the stated benefits of focus group discussion, was not found to occur, however (Sussman et al., 1991).

Given that there is a large minority of elderly who experience significant distress due to chronic worry, and that this population is not likely to seek out individual professional psychological treatment, together with the data on the benefits of emotional expression and group interaction in reducing worry and anxiety, it would appear that a brief, focused discussion group format might be beneficial in reducing worry in the elderly. A focus group treatment approach may satisfy the numerous conditions inherent in psychological work with the elderly which could lead to therapeutic effectiveness. There is also the question of adverse effects of a focus group discussion, however. Is the worry of focus group participants more frequent and intense after an in depth discussion with peers who are also chronic worriers?

The purpose of this study was to determine if a focus group discussion, designed to promote an in depth exploration of worry and anxiety among groups of older adults contributes to the long-term reduction of or increase in worry.

Two central questions were asked: (1) Did the focus group discussion provide any therapeutic benefit? and (2) Did the focus group discussion have any adverse effects on participants?

The hypotheses are: first, that the subjects who participate in the focus groups will show significant decreases on worry scores on pre-to-post measures, compared with a control group of non-participants; Second, that those symptom domains unrelated to the focus group discussion, such as depression, somatization, obsessive-compulsive, interpersonal sensitivity, hostility, paranoid ideation, and psychoticism will show no change on pre-to-post measures.

## CHAPTER II

## METHOD

### Subjects

Subjects for this follow up study consisted of two groups: (1) Non-focus group participants (N=20); and (2) Focus group participants (N=21). Initially for the pretest measures there were thirty subjects in each group. In the non-focus group condition three subjects could not be reached by phone or mail, three subjects refused to participate, and one subject provided incomplete materials. In the focus group condition five subjects could not be reached by phone or mail, four subjects refused to participate, and two subjects provided incomplete materials. Thus from pretest to posttest there was about a 34% drop out rate for the focus group condition and a 26% drop out rate for the control condition. All subjects were self-designated worriers and were at least 70 years of age.

All subjects had agreed to participate in the focus group discussions, but some subjects could not be scheduled during the meeting times. This group was used as a control. The control group consisted of 16 Caucasian and 4 African-American individuals. The average age of this group was 78.4 years with a standard deviation of 4.7 years. Seventy-five percent of the control group was female. The average number of years of education was 13.15 with a standard deviation of 3.42. Half of these subjects were widowed,

eight were currently married, one was divorced, and one had never been married. Ninety percent of these subjects were currently retired, one was working as a skilled worker, and one was working in a professional position. Sixty-five percent had held professional positions in their previous occupations, three were skilled workers, and four were laborers.

The experimental group consisted of 21 subjects, 19 of whom were Caucasian, and one African-American. The average age of this group was 78.7 years with a standard deviation of 4.8. Ninety-five percent of the experimental group was female. The average number of years of education was 12.14 with a standard deviation of 2.72. Nine were currently widowed, eight were married, one was divorced, and three had never married. Ninety-five percent of these subjects were currently retired, one was employed as a skilled worker. The preretirement occupations of this group included nine professionals, eight skilled workers, and three laborers. These subjects were seen in 6 focus groups conducted over a period of twelve months. The group sizes ranged from 3 to 8 participants, with a mean of 5.

Measures

All subjects completed the following questionnaires prior to being contacted about the focus groups: (1) a demographic questionnaire which provided information on age,

sex, race, former occupation, education, marital status, income, self-reported health status, self-reported status of social relationships, and religiosity; (2) the SCL-90R (Derogatis, Rickels, & Rock, 1976), a 90 item symptom checklist which uses a five point Likert scale ranging from "not at all" to "extremely" and includes items which cover nine symptom dimensions: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism; (3) a Worry Questionnaire (Appendix A) in which respondents indicated the percentage of each day spent worrying, the amount of worry experienced in the domains of health, finances, and social relationships, and feelings and physical conditions that may accompany worry.

Procedure

Subjects were invited to attend a focus group if they indicated a high frequency of worry on the Worry Questionnaire (over 5% of the day spent worrying). Groups met at the Providence Hospital in Holyoke, MA. The experimenters provided transportation for most subjects. Subjects were assured that their anonymity would be protected. Their permission was sought for taping the sessions and they verbally consented to the process. Subjects were seated around a rectangular table with the discussion moderator at the head. The other two

experimenters sat off to the side, in an unobtrusive spot. Groups began with refreshments and a general discussion to encourage a relaxed atmosphere. The experimenters told the subjects that they were there to talk about topics related to worry and that everyone's opinion was important. Subjects were told that they were the "experts" for this group experience and that the experimenters were there to learn from them. This was done in compliance with the directive that a hierarchical relationship is not as productive as a lateral one at drawing out complex, internal information (Goldman & McDonald, 1987). The experimenters started the discussion with a general question about what is difficult about being older these days. The following questions were introduced in the course of the discussion:

1) What kinds of things do you worry about?
2) Is this worry common to people your age?
3) How can you tell when you are worried?
4) Can you differentiate between worry and anxiety and worry and depression?
5) Has the focus and frequency of your worry changed over your lifetime?
6) What kinds of things contribute to your worry?
7) What are the effects of worry on you?
8) What do you do to not worry and how do you stop it when it happens?
9) How would you define worry?

The order of the presentation of these questions was dependent on the content of the discussion. Most of the group discussions lasted an hour and a half. Afterwards subjects read a debriefing form and filled out an evaluation of their experience in the study. Names and addresses of

subjects who wanted a report of the results were retained. Subjects were thanked and given checks for $20.00.

Twelve months after the last focus group was completed, all participants and non-participants were contacted again and asked to fill out the following questionnaires: (1) The Worry Questionnaire; (2) The SCL-90R (Derogatis, Rickles, & Rock, 1976); (3) A Life Events Questionnaire (Appendix B) which asked subjects to indicate whether they experienced any of 12 items during the past year; and (4) Life Satisfaction questions (Appendix C).

The focus group participants were asked to complete an additional questionnaire relevant to their participation. The Focus Group Follow-up Questionnaire (Appendix D), designed specifically for this study to assess possible long-term effects of the focus group experience, consists of 14-items rated on a 5 point Likert scale.

All subjects were contacted by mail with an introductory letter, a Consent Form (Appendix E), and the above questionnaires. A follow-up with a phone call was also made to solicit participation. Those who agreed to respond were paid $5.00 for completing the questionnaires. Subjects were once again given a Debriefing Form (Appendix F).

## CHAPTER III

## RESULTS

### Design and Analysis

Correlations were performed on the measures of worry, anxiety, life satisfaction, and SCL90-R GSI, to determine the strength of the relationship between these variables. Between group effects were analyzed by an Analysis of Covariance (ANCOVA) on post measures with pre measures as the covariate. Benefits of the focus group discussions were analyzed qualitatively by reporting the focus group participants' responses to the Follow Up Questionnaire.

### Correlations Among Measures

Table 1 shows the correlations between the mean pre and post dependent measures for the experimental group and control group, respectively. As expected, for both groups the Worry Questionnaire correlated highest with the SCL-90R Anxiety Subscale (r1 = .85, r2 = .82), and next highest with the SCL-90R Global Symptom Index (r1 = .84, r2 = .80), which includes items from the Anxiety Subscale. The Worry Questionnaire also correlated highly with the SCL-90R Depression Subscale (r1 = .75, r2 = .68). The lowest correlation occurred between the Worry Questionnaire and the question about the percentage of the day spent worrying (r1 = .49, r2 = .62), but the correlations were still

significant. The Worry Questionnaire correlated negatively with the Life Satisfaction measure (r1 = -.37, r2 = -.40), but these correlations were not significant. There were significant negative correlations between the Life Satisfaction measure and the SCL-90R Depression Subscale for both groups (r1 = -.53, r2 = -.52), and the Life Satisfaction measure and the SCL-90R GSI for the control group only (r2 = -.46). The question about percent of the day spent worrying correlated significantly with the SCL-90R Anxiety Subscale (r1 = .44, r2 = .46) for both groups and with the Depression Subscale for the experimental group only (r1 = .44, r2 = .19).

**Table 1. Correlation Matrices for Measures: Pre and Post Tests Scores for Experimental and Control Groups.**

| Experimental Group | | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| 1) Worry Quest. | | | | | |
| 2) Life Satis. | -.37 | | | | |
| 3) Percent Worry | .49* | -.12 | | | |
| 4) SCL-90R: Anxiety | .85** | -.26 | .44* | | |
| 5) SCL-90R: Depression | .75** | -.53* | .44* | .70** | |
| 6) SCL-90R: GSI | .84** | -.19 | .39 | .92** | .80** |

| Control Group | | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| 1) Worry Quest. | | | | | |
| 2) Life Satis. | -.40 | | | | |
| 3) Percent Worry | .62** | .02 | | | |
| 4) SCL-90R: Anxiety | .82** | -.33 | .46* | | |
| 5) SCL-90R: Depression | .68** | -.52* | .19 | .70** | |
| 6) SCL-90R: GSI | .80** | -.46* | .38 | .80** | .91** |

* $p < .05$
** $p < .01$

Between Group Effects

There were no differences between those subjects who did and did not participate in the study on the pre measures of percent of day spent worrying and worry questionnaire.

A multivariate test for group differences on prescores of the Worry Questionnaire, Percentage of Day Spent Worrying, Life Satisfaction, SCL-90R: Global Symptom Index, Depression, and Anxiety Subscales indicated a significant difference between the groups, $F(6,34) = 2.51$, $p = .04$. The univariate F-tests indicated that the Worry Questionnaire $F(1,39) = 6.36$, $p = .02$, the Percentage of Day Spent Worrying $F(1,39) = 11.24$, $p = .002$, and the SCL-90R GSI $F(1,39) = 6.30$, $p = .02$, all contributed to the prescore differences between groups where the experimental group had significantly higher means on all three measures.

Table 2 shows the means, standard deviations, and Ancova F values for the between group effects on postscores using the prescores as the covariate. The Worry Questionnaire mean scores for both the experimental group (pre M = 35.24, post M = 36.04) and the control group (pre M = 27.10, post M = 28.00), did not increase to a significant extent, $F(1,37) = .12$, $p > .05$. The Percent of Worry decreased for both the experimental group (pre M = 29.26, post M = 13.89), and the control group (pre M = 10.65, post M = 8.70), but the decrease was not significant, $F(1,35) = .76$, $p > .05$. While the SCL-90R Anxiety Subscale scores

increased for the experimental group (pre M = 58.85, post M = 59.30), and decreased for the control group (pre M = 54.35, post M = 53.50), the group effect was not significant, $F(1,36) = .45$, $p > .05$. The group effect for Life Satisfaction was also not significant, $F(1,37) = .81$, $p > .05$, despite increases for both the experimental group (pre M = 13.09, post M = 13.57), and the control group (pre M = 14.45, post M = 14.85). The SCL-90R Global Symptom Index decreased for the experimental group (pre M = 63.05, post M = 61.65), and increased for the control group (pre M = 57.10, post M = 57.80). The group effect was insignificant, however, $F(1,36) = .01$, $p > .05$. On the SCL-90R Depression Subscale the experimental group decreased (pre M = 61.35, post M = 59.45), whereas the control group increased slightly (pre M = 57.10, post M = 57.55). The group effect was not significant, $F(1,36) = 1.07$, $p > .05$.

A MANOVA on the difference scores of the six variables was not significant, $F(6,31) = .268$, $p = .114$. Univariate F tests indicated that only the Percentage of Day Spent Worrying was significant, $F(1,36) = 6.67$, $p < .01$, indicating that there was a significant change for the experimental group but not for the control group.

There were no significant between group effects for the symptom domains unrelated to the focus group topic such as somatization $F(1,39) = 0$, $p > .05$, obsessive-compulsive $F(1,39) = .38$, $p > .05$, interpersonal sensitivity $F(1,39) =$

.22, $p > .05$, hostility $F(1,39) = .16$, $p > .05$, paranoid ideation $F(1,39) = 1.6$, $p > .05$, and psychoticism $F(1,39) = .48$, $p > .05$.

**Table 2. Means, Standard Deviations, and Ancova F-Values on Measures by Group with Pre Score as Covariate.**

| MEASURES: | EXPERIMENTAL GROUP PRE | EXPERIMENTAL GROUP POST | CONTROL GROUP PRE | CONTROL GROUP POST | FValue |
|---|---|---|---|---|---|
| WORRY QUESTIONNAIRE | | | | | |
| MEANS | 35.24 | 36.04 | 27.10 | 28.00 | .12* |
| S.D. | 11.23 | 13.52 | 9.29 | 10.87 | |
| PERCENT OF DAY WORRY | | | | | |
| MEANS | 29.26 | 13.89 | 10.65 | 8.70 | .76* |
| S.D. | 15.10 | 17.71 | 18.87 | 13.32 | |
| LIFE SATISFACTION | | | | | |
| MEANS | 13.09 | 13.57 | 14.45 | 14.85 | .81* |
| S.D. | 3.54 | 3.38 | 3.03 | 3.13 | |
| SCL-90-R: GLOBAL SYMPTOM INDEX | | | | | |
| MEANS | 63.05 | 61.65 | 57.10 | 57.80 | .01* |
| S.D. | 7.15 | 10.88 | 8.39 | 9.10 | |
| ANXIETY | | | | | |
| MEANS | 58.85 | 59.30 | 54.35 | 53.50 | .45* |
| S.D. | 10.27 | 11.51 | 9.30 | 9.31 | |
| DEPRESSION | | | | | |
| MEANS | 61.35 | 59.45 | 57.10 | 57.55 | 1.07* |
| S.D. | 6.99 | 7.90 | 8.75 | 8.83 | |

* = not significant at p<.05.
NOTE: MANOVA ON THE PRE SCORE VARIABLES ABOVE SHOWED A (F=2.51,P<.04) SIGNIFICANT DIFFERENCE BETWEEN GROUPS. UNIVARIATE F-TESTS REVEALED THAT THE VARIABLES CONTRIBUTING TO THIS DIFFERENCE WERE: WORRY QUESTIONNAIRE (F=6.53,P<.02); PERCENT OF WORRY (F=11.23,P<.002); AND GLOBAL SYMPTOM INDEX (F=6.3,P<.02).
NOTE: ANOVA ON DIFFERENCE SCORES REVEALED NO GROUP EFFECT.

As Table 3 shows, the experimental group (M = 4.25) reported on average more stressful life events during the past year than did the control group (M = 2.58), but this difference was not a significant one ($t_{22} = 1.24$, $p > .05$). A higher percentage of the control group subjects reported experiencing only two items (new person in household and serious illness of spouse) more experimental group during the past year. No one in the control group reported experiencing the following four items during the past year: "retirement", "death of a spouse", "major personal physical illness", and "death of a child", while these experiences were reported by the experimental.

**Table 3. Life Events During Past Year (Number and Percent Reporting Event).**

| LIFE EVENT | EXPERIMENTAL GROUP | CONTROL GROUP |
|---|---|---|
| 1.DEATH OF FAMILY MEMBER OR CLOSE FRIEND | 10(47.6%) | 9(45%) |
| 2.RETIREMENT | 3(14.3%) | 0(0%) |
| 3.DEATH OF SPOUSE | 1(4.8%) | 0(0%) |
| 4.NEW PERSON IN HOUSEHOLD | 1(4.8%) | 2(10%) |
| 5.FINANCIAL DIFFICULTIES | 11(55%) | 5(25%) |
| 6.HOSPITALIZATION OF FAMILY MEMBER | 8(38.1%) | 5(25%) |
| 7.HOSPITALIZATION OF YOURSELF | 5(23.8%) | 3(15%) |
| 8.MAJOR PERSONAL PHYSICAL ILLNESS | 2(9.5%) | 0(0%) |
| 9.DEATH OF CHILD | 1(4.8%) | 0(0%) |
| 10.LOSS OF PERSONALLY VALUABLE OBJECT | 3(14.3%) | 1(5%) |
| 11.SERIOUS ILLNESS OF SPOUSE | 0(0%) | 2(10%) |
| 12.SERIOUS IMPAIRMENT OF EYESIGHT OR HEARING | 6(28.6%) | 4(20%) |
| MEAN = | 4.25 | 2.58 |
| S.D. = | 3.74 | 2.78 |

NOTE: T-test on total means was not significant. Chi-square tests of independence on each item were not significant.

Within Focus Group Effects

As Table 4 shows, the majority of subjects who participated in the focus group discussions reported that they did not do so for the money, or because they had nothing better to do that day, but rather because they wanted to better understand and deal with worry.

**Table 4. Reasons Subjects Participated in Focus Group (Percent Responding).**

| REASON | YES | NO |
|---|---|---|
| 1.FOR THE MONEY | 19.0 | 81.0 |
| 2.TO BE WITH OTHER PEOPLE | 42.8 | 57.2 |
| 3.TO UNDERSTAND WORRY BETTER | 61.9 | 38.1 |
| 4.TO DEAL WITH WORRY BETTER | 61.9 | 38.1 |
| 5.HAD NOTHING BETTER TO DO THAT DAY | 23.9 | 76.1 |
| 6.OTHER | 19.1 | 80.9 |

Responses to the Focus Group Follow Up Questionnaire are presented below. On the two questions asking if subjects remembered where the discussions took place and how many people were in their group, subjects responded accurately 48% and 38% of the time respectively.

Regarding the impact of the focus group discussion on behavior outside of the group, the majority of the subjects (71.4%) reported discussing issues raised in the focus group with other people in their lives. Another 9.6% said they discussed issues a great deal. Nineteen percent of the group reported not discussing the issues at all.

About 48% of the subjects said that after the group was over they thought about the issues raised during the group a moderate amount, and 42.8% of them said they thought about them a great deal. Very few subjects (9.5%) reported that they did not think about the issues raised at all, after the focus groups were over.

A full 85.7% of subjects reported that they were not at all motivated by the focus group discussion to seek psychological treatment for worry or anxiety. Only 14.3% said that they were moderately motivated to seek treatment, and no subjects said that they were extremely motivated.

The majority of subjects (52.4%) responded moderately to the question "how much did you follow up on ideas or issues that you became aware of during the discussion group". An equal number of subjects reported that they either did not follow up at all (23.8%) or followed up a great deal (23.8%) on ideas or issues discussed in the group.

Most subjects (76.2%) reported that they have not maintained contact with other group members. Nineteen

percent of them said that they have maintained a moderate amount of contact, and 4.8% of subjects said that they have had a great deal of contact with other group members.

The majority of subjects reported that the group helped them to think about life differently either moderately (52.4%), or a great deal (28.5%), and only 19% reported not being helped in this way at all.

Most subjects reported that they either learned a moderate amount (61.9%), or a great deal (28.5%) about themselves in the focus group discussion. Only 9.5% of subjects said that they did not learn anything new about themselves.

Regarding effects during the discussion, 47.6% of the subjects said that it was extremely helpful hearing the ideas and opinions of other members of the discussion group. About 38% of them said that this was moderately helpful, and only 14.3% of the subjects reported that it was not at all helpful.

Thirty-eight percent of subjects reported receiving a moderate amount of ideas and another 38% of them said that they received many ideas about alleviating worry or anxiety. About 24% of subjects said that the focus group discussion provided no ideas about alleviating worry or anxiety in their lives.

About 66.7% of subjects said that participating in the groups was not at all a waste of time. About 24% of them

reported that it was a moderate waste of time, and only 9.6% of subjects felt that the discussion group was an extreme waste of time.

Most subjects said that the discussion group showed them that they knew as much as the "experts" either a moderate amount (57.2%) or not at all (33.3%). Only 9.5% of subjects reported that they strongly felt the discussion group showed them that they knew as much as the "experts".

The majority of subjects reported that seeing other people with similar problems was either moderately helpful (42.9%), or extremely helpful (38%). Nineteen percent of subjects reported that it was not at all helpful to see others.

Most subjects felt that the group was only moderately helpful (61.9%), as opposed to extremely helpful (19.1%), with clarifying thoughts and ideas. Nineteen percent of subjects reported that the group was not at all helpful in this regard.

Finally, most subjects reported that it was extremely helpful (45%) to express their thoughts and feelings about worry or anxiety in the group. Thirty-five percent said that it was moderately helpful, and 20% said that it was not at all helpful.

# CHAPTER IV

# DISCUSSION

## Summary of Findings

Based on the results of the between groups analyses of post measures, it appears that the subjects who participated in the focus groups did not differ significantly from the control subjects on any of the measures. The focus group participants did not report significantly more worry, anxiety, or depression than the control group on the follow up measures. They also did not differ in life satisfaction or psychological symptoms unrelated to the focus group topic such as somatization, hostility, obsessive-compulsiveness, interpersonal sensitivity, psychoticism, and paranoid ideation. Thus, in evaluating the focus group as a therapeutic approach to alleviating worry in the elderly, the data from this study do not support the idea that it is a more effective therapeutic device, than no focus group, despite the fact that experimental subjects reported benefitting from the focus group discussions.

A major problem in drawing conclusions about the effects of the focus group is that some of the pretest measures for the experimental group were significantly higher than they were for the control group. Because of this it is difficult to determine whether the two samples actually came from the same population.

When we examine the responses of the focus group participants on the follow-up questionnaire, we find that the majority had a positive experience and reported a number of benefits from the group. These benefits included learning more about themselves, learning ways of decreasing anxiety and worry in their lives, clarifying their thinking, and expressing their thoughts and feelings about worry. The majority reported that they discussed the issues raised in the focus groups with others outside the group and followed-up on the ideas raised in the group. Most did not, however, seek treatment for any anxiety problem, most likely because they did not believe that they had a problem, and most did not maintain contact with group members, also not a surprising outcome.

These findings are consistent with those of Swensen et al., (1992) in their assessment of focus group effects. While they did not use a pre-post design, they did ask participants to respond to follow up questions and there are similarities in the results from their follow up questionnaire and the one used in this study. An important point to keep in mind is that the results from our study may reflect a bias in the response style of subjects, because one-third of the total subject pool did not return the follow up questionnaires. Thus it is not known whether the current sample reflects a sample of subjects who benefitted more or less than those subjects who did not respond to the

follow up measures. Although it is clear that there were no pre test differences between these groups.

Another relevant point is that the focus group participants reported a greater mean number of stressful events during the past year than did the control group. Despite the fact that there were no control group subjects who reported experiencing retirement, the death of a spouse, a major personal physical illness, or the death of a child (all commonly occurring events for the focus group subjects), the difference in mean stressful events between the groups was not significant. It is interesting to note, however, that even though this measure indicated a greater number of stressful events for the experimental group, they did not score higher than the control group on worry and anxiety measures, or any other measure, perhaps indicating that the focus group had some beneficial effect on helping them to cope. This of course is quite speculative, but relevant, considering the fact that many of the focus group participants reported learning new ways to cope with worry and anxiety during the group discussion.

## Implications

As described earlier in this paper there are unique aspects of the focus group discussion which make it an attractive therapeutic modality for the elderly in psychological distress. In this study, however, we did not

find that the focus group discussions contributed to a reduction in psychological symptoms. There are three possible reasons for this finding.

First, and possibly of greatest importance, is the number and duration of the groups. In this study each subject participated in only one discussion group which lasted for approximately one and one-half to two hours. While some psychoeducational groups for the elderly are run for only one session, most require more than one session (Thompson, Gallagher, Nies, & Epstein, 1983; Hedlund & Thompson, 1980). A number of the group psychotherapy factors discussed earlier in this paper, which make the focus group especially useful for the elderly, are unlikely to fully develop in only one session. For instance, while the group format often provides mutual emotional support derived from members of the group, it is unlikely that members would feel enough comfort and trust in only one meeting to share deeply emotional material with each other. Also, while the group experience gives members a chance to express aspects of themselves and their thinking that they may not normally express in their everyday environments in a cathartic way, there were no follow up groups that would be useful in allowing members to work through these important psychological issues. Groups that meet over a number of months allow for the development of relationships between

group members. In this case a one time group meeting does not allow for enough time to form such relationships.

On the other hand subjects were able to learn new ways of dealing with worry from the group discussion. Also, it appears that through discussion and interaction in a small group, participants were able to articulate and comprehend better their own understanding of worry in their lives. The one-session focus group format also seems to have allowed for downward social comparison in the participants' coping efforts.

Second, the heavy reliance on the peer relationship for therapeutic change is a questionable approach when restricted to the one-session focus group format. One assumption of focus group discussions is that the peer influence will draw out material from participants and allow for greater learning and change. In evaluating the professional versus nonprofessional effectiveness of instructors in a course on "coping with depression" Thompson, et al., (1983) held 2 hour meetings once a week for 6 weeks. A new behavioral skill was introduced each week. The results of this psychoeducational approach revealed that overall the course was effective in reducing depressive symptoms, but that professional instructors were no more effective than nonprofessionals. Somewhat contradictory findings were reported by Lieberman and Gourash-Bliwise (1985) who examined peer versus

professionally directed self-help groups for the elderly and found that professionally led groups had a greater impact on the overall mental health of the participants than the peer led groups. These self-help groups consisted of 10 to 15 members who met with two leaders every week for 3 to 4 hour sessions over a 9 month period. There were structured exercises through which the leaders guided members.

Further examples of effective groups for the elderly which incorporated a strong peer emphasis include support groups for elderly in the community (Petty, Moeller, & Campbell, 1976), focus on feeling groups for adult day care patients (Van Wylen, Dykema-Lamse, 1990), cognitive telephone group therapy for physically disabled elderly (Evans, et al., 1986), integrative outpatient group therapy for discharged elderly psychiatric patients (Schmid & Rouslin, 1992), and anxiety and depression management groups for the elderly using a learning based approach (Sallis, et al., 1983). All of these groups showed some effectiveness in reducing symptoms and/or enhancing mental health. A common thread through all of these studies is the emphasis on effective therapeutic benefit and learning occurring in the group format with both professional and peer leaders who are well-trained in the presentation and teaching of structured information.

The final factor that distinguishes most effective psychoeducational and/or peer group methods for the elderly

from the focus group format is the way potentially therapeutically relevant material is presented in the group. While the questions discussed in the focus groups in this study touched on how to define worry, how to identify when worrying starts, how to differentiate between worry and other psychological concepts, what the effects of worry are on the elderly, and ways to control worry and anxiety, the purpose of the group was to investigate how a sample of elderly felt and thought about worry. Its purpose was not to provide therapy or to educate the groups. Thus, unlike the groups by Thompson et al., (1983) and Lieberman and Gourash-Bliwise (1985), the professional moderator made no effort to encourage one direction or another. Also, well developed behavioral techniques for controlling worry and anxiety such as thought stopping, relaxation, and systematic desensitization were not formally presented to group members. Such a presentation may have had therapeutic benefit for the participants, but it would have changed the nature and purpose of the group.

There is no evidence that the focus groups had any adverse effects in the subjects. The focus group discussions did not appear to increase, intensify, or polarize the worry already experienced by subjects. Given that there was a one third drop out rate for all subjects, it is possible that those focus group participants who did not respond to the follow up measures found the experience a

negative one. In follow-up phone calls to subjects, however, only one person reacted negatively and refused to participate further. The other non-responding subjects could not be reached because their address and/or phone numbers had changed.

As has been demonstrated in a design similar to that used in this study, the focus group discussion can lead to more extreme views than were held before participating in the group, without the benefit of brainstorming (Sussman et al., 1991). While this has obvious implications for data collection in terms of biasing the intensity of information obtained, the potential negative implications for mental health are disastrous. Our study does not support this polarization effect. Worry scores did not increase for the focus group participants any more than the for the control group.

## Limitations

There are a number of problems with the design of this study which severely limit the conclusiveness of statements made. First, based on the findings that the experimental and control groups differed significantly on worry pre measures, the assumption of random assignment from the same population is probably inaccurate. The subjects who reported experiencing more frequent worry on the pre screening measures more often were found in the experimental

group. Second, there was a one-third drop out rate for both the experimental and control groups. It is quite possible that those subjects who did not respond to the follow up questionnaires might have been positively or negatively affected by the group and/or questionnaire experience. A larger sample would have provided more power in the statistical analysis to determine whether there were any significant therapeutic effects. Finally, because the follow up measures were administered 1-year after the last focus group ended, it is possible that there were effects immediately after the group experience, but they did not last. Ideally post measures should have been administered within a month after a subject participated in the focus group discussion.

## Conclusions

As stated above, due to the limitations of the study, it is difficult to draw firm conclusions. In comparing the two groups of subjects, it appears that the focus group discussions on worry did not differentially affect the worries or anxieties of the experimental group. A potentially more useful approach might involve a more structured group psychoeducational model with more than one session. The focus group participants did, however, indicate that the discussions were helpful to them in understanding their own worries and in taking action to cope

with them. In examining the focus group experience for adverse effects, no evidence was found to suggest that spending time focused on worry had negative effects on participants.

## APPENDIX A

## WORRY QUESTIONNAIRE

Please circle or fill in the appropriate answers on the front and back of this sheet.

1. What percentage of the day do you typically worry?____%

2. Use the following scale to answer each question and circle the number which best represents your feeling about the item.

| | Not at all | | Moderate Amount | | Great Deal |
|---|---|---|---|---|---|
| a. How concerned are you about your finances? | 1 | 2 | 3 | 4 | 5 |
| b. How troublesome is worry to you? | 1 | 2 | 3 | 4 | 5 |
| c. How difficult is it to stop worrying once it starts? | 1 | 2 | 3 | 4 | 5 |
| d. How much do you worry about your finances? | 1 | 2 | 3 | 4 | 5 |
| e. How much do you worry about your health? | 1 | 2 | 3 | 4 | 5 |
| f. How often do you participate in social activities? | 1 | 2 | 3 | 4 | 5 |
| g. To what degree is worrying usually related to: | | | | | |
| (1) a past experience? | 1 | 2 | 3 | 4 | 5 |
| (2) a present experience? | 1 | 2 | 3 | 4 | 5 |
| (3) a future experience? | 1 | 2 | 3 | 4 | 5 |
| (4) solving a problem? | 1 | 2 | 3 | 4 | 5 |
| (5) a realistic change you want to make? | 1 | 2 | 3 | 4 | 5 |

(6) an unrealistic change you want to make? 1 2 3 4 5

7. Circle any of the following feelings which may accompany your worries:

anxiety depression fearfulness frustration

hopelessness demobilization inferiority

increased-sensitivity-to-people irritability

resentment self-consciousness self-hatred

hostility suspiciousness upsetting-thoughts

worthlessness morbid-feelings insecurity

sadness bad-attitude avoid-people

8. Circle any of the following conditions which may accompany your worries:

back-pain blurred-vision clenched-jaw

crying-spells dryness-of-mouth diarrhea

dizziness faintness headaches

high-blood-pressure hair-loss

heart-palpitations nausea hot/cold-spells

inability-to-make-decisions muscle-tension

lack-of-concentration poor-appetite

sweaty-palms stomach-upset sleeplessness

memory-problems skin-problems

## APPENDIX B

## LIFE EVENTS DURING PAST YEAR

If you have experienced any of the following in the past year please check all that apply.

___death of family member or close friend

___retirement

___death of spouse

___new person in household

___financial difficulties

___hospitalization of family member

___hospitalization of yourself

___major personal physical illness

___death of child

___loss of personally valuable object

___serious illness of spouse

___serious impairment of eyesight or hearing

## APPENDIX C

## LIFE SATISFACTION QUESTIONS

1. What is your current health condition?

Bad Poor Fair Good Excellent

2. How often do you participate in social activities?

Not at all Moderate Amount A Great Deal

1 2 3 4 5

3. Do your relationships satisfy you?

Not at all Moderate Amount A Great Deal

1 2 3 4 5

4. Do religious beliefs give you comfort?

Not at all Moderate Amount A Great Deal

1 2 3 4 5

## APPENDIX D

## FOCUS GROUP FOLLOW-UP QUESTIONNAIRE

Last year you participated in a discussion group about the experience of worry. We are interested in your feelings about that discussion group and any feelings about worry you may have had over the past few months. Please answer the following questions as honestly and completely as possible. Circle the appropriate number following the questions on the front and back of this form.

| | Not at all | | Moderate Amount | | Great Deal |
|---|---|---|---|---|---|
| 1. How much have you discussed the issues raised in the discussion group with other people in your life? | 1 | 2 | 3 | 4 | 5 |
| 2. How helpful was it for you to hear the ideas and opinions of the other members of the discussion group? | 1 | 2 | 3 | 4 | 5 |
| 3. After the discussion group was over, how much time did you spend thinking about the issues brought up during it? | 1 | 2 | 3 | 4 | 5 |
| 4. How much did the discussion group help to give you ideas about what you can do to reduce worry and/or anxiety in your life? | 1 | 2 | 3 | 4 | 5 |
| 5. How much were you motivated to seek psychological treatment for worry/anxiety? | 1 | 2 | 3 | 4 | 5 |
| 6. How much did you feel that the discussion group was a waste of time? | 1 | 2 | 3 | 4 | 5 |
| 7. How helpful was it seeing other people with similar problems? | 1 | 2 | 3 | 4 | 5 |
| 8. How much did the group help you to think about life differently? | 1 | 2 | 3 | 4 | 5 |
| 9. How much did the group help you by clarifying your thoughts and ideas? | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| 10. How much did the discussion group show you that you know as much as the so-called "experts"? | 1 | 2 | 3 | 4 | 5 |
| 11. How much did you follow-up on ideas or issues that you became aware of during the discussion group? | 1 | 2 | 3 | 4 | 5 |
| 12. How much did you learn about yourself that you didn't already know? | 1 | 2 | 3 | 4 | 5 |
| 13. How helpful was it to express your thoughts and feeling on worry/anxiety in the group? | 1 | 2 | 3 | 4 | 5 |
| 14. How much have you maintained contact with other group members? | 1 | 2 | 3 | 4 | 5 |

15. Please rank order your reasons for participating in this discussion group? Number 1 being your most important reason; number 2, the second most important reason and so on.

___For the money
___To be with other people
___To understand worry better
___To deal with worry better
___I had nothing better to do that day
___Other reasons_____

16. Please tell us here where your discussion group took place and how many people (excluding the researchers) were in your group.

Location of Discussion Group_____

Number of People in Group_____

## APPENDIX E

## INFORMED CONSENT FORM

Title of Study: Worry in the Elderly

Principal
Investigators: Charles B. Powers, B.S., Patricia A. Wisocki, Ph.D.
Department of Psychology, University of Massachusetts
Days: (413) 545-4276 Amherst
Nights: (413) 268-7156 Williamsburg

I agree to participate in this research project. It has been explained to me as follows:

This study's major purpose is to understand how and why elderly people worry, and variables that are related to worry. This study involves filling out the enclosed questionnaires and sending them back to the experimenter within a week after I receive them in the mail in the enclosed envelope. The experimenter will then send me $5.00.

I am not obligated to participate in this study and I may withdraw at any time. Only the researchers will know my identity.

Any questions or concerns I have can be addressed to the above investigators.

_____

Your Signature

## APPENDIX F

## DEBRIEFING STATEMENT

This study was designed to investigate whether participating in a focused discussion group on the topic of worry had any effects on the experience of worry among elderly citizens. We anticipate that your participation will allow us to better understand the experience and impact of worry on the everyday life of senior citizens. We thank you for your participation. If you wish to find out about the results of this study, please leave your name and address.

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