

The Effectiveness of Cognitive-Existential Group Therapy on Reducing Demoralization in the Elderly

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Abstract

Introduction and Objective: Elderly people face existential issues such as death, loss of meaning in life, fear of death, lack of life and last chances. If people, cannot effectively confront it, this loss of meaning in life, will form the main core of a set of syndromes that are called "demoralization". This study aims to investigate the effectiveness of cognitive-existential therapy on reducing demoralization in the elderly.

Method: The present study was carried out using a pretest-posttest semi-experimental design with control group and random assignment. The statistical population included all the elderly women in Yas Daily Rehabilitation Center. In this study, 22 people were selected through non-random sampling and after answering the demoralization scale (Kissane, 2004) and Cognitive Distortions Questionnaire (Abdollahzade et al. 2010 quoted from Farmani-Shahreza et al. 2016) they were randomly assigned to experimental and control groups (each group included 11 people). The experimental group participated in 12 cognitive-emotional group therapy sessions (each session 90 minutes) once a week, but the control group did not receive any intervention. The collected data were processed using SPSS-20 software to calculate covariance analysis.

Results: The results showed a significant reduction in the demoralization and cognitive distortions compared to the pretest. Also, in a two month follow-up session, demoralization and cognitive distortion scores were significantly reduced compared to pretest.

Conclusion: Cognitive existential group therapy on the one hand, due to addressing the existential issues of the elderly, and, on the other hand, working with their irrational beliefs and replacing rational beliefs, can have an effect on reducing of the demoralization syndrome in the elderly.

Key words: cognitive-existential group therapy, demoralization, cognitive distortions, the elderly

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Introduction

Elderly refers to a stage of life which occurs following biological, biochemical and anatomical changes in body cells. The changes generally begin after age 60 and affect gradually body cell functions. Being elderly isn't an illness but a natural evolution which can't be stopped or reversed (World Health Organization, 2001).

Iran is a country with a large aging population. About 8.3 percent of population was over 60 in 2012 (Iran, 2012). According to statistics, nearly 10 million elderly people are expected by 2022, which means approximately 10 percent of Iran's population in that time (Darani, Abedi, & Riji, 2009).

Elderly people may confront difficulties in different dimensions such as severe financial constraints, physical disabilities or existential conflicts. In the physical dimension they may face problems such as: 1- chronic illnesses (blood pressure, cardiovascular disease and diabetes) 2- progressive vision and hearing loss 3- neurological and psychiatric disorders such as Dementia, Alzheimers and Depression (Duberstein, Pálsson, Waern, & Skoog, 2008).

Socio-economic problems which old age people suffer from, include financial problems, losing job and social status, death and loss of friends, peers and loved ones (Wurtman, 1993). Isolation due to physical weakness and diminished mobility is also reported (Mussen, Conger, Kagan, & Houston, 2002).

The other dimension, with regard to psychological problems that older people suffer from include: Loneliness (Alpass & Neville, 2003; Heravi Karimloo et al., 2008; Wurtman, 1993), impatience, anger, absurdity, anxiety, insomnia and fatigue (Kaldi, Ali Akbari, & Foroghan, 2004).

Aging can trigger existential distress which recalls fear of death. Seeing friends and peer groups getting cancer or cardiovascular disease reminds them that they have stepped into the final stages of life. Elderly people are aware of their limited time but they have much unfinished business. This makes them change their life style but also can give rise to conscious feelings of fear and anxiety (Vincent, 2003).

According to existential approach, we face existential concerns such as death, isolation, meaninglessness, responsibility and freedom during our lives. The human search for foundational supporting structures for existence deals with deeper levels of anxiety. Although every human being needs to be immortal, stable and have a role model to follow, all of us confront existential concerns such as death, absurdness and isolation (Yalom, 1980).

Even though existential distress is a normal reaction to the concept of inexistency as a consequence of consciousness, if the person fails in coping efficiently with existential crisis, it may cause distress and demoralization (Blinderman & Cherny, 2005; Leung & Esplen, 2010).

The starting point of demoralization syndrome is a sense of incompetency and inefficiency in dealing with a debilitating situation which leads to some fundamental questions. If the person fails in finding proper answers to these questions, he/she might end up with demoralization syndrome. Therefore, the most specific feature of demoralization syndrome is failure in adding value and meaning to life (D. W. Kissane, Clarke, & Street, 2001).

Kissane and Clarke (2001) considered demoralization as a psychiatric diagnosis for existential suffering and suggested diagnostic criteria as following: 1- hopelessness, loss of meaning and purpose in life 2- pessimistic attitudes and thoughts, helplessness, feeling trapped and failed, lack of a worthwhile future 3-lack of motivation for coping differently 4- social isolation and feelings of losing support 5- symptoms persistence for more than two weeks 6- The symptoms are not attributable to major depression or another psychiatric disorders.

Kissane(2011)believesthatsometimesphenomenological similarities between depression and demoralization syndrome, these two concepts are basically different.

A depressed person is not satisfied with his past, not pleased with his present and also disappointed about the future and even when the course of action is clear he may not be able to experience overall pleasure and is not motivated enough to persist steadfastly in pursuing the task and experience pervasive anhedonia. While a person with demoralization syndrome does not have serious problem with his past. Although he/she might be able to experience pleasure at the moment, due to the confusion (not knowing what to do and what he can do), practically he feels helpless, inadequate, suppressed and experiences anticipatory anhedonia and he sees future as worthless (Clarke & Kissane, 2002).

Beside aging hardships, elderly people might face existential concerns such as death, loss, absurdness, meaninglessness and regret of missed opportunities. They might face challenges to make meaning in their lives (Yalom, 1980). If they cannot find a genuine answer to their existential issues they will suffer pathological anxiety.

One of the important dimensions of demoralization syndrome is cognitive distortion in finding meaning. The demoralized have negative and black and white thoughts about events and have self-contempt, exaggeration, and low self-confidence (Watson & Kissane, 2011). Since demoralization syndrome consists of emotional, cognitive and behavioral components, it seems that any intervention to decreasing its symptoms should cover cognitive components which are effective in forming new thoughts and meaning.

A range of psychological interventions have been used to reduce the psychological problems of the elderly, which indicates the need for psychological services for these elderly people. This range includes: cognitive-behavioral therapies (Hedayat, 2015; Barghi Irani, 2015), existential group therapy (Mooziri, 2013), spirituality-based cognitive therapy (Rahimi, 2014), group logo therapy (Poorebrahim,

2006; Fakhar, 2007, Yazdan Bakhsh, 2015); memory telling (Majzooobi, 2012), hope therapy (Parvaneh, 2015) and cognitive-existential therapy (Barekati & Bahmani, 2017). The literature indicates that existential group therapy and group logo therapy were not effective on the elderly (Mooziri, 2013; Poorebrahim, 2007; Fakhar, 2007).

Furthermore, the focus of most interventions for the elderly has been on the treatment of death anxiety, feelings of loneliness, depression, and enhancement of life expectancy, happiness, self-efficacy, mental health, quality of life and quality of sleep in the elderly. It seems essential to address the anxieties because of their prevalence while less attention has been paid to demoralization in the elderly.

It would be beneficial to find the most effective and practical intervention method to reduce the demoralization subsequent to aging due to the need to respect the human rights of the elderly and also to save time, effort and facilities. In cognitive-existential group therapy, it aims to use techniques of "cognitive therapy" to refine some schemas, negative automatic thoughts, and to correct the cognitive errors that contribute to the formation of psychological distress caused by the non-genuine response to existential anxiety. Moreover, this method pays attention to existential concerns such as death anxiety, uncertainty, meaninglessness, loneliness, and uncontrollability of the world that are intensified by the death threat in patients. In most intervention methods such concerns do not receive systematic attention. Therefore, it is expected that through this intervention, individuals will find their own unknown fears and conflicts over the issues of existence and will be able to cope with them in a genuine and effective way (Bahmani, 2010). Previous studies indicate that cognitive-existential therapy plays an effective role in reducing psychological distress in different populations (Bahmani, 2010; Naghyiaee, 2014, Farmani Shahreza, 2014; Paknia, 2015). In this regard, we seek to investigate the impact of this intervention on the elderly and to answer the question of "whether cognitive-existential group therapy can reduce demoralization in the elderly?"

Method

The study was carried out using a pretest-post-test semi-experimental design with control group and random assignment. The statistical population included all the elderly women in Yas Daily Rehabilitation Center. The sample included 22 people selected through a non-random sampling from among the elderly present in the center during the sampling period (spring 2017) who were prepared to participate in the group therapy and who were eligible for inclusion criteria. The sample was divided into experimental and control groups in a random assignment (11 individuals in each group).

In this research, the dependent variable is measured before and after the presentation of the independent variable, and its design graph is as follows:

Experimental Group	G ₁	T ₁	X	T ₂	T ₃
Control Group	G ₂	T ₄	-	T ₅	T ₆

T₁ and T₄ represent the pretest, T₂ and T₅ the posttest, T₃ and T₆ show the follow-up and X is the Cognitive-Existential Group Therapy.

Instruments

In this research, Demoralization scale syndrome was used to measure demoralization. Demoralization Scale (DS) is a 24-item scale and contains 5 subscales including meaninglessness, helplessness, feeling failure, disheartened and dysphoria. An alpha coefficient for the DS scale was reported as 94%. The Persian version of the scale was translated and administered by Bahmani and Naghyiaee (2014) among women with breast cancer and its alpha coefficient was reported as 86%. In order to measure cognitive distortions, the 20-item scale of Cognitive Distortions developed by Hassan Abdollahzadeh and Maryam Salar (2010) was used. The standardized Cronbach's alpha was 80%.

Procedure

After preliminary studies and preparation of the protocol, and receiving a referral letter from the University of Welfare and Rehabilitation Sciences to the Welfare Organization of Tehran province, we got the necessary permissions and referred to the Yas Daily Rehabilitation Center. The research process began after permission was gained from the head of the Center. First, through broadcasting announcements and talks with the elderly in the Yas Daily Rehabilitation Center, they were informed of the study. Subsequently, after describing the research goals and obtaining consent from the elderly and observing the ethical rules, the conditions for the participation in the research were prepared. After interviewing from the individuals completing demoralization and Cognitive Distortions questionnaires, 22 elderly were selected according to inclusion and exclusion criteria and randomly assigned to the control and experimental groups. The inclusion criteria were: age of 60 and over, having the ability to speak, having no cognitive problems and a score of over 30 in the Demoralization scale. Exclusion criteria included: having mind and brain disorders such as Parkinson's and dementia, having any psychiatric disorders based on the written contents of their file in the center and use of any psychotherapy and counseling services at the time of the research.

Subsequently, cognitive-existential group therapy was performed for 12 sessions of 90 minutes and once a week for the experimental group (Table 1), while the control group received no intervention. In order to observe ethical issues, after group treatment with the experimental group, group therapy was also performed for the control group.

At the last session, the mentioned questionnaires were repeated on the participants of both groups. In order to ensure the durability of the therapeutic results, two months after the completion of the group therapy in the follow

Table 1: the protocol for cognitive-existential group therapy

Sessions	Objectives
First	Setting goals and defining the process of cognitive-existential group therapy Explaining the outline of the sessions that are essential for creating group atmosphere in the sessions
Second	Continuation of the work for the desirable establishment of the group's forming traditions: accountability for themselves and others Introduction to the concept of existential anxiety and its difference from neurotic anxiety
Third	Investigating the concept of death anxiety and the related cognitive distortions
Forth	Helping to accept loneliness as a genuine experience to increase the desire and motivation for being with others and family members
Fifth	Challenging false beliefs about loneliness and social isolation, feelings of rejection, dependency, feelings of uselessness, hopelessness, fear of death and dying
Sixth	Helping the individuals to face the consequences of not accepting responsibility and ignoring the principle of freedom and choice
Seventh	Helping to reduce the fear of dependency and the sense of uselessness and hopelessness as sources of anxiety
Eighth	Challenging the concept of losing meaning in life Helping the elderly to find effective meaning and be free of cognitive distortions
Ninth	Continuing the process of reviewing goals and establishing new directions in life
Tenth	Facilitating continuous and consistent commitment to work in order to achieve new goals
Eleventh	Wrap-up session
Twelfth	Expressing the feelings of the participants about the group therapy Coordination for the follow-up meeting Post test

up phase, the participants again were assessed using questionnaires.

Data from pretest and posttest was entered in version 20 of SPSS software. After analyzing the assumptions of covariance analysis, this statistical method was used to analyze the data. Covariance analysis limits or eliminates the effect of the pretest variable and measures it using the regression equation. Among the important assumptions of this statistical method was the homogeneity of variances using Levene's test and Normality test by Kolmogorov–Smirnov test. These assumptions were checked and verified in the study.

The ethical considerations of this study included the following topics: 1) the participants in the research were assured that the information received would be confidential; 2) scores were given to those who would like to know their scores; 3) the planning of group counseling sessions was carried out in a way that would not interfere with the programs of the Yas Daily Rehabilitation Center; 4) The control group was assured that they would participate in

eight sessions of Cognitive-Existential group therapy after the end of the research; 5) Any of the participants could freely leave the program at any time during the research.

Results

The sample consisted of 22 elderly women with an average age of 69 who were randomly assigned into two groups of 11 in experimental and control groups (waiting list). According to the results of the Mann-Whitney U test, the two groups were homogeneous in demographic variables of age and education. In addition, the assumptions of the covariance test for the normality of the data distribution were confirmed by Kolmogorov-Smirnov test and homogeneity of variances were confirmed by Levin's test of two groups in dependent variables of demoralization and cognitive distortions.

In Table 2, the comparison of mean scores in the pretest, posttest and the two-month follow up of the experimental group showed that the scores in the posttest and follow-up were reduced compared to the pretest.

Table 3: Mean and standard deviation of cognitive distortion scores in pretest, posttest and follow up

Variable	Test stage	Experimental group		Control group	
		Mean	standard deviation	Mean	standard deviation
Cognitive distortions	Pretest	55/09	3/91	52	4/28
	Posttest	75/63	4/86	55/36	3/29
	Follow up	72/09	7/11	52/90	3/83

In Table 3, the comparison of mean scores of cognitive distortions in the pretest, posttest and follow-up tests showed that scores in post-test and follow-up were increased in comparison with the pretest. Considering that the higher the number of scores, the more positive the thinking is; the increase in scores shows that the cognitive distortions have been decreased.

Table 4: The results of covariance analysis of the comparison of the experimental group and control group in demoralization and its subscales' post-test scores

Variable	Source of variance	Sum of squares	Degrees of freedom	Average squared	F	Sig	Effect size	Statistical power
Demoralization	Pretest	73.055	1	73.055	6.933	0.016		
	Group	490.216	1	490.216	46.520	0.000	0.710	1
	Error	200.218	19	10.538				
	Total	23201	22					
Meaninglessness	Pretest	21.375	1	21.375	7.219	0.015		
	Group	37.424	1	37.424	12.638	0.002	0.399	0.921
	Error	56.261	19	2.961				
	Total	1922	22					
Dysphoria	Pretest	11.112	1	11.112	6.020	0.024		
	Group	23.123	1	23.123	12.528	0.000	0.397	0.919
	Error	35.070	10	1.846				
	Total	1683	22					
Disheartened	Pretest	0.496	1	0.496	0.354	0.559		
	Group	36.835	1	36.835	26.315	0.000	0.581	0.998
	Error	26.595	19	1.400				
	Total	1333	22					
Helplessness	Pretest	0.834	1	0.834	0.465	0.503		
	Group	8.160	1	8.160	4.550	0.046	0.193	0.526
	Error	34.075	19	1.793				
	Total	563	22					
Feeling failure	Pretest	8.385	1	8.385	19.523	0.000		
	Group	18.794	1	18.794	43.758	0.000	0.697	1
	Error	8.160	19	0.429				
	Total	254	22					1

As shown in Table 4, participation in the cognitive- existential group therapy has significantly decreased the demoralization and its subscales in the elderly. Also in the follow-up phase, a significant decrease was continued.

Table 5: The results of covariance analysis of the comparison of the experimental group and control group in cognitive distortion post-test scores

Variable	Source of variance	Sum of squares	Degrees of freedom	Average squared	F	Sig	Effect size	Statistical power
cognitive distortion	Pretest	72.570	1	72.570	5.060	0.037		
	Group	1688.486	1	1688.486	117.720	0.000	0.861	1
	Error	272.521	19	14.343				
	Total	96991	22					

As shown in Table 5, participation in the cognitive-existential group therapy has significantly decreased the cognitive distortion in the elderly. Also in the follow-up phase, a significant decrease was continued.

Discussion

The present study was performed to investigate the general assumption that "cognitive-existential group therapy reduces demoralization of the elderly".

The demoralization total mean score were declared as following: pretest (40.27), posttest (27.36) and Follow up (28.54). The results revealed that cognitive-existential group therapy reduces demoralization of the elderly.

Although previous research didn't mention a direct link on the effectiveness of cognitive-existential group therapy in reducing demoralization in the elderly we considered the present results consistent with cognitive-existential group therapy on reducing demoralization in various populations such as people who have: cancer (Kissan et al,1997., Kissan et al, 2003., Breitbart, 2001., Bahmani et al,2010., Naghiay & Bahmani,2014), AIDS (Farmani Shahreza & Bahmani,2016) and MS (Paknia & Bahmani,2015), which showed the effectiveness of cognitive-existential group therapy on reducing demoralization.

As the findings in Table 4 show, the findings confirm the mentioned hypothesis. It seems that the cognitive-existential group therapy and the elements proposed in the treatment protocol, as well as the special way of relations in the sessions have been able to create a positive and significant change in reducing demoralization and its subscales. It should be considered that the treatment atmosphere in the cognitive-existential group therapy is based on listening to the subject's stories considering the here and now, familiarity with the sufferings of others, the use of emotional support and receiving feedback from different people to reduce the feeling of being a victim, the uniqueness of the problem, loneliness and helplessness, discrimination and oppression, feeling of security, secrecy, reflection and empathy, emotional release, self-disclosure, exposure, feedback, affection, acceptance and humour; this can be mentioned as a positive factor for this approach. In this method, the group continued the sessions assuming that the confidence and sympathy between the group members persists and the psychological refinement was done every session.

Part of the content of the cognitive-existential group therapy helps understanding the phenomenological world of individuals using the prepared existential concepts. Using such concepts helps individuals to encounter their existential anxiety and to communicate with their original selves with all the inevitable existential anxieties and instead of denying and reprimanding their unpleasant feelings and emotions, experience them and take responsibility for their feelings, and most importantly, express these feelings and emotions. According to Kissane it is a useful intervention method that can deal with these fears fast and clear enough

and can help reduce mental health problems (Kissane, et al., 2002; quoted from Bahmani et al., 2010).

During the treatment process, the elderly were involved with their existential questions. These questions caused them to activate and discharge their existential anxieties. In general, during the sessions, it became clear that the feeling of lack of a worthwhile future and lack of self-efficacy to achieve it, inevitability and fear of death, lack of faith in the future, feeling of hopelessness, lack of meaning and purpose, and loneliness deprives the elderly from the motivation to try. Existential crisis and disturbances are developed as a result of fear of confrontation with existential anxieties. So during the group process, we tried to help the elderly understand the unpredictability of the world and the uncertainty of the universe, assess their thoughts and assumptions about the uncontrollability of death and loss of opportunities in the past and the resulting anxieties, identify and challenge their cognitive distortions about the meaning of death anxiety (seeing death as the end of everything, unwillingness to track down their illnesses, fear of being forgotten after death, fear of painful death, disqualifying their efforts in their lives, fear of disability) and end their fears by accepting the anxiety of unpredictability and death. We also tried to introduce the concept of fundamental loneliness anxiety and help them identify and challenge their cognitive distortions about the meaning of loneliness (not being understood by close people, especially their spouse and children, the feeling of failing to understand others, the feeling of separation from children, attachment to other individuals to escape loneliness) and accept loneliness as a genuine experience to increase the desire and motivation to be with others and family members. They were also helped to challenge the meaning of their lives created by psychological disturbances and existential anxieties, and find a meaningful term for their lives, and change their attitudes toward problems and tolerance of difficulties, and through giving meaning to the sufferings and pains, change their focus from what has been lost, because the sense of the new meaning and purpose in life during the aging period (which includes the ability to combine and integrate the experiences and achieve an understanding of themselves and the world) is a protective factor against meaninglessness. Also, in the process of group therapy, elderly people tried to accept responsibility and freedom of choice, to identify and challenge their cognitive distortions about the anxiety of responsibility and freedom of choice (assigning responsibility for life events to others or social, cultural, economic, etc. circumstances, leaving the choice to others, believing in luck, trying to show oneself as victim) and to evaluate their priorities and decisions, and accept their own responsibility for their own destiny. In general, the group therapist tried to help the elderly to accept cognitive distortions that prevented them from experiencing demoralization and activated their defense mechanisms.

In general, according to previous studies cognitive-existential group therapy can be considered as a suitable factor in reducing different types of mental disorders. Bahmani et al. (2010) in their research showed that

cognitive-existential group therapy was more effective than cognitive therapy in reducing the mean of depression and increasing the mean of hopefulness.

Previous studies, consistent with the present study, of Kissane et al. (1997) showed that using this method of treatment is helpful to reduce the amount of sadness and grief in patients with cancer, increase their problem solving ability and also create cognitive strategies. Breitbart (2001) suggested that existential therapies are one of the most appropriate approaches to reduce depression and increase hope in cancer patients. In addition Kissane et al. (2003) concluded that cognitive-existential therapy has a positive effect in reducing overall symptoms of psychological distress in women with non-metastatic breast cancer. In another study, Kissane et al. (2004) concluded that this method would greatly reduce psychological distress and anxiety, and improve family relationships.

Therefore, according to the findings, the cognitive-existential therapy has been able to affect people with chronic conditions such as cancers, breast cancer, human immunodeficiency virus, and the elderly. This should be due to the main distinguishing feature of this intervention method, namely, paying attention to the existential anxieties and considering here and now during the treatment sessions as compared to other methods.

Also, the results of the two-month follow-up showed that cognitive-existential group therapy has a lasting and stable effect on the improvement of demoralization. In explaining this finding, it can be said that Cognitive-Existential psychotherapy can lead to long-term changes in terms of creating philosophical insights and changing attitudes in individuals.

Conclusions

In general, cognitive-existential group therapy due to addressing the existential concepts, especially for the elderly and dealing with these concepts and working with the unreasonable beliefs of individuals and substituting logical beliefs can lead to the reduction of psychological factors and existential anxieties. Therefore, this method of intervention can be used in the treatment of the elderly, since the elderly need to continue their lives with meaning and purpose without fear of confrontation with death, loneliness, and existential concerns.

Limitations

The most important limitation of this study was research in the only daily rehabilitation center, which reduced the generalization power of the research.

Suggestions

Given that existential anxiety is activated in the elderly and addressing these anxieties in counseling and psychotherapy sessions can help to improve the existential crisis of the elderly, it is suggested that counselors of care centers,

rehabilitation centers for the elderly and counseling and psychology clinics be trained based on the treatment plan presented in this study and take advantage of it to help the elderly. In addition, the results of this study can be used to improve the design of educational programs for health care and rehabilitation providers, as well as to plan for prevention of existential crises and to improve the health of the elderly and to prevent serious problems such as suicide in the elderly. Also, it is suggested that the effect of this therapeutic approach on other psychological variables be examined and the effectiveness of this treatment method be compared with other types of cognitive therapies in order to reduce the psychological problems of the elderly in order to achieve the most effective treatment method for this group.

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