

BY BARRY J. JACOBS

Receiving with Grace

Teaching reluctant seniors to accept help

A: FOR THOSE WHO'VE spent their lifetimes taking pride in giving generously to others, suddenly being on the receiving end of care because of illness or age-related infirmity can be tormenting. Stalwart seniors frequently reject offers of help without consideration, declaring, "I don't take handouts." Their baby-boomer, adult children may be just as reluctant to accept outside help, flatly stating, "Our family takes care of its own." Despite the fact that many of these families desperately need emotional, financial, and hands-on support, their reticence to accept help serves to prove the common adage, "It's easier to give than to receive."

For many people, reaching out for and accepting help aren't seen as ways of marshaling forces to fight the good fight, but rather as tantamount to admitting weakness, being defeatist, and advertising failure. By contrast, rejecting help is regarded as a measure of one's courage and determination in battling family crises brought on by old age or disease. So, accepting help is perceived as disempowering; rejecting it is empowering.

This line of thinking often dovetails with concerns about self-identity. For those who've long occupied the high moral ground of kindly caring for others, being reduced to needing care themselves is experienced as a painful

loss or diminishment of who they are. It's intolerably humiliating and shameful. Therefore, they cling to what they're sure are their own best virtues by vigorously staving off any offers of aid from others—even from

grateful and willing relatives and neighbors whom they've previously helped.

This is compounded by worries about others' judgments. Many seniors and their caregivers fear that going to support groups, employing home health aides, or accepting other assistance will be viewed by family and friends as signs of weakness. I recall debating a 62-year-old, Parkinson's-stricken man and his wife at an educational workshop who were convinced that their adult sons would be aghast if their father agreed to use a walker to help him compensate for his shuffling gait. I suspect-

ed that they themselves couldn't tolerate the reality of the man's increasing loss of physical self-control, and that they projected their fear and loathing of his condition onto their sons. Consequently, he refused the walker and all other assistive devices. I asked them whether their sons would think they were stronger and more independent if he struggled to walk 100 yards on his own or used the walker and traversed 1,000 yards. They steadfastly chose the former.

Q: *Many of my older clients and their family caregivers resist accepting help from others. How can I get them to receive the care they need?*

Helpful Strategies

What are the best ways of overcoming this common tendency to refuse help? Many of the world's major religions have developed precepts for overcoming these feelings of abhorrence at our own human weakness and dependency. Within the Judeo-Christian tradition, there's the concept of acknowledging and expressing gratitude on a daily basis for the food, air, and other essentials that we receive from God that enable us to live. We're enjoined to extend this sense of gratitude for the good works and blessings we've received from our fellow human beings.

Buddhist monks from Thailand go into their communities each day to beg for alms, not because they need food—they have plenty of supplies back at their monasteries—but to engage in two spiritual practices: to learn the humility of graciously receiving whatever they're given and to provide for those who place food in their alms bowls the salutary experience of giving to others.

Therapists can effectively draw on these spiritual teachings, but first must figure out how to connect with proud seniors and caregivers who are so adept at deflecting offers of help. Right from the outset, I openly acknowledge that I understand they aren't especially happy to be visiting a psychotherapist. By being curious and receptive, I make sure I do all I can to avoid treating them like supplicants at the feet of a psychological expert. They are the experts on how well they're coping, I quickly concede. I assure them I'm just interested in hearing their stories of how they're overcoming whatever challenges they're facing. ►

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Part of what I'm interested in learning is how they feel about landing in a life circumstance that makes them the object of others' concerns. I ask them specifically about what the idea of receiving help means to them. If they tell me it makes them feel resentful and "lousy," I empathize sincerely. But I also question the idea that receiving care is necessarily disempowering. Couldn't it increase their sense of self-efficacy, I wonder, if it lends them the capacity to do more of what they want?

If they're failing seniors who are against accepting help from their adult children, I always inquire if they themselves helped out their parents when they were declining years ago. If the answer is yes (as it nearly always is), I wonder about the example that their parents set while being the "burden" of care—did they grouse, chafe silently, or display grace? I ask them about the kind of example they want to set for their children and grandchildren. Finally, I suggest that this is an issue of generativity: teaching those next in line about how life's vicissitudes should be handled.

I point out that receiving graciously can be a teaching tool. Be magnanimous and allow your kids to reap the satisfaction of helping you, I exhort the parents. Let your children feel that they're making a substantial contribution, and they'll gain a greater sense of maturity and mastery than they've ever had before. When the idea of accepting help is placed within this relational context, many stubborn seniors finally begin to perceive the giving that's within receiving and go along with the plan.

When this, too, fails, I opt to emphasize the *giving* that these seniors can do—giving that has *receiving* built into it almost as a kind of afterthought. I learned the power of this approach years ago, when I was asked to run a support group for amputees in a hospital-based physical rehabilitation unit. The patients' tangential bantering, incessant joking, and outright hostility quickly revealed to me that none of them wanted to receive psychological advice of any sort; they

weren't interested in adding the loss of dignity to their loss of limbs. It was only when I told them that I needed their help to write a manual on coping for future amputees who'd be patients in that hospital that the group members poured out their hearts with their own observations, feelings, even tears. They were certainly receiving support from each other in the group as they helped put the manual together, but only in the guise of giving me some help. That, for them, was much more palatable than the prospect of receiving what they perceived as pity or busy-body exhortations from me.

As a consequence of that experience, I now frequently ask reluctant seniors and caregivers if they'd be willing to reach out and help others in similar positions. Most readily agree. I then give them the phone numbers or e-mail addresses of other clients who are also resistant to receiving help. In this way, relationships are formed in which all parties are happily giving to each other. The fact that they're simultaneously receiving from each other is a small point that I don't bother to mention.

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Barry J. Jacobs, Psy.D., is director of behavioral sciences for the Crozer-Keystone Family Medicine Residency in Springfield, Pennsylvania, and the author of The Emotional Survival Guide for Caregivers—Looking After Yourself and Your Family While Helping an Aging Parent. Contact: barryjacobs4@comcast.net. Letters to the Editor about this department may be e-mailed to letters@psychnetworker.org.

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Honoring the Mission

Don't be too quick to ease the caregiver's burden

A: The 25 million Americans who care for ill or disabled loved ones on a daily basis frequently become depleted from feeding and toileting, bathing and dressing, comforting and cajoling their aged relatives for months or even years. It isn't surprising, then, that they have very high rates of depression, anxiety, and medical problems of their own.

But caregivers are notoriously loath to seek help for themselves, because they feel guilty about focusing on their own needs when their family members are in so much worse shape. As a consequence, they generally enter psychotherapy reluctantly, only after being hauled in by relatives or strong-armed by physicians, usually because they seem to be near the breaking point, emotionally or physically.

The crucial mistake that many therapists and other health care professionals make initially with one of these bedraggled, middle-aged, female caregivers (and most caregivers are females in their fifties and sixties), sitting tensely on the edge of her chair, is to listen with empathy to the story of her arduous life and then state what seems obvious: she's burning herself out by doing too much for others and too little for herself. The therapist will then advise her to take some time off to replenish herself. The common

response is that she'll glaze over, nod politely, and keep a straight face, but she'll be thinking the therapist doesn't have the foggiest understanding of her or her situation. She may even balk at returning for further sessions.

Q: *My clients*

who take care of

aging parents

complain about

being exhausted,

depressed, and

resentful, but

resist my

suggestions for

making their

lives easier.

What approach

is effective with

them?

The problem is that, for her, the job of family caregiving and her reasons for doing it involve issues that are too complicated to be resolved with simple bromides of the kind the therapist is offering. Life circumstances have obliged her to make the hard choice of sacrificing her personal dreams for the well-being of another and the collective good of the family. Such a choice—and she's chosen not to simply walk away—demands a measure of love, a modicum of loyalty, and a high degree of commitment. But it requires most of all an essentially moral decision to choose selflessness—even if she harbors ambivalence about it—and to become, in her own eyes, a different kind of person than she might otherwise have become. The suggestion that she just take time off and relax (“Go see a movie once a month”) strikes her as glib at best, uncomprehending and possibly condescending at worst. It makes her feel that her sense of pur-

pose, with which she justifies her self-neglect, is being trivialized.

A better approach for therapists initiating relationship with a caregiver is to express wonder for what she's doing, rather than to implicitly denigrate her sacrifice by telling her that she ought to be doing less of it. I begin by exploring in great detail what the caregiver does day-to-day to help her parent, spouse, or partner. I then marvel at her mastery of the thousand caregiving tasks, rather than gape at her masochism.

Once I've conveyed that I appreciate and admire all that she accomplishes each day, I ask her to reflect on her motivation for doing what she does and the meaning she attributes to her mission: “Why do you do all you do for your loved one? What has it meant for you at this point in your life?” She usually pauses, as if surprised that I'm not just offering advice. She'll then often struggle to put into words her reasons for being a caregiver: “Because she always took good care of me, and now I want to give something back to her”; “Because God has put this task in my path, and I hope I'm up to it”; “Because I vowed to be there ‘for better or worse’”; “Because I know I'm making a difference in someone else's life.”

This emotional exchange alone can be enough to bolster the therapeutic alliance, so that the caregiver may actually be readier to consider accepting advice. But before risking a recommendation, I build on the initial exchange by honoring the caregiver's mission and inquiring about sustaining it. For example, I may say, “It's wonderful that you're demonstrating your gratitude to your mother for all she did for you by taking care of her now. I think you're also demonstrating to your own children what the ►

value of family is—to be there for one another in the hour of need.” I then add a cautionary note: “But what I know of most caregiver situations is that they’re not sprints, they’re marathons. They go uphill and downhill for long stretches, during which caregivers must pace themselves, and take breaks for water and a little nourishment. Have you given any thought to how you can sustain yourself for that marathon, so you can do what you’ve chosen to do for as long as the course runs and you decide to continue?”

If I’ve been successful thus far, the caregiver feels that I’m running along beside her cheering her on, rather than putting obstacles in her path. She realizes that I’m supporting her choice and purpose, not trying to supplant them with my own agenda drawn from my supposed expertise. The focus of the conversation has now subtly shifted from resisting change to sustaining the status quo. But the issue of sustainability brings up questions about sustenance. Is the caregiver taking in what she needs to finish the race? What is sustenance for her? While I certainly have my own ideas about what’s essential to continue caregiving over the long haul, I find that different caregivers have different ideas about what constitutes sustenance.

For instance, when I ask, “What do you need in order to do more of what you’re choosing to do?,” some caregivers simply answer, “Someone to listen to me and understand what I’m going through.” I don’t challenge this, even if I think she might benefit from other things, too; instead, I take it as a starting point for our work together. I offer ongoing sessions for us to talk further. I ask her if she wants to reach out to others for similar conversations. If she agrees, then we’ll discuss the possibilities for being heard and cared for by family members and friends. I’ll also suggest local support groups and online chat rooms, knowing that not only will the caregiver feel understood in those forums, but, by having the chance to hear and understand how others like herself think and feel about caregiving, she may adopt a broader view of her own mission.

If the caregiver’s idea of sustenance is having hands-on assistance in the

home, then I’ll ask her what efforts she’s already made to recruit such help. If she hasn’t done so because she doesn’t want to burden anyone, then I’ll remind her that if others share her goal of caring for their loved one, they may be willing to contribute, to keep her going in the good work she’s doing. I may also provide specific information about hiring home health aides, using Meals on Wheels programs, or seeking church volunteers.

If the caregiver says that nothing will help sustain her, then I bring up the marathon metaphor again. Can she really last as long as is necessary, I ask her, without a bottle of Gatorade and a cool breeze at her back? I suggest that, even if she feels no need for sustenance now, she may in the future, and should devise contingency plans. I add that living one day at a time is a fine way to cope with many kinds of stress, but not necessarily with caregiving. In this case, the ability to look down the road and prepare for changes in the loved one’s medical state or financial status can make the difference between finishing the race and dropping out before the end.

These are the beginning stages of what may be the therapist’s own marathon with the caregiver. I’ve met with some of my caregiver-clients for years as they struggle with the vicissitudes of their family member’s lingering old age, chronic illness, or disability. The next stages of psychotherapy often include a more thorough exploration of the caregiver’s feelings about her endeavors—reflecting upon her past and present relationships with the person receiving care, discerning the impact of her caregiving on other family members, and attempting to recapture some of her own dreams for herself. But without the emphasis at the outset on identifying, honoring, and sustaining the caregiver’s mission, you’re unlikely to ever progress beyond the starting line. ■

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Barry Jacobs, Psy.D., is the director of behavioral sciences for the Crozer-Keystone Family Medicine Residency Program in Springfield, Pennsylvania. His book The Emotional Survival Guide for Caregivers, will be published in June by Guilford. Contact: barryjacobs4@comcast.net. Letters to the Editor about this department may be e-mailed to letters@psychnetworker.org.

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