

# Life Domains and Adaptive Strategies of a Group of Low-Income, Well Older Adults

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*Older adults are at increased risk for a variety of physical and functional limitations that threaten their ability to lead independent and fulfilling lives. Consequently, they stand to benefit from personalized strategies of adaptation that enable them to achieve successful outcomes in their daily activities and desired goals. In the current investigation, a qualitative descriptive methodology was used to document the perceived life domains of importance and associated strategies of adaptation of 29 residents of Angelus Plaza, a federally subsidized apartment complex in downtown Los Angeles for low-income, well older adults. On the basis of interview data, 10 life domains were identified, and within each domain, a typology of adaptive strategies was derived. The domains were activities of daily living (ADL), adaptation to a multicultural environment, free time usage, grave illness and death—spirituality, health maintenance, mobility maintenance, personal finances, personal safety, psychological well-being and happiness, and relationships with others. Although the typology should not be generalized to a geriatric population, therapists may wish to refer to it to gain a sense of the extent to which certain adaptive strategies may be applicable to the lives of particular older adults to whom they deliver services. The teaching of these adaptive strategies could then be incorporated into an individualized treatment plan.*

*The typology also provides a broad picture of the kinds of adaptive strategies used by the older adults as a way of coping and adapting to their setting. Although some of the domains do not differ from those typically addressed in occupational therapy textbooks on geriatric care (e.g., ADL, health maintenance), others seem uniquely tailored to the specifics of the Angelus Plaza context (e.g., personal safety). Finally, certain domains emerged that may be highly relevant to older adults in most settings but are not typically the focus of occupational therapy programs (e.g., grave illness and death—spirituality, relationships with others). The emergence of these domains from our data suggests that therapists may wish to consider them more in treatment if they are convinced that they possess local relevance.*

**T**he ongoing upward shift in the number of older Americans promises to have a major impact on society's social values, institutions, and services (Restrepo & Rozental, 1994). In this regard, a key challenge for the future resides in society's ability to offer a high quality of life to its older citizens.

Although technological breakthroughs in modern medicine have increased the average life span, corresponding advances in the treatment of chronic health conditions that beset older persons have failed to develop. As a result, older adults are commonly forced to cope with longstanding health conditions such as arthritis, rheumatism, hypertension, heart disease, orthopedic

problems, and impairments in hearing, vision, sensation, or cognition (e.g., Bild et al., 1993; Bonder & Wagner, 1994). These health problems increase in prevalence with age and threaten older adults' ability to live independently. In addition to physical illness, older adults are at risk for psychological disorders such as depression, schizophrenia, anxiety states, or substance abuse, which, like physical illness, can be functionally disabling with respect to the performance of necessary activities of daily living (ADL) (Riley, 1994; Smyth, 1994; Trace & Howell, 1991).

Despite these problems, older adults are by no means inherently consigned to lead dysfunctional, unsatisfying lives. The physical and psychosocial disorders commonly associated with aging are by no means inevitable (Stahl & Feller, 1990). Even when such problems are present, their adverse effects can be overcome through successful efforts to cope and adapt. Accordingly, Verbrugge (1990) has stressed that effective accommodations to a chronic condition can serve as a buffer that prevents the loss of function or reduced sense of well-being that would otherwise occur. From this perspective, the degree of disability resulting from a chronic condition does not necessarily mirror the extent of physical deficit. Rather, it is based on the size of the gap between a person's net capability, which includes coping skills, and the demands placed on him or her by the environment (Verbrugge, 1990). Verbrugge's analysis implies that a person with a severe physical problem who has excellent coping skills may have a lesser degree of disability or impairment than a person who has a mild physical deficit and has no coping skills. Because the lengthening of the life span has correspondingly increased the fraction of persons' lives spent in old age (during which time threats to compromised functioning are more likely to occur), it is important to document the nature and role of coping mechanisms and adaptive strategies that eliminate or minimize the effects of the common problems that challenge older adults' ability to pursue independent and satisfying lives.

## Literature Review

The research literature is consistent with the above notions mentioned in that it underscores the importance of coping responses in mediating the impact of physical and social stressors on the well-being of older adults (e.g., Folkman, Lazarus, Pimley, & Novacek, 1987; Krause, 1987; Lohr, Essex, & Klein, 1988; Rhode, Lewinsohn, Tilson, & Seeley, 1990). Typically in this research, broad personal coping styles are studied in terms of their role in meeting the challenges of major life stressors or minor daily hassles or strains.

At a more specific level than broad-based coping predispositions, adaptive strategies represent individualized schemata or plans that are used in either stressful or non-stressful situations to obtain a desired outcome in the face of a particular challenge or need (Frank, 1984; McCuaig, 1989; McCuaig & Frank, 1991). For example, if an older woman is unable to go on shopping trips as a result of physical immobility, she may instead shop at home through television, solicit requests for salespersons to make visits to her home, ask a friend to shop for her, or use a combination of the above approaches. The effective use of such adaptive strategies has the potential to mitigate the effects of chronic illness and thereby increase older adults' capacity to maintain a stable and satisfying round of daily activities. In this regard, behavioral and life-style factors that predict healthy aging, such as exercising regularly, abstaining from alcohol and tobacco, practicing good nutritional habits, and taking advantage of social support systems (Clair, 1990), can be construed as adaptive strategies that enhance one's physical and psychosocial outcomes. Beyond their specific benefits in enabling the achievement of personally meaningful goals, adaptive strategies are potentially important because of their possible role in bolstering feelings of self-efficacy and personal control, factors that are related to positive life outcomes in older adults (Holahan & Holahan, 1987; Langer & Rodin, 1976; Reich & Zautra, 1984).

As implied in the previous paragraphs, stress among older adults can be caused by both major catastrophic events and the daily strains of living with functional impairments. Research has shown that the outcomes of repetitive life experiences, such as daily obligations and demands, relate more strongly to psychological well-being than do major life events (Holahan & Holahan, 1987; Kanner, Coyne, Schaefer, & Lazarus, 1981). Both response to and success in the outcomes of relatively mundane daily events are associated with positive affect, generalized well-being, and quality of life in older adults (Reich, Zautra, & Hill, 1987). These findings are of practical importance because appropriate efficacious reactions to everyday events may be enhanced by interventions, such as occupational therapy, that facilitate the use of adaptive strategies.

In attempting to understand the use of adaptive strategies among older adults, it is important to consider the full gamut of life domains within which such efforts occur. In the past, the activity domains of personal care (ADL) and household management (instrumental activities of daily living [IADL]) have generally received most of the emphasis in research and evaluation, possibly because of their obligatory nature for all members of soci-

ety, relatively uniform structure across people, and implications for diagnosing disability if performed with difficulty (Verbrugge, 1990). However, we have observed that outcomes associated with additional activities or life domains, such as hobbies and use of leisure time, social relationships, or spiritual pursuits, also affect older adults' health and sense of well-being. For example, older adults' life satisfaction has been found to correlate with their degree of enjoyment of leisure activities (Guinn, 1980; Ragheb & Griffith, 1982); their participation in religious activities (Cutler, 1976; Edwards & Klemmack, 1973); and, more generally, the extent of congruence between their desired and actual use of time (Seleen, 1982). Thus, within realms other than required ADL, successful coping mechanisms and adaptive strategies may contribute toward a more meaningful and fulfilling life.

Previous studies have typologized the varieties of activities that make up the daily lives of older adults. For example, Baltes, Wahl, and Schmidt-Furtoss (1990) categorized, using time diary methodology, the activities of 49 older German adults who were living independently. Aggregated activity categories included obligatory activities (including ADL and IADL, medical treatment, transportation, and daytime resting activities) and leisure activities (including physical activities, mental activities, media consumption, socializing, volunteer social engagement, religious activities, and other leisure-type activities). The authors observed that the frequency of engagement in selected clusters of activities correlated with functional health, perceptions of personal control, or both.

Such objectively based studies of time use are valuable and further our understanding of the key activity domains in older adults' lives. However, complementary information about older adults' subjectively reported life domains and activities of importance is also potentially useful because it may enhance our awareness of the personally meaningful concerns that result in the use of adaptive strategies. This emphasis is harmonious with the working assumption of occupational science (a nascent discipline intended to elucidate the form, function, and meaning of human occupation) that the personal meaning and degree of importance assigned to an activity critically mediate the manner in which it is experienced and the role that it plays in a person's life (Clark et al., 1991; Clark & Larson, 1993; Yerxa et al., 1989).

To summarize, a focus on psychologically salient life domains and adaptive strategies is important because

- Effective methods of adapting to and coping with life's challenges can undercut the likelihood that an intrinsic disability will lead to a gap in function

between environmental demands and a person's net capabilities.

- Acquisition and use of adaptive strategies can potentially improve health and well-being through enhancing perceptions of personal control.
- Outcomes of everyday life events, which can be influenced by the use of adaptive strategies, are potentially more malleable and more strongly linked to older adults' health and well-being than are major life events.

The present study, which blended qualitative and quantitative methods, was designed to document a sample of older adults' subjective perceptions regarding life domains (areas of activity of personal importance), as well as provide a preliminary typology of adaptive strategies that they use to obtain salient goals within each domain. It was expected that the expressed domains of personal daily living concerns would overlap, but not be identical to, the activity configurational types observed in previous objectively based research. The delineation of adaptive strategies represented a preliminary attempt to document existing, potentially workable approaches to meeting the challenges that older persons face.

## Method

### *Setting and Informants*

All informants were English-speaking older adults who resided at Angelus Plaza, a large, federally subsidized housing project for low-income, well older adults located in downtown Los Angeles. Angelus Plaza includes four high-rise buildings connected by a parking garage and contains nearly 1,200 single bedroom apartments. Most residents are subsidized for up to two thirds of their rent through government assistance and pay the remaining portion through Social Security. Angelus Plaza has a variety of on-site services for older adults, including a medical clinic, a government-subsidized cafeteria offering complete and balanced meals, and regularly scheduled activities and outings. Ninety-six percent of the more than 1,200 residents housed at Angelus Plaza are aged 60 years or more, with African-Americans, Asians, and Hispanics constituting nearly two thirds of the facility's population. Approximately 80% of the residents speak English, with the majority of the remainder speaking only Spanish or only Chinese. To remain at Angelus Plaza, all residents must be independent or semi-independent in their daily living abilities.

The informants were 20 women and 9 men of African-American (2), Asian (1), Caucasian (20), and Hispanic (6) ethnic status. Their average age was 80

years. The informants volunteered for the study by attending a brief presentation about the study made by the secretary at the Angelus Plaza medical clinic and by signing an informed consent form.

### *Data Collection*

Data were collected through semistructured interviews administered by three graduate research assistants (interviewers; all Caucasian women) who each held one-on-one interview sessions with between 8 and 12 informants. The interviews lasted between 1 hr and 2 hr each and were conducted at the Angelus Plaza medical clinic. Before being interviewed, background data on each informant's age, gender, ethnicity, primary language, and length of stay at Angelus Plaza were gathered and recorded on a coding sheet.

During the interviews, the informants were instructed to provide a complete answer to each of the following open-ended questions or prompts, which we assumed would lead to disclosure of the adaptive strategies they were using:

1. Tell me about your life at Angelus Plaza.
2. Do you like living here? Why or why not, and what do you or don't you like about it?
3. What do you do every day to stay happy and healthy?
4. What is different about here compared with other situations in which you've lived?
5. Why do people leave Angelus Plaza?

All interviews were tape recorded, and the interviewers composed field notes pertaining to the informants' adaptive strategies both during and immediately after each session. Because of the exploratory nature of the study, open-ended questions were used to avoid suggesting particular adaptive strategies to the informants. Typically, the informants spontaneously provided more information than expected in response to the questions. In cases where the interviewer sensed that an answer was incomplete, additional prompting was used to elicit a more thorough response.

Across her successive series of informants, each interviewer iteratively used information from previous informants' responses to alter the content of questions contained in subsequent interviews (Lincoln & Guba, 1985). In modifying subsequent interviews, the five questions and prompts listed in the previous paragraph were always presented first and in the same order. However, additional questioning was added at the conclusion of the altered interviews to evaluate the consistency across informants

of life domains and strategies voiced by previous informants.

### *Data Analysis*

Several steps were performed to develop typologies of life domains and the major classes of adaptive strategies within them. To facilitate the data analysis, each interviewer was asked to type a 1-page to 2-page summary of the content of the interview responses for each informant as well as record on a notecard each individual unit constituting an identifiable statement about an adaptive strategy expressed by each informant. Six hundred fifty such units were obtained for the 29 informants. Both the summaries and recording of units were based on a thorough review of the taped interview sessions and field notes.

After generating the summary information, the following steps were conducted to form relevant typologies:

1. Each interviewer independently generated a typology of life domains within which adaptive strategies were expressed by her informants.
2. The senior author successively interviewed each of the interviewers regarding her respective typology of life domains, using Lincoln and Guba's (1985) procedure to incorporate previous information when questioning subsequent respondents. The result of this process was a single preliminary typology of life domains, which was reviewed by the interviewers to confirm accuracy. The typology that was developed represented the consensus of the interviewers.
3. A series of group discussions (spanning three sessions for a total of approximately 6 hr) were convened, during which, through hermeneutic dialogue and reasoning (see Lincoln & Guba, 1985), the preliminary typology of life domains were lumped and split to eliminate several overlapping and ambiguous categories. The product resulting from this step was a more refined, 10-element typology of informants' life domains.
4. The reliability of each of the 10 life domain categories was examined by two additional graduate research assistants (raters) who independently reviewed copies of the summaries of the informants' responses. (Each rater was provided with a list and brief description of each of the 10 life domains, along with five sets of the 29 summaries, and was instructed to color-code passages reflective of each of the 10 life domain elements. For each rater, 2 of the 10 assigned domains were attended to within each of the five passes through the set of summaries.) To document the interobserver reliability

of each life domain element, the number of instances in which the same passage was marked by the two raters as exemplifying the same life domain was tabulated. Additionally, the proportion of these joint identifications relative to the total set of cases in which at least one rater judged the life domain element to have occurred was determined.

5. On the basis of a review of the entire set of units, three of the authors (who had not been interviewers) independently developed a typology of classes of adaptive strategies that occurred within each life domain.
6. Through a group discussion, these three authors generated a single typology of varieties of adaptive strategies within each of the 10 life domains.

## Results and Discussion

### *Life Domains*

The 10 life domains that were obtained in the study are presented in the Appendix. In generating the life domain typology through second-order interviewing (data analysis step 2), a high degree of consistency was generally observed in the content of the life domain categories independently identified by the three interviewers. It is important to note that not every informant referred to each of the life domains in his or her interview. However, each of the life domain elements emerged repeatedly among subsets of informants. Additionally, it should be stressed that the categories are not presumed to be mutually exclusive. Goals, thoughts, and adaptive strategies that are pertinent to one category can be expected to frequently influence outcomes for additional categories. For example, strain in the domain of personal finances may negatively affect an older adults' sense of psychological well-being as well as physical health.

On the basis of the procedures described in data analysis step 4, each of the life domains was jointly identified six or more times by the two raters as having occurred in the same interview passage (across the 10 domains, the average number of joint identifications was 24). On average, if one rater identified a specific domain in a passage, the other rater identified the same domain in the passage 68.3% of the time. These results indicate that the raters, who did not participate in the derivation of the life domain typology, were able to (a) independently agree on numerous occasions in identifying each of the specific category instances and (b) confirm that repeated references to each of the categories were present in the summary reports.

As a set, the life domain categories represent the most salient concerns of the informants. Most of the categories

reflect previously documented key issues of importance to older adults, such as health maintenance, ADL, relationships with others, and free time usage (Baltes et al., 1990). However, other categories, such as adaptation to a multicultural environment, are less frequently addressed in the gerontological literature. Although on intuitive grounds most of the categories would seem to apply to other independent-living contexts for older adults, to some degree the results may reflect the downtown Los Angeles environment in which Angelus Plaza is located. For example, the domains of adaptation to a multicultural environment and personal safety are likely to have been more prominent as a result of Angelus Plaza's ethnic diversity in an urban setting and location in a high crime area. Likewise, across settings, the salience of the remaining domains would be expected to wax and wane in accordance with contextually specific differences in the older adults' age, degree of wellness, income, and other characteristics. However, it is likely that all or nearly all of the life domains are potentially important to consider in attempting to understand the lives of older adults.

Particular life domain categories exhibit varying relationships to Baltes et al.'s (1990) objectively based classification of older adults' activities. Some life domains (e.g., ADL, free time usage, mobility maintenance) correspond closely to identified activity categories or sets of activity categories. Other life domains represent a general theme or goal that selected activities presumably help to fulfill (e.g., psychological well-being and happiness is potentially served by participation in all the activity categories identified by Baltes et al., whereas the domain of health maintenance is directly related to Baltes et al.'s activity category of medical treatment and less directly to their leisure activity subcategories). Finally, selected life domains, such as personal safety, adaptation to a multicultural environment, and grave illness and death-spirituality, are not clearly reflected in Baltes et al.'s typology of activities. In this latter case, sample differences may partially explain this result because Baltes et al.'s sample of older German adults is likely to have been less threatened by crime, more healthy physically, and more ethnically homogeneous. However, overall, the lack of isomorphism between the life domains and Baltes et al.'s objective activity categories suggests that activities do not uniformly relate simply and directly to key personal areas of interest and that subjectively reported information is important to consider in attempting to fully understand the lives of older adults.

### *Adaptive Strategies*

The typologies of adaptive strategies within each of the

life domains are shown in the Appendix. Where provided, examples of adaptive strategies that represent actual cases reported by informants are also shown.

Although when possible natural clusterings of adaptive strategies were used to generate the categories, decisions to combine or divide varieties of adaptive strategies in deriving typological elements were based, to an extent, on arbitrary considerations. Thus, the typologies should not be viewed as ironclad, but rather as containing fluid, occasionally overlapping categories that are intended to provide an overview of the informants' main strategies to achieve goals associated with the corresponding life domains.

The adaptive strategies in the ADL domain often seemed to involve reliance on support systems. Thus, paradoxically, the ability to remain independent seemed to involve dependence on equipment and technology and on use of informal help and formal service networks. One informant, for example, had a housekeeper who helped her take care of all her needs, including shopping, cleaning, cooking, going to appointments, and remembering information. Another informant depended on a nephew. The ability to structure the environment so as to minimize workload was also a common adaptive strategy as well as investment in health habits and practices, such as eating nutritious meals, taking medications regularly, and getting sufficient amounts of sleep.

Many of the informants identified adaptation to a multicultural environment as a crucial domain and invested a multitude of strategies for dealing with this facet of their lives. Techniques ranged from seeking out information about diverse cultural groups and making personal accommodations, such as letting others move around oneself in the elevator and scheduling desired contact, to avoiding and responding negatively to those from different cultural groups. One informant who performed magic tricks would not do so for those he called "foreign residents"; another learned to "greet everyone with a smile"; and a third scheduled herself carefully so that she could regulate her contact with persons of a different culture. Although the development of strategies for handling living in a multicultural community is not typically part of an occupational therapy treatment protocol, our data suggest that possessing such strategies was seen as very important by our informants for maintaining health and well-being. The rich list of strategies they described provides a repository of content that could be covered in an occupational therapy treatment program.

The informants had also developed a rich repertoire of strategies for dealing with free time usage. They believed that keeping active was crucial to their life satis-

faction, and they participated in an abundance of leisure activities, including attending classes and clubs, walking, making gifts for others, spending time with friends, attending church, and praying. Many also reserved periods of the day for quiet time and rest.

The grave illness and death-spirituality domain emerged strongly from the data. Confrontation with one's own mortality seemed to be a crucial element of the context to which the informants had to adapt. As was the case for the other domains, the adaptation strategies varied. Some informants seemed to devote considerable time to this issue, making extensive preparations for their own deaths. For others, simply talking about this topic sufficed. Another approach was to concede to death's inevitability; for example, one informant said, "It makes you feel sad, but that's one thing life is about. You can't live forever...I'm leaving everything up to God. He takes care of everything."

Health maintenance and mobility maintenance were two domains that are typically covered in the occupational therapy literature. However, selected adaptation strategies took into account issues that usually are not considered. For example, in the domain of mobility maintenance, certain informants used situational contexts to maximize their ability to be physically mobile. One would wait for a pain medication to be effective before walking; another walked in the afternoon when her stomach was less queasy. In contrast, a third informant whose legs hurt her indicated that she spent a good deal of time trying to figure out how to avoid walking. However, in making this comment, tears welled up in her eyes and she added, "Isn't it horrible to think that it's all you can do in life is walk across the street to the market and back and that's your whole life!" In the domain of health maintenance, the informants extensively invested in strategies such as staying active, visiting physicians, and exercising to manage their attitudes and feelings about health. One informant was determined to "not let anything" beat him. Three informants refused to allow rules to constrain them; several others used humor to stay healthy.

To adapt and stay healthy, the informants had learned to manage their personal finances carefully and had developed numerous strategies for ensuring personal safety. Although most of the strategies they used in these domains were not extraordinary, they could constitute important areas of focus in occupational therapy programming. Among the adaptive strategies in these domains, the informants tended to plan and adhere to a budget and avoid dangerous neighborhoods. They also took advantage of formal and informal money making and saving opportunities. For example, one informant

would receive money for doing magic shows, another would sell his meal tickets, and a third bought damaged clothing and repaired it herself.

The psychological well-being and happiness domain contained the most entries of adaptive strategies in our data set. Our informants were concerned with living a satisfying and happy life. They participated in activities they valued, tried to maintain a positive attitude, and invested energy in treating others properly. In extreme circumstances, they would seek professional help. Of particular interest was the extent to which occupations constituted the strategies that promoted psychological well-being. Religious activities, listening to music, attending concerts, caring for a pet, reading, going to parties, performing magic, crafting gifts for others, cutting flowers, and having sex were some of the occupations that enabled the informants to enhance their quality of life and psychological well-being.

Negotiating relationships with others was the final domain to emerge from the data. The informants invested much time on issues surrounding contact with their families and friends, coping with loneliness, and dealing with interpersonal contacts. The majority discovered that occupations often became a context for interacting with others, and many belonged to clubs or church groups or volunteered, in part, to build social relationships. Others learned to cope with loneliness by watching television, having a pet, or talking on the phone. In addition, the informants developed numerous strategies to prevent exposure to the negative aspects of social life. One respondent who said that she preferred to be alone revealed that she may experience a twinge of loneliness on holidays such as Christmas and Easter. Her solution was to watch an organized celebration on television, such as the Pope's address on Easter. Another resident was very insecure about her intelligence and was afraid to interact with others when she moved into Angelus Plaza. However, she decided to join the Wednesday Coffee Klatch where through baking cookies, being a good listener, and doing some reading, she gradually gained confidence in being able to socialize with the other members of the group. She says now that she "can look at [herself] for what [she] is and so many things don't bother [her any more]." She believes that there is much power in love because it gives her confidence. She further stated that "people don't realize what power we have, what we could do for each other just by smiling."

### *Implications for Occupational Therapy*

State-of-the-art occupational therapy approaches de-

signed to meet the needs of older adults recognize the importance of attending to individualized values and interests, needs, and goals for recovery (e.g., Crabtree & Caron-Parker, 1991; Hasselkus, 1993; Levine & Gitlin, 1993). The set of adaptive strategies obtained in the present study constitutes a collection of helpful hints that can be used to design treatment interventions for older adults. It can also be used to explore options that are available to an older person who is attempting to cope with challenges arising from a given life domain. Although the findings of qualitative studies should not be generalized, therapists may feel free to refer to the Appendix for ideas of adaptive strategies in each domain that may be relevant to the life issues of their patients. Part of the occupational therapy program could include suggesting and teaching these strategies. For example, in the ADL domain, a therapist might find it helpful to teach a patient how to structure the environment to minimize the burden of performing necessary activities. However, it should be noted that some of the informants' strategies (e.g., avoiding or acting negatively toward members of different ethnic groups in attempting to adapt to the demands of a multicultural environment) are questionable in terms of their actual use or ethical content. Other strategies, such as the practice of self-defense as a preventive measure to promote personal safety, may be inappropriate for some older adults.

In considering the variety of informants' adaptive strategies, some interesting questions are raised about the definition of adaptation. In some cases, a strategy clearly serves to fulfill a worthwhile goal within a particular life domain. For example, the strategy of maintaining a proper diet with the intention of promoting good health is clearly adaptive for nearly all older persons. However, at least two types of adaptive strategies of questionable value emerged. One type included strategies that were likely to vary widely in value for different persons. For example, reliance on a pet or teddy bear as a substitute for human companionship (the relationships with others domain; see Appendix) may steer a person away from the attainment of more fulfilling relationships with other human beings. In this case, use of such a proxy may be based on, and counterproductively perpetuate, an older adult's misperception that his or her achievement of normal human friendship is not possible. However, the use of a pet or teddy bear may for another person provide an important, worthwhile supplement to existing human friendships. These discrepant possibilities underscore the necessity for a therapist to carefully attend to individual characteristics and needs in making recommendations surrounding the use of adaptive strategies. Some strategies that are general-

ly adaptive, and therefore useful to consider as helpful hints, may be harmful for selected subgroups of older adults.

A second type of strategy of questionable adaptive value pertains to instances in which strategies fulfill a need within a person that is itself seemingly counterproductive in the long term. This pattern was observed fairly frequently within the sample. For example, in the realm of relationships, some informants indicated that they used strategies designed to distance themselves from others. Although such behavior may be adaptive in that it serves a person's immediate defensively based psychological need to withdraw from others, such strategies may simultaneously reinforce a deeper pattern of maladaptation and prevent the person from experiencing a normal or fulfilling social life. If the existing maladaptive pattern is permanent, then it is arguable that an otherwise questionable strategy that caters to the maladaptation is adaptive because it may be the most promising therapeutic option from a range of realistic alternatives. This possibility suggests that the adaptive value of a strategy is contingent on selected background factors such as deep-set lifestyle or personality patterns. When firmly entrenched pathological or otherwise abnormal background characteristics are present, a normally maladaptive strategy may prove to be adaptive and, conversely, a strategy that is normally adaptive may backfire (e.g., when a chronic misanthrope is induced to interact with others). Such instances point to the individualized nature of adaptation, raise difficult ethical questions in regard to the use of adaptive strategies in treatment contexts, and may partially explain a common reason for cases of treatment failure (i.e., encouraging the use of strategies that possess general, but not universal, adaptive value).

Because this study primarily used a qualitative research methodology, the findings are not intended to be generalized to other settings and older adults, but they can be used selectively and judiciously for program development. Additionally, aspects of the present research methodology can be replicated in individual treatment to gain an understanding of the domains and strategies that are potentially relevant to persons in those settings.

Because of their close connection to the achievement of key life goals, adaptive strategies are worthy of future investigation. Additional research topics include studying whether the strategies obtained from this study remain consistent across varying samples, the characteristics of strategies used among older adults who exemplify a pattern of successful aging, the relationship of adaptive strategies to happiness and life satisfaction, and the manner in which older adults combine specific strategies to

compose wider based adaptive systems. ▲

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## Appendix

### Ten Life Domains of Older Adults and the Types of Adaptive Strategies Within Each

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*Activities of daily living.* Concern with the basic tasks necessary for daily living, including eating, grooming, dressing, resting or sleeping, and cleaning.

1. Using technological aids or adaptive equipment
2. Practicing good health habits related to ADL (e.g., going to bed early, eating healthy food)
3. Structuring one's environment to minimize the burden of performing necessary activities (e.g., choosing to live in a location where no yard work is required)
4. Using informal help (e.g., from friends, acquaintances, or neighbors) to assist with the performance of required ADL
5. Using formal services to complete ADL requirements (e.g., going to a restaurant to avoid cooking, hiring a housekeeper to clean)

*Adaptation to a multicultural environment.* Confrontation of issues regarding interactions with residents and other people who are ethnically diverse from oneself.

1. Altering one's specific behaviors to get along with others who are different (e.g., smiling, changing one's speaking habits)
2. Learning about different ethnic or cultural groups
3. Cultivating a generalized attitude of respect and toleration for all people
4. Avoiding persons from different ethnic or cultural groups (e.g., physically withdrawing from or refusing to speak to those who are different)
5. Responding negatively toward persons from different ethnic or cultural groups

*Free time usage.* Engagement in free time activity, in-



cluding leisure, entertainment, media consumption, volunteerism, and church activities.

1. Attempting to keep active and engage in a variety of leisure activities
2. Planning and scheduling to facilitate optimal use of free time

*Grave illness and death—spirituality.* Confrontation of sickness, dying, and death in terms of their implications for meaning in life and the spiritual dimensions of one's being.

1. Strengthening one's personal relationship with God (e.g., through praying, reading the Bible, attending church)
2. Preparing for one's own death (e.g., developing the proper mental attitude toward death, composing a will)
3. Talking to others about death and dying
4. Not worrying about catastrophic illness or death
5. Avoiding close relationships with others to minimize the pain of dying

*Health maintenance.* Concern with avoiding illness and maintaining or enhancing one's physical health.

1. Complying with general health knowledge (e.g., maintaining a proper diet, staying active, exercising)
2. Seeking formal medical assistance (e.g., visiting doctors and complying with their recommendations)
3. Maintaining a positive mental attitude toward health

*Mobility maintenance.* Concern with one's capacity to physically get around.

1. Promoting one's generalized or future ability to be physically mobile (e.g., walking to maintain one's physical capacity to remain mobile in the future)
2. Using public or private transportation (e.g., car, bus, taxi)
3. Using situational contextual cues to maximize one's potential to be physically mobile (e.g., waiting for a nice day before going on a shopping trip, allowing one's stomach to settle before walking)

*Personal finances.* Attention to personal income, budgeting, and financial decisions.

1. Planning and adhering to a budget
2. Avoiding unnecessary expenditures and items (e.g., not buying a pet)
3. Engaging in informal money-making or saving ideas (e.g., selling one's meal tickets)
4. Taking advantage of formal money making oppor-

tunities that extend to seniors (e.g., receiving payment for jury duty)

*Personal safety.* Coping with threats to one's physical well-being such as crime and violence, physical disaster, and personal mishaps.

1. Maintaining oneself in a safe physical location (e.g., avoiding dangerous neighborhoods, staying inside, choosing to reside in a low crime district)
2. Using the protective advantage of other people (e.g., going out with other people as opposed to alone, engaging in crime watch networks with other residents)
3. Making use of general preventive measures (e.g., concealing one's purse when outside, exercising earthquake preparedness, staying alert, practicing self-defense)

*Psychological well-being and happiness.* Concern with living a satisfying and happy life.

1. Keeping active by engaging in worthwhile activities (e.g., spiritual activities, visiting with one's family)
2. Using formal professional services to remain happy or well (e.g., seeking psychiatric help to avoid depression)
3. Maintaining a proper, positive state of mind (e.g., avoiding feeling sorry for oneself)
4. Treating other persons properly (e.g., going out of one's way to help another person)

*Relationships with others.* Attention to issues surrounding contact with one's family, pursuing friendships, coping with loneliness, and dealing with interpersonal conflicts.

1. Making use of formal gatherings to meet and interact with others (e.g., being a member of a club)
2. Treating other persons in such a way as to foster positive relationships with them
3. Reaching out to family and friends
4. Resorting to alternate channels to furnish substitutes when human friendship is not available (e.g., buying a pet, owning a teddy bear, reading a book)
5. Avoiding others to prevent the negative aspects of social life (e.g., refusing to open up to nonworthwhile persons, attempting to limit one's relationships to a circle of close friends)

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