FACILITATIVE EFFECTIVENESS OF ELDERLY AND ADOLESCENT VOLUNTEER COUNSELORS IN A NURSING HOME SETTING

DISSERTATION

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By

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This study examined the effects of volunteer counselor training (empathy training versus information only) and age of volunteer (senior citizens versus adolescents) upon depression level of nursing home residents. Sixty elderly nursing home residents were found to be depressed as measured on the Zung Self-Rating Depression Scale (SDS). Twenty volunteers (10 elderly, 10 adolescent) were trained in empathic listening with the elderly and twenty volunteers (10 elderly, 10 adolescent) were given information only regarding the aging process. They met individually with a randomly assigned nursing home resident two times per week for five weeks. Zung SDS posttest measures were obtained from each training group and a no volunteer control group (n = 20). Results showed that residents who received a volunteer counselor significantly improved ($p < .01$) in level of depression compared to the no volunteer control group. The empathy trained counselors were not significantly more effective than the information only group. The age of the volunteer counselor was found not to be a significant variable.
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INTRODUCTION
The evolution of western society, within the last century, has produced enormous wealth and great technological advances. The quality of life has improved in exponential increments as measured by most societal standards. Improved living conditions and far-reaching medical advances have sharply reduced the infant mortality rate and steadily lengthened adult life expectancies. Where in 1900 the average life expectancy was 47 years and only 4 per cent of the population were 65 and older, these figures have increased to an average life expectancy of 71 years with 10 per cent of the population now represented by the elderly (Butler & Lewis, 1977). By the year 2010 projections estimate that nearly 15 per cent of the population will be over age 65 (Romaniuk, 1982). These figures have enormous implications for our culture in light of the present problems facing today's elderly and projected trends for the future.

People in our society generally cannot think of old age as a time of potential health and growth. To some degree this is a realistic viewpoint, considering the plight of many older people who have been socially outcast, becoming lonely, bitter, poor and emotionally or physically ill. But from a larger perspective, the negative stereotype of old age is a problem characteristic of Western civilization.
Butler and Lewis (1977) point out the sharp contrast between Western and Oriental concepts of the life cycle. In the eastern tradition, the individual, his life, and his death are viewed as within the whole of human experience. Thus, life and death are accepted as part of one process. In the West, death is an external entity alien to the process of being (Butler & Lewis, 1977). To be a person one must be alive, in control, and ever moving forward. The societal value placed on individuality and control makes death an insult, rather than the natural and vital process of old life giving way to new. Religious convictions held by some elderly may alleviate its impact (Spikes, 1980), but this philosophy translates into a way of life which places an enormous emphasis on "progress." The Western penchant for control over nature and for personal self-fulfillment, proves to be increasingly problematic for the elderly and those approaching old age. This is especially true when our modern zeitgeist emphasizes and broadens the notion of measuring human worth in terms of individual productivity and power. Cognizance of the psychosocial context derived from this cultural milieu thus becomes an important consideration as we attempt to understand their plight, as well as make responsible judgements as to their adjustment or maladjustment to old age (Bozzetti & MacMurray, 1977).
Numerous authors have commented on the effect our changing culture has had on its older members (Bozzetti & MacMurray, 1977; Butler & Lewis, 1977; Williams, 1978). The popular societal orientation is toward youthfulness and productivity (Kowalski & Cangemi, 1978). Our highly technological society, with its rapidly changing customs, has made the world and the values of the elderly increasingly more irrelevant. As the knowledge and skills of the older population become obsolete, they feel ever more isolated. Palmore and Wittington (1971) suggest that old age has become the "roleless role" leaving the elderly stripped of meaningful functions or of having a valued identity as a social group. Retirement, particularly involuntary retirement, contributes most to this situation since, contrary to preindustrial societies, there are no institutionalized roles for the person who is no longer a substantive contributor (Bozzetti & MacMurray, 1977). And it is axiomatic in these times that our society is highly mobile, both in terms of residential and social class shifting. This has frequently resulted in the loosening of ties between family members as children and parents move independently in following their own pursuits. This phenomenon has been reported to be particularly evident in the middle socio-economic class (Schur, 1975), but clearly impacts across the whole of the aged population. As a result, growing numbers experience a sense of emotional deprivation,
and their interpersonal relations become ephemeral and superficial. Often left behind with neither the financial nor the interactional facilities, the aged are ill-equipped to adjust to their social isolation and emotional deprivation (Bozzetti & MacMurray, 1977).

The problems which accompany growing older stem from societal influences and the natural developmental consequences of the aging process. Most notably observed by those who work with the elderly is a pervasive and persistent theme of loss (Brink, 1979; Burnside, 1970; Palmore, 1973). Those attributes which define one's life and give it meaning dwindle with the passage of years, i.e., health, beauty, career, financial security, status, and a stable self-image (Zung, 1980). Common to all is a gradual decline in agility, reaction time, and an adaptability to new things in terms of cognitive/attitudinal rigidity (Kowalski & Cangemi, 1978). They are more prone to sickness. Investigations show that 70 per cent of the elderly have one or more chronic disease and they take longer to recuperate from sickness and injury (Butler & Lewis, 1977). Burnside (1970) noted that loss of eyesight was a particularly distressful ailment along with loss of mobility. And Eisdorfer (1970) presented evidence that loss of hearing is associated with impaired cognitive functioning. Such loss, whether it be slowing of response speed, loss of intellectual capability, lessened learning
capacity, deficit in memory, or poor integrative functions, may produce severe stress in adapting to the problems of old age.

The death of a spouse may constitute a major loss. Among the elderly, 56 per cent are widowed with four times as many women as men surviving their spouse (Butler & Lewis, 1977). In addition, many others have suffered bereavement from death of children, other relatives, and close friends. It has not been ascertained exactly how stressful such bereavement is, but there is substantial evidence that it often is a severe stress. Many writers agree (Gallagher, Thomson & Peterson, 1982; Spikes, 1980) that death of a spouse is the most stressful thing that can happen to most people. Often noted is a pattern in which the individual may be reconciled to his own impending death but deeply distressed by that of a loved one (Brink, 1979).

Where the losses are light or the individual's coping capacities are high, mental health can be preserved or even enhanced in the later years. However, many times these losses become crises necessitating therapeutic intervention. Although the extent of mental illness among the aged is often exaggerated, it is evident that the aged suffer from more of the severe mental illnesses than young people (Redich & Taube, 1980). Riley and Foner (1968) report the rate of resident patients in state and county mental hospitals shows a steady increase from 178 per 100,000 persons aged 25-34,
to 704 persons over 65 years old. The rate of first admissions to state and county hospitals shows a first peak at ages 24-34 (100 per 100,000), then a small decline in middle age, and finally a sharp rise to the highest rate at ages over 75 (211 per 100,000). These figures, however, may be partially inflated due to the artifact of limited residential facilities available to the feeble aged (Brink, 1979). A large proportion of this higher rate may be attributed to organic deterioration. Most prevalence studies estimate that more than half of the psychotic persons over 65 have primarily organic psychosis (Kay & Bergman, 1980). Nevertheless, there is abundant evidence that a large segment of the older population suffer, to varying degrees, significant functional emotional disorder.

Numerous writers agree that by far the most common psychiatric disorders encountered in old age are affective disorders, especially depressions (Fassler & Gaviria, 1978; Hale, 1982). This preponderance of affective disorders is obtained whether one examines populations of elderly persons attending psychiatric treatment facilities, or populations of elderly persons living in their communities (Blazer, 1982; Feigenbaum, 1970). The relationship of the incidence of depression to advancing years has been demonstrated in numerous surveys (Brink, 1977). The quantity and severity of depressive symptoms increase after age 40 with the 70+ group having a higher rate than any other age group. Studies of incidence are scarce and incomplete, but figures range
from 10% to 65% for the presence of affective disorders in hospitalized and community resident older persons (Butler, 1975; Hale, 1982).

The seriousness of depression in the elderly is shown by the increase in and success of suicide attempts among this group. The elderly, about 10% of the population, account for roughly 25% of reported suicides. For the entire U.S. population the suicide rate is 10 to 11 per 100,000. The rate for elder females and elder males is two times and four times the national rate, respectively. And for elderly, divorced, white males in the seventh age decade it is 150 per 100,000, the highest risk group (Resnik & Cantor, 1970). The ratio among young people who attempt suicide and those who succeed is approximately 7:1. The number of old people attempting is roughly the same as the number actually committing suicide (Benson & Brodie, 1975). It is clear that elders who attempt suicide are determined to be successful and choose effective methods.

Depressive symptomology found in the elderly may largely resemble that observed in the general adult population. Symptoms can vary from mild to severe, and include feelings of hopelessness, anxiety, self-depreciation, and hypochondrical preoccupations, at one end of the spectrum, and severe obsessive ideation, feelings of depersonalization, nihilistic delusions and suicidal ideations at the other end of the spectrum. Physiological concomitants include disturbances
in bodily cycles, such as sleep (insomnia and early morning awakening), appetite (anorexia and weight loss), elimination (constipation and diarrhea), and diurnal mood shifts (usually worse in the morning). There are also associated behavioral disturbances, and depression may be manifested by isolation, withdrawal or apathy, or by compulsive, agitated, or hostile behavior (Brink, 1977; Hirschfeld & Klerman, 1979).

It can be seen that the descriptors of depression in older persons closely resemble that of adults in general. However, some important distinguishing characteristics have been noted by several authors which point to the conclusion that the underlying dynamics which give rise to the depression are different among the two groups (Brink, 1977; Goldstein, 1979; Levin, 1963). In one reported study of depression in the normal aged (Zung, 1967), the Self-Rating Depression Scale (Zung, 1965) was used and test items were then factor analyzed. The first of four factors clustered around items that measured personal devaluation, emptiness, indecisiveness, dissatisfaction, hopelessness, suicidal rumination, and confusion. This factor was called "Loss of self-esteem." The second, third, and fourth factors were weighted in the direction of the biological symptoms which included the previously described vegetative signs. The importance of the first factor in the etiology of depression in the aged was underscored by Brink (1977). He reported that, in his
experience, guilt and introjection of unacceptable impulses were relatively unimportant factors with elderly people, and not the major cause of feelings of depression. Instead, he suggested that depression was more related to feelings of inferiority and the loss of self-esteem. In this view, pathological aging is seen as an extension of normal aging in interaction with changing environmental circumstances.

Identification of depression among elderly persons can be greatly complicated, then, when the individual presents a mixed configuration of medical, social, and emotional elements. Just as medical illness or physical decline may present as depression or as depressive-like symptoms, the opposite is also true. Depression may manifest itself through a variety of physical symptoms (Ouslander, 1982; Salzman & Shader, 1978a). The use of somatic complaints to communicate affective states may, in some cases, represent an adaptive-coping mechanism. On the other hand, somatic complaints may be an indication of hypochondriasis, which functionally serves to remove responsibility for the etiology of the depression from the old person (Verwoerdt, 1976). The terms "depressive equivalent" or "masked depression" are used to describe the expression of depression through complaints of physical dysfunction (Goldfarb, 1967). A host of symptoms may be unconsciously adopted by a patient to mask depression, as well as to communicate the desire for help. Symptoms involving the digestive tract are the most common (Salzman &
Shader, 1978b). The patient is preoccupied with constipation, flatulence, and abdominal pains. Other frequent sites targeted as depressive equivalents are the mouth (bad taste, burning tongue, toothaches) and the genitourinary tract (burning urination, lower abdominal pain). Also, more vague symptoms as headaches, backaches, easy fatigability, and general discomfort may be somatic manifestations of depression (Salzman & Shader, 1978a).

A related phenomenon observed in the geriatric population is "pseudodementia," first reported by Madden, Luhan, Kaplan, and Manfredi (1952). This term is applied to the clinical condition appearing in elderly patients with depression who manifest transient cognitive impairment. It is a nondementing psychosis with the following clinical features: disorientation, defects in recent memory, retention, numerical reasoning, and judgement. These features disappear via short-term intensive therapy in conjunction with antidepressant medication (Libow, 1973) or electroconvulsive therapy (ECT) (Good & Dubovsky, 1982). Differential diagnosis may be ascertained if inquiry reveals a relatively short history of symptoms, sometimes an occurrence of previous attacks, a family history of depressive illness, and inconsistent manifestations of the intellectual impairment (Epstein, 1976). Also, negativism is common such that the patient replies "I don't know" rather than confabulate, as do many neurologically impaired patients (Busse, 1973). In addition,
positive response to antidepressant medication may provide a post-hoc diagnosis (Libow, 1973).

It is readily apparent that accurate assessment of clinical depression becomes increasingly problematic with patients of advanced years. Studies have suggested that depression among medical patients goes undetected in many cases. Nielsen & Williams (1980) screened geriatric patients using the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and found in a systematic chart review that 50% of these patients remained unidentified as having a mental disorder. A study by Okimoto, Veith, & Raskind (1979) further substantiates the prevalence of geriatric medical patients whose depression remains unidentified. In this study, patients, aged 60 and older, attending a medical clinic were administered the Zung Self-Rating Depression Scale (SDS), (Zung, 1965), the Popoff Index of Depression (Popoff, 1969), and a psychiatric interview. In their sample, only 35% of identified depressed subjects had been recognized by the provider as being depressed. Almost a full two-thirds went unidentified.

Just as the elderly individual's problems, environmental changes and societal attitudes conspire to cause and perpetuate emotional disturbance, so do they interact in a way which hinders the delivery of effective services. It is estimated that only 2% of all psychiatric outpatients seen in private practice or at community mental health centers are 65 years
of age or older. This, despite the fact that the elderly constitute more than 10% of the population and have a higher incidence of mental health problems than other age groups (Freedman, Bucci & Elkowitz, 1982). It has been postulated by several authors (e.g., Cohen, 1976; Gaitz, 1974; Weissman & Myers, 1979) that culturally ingrained stereotypes, attitudes, and values regarding old age affect both patient and therapist alike.

Reluctance on the part of the elderly person to seek treatment for emotional problems may stem largely from a disinclination to acknowledge the need for psychiatric and mental health services. The elderly have been described as having attitudinal characteristics that keep them from asking for help. It is reasonable to conjecture that those who matured when psychotherapy was not widely accepted do not readily think of therapy as a solution to problems. This may be considered especially true of the rural aged. Auerbach (1976) describes a strengthening in the attitudes of the rural aged that emphasizes the insularity, independence, isolation, and individualism that typifies the psychology of rural living. They are likely to be less familiar with available social services, and have more of a tendency to handle problems within the confines of the family. Their resistance is often reinforced, perhaps unintentionally, by family members with similar beliefs. A spouse or child may have as difficult a time admitting the existence of emotional
disorder as the patient. Furthermore, both patient and family may view manifestations of physical and mental decline as the inevitable concomitants of growing old. Indicators of emotional distress that would evoke alarm in a younger person, are simply tolerated as the expected signs of old age (Gaitz, 1974).

Several authors have asserted that, to a significant degree, mental health providers have been a contributing factor to the low rate of service delivery to the elderly (Butler, 1975; Cohen, 1976; Gaitz, 1974). Prevailing attitudes among medical and mental health professionals largely reflect acceptance of the negative stereotypes and myths regarding the elderly. Knight (1979) notes the continued existence of an accepted pessimism of the therapeutic outcome of treatment of the aged. This is based on the beliefs that the aged are too rigid to learn, that they present with too much life history to deal with in therapy, and that the mental health of the elderly is a low priority. Inadequate training in medical and graduate schools perpetuate the cycle of misunderstanding (Butler, 1975). It has been suggested that this "age-ism" (Butler, 1969; Nuessel, 1982) persists because the problems this group present overwhelm the therapist with fears about old age, reawaken unresolved parental conflicts and cause concern that treatment would be wasted on someone who will soon die (Cohen, 1976; Lewis & Johansen, 1982).
Whether the reasons be resistance of older people to seek help and of therapists to provide it, limitations of trained personnel and available programs, or financial and transportation problems, it is evident that older people receive a disproportionately small share of psychotherapeutic services. Despite the tremendous growth and influence of the mental health movement, older people seem to have been largely overlooked by the psychiatric system (Kahn, 1975). This is unfortunate as it has been demonstrated that aged individuals can unquestionably benefit from therapeutic encounters which encourage them to mobilize their inner resources and regain a sense of belongingness (Knight, 1979; Willner, 1978; Yesavage & Karasu, 1982).

Meeting the growing needs of the elderly can be attempted by either increasing the number of mental health personnel or changing the traditional manner of psychotherapeutic intervention. Educational programs designed to disspell negative attitudes and misconceptions regarding the elderly can help promote attitudinal changes among today's professionals. Further, increasing the enrollment in existing programs and development of new programs would help alleviate the problem. But this is not realistically feasible in light of the great financial and time expenditures attendant with these measures. Consequently, a more expedient approach to addressing the problem is to change the conventional manner of delivering psychotherapeutic services.
A growing trend, begun in the 1960's has been to utilize nonprofessionals as psychotherapeutic agents who are trained and supervised by professionals. In this way, larger numbers of people in need may be reached in a more efficient and cost effective manner (Christensen, Miller, & Munoz, 1978). The efficacy of this approach and results of treatment outcome, have been reviewed by several investigators (Balch & Solomon, 1976; Brown, 1974; Karlsruher, 1974). Though critical of the various methodological flaws, they conclude that the body of evidence generally supports the view that nonprofessional personnel can function as effective counselors.

Paraprofessionals have been utilized in various settings with different patient populations, performing a wide range of therapeutic functions. Adult inpatients are the most frequently studied (e.g., Carkhuff & Truax, 1965; Gelineau & Evans, 1970; Hartlage, 1970), followed by adult outpatients (e.g., Magoon & Golann, 1966; Truax & Lister, 1970), and college students (Brown, 1965; Gruver, 1971; Persons, Clark, Persons, Kadish, & Patterson, 1973). The lay helpers have engaged, either as co-therapists or independently, in individual and group psychotherapy (Karlsruher, 1974). And they have been trained in both the "talking therapies" and behavior modification techniques (Balch & Solomon, 1975). Their helping potential has been put to the test across the full range of problems in living. Presenting problems such
as: chronic schizophrenia (Buckley, Muench, & Sjoberg, 1970); mental deficiency (Gardner, 1972); anxiety management, alcoholism and situational depression (Nicoletti & Flater-Benz, 1975); have been addressed in the mental health setting. Likewise, educational achievement (Hefele, 1971); interpersonal problems (Gruver, 1971); personal-emotional difficulties (Brown, 1965); and delinquent behaviors (Schaefer, 1981) have been targeted on the school and college campuses.

Any one of these studies, taken singly, is inconclusive. However, the body of evidence gathered from such a diversity of sources, using widely different methodologies and measurement devices, tends to support the conclusion that paraprofessional counselors contribute to the improved adjustment of their clients in a significant way (Brown, 1974).

Only recently have investigators turned their focus to elderly persons as both providers and recipients of paraprofessional counseling. Much of the reported work is methodologically flawed and non-systematized but nevertheless offers a foundation from which to make some hypotheses. Early exploration into using senior citizens as helping agents was done by Saltz (1971). A Foster Grandparents Program was shown to have a positive impact on both the emotional growth of institutionalized, handicapped children and on the life adjustment of the older volunteer. Similar programs have been reported which substantiate the important role the elderly can play in extending services to those who need them and also
to benefit themselves in terms of self-fulfillment and
spiritual renewal (Arch, 1978; Hirschowitz, 1973; Matefy,
1978).

The seemingly obvious place to explore the potential
utility of elderly paraprofessionals is with other, less
adjusted, older people. Surprisingly, only a few such projects
have been undertaken, but the results reported are positive.
The capacity for elderly persons to learn effective communi-
cation skills and empathic responding was demonstrated by
Becker and Zarit (1978), and Isquick (1981). Compared to
no-treatment controls, the seniors who participated in the
skills training programs significantly improved in the
therapeutic core conditions of empathy and warmth (Truax &
Mitchell, 1971) and manifested these at levels sufficient
for therapeutic effectiveness. These elderly volunteers
have served various counseling functions within the treatment
center. Under professional supervision, these peer counselors
provide individual and group supportive therapy, telephone
reassurance, and referral services to clients (Becker &
Zarit, 1978).

Waters, Fink, and White (1976) developed a peer counseling
program which trained the volunteer to lead personal growth
groups. Following the Carkhuff model (1972), trainers were
taught the principles of non-verbal communication, attending
to content and feelings, reflective listening, etc. Role-play
exercises and homework assignments reinforced skills practice.
After completion of the training program, counselors were
then assigned to lead or co-lead their own groups. New trainers were recruited from within the new groups in pyramid fashion. Reported outcome of this innovative project is in the form of questionnaire responses from clients, peer counselors, and professional staff. Generally, responses were positive. Clients report improvement in self-regard, interpersonal relationships, and flexibility in new situations. Group leaders reported observing improved social interaction, willingness to self-disclose, and neater personal appearance. Staff observers were similarly favorable.

Descriptive reports of projects using elderly volunteers as peer counselors have appeared in the recent literature. Campbell and Chenoweth (1980) employed volunteers to lead group discussions following formal presentations of relevant topics. Gattshall (1978) trained elderly peer counselors in communication skills, empathic listening, problem solving, and comprehensive knowledge of available social and medical services. The peer counselors functioned as case managers and became a major referral source for low income elderly community residents. Bolton and Dignum-Scott (1979) used trained peer counselors to serve as role models for their peers and to facilitate appropriate assertiveness and problem-solving in their clients. Haber (1982) developed the Senior Campanion Program which trained elderly participants to provide emotional support, advice and referral information to their peers.
Emotionally readjusted elderly widows have been paired with newly widowed clients (Parham, Romaniuk, Priddy, & Wenzel, 1980; Silverman & Cooperband, 1975). These peer counselors were reportedly effective in helping the clients work through their bereavement and reintegrate back into the community as a person without a partner.

Conclusions reached in all of the above mentioned studies agree that elderly people are able to learn facilitative skills and to utilize them effectively with their peers. Substantial improvement in self-esteem, self-understanding, and establishing of warm relationships with others was reported for both clients and peer helpers alike. In addition, Bond (1982) found volunteerism to be positively correlated with life satisfaction among the elderly.

Innovative and creative programs such as these point the way to a means of tapping an enormous potential in our senior citizenry. Up to this point, however, the outcome data is essentially impressionistic and subject to the familiar criticisms which plague most treatment outcome studies (Bergin & Garfield, 1971). Absence of control groups, variable training and treatment periods, and vaguely specified procedures make realistic evaluations of effectiveness untenable and replication impossible. Thus, confident appraisal of the utility of elderly paraprofessional counselors awaits further, more systematic investigation.
Just as we have chosen not to avail ourselves of the potential talents of the elderly, so have we overlooked an equally bountiful population—adolescents. Could adolescent volunteers function as psychotherapeutic agents to the elderly? Review of relevant studies, again poorly controlled and methodologically flawed (Scott & Warner, 1974), suggests that they possess such potential (Anderson, 1976). Young people in the elementary, secondary, and college level years have been employed as peer counselors. The majority have been conducted at the college level (Scott & Warner, 1974). Adolescent peer counseling programs have been established to be used in a variety of ways. They are used in drug treatment and prevention (Pyle, 1977) to develop interpersonal and social skills (Buck, 1977; Fine, Knight-Webb, & Vernon, 1977), for academic adjustment (Fremouw & Feindler, 1978), and simply to be helpful companions (McCann, 1975). Communication skills, emphasizing empathy, warmth, and non-judgemental acceptance have reportedly been learned and utilized effectively by high school trainees (Cherchia, 1974; Haynes, 1979). In one program (Hamburg & Varenhorst, 1972; Varenhorst, 1974), secondary school students were taught facilitative skills and counseling strategies. They were then assigned to work in a one-to-one relationship with a younger child. Results were reported as uniformly positive with respect to academic improvement, increased social involvement, and decreased behavioral problems in both the helpees and the helpers. The
importance of residual gains to the peer counselor were underscored by Ayal and Bekerman (1978).

The underlying principle providing the rationale for using nonprofessional personnel is that many lay people possess some of the personal characteristics necessary for effective counseling. The consensus of those who have worked with adolescents in this regard is that they satisfy the core conditions (Rogers, 1957, 1975) and can translate them into practice. Common practice has been to train and supervise adolescents to work with peers. However, there is no theoretical argument that would mitigate their potential effectiveness with the elderly population. Simply stated, establishment of a facilitative relationship based on genuine concern, warmth, and empathic understanding is fundamentally therapeutic across chronological barriers.

One project, described by Sobey (1970), used adolescents involved in milieu treatment with older mental patients. They were reportedly successful in teaching home management and personal adjustment skills required by the elderly mental patient upon returning to the community. He cited the "enthusiastic concern" of the youthful helpers in encouraging the patients to revive long forgotten coping strategies.

The special qualities inherent in the young have been echoed by Gruver (1971) as being significant factors in their helping potential. He describes their vitality and spontaneity as disarming features which can have a positive
influence in the helping role. Their own developmental search for identity and independence might engender a more empathic response to the distressed patient. And finally, the cause of serving the less fortunate may appeal to their idealism. This researcher has received reports from nursing home staff that the nursing home residents seem to respond more noticeably when young people visit. As was the case with regard to elderly lay people, the evidence is suggestive, though not conclusive, that trained and supervised adolescent volunteers can serve a valuable function in meeting the emotional needs of the elderly population.

This study is intended to determine the effectiveness of elderly and adolescent volunteers comparably trained in the helping skills. The counselor skill selected for training was accurate empathy. Considerable debate centering around the construct of empathy and its measurement has prevailed for some time (Chinsky & Rappaport, 1970; Gladstein, 1970, 1977). However, there is substantial evidence establishing its significance in therapy (Rogers, 1975; Truax & Mitchell, 1971) and its construct validity (Conklin & Hunt, 1975).

Method

Subjects

The target patient population consisted of 60 residents (16 male, 44 female) selected from three area nursing homes.
Ages ranged from 64 to 86 years with a mean age of 74. Patients' names were provided by nursing home staff familiar with the diagnostic criteria and were screened and evaluated to determine their appropriateness for inclusion in the study. Each resident was given the Mental Status Questionnaire and the Simultaneous Bilateral Physical Stimulation Test as measures of organic brain syndrome (Yesavage, 1979) (See Appendix A). Patients whose score on these measures fell in the moderate to severe range of neurological impairment were eliminated from further investigation. In addition, residents presenting with overt psychotic symptomatology, i.e., presence of hallucinations, delusions, or manifest thought disorder, were ruled out and referred for more appropriate interventions. Eligible patients were then given the Self-Rating Depression Scale (SDS) (Zung, 1965) to measure their level of depression (See Appendix B). Subjects whose SDS raw score fell in the 40 to 61 range were included in the study as this range represents mild to marked depression (Zung, 1967). Subjects whose SDS raw score was 62 or greater (severe to most extremely depressed) were referred to mental health staff for further treatment. One additional assessment measure was administered once the resident satisfied the screening criteria. This was the Philadelphia Geriatric Center Morale Scale (Lawton, 1975) (See Appendix C). This is a 17 item true or false questionnaire. As general guidelines scores of 13 to 17 would be considered high, scores 10-12 fall
within the mid-range, and scores under 9 are at the low end of the scale.

Resident social interaction in a small rural nursing home is frequent. Therefore, the danger in confounding results vis-a-vis differential contact with community volunteers presented a problem. Consequently, the no treatment control patients (n = 20) were selected from a different nursing home (Cedars Nursing Home, Charlottesville, VA.) than those who were assigned a volunteer. The original program format called for all of the eligible patients to be served in one nursing home (Orange Nursing Home) by volunteers from one county (Orange, VA.). Unfortunately, low volunteer turnout necessitated that an alternate site (Culpeper County Nursing Home) be found to reach criteria. Table 1 shows the proportion of nursing home patients who were screened and their disposition in terms of qualifying for inclusion in the study.

It can be seen that the percentage of patients screened and found to be qualified in the Culpeper (60%) and Cedars (66%) nursing homes is far higher than that of Orange (42%). In Orange, the original goal was to identify 40 qualified residents for participation in this study. The nursing home staff were familiar with the screening criteria and directed the screeners to the most likely candidates first. However, after the first 20-25 subjects were identified the screening
Table 1

Outcome of Screening Procedures in Three Nursing Homes

<table>
<thead>
<tr>
<th>Nursing Home</th>
<th># of Beds</th>
<th># Screened</th>
<th>Qualified</th>
<th>MSQa</th>
<th>Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orange</td>
<td>120</td>
<td>79</td>
<td>34</td>
<td>26</td>
<td>19</td>
</tr>
<tr>
<td>Culpeper</td>
<td>32</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Cedars</td>
<td>150</td>
<td>30</td>
<td>20</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>

Note. Subject qualifies if MSQ is passed and Zung SDS depression raw score > 40.

aMSQ = Mental Status Questionnaire (Yesavage, 1979)

process expanded in an attempt to reach n = 40. Consequently, a greater number of ineligible residents were screened. The Culpeper and Cedars nursing home staff also directed the screeners to probable qualifiers. Because the number of subjects needed to qualify was smaller, the higher proportion of positive identifications was obtained.

Volunteer Counselors

Volunteer counselors were recruited from each of two populations. The younger group (n = 20) was comprised of
11 males and 9 females whose ages ranged from 14 to 18 years (M age = 15.0). These were local middle school and high school students who generally were either in an educational tract designed for the helping professions (e.g. nurses' aides) or were college bound. The older volunteer group (n= 20) was comprised of 2 males and 18 females generally recruited from various senior citizen organizations. Ages ranged from 60 to 74 (M= 67.1) with the majority having some high school education (M = 10.4 years). Although many of the volunteers had previous experience doing volunteer work, none had any previous specialized training in counseling or communication skills.

Procedure

Volunteer Training Conditions. Volunteer counselors were assigned to one of two conditions. A skills training treatment group consisted of ten older volunteers (OS group) and ten younger (YS group) volunteers. A Counselor Education group was comprised of ten older (OE) and ten younger (YE) volunteers. This group was designed to function as an attention-placebo control group.

Skills Training Group. The OS and YS groups participated in a two day workshop held on consecutive Saturdays, for six hours each day. The training program was adapted from Gerontology Practitioner Training Manual: Communication Skills in the Gerontological Environment (Greenburg, Fatula,
Hameister, & Hickey, 1976), a program modeled on Carkhuff's (1969) curriculum for lay counselors designed for the geriatric population. Two components were stressed: one involved the learning and practicing of the counseling skills defined as accurate empathy, the other stressed the basic process of aging in order to free the counselors from stereotypic and mythological thinking about the behavior and needs of older persons. A complete description of this training workshop is provided in Appendix D. Briefly, this program was designed to provide both didactic and experiential learning in the fundamental components of facilitative human relations. Particular emphasis was placed on effectively communicating empathy towards others. The training paradigm primarily consisted of triad and dyad exercises specifically designed to teach reflective listening and its derivatives.

Counselor Education Group. The older education (OE) and younger education (YE) groups also participated in Saturday workshops for a comparable period of time. These workshops, however, kept their focus almost entirely on the process of dispelling the myths and stereotypes of the elderly held by the participants. Didactic material on the aging process, effects of loss, and the special needs associated with growing old were covered. Group discussions centered around values clarification and expression of feelings generated by their own experiences with growing older. Written material and film presentations reinforcing
the dignity and potential of the aged were presented and discussed. These group discussions and didactic materials were designed to impart an accurate understanding of the difficulties associated with growing old. Also, they allowed participants to become more aware of their own values and attitudes regarding the elderly. They did not, however, involve direct training and practice in the communication of empathic responses. Apart from the modeling inevitably presented by the trainers themselves, no specific experience in empathic responding was provided. A complete description of the procedures followed for the attention-placebo workshop, called the Counselor Education Manual, is provided in Appendix E.

It is recognized that closer scrutiny of the "attention-placebo" group raises questions regarding whether this group may be accurately defined as "placebo." This group was given rather detailed exposure to the process of aging and the emotional concomitants often experienced by the aged. It can be argued that this education group constituted a separate treatment modality in that the information provided served as a valid counselor training paradigm. Critical review of the empathy training literature (e.g. Gladstein, 1970 & 1977; Gormally & Hill, 1974; Lambert & DeJulio, 1977) cite failure to control for the non-specific effects of counselor training as a common flaw. Such components as
counselor motivation and expectations, and degree of perceived usefulness are rarely comparable among groups.

In this study, the pragmatics involved in meeting the needs of counselor, counselee, and service agencies dictated that the education group receive more than twelve hours of wholly innocuous and irrelevant material. Thus, they received material designed to foster a cognitive understanding of the potential problems encountered by their prospective counselee but no specific training in effectively transmitting the affective/cognitive material to the client. This, of course, is argued as being crucial to the facilitative process (Carkhuff, 1969, Rogers, 1975; Truax & Mitchell).

Recruitment and Training. Prior to the start of the first volunteer workshop the names of 30 adolescents and 20 senior citizens were randomly assigned to each of the two training conditions. On the day of the first workshop only 7 of the 15 adolescents and 6 of 10 seniors appeared. That number was reduced to 2 adolescents and 4 senior volunteers completing the program. Subsequent attempts proved equally disappointing. The attrition rate of individuals failing to follow through in their training was such that pragmatics forced a departure from the original design. Rather than the planned procedure of running two large workshops each comprised of 10 younger and 10 older randomly assigned volunteers the strategy changed to running a series of small
workshops until the criterion number of younger and older volunteers was attained.

This process expanded a period of 18 months in which five workshops (2 skills, 3 education) were presented. In addition, four other workshops were planned, promoted, and subsequently aborted due to lack of response. In all, a total of 60 adolescents and 35 older people indicated an initial interest. As can be seen in Table 2 the actual turnout was far less and those who completed the program were even fewer.

Table 2

Attrition Rate of Elderly and Younger Volunteers Attending Two Types of Counselor Training Programs

<table>
<thead>
<tr>
<th>Condition</th>
<th>Workshop 1</th>
<th>Workshop 2</th>
<th>Workshop 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills(^a) Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>2</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Older</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Education(^b) Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>4</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Older</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Note. C = Completed program. D-0 = Dropped Out. Third workshop not required for skills group.

\(^a\)Empathy skills training group

\(^b\)Information only group
An adjustment which proved useful for the adolescents was the provision for extra credit in certain classes as an incentive. After the second education workshop series the criterion number of adolescents was obtained but there was still a shortage of six senior volunteers. The Orange County community had been aggressively canvassed and so an alternative pool of volunteers was sought. This brought about the inclusion of a third, smaller nursing home in Culpeper County, Virginia and the recruitment of the remainder of the volunteers.

**Empathy Pre-Test.** Prior to entry into these workshops, a pretest of counselor's level of therapeutic skills was administered to all volunteers. Two videotapes were made showing, respectively, an older female and a younger female, who each read five statements high in affective content. Videotaped instructions directed the subjects to respond to each statement on the tape as they would to a client. Half of the subjects in each group viewed the older female client's tape before training and the younger client's after the two day workshop. The order of the tapes was reversed for the older subjects. No time limit was required in responding and the responses were tape recorded. The tapes were then blind-rated by two mental health therapists who had been trained in the rating of the therapeutic conditions. The Carkhuff Scale for Empathic Understanding in Interpersonal Processes (Carkhuff, 1969) was selected as the measure of
counselor responses. This scale has five levels with the third level being regarded as the minimum necessary for a therapeutic encounter.

Empathy Posttest. After completion of each workshop all participants were again rated on the Carkhuff Empathy Scale. Ratings for members of the education group were recorded and subjects were then randomly assigned to their nursing home resident.

In order to ensure that both OS and YS groups were equally proficient in the use of the communication skills, a criterion level of empathic responding was imposed. All subjects were required, upon posttesting, to have scored a rating of three or more.

It was prearranged that subjects whose responses on the tape or whose behavior in the workshop was determined inappropriate for interaction with patients would be dismissed from the program. It was also planned that a skills group counselor who scored less than a 3.0 would be retained for further training until criterion was achieved. No volunteers were dismissed or required empathy retraining.

The residents were identified and assigned a volunteer as the training groups were formed. Screening occurred in the week following the workshop sessions so that the number to be screened would be accurate. This served two purposes: 1) to ensure that pre-post periods were comparable; and 2) to avoid promising a volunteer to a resident and then not having one available.
Treatment Period. Having reached their respective criteria, counselors from both the skills training and education groups met with their nursing home resident for one hour, two times per week, for five weeks. Education group counselors engaged in various recreational and social activities with their counselee and generally maintained a companionship role. Counselors in the skills training group endeavored to utilize their communication skills to facilitate expression of emotional concerns and to establish a therapeutic alliance.

In addition, counselors attended a group supervision session for one hour per week. Education group supervision sessions were structured to reinforce didactic material and allow discussion of volunteer reactions to their counseling experiences. These groups were designed primarily to foster group cohesiveness and a mutually reinforcing support system.

The weekly supervision sessions attended by the skills training group were primarily focused on continued training in facilitative responding. Role play exercises, derived from experiences encountered with their counselee, reinforced their learning. Group members also were encouraged to express their own feelings regarding their experiences and to function as a support group.

Treatment Outcome. After the five week counseling period for both the treatment group and attention placebo group
the nursing home residents were posttested on the two affective
response measures. The Zung SDS and Philadelphia Geriatric
Center Morale Scale were again administered. The no-treatment
control group was simply re-tested after five weeks without
intervention beyond their regularly delivered services.

Results

Preliminary Tests

Given the numerous problems in the implementation of
this program, a series of test analyses were performed to de-
termine whether the assumptions of comparability among volunteer
and resident parameters were violated. A Chi Square analysis
was performed on the dropout rate within each workshop as
reported in Table 2. The purpose was to examine the possi-
bility that any one workshop had a significantly higher or
lower attrition rate for any reason. A 2x5 contingency
Chi Square analysis indicated that there were no significant
differences in dropout rate from workshop to workshop,
\[ X^2 (4, N = 64) = 9.19, p > .05. \]

Tests of inter-rater reliability of empathic responses
resulted in a Pearson \( r \) of .8438 for pretest and .9333 for
posttest of all volunteers (\( N = 40, p < .001 \)). For the various
dimensions associated with the volunteers it was found that
empathy pretests showed no difference in empathy ratings
across the five workshops, \( F (4, 35) = 1.03, p > .05. \) Within
the education group there were no differences between the
Culpeper volunteers and the Orange volunteers taken as a whole, $t(18) = 1.16$, $p > .05$, or in comparing the two senior subgroups, $t(8) = 0.26$, $p > .05$. Hence it was possible to collapse the subject population across workshops and to statistically pool the volunteer empathy responses.

Pre and posttest mean empathy ratings are shown in Table 3. Tests of apriori predictions were made finding that the skills training group and the education group were not significantly different at pretest, $t(36) = -0.8346$, $p > .05$. The skills training group increased their empathy rating such that they were significantly more empathic than their pretest score $t(36) = -13.3507$, $p < .001$, and also higher than the education group's posttest rating $t(36) = 6.3533$, $p < .001$. The pre and posttest ratings of the education group showed no significant difference, $t(36) = -1.5274$, $p > .05$.

Table 3
Comparison of Pretest and Posttest Empathy Ratings as a Function of Counselor Training Model

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
<th>Pretest M</th>
<th>Pretest SD</th>
<th>Posttest M</th>
<th>Posttest SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills Group</td>
<td>20</td>
<td>2.088</td>
<td>.56</td>
<td>3.469*</td>
<td>.34</td>
</tr>
<tr>
<td>Education Group</td>
<td>20</td>
<td>2.230</td>
<td>.51</td>
<td>2.388</td>
<td>.56</td>
</tr>
</tbody>
</table>

*aEmpathy skills training group

*bInformation only group

*p < .001
In order to test for differences among the various age and training variables a $2 \times 2 \times 2$ split plot ANOVA with repeated measures was performed (see Table 4). There were no differences between the four groups at pretest, $F(3, 36) = 0.76, p > .05$. Significant main effects were found for training, $F(1, 36) = 9.35, p < .004$, and time, $F(1, 36) = 110.95, p < .001$, but the age variable was found not to be significant, $F(1, 36) = 0.35, p > .05$. Furthermore, a significant training by time interaction was found, $F(1, 36) = 76.05, p < .001$.

Table 4

Comparison of Pretest and Posttest Empathy Ratings as a Function of Counselor Age and Training Model

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Empathy</td>
<td></td>
</tr>
<tr>
<td>Skills$^a$</td>
<td></td>
<td>Pretest</td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>10</td>
<td>2.037</td>
<td>.57</td>
</tr>
<tr>
<td>Older</td>
<td>10</td>
<td>2.139</td>
<td>.57</td>
</tr>
<tr>
<td>Education$^b$</td>
<td></td>
<td>Pretest</td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>10</td>
<td>2.152</td>
<td>.48</td>
</tr>
<tr>
<td>Older</td>
<td>10</td>
<td>2.307</td>
<td>.53</td>
</tr>
</tbody>
</table>

$^a$Empathy skills training group

$^b$Information only group

*p < .001
The main conclusion to be drawn from these analyses was that, as anticipated, the empathy training did have the desired outcome on the counselor trainees. It also demonstrated that this training was equally suited to both the adolescent and senior volunteer groups.

At the end of each of the two workshop sessions a Workshop Rating Form (See Appendix F) was completed by every volunteer. This form included seven 5-point Likert scale items which asked the volunteers to rate (a) their level of interest, (b) quality of material learned, and (c) degree of applicability. Using the average rating across the two workshops for each volunteer as the dependent measure, a series of tests for differences was made.

First, a one-way ANOVA across the five workshops was conducted. Results showed no significant differences were found between the groups, $F(4,35) = 1.3, p > .05$. It was determined that each of the five workshop presentations were received with comparable enthusiasm. Effects of having different trainers conducting the workshops, different group compositions, and other uncontrolled variables did not significantly affect the volunteers perceived usefulness of the material or relevance to their duties.

Comparison tests were also made among the treatment group and age variables with no significant differences obtained. Volunteers from the two skills training groups and from the three counselor education groups were equally
satisfied with their training experience and felt equally prepared to engage with a nursing home resident, $t(18) = 0.28, p > .05$. Similar results were found between the younger and older volunteers, $t(18) = 0.14, p > .05$.

Comparisons were made of the nursing home residents who received volunteers trained in the five different workshops. A one way ANOVA comparison of the pretest depression scores on the Zung SDS showed that the groups were essentially equivalent (i.e., no statistical differences) in terms of level of depression, $F(4, 35) = 0.82, p > .05$ (see Table 5).

Table 5
Pretest Depression Scores of Nursing Home Residents Paired with Volunteers from Two Training Models

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
<th>Zung SDS Pretest</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Skills Group (A)</td>
<td>6</td>
<td>46.16</td>
<td>3.97</td>
</tr>
<tr>
<td>Skills Group (B)</td>
<td>14</td>
<td>47.57</td>
<td>5.02</td>
</tr>
<tr>
<td>Education Group (A)</td>
<td>6</td>
<td>46.00</td>
<td>3.09</td>
</tr>
<tr>
<td>Education Group (B)</td>
<td>8</td>
<td>44.75</td>
<td>3.89</td>
</tr>
<tr>
<td>Education Group (C)</td>
<td>6</td>
<td>48.33</td>
<td>3.59</td>
</tr>
</tbody>
</table>

Note. Administered Zung Self-Rating Depression Scale (Zung, 1965)

aEmpathy skills training group

bInformation only group
Comparisons of the depression pretest scores of the Culpeper Nursing Home residents were made to the Orange Nursing Home subjects as a whole, those who received an elderly volunteer, and those who received an OE volunteer. The results in all cases were not significant, $F(3, 54) = 0.74, p > .05$.

Table 6

Pretest Depression Scores of Culpeper Nursing Home Residents Compared with Orange Nursing Home Residents Across Treatment Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culpeper NH</td>
<td>6</td>
<td>48.3</td>
<td>3.59</td>
</tr>
<tr>
<td>OE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange NH</td>
<td>4</td>
<td>45.0</td>
<td>2.55</td>
</tr>
<tr>
<td>OE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange NH</td>
<td>14</td>
<td>45.7</td>
<td>3.41</td>
</tr>
<tr>
<td>All Senior Volunteers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange NH</td>
<td>34</td>
<td>45.38</td>
<td>4.51</td>
</tr>
<tr>
<td>All Volunteers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Administered Zung Self-Rating Depression Scale (Zung, 1965).

OE = older education group
A repetition of the pretest analyses was performed using the Philadelphia Geriatric Morale Scale and yielded similar non-significant results $F(3, 54) = 1.66, p > .05$, (see Table 7). The Culpeper Nursing Home residents were then included in the subject pool for all subsequent analyses.

Table 7
Pretest Morale Scores of Culpeper Nursing Home Residents Compared with Orange Nursing Home Residents Across Treatment Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
<th>Pretest M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culpeper NH</td>
<td>6</td>
<td>11.6</td>
<td>2.28</td>
</tr>
<tr>
<td>OE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange NH</td>
<td>4</td>
<td>7.75</td>
<td>3.49</td>
</tr>
<tr>
<td>OE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange NH</td>
<td>14</td>
<td>9.6</td>
<td>3.17</td>
</tr>
<tr>
<td>All Senior Volunteers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange NH</td>
<td>34</td>
<td>11.5</td>
<td>3.47</td>
</tr>
<tr>
<td>All Volunteers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Administered Philadelphia Geriatric Center Morale Scale (Lawton, 1975).

OE = older education group
Differences in nursing home policies and procedures in regard to disclosure of patient information rendered data collection of demographic information and medical history insufficient for analysis. Both depression and morale pretest results established that these groups were not significantly different. Therefore, it could be assumed that any confounding variables would be randomly distributed across all three patient groups.

**Treatment Outcome**

A 3 x 2 split plot ANOVA with repeated measures was performed using the pre and posttest measures of the Zung Self-Rating Depression Scale (SDS). This analysis found significant main effects for Type of Training, $F(2,57) = 5.33, p < .01$, and Time, $F(1,57) = 38.7, p < .001$, and a significant Training x Time interaction, $F(2,57) = 5.61, p < .01$.

A series of comparison tests were then conducted of apriori predictions made concerning the nature and direction of significance of the various treatment conditions. A total of nine tests were performed. While they may be evaluated for significance at the nominal alpha level (1 tail), in order to control for chance significance one takes $0.05/9 = 0.0055$ as the significance level for the family of tests. Table 8 presents the various comparisons and their outcomes.
<table>
<thead>
<tr>
<th>Comparison</th>
<th>Zung SDS</th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>(1 tail)</td>
<td>(2 tail)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td>t(57)</td>
<td>P</td>
<td>P</td>
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<tr>
<td>Skills(^a) Pre vs Skills</td>
<td>45.60</td>
<td>4.77</td>
<td>39.80</td>
<td>6.62</td>
<td>5.8166</td>
<td>.0005</td>
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<tr>
<td>Post</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educ(^b) Pre vs Educ</td>
<td>46.05</td>
<td>3.65</td>
<td>42.20</td>
<td>4.25</td>
<td>3.8610</td>
<td>.0005</td>
<td>.001</td>
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<tr>
<td>Post</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Pre vs Control</td>
<td>49.60</td>
<td>6.97</td>
<td>48.50</td>
<td>6.20</td>
<td>1.1031</td>
<td>.15</td>
<td>.30</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills Pre vs Educ Pre</td>
<td>45.50</td>
<td>4.77</td>
<td>46.05</td>
<td>3.65</td>
<td>-0.208</td>
<td>.10</td>
<td>.20</td>
</tr>
<tr>
<td>Pre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills Pre vs Control Pre</td>
<td>45.60</td>
<td>4.77</td>
<td>49.60</td>
<td>6.97</td>
<td>-1.8527</td>
<td>.05</td>
<td>.10</td>
</tr>
<tr>
<td>Pre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educ Pre vs Control Pre</td>
<td>46.05</td>
<td>3.65</td>
<td>49.60</td>
<td>6.97</td>
<td>-1.6443</td>
<td>.10</td>
<td>.20</td>
</tr>
<tr>
<td>Pre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Comparison</td>
<td>Zung SDS</td>
<td></td>
<td></td>
<td></td>
<td>t(57)</td>
<td>p</td>
<td>p</td>
</tr>
<tr>
<td>---------------</td>
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<td>---</td>
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<td>-------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skills Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vs Educ Post</td>
<td>39.80</td>
<td>6.62</td>
<td>42.20</td>
<td>4.26</td>
<td>-1.1116</td>
<td>.15</td>
<td>.30</td>
</tr>
<tr>
<td>Skills Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vs Control Post</td>
<td>39.80</td>
<td>6.62</td>
<td>48.50</td>
<td>6.20</td>
<td>-4.0296</td>
<td>.0005</td>
<td>.001</td>
</tr>
<tr>
<td>Educ Post</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>vs Control Post</td>
<td>42.20</td>
<td>4.26</td>
<td>48.50</td>
<td>6.20</td>
<td>-2.9180</td>
<td>.005</td>
<td>.01</td>
</tr>
</tbody>
</table>

Note. Administered Zung Self-Rating Depression Scale (Zung, 1965).

*aEmpathy skills training group

*bInformation only group

This body of tests indicates that residents who were seen by volunteer counselors from both the skills group and the education group improved on depression scores from pretest to posttest, whereas this was not true for the no-treatment control group.

None of the groups differed at pretest. At posttest the empathy trained counselor's group and the education group
both differed from the control group significantly. However, these two groups did not differ significantly from one another at posttest.

It is noted that the degree of significance between the Skills Post vs Control Post comparison is substantially greater than the significance level between the Education Post and Control Post comparison. Further, the skills group did seem to improve more from pretest to posttest.

**Within Groups Comparisons**

A 2 x 2 x 2 split plot ANOVA was performed examining the pre and posttest performance of the younger and older volunteers in the two treatment groups. A significant main effect was found for time, $F(1,36) = 60.03$, $p < .001$, but neither type of training, $F(1,36) = 0.53$, $p > .05$, or age of counselor, $F(1,36) = 2.54$, $p > .05$, were found to be significant (See Table 9). Further, there were no interaction effects found $F(1,36) = 0.71$, $p > .05$. Collapsing the age groups across treatment modalities in a 2 x 2 ANOVA (See Table 10) indicated there were no significant differences in counseling effectiveness as a function of age, $F(1,36) = 2.98$, $p > .05$. 
Table 9
Comparison of Pretest and Posttest Mean Depression Scores as a Function of Counselor Age and Training Model

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Zung SDS</td>
<td></td>
<td>Zung SDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pretest</td>
<td></td>
<td>Posttest</td>
<td></td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td>a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>10</td>
<td>48.3</td>
<td>5.44</td>
<td>44.1</td>
<td>7.40</td>
</tr>
<tr>
<td>Older</td>
<td>10</td>
<td>42.9</td>
<td>3.66</td>
<td>35.5</td>
<td>4.14</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>10</td>
<td>45.4</td>
<td>3.38</td>
<td>42.1</td>
<td>4.04</td>
</tr>
<tr>
<td>Older</td>
<td>10</td>
<td>46.7</td>
<td>3.79</td>
<td>42.3</td>
<td>3.57</td>
</tr>
</tbody>
</table>

**Note.** Administered Zung Self-Rating Depression Scale (Zung, 1965)

aEmpathy skills group
bInformation only group
Table 10

Comparison of Mean Depression Outcome Scores as a Function of Age of Volunteer Counselor

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Younger Volunteers</td>
<td>20</td>
<td>46.85</td>
<td>4.75</td>
<td>43.10</td>
<td>6.37</td>
</tr>
<tr>
<td>All Older Volunteers</td>
<td>20</td>
<td>44.80</td>
<td>3.74</td>
<td>38.90</td>
<td>4.27</td>
</tr>
</tbody>
</table>

Note. Administered Zung Self-Rating Depression Scale (Zung, 1965).

Morale. A 3 X 2 split plot ANOVA with repeated measures was performed (see Table 11). A significant main effect was found for the time variable. At posttest, morale scores were significantly lower than at pretest $F(2, 57) = 8.86$, $p < .01$. No other main effects or interactions were significant. In the absence of other significant findings, further tests of group differences would prove superfluous.
Table 11

Comparison of Mean Morale Outcome Scores in Three Treatment Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
<th>Pretest M</th>
<th>SD</th>
<th>Posttest M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills Group</td>
<td>20</td>
<td>10.3</td>
<td>3.90</td>
<td>11.65</td>
<td>3.44</td>
</tr>
<tr>
<td>Education Group</td>
<td>20</td>
<td>10.15</td>
<td>2.45</td>
<td>11.15</td>
<td>2.88</td>
</tr>
<tr>
<td>No Treatment Group</td>
<td>20</td>
<td>11.25</td>
<td>2.86</td>
<td>12.00</td>
<td>3.11</td>
</tr>
</tbody>
</table>

Note. Administered the Philadelphia Geriatric Center Morale Scale (Lawton, 1975).

*a* Empathy skills training group

*b* Information only group

A 2 X 2 X 2 split plot ANOVA with repeated measures was performed to analyze for effects of age of volunteer and type of training received (see Table 12).
Table 12

Comparison of Pretest and Posttest Mean Morale Scores as a Function of Counselor Age and Training Model

<table>
<thead>
<tr>
<th>Condition</th>
<th>n</th>
<th>Pretest M</th>
<th>SD</th>
<th>Posttest M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills^a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>10</td>
<td>11.0</td>
<td>3.92</td>
<td>12.0</td>
<td>3.89</td>
</tr>
<tr>
<td>Older</td>
<td>10</td>
<td>9.6</td>
<td>3.72</td>
<td>11.3</td>
<td>2.69</td>
</tr>
<tr>
<td>Education^b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger</td>
<td>10</td>
<td>10.2</td>
<td>2.40</td>
<td>11.9</td>
<td>2.70</td>
</tr>
<tr>
<td>Older</td>
<td>10</td>
<td>10.1</td>
<td>2.51</td>
<td>10.4</td>
<td>2.87</td>
</tr>
</tbody>
</table>

Note. Administered the Philadelphia Geriatric Center Morale Scale (Lawton, 1975)

^aEmpathy skills training group
^bInformation only group

As in the first analysis, a significant main effect was found for the time variable with a significant decrease in morale scores at posttest when compared to pretest $\bar{F}(1, 36) = 6.94, p < .01$. No other effects proved significant.

The results of the analyses of morale data indicated only that, at posttest, morale improved. There were no significant
effects for the type of training required. Nor did training interact with time. Neither counselor age nor type of training were shown to have an effect on morale.

Discussion

Despite the administrative difficulties encountered by this researcher, two unambiguous conclusions may be drawn from this study: 1) both senior citizen and adolescent volunteers are capable of learning and effectively utilizing empathy listening skills in in vivo counseling sessions and 2) volunteer counselors, whether elderly or adolescent, are demonstrably effective therapeutic agents in helping to improve affective responses in elderly patients.

Consistent with the work of Isquick (1981) and Waters, Fink, and White (1976) the senior volunteers who completed the training program became proficient in the appropriate use of reflective listening. This challenges the popular conception that elderly people are resistant to new learning. One explanation could be that the more receptive individuals remained in the program and that the varied format of the training program (which included didactic, experiential, film and written material) provided an enriched learning environment. A similar process likely took place among the adolescent volunteers where the ones most suited to the program (and, therefore, to working with a depressed patient) were the ones who completed the project. Although a confounding
variable as far as purity of research design, this self-
selection process perhaps served as a protective mechanism
in the interest of the nursing home resident. The consequence
is that the degree to which the results can be generalized
is restricted to highly motivated, altruistic volunteers
already possessing Rogerian empathy.

The Alpha level chosen for statistical significance
was set at a conservative level and so the results are
convincing. Compared to no treatment controls, nursing
home residents who receive regular visits from a volunteer
counselor are significantly more likely to improve in level
of depression. With considerable strength, it was demonstrated
that volunteers engaging in a helping relationship can provide
the catalyst for therapeutic change. It was also shown that
both elderly and adolescent counselors are comparable in
skill and outcome.

No statistical differences were obtained in comparison
tests between the empathy skills trained group and their
"education only" counterpart. These results do not support
the hypothesis that empathy trained volunteers are more
effective counselors than an "attention-placebo" control group.
However, the skills group subjects improved to a greater degree
over the controls than did the education group and in fact the
mean posttest score fell below the depression threshold on the
Zung SDS.

Anecdotal feedback regarding the supervisory sessions
implied support for the empathy training paradigm. Where the
education group tended to be superficial and activity oriented, the skills group consistently honed in on client affect and deeper emotional issues. In terms of general clinical practice the former is considered the superior accomplishment.

Several indicators emerged which suggest a direction to follow in future research. The changes in depression score occurred over a treatment period of five weeks. Perhaps a longer trial period would have accentuated the results and a three month follow-up could measure outcome stability. The Zung SDS was used to screen eligible subjects and was the dependent variable. Restricting the range of Zung SDS pretest scores likely attenuated the difference scores at posttest. This raises practical questions regarding the generalizability of statistical depression score differences versus observable clinical differences. Since factor loadings on the Zung stress both emotional and somatic components (Freedman, Bucci, & Elkowitz, 1982; Zung, 1967), it is likely that dysphoric mood symptoms are more susceptible to counselor influences than are vegetative symptoms. Comparison tests by factor loading which are correlated with a behavior checklist would yield results with the most clinical utility.

The Morale variable did not show an association with the presence or absence of a volunteer. The morale instrument was included to obtain a broader range of affective response measures as supportive data and no hypotheses were generated. Apparently, morale or life satisfaction,
can fluctuate somewhat independently of more pervasive and clinically significant depression.

**Delimitations**

A problem of interpretation of these results arises out of the ambiguity of the role of the Counselor Education group as an "attention-placebo". The education group emerged from their 12-hour workshop series perceiving themselves as equally prepared and enthusiastic about their role as a counselor as the skills group volunteers. They also received direct factual information designed to increase their knowledge and appreciation of the aging process. Where this is an improvement over previous designs (Gormally and Hill, 1974), the present study may be criticized on two counts: 1) Without a truly innocuous attention-placebo group it cannot be ascertained whether the clinical gains which were obtained were not simply a function of time spent with another person. 2) Since there were, in effect, two treatment groups, the design did not control for trainer effects. That is, better results obtained in one group may have been due to superior trainers rather than a superior training paradigm.

To account for these factors the design would have had to include a third "no training" placebo group and then run several workshops systematically counterbalancing the trainers across treatment modes. This procedure was hardly practical and so the criticisms stand.
Certain assumptions of standardization of treatment may be questioned due to the fact that the nursing home residents were derived from separate local nursing homes. These nursing homes all conformed to the same state and county regulations and each drew their residents from the same Central Virginia region. But it is recognized that systematic spurious effects could be associated with place of residence. Conceivably one facility may be more depression inducing or depression resistant by virtue of staff personnel and procedures. However, the population of each nursing home was too small to be able to identify 60 residents who met criteria. Also, as described earlier, the residents would have been well aware of who was receiving a volunteer and this presented its own confounding problems.

More critical was that a lack of access to medical records made it impossible to correlate physical disability and medication regimen (particularly psychotropic medications) with affective change. This study assumes a randomization process across the three patient groups but the results would be more powerful if that assumption were statistically confirmed.

An unexpected development in the volunteer recruitment process was a disproportionate loading of males in the adolescent group compared to the senior citizens. Generally, the volunteer workforce for these age groups is comprised
mostly of females (Gallup, 1984). In fact, the empathy videotape vignettes featured young and old females in anticipation of female viewers. The aftermath is that the sub-group comparisons by age must be qualified in that the comparison is actually between an adolescent male/female composite versus elderly females. One can only speculate as to the significance of this distinction.

Postfact anecdotal evidence was offered in support of the skills based training paradigm over the "education only" approach. In retrospect, this point could have been more fully explored had the information been collected in some quantifiable form. It is suggested in future studies that a weekly content checklist be completed at the end of each counseling and supervision session. This checklist would include common examples of content and affect and the counselor would indicate those which were addressed in each session. These checklists could then be correlated with type of training received and therapeutic effect.

The Volunteer Program - Practicalities

The setting in which this project was undertaken is a rural, agricultural community with limited support services and a generally disadvantaged population. The implementation of the program proved to be extremely difficult due to logistical and financial constraints. The population is small and dispersed over a wide geographical area. Transportation is the bane of human services providers under these
circumstances and seriously hampered the project. In cooperation with the Retired Senior Volunteer Program (RSVP) the elderly volunteers who owned cars were reimbursed for their gas mileage but this benefitted only several of the participants.

The pattern of volunteer attrition indicated that the problem did not lie so much in the recruitment process as in maintaining their commitment. Promotional methods to gain volunteer interest included local radio and newspaper announcements and presentations in local schools, churches, youth groups, adult service organizations (e.g. Rotary Club), senior organizations, and senior nutrition sites. Many individuals expressed interest in participating and then retreated. Several factors appeared to be at work. First, the program required a significant commitment of time, energy, and emotional strength to which many individuals balked. Some of the senior citizens questioned their own physical stamina and the youngsters had extra-curricular commitments. Two full Saturdays followed by three service hours per week may have been too rigorous a format.

Second, the inherent nature of this project challenged a number of popular preconceptions and community values. In one stroke it asked: senior citizens and adolescents to work side-by-side; seniors and teens to openly explore their feelings regarding aging, death, and affective disturbance; seniors and adolescents to make an emotional investment in a
depressed, aged patient; and for seniors and adolescents to overcome the stigma associated with a mental health agency and a nursing home.

Third, Nicoletti & Flater-Benz, (1974) point out that it is critical to develop a system of incentives and rewards which reinforces volunteer interest and motivation. It is the intrinsic reinforcement that is primary but the external tokens of recognition and appreciation serve a valuable function. Such activities as social gatherings and parties, certificates of appreciation, newspaper citations, etc. bolster morale. Fiscal considerations limited the available reinforcers to letters of appreciation, college or job character references, mention in a newspaper story, and extra course credit for some of the students.

Several lessons were learned from this study which have implications for future research as well as for future community volunteer programs. The design included certain features that incorporated the suggestions of critical reviews of paraprofessional training models. The dependent measure used to determine the effectiveness of the training program was taken of the patient rather than the counselor. Also, this study included a "placebo" counselor group whose motivation and expectations were measurably equivalent in order to control for non-specific counselor effects.

Significant barriers to establishing an effective volunteer counselor program must be overcome in a rural area.
However, if overcome this study confirms that volunteers are a viable treatment alternative. The implications are that such a program could expand the quantity, quality, and modalities of services available to the elderly. If the administrative costs would permit, this study suggests the possibility of utilizing volunteers in a home visitation counseling program. Such a program would offset the reluctance on the part of the elderly to seek mental health services. This form of community outreach program could serve a primary prevention function by targeting loneliness issues which arise in advance of depressive symptomatology.

Though the attrition rate among the adolescents was particularly high, those who completed the program proved their mettle. Their effectiveness with the elderly patients suggests that further pursuit of their talents would be well served. Incorporating them into a comprehensive volunteer program would (a) expand the resource pool, (b) involve them in a redeeming educational experience and (c) provide a vehicle for bridging the ever expanding gap between the generations.
## Mental Status Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Incorrect Responses(x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the name of this place?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Where is it located (address)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. What is today's date (day of month)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. What month is it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. What is the year?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. How old are you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. When is your birthday?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. When were you born (year)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Who is president of the U.S.?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Who was president before him?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL INCORRECT:**

### Simultaneous Bilateral Physical Stimulation Test

#### A. Initial practice and teaching trials

**Order of touches by examiner**

1. Right cheek and left hand
2. Left cheek and right hand
3. Right cheek and right hand
4. Left cheek and left hand
5. Right cheek and left cheek
6. Right hand and left hand
B. Evaluation trials

<table>
<thead>
<tr>
<th>Order of touches by examiner</th>
<th>Response (circle)</th>
<th>Incorrect responses (x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Right cheek and left hand</td>
<td>R L R L</td>
<td></td>
</tr>
<tr>
<td>8. Left cheek and right hand</td>
<td>R L R L</td>
<td></td>
</tr>
<tr>
<td>9. Right cheek and right hand</td>
<td>R L R L</td>
<td></td>
</tr>
<tr>
<td>10. Left cheek and left hand</td>
<td>R L R L</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL INCORRECT:  

Trial 1  

Trial 2
Appendix B

Zung Self-Rating Depression Scale (SDS)

<table>
<thead>
<tr>
<th>Name</th>
<th>None OR a little of the Time</th>
<th>Some of the Time</th>
<th>Good Part of the Time</th>
<th>Most OR All of the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Sex</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I feel down-hearted, blue and sad  1 2 3 4
2. Morning is when I feel the best  4 3 2 1
3. I have crying spells or feel like it  1 2 3 4
4. I have trouble sleeping through the night  1 2 3 4
5. I eat as much as I used to  4 3 2 1
6. I enjoy looking at, talking to and being with attractive women/men  4 3 2 1
7. I notice that I am losing weight  1 2 3 4
8. I have trouble with constipation  1 2 3 4
9. My heart beats faster than usual  1 2 3 4
10. I get tired for no reason  1 2 3 4
11. My mind is as clear as it used to be  4 3 2 1
12. I find it easy to do the things I used to  4 3 2 1
<table>
<thead>
<tr>
<th></th>
<th>None OR</th>
<th>a little</th>
<th>Some of</th>
<th>Good Part</th>
<th>Most OR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>of the</td>
<td>of the</td>
<td>of the</td>
<td>All of</td>
<td>of the</td>
</tr>
<tr>
<td></td>
<td>Time</td>
<td>Time</td>
<td>Time</td>
<td>Time</td>
<td>Time</td>
</tr>
<tr>
<td>13. I am restless and can't keep still</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>14. I feel hopeful about the future</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>15. I am more irritable than usual</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>16. I find it easy to make decisions</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>17. I feel that I am useful and needed</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>18. My life is pretty full</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>19. I feel that others would be better off if I were dead</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>20. I still enjoy the things I used to do</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

Philadelphia Geriatric Center Morale Scale

1. Things keep getting worse as I get older.
2. I have as much pep as I did last year.
3. How much do you feel lonely?
4. Little things bother me more this year.
5. I see enough of my friends and relatives.
6. As you get older, you are less useful.
7. I sometimes worry so much I can't sleep.
8. As I get older, things are (better, worse, the same) than/as I thought they'd be.
9. I sometimes feel that life isn't worth living.
10. I am as happy now as I was when I was younger.
11. I have a lot to be sad about.
12. I am afraid of a lot of things.
13. I get mad more often than I used to.
14. Life is hard for me most of the time.
15. How satisfied are you with your life today?
16. I take things hard.
17. I get upset easily.
Appendix D

Volunteer Counselor Skills Training Manual
Volunteer Counselor Skills Training Manual

Session I - Morning (9am - 12 noon)

A. Welcome and Introductions (5 minutes)
B. Overview of Training (5 minutes)
C. Orientation to Nursing Home (30 minutes)
D. Warm-up Exercise (30 minutes)
E. Myths and Realities of Aging (45 minutes)
    Break 10:45 - 11:00
F. The Aging Process - Lecture (45-60 minutes)
    Lunch 12 noon - 1 pm

Session I - Afternoon (1 pm - 4 pm)

A. Introduction to Nonverbal and Verbal Communication:
   Trainees and Their Roles - Lecture (5 minutes)
B. Nonverbal Communication - Lectures and Exercises (70 minutes)
C. Debriefing in Small Groups (10 minutes)
    Break 2:25 - 2:35 pm
D. Verbal Communication - Part I - Lectures and Exercises (1 hr. 25 mins.)
E. Debriefing in Small Groups (5 minutes)
F. Explanation of Homework Exercises (5 minutes)
G. Reaction Forms (10 minutes)
Session II - Morning (9 am - 12 noon)

A. Recap of Session I - Large Group (10 minutes)
B. Review Homework - Small Groups (15 minutes)
C. Verbal Communication
   1. Open-Ended Questions (15 minutes)
   2. Other Responses (5 minutes)
   3. Questioning Exercise (45 minutes)

   Break 10:30 - 11:00

D. Verbal Communication - Part II
   1. Empathy - Lecture (5 minutes)
   2. Affective Responses - Lecture (5 minutes)
   3. Empathic/Affective Exercises - a through e (55 minutes)

   Lunch 12 noon - 1 pm

Session II - Afternoon (1 pm - 4 pm)

A. Exercise in Active Listening (90 minutes)

   Break 2:30 - 2:34

B. Recap of paraphrasing, feeling, responses, and open-ended questions - Large Group (10 minutes)
C. "Exercise in Helping" - Small Groups (20 minutes)
D. Roleplaying (15 minutes)
E. Wrap-up (20 minutes)
F. Reaction Forms (10 minutes)
Session I - Morning (9 a.m.-12noon)

A. Welcome and Introductions (3-5 minutes)

1. Arrange group in one large circle.

2. Representative from Mental Health Clinic to give official welcome to volunteers.

There are over 20 million elderly people in the United States today. This age group composes approximately 10% of the population. While most elderly people are physically and psychologically well, there is a minority, about 5% of the elderly, who are in nursing homes. While this 5% includes a variety of people with different needs, it is the depressed and lonely ones whom we are trying to reach in the Volunteer Counselor Education Project. We feel that working through volunteers is an excellent way to reach such people.

Volunteering is one way a community can show its support.

Volunteering has two impacts:

a) immediate job at hand gets done

b) citizens become aware of problems within the system and can make intelligent decisions about supporting change.

3. Introduce Staff and Volunteer Trainers who make it possible for volunteers to function.
B. Overview of Training

1. Operating Procedures: time, restroom, coffee, phone, parking

2. Comments on experiential training
   Large and small groups, cooperative learning, role of volunteer trainers as facilitators.

3. Volunteer manual: Format and how to use
   Bring to both training sessions.

4. Training progression
   a) Two 6-hour training sessions
   b) Randomly assigned to a resident whom you will visit for two 1-hour sessions per week for five weeks.
   c) Supervision

C. Orientation to Nursing Home - Nursing Home Staff (20-30 minutes)

1. Welcome and thanks for participation

2. Characteristics of nursing home
   a) number of staff - qualifications
   b) number of residents - % male, % female, age range
   c) typical problems which residents bring to nursing home (e.g., physical limitations, mental and emotional decline, family supports diminished)

3. Facilities and services provided by nursing home
   a) meals, shelter, etc.
   b) recreational activities
   c) social activities
4. Rules and guidelines for volunteers
   a) sign in and sign out
   b) confidentiality - no access to charts
   c) restricted areas (if any)
   d) do not assist resident out of or into bed, etc.

5. Procedures in case of emergency

D. Warm-Up Exercise (30 minutes)

   I would like you to divide into pairs (dyads) with someone here whom you don't know (or don't know very well). Please pair off so that each dyad is composed of an older person and a younger person. In the dyad I'd like you to discuss some topics that will help you to get to know each other. You might discuss such things as: 1) what you enjoy doing in your spare time, 2) what things are most important to you, 3) what you feel you do best, 4) something you're looking forward to in the future. In addition, you should explain the work experiences you've had working with the elderly. When you come back to the larger group, I want you to introduce each other to the rest of us and tell us what you learned about the other person.

E. Myths and Realities of Aging (45 minutes)

   Distribute "Aging Quotient" sheets. Ask trainees to complete the sheets and then discuss answers.

("Aging Quotient" questionnaire was obtained from:}
Elinor Waters, Adele Weaver, and Betty White,
Gerontological Counseling Skills - A Manual for Training
Service Providers, Continuum Center, Oakland University,
Rochester, Michigan, 1980, pp. 1-5 to 1-10; Appendix A,
p. 3.) Answers and discussion to "Aging Quotient"
questionnaire: (See Handout, p. 1)

1) As people age, they become less alike and more heterogeneous.

True. Variability increases with age. We have had longer to develop our individual differences. Most older people think they are better off than others their age. A new book, What Do You Want to be When You Grow Old? by Harris Dienstfrey and Joseph Lederer (1979) attests to that variability and wide choice of life styles among the older population.

2) Over 15% of the U.S. population are now age 65 or over.

False. The last year for which we have reliable statistics was 1975. At that time 10.5% of the population (22.4 million) were over 65, up from 4.1% (3.1 million) in 1900. Predictions about changes obviously depend on the birth rate. Assuming zero population growth, the older population will constitute 11.6% by the year 2000, and 13% by 2020. (Fact Book on Aging, 1978.)

3) By the year 2000, people over 65 will have better health and a higher socioeconomic status than older people do today.
True. There will be no dramatic changes in the length of the human life span within the next few decades, but instead, there will be relatively regular improvements with regard to medical knowledge and health care that will mean improved health status for older persons in the future. (Neugarten, 1975.)

The evident certainty of national health insurance, together with the spread of private and public pensions and profit-sharing plans, seems to insure that the over-65 population should be more financially secure than their predecessors.

The gains in educational level in successive cohorts of the population have been so substantial that by 1990 the over-65 group will be, on the average, high school graduates. (Neugarten, 1975). Thus, older adults will more closely resemble younger adults than they do today.

4) Almost 10% of the elderly are senile (i.e., defective memory, disoriented, displaying bizarre behaviors). False. The term senility is a "catch-all" label which sometimes serves as an excuse for not seeking and/or receiving adequate medical attention and treatment, and consequently it strikes fear in the hearts of many needlessly. The majority of older people are not senile; that is, they are not disoriented, do not have defective memories, and are not demented. Only about 2-3%
Appendix—Continued

of persons aged 65 or over are institutionalized as a result of psychiatric illness (Busse and Pfeiffer, 1977). There is much mislabeling of older persons who manifest symptoms of disorientation or poor memory as being senile, when they may in fact be bored, anxious, over-medicated or depressed.

5) Depression is the most common emotional problem of the elderly. True. In part this is a reaction to the barrage of losses which older persons experience, and in part to fears of dependency. As stated earlier, depression is commonly misdiagnosed as organic brain syndrome... health professionals refer to depression as the common cold of the elderly. It affects between 20-25% of older people. Some estimates are that up to 50% of the aged suffer symptoms of depression which are similar to those seen in younger people; such as sadness, sleep and appetite disturbances, slowed motor and verbal responses, social isolation, memory problems, and poor self-esteem. In addition to these, the older person often has physical ailments and fatigue. Service providers need to be on the alert for dramatic shifts in behavior and appearance among their clients (Butler, 1975).

6) At least 10% of the aged are living in long-term care institutions such as nursing homes, homes for the aged, etc.
False. In 1971, about 3.1% of men and 4.6% of women over 65 were living in institutions. The thought of "going to a nursing home" seems to be one of the greatest fears of many older people. Over the age of 85, the percentage of persons living in long-term care facilities rises sharply to about 20% (Butler, 1975).

7) All five senses tend to decline in old age.
True. Sight, hearing and touch experience more marked changes, but evidence exists that taste and smell also decline. Nerve cells or neurons are lost during the process of aging. Associated with this decline is a decreased capacity for sending nerve impulses to and from the brain. Conduction velocity decreases, voluntary motor movements slow down, and the reflex time for skeletal muscles is increased. The decline in vision and hearing may cause an older person to become socially isolated; while the decline in taste and smell, particularly, may explain why older persons often derive less enjoyment from eating. They may also tend to over-salt and/or sweeten their food at a time when excess salt and sugar may be injurious to their health (Kart, Metress, & Metress, 1978).

8) Most older workers cannot work as effectively as younger workers.
False. Despite declines in perception and reaction speed, studies of older workers under actual working
conditions generally show that they perform as well as, if not better than, younger workers. Consistency of output tends to increase by age, as older workers perform at steadier rates from week to week than younger workers do. In addition, they have less job turnover, less accidents, and less absenteeism than younger workers (Riley & Foner, 1968).

9) On the average, the elderly sustain a greater number of losses than other age groups.
True. These include loss of spouse and close friends, often the family home, status in the community, reduction in income, physical vigor and beauty of society's standards, and loss of a job together with all the work-related activities and acquaintances (Butler & Lewis, 1977).

10) Diminished interest in, and capacity for, sexual intimacy is part of the aging process.
False. The majority of older persons have both interest in, and capacity for, sexual relations. The Duke Longitudinal Studies found that sex continues to play an important role in the lives of most men and the majority of women through the seventh decade of life (Palmore, 1974). However, older people may need considerable sexual information; e.g. many men do not know that their need to ejaculate with intercourse may be
considerably reduced. Women may need information about the availability of lubricants so that intercourse is not painful, since elasticity of the vaginal walls and the amount of lubrication declines with age. Touching and intimacy are very important elements in expressing sexuality. Sexual fulfillment poses a problem for older women as there is a lack of available partners, and often a conflict of values which prevents them from seeking alternative sexual expression (Comfort, 1976).

11) While retirement often is associated with strains in the marital relationship, older couples generally express high levels of satisfaction with their marriages. True. The literature, however, is mixed. For marriages which have been good, they often get better with retirement. Marriages which have had problems that could be ignored when one or both were working may find the increased contact brings intolerable tensions. As elsewhere, divorce is on the increase among post-retired couples. It appears that couples with more traditional expectations of marriage express greater satisfaction. Troll mentions the shift in meanings of marriage from romantic attraction to congenial attachment (Troll, Miller & Atchley, 1979). For those who marry late in life, the most critical factor in the success of the marriage is the attitude of their adult children.
There is often a blurring of sex-role distinctions; for instance, men exhibit more expressive roles than previously while women adopt instrumental roles.

12) More than 50% of older people move to a warm climate after retirement.
False. Most older people live relatively near their adult children. This may be due in part to economic consideration, as traveling to visit becomes more costly. Only about 5% of all retirees leave their state after retirement. 70% continue to live in their pre-retirement homes, and about 25% move to a smaller home in the same general area (Kart, Metress & Metress, 1978).

13) About 80% of the aged are healthy enough to carry out their normal activities.
True. About 5% of those over age 65 are institutionalized, and another 15% among the noninstitutionalized say they are unable to engage in their major activity (such as work or housework) because of chronic physical conditions. This leaves 80% who are able to engage in their activities of daily living (Palmore, 1977).

14) Reaction time and the ability to learn new things are unaffected by the aging process.
False. Reaction time increases with age, and appears mainly to involve the central nervous system. It takes longer for older people to process information,
to learn new material or new tasks. The more choices that are involved in the task, the longer it takes for them to react (Waugh, 1973). Botwinick (1973) suggests that cautiousness may play a big part, since there is a tendency on the part of older people toward accuracy and certainty. In addition, he points out that exercise, increased motivation, and practice can reduce the effects of a slowing in reaction time.

15) Older adults utilize more than half of all the health care services provided in the United States. True. 86% of the over-65 population have at least one chronic illness. In 1969, people aged 17 to 44 averaged 4.2 physician visits, compared to 6.1 visits among people 65 and over. Older people with annual family incomes over $10,000 averaged 7.5 physician visits. They are also more likely than the young to go to a short-stay hospital and are more likely to stay longer. Compared to people under 17, older people have more than three times as many hospitalizations per 1,000 and have about three times as long an average duration of stay (Atchley, 1980).

16) Most American families maintain frequent contact with their older relatives. True. The belief that older people are neglected or abandoned by their adult children is not generally true.
Although the quality of the visits were not assessed when Ethel Shanas conducted research among older parents not living with their children, she found that 52% had seen a child within the previous 24 hours, and 78% had seen a child within the previous week (Shanas, 1973). Not only is there frequent contact; often older parents are sources of help to their children, e.g., providing services, living quarters, and financial assistance (Neugarten, 1968).
"Aging Quotient" References


Break (10:45 - 11:00)

F. The Aging Process* - Lecture (45-60 minutes)

This section will discuss various aspects of aging and will especially focus on some frequent problems which arise as a result of the aging process. The process of aging is actually a process which begins at birth and continues until death. From the moment we are born we begin to age, and at each age in the life cycle we are faced with specific developmental tasks. For example, a young child has the tasks of learning to crawl, walk, and talk. During adolescence, important developmental tasks include beginning to achieve some independence from one's parents, dating, and starting to choose a career. Each age brings with it a new set of developmental tasks. In old age, an important developmental task is to "clarify, deepen, and find use for what one has already attained in a lifetime of learning and adapting." (Butler & Lewis, p. 19). Various changes occur in old age, which will be defined as age 65 and over, and the way in which a person adapts to and copes with these changes determines how successful and healthy that person will age. The ability to adapt to change and be flexible is essential for a healthy adjustment at any age and this especially

* The following reference was used in preparing this lecture: Robert Butler and Myrna Lewis, Aging and Mental Health - Positive Psychosocial Approaches, 2nd Edition, the C.V. Mosby Company, Saint Louis, 1977.
holds true during old age when people are often faced with a number of drastic changes. It is important to point out that different people "age" in different ways and that the type of personality which a person has as he/she enters old age will greatly affect how that person will respond to changes resulting from aging.

In general, loss is frequently a predominant theme among the aged. "The elderly are confronted by multiple losses, which may occur simultaneously: death of marital partner, older friends, colleagues, relatives; decline of physical health and coming to personal terms with death; loss of status, prestige, and participation in society; and for large numbers of the older population, additional burdens of marginal living standards." (Butler & Lewis, p. 34)

One normative life crisis which faces many older people, regardless of socioeconomic or cultural influences, is widowhood. Fifty-six (56) out of every 100 elderly in the U.S. become widowed, and three times as many women as men are widowed. (Butler & Lewis, p. 35) A number of issues arise simultaneously with widowhood: "The mourning process itself occurs at the same time as the need to make practical though emotion-laden decisions about where to live, what to do about the family home and possessions, how to dispose of the spouse's personal effects, what kind of contact to maintain with the spouse's relatives, and what to do about new social roles." (Butler & Lewis, p. 35) For example, whereas prior to widowhood, a
person may have socialized and interacted with others as a member of a couple, upon widowhood the person may have to seek new social contacts.

In addition to widowhood are problems or adjustments faced by some couples who enter old age together. One frequent adjustment is that the husband, who is retired, has more free time and the couple has more time together. While this may be a welcome change, this increased contact, especially if the husband does not have interests outside of work, can cause a strain on the relationship. Also, since the lifespan of women in the U.S. is approximately 7 years longer than men (while the life expectancy of females in the U.S. is 74 years, that of males is 67 years, according to Butler & Lewis, p. 5.) and because of the tendency of men to be older than their wives at the time of marriage, the wife is often in the position of caring for a husband who is ill. A chronic illness, especially if it is longlasting, can place emotional stress on both the wife and the relationship.

One important aspect of relationships during old age as during other ages is sexuality. "Sex relations, although tending to be diminished in frequency, are practiced by many older people." (Butler & Lewis, p. 36) A number of possible problems, however, may arise which may interfere with a person's normal sexual activities. For example, a colostomy could cause problems because of both aesthetic and physical
reasons. "Elderly people, like the young, tend to react with anxiety and depression over threats to potency and sexual fulfillment." (Butler & Lewis, p. 36)

Another change which affects the lives of many older people is retirement. For many women who have spent most of their time as homemakers and who have not worked outside of the home, such an adjustment is not necessary. However, for men who have worked for years, especially those who could accurately be termed "workaholics" and who have not developed hobbies and interests outside of work, retirement constitutes a change in lifestyle which may be a difficult adjustment. For some people "work and life become so interconnected that the loss of a job can demolish the reason for living." (Butler & Lewis, p. 37) Fortunately for those who have developed interests apart from work and who do not derive their self-worth totally from work activities, retirement may be a welcomed time in which they can finally have time to engage in other activities.

Sensory loss represents another change which faces many older adults. "Significant hearing loss, which affects men more than women (probably due to industrial noise), occurs in some 30% of all older people and is potentially the most problematical of the perceptual impairments. It can reduce reality testing and lead to marked suspiciousness, even paranoia." (Butler & Lewis, p. 37)
A connection between hearing loss and depression has been observed. (Butler & Lewis, p. 37) Hearing loss can result in more social isolation than blindness, and often people who have a hearing loss may be mistaken as being "senile" since their hearing difficulty may render it difficult to keep up with what is being said and what is happening around them.

Although most old people need glasses, "about 80% have fair to adequate visual acuity to age 90 and even beyond". (Butler and Lewis, p. 38) Loss of vision, nevertheless, can lead to difficulty with mobility, disorientation, and at times hallucinations. In addition, hobbies such as reading, watching television, and doing needlework, may be rendered impossible.

"Smell also declines with age, and up to 30% of people who are over 80 years have difficulty identifying common substances by smell. Taste too is affected, since two thirds of taste sensations are dependent on the ability to smell; in addition, taste buds decrease sharply in number with age. There is also a fall off of tactile response as both perception and motor expression decline in reaction to stimuli." (Butler and Lewis, p. 38)

Still another change facing older adults involves physiological changes as well as changes associated with disease and pain. A person's physical well-being often determines or affects one's activities, energy level, and emotional
well-being. Some common outwardly visible physical changes which may occur during old age are "graying of hair, loss of hair and teeth, elongation of ears and nose, subcutaneous fat losses, particularly around the face, skin wrinkles, fading of eyesight and hearing, postural changes, and a progressive structural decline that may result in a shortened trunk with comparatively long arms and legs." (Butler and Lewis, p. 21) While these are normal, expected changes which occur with age, they nevertheless may require adjustments on the part of the older person. On a positive note, various studies have revealed that there appears to be no overall decline in intelligence with age. Abilities such as judgment, accuracy, and general knowledge may even increase with age. (Butler and Lewis, p. 23)

Even greater adjustments are necessary to cope with physical illness. "Physical illness frequently generates both appropriate and distorted emotional reactions, since it represents so much that is inherently frightening to human beings. Latent fear and anxiety about death grow real with illness. Feelings of helplessness and vulnerability buried deep within the individual are resurrected in the face of implacable illness and the aging process." (Butler and Lewis, p. 39) In addition "... aging and disease threaten people's sense of who they are - their identities - as their bodies change 'in front of their eyes'. People report feelings
of shock and disbelief at their mirror images, in reaction both to aging (is that old person me?) and to illnesses, which even more rapidly change the size, shape, and appearance of the body." (Butler and Lewis, p. 39)

"Bodily processes that formerly took care of themselves or required minimal attention begin to demand more and more time as people age. Among the elderly, 86% have some kind of chronic health problem requiring more visits to the doctor, added stays in the hospital, special diets, exercises, drugs, rehabilitative therapy, or additional provisions for daily life at home. With 81% of the elderly ambulatory and to a substantial degree responsible for their own self-care (only 5% are in institutions and, even there, many have some degree of self-care), it is apparent that body monitoring is a compelling preoccupation." (Butler and Lewis, p. 39)

Pain constitutes another preoccupation of many older people. The recurring aches associated with arthritis and rheumatism are examples of pains which old age often brings. How this pain is dealt with depends on a number of factors including one's personality and pain threshold. While medication often alleviates pain, this same medication can have disturbing side effects such as dizziness, disorientation, nausea, and others.

Dealing with hospitalization and surgery is another area with which older people often have to cope. "Heart and circulatory diseases, digestive conditions, and disturbances
of the nervous system are the primary causes of hospitalization after 65." (Butler and Lewis, p. 39) Apart from general fears about one's physical health, additional fears may be generated "since so many of the elderly die in hospitals and nursing homes rather than at home" (Butler and Lewis, p. 39-40) and since a hospital or nursing home may be viewed more as a place to die rather than as a place to reinstate good health. Further, being away from one's home environment may lead to less interaction with one's family and friends, which may lead to loneliness and depression, and being in an unfamiliar environment can precipitate disorientation and confusion.

Preparation for death is another developmental task facing the elderly. "...Although fear of death is part of human experience, older people tend to fear it less than the young do and often are more concerned about the death of those they love than about their own." (Butler and Lewis, p. 40) The subject of death has become a topic of growing interest. One notable author in this area is Elizabeth Kubler-Ross who described people as going through five stages - denial, anger, bargaining, depression, and then acceptance of one's death.

The particular way in which each individual deals with death, illness, pain, physical changes, and other occurrences associated with old age varies from person to person. Typical emotional reactions include grief, guilt, loneliness, depression,
and anxiety. It is notable that "depressive reactions increase in degree and frequency with old age as a corollary to the increased loss of much that is emotionally valued by the elderly person." (Butler and Lewis, p. 44) One reaction or process which is thought to be universal among the elderly is what is called the "life review." This is a healthy reaction to old age in which the older person reminisces, looking back over his life in an attempt to see some order and purpose in his life. Hopefully this life review will result in "righting of old wrongs, making up with enemies, coming to acceptance of mortal life, and sense of serenity, pride in accomplishment, and a feeling of having done one's best." (Butler and Lewis, p. 50) At any rate, the life review is a "necessary and healthy process" (Butler and Lewis, p. 50) which has therapeutic, healing effects.

Lunch (1 hour) 12 noon - 1:00 p.m.
Appendix D—Continued

Session I - Afternoon (1 - 4 P.M.)

A. Introduction to Nonverbal and Verbal Communication:

Trainees and Their Roles - Lecture (5 minutes)

The purpose of this program is basic communication skill improvement. Everyone communicates on some level, but the objective here is to communicate on an effective level so that your work with the elderly will be more meaningful to both you and the elderly person. The program emphasizes being aware of the client's behaviors and feelings and being able to accept him within your working situation. Acceptance, a non-judgmental appreciation of the other person's feelings, is a key issue in good communications. Although, you may have perfected the proper skills for effective communication, unless they are coupled with acceptance of the other person with whom you are communicating, the communication skills will be ineffective. A person who does not feel accepted will not be interested in either talking or listening to you no matter how good your communication skills may be.

This program will give you some knowledge of the essential components of effective communication in addition to experience in practicing these skills. The first part of the program is directed at non-verbal skills, followed by various kinds of verbal responses which are effective in developing more meaningful interpersonal communication with the elderly.
Appendix D—Continued

B. Nonverbal Communication

1. Preliminary Illustration: Back-to-Back Exercise

At the outset of this session ask the group to stand back to back with his/her neighbor without touching. Then instruct group to carry on a conversation without turning the head to look at his/her partner. This is an excellent exercise for pointing out the importance of nonverbal cues in communicating. (5 minutes)

When the exercise has concluded, present the Opening Lecture to the group.

2. Feedback - Role of Facilitator - Lecture

When communicating with others we are expressing ourselves in many ways through various cues. The most noticeable cues are usually verbal—what we say to the other person. But nonverbal cues constitute an even more basic form of communication, one that we used even before we knew how to talk.

Some type of communication is inevitable. We cannot not communicate. We can choose to communicate with words, but we cannot escape nonverbal communication. Silence is a form of communication in itself. We cannot refrain from moving and expressing ourselves with facial expressions, gestures, and body posture. Whatever behavior we engage in, we are communicating something about ourselves to others, and something about our perception of the other person.

This is especially important to remember when you are in a situation in which you are supposed to act, at times, in a way you do not feel. Perhaps you have a client whom you do not particularly favor. Verbally you will most likely not express your feelings toward him, but it will probably come out in your nonverbal behaviors because nonverbal
messages are usually more obvious than spoken messages. Exposing your real feelings in this way may be detrimental to you, as well as to the other person. (On the other hand, being aware of your feelings toward this person, and having knowledge of nonverbal skills, you should be able to create an understanding atmosphere. This would probably be beneficial for both communicators.)

Our culture is a very verbal one, and it is possible that we have, to some degree, lost touch with recognizing and using nonverbal behavior and nonverbal messages effectively in communicating. It is important in a helping relationship to be aware of the nonverbal cues you are projecting. They can either be a help or hindrance to the relationship. You can give the impression of being interested, concerned, helpful, and competent by the cues you give to the other person. The presence of these characteristics is imperative in developing a trusting relationship.

It might be helpful at this point to ask the class what sort of nonverbal behavior might give the impression of interest, concern, etc.

We will discuss a number of characteristics of nonverbal communication and how they relate to working better with the elderly. These skills are related to nonverbal attending behaviors (i.e., observing the other person and reacting to them by using nonverbal skills).

But first it is necessary to explain the role each of you will be taking as a facilitator when you are practicing the skills in small groups.
The purpose of this section of the program is to increase the significance of skill practice sessions. An observer can be more objective in noting correct or incorrect use of communication skills than either the speaker or listener. Therefore, the facilitator plays an essential role in helping others to attain high skill levels.

When interpersonal communication occurs between two people in the presence of a third person (as is the case in many of the exercises we will do), that third person can exert a strong influence. He can be a facilitator and assist the speaker and listener in achieving clearer communication. The facilitator may also be called an observer, but the task is much greater than just watching the other two people. In addition, to observing the nonverbal and verbal skills of the communicators, it is the facilitator's job to give constructive feedback—that is, to share his observations and reactions with the others. Also, the listener should be able to give feedback to the speaker.

Feedback is essential to the continuous process of communication. We guide our future communication by using a rear-view mirror of our own past. We direct our communication by finding out from others how they are receiving the message we are communicating. The speaker is perceiving the listener's verbal and nonverbal response to his communication and adjusts the next response according to how he interprets the feedback received from the listener. The facilitator, since he is not involved directly in the communication, observes how effectively the listener and speaker are using the skills being practiced. The content of this feedback
should include comments noting skills well used or suggestions on how both communicators could improve. Constructive feedback should be helpful to the person receiving it in order to facilitate improvement in the person's skill level.

It is necessary that the following criteria be met for the feedback to be constructive to the person you are giving it to:

Trainer should refer to sheet in volunteer manual entitled "Criteria for Constructive Feedback".
1. Feedback should be requested by the receiver rather than imposed.

2. Feedback should be given in a non-threatening manner.

3. Feedback should be specific rather than general.

4. Feedback should focus on the behavior rather than the person.

5. Feedback should be "I"-centered rather than "You"-centered. (i.e., "I am confused by what you are saying," rather than "You are confused," because it is an opinion, and you, the trainer, are not the final authority on the subject).

6. Feedback should include strengths as well as weaknesses.

7. Feedback should concentrate on things the person can change (e.g., "If my tone of voice annoys you, I can alter it; but if you don't like my crooked nose, there is little I can do about it").

8. Feedback should focus on the sharing of ideas and information rather than on giving advice.

9. Feedback is discussed between giver and receiver to assure that what is being communicated is understood.

3. An exercise in Nonverbal Communication (15 minutes)

(To the Trainer: Do not read this material to the trainees, except to give instructions to the speaker in (c) and the listener in (d).

a) The basic idea of this exercise is for the speaker to point out the important nonverbal components of communication by telling the listener what to do in order to become a responsive listener who is interested.

b) The trainees should arrange their chairs in a circle. The trainer should ask for two volunteers (or else choose two trainees). The two trainees should bring their chairs into the middle of the circle. The person designated as listener (the other person is the speaker) should be sitting in his chair with his back to the speaker.

c) The instructions to the speaker should be as follows: Choose a topic (something that has happened to you, your feelings on a subject) about anything that you can talk about for at least 5-10 minutes. The other trainee will listen to you but will not be able to speak—only listen. When you are dissatisfied with the kind of nonverbal feedback you are getting from the listener, tell the listener what you think he should or should not be doing to improve the feedback you are getting and he will comply. (Make sure these commands relate only to specific behaviors that will help you to feel the person is listening).
d) Instructions to the listener should be whispered to him and should be as follows: "You are to be silent and be totally unresponsive bodily and facially." (You may want to go into more detail, e.g., do not appear bored, do not face the speaker, do not use your hands but keep them absolutely still.) "You will only be responsive when the speaker asks; you will do only what he says and nothing more." (It might simplify matters if the instructions to the listener were printed on a handout—or the trainer might gather the listeners in a group and give them their instructions at the same time; out of hearing of the speakers.) "After about five minutes, I will tell you that you may answer. Say whatever you would normally say in response to the speaker but speak either too loud or soft and speak in a monotone. You may adjust your speech as the speaker instructs you."

e) The trainer should write on the chalkboard all the instructions the speaker gives to the listener.

f) The trainer should not interrupt the practice unless the speaker does not seem to be picking up on all the nonverbal behaviors. The trainer should facilitate the process when necessary by saying things like: "How do you feel about the other trainee's body position while you are talking to him? Do you think he is listening to you—if not—what would you like him to do?"
g) In concluding the exercise, the trainer should point out that this practice session has demonstrated some of the components of nonverbal behavior that are important to use when trying to convey that one is an interested and attentive listener. Then proceed with the sections on the various nonverbal behaviors trying to tie in those instructions listed on the chalkboard.

It would be helpful when discussing these sections on various nonverbal behavior to demonstrate the "poor" behavior as you talk about them in addition to demonstrating good nonverbal behavior the remainder of the time. Or it might be helpful to ask various class members to demonstrate these nonverbal responses.

You might ask class members to think about someone they dislike talking to and to discuss possible reasons for their aversion.

4. Eye Contact and Facial Expressions - Lecture (10 minutes)

We are seldom expressionless. Our face communicates a great deal about our emotions and reactions. Some of the time we deliberately frown or smile, stare directly at someone, or avoid eye contact. Much of the time, however, these movements are so much a part of us that they appear unconscious or unintentional. In our working roles, in particular, we must attend to our nonverbal messages and be aware of how they affect others.
Demonstrate lack of eye contact, blank staring.

One thing that is important to do is to establish eye contact by looking at the client when he is talking to you. Our eyes can show intense interest in communicating with the other person. It is not necessary, though, to stare intensely at the person in order to let him know you are being attentive. When eye contact is spontaneous (i.e., looking at the person when he is talking but also allowing your eyes to drift away and then return them to the person) it will communicate your interest and desire to understand.

Eye contact is important in another sense as well. Often we may be looking at someone or something, but not really seeing and understanding what is happening. Seeing is a matter of focusing our eyes in addition to really attending to what is before us. When working with older people this may be especially important in that they may not always be able to see too well, and it is our job, as helpers, to inform them about their world. We must also be attuned to their nonverbal messages because when working with the elderly, some of whom are ill, it is imperative to see cues and signals which communicate that something may be wrong with them.

Facial expressions usually convey to the other person our emotions. Often we are not aware that we might be saying one thing, but our face is saying another. Our facial
expression can convey inattention (a "poker face"), intense excitement, or deep caring.

Demonstrate poker face, excitement, caring.

In the position of a helper one should be responsive facially. A very quizzical look would indicate that you would like them to clarify what was said. Smiling spontaneously at the person would show you understood him. Animation in facial expressions gives the other person the feeling you are alert and responding to his communication. Affirmative head nods would show that you are listening and/or in agreement. When overdone, however, they can become distracting. Occasional head nods paired with good eye contact and attentive facial expressions will indicate your involvement and acceptance of the client. Good facial expressions include matching their mood or feeling with an appropriate mood or facial expression of your own.

5. Posture and Gesturing - Lecture (10 minutes)

Demonstrate nonverbal behaviors as in former section.

Posture may be a natural indicator of interest in what the other person is saying. Leaning forward in a relaxed manner encourages the person to continue talking. On the other hand, not facing a person, sitting
in a very rigid position or slouching, is indicative of disinterest. Particularly with older people who depend on your company for many things, it is necessary to position yourself in front of the person so they know you are there and interested.

Gestures, when coupled with verbal responses, can be very effective in helping to get your message across. Such gestures might include pointing, to emphasize ideas or to indicate something, signaling for attention, or nervous gestures such as foot shaking or playing with a pencil. Ideally, gestures should be used to further emphasize the verbal message in such a way that they are purposeful and natural.

Touching is an important component of close and meaningful communication, particularly with the elderly who may have fewer personal contacts as they grow older and become more detached from the main stream of our society. The desire for human contact is a need each one of us has. It may indicate caring on a very personal level or on a less intimate one. Touching someone may indicate to you their emotional or physiological state which is extremely important for you to know in order to relate to them better.

It is important to be aware of how the other person feels about being touched, because although touching has become more socially acceptable on a less intimate
level than it once was, it is still a personally meaningful contact. Tied in with this is the issue of distance and how close should one come to another without making him feel uncomfortable. Great distance will often discourage communication, but being too close may be considered an invasion of territorial rights.

Define territoriality: The sense of or defense of one's own.

You can usually tell how the other person is feeling about this by attending to his nonverbal cues.

6. Vocal Quality - Lecture (5 minutes)

As we have seen, nonverbal cues are extremely important in communicating with others. Vocal quality may not seem to be a nonverbal skill, but it is because we are not talking about what is said, but how it is said. Vocal quality may convey excitement, disappointment, anxiety, surprise or many other feelings.

Demonstrate: Excitement, Anxiety, Surprise, and Tones of Voice.

To demonstrate the importance of voice tones to those with hearing loss the trainer might instruct class to rub hands over their ears while trainer is speaking or play a record with the volume turned very low.

To demonstrate importance of voice tone to the message being communicated the trainer might say "I have bad news for you," in a loud, happy, triumphant tone of voice.
To be an effective helper one should maintain a pleasant, interested tone—speaking neither too loud, too soft (paying particular attention to the elderly with hearing problems), not too commanding.

We need to communicate with the elderly with an awareness of the possibility of certain hearing losses, particularly:

**Presbycusis** - Loss of high frequency sounds. Lower voice tone, speak clearly.

**Otosclerosis** - New formation of bone in the ear, resulting in progressively increasing deafness. Enunciate clearly and speak louder but do not shout, move nearer to the listener.

The vocal channels seem to be under less conscious control than the verbal component. Therefore, awareness of incongruence between what the speaker says and how he says it may be a cue to potential concern.

7. **Nonverbal Communication Exercise #2**

**Practice Session:**

Eye Contact & Facial Expressions, Posture & Gesturing, and Vocal Quality.

**Objective:**

To be able to identify and use effectively the positive components of eye contact, facial expressions, posture, gesturing, and vocal quality.
Procedure:

Arrange trainees in groups of five. Distribute to each person in the group a slip of paper on which a different feeling is written. Examples of feelings might be anxious, depressed, happy, uncertain, afraid, excited, and embarrassed (an extensive list appears in the Handout). Instruct each person to express the emotional concept nonverbally through the use of gestures and other nonverbal communication. The trainee may use voice quality to demonstrate the feeling by repeating the alphabet. (15 minutes) Other group members are to guess what emotion the speaker is trying to communicate.

C. Debriefing in Small Groups (10 minutes)

Break 2:25-2:35

D. Verbal Communication - Part I: Opening Lecture

Just as good nonverbal attentive behavior is necessary in establishing effective communication, so too, is good verbal communication. It is essential in helping the elderly to develop a strong, trusting relationship. The ability to understand another is the basis for developing a good relationship. It is necessary, though, to go beyond mental and emotional understanding to the act of verbally conveying that understanding to the other person. In this way he will be assured that you are
following what is being said and that you are attentive to his feelings. What you say will have a tremendously important impact on the kind of relationship that develops.

There are various ways to respond—each serving a different purpose in furthering the conversation and developing a deeper understanding of how the other person feels. We will discuss what part these responses have in developing a trusting relationship and practice a number of these different responses in order to learn more effective ways of communicating with the elderly.

1. Content Responses: "Mirror" Response - Lecture (10 minutes)

These responses and the ones which follow may more appropriately be called active listening because the listener has a very definite responsibility. He actively tries to grasp the facts and feelings he hears the other person expressing. In order to be effective as an active listener, you must convey acceptance of the other person. A feeling of acceptance is necessary to anyone to feel free to express what he really thinks and feels.

Hearing accurately what the other person has said to us is one of the first steps in establishing good listening and good communication. One way to check out if you heard correctly is to be able to "mirror" or repeat back to the person what he said, and get his confirmation that it was right. Usually you would not
want to use this response very often since it would become a very repetitive conversation. There are instances when you might want to use it though, such as when you've told the other person how much of his medicine to take and how often: he should repeat it back, and you may want to mirror for more emphasis. Especially when working with older people, there may be some doubt as to exactly what was said because of unclear speech, not speaking loudly enough, or confusing thoughts. Then the mirror response would be appropriate. (This is especially important when communicating with an older person who is aphasic—suffering from a speech disorder due to brain cell damage.)

**Example:**

**Older person:** "My social security check should have come in the mail today."

**Listener:** "You're saying that your social security check should have come in the mail today."

**Older person:** "I wish I was able to do more things for myself so I wouldn't have to move to the nursing home."

**Listener:** "You seem to be saying that you wish you were able to do more things for yourself so you wouldn't have to move to the nursing home."

This type of responding may seem unnatural, but it is the first step in learning to listen well. It may be helpful to begin with tentative phrases such as,
"It seems to me you're saying . . . ," "Let's see if I have this straight . . . ," or "What I hear you saying . . . ."

2. Mirroring Exercise

Objective: To "mirror" or repeat accurately what the speaker has said each time.

Procedure: Do a round robin exercise with the entire group, asking them to state a sentence or two about anything they choose. The person next to them should do a mirror response. The trainer should do the first example. (Note: The trainer should reinforce each member of the group when they do it correctly and, if necessary, help those who are unsure.) (15 minutes)

3. Content Responses: Paraphrasing - Lecture (10 minutes)

Although the mirror response is a good beginning for promoting effective listening, it is not practical to use it too often. On a higher skill level of content responses, paraphrasing would be more appropriate and also more natural. The purpose of checking out what you heard to see if it's right is still the goal, but now you use your own words to repeat the content of what was said.
Example:

Older person: "My social security check should have come in the mail today."

Listener: "Your check hasn't come yet?"

Older person: "I wish I was able to do more things for myself so I wouldn't have to move to the nursing home."

Listener: "You'd like to be more independent so you could stay in your own home?"

4. Paraphrasing Exercise

Objective: To paraphrase the speaker's statements accurately each time. To be able to use this skill of paraphrasing content in working with the elderly.

Procedure:

a) The trainer should ask for a volunteer from the group to be the speaker and to play the role of a client talking about a concern. (Volunteer will be given example from Role Playing Situations sheet. See Handout, p. 2) The trainer should model paraphrasing (concise own work responses). This may be followed by a brief discussion of the usefulness of these responses within the trainees' work settings. (10 minutes)

b) Instruct the group to form three (3) small groups. Following the model of the trainer, one person should take the role of the client and one person should be the active listener. The client will role play a situation from Role Play Situations
sheet. Switch roles so that everyone has a turn at each part. Continue this process until all trainees appear to understand. (20 minutes)
c) Then instruct each small group to form triads. Continue to practice paraphrasing with the client providing short statements consisting of one or two sentences. The third person should act as facilitator giving constructive feedback to the listener. Switch roles so everyone has a turn at each part. (10 minutes)

E. Debriefing - small groups (5 minutes)

F. Explanation of Homework Exercises (5 minutes)
Appendix D—Continued

Homework Exercise #1

Read each statement and paraphrase in writing.

Sample:

Statement: I used to read all day long but these cataracts have ruined my eyesight. I can't read the newspaper. I can't even see to read stories to my little granddaughter.

Paraphrase Response: You can't see to do two things which you used to enjoy - reading the newspaper and reading to your granddaughter.

The following statements are quoted from Patricia Alpaugh and Margaret Haney, Counseling the Older Adult - A Training Manual, The Ethel Percy Andrus Gerontology Center, The University of Southern California Press, 1979, p. 18.

1. "I don't know anymore. I'm just not as fast and as quick as I used to be. I can't stand the notion of having to write things down in order to remember them."

2. "Taking care of her can be unbearable at times. There are times when I just feel like walking out and never returning. But then I can't you know, she was such a good wife to me all those years."
3. "Without a job I feel useless. I really need to work, do something useful. But do what? I go round and round on this. I don't know what to do with myself!"

4. "A lot you know! What am I doing here anyway? I only came here cause my wife nagged me into it."

5. "For so long I thought the kids needed me, but now I know they haven't needed me in years. What do I do now? There's no meaning to my life."
Homework Exercise #2

Use paraphrasing responses three (3) times during the following week. Use this sheet to record your activities.

Please describe the situation in which you used paraphrasing:

Situation I

Who were you talking to?
What was it about?
What paraphrasing response did you use?
How did it work?

Situation II

Who were you talking to?
What was it about?
What paraphrasing response did you use?
How did it work?

Situation III

Who were you talking to?
What was it about?
What paraphrasing response did you use?
How did it work?

G. Have participants fill out Reaction Forms.
Session II - Morning

A. Recap of Session I - large group (10 minutes)

Last session we covered quite a bit of information. In the morning we discussed some stereotypes of aging and looked at the aging process from both a psychological and physiological viewpoint.

During the afternoon session, we talked about nonverbal communication - that is, how we communicate to others through body posture, eye contact, facial expression, and vocal quality. Then we began discussing verbal communication. We role played different situations and "mirrored" and "Paraphrased" the clients' statements. Then you were given homework in which you were asked to paraphrase statements. (Ask trainees to get completed homework sheets.) Let's divide into three groups and go over your responses to these statements.

B. Review Homework - small groups (15 minutes)

C. Verbal Communication

1. Open-Ended Questions (15 minutes)

These types of questions are those which cannot be answered with a "yes" or "no." Open-ended questions allow the person to explore issues further or take the conversation in any direction he chooses, rather than be led by the helper. These questions should elicit
information and feelings, not inhibit them. Following is a discussion regarding different types of questions. (The following is quoted directly from Elinor Walters, Adele Weaver, and Betty White, Gerontological Counseling Skills - A Manual for Training Service Providers, Continium Center, Oakland University, Rochester, Michigan, 1980, pp. 4-8 to 4-10).

a. Closed Questions. Closed questions are narrow and restrictive of the client's freedom. They limit the client to a brief, factual answer; often 'yes' or 'no'. In some cases, this is what the counselor wants to do. (Example: Do you want to discuss this issue further?) However, in most cases, closed questions keep the control and direction of the interview in the hands of the counselor, and reinforce dependency on the part of the client.

b. Open Questions. In contrast, questions which are termed "open" are broad and allow clients freedom to find their own answers. Open questions also put the responsibility for specificity on the client, rather than having the counselor provide control and direction.

To underline the difference, we have listed below examples of both closed and open questions on the same topic. (You may want to put the questions on the board or newsprint.)
Appendix D—Continued

<table>
<thead>
<tr>
<th>Closed Questions</th>
<th>Open Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you like retirement?</td>
<td>1. How do you feel about retirement?</td>
</tr>
<tr>
<td>2. Is your hobby reading?</td>
<td>2. What are your hobbies?</td>
</tr>
<tr>
<td>3. Are you and your spouse having sexual problems?</td>
<td>3. What kinds of problems are you and your spouse having?</td>
</tr>
<tr>
<td>4. Do you spend most of your time at home?</td>
<td>4. How do you spend most of your time?</td>
</tr>
<tr>
<td>5. Are you upset in your present situation?</td>
<td>5. Some people might be upset in your situation; others probably wouldn't. How do you feel?</td>
</tr>
</tbody>
</table>

c. Double-Questions. There are two separate types of double questions. One limits the options of the client to one or two choices; and is usually framed in an either/or, yes/no manner. This type of question might be appropriate in those circumstances when only two choices are available. For example, can you be here at 4:00 or 5:00? The other kind of double question is really two separate questions joined together. Such questions are difficult for the counselee to answer, and often yield information which is confusing to the counselor. Both of these kinds of double questions restrict the client's freedom and keep the counselor in control of the interview.
Examples of both kinds of double questions are:

Do you want to study pottery or painting?
Do you want to talk now or later?
Do you like your new doctor, and does he listen to you?
Where do you want to move to, and what does your daughter think about it?

d. Bombardment. Bombarding is a process of asking too many questions in rapid succession. Along with using too many questions, the counselor does not reflect content or feeling, and his/her voice and expression may also take on the manner of an interrogator. The result of this behavior is that the counselee may feel overwhelmed and attacked, and the establishment of trust is definitely impeded. Although counselors often need to ask a series of factual questions, the counselor must be very careful not to turn it into a bombardment because at best this technique results in a very superficial interview.

An example of bombardment follows: (Note to trainers: It is helpful to have two people read this out loud. Be sure to ask both (the counselor and client) for their reactions to this brief role-play.)

Counselor: When did you retire?
Client: About a year ago and . . .
Counselor: What have you done in the last year?
Client: Not a lot. It's hard for me to get going, and I feel badly about having to stop working.
Counselor: What kinds of things do you like to do?
Client: Well, I used to like to fish and play tennis and things like that.
Counselor: Were you very good at tennis?
Client: Yes, but I've really slowed down a lot. I haven't been feeling so good lately.
Counselor: What other things do you like to do?
Client: Well, not much.
Counselor: Well, can you think of anything?

In contrast to bombarding the client with too many questions rapidly asked, the counselor would do well to provide the client with time to think before responding. A good rule of thumb for counselors is to make one or two reflective statements after the client's response to each question.

e. "Why" Questions. "Why" questions are unhelpful for many reasons. For one thing, "why" questions connote disapproval and force the client into defending and explaining his/her position. Further, while searching for the answer, the client is not experiencing or expressing feelings, and may create an answer in order to please the counselor.

Below are examples of a few "why" questions which have been rephrased. Think about your feelings as you imagine asking and answering each question.
Why don't you like retirement? How do you feel about retirement?

Why don't you participate in any activities in our building? I've noticed you haven't participated in any of the activities in our building. How do you spend your time?

Why are you interested in that organization? What about that organization appeals to you?

2. Other Responses (5 minutes) Some other responses besides questioning are termed "keep it coming responses" and are as follows:
   a. Silence (passive listening)
   b. Non-committal acknowledgement ("Oh", "I see," "Mm-hmm," "Really")
   c. Feedback of ideas, mirroring the sender's comment, paraphrasing.

3. Questioning Exercise (45 minutes)
   Objective: To be able to use open-ended questions when appropriate in conversation.
   Procedure:
   a. With everyone in the group, ask everyone in the group to think back to some time in their life when they needed someone to talk to. Some time when something was bothering them greatly, and their feelings were very strong. Some examples might be:
broke up with girl/boy friend
teacher unfair
parents trying to control life

b. Give the whole group a few minutes to think back on their own experiences, and then ask if everyone has been able to think of an example. Ask for a few people to share examples verbally with the group. (10 minutes for a and b)

c. The trainer should engage in a three- or four-minute conversation with one of the group members about a concern the trainee has. The questions should all be close-ended. A discussion of how the trainee was hindered from exploring the concern further should follow. A videotape example may be substituted for the above live example. If this is used, the person speaking with the trainer should be an elderly person. (10 minutes)

d. The same procedure as above should be followed; however, the trainer should use all open-ended questions. (10 minutes)

e. Instruct the group to meet in triads with one person taking the part of the speaker, one the listener part, and one the facilitator. Engage in a five minute conversation about a concern of the speaker. The listener should concentrate on using open-ended questions to enable the speaker to explore the concern. The facilitator should give feedback. Content responses may also be used when appropriate. (15 minutes)
D. Verbal Communication - Part II

1. Empathy - Lecture (5 minutes)

Acceptance has been mentioned before as a necessary condition for developing good listening skills. Empathy is another fundamental component of good listening. Empathy is the ability to experience what another person feels as if the feelings were one's own. The presence of empathy helps to create an atmosphere of closeness and warmth. It also contributes to a sense of self-acceptance for the person with whom you are working, which is important to all of us. Empathy is particularly important when working with elderly people. You may often be one of their few human contacts because they may have few family members or friends left. The elderly are sometimes ignored and no longer listened to. To understand their feelings, to empathize and accept them as important and worthwhile is a giant step in developing good interpersonal communication skills. "Without empathy we isolate ourselves from the experience of others to the degree that we live only by our own feelings and limit our 'knowing' to those things we have experienced."*

Being empathic conveys to the older person that you, the listener, are feeling with him, putting yourself in his shoes. Understanding feelings conveys a deeper sense of understanding than understanding content (although you must understand the content first before you can accurately look beyond it for feelings). Think of the people you are closest to. They are probably the ones who best understand your feelings and let you know that they do. You should do the same for the elderly people you work with. Keep in mind that being empathic is not only the ability to "feel with" another, but also the ability to echo these feelings. In addition to understanding the other person you must be able to verbalize your understanding by acting as a "mirror" for the feeling.

2. Affective Responses - Lecture (5 minutes)

Reflecting these feelings is another type of verbal response, sometimes called a 'feeling' response, because the way a person is feeling is the focus of the response. It is a difficult type of response to achieve because one must go beyond the content of what is said to try to determine the feelings which are expressed or implied. It is necessary to listen carefully to the content, but, in addition, how it is said is very important to understanding the feelings.
If the feeling is clearly expressed in the message, then you could reflect by using a different feeling word, but one that captures the same emotions and intensity expressed by the client. At a deeper level the feeling may be less obviously expressed or implied in the message. Skillful use of reflecting depends on the helper's ability to identify these feelings through cues such as nonverbal behavior, voice quality, and the content of the message.

Example:

Older person: "I don't know why my daughter didn't come to visit me today: she promised she would."

Listener: "You're upset that your daughter didn't come to visit today." Or (depending on previous statements and nonverbal cues),

Listener: "You're concerned something might have delayed your daughter."

Older person: "I had so much company today. I just can't believe all my grandchildren came to visit on the same day."

Listener: "You're really excited to have had so many visitors today." Or (again, depending on nonverbal cues, etc.)

Listener: "You're overwhelmed by so many visitors in one day."

Sometimes following your instincts or trying your best guess may work. Or you may think of yourself in the other person's position and try to determine how you would feel in that situation. If you are unsure about the feeling being
expressed, you may want to be tentative in your statement by beginning it with, "It seems to me that you're . . ." or "It sound like you're . . ." "I hear you saying . . ." Initially, the best thing to do is try to identify the feeling being expressed, then translate the identification of feelings into sentences. When you state it to the other person, you will be checking out your own perception of the situation as well as helping to clarify the feelings underlying the situation and accepting the other person so he feels free to explore it further.

3. Empathic/Affective Exercise

**Objectives:** To be able to identify the feelings, either stated or implied, in a conversation. To be able to use affective responses appropriately in conversing with elderly people.

**Procedure:**

a) Hand out the list of feeling words (See Handout, page 3) and give the trainees time to look it over. (5 minutes)

b) Exercise on remembering feelings (See Handout, p. 6). large group - 15 minutes.

c) Divide into 3 small groups. Hand out the series of statements entitled "An Exercise in Identifying Feelings" (See Handout, p. 7) to each member of the group. Go around the group, each person reading a statement and the person next to
him identifying a feeling reflected by the statement and putting the feeling into the statement, "You feel ______". (Then the other trainees may identify additional feelings). (20 minutes)

d) Instruct the group to break into triads with each person making a number of statements giving the other people a chance to reply by stating, "You feel because ______". If the feeling stated is incorrect, the speaker should say so, and the helper should try again. (15 minutes)

e) Debriefing in small groups. (10 minutes)

Lunch 12:00 - 1:00
Session II - Afternoon (1 - 4 P.M.)

A. Exercise in Active Listening - Small Groups

(25 minutes for exercise and 10 minutes for debriefing)

(1) Goals: To help the group experience the way in which Active Listening responses can help a person progress in facing his problem and in working down to the core of the situation. To give group members further practice in Active Listening skills.

(2) Process: If there are 2 trainers, one will play the part of the 70 year old woman and the other will coach the group. If there is only 1 trainer, he can play both roles, stepping out of the 70 year old woman role as necessary to "coach". Keep the role play moving quickly. If you take too long on each comment, or let more than one person respond, or try to analyze during the role play, the group will lose the drift and the continuity. Go through the whole role play, and then go back and discuss particular points.

(3) Introduction: This exercise will give us a chance to practice our Active Listening skills in a different way. The trainer will play the part of the 70 year old woman. The group will collectively play the part of the woman's volunteer. This volunteer has just learned to use Active Listening, and he really wants to practice! Therefore, no matter what your natural inclination might be, for this exercise, use
only Active Listening responses. The trainer will start with the person on his right, and will address his first comment to them. The person on the right, acting as a volunteer, will try to make an Active Listening response—trying to pick up the feeling underneath the woman’s comment and to reflect back or feedback this feeling verbally. When the trainer feels that the woman’s feelings have been "heard" and understood, he will go on to the next comment and address this to the next person in the circle.

In this way, each of you in turn will have a chance to play the "volunteer"

*Warn group: The feelings will change with each comment, so each person in turn should focus on the last comment that was made, the one which is addressed to him.

Relieve anxiety: Nobody is expected to be perfect—if anyone gets stuck for a response, the rest of the group can help him out. Trainer can also comment on how he felt "on the hot seat" when he first did the exercise.

Remember: It is not that these might be the only comments or responses that could be effective in this situation, but they will be effective and will help us understand another dimension to Active Listening, so right now, let’s try to stick with Active Listening responses.

(4) Instructions to Coach: If group member is having trouble with a response, help them shape one by asking "what feeling do you observe," then "can you put that into words". If after shaping, one group member still cannot plug
in, coach can open situation to rest of group and ask for other suggestions. If none of group seems to be able to plug in, perhaps it is because the "woman" is not coming through clearly. Ask "woman" to re-send message, perhaps giving her some feedback on what seems to be confusing the issue—for example "maybe your tone of voice is not on the same wavelength as your facial expression".

(5) Instruction to Trainer Playing Woman:

a. Communicate the feelings listed in the left hand column not only with words, but with tone of voice, facial expression, gestures. Ham it up!

b. Put the comments into your own words, tailor your comments to the previous response if necessary. Do anything to get the message across clearly.

c. Do not be rigid about the kinds of responses you will accept. If the "volunteer" seems reasonably tuned in to your feelings, say "yeah" or "uh" or otherwise nod and indicate that you heard and accepted the response, and then go on to the next comment.

If the response is not at all close, then shake your head, or say "not quite--keep trying". Coach will then help member and group to shape a response.

(6) Script for Exercise:

Trainer: I am a 70 year old woman who has been at the nursing home for a couple of months. I came here after breaking a hip, am here in order to convalesce, and plan on going home when I get better. Each of you in turn will be my volunteer. You have
been working with me for a month, and we have begun to develop a good relationship. I feel your concern and involvement, and am beginning to trust you. However, I still feel a little cautious and am not sure how far I can trust you.

<table>
<thead>
<tr>
<th>Feelings to be Reflected</th>
<th>Comments for Person Playing Role of Seventy Year Old Woman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>a. Hello (Said in a very depressed tone, followed by silence.)</td>
</tr>
<tr>
<td>Discouragement</td>
<td>b. I don't think I can stand it in this nursing home any longer. I might as well be at home. They aren't doing me any good.</td>
</tr>
<tr>
<td>Bitterness-Resentment</td>
<td>c. The food is bad. The nursing aides don't come when I ring the bell. It's not fair that I ended up here.</td>
</tr>
<tr>
<td>Anger</td>
<td>d. The physical therapist only comes twice a day - once in the morning, and once in the afternoon. She only works with me for a few minutes at a time. She says she would spend more time with me if I were trying harder.</td>
</tr>
<tr>
<td>Pride Despair</td>
<td>e. I've really been trying. I have always done things well. I just can't work all the muscles she's asking me to move.</td>
</tr>
<tr>
<td>Confused-Can't Understand Why</td>
<td>f. I really thought I'd be home by now. I've worked so hard. I want to get well, but I just can't seem to get myself motivated to do all the work in physical therapy that it's going to take for me to get well. I can't seem to concentrate on exercising and building my strength.</td>
</tr>
<tr>
<td>Thoughtful-Tentatively Attempting to Get to Real Problem</td>
<td>g. I guess I know what the matter is. I don't feel comfortable going home alone with no one to help me.</td>
</tr>
<tr>
<td>Uncertainty, Want h. To Tell But Not Sure If Can Trust Volunteer</td>
<td>h. Well, last night I was really upset ... ah ... I don't know if I should tell you this or not.</td>
</tr>
</tbody>
</table>
Fear Volunteer Will be Critical
You see, it's kind of personal. I don't know what you'd think of me if I tell you.

Loneliness Confusion Uncertainty
You see, my husband died from a heart attack, just before I came to the nursing home. I lost my husband and I had to leave my home temporarily. I just don't know what to do.

Sadness, Hopelessness Helplessness
I've been crying a lot and I just feel awful. I have no family close by and I just don't know how I'm going to make it by myself.

Determination Acceptance of Reality
I guess I need to place more trust in my close friends. They tell me they'll help me out. And I guess I should try to make some new friends here.

Would Like Some Help Wondering About Other Alternatives
What else can I do?

(7) Debriefing After the Role Play:

a. Ask for comments from group, what they felt, what they observed. If comments are critical of the role play as a vehicle for learning, trainers respond with Active Listening, rather than attempting to defend process.

b. Identify specific examples. Encourage group to relate comments to a particular point in the role play.

If questions come up about how other kinds of responses would have worked, (for example: "Why couldn't you just have asked a question at that point?") go back to point in question and replay the situation with the suggested alternative response, and analyze results and feelings.

c. Analyze what happened at these points—how did the woman feel, what were volunteers feelings, what happened. Generalize learning about Active Listening:
If Active Listening had not been used, but if the sponsor had attempted to "solve the woman's problem" right away, what problem would they have been attacking?

Ask group members to state "what is most important thing I learned from this exercise? Can anyone think of examples from our own experiences in which Active Listening could have been used to help someone identify a problem?"

d. Summary: When people are very upset about something they often cannot think clearly, because their feelings keep churning around inside. Once they have a chance to get their feelings out, they can often see solutions to their own problems--or at least can see clearly what the problem is. People must deal with their feelings about a situation before they can do anything else. Active Listening helps a person work through his feelings in a constructive fashion, therefore it is one of the most important skills in establishing a helping relationship.

e. The trainer should model using affective responses in a conversation with a member of the group who is portraying an elderly client (or it may be video-taped). (10 minutes)

f. Instruct the group to meet in triads. One person should be speaker, one listener, and one facilitator. The speaker should play the role of a client. (5 minute conversation) and the listener should use affective responses including "You feel" and/or "You feel ______ because ______". The facilitator should be helpful in giving feedback. Then
switch roles so each person has a chance in each role.

(15 minutes)

i) Debriefing in large group.

Break 2:30 - 2:45

B. Recap of paraphrasing, feeling responses, and open-ended questions - large group (10 minutes).

During today's session and the session last week, we have discussed various ways of responding to people in an understanding, empathic way. One way which we discussed and practiced was paraphrasing, which basically involves mirroring or restating what the client says. We also talked about feeling responses in which the volunteer responds by stating "you feel _____" or "You feel _____ because _____." In addition, we noted the value of silence as a response and the use of noncommittal acknowledgments such as "Oh," "I see," "mm-hmm", or "really". Finally, we explored different types of questions and focused on open-ended questions as a way to facilitate a client's talking.

Although we have discussed each of these responses as completely separate entities, in actually working with a client a combination of these responses is needed. For example, there may be times when you need to gather more information in order to understand what a client is telling you and in such a case open-ended questions would enable you to get this additional information.
There may be other times when a client is discussing his feelings and you might use a feeling response to let him know that you understand how he is feeling. Or perhaps a client simply needs for you to indicate you are listening by saying "um-hmm".

Later this afternoon you will have a chance to practice using a combination of responses. The skills which you have learned during these sessions and your natural abilities in interacting with people will enable you to determine when to use which response.

C. "Exercise in Helping" (20 minutes)

This exercise can be found in Handout page 11. Read instructions to group. Each item stem and response alternatives should be read out loud to group. Rationale for correct response and explanations as to incorrectness of others should be offered.

D. Roleplaying (15 minutes)

Break into dyads with one person acting as speaker and one as listener. Speaker should discuss a concern (5 - 10 minutes) and listener should respond, using paraphrasing, feeling responses, and open ended questions. Then reverse roles.

E. Wrap-up (20 minutes)

Review of topics covered throughout the course of the training workshop; clarification of any questions or concerns of group members; procedures to be followed
in assignment of nursing home resident; designation of group supervision date and time.

F. Reaction Forms (10 minutes)
The following true and false questions are designed to assess your understanding of the physical, mental, and social facts about aging. For each of the 20 items, indicate either "T" for true, or "F" for False.

1. As people age, they become less alike and more heterogeneous.
2. Over 15% of the U.S. population are now age 65 or over.
3. By the year 2000, people over 65 will have better health and a higher socioeconomic status than older people do today.
4. Almost 10% of the elderly are senile (i.e., defective memory, disoriented, displaying bizarre behaviors).
5. Depression is the most common emotional problem of the elderly.
6. At least 10% of the aged are living in long-term care institutions such as nursing homes, homes for the aged, etc.
7. All five senses tend to decline in old age.
8. Most older workers cannot work as effectively as younger workers.
9. On the average, the elderly sustain a greater number of losses than other age groups.
10. Diminished interest in, and capacity for, sexual intimacy is part of the aging process.
11. While retirement often is associated with strain in the marital relationship, older couples generally express high levels of satisfaction with their marriages.
12. More than 50% of older people move to a warm climate after retirement.

13. About 80% of the aged are healthy enough to carry out their normal activities.

14. Reaction time and the ability to learn new things are unaffected by the aging process.

15. Older adults utilize more than half of all the health care services provided in the United States.

16. Most American families maintain frequent contact with their older relatives.
Role Playing Situations*

1. Statement: "Things will never be the same. It's terrible. I feel like giving up.

2. Statement: "Right now I'm pretty alone. Deserted you might say. My wife is dead and I don't like to go out much. I watch T.V. some, but it really doesn't interest me that much."

3. Statement: "My daughter's going to be here for Christmas. It's been so long since I've seen her. She said she could stay even beyond the holidays.

4. Statement: "I never thought I'd feel that way about a son of mine. I've always been so proud of him. I loved him so much and did everything I could to raise him right. Now he goes out and does a thing like this."

5. Statement: "I don't trust my doctor. He says one thing to me and another to my children. I wish I didn't have to go back."

6. Statement: "I'd like to talk about it but I just can't. It's one of those things we were raised not to talk about. It's just too personal a thing to talk over with someone, especially a stranger."

* Statements from Patricia Alpaugh and Margaret Haney, Counseling the Older Adult - A Training Manual, The Ethel Percy Andrus Gerontology Center, University of Southern California Press, 1979, p. 6.
### Feeling Vocabulary*

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Appendix D—Continued

lost
loved
loving
low
lucky
mad
magnificent
miserable
moody
morbid
mystified
nagged
nervous
noisy
numb
obsessed
offended
open
overjoyed
overwhelmed
panicky
passionate
patient
peaceful

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perplexed
perturbed
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phoney
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puzzled
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respected
responsible

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selfish
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sick
silly
smart
sorry
spiteful
stagnant
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strong
stunned
subdued

successful
sullen
sure
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Remembering Feelings*

In order to understand what a client could be feeling in certain situations, it is important that the counselors be able to experience feelings at deeper levels themselves. This exercise is designed to aid the counselors in becoming aware of their own feelings.

1. Find a comfortable position and become as relaxed as possible.

2. Once you are relaxed, try to recall in vivid detail an event or experience that made you feel good. Take your time, concentrate on the details of the situation, and recapture as many pleasant feelings as you can that are associated with that event.

3. When the trainer calls times, look back to your vocabulary sheet and mark off the words which best describe your feelings.

4. After the group has discussed pleasant feeling words, relive an experience which was painful. When the trainer ends the exercise, mark off on the feeling sheet those words which best describe how you felt in that situation. You may wish to share some of the feelings you experienced with the group.

* Exercise quoted from Patricia Alpaugh and Margaret Haney, Counseling the Older Adult - A Training Manual, The Ethel Percy Andrus Gerontology Center, The University of Southern California Press, 1979, p. 5.
An Exercise in Identifying Feelings

1. I just can't believe that you really seem to understand. This is the first time anyone has understood me.

2. I don't know what to do anymore. I'm just not able to do all the things I could do when I was younger.

3. I had three visitors yesterday and two more today!

4. This physical therapy just doesn't seem to be helping me at all.

5. Nobody really cares about me anymore. I'm so isolated from everyone.

6. I'd like to tell her how much I appreciate all that she does for me, but I just don't know how.

7. I know I can count on you to look in on me once a week. It gives me something to look forward to.

8. My first great grandchild was born yesterday.

9. I'm sure glad my neighbor was home. I just don't know how I lost the key to my apartment.

10. Why don't they have more time to talk to me? I really would like some company.
11. I don't know what all these pills are for. I don't even know when to take them.

12. It's been a long time since I've been to a movie, and I liked going last night.

13. There's nothing for me to do here, nothing at all.

14. I'm looking forward to my children coming to visit me this Christmas.

15. I can't believe my good neighbor, Sarah, died. She was in such good health—and such a good woman.

16. If it weren't for you, I'd be totally alone.

17. Doing some things for myself is hard, but I will not let them help me.

18. It makes me feel all warm inside to think that people really care about me.

19. I can't wait to move out of here and into that new high rise with people of my own kind.

20. The world just isn't the way it used to be. There are so many things now that I just don't understand.
Suggested Answers to "An Exercise in Identifying Feelings"

Amazed, astonished, cared for, excited, happy, pleased

Depressed, dismal, disturbed, down, forlorn, grim, lost, low, sad, troubled, useless.

Cared for, cheerful, delighted, ecstatic, elated, excited, exhilarated, exuberant, happy, liked, overjoyed, pleased, wanted.

Aggravated, angry, annoyed, bothered, disappointed, disgusted, dissatisfied, frustrated, irritated, perturbed, upset.

Abandoned, alone, depressed, deserted, disturbed, down, hopeless, lonely, low, sad, unhappy, upset, worthless, isolated.

Baffled, concerned, confused, grateful, sincere.

Good, grateful, hopeful, cared for, pleased, wanted, warm.

Delighted, elated, excited, exhilarated, exuberant, gay, happy, overjoyed, pleased, proud.

Confused, irritated, lucky, perplexed, perturbed, shamed, grateful.

Abandoned, alone, bad, depressed, deserted, disappointed, down, grim, hurt, isolated, rejected, sad.

Alarmed, anxious, concerned, confused, panicky, uncertain.

Cheerful, happy, impressed, joyful, vibrant.

Bored, depressed, anxious, down, doomed, edgy, empty, forlorn, frustrated, perturbed.

Delighted, happy, hopeful, joyful, excited, eager.

Amazed, depressed, sad, distraught, disturbed, down, freaked out, upset.

Grateful, cared for.

Determined, proud, independent, hopeful, confident.

Accepted, warm, approved, appealing, cared for, close, gratified, secure.
Confident, eager, excited, hopeful.

Bewildered, concerned, confused, uncertain, disappointed, overwhelmed, removed, resentful, wearied.
Exercise in Helping

The following are 10 statements which you should assume are made to you by other persons during an initial interview. For each statement, your task is to choose from the response alternatives that which you consider to be the most appropriate and helpful response to the person.

1. I retired last year and have nothing to do. I can't go back to work. I don't have enough money to really do what I would like to do, so I just hang around. My wife says I depress her.

Circle the most helpful response:

a. Maybe you could find some volunteer work to do to occupy your time.

b. What type of work did you used to do?

c. You're feeling frustrated and confused about what to do.

d. Why not join in down at the neighborhood senior center?

e. You're feeling depressed because of the lack of activities available which interest you.

2. It seems that everyday I get up, and something else goes wrong. My back aches more, I don't have as much pep as I used to have. Time just drags, just doing the dishes takes half my day.

Circle the most helpful response:

a. Maybe you could find someone to help with your chores.

b. You're feeling discouraged and tired because your energy level is down noticeably.

c. I have those same aches in my back. I know just how you feel.

d. You're feeling depressed and down.

e. Time seems to just wander for you, and lots of things seem to be changing for the worse.
3. My children are all away from home and they stay in touch, but not very often. My husband died last year, and I am all alone. No one seems to care.

Circle the most helpful response:

a. What did your husband die of?

b. You're feeling unhappy because of your husband's death and the distance you are from your family.

c. You're feeling lonely and sad because the closeness and support of your family has disappeared.

d. Your family is not as close as it once was and no one seems to care about you.

e. Why don't you find some hobby or community outlet to help you make friends?

4. My wife and I are having marital problems. I never thought that after 42 years of marriage and five children I could think of getting a divorce but I'm just not happy anymore.

Circle the most helpful response:

a. You're feeling confused because you would like your marriage to be fulfilling, but it isn't.

b. Have you considered talking about this problem with a marriage counselor?

c. Maybe if you got involved in some activity, your home life wouldn't be as unhappy.

d. You're feeling devastated because what you have planned on for most of your life has suddenly become a source of unhappiness.

e. How old are your children now?

5. My doctor just told me I have to go into the hospital for a hysterectomy. I'm worried that at my age I won't recover, that I'll never leave the hospital.

Circle the most helpful response:

a. You're feeling sad because you think you may die.
b. Maybe you could talk with other women who have had the same operation.

c. Have you talked to your doctor about your fears? He may be able to reassure you.

d. Don't you think your doctor knows what he is doing?

e. You feel concerned because you think your age may interfere with your recovery.

6. My wife and I are moving into an older adult community and we have to get rid of most of our furniture and possessions. Some of them we've had all our married lives and they mean a lot to us. I just don't know what to do.

Circle the most helpful response:

a. You feel unhappy because you have to give up most of your cherished possessions.

b. In order to move into your new home, you are going to have to dispose of some items which have deep meaning to you.

c. Maybe you could write a letter asking to be excused from this rule. I couldn't hurt.

d. You feel depressed and sad because you must give up many of your treasured belongings in order to move to your new home.

e. What kinds of possessions do you have to leave behind?

7. My children don't seem to understand me anymore. They are constantly making arrangements and appointments for me and treating me like I'm helpless. I love them, but I don't want them interfering all the time.

Circle the most helpful response:

a. Your children have begun treating you like a helpless child.

b. How many children do you have?
c. You're feeling frustrated because your children are not honoring your sense of independence.

d. Perhaps you could talk with others your age to find out how they handled this situation.

e. You're feeling demeaned because your children are not letting you lead your own life.

8. Now that I'm retired, I'd like to go to college to get involved in classes and maybe start a second career. But I don't know what curriculum to take.

Circle the most helpful response:

a. Why don't you find out more about some careers you may be interested in.

b. You're feeling confused about your future because you don't know where to center your efforts at a new career.

c. What kind of career did you used to have?

d. You're feeling unsettled because you don't know second career you'd like.

e. You're feeling depressed because you want to start on a new career and don't know how to begin.

9. I've been going out with a really nice man for some time now, and he's asked me to marry him. I love him, but I don't know if it could work out at our age.

Circle the most helpful response:

a. Have you ever been married before?

b. You're feeling anxious and concerned.

c. You're feeling worried about the success of a possible marriage because of your age.

d. It has been my experience that marriages at your age tend to work out better than in earlier adulthood.

e. You're feeling upset about the situation.
10. I'm not seeing as well lately because my eyesight is getting worse. My wife and kids think I should stop driving, but I don't want to be dependent on everyone else for my needs.

Circle the most helpful response:

a. You're feeling scared of losing your independence because driving is one of the last vestiges of autonomy you have.

b. Have you thought about just driving less than you do now?

c. You're losing your eyesight and along with it some of the things which you depend on.

d. How long have you been driving?

e. You're feeling afraid of losing your sense of effectiveness.

Appendix E

Volunteer Counselor Education Manual
Session I: Morning (9am - 12 noon)
A. Welcome and Introductions (5 minutes)
B. Overview of Training (5 minutes)
C. Orientation to Nursing Home (30 minutes)
D. Warm-up Exercise (30 minutes)
E. Myths and Realities of Aging (45 minutes)
   Break (10:45 - 11:00)
F. Physiology of Aging and Discussion (45-60 minutes)
   Lunch (12 noon - 1 pm)

Session I: Afternoon (1 pm - 4 pm)
A. Film and Discussion. "Nobody Ever Died of Old Age"
   (90 minutes)
   Break (2:30 - 2:45)
B. Values Clarification Exercise. "Airplane Survival"
   (40 minutes)
C. Discussion of Personal Experience in Aging (40 minutes)
D. Strength Bombardment Exercise (15 minutes)
E. Reaction Form (10 minutes)
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Volunteer Counselor Education Manual

Session II: Morning (9am - 12 noon)
A. Recap of Session I (10 minutes)
B. Warm-up Exercise. 1. "Wipe the Slate Clean"
   2. "Guess Who I Am" (50 minutes)
C. Emotional Aspects of Aging - Part I (30 minutes)
   Break (10:45 - 11:00)
   Emotional Aspects of Aging - Part II (45 minutes)
D. Discussion of Being a Volunteer (30 minutes)
   Lunch

Session II: Afternoon (1 pm - 4 pm)
A. Community Supports Following Discharge (60 minutes)
B. Nutritional Needs of the Elderly (25 minutes)
   Break (2:25 - 2:40)
C. Film and Discussion. "Interdependent Relationships"
   (60 minutes)
D. Wrap-up (20 minutes)
E. Reaction Form (10 minutes)
Session I - Morning (9 am - 12 noon)

A. Welcome and Introductions (3-5 minutes)
1. Arrange group in one large circle.
2. Representative from Mental Health Clinic to give official welcome to volunteers.

There are over 20 million elderly people in the United States today. This age group composes approximately 10% of the population. While most elderly people are physically and psychologically well, there is a minority, about 5% of the elderly, who are in nursing homes. While this 5% includes a variety of people with different needs, it is the depressed and lonely ones whom we are trying to reach in the Volunteer Counselor Education Project. We feel that working through volunteers is an excellent way to reach such people.

Volunteering is one way a community can show its support. Volunteering has two impacts:
   a. immediate job at hand gets done
   b. citizens become aware of problems within the system and can make intelligent decisions about supporting change.
3. Introduce Staff and Volunteer Trainers who make it possible for volunteers to function.
Appendix E—Continued

B. Overview of Training

1. Operating Procedures: time, restroom, coffee, phone, parking

2. Comments on experiential training

Large and small groups, cooperative learning, role of volunteer trainers as facilitators.

3. Volunteer manual: Format and how to use

Bring to both training sessions.

4. Training progression

a) Two 6-hour training sessions

b) Randomly assigned to a resident whom you will visit for two 1-hour sessions per week for five weeks.

c) Supervision

C. Orientation to Nursing Home - Nursing Home Staff

(20 minutes)

1. Welcome and thanks for participation

2. Characteristics of nursing home

a) number of staff - qualifications

b) number of residents - % male, % female, age range
c) typical problems which residents bring to nursing home (e.g., physical limitations, mental and emotional decline, family supports diminished)

3. Facilities and services provided by nursing home

a) meals, shelter, etc.
b) recreational activities
c) social activities

4. Rules and guidelines for volunteers
   a) sign in and sign out
   b) confidentiality – no access to charts
   c) restricted areas (if any)
   d) do not assist resident out of or into bed, etc.

5. Procedures in case of emergency

D. Warm-up Exercise (30 minutes)

   I would like you to divide into pairs (dyads) with someone here whom you don't know (or don't know very well). Please pair off so that each dyad is composed of an older person and a younger person. In the dyad I'd like you to discuss some topics that will help you to get to know each other. You might discuss such things as: 1) what you enjoy doing in your spare time, 2) what things are most important to you, 3) what you feel you do best, 4) something you're looking forward to in the future. In addition, you should explain the work experience you've had working with the elderly. When you come back to the larger group, I want you to introduce each other to the rest of us and tell us what you learned about the other person.
E. Myths and Realities of Aging (45 minutes)

Distribute "Aging Quotient" sheets. Ask trainees to complete the sheets and then discuss answers.

("Aging Quotient" questionnaire was obtained from: Elinor Walters, Adele Weaver, and Betty White, Gerontological Counseling Skills - A Manual for Training Service Providers, Continuum Center, Oakland University, Rochester, Michigan, 1980, pp. 1-5 to 1-10; Appendix A, p. 3.) Answers and discussion to "Aging Quotient" questionnaire:

1. As people age, they become less alike and more heterogeneous.

   True. Variability increases with age. We have had longer to develop our individual differences. Most older people think they are better off than others their age. A new book, What Do You Want to be When You Grow Old? by Harris Dienstfrey and Joseph Lederer (1979) attests to that variability of wide choice of life styles among the older population.

2. Over 15% of the U.S. population are now age 65 or over.

   False. The last year for which we have reliable statistics was 1975. At that time 10.5% of the population (22.4 million) were over 65, up from 4.1% (3.1 million) in 1900. Predictions about changes obviously depend on the birth rate. Assuming zero population growth, the older population will
constitute 11.6% by the year 2000, and 13% by 2020 (Fact Book on Aging, 1978).

3) By the year 2000, people over 65 will have better health and a higher socioeconomic status than older people do today.

True. There will no dramatic changes in the length of the human life span within the next few decades, but instead, there will be relatively regular improvements with regard to medical knowledge and health care that will mean improved health status for older persons in the future (Neugarten, 1975).

The evident certainty of national health insurance, together with the spread of private and public pensions and profit-sharing plans, seems to insure that the over-65 population should be more financially secure than their predecessors.

The gains in educational level in successive cohorts of the population have been so substantial that by 1990 the over-65 group will be, on the average, high school graduates (Neugarten, 1975). Thus, older adults will more closely resemble younger adults than they do today.

4. Almost 15% of the elderly are senile (i.e., defective memory, disoriented, displaying bizarre behaviors).

False. The term senility is a "catch-all" label which sometimes serves as an excuse for not seeking and/or
receiving adequate medical attention and treatment, and consequently it strikes fear in the hearts of many needlessly. The majority of older people are not senile; that is, they are not disoriented, do not have defective memories, and are not demented. Only about 2-3% of persons aged 65 or over are institutionalized as a result of psychiatric illness (Busse and Pfeiffer, 1977). There is much mislabeling of older persons who manifest symptoms of disorientation or poor memory as being senile, when they may in fact be bored, anxious, over-medicated or depressed.

5) Depression is the most common emotional problem of the elderly.

True. In part this is a reaction to the barrage of losses which older persons experience, and in part to fears of dependency. As stated earlier, depression is commonly misdiagnosed as organic brain syndrome . . . health professionals refer to depression as the common cold of the elderly. It affects between 20-25% of older people. Some estimates are that up to 50% of the aged suffer symptoms of depression which are similar to those seen in younger people; such as sadness, sleep and appetite disturbances, slowed motor and verbal responses, social isolation, memory problems, and poor self-esteem. In addition to these, the older person often has physical ailments and
Appendix E—Continued

fatigue. Service providers need to be on the alert for dramatic shifts in behavior and appearance among their clients (Butler, 1975).

6) At least 10% of the aged are living in long-term care institutions such as nursing homes, homes for the aged, etc.
False. In 1971, about 3.1% of men and 4.6% of women over 65 were living in institutions. The thought of "going to a nursing home" seems to be one the greatest fears of many older people. Over the age of 85, the percentage of persons living in long-term care facilities rises sharply to about 20% (Butler, 1975).

7) All five senses tend to decline in old age.
True. Sight, hearing and touch experience more marked changes, but evidence exists that taste and smell also decline. Nerve cells or neurons, are lost during the process of aging. Associated with this decline is a decreased capacity for sending nerve impulses to and from the brain. Conduction velocity decreases, voluntary motor movements slow down, and the reflex time for skeletal muscles is increased. The decline in vision and hearing may cause an older person to become socially isolated; while the decline in taste and smell, particularly, may explain why older persons often derive less enjoyment from eating. They may also tend to over-salt and/or sweeten their food at a
time when excess salt and sugar may be injurious to their health (Kart, Metress, & Metress, 1978).

8) Most older workers cannot work as effectively as younger workers.
False. Despite declines in perception and reaction speed, studies of older workers under actual working conditions generally show that they perform as well as, if not better than, younger workers. Consistency of output tends to increase by age, as older workers perform at steadier rates from week to week than younger workers do. In addition, they have less job turnover, less accidents, and less absenteeism than younger workers (Riley & Foner, 1968).

9) On the average, the elderly sustain a greater number of losses than other age groups.
True. These include loss of spouse and close friends, often the family home, status in the community, reduction in income, physical vigor and beauty of society's standards, and loss of a job together will all the work-related activities and acquaintances (Butler & Lewis, 1977).

10) Diminished interest in, and capacity for, sexual intimacy is part of the aging process.
False. The majority of older persons have both interest in, and capacity for, sexual relations. The Duke Longitudinal Studies found that sex continues to
play an important role in the lives of most men and the majority of women through the seventh decade of life (Palmore, 1974). However, older people may need considerable sexual information; e.g., many men do not know that their need to ejaculate with intercourse may be considerably reduced. Women may need information about the availability of lubricants so that intercourse is not painful, since elasticity of the vaginal walls and the amount of lubrication declines with age. Touching and intimacy are very important elements in expressing sexuality. Sexual fulfillment poses a problem for older women as there is a lack of available partners, and often a conflict of values which prevents them from seeking alternative sexual expression (Comfort, 1976).

11) While retirement often is associated with strains in the marital relationship, older couples generally express high levels of satisfaction with their marriages.

True. The literature, however, is mixed. For marriages which have been good, they often get better with retirement. Marriages which have had problems that could be ignored when one or both were working may find the increased contact brings intolerable tensions. As elsewhere, divorce is on the increase among post-retired couples. It appears that couples
with more traditional expectations of marriage express greater satisfaction. Troll mentions the shift in meanings of marriage from romantic attraction to congenial attachment (Troll, Miller & Atchley, 1979). For those who marry late in life, the most critical factor in the success of the marriage is the attitude of their adult children. This is often a blurring of sex-role distinctions; for instance, men exhibit more expressive roles than previously while women adopt instrumental roles.

12) More than 50% of older people move to a warm climate after retirement.
False. Most older people live relatively near their adult children. This may be due in part to economic consideration, as traveling to visit becomes more costly. Only about 5% of all retirees leave their state after retirement. 70% continue to live in their pre-retirement homes, and about 25% move to a smaller home in the same general area (Kart, Metress & Metress, 1978).

13) About 80% of the aged are healthy enough to carry out their normal activities.
True. About 5% of those over age 65 are institutionalized, and another 15% among the noninstitutionalized say they are unable to engage in their activities of daily living (Palmore, 1977).
14) Reaction time and the ability to learn new things are unaffected by the aging process.
False. Reaction time increases with age, and appears mainly to involve the central nervous system. It takes longer for older people to process information, to learn new material or new tasks. The more choices that are involved in the task, the longer it takes for them to react (Waugh, 1973). Botwinick (1973) suggests that cautiousness may play a big part, since there is a tendency on the part of older people toward accuracy and certainty. In addition, he points out that exercise, increased motivation, and practice can reduce the effects of slowing in reaction time.

15) Older adults utilize more than half of all the health care services provided in the United States.
True. 86% of the over-65 population have at least one chronic illness. In 1969, people aged 17 to 44 average 4.2 physician visits, compared to 6.1 visits among people 65 and over. Older people with annual family incomes over $10,000 averaged 7.5 physician visits. They are also more likely than the young to go to a short-stay hospital and are more likely to stay longer. Compared to people under 17, older people have more than three times as many hospitalizations per 1,000 and have about three times as long an average duration of stay (Atchley, 1980).
16) Most American families maintain frequent contact with their older relatives.

True. The belief that older people are neglected or abandoned by their adult children is not generally true. Although the quality of the visits were not assessed when Ethel Shanas conducted research among older parents not living with their children, she found that 52% had seen a child within the previous 24 hours, and 78% had seen a child within the previous week (Shanas, 1973). Not only is there frequent contact; often older parents are sources of help to their children, e.g., providing services, living quarters, and financial assistance (Neugarten, 1968).
"Aging Quotient" References


F. Lecture: The Physiology of Aging* (45 - 60 minutes)

This lecture is not designed to give you an in-depth view of the physiology of aging, but rather a brief overview of age-related physical changes, and should be used if the filmstrip is not available. It is a perspective we must always keep in mind as we work with older people. We will first make some general observations about the physiology of aging. There are four basic characteristics of normal age-related changes. First, these changes are universal; that is they affect all older people. However, they affect each person differently. For example, each of us can expect to have a hearing loss as a part of our own aging process but the onset and degree of this hearing loss will be different for each of us.

The second general characteristic of age-related changes is that their onset is gradual; they occur very slowly, so that there may be little awareness of their occurrence. Accommodation to these changes also happens without the awareness of the older person. Awareness of age-related changes may be measured by outside events such as changing one's prescription for glasses, or a comment by a friend or doctor.

The third characteristic to be discussed is that these changes are progressive and detrimental and are generally thought to be irreversible. Sometimes with
a change in health habits such as diet and exercise, a
person can reverse a declining health situation and, in
fact, regain a state of health that is better than in
earlier years; but assuming no change in behavior, one can expect age-related changes to be detrimental.

The last of these general observations is that normal age-related changes are intrinsic; that is, they occur from inside. There are many outside factors which affect the aging process, but the age related changes occur regardless of outside events. Influencing the normal age-related changes which occur in each individual is his/her own genetic, social, environmental, and health history. All of the events in life affect how a person ages, and cause the aging of each person to be uniquely his or hers and differing from that of all other people.

We begin this discussion with a brief overview of statistical information related to health and aging. Eighty-six percent of people over 65 have at least one chronic health problem. That statistic includes hearing and vision problems. However, 80% of older people have health good enough that they can live independent lives. That is a very significant figure to keep in mind, because as we focus on the physiological changes occurring with aging it is very easy to lose perspective and experience the thought
that aging is terrible. How can a person ever manage? One of the reasons that most older people manage to cope so well with these changes is that they are gradual, which allows a psychological adjustment to living with difficulties that a younger person might find disabling.

Approximately 20% of older people, depending which source of reference is used, need outside assistance to manage. These people are in the category of the "frail elderly." This percentage is 3 to 4 million people which is equal to the population of the State of Connecticut. Therefore, while it is important not to lose perspective about the actual number of older people who function independently, it is just as important to recognize the significant numbers of "frail elderly" who do require outside assistance.

Next we'd like to discuss specific age related changes in the body, by reviewing each body system. There are four general changes in the older person, however, that affect all body systems. The first of these is the loss of the reserve capacity of the body. Imagine the body as an airplane with all of its reserve backup systems, such as extra braking and steering controls. If one should fail to function or be under stress there are other controls. The human body is designed similarly. The healthy person has
significant reserve capacity in his heart, liver, kidneys and most other body organs. However, as one ages the functioning of these organs decrease and there is little or no reserve capacity. The awareness of the loss of this reserve capacity does not usually occur until a disease process places extra stress upon the body.

It's interesting that this observation about reserve capacity is now challenged. There is a new perspective that this loss of reserve capacity may not be inherent in the aging process but rather a sociologically defined phenomenon. This phenomenon is based on a condition called "hypokinetic disease," which is a disease of inactivity. Inactivity causes vital functions to decline - kidney function, liver, heart and lungs. It is being hypothesized that hypokinetic disease is the cause of loss of reserve capacity.

Second among these general changes is the reduced effectiveness of normal control mechanisms of the body. An example of reduced effectiveness is the way in which the temperature regulation mechanism, affected by several processes, is more easily disturbed. Sweat glands, an important part of the body-cooling mechanism, atrophy with age and cease to function efficiently. As aging proceeds, subcutaneous
fat tissue decreases so the insulating function of this tissue is lost. With the loss of these capacities, the ability of the body to regulate its temperature is diminished.

An increased need for recovery time from physical and emotional stress is the third general body change. This need is reflected in prolonged hospital stays as well as in the fatigue from exertion experienced by the elderly.

Fourth and last among general changes in the body system is an increased vulnerability to infection. Four factors which influence this vulnerability are: 1) degenerative changes and diseases associated with aging such as decreased lung capacity and neuromuscular changes in the urinary tract system; 2) age-related circulatory dysfunction so that tissues do not receive an adequate supply of blood and concurrent infection-fighting elements; 3) significant incidence of sub-clinical (without obvious symptoms) dietary deficiencies; and 4) changes in the immune system which decreases resistance to disease.

1. Changes in Specific Body Systems

The Cardio-Pulmonary System. This is the heart-lung system. Heart disease is the most frequent cause of limitation of activity in older people and the most common cause of death over the age of sixty-five.
There are several changes associated with the cardio-pulmonary system. There is loss of cells in the heart muscle itself; there are changes in the lungs which cause reduced adsorption of oxygen and result in diminished lung capacity, and there is decreased elasticity of the artery walls. All of these changes result in up to a 40% decrease in cardiac output under stress.

Common diseases of this system are:

a. coronary artery disease - arteriosclerosis (hardening of arterial walls) and atherosclerosis (narrowing of vessels). Both lead to a decreased supply of blood to the heart.

b. hypertension - (high blood pressure) reduces blood flow to vital organs.

c. congestive heart failure - (cardiac failure or cardiac insufficiency) a set of symptoms associated with impaired pumping performance of the heart causing fatigue, shortness of breath, edema (retention of body fluid).

d. pulmonary heart disease - damage in lungs (pneumonia, emphysema) causes enlarged heart leading to congestive heart failure.

e. pneumonia - (lungs fill) 25% mortality rate among people over 65.
f. chronic obstructive lung disease - (bronchitis and emphysema) chronic cough, abundant mucous, shortness of breath.

g. lung cancer - usually co-exists with chronic obstructive lung disease.

h. cerebrovascular disease - (stroke) caused by lung disease, arteriosclerosis and atherosclerosis; results in lack of oxygen supply to brain.

The Digestive System. There are many changes occurring in the digestive system. In the mouth changes in the taste buds result in decreased sensitivity to the tastes of sweet and salt. This may result in an increase of sugar and salt intake to make foods taste the same to a person as they always have. The tastes of sour and bitter do not decline in strength and may further affect the way food tastes to older people.

The teeth have an important impact on the digestive system. More than 75% of people over 65 have complete dentures. Poorly fitted dentures (some people believe they need to be changed every five years to be well fitted), and loose teeth or no teeth all affect what older people can eat as well as their motivation and interest in eating. The mouth is generally more sensitive to injury and disease in the older person. The tissues are thinner and dryer; and
sores are more likely to develop. Pyorrhea is the most common cause of loss of teeth.

Digestive enzymes are less effective in the older person, and fat digestion, which is directly related to decreased functioning in the liver and gall bladder, is reduced.

Constipation may be the number one digestive complaint of older people. This problem is the result of many and interrelated processes. There is no definition of "normal" elimination patterns. The combination of social, cultural, nutritional, emotional, and physical aspects of a person's life determine what each individual defines as normal, and conversely, abnormal, in terms of their bowel habits. There is no conclusive evidence that there is an age-related reduction of intestinal motility to correlate with the increase problems of constipation.

Normal age-related changes in the digestive system alone or in combination with other disease conditions, make this a sensitive system with symptomology particularly obvious to the older person. Many of the problems of this system are not in themselves serious and may be controlled by diet and environmental measures.

The Skeleto-muscular System. Some changes in this system are: 1) general decrease in strength; 2) muscle
cells are replaced by fat cells; 3) bones become thinner and more brittle; 4) height is reduced up to two inches, due to a compacting effect related to aging. (Some hypothesize that there is a reduction of air space between parts of the body.) Diseases of the skeleto-muscular system are the second most common disabling conditions in people over sixty-five. These diseases are: osteoarthritis, rheumatoid arthritis, gout and osteoporosis.

In this system, as in all others, it is very important to distinguish between pathological disorders and age-related change. For example, while it is true that older people's bones are brittle and break more easily, it is also true that there is a disease condition, osteoporosis, that causes pathological fractures with very little, or no, stress or injury.

Urinary System. Only 3% of older people have kidneys with normal tissue structure. Microscopic examination reveals changes in the cellular structure of the kidneys for most older people. Two main changes occurring in this system are: 1) decreasing bladder capacity, and 2) delayed urination reflex which results in poor and delayed emptying of the bladder. The primary results of these changes are urinary tract infections, and urinary incontinence.
Diseases of this system alone, or as a result of other problems, are a significant cause of death among the elderly. On a less serious level, because of the bladder's smaller capacity and the impulse to urinate taking longer to manifest itself, there is often a strong sense of urgency when it does occur.

Urinary incontinence is a major problem for 7% of the over 65 populace which affects both physical and emotional health. The percentage of people affected by this problem is even higher for institutionalized elderly, and is estimated at 25% for bed-ridden patients. Incontinence is often the event precipitating admission to a nursing home. It frequently becomes the problem that family members can no longer deal with -- the last straw -- which indicates that other arrangements such as institutionalization need to be considered. Underlying causes of this difficult-to-treat problem are disease factors, psychological factors, physical changes, drugs, limited activities (confinement to bed), and poor motivation.

Skin (integument). The changes that occur in the skin of an aging person, while not usually life-threatening, have potential for great impact on the older person. Those changes are often the most obvious manifestations of the aging process.
Wrinkling, the graying of hair and the sagging of skin are the most common. They are due to changes in muscular tissue, a loss of subcutaneous fat cells, and atrophy of the sweat glands. Decreased blood supply to the skin and atrophy of the sebaceous glands also add to these changes. A greater sensitivity to temperatures, cold and heat, result from these changes and can sometimes have serious consequences such as heat prostration or pneumonia due to exposure.

Decubitus ulcers, sometimes called bed sores or more accurately pressure sores, can come from too much sitting as well as lying, and are the most serious skin problem of the elderly. They can occur with devastating swiftness and severity. Another common disease is senile pruritus (itching). Dry skin, due to decreased oil secretion and less water in tissues, is the cause of this uncomfortable condition.

Genital System. There are changes in the sexual organs, as well, with age. In females, there is lowered output of vaginal lubrication and a weakening and thinning of the vaginal walls. In extreme cases, vaginitis develops which makes intercourse quite painful. Hormonal treatment and steroid cremes often prove beneficial. Generally, these changes result in more time and stimulation needed to reach excitement. There is a lower level at the plateau phase, less
intense muscle- and vaginal-wall contractions in the orgasmic phase, and a shorter span of time in the resolution phase.

In males, more stimulation and time is needed for attainment of erection. Full penile erection generally takes longer to achieve. There is a longer span of time in the plateau phase, thus achieving better ejaculatory control than a younger male. In the orgasmic phase, rectal contractions are lessened, the ejaculations are fewer in number and intensity, and less semen is emitted. Loss of erection occurs faster in the resolution phase for older men.

There are many social, societal and physical factors inhibiting the expression of sexuality among the elderly in our culture, but the capacity and need for intimacy is always present.

**Neuro-sensory System.** The main age-related change occurring in this system and affecting all of the sensory organs is a decreasing sensitivity to outside stimuli. The senses of touch, taste, hearing, sight, and smell are all affected by the aging process. We will be showing a slide-tape presentation of the characteristics of these changes and exploring the impact of the changes by having each of you experience some of these changes for yourself. We will be coming back to this subject later in this session.
We have discussed the age related changes in each of the body systems and now want to describe some of the disease processes which also may take place. There are three characteristics of disease process in general which are different for elderly people. There is a much higher incidence of chronic illness among the elderly and, as mentioned earlier, over 85% of the elderly have one or more chronic illnesses. Concurrently, there are fewer acute illnesses among the elderly. Diseases, occurring also in younger people such as diabetes or leukemia, are milder and can be treated with more conservative measures, such as diet and weight reduction in the case of diabetes. These diseases progress more slowly and have milder symptoms among the aged.

A third characteristic of health problems in the elderly is that their symptoms are less acute and may differ radically from those of a younger person. Infections may be present without an elevated temperature, or any pain. In the older person a physical illness may be manifested by behavioral symptoms, i.e., confusion and depression. Paranoid behavior may be the only manifestation of a hearing loss, and psychological problems may be manifested by complaints of physical problems. Therefore, it is more difficult to sort out the causes of and prescribe
appropriate treatment for, health problems of the elderly.

The importance of careful examination and treatment of older people is underlined by a story Robert Butler, of the national Institute of Aging, tells about an older man who went to his doctor complaining of a sore right leg. The doctor brushed aside the patient's concerns with a comment indicating that such pains are to be expected in old age. "Well," replied the man, "my left leg is the same age as my right leg, and it doesn't hurt at all." The moral of that story seems to be that while it is realistic to expect some age-related changes, we do not need to utilize physicians who, without examination, attribute symptoms merely to age.

Lunch (12:00 - 1:00)
Session I - Afternoon (1:00 – 4:00)

A. Film and Discussion - (90 minutes)

"Nobody Ever Died Of Old Age"

Dramatization of the lives of a series of resourcefully independent citizens in their later years who are struggling to survive, with some degree of dignity, the odds against them. In episodes ranging from harsh to humorous to poignant, the film combines praise for old people with outrage at the dehumanization they experience at the hands of society.

Break (2:30 – 2:45)

B. Values Clarification Exercise - (40 minutes)

Airplane Survival Exercise

Write the descriptions of each person on newsprint. Tell the volunteers that this airplane is going to crash. There are only 10 parachutes. Ask the members to pretend that they are the ones who have to decide which 10 to give the parachutes to. Assume that all of the people can use the parachutes effectively.

Go down the list, have them discuss that person and their feelings about giving him (her) a parachute. You will probably be able to think of some challenging
questions to ask. Ask the members to justify their decisions - why should that person be given a parachute and not another? Then take a vote as to whether that person should or should not receive a parachute. When you finish the list count the number of parachutes given. You may be able to give some more out, or you may have to take one away from somebody.

Male, age 76, Dr. on verge of cure of cancer.
Female, age 16, hasn't spoken since age 4.
Female, age 66, married six times.
Male, age 19, negro ghetto leader, on most wanted list for murder.
Male, age 6, incurable cancer.
Female, age 15, on probation, heavy drug, runaway.
Female, age 28, drug user, left husband and 3 small children.
Male, playboy, age 36, never works.
Female, age 14, no family, low IQ.
Male, age 88, wealthy, scientist.
Male, age 13, crippled, very musical.
Female, age 21, needs plastic surgery for deformed face.
Male, age 52, 6 children, salesman.
Female, age 34, welfare worker, not married.
Male 18, writes bad checks, only child, sick mother.
C. Discussion of Personal Experiences in Aging (40 minutes)

Purpose: To facilitate open communication between young and old participants; to promote understanding and to gap intergenerational boundaries; to gain self-awareness regarding values of aging.

Directions: Divide into three small groups with each group being composed of an equal number of adolescents and older adults. Group discussion should focus on group members' perception of aging -- with the older members sharing their experiences of aging (what changes they have experienced, how they have coped with these changes how they feel about being an older adult) and the adolescents discussing perceptions and feelings regarding older adults whom they have known and feelings about their own aging.

D. Strength Bombardment (15 minutes)

Have the volunteers break into groups of six, preferably with other members they know well and feel comfortable with. Focusing on one person at a time, the group is to bombard him will all strengths they see in him. The person being bombarded should remain silent until the group has finished. One member of
the group should act as recorder listing the strengths and giving them to the person when the group has finished.

The volunteers should be instructed to list at least fifteen strengths for each member. They should also be cautioned that no "put-down" statements are allowed. Only positive assets are to be mentioned. At the end of the exercise ask the members to discuss how they felt giving and receiving positive feedback. Was one easier than the other? Which one?

In some groups it is wise to spend ten minutes discussing with the group the different types of strengths that exist, as well as developing a vocabulary of strength words they can use.

E. Reaction Forms (10 minutes)
Session II - Morning (9:00 am - 12:00 Noon)

A. Recap of Session I (10 minutes)

B. Warm up Exercises (5 minutes)

1. Wipe The Slate Clean

This one can only be done after the whole group is present.

Process: Have everyone seat themselves comfortably and close their eyes.

In their minds, imagine a large blackboard, with themselves standing in front of it, chalk in hand. They are to write on the blackboard everything which is on their minds right now. Every concern, worry, joy, fear, anything which is on their mind. When they have written everything they can think of, they are to imagine taking a damp sponge and erasing everything they have written until the slate is clean. Then open their eyes and come back to the group.

2. Guess Who I Am?

This can be used as a get-acquainted activity. It focuses everyone's attention on one person in a healthy way and gives that person a moment in the spotlight.

Have volunteers write out some biographical information that described them but does not make it too obvious who they are. Include such things as
hobbies, talents, major trips they have taken, unusual things about their family, and so on.

When each person has done this, collect the cards and read them while the group attempts to guess who is being described.

Include a card of your own!

C. Common Emotional Problems (Part 1 - 39 minutes, Part 2 - 45 minutes) 15 minute break in between.

Loss is a predominant theme in characterizing the emotional experience of elderly people. The psychological treatment goal is obtaining insight and restitution possibilities within the limits of the life situation and individual personality. Losses in every aspect of late life compel the elderly to expend enormous amounts of physical and emotional energy in grieving and resolving grief, adapting to the changes that result from loss, and recovering from the stresses inherent in these processes. The elderly are confronted by multiple losses, which may occur simultaneously: death of marital partner, older friends, colleagues, relatives; decline of physical health and coming to personal terms with death, loss of status, prestige, and participation in society; and for large numbers of the older population, additional burdens of marginal living standards.
Inevitable losses of aging and death are compounded by potentially ameliorable cultural devaluation and neglect.

Older people often are handicapped by their own bodies, which respond to challenge with less energy and strength than were formerly available, particularly if major illnesses have taken their toll. Emotionally, a rapid succession of losses can leave individuals with accumulated layers of unresolved grief along with fatigue and a sense of emptiness. There may be little societal support for grief and mourning as the rituals of religion and customs are increasingly questioned and discarded.

It is odd distortion of reality when the elderly are popularly depicted as weak, unassuming, gently tranquil people who passively wait out their last days. Becoming old, being old, and dying are active physical and emotional processes that test the mettle of each person. Reluctance to accord the elderly appropriate recognition for their strengths and capacities indicates a failure to understand what is required in being old. We have lost our naivete about the care-free nature of childhood as we have developed our understanding of the difficult and frightening developmental work each child must do to grow up. But simplistic illusions about old age continue, with
little conceptualization of the normative stages one must pass through in late life. Certain dramatic events (for example, widowhood) have been more widely studied than others, but there is as yet no cohesive, reliable body of information against which one can measure adjustment patterns.

**Emotional Reactions to Age-Related Life Crises**

Certain life crises occur in old age regardless of socio-economic and cultural circumstances, as part of the current aging experience in the United States.

**Widowhood**

With 56 out of every 100 of the elderly now becoming widowed (three times as many women as men), the loss of spouse represents a major psychological issue. The mourning process itself occurs at the same time as the need to make practical though emotion-laden decisions about where to live, what to do about the family home and possessions, how to dispose of the spouse's personal effects, what kind of contact to maintain with the spouse's relatives, and what to do about new social roles. Although research data are not available on the progress of couples (or of individuals, for that matter) through the entire lifespan, one can observe the interdependence that results from years of living together. Yarrow, Butler, et al. (1963) found that losses of significant persons were
important factors where there were any evidences of
deteriorated functioning in healthy aged men. Other
investigations point toward associations between
bereavement and increased medical and psychiatric
morbidity. The widowed and their children may be
ambivalent about the more involved roles that many grown
children feel compelled to accept in relation to the
remaining parent. Friends and associates tend to socially
ostracize the widowed individual for varieties of reasons:
pain over the reminder of the loss of a friend; anxieties
and denial of their own aging; awkwardness in knowing how
to comfort a grieving person; and uneasiness about
accepting a single man or woman into a cultural pattern of
couples. Thus widows and widowers may be forced to seek
out each other's companionship or fall back on their own
resources.

Marital Problems

Couples who enter old age together find new situations
awaiting them. There is a greater amount of close contact
and free time for each other. With retirement, the
elderly man spends most of his day at home for the first
time in his adult life. Wives may complain of husbands
being underfoot all day with nothing to do as the wives
continue their accustomed routines of housework. Some
men actively pursue new interests but many encounter
difficulties in finding a meaningful substitute for work. As one or the other becomes ill and requires nursing care, the healthy spouse is torn between the desire to provide such care for the sick person and a need to have a life of his or her own outside the sickroom. Typically, because of a shorter life expectancy and a tendency to be older than his wife at the time of marriage, it is the husband who becomes ill, often chronically so and the wife nurses him until his death. If the illness is a long and draining one, the wife can be expected to feel some bitterness and sense of exploitation. This becomes a more serious problem when the wife denies her feelings and insists on the pretense that her husband is no burden. The husband, sensing his wife's frustrations, may react with hurt and anger, and a troubled marital relationship ensues wherein both need guidance and reassurance.

Discrepant rates of change, narcissism, fear of death, and the relationship to the children are among critical variables that seem pertinent to marital problems in late life and require study.

At times, underlying disease states may be misread by a spouse as emotional moods.

Sexual Problems

Sex relations, although tending to be diminished in frequency, are practiced by many older people; however,
problems can arise physically and emotionally in relationship to aging and illness. Surgery requiring a colostomy, for example, can seriously deter sexual expression for aesthetic and physical reasons. Physiological changes in females (for example, untreated "senile" vaginitis) and prostatic problems in males are some of the possible organic impediments to sexual intercourse. Elderly people, like the young, tend to react with anxiety and depression over threats to potency and sexual fulfillment. In addition, new fears can present themselves. One of the more common worries is fear of the effects of sexual exertion on the heart or circulatory system. Studies indicate that more fear is present than is warranted. Other problems result from spending a long life together: one partner may begin to find the other less and less sexually attractive as they age or be simply bored by the routine of the same partner over a period of years. A widow has an especially difficult situation, since chances for remarriage are so slight. The elderly are inclined to follow the strict sexual customs of their youth - no sex outside of marriage - and are therefore forced into celibacy regardless of personal inclination.

Iatrogenicity (a physician's induction of pathological reactions) is pertinent to the discussion of sexual problems. By means that range from the injunction to
"take it easy," said to the active man now suffering from a cardiac disorder, to the failure to prepare the patient who is about to have a prostatectomy and orchidectomy, the physician may contribute to depressive reactions so common in older people.

Retirement

Women enjoy a mixed blessing in relation to retirement. Many never work outside the home and therefore are not as subject as men to the generally arbitrary retirement policies of employers. The traditional housewife's job identity is threatened in mid-life as her children leave home but as she adjusts to caring for only herself and her husband, she has a definite pattern of work — at least until her husband dies. Even in her widowhood a woman continues to have the routines of homemaking available to her. For those women who do work outside the home, many still retain the dual role of homemaker and career person, thus ameliorating the impact of retirement.

For men, retirement is a concern that can affect the very essence of their lives. A large number of men derive an almost single-minded identity from their work (some even becoming "workaholics" — addicted to work). Work and life become so interconnected that the loss of a job can demolish the reason for living.
The syndrome of the restless and depressed retired person is common indeed, with little hope for wide-ranging solutions in the near future. There is both commonsense and research evidence that people adjust better if they can choose when and how completely they wish to retire, but such evidence is of little import in a youth and production oriented economic system. Eventually a redefinition of work itself may bring a more satisfying retirement picture. Perhaps work, leisure, and study could be alternated throughout the life cycle instead of being parceled out according to age group.

Men should also be encouraged to take a more active part in other aspects of life with more involvement in the care of children and home, a sharing of responsibility for financial support with the wife, more leisure time throughout life for rest and study, and active involvement in cultural and social activities. A call for male as well as female liberation is in order if men are to escape the crushing burden of over-identification with work and the problems of stress, coronary disease, retirement shock, and shortened life expectancy that are associated with it.

**Sensory Loss**

Significant hearing loss which affects men more often than women (probably due to industrial noise), occurs in
some 30% of all older people and is potentially the most
problematical of the perceptual impairments. It can
reduce reality testing and lead to marked suspiciousness,
even paranoia.

Hearing loss causes greater social isolation than
blindness. Onlookers may mistake the hard-of-hearing as
mentally abnormal or "senile." There is little social
sympathy, and older people who are deaf are often excluded
from activities to become less and less well oriented.
The loud or badly articulated speech associated with
hearing loss can have a negative effect on others and the
hard-of-hearing are given less consideration than the
elderly blind, probably because verbal communication is so
vital to human interaction.

Although most old people need glasses, poor vision is
not as widespread as is usually thought. About 80% have
fair to adequate visual acuity to age 90 and even beyond.
Often one eye may continue to function, even if the other
does not. The elderly find the possibility of cataracts,
glaucoma, and other disorders frightening because of the
isolating and immobilizing effects. Visual loss can cause
decreasing mobility, poor orientation, and frightening
visual impressions that resemble hallucinations. Reading,
television, and other visual pastimes are reduced or
eliminated. Furthermore, older people feel more
vulnerable to danger and crime when handicapped by sensory loss.

Smell also declines with age, and up to 30% of people who are over 80 years have difficulty identifying common substances by smell. Taste too is affected, since two thirds of taste sensations are dependent on the ability to smell; in addition, taste buds decrease sharply in number with age. There is also a falloff of tactile response as both perception and motor expression decline in reaction to stimuli. However, the slowing of speed and response, which at first appears to be a characteristic of old age, was found in the NIMH studies to be also related to environmental deprivation and depression.

On a more positive note, Beard in 1967 studied 270 male and female centenarians (100 years old or more) and found only 5.2% blind and only 1.9% completely deaf. However, 58.5% had only fair to poor vision. Hearing disappeared more slowly than sight. Woman lost more vision than the men, and men lost more hearing than did women.

**Aging, Disease, and Pain**

The chronic and acute illnesses and diseases in old age provide the fulcrum determining the physical functioning and energy levels that are available to elderly people. Just as loss and grief define the
critical emotional variable for the old, so illness presents the prime physical variable. The Roman adage "mens sana in corpore sano," a sound mind in a sound body, recognizes the interrelationships between the two. Psychometric tests have proved to be unusually sensitive to even minimal disease. Physical illness frequently generates both appropriate and distorted emotional reactions since it represents so much that is inherently frightening to human beings. Latent fear and anxiety about death grow real with illness. Feelings of helplessness and vulnerability buried deep within the individual are resurrected in the face of implacable illness and the aging process. Hope for cures from medicines, luck, or a supreme being diminishes in the light of the general knowledge most people now possess about aging and the current irreversibility of many chronic diseases. Older people's sense of pride in their own body's reliability is shaken when they experience greater susceptibility to communicable diseases, air pollution, dampness, cold weather, and exertion. Moreover, aging and disease threaten people's sense of who they are -- their identities -- as their bodies change "in front of their eyes." People report feelings of shock and disbelief at their mirror images, in reaction both to aging (is that old person me?) and to illnesses, which even more
rapidly change the size, shape, and appearance of the body.

A common feature of old age, which begins in the middle years, is "body monitoring" -- the need to concern oneself with the care of one's body and its functions in a more concerted way than before. Bodily processes that formerly took care of themselves or required minimal attention begin to demand more and more time as people age. Among the elderly, 86% have some kind of chronic health problem requiring more visits to the doctor, added stays in the hospital, special diets, exercises, drugs, rehabilitative therapy, or additional provisions for daily life at home. With 81% of the elderly ambulatory and to a substantial degree responsible for their own self-care (only 5% are in institutions and, even there, many have some degree of self-care), it is apparent that body monitoring is a compelling preoccupation. Some older people welcome the relief from other anxieties, which occurs as they absorb themselves in their own care. But others are annoyed, wearied, or bored by the routines imposed on them by ill health and the decline of their bodies. The composer Stravinsky in his eighties wrote of his irritation at having to spend so much time on his body when he wanted to write music. One can assume that his complaint is echoed by many who wish to continue active, interesting lives.
Hospitalization and Surgery

Heart and circulatory diseases, digestive conditions, and disturbances of the nervous system are the primary causes of hospitalization after age 65. Hospitalization is drastic and dramatic proof that something is wrong or may be wrong. Fears become heightened and, since so many of the elderly now die in hospitals and nursing homes rather than at home, such institutions come to be viewed as places to die as well as places to regain health. There is still far too little attention paid to the emotional feelings of sick people, and this is especially the case with the elderly. The emphasis on treating physical disease, the often cold and cheerless environment of hospitals, the generally efficient but over worked and impersonal medical staff, and too rigid visiting regulations combine to make the elderly person feel isolated, unprotected, lonely, and bored. There is little to do except watch television, a pastime that becomes limited if hearing or sight is impaired. Occupational and recreational therapies are usually minimal. Removal from the home environment (with consequent deprivation of adequate contact with family and friends, lack of responsibility, and restriction of mental and somatic activity) encourage anxiety, irritability, disorientation, and eventual regression.
Insufficient thought has been given to the side effects of various surgical procedures. An example is the "black patch" syndrome, which until relatively recently puzzled the medical profession. Following bilateral cataract surgery when patches were placed over both eyes, some old people became delirious and disoriented. It was observed that the syndrome did not occur when one eye was operated on at a time, leaving the sight in the other available to the patient. Finally, the conclusion was correctly draw that the black patch reaction was simply the result of loss of contact with people and environment. Therefore, operating on one eye at a time and providing additional sensory stimuli will allow patients to maintain orientation. It seems logical that other undesirable side effects of surgery might be alleviated through just such careful thinking through of the problems.

Several organizations assist persons undergoing particular kinds of surgery. The Reach to Recovery program of the American Cancer Society is a rehabilitation program for women who have had breast surgery. The United Ostomy Clubs offer information and counseling to those who have had colostomies and ileostomies.

Dying and Death

Preparation for death involves a condition unknown in past or present experience, for one cannot truly imagine
one's own nonexistence. Yet, strangely, although fear of death is part of human experience, older people tend to fear it less than the young do and often are more concerned about the death of those they love than about their own. Many can accept personal death with equanimity. In terminal illness it may even be welcomed as a release from pain and struggle. Reactions to death are closely related to a resolution of life's experiences and problems as well as a sense of one's contributions to others. Profound religious and philosophical convictions facilitate acceptance. The process of working through one's feelings about death begins with a growing personal awareness of the eventual end of life and the implications of this for one's remaining time alive. For some people the process begins early; for others the physical signs of aging occur before awareness is allowed to surface. Some few attempt to deny death to the very end. A resolution of feelings about death may be responsible for those elusive qualities, seen in various old people, known as "wisdom" and "serenity." The German philosopher Feurbach has written that "anticipation of death is seen as the instrument of being -- of authentic existence." There are of course varying degrees and levels of acceptance perhaps the most satisfying is that described by another philosopher, Spinoza: "The adult who sees death as completion of a pattern and who has spent life unfettered
by fears, living richly and productively, can integrate and accept the thought that life will stop."

Few elderly persons today have the opportunity to die at home as their parents and grandparents did. More than 50% of all deaths take place in hospitals, and many in nursing homes. The process of dying is made more difficult by this shift from home to institutions, where the emphasis is on physical rather than emotional concerns. Short and inflexible visiting hours and lack of accommodations for intimate family contact encourage families and friends to withdraw from dying persons, in anticipatory grief (working out feelings of grief as though the person were already dead). Thus the aged person, who may have resolved many of his own difficult feelings about death itself, is left without human comfort and warmth as death approaches. Older people often remark that their greatest fear is of "dying alone."

There is an increasing interest in the subject of death and dying, as evidenced by a growing body of research and literature. One of the best-known reports is the Kubler-Ross work (1970) on the stages of dying, in which she suggests five more or less distinct stages or levels of experience during the actual course of dying. The first stage is denial of death, in which the person simply refuses to believe the evidence of his own approaching demise. In the second stage, denial is
replaced by anger and rage at the injustice and unfairness of life's ending. Third, the person moves into a bargaining stage during which he tries to make a deal with God or fate in return for his life (promises of being a better person, showing more concern for others, etc.). When this is seen to be futile, the person moves into a period of depression and preparatory grief over the loss of life and loved ones. Finally, in the last stages, a level of acceptance is reached -- a quiet expectation of death and a lessening of interest in the outer world, including loved ones. In our experience and that of others working with dying persons, these stages seldom occur as neatly and orderly as described here. Therefore, keeping the various stages in mind can be very useful in understanding the dying, as long as one does not depend on them too rigidly.

Break - 15 Minutes

Common Emotional Reactions as Expressed in Old Age

The elderly experience human feelings that are similar for people of every age, but as with each age, there is a uniqueness in the character of such feelings as they reflect the life events of old people. Both the uniqueness and the similarities bear examination if one is to clarify the distinctive nature of old age.
As has been previously discussed, grief as a result of loss is a predominate factor in aging. Loss of the marital partner or other significant and loved people can be profound, particularly since it is difficult in later life to find any kind of substitute for such losses.

The primary adaptive purpose of grief and mourning is to accept the reality of the loss and to begin to find ways of filling up the emptiness caused by the loss through identifying with a new style of life and new people. Parkes (1970), in his studies of London widows, describes the futile search for the lost love object in which the mourner is torn between the desire to recover or resurrect the dead person and the knowledge that this is irrational. A cultural adaptation is found in the practice of ancestor worship in Shintoism and Buddhism where the mourner believes the presence of a departed loved one remains (to be fed, prayed to, etc.) yet in a new spirit form that does not allow direct physical contact. Thus both the reality of death and the wishful recovery of the person are provided for in a religious belief that gives structure to grief process.

A typical grief reaction has an almost predictable pattern of onset, regardless of age -- numbness and inability to accept the loss, followed by the shock of reality as it begins to penetrate. There are physical
feelings of emptiness in the pit of the stomach, weak knees, perhaps a feeling of suffocation, shortness of breath, and a tendency to deep sighing. Emotionally the person experiences great distress. There may be a sense of unreality, including delusions and obsessive preoccupations with the image of the lost person and acting as though the deceased were still present as well as anger and irritability, even toward friends and relatives. There is usually a disorganization of normal patterns of response, with the bereaved person wandering about aimlessly, unable to work or take social initiative. Anxiety and longing alternate with depression and despair. Insomnia, digestive disturbances, and anorexia are common. Acute grief ordinarily lasts a month or two and then begins to lessen; on the average, grief may be largely over in six to twelve months, although further loss, stress, or some reminder can reactivate it.

"Morbid" grief reactions are distortions or prolongations of typical grief. Such reactions may take the form of delay, in which the grief is delayed for days, months, or even years, and in its extreme form is generally bound up with conscious or unconscious antagonism or ambivalence toward the deceased. Inhibited grief, according to Parkes, produces minimal mourning but other symptoms develop such as somatic illnesses, overactivity, or disturbed social interaction. Chronic
grief, yet another of the morbid grief reactions, is the prolongation and intensification of normal grief over an extended or limited period of time.

We have observed a not infrequent form of grief reaction that we call "enshrinement," which the survivor attempts to keep things just as they were before the death of a loved one occurred. The dead person's possessions and even entire rooms may be kept intact as shrines to the person's memory. The survivor may surround himself with photographs and memorabilia connected with the lost person and make regular and conscious attempts to evoke memories of the deceased. There may be frequent references to the dead person in conversation with others, as well as a deliberate avoidance of new contacts that might replace the role of the one who died. Much of this is due to survival guilt and a misplaced fear of infidelity if one were to take an active role in getting life moving again.

Anticipatory grief is the process of mourning in advance, before an actual loss is sustained. This form of mourning can occur during long illnesses; for example, a wife caring for a sick husband may go through a grief reaction and may have reached some degree of acceptance before death occurs. Such grief is seen as a protective device that prepares the bereaved for their loss, but it can lead to problems if it causes loved ones to disengage
themselves prematurely from the dying person, leaving him isolated and alone.

Interrelationships between grief and vulnerability to both physical and emotional illness have been the subject of a number of investigations. Bereavement as a loss is hypothesized to be the single most crucial factor in predicting decline or breakdown in functioning on a physical or emotional level. In addition, losses of health, money, possessions, employment, or social status or changes in appearance seem to be possible factors in precipitating decline or lowering resistance.

Guilt

Old age is a time of reflection and reminiscence that can evoke a resurgence of past conflicts and regrets. Guilt feelings may play a significant role as the elderly person reviews his life, attempting to consolidate a meaningful judgment as to the manner in which life has been lived and to prepare for death and cope with any fears of death. The sins of omission and commission for which an individual blames himself weigh even more heavily in the light of approaching death and dissolution. If expiation and atonement are to occur, they must occur now; time for procrastination begins to run out. Individuals who have held grudges for a lifetime may decide to resolve their differences. Some may undertake a variety of
reparations for the past. Others become more religiously active, in the hope of forgiveness. Such feelings should be dealt with seriously and not simply treated with facile reassurance. For many the resolution of guilt feelings is an essential part of final acceptance of their lives as worthwhile.

Other forms of guilt are the "death survival guilt" from outliving others and "retirement guilt" from no longer being employed and working. The latter is especially hard on Horatio Alger types.

**Loneliness**

In infancy, being alone is a condition that provokes terror, anger, and disconsolation. A baby's early cries communicate the primitive drive for physical survival. But very early a new element is introduced. As the child alternately experiences the gratifying warmth and comfort of his family and the aloneness of his crib, he learns a new fear, the fear of not being able to get back to people -- of being left alone. Thus, there appears to be two elements in the early sense of loneliness: aloneness, or the fear for physical survival in a threatening uncertain world and loneliness, the fear of emotional isolation, of being locked inside oneself and unable to obtain the warmth and comfort that one has learned is available from others if one can gain it. Growth and a refinement occur
as children move outside of themselves and their isolation, not only toward other people but also toward an absorption in play, learning, work, and other creative efforts. That moment is significant when the child first learns to escape his own aloneness or consciousness of himself and becomes totally involved in a task -- a moment described as an escape from loneliness, which is not dependent on the presence of another person. (Paul Tillich describes this as a distinction between loneliness and solitude.)

The etiology of loneliness developmentally is significant in regard to older people, not in a simplistic sense of comparing them to children but in attempting to comprehend the special character of loneliness in old age. The primitive fears concerning physical survival and emotional isolation recede as human beings grow to adulthood and learn to successfully provide for their own physical sustenance and achieve emotional satisfactions through family, friends, and work. But with old age, the combination of harsh external forces and diminishing self-mastery revives once again the latent threats. The old adage that we are born alone and we die alone reflects the experience that each of us encounters in the course of the life cycle. But, unlike the usual experience of children, the elderly person does not suffer so much from a fear of being unable to relate as from the reality of having no
one to relate to. With the death of loved ones there is a diminishing circle of significant people who are not readily replaceable. Former compensations of work may be gone. Children and grandchildren, if they exist, may live far away. The all too limited outlets of religion, hobbies, television, pets, and a few acquaintances, which form the daily existence of so many of the elderly, are not enough to satisfy emotional needs.

The American dream of self-reliance and independence can further isolate the older person within himself. At a time when increased human contact could be supportive, elderly people hold on to cultural notions that living alone and "doing for oneself" must be maintained. Familiarity with and determination to continue such patterns make communal living in hospitals, nursing homes, or group homes difficult in sheerly social terms. It has been observed that older people in more group-oriented societies such as the rural kibbutzim in Israel can enjoy the companionship and involvement inherent in a close living situation with others without the same loss of self-esteem and sense of dependency felt by "rugged individualists." Cultures that advocate societal and group responsibility for the individual are perhaps more in sympathy with the natural needs of older people.
Appendix E—Continued

**Depression**

Depressive reactions increase in degree and frequency with old age as a corollary to the increased loss of much that is emotionally valued by the elderly person. Unresolved grief, guilt, loneliness, and anger are expressed in mild to severe depressions with symptomatology including insomnia, despair, lethargy, anorexia, loss of interest, and somatic complaints.

**Anxiety**

The sense of free-floating anxiety intensifies in elderly people as illness and imminent death undermine illusions of invulnerability build up as protection during a lifetime. (A very powerful anxiety is the fear of becoming a pauper.) In addition, new modes of adaptation become necessary, creating additional anxieties in the face of constant change. Notice is seldom taken of the amount of new learning an older person must undergo to adapt to the accelerating changes in body, feelings, and environment. As with any new learning, anxiety develops in proportion to the task at hand, the resources available to master it, and the chances for and consequences of failure. Anxiety manifests itself in many forms: rigid thinking to protectively exclude external stimuli (a person may "hear what he wants to hear), fear of being alone, and suspiciousness to the point of paranoid states.
Appendix E—Continued

It may also become somatized into physical illness. Frequently anxiety and its expressions are incorrectly diagnosed as "senility" and wrongly considered untreatable.

One type of anxiety derives from life history, the observations of older people during one's childhood. For example, the fear that they will have the diseases of old age that as children they observed in their grandparents or in other older people is one possible ingredient in the denial or projection seen in the aged.

**Sense of Impotence and Helplessness**

A significant reaction for older men, particularly those white men who as a group can be postulated to have once held the power and influence of the society, is a sense of their present impotence and helplessness. The highest suicide rates occur among older white men in their eighties. The elderly black male and all women, black or white, are affected by loss of esteem and cultural status as they age but do not experience quite the same degree of loss of power and privilege. In fact, an interesting reversal can occur for older women within the traditional marital relationship. As their husbands decline, wives may assume more of the initiative, taking over financial management, nursing care, and household repairs; they may
therefore feel more status and influence than at any previous point in their lives.

Rage

Another of the emotional manifestations of old age is a sense of rage at the seemingly uncontrollable forces that confront the elderly, as well as the indignities and neglect of the society that once valued their productive capacities. The description of some older people as cantankerous, ornery, irritable, or querulous would be more realistically interpreted if one became sensitive to the degree of outrage the elderly feel, consciously or unconsciously, at viewing their situation. (Interestingly, grouchiness and pugnacity have been related to a longer life expectancy in one study.) Much of the rage is an appropriate response to inhumane treatment. Some older people, of course, rage against the inevitable nature of aging and death, at least at some point in their coming to terms with these forces, but this too would seem to be a legitimate reaction. Dylan Thomas's words, "Do not go gently into that good night," express the desire of many to be alive to the end and to die with a sense of worth and purpose, if not righteous indignation at being obliged to leave life.
Common Adaptive Techniques

Defense Mechanisms

The elderly have throughout their lifetimes acquired individual and characteristic methods of handling anxiety, aggressive impulses, resentments, and frustration. Such methods, known as defense mechanisms, are internal, automatic, unconscious processes whereby the personality protects itself by attempting to provide psychological stability in the midst of conflicting or overwhelming needs and stresses that are part of human existence. As people mature, some new defenses may be added and old ones discarded; but others persist throughout life, taking on different tones and colorations at different stages in the life cycle. Emphasis here will be on the defense mechanisms that most often appear in old age and on nuances that are characteristic of older people.

Denial

The denial of old age and death found in the young person's attitude of "This won't happen to me" may also occur in old age in the form of "This isn't happening to me." In one of its extreme forms denial can manifest itself in a "Peter Pan" syndrome, with the older person pretending to be young and refusing to deal with the realities of aging. There may be a self-attribution of strength-claiming that one is still capable of everything.
Not all denial is pathological. It is, in fact, a necessary and useful component for maintaining a sense of stability and equilibrium. But the usefullness of denial is eroded when it begins to seriously interfere with the developmental work of any particular age. In old age, an individual who denies that he is sick and refuses to take medicine or see a doctor is showing an example of denial that no longer accomplishes a life-protective purpose.

**Projection**

Some elderly persons attempt to allay anxieties by projecting feelings outward onto someone else. They may appear suspicious and fearful, with characteristic complaints and fears about situations that exist, either potentially or in actuality, and one runs the risk of denying reality by labeling them projection. But actual projection itself does occur, signifying internal stress (people with hearing losses are prime victims) and can reach paranoid proportions unless the stress is alleviated.

**Fixation**

Fixation is most often associated with old age as a carryover defense from earlier life, implying that the fixation point occurred somewhere in childhood. But if one views old age as having developmental work of its own, fixation is a useful concept in describing the elderly
person who may reach a particular level of development and be unable to go further. An example might be the person who has adapted well to living alone, without a spouse, but cannot accept in an insightful manner the need for outside help as physical strength wanes. Such a person may unconsciously want to stop the action and refuse to accept a new change.

**Regression**

Regression, or a return to an earlier level of adaptation, is an overused and catchall explanation for much behavior in old age. Familiar descriptions of older people as "childlike," "childish," or "in second childhood" imply a reverse slide back to earlier developmental stages with no cognizance of a lifetime of experience that unalterably separated them from their childhood patterns of coping. A perjorative connotation is given, with the notion that older people lose their "adultness" under stress of illness and age and begin to act like children. Regression implies a disruptive, deteriorative, nonadaptive retreat in which the personality is not up to facing the stress it must overcome; weakness is internal. But in old age much of the stress is from external sources that strain the resources of even the most healthy personalities. The use of the concept of regression to describe the attempts of
elderly people to adapt in such situations is similar to
the popular use of "paranoid" to describe the reactions of
black people to racism. What appears to be something
pathological may indeed be the normal and necessary
patterns of behavior.

Displacement

The function of displacement is to disguise the real
source of anxiety or discomfort for a person by placing it
on some other object or circumstance. For example, a
person whose body is drastically undergoing change may
displace the cause of his problems by declaring that the
world is going to ruin or that things are not the way they
were when he was young.

Counterphobia

Counterphobia is the compelling and sometimes risky
tendency to look danger in the face in an attempt to
convince oneself that it can be overcome. An elderly man
with dizzy spells may insist on climbing a ladder to fix
his own roof. Another, with a history of visual
blackouts, may demand that he drive the family car just as
before. A woman with heart trouble ignores her racing
pulse as she continues to carry tubs of laundry from her
basement. In each case the individual ignores a realistic
appraisal of his limitations and relies upon sheer force
of will to undo the danger.
Idealization

One type of defense is the idealization of the lost object, be it person, place, lifestyle, or status. A person may, for instance, idolize a deceased mate, glorifying the past and the good old days.

Rigidity

There is little evidence that older people become rigid in personality as they age. Rather, when rigidity is seen, it is a defense against a general sense of threat or actual crises.

Other Defensive Behavior
Selective Memory

The dulling of memory and the propensity to remember distant past events over the recent past have generally been attributed to arteriosclerotic and senile brain changes in old age. However, it appears that such memory characteristics can at times have a psychological base, in that the older person may be turning away from or tuning out the painfulness of the present to dwell on a more satisfying past.

Selective Sensory Reception

A process of "exclusion of stimuli" described by Weinberg (1956) has been observed in elderly people, by which they block off the sensorium that they feel
unprepared to deal with. This is more often observed in people with hearing problems, who at times seem to hear what they want to hear. This may be the only way an older person can control the amount of input impinging upon him.

**Exploitation of Age and Disability**

Elderly people can use changes occurring in their lives to obtain secondary gains -- that is, benefits which in and of themselves may be satisfying or desired. An example is shown by older persons who insist they must remain in a hospital or other care facility, even though they no longer need medical care, because they enjoy the extra attention and sense of importance accruing from the illness. Or an individual with a proclivity to control others can use illness or impending death to manipulate those around him. Examples are the tyrant on the sick bed who terrorizes family and friends through guilt, and the invalid who commandeers personal services from everyone through appearing totally helpless and passive. Exploitation of age and disability can also result in freedom from social expectation; with the elderly person not feeling bound by the social amenities and established patterns. In this sense, the defensive behavior may allow the person to try on a new identity or a new way of relating. Behavior that in youth might have been
considered unacceptable or even bizarre can be viewed in old age as pleasantly idiosyncratic or at least harmless.

An interesting form of age exploitation is what we have called the "old man" or "old woman" act. This is the older person who, even when physically and mentally sound, puts on the act of being a tottering, frail, helpless "old" person. This phenomenon can occur as early as the fifties but may be used by older people at any age to avoid responsibility toward themselves and others and to evoke sympathy. Sometimes the older person uses this act very selectively on those who are most gullible while appearing quite sound and capable to others.

Restitution, Replacement, or Compensatory Behavior

Numerous activities may be adopted to make up for a loss. These may include practical measures such as memory pads and reminders of all kinds to compensate for poor memory. Or they can take the form of finding new persons to replace lost ones. Attempted restitution is frequently seen, in which a person tries to give back or get back that which has been lost or taken away.

Use of Activity of Busyness

General busyness, known as "working off the blues," is a defense against depression, anxiety, and other conditions that are painful or unacceptable. It involves concentrating on activity of some kind, whether productive
or nonproductive, with the purpose of warding off the unwanted feelings.

**Insight as an Adaptive Technique**

Successful adjustments to real life conditions are not optimally possible if feelings and behavior are unconsciously motivated and therefore not subject to conscious control. Similarly, it can prove nonadaptive to be unaware of the natural course of life: what to expect, what can be changed, and what cannot. Thus, insight requires not only an inner sense of oneself and motivations but also an inner knowledge of the human life cycle — a realization of life and how it changes. The elderly individual who has a steady comprehension of the life process from birth to death is thereby assisted in his efforts to decide what to oppose and what to accept, when to struggle and when to acquiesce, and, ultimately, to understand the limits of what is possible. An example is what one of us calls "responsible dependency." This concept implies the realistic evaluation of when one begins to require help from others and an ability to accept that help with dignity and cooperativeness, rather than denying the need or abusing the opportunity to be dependent. Insight includes the willingness and ability to substitute available satisfactions for losses incurred.
It is the most widely used and successful adaptation found in healthy older people.

Related to adaptation is the changing adaptiveness found with psychopathology. Paranoid personality structures appear to become even less adaptive with age as the few persons in the paranoid's circle die, isolation hardens, and crises occur. On the other hand, the schizoid personality structure seems to insulate against loss. The obsessional and compulsive personality whose fussbudget behavior may have impaired his effectiveness earlier in life may adjust well to void of retirement or losses, through meticulous and ritualistic activities.

The Life Review

The tendency of the elderly toward self-reflection and reminiscence used to be thought of as indicating a loss of recent memory and therefore a sign of aging. However, Butler (1961) postulated that reminiscence in the aged was part of a normal life review process brought about by realization of approaching dissolution and death. It is characterized by the progressive return to consciousness of past experiences and particularly the resurgence of unresolved conflicts which can be looked at again and reintegrated. If the reintegration is successful, it can give new significance and meaning to one's life and prepare one for death, by mitigating fear and anxiety.
This is a process that is believed to occur universally in all persons in the final years of their lives, although they may not be totally aware of it and may in part defend themselves from realizing its presence. It is spontaneous, unselective, and seen in other age groups as well (adolescence, middle age); but the intensity and emphasis on putting one's life in order are most striking in old age. In late life people have a particularly vivid imagination and memory for the past and can recall with sudden and remarkable clarity early life events. There is renewed ability to free-associate and bring up material from the unconscious. Individuals realize that their own personal myth of invulnerability and immortality can no longer be maintained. All of this results in reassessment of life, which brings depression, acceptance, or satisfaction.

The life review can occur in a mild form through mild nostalgia, mild regret, a tendency to reminisce, storytelling, and the like. Often the person will give his life story to anyone who will listen. At other times it is conducted in monologue without another person hearing it. It is in many ways similar to the psychotherapeutic situation in which a person is reviewing his life in order to understand his present circumstances.

As part of the life review one may experience a sense of regret that is increasingly painful. In severe forms
it can yield anxiety, guilt, despair, and depression. And in extreme cases if a person is unable to resolve problems or accept them, terror, panic, and suicide can result. The most tragic life review is that in which a person decides life was a total waste.

Some of the positive results of reviewing one's life can be a righting of old wrongs, making up with enemies, coming to acceptance of mortal life, a sense of serenity, pride in accomplishment, and a feeling of having done one's best. It gives people an opportunity to decide what to do with the time left to them and work out emotional and material legacies. People become ready but in no hurry to die. Possibly the qualities of serenity, philosophical development, and wisdom observable in some older people reflect a state of resolution of their life conflicts. A lively capacity to live in the present is usually associated, including the direct enjoyment of elemental pleasures such as nature, children, forms, colors, warmth, love, and humor. One may become more capable or mutuality with a comfortable acceptance of the life cycle, the universe, and the generations. Creative works may result such as memoirs, art, and music. People may put together family albums, scrapbooks and study their genealogies.

One of the greatest difficulties for younger persons (including mental health personnel) is to listen
thoughtfully to the reminiscences of older people. We have been taught that this nostalgia represents living in the past and a preoccupation with self and that it is generally boring, meaningless, and time-consuming. Yet as a natural healing process it represent one of the underlying human capacities on which all psychotherapy depends. The life review as a necessary and healthy process should be recognized in daily life as well as used in the mental health care of older people.
References


Note: This section was adapted from Butler, R.N. & Lewis, M.I., *Aging and mental health: Positive psychosocial approaches*. Saint Louis: C.V. Mosby Co., 1977, Chapter 3.
D. Discussion of Being a Volunteer (30 minutes)

Divide into three groups with each group composed of an equal number of adolescents and older adults. Discussion should focus on the expectations of working with a resident. Issues which should be explored are: any problems anticipated; physical illnesses which they might encounter; responses they might expect form the resident; emotional state of the resident (i.e., loneliness) and various activities to do with the residents.

Lunch (12:00 - 1:00)
Session II - Afternoon (1 - 4pm)

A. Community Supports Following Discharge Lecture
(60 minutes)

This section will include information regarding community supports available to residents following discharge from the nursing home. A representative from the Department of Welfare, the Mental Health Clinic, Legal Aid Services, Health Department, and the Area Agency on Aging will present brief overviews of each agency.

The information to be provided in each presentation will include:

**Welfare:** General criteria for determination of eligibility; food stamps; rental assistance; oil and heat allowance; companion services; health related services; and other financial assistance.

**Mental Health:** Fee based on sliding scale; individual and group counseling; couple or family therapy; psychiatric consultation for mediation management; Day Treatment Program; Aftercare Program; alcohol and drug abuse counseling; psychological testing; community outreach programs.

**Legal Aid Services:** Eligibility; types of cases handled by agency, e.g., consumer and employment problems (contracts, warranties, bankruptcies, job
discrimination, etc.); administrative matters (Social Security, SSI Benefits, Health Law appeals, etc.); housing problems (landlord/tenant complaints, subsidized housing, housing discrimination, etc.); domestic concerns (divorce, custody, adoption, etc.).

**Health Department:** Eligibility and sliding fee schedule: Home Health Nursing (skilled nurses); Chronic Disease Program (periodic home visits and medical check-ups).

**Area Agency on Aging:** Nutrition Services Program; socialization programs; transportation services; the Voice of America newsletter; homemaker service; Advocacy and Counseling services; senior discounts; emergency grants; Home Winterization services; the Retired Senior Volunteer Program (RSVP).

**B. Nutritional Needs of the Elderly Lecture (25 minutes)**

This section will be presented by the clinic nurse. Lecture and discussion will focus on changes in nutritional needs that come with physiological aging. Importance of sufficient vitamin and nutrient balance in the daily diet will be emphasized. Some common diet deficiencies and their consequences will be explored. Current trends in nutritional counseling with the aged and results of diet supplement studies will be reviewed.
C. Film and Discussion (60 minutes)

"Interdependent Relationships"

Focuses on members of the older generation who have successfully addressed the issue of aging and are experiencing the "Prime Time" of their lives. It emphasizes the accomplishments of the older generation, their characteristics, their philosophies, and their uniqueness. This film shows a few examples of the kinds of interdependent relationships we have as we grow older and how they affect the quality of our lives.

D. Wrap-up (20 minutes)

Review of topics covered throughout the course of the education workshop; clarification of any questions or concerns of group members; procedures to be followed in assignment of nursing home resident; designation of groups supervision date and time.

E. Reaction Form (10 minutes)
Appendix F

REACTION FORM

Please fill out this form anonymously.

In the first seven questions circle the number that best describes your feelings concerning that question.

On numbers eight through twelve answer in a brief sentence or two.

1. How interesting was today’s session to you?
   Very interesting
   1 2 3 4 5
   Not at all interesting

2. How much do you feel you learned in today’s session?
   Very much
   1 2 3 4 5
   Nothing at all

3. How applicable were the topics discussed today to the work you do with the elderly?
   Very much
   1 2 3 4 5
   Not at all

4. How helpful was the procedure part of the session in helping you to learn the skills (to better understand the client/patient)?
   Very helpful
   1 2 3 4 5
   Not at all helpful
5. How well do you feel you understand the skill so that with more practice you could use it effectively with clients/patients?

Very well  Not at all

1   2   3   4   5

6. How clearly do you feel the material was presented by the trainer?

Clearly  Not Clearly

1   2   3   4   5

7. How much do you feel this work will help you with your work with the nursing home residents?

Very Much  Not at all

1   2   3   4   5

8. What was the valuable part of the training presented today? Why?

9. What was the least valuable part of the training presented today? Why?

10. What would you suggest to improve the session?

11. Please list the things we talked about today that you would like to know more about.
12. Would you have come to this session if not required?

13. Other comments
References


